Tackling social inequalities to reduce mental health problems: How everyone can flourish equally

In-depth report

Why some communities and people face much greater risks of mental health problems and what we can do to improve mental health for all - leaving no-one behind.
“Whatever affects one directly, affects all indirectly. I can never be what I ought to be until you are what you ought to be. This is the interrelated structure of reality.”

Dr Martin Luther King
Contents

7. **Introduction**

9. A socio-ecological model for promoting mental health

15. Structure of the report

16. Note on the limits of our knowledge

18. **1. The nature and extent of mental health inequalities**

21. 1.1 The social gradient in mental health

24. 1.2 How do socioeconomic inequalities lead to mental health problems?

30. 1.2.1 The mechanism linking socioeconomic inequalities and mental health problems

33. 1.3 Summary of the nature and extent of mental health inequalities

33. **2. Mapping the problem: inequalities that influence mental health**

39. 2.1 Economic determinants

39. 2.1.1 Living in poverty/debt/income inequality
42. 2.1.2 Employment and unemployment
44. 2.1.3 Quality of employment
48. 2.1.4 Education level
51. 2.1.5 Summary of socioeconomic determinants
52. 2.2 Other relational determinants
52. 2.2.1 Cultural/social group status
63. 2.2.2 Adverse childhood experiences (ACEs)
71. 2.2.3 Adverse experiences in adulthood
78. 2.2.4 Summary of relational determinants
79. 2.3 Health/disability/ageing determinants
79. 2.3.1 Health risk
80. 2.3.2 Long-term conditions
82. 2.3.3 Physical and sensory disability
84. 2.3.4 Learning disability
86. 2.3.5 Substance misuse
87. 2.3.6 Summary of health/disability/ageing determinants
89. 2.4 Ecological determinants
3. Tackling socioeconomic inequalities to reduce mental health problems

3.1 Why action is needed to prevent mental health problems

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

3.3 How inequalities can be addressed

3.3.2 Effective structural approaches for reducing the impact of inequalities

3.3.3 The whole community model

3.3.4 Mobilising community assets

3.3.5 Genuine co-production: the shift to “power with”
3.4 Examples of interventions at individual level to prevent mental health problems and promote mental wellbeing

Conclusion

References
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 make-up, 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 and highlights where we can be most effective in our efforts to prevent mental health problems for future generations and for those at risk now.
Flourishing unequally

Child adversity / trauma

Unemployed / economically strained

Economically secure / well-housed / majority culture / well-educated

Minority status

Disability / health condition

Poor environment
A socio-ecological model for promoting mental health

Within the field of public health, there is recognition that health is determined by a multi-dimensional and symbiotic relationship between the individual and the layers of their environment; from the family home, through to the wider social and physical environment in which we live including the cultural and political context. This describes a socio-ecological approach to health that has been advocated by Evans and Stoddart\(^{(1,2)}\) amongst others and applied to human development by Bronfenbrenner.\(^{(3)}\)

As part of this human development theory, Bronfenbrenner describes the environment as containing four systems that interact with each other and with individual development:

- **Microsystems** – immediate social and physical surroundings, such as home, family, neighbourhood and friendship groups.

- **Mesosystems** – wider systems within the environment, such as schools and health care.

- **Exosystems** – social, political and economic conditions, such as the policy and legal environment including housing and welfare system, the cost and standards of living.

- **Macrosystems** – beliefs and attitudes shared by members of society, including stigma and prejudice, views on social justice, equality and inclusion.
This socio-ecological model of health has much to offer within a mental health context where there can be a tendency to focus attention on the individual in isolation from the social and ecological conditions in which they exist. An individualised approach is being increasingly contested by many, including clinicians who understand the impact that environmental systems have had on the psycho-social development of individuals.
In recent years, the debate on nature versus nurture has been further invigorated by research examining whether mental health can be influenced in utero through parental exposure to stressors. Epigenetics has further added to this discourse with research revealing that genes can be activated or not, dependent on influences such as experiences of adverse life events. Brain development in childhood also relies heavily on relational factors including secure attachment and attunement with caregivers/parents. At worst neurogenesis, the growth of new brain cells within the infant, can be reduced and development of prosocial skills inhibited in contexts of insecure attachment and/or attunement with caregivers/parents.

Mental health must therefore be considered as a dynamic state, whereby individual psycho-social development is influenced by multiple layers of intersecting social and environmental factors. This starts in the womb, with the mental and physical health status of mothers during pregnancy affecting the developing foetus. The very early years are greatly affected by parental bonding and the home environment in infancy. Thereafter factors such as: exposure to nurture or conversely neglect or abuse in childhood; relationship, financial/employment and health/housing status in adulthood; and levels of social and community connectedness in later life all have a part to play in influencing an individual’s mental health.

It is therefore crucial that if mental health problems are to be prevented, then the social, economic, health and ecological
environment in which they arise need to be addressed. Understanding how these factors influence risk and how this can be mitigated is vital.

**Table 1: Main social determinants of mental health**

<table>
<thead>
<tr>
<th>RISK FACTORS</th>
<th>PROTECTIVE FACTORS</th>
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</thead>
<tbody>
<tr>
<td><strong>Early Years</strong></td>
<td>• Positive parenting</td>
</tr>
<tr>
<td>• Parental neglect</td>
<td>• Nurturing home environment</td>
</tr>
<tr>
<td>• Parental substance misuse</td>
<td>• Strong attachment</td>
</tr>
<tr>
<td>• Parental mental health problems</td>
<td>• Adequate household income</td>
</tr>
<tr>
<td>• Disability</td>
<td>• Parents’ education level</td>
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<tr>
<td>• Family poverty</td>
<td>• Parental mental health</td>
</tr>
<tr>
<td>• Family adversity</td>
<td>• Safe &amp; secure housing</td>
</tr>
<tr>
<td></td>
<td>• Health &amp; social care provision</td>
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<tr>
<td><strong>Childhood &amp; Teens</strong></td>
<td>• Supportive parenting</td>
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<tr>
<td>• Malnutrition</td>
<td>• Emotional literacy</td>
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<tr>
<td>• Parental divorce</td>
<td>• Friendships</td>
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<tr>
<td>• Adverse childhood experiences (e.g. abuse)</td>
<td>• Affirmation of sexuality</td>
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<tr>
<td>• Parental substance misuse</td>
<td>• Positive body image</td>
</tr>
<tr>
<td>• Parental mental health problems</td>
<td>• Good education</td>
</tr>
<tr>
<td>• School failure/drop-out</td>
<td>• Adequate household income</td>
</tr>
<tr>
<td>• Child poverty</td>
<td>• Safe &amp; secure housing</td>
</tr>
<tr>
<td>• Lack of green &amp; blue space</td>
<td>• Access to green &amp; blue space</td>
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<tr>
<td></td>
<td>• Access to recreation facilities</td>
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<tr>
<td></td>
<td>• Cultural respect</td>
</tr>
<tr>
<td></td>
<td>• Opportunities for participation</td>
</tr>
<tr>
<td></td>
<td>• Health &amp; social care provision</td>
</tr>
</tbody>
</table>
### Protective Factors

- Self-esteem
- Connectedness
- Mental health literacy
- Adequate household income
- Employment / good quality job
- Educational attainment
- Safe & secure housing
- Low density living area
- Access to green & blue space
- Access to recreation facilities
- Cultural respect
- Opportunities for participation
- Health & social care provision

### Risk Factors

- Isolation
- Adverse experiences / trauma
- Poverty / debt
- Prejudice / discrimination
- Low educational attainment
- Unemployment / poor quality job
- Insecure / unsafe housing
- Deprived or dense living area
- Lack of green & blue space

### Protective Factors

- Connectedness
- Positive roles
- Adequate household income
- Educational attainment
- Safe & secure housing
- Low density living area
- Cultural respect
- Opportunities for participation
- Health & social care provision

### Risk Factors

- Bereavement
- Isolation
- Poverty / debt
- Insecure / unsafe housing
- Deprived or dense living area
- Lack of green & blue space
- Adverse experiences
- Prejudice / discrimination
- Impairment and disablement
- Inadequate health & social care provision

### Protective Factors

- Connectedness
- Positive roles
- Adequate household income
- Educational attainment
- Safe & secure housing
- Low density living area
- Cultural respect
- Opportunities for participation
- Health & social care provision

Adapted from A. Kousoulis (2019) [296]
The bi-directional and intersecting connections between people’s mental health and the physical and social environments in which they live can paint a complicated picture for policy makers and service commissioners, resulting in a hesitancy to act. However, if society is to thrive in the future then grappling with this complexity will be necessary. The solutions and resources to support good mental health will not exist in the health system alone. In this report we will explain why working across public policies and services to identify and reduce those conditions that place people at higher risk of developing mental health problems is not only desirable but essential.

Mental ill-health has for centuries 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 report will show, addressing social, economic, cultural and environmental inequalities will take us a long way towards achieving this goal.
**Structure of the report**

Following this introduction, the report is set out in three chapters that aim to provide:

1. An analysis of the relationship between inequality and mental health – providing an overview of the evidence that mental health problems are linked to socioeconomic inequalities and some theories on the mechanism that links them.

2. A chapter that maps the types of inequalities that negatively affect mental health. To this end we have chosen to examine the social determinants of mental health and not its genetic or biological influences, which are generally less within our control.

3. The case for cross-sectoral action – explaining why mental health should be a central priority in all public policy, service development and implementation, and why prevention needs to be the starting point to reduce the impact of mental health problems. This chapter presents a socio-ecological model to underpin preventative action and then describes specific actions that can help to prevent mental health problems. The chapter concludes with some examples of promising cross-sectoral practice. These initiatives are aimed at building resilience within individuals, families and communities.
Note on the limits of our knowledge

Every attempt has been made for this report to be rooted in the best available evidence on the issue of mental health inequalities, as there is a wealth of evidence on the social, economic, cultural and environmental circumstances in which we live, and their impact on our mental health.

However, it should be acknowledged that historically and to this day, there has been an underrepresentation of women and minority communities in research. The reasons for this are structural and complex but they include, among other factors, 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. This has led to a relatively 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 mental health risk to which certain population groups are exposed.

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 complex and multi-faceted
and focusing on one aspect of individual or group identity or experience at the expense of another can sometimes mean we miss a more detailed and diverse understanding of how things such as 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. This link between poverty and mental health has been recognised for many years and is well evidenced. 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 experiencing discrimination in employment and a 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. The seminal report of the Strategic Review of Health Inequalities in England, chaired by Professor Sir Michael Marmot, addressed the “social determinants” of health. The report described the relationship between socioeconomic position and health, including mental health status. 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. Mental health also worsens with each step decrease in income; this is referred to as a “social gradient”, meaning that mental health problems are more common further down the social ladder. The World Health Organization (WHO) supports the idea of a social gradient in mental health, stating that “common mental disorders are distributed according to a gradient of economic disadvantage,” and that people who are economically disadvantaged have higher rates of common mental disorders. The social gradient is evident from early childhood, with children as young as three and five years of age showing a social gradient for socio-emotional and behavioural difficulties. Thus, while absolute income matters because it determines how much one is able to purchase for one’s health, relative position in the hierarchy of income groups can also affect one’s potential for experiencing good mental health. This social gradient is not purely economic in nature, as it is also affected by cultural, relational and environmental influences.

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. The evidence points to worse mental health in more economically unequal countries, even for people in higher income groups. So, for example, Wilkinson and Pickett (2018) report a UK study which found that not only are the bottom 20% of the population, in income terms, more likely
to have a common mental disorder than the top 20%, but also that the increased risk is not restricted to the poorest group – men in the second highest income group were at higher risk than those in the highest income group.\(^\text{(14)}\)

Beyond financial circumstances and economic position, a variety of other social circumstances are known to be associated with poor mental health. These social statuses can relate to being in a disadvantaged group (such as, black, Asian and minority ethnic [BAME] communities or lesbian, gay, bisexual, transgender/transsexual plus [LGBT+]), being female, having a long-term physical health condition, or having certain experiences. Such experiences 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. These social inequalities are mapped in more detail in the next chapter.
1.2 How do socioeconomic inequalities lead to mental health problems?

While the associations between inequalities and mental health problems have long been recognised, it is only in the last ten years or so that researchers have made a strong case that such inequalities can cause mental health problems.

With regard to health in general, the Strategic Review of
Health Inequalities (Marmot Review group) put forward the view that social inequalities cause health inequalities. Building on the evidence of the WHO’s Commission on the Social Determinants of Health, which had concluded that “social injustice is killing on a grand scale” (16), the Marmot Review group found that in England, “[i]nequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age.” (13) Contrary to some explanations, the strategic review argued that these inequalities cannot be attributed simply to genetics, differences in behaviour, or difficulties in access to health services. Thus the strategic review group strongly advocated for action to address social inequalities. In early 2020, the case for addressing health inequalities was reiterated with the publication of Health Equity in England: The Marmot Review 10 Years On. (17) A decade after his first report, Sir Marmot’s update showed that rather than a reduction in inequalities, a range of socioeconomic inequalities affecting health had persisted or worsened. Most significantly, increases in life expectancy had slowed since 2010, with the slowdown greatest in more deprived areas of the country. Furthermore, inequalities in life expectancy had increased since 2010, especially for women, while healthy life expectancy had declined for women since 2010 and the percentage of life spent in ill health had increased for men and women.

More recently, a similar argument has been made about social inequalities and mental health. In 2014, the WHO published
its paper The Social Determinants of Mental Health, concluding that action to reduce social inequalities is likely to improve the mental health of the population and prevent mental health problems. WHO stated that “considerable and growing evidence shows that mental health and many common mental disorders are shaped to a great extent by social, economic and environmental factors.” To substantiate their view, they highlighted systematic review evidence supporting a relationship between socioeconomic disadvantage and depression. They also referred to evidence supporting a link between gender and mental disorders, with disorders being more common among women. They pointed out that this social gradient exists even in early childhood, with children as young as three and five years of age showing a social gradient for socioemotional and behavioural difficulties. Other evidence supports an income inequality-associated risk for common mental disorders, suicide, alcohol and cannabis use, first episode psychosis, and schizophrenia.

Similarly, Wilkinson and Pickett summarise the case that income inequality leads to mental health difficulties in their book The Inner Level. They argue that income inequality is leading to increased social anxiety, which in turn engenders greater levels of mental health problems. The mechanisms by which this may occur are discussed in more detail below.

