Centre for
Mental Health
Commission for Equality

Commission for Equality in Mental Health

BRIEFING 1: Determinants of mental health

Centre for Mental Health, January 2020

CONTENTS

SUMMARY

Anyone can experience a mental health problem. But our chances of having good or poor mental health are far from equal.

The Commission for Equality in Mental Health was set up by Centre for Mental Health to investigate inequalities in mental health in the UK and produce policy and practice proposals to tackle them. The Commission is seeking to understand why and how inequalities in mental health happen, what ways they manifest, and most importantly what can be done to prevent or mitigate them.

This briefing paper focuses on the unequal determinants of mental health. The determinants of mental health are the factors that influence our mental health throughout our lives.

All of us have multiple layers of identity and belong to communities of geography, gender, ethnicity, social class and many more. And many of us experience forms of disadvantage resulting from poverty, homelessness, exclusion, discrimination or oppression. We have fewer choices, less of a voice, less power and fewer opportunities.

The determinants of mental health interact with these inequalities in ways that put some people at a far higher risk of poor mental health than others. For example:

• Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%

• Children and young people with a learning disability are three times more likely than average to have a mental health problem

• Men and women from African-Caribbean communities in the UK have higher rates of post-traumatic stress disorder and suicide risk and are more likely than average to be diagnosed with schizophrenia

• 40% or more of people over the age of 85 and those in nursing homes have depression.

We have identified a range of suggestions from previous research and from our call for evidence about specific actions and approaches that could help to prevent, reduce or mitigate inequalities in the determinants of mental health. These include:

• Community-led peer support and social change movements

• Prioritising early years interventions, including parenting programmes

• A whole school approach to mental health with a focus on equality

• Action to increase the price and reduce the availability of alcohol

• Addressing income inequality, work insecurity and working conditions

• Improving housing quality and security and preventing homelessness.

The Commission will produce two further briefing papers, on access to support and on experiences of and outcomes from services, and a final report with recommendations for policy and practice in 2020.

WHAT WE MEAN BY DETERMINANTS

This briefing paper focuses on the unequal determinants of mental health. The determinants of mental health are the factors in our lives – from our genetic inheritance to our experiences throughout life – that influence our mental health. Some factors are known to protect our mental health: for example positive parenting early in life and good social connections from childhood into later life. Others, such as experiencing abuse or being bullied, are known to undermine our mental health and cause harm that can last a lifetime.

Mental health is not simply about the absence or presence of mental illness. While mental ill health is widespread – affecting one in four of us each year – all of us are on a spectrum with our wellbeing and many of us will be at very different points during our lives, whether or not we experience a diagnosable mental illness.

The determinants of mental health can all affect our wellbeing and mental health at different times in our lives: our chances of having good mental health and our risk of having difficulties. Risk factors make it more likely we will experience poor mental health while protective factors can reduce that likelihood. Evidence from a review of children and young people's mental health (Khan, 2016) suggests that the more risks a child is exposed to, the more severe they are, and the longer they are exposed to them, the greater the chances are that they will experience significant levels of mental ill health during their lives.

While evidence about the determinants of mental health is still emerging and often contested, it is clear that the environment we live in, from conception onwards, has a major influence on both mental and physical health. The Health Foundation for example has pointed to the importance of 'allostatic load': the amount of stress that we are subjected to in our lives – particularly early on – and the way this can erode away our wellbeing (Kelly-Irving, 2019). The higher this load is, the more at risk we are of experiencing a range of health problems during the rest of our lives, long after the source of stress is no longer there.

These sources of stress have a direct impact on our psychological wellbeing. But they have also been shown to affect our physical health. This may be directly – from weakening the immune system or causing a traumatic brain injury – or indirectly – for example if a person manages stress through smoking or excessive drinking or eating (PHE 2017).

