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Local Approaches to poverty reduction: The Well-Being of Future
Generations Act and public service boards

Ymateb gan: Sefydliad Iechyd Meddwl

Response from: Mental Health Foundation

Poverty and mental health

A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy



Mental Health
Foundation

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Poverty and Mental Health:
A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy

Iris Elliott PhD FRSA
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Executive Summary



Poverty increases the risk of mental health problems and can be both a causal factor and a consequence of mental ill health. Mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live. Successfully supporting the mental health and wellbeing of people living in poverty, and reducing the number of people with mental health problems experiencing poverty, require engagement with this complexity.

The review presents a conceptual framework for understanding the relationship between poverty and mental health, which draws together: a life course analysis; a discussion of the socio-economic factors (or social determinants) impacting mental health and poverty; the principles of human rights, equity, anti-stigma and non-discrimination; and the approaches of prevention, self-management, peer support, community development and social movement building.

There are a number of imminent opportunities for addressing mental health and poverty across the UK, including the programmes for government of the recently elected devolved administrations in Scotland, Wales and Northern Ireland.

Recommendations for action are made across a number of cross-cutting areas (data and research; stigma and

discrimination; and policy development) at different stages of life and across the whole of the life course. Attention is given to pressure points and transitions throughout life, particularly when these are adverse experiences such as homelessness, redundancy and family breakdown, which can be traumatic and have cumulative impacts. People with complex needs are discussed across the review.

In order to strengthen the evidence base, mental health must be addressed within poverty data and research, and, likewise, poverty addressed within mental health data and research. A mental health and poverty research agenda should be co-produced with individuals, families and communities with lived experience of these issues. This research agenda should include economic research that has proved persuasive in key areas such as maternal mental health (see Costings section 6). Implementation science methodologies should be employed to scale and test programmes and interventions in order to ensure that they are appropriate and effective for people living in poverty.

The review recognises the corrosive impact of stigma and discrimination on people experiencing mental health problems and those living in poverty. It proposes the integration of social contact approaches around mental health and poverty within current anti-stigma campaigns and initiatives.



The development of Mental Health in All Policies (MHiAP) at national and local government levels is recommended for areas of public policy considered within this review (health, education, employment, social security, advice and planning the built environment), noting that this is not an exhaustive list.

The life course stages are framed within this report as: perinatal (pregnancy and the first year following birth), early years, children and young people; working age; and later life (from 50 years onwards). It is essential that the National Institute for Health and Care Excellence (NICE) perinatal care pathway is implemented across the UK. Recommended supports for families, children and young people are the Family Nurse Partnership, evidence-based positive parenting programmes (including for families with a parent who has mental health problems), the adoption of the whole-school approach, and particular supports for vulnerable and excluded children, many of whom may not be in education.

During working age, policy should support people to enter and remain in work through the adoption of whole-workplace approaches, a national individual placement and support (IPS) programme, and development of mental health and wellbeing programmes for small and medium-sized enterprise (SME) owner-managers and employees. The social security system needs to be leveraged to ensure that claimants with mental health problems receive their full social security entitlements, and are the beneficiaries of programmes such as Access to Work. There needs to be an improvement in the quality of

treatment for claimants with mental health problems across the social security system. At a minimum, the Work Programme needs to be completely overhauled.

In later life, the evidence base for effective interventions needs to be further developed, particularly for initiatives that facilitate social and cultural participation, enhance social connection and reduce isolation. The commissioning of systematic reviews of evidence would be a valuable first step in identifying what works with regards to addressing mental health and poverty in later life. Primary care screening for mental health problems (particularly depression and dementia) is one way to promote early intervention.

People experiencing poverty and mental health problems would benefit from a number of initiatives across the life course. The creation of accessible, integrated public service hubs within deprived communities would provide individuals, families and groups with timely, appropriate and local support and care. A national programme of primary-care-based social prescribing within these communities would facilitate people's access to mental health, enhancing social, cultural and leisure activities that are beyond their economic reach.

Mental health problems can disrupt people's education, training and entry into, and progression within, work. Local opportunities for lifelong learning are an important way of addressing the disadvantage and exclusion that this leads to.

The use of parity within policy advocacy in order to advance fair investment in mental health has magnified the false dichotomy between mental and physical health. Addressing the mental health of children and adults with long-term physical health conditions improves their engagement with care and treatment, and their prognosis, as well as their family members' and carers' mental health and wellbeing. Tackling the high levels of physical ill health and early death among people with serious mental health problems is a priority. The development of integrated pathways across the life course for people with co- and multiple morbidities is recommended.

Concerns about the relationship between mental health and criminal justice have been raised over many years, each successive report building the case for a complete health and justice pathway. This report recommends the development of such a pathway, improved mental health provision across all criminal justice settings, and a comprehensive national liaison and diversion programme. The needs of Black, Asian and Minority Ethnic (BAME) community members, women, and older offenders require particular attention within this work.

The Psychologically Informed Planned Environments (PIPEs) approach has been piloted within some criminal justice settings. PIPEs are a form of Psychologically Informed Environment (PIE). The evidence base is developing but promising, and the report recommends the scaling and testing of PIEs in services for people with complex needs.

This review has synthesised evidence across a considerable breadth of public policy agendas. Although it is not a systematic review, the evidence has come from authoritative sources. Where the evidence base is developing but promising, this is noted (see Methodology).

It is intended that the review is relevant to policy, provision and people across the UK. The type, quality and scope of statistical information and other evidence about mental health and poverty varies across the UK. These variations are noted, but the review's narrative and recommendations have been written to be as relevant to each part of the UK as possible.

1. Introduction



One in four adults and one in ten children experience mental health problems to some degree in any year;ⁱ and the impacts of mental health problems ripple out to affect many more people through their social networks of family, education, work and community. The 2015 'Monitoring Poverty and Social Exclusion' report's comparison of data between 2005 and 2012 found that a greater proportion of women were assessed as being at high risk of mental health problems compared to men; within the lowest social economic class, 26% of women and 23% of men were at high risk of mental health problems.ⁱⁱ Three-quarters of people with a mental health problem do not receive ongoing treatment.ⁱⁱⁱ Poverty¹ increases the risk of mental health problems, and can be both a causal factor and a consequence of mental ill health.^{iv} Mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live.^v Successfully supporting the

mental health and wellbeing of people living in poverty and reducing the numbers of people with mental health problems experiencing poverty requires engagement with this complexity.

There is a growing UK policy consensus that mental health requires substantial attention and investment in order to address the huge economic and social costs to individuals, families, communities and society. This agenda encompasses addressing the range of social and economic factors that affect mental health (referred to as the 'social determinants of health'), challenging the stigma and discrimination that continue to impact people with mental health problems and their families in all areas of their lives, removing barriers to full participation within society – including in education, employment and the community – providing public services in a timely manner, and developing research and data in order to ensure that policy and provision are evidence based, and that progress is tracked.^{2,vi}

¹The Joseph Rowntree Foundation's definition of poverty is: "When a person's resources (mainly their material resources) are not sufficient to meet their minimum needs (including social participation)." <https://www.jrf.org.uk/report/definition-poverty>

²The Mental Health Foundation's UK public inquiry into the future of mental health services (December 2012–September 2013) synthesised evidence from twelve oral evidence sessions held across the UK, 1,533 submissions to its call for evidence, three individual interviews, four background papers ('Inequalities and Mental Health'; 'A Brief History of Specialist Mental Health Services'; 'Healthcare Informatics for Mental Health: Recent advances and the outlook for the future'; and 'Mental Health Professional Education and Training in the UK'), and an expert seminar.



Although mental health problems can affect anyone at any time, they are not equally distributed and prevalence varies across social groups. The Chief Medical Officer for England identified a number of groups of young people as being at risk of developing mental health problems, including children living at a socio-economic disadvantage, children with parents who have mental health or substance misuse problems, and looked-after children. Among adults, she identified higher risk among people who have been homeless, adults with a history of violence or abuse, Travellers, asylum seekers and refugees, and isolated older people.³ Higher rates of mental health problems are associated with poverty and socio-economic disadvantage. Social characteristics, such as gender, disability, age, race and ethnicity, sexual orientation and family status influence the rates and presentation of mental health problems, and access to support and services.

People who experience several complex and interrelated issues, who are referred to as having 'complex needs', are at higher risk of mental health problems and require tailored responses within

policy and services. Such complex needs in adulthood can originate in 'complex trauma' – that is, exposure to traumatising events from an early age that lead to complex symptoms and behaviours.^{vii} Complex trauma can affect people's ability to form trusting relationships and emotional management;^{viii} but, if addressed, recovery is possible.^{ix} Trauma-informed care (TIC) has been described as:

"an over-arching framework that emphasizes the impact of trauma and that guides the general organisation and behavior of an entire system. Trauma-Specific Services may be offered within a trauma-informed program or as stand-alone services".

Different approaches to TIC have a number of common characteristics: trauma awareness, an emphasis on safety, opportunities to rebuild control and a strengths-based approach.^x

The experience of homelessness illustrates the relationship between complex trauma and consequent complex needs. People experiencing homelessness, particularly single

³ In her 2013 annual report themed on public mental health, England's Chief Medical Officer identified particular groups of young people at risk of developing mental health problems: children living at a socio-economic disadvantage; children with parents who have mental health or substance misuse problems; children experiencing personal abuse or witnessing domestic violence; looked-after children; children excluded from school; teen parents; young offenders; young lesbian, gay, bisexual or transgender (LGBT) people; and young black and minority ethnic people. The groups of adults who have higher vulnerabilities to experiencing mental health problems were listed as: people with past mental health problems; people who have been homeless; adults with a history of violence or abuse; adults who misuse alcohol or other substances; offenders and ex-offenders; LGBT adults; Travellers, asylum seekers and refugees; adults with a history of being looked after or adopted; people with learning disabilities; isolated older people; and people from BAME communities.



people⁴ and women,⁵ have high levels of mental health problems. High levels of histories of neglect, abuse and traumatic childhood experiences were found in a 2011 census survey of 1,286 participants living in urban homelessness communities.^{xi} Additionally, people who are homeless may experience significant social exclusion and be affected by substance misuse, which, in themselves, can be traumatic experiences.^{xii} All of these experiences and issues are further associated with involvement in the criminal justice system. Promising approaches to addressing complex trauma include the development of PIEs within services used by people with complex needs (discussed in section 4.1.4).^{xiii}

Poverty produces an environment that is extremely harmful to individuals', families' and communities' mental health. The impacts of poverty are present throughout the life course (before birth and into older age) and have cumulative impacts. However, there are evidence-based measures to progress mental health promotion, ill health prevention, early intervention, and care and treatment that lead to resilience and recovery and can be delivered at individual, family, community and national levels.^{xiv}

1.1 The Impact of the Financial and Economic Crisis

The global financial and economic crisis has accentuated and reinforced long-term trends in inequality, low pay and related poverty in Europe. While the initial impact was high rates of male redundancy, women have experienced higher wage cuts. Disabled people (including people with mental health problems), women and ethnic minorities have experienced disproportionately negative impacts.^{xv}

The primary health impacts of economic downturns are on mental health (including the risk of suicide).^{xvi} People with no previous history of mental health problems may develop them as a consequence of having to cope with the ongoing stress of job insecurity, sudden and unexpected redundancy, and the impacts of loss of employment (financial, social and psychological). Keeping people with mental health problems in work and getting people back to work are key policy and service responses to the economic downturn.^{xvii}

A review of UK and international literature, and two Welsh local authority case studies by the Cardiff

⁴'Single homeless people' is generally understood to be those who are homeless but do not meet the priority needed to be housed by their local authority. They may live in supported accommodation – such as hostels and semi-independent housing projects – sleep rough, sofa surf or live in squats. Many have significant support needs (St Mungo's (2014) in Breedvelt (February 2016)).

⁵Women represent around 30% of people using homelessness accommodation. Women, in particular, may have experienced complex trauma and be further subjected to this through sexual and domestic violence, separation from children, relationship breakdowns, and bereavement. They can benefit from a different – that is, gender-sensitive – approach to meeting their complex needs. (Hutchinson et al. (2014) in Breedvelt (February 2016))



Institute of Society and Health and the Wales Health Impact Support Unit, found that the health impacts of recession and its aftermath are likely to be felt directly through uncertainty, insecurity and lack of control. Within the labour market, these impacts include anticipation of redundancy, unemployment, underemployment, changes in expectations of productivity and working practice, reductions in income, experiences of debt, financial tension, and relationship strain. Studies about the rapid de-industrialisation in the UK during the 1980s (in Wales, and in the West Midlands and North East of England) found that, although living in areas of high unemployment may protect against some psychological impacts of unemployment (such as stigma and shame), in the long term, people living in these communities are exposed to other mental health risks associated with economically deprived areas.^{xviii} The impacts of recession on such communities highlight how disadvantage accumulates within places – for example, the loss of community resources and facilities when the local economy cannot sustain them, and the erosion of social capital due to weakened social networks and reduced social interaction.^{xix}

As signs of recovery emerge within the UK, it is important to distinguish between economic recession, which may be of a relatively short duration, and the consequences that can negatively affect particular people and places over a longer period of time, depending on the interaction of social class, age, gender and the type of work that has been lost.^{xx} Researchers who looked into the suicide rates in Europe between 2007 and

2009 commented: “there is likely to be a long tail of human suffering following the downturn”.^{xxi} Longitudinal research is required to understand the long-term impacts of the financial and economic crisis within the UK, both across geographical areas and within population groups. In Northern Ireland, such research should consider the impacts of both the UK and Irish recessions.

1.2 Policy Opportunities

After many years of advocacy, mental health is receiving significant attention from policy-makers across the UK, in Europe and globally. Milestone reports include the national Foresight report on mental capital^{xxii} and the World Health Organization’s (WHO’s) series of reports: ‘Mental Health, Resilience and Inequalities’,^{xxiii} ‘Mental Health Action Plan 2013–2020’,^{xxiv} ‘Social Determinants of Mental Health’^{xxv} and ‘ROAMER: A Roadmap for Mental Health and Wellbeing Research in Europe’ (ROAMER).^{xxvi} This valuable body of policy and research reports is coalescing around a common, evidence-based agenda across the life course, combining, firstly, public mental health through addressing the social determinants of mental health and advocating a proportionate universalist approach in order to reduce health inequalities, and, secondly, integrated mental health and social care services that are focused on early intervention and characterised by access, choice, quality and timeliness.

