

The Centre for Social Justice

Mental Health: Poverty, Ethnicity and Family Breakdown

Interim Policy Briefing

February 2011

THE CENTRE FOR
SOCIAL
JUSTICE

The Centre for Social Justice

Mental Health: Poverty, Ethnicity and Family Breakdown

Interim Policy Briefing

February 2011

THE CENTRE FOR
SOCIAL
JUSTICE

The Centre for Social Justice: *Mental Health: Poverty, Ethnicity and Family Breakdown*

© The Centre for Social Justice, 2011

Published by the Centre for Social Justice, 1 Westminster Palace Gardens, Artillery Row, London SW1P 1RL

www.centreforsocialjustice.org.uk

Contents

Mental Health: Poverty, Ethnicity and Family Breakdown	3
<i>Poor mental health and poverty</i>	4
<i>Poor mental health and ethnicity</i>	5
<i>Poor mental health and vulnerable children</i>	6
<i>Picking up the pieces: mental ill-health and criminal justice</i>	8
<i>Causes of poor mental health</i>	9
<i>Effects of poor mental health</i>	10
<i>Family breakdown is both a cause and effect of poor mental health</i>	11
<i>A defined focus for reform: prevention and better treatment for those with mental ill-health by tackling root causes</i>	12
<i>Conclusion</i>	18
Members of the Centre for Social Justice Mental Health Review	19

Mental Health: Poverty, Ethnicity and Family Breakdown

In February 2010, the Centre for Social Justice (CSJ) launched a wide ranging review of mental health, the final report from which is due in early Autumn 2011. In this briefing paper we highlight key findings from our research to date. CSJ policy work is always informed by the academic and policy literature, evidence-gathering hearings and specially commissioned polling.¹ We focus on the causes and effects of poor mental health, particularly as experienced in certain key groups, and conclude by setting out the broad outline of our agenda for reform. This will be fully fleshed out in our final report.

No other health condition matches mental ill-health in terms of prevalence, persistence and breadth of social and economic impact. According to the World Health Organisation (WHO), nearly a quarter of all the years of life lost due to ill-health, disability or early death are the result of mental disorder (cancer and cardiovascular illness account for significantly less; a sixth each).² The economic burden is also significant; costs to our society have been estimated at £105 billion.³

However, the subject of mental health is shrouded with stigma, misunderstanding and fear despite the fact that one in four people will suffer from a mental health condition at some point in their lives.⁴

One in four people will suffer from a mental health condition at some point in their lives

-
- 1 To date we have taken evidence from around 50 individuals and held around 60 hours of hearings both in Westminster and on the premises of mental health service providers in England and Northern Ireland. Our polling, conducted in May 2011, asked 1005 people (who had themselves been diagnosed with a mental illness or who had a close friend/relative in this position) about their perceptions of mental health and the effectiveness of services.
 - 2 World Health Organization, *Global Burden of Disease Report*, Geneva, Switzerland, 2008 (http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html)
 - 3 Centre for Mental Health, *The Economic and Social Costs of Mental Health Problems in 2009/10*. Centre for Mental Health, London, 2010 (http://www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf)
 - 4 World Health Organization, *The World Health Report 2001. Mental Health: New Understanding, New Hope*. Geneva, Switzerland 2001 (http://www.who.int/whr/2001hr01_en.pdf)

The last Government made significant improvements in mental health services but this review has heard that there is still too much bureaucracy, risk aversion and ineffectiveness. We need to be more family-based and community-oriented in our response. The Review has been concerned by the lack of flexibility of services when mental illness is often expressed in a highly individualised way. It is insufficient to have a patient-centred approach; care and support must also be *person-centred*, identifying and taking into account people's unique needs – and strengths.

Poor mental health and poverty

This Review is particularly concerned with the relationship between poverty and mental ill-health and previous CSJ Commissions have revealed the extent to which poor mental health is both a cause and effect of social breakdown. The consistent thread running through our analysis of the problems associated with, for example, family breakdown, housing, looked-after children, asylum seeking and the criminal justice system, is the high level of mental ill-health in our poorest and most disadvantaged communities. It is a key barrier to their transformation and to the unlocking of potential in young and old alike.

Children and adults from the lowest quintile (20 per cent) of household income are three times more likely to have common mental health problems (than those in the richest quintile)⁵ and nine times as likely to have psychotic disorders.⁶ International research suggests that the same disparities in prevalence of dementia in adults over 55 exist between the two quintiles. 15 per cent of the poorest and 5 per cent of the richest adults in this age group experience the condition.⁷

Self-harm is more than three times as common in men and 2.5 times as common in women from the lowest 20 per cent of income compared with those from the highest 20 per cent.⁸

Deprivation causes physical health problems which greatly increase the risk of mental illness, particularly depression. The chronic low level stress of coping with daily hardship and disadvantage affects the way the body reacts, impacting on people's physical health through higher cholesterol levels, blood pressure and heart disease.⁹