INEQUALITIES IN THE DETERMINANTS OF MENTAL HEALTH

Many mental health awareness campaigns begin with the premise that anyone can experience a mental health problem – and this is true. But our chances of having a mental health problem (or not) are far from equal. The determinants of our mental health are not equally distributed. The relationships between the risk and protective factors for mental health and different groups of people is of course complex.

All of us have multiple layers of identity and belong to communities of geography, of gender, ethnicity, social class, sexuality and many more. And many people experience forms of disadvantage resulting from poverty, homelessness, exclusion – and discrimination or oppression, for instance on grounds of disability or gender identity. They mean we have fewer choices, less of a voice, less power and fewer opportunities.

The determinants of mental health interact with these inequalities in ways that put some people at a far higher risk of poor mental health than others. Coming from a particular social group may not in itself put you at higher risk of mental ill health; but the experiences and injustices that too often come with it mean that you face a higher likelihood than others. Young LGBT+ people, for example, experience higher levels of bullying than their peers (Statham et al, 2012; Khan 2016); and young people with learning disabilities are more likely to be lonely and feel isolation (Lavis et al, 2019). Among older people, risk factors for poor mental health include having a caring responsibility, bereavement, isolation and having a long-term physical condition, and combinations of these factors can create especially high risks (Independent Age evidence to the Commission).

Unfortunately, some efforts to explain these inequalities have sought explanations in the characteristics of the group itself: for example those that attribute higher levels of psychosis among African and Caribbean people in adult life to a genetic predisposition or social dysfunction. Such explanations can perpetuate stereotypes and harmful assumptions about the causes of inequality, and they obscure the experiences of racism and oppression communities experience and how they might be addressed (Barnett et al 2019).

It is also clear that inequalities in mental health are not one- or even two-dimensional. Single attributes are not enough on their own to explain mental health inequalities or understand the experiences that generate them. Age, gender, wealth, ethnicity, disability and sexuality (among others) are interrelated, and the ways they expose people to risks or offer protection can only be understood in combination. The prevalence of common mental health problems appears, for example, to vary more strongly by household income among women than men (WHO, 2014). And bullying during childhood is experienced differently by girls (for example in the form of sexual harassment), and by people from BAME backgrounds, disabled people and people who identify as LGBT+ (Girlguiding evidence to the Commission).

The interconnections between inequalities that are often viewed separately can be seen in the relationships between financial wellbeing, ethnicity and mental health. Ethnic groups with higher rates of poverty also experience higher rates of compulsory mental health treatment in the UK (See figure 1 overleaf).

Mental health inequalities need to be viewed as cumulative during a person's lifetime. During our lives, risk and protective factors may change but the accumulation of risks from earlier in life and their impact on a person's mental health build up over time. There is also evidence that these cumulative impacts can perpetuate through generations in families and communities as a form of 'collective historical trauma' – for example those affected by histories of slavery (Khan et al, 2017; Mohatt et al, 2014). A contemporary account of this phenomenon was described powerfully by Akala (2018).

Mental health inequalities also interact with economic and political changes in society. Data from the UK suggests that between 2008 and 2010 there were an additional 846 suicide deaths among men and 155 among women during the recession, with rising unemployment a factor in two-fifths of cases among men (Barr et al, 2012). Changing policies relating to social security can also have profound effects on mental health: for example if they engender fear, shame or humiliation in the process of receiving financial benefits or if they provide insufficient funds so people have to rely on food banks (Psychologists Against Austerity, 2015). And the experiences of older LGBT+ people will be different to those of younger generations, for example, as a result of changing attitudes towards sexuality and gender identity over the last fifty years.

There is also evidence that place can have an impact on mental health: that inequalities can be either heightened or mitigated by the places we live in. Recent research has identified differences in ethnic inequalities in mental health between inner city and other areas: with the former associated with more pronounced inequalities for Black men but not South Asian men (Coid et al, 2019). Research has also identified that people affected by flooding and weather damage have higher levels of mental ill health (Graham et al, 2019) and that people on lower incomes were more likely to experience poor mental health following an incident.