A crucial point requiring consideration is that becoming more prosperous as a nation does not in itself improve mental health
if the inequality gap remains. As argued by the Strategic Review of Health Inequalities group, inequality can have a negative impact on the whole of society, though particularly those at the lower end of the spectrum.

1.2.1 The mechanism linking socioeconomic inequalities and mental health problems

How do the negative effects of socioeconomic inequalities happen? There are a number of prominent explanations for the link between economic inequality and increased risk of mental health problems, including explanations based on social comparison, differences in levels of trust and social connectedness, and material conditions.

One of the most widely discussed is the social anxiety, social status, or social comparison hypothesis. This social status hypothesis proposes that mental health problems arise due to social comparison between people of lower and higher rank in contexts of income inequality. In other words, people in lower ranked groups experience mental or emotional distress due to how they compare themselves with others of higher rank. Analyses of large-scale datasets have found supporting evidence for the social status hypothesis. However, the extent to which the social status hypothesis can wholly explain the phenomenon is not yet known. At least one study has not found support for the hypothesis, rather concluding that neither social comparison nor coping resources can explain
levels of status anxiety.\(^{(24)}\) Another finds support for a weak version of the thesis, showing that low-inequality countries reported less status anxiety than higher inequality countries at all points on the income-rank curve, but not a stronger version of it, which would require evidence that the negative effect of income rank on status anxiety is exacerbated by increasing income inequality.\(^{(21)}\)

Some authors argue that other factors, such as the material conditions resulting from financial hardship, may explain anxiety better than processes of social comparison. For example, Sommet, Morseli and Spini (2018) carried out an analysis which found that the psychological effects of income inequality can be explained by scarcity. In cross-sectional analysis of large-scale international data sets, they found that the within-country effect of national income inequality on feelings of unhappiness was limited to individuals facing scarcity, while longitudinal national data from Switzerland revealed that the within-life-course effect of local income inequality on psychological health problems was also limited to individuals facing scarcity.\(^{(25)}\)

Another explanation is the social capital thesis, which argues that inadequate bonds of trust and less frequent interaction between unequal groups gives rise to poorer mental health outcomes.\(^{(19)}\) If this thesis were proven, then it could mean that building stronger social bonds could protect against mental health problems. Systematic review evidence shows a well-substantiated relationship between so-called individual-level
“cognitive social capital” (perceived trust and reported social engagement) and mental health such that higher levels of cognitive social capital at the individual level have been found to be protective against common mental disorders. This same research found support for the idea that social capital at the community level protects against common mental disorders. In terms of the longitudinal effects of socioeconomic inequalities, the dominant theory is that social disadvantage and its associated stress accumulate in their impact on mental health throughout the lifespan:

“A dominant hypothesis linking social status and mental disorders focuses on the level, frequency, and duration of stressful experiences and the extent to which they are buffered by social supports in the form of emotional, informational, or instrumental resources provided by or shared with others, and by individual capabilities and ways of coping. Those lower on the social hierarchy are more likely to experience less favourable economic, social, and environmental conditions throughout life and have access to fewer buffers and supports. These disadvantages start before birth and tend to accumulate throughout life, although not all individuals with similar exposures have the same vulnerabilities; some are more resilient or have access to buffers and supports to mitigate the potential mental health effects of disadvantage and poverty.”
These factors will affect each individual differently, depending on how they are buffered by resources such as social support, financial resources and emotional resilience, but overall it is harder to develop this resilience and have access to the right social support when you 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.

One way that inequalities engender later mental health problems is through the impact of adverse childhood experiences (ACEs). A growing body of evidence supports a link between exposure to ACEs and poor physical and mental health outcomes. Experiencing an ACE represents an inequality in itself, but children are also more likely to experience adverse experiences in conditions of socioeconomic deprivation.

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,\(^{(34,35)}\) and ACEs have been found to account for 29.8% of mental disorders.\(^{(36)}\) ACEs are said to engender chronic stress which then leads to problems with child development; these problems, in turn, lead to health-harming behaviours and poor mental health. Ashton, et al. (citing Petchel and Pizzagalli, 2011) state that:

“Chronic exposure to ACEs can affect neurological, immunological and hormonal system development. As a result, individuals exposed to such experiences during childhood may develop problems with emotional regulation, cognitive response, attachment, memory and learning that can continue into and throughout adult life.”\(^{(32)}\)

There is growing evidence that the impact of ACEs is cumulative, that is, the greater number of ACEs one experiences, the more likely one is to have a mental health problem.\(^{(37–39)}\) One study of the impact of ACEs on young people’s mental health in the USA found that ACEs were strongly associated with depressive symptoms, drug misuse and anti-social behaviour.\(^{(37)}\) This study among young people from socioeconomically disadvantaged communities also found that the effect of ACEs was cumulative. A 2017 study in Wales has found that having at least four ACEs is strongly associated with increased risk of mental health problems and alcohol misuse.\(^{(38)}\) The authors of this study again emphasise that the impact of ACEs is cumulative, with greater risk of poor health outcomes arising from a greater number of ACEs. They advocate that “to
sustain improvements in public health requires a shift in focus to include prevention of ACEs, resilience building, and ACE-informed service provision.” Copeland, et al. (2018) also found associations between cumulative trauma and mental health problems in adulthood. Importantly, their analysis is drawn from a prospective designed longitudinal study that assessed trauma exposure from children and their parents up to eight times in childhood from ages nine to sixteen years. Participants were then followed up four times in adulthood from ages nineteen to thirty years to study adult mental health and functional outcomes.(40)

Apart from mental health problems, these experiences can lead to a range of other undesirable social and health outcomes that can cast a long shadow well into adult life, such as poor educational achievement, adoption of health harming behaviours and poorer sexual and physical health. Professor Mark Bellis has stated that:

“By stopping abuse, neglect and other harmful experiences faced by children we could prevent around a third of all high-risk drinking, a quarter of smoking and as much as 60% of violence in adults.”(41)

There are overlaps between adverse childhood experiences and the wider issue of trauma, which has also been linked to mental health problems. As described in the Mental Health Foundation and Centre for Mental Health’s paper Engaging
with Complexity: Providing effective trauma-informed care for women (2019), a traumatic experience has been defined as:

“an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual wellbeing.” (Substance Abuse and Mental Health Services Administration, 2014)

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 include: sleep disturbances, impulsive behaviour, mood swings, impaired judgement, poor memory, dissociation, intrusive thoughts, lowered immune-system functioning, greater risk of cardio-vascular disease, a greater risk of mental health disorders and a greater risk of substance misuse issues.

1.3 Summary of the nature and extent of mental health inequalities

- Populations living in poor socioeconomic circumstances are at increased risk of mental health problems and lower mental wellbeing.

- There is a “social gradient” to mental health problems, meaning that mental health problems are more common further down the social ladder.
• While poverty and income are the most widely influential factors driving lower levels of mental health in populations, a range of other disadvantaged social statuses also have a negative impact. These social statuses can relate to being in a disadvantaged group (for example a BAME community, LGBT+), being female, having a long-term physical health condition, or having certain experiences, such as prejudice, discrimination, sexual, emotional or physical abuse, exposure to a natural disaster, homelessness, or other adverse experiences in childhood or later life.

• There are several theories to explain how inequalities affect mental health, including those based on social comparison, differences in levels of trust and social connectedness, and material conditions.

• Adverse childhood experiences, including experiencing physical, sexual or verbal abuse, violence, parental separation, bereavement and being in a household with mental illness, alcohol or substance misuse, or where a household member has been imprisoned, are known to create a higher risk of mental health and substance misuse problems.

• Trauma experienced by individuals at any age is known to increase the risk of their developing mental health problems.

• Both adverse childhood experiences and trauma occur more often among people in socially disadvantaged groups.
• Reducing socioeconomic inequality and its effects is likely to reduce mental health problems at the population level, as well as reducing the incidence of ACEs and trauma that can lead to mental health problems in later life.
2. Mapping the problem: Inequalities that influence mental health

In this report, we present the specific 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. Mapping the problem: inequalities that influence mental health

2. Other relational influences

3. Health, disability and ageing influences

4. Ecological 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 to enable us to examine 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. The characteristics that are protected by the Equality Act 2010 are: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief and sex. 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 have experienced one or more types of trauma, who are in recovery from mental health problems, those experiencing abuse or being victimised and those who belong to more than one of these groups, which often intersect with one another.
2. Mapping the problem: inequalities that influence mental health

Table 2: An overview of socioeconomic, relational, health and ecological risk factors for mental health problems relevant in the UK, with indicative levels of experience

<table>
<thead>
<tr>
<th>PRIORITY RISK GROUP</th>
<th>Prevalence of mental health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOCIOECONOMIC</strong></td>
<td></td>
</tr>
<tr>
<td>1. Low income</td>
<td>73% of people living in the lowest household income bracket (less than £1,200 per month) reported having a mental health problem, compared to 59% in the highest household income bracket (over £3,701 per month).&lt;sup&gt;(43)&lt;/sup&gt;</td>
</tr>
<tr>
<td>2. Unemployed</td>
<td>34% of unemployed people have been found to have mental distress compared to 16% of those in employment.&lt;sup&gt;(44)&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>OTHER RELATIONAL</strong></td>
<td></td>
</tr>
<tr>
<td>3. Gender</td>
<td>In 2014, young women in England were three times more likely than men to have experienced symptoms of a common mental health problem in the prior week.&lt;sup&gt;(45)&lt;/sup&gt;</td>
</tr>
<tr>
<td>4. BAME</td>
<td>People from Black African and Caribbean communities are 40% more likely than white British people to come into contact with mental health services through the criminal justice system, rather than being referred from GPs or psychological therapists.&lt;sup&gt;(46)&lt;/sup&gt;</td>
</tr>
<tr>
<td>5. Refugees</td>
<td>Refugees who have resettled in Western countries are 10 times more likely to have post-traumatic stress than the general population.&lt;sup&gt;(47)&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
### Mapping the problem: inequalities that influence mental health

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td><strong>OTHER RELATIONAL (CONT.)</strong></td>
<td></td>
</tr>
<tr>
<td>6. LGBT</td>
<td>34.9% of lesbian, gay, bisexual or other teenagers aged 14-19 in England had a mental disorder in 2017 compared to 13.2% of heterosexual teenagers.(^{48})</td>
</tr>
<tr>
<td>7. Adverse childhood experiences</td>
<td>Childhood adversities accounted for 29.8% of all mental ill-health across 21 countries.(^{56})</td>
</tr>
<tr>
<td>8. Looked after children</td>
<td>46.4% of looked after children in Britain have a mental health problem.(^{49})</td>
</tr>
<tr>
<td>9. Prisoners</td>
<td>A large-scale 2019 study in the London area found that prevalence rates among the prison population were between 4.5 and 5 times higher than the general population for personality disorder, anxiety, mood disorders and post-traumatic stress disorder, while rates were also higher for psychosis and eating disorders.(^{50})</td>
</tr>
<tr>
<td>10. Severe and multiple disadvantage</td>
<td>92% of people who have experienced homelessness, prison and addiction have a diagnosed mental health problem.(^{61})</td>
</tr>
<tr>
<td><strong>HEALTH, DISABILITY AND AGEING</strong></td>
<td></td>
</tr>
<tr>
<td>11. Long-term conditions</td>
<td>In England in 2014, over a third (37.6%) of people with severe symptoms of a common mental disorder reported having a chronic physical health condition.(^{45})</td>
</tr>
</tbody>
</table>
### 2. Mapping the problem: inequalities that influence mental health

<table>
<thead>
<tr>
<th><strong>PRIORITY RISK GROUP</strong></th>
<th><strong>Prevalence of mental health problems</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH, DISABILITY AND AGEING (CONT.)</strong></td>
<td></td>
</tr>
<tr>
<td>12. Sensory impairment</td>
<td>31% of women and 14% of men who are deaf report having a mental health problem.(^{(52)})</td>
</tr>
<tr>
<td>13. Learning disability</td>
<td>40.9% of those with an intellectual disability had a clinically diagnosed mental health condition.(^{(53)})</td>
</tr>
<tr>
<td><strong>ECOLOGICAL</strong></td>
<td></td>
</tr>
<tr>
<td>14. Urban environments</td>
<td>Mood and anxiety disorders are higher in urban areas compared to rural areas (39% and 21%, respectively).(^{(54)})</td>
</tr>
<tr>
<td>15. Housing</td>
<td>19% of those living in poor quality housing report problems with mental health compared to 14% of those living in good quality housing.(^{(55)})</td>
</tr>
<tr>
<td>16. Homeless</td>
<td>80% of homeless people reported having some form of mental health problem and 45% reported having a diagnosed condition.(^{(56)})</td>
</tr>
</tbody>
</table>
2.1 Economic determinants

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 pre-school and 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 link between poverty and mental health has been recognised for many years and is well evidenced. The Health Survey in England has consistently found that people in the lowest socioeconomic class have the highest risk of having a mental health problem.

The risk to mental health of economic hardship starts early in life. A 2013 international systematic review of socioeconomically disadvantaged children and adolescents found that they are two to three times more likely to develop mental health problems. The same review found that low
socioeconomic status that persisted over time was strongly related to higher rates of mental health problems. This finding is 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.\(^{(59)}\) However, it may be the environmental factors related to income, and not the income status itself that exert the biggest influence, such as parental education, neighbourhood violence and family benefit status.

Higher national levels of income inequality are linked to a higher prevalence of mental health problems, and as countries become richer but remain unequal the rates of mental health problems increase.\(^{(60)}\) The Mental Health Foundation has previously reported that socio-emotional and behavioural difficulties have been found to be inversely distributed by household wealth as a measure of socioeconomic position in children as young as three years old.\(^{(12)}\)

According to Friedli (2009), for those who are economically poor, developing better emotional and cognitive skills only partially offsets the effects of material disadvantage. Although children from deprived environments with higher emotional wellbeing have better mental health than those without, children from wealthier settings do better still, regardless of emotional wellbeing.\(^{(60)}\) The WHO has concluded that material
disadvantage “trumps” emotional and cognitive advantages.\(^{60}\) In other words, 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, research has found that high cognitive capability in early life is generally not able to protect against the effects of childhood economic disadvantage.\(^{60}\) Socioeconomic status is highly related to levels of anxiety, aggression, confidence and concentration; emotional and cognitive development; and school readiness.\(^{61}\) Furthermore, economic pressure, through its influence on parental mental health, marital interaction and parenting, has been shown to negatively affect the mental health of children and young people.\(^{62,63}\)

Debt itself is an issue: people in debt are more likely to have a common mental health problem,\(^{64}\) and the more debt people have, the greater the likelihood of this.\(^{65}\) One in four people experiencing a mental health problem is in problem debt, and people with mental health problems are three times more likely to be in financial difficulty.\(^{66}\) 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.\(^{67}\) However, a causal link is not yet proven,\(^{64,68}\) and it is likely that the relationship can work both ways: personal debt may lead to some mental health problems, while mental health problems may also lead to being in debt.
2. Mapping the problem: inequalities that influence mental health

2.1.2 Employment and unemployment

Employment is one of the most strongly evidenced determinants of mental health.\(^{(69)}\) It can be an important factor in individual fulfilment, bringing autonomy, pride and confidence. In childhood, living in a workless household increases the risk of material poverty.\(^{(70)}\) 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.\(^{(71)}\) In later life, the previous working life often determines our ability to support ourselves financially and socially in retirement.