-
- 5 Green H, McGinnity A, Meltzer H, et al. Mental Health of Children and Young People in Great Britain, 2004. Office for National Statistics, London: The Stationery Office, 2005 & McManus S, Meltzer H, Brugha T, et al. Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey. Health and Social Information Centre, Social Care Statistics, London, 2009
 - 6 Marmot M et al, Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010. The Marmot Review, London, 2010 (<http://www.marmotreview.org/AssetLibrary/pdfs/chapters%20of%20fshi/FairSocietyHealthyLivesChapter2.pdf>)
 - 7 Manitoba Centre for Health Policy, Patterns of Regional Mental Illness Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study. Department of Community Health Sciences Faculty of Medicine, University of Manitoba, Manitoba, 2004
 - 8 McManus S, Meltzer H, Brugha T, et al. Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey. Health and Social Information Centre, Social Care Statistics, London, 2009
 - 9 Friedli L, Mental Health, Resilience and Inequalities. Mental Health Foundation, World Health Organisation, Geneva, Switzerland 2009 (<http://www.mentalhealth.org.uk/publications/?entryid5=68603&p=2&char=M>)

WHY ARE PEOPLE LIVING IN POVERTY MORE LIKELY TO EXPERIENCE MENTAL ILL-HEALTH?

People living in deprived neighbourhoods are more likely to experience many of the risk factors that have been identified for poor mental health. Putting it another way, the 'pathways to poverty' that the CSJ has identified,¹⁰ and are the focus of our work, also contribute to the development or sustainment of poor mental health:

- Worklessness, the lack of opportunities that benefit-dependency affords and the propensity to get into debt
- Poor educational attainment
- Family breakdown which leads to social isolation and
- Addiction to drugs and alcohol.

Just as the causes of poverty are also its effects, so too the underlying contributory reasons for people suffering poor mental health are also reproduced in their lives. They often find it very hard to hold down a job, get a good education and sustain healthy and positive relationships. Many people with mental health problems self-medicate with drugs and alcohol.¹¹

Poor mental health and ethnicity

There are ethnic as well as socioeconomic dimensions to the prevalence of mental ill-health. Members of black and minority ethnic communities are disproportionately represented in hospital statistics, with Black African, Black Caribbean and Black/White mixed groups of adults three times more likely to be admitted to hospital than the population as a whole.¹² They are also up to 44 per cent more likely to be sectioned; that is, detained without their consent.¹³

Black and minority ethnic groups (7.9 per cent of population) have a three-fold increased risk of psychosis,¹⁴ with a seven-fold increased risk in black African-Caribbean groups¹⁵ and a two- to three-fold increased suicide risk.¹⁶ Yet Black people are 40 per cent more likely to be turned away than White people when they asked for help from mental health services.¹⁷ Black African Caribbean and South Asian patients are less likely to have their mental health problems detected by a GP. At the same time, and

10 Centre for Social Justice, *Breakthrough Britain: Ending the Costs of Social Breakdown*, Centre for Social Justice, 2007

11 Murali V, Oyeboode F. 'Poverty, social inequality and mental health'. *Advances in Psychiatric Treatment*, 10, 2004, pp.216–224

12 The Mental Health Act Commission, *Risk, Rights, Recovery: Twelfth Biennial Report 2005-2007* London: The Stationery Office, 2008

13 Care Quality Commission, *Count Me in 2009: Results of the 2009 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. London: Care Quality Commission, 2010

14 Kirkbride JB, Barker D, Cowden F, et al. 'Psychoses, ethnicity and socio-economic status'. *British Journal of Psychiatry*, 193, pp. 18–24, London, 2008

15 Fearon P, Kirkbride J, Morgan C, et al. 'Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study'. *Psychological Medicine*, 36, pp.1541–1550, London, 2006

16 Bhui K, Mckenzie K, 'Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales'. *Psychiatric Services*, 59, pp. 414–420, London, 2008

17 Rethink, *Behind Closed Doors: The Current State and Future Vision of Acute Mental Health care in the UK*, Rethink, London, 2006 (http://www.mentalhealthshop.org/display_images/document_icons/pdf.gif)

paradoxically, they are more likely to have other problems wrongly attributed to mental health.¹⁸

Black Caribbean, Black African and White/Black Caribbean mixed groups are 40 – 60 per cent more likely than average to be admitted to hospital from a criminal justice referral¹⁹ which means their mental health problems are often only detected when they come into contact with law enforcement agencies. Black men are also almost twice as likely as white men to be detained in police custody under Section 136 of the Mental Health Act.²⁰

Given these trends, amongst these populations there is a high level of fear associated with mental health treatment; that they will receive inappropriate and poor treatment (e.g. excessive restraint and medication) and be discriminated against. The problems in mental health care seem to be amplified for ethnic groups and for the disadvantaged, with the inverse care law applying. That is, those who are in most need of support are the least likely to access the services which provide this support. The provision of good medical care tends to vary inversely with the need for it in the population served.

“I made one of the biggest mistakes of my life when I rushed my son to the hospital...finding that he had been trapped in the wilderness. He went in expecting to come out. When they catch a bird in the wilderness they mend its wing so it can fly. They didn't do that for my son.”

“When he went into hospital they didn't ask him nothing, they just gave him drugs, they turn him fool...he just wanted some back up.”