Finally, there is evidence that inequality in itself can be a risk factor for poor mental health. International literature demonstrates that societies with higher levels of economic inequality have higher rates of depression (Patel et al, 2018; Pickett and Wilkinson, 2018). Unsurprisingly, most of the burden falls on those with the lowest incomes and least wealth. Research has identified strong links between levels of poverty and the prescribing of antidepressants in the UK, mediated not just by material deprivation but by feelings of being judged and shamed for being poor, being excluded from everyday activities, being assessed and reassessed for benefits, and the dehumanising effect of having their experiences dismissed or disbelieved (Thomas et al, 2019). Racism has also been shown to have a direct impact – itself creating an additional allostatic load on a young person every time they experience a racially-motivated 'micro- aggression' (Khan et al, 2017) on top of the daily struggle to survive in what can be a 'hostile environment'. For some of the most marginalised communities, such as Gypsy, Roma and Traveller communities, this interacts with cultural and political hostility in ways that have been described as rendering them 'abject' (Tyler, 2013).

Figure 1: Comparing child poverty, race and Mental Health Act statistics

Standardised rate of MHA detentions (per 100,000 population)
(from NHS Digital, 2019)

Child poverty rates after housing costs (%)
(from Runnymede Trust nd)

MENTAL HEALTH INEQUALITIES IN NUMBERS

Children from the **poorest 20%** of households are **four times** as likely to have **serious mental health difficulties** by the age of 11 as those from the wealthiest 20% (Morrison Gutman et al, 2015)

Children and young people with a **learning disability** are **three times** more likely than average to have a **mental health problem** (Lavis et al, 2019)

70% of **children** with **autism** (Simonoff et al, 2008) and **80%** of **adults** with **autism** (Lever and Geurts, 2016) have at least one **mental health condition** (Autistica evidence to the Commission)

Men and women from **African-Caribbean communities in the UK** have **higher rates of post-traumatic stress disorder** and **suicide risk** and are more likely to be **diagnosed with schizophrenia** (Khan et al, 2017)

Deaf people are **twice as likely** to experience **mental health difficulties** (All Wales Deaf Mental Health and Well-Being evidence to the Commission)
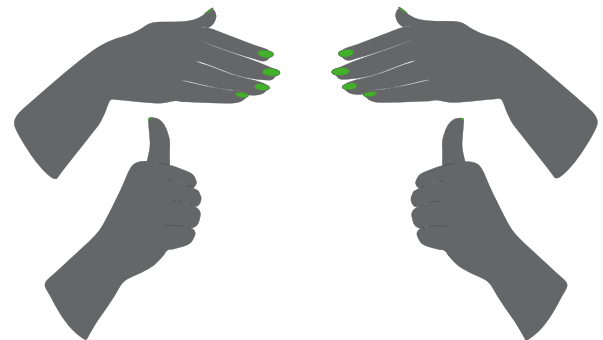
Women are ten times as likely as men to have experienced extensive **physical and sexual abuse** during their lives: of those who have, **36%** have **attempted suicide**, **22%** have **self-harmed** and **21%** have **been homeless** (Scott and McManus, 2016)

People who identify as **LGBT+** have **higher rates** of common **mental health problems** and **lower wellbeing** than heterosexual people, and the gap is **greater for older adults** (over 55 years) and those **under 35** than during middle age (Semlyen et al, 2016)

IDEAS TO REDUCE INEQUALITIES

"*We are unlikely to be able to eliminate the social gradient in health completely, but it is possible to have a shallower gradient in health and wellbeing than is currently the case for England.*" (Marmot, 2010)

Tackling the unequal determinants of mental health is one of the most challenging areas of policy and practice. Risk factors for poor mental health cover such a broad canvas and go well beyond the usual confines of health policy or practice. So tackling them requires significant social change: dealing with poverty, economic inequality, racism, violence and insecurity.