The workplace as an environment can be a protective space; WHO has described it as an environment where mental health can be improved through improving mental health literacy, promoting tools and support to identify and manage emerging problems and providing links through to services.\(^{(72)}\)

However, 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.\(^{(73)}\) Being unemployed can place mental health at risk. Studies have found that unemployment brings with it a range of negative effects, such as relative poverty or a drop in standards of living for those who lose a job, stresses associated with financial insecurity, the shame of being unemployed and in receipt of social welfare and loss of vital social networks.\(^{(74)}\) The OECD has described
Mapping the problem: inequalities that influence mental health

how job loss has a traumatic and immediate negative impact on mental health and that there is further damage where unemployment continues into the long term.\(^{75}\) A meta-analysis has shown that unemployment is associated with varieties of distress including mixed symptoms of distress, depression, anxiety, psychosomatic symptoms, subjective wellbeing, and self-esteem. The same study found that 34% of unemployed people had mental distress compared to 16% of those in employment. Importantly the analysis showed that unemployment causes this distress.\(^{44}\) Unemployment has also been associated with lower wellbeing,\(^{76}\) though one study found that it did not affect women’s wellbeing after controlling for other factors.\(^{77}\) Furthermore, job insecurity and restructuring also have negative impacts on employee wellbeing over time.\(^{78}\)

A study by the Joseph Rowntree Foundation has debunked the myth of three generations of worklessness within deprived neighbourhoods and found that even two generations were rare in the study areas of Middlesbrough and Glasgow.\(^{79}\) It found that being unemployed was often a result of a complex range of systemic and structural factors associated with poverty that prevented people from escaping the spiral of deprivation, including mental health problems themselves. Participants in the study stressed the “social” and “financial value” of work but also the psychological benefits; they described long term unemployment as “a miserable existence”.

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 condition due to fear of them being stigmatised by their co-workers. The same survey found that half of employers saw employing individuals with mental health conditions as a “significant risk” to their business.\(^{(80)}\) This prejudice extends to the general public; more than one in four people stated in 2009 that someone with a mental health problem should not have the same rights to a job as anyone else.\(^{(81)}\) 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.\(^{(82)}\)

### 2.1.3 Quality of employment

It is not only the fact of having a job that can benefit mental health; the OECD has recognised that the quality of employment matters for supporting mental wellbeing.\(^{(75)}\) In their 2008 Employment Outlook report, the OECD found that work-related mental health problems occur more often for employees with detrimental working conditions.\(^{(75)}\) The conclusion that good quality work is important for fostering
good mental health has been affirmed by successive UK policy reports and was emphasised by Farmer and Stevenson in their review of mental health and employment.\(^{(83)}\) In 2017, the Stevenson/Farmer Review of Mental Health and Employers incorporated good working conditions as one of its mental health core standards.\(^{(83)}\) On a broader basis, Van Aerden, et al. have developed a typology of contemporary work arrangements and demonstrated an association between types of work and mental health.\(^{(84)}\) Recent UK research published by Business in the Community found that two in five (39\%) employees have experienced “symptoms” [sic] of poor mental health where work was a factor in the last year.\(^{(85)}\) This is of concern as good mental health among employees has been associated with higher staff retention, improved productivity and performance, higher levels of collaboration, and reduced sickness and absenteeism. It has been estimated that good mental health among employees can save UK businesses up to £8 billion a year.\(^{(86)}\)

Less job security and control negatively affect mental health. In 2011, the OECD reported a tendency for job strain to increase over time in some occupations across the OECD area.\(^{(87)}\) This concern is supported by the findings from the Business in the Community’s 2019 UK survey, which found that of those employees who experienced work-related mental health problems, 52\% said pressure, such as too many targets or priorities, was a cause, while 36\% cited workload, to the point
of working overtime and not taking annual leave, and 24% cited bullying and harassment from their manager.\textsuperscript{85} A 2014 cross-European study found that for both men and women, poor quality work was related to reduced mental wellbeing. For men, significant factors influencing mental wellbeing were: having insufficient household income, having irregular/unsocial working hours, a lack of representation and a lack of participation. For women, significant factors were having insufficient household income, having irregular/unsocial working hours, part-time employment, involuntary part-time employment, a lack of representation and a lack of participation. The authors conclude that there are significant relationships between low quality work and poor mental wellbeing.\textsuperscript{88}

In contrast, good work is characterised by: a living wage, control over one’s 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.\textsuperscript{13} Gym memberships, salary sacrifice schemes, flexible pay and pension packages, and annual leave buy-back schemes are all good examples of initiatives that have a positive effect on employee mental health.\textsuperscript{82}

According to the Foundation’s Surviving or Thriving? survey, mental health problems are less commonly reported in people who are retired with just over half of retirees reporting a mental
health problem. Importantly, the evidence points to mental health and wellbeing for the most part being worse for people who are involuntarily retired and better for those who have control over the timing or planning of their retirement. This ability to self-determine and to plan for retirement appears to be an important protective feature. Involuntary retirement due to health reasons can be expected to cause more stress and to negatively affect individual well-being.

Workers with sickness absence due to mental health problems are seven times more likely to have further absence than those with physical health-related sick leave. This may be explained in part by the lack of openness around the issue which can hinder individuals from seeking support to remain in or return to work. In a 2016 survey, 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 barriers they reported 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 their employer’s business (45%). Half of those who disclosed having a mental health problem reported that they had been well supported by their line manager, however those who disclosed also reported experiencing the most discrimination, and were most likely to feel that their career or job security would be jeopardised by their mental health problem. Reinforcing this view, a 2014 study revealed that one in five of those who disclosed to their employer that
they had a mental health problem felt that they had been sacked or forced out of their jobs as a result.\(^{(92)}\)

2.1.4 Education level

The relationship between education, school attendance and mental health first gained consideration in the early 20\(^{th}\) century and there has been much written and researched about the reciprocal association between education and mental health since 1998.\(^{(93)}\) Social and emotional school readiness, and the discipline of learning do not come easily for some children, while accumulating evidence shows that social and emotional competencies often predict academic achievement.\(^{(94)}\) Recent evidence from a Wales population-level analysis found that pro-social behaviour has a positive relationship with achievement in kindergarten which in turn leads to better achievement in grade 3.\(^{(95)}\) Conversely, certain social and emotional problems such as anxiety and depression negatively predict later academic achievement.\(^{(95)}\)

Women with low levels of literacy are at five times higher risk of depression than those with average or good literacy skills.\(^{(96)}\) Similarly, dropping out of education has been associated with current substance misuse, mood disorders and suicidal ideation.\(^{(97)}\)

In the educational context, WHO has identified several risk factors for mental health,\(^{(98)}\) including:

- failure to provide an appropriate environment to support...
2. Mapping the problem: inequalities that influence mental health

attendance and learning;

• inadequate or inappropriate provision of education to assist those that require additional support; and

• academic failure.

School research into those that leave schooling early has consistently identified a relationship between substance use and early school leaving.\(^{(97)}\) Such research in the USA has found that mood and anxiety disorders and suicidal ideation predict secondary school early school leaving.\(^{(97)}\) However, the strongest mental health predictors of early school leaving are externalising disorders such as conduct disorder “oppositional defiant disorder” and “antisocial personality”, particularly when these have arisen early in childhood.\(^{(97)}\) An important time of vulnerability in this context is transitions from one place of education to another. Traditional higher education students will, according to Ecclestone, et al. (2005), have experienced at least five transitions in their initial learning career, from first entry to school to leaving higher education. Some students may find the transitions harder to cope with.\(^{(99)}\) For example, surveys have shown that as students move from primary to secondary school their wellbeing in the school context declines considerably over the year.\(^{(100)}\) These transitions can be particularly difficult for students with a disability as a transition means that they have to learn to deal with their particular challenges and support needs in a new setting. If the transition between primary school and
secondary school is not well-managed, they can end up feeling isolated and vulnerable, which is especially the case for children with special educational needs.\(^{(101)}\)

A UK report on students who died from suicide noted that those with mental health problems were particularly at risk and that periods of transition, such as at the beginning or the end of the academic year, were times when this group of students were particularly vulnerable.\(^{(102)}\) Two kinds of models have been proposed to explain these variations: differential access to coping resources for dealing with stressful situations, and variation in the characteristics of transitions, such as their desirability and foreseeability.\(^{(103)}\)

A growing body of research in the past 15 years has clearly indicated that school-age perpetration, victimisation, and witnessing of bullying behaviour are significant predictors of concurrent mental health risk.\(^{(104–107)}\) In fact, the evidence supports a causal association between exposure to bullying 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.\(^{(107)}\) Elsewhere, a causal association has been found between being a victim of bullying and having anxiety and depression, though these effects reduce in the long term.\(^{(106)}\) When compared with their non-aggressive peers, perpetrators report lower levels of school engagement and belonging, as well as higher rates of delinquent behaviour outside school.\(^{(108)}\) Finally,
observing the victimisation of other peers can have a significant negative impact on multiple indicators of mental health.\(^{108}\)

### 2.1.5 Summary of socioeconomic determinants

- The link between poverty and mental health has been recognised for many years and is well evidenced.\(^{12}\) The Health Survey in England has consistently found that people in the lowest socioeconomic class have the highest risk of having a mental health problem.\(^{57}\)

- Higher national levels of income inequality are linked to a higher prevalence of mental health problems, and as countries become richer but remain unequal the rates of mental health problems increase.\(^{60}\)

- Socio-emotional and behavioural difficulties have been found to be inversely distributed by household wealth as a measure of socioeconomic position in children as young as three years old.\(^{12}\)

- People in debt are more likely to have a common mental health problem,\(^{64}\) and the more debt people have, the greater the likelihood of this.\(^{65}\)

- Unemployment is associated with varieties of distress including mixed symptoms of distress, depression, anxiety, psychosomatic symptoms, subjective wellbeing, and self-esteem. The same study found that 34% of unemployed people had mental distress compared to 16% of those
in employment. Importantly the analysis showed that unemployment causes this distress.\(^{44}\)

- Work-related mental health problems occur more often for employees with detrimental working conditions.\(^{75}\)

- Pro-social behaviour has a positive relationship with achievement in kindergarten, which in turn leads to better achievement in grade 3.\(^{95}\) Conversely, certain social and emotional problems such as anxiety and depression negatively predict later academic achievement.\(^{95}\)

### 2.2 Other relational determinants

Being socially connected is closely linked to good mental health outcomes; access to positive relationships from an early age are critical to our development, and our health and happiness across life. Conversely, many of the main risks to mental health also involve social relationships, such as 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.

#### 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.

Immigration status

It is estimated that 244 million people (3.3% of the world’s population) live outside their country of origin,\(^{109}\) of whom, in 2015 an all-time high of 65 million were forcibly displaced as a result of ongoing conflict and persecution.\(^ {110}\)

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.\(^ {47,111}\) Research in Leeds indicated that asylum seekers are five times more likely to have mental health problems than the general population and more than 61% will experience severe mental distress.\(^ {112}\) 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.\(^ {113,114}\) In spite of such high
prevalence rates, secondary healthcare data indicates that refugees and asylum seekers have been significantly less likely to receive mental health support than the general population.\(^{(115)}\)

Similarly to other BAME communities, refugees report mental health related stigma within their own communities.\(^{(116)}\) The experience of stigma associated with mental health problems can lead to feelings of shame and reluctance to access support. For some refugees and asylum seekers, the western individualised concept of mental health does not fit with their own existing cultural views. Mental health literacy, including awareness of where and how to access sources of support, can be low among refugees. This in turn can lead to resistance both to offering help to others and to seeking help for themselves.\(^{(117)}\)

More broadly, meta-analysis of population studies shows that a personal or family history of migration is an important risk factor for schizophrenia, and the risk is particularly increased in immigrant groups who migrate from a country where the population is predominantly black skinned to a country where the population is predominantly white skinned.\(^{(118)}\)

Black, Asian and minority ethnic communities

Studies in the UK and elsewhere have suggested a high risk of adverse mental health outcomes for some BAME populations, although the evidence is mixed. A UK study found a nine-fold increased risk for a diagnosis of schizophrenia among black Caribbean people and concluded that isolation and social
exclusion are significant factors in the higher incidence of schizophrenia among this group.\(^\text{(119)}\) Others have argued that the disparity in schizophrenia rates between ethnic minority populations and white majority populations could be due to exposure to discrimination.\(^\text{(120)}\)

Being a victim of racism has been associated with mental health problems.\(^\text{(121)}\) Analysis of two studies in the USA concluded that in general, the emotional and psychological effects of racism are consistent with traumatic stress,\(^\text{(122)}\) while a meta-analysis has also found positive associations between perceived racism and psychological distress.\(^\text{(123)}\) In the UK in particular, analysis of a large-scale sample over time has found that the negative effects of racial discrimination on the mental health of ethnic minorities are cumulative; the study found a negative effect of racism at the first point in time examined (2009), but the effects were much greater at a time period five years later (2013).\(^\text{(124)}\) Carter argues that the effects of racism should be viewed as “psychological and emotional injuries”.\(^\text{(122)}\)

Racism and a lack of cultural awareness also may contribute to the discrimination experienced by people from BAME communities in mental health services,\(^\text{(125)}\) 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.\(^\text{(46,126,127)}\) According to a
report submitted to the review of the Mental Health Act by the Mental Health Act Review African and Caribbean Group (published in 2019), people from Black African and Caribbean communities are 40% more likely than white British people to come into contact with mental health services through the criminal justice system, rather than being referred from GPs or talking therapies.\(^{(46)}\) Furthermore, Black adults are more likely than adults from other ethnic groups to have been detained under a section of the Mental Health Act, while White British adults are more likely to receive treatment for mental health problems than adults in other ethnic groups (13.3% for white British adults versus 6.3% for Black adults, who have the lowest treatment rate).\(^{(46)}\) Black people are also more likely to be subject to Section 136 of the Mental Health Act, 1983, have longer average lengths of stay in hospital, have higher rates of repeat admissions, have higher rates of seclusion, are up to eight times more likely to be placed on Community Treatment Orders, are less likely to be offered talking therapies and have higher drop-out rates from cognitive behavioural therapy for psychosis.\(^{(46)}\)

However, others have argued that economic deprivation is a significant factor for involuntarily detained in-patients and that those that are involuntarily detained are both Black and White populations from deprived areas.\(^{(128)}\) Economic deprivation has been found to be a significant factor in getting support as well as the establishment of a therapeutic
relationship. However, individuals from BAME communities are found to be less likely to be offered talking therapies.\(^{(129)}\)

Stigma and self-stigma play a role in deterring help-seeking. The concept of “Double Stigma” has been developed to help to explain the impact of stigma on this group, in which individuals from BAME communities with mental ill health may suffer prejudiced attitudes not only because of their ethnicity but also because of their mental health problem. As a result of this double stigma, individuals from BAME communities may delay or avoid seeking out support.\(^{(130)}\)

People from BAME communities also face a variety of other barriers to help-seeking, including communication barriers and challenges due to having different interpretations of mental distress.\(^{(130)}\)

Certain population groups (South Asian populations, “White” subgroups) are underrepresented in research and the research literature, as is research in certain settings, for example primary care and community settings.\(^{(131)}\) Asian populations are less likely to use inpatient facilities but have been found to be more likely to frequent GP and primary care services. Among ethnic groups, South Asians have been found to have the highest community rates of mental health problems, are the most frequent consulters of primary care services and are less likely than the White majority population to have their issues recognised.\(^{(131)}\)
Black men have the highest rates of drug use and drug dependency in the UK, 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.