For decades, mental health campaigners have drawn attention to the historical underinvestment and marginalisation of mental health in public policy, service



provision, research and data. Mental health problems are the largest single source of disability in the UK, accounting for 23% of the total 'burden of disease' (a composite measure of mortality and reduced quality of life).^{xxvii} However, it is difficult to get a comprehensive understanding of mental health, including mental health and poverty, due to inadequate research and data. A recent briefing by The King's Fund commented on the challenges of reporting reliable data on the levels of funding for mental health services in England, and that, consequently, the quality of services cannot be definitely assessed;^{xxviii} this is a challenge across the UK.^{xxix} With regards to research, mental health receives only 5.5% of the health research budget (this is discussed further in section 5).^{xxx}

There is a common agenda around the development of future mental health services. It will be important to ensure that any additional investment is used to co-produce progressive provision with people who have lived experience of mental health problems through involving them in the design, delivery, monitoring and evaluation of services. Over time, mental health services should reorient from traditional, individualised, biomedical approaches towards integrated biopsychosocial service models that resource self-management, peer support, and collective leadership by people with lived experience of mental health problems and communities with higher prevalence of mental ill health.^{xxxi}

Finally, this advocacy is securing significant policy (if not substantial budgetary) successes. In England, there are policy commitments to parity of investment in the 'No health without mental health' national policy, the NHS Mandate, the NHS 'Five Year Forward View' (2015–2020), the Children and Young People's Taskforce's 'Future in Mind' 2015 report, and the independent Mental Health Taskforce established by NHS England (NHSE), which reported in February 2016. The public and private sectors are recognising that the economic and social costs of underinvesting in mental health are not sustainable.

This report is a timely contribution that can inform the ongoing development of public policy for the Westminster Government and the devolved administrations of Scotland, Wales and Northern Ireland elected in May 2016. In England, it will be important for the Joseph Rowntree Foundation's (JRF's) Anti-Poverty Strategy to inform the implementation of national mental health policy and the Mental Health Taskforce's report, 'The Five Year Forward View for Mental Health', and to support the Prevention Concordat and proposed mentally healthy communities agenda, including Health and Wellbeing Boards' mental health joint strategic needs assessments and new Mental Health Prevention Plans (leveraging the optimum gains from local authorities' public health functions). In 2016, Scotland will progress its new mental health strategy and Wales will review 'Together for Mental Health'. In Northern Ireland, the new Minister for Health has announced her intention to develop a 10 year mental health strategy.



1.3 Mental Health in All Policies

The WHO recognises the need for a comprehensive and multi-sectoral approach to mental health promotion, prevention, treatment, rehabilitation, care and recovery.⁶ Given that households living in poverty are exposed to preventable risk to mental health, greater attention needs to be paid to mental health problems related to marginalisation and impoverishment.^{xxxii}

Mental health is a cross-cutting and mediating factor in public policy supported by the development of MHiAP frameworks and the contributions of champions, such as the Westminster All-Party Parliamentary Group on Health in All Policies, which published a recent report on child poverty, health inequalities and welfare reform.^{xxxiii} Although JRF cautions against broadening the definition of poverty in order to avoid the risks of diversion or dilution, it recognises the intersectional dynamics between poverty and inequality that impact the experience of poverty.^{xxxiv} Integrating a poverty focus into MHiAP should be a priority.^{xxxv}

1.4 Human Rights-Based Approach

This review uses a human rights-based approach in recognition of the extensive human rights violations and discrimination experienced by people with mental health problems.⁷ It frames mental health problems within a social model of disability and draws on international definitions for mental health, mental disorders, psychosocial disabilities, vulnerable groups and recovery (see Glossary). Although this review references the authority of the global consensus articulated in the UN Convention on the Rights of Persons with Disabilities (UNCRPD), it recognises the limitations of relying on legal instruments to advance the human rights of people with mental health problems. Therefore, the review considers the importance of collective approaches to human rights, such as social movements and community development.

⁶ The WHO's Mental Health Action Plan (2013–2020) has set out four major objectives for mental health: more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in community-based settings; the implementation of strategies for promotion and prevention; and strengthened information systems, evidence and research. This would be progressed by the realisation of six cross-cutting principles and approaches: universal health coverage, human rights, evidence-based practice, the life course approach, the multi-sectoral approach and the empowerment of people with mental disorders and psychosocial disabilities.

⁷ Human rights-based approaches in mental health are described in the British Institute of Human Rights' publication *Mental Health Advocacy and Human Rights: Your Guide*, which was developed by its Human Rights in Healthcare project in England and its ongoing mental health and human rights programme, including the *Care and Support: a Human Rights Approach to Advocacy* programme (<https://www.bihhr.org.uk/a-human-rights-approach-to-advocacy>, accessed 16 February 2016) and *Human Rights in a Health Care Setting: Making it Work for Everyone*, which reported the evaluation of the Scottish Human Rights Commission's initiative in the State Hospital, which, in turn, provides forensic mental healthcare for Scotland and Northern Ireland.



A whole-government approach to legislation, policy, strategies, services and programmes that addresses mental health and poverty needs to be in line with UK, European and UN commitments to protect, promote and respect the rights of people with mental health problems. The UK Government ratified the UNCRPD in 2009. It is anticipated that the UN Committee will review the UK's realisation of these human rights commitments – including Article 28: Adequate Standard of Living and Social Protection – in 2017. Currently, the impact of austerity policies on the UK Government's realisation of CRPD rights has been investigated under the Convention's Optional Protocol procedure. Further, all of the UK's human rights commitments are to be reviewed under the UN's Universal Periodic Review mechanism in 2017.

1.5 Methodology

In order to inform the development of the JRF Anti-Poverty Strategy, this review posed the following question.

What public policies⁸ or services⁹ have been evidenced to effectively address mental health and poverty experienced by children and adults¹⁰ through:

- preventing people in/experiencing poverty¹¹ from developing mental health problems;
- supporting people in/experiencing poverty with mental health problems to recover;
- preventing people in/experiencing poverty with mental health problems from becoming poor; and
- supporting people in/experiencing poverty with mental health problems to move out of poverty?

The Mental Health Foundation used its Stepwise approach to identify peer-reviewed and grey literature publications on 'mental health' and 'poverty', and produced a new iteration of its quality criteria to screen these. The primary limitation of this review is that the time and resources available meant that these documents were not systematically reviewed. It has drawn together existing policy and research material and made recommendations based on the strongest evidence (systematic reviews and meta-analyses) and credible sources (including government, public bodies, and civil society think tanks and policy groups).

⁸ national and international

⁹ health, social care, education, employment, social security and advice

¹⁰ including those with complex needs

¹¹ including individuals, families and communities



1.6 Summary

The review begins by considering the relationship between poverty and mental health, and proposes a conceptual framework for addressing this. It outlines mental health and poverty across the life course, including its cumulative impacts. The importance of promoting self-management, peer support, community development and movement building is advanced. The review then discusses the significance of public services (health, social care, education, employment, social security, advice and planning) in reducing poverty and mental ill health. The challenges of costings – and the evidence base for investing in mental health as a poverty reduction strategy – are presented. Finally, a set of recommendations are made, informed by JRF's '4 Ps': Pockets (the resources available to households), Prospects (people's life chances), Prevention (stopping people from falling into poverty) and Places (where people live – their homes and communities). These recommendations address cross-cutting themes of data and research, stigma and discrimination, and MHiAP; actions at each stage of the life course (perinatal, early years, childhood, adolescence, working age, and later life); and actions across the life course.

2. Poverty and Mental Health: A Conceptual Framework



Mental health is a universal asset that we all share. Good mental health supports us all to reach our potential, individually and collectively. The Mental Health Foundation has argued that mental health is a mediating factor between economic and social conditions. Poor mental health experienced by individuals is a significant cause of wider social and health problems, including low levels of education achievement and work productivity, poor community cohesion, high levels of physical ill health, premature mortality, violence, and relationship breakdown. For some of these factors, such as relationship breakdown, the causal relationship runs both ways.^{xxxvi} Good mental health, in contrast, leads to healthier lifestyles, better physical health, improved educational attainment and productivity, and lower levels of violence and crime.^{xxxvii}

Poverty and mental health problems are not marginal experiences of a separate group in society: anyone can experience either over their lifetime, and there is a clear intersection between mental health and poverty. Whether or not someone develops mental health problems or moves into poverty, how long this lasts for and its severity, and if and how someone recovers their mental health or secures a route out of poverty depends on their access to sufficient quality and quantity of resources, and the timeliness of this access. Poverty's dynamic character also means that the risk of experiencing mental health exists

for more people that are in poverty. This underlines the importance of preventing poverty as well as progressing routes out of it.^{xxxviii}

2.1 Life Course

Neither poverty nor mental health is a static category or experience. So, what an individual, household, family or community needs in terms of protective, preventative, and promotional resources changes. For individuals, these needs and resources change over their life course – particularly at transition points between these stages and at pressure points (for example, during acute and chronic periods of pressure, such as diagnosis and management of a long-term health condition, redundancy, relationship breakdown or bereavement). Given the cumulative impacts on mental health of disadvantage and advantage over the life course, the WHO has stressed the importance of early intervention.^{xxxix}

2.2 Socio-Economic Factors Impacting Mental Health

Individuals', families', communities' and nations' mental health is determined by a wide range of socio-economic factors (referred to as 'social determinants'), which both influence health status and the physical, social and personal resources available for dealing with environmental stressors, satisfying needs and realising potential. The social determinants of mental health are not limited to individual attributes



(emotions, thoughts, behaviours and interactions with others), but also include social, cultural, economic, political and environmental factors such as living standards, working conditions, social protection and community social supports.^{xi}

The following table provides illustrative examples of factors that influence mental health.

Some factors that influence mental health

Society	Community	Family	Individual
Inequality	Personal safety	Family structure	Lifestyle (diet, exercise, alcohol)
Unemployment levels	Housing and open spaces	Family dynamics and functioning	Attributional style (i.e. how events are understood)
Social coherence	Economic status of the community	Genetic makeup	Debt/lack of debt
Education	Isolation and loneliness	Intergenerational contact	Physical health
Health and social care provision	Neighbourliness	Parenting	Relationships

(Adapted from McCulloch and Goldie (2010) in Goldie (2015))^{xli}

Mental health can also be affected by sudden life events, which are sometimes referred to in the literature as 'pressure' or 'transition' points. A recent UK study explored the relationship between difficult life events (relationship breakdown, eviction or repossession, and job loss), poor mental health and distinctive patterns of mobility. It found that difficult life events appear to harm both mental health and residential opportunities, increasing the likelihood that people with poor mental health

will live in socio-economically deprived neighbourhoods. It concluded that moves related to difficult life events could reinforce socio-economic inequalities in health between areas by concentrating people with poor health in disadvantaged areas.^{xliii}

Studies evidence a social gradient in relation to poverty and/or economic inequality and poorer mental health and wellbeing. Populations living in poor socio-economic circumstances are at increased risk of poor mental

health, depression and lower subjective wellbeing.^{xliii} Across the UK, both men and women in the poorest fifth of the population are twice as likely to be at risk of developing mental health problems as those on average incomes.^{xliv, xlv} Material disadvantage (with low educational attainment and unemployment) was associated with common mental health problems (depression and anxiety) in a review of population surveys in Europe.^{xlvi} The social distribution of common mental health problems has a social gradient and is more marked in women than in men;^{xlvii} this is also evident in children. A systematic literature review found that young people aged 10 to 15 years with low socio-economic status had a 2.5 higher prevalence of anxiety or depressed mood than their peers with high socio-economic status.^{xlviii} Socio-emotional and behavioural difficulties have been found to be inversely distributed by household wealth as a measure of socio-economic position in children as young as 3 years old.^{xlix}

Mental health and debt interact with each other. An English study found that, in the general population, half of those with debt have a diagnosis of a mental disorder, compared to only 14% of people with no debts.ⁱ A study by the Irish Economic and Social Research Institute found associations between financial exclusions and households at risk of poverty headed by a person who is unable to work due to illness or disability.ⁱⁱ However, it is important not to pathologise social, economic and financial problems.ⁱⁱⁱ

2.3 Human Rights

The UK Government has committed to progressively realise disabled people's right to an adequate standard of living and social protection. Under UNCRPD Article 28, the state commits to ensure equal access to appropriate and affordable services, social protection programmes and poverty reduction programmes (including access for persons with disabilities and their families living in poverty to state assistance with disability-related expenses, such as adequate training, counselling, financial assistance and respite care). This human right chimes with a number of public policies and sectors covered in this report. JRF's Anti-Poverty Strategy may be one way in which the UK State could co-ordinate activity across the UK to implement UNCRPD.

2.4 Equity

'Inequalities in health' refers to differences between individuals or groups of people in terms of health status, presence of disease, and access to healthcare or health outcomes, regardless of the cause of these differences. 'Health equity' refers to the presence or absence of differences in health, or in the major social determinants of health that are unnecessary or unavoidable between population groups with social advantages.ⁱⁱⁱⁱ

Inequities in health systematically put people who may already be socially disadvantaged at a further disadvantage with respect to their health.^{liv} Inequalities



in health, including mental health, arise because of inequalities in society – such as the conditions in which people are born, grow, live, work and age. The Marmot Review provides a template for addressing mental health inequities by tackling the social factors that influence mental health in order to achieve explicit policy objectives.^{12,iv} Using an inequalities framework enables us to consider how poverty and mental health intersect with identity.

