Mental health and inequalities

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Introduction

Mental health determines and is determined by a wide range of social and health outcomes at individual, community and societal levels and has an impact on all aspects of our lives. Poor mental health contributes to socio-economic and health problems such as higher levels of physical morbidity and mortality, lower levels of educational attainment, poorer work performance/productivity, greater incidence of addictions, higher crime rates and poor community and societal cohesion (McCulloch & Goldie, 2010).

There is much confusion about what is meant by mental health, as a term it is often misunderstood and is often accepted as a euphemism for mental illness, mental disorder or mental health problems (Henderson, 2010). However the term mental health relates to a positive state; often described as wellbeing or mental wellbeing. Mental health is therefore something that we all share and the status of this resource in individuals, communities and society as a whole should be a common concern. However, mental health is not evenly distributed with those who experience the highest levels of social disadvantage also experiencing poorer mental health than that of the more advantaged members.

Inequality in mental health means the unequal distribution of factors that promote and protect positive mental health and factors that are detrimental to mental health. Despite investment to address social disadvantage deep inequalities remain in our society with the gap between the rich and poorest increasing (Howell, 2013; Black and O'Sullivan, 2012). Our unequal society and the costs of this to mental health should be a central concern for us all; it leads to an unequal distribution across population groups of mental health problems and illness and in people's ability to recover and lead fulfilling lives.

If our aim is to create a fairer and more just society and then we need to address the chronic stress and fractures that having less power, status and control brings; and work with people to build strong communities and empowering services. To do this we need to work across all areas of policy to influence the factors that serve as determinants of mental health and enable inequalities and disadvantage to grow.

This paper provides an overview of the relationship between inequalities and mental health and outlines our views on the future threats and opportunities within society to tackle inequalities and improve the mental health of all.

Determinants of mental health

The concept of mental health cannot be separated from that of overall health with the determinants of health closely aligned to the factors that create optimal or minimal mental health and wellbeing. These factors operate at many levels and include; personal (e.g. genetic factors, diet, exercise, relationships, how a person may perceive events), social and community (e.g. family structure, friends, isolation, area of deprivation) and larger societal and environmental conditions (e.g. education, social connectedness, health care provision, unemployment levels, equality).

Demographics such as age, gender and ethnicity are also important determinants, influencing explores to risk and protection factors across the life course. (Barry, 2010).

The combined influence of these factors determines an individual's health status. As individuals, we have more control over some of these factors than others. In addition our life circumstances significantly impacts upon our motivation and capacity to make healthy choices and engage with health services and treatment. Any attempt at understanding how these factors interact and impact upon the health of individuals and communities needs to be understood in their sociocultural and environmental setting. Examples of mental health determinants are shown in Table 1:

Table 1 Examples of determinants of mental health (McCulloch and Goldie, 2010)

Society	Community	Family	Individual
Equality versus discrimination	Personal Safety	Family Structure	Lifestyle factors (diet, exercise, alcohol intake)
Unemployment Levels	Housing and access to open space	Family dynamics (eg. High/low expressed emotion)	Attributional style (ie. How events are understood)
Social Coherence	Economic status of the community	Genetic Makeup	Debt versus financial security
Education	Isolation	Intergenerational Contact	Physical Health
Health Care Provision	Neighbourliness	Parenting	Individual relationships and responses to these

There has been increased recognition on the broader determinants of mental health with greater application of the social model of health to the mental health sphere. This recognises that achieving positive mental health requires a focus on structural and environmental factors that create conditions of poverty, discrimination and inequity (Friedli, 2009; Marmot, 2010).

As we move forward, consideration should also be given to the physiological effects of inequality, on both neurological systems and other processes. Traditionally there has been a binary distinction between 'biological and medical' models of mental health and social models. Moving forward, it is clear that a greater understanding of the physiological effects of exposure to social determinants of mental health may provide another route to understanding complexity, multi-morbidity and the way in which treatments can be more efficacious.