Gender

The 2014 Adult Psychiatric Morbidity Survey highlighted higher rates of common mental health problems among women than men, and particularly high rates amongst young women and girls. In 2014, young women were three times more likely than men to experience common mental health problems, with more than 25% reporting symptoms of common mental disorders (sic) in the week prior to the survey. The gap between young women and men had increased significantly since the previous survey in 1993, when young women were twice as likely as young men to report symptoms of mental health problems. Rates of self-harm amongst young women have tripled between 1993 and 2014, and young women are three times more likely to experience PTSD or eating disorders. As a result, young women have “emerged as a high-risk group”, and a Women’s Mental Health Taskforce was set up by the government.

The underlying reasons for these differences are complex. In part they involve the greater risks for women of powerlessness
and victimisation, social pressure and economic hardship. Across Europe, women are more likely to experience intimate partner violence than men, and such violence is known to increase the risk of emotional distress and suicidal ideation. (134) In the 2019 Crime Survey for England and Wales, as in prior years, women were also more likely than men to have experienced domestic abuse. In terms of sexual assault, women were around six times as likely as men to have experienced sexual assault by a partner in the last year. (135)

Online culture, social media and pornography as sources of increased pressure on young women and girls may also play a role. (136) According to research from The Royal Society for Public Health and Youth Health Movement, 90% of teenage girls say they are unhappy with their bodies, and exposure to photographs online was linked to low body confidence. (136) A more recent survey carried out for the Mental Health Foundation reported consistently higher levels of distress with regard to body image from women and girls than from men and boys. For example, 54% of girls said images on social media had caused them to worry about their body image compared to 26% of boys, while 43% of adult women felt down or low because of their body image compared to 25% of men. (137) Austerity has also hit women particularly hard with House of Commons research showing that 86% of the burden for recent cut-backs has fallen upon women. (138) Financial pressures have been particularly tough for black and ethnic
minority women, and research from the Young Women’s Trust showed that 40% of black and ethnic minority women said they had been discriminated against when working or looking for work because of their ethnicity, compared with 5% of women who identified as White.\textsuperscript{(139)}

There are also gender differences in the ways that mental health affects men. Three-quarters of suicides are by men;\textsuperscript{(140)} and men are nearly three times more likely than women to become alcohol dependent (8.7% of men compared to 3.3% of women).\textsuperscript{(141)} Homelessness and being subject to the criminal justice system are known to be affected by gender, with 87% of rough sleepers being men, and men making up 95% of the prison population.\textsuperscript{(142)}

There are also gender differences in disclosure and help-seeking, which may mean that men are less likely to get early help for their mental or emotional distress. A survey conducted by YouGov for the Foundation in 2016 found that a third of women (33%) who disclosed a mental health problem to a friend or loved one did so within a month, compared to only a quarter of men (25%). More than a third of men (35%) waited more than two years or had never disclosed a mental health problem to a friend or family member, compared to a quarter of women (25%).\textsuperscript{(143)}

\textbf{Sexual orientation}

It has been thought that people who identify as lesbian, gay,
bisexual and/or transgender (LGBT+) are at a higher risk of experiencing poor mental health,\(^{(144)}\) but recent Canadian evidence points to their greater prevalence of depression not being based on sexual orientation itself.\(^{(145)}\) Although the acronym LGBT+ is used as an umbrella term, and the health needs of this community are often grouped together, each of these letters represents a distinct population with its own health concerns. (Abbreviations used in this section for people who are lesbian, gay, bisexual, transgender or other sexual orientation vary according to the population covered in the referenced study.)

The main framework for understanding any excess in the prevalence of mental health problems they experience is the concept of “minority stress”, which theorises that stigma, prejudice, and discrimination create a hostile and stressful social environment that contributes to the development of mental health problems.\(^{(146)}\) The mental health related stigma and discrimination can be compounded by discrimination related to sexual orientation;\(^{(116)}\) this can include experience of prejudice events, expectations of rejection, hiding and concealing. More than half (55%) of younger LGBT+ people experience homophobic bullying in Britain’s schools. Most pupils who experience homophobic bullying have symptoms consistent with depression.\(^{(147)}\)

Experiences of bullying and violence place LGBT+ people at substantial risk for poor mental health outcomes, especially
through the link to suicide attempts, substance use and difficulties attending school.\(^{148}\) 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.\(^{149}\) Evidence from the USA has found that 29% of LGBT+ teenagers attempted suicide in the past year, and they were two to five times more likely to report using illegal drugs, and two times more likely to have missed school during the past 30 days because of safety concerns.\(^{150}\)

Estimates from the USA of mental health diagnoses among LGBT adolescents indicate that 10% have a mood disorder, 25% an anxiety disorder, and 8.3% a substance use disorder.\(^{151}\) Also, although not explicitly tested in all studies, results often indicate that bisexual youth (those attracted to both men and women) are at greater risk for poor mental health when compared to heterosexual and solely same-sex-attracted counterparts.\(^{149}\) Equally, the risk is higher among older LGBT+ adults, who are more likely to have experienced mistreatment and discrimination due to living the majority of their lives prior to recent advances in social acceptance and equal treatment of people who are LGBT+.\(^{152}\) Systematic reviews have consistently found an increased rate of suicidality among LGB people in comparison with heterosexual people.\(^{153–155}\) For transgender people, the available studies, though with
Mapping the problem: inequalities that influence mental health

limitations, generally suggest high rates of negative mental health outcomes.\(^{(156)}\)

Mental health stigma and discrimination

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, and can include problems of knowledge (ignorance), attitudes (prejudice), and behaviour (discrimination).\(^{(157)}\) Research has found that as many as nine out of ten people with mental health problems have experienced stigma or discrimination at least once in their life, either at work, in education, from professionals or at home.\(^{(158)}\) 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%).\(^{(82)}\) Moreover, systematic review evidence has shown that stigma has a small to moderate-sized negative effect on help-seeking for mental health problems.\(^{(159)}\) Stigma can also negatively affect mental health, with one study showing an increased risk of suicidal ideation among people labelled “mentally ill”.\(^{(160)}\)

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.\(^{(36)}\) ACEs have been defined as “stressful experiences occurring during childhood that directly hurt a child, such as maltreatment, or affect them through the environment in which they live, such as growing up in a house with domestic violence.”\(^{(161)}\) Typical ACEs include experiencing physical, sexual or verbal abuse, violence, parental separation, bereavement, and being in a household with mental illness, alcohol or substance misuse, or where a household member has been imprisoned.

Among others, the ACE study of more than 17,000 adults in the USA indicated that the majority of adults have experienced more than one ACE during their childhood and there is a strong graded relationship generally evident between the number of ACEs men and women have experienced and their experience of mental health problems.\(^{(162)}\) Similarly, a national household survey of adults in England undertaken between April and July 2013 found that almost half (47%) of individuals had experienced at least one of the nine ACEs studied. Prevalence of childhood sexual, physical, and verbal abuse was 6.3%, 14.8%, and 18.2% respectively. Nine per cent of the people surveyed had experienced four or more ACEs.\(^{(163)}\)

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.\(^{(38)}\) Such findings suggest that experiencing multiple forms of abuse or household dysfunction during childhood can have a particularly deleterious effect on adult mental health.\(^{(164)}\)

Further evidence of this harm comes from large cohort studies using standardised assessments which have consistently found strong “dose-response” relationships between the ACE score and the probability of lifetime and recent depressive disorders and other affective outcomes or substance abuse,\(^{(164–166)}\) meaning that the more one has been exposed to childhood adversity, the greater the likelihood of having these negative outcomes. 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 (OCD), phobias, substance abuse, eating disorders, and personality disorders.\(^{(167)}\)

Socioeconomic status analysis of the Welsh ACEs study found that ACEs and health harming behaviours were associated with deprivation, with a greater percentage of people in more deprived social groups reporting four or more ACEs than those in the most affluent group. Only 4.3% of individuals in the most affluent quintile reported four or more ACES, rising to 12.7% of those in the most deprived quintile.\(^{(163)}\)

In the same Welsh study, more than half of cases of violence
perpetration, violence victimisation, incarceration, and heroin/crack cocaine use could be explained by ACEs.\textsuperscript{168} They also accounted for around a third of individuals reporting early sexual initiation and unintended teenage pregnancy, leading to babies being born into settings that are less prepared for them and with fewer resources for child-rearing, which in turn can lead to greater risk of exposure to abuse.\textsuperscript{163} Early life trauma was found to affect factors such as emotional regulation and fear responses, and predispose individuals to health harming behaviours.

For displaced and refugee children, exposure to violence has been shown to be a key risk factor for a child developing mental health problems,\textsuperscript{169} and increased levels of depression, anxiety disorders and post-traumatic stress have been found among refugee children.\textsuperscript{170} A study conducted in the USA found that 44\% of children in one immigration detention centre had at least one emotional or behavioural concern, with 32\% having elevated scores for emotional problems and 14\% for peer problems.\textsuperscript{171} In the UK, a study of unaccompanied minors arriving in Kent in 2015 found that in one clinic, the assessing clinician was concerned about the child’s mental health in 94\% of cases.\textsuperscript{172}

Living in care

It has been recognised that looked after children need to have strong positive relationships with those that care for them, even more than the general population, having already experienced
poor and disrupted attachment, which has been shown to have a significant and negative impact on their mental health.\(^{173}\)

There is a wealth of studies that show looked after children have poorer mental health than other children.\(^{49}\) In particular, evidence from Britain suggests that all looked after children have a higher risk of mental health problems, with the 9\% of children cared for in residential accommodation (including children’s homes, hostels and secure accommodation) having worse mental health than those in other types of placements.\(^{49}\) This is a position that has remained the same for the past 50 years despite changes in policy and improvements in care.\(^{174}\) Estimates are that 45\% of looked after children in the UK have a diagnosable mental health problem with up to 70-80\% showing signs of distress.\(^{174}\) Moreover, studies of very young children in care indicate that as many as one in five show signs of emotional or behavioural problems.\(^{175}\)

Young people who have been in care also experience high levels of social disadvantage, ill health and risk-taking behaviours after leaving care. Studies in the mid-90s found that 50\% of young people will be unemployed on leaving care and 20\% will experience some kind of homelessness within two years.\(^{176,177}\) Recent statistics on educational outcomes for care leavers suggest that the percentage of looked after children achieving 5+ GCSEs A*C or equivalent including English and mathematics was 13.6\% in 2016, compared to 53\% of non-looked after children (England only).\(^{178}\)
Poor familial relations

The security generated from a child’s attachment to parents or guardians is central to a child’s psychological and social development; therefore, relationships formed as infants, children and young people are predictors of future mental health and wellbeing. Changes in family structure, and increased levels of family breakdown, can act to interrupt the formation and/or continuation of positive bonds and have been found to impact negatively on academic attainment, as well as future attitudes to relationships. Research has shown that poor or insecure attachments are associated with depression, anxiety, PTSD, suicidal thoughts or behaviours, and eating disorders.

Children of parents with mental health problems

It is estimated that one in four children aged 5-15 have mothers who would be classified as having a risk of a common mental health problem, while it is probable that among the non-elderly adult population, at any one time around nine to ten per cent of women and five to six per cent of men in Great Britain are parents with a mental health problem. If not managed well, parental mental health problems have the potential to negatively affect their children. A nationally representative study in the UK has found that sustained levels and transitions into mothers’ mental health problems are strongly associated with levels and transitions into children’s mental health problems. Specifically, having
a mother with moderate to severe post-natal depression can negatively affect the behavioural, emotional and intellectual development of a child.\textsuperscript{(182)} It is difficult to accurately measure the rates of parental mental health problems due to their under identification and incomplete data records.\textsuperscript{(183)} However, UK research has identified parental mental health problems as a significant factor in around 25\% of new referrals to social service departments.\textsuperscript{(184)} Children living with a parent or parents with mental health problems may not have their emotional or developmental needs met at a very early age.\textsuperscript{(180)} As they grow up, they may assume a caring role in order to maintain a relationship with their parents, which can affect their educational performance.\textsuperscript{(183)} Therefore, there may be no adult in the house providing the care and support that the children need to make a transition into adulthood. As a result 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, although contextual factors such as other types of socioeconomic disadvantage may be stronger influences than the parent’s mental health problem.\textsuperscript{(180)} It is important, therefore, that interventions for parents with a mental health problem consider the parents’ wider social context.