The World Health Organisation (2019) has identified five key factors in determining health inequity, which it describes as:

- Health services

- Income security and social protection

- Living conditions: including housing deprivation, unsafe neighbourhoods and lack of green spaces

- Social and human capital: incorporating education, trust and political voice

- Employment and working conditions.

For mental health, the WHO concludes that income security and social protection contributes 46% of all inequality, with living conditions the next largest contributor (30%) (see figure 2).

"*The struggle to make ends meet, including being able to afford to pay for the goods and services considered essential to living a dignified, decent and independent life (such as fuel, food and housing) is a major factor explaining inequities in self-reported health between social groups in countries across the WHO European Region.*" (WHO 2019 p. xxvi)

We have identified a range of suggestions from previous research and from our call for evidence about specific actions and approaches that could help to prevent, reduce or mitigate inequalities in the determinants of mental health. We will be investigating these and other potential solutions during the coming months as we develop our final report.

Figure 02. The five conditions' contributions to inequities in self-reported health, mental health and life satisfaction (EU countries)

% of the gap explained by each of the 5 conditions
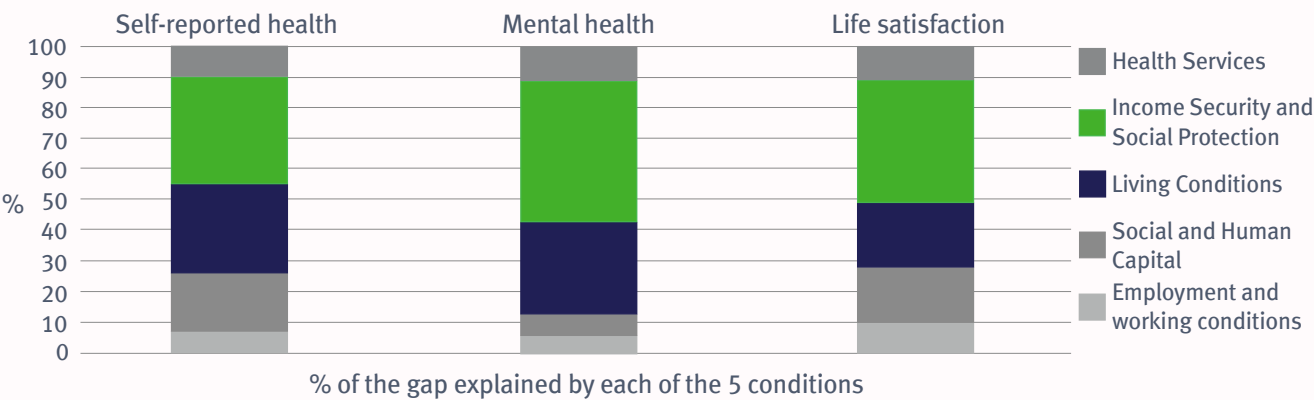
Adapted from World Health Organisation (2019)

1. Community-led initiatives

Peer support: initiatives led by communities and community groups can offer groups of people opportunities to improve mental health and prevent mental health difficulties (Mental Health Foundation evidence to the Commission). These have been found to have benefits for a broad range of communities. Creating the conditions that enable such approaches to thrive is therefore important for statutory bodies both locally and nationally.

Social change movements: communities can also create movements that seek to address the inequalities that undermine their mental health. The Black Thrive initiative in Lambeth, bringing together community members and the borough council using a 'collective impact model', is an example of such an approach led from within a community with the explicit aim of reducing mental health inequality by addressing the structural causes and power imbalances that lie behind it.

2. Local and regional systems

Housing quality and security: there is clear evidence about the benefits of safe, secure and decent housing to mental health, and about the significance of poor housing as a driver of mental health inequality. An evaluation of the Warm Front scheme (a UK Government initiative to enable vulnerable people to keep their homes warmer, from 2000 to 2005) found that reducing fuel poverty and cold brought about a 40% reduction in psychological distress (Green and Gilbertson, 2008). Measures to tackle housing insecurity and housing poverty, especially for people in private rented accommodation, may also have significant mental health benefits.