The link between mental health and inequalities

There is a strong body of evidence that living in poverty brings with it poorer mental health, and that the stresses of living in poverty increases the risk of developing mental health problems. In addition that living with a mental health problem brings with it increased social disadvantage, such as higher levels of unemployment. Across the UK, we experience mental health inequities, these are inequalities in relation to mental health status that can be described as 'morally or ethically' unfair or unjust (Whitehead, 1990). These inequities are often experienced by the same people and accumulate over a lifetime, placing older people who experience poverty at increased risk of poor mental health and of developing mental health problems.

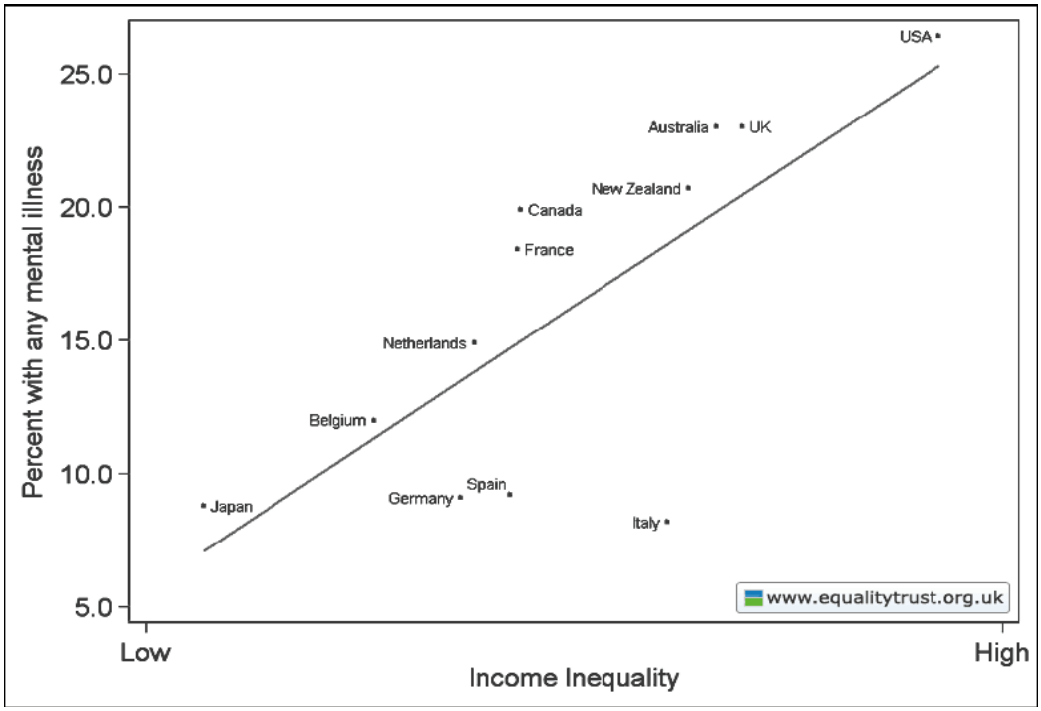
Adverse mental health outcomes are 2 to 2.5 times higher among those experiencing greatest social disadvantage compared to those experiencing least disadvantage (Kessler et al., 1994; Macran et al., 1996; Gilbert & Allan, 1998; Murali & Oyebode, 2004). In addition those living with disability or a mental health problem remain at highest risk of poverty (Parckar, 2008). Socio-economic pressures such as poverty and low levels of education are recognised risks to mental health for individuals and communities. The greater the gap between the rich and the poor, the greater differences are observed in health.

> The most common definition of poverty is **relative poverty**, defined as those living below 60% of the UK's average household income

Many problems associated with relative deprivation are more prevalent in more unequal societies. A review of the evidence suggested that this may be true of morbidity and mortality, obesity, teenage birth rates, mental illness, homicide, low trust, low social capital, hostility, racism, poor educational performance among school children, the proportion of the population imprisoned, drug overdose mortality and low social mobility (Wilkinson & Pickett, 2007). Arguably these are all part of the same pattern of social problems in which mental illness is a (large) player.