Mothers of Black Caribbean men with mental health problems.²¹

Poor mental health and vulnerable children

Overall, one in five children and young people has a mental health problem at some point, and one in 10 has a clinically recognisable mental health disorder.²² Up to one in 12 children in Britain deliberately hurt themselves on a regular basis; this is the highest rate in Europe.²³

18 National Institute for Mental Health in England, *Inside Outside: Improving Mental Health Service for Black and Minority Ethnic Communities in England*, Department of Health, London, 2003

19 Care Quality Commission, *Count Me in 2009: Results of the 2009 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. London: Care Quality Commission, 2010

20 Docking M, Grace K, and Bucke T, *Police Custody as a "Place of Safety": Examining the Use of Section 136 of the Mental Health Act 1983*, Independent Police Complaints Commission: London, 2008

21 Testimony taken from 'Carers' Journeys' DVD (produced by Care Services Improvement Partnership, 2008)

22 Green H, McGinnity A, Meltzer H, et al. *Mental Health of Children and Young People in Great Britain*, 2004. Office for National Statistics, London: The Stationery Office, 2005

23 The Children's Society, *The Good Childhood Inquiry*, The Children's Society, London, 2009

The UK ranked lowest for children's well-being compared with North America and 18 European countries²⁴ and ranked 24th out of 29 European countries in a more recent survey.²⁵

In our polling 90 per cent of people agreed that more should be done to safeguard the mental health of children and adolescents. This indicates that those who have had direct experience of poor mental health understand that mental health difficulties start early in life; research shows that 50 per cent of lifetime mental illness (excluding dementia in older age) starts by age 14.²⁶

As disorders tend to persist into adulthood and are difficult to remedy, prevention should be a priority. This fits well with the current government's emphasis on public mental health and the early intervention approach which the CSJ has championed for several years. Effective prevention is a key objective of this review.

Children and adolescents with learning disabilities have high rates of mental health problems and behavioural difficulties. Comorbid disorders such as epilepsy, autism and attention-deficit hyperactivity disorder are common²⁷ and overall there is more than a six-fold increased risk of mental illness.²⁸

“Autism is not a mental illness but children with autism tend to encounter a lot of misunderstanding and become very isolated. This makes it far more likely that they will suffer from depression or develop some other mental disorder.”

CSJ interview with autism specialist.

Looked after children have a five-fold increased risk of mental disorder.²⁹ Yet polling conducted for the CSJ's 2008 report on children in care found that 71 per cent of care leavers believe that the emotional needs of children in care are badly supported.³⁰

Thirty thousand children are on the waiting list for NHS child and adolescent mental health services³¹ but evidence-based parenting

24 UNICEF, *Child Poverty in Perspective: An Overview of Child Well-Being in Rich Countries*. UNICEF Innocenti Research Centre, Florence, Italy, 2007

25 Bradshaw J, Richardson D, 'An index of child well-being in Europe'. *Child Indicators Research*, 2, pp. 319–351. London, 2009

26 Kessler RC, Amminger GP, Aguilar-Gaxiola S, et al. 'Age of onset of mental disorders: a review of recent literature'. *Current Opinion in Psychiatry*, 20, 359–364. London, 2007

27 Allington-Smith P, 'Mental Health of Children with Learning Disabilities'. *Advances in Psychiatric Treatment*, Royal College of Psychiatrists, London, 2006

28 Emerson E, Hatton C, 'Mental health of children and adolescents with intellectual disabilities in Britain'. *The British Journal of Psychiatry*, Royal College of Psychiatry, London, 2007

29 Meltzer H, Gatward R, Corbin T, et al. *Persistence, Onset, Risk Factors and Outcomes of Childhood Mental Disorders*. Office for National Statistics, London: The Stationery Office, 2003

30 Centre for Social Justice, *Couldn't Care Less: A report from the Children in Care Working Group*. Centre for Social Justice. London, 2008

31 British Medical Association Board of Science, *Child and Adolescent Mental Health: A guide for healthcare professionals*, BMJ Books, Oxford, 2006

interventions can have a significant and positive impact.³² If the family can be at the root of the problem it is also, very often, at the heart of the solution.

Picking up the pieces: mental ill-health and criminal justice

More than 70 per cent of the prison population has two or more mental health disorders. Male and female prisoners are 14 and 35 times respectively more likely to have two or more disorders than men and women in the general population.³³

Young men in custody aged 15–17 have an 18-fold increased risk of suicide³⁴ and 50 per cent of individuals who die in police custody have had prior mental health problems.³⁵ Prisoners have a 20 fold higher risk of psychosis³⁶ and a 130 fold higher risk of antisocial personality disorder.³⁷

“I stayed off school to care for my mum who had drug and alcohol problems and kept attempting suicide. When I was thirteen I came back home and found her dead. I adored her but looking back I can see that bad things happened – she gave me drugs and alcohol and there were always strange men around. I got into crime early on: indecent assault, theft and other things and have been inside for a long time. Doing art really helps cos when I’m painting I’m in another place and not thinking about all the awful stuff.”

Terry, personality-disordered forensic patient in medium-secure hospital, aged 30.