**Children of parents with substance misuse problems**

Parental substance misuse also can reduce the parent’s 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 and relationship difficulties in later life, academic underachievement, and an increased risk of misusing drugs or alcohol themselves.\(^{(185)}\)

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.\(^{(185)}\)

An exploration of the experiences of young people (15-27 years old) affected by parental drug and/or alcohol misuse in Scotland found that many young people felt that their parents were unable to provide consistent practical or emotional care. Comparing the two, the effects of drug and alcohol abuse on young people were similar, with the former bringing with it more anxiety and social stigma and the latter being more associated with violence and parental absence. Young people felt their childhood was shortened through having to assume early responsibility for their own and others’ wellbeing.\(^{(186)}\)

For children of drug-misusing parents, treatment of the parents has been found to be a protective factor. The problems caused by addiction will motivate many parents to find help, and entering treatment has major benefits not only for them but also for their children, such as being given support so they are
better able to look after their children and provide them with greater stability.\(^{(187)}\) However, such engagement is not easy, and the services do not always exist. Models such as the Family Drug and Alcohol Court (FDAC) have operated on a trial basis in the UK.

### 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 and for some this can have a cumulative effect following on from, and compounding, the damage felt from an adverse life experience in childhood.\(^{(188)}\) Further, adverse experiences in adulthood can be more difficult to cope with if someone has already experienced adversity in childhood.\(^{(189)}\)

**Trauma**

Trauma refers to events or circumstances that are experienced as harmful or life-threatening and that have lasting impacts on mental, physical, emotional and/or social well-being.\(^{(190)}\)

Not all persons with a history of trauma exhibit symptoms of post-traumatic stress disorder, however many people who have a history of trauma experience symptoms and display behaviours related to toxic stress.\(^{(190)}\) Common symptoms of PTSD include re-experiencing the event in nightmares or flashbacks, avoiding things or places associated with the event,
panic attacks, sleep disturbance and poor concentration. Depression, emotional numbing, drug or alcohol misuse and anger are also common.

Trauma can arise from a single event or from multiple events that are compounded over time. Trauma encompasses experiences of interpersonal violence, such as rape or domestic violence but also childhood and developmental traumas such as abuse, neglect, abandonment and family separation, and community violence such as bullying, gang culture, homicide and war. Less well understood forms of trauma include social trauma such as marginalisation, racism and the trauma legacy of violence committed against entire groups of people such as slavery, genocide and the Holocaust.

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 actual or threatened death, serious injury or sexual violence.

As previously reported by the Foundation, trauma disproportionately affects marginalised populations and is inseparably bound up with systems of power and oppression. For example, research has shown that traumatic and other stressful events tend to be more frequent in individuals of low socioeconomic status, racial and ethnic minorities, and younger age groups.
There is an important gender dimension to trauma: women are more likely than men to experience psychological harm from trauma, and they are more likely to develop internalising disorders following trauma exposure.\(^{(42)}\) Self-harm, eating disorders and emotionally unstable personality disorder, which are more common among women than men, have all been associated with experiences of violence and abuse.\(^{(42)}\)

**Loneliness**

The report of the Jo Cox Commission on Loneliness stated that research consistently finds between 5 and 15% of older people report being often or always lonely. There is less information on the prevalence of loneliness among other age groups. The Commission reported that while recent data suggests that loneliness levels are high, it is unclear whether this has resulted from reduced stigma or increased experienced loneliness.\(^{(192)}\)

A 2010 survey by the Mental Health Foundation found that 48% of participants believe that, in general, people are becoming lonelier. Only 22% of participants never felt lonely and one in ten participants felt lonely often (11%). Worryingly, more than a third of participants (42%) had felt depressed because they felt alone.\(^{(193)}\) For older people, 30% of those aged 65 and over said they feel lonely, with nine per cent reporting this as severe loneliness,\(^{(194)}\) representing the highest levels of loneliness among the population. Older adults who are widowed or divorced are more likely to present with more symptoms of
depression, poorer physical functioning, and they face a greater mortality risk than their married counterparts.\(^{(195)}\)

Social isolation can be defined as the absence of relationships with family or friends on an individual level, and with society on a broader level. The size and strength of a person’s social network indicates whether the person is socially isolated.\(^{(193)}\)

Social isolation can impact on our mental health in different ways throughout the life course. From middle age onwards key risks - retirement, children leaving the family home, divorce and bereavement - can accumulate and affect emotional wellbeing. Social isolation is an important risk factor for both deteriorating mental health and suicide.\(^{(193)}\) 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.\(^{(196)}\) Loneliness is not an inevitable part of older age, but it is more likely to affect retired people because of bereavement, ill health and poverty. However young people are in no way immune to feeling lonely. In fact, the 18 to 34-year-olds surveyed in The Lonely Society? (2010) report for the Foundation were more likely than the over 55s to feel lonely often, to worry about feeling alone and to feel depressed because of loneliness.\(^{(193)}\)

Loneliness has been found to affect the way we regulate ourselves and can lead to self-destructive habits, such as overeating, drinking too much or not taking exercise. Over
time, loneliness weakens willpower and perseverance, so people who have been lonely for a while are more likely to indulge in behaviour that damages their health. Loneliness has also been found to adversely affect the immune and cardiovascular systems.\(^{(197)}\)

**Bereavement**

In addition, the death of a significant other may increase feelings of isolation due to the immediate decrease in social and instrumental support that a life partner provides. Those who are widowed are three times more likely to feel lonely.\(^{(194)}\)

Being bereaved carries with it a considerable risk of isolation, particularly for people in later life. Those most at risk are people aged 75 and over, as they are more likely to be widowed and to live alone. Research has found that there is a greater risk of older people entering care homes or sheltered living following the loss of a partner.\(^{(198)}\)

Older adults who are widowed or divorced are also more likely to present with more symptoms of depression, poorer physical functioning, and face a greater mortality risk than their married counterparts.\(^{(195)}\)

**Hate crime**

The most recent statistics from the Crime Survey for England and Wales (CSEW), combined for 2015/16 and 2017/18, estimated 184,000 incidents of hate crime each year.\(^{(199)}\) This
represents a decrease of 40% since the same surveys from 2007/8 and 2008/9.

In terms of mental health impact, the CSEW showed that victims of hate crime were more likely to be affected emotionally and psychologically than those of other types of crime. For example, 27% of hate-crime victims had trouble sleeping compared to 13% of victims of all crimes; 36% of hate-crime victims suffered from anxiety or panic attacks compared with 13% for all crimes; and 23% of hate-crime victims felt depressed after the attack compared with 8% of victims of all crimes.\(^{199}\)

Analysis of an earlier survey showed that the most prevalent of hate crimes were racially motivated (48%), followed by disability-related (31%) and thirdly, anti-religious hate crimes (17%).\(^{200}\) However, the most recently published police recorded statistics show that the overwhelming number of incidents in England and Wales were racially motivated (76%), with the next most commonly recorded being based on sexual orientation (14%).\(^{201}\)

In Scotland there were 5,336 hate crime charges in 2017/18, of which 61% were racially motivated while the next most prevalent related to sexual orientation (21%). According to police statistics, there were 2,400 recorded hate crime incidents in Northern Ireland in 2017/18, and the vast bulk of these were either racist or sectarian in motivation. Interestingly,
during this period sectarian hate crime incidents reduced by 39% while racist hate crime incidents increased by 22%.\textsuperscript{(199)}

Social trauma

Less is known and understood about social trauma than about the effects of marginalisation, racism and poverty. However, there are well-established statistics demonstrating a higher prevalence of trauma-related mental distress in post-conflict societies. Studies looking at the consequences of mass organised violence and genocide demonstrate the significant impact of war and genocide on: trauma of societies or nations; the inter-generational transmission of trauma; and the gaps in mental health support.\textsuperscript{(202,203)}

The use of gender-based violence and mass rape as a weapon of war has also gained more attention in recent years. Estimates of rapes of women during the 1994 genocide in Rwanda are between 250,000 and 500,000. During the civil war in Sierra Leone, at least 50,000 women were victims of gender-based sexual violence. In post conflict countries, the perpetration of rape as a weapon of war has had devastating effects on the mental health of women and their families, and it has been argued that this has had major implications including unwanted pregnancies and children, diseases, social stigmatisation, and familial rejection, that can result in the breakdown of family structure.\textsuperscript{(203)}
2. Mapping the problem: inequalities that influence mental health

2.2.4 Summary of relational determinants

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.

- There is consistent evidence of a higher incidence of psychosis among immigrants, particularly among ethnic minority populations. 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.\(^{(95)}\)

- Associations have been found between perceived racism and psychological distress,\(^{(123)}\) and the emotional and psychological effects of racism are consistent with traumatic stress.\(^{(122)}\)

- The 2014 Adult Psychiatric Morbidity Survey highlighted higher rates of common mental health problems among women than men, and particularly high rates among young women and girls.

- Experiences of bullying and violence place LGBT+ people at substantial risk for poor mental health outcomes, especially through the link to suicide attempts, substance use and difficulties attending school.\(^{(148)}\)

- Research has found that as many as nine out of ten people with mental health problems have experienced stigma or
Mapping the problem: inequalities that influence mental health
discrimination at least once in their life, either at work, in education, from professionals or at home.(158)

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.(36) Experiencing two or more adverse life events in adulthood – such as serious illness, job loss, or bereavement - is also associated with mental health problems and for some this can have a cumulative effect following on from and compounding the damage felt from an adverse life experience in childhood.(188)

2.3 Health/disability/ageing determinants

2.3.1 Health risk

Good mental health enables people to move beyond meeting their basic needs to considering their wider health and wellbeing, including the adoption of healthy lifestyles. It is also fundamental in supporting self-management of long-term health conditions. In turn, poor physical health increases the risk of mental health problems. More than 15 million people – 30% of the UK population – live with one or more long-term health condition(s) and more than four million of them will also have a mental health problem.(204)

The connection between physical and mental health is bi-directional: 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 risk for people with health conditions and disabilities can be complex, often requiring improvements across a mix of health behaviours, as well as improvements in their social, economic and environmental circumstances.

2.3.2 Long-term conditions

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.\(^{(204)}\) Despite this, in 2008 a systematic review showed that non-psychiatric health professionals’ detection of depression in patients with physical illness was low,\(^{(205)}\) while a qualitative study published in 2011 suggested that wider discussion and treatment of emotional problems in the context of physical illness was also low.\(^{(206)}\) In the UK, GPs were incentivised to screen for depression among people with coronary heart disease and diabetes between 2006-13. While one study showed an increase in diagnosis of depression during the incentivisation scheme, the scheme has since been stopped and the outcome of this stoppage is not yet known.\(^{(207)}\)

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.\(^{(208)}\) 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 (COPD) or asthma.\(^{(204)}\)

Conversely, those experiencing severe mental health problems die, on average, 15-20 years earlier than the general population,\(^{(209)}\) while those with mild mental health problems such as depression die 7-10 years earlier.\(^{(210)}\) Although, lower life expectancy is partly associated with higher suicide rates amongst people with mental health problems, the bulk of excess mortality in people diagnosed with severe mental health problems is largely attributed to preventable physical health problems such as cardiovascular disease, obesity and diabetes.\(^{(211)}\) Recent large-scale studies have provided supporting evidence for this analysis. One meta-analysis found that people with major depression, bipolar disorder and schizophrenia all had a higher prevalence and higher risk of death from cardiovascular disease than those without severe mental illness.\(^{(212)}\) A Swedish study of more than one million men showed that men who were diagnosed with any early-onset mental disorder [sic] or who had a psychiatric hospitalisation during a follow-up period of 22 years had an increased risk of death from natural causes, particularly cardiovascular disease, even after adjustment for numerous confounders.\(^{(204)}\)

These striking and persistent inequalities related to long-term health conditions serve as a powerful reminder that
the case for an integrated approach to mental and physical health is an ethical one as much as an economic one. Based on these inequalities in health outcomes, the King’s Fund has recommended as a priority that people with long-term physical health conditions should receive support for the psychological aspects of their condition as a standard part of their physical health care.\(^{(213)}\)

### 2.3.3 Physical and sensory disability

People who live with a physical impairment are not necessarily ill, although they may live with a physical condition that impairs their functioning. The social model of disability views the disabling effects of physical impairment as arising not only from the physical effects of these physical conditions, but also, and especially, from the way that society is organised, which frequently creates barriers for people with such impairments. From this perspective, while some of the negative effects of being disabled may arise from the impairment itself, some are due to the social barriers faced by people with physical impairments, such as prejudice, discrimination, and social isolation due to inaccessible infrastructure.

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,\(^{(214)}\) although Jenny Morris has pointed out that studies have sometimes presumed that having an
83. Mapping the problem: inequalities that influence mental health

Impairment will cause a mental health problem.\(^{(10)}\) Morris points out that many people with adult-onset physical disabilities have a quality of life equivalent to their non-disabled peers. While people with physical disabilities may experience pain and fatigue that negatively affects their mental health, she also locates some of the potential causes of their mental health problems in the disabling attitudes of non-disabled people, as well as the disabling environments they must face on a daily basis.

Recent research points to how resilience can protect people with physical disabilities from poor mental health. In a study carried out in Washington, USA among people living with multiple sclerosis, muscular dystrophy, post-polio myelitis, and spinal injury, the researchers found less depression among people identified at the start of the study as having resilience; further, greater resilience at the start of the study predicted lower levels of depression three years later. The authors measured resilience using the short-form (10-item) version of the Connor-Davidson Resilience Scale which measures participants’ adaptability to change and stress. The authors conclude that resilience may be a protective factor against depression among those ageing with disabilities.\(^{(214)}\)

Individuals experiencing sensory impairments have also been found to be at a much higher risk of having mental health problems across the life course; however, the needs of this group tend to be underrepresented in research. We do know that deaf children are more likely to experience mental health
problems: estimates suggest a 40% prevalence rate of mental health problems in deaf children, compared to 25% prevalence in children without hearing loss.\(^{(215)}\) 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 normally-sighted peers. The most prevalent anxiety disorders are agoraphobia and social phobia.\(^{(216)}\) Again, it is reasonable to conclude that many of the mental health problems experienced by people with sensory impairment arise from the social isolation they experience due to inaccessible environments.

2.3.4 Learning disability

People with learning disabilities have an increased risk of developing a mental health problem (between 25 and 40% of those with learning disabilities experience mental health problems)\(^{(217)}\) due to social, economic, psychological and emotional factors as well as some biomedical factors.

