# Inequality is Bad for Mental Health
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Oyebode (2022) described the scope of psychiatry as encompassing the following:

- minor emotional disturbances that are meaningful reactions to environmental or psychosocial stress;
- profound psychological change that is unheralded by significant or meaningful stress;
- disturbances of personality that have a pervasive influence on behaviour such that the person or others suffer;
- psychological changes that are directly the consequences of demonstrable organic brain change and
- psychological and behavioural consequences of the use of substances such as alcohol, cannabis or cocaine.

Twenty five percent of people will suffer with a mental health problem each year and although anyone can develop a mental health problem, there are some who are more at risk than others. These tend to be those who are more likely to be minoritised (made inferior), or marginalised (othered and cut off) (WHO 2022).

## Who is most at risk of developing mental health problems and why?

At risk groups include – women, people from LGBTQ+ backgrounds, people with disability, especially those with Learning Disability, Homeless people and people from minoritised ethnic groups. Of note is that rates of mental illness are much higher in people from minoritised ethnic groups living in White majority countries, than in the White majority population. This is particularly stark for people from Black backgrounds who are more likely to be diagnosed with a severe mental illness such as bipolar illness, schizophrenia or some other type of enduring psychosis. In addition, people from minoritised ethnic backgrounds are more likely to be detained under a section of the Mental Health Act than the White British majority population and come into contact with mental health services during a mental health crisis, but far less likely to receive routine psychological treatment. There are clear issues with accessing appropriate treatment for people from minoritised ethnic backgrounds, and when they do manage to get into treatment, that treatment is more likely to be stopped sooner than would be expected compared with the White British population (Royal College of Psychiatrists 2019).

There are also ethnic differences in suicidal behaviour. Suicide risk is highest in the White British majority population, particularly in men. Being from an ethnic group in the UK reduces the risk of suicide, the exception being for females from mixed heritage backgrounds and males from Gypsy Roma and Traveller backgrounds, who are approximately twice as likely to die by suicide than their White British counterparts (Knifpe et al 2024). To place this in context, compared with other countries, the suicide rate in the UK is

favourable at 7.9/100k. The highest rates of suicide are seen in Lesotho, 79.2/100k (WHO 2024).

It has long been known that certain groups of people are more at risk of mental illness, but there has been scant investigation into why this might be, with assumptions made that this is likely due to underlying inherent propensity to mental illness, for example greater genetic predisposition. However, it is becoming increasingly evident that underlying biological factors are insufficient to explain the significant disparity in prevalence of mental illness between different groups. What could explain the excessive rates of mental illness seen in minoritised and marginalised groups?

**Risk Factors for Mental Illness include:**

- Genetics - Genetics and familial inheritance
- Perinatal factors - maternal exposure to toxins, viruses, impaired foetal development, prenatal malnutrition, obstetric complications
- Trauma – physical and psychological (emotional, physical and sexual abuse)
- Adverse Childhood Experiences (ACEs)
- Early and/or persistent substance use
- Negative life events e.g. bereavement, job loss, moving house, homelessness, financial difficulties
- Social isolation
- Poverty (the state of being *impoverished)*

## What is it about poverty that is problematic to health?

Social determinants of health are the conditions into which we are born, we grow and age and in which we live and work…"Disadvantage can start even before a child is born, and can accumulate over time and impact on future generations". If you are born to parents who are comfortably off and grow up in a relatively affluent area, barring a genetic disorder or unfortunate accident, then you will likely live to a good age and spend the majority of that time in good health. If, however, you are born into relative poverty and grow up in a deprived area, then you will have a shorter life expectancy and you will spend much more of your life in ill-health (Public Health England 2018).

This is most obvious when we look at regional differences in health. The Northwest of England has the highest percentage of people living in the 10% most deprived areas of the country. Prevalence rates of depression and anxiety are much higher here than in other more affluent parts of the country, with 20% of people reporting depression and anxiety, twice the rates seen in richer parts of the country. People living in Greater Manchester, one of the poorest places in the country, are four times more likely to present in crisis and require detention under the Mental Health Act than people living in Surrey, which is far wealthier (GP Patient survey 2017).

People from ethnic minority backgrounds in the UK are more likely to be poorer than White British people, although there are important differences between ethnic groups. For example South Asian people of Indian origin are likely to be as wealthy as White British people, whereas South Asian people of Bangladeshi or Pakistani origin are much more likely to live in deprived areas and have much lower household incomes. Of note is that these different ethnic groups have different health outcomes, with people from Bangladeshi backgrounds, in particular, having some of the worse health outcomes across the board. This emphasises the importance of disaggregating the data, i.e. not lumping people together based on the colour of their skin (Office for National Statistics 2024, Kings Fund 2021).

## What is Discrimination and does it affect mental health?

Camara Phylis Jones' Gardeners Tale (2000) describes the different types of racism and how they might affect people. Her definitions can be extrapolated to understand the various types of discrimination and how they play out in practice (Jones 2000). When this is understood, it is possible to understand how policies can bring about or bake in discrimination.

The impact of discrimination because of sexuality or gender divergence, has been described by Ilan Meyer (2003) in his minority stress theory. Arline Geronimus (1992) described "racial weathering" to describe how repeated experiences of social, economic and political adversity and marginalisation coalesce and result in negative health impacts. Robert Carter (2009) described racial trauma, arguing that the emotional impact of racism is severe and can result in depression, anxiety and other post-traumatic stress symptoms.

## Is there any evidence that social disadvantage and/or discrimination increase the risk of mental disorder?

The short answer is, yes. There is good evidence that discrimination on the grounds of sex, gender, sexuality, and ethnicity or race is associated with a higher risk of mental illness – common mental disorder, such as depression and anxiety, but also severe mental illness such as psychosis. One study showed that if social disadvantage was accounted for, rates of psychosis in Black people would be similar to the rates seen in the White British population (Hackett et al 2019, Hacket et al 2024, Stepanikova et al 2020, Pellicane and Ciesla 2022, Branstrom 2019, Argyriou 2019, Hatch et al 2016, Pearce et al 2019, Jongsma et al 2019).

## What Can Be Done to Reduce Mental Health Inequality?

System change is required. This is not simply about individuals trying to be nicer to their fellow human beings. Health equity delivery systems based on incremental change in policy, procedure and processes designed from the outset with those who are marginalised are most likely to be systems where the most in need and underserved get better access, experience and outcomes in mental health care.

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