2.5 Anti-Stigma and Non-Discrimination

Stigma and discrimination affect people experiencing poverty and people with mental health problems.^{lvi} Stigma can be internalised, which has corrosive effects: silencing people and preventing them from seeking and receiving support; undermining their sense of self, such as their self-esteem and confidence;

and limiting the horizons of their expectations for health, education, employment and relationships. Social contact is fundamentally important for improving attitudes and behaviours towards stigmatised groups, and it has been crucial in building public and political support for prioritising mental health policy and services.^{lvii}

2.6 Prevention

Prevention is a central approach to mental health¹³ and is also a key theme in the Anti-Poverty Strategy. Effective mental health prevention requires a multifaceted approach that takes account of needs at different stages of the life course, differing levels of risk, the degree to which people may be managing complex challenges (and perhaps finding it hard to cope), and the settings in which they can be best reached. Prevention may be focused on different groups of people based

¹²1. Give every child the best start in life; 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives; 3. Create fair employment and good work for all; 4. Ensure a healthy standard of living for all; 5. Create and develop healthy and sustainable places and communities; and 6. Strengthen the role and impact of ill health prevention. This will require the combined effort of central and local governments, the NHS, third and private sectors, and community groups. As well as local delivery systems for national policies, individuals and communities need to be empowered to engage in effective participatory decision-making.

¹³ NHSE (September 2015) The Five Year Forward View Mental Health Taskforce: public engagement findings. A report from the independent Mental Health Taskforce to the NHS in England. Available at: <http://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/09/fyfv-mental-hlth-taskforce.pdf> [Accessed 2 September 2015].

¹⁴ Universal – for everyone: targeting the whole population, and groups or settings where there is an opportunity to improve mental health, such as schools or workplaces.
Selective – for people in groups, demographics or communities with higher prevalence of mental health problems: targeting individuals or subgroups of the population based on vulnerability and exposure to adversity, such as those living with challenges that are known to be corrosive to mental health.
Indicated – for people with early detectable signs of mental health stress or distress: targeting people at the highest risk of mental health problems.



on their risk profile.^{14,lviii} Prevention can also operate at different phases in the development of mental health problems and recovery from them.^{15,lix}

2.7 Self-Management, Peer Support, Community Development and Movement Building

Individualised, clinical discourses primarily drawn from the biomedical model of psychiatry have traditionally dominated mental health services. An important trend within mental health policy and practice has been the growing involvement of people with lived experience¹⁶ of mental health problems, including the establishment of formal structures to include service users in the

development, and the monitoring and evaluation, of mental health policy.¹⁷ This involvement ranges from peer-support and self-management programmes,¹⁸ both those within and independent of mental health services, to the collective organisation of people with lived experience in social movement organisations, coalitions and alliances. (A recent guide to self-management support by the Health Foundation usefully outlines the wide range of approaches to self-management for people with long-term conditions, including mental health, and how these can be put into practice.)^x

¹⁵ Primary prevention – aims to stop ill health occurring entirely by using ‘upstream’ approaches for the majority of the population, coupled with selective and indicated interventions focused on people and communities most at risk.

Secondary prevention – aims to identify signs of health problems through awareness, self-identification, help from friends and colleagues, etc., ensuring that effective early intervention is provided to minimise progression into a full mental health condition.

Tertiary prevention – works with people who have had established mental health problems to prevent relapse and ensure sustainable recovery.

¹⁶ The term ‘people with lived experience’ is more frequently used than ‘service user’ or its other variations (including ‘client’ and ‘patient’) in order to recognise that most people who experience mental health problems are not users of health and social care services. Further, concepts of ‘peer’ are problematised by people with lived experience, evolving our understanding of what types of common experience (of mental ill health, services and legislation) create peer relationships and how peer identities intersect with other social identities (including socio-economic status and protected characteristics under equality legislation).

¹⁷ In public mental health, this extends to population groups with greater exposure to risk factors associated with mental health problems and lesser access to health-protecting resources.

¹⁸ The common underlying principles of self-management in mental health are that people (rather than professionals or clinicians) have control, are life orientated not condition orientated, work together (moving the emphasis from self-management as an individual activity to self-management and peer support as a group activity – independence to interdependence), and that every facilitator is a former participant. Goal setting, problem solving and peer support are key components (Crepaz-Keay, 2015).



Within the context of human rights-based approaches, it is important to include both the implementation of these approaches at service levels and the strategic leadership of mental health social movement actors.^{19, lxi} The degree, form and dynamics of involvement varies significantly and embodies the power relationships that operate within mental health between people with lived experience of mental health; their families, friends and carers; clinicians; services; and the state bodies that operate mental health and mental capacity legislation.

The concept of recovery has been critical to changing the power dynamics within mental health from the psychiatric prognosis of lifelong illness, clinically controlled interventions and significant exclusion from ordinary life. The WHO provides a person-centred definition of recovery (see Glossary).

However, research has highlighted that varying interpretations of 'recovery' have developed. In a recent systematic review and narrative synthesis of primary research that explored clinicians' and managers' understandings of recovery-orientated practice in mental health services, the authors identified three descriptive headings: clinical, personal and service defined.^{lxii}

Multiple interpretations of core concepts within mental health, such as self-management and recovery, highlight the importance of co-production as a central way for public services, policy-makers and researchers to engage with people with lived experience of mental health and poverty. This review proposes the importance of co-production of meanings and approaches to mental health, 'peer support' and 'self-management' for individuals and communities living in poverty.

Motivations to promote self-management and peer-support approaches are complex. The Sustainable Development Commission commented that self-care is a more sustainable approach to health service delivery, and observed that, as well as empowering people to be in charge of their own healthcare, it reduces health inequalities.^{lxiii} The Scottish Government, in particular, has focused on involving people with experience of mental health problems and mental health services, and the importance of self-help, self-referral, self-management, and self-directed and peer-to-peer support in service design and delivery.^{lxiv}

Community development and social movement building catalyse local action, which is necessary for tackling mental health and poverty. Change can

¹⁹ Examples of collective organisations are the National Survivor User Network (NSUN) in England and Voices of Experience (VOX) in Scotland. In Wales and Northern Ireland, structures have been established to include service user (and carer) voices in the implementation of mental health policy (the Welsh Service User and Carer Forum, and the Bamford Monitoring Group in Northern Ireland).



be achieved through the initiatives of local public services, but it is important that communities are treated as autonomous change agents, and that individuals, households and communities are empowered to have more control over their lives across the social determinants of health. The building of social capital that creates connections within (bonding) and between (bridging) communities can grow resilience, protect against health risk factors, provide social support, and enable people to access a range of material, social, psychological and economic resources, including work opportunities. Improving community capital and reducing social isolation across the social gradient can be progressed through locally developed and evidence-based community regeneration programmes. Such programmes should address barriers to community participation and action, which can be structural and linked to community members' capacity and capability.^{lxv}

Public Health England (PHE) published a briefing on community-centred approaches, which can inform their inclusion in local public service planning and delivery in areas experiencing material deprivation and a high prevalence of mental health problems.^{lxvi} The English Mental Health Taskforce report proposed the development of mentally healthy communities, including through the use of social movement approaches.^{lxvii} In the US, the Promise Neighborhoods Research Consortium has proposed a community-wide approach for promoting child health and development within high-poverty neighbourhoods by distilling evidence-

based and effective interventions into the Creating Nurturing Environments framework. While this is a theoretical model, it is a useful resource for informing planning-integrated, sustained and co-ordinated programmes at a neighbourhood level.^{lxviii} The Mental Health Foundation is publishing a whole-community approach to mental health.^{lxix}

Social movement building to advance mental health involves more complex approaches and the engagement of a wider range of actors, such as the decade-long wellbeing movement co-launched by the NHS and Liverpool City Council, which mobilised community, voluntary, health, local government and business sectors.^{lxx}

3. Poverty and Mental Health Across the Life Course



The WHO's report on the social determinants of mental health^{lxxi} highlighted that the effects of exposure over the life course on both disadvantage and advantage accumulate over time. The following key factors affect mental health across all stages of life, influencing the risk of people having mental health difficulties and presenting opportunities to reduce risk.

- parenting behaviours/attitudes;
- material conditions (income, access to resources, food/nutrition, water, sanitation, housing and employment);
- employment conditions and unemployment;
- parental mental and physical health; and
- maternal care and social support.^{lxxii}

These cumulative impacts are evident individually in a person's epigenetic, psychosocial, physiological and behavioural attributes, and collectively in families' and communities' social conditions. Social and economic inequities result, and these lead to inequitable mental and physical health outcomes. Therefore, policies that help to equalise life chances can be expected to have an impact on mental health as well as on other outcomes. Recognising this, it is important to note that this review is not intended to cover the broad

range of policies that can contribute to this higher level goal, but, rather, it focuses on more specific policies that can address mental health needs within current social conditions.^{lxxiii}

This report considers mental health at the following stages.

- perinatal (pregnancy and the first year after birth), early years, children and young people;
- working age, including family formation, employment, unemployment and worklessness; and
- later life.

There are a number of evidence reviews for mental health-related policy, service and programmatic interventions across the life course, including economic evidence. However, these mainly focus on pre-natal, perinatal, early years, children and young people. There is a lack of evidence reviews about mental health in later life, which includes consideration of poverty and equality. JRF published a report on the relationship between mental health and child poverty almost a decade ago.^{lxxiv} The Scottish Government published a review of interventions to address health inequalities in the early years.^{lxxv} Health Scotland produced an evidence summary of public mental health interventions for perinatal through to adolescence



within familial, health and social care, community and school settings.^{lxxvi} In England, the Children and Young People's Mental Health Taskforce drew together current evidence and made clear and substantial recommendations in its 'Future in Mind' (2015) report.^{lxxvii} The UK Faculty of Public Health made the case for improving children's mental health and wellbeing across the themes of pre-school, family culture, parenting support, schools, the built and natural environments, and media and advertising.^{lxxviii} The UN published a review of the interventions to support the social inclusion of young people with mental health problems.^{lxxix} (Recommendations based on this evidence are discussed below in section 7.)

3.1 Perinatal, Early Years, Children and Young People

The National Equality Panel commented that: "the long arm of people's origins [shapes] their life chances, stretching through life stages, literally from cradle to grave".^{lxxx} Mental health problems in childhood can lead to reduced life chances by disrupting education and limiting attainment, impacting social participation and reducing the ability to find and sustain employment – particularly work that provides for an adequate standard of living. This, in turn, can lead to an impoverished and unhealthy later life. The King's Fund produced a review of evidence-based public health interventions for local

authorities with a commentary on ways in which some could be targeted at disadvantaged individuals and groups across the life course.^{lxxxi}

The case for investing in the prevention of mental health problems and intervening early in childhood and adolescence is overwhelming; this is when much of our mental health is developed. Seventy-five per cent of mental health problems are established by age 24, and 50% by age 14.^{lxxxii} One in ten school-age children has a clinically diagnosable mental health problem, including depression, anxiety or psychosis. A recent English study on children with severe behavioural problems reported that about 5% of children aged 5–10 years have a 'conduct disorder' – that is, they display severe, frequent and persistent behavioural problems²⁰ – and that a further 15–20% who do not reach this diagnostic threshold display concerning behaviours. Conduct disorder is twice as high in boys as in girls. Rates of conduct disorder are higher among children from disadvantaged backgrounds. For about half of these children, serious problems will persist into adolescence and adulthood.^{lxxxiii}

In the last major British study of the mental health of children and young people (Office for National Statistics, 2004), the rates of diagnosable mental health problems were higher among children:

²⁰ Depending on age, these behaviours may include persistent disobedience, angry outbursts and tantrums, physical aggression, destruction of property, fighting, bullying, lying or stealing.



- whose parent interviewed for the study had no educational qualifications (17%) compared to those who had a degree-level qualification (4%);
- in families with neither parent working (20%) compared to families in which both parents work (8%);
- in families with a gross weekly household income of less than £100 (16%) compared with those with an income of £600 (5%);
- in households in which someone receives disability benefit (24%) compared to those that receive no benefit (8%); and
- living in areas classed as 'hard-pressed' (15%) compared to those living in areas classed as 'wealthy achievers' or 'urban prosperity' (6% and 7% respectively).^{lxxxiv}

The prevalence of severe mental health problems among 11 year olds participating in the UK Millennium Cohort Study (MCS) using the Strengths and Difficulties Scale was 10%; a prevalence of 13% of boys and 8% of girls. In defining persistent cases of children with severe mental health problems at three or four study points (data was collected at ages 3,

5, 7 and 11), 3.6% could be categorised as such. Comparisons between ethnic groups found that severe problems were most common among children from mixed ethnic origins, followed by those of white origin (particularly boys); prevalence was lowest among children of Indian origin. Having severe mental health problems was strongly related to parental education, parental occupation and family income. Seventeen per cent of 11 year olds in 2012 from families in the bottom fifth of income distribution were identified as having severe mental health problems compared to 4% in the top fifth.^{lxxxv}

The income-related gradient in prevalence appears to have become steeper and is much steeper among children than among adults. Seventy per cent of conduct problems are in the bottom two income groups; hyperactivity/inattention and peer problems have 60% of the cases from the bottom 40% of income; and emotional problems have 50%. The 2004 prevalence of severe mental health problems in children aged 11–16 was three times as high in the bottom fifth of family income as among those in the top fifth; the MCS suggests a fourfold difference.^{lxxxvi}

Childhood adversity impacts mental health and wellbeing. Adverse childhood

²¹ Examples of childhood experiences within the family were physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, physical punishment, witnessing domestic violence, household member's substance misuse, household member's illness, household member's incarceration, parental separation/divorce or child separation from family. Examples of childhood experiences within the social context were poverty/socio-economic stratification, racial segregation, political conflict, hospitalisation, community violence, school violence/bullying, maltreatment by teacher or natural disaster.



experiences have been defined as follows.

“Adverse childhood experiences are childhood events, varying in severity and often chronic, occurring within the child’s family or social environment that cause harm or distress, thereby disrupting the child’s physical or psychological health and development.”