The surveys by the World Health Organisation show that different societies have different levels of mental illness. In some countries, 5–10% of the adult population has suffered from any mental illness in the past year, but for example in the USA it is more than 25%. The Equality Trust demonstrated a relationship between mental illness and income inequality in developed countries with mental illness being more common in more unequal countries (Figure 1; Picket et al, 2006).

Figure 1: Relationship between income inequality and prevalence of mental illness in developed countries (The Equality Trust)



One reason for this phenomenon may be that relative deprivation is a catalyst for a range of negative emotional and cognitive responses to inequality. That is, levels of inequality have a strong impact on how people feel and how people feel (emotional wellbeing) is a powerful indicator of their mental health. Socioeconomic position shapes access to resources, aspects of experience in the home, neighbourhood and workplace (Krieger, 2001; Graham, 2004; Regidor, 2006). In addition, aspects of socioeconomic position such as education, income and occupation prestige may influence health.

When discussing inequality it is important to reflect on groups of people who experience discrimination, and although are also highly represented within lower socio-economic groups, also encounter additional social injuries. Clear examples of this are people from minority ethnic communities, refugees and asylum seekers, older people and people with disabilities, including mental health problems and learning disabilities.

Not everyone that experiences discrimination encounters socio-economic inequalities although very many do, with large numbers of people with mental health problems unemployed and poverty a very real experience for many older people (Age Concern and Mental Health Foundation, 2006). People with disabilities and long term health conditions have the additional disadvantage associated with their health conditions, such as pain, unpredictability and the impact of long term use of medications. All of this can serve to limit their lives and therefore their ability to access opportunities that can work to protect mental health, such as employment and social support.

In 2007, NHS Health Scotland and the National Resource Centre for Ethnic Minority Health (NRCEMH) produced a report focused on the 6 equality and diversity strands of: Gender; Age; Disability; Sexual Orientation – LGBT; Race and Ethnicity; Spirituality. The report took as its starting point the argument that the factors that can undermine mental health or promote well-being are not randomly distributed but reflect social divisions of class and socio-economic status, aspects of social identity such as age, gender race or ethnicity, sexual orientation, disability (including the experience of mental health problems), religion and belief. The report made the point that it is not being a woman, or being black or gay, per se that cause mental distress, but the fact that some aspects of social identity can expose people to discrimination, stigma and prejudice. The experience of discrimination and prejudice can undermine mental health and well-being directly through exposure to, for example, harassment, and indirectly through the experience of poverty, deprivation, exclusion and inequality with which they are associated (NHS Health Scotland, 2007).

Approaches to mental health improvement and tackling inequalities

As outlined activities which are beneficial to health overall also have a positive impact on mental health. In recent years UK and devolved government policy on health improvement have focused on traditional approaches to promoting health. This includes the promotion of healthy lifestyles – e.g. higher levels of physical activity, eating fruit and vegetables, not smoking and drinking moderately - through investment in population wide social marketing campaigns and policy initiatives that encourage individual health behaviour change e.g. Keep Well Initiative in Scotland and Every Contact Counts in England. Some of these have been supported by wider policies - such as the no smoking ban - and some also recognise inequalities by targeting campaigns at those living in the most deprived areas.

However, a review in Scotland into the future of Public Services (Christie Commission, 2011) discusses the current failure within public services to prioritise a preventative approach in order to break the cycle of deprivation and low aspiration. It talks of 'Failure demand' – demand on public services which could have been avoided by earlier preventative measures – and of a system which is reactive and targets the consequences not causes of inequalities. A key recommendation within the report is the prioritisation of preventative services with a specific focus on addressing generational inequalities (Christie Commission, 2011).