In 2007, the prevalence of diagnosed mental health conditions was estimated to be 36% among children with learning disabilities compared to 8% among children without a learning disability, although this study included autism spectrum disorder as a mental health condition. Increased prevalence was particularly marked for autism spectrum, attention deficit and conduct disorders.\(^{(218)}\) The same study found that children with learning disabilities were at higher risk of exposure to social disadvantage, while lower exposure to social disadvantage
Mapping the problem: inequalities that influence mental health

reduced the risk of mental disorders between 33% and 51%, depending on the disorder. This suggests that measures to reduce social disadvantage among children with learning disabilities could significantly reduce the prevalence of mental disorders in this group.

The Adult Psychiatric Morbidity Survey for England (2014) included brief analysis showing that predicted verbal IQ is strongly linked with mental health problems, with people with learning impairment being twice as likely as those with high verbal IQ to have an anxiety disorder or depression (25% compared with 13%). The disparity was even more pronounced for rates of probable psychotic disorder.\(^{(45)}\)

Overall, and as evidenced by a 2015 report by Public Health England, children with learning disabilities, when compared with their non-disabled peers, are more likely to be exposed to a number of inequalities that are risk factors for mental health problems, including: living in overcrowded housing, living in housing in a poor state of repair and housing that was too cold in winter; being at increased risk of exposure to violence, including bullying, physical, sexual, emotional abuse or neglect; being less likely to have a close relationship with their mother; being more likely to be exposed to inconsistent and harsh parenting and more chaotic family environments; and being more likely to be exposed to a greater number and wider range of potentially adverse life events.\(^{(219)}\)
2. Mapping the problem: inequalities that influence mental health

2.3.5 Substance misuse

Substance misuse is the taking of a drug or alcohol in such a way that it leads to harm. Examples of harm include addiction, physical or psychological harm, debt, criminal actions and relationship problems. Poor mental health is associated with higher levels of risk-taking behaviour such as drug and alcohol misuse. Substance misuse may also include smoking cigarettes or drinking excessive amounts of coffee.

A complex and mutually reinforcing relationship exists between mental health and alcohol consumption. The evidence from numerous studies is that there is a strong association between substance misuse, including alcohol misuse, and both mood and anxiety disorders.\(^{(220)}\) 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,\(^{(221)}\) and illicit drug use has been associated with an increased risk of depression.\(^{(222)}\)

In clinical contexts experiencing a co-occurring mental health and substance misuse problem is called “dual diagnosis”. Those who engage in these health-risk behaviours are also more likely to experience poor mental health; there is a mutually reinforcing relationship between the two and, as a result, NICE has recommended that people who misuse alcohol or drugs be offered evidence-based psychological interventions.\(^{(223,224)}\)
Dual diagnosis often results in people not receiving adequate support because one issue, such as the mental health problem or the substance use/misuse, may be viewed as being symptomatic of the other and professionals may opt to treat only one of these two conditions. In 2015, DrugScope reported that people with drug and alcohol problems have struggled to get appropriate support through the Improving Access to Psychological Therapy (IAPT) programme in England.\(^{(225)}\)

Good mental health can protect physical health by moderating risk-taking behaviour such as heavy drinking, illegal drug use, smoking and unhealthy food choices, all of which are often used as coping and management mechanisms in the absence of other support.\(^{(188)}\)

### 2.3.6 Summary of health/disability/ageing determinants

The connection between physical and mental health is bi-directional: 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 risk for people with health conditions and disabilities can be complex, often requiring improvements across a mix of health behaviours, as well as improvements in their social, economic 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
Mapping the problem: inequalities that influence mental health

Despite this, in 2008 a systematic review showed that non-psychiatric health professionals’ detection of depression in patients with physical illness was low.\(^205\)

- 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,\(^214\) although Jenny Morris has pointed out that studies have sometimes presumed that having an impairment will cause a mental health problem.\(^10\)

- Individuals experiencing sensory impairments have also been found to be at a much higher risk of having mental health problems across the life course.

- People with learning disabilities have an increased risk of developing a mental health problem (between 25% and 40% of those with learning disabilities experience mental health problems)\(^217\) due to social, economic, psychological and emotional factors as well as some biomedical factors.

- The evidence from numerous studies is that there is a strong association between substance misuse, including alcohol misuse, and both mood and anxiety disorders.\(^220\) Regular cannabis use in adolescence increases the risk of developing psychosis,\(^221\) and illicit drug use has been associated with an increased risk of depression.\(^222\)
2.4 Ecological determinants

There is now strong evidence that the environments in which people live, grow and work affect their mental health. As shown in this section, ecological risk factors for mental health problems include a lack of adequate housing and transport options, neighbourhood deprivation and an adverse built environment, living in an urban environment, and living in 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,\(^{226}\) while transitioning from homelessness to housing, or experiencing housing improvements, have both been shown to improve mental health.

2.4.1 Housing and homelessness

The Foundation has previously highlighted the importance of a safe, secure and suitable home for mental wellbeing.\(^{188}\) A recent systematic review has found a consistent, robust, and temporally ordered association between prior housing disadvantage and mental health, where housing disadvantage was defined in terms of tenure, precarity and physical characteristics.\(^{227}\)

Being homeless or at risk of homelessness is strongly associated with mental health problems\(^{188}\) and this association is supported by at least one systematic review.\(^{227}\) One 2014 study found that 80% of homeless people in England reported
that they experienced mental distress, with 45% having been diagnosed with a mental health problem.\(^{(56)}\) The UK’s Five Year Forward View on Mental Health affirmed that common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to fifteen times higher.\(^{(228)}\) Homelessness also can have a considerable impact on children if adequate supports are not in place. Homelessness increases the risk of pre-term birth and low birth weight, while homeless infants experience significant development delays between 4 and 30 months, which can negatively impact on their cognitive, behavioural and academic development.\(^{(229)}\) The quality of a person’s home is also important for their mental health. Poor quality housing, and housing that is unsafe and insecure, are risk factors for poor mental health and the exacerbation of existing mental health problems.\(^{(230)}\)

2.4.2 Neighbourhoods

A report written for the WHO states that social fragmentation and conflict in communities, as well as high levels of neighbourhood problems, influence health outcomes independently of socioeconomic status.\(^{(60)}\) The same author highlights how mistrust and powerlessness amplify the effect of neighbourhood disorder, making where a person lives as important for their health and wellbeing as their personal circumstances. Conversely, she argues that communities
with high social capital in terms of trust, reciprocity and participation are supportive of good mental health. For example, young people in the UK who experience fewer positive and greater negative social relations have been found to have lower wellbeing.\(^{(231)}\) Emerging evidence also suggests that social cohesion may reduce the negative effects of neighbourhood deprivation on mental health.\(^{(232)}\)

Living in an urban environment is a known risk factor for depression and anxiety.\(^{(54,233)}\) Urbanisation and urban living are linked to mental health stressors such as areas with concentrations of socioeconomic deprivation, low social support, social segregation, and stressors in the physical environment such as air, water and noise pollution, as well as exposure to physical threats (accidents and violence).\(^{(233)}\) Furthermore, a lack of public space can prevent community cohesion from developing, which is needed to increase social connectedness and reduce loneliness.\(^{(234)}\)

A person’s neighbourhood environment can also reinforce isolation and exclusion. For people with learning disabilities, segregated schools, living a separate existence to the general community, and a lack of community connections makes them vulnerable to hate crime and discrimination, leading in turn to an increased risk of mental health problems.\(^{(235)}\)

\subsection*{2.4.3 Built environment}

There is some evidence 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, south London, the most important factors reported were neighbour noise, a sense of over-crowding in the home and having limited access to escape facilities such as green spaces and community facilities, and fear of crime, all of which led to lower reported mental wellbeing.\(^{(236)}\)

As reported in the 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 also been found to be a causative factor in increased mental health problems among children and young people.\(^{(12)}\)

2.4.4 The natural environment

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.\(^{(237)}\) The North Atlantic Treaty Organisation (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.\textsuperscript{(238)} In England, an analysis of data from the Adult Psychiatric Morbidity Survey carried out in 2014/2015 found that experiencing storm- or flood-related damage in the home increased the risk of having a common mental disorder, over and above other established predictors of poor mental health. People who had experienced storm or flood-related damage to their home in the six months before completing the survey had poorer mental health.\textsuperscript{(239)}

On the positive side, spending time in natural environments reduces levels of stress and/or improves attention fatigue and mood more than built-up environments.\textsuperscript{(240)} The positive effects of availability of green and blue (visible water) space are discussed in chapter three.

2.4.5 Summary of ecological determinants

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 a lack of adequate housing and transport options, neighbourhood deprivation and an adverse built environment, living in an urban environment, and living in an adverse natural environment.

- Being homeless or at risk of homelessness is strongly associated with mental health problems\textsuperscript{(188)} and this association is supported by at least one systematic review.\textsuperscript{(227)}

- Poor quality housing, and housing that is unsafe and
insecure, are risk factors for poor mental health and the exacerbation of existing mental health problems.\(^{(230)}\)

- Living in an urban environment is a known risk factor for depression and anxiety.\(^{(54,233)}\) Urbanisation and urban living are linked to mental health stressors such as areas with concentrations of socioeconomic deprivation, low social support, social segregation, and stressors in the physical environment such as air, water and noise pollution, as well as exposure to physical threats (accidents and violence).\(^{(233)}\)

- There is some evidence from the UK that the built environment can have an impact on self-reported mental wellbeing.

- 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.\(^{(237)}\)
3. Tackling socioeconomic inequalities to reduce mental health problems

3.1 Why action is needed to prevent mental health problems

“Mental health and wellbeing are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life.”

WHO (2013), Investing in Mental Health: Evidence for Action

Mental health should be valued and understood as a key that allows us to unlock a wide range of health and social benefits. When this asset is damaged it leaves us unable to reach our collective potential. Yet the extent of mental health problems in the population means that...
many people are not attaining these benefits. Every week in England, one in six adults experiences a common mental health problem such as anxiety or depression, and one in five adults has considered taking their own life at some point.\(^{(45)}\) In the Mental Health Foundation’s Surviving or Thriving Report (2017) based on a NatCen survey, 65% of participants reported that they had experienced a mental health problem in their lifetime and this figure rose to 71% among young people aged 18–34. Unemployed people (85%), people on low incomes (73%) and people living alone (71%) were more likely to report having had a mental health problem.\(^{(43)}\)

Internationally, the WHO is concerned that if we do not take urgent action, then by 2030 depression will be the leading global health challenge.\(^{(242)}\) With reference to depression, special rapporteur Dainius Pūras of the United Nations Office of the High Commissioner for Human Rights has stated that:

“[Depression] is a widespread and systemic public health and human rights issue which demands urgent reconsideration of how we invest in mental health and how we manage conditions such as depression.”\(^{(243)}\)

The Organisation for Economic Co-operation and Development (OECD) has said:

“Mental disorders account for one of the largest and fastest growing categories of the burden of disease with which health systems must cope, often accounting for a greater
burden than cardiovascular disease and cancer... A significant proportion of the population suffering from mental ill-health remains hidden.”(244)

WHO has identified the importance of investing in better mental health of the population, referring particularly to the costs of mental, neurological and substance use disorders which account for nine out of the 20 leading causes of years lived with a disability and 10% of the global burden of disease. (244) The UK’s then Department of Health reported in 2011 that mental health problems are the single largest cause of disability, contributing up to 22.8% of the total burden of disability. (245) Furthermore, according to the OECD, mental health problems cost the UK £94 billion every year. (246) Importantly, while this includes the direct costs of mental health services, many of the costs of mental health problems extend beyond the health service and consist in lost productivity at work and reduced quality of life. (245)

Numerous experts and authorities, including WHO, the UN Special Rapporteur on the Right to Health (Dainius Pūras), and the UK Department of Health and Social Care, have argued that the costs of mental health problems require mental health to be regarded as a significant issue not only in efforts to improve public health, but also in economic development, social welfare, education and across other parts of society. (241,243,245)
One reason to try to prevent mental health problems is that mental health services cannot cope with current demand. The huge prevalence of mental health problems is not currently being met by adequate service provision, and projections indicate that this will not be possible for many years. In England, child and adolescent mental health services are unable to cope with escalating demand. One quarter of children aged 5-19 have had no contact with professional or informal sources of support for worries about their mental health in the past year, while only 58.6% have accessed some form of primary or specialist mental health support. The plan for the UK Government’s Transforming Children and Young People’s Mental Health Provision pilot programme anticipated reaching only one-fifth to one-quarter of the country by 2023, and the Government’s own Five Year Forward View for Mental Health expects that only one in three children and adolescents with a mental disorder will access NHS mental health community services by 2020-21, while the more recent Long Term Plan for NHS England does not expect that 100% of children and young people who need specialist care will be able to access it until 2028-29. These targets indicate that access to needed mental health support for all children and young people is a long way off. This is one reason that a new approach is needed, one that focuses on preventing mental health problems from arising.

Another reason is that preventing mental health problems is an issue of social justice. Mental health influences our
social, economic and health outcomes. When we experience good mental health, we can thrive. When our mental health is not protected, the impact can significantly limit life chances, resulting in higher levels of physical morbidity and mortality, lower levels of educational attainment, poorer work performance/productivity, a greater incidence of addictions and poorer community and societal cohesion. The quality of life for many people with mental health problems is also blighted by widespread prejudice leading to a high risk of discrimination and social exclusion. And we know that mental health problems are preventable, with good evidence for many interventions. For these reasons, the Strategic (Marmot) Review emphasised that “reducing health inequalities is a matter of fairness and social justice.” (13)

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

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras stated in 2017 that:

“... at the population level, an effective and rights-based approach to address depression requires scaling mental health across policies and services in general health, education, poverty reduction, violence prevention, etc. so that major risk factors are reduced, while protective factors
and the resilience of individuals, families and communities is strengthened.”(243)

In so stating, he reinforced a perspective that has gained momentum both within the UK and internationally. The need for cross-sectoral action on mental health has been recognised at European level for some time and was part of the EU Joint Action for Mental Health and Wellbeing.(249)

As has already been discussed in chapters one and two, there is strong and accumulating evidence that social inequalities such as poverty and income inequality, gender, a variety of minority statuses, and adverse childhood experiences and trauma, increase the risk of mental health problems. It is therefore logical that reducing these inequalities could prevent mental health problems.(76) 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 disorders.(15) Other experts, including Professor Sir Michael Marmot, have joined this call, stating that:

“...
mental health, and for reducing [the] risk of those mental disorders that are associated with social inequalities.\(^{(250)}\)

Professor Marmot’s view was reiterated in the Institute for Health Equity’s update report published early in 2020. The update report called for a national strategy for action on the social determinants of health with the aim of reducing inequalities in health. It also included a set of principles, as well as other actions to reduce health inequalities. Now, only a couple of months after publication of this report, it is likely that socioeconomic inequalities will substantially worsen as a result of the COVID-19 pandemic and its aftermath. The need for such a national strategy, therefore, has never been greater.