²⁷ lxxxvii

Adversity itself tends to be cumulative, with a large-scale US study reporting childhood economic adversity in 11% of the sample – 84% of which had experienced at least one other childhood adversity. The study also suggests that multiple childhood adversities are associated with up to 45% of all childhood-onset mental disorders.^{lxxxviii} The ‘Building a better future’ report outlines a number of risk factors for children developing severe behavioural problems; this illustrates the range of adversities experienced by children and young people, and their cumulative impact.^{lxxxix}

In the early years, children’s life chances (mental and physical health, social behaviour, educational outcomes and employment status) are negatively impacted by lack of secure attachment, lack of quality stimulation, neglect and conflict.^{xc} Particularly damaging is exposure to neglect, direct physical and psychological abuse, and being raised in families where there is domestic violence.^{xcii} The development of severe behavioural problems is linked to a wide range of environmental and genetic risk factors, but adverse familial experiences – such as harsh, inconsistent and

neglectful parenting, and maltreatment – are particularly important. Loving, responsive and stable relationships with a caring adult that provide social support and build secure attachment are fundamentally important for buffering the effects of stressors and coping with them.^{xciii} Familial and community social supports, and positive beliefs (optimism, self-esteem and a sense of control), continue to act as buffers throughout childhood and into adulthood.^{xciii}

For children born into poverty, the cumulative impact of poverty intersecting with other inequalities is evident throughout their life course. The health of children born to mothers in/ experiencing poverty is more likely to be compromised due to their mothers’ poor nutrition, exposure to stress, and poor working conditions,^{xciv} as well as limited access to poorer quality public services. Children with lower socio-economic status have poorer cognitive performance across areas that include language function and cognitive control (attention, planning and decision-making).^{xcv} Stressors such as the experience of poverty during sensitive early development periods affect biological stress regulatory systems – neural mechanisms by which stress responses are regulated in the brain – and the expression of genes related to stress responses.^{xcvi} Cumulative exposure to stressors over time leads to changes in stress responses that have physiological effects on the immune system, cardiovascular function, respiratory system and other systems, including the brain, which damage health.^{xcvii}



The effects of poverty on adolescent mental health are severe and cumulative. As poverty interacts with a complex range of social and economic environmental factors, data has not been identified in this paper that attributes the proportion of child mental ill health to poverty. However, chronic exposure to poverty increases adolescents' risks for developing conditions such as depression, and behavioural risks such as substance use, early sexual activity and criminal activity.^{xcviii} The awareness of financial problems in their families also negatively impacts adolescents' mental health and is associated with depression among girls and drinking to intoxication in boys, as well as a sense of helplessness and feelings of shame and inferiority.^{xcix}

Children and young people who experience mental health problems can have their education disrupted due to missing school during periods of ill health or being excluded if they have significant behavioural problems. In one study, children with an emotional disorder had more time off school than other children: 43% had more than five days' absence and 17% had more than 15 days' absence in the previous term; this compares with children with no diagnosed disorder (21% and 4% respectively). Children with generalised anxiety disorder and those with depression had the most days away from school (a quarter had more than 15 days' absence in the previous term). They then become behind with their learning and, without additional support to catch up, may not attain their full educational potential. This has important impacts in terms of educational attainment, employment and income.^c

Having a parent with a mental health problem can be a risk factor for children's mental health and wellbeing. It is difficult to establish the rates of parental mental health due to factors including the under-identification of mental health problems and incomplete recording of mental health service users as parents.^{ci} The last British study of the mental health of children and young people found that children with an emotional disorder were more than twice as likely as other children to have parents with a score on the General Health Questionnaire (GHQ-12) indicative of an emotional disorder (51% compared with 23% among other parents). Over half (55%) of children with an emotional disorder had experienced their parents' separation, and over a quarter (28%) had a parent with a serious mental health problem (for other children, these figures were 30% and 7%). UK research has identified that parental mental health problems are a significant factor in around 25% of new referrals to social service departments,^{cii} that more than one-third of adults with mental health problems are parents, and it is estimated that two million children live in households where at least one parent has a mental health problem.^{ciii}

Children who have a parent with mental health problems can be affected by spending increased periods of time alone in the family home and becoming socially isolated.^{civ} Children may assume a caring role – a responsibility that can affect their educational experience, including attendance, participation and attainment;^{cv} however, some young carers regard school as a refuge.^{cvi} The Mental Health Foundation's study of



young carers found that, while some received social support to provide respite or to enable them to participate in social activities, more intervention was needed to address difficulties experienced around school, including regular lateness or absence, completing schoolwork on time, and behavioural issues such as their being disruptive, being bullied or having difficulty in developing friendships. Young carers of parents with mental health problems need to have more information about mental health, support to cope with their own feelings and additional assistance to ensure that they attain educational qualifications.^{cvii}

There is a clear evidence base around the potential mental health problems that can develop during the perinatal period and a NICE-approved perinatal care pathway. The economic case for investing in a comprehensive, timely range of mental health and social care services for the mother, her partner and their family network is discussed in Costings (section 6). The UK Maternal Mental Health Alliance has provided leadership across the UK around these issues, including through the Everyone's Business campaign (which runs until September 2016). The Recommendations (section 7) draw on their ideas as well as on wider evidence.^{cviii}

Interventions with a strong evidence base include parenting programmes – particularly those for parents in disadvantaged areas and who have existing mental health problems. A meta-synthesis of qualitative evidence from twelve UK studies focused on

parents' subjective experiences of caring for children in impoverished circumstances. It found that parents gain material and emotional support from naturally occurring support systems, but these may not be available and can have negative associations. Low-income lone mothers enjoyed smaller support networks and were more reliant on mutual support than two-parent families. The most socially isolated mothers were those least likely to seek professional help; low-income parents' experiences of health and social welfare agencies were mixed. This study concluded that, while formal support services could valuably complement informal support systems, they needed to include parents' perspectives in their design, development and evaluation.^{cix}

Parenting programmes, particularly those that encourage positive parenting, can be very effective across different family types and ethnic groups by improving the behaviour of a child with conduct issues, their siblings' behaviour, and the mental health and wellbeing of parents. However, programmes must be implemented with strong fidelity to the evidence-based model, and must continue to be evaluated as they are scaled up and transferred for use with different groups of parents; it is also important to learn more about the efficacy of parenting problems over time through longitudinal studies.^{cx}

The UNESCO review on maternal mental health, poverty and children's education outcomes recommended targeted interventions for families experiencing mental health problems within existing parenting programmes.



It referenced child-centred, whole-family interventions such as the Canadian Family Association for Mental Health Everywhere, which helps children to better understand their parents' mental health problems; the Australian Simplifying Mental Illness Life Enhancement Skills (SMILES), which supports children in gaining a better understanding of their parents' mental health problems, reduces isolation and builds their self-confidence; and the Australian peer support programme Children and Mentally Ill Parents. These programmes have demonstrated positive outcomes such as improved self-esteem and coping strategies, and stronger family relationships for children and parents. The Family SMILES programme has been adapted and is run in the UK by the NSPCC²² and the Strengthening Families Programme has been adapted in the UK and Ireland.^{23, cxi}

A substantial body of studies has been undertaken regarding the relationship between mental health and wellbeing in childhood (and their long-term effects in adulthood), and the importance of developing social and emotional skills among children,^{cxii} including building resilience.^{cxiii} Whole-school approaches can reach children, staff, parents and communities, and can improve mental health and wellbeing by developing the curriculum, health promotion initiatives, support programmes and services.^{cxiv}

3.2 Working Age, Including Family Formation and Employment

3.2.1 Family Formation

The age, socio-economic context, capabilities, and personal and material resources of parents significantly influence their experiences of forming a family and parenting. The mental health of parents can be supported from adolescence through whole-school programmes, which develop self-esteem, confidence and communication skills that support young people to negotiate positive and safe relationships, to use contraception and to be a nurturing parent.

Mothers and fathers with mental health problems have the right to family life under the UNCRC. Women with pre-existing mental health conditions may need support to have a healthy pregnancy and birth through advice and guidance about managing medication, and through co-producing an integrated perinatal plan with mental health and maternity services. This is particularly the case for women with complex needs, including those who misuse alcohol and other substances. Stigmatising attitudes among health and social care staff, and family and community members, may need to be addressed. Personalising care may require negotiation of reasonable

²² <https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/family-smiles/>

²³ <http://mystrongfamily.co.uk/>



accommodations so that parents with mental health problems who are living in poverty receive equitable access to services. The high risk of children of parents with mental health problems going on to develop these too means that it is important to provide parenting and family support from pregnancy and throughout childhood.

3.2.2 *Employment, Unemployment and Worklessness*

It is good work, rather than simply a job, that is associated with good mental health. 'Good' work and employment is a substantial health asset. Work is central to individual identity, social status and social roles. It meets important psychosocial needs in societies where it is the norm. Socio-economic status is the main driver of social gradients in mental and physical health and mortality. Employment is the most important means by which to obtain adequate economic resources that are necessary for material wellbeing and full participation in society. Psychosocial attributes (insecurity, demands, control and support) and material aspects such as income are ways in which people weigh 'good' or 'bad' work. Key characteristics of work and employment that are protective and beneficial for health include high levels of supervisor and peer support and job control, and low levels of insecurity and the absence of in-work poverty.^{cxv} Mirroring JRF's concerns about the UK's high rates of in-work poverty, this review notes that in-work mental ill health is also a concern.

The interrelationship between poverty, unemployment and mental health problems occurs in a number of ways.

Psychosocial health impacts occur indirectly through the perception of social exclusion and loneliness. Unemployment, 'bad' employment and in-work poverty are harmful to health and are associated with poorer mental health, psychological distress and minor psychological/psychiatric morbidity; poorer general health; lengthy illness; higher rates of medical consultation, medication and hospital admission; and higher mortality.^{cxvi}

The Marmot Review set the policy objective of creating fair employment and good work for all, to be achieved through improving access to good jobs and reducing long-term unemployment across the social gradient; making it easier for people who are disadvantaged in the labour market to obtain and keep work; and improving the quality of jobs across the social gradient.^{cxvii}

Employment is central to addressing the relationship between poverty and mental health. Workplaces need to:

- promote mental health and prevent the development of work-related mental health problems;
- make reasonable adjustments when employees are experiencing a period of mental ill health (either a one-off event or as a symptom of a fluctuating condition), or when employees have to care for someone with a mental health problem; and
- be receptive to supporting people with mental health problems in engaging in work.



Whole-workplace approaches are ways of drawing together good practices that can achieve all of these.^{cxviii}

It is important that the primary policy goal for people with mental health problems should be securing employment that provides a living wage, combined with providing adequate integrated health and work support, focused (with regards to health) on recovery and (with regards to employment) on retention and progression.

Work, mental health and poverty are discussed in section 4.5, including getting on in work, moving into work and self-employment/entrepreneurship.

The social security system should provide an adequate standard of living for those who cannot secure or sustain employment, including the flexibility to respond quickly when someone falls out of work for either a period of time or permanently. As discussed in Social Security below (section 4.6), one of the effects of the disproportionately negative impacts of welfare reform on disabled claimants is that people with mental health problems are concerned about trying to enter the labour market in case they lose the social security safety net during periods of ill health.^{cxix}

3.3 Later Life

JRF distinguishes between future pensioners in age cohorts: 'younger cohorts' (30–49) and 'about to retire' (50–64); and pensioners today: 'younger pensioners' (65–75) and 'older pensioners' (over 75s). The Mental

Health Foundation defines later life as commencing at 50 years old, as this is the time when many people will begin to experience a mental or physical decline or deterioration, and many also begin to seriously plan for their retirement, take early retirement, or find it difficult to secure employment.^{cxx} People who have experienced poverty and inequality during their lifetime may experience the effects of ageing earlier in their life course.^{xxxi} This can be the case particularly for people who have serious mental health problems, are long-term users of psychiatric medication, or have developed one or more long-term physical health conditions (see section 4.2.2). The lifespan of such individuals may be shortened by up to 25 years.^{cxxii}

There is noticeably less research and policy material around later life, mental health and poverty. The 2007 UK Inquiry into mental health and wellbeing in later life described older people with severe and enduring mental health problems as "invisible in policy, practice and research".^{cxxiii} However, it is clear that the cumulative impacts of mental health problems for both the individual and family are apparent in later life. The lifelong effects of lower educational achievement, disrupted, low-paid, insecure and poor-quality work, and reliance on social security payments become evident. The effects include the reduced ability to acquire the material resources necessary for mental health and wellbeing, such as secure and good-quality housing, and adequate pension and savings.



The inquiry into mental health and wellbeing in later life found that older people with severe and enduring mental health problems experience ageism and stigma. Research has found that this group is at a greater risk of receiving inadequate and inappropriate care.^{cxxiv}

The combination of poverty and mental health problems in later life exacerbates the risk of social isolation, which is a significant issue for people with mental health problems across the life course.^{cxxv} This is also an issue for people living in poverty due to their lack of access to funds for engaging in social and cultural activities, and the weak social capital that can characterise deprived areas.^{cxxvi}

Across all public services, tailored action is required to meet the needs of people in later life who are experiencing mental health problems or living in poverty (or at risk of either of these) in order that they can be independent and well.^{cxxvii} These actions include:

- provision of health and social care, which promotes mental health and wellbeing;
- screening for early detection of mental health problems (particularly depression and dementia);
- support for people at key transitions and pressure points in later life; and
- aids for recovery (as determined by the individual).

Access to lifelong learning opportunities and support to retain, progress in and gain employment is necessary to

maximise salary, pension entitlements and savings. Social security may be an important (or the sole) source of income, and so social security and advice services need to assist people in maximising their incomes by ensuring they receive all of their entitlements.