Women in custody are five times more likely to have a mental health concern than women in the general population with 78 per cent exhibiting some level of psychological disturbance when measured on reception to prison, compared with a figure of 15 per cent for the general adult female

-
- 32 Evidence obtained from Professor Matt Sanders, founder of Triple P – Positive Parenting Program, 19 July 2011
 - 33 Social Exclusion Unit, *Mental Health and Social Exclusion*. Office of the Deputy Prime Minister, London: The Stationery Office, 2004 & N Singleton, H Meltzer, R Gatward, J Coid and D Deasy, *Psychiatric Morbidity among Prisoners in England and Wales*. London: Office of National Statistics, 1998
 - 34 Fazel S, Benning R, Danesh J, ‘Suicides in male prisoners in England and Wales, 1978–2003’. *Lancet*, 366, 1301–1302. London: The Stationery Office, 2005
 - 35 House of Commons and House of Lords, Joint Committee on Human Rights: Deaths in Custody. Third Report of Session 2004–05. Volume I, London: The Stationery Office, 2004
 - 36 Stewart D, *The Problems and Needs of Newly Sentenced Prisoners: Results from a National Survey*. Ministry of Justice Research Series, Ministry of Justice, London: The Stationery Office, 2008
 - 37 National Institute for Health and Clinical Excellence, *Antisocial Personality Disorder, Treatment, Management and Prevention*. NICE, London, 2009 (<http://guidance.nice.org.uk/CG77>)

population.³⁸ Two thirds of women in custody have dependent children³⁹ who are subsequently at greater risk of becoming problem drug users and involved in crime.⁴⁰

Causes of poor mental health

Commonly divided into biological, social and psychological causes, there are also interactions between these three categories such that early childhood deprivation (psychological and social factors) can cause biological changes to brain structure and neuro-endocrine function. The new field of epigenetics points to gene-environment interaction; some people are more susceptible to developing mental health conditions and are therefore more vulnerable to adverse environments.

- **Biological factors** include genetic predisposition, brain injury and the effect of illicit drugs.
- **Social factors** include fragmented and unsupportive communities, poor housing, inadequate health care, poverty and racial or sexual discrimination.
- **Psychological factors** include insecure attachments to parents in infancy, sexual and physical abuse in childhood, poor parenting, bullying or harassment, the absence of one or more confiding relationships, family breakdown and bereavement.

In particular it is important to be aware of the contributing effects of:

- Poor parental mental health: children growing up with parents who are depressed or have serious mental health conditions themselves experience a four to five fold increase in the rate of onset of emotional and conduct disorder.⁴¹
- Parental unemployment, which carries with it a two to three fold increased rate of onset of emotional/conduct disorder in childhood.⁴²
- Child abuse and adverse childhood experiences: these result in a several-fold increased rate of mental illness and substance misuse/dependence in later life.⁴³
- Mental disorder in childhood and adolescence also leads to a broad range of poor adult outcomes including higher rates of adult mental illness, poor educational outcomes, unemployment and low earnings, teenage

38 Prison Reform Trust, *Women in Prison*. London: Prison Reform Trust, 2010

39 Home Office Research Study 208, and Hansard, House of Commons, 28 April 2003

40 New Economics Foundation, *Unlocking value: How we all benefit from investing in alternatives to prison for women offenders*, London: New Economics Foundation, 2008

41 Meltzer H, Gatward R, Corbin T, et al. *Persistence, Onset, Risk Factors and Outcomes of Childhood Mental Disorders*. Office for National Statistics, London: The Stationery Office, 2003

42 Green H, McGinnity A, Meltzer H et al, *Mental health of children and young people in Great Britain*, 2004. ONS, London: The Stationery Office, 2005 & Meltzer H, Gatward R, Corbin T et al, *Persistence, onset, risk factors and outcomes of childhood mental disorders*. ONS, London: The Stationery Office, 2003

43 Centres for Disease Control and Prevention, *Adverse Childhood Experiences Study* (<http://www.cdc.gov/nccdphp/ace/prevalence.htm>) accessed 10 Dec 2009 & Collishaw S, Pickles A, Messer J et al, 'Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample'. *Child Abuse & Neglect*, 31, pp.211–229

parenthood, marital/relationship problems and criminal activity.⁴⁴ Early effective treatment during childhood and adolescence can prevent a significant proportion of adult mental disorder;⁴⁵ interventions with parents and especially those that take place in the early years provide key opportunities to promote mental health and prevent mental illness.

- Physical illness: this greatly increases risk of mental illness, with studies indicating that between 17 per cent and 27 per cent of hospitalised patients experience major depression after coronary artery disease (CAD)⁴⁶ and as many as half of all cancer sufferers become depressed.⁴⁷ (Mental illness is also causally associated with poor physical health, as we outline below).

“As a teenager I was very violent and diagnosed as being mentally ill. I was completely traumatised by the repeated sexual abuse I had experienced as a child. The doctors knew that a talking therapy would help but I had to go on a waiting list for two years. By then they said I was too unstable to have therapy. They didn’t want to take the risk. It’s like they hold you in this awful state and there isn’t the time or space to give you what they know you need.”

Angie, a former mental health patient who has made a complete recovery after eventually receiving therapy.