A further motivation for addressing these social inequalities relates to where benefits can accrue, as the costs of mental disorders extend well beyond the health sector. For example, reducing social inequalities 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, where this is possible for the individual, would also accrue savings in social welfare benefits. Overall, the UK Department of Health and Social Care has reported that the achievement of good mental health and wellbeing in the population would result in the following benefits:
3. Tackling social inequalities to reduce mental health problems

• Better physical health.
• Reductions in health-damaging behaviour.
• Greater educational achievement.
• Improved productivity.
• Higher incomes.
• Reduced absenteeism.
• Less crime.
• More participation in community life.
• Improved overall functioning.
• Reduced mortality.\(^{(245)}\)

It is also clear that many of these benefits can help achieve strategic policy goals in sectors beyond health, such as reducing levels of imprisonment, disability benefits and homelessness, and increasing productivity. It is not surprising that at EU-level, a Mental Health in All Policies approach has been recommended.\(^{(249)}\) The EU Joint Action for Mental Health and Wellbeing concluded that:

“Prevention of mental disorder involves addressing risk factors, many of which lie in non-health areas, such as poverty and socioeconomic inequalities, violence and abuse, poor education, unemployment and social isolation.”
In particular, childhood adversity has [a] powerful influence on the development of mental disorder, and therefore, effectively addressing such adversity particularly for more disadvantaged children is important.”(249)

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, schools and workplaces).(250) Measures to address social determinants at the structural level require action by government departments other than health, for example housing, education, justice, transport and welfare. (250) Cross-sectoral action has been endorsed by the WHO in its Mental Health Action Plan 2013-2020.

One advocate has gone further than discussion about acting cross-sectorally, specifying that such action must be taken at a structural level, at least in part. Patel argues that country-level case study evidence substantiates the rationale for measures to reduce poverty, economic inequality and gender-based violence as a means of improving mental health. He cites the example of China, where suicide rates have reduced over the past decade alongside improved living conditions in rural areas and empowerment of women.(251)

So too, action needs to occur among people who are at particularly high risk, such as refugees and asylum-seekers, people experiencing homelessness, prisoners, victims of violence and abuse, people with disabilities, and other minority groups,
and must take place in contexts where they can be reached, in ways that are meaningful and effective for them. Many people at higher risk of developing a mental health problem will not come in contact with health services, so preventative actions need to be undertaken in the settings where they 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.

Preventing ACEs warrants particular attention when considering action for preventing later mental health problems. As discussed in section 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 them. There are 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, family and parental support; provision of psychological therapies for children exposed to trauma; safeguarding of children; prevention of alcohol and substance misuse; and addressing domestic violence and abuse.\(^{(76)}\)
Tackling inequalities to improve mental health: We need to move upstream

**STRATEGIES**

**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
- Trauma-informed public services

**DOWNSTREAM** - Individual / group resilience
- 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
3.3 How inequalities can be addressed

This section describes measures that the UK and devolved national governments, local communities and individuals can take to reduce the mental health effects of socioeconomic inequalities. Measures proposed relate to the inequalities identified in the paper. The discussion begins with a focus on the structural level, proceeds to consider the community level, and concludes with a brief consideration of relevant individual-level interventions.

3.3.2 Effective structural approaches for reducing the impact of inequalities

Given the strong evidence for a range of socioeconomic drivers of poor mental health, reducing the prevalence of mental health problems requires action that directly addresses these factors. Preventing mental health problems means reducing and ameliorating the risk factors, particularly the inequalities that influence them. Such inequalities are amenable to policy intervention that could provide effective means of improving the mental health of the population.

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 include seeking to reduce income inequality, poverty, unemployment,
domestic violence, discrimination and homelessness. Measures to promote community assets include activities to increase social connectedness, improve community environments, foster participation in community decision-making, and increase awareness both of risk factors and of 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.

The below recommended actions are in keeping with the Institute of Health Equity’s principles for reducing health inequalities in England, published in early 2020, which are:\(^{(17)}\)

**Principles for governance for health equity**

1. Health equity is an indicator of societal wellbeing.

2. The whole of government is responsible for prioritising health equity in all policies.

3. Development of strategies and interventions must involve a wide range of stakeholders.

4. Accountability must be transparent with
3. Tackling social inequalities to reduce mental health problems

5. Communities must be involved in decisions about programmes and policies for achieving health equity.

**Principles for implementing action on health inequalities and their social determinants**

1. Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health.

2. Ensure proportionate universal allocation of resources and implementation of policies.

3. Early intervention to prevent health inequalities.

4. Develop the social determinants of health workforce.

5. Engage the public.

6. Develop whole systems monitoring and strengthen accountability for health inequalities.

Source: Marmot, et al. (2020)

3.3.2.1 Act with proportionate universalism

Often there is a tendency to focus on targeted interventions for particular 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 and Marmot Update reports.\(^{(13,17)}\) 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 which means ensuring support for everyone, because we all have mental health, but also focusing targeted support to address the greater risks faced by some people and groups.

### 3.3.2.2 Map the social determinants of mental health in regions

A valuable cross-cutting approach is to map the social determinants of mental health in a geographical area as a basis for prioritising action and planning and resourcing interventions. The Mental Health Foundation’s rapid review of social determinants of mental health in the boroughs of London provides a good example of this approach. This research involved gathering available data on a range of social determinants and risk factors by local authority and City of London area within London. Through analysis of this data heat maps of high-risk areas for mental health problems were produced. The analysis was structured by five lines of inquiry: children and young people, employment and mental health, community strength, crisis care and people who have complex
needs, and suicide reduction. The resulting analysis identified higher risk areas and informed the development of programmes under Thrive LDN.(252)

3.3.2.3 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. For example, Wahlbeck, et al. (2015) argue that action to reduce poverty and disadvantage, among other actions, may help to reduce the prevalence of depression.(253)

One measure to consider is the introduction of a universal basic income (UBI). WHO has recently considered the potential of UBI to address health inequities.(254) In a paper prepared for WHO, Haagh and Rohregger have argued that “[a]s part of a tiered model, UBI – in close complementarity with universal services – can help support the building of welfare systems based on the principle of proportionate universalism, providing basic income stability that is both crises preventative and health constitutive.”(254) This approach is supported by evidence that debt and financial difficulties can lead to or exacerbate mental health problems, with evidence showing that the more debt people have, the more likely they are to have mental health problems overall.(65)

Indeed, there is emerging evidence that UBI can have positive effects on mental health. For example, an unconditional cash
transfer experiment in Malawi resulted in better mental health among schoolgirls who were 38% less likely to experience psychological distress than a control group, while research in Kenya has shown that income supplements resulted in a 24% decrease in depressive symptoms among young people.

New analysis of a basic-income town experiment carried out in Canada in the 1970s has found that there was an 8.5% reduction in hospitalisation compared to controls, particularly for accidents, injuries and mental health. This analysis also found that visits to GPs for mental health problems were reduced among those receiving the basic income.

Thus evidence to date points to a positive effect on mental health from unconditional, basic-income measures. In 2019, the WHO Regional Office for Europe published a report on UBI which suggests that governments should see it as a long-term goal, but that discrete steps can also be taken towards achieving it through actions such as reducing conditionality. The report’s authors suggest that “UBI experiments have shown that even small changes to the current known welfare logic can have huge impact, such as lifting conditionalities and sanctioning regimes.”

3.3.2.4 Provide adequate housing

Addressing housing need may also improve individuals’ mental health, though the evidence so far is still emerging. Clearly, ensuring that people can access and retain safe, good-quality accommodation should be considered a positive mental health measure. Experts have also said that improving housing
conditions can improve mental health.\(^{(253)}\)

Some high-quality studies have found a reduction in psychiatric symptoms among people with severe mental health difficulties, as a result of the “housing first” approach, which seeks to provide permanent housing for homeless people rather than taking a stepped approach.\(^{(257)}\) The evidence of the mental health effects of housing improvement more generally has been said to be limited, small-scale and poor in quality.\(^{(230)}\) However, a study of the effects of housing improvements in Glasgow found improved mental health among participants. For example, new front doors had a substantial positive association with mental health within the first year after intervention (but not thereafter), while new kitchens and bathrooms had positive associations with mental health one year after the intervention and beyond.\(^{(258)}\)

### 3.3.2.5 Provide adequate access to green and blue space

Ensuring that people have access to green and blue (visible water) spaces may also help protect against mental health problems. As mentioned above, spending time in natural environments reduces levels of stress and/or improves attention fatigue and mood more than built up environments. A systematic review published in 2015 found strong evidence for a positive association between the quantity of green space and perceived mental health such that living in greener environments was associated with better mental health.\(^{(259)}\)
Another study found that long-term exposure to green space may be a protective factor against anxiety and depression,\(^{260}\) and a Danish study published in 2019 found that high levels of green space presence during childhood are associated with lower risk of a wide spectrum of psychiatric disorders later in life. Risk for subsequent mental illness for those who lived with the lowest level of green space during childhood was up to 55% higher across various disorders compared with those who lived with the highest level of green space.\(^{261}\) There is also emerging evidence of an association between available spaces with visible water (so-called blue space) and better mental health,\(^{240}\) although evidence is mixed. One study in Spain did not find evidence that long-term exposure to blue space was protective against anxiety or depression,\(^{260}\) however, an Irish study found that older people with the most sea-view visibility had lower scores on the Center for Epidemiologic Studies Depression (CES-D) scale,\(^{262}\) and a study in England found a positive effect of sea-view visibility but only for those in the lowest-income earning households.\(^{263}\) Thus, making green and blue space more available for people in deprived areas may help to decrease their levels of anxiety and distress, though this idea requires more research.

Exposure to, and engagement with, nature has also been linked to more positive mental health in children and young people, though more research in this area is needed.\(^{264}\) One review found that when students engaged in physical activity
outdoors, they gained greater benefits in terms of energy and enjoyment and their feelings of anger and depression decreased, when compared to doing that same activity indoors. This benefit may be especially pronounced for children living in disadvantaged areas. One study followed more than 6,000 children and young people from ages three to five and found that neighbourhood green spaces were related to them experiencing fewer emotional problems, although only for children from poorer urban neighbourhoods.

With regard to natural disasters, the Foundation has previously advised that ensuring people are living in a safe and secure setting, free from conflict and where the effects of disasters, such as flooding, bombings and economic disasters, are limited, can have a direct beneficial effect on mental wellbeing.

### 3.3.2.6 Protect people from discrimination, abuse and other adversity

As discrimination on the basis of social identity (for example ethnicity, disability, gender, 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 of individuals in these identity groups. Given the known negative impact of racism on mental health, there are good reasons for thinking that anti-racism measures would have a positive effect on the mental health of those from BAME communities. At the very
least, action should be taken to enforce the legal protections already in place, while political leaders should ensure that their statements about ethnic minority groups are accurate.\(^{(268)}\)

Further, action to prevent bullying that is motivated by negative stereotypes around gender, sexual orientation, body image, disability or ethnicity would lower the prevalence of this type of stressor and thereby potentially reduce mental and emotional distress. Recognising that action to prevent bullying, prejudice and discrimination could improve the mental health of the population may provide an additional motivation for such action beyond its intrinsic social justice value.

Similarly, a greater focus on 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.\(^{(76)}\)

For disadvantaged groups, another effective means of preventing mental health problems is to support their empowerment and participation in society. For this reason, the Foundation has developed programmes to support the empowerment and participation of refugees and people with intellectual disability. The same type of approach would be very relevant for women and girls, people with other types of disabilities, and older people.

### 3.3.2.7 Reduce substance and alcohol misuse

While mental health problems can sometimes lead to people
engaging in alcohol and other substance misuse, there is good reason to think that preventing alcohol and other types of substance misuse could reduce the prevalence of mental health problems. Campion concludes that alcohol misuse can be prevented through action on price, availability, marketing, licensing, screening and brief interventions, including school-based interventions, while drug abuse among children and young people can be prevented through school-based interventions.\(^{76}\)

### 3.3.2.8 Improve the educational attainment of teenagers

Given the links between educational attainment and mental health, a recommended approach is to reduce early school leaving.\(^{269}\) Interventions tend to focus on improving the engagement of students in schooling, as well as providing better links between students and employment pathways. While early school leaving has reduced in the UK since 2011, it was still at 10.6% in 2017.\(^{270}\) A systematic review has found that there is a wide range of intervention strategies for preventing school dropout, most of which are designed to target some of the common risk factors associated with failure to complete school, and others that aim to design more relevant schooling for students.\(^{271}\) A common approach is to reduce class sizes or create lower teacher-student ratios. The systematic review found that no particular programme was better than others, and the most important factor for success was choosing a programme that can be implemented well within the school.
3.3.3 The whole community model

A whole communities approach to mental health acknowledges the role that national policy plays in creating the conditions that support the development of mentally healthy communities, and also that mental health improvement interventions must operate across multiple system levels. More specifically, this model adopts an “in all policies” approach, in parallel with considering “all settings” and “all services” that provide connection points with individuals, families and groups within communities. In adopting such a model, much of the improvement impact will be experienced not only within the health system through a reduction in more acute and long-term mental health and social care support services but also across systems that rely on social capital (workplaces, schools) and the public support infrastructure (criminal justice, health and welfare systems, housing, community/urban planning and regeneration). It is important, therefore, that the measurement of the impact of prevention extends beyond the health and social care services.

This whole community model draws on Bronfenbrenner’s Socio-ecological Systems Theory,(3) which provides a theoretical framework that has a useful application to mental health due to its emphasis on psycho-social human development. Bronfenbrenner’s approach to systems theory still takes account of the role that people play in influencing their own mental health, whilst also considering their significant
relationships such as with families, neighbours and colleagues. In this way, the framework acknowledges the interconnections and dependencies amongst community members and between those groups and local environmental factors.

A useful starting point for action at the community level is the New York Thrive approach and an adaptation of its six guiding principles (Diagram 1):\(^{(272)}\)
The whole community model provides a useful explanation of:

- how we develop emotions, cognitions and behaviours that are adaptive to our social and physical conditions;

- the impact on our mental health of key influences (relationships, systems and structures that support us or put us under pressure); and

- the way in which stigma and discrimination shape the cultural context of how mental health is viewed and valued.