A perverse and unintended consequence of the welcome attention that is increasingly being given to early intervention is lesser attention being given to later life interventions. It is important to highlight that the Marmot Review – which champions giving every child the best start – also recognises that there is a wealth of interventions that can be invested in to improve the health and lives of people at all stages of the life course. More research is needed in order to understand what these interventions are for people in later life who are experiencing (or are at risk of) mental health problems and poverty. This is an important and under-resourced research agenda. From the Mental Health Foundation’s mapping of public mental health evidence, it is apparent that much of the limited investment in mental health research focuses on children and parenting, with a paucity of research being conducted around public mental health in working age and later life.^{cxxviii}

4. Public Services



Addressing health inequalities associated with mental health and poverty involves changing social arrangements and institutions. The WHO has recognised that the public sector has an important role to play in advancing mental health equity.^{cxxix} This review considers the contribution of a number of public services: health, education, employment, social security, advice and the built environment. Although social care is included, it is discussed only briefly due to the lack of systematic or meta-reviews on social care, mental health and poverty. When considering public services' potential impact on poverty and mental health, their contributions as purchasers of goods and services, and as employers, should be considered alongside their provision of public goods in the form of health, social care, education, employment support, social security and advice. These public goods should be available to the whole population, with targeted support for individuals, families and communities in greatest need.^{cxxx}

It is not possible to present an overview of the current state of provision for people who experience mental health problems given the broad scope of public services included in this paper, the paucity of data and research across governments and the UK, and the current stage within the mental health policy development cycle.

The WHO's 'Mental Health Action Plan 2013–2020' provides a set of actions

for member states to advance mental health.

- Service reorganisation and expanded coverage: shifting the location of mental healthcare into communities, including the provision of supported housing and increasing the coverage of evidence-based interventions.
- Integrated and responsive care: integrating and co-ordinating holistic mental ill health prevention, mental health promotion, rehabilitation, care and support that meets mental and physical health needs and that facilitates recovery across general health and social services (including promoting human rights regarding employment, housing and education) through service-user-driven treatment and recovery plans, and the input of families and carers, as appropriate.
- Human resource development: building the knowledge and skills of general and specialised health workers to deliver evidence-based, culturally appropriate and human rights-orientated mental health and social care services across the life course through integrating mental health into professional curricula and training and mentoring in practice.



- Address disparities: proactively identifying and providing appropriate support for groups at particular risk of developing mental health problems who have poor access to services.^{cxxxix}

4.1 Cross-Cutting Themes

Before moving into the specific areas of public service – health, social care, education, employment, social security, advice and planning the built environment – there are a number of cross-cutting themes that can address mental health and poverty in all areas of provision. These themes are MHiAP, stigma, whole-place approaches and service navigators.

4.1.1 Mental Health in All Policies

A logical progression from the evidence around social determinants of mental health is the systematic review of all public policies in order to identify how positive impacts on mental health and poverty can be maximised, and how negative impacts can be minimised and mitigated. The King's Fund has called for core government policy reforms, including social security, to be subject to macro-level health impact assessments (HIAs), and for the delivery of HIAs on local government policies as well.^{24, cxxxix} The European MHiAP Joint Action programme (including UK partners)

produced a framework for MHiAP for all member states at different levels of governance (local, regional and national).^{cxxxix} The All-Party Parliamentary Group on Health in All Policies exemplifies how parliamentarians can champion this agenda.^{cxxxix}

4.1.2 Stigma and Discrimination

The experiences of both poverty and mental health are characterised and impacted by social and self-stigma. Fell and Hewstone reported that people living in poverty show lower levels of confidence in their ability to succeed, and this can have negative mental and physical health consequences, and reduces educational and professional attainment.^{cxxxix} People with different mental health problems may experience different forms of discrimination and stigma, leading to different consequences.^{cxxxix} Stigma is a significant barrier to improving care for people with mental health problems,^{cxxxix} is associated with mental health problems and is linked to limited life chances in a number of areas, including housing and employment,^{cxxxix} social isolation,^{cxxxix} low self-esteem,^{cxl} and delayed help-seeking.^{cxli} The family and friends of people with mental health problems may experience stigma.

The Anti-Stigma Programme – European Network (ASPEN) was a three-year European study led through the Institute

²⁴ The King's Fund notes that there is a range of accessible resources to support the conduct of HIAs, including HIA Gateway (England), Health Impact Assessment in Practice (Scotland), Wales Health Impact Assessment Support Unit, International Health Impact Assessment Consortium (University of Liverpool), and the Spatial Planning and Health Group's 'Steps to Healthy Planning' (2011). The Institute of Public Health in Ireland has developed HIAs across the island.



of Psychiatry at King's College London.²⁵ The identified effective approaches to mental health stigma were addressing mental health stigma generally – for example, by focusing on discrimination and behaviour change (Thornicroft); using protest, education and contact (Corrigan); ensuring targeted messages for different audiences (Byrne); and considering structural reform and power (Link and Phelan).^{cxliii} Interventions that use social contact have delivered the most consistent results in improving perceptions and recollections about individuals with mental health problems and reducing stigma; approaches that combine contact and education lead to reduced stigma.^{cxliii}

The Scottish national mental health anti-stigma campaign, See Me,²⁶ employs rights-based and movement-building approaches within community, workplace, education, and health and

social care settings informed by a series of evidence-based reviews and learnings from the ASPEN programme.^{cxliv} See Me is one of the world's longest running national anti-stigma campaigns.^{cxlv} The Time to Change campaign runs in England and Wales.²⁷ Both are members of the Global Anti-Stigma Alliance.²⁸ A Northern Ireland campaign, Change Your Mind, was launched in March 2016.

4.1.3 Whole-Place Approaches

Health-promoting settings programmes are a well-established and evidenced approach to combining interventions to improve the mental health of whole populations, those at high risk (or in the early stages) of developing mental health problems, and those who are in the process of recovering from a mental health problem.²⁹ Models include healthy cities, health-promoting hospitals, healthy schools, and

²⁵ ASPEN used a mixed-method approach to draw together evidence about anti-stigma depression programmes from cross-sectional surveys and face-to-face interviews with (stigma) scales involving a minimum of 1,100 participants; literature reviews regarding best practice, policy-making and legislation; focus groups with non-governmental organisations and service users; and in-depth interviews with government officials. Twenty-six programmes within 18 EU countries were reviewed. The study findings are presented in the ASPEN Network Toolkit.

²⁶ <https://www.seemescotland.org/>

²⁷ <http://www.time-to-change.org.uk/>

²⁸ <http://www.time-to-change.org.uk/globalalliance>

²⁹ The Healthy Settings movement originated in the WHO's Health for All strategy in 1980. A 'setting' is defined as a place where people actively use and shape the environment, creating and solving problems relating to health. They are usually identified as having physical boundaries, a range of people with defined roles and an organisational infrastructure. Settings or whole-place approaches are an effective and efficient way of reaching everyone who is in the setting to tailor and optimise interventions in real-world contexts where people live, work and play, including mental health services and programmes; to make system-level changes, including to structure, administration and management; and to create synergy between health-protecting and promoting activities within the whole system/place. http://www.who.int/healthy_settings/about/en



healthy communities.^{cxlvi} Whole-place approaches are discussed in the sections 4.4 and 4.5 below, but can be used to develop comprehensive mental health and wellbeing strategies across all public services.

Within sectors associated with high rates of mental health problems, there is a case for developing tailored whole-place approaches. The criminal justice system is one such sector. Up to 90% of prisoners have some form of mental health problem,^{cxlvii} and 10% of male and 30% of female prisoners have previously experienced a psychiatric acute admission to hospital.^{cxlviii} The Corston Report detailed the high levels of psychological disturbance, daily drug use (including illicit drug use) and persistent severe self-mutilation among women in the criminal justice system.^{cxlix} Mental health approaches within prisons need to take account of the specific needs of groups who are over-represented within their populations. BAME populations are over-represented in prison; they represent 10% of the UK population, but 26% of the prison population. People aged 60 and over are the fastest-growing age group within the prison population, and more than 50% have some form of mental health problem often associated with imprisonment.^{cl}

There are opportunities for mental health interventions around prevention, care and recovery across the criminal justice system. These include the provision of liaison and diversion teams for police stations and courts, mental health and wellbeing programmes, and access to NHS-delivered mental healthcare and support. The use of PIEs is an approach that has developed internationally across a range of services – particularly those for people with complex needs – in order to maximise the psychological benefits and mitigate the harms of material and social service environments. Broadly, the intention is for a service to be designed and run with service users’ emotional and psychological needs as the primary focus.^{cli}

Between 2008 and 2015, a range of UK Government, academic, private and third-sector initiatives within homelessness services and the criminal justice system advanced the development of PIEs (referred to as PIPEs within criminal justice).^{30,31} Examples of PIE pilots are provided in the 2012 Good Practice Guidance.^{clii}

The Royal College of Psychiatrists’ Enabling Environments working group clarified the core elements of an enabling environment.

³⁰ PIPEs were piloted in six criminal justice settings by the National Offender Management Service in 2010: three male prisons, two female prisons and two probation-approved services. PIPEs are currently only in prison settings. Within this planned environment, PIPEs support offenders to progress through different stages of an intervention and offender pathways, with awareness of the psychological needs and the effects this might have on the individual (Breedvelt, February 2016).

³¹ The initiatives included pilot programmes, the Good Practice Guide on Complex Trauma (UK Department for Communities and Local Government and National Mental Health Development Unit, 2010), and Good Practice Guidance (Keats et al., 2012)



- The **nature and quality of relationships** between participants or members would be recognised and highly valued.
- The participants share some **measure of responsibility for the environment** as a whole, especially for their own part in it, where all participants – staff, volunteers and service users alike – are equally valued and supported in their particular contributions.
- **Engagement and purposeful** activity is encouraged.
- Decision-making is **transparent**, and both formal and informal leadership roles are acknowledged.
- Power and authority is **clearly accountable** and open to discussion.
- Formal rules and informal expectations of behaviour **are clear** or, if unclear, there is good reason for it.^{cliii}

Although there has been a strong interest in the development of enabling environments, PIEs and PIPEs, and their further evolution into psychosocially informed environments, the evidence base remains promising but under-developed. Further research is needed into the gender and life course sensitivity of PIEs and PIPEs.

4.1.4 Assistance in Navigating Services

For people who are engaged with a range of public services, particularly people with complex needs, the role of

a ‘service navigator’ is a valuable one. This is distinct from the public service ‘key worker’ or ‘care co-ordinator’ roles. During the Mental Health Foundation’s UK public inquiry into the future of mental health services, a case was made for the navigator to have peer experience and be skilled in negotiating the access barriers experienced by particular groups, such as members of BAME and LGBT communities.^{cliv}

The navigator develops a good sense of the needs an individual and/or their family has, as well as the particular barriers they experience in accessing goods and services. Then, the navigator identifies the range and combination of supports required, signposts appropriate information and other resources in a timely manner, provides consistent personalised support, and assists the person in accessing services. These services may include advice and advocacy.

4.2 Health

“There is very little history of a poverty narrative within the NHS to bring together and shape all the levers in its control, and over which it has influence, in order to deliver on poverty. The closest the system has is a narrative on tackling inequalities.”^{clv}

The more affluent and better educated a person is, the greater the health benefits gained from the NHS. Health services need to be developed to ensure that people from lower socio-economic groups and members of socially excluded groups gain equal benefits from public services as higher socio-economic groups.^{clvi}



England, Scotland, Wales and Northern Ireland all have NHS and local authority provision of mental health (and social care) services, as well as delivery by private, voluntary and community sectors, but with significant variation in law, service structure, governance, funding, commissioning and provision. Integration is configured differently within these systems. However, it is a central agenda both between health and other public services, and within the health system itself – horizontally across different services, particularly physical and mental health, and vertically from primary to tertiary care.^{clvii} There is a lack of awareness about the scope and potential to strengthen a focus on mental health and wellbeing within services, and it has been proposed that this should be framed as a quality service improvement issue with the purpose of making every contact count, rather than a separate agenda.^{clviii}

The mental health sector has been described as a set of interrelated services (disaggregated as crisis care, community care, social care and specialist services) for a range of conditions that creates a system of care.^{clix} It is noted that these services operate alongside peer-support and self-management programmes run by people with lived experience, family members and carers. In turn, these mental health services have integral relationships with a broad range of other public services, including physical healthcare, social security and housing. The NICE approves evidence-based interventions and treatments that can be provided by the NHS and other bodies across the life course in particular settings (such as

health services, schools and workplaces) and for particular diagnoses.

Lawton-Smith commented that there is substantial agreement about what mental health services should look like across the UK, summarised by the Mental Health Foundation in the 2013 'Starting Today: Future of Mental Health Services' report of its UK public inquiry as:

“holistic/integrated and multidisciplinary/local/community based/easy to access/early to intervene/recovery based/and co-produced with service users and carers”.^{clx}

The future development of mental health services must address the particular needs of communities and groups that experience health inequalities and persistent systemic difficulties in accessing timely, adequate and appropriate support. BAME communities have poor access to mental health services and experience racialised stereotyping of their mental distress. For example, black African and Caribbean service users experience poor or harsh treatment from primary or secondary mental health services, and detention under the Mental Health Act was 2.2 times higher for black African, 4.2 times higher for black Caribbean, and 6.6 times higher for black other ethnic groups than average.^{clxi}

Although The King's Fund's Mental health under pressure publication is limited to England and mental healthcare provided to those aged 16–65 years, it provides a timely briefing on how the government mandate to realise parity of esteem between mental and physical



health has progressed. It sets the context that 17.6% of this population meets the criteria for one or more common mental health problems, and 0.4% has experienced a psychotic disorder.^{clxii} In 2014/15 there was a 4.9% increase in the number of people in contact with mental health services on the previous year (a total of 1,835,996 people).^{clxiii}

The King's Fund reports that – even with ministerial support, inclusion of parity within the NHS Mandate and the introduction of a rolling programme of access standards for mental healthcare – funding for mental health services has been cut, with 40% of mental health trusts experiencing income reductions in 2013/14 and 2014/15. The national tariff (the fixed standard price for certain NHS services) and planning guidance are two key annual mechanisms by which funding for mental health services can be raised. In 2014/15, Monitor, as sector regulator, reduced the national tariff for mental health and community trusts by 1.6%. Allowing for the additional funding to uplift tariff prices by 0.35% to support the implementation of the access standards,^{clxiv} in practice, there was a 1.25% reduction in the price paid for services despite the requirement in some areas to increase the scope and scale of provision. While the NHSE 2015/16 planning guidance instructed commissioners to increase funding for mental health services in proportion to their annual funding allocation,^{clxv} a survey of 67 clinical commissioning groups (CCGs) found that 51% planned to increase spending by 1–2% in cash terms, 16% planned an increase of less than 1%, and 31% planned an increase of more than 3%.^{clxvi}

Drawing data from a range of sources, The King's Fund found that funding for adults' and older people's mental health services fell for the first time in a decade by 1% to £6.63 billion once inflation was taken into account.^{clxvii} Between 2012/13 and 2013/14, 44.8% of mental health trusts had a reduction in income (this proportion fell to 38.6% in 2014/15); however, this data does not take the costs of inflation into consideration. A freedom of information request found that 44 NHS mental health providers experienced a 2.36% reduction in real-terms funding between 2011/12 and 2013/14.^{clxviii} There appear to be trends in funding moving between different types of provision. This is illustrated by reductions in crisis resolution and home treatment (a real-terms reduction of 1.7% between 2011/12 and 2013/14)^{clxix} and community mental health teams (a 0.3% real-terms reduction across 36 NHS mental health providers between 2011/12 and 2013/14), and increased spending on out-of-area placements (an increase, according to data from 23 trusts, from £21.1 million in 2011/12 to £35.5 million in 2013/14).^{clxx}

The complexity and effort of accessing funding information that takes inflation into consideration indicates the need for transparent, consistent and credible reporting of funding for the mental health system of care, across all types of providers, that is disaggregated into its interrelated sets of services (including health and social care) and drilled down to health and local government areas. Funding for prevention needs to be disaggregated across these systems.