Effects of poor mental health

As well as the economic costs mentioned earlier, mental ill-health is strongly associated with poor social and physical outcomes:

- **Anti-social behaviour, youth offending and crime:** conduct disorder in children is associated with the development of anti-social personality disorder (ASPD) in adults, defined as a pervasive pattern of disregard for and violation of the rights of others.⁴⁸
- **Stigma and discrimination.**

44 Richards M, Abbott R, *Childhood Mental Health and Life Chances in Post-War Britain: Insights from Three National Birth Cohort Studies*. Centre for Mental Health, London, 2009 (http://www.scmh.org.uk/pdfs/life_chances_report.pdf).

45 Kim-Cohen J, Caspi A, Moffitt TE, et al, 'Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort'. *Archives of General Psychiatry*, 60, pp. 709-717. London, 2003

46 Rudisch B, Nemeroff CB, 'Epidemiology of comorbid coronary artery disease and depression'. *Biological Psychiatry*; 54, pp. 227-240. London, 2003

47 Massie M.J, 'Prevalence of Depression in Patients With Cancer' *Journal of the National Cancer Institute Monograph* 32, pp. 57-7, 2004

48 Utting D, Monteiro H, Ghate D, *Interventions for Children at Risk of Developing Antisocial Personality Disorder* London: PRB with Department of Health and the Cabinet Office, 2007

- **Poor physical health:** not only can depression develop following chronic and severe illness, but it can itself be a causal factor in the onset of physical diseases. It is associated with a two-fold increased risk of coronary heart disease⁴⁹ and unhealthy behaviours such as poor diet, less exercise, self-harm, significantly greater prevalence of smoking and drug and alcohol misuse.
- **Reduced life expectancy:** schizophrenia is associated with a 20.5 year reduced life expectancy for men and 16.4 year reduced life expectancy for women.⁵⁰ Schizophrenia and depression are associated with increased mortality from all diseases.⁵¹ Those who are mentally ill are also at much higher risk of suicide.

Family breakdown is both a cause and effect of poor mental health

In this and our earlier work⁵² we use the term family breakdown in an inclusive way, associating it with dissolution (divorce or separation), dysfunction or ‘dad-lessness’. Family breakdown in all its forms is strongly associated with poor mental health in adults and children.⁵³ People with mental health problems can struggle to nurture and support other family members and relationships can break down as a result. However the role family breakdown plays in the aetiology (causes) of mental disorder is frequently unacknowledged. For example, the Government’s mental health strategy launched recently makes no mention of the effect on children’s mental health of conflict between parents and living in fractured families.⁵⁴ Working with the whole family not only prevents many children from being labeled as mentally ill but can also tackle the causes of their problems – often rooted in or sustained by the dynamics of family relationships.

Recent research and our new poll highlight the association between mental illness and coming from fractured, dysfunctional and fatherless families. The recent Good Childhood Inquiry report concluded that mental health problems are ‘on the increase’ and cited poor parenting (either a lack of affection or the failure to show authority and set boundaries) as a significant contributing factor.⁵⁵ Depression and anxiety have increased for boys and girls aged 15 to 16 since the mid-1980s, as have what are called ‘non-aggressive conduct problems’ such as lying, stealing and disobedience.

49 Hemingway H, Marmot M, ‘Evidence based cardiology. Psychosocial factors in the aetiology and prognosis of coronary heart disease: systematic review of prospective cohort studies’. *British Medical Journal*, 318, pp. 1460–1467, London, 1999

50 Brown S, Kim M, Mitchell C, et al, ‘Twenty-five year mortality of a community cohort with schizophrenia’. *British Journal of Psychiatry*, 196, pp. 116–121. London, 2010

51 Mykletun A, Bjerkeset O, Overland S, et al, ‘Levels of anxiety and depression as predictors of mortality: the HUNT study’. *British Journal of Psychiatry*, 195, pp. 118–125, London, 2009

52 Centre for Social Justice, *Breakthrough Britain: Ending the Costs of Social Breakdown*, Centre for Social Justice, 2007

53 Mooney A et al. *Impact of Family Breakdown on Children’s Well-Being: Evidence Review*, DCSF-RR113, London: Institute of Education, 2009 (<https://www.education.gov.uk/publications/eOrderingDownload/DCSF-RR113.pdf>)

54 Department of Health, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. London: HM Government, 2011

55 Layard R, Dunn J, *A Good Childhood: searching for values in a competitive age*. Penguin, London, 2009

Family breakdown and conflict were considered by the Inquiry to have the biggest adverse impact on children's well-being. Conflict between parents has been associated with an array of adjustment problems in children, for instance; poor peer interaction, conduct problems, ill health, depression and anxiety, low self esteem, eating disorders, substance misuse and poor attachment.⁵⁶ The Inquiry found that children with separated, single or step-parents are 50 per cent more likely to fail at school, have low esteem, struggle with peer relationships and have behavioural difficulties, anxiety or depression. The report concluded that "Child-rearing is one of the most challenging tasks in life and ideally it requires two people".⁵⁷

A key finding of our review to date has been the importance of the family as both a risk and protective factor for mental illness.

In our own polling, half of those surveyed thought family breakdown was a major cause of poor mental health and more than 60 per cent thought poor mental health was a contributor to family breakdown (whereas fewer than a third thought poverty was a major cause of poor mental health). About half said that childhood and family factors were a major cause of their or their relative or friends' poor mental health.