When the whole community approach is implemented in a particular geographical and social context, it is referred to as a “place-based” approach. The place-based approach has been endorsed by WHO (2010) and involves bringing together policies and sectors within a geographical or social context.\(^{273}\)

There is a range of international initiatives that take a systems- and place-based approach to improving health. From the WHO’s Healthy Cities\(^ {274,275}\) and Resilient Cities\(^ {276}\) initiatives, it has been understood that for real change to occur, it needs to be embedded at multiple levels across and alongside communities and throughout a range of systems. More recently, Dementia Friendly Communities\(^ {277}\) have taken this systemic view and applied it to support for people with dementia, enabling them to have access to the opportunities required to function as full citizens within environments that are inclusive and non-stigmatising. Similar models have been adopted at the other end
of the age spectrum to give children and young people the best start in life, including work to establish nurturing environments through the Promise Neighbourhoods Initiative,\(^{(278)}\) developed around neighbourhoods that were in distress.

### 3.3.4 Mobilising community assets

The Five Year Forward View for Mental Health acknowledged the role of mental health service users and the community and voluntary sector in meeting the growing demand for mental health improvement.\(^{(279)}\) It will not be enough to expect public policy alone to achieve the level of change required. To make a real difference and have fewer people experiencing mental 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 make a difference, and to build thriving communities.\(^{(280)}\)

Asset-based approaches to community development are gathering momentum as a result. This approach looks to the positive capacity of individuals and communities, rather than focusing on their needs and problems. The approach is similar to salutogenesis which considers the factors that support health rather than those that cause ill-health and disease.\(^{(281)}\) “Assets” are strengths, identified by a community as valuable to them, that when exposed to the right conditions 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 psycho-social, such as self-esteem, confidence, a sense of coherence, knowledge, skills, social networks or collective efficacy.\(^{(282)}\) There is some evidence that asset-based approaches at the community level can improve individuals’ mental health outcomes such as self-esteem and social isolation.\(^{(281)}\)

Table 3 summarises the 12 values that underpin asset-based community development, modified to enable practical application to communities’ mental health improvement.

**Table 3: Values that underpin asset-based community development adapted from the International Association for Community Development.**\(^{(283)}\)

<table>
<thead>
<tr>
<th>VALUE</th>
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<tr>
<td>Local leadership</td>
<td>The community leads its own development and community leaders are themselves capable of opening doors to the wider citizenry. Local leaders are therefore defined by the relationships they have within the community by their social, rather than political or financial capital (see below). Within a mental health improvement context there is the potential to connect with existing community leaders who can potentially identify and access people within communities who are at higher risk.</td>
</tr>
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<td>Social capital</td>
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### 3. Tackling social inequalities to reduce mental health problems

<table>
<thead>
<tr>
<th>VALUE</th>
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<tr>
<td><strong>Social capital (cont.)</strong></td>
<td>community by their social, rather than political or financial capital (see below). Within a mental health improvement context there is the potential to connect with existing community leaders who can potentially identify and access people within communities who are at higher risk.</td>
</tr>
<tr>
<td><strong>Equality and social inclusion</strong></td>
<td>All community members, regardless of gender, age, ability (or disability), mental health status, race, culture, language, sexual orientation, or social and economic status have equal opportunity to become engaged in the community development process and are able to access its social and economic benefits.</td>
</tr>
<tr>
<td><strong>Focus on community assets</strong></td>
<td>Community development starts from recognising existing community capacity and assets, building on what we have. This includes assets within people who are most often excluded from communities and therefore at higher risk of mental health inequity.</td>
</tr>
<tr>
<td><strong>Balance</strong></td>
<td>Community development builds on a balanced approach that addresses and integrates economic, social, environmental and cultural considerations, thereby adopting a socio-ecological approach.</td>
</tr>
<tr>
<td><strong>Appreciation and celebration of past successes</strong></td>
<td>This strengthens people’s confidence in their own capacities and inspires them to take action, including people whose achievements are less often recognised.</td>
</tr>
<tr>
<td><strong>Transparency and accountability</strong></td>
<td>This framework encourages and requires government, the voluntary sector and any other outside involvement in</td>
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<tr>
<td><strong>Transparency and accountability (cont.)</strong></td>
<td>Community development to be transparent, accountable, and participatory. In turn, communities hold each other to the same values of transparency and accountability, expecting no less of each other than of external agencies.</td>
</tr>
<tr>
<td><strong>The recognition of the power of association</strong></td>
<td>In association we join our gifts and strengths together and they become amplified, magnified, productive, and celebrated (McKnight, 2009). Essentially, the whole is greater than the sum of the individual parts and includes engagement with all members of the community – with everyone’s contribution being valued.</td>
</tr>
<tr>
<td><strong>Participatory approaches to development</strong></td>
<td>These are based on principles of empowerment and ownership of the development process. Participation also includes people who have least experience of participating and may need more support to do so effectively.</td>
</tr>
<tr>
<td><strong>Efforts to strengthen civil society</strong></td>
<td>These efforts have focused on how to engage people as citizens (rather than as clients or service users) in development, and how to make local governance more effective and responsive (IACD, 2007; Braithwaite, 2005).</td>
</tr>
<tr>
<td><strong>A focus on social change</strong></td>
<td>Asset-based community development is about change for the better as defined by the community itself.</td>
</tr>
<tr>
<td><strong>A focus on local communities</strong></td>
<td>Asset-based community development is a place-based approach focusing on the assets of an identified geographical area, a place that residents describe as “home”, but which may also include settings which influence mental health such as schools, prisons, hospitals and workplaces.</td>
</tr>
</tbody>
</table>
3.3.5 Genuine co-production: the shift to “power with”

The concept of co-production has been applied increasingly in practice across the UK. Co-production refers to processes wherein people who use services work in equal partnership with providers of services. Co-production can be used to innovate, plan, develop, implement and evaluate new approaches to health improvement. One example is the Expert Citizen movement in Stoke on Trent, 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.

When undertaking co-production, it is important to operate with a nuanced understanding of power. In a discussion paper prepared for the WHO, the authors refer to four types of power, as set out below: (284)

- “Power over” whereby some people are able to influence or coerce others.
- “Power to” whereby individuals are broadly able to organise and change existing hierarchies.
- “Power with” is the collective power of communities or organisations.
- “Power within” is individual capacity to exercise power.
Action to involve communities must recognise that power is differently distributed not only between services and community members but also amongst community members. This power distribution is not always explicit and can be either hidden or subtle.\(^{(284)}\) 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 and how these dynamics will impact on the process. To co-produce actions that will address mental health inequalities, power imbalances need to be redressed and moved from “Power over” to “Power to” and “Power with”.\(^{(285)}\) If successful, community members will view themselves as architects of change rather than only its recipients.

The Mental Health Foundation’s programme of conversations with London residents under the Thrive initiative is a good example of how co-production can be carried out on a large-scale basis to inform programme development. The programme was conducted through 17 community conversations in half of all London’s boroughs and involved face-to-face contact with more than 1,000 Londoners including those who commission, provide and use services. A key message from participants was that rather than top-down approaches, they want the knowledge, skills and support to look after themselves and their neighbours.\(^{(286)}\) Feedback from participants included:
“The local community and voluntary sector is vibrant and gives a feeling there is a sense of community connectedness. The next step is to make sure that decisions are owned by the community and that they are for the community.”

“We need community health champions – volunteer residents who talk to other residents to reduce isolation and promote good health. Volunteering builds confidence and giving something back improves [the] wellbeing of the volunteer and those they support.”

“It would be good to have free indoor gyms, swimming and so on. Often people at highest risk don’t have resources to use these facilities. Perhaps a scheme where these can be used off peak, may be good for unemployed people?”

“Give young people the power to lead and have their own conversations. It is important to have more conversations about race and class. Young people are regularly undermined in the community, there is not enough time invested in them.”

3.4 Examples of interventions at individual level to prevent mental health problems and promote mental wellbeing

This paper has identified sub-populations of people who, by reason of their unequal position in society, are at high risk of developing a mental health problem. There is strong evidence for many interventions that operate
at the individual level to reduce the effects of socioeconomic inequalities and produce better mental health outcomes. Some programmes focus on preventing ACEs by fostering parenting skills and providing support to parents. Others focus on preventing or being able to cope with particular social circumstances. The Royal Society of Public Health has published a comprehensive analysis of interventions designed to prevent mental health problems and promote mental wellbeing.\(^{(76)}\) This section highlights some individual-level interventions that relate to the inequalities identified earlier, and in particular, interventions that have been piloted by the Mental Health Foundation.

In general, a review has found that there is good evidence to support empowerment strategies to improve mental well-being among disadvantaged groups such as women, older people and people at risk of HIV/AIDS.\(^{(287)}\) This research shows that programmes employing an empowerment approach have had a positive effective on psychological well-being, self-esteem, self-confidence and sense of self-efficacy.

Given the association between debt and mental health problems, some interventions have been proposed for people in debt.\(^{(76)}\) The Forum for Mental Health in Primary Care has suggested a variety of initiatives that primary care staff could undertake to help their patients cope with debt,\(^{(288)}\) including mental health screening for people in debt, and assisting patients to find debt advice.
3. Tackling social inequalities to reduce mental health problems

**For students**, the Foundation’s Peer Education Project in schools is a scalable intervention comprising five mental health and wellbeing lessons, delivered to all Year 7 students by their older, Year 12, peers. The lessons aim to introduce the ideas of mental health and mental illness to young people, and also to give students the skills to keep well, improve their mental wellbeing and support their friends. The evaluation of this project found a statistically significant reduction in emotional difficulties across the Year 7 population. Importantly, in terms of the programme’s acceptability, more than half (57%) of Year 7 students found it helpful to learn about mental health from a peer educator rather than from their usual teacher, while 35% said it did not make a difference.

**For prevention of ACEs**, the Foundation’s Young Mums Together project worked in partnership with local children’s centres and other community groups to develop sustainable hubs of peer and professional support for young mothers (under the age of 25) in three London boroughs. The qualitative analysis from interviews with mothers demonstrated that participants felt that the groups helped to: develop parental confidence by reinforcing a sense of purpose; increase resilience through discussion among peers; improve mental health awareness through psychoeducation around risk factors; and encourage mothers’ hopes about the future through practical advice and information-sharing.

The Mums and Babies in Mind project (MABIM), hosted by the
Mental Health Foundation on behalf of the Maternal Mental Health Alliance, was a three-year initiative for commissioners and providers in four sites in the UK to “improve care and quality of life for mums with mental health problems during pregnancy and the first year of life, and their babies.”\(^{(290)}\) The evaluation found that participants valued the bespoke support, masterclasses and pathway assessment tool provided through MABIM. While it was difficult to determine the project’s impact on service delivery, the evaluators reported that “[t]he case study illustrates how MABIM helped service providers look at the care pathway as a whole, which resulted in a more cohesive pathway and facilitated the inclusion of multiple agencies, such as third sector organisations.”\(^{(290)}\) The findings could inform support pathways linked to specialist parent-infant relationship teams, highlighted by the Parent Infant Partnership UK’s (now the Parent Infant Foundation) recent report highlighting the need for roll-out of such teams. Their research found that “most babies in the UK live in an area where there is no specialised parent-infant relationship team. And there is very little mental health provision at all for children aged two and under.”\(^{(291)}\)

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.\(^{(292)}\) It has
also been reported that seeking social support and having a strong sense of racial identity/concept are helpful, while “racial socialisation” has been recommended. The latter involves learning how to identify racism, having role models who demonstrate appropriate responses, and understanding the experience of racism.\(^\text{292,293}\)

The Foundation’s Refugee Health Policy and Strategy Action Group is a project focused on increasing awareness and subsequent engagement of refugees with the wider health and social care policy landscape. Through a programme of training, the Mental Health Foundation is engaging volunteers from refugee backgrounds to enable them to consider their own lived experience and place it in a wider policy context where their personal experience can be harnessed to advocate for informed policies reflecting the lived experience of refugees. Evolving from this are opportunities for volunteers to engage with national health and social policy forums as well as refugee specific groups within statutory agencies. The Refugee Health Policy and Strategy Action Group is connected to the New Scots Strategy, a national framework designed to support refugee integration in Scotland. The Foundation co-chairs the Health and Wellbeing Subgroup of the New Scots Strategy. The work of the Refugee Health Policy and Strategy Action Group is placed in the context of these structures and supports the implementation of the actions associated with the subgroup. The volunteer team are now delivering local projects in Fife,
Dundee, Glasgow, North Lanarkshire, North Ayrshire and West Dunbartonshire.

As loneliness has been identified as a risk factor, **fostering 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 their risk of developing mental health problems. For example, The Foundation’s Standing Together Project was a three-year Big Lottery-funded initiative to address loneliness, social isolation and poor mental health in residents living in later life housing. Over the course of its delivery, 19 peer support groups, with a combined total of more than 300 participants, were set up in retirement and extra-care housing schemes around London. These groups were facilitated for six months by project staff, and 10 of the 19 groups sustained themselves beyond this period through investment by housing associations, volunteer support, and self-facilitation. The results of the project evaluation indicated that Standing Together groups were successful in fostering a greater sense of social connectedness among participants.

Given the high prevalence of **mental health problems among people with long-term physical health conditions**, improving the detection and treatment of conditions such as anxiety and depression among this group would be likely to reduce the prevalence of mental health problems in this group as well as improve their overall health outcomes. For example,
one study found that people with coronary heart disease who were offered stress management training with their cardiac rehabilitation programme showed reduced stress and improved clinical outcomes when compared to patients who received cardiac rehabilitation alone.\textsuperscript{(76)} Mindfulness programmes have also been shown to have a positive impact on people with diabetes and people with chronic health conditions.\textsuperscript{(76)}

Finally, as \textbf{being the child of a person with a mental health problem can increase the child’s risk}, family interventions and ensuring that mental health services are family-orientated would be likely to improve the mental health outcomes of these children. One approach is to follow the Social Care Institute for Excellence’s guidance ‘Think child, think parent, think family: a guide to parental mental health and child welfare’, which makes practical suggestions on how to adopt a family-orientated approach in mental healthcare.\textsuperscript{(294)}
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. 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, organisations, public and private, communities and individuals. To achieve this high aim – which is so well understood when it comes to physical health – we 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 adverse childhood experience 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.

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 communities” 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. Such a cross-governmental approach is likely to be even more necessary in the context of the aftermath of the COVID-19 pandemic.

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 over-stretched 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 cohere with individuals’ aspirations and actions to bring about the resilient communities in which everyone can flourish equally.
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