Joint Strategic Needs Assessments: local authorities have a statutory duty to assess the health needs of their communities and to develop health and wellbeing strategies based on this. Effective JSNAs can provide clear and compelling evidence about mental health inequalities and what can be done to address them (Bell, 2016).

The Mental Health Foundation's evidence to the Commission recommends local areas gather data and intelligence about the social determinants of mental health and use that to inform local plans alongside 'community conversations' to identify priorities for action.

Public services as 'anchor institutions': local authorities, NHS organisations and universities can influence their local economy and environment in ways that could reduce mental health inequalities, for example as employers and by investing in their local area (Elwell-Sutton et al, 2019).

Further, higher and adult education: local further and adult education services may play an important role in creating opportunities for learning, including non-vocational education and mental health literacy, that may reverse or mitigate inequalities earlier in life (Chandola and Jenkins, 2014). Universities can also help to address inequalities through their admissions processes.

Improved working conditions: the Marmot Report (2010) advocates jobs that offer not just a decent wage but "opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions... Getting people off benefits and into low-paid, insecure and health damaging work is not a desirable option." (p20). The more recent Taylor review of working practices draws similar conclusions in the context of the changing labour market (Taylor, 2017). Many of the known workplace risk factors for poor mental health – such as "high job demands, low job control, high effort-reward imbalance, low relational justice, low procedural justice, role stress, bullying and low social support" (Harvey et al, 2017, p1) are more likely to affect those on lower incomes and in less secure employment.

Action to prevent hate crime: many groups facing a high risk of hate crime also have a higher risk of poor mental health, and experiences of hate crime are likely to add to that risk significantly (Mental Health Foundation evidence to the Commission).

Use spatial planning to improve mental health:

local authorities' spatial and economic planning powers could help to reduce mental health inequalities, for example by increasing access to green spaces, places for children to play and leisure facilities; reducing the risk of flooding and weather damage; and preventing vandalism and antisocial behaviour (Cave and Molyneux, 2004).

3. National policies

Prioritise early years interventions:

the World Health Organisation (2014) and the Marmot Review (2010) both regard policies that seek to give every child a good start in life as a priority for improving population mental health and reducing inequalities. This includes tackling depression or anxiety during pregnancy, reducing child poverty and offering evidence-based parenting programmes at a sufficient scale (WHO, 2014; Marmot, 2010). The Marmot report cites Sure Start as "a good example of a scaled-up approach to early years intervention...[that is] available and easily accessible to the most disadvantaged and deprived" (p27) yet many of these facilities have since been closed or reduced in size. More recent studies have noted the economic as well as human benefits of Sure Start (eg IFS, 2019) and the importance of combining 'income transfers and open access services' to young families on low incomes to give children the best start in life (Oppenheim and Eisenstadt, 2019).

Whole school approach:

placing Social and Emotional Learning on the school curriculum as part of a wider whole school approach to mental health. The whole school approach, recommended by the World Health Organisation, includes effective action to tackle bullying and support children with emerging behavioural difficulties. The Marmot Review (2010) also advocates a higher priority for 'life skills' education alongside the attainment of qualifications; a view shared by young people, who also wanted more access to creative and cultural education (Abdinasir, 2019).

A whole school approach would also need to address the "hidden curriculum... which perpetuates disadvantage in education along class lines" (Morris et al, 2019, p22) such as streaming, school trips, sports and assemblies as well as the broader social 'segregation' between schools in the UK (ibid).

Inclusive education:

LGBT+ inclusive education has been found to bring about lower rates of bullying, suicidal thoughts and depression symptoms (Proulx et al, 2018). The UK Government has made a number of commitments to relationship and sex education in schools and to LGBT+ inclusive teaching. Education that is inclusive of disabled people can also bring similar benefits.