Furthermore, a recent report by the Kings Fund (Buck & Frosini, 2012) - which analyzed data from the Health Survey in England in 2003 and 2008 to explore how lifestyle risk behaviours cluster in the population and are distributed over time - outlined that although the proportion of people engaging in multiple risky behaviours (smoking, excessive drinking, physical activity and eating 5 fruit and veg) had fallen overall in the general population the greatest reductions were among those in higher socio-economic groups thus exacerbating health inequalities. This led the authors to comment:

"This reflects one of public health's most difficult dilemmas: unless consciously designed not to, policies and actions that work for populations as a whole often inadvertently entrench inequalities."

A critique of the health behaviour approach is that the focus is on blaming the most disadvantaged and changing their behaviour rather than seeking to create – through better social and financial environments - the conditions that enable individuals and communities to have more control over their health and wellbeing (Gamsu, 2012).

It has also been suggested that population wide approaches are often not sensitive to the needs of equality groups. This includes those from minority ethnic communities with key messages being built on western concepts of mental health; and approaches not being flexible enough to provide messages that are meaningful to older people or people living with a disability or long-term condition and seldom translating effectively into communities where people live with daily challenges such as unemployment, poor housing or poverty.

Not surprisingly these individualistic and universal approaches have not been successful in improving mental health inequalities, which continue to widen. The social gradient that exists in mental health clearly indicates that material advantage has a key role to play in mental health outcomes. We know that poverty is a major determinant of poor mental health, and that universal approaches to mental health improvement may achieve mental health gain across the population but fail to address equity or reduce inequalities.

Future Trends and Challenges around Inequalities

In considering how best to improve mental health in the future and to deliver services that meet the need of a future population a range of factors will need to be taken into account, including:

- Shifting demographics, where an ageing population will create an increased burden on health services including mental health services. It can be anticipated that there will be higher levels of complexity to respond to due to multiple morbidity, which will require an integrated approach to health. Alongside this it can be predicted that prevalence of depression amongst older people may increase if family fragmentation as a phenomena continues and growing rates of dementia will bring a whole new spectrum of issues. Not only will this require a new way of approaching health care but health and social care will also need to take a more fundamentally integrated approach. It will also be important to consider how best to support informal carers in the future as demands on them increase.

- Countries where there exists a socio-economic gap experience worst health and mental health outcomes. Within the UK there has been little headway in addressing this and the gap continues to grow. It can therefore be expected that if this trajectory continues there may be an increased demand on mental health services.

- Welfare reform has the potential to deepen inequalities with wide spread concern that many of the current changes may disproportionately affect people with disabilities, older people and people with mental health problems. Concerns include the assessment processes in relation to entitlements and changes to housing benefit. It appears unlikely that in future there will be a reversal of the fundamental changes being made in our approach to social protection.

- People with mental health problems and levels of service provision are also not immune to the impact of austerity and UK debt which will impact for many years with estimated health spending taking approximately 15 years to return to 2010 levels again. This raises fundamental questions for example in relation to equality of opportunity for people with mental health problems to access employment and availability of support services to facilitate this process.

- Changes in employment practices are reducing opportunities for many with outsourcing of jobs within the wider global community and changes to manufacturing where new emerging patterns mean that jobs that would previously have been undertaken by semi-skilled or unskilled workers becoming increasingly mechanised. These changes alongside issues such as the Eurozone crisis where we are seeing banks taking a more cautious approach to lending impacting in many ways within the UK including the capacity to purchase property. Alongside these concerns the general unpredictability of the times and are impacting on mental health in many ways but will again disproportionately impact on those who don't have savings to provide a buffer and who aren't already on the property ladder.

- The current financial crisis has a direct impact on people as they age and older people will be placed at higher risk of poverty due to changes in the way that pensions are operated (closing of final salary pension schemes). The increase in working age may serve to ensure that people experience the protective benefits of work for longer, however although people are living for longer this does not mean disability free. The assumption that the workforce will be able to work for longer ignores the levels of disability amongst those in lowest paid jobs and that entry level jobs are often more physically demanding.