However, over 80 per cent claimed that families gave support, with over half saying they received a lot of support from family members.

The National Child Development Study (which has tracked around 17,000 people born in Britain during one week in 1958 over the course of their lives) has recently shown that greater social acceptance of divorce has not reduced its impact on children. When outcomes for this group were compared with children born in 1970, children from both cohorts whose parents split up are equally likely to end up without qualifications, claiming benefits and suffering depression⁵⁸ (and more likely than those from intact families).

A defined focus for reform: prevention and better treatment for those with mental ill-health by tackling root causes

Previous CSJ work, such as *Breakthrough Britain: the Next Generation*, emphasised the need for an early years and early intervention approach to mental ill-health, and key reviews commissioned by the Coalition Government have endorsed that message.⁵⁹ The recommendations of this current Review will also be shaped by this prevention perspective.

However, we are equally concerned with those who have already developed mental health conditions and how treatment of disorders can both prevent

56 Cummings E, Davies D, *Children and Marital Conflict: The Impact of Family Dispute and Resolution*, Guilford Press, New York, 2004

57 Layard R, Dunn J, *A Good Childhood: searching for values in a competitive age*. Penguin, London, 2009. p28

58 Elliott J and Vaitilingham R, *Now we are 50: Key findings from the Child Development Study*, Centre for Longitudinal Studies, Institute of Education, London, 2008

59 Field F, *The Foundation Years: Preventing poor children from becoming poor adults, the report of the Independent Review on Poverty and Life Chance*. London: HM Government, 2010 & Allen G, *Early Intervention: The Next Steps, An Independent Review to Her Majesty's Government*. London: HM Government, 2011

Two thirds of the people we polled agreed that gaining access to mental health services meant coping with a lot of red tape. Nearly half of them thought that hospital care was ineffective and more than half considered that hospital did not aid recovery.

further harm and offer hope for a better future. Current levels of treatment reduce the overall burden of for mental illness by only 13 per cent, therefore there is a need for improved coverage and effectiveness.⁶⁰

Yet, some evidence suggests that providing even the best treatment for all those with poor mental health will only reduce the burden of mental illness by 28 per cent.⁶¹ Putting this another way, more than two thirds of the burden of mental illness is not reduced by treatment. There is an urgent need to tackle the contributing causes of mental ill-health and also to look at the role of social factors and the wider community. Social networks and social support can promote a sense of belonging and well-being and may prevent mental health problems.⁶²

BREAKING THE STIGMA AND TACKLING THE FEAR OF MENTAL ILL-HEALTH

It is widely acknowledged that mental illness attracts stigma. Previous reviews have suggested that stigma could be tackled by increasing public understanding of mental disorder⁶³ and there is no doubt that our society's historical approach to those with mental illness has played a significant part in cloaking the subject with misunderstanding and fear. For several generations, the mentally ill were out of sight and out of mind and there has been very little tradition of 'social contact', despite the closure of the asylums following the 1959 Mental Health Act which encouraged the development of community care.

Outcomes data from the current Time to Change campaign⁶⁴ indicate that public education and media campaigning against stigma in mental illness have an impact on the knowledge, attitudes and behaviour of the general public, when combined with 'social contact' (when people are able to speak directly with someone experiencing mental illness).

60 Andrews G, Issakidis, Sanderson K, et al, 'Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders'. *British Journal of Psychiatry*, 184, pp.526–533, 2004.

61 Andrews G, Issakidis, Sanderson K, et al, 'Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders'. *British Journal of Psychiatry*, 184, pp. 526–533. London, 2004

62 Brugha TS, Weich S, Singleton N, et al, 'Primary group size, social support, gender and future mental health status in a prospective study of people living in private households throughout Great Britain'. *Psychological Medicine*, 35, pp. 705–14. London, 2005 & Melzer D, Fryers T, Jenkins R, *Social Inequalities and the Distribution of Common Mental Disorders*. Maudsley Monographs, Hove: Psychology Press, London, 2004

63 Davidson J et al, *Children & Young People in Mind: the Final Report from the National CAMHS Review*, Department of Health and Department for Children, Schools and Families, London: The Stationery Office, 2008

64 <http://www.time-to-change.org.uk/news/time-change-having-positive-effect-reducing-mental-health-stigma-and-discrimination>

Our work also suggests that human beings' deeply-rooted antipathy to mental illness may be based in bio-neurology as well as in misunderstanding. There may be something fundamental about mental illness that frightens us more than physical disease of any sort and forces us to turn away from it.

Recent research shows that the human brain is biologically oriented towards working out what others see, from very much earlier in life than we might previously have thought (experiments have seen this in babies of seven months⁶⁵). Adults likewise automatically identify, remember and are affected by the beliefs of others – and expect them to be as rational and coherent as their own.

Engaging with someone whose mind does not fit into our model of rational behaviour is therefore deeply disturbing. In full-fledged mental illness, we see a mind that cannot be incorporated into what we know and understand (our reality) because it is not in control and is therefore not predictable. Mental disorder arouses acute anxiety because we expect that others, like ourselves, will know what they are doing. Stigmatising those who act irrationally is a way of avoiding contact with their unmanageable thinking.