The quality of care funded in England is poor: only 14% of service users reported receiving adequate care in a crisis, and reports of poor community mental healthcare have increased.^{clxxi} Inadequate levels of community mental health support have resulted in bed occupancy frequently being above recommended levels, and high numbers of costly and detrimental out-of-area placements (among 37 NHS mental health providers there was an increase of 23.1% in out-of-area placements: 4,447 people).^{clxxii} Further, 30% of delayed discharges from mental health hospital units were associated with the absence of good-quality, well-resourced community teams.^{clxxiii} Detentions under the Mental Health Act increased by 9.8% in 2014/15 compared to 2013/14,^{clxxiv} and a Royal College of Psychiatrists survey indicates that detention is being used as a means by which to access care.^{clxxv}

Worryingly, mental health trusts are initiating large-scale transformation programmes around service, workforce and corporate infrastructure to deliver cost reductions, reportedly reconfiguring care pathways and models to use approaches with limited evidence, or planned evaluation. The King's Fund makes a timely call for stable funding and no more cuts to budgets, and the use of evidence to improve practice and reduce variations in the quality and access to care. The NHSE-commissioned Mental Health Taskforce report, 'The Five Year Forward View for Mental Health', outlined a costed blueprint to achieve parity, providing a mental health agenda that engages all the health (so-called) arms-length bodies to complement the NHSE Five Year Forward View (2015–2020).

This section considers (i) how the NHS as a whole system can maximise its impact on poverty, (ii) how integrated, whole-system approaches can address the mental health of children and young people from low-income families, (iii) how innovative approaches such as social prescribing can support people on low incomes to access social, cultural and leisure activities that are beneficial to their mental health, and (iv) the importance of mental health provision in the criminal justice system.

The JRF-commissioned paper on poverty and the NHS considered how the NHS could be incentivised and assisted to adapt, mitigate, reduce and prevent poverty, and identified what the NHS could do more of to make use of its economic power, scale and reach in the population. Recognising that people with mental health problems are at greater risk of poverty, and the high rates of absenteeism, premature retirement and long-term unemployment among people with common mental health problems, The King's Fund commented that it was particularly important for the NHS to meet and adapt to these people's needs. It identified three areas for service action:

- access to evidence-based mental health interventions, particularly in primary care;
- appropriate pathways of access to secondary care for BAME communities; and
- access to appropriate physical healthcare.



The NHS needs to develop a clear, evidence-based narrative centred on a social model of health that explains the ways in which the NHS can contribute to tackling poverty. This would lay out how the NHS can mitigate, reduce and prevent poverty through service provision, public health measures (both health promotion and ill health prevention), and the use of its economic power through procurement and employment. Senior managers and clinical leaders should be aware of this narrative and encouraged to embed it in their services.^{clxxvi}

The most recent policy development in the UK addressing children's and young people's mental health was the NHSE commissioned Mental Health Taskforce's report 'Future in Mind'.³² 'The Five Year Forward View for Mental Health' recommends the full implementation of the recommendations of 'Future in Mind'. 'Future in Mind' outlined a number of key thematic areas for action across the whole system of the NHS, public health, local authorities (responsible for education), social care and youth justice sectors:

- promoting resilience, prevention and early intervention;
- improving access to effective support – a system without tiers;
- care for the most vulnerable;

- accountability and transparency; and
- developing the workforce.

Children from low-income families are specifically mentioned within the chapter on vulnerable children and young people, and the following approach was proposed:

- development of a flexible, integrated system to meet the needs of vulnerable children and young people;
- development of trauma-focused care (including for children who had witnessed or experienced violence, abuse and/or severe neglect);
- delivery of care to vulnerable groups through specific models of provision;
- establishment of a consultation and liaison service that would advise, troubleshoot, and provide formal consultation and care planning or assessment and intervention;
- embedding of mental health practitioners within teams responsible for groups of vulnerable children and young people, scaling up the MAC-UK Integrate Model;³³ and
- reducing of health inequalities and promotion of equality.

³² The Taskforce was established in September 2014 to "consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided".

This focus on excluded and vulnerable children and young people is echoed in NHS England’s ‘The Five Year Forward View for Mental Health’ report, with particular reference to children who are looked after, care leavers, victims of abuse or exploitation, those with disabilities and long-term conditions, or who are within the criminal justice system. It proposes that the Department of Health and Education should establish an expert group to examine their complex needs and how these should best be met, including through the provision of personalised budgets. Following the prime minister’s announcement of a significant expansion of parenting programmes, the NHSE commissioned Mental Health Taskforce proposes that the government should integrate the scaling of evidence-based programmes with local transformation plans for children’s and young people’s mental health services.

‘Future in Mind’ specified that services within current funding should:

- proactively follow up with children, young people and families who did not attend appointments, find out why, and offer additional support;
- develop bespoke care pathways across education, health, social care and young justice, incorporating evidence-based interventions;
- develop multi-agency teams with flexible acceptable criteria based on presenting problems and the level of family or professional concern – and not only on clinical diagnosis;

- include sensitive inquiries about neglect, violence and abuse in mental health assessments, and do this routinely for young people aged over 16 years;
- ensure that multi-agency safeguarding hubs have active representation by mental health services for children and young people; and
- strengthen the lead professional approach to co-ordination of services for very vulnerable young people with multiple and complex needs in order to prevent them from falling between services.

With additional government funding, recommended service developments were:

- developing staff skills across sectors around trauma and evidence-based interventions;
- piloting the rollout of teams specialising in working with vulnerable children and young people; and
- embedding mental health practitioners in teams working with vulnerable children and young people – for example, those in gangs, who are homeless, who have been or are being sexually exploited, looked-after children and those in contact with youth justice.^{clxxvii}

³³ www.mac-uk.org



Given the historical underinvestment in mental health provision at primary, secondary and tertiary levels, the main agendas within healthcare include:

- securing equitable investment in mental health services;
- agreeing mandatory waiting times for NICE-approved mental health interventions across the life course; and
- ensuring that populations with higher risk and prevalence of mental health problems have access to a choice of appropriate supports in a timely and flexible manner.

This includes removing hidden costs of mental health service use, such as having to take time off work or pay for child- or adult care in order to attend inflexible appointments, transport costs, and prescription charges (where applicable).

The principle of whole-system approaches to preventing, treating and supporting recovery from mental health problems is a recurrent theme within health policy and provision. Social prescribing is an example of an effective intervention that provides access to appropriate social, cultural and leisure activities that benefit mental health. It has been defined as:

“a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with,

for example, employment, benefits, housing, debt, legal advice, or parenting problems.”^{clxxviii}

Usually delivered through primary care, social prescribing has been found to provide emotional, cognitive and social benefits for people with mild to moderate mental health problems, and reduces social exclusion experienced by people with enduring mental health problems, as well as vulnerable and disadvantaged populations.

^{clxxix} It provides an option for health professionals such as GPs to promote mental health and wellbeing, and respond at an early stage to a person who is at risk of developing a mental health problem or expressing mental distress. Social prescribing can be an alternative to medication for the 60% of GPs who said that they would prescribe antidepressants less frequently if other options were available to them.^{clxxx}

People with complex needs may access a range of specialist services for mental health and/or substance misuse, including in the criminal justice system. In criminal justice settings, a range of mental health services needs to be provided. Liaison and diversion services reduce the number of people with mental health problems in the criminal justice system. Preventative and early-intervention mental health programmes for young people and adults within the criminal justice system protect them from developing (or worsening) mental health problems. Accessible, appropriate and good-quality mental health supports to manage and recover their mental health should be delivered for people in all parts of the criminal

justice system, including young offender institutions, prisons, and secure care, and in community programmes. There is a relationship between involvement in the criminal justice system, mental health and socio-economic status intersected with other social identities, including gender, race and ethnicity. The Bradley Commission Report and its five-year review in 2009 continue to be valuable and relevant documents in setting out a policy and provision agenda,^{clxxxix} and the Centre for Mental Health has outlined public mental health approaches to the criminal justice system to promote and protect offenders' mental health and wellbeing.^{clxxxii}

4.2.1 Co-Morbidity

People with mental health problems experience significant physical health inequalities due to the early onset of mental health problems, the effects of some psychiatric interventions, and the high levels of risky health behaviours among people with a diagnosis of serious mental health problems, such as smoking, alcohol consumption, substance misuse and overeating (sometimes as ways of managing the mental distress they are experiencing). Those with mental health problems have greater risk (and higher rates), of heart disease, diabetes, respiratory disease, cancer and infections. Physical health conditions are often missed because of 'diagnostic overshadowing', whereby symptoms are ascribed to the individual's mental health problem or treatment and physical causes are not considered or investigated; this limits early identification and treatment of physical health conditions among people

with mental health problems.^{clxxxiii} The poor rates of routine health monitoring for this group heighten the risk of physical health conditions being missed or misdiagnosed. Together, these service deficits result in lower life expectancy, with people with mental health problems dying up to 25 years younger than the general population.^{clxxxiv} In order to reduce these rates of co-morbidity and premature mortality, the health service needs to develop integrated care pathways that deliver prevention, early intervention and high-quality, non-stigmatised care for people with mental health problems.^{clxxxv}

Another perspective on co- or multiple morbidities is that many people with long-term physical health problems (the most frequent users of healthcare services) commonly also have mental health problems, such as depression and anxiety (or dementia, in the case of older people). It is thought that the causal relationship between physical and mental co-morbidities is two way, and operates through complex mechanisms combining biological, psychosocial, environmental and behavioural factors.^{clxxxvi} More than 15 million people in England alone (30% of the population) have one or more long-term conditions. People with long-term conditions are two to three times more likely to experience mental health problems than the general population, with a particularly strong evidence base for a close association between mental health and cardiovascular disease, diabetes, chronic obstructive pulmonary disease and musculoskeletal conditions. According to The King's Fund and Centre for Mental Health, a conservative estimate is that



at least 30% of all people with a long-term condition also have a mental health problem.^{clxxxvii, clxxxviii}

- There is a three-way interaction between mental health, physical health and social conditions. Socio-economic deprivation exacerbates the relationship between having multiple long-term conditions and experiencing psychological distress as follows:
- a larger proportion of people in poorer areas have multiple long-term conditions; and
- the effect of multiple morbidity on mental health is stronger when deprivation is present.^{clxxxix}
- A number of studies have found higher rates of co-morbid mental health problems among women.^{cx}

The impacts of physical and mental co-morbidity for the service user include significantly poorer clinical outcomes and prognosis, adverse health behaviours, poorer self-care and reduced quality of life. For the health and social care system, the impacts include increased service use (such as hospital admissions and readmissions, and GP consultations) and higher health service costs (such as outpatient clinic attendance, pharmaceutical use and inpatient stays). There are also wider economic costs, as people with long-term conditions and mental health needs are less likely to be employed or, if in work, are less productive and take more sickness absence. Co-morbidities reduce economic output due to their impact on premature mortality and

the increased likelihood of their family members providing informal care and support, involving time off work.^{cxci} (This is discussed in section 6.)

The institutional and professional separation of mental and physical healthcare – particularly in countries with non-integrated health and social care (like England) – increasing sub-specialism and the decline in generalisation^{cxcii} have all contributed to fragmented approaches and missed opportunities to improve co-ordination, oversight, quality and efficiency in support for people with multiple needs.

4.3 Social Care

Social care encompasses social work, residential care, domiciliary care, day centres and personal assistants.^{cxci} Provided to individuals and families across the whole of the life course, social care can address a wide range of support needs – for example, due to disability (including mental health problems). In the context of mental health, the Social Care Institute for Excellence describes recovery and personalisation as core approaches, and outlines the care pathway of holistic assessment leading to a care plan, including a crisis and contingency plan led and organised by a care co-ordinator.^{cxci}

Many of the interventions across the life course that are described in this paper fall within this broad definition of social care. The social care ethos draws on social science analysis of social structures, systems and relationships, which include the dynamics of poverty, disadvantage, inequality, and exclusion.