- The growing diversity in the UK brings a range of opportunities but will also challenge the way services operate. Currently there is a distance to travel to achieve equity in service provision for the settled Black and minority ethnic communities and new patterns of migration will expose the shortfalls further. For example one study found that as many as 57% of Refugee and asylum seeking women were above the cut off point for Post Traumatic Stress Disorder (LSHTM & SRC, 2009).

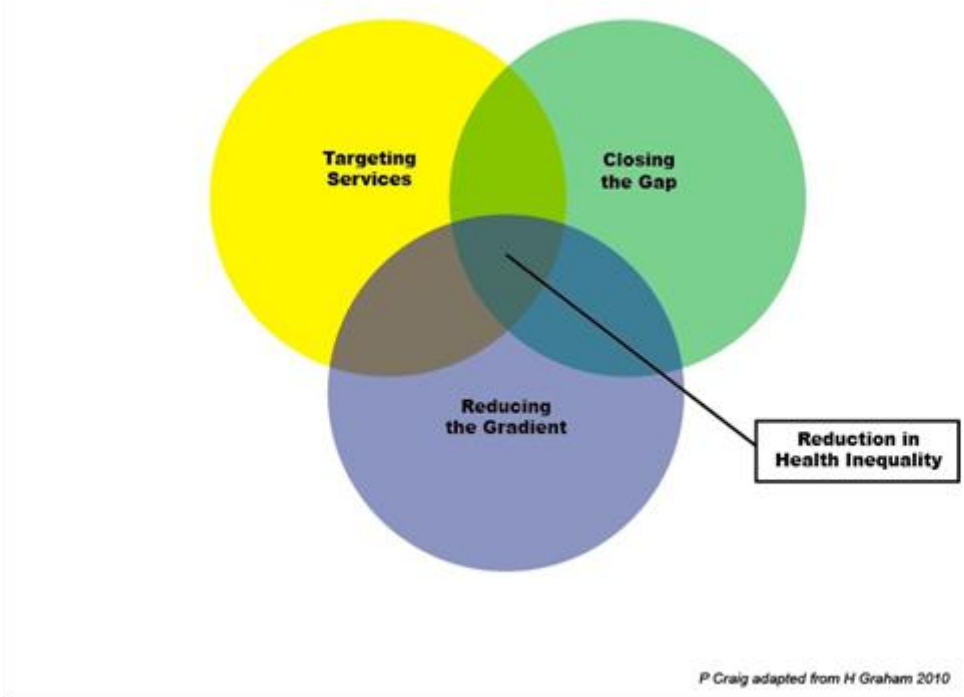
- The creation of a global community brings many opportunities such as efficient travel, widening access to technology, cross cultural interaction and a collective approach to public health and environmental challenges (Okasha, 2005a). However, a deregulated market and the development of

supernational political and economic bodies has contributed to deepening inequalities between societies. New technology and wealth is located with the privileged minority with 80% of the global community living in poverty and 6% owning the majority of the wealth (North America). For example only 1% have access to a computer (Okasha, 2005b). Within mental health there has been increased interest in developing global policies and strategies to attempt to improve mental health. This is not without challenge as there is no shared meaning in relation to mental health and not all countries have the infrastructure to implement these equally.

What will be needed to meet this challenges will be a fundamental change in approach. Some areas to be considered include:

- More integrated approaches to both health and health and social care to respond to increased co-morbidity and multiple morbidity.
- More investment upstream to prevent failure demand.
- Ensuring policy and strategy is linked up and not in silos: that there is an understanding that approaches to improving health and inequality outcomes are integrated.
- Taking an evidence based approach to improving public health with a shift in focus from a dependence on universal approaches and large scale public health social marketing campaigns to a model that takes account of inequalities (see fig 1).
- A proactive and consistent approach to ensuring equality, working alongside equality groups and within communities to co-produce services that respond to their specific needs.

Fig 1.



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