Centre for Mental Health

Mental health inequalities: evidence to the Welsh Parliament health and social care committee

February 2022

Summary

Inequalities in mental health are stark and deeply entrenched. Our chances of having good or poor mental health are influenced from before birth and throughout life by our environments and experiences.

Groups of people who face a higher risk of poor mental health include those living in poverty, women, racialised communities, people with long-term physical illnesses, disabled and neurodiverse people, and LGBTQ+ people.

Mental health inequalities are caused by economic and social inequalities and injustices. Major risk factors for poor mental health include:

- Poverty and financial inequality
- Violence, abuse and bullying
- Racism and discrimination
- Isolation and loneliness.

Unequal access to mental health support is not simply about whether services are available and accessible. It is also about whether those services are relevant, trusted, safe and (where necessary) adapted to people's needs.

A whole system approach is needed to address both the causes and the consequences of mental health inequalities, including:

- A 'mental health in all policies' approach that ensures all government decisions and actions are taken with mental health in mind
- A commitment to reducing financial inequality and poverty
- Tackling racism and ending racial injustice
- Investing in communities to promote and support good mental health
- Developing and implementing strategies to secure equality of access, experience and outcomes from mental health services at all levels and for all age groups.

Introduction

Centre for Mental Health is an independent organisation dedicated to eradicating inequalities in mental health. We work across the UK to address the causes of mental health inequalities and to spur action that reduces them.

We are pleased to provide evidence for the Committee's inquiry. While we do not have evidence specific to Wales from our work to date, our submission draws on UK wide and

international evidence about mental health inequalities: what causes them, what perpetuates them, and what can be done to reduce them.

Responses to the Committee's questions

Which groups of people are disproportionately affected by poor mental health in Wales?

Mental health inequalities are stark and often deeply entrenched. Groups of people who face significantly higher than average levels of poor mental health – but poorer access to effective support – include (but are not limited to):

People living in poverty: children from the most deprived 20% of households in the UK are four times more likely to have a serious mental health difficulty by the age of 11 as those from the wealthiest 20% (Morrison Gutman et al, 2015). Referrals to Improving Access to Psychological Therapies (IAPT) services in England are progressively higher for each decile of deprivation; but completion and recovery rates follow the opposite pattern (Health Foundation, 2020).

Girls and women: women face higher levels of mental ill health than men, with the gap especially pronounced among young women between 16 and 24 (NHS Digital, 2016). There is also evidence of a growing gap between girls and boys of secondary school age

Racialised communities: people from some racialised communities are more likely to be diagnosed with a severe mental illness (especially psychosis). People from racialised communities are less likely to be referred for mental health support by their GP but more likely to come into contact with services through the police, four times as likely as white people to be sectioned under the Mental Health Act, and ten times more likely be given a community treatment order after they leave hospital (NHS Digital, 2021).

LGBTQ+ people: data from the Millennium Cohort Study shows that lesbian, gay and bisexual adolescents are five times more likely to be depressed and almost six times more likely to have self-harmed in the past year compared to heterosexual teens (Amos et al, 2019). Trans young people also have very high levels of depression and anxiety, with more than half having considered suicide within a year of being surveyed (Bachmann and Gooch, 2018).

People with long-term physical conditions: having a long-term physical illness is associated with a doubling of the risk of depression; for people with multiple long-term conditions the risk is greater still. People with long-term conditions have told us that emotional support is often absent in the care they receive for their physical illness, and when they do get mental health support it's often poorly adapted to their needs (National Voices and Centre for Mental Health, 2021)

Disabled and neurodiverse people: children with a learning disability are three to four times more likely than average to have a mental health difficulty (Lavis et al, 2019). Rates of poor mental health are higher than average for autistic children and adults. Many find that mental health services (especially those using psychological interventions that are typically developed for neurotypical people) are poorly adapted to meet their needs (Harper et al, 2019).

For many people, multiple layers of identity means they face higher risks of poor mental health across many of these groups.

What factors contribute to worse mental health within these groups?

Our mental health is determined by our experiences and environments. These create risk and protective factors for mental health: protective factors are things that make it more likely we will enjoy good mental health, while risk factors do the opposite.

People from the groups listed above are more likely to face higher risks and to enjoy fewer protective factors. The balance between the two

There is compelling evidence that **poverty and economic inequality** are major risk factors in themselves. Economic insecurity is a major cause of stress and distress. Studies have shown that moving people out of poverty improves mental health, and vice versa (Ridley, 2020). Reductions in the value of social security benefits or in eligibility have consistently been found to cause increases in levels of depression (Bell, 2020). And societies with higher levels of economic inequality have higher overall levels of poor mental health (Patel et al, 2018).

Violence, abuse and bullying are also major risk factors for poor mental health, whether they take the form of significant traumatic events or ongoing maltreatment. Domestic violence and abuse have been shown to be a major contributor to poor mental health among women (Scott & McManus, 2016). In schools, racist and homophobic bullying may contribute to higher levels of poor mental health among LGBTQ+ and racialised communities (Statham et al., 2012). There is evidence that LGBTQ+ inclusive education reduces the incidence of homophobic bullying (Proulx et al., 2019). Bullying in workplaces has also been noted as a risk factor for poor mental health in adult life (Fitzpatrick and Thorne, 2019).