Social care services are fundamentally important in supporting people with mental health problems, but access to social care has significantly reduced in England.^{cxcv} Since 2009/10, there has been a 25.5% reduction in the number of people receiving social care for mental health problems, with no evidence of a reduction in the need for such support.^{cxcvi} NHS trusts have identified local authority budget cuts as having a negative impact on services.^{cxcvii} People with mental health problems living in poverty are reliant on publicly funded social care. Social care plays a critical role in supporting people who experience mental health problems to recover, live independently in the community, and gain and retain employment. However, some seldom-heard groups experience mainstream social care provision as disempowering and inaccessible.^{cxcviii}

Social care professionals are also centrally involved in the implementation of mental health and mental capacity legislation. Reports of the undermining of mental health social work are concerning; these include shortages of social workers in mental health services,^{cxci} limited mental health content within social work training, social workers feeling devalued and de-professionalised,^{cc} and high levels of emotional exhaustion^{cci} and work-related stress^{ccii} within the profession.

It is striking that the search undertaken for this review did not identify policy and research texts that addressed mental health, poverty and social care. Therefore, the points made in this section are brief and refer back to cross-

cutting issues for all public services. This lack of national and international material suggests that the Social Care Institute for Excellence, the NICE, and training and regulatory bodies across the UK could valuably undertake evidence reviews to inform the development of policy, practice and provision, applying core principles of social care. These are personalisation, recovery, rights-based approaches, and equity to the intersection of mental health and poverty.

From a mental health perspective, there has been a historical under-investment in social care for people with mental health problems. In the current context of funding cuts and service retrenchment, progressively higher thresholds for social care entitlement lead to mental health needs not being met. While urgent and complex social care arrangement may meet these thresholds, the importance of low-level and ongoing social care support – including supporting people to get out of bed, undertake self-care, go out, and participate in and contribute to their community – may not be well-understood. However, reduction or withdrawal of such a service will have a significant impact on an individual's quality of life, risk deterioration of their mental health, stall or reverse recovery and could increase social isolation.

4.4 Education

Together, the education and health sectors have central roles in promoting mental health and wellbeing, preventing mental health problems from developing and escalating, and supporting recovery.



The 'Future in Mind' report outlines the necessity of whole-system, integrated approaches to children's and young people's mental health (discussed in section 4.2).

The Marmot Review found that a central plank of public policy should be to enable all children, young people and adults to maximise their capabilities and have control over their lives. The priority objectives for achieving this were reducing the social gradient in skills and qualifications; ensuring that schools, families and communities work in partnership to reduce the gradient in health, wellbeing and resilience of children and young people; and improving the access and use of quality lifelong learning across the social gradient.^{cciii}

The education sector at primary, secondary and tertiary levels can make substantial contributions to addressing mental health and poverty by:

- providing opportunities for education attainment across the life course, enhancing prospects for securing good work;
- developing knowledge, skills and attributes for mental health and wellbeing of all members of the educational community (staff, students, family members and the wider community in which an institution is based);
- providing access to mental health supports – for example, school nurses^{cciv} and health visitors,^{ccv} psychological therapies and peer support, and parenting programmes;

and

- providing access to materials and relational resources associated with mental health and wellbeing (such as a physically^{ccvi} and psychologically safe space, and consistent positive relationships with adults and peers).

England's 'Future in Mind' report by the Children and Young People's Mental Health Taskforce recommended the use of the whole-school approach. The King's Fund's review of public health interventions included the following targeted interventions within the whole-school approach for children and young people who present with mental health or behavioural problems:

- interventions to reduce drop-out and exclusion rates, focusing on raising the educational standards of the most vulnerable children and young people;^{ccvii}
- support and expect schools to reduce bullying through implementing evidence-based guidance;^{ccviii}
- support and expect schools to reduce the prevalence and impact of conduct disorders through programmes that have been shown to improve students' social and emotional skills, attitudes, behaviours and attainment;^{ccix}
- support schools to develop children's life skills, such as problem solving, and build self-esteem and resilience to peer and media pressure;^{ccx}

- develop targeted wellness services towards clusters of children identified as being at high risk of multiple poor behaviours, rather than providing single-issue services only. Schools should be encouraged to foster a strong sense of culture and belonging, and connectedness with teachers,^{ccxi} and
- support the use of resources such as the Department for Education's Healthy Schools Toolkit.^{ccxii}
- staff development to support their own wellbeing and that of students;
- identifying need and monitoring impact of interventions;
- working with parents/carers; and
- targeted support and appropriate referral.

4.4.1 Whole-School and College Approach

One way to encapsulate many of these benefits is to promote a whole-place approach. The health-promoting school,^{ccxiii} college and university are well-established models, and there is a strong evidence base and body of resources to support implementation.

The whole-school and college approach to promoting emotional health and wellbeing in schools is founded on eight principles:^{ccxiv}

- leadership and management that supports and champions efforts to promote emotional health and wellbeing;
- an ethos and environment that promotes respect and values diversity;
- curriculum teaching and learning to promote resilience and support social and emotional learning;
- enabling student voice to influence decisions;

Integration with other services within and beyond education is an important component of the success of the whole-school approach. The promotion of students' mental health and wellbeing is a shared responsibility, as demonstrated in the framework of recommended universal and progressive services for 5–19 year olds in England's Healthy Child Programme.^{ccxv}

In its review of public health interventions for local authorities, The King's Fund evidenced the value of whole-school approaches and made particular recommendations around fostering a strong culture of belonging and connection with teachers, and running programmes to develop problem-solving life skills, resilience and self-esteem. Alongside these universal interventions, it recommended targeted action around bullying, conduct disorders, reducing school dropout and exclusion, and focusing on raising educational attainment among vulnerable children and young people.^{ccxvi}

Adopting a whole-school approach involves action at systemic, universal and targeted levels.



- Systemic – changes to school ethos, teacher education, working with parents, community engagement and co-ordination with other support agencies.
- Universal for all pupils – curriculum-based teaching of skills for social problem solving, social awareness and emotional literacy, delivered through active classroom methodologies such as games, simulations and group work.
- Targeted – focusing on children with particular issues, such as behavioural problems or other signs of mental health problems.^{ccxvii}

The Children and Young People’s Mental Health Coalition, England, produced a briefing^{ccxviii} with PHE that described mental health and resilience^{ccxix} and the contribution that a whole-school approach can make to promoting mental health and wellbeing, including building resilience, linked to both Ofsted’s inspection framework,^{ccxx} the Department of Education England’s statutory guidance³⁴ and advice,³⁵ and NICE guidance.^{ccxxi, ccxxii, ccxxiii} The briefing lists resources that include (Westminster) Government guidance and advice, evidence reports,^{ccxxiv} data sources (England), curriculum resources, training, organisations, and examples of approaches (programmes for children and parents, counselling and helplines).

4.4.2 Children and Young People Who Are Out of Education

Children with mental health problems experience disrupted education. According to the last study on the mental health of children and young people (in England, Wales and Scotland in 2004), children with mental health problems are more likely to have time off school: 17% of those with emotional disorders, 14% of those with conduct disorders and 11% of those with hyperkinetic disorders had been away from school for over 15 days in the previous term; these rates compare with 4% of other children. As many as one in three children with a conduct disorder had been excluded from school and nearly a quarter had been excluded more than once.^{ccxxv}

Over two-fifths (44%) of children with an emotional disorder were behind in their intellectual development, with 23% being two or more years behind (compared with 24% and 9% of other children). Children with an emotional disorder were twice as likely as other children to have special educational needs (35% compared to 16%). One in five children was diagnosed with more than one of the main categories of mental disorder, 72% of which were boys. Sixty-three per cent were behind with their schooling and 40% were more than a year behind.

Although education may be delivered primarily through formal education

³⁴ on safeguarding, supporting pupils at school with medical conditions, and promoting the health and wellbeing of looked-after children

³⁵ on mental health and behaviour, and counselling in schools

settings such as schools and third-level institutions, education makes an important contribution when delivered in community, health, social care, and criminal justice spaces. Mental health and wellbeing curricula, programmes and supports need to be provided within these places too. Children and young people who are not consistently in formal education often belong to groups that have higher prevalence of mental health problems, including homeless children, young offenders, members of the Gypsy and Traveller communities, looked-after children and refugee and asylum-seeking children. Therefore, public services need to develop innovative ways for reaching these children too.

A systematic review of literature about child and family homelessness recognised the importance of screening for psychosocial stressors at routine child health appointments and referring for support; minimising the harm to mental health while families are in temporary accommodation (with actions akin to the PIEs approach discussed in section 4.1.4); and ensuring ongoing support to address psychological harm caused by the experience of homelessness when a family's situation stabilises. Appropriate case management support for homeless families could address rehousing, health and related services, job training and placement,

entitlements, and legal assistance.^{ccxxvi} A systematic review of case management approaches with individuals who experienced homelessness found that different approaches delivered variable impacts.^{36, ccxxvii}

4.4.3 Lifelong Learning

Individual and familial mental health problems and poverty can disrupt education and training, and people can therefore miss out on opportunities for educational and employment attainment. Young people can fall between the gaps in services as they transition between adolescent and adult health, and education, training and employment provision. They can be assisted to continue their development and recovery through integrated mental health, education, employment and other services, including IPS (described in the section 4.5 below), and the 'Clubhouse International Model'³⁷ (adapted to meet their needs).^{ccxxviii} Programmes to engage people throughout their life course in education and training should include mental health and wellbeing components that promote mental health knowledge and skills, resilience, self-efficacy, self-management, and recovery. The National Equality Panel recommends commitments to lifelong learning and training that extend beyond the already well-qualified.^{ccxxix}

³⁶ Standard case management was found to improve housing stability, reduce substance use and remove substance employment barriers for substance users. Assertive community treatment improved housing stability and was cost-effective for people with mental health problems, and people with a dual-diagnosis of mental ill health and substance use. Critical time intervention was a promising intervention for housing, substance use and mental health problems, and was cost-effective for people with mental health problems. There was little evidence for the effectiveness of Intensive case management.



4.5 Employment

Discussions about mental health at work in policy documents can be framed around costs to the economy, costs to the public purse and the importance of good work for mental health.

Firstly, in terms of costs to the economy, the costs of mental health problems to UK workplaces are estimated to be £26 billion across the economy, or £1,000 per employee per year.^{ccxxx}

The main costs are from presenteeism (when people are at work, but are underperforming), with sickness absence accounting for just under a third.^{ccxxxi} However, many employers are unaware of how common mental health problems are, the impact these have on their business, and how employees with mental health problems can be supported through simple, reasonable accommodations. This lack of awareness can mean that employers hold negative views of how a person with a mental health problem could perform at work.

^{ccxxxii}

Secondly, in terms of the costs to the public purse of people with mental health problems being unemployed and in receipt of social security, health, social care and housing (and not contributing through taxation), a 2014 study by the OECD costed mental health problems at 4.5% of GDP (£70 billion) each year due to productivity losses, benefit payments

and costs to the NHS. It reported that mental health was the cause of 40% of new disability benefit claims each year (representing 1% of the working-age population, and the highest of the 34 nations reviewed); it also noted that the risk of poverty for people with mental health problems was highest in the UK among the ten OECD countries in a comparative study.^{ccxxxiii}

Thirdly, good work for mental health – as both a protective factor against developing mental health problems and also as a valuable route to recovery for people who have experienced mental ill health – is important.^{ccxxxiv}

4.5.1 *Getting on in Work: Supporting People to Remain in Work and to Progress*

Better mental health and wellbeing among employees has been associated with higher staff retention, improved productivity and performance, higher levels of collaboration, and reduced sickness and absenteeism.^{ccxxxv} Whole-workplace approaches to mental health create a psychosocially informed environment in which workers' mental health and wellbeing is promoted and protected.^{ccxxxvi} They incorporate a strong anti-stigma aspect so that talking about and dealing with mental health positively is part of the workplace's culture.

³⁷ A clubhouse is a community of people who are working together to achieve a common goal: recovery from mental illness. Clubhouses are local community centres that provide members with opportunities to build long-term relationships that, in turn, support them in obtaining employment, education and housing. They provide a restorative environment for people whose lives have been severely disrupted because of their mental illness, and who need the support of others who are in recovery and believe that mental illness is treatable. <http://www.iccd.org/whatis.html>



The majority of people with mental health problems are already in work. They may have had a pre-existing problem before getting a job or develop a problem while they are in work. A whole-workplace approach to mental health and wellbeing should incorporate initiatives, policies, and management practices that create a mentally healthy workplace culture that:

- promotes and protects the mental health and wellbeing of all employees;
- intervenes early when an employee is at risk or displaying signs of stress or distress;
- enables employees to remain in work, or return in a timely and supported manner (including referral to the Fit for Work programme);
- uses existing government programmes, such as Access to Work, to support people with mental health problems both in work or seeking work; and
- supports schemes, such as IPS, to help people with existing mental health problems in finding employment.

Examples of whole-workplace approaches are found within Business in the Community's WorkWell initiative, which has a number of national

companies³⁸ as founding members of its Mental Health Champions Group. The initiative outlines the business case for addressing mental health in the workplace. The WorkWell Model details a range of actions that businesses can take to change organisational culture around mental health through: providing leadership from a boardroom level; ending the silence around mental health by running mental health events and programmes; training line managers in mental health and proactively supporting staff who are under pressure or experiencing mental health problems – for example, by making reasonable accommodations, investing in employee assistance programmes and workplace counselling; signing up to anti-stigma campaigns; and publicly reporting on employee engagement and wellbeing using the WorkWell Model as a framework. WorkWell provides case studies of companies³⁹ that have adopted their approach.^{ccxxxvii}

Employers can do a lot to support people to remain in work and to progress in their careers by:

- providing a supportive environment so that workers feel comfortable and safe to disclose their condition;
- having trained line managers that can engage appropriately and effectively, using best-practice procedures to make reasonable accommodations;

³⁸ American Express, BaxterStorey, BT, Bupa, Friends Life, Mars, National Grid, Procter & Gamble, Right Management, Royal Bank of Scotland and Santander



- offering occupational health support or employee assistance in order for the worker to remain in work; and
- proactively supporting return to work so that the individual does not drop out of employment.

There is a wealth of resources and initiatives jointly developed by mental health organisations, public bodies and businesses for all sizes of workplace (although more needs to be done around SMEs – particularly micro- and small enterprises).