Minimum Unit Pricing and duty increases for alcohol:

this combination approach is recommended by the Alcohol Health Alliance in its evidence to the Commission to reduce harm, particularly among those on the lowest incomes and most deprived areas. Early evidence from Scotland suggests that MUP is making an impact (eg The Independent, 2019) and should be employed in other parts of the UK.

Amend licensing laws:

to enable local authorities to take public health into account when making decisions about where and when alcohol can be sold. These are currently in place to some extent in Scotland and Northern Ireland to place limits on the density of places where alcohol is available or on 24-hour sales (Alcohol Health Alliance evidence to the Commission).

Address income and wealth inequalities:

some submissions to the Commission have advocated Universal Basic Income policies that guarantee everyone a level of income that allows them to maintain their health (eg Marmot, 2010; Psychologists for Social Change, nd). Other evidence has noted flaws in this approach and called instead for more public services, such as social care, to be available without cost (eg Coote, 2019); or for reductions in the use of conditionality in social security systems:

"*Robust, multilevel, inclusive social security systems – with an unconditional tier at the base and supplemented by state-supported contributory schemes – have the highest effect in terms of reducing health inequities.*" (WHO Europe, 2019 p.xxvii)

Reduce work insecurity: the WHO recommends national policies that protect people in work from insecurity, for example parental leave policies and pensions (WHO Europe, 2019). Concerns have also been raised about the mental health implications of rising levels of under-employment and zero-hours contracts in the UK economy. The Taylor review (2017) sets out ways in which work practices can change to address these concerns and ultimately improve productivity as well as health.

Tackle homelessness and its causes: taking action to reduce the risk of homelessness may prevent the traumas that surround this experience for both families and individuals.

Mental health in all decisions: this is an approach that would require government departments to make policies that would seek to maximise mental health and reduce inequalities. A similar approach could be applied regionally and locally through devolved administrations, local councils and combined authorities.

IMPLICATIONS FOR POLICY AND PRACTICE

Prioritising inequalities in mental health has profound and wide-ranging implications for policy and practice at every level. It calls into question existing policies and practices, in mental health, the wider health and care system and well beyond, which have been embarked upon without an explicit focus on inequality.

Inequalities in the determinants of our mental health begin early in life and are threaded into the fabric of society. Unpicking them means being prepared to change some of the most deeply rooted inequalities and injustices and shifting the balance of public spending towards very different priorities.

Mental health policies and strategies

In England, the NHS has taken a leading role in the development of mental health strategy since the 2012 Health and Social Care Act. This has produced two important and ambitious plans[1] that, between them, have brought about significant increases in mental health service funding and improvements in care and support. An unintentional effect of this shift from central government to arm's length leadership, however, has been a gap in strategic leadership across the wider system. The last cross-government mental health strategy, *No Health Without Mental Health*, dates back to 2011 and has long since been superseded.

A key influencer of mental health inequality is income inequality. Both absolute and relative poverty are major risk factors for poor mental health for people of any age, but especially for children. This implies that any effective mental health strategy would need to address poverty as a priority.

As Lai et al (2019) observed:

"*Any strategy with specific targets to improve life chances for children (eg, child mental health) without focusing on child poverty will struggle as there will be an increased need on services as poverty levels rise...*" (Lai et al 2019 p5)

No national mental health strategy in England has yet done this. The majority have focused solely or predominantly on mental health services and been 'owned' by the Department of Health and Social Care or its predecessors. None has made far-reaching proposals that address the 'causes of the causes' of mental health inequality.