Racism and discrimination are toxic to mental health for people from racialised and marginalised communities. Racist abuse and injustice have been shown to 'erode' mental health: and because racism is systemic, it's experienced in all aspects of people's lives with a cumulative effect during a person's lifetime and in families and communities across generations (Khan et al., 2017).

Isolation and loneliness are risk factors to mental health. This has been noted to be a potential risk factor for disabled and neurodiverse children, young carers, and children and young people living in remote rural areas (who may, for example, go to school far from home and thus lack opportunities to socialise with their peers) (Allwood, 2020).

For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

The barriers to accessing mental health support are multiple and complex. Access to mental health support requires it to be:

Available (close to home): proximity is important to encourage help-seeking (at least when it comes to face-to-face services). Locating support in familiar, trusted locations (eg GP surgeries, schools, youth centres) can make it more attractive and less clinical. This is especially important for groups of people who cannot travel easily (eg children and young people, older and disabled people, those relying on public transport). Locating services close to home is especially challenging in rural and coastal areas, though it can also be a significant barrier for young people in urban areas where travel outside their locality may be unsafe.

Timely: knowing that support will be available quickly makes a big difference to people's confidence in seeking help. Long waiting times both prolong distress and deter help-seeking. There is currently wide variation in waiting times for mental health support: some services available quickly (for example those subject to nationally mandated targets) and others with long waits or high service thresholds (that mean people's difficulties escalate to become more serious before an offer of help is made).

Well-communicated: services need to be proactive in encouraging help-seeking and making themselves readily available, warm and welcoming. This is important for all communities and age groups, but has been noted to be especially important to young people, who are more likely to find formal and clinical feeling services offputting.

Non-stigmatising: while the stigma of poor mental health is gradually reducing, it is still a factor that can make services less accessible. Services can feel less stigmatising through the locations they use (if they are familiar and safe) and their language (avoiding overly clinical terminology).

Relevant: services need to be able to demonstrate that they will meet people's needs and understand their lives and their challenges. If people don't believe that mental health services will be helpful, they may not see any benefit in taking the risk. Some innovative services prioritise engagement with young people by offering help with money, housing or legal difficulties first.

Trustworthy: for some marginalised and racialised communities, mental health services are not trusted. Many fear that seeking help for their mental health will result in the use of coercion: being locked up and restrained. Marginalised young people express fears that health professionals are no different to the police and they won't be safe if they engage. Mental health services need to be actively anti-racist – taking proactive steps to combat and reverse ingrained patterns of oppression and injustice towards racialised communities.

Adapted: for some groups of people, adaptations and adjustments are needed to make mental health support relevant and accessible. This includes many neurodiverse and disabled people (for example from the deaf community) as well as those requiring language interpretation. Being trauma-informed can also help to make services more accessible and safe to people who have experienced traumatic events including gender-based and racial violence.

What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

A whole system approach is needed to address both the causes and the consequences of mental health inequalities (Commission for Equality in Mental Health, 2020). For any government and wider society to tackle mental health inequalities, important steps include:

A **'mental health in all policies'** approach that ensures all government decisions and actions are taken with mental health in mind: seeking to benefit (and not to harm) mental health, with a clear commitment to reduce mental health inequalities. In education, for example, this would include adopting inclusive education practices and trauma-informed behaviour policies as part of a 'whole school approach' to mental health. Similar gains can be made across all government departments and policies, from combating the climate crisis to preventing homelessness and creating safer and more cohesive communities.

A commitment to **reducing financial inequality and poverty**: this can include measures to boost pay (for example adopting the Real Living Wage in all public sector organisations and their contractors), to increase the value of social security benefits, and to ensure people are able to get benefits they are entitled to (eg through widening access to high quality money and welfare advice).

Tackling racism and **ending racial injustice**: recognising that racism is a public health hazard and taking action to ensure that racial injustices are tackled robustly. This may include addressing discriminatory policies and practices in education, policing, immigration and other areas of public policy as well as within the health and care system.

Investing in communities: mental health is made in communities and community organisations can play an important part in creating the conditions for promoting good mental health, especially among groups that are poorly served by mainstream services. They need sufficient and sustainable funding (charitable as well as statutory) to be able to fulfil their potential, and especially to be able to advocate for change and challenge established power structures and systems.

Develop and implement strategies to secure equality of **access, experience and outcomes from mental health services** at all levels and for all age groups. NHS England's *Advancing Mental Health Equalities* strategy seeks to take a systematic approach to reducing inequalities in services. This includes action to ensure the mental health workforce is more representative of the communities it serves as well as having the necessary competencies. And it sets out to improve data and transparency about how well services are reducing inequalities. Reforms of the Mental Health Act will also play an important part in addressing some of the inequalities in the use of coercion, but will not by themselves be enough to shift the dial.

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