The fear of dangerous mentally disordered patients has some, albeit limited, basis in reality. For example, where patients are being inadequately treated in the community and escalating symptoms go untreated (often despite warnings to professionals from family members), violent and random attacks on members of the public do take place. Despite their rarity, such events create a distorted impression of the association between violence and mental illness in the eyes of the public.

Improving the effectiveness of mental health services is an essential prerequisite if sufferers are to overcome their own fears that they are somehow beyond help. Among other things this demands a consideration of how health professionals may react to people when they are unable to understand their distorted perspectives. People who have had first-hand prior experience of mental health problems (and who have 'recovered') are closest to the perspectives of the mentally disordered mind and are often very motivated to help others recover. We will be looking at ways to draw in their expert experience as recognised by the government's NHS white paper.⁶⁶ We will also be looking at how other countries, such as Norway, have challenged the pervasive stigma surrounding mental ill-health.

A FAMILY FOCUS

As we have already made clear, one's family can be a causal factor in poor mental health as well as a key part of the recovery process. Yet patients are often treated as individuals unconnected to a family system. Their needs are also 'shoe horned' into service silos that are managed for the benefit of professionals and not for the patients they are there to help.

65 Kovacs A, Teglas, E, Endress, A. 'The Social Sense; Susceptibility to others' beliefs in human infants and adults' *Science* 330 (6012) 1830-1834, 2010

66 Department of Health, *Equity and Excellence: Liberating the NHS* (White Paper. National Health Service, HM Government, London: The Stationery Office, 2010

“No one in the community mental health team seems to respect my opinion or acknowledge that I have a good handle on [wife] Jill’s bipolar disorder. I am treated as if I was in the way, possibly even responsible for her condition. But I have to hold down a full-time job and somehow look after our two young children when she becomes ill. If I can see that she is deteriorating they should listen to me as it is better for everyone if she doesn’t get so bad that she has to be admitted into hospital.”

Husband of woman with bipolar disorder giving evidence to the CSJ.

We are looking at how family services can be developed which will help break down unhelpful divisions between child/adolescent and adult mental health services. Very young children rarely receive the care they need, as infant mental health services (that also work closely with parents) are few and far between. Similarly, some services are only available for adults despite the fact that the conditions they treat are already evident in younger patients. On the other hand some aspects of care may also be withdrawn when adolescents make the transition to adult mental health services.

PRIMARY CARE

Nearly 80 per cent of those polled in our survey said they had been supported by their GP, with more than two fifths saying they had received a lot of support from their GP.

Mental health problems occupy one third of a GP’s time and mental illness/distress accounts for 30 per cent of GP consultations.⁶⁷ Moreover,

- 90 per cent of all mental disorders presenting to the NHS are dealt with entirely within primary care.⁶⁸
- 30–50 per cent of people with severe mental illness are cared for solely by primary care, without support from specialist services.⁶⁹ However, even if GPs wanted or needed that support, it can be very hard to come by.

⁶⁷ Social Exclusion Unit, *Mental Health and Social Exclusion*. Office of the Deputy Prime Minister, London: The Stationery Office, 2004, p40

⁶⁸ Lester H, Glasby J, Tylee A. ‘Integrated primary mental health care: threat or opportunity in the new NHS?’ *British Journal of General Practice*, 54, pp. 285-291, 2010

⁶⁹ Ibid

GPs who gave evidence to the review described the systemic boundaries that exist within the healthcare system: “I used to be able to pick up the phone and discuss a case with a psychiatrist. Silo working makes that much more difficult now.”

- Shared care and 24 hour access to GP services make it highly unlikely that people will usually see their ‘own’ doctor, with the consequence that 7-10 minute consultations often do not begin to scratch the surface of mental distress. Brief consultations only tend to work if there is continuity of care, and it is particularly helpful if the GP knows the family background and understands the dynamics of the relationships involved.
- On average 10 per cent of inpatients were referred for admission by a GP. GP referral rates into inpatient units are 8 per cent higher than average in the White British group and 26-64 per cent lower than average in BME groups (Other White, Black Caribbean, White and Black Caribbean Mixed, Black African and Other groups).⁷⁰

Given this review’s focus on family and poverty, we will be developing recommendations that will fit with the new GP commissioning model and ensure that mental health treatment takes a holistic approach, drawing in other non-health based services where necessary. We believe that GP commissioning offers an opportunity for creative and flexible treatment design that breaks out of current professional silos.

INTEGRATING MENTAL AND PHYSICAL HEALTH

Western approaches to mental health treatment do not tend to view the individual in a holistic way or acknowledge that their physical, emotional, mental (and spiritual) aspects are inextricably linked.⁷¹ We intend our reforms to break down impermeable boundaries between mental and physical health. For example, in the area of smoking cessation, campaigns have tended to bypass those with mental illness. Yet half of national tobacco is consumed by those with a mental disorder⁷² who also account for half of smoking-related deaths.⁷³ Tobacco use can be driven by the need to self-medicate (as can substance misuse) but nicotine substitutes and other aids are not being routinely offered despite the implications for poor physical health.