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[1] The Five Year Forward View for Mental Health, 2016, and the NHS Long Term Plan, 2019

Public health policies and strategies

Another major challenge in giving priority to actions that might reduce mental health inequalities is the tendency that some commentators have observed in public health policy and practice towards 'lifestyle drift' (Popay et al, 2010). While evidence points increasingly to structural and collective determinants of health, public health activity tends towards individual 'behaviour' or 'lifestyle' modification. Even where policies or projects begin with a focus on structural inequalities, over time they shift towards a more individualistic approach that places responsibility on individual citizens to look after their own health (Williams and Fullagar, 2018). This has been explained variously as resulting from a need for short-term results, from stereotypes about people and communities with poorer health, and from a belief that public services should 'mimic markets' (Popay et al, 2010) in focusing on individual 'consumer' behaviour. The importance of looking beyond individual behaviour is well illustrated in relation to alcohol. Evidence provided to the Commission by the Alcohol Health Alliance demonstrates that among lower income groups, alcohol consumption is lower than average, yet rates of alcohol related harm are higher. Health promotion activities that rely solely on information are noted to increase inequalities, whereas steps to increase the cost of alcohol (such as minimum unit pricing) may reduce them.

The impact of lifestyle drift in public mental health can be seen in the growing number of campaigns that seek to place 'resilience' in the hands of individuals: focusing on 'actions we can all take' to improve our mental health. A different approach would seek to locate resilience within communities and identify the actions that can be taken to support this.

Similarly, the risk of an individualised approach to mental health promotion is that it ignores the cumulative impact of the determinants of mental health: that we are all influenced by events and environments during our lifetimes which we cannot control in the here and now. Morris et al (2019) note that approaches to wider inequalities that focus on creating opportunities *"to encourage preferable life outcomes...can compound existing inequalities as they shift the focus from societal needs to individual choices"* (p22).

A further challenge for public health policies and practices seeking to reduce inequality is the extent to which service-based responses should be made available universally or offered specifically to the most disadvantaged. While the latter is more likely, in the short-term at least, to reduce inequalities, as the WHO (2014) observes, *"services for the poor often become poor services and are easily reduced or stopped altogether...[because] they do not enjoy the support of the whole population"* (p39). Yet a universal approach may fail to reduce inequality, or even make it worse. The WHO advocates 'proportionate universalism', an approach which it says offers interventions universally but which are 'calibrated...to the level of disadvantage' (ibid).

The provision of parenting programmes is one area where this dilemma is particularly acute: there is evidence that universal offers either miss those who need help most or have higher attrition rates (or at the very least provide lower value for money), yet targeted programmes have attracted poor and patchy funding (Brown et al, 2012). The Republic of Ireland has sought to overcome this through a stepped programme of parenting provision (Doyle et al, 2018). And the best examples of Sure Start did achieve proportionate universalism – a universal offer, with more intense forms of support available for those facing greatest inequality (IFS, 2019).

Legislative and wider policy issues

Any effective approach to reducing mental health inequalities will have to take place at scale and look well beyond the usual confines of health or even social policy. Evidence points to the conclusion that mental health inequalities often begin early in life and build up over many years. Inequalities in wealth and assets, and not just income, are evident in children's early years, and early experiences can have lasting effects on mental health (Straatman et al, 2019). Likewise, inequalities in the housing market have effects on educational opportunities (as wealthier families drive up prices near to high performing schools) and thus on labour market and health outcomes (Morris et al, 2019). So policy responses need to recognise and act on the intersections between all of these factors and respond to the build-up of inequalities over time.

Equality and human rights policies and legislation may have a particular role to play in securing change with the necessary level of ambition. The Public Sector Equality Duty, for example, could provide the necessary space for public bodies to seek to prevent mental health inequalities if it was employed strategically to inform priorities for action and resource allocation.

The devolved nations have taken a lead in this regard in the UK. The Scottish Government has decided to implement a 'socio-economic duty' with the aim of ensuring that policies and practices are designed to reduce economic inequalities – as well as inequalities linked to 'protected characteristics'. There is provision in the Equality Act 2010 for a socio-economic duty, but in England this has not been implemented. This could help develop a more integrated narrative between the different dimensions of inequality and a more effective approach to addressing economic inequalities. The Wellbeing of Future Generations Act in Wales, meanwhile, requires public bodies to take decisions that support the wellbeing of both present and future generations, with the potential to generate longer-term approaches to policy- making (Elwell-Sutton et al, 2019). Both offer opportunities for other parts of the UK to learn from their experience.

The United Nations' Human Rights Council (2019), meanwhile, noted in a recent report that protecting human rights in and of itself "is a core determinant of mental health" (p4): that without the rights to liberty, freedom from torture and housing, good mental health is not possible to attain. It includes within its list of determinants "non-violent school and home environments, healthy workplaces that respect the full spectrum of labour rights, and a robust and active civil society supporting the struggles of those furthest behind" (p7). This has profound implications for the scope and scale of a rights-based approach to tackling the determinants of mental health inequalities.

It is also clear from the evidence we have reviewed that the voices of people who experience mental health inequalities are still not being heard, and much of the language to describe inequalities in general excludes and often diminishes those who are experiencing it first-hand (Morris et al, 2019). This makes it easier to blame the people, families and communities that have the poorest mental health for their lack of 'resilience' while concealing the determinants that undermined their mental health from before birth and throughout life. While it is true that people can take steps to support their own mental health, we all need the right conditions to do so.

ABOUT THE COMMISSION

The Commission for Equality in Mental Health was set up by Centre for Mental Health in 2018 with an 18-month mission to investigate inequalities in mental health in the UK and produce policy and practice proposals to tackle them.

The Commission is chaired by Liz Sayce and includes members with personal and professional knowledge and expertise about mental health inequalities. It issued a call for evidence at the start of 2019 and has received about 100 responses from across the country. The Commission sought evidence from as wide a range of people and places as possible, from published academic papers to narratives from groups and individuals. We particularly welcomed evidence from people and communities that experienced mental health inequalities first hand.

The Commission is seeking to understand why and how inequalities in mental health happen, what ways they manifest, and most importantly what can be done to prevent or mitigate them. Our call for evidence sought evidence about inequalities in the determinants of mental health (the factors that have an influence on how good or poor our mental health is during our lives), in access to help (of all kinds) for our mental health, and in the outcomes that people get when they receive support.

The Commission has particularly sought solutions to mental health inequalities. It is interested in solutions at every level: from community-led initiatives that seek to challenge power or resource imbalances locally to national policies that could help to make mental health more equitable.

The Commission's ultimate aim is to bring about a significant and sustained reduction in mental health inequalities. This is the first of three briefing papers from the Commission's work so far, which share our initial findings and identify key lines of enquiry for policy and practice change. We will publish a final report in the spring of 2020 that will set out our recommendations for what a system designed for equality should look like.
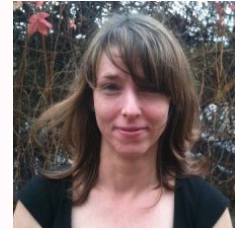
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Commission for Equality in Mental health

Briefing 1: Determinants of mental health

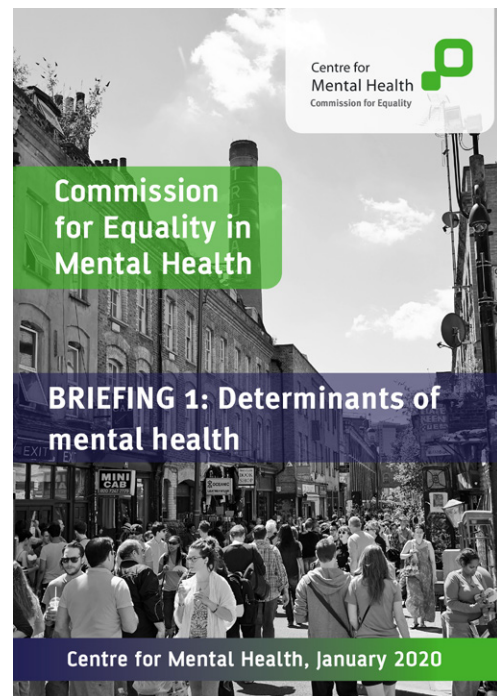Published January 2020

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