70 Care Quality Commission, *Count Me In 2009: Results of the 2009 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. Care Quality Commission, London, 2010

71 Faulkner A, *Knowing our own minds*. London, Mental Health Foundation, 1997

72 Lasser K, Boyd JW, Woolhandler S, et al, ‘Smoking and mental illness: a population-based prevalence study’. *JAMA*, 284, pp.2606–2610, 2010

73 Williams JM, Ziedonis S, ‘Addressing tobacco among individuals with a mental illness or an addiction’. *Addictive Behaviours*, 29, pp.1067–1083, 2004

PRIORITISING RECOVERY

A focus on maximising the potential for recovery in mental health would be informed by the realisation that mental disorder rarely exists in isolation. Family dysfunction, poor educational attainment, inability to access the labour market without a high level of specialised support and poor physical health are just some of the barriers the mentally-ill commonly face in rebuilding their lives. Unless statutory and private mental health services (in partnership with each other and with the voluntary sector where appropriate) work with patients to overcome these hurdles, there will be no transformation of life chances. Patients' quality of life will see no marked improvement, dependency will be maintained and they will continue to require costly interventions.

REINVIGORATING CARE IN THE COMMUNITY

When it is in the interests of people's recovery to be discharged from hospital (and not simply to save money) this should happen. However, present funding arrangements can act as a deterrent to this 'step down' process. Resources and expertise are 'locked up' inside secondary care (hospitals) instead of 'following the patient' and being made available to provide an appropriate level of care in the community. Many professionals we talked to were concerned that there are perverse incentives to keep people in a hospital setting, even when they were making no progress, because of the inflexibility of funding streams. People are unable to make the gradual and supported transitions that are vital for them to begin to rebuild their lives. We are looking at models for how funding could 'follow the patient' into the community so that this support can be provided. This might, for example, involve peripatetic consultants spending some of each week working with discharged patients in supported community settings to prevent them either being hospitalised indefinitely or left to struggle on their own.

In disadvantaged communities many people's mental health conditions are not treated at all and they are not registered with GPs. This may be because of a distrust of services or their lack of acknowledgement that mental illness is an issue for them. We have been looking at outreach by GPs and specialist mental health teams, which go to those places where people gather, identify where there are mental health difficulties and help individuals in the bespoke way that is necessary for example with housing issues. This builds trust and can prevent crises in physical and mental health as well as attempted and actual suicide.

Finally, outreach initiatives can also draw in other members of the community. In the London borough of Southwark, community-based mental health clinicians have trained over a dozen barbers in counselling so that they are able to listen therapeutically to their clients and introduce them to non-stigmatised services which may, for example, refer to the 'cares of life' rather than to mental ill-health.

Conclusion

Although it is argued that spending on mental health is disproportionately low (compared with physical health) given the high overall disease burden that it represents, it is vital that the £10.4 billion we do spend⁷⁴ is allocated effectively and in a way that enables people to make genuine progress. In very many cases mental disorder is not a lifelong condition and recovery is possible. When people come into contact with services this provides an opportunity to address underlying causes of disadvantage as well as their mental health condition, as these are often closely related. At present, however, this opportunity is rarely seized.

In the Government's recently published Mental Health Strategy,⁷⁵ the need to improve quality and make the most of resources is emphasised. We believe that better outcomes are achievable within existing budgets but the 'parity of esteem between mental and physical health services' called for by the Government will also require a rebalancing of investment. We would echo the Government's advice to local commissioners that 'any efficiencies in mental health services need to be carefully thought through so that false economies and greater costs elsewhere in the health and social care system are avoided'. This is particularly the case if cuts in effective early intervention projects are being considered. The ambition of this review is to make mental health policy recommendations for national and local Government, and other political parties, that will lead to better access to those services which have proven effectiveness in transforming people's life chances. Our concern is that current provision too often consigns the mentally ill to dependency and the poverty of low expectations.

We are particularly interested in family-based solutions and services, how the greater prevalence of mental disorder in some sections of the BME communities and in the vulnerable can be addressed and how stigma surrounding mental disorder can be reduced so that people access help earlier and are met with more understanding. A quarter of the population will suffer some form of mental disorder at some point in their lives. The potential gains to the nation's overall wellbeing and productivity by improving this aspect of health cannot be over-emphasised.

74 Department of Health, *Mid Essex Annual Public Health Report 2009-10*. National Health Service Mid Essex, the primary care trust for Braintree, Chelmsford and Maldon, 2010

75 Department of Health, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. London: HM Government, 2011

Members of the Centre for Social Justice Mental Health Review

Dr Samantha Callan (Chair)

(in alphabetical order)

Dr Martin Baggaley

David Bolton

Paul Farmer

Professor Peter Fonagy

Ivor Frank

Melanie Gill

Professor Richard Gray

Dr Penelope Leach

Matilda McAttram

Professor Chris Thompson

For further information contact Dr Samantha Callan, Chair of the Mental Health Review through admin@centreforsocialjustice.org.uk.

THE CENTRE FOR
SOCIAL
JUSTICE

The Centre for Social Justice

1 Westminster Palace Gardens, Artillery Row, London SW1P 1RL

t: 020 7340 9650 ● e: admin@centreforsocialjustice.org.uk

www.centreforsocialjustice.org.uk