The government's Fit for Work programme was rolled out across the UK from 2015.^{ccxxxviii} This will provide a free Fit for Work occupational health assessment for employees who have been off sick for four weeks, as well as advice to employers, employees and GPs.

4.5.2 Moving into Work: Supporting People to Enter the Labour Market

Active labour market programmes (ALMPs) are used to increase employability and reduce the risk of unemployment. ALMP interventions include job search assistance, training, and wage and employment subsidies. Research into the effectiveness of ALMPs almost exclusively focuses on economic outcomes (earnings, re-employment opportunities and cost-effectiveness), and there is little evaluation evidence about how these policies and interventions deliver health outcomes and affect target

groups, health and wellbeing. A study published by the Scottish Government found that disadvantages in the labour market are associated with negative health outcomes. However, there is limited evidence regarding the reversibility of disadvantage through policy interventions, and some studies suggest that it is unrealistic to expect a quick reversal of accumulated health damage from poverty due to an improvement in an individual's economic or psychosocial situation. A sustained and significant improvement in material and psychosocial health determinants will probably be necessary for reducing health inequalities, particularly for the most disadvantaged and those worst affected by the recession.^{ccxxxix}

Work is very important for people with mental health problems. It provides income, social status, a sense of achievement and a means of structuring one's time. Participating in work for people with poor mental health has a therapeutic value, as well as indicating a successful outcome.^{ccxli} People with mental health problems see work as a means for helping them recover an ordinary life.^{ccxli}

But, even where proven interventions are available, there are many barriers that prevent people with mental health problems from taking up work. These barriers include stigma and discrimination, poorly structured social welfare systems, low expectations, fear of failure, lack of life skills, and

³⁹ Deloitte, Procter & Gamble, National Grid and Mars



employers' lack of knowledge in dealing with mental health problems.^{ccxlii} Some people who have experienced stigma and discrimination at work stop looking for a job because they anticipate further incidents.^{ccxlili}

Absence from work impacts economic security and social connectedness. The weakening of economic and social ties may erode self-confidence and self-esteem in people with mental health problems, which exacerbates their vulnerability to further periods of ill health. People may become trapped in a cycle of exclusion that leads to despair and hopelessness outside the mainstream of economic and social life.^{ccxliv}

For people with mental health problems who find it hard to sustain ongoing employment (perhaps because of the lack of specialist support to help them gain employment, or reasonable accommodations during periods of fluctuating ill health to retain employment), there need to be other approaches for enabling and recognising the contributions that they make (for example, through volunteering) so that they can live with dignity and respect.

People with severe and enduring mental health problems have the lowest employment rate of all disability groups at less than 10%, but there is strong research about supported employment for this group.^{ccxlv} Placing individuals in open employment and providing them

with ongoing support are generally more successful in helping people find competitive employment than pre-work training; in addition, place and train models are more cost-effective than vocational rehabilitation approaches.

^{ccxlvii} Developed in the US in the 1990s, IPS is evidenced to be the most effective approach to supporting this group to get into employment, and service user stories illustrate the experience⁴⁰. Further, IPS can be successfully adapted to support people with drug or alcohol addictions.^{ccxlviii, ccxlix}

1. IPS services have to adhere to eight principles.
2. Competitive employment is the primary goal.
3. Everyone who wants it is eligible for employment support.
4. Job search is in line with individual preferences and strengths.
5. Job search is rapid – it begins within four weeks.
6. Employment specialists and clinical teams work and are located together.
7. Support is time-unlimited and individualised to both the employee and the employer.
8. Welfare benefits advice and information is available.
9. Jobs are developed with local employers.^{cci}

This personalised approach to supporting people to get into work

⁴⁰ <http://www.centreformentalhealth.org.uk/individual-placement-and-support>



is fully integrated with mental health support services. All referrals are from people who are already receiving mental health support while they are searching for employment and they continue to have that support once they are in employment. Referral is voluntary. IPS has developed the evidence base around the importance of co-locating employment support with mental health services, and of not mandating or coercing people with mental health problems into seeking or engaging in employment. This has informed the UK Mental Health Welfare Reform Group's (MHWRG's) proposals on the fundamental reform of the Work Programme (see section 4.6).

4.5.3 Self-Employment and Entrepreneurship

SMEs made up 99.3% of the private sector in 2014, and accounted for just under half (48%) of UK private sector employment. The Federation of Small Businesses has found that 95% of those moving from economic inactivity into employment between 2008 and 2011 found work in SMEs.^{ccli} Entrepreneurship programmes can positively impact young people's economic and psychosocial functioning and result in healthier decision-making, but this needs to be further tested using integrated health and microenterprise models.^{cclii} Self-employment and entrepreneurship have the advantages of flexibility in work hours and location, and allow individuals to capitalise on their unique creativity, innovate, and pursue their talents.^{ccliii}

The mental health and wellbeing of owner-managers as well as employees

is critical to the sustainability of small businesses, yet this sector is least likely to have access to occupational health or employee assistance support; in addition, among owner-managers, there are particular pressures to keep working even when they are unwell.^{ccliv}

4.6 Social Security

Social security is a central plank of social protection, defined as:

"policies and programmes designed to prevent, manage, and overcome situations that adversely affect the well-being of individuals and populations".^{cclv}

In anticipation of the devolution of additional social security powers through the Scotland Bill 2015–2016, the Scottish Government published a report on its public dialogue on the future of social security, distilled into a set of principles⁴¹ and key messages around fairness, dignity and respect; universality and take-up; and service design, which will ground a vision paper and future social security legislation.

The calculation of Minimum Income for Healthy Living includes the level of income needed for adequate nutrition, physical activity, housing, social interactions, transport, medical care and hygiene.^{cclvi} The social security system recognises that having a disability, including a psychosocial disability, incurs additional costs paid through the Disability Living Allowance/ Personal Independence Payment. Having ratified the UNCRPD in 2009, the UK Government has committed to progressively realising the human right



of people with mental health problems to an adequate standard of living and social protection.

The welfare reform policy agenda has marked detrimental impacts, both on disabled claimants – including those with mental health problems – and the mental health and wellbeing of claimants (Mental Welfare Commission for Scotland, 2013). Claimants find it distressing, inaccurate, unsupportive and counterproductive with regards to engaging them in work. The Scottish Parliament’s Welfare Reform Committee has published a series of reports on the impact of welfare reform in Scotland, which have repeatedly highlighted the disproportionate and cumulative impacts on disabled claimants who are affected by several different elements of the reforms, deprived communities and women.^{cclvii}

The public stigmatisation of disabled claimants is considered to have weakened social solidarity for people with mental health problems, leading to their feeling silenced, ashamed and fearful, and reluctant to seek advice and support (UK MHWRG). The implementation of the replacement of the Incapacity Benefit with the Employment and Support Allowance (ESA) using the Work Capability Assessment (WCA) has been notoriously

damaging for the mental health of claimants and has raised significant concern about the operation of welfare reform among claimants, the voluntary sector organisations working with them, professional bodies and parliamentarians. The UK MHWRG has called for a fundamental reform of the new social security system, and an integrated assessment and support system across social security, employment, and health and social care.

Although social security policy is the responsibility of the Westminster Government, the devolved administrations have had a range of responses to its implementation – including the introduction of mitigating measures and the establishment of a Welfare Reform Committee by the Scottish Parliament, and a halting of the Welfare Reform Bill in the Northern Ireland Assembly.

The Mental Welfare Commission for Scotland (MWCS) undertook an investigation into a death by suicide following a WCA of a female claimant who had long-standing mental health problems and was using mental health services.^{cclviii} The investigation’s methodology included a survey of psychiatrists in Scotland in June 2013 about the effect of benefit changes

⁴¹ Dignity and respect; rights-based; aspirational; person-centred; social investment; adequacy; simple (clear point of access, transparent and accountable) but complex (to meet diversity of needs); choice; accessibility; universal welfare system; flexible, responsive and sensitive; common sense; trusted/honest; preventative; joined up; a system for everyone – not based on ‘them’ and ‘us’; clear outcomes; and tackling poverty and inequality (2013, pp. 10–12).

⁴² The Mental Health Foundation, Mind/Mind Cymru, Rethink, the Centre for Mental Health, the Scottish Association for Mental Health, the Northern Ireland Association for Mental Health and the Royal College of Psychiatrists

on their patients; the survey response rate was 70 out of 320 general adult psychiatry consultants in Scotland, including 56 completed by responsible medical officers (RMOs) whose patients had undergone a WCA. The MWCS reported that 75% of RMOs had not been asked for their opinion at any point in the WCA process by the Department for Work and Pensions (DWP) or Atos; 95% had been asked by patients to provide medical evidence at some point, with 73% being asked as part of the appeal process against the DWP's decision. Asked if any of their patients had been distressed by the WCA process, 96% of RMOs responded "yes".

The UK MHWRG (whose membership includes the main mental health organisations in England, Scotland, Wales and Northern Ireland)⁴² uses the term 'displaced expenditure' to describe the costs of welfare reform implementation to health and social services. This is illustrated in the MWCS report, which stated that the overall theme of the survey was patients' distress and the consequent demands on mental health services. The MWCS asked RMOs about patient experiences following the WCA to which the assessment process or outcome contributed (in the RMO's opinion). Psychiatrists reported additional demands on their services due to the ways in which the WCA had distressed and destabilised clients (increased frequency of appointments, changes to medication, and referral for additional support, including intensive home treatment), increased admissions to hospital (including detention), and increased time involved in mental health professionals attending WCAs in order

to provide support. Forty per cent of RMOs had at least one patient who self-harmed after the WCA. Thirteen per cent reported that a patient had attempted suicide, and 4% (two RMOs) stated that a patient had taken his/her own life. Thirty-five per cent said that at least one of their patients had been admitted to hospital as a consequence of the WCA, and 4% reported a patient being detained under the Mental Health (Care and Treatment) (Scotland) Act 2003.

The quality of the WCA experience reported by psychiatrists to the MWCS mirrors issues raised by the UK MHWRG in multiple policy submissions to the Harrington and Litchfield Independent reviews of WCA: insensitive assessors without the requisite knowledge or skills around mental health problems; distressing and demeaning experiences that left claimants feeling stigmatised and victimised; inconsistencies between what had been said by claimants in a WCA and what was reported by the assessor; and the worsening of mental health symptoms – particularly anxiety and depression – as well as occurrence of thoughts of self-harm.

The MWCS report, the body of policy work undertaken by the UK MHWRG and the Scottish Government's public engagement around social security have been synthesised into a number of recommendations around social security and mental health.

4.6.1 Benefit Take-Up

There is a need to enhance the take-up of benefit entitlements. However,



the stigma associated with claiming benefits intersects with the stigma (social and internal) around mental health. Mental health and advice organisations have expressed concern that government departments and agencies do little to inform the public about the necessity and function of social security. Integrating messages about the importance of social security to people with mental health problems in social marketing and social contact anti-stigma campaigns is one way of addressing the stigma attached to claimants. This requires leadership from the media, government departments and parliamentarians.

Targeted advertising of benefits should be co-produced with people with lived experience of mental health problems, their families and carers, and the organisations that work with them. This should be supplemented by take-up campaigns using health and social care providers and community gatekeepers. Other innovative approaches could involve jointly run programmes by advice and mental health organisations on social security advice and financial management. (A Big Lottery-funded live-and-learn partnership in Northern Ireland reduced claimant anxiety, promoted an understanding of the social security system and maximised incomes.)^{cclix}

Further, claim procedures need to be simplified and the system made more receptive to, and supportive of, claimants with mental health problems. This could happen by having the same worker throughout the claim process, and providing training for all levels of staff to

enhance their mental health knowledge and communication skills.

4.6.2 Access to Work

Access to Work is well regarded by employers and employees and has excellent performance results (90% retention rates). In its response to the 2014 Access to Work Inquiry, the UK MHWRG drew attention to the low numbers of people with mental health problems who had been supported by Access to Work's Workplace Mental Health Support Service in England, Scotland and Wales. Concerns were raised about the low level of funding (less than 2% of the Access to Work budget), which was unrepresentative of the number of people with mental health problems in the workforce and applying for employment.

Jobseekers with mental health problems may be fearful of disclosing or discussing their mental health problem with a prospective employer due to pervasive societal stigma. It may be hard for them and prospective employers to understand what types of support could be resourced and how this would enable them to retain and progress in their job. In order to increase the likelihood of securing employment, it is helpful if all measures can be taken to reduce the applicant's anxiety and support their open communication.

The UK MHWRG proposed the following changes to Access to Work in order to increase its reach and benefit to claimants with mental health problems.

1. Allow for an agreement of support before someone secures a job and a portable package of support that travels with the person from job to job.
2. Allow for people with mental health problems to discuss the support they may receive before getting an interview with an employer.
3. Confirm in the Access to Work eligibility letter the general type and level of support that the jobseeker will receive if they secure employment.
4. Showcase the types of support that a jobseeker/employer may receive through Access to Work, using success stories of identifying and managing workplace triggers and coping strategies, and developing a workplace wellness and recovery action plan.
5. Proactively market the Access to Work scheme to jobseekers with mental health problems.
6. Enhance training for all Access to Work call handlers on mental health problems and the services offered through Access to Work, and arrange for consistent support from one person throughout the process.^{cclx}

4.6.3 The Work Programme

The policy aim of the Work Programme is to help people who have been out of work for long periods to find and keep jobs, and, specifically, to increase employment, reduce the time that people spend on benefit, and improve support for groups, including claimants, with mental health problems

who have particular difficulties in accessing employment – the so-called harder to help group. Reports by the Public Accounts Committee (PAC) present several shortcomings of the Work Programme, including the low numbers of people who have accessed and sustained employment, and commissioned providers' failure to engage with the harder to help groups despite incentives to do so. The PAC's 2014 report on the Work Programme reported that only 11% of new ESA claimants achieved job outcomes compared to the DWP's original (22%) and revised (13%) performance expectations; this means that 90% of ESA claimants on the Work Programme had not moved into employment.^{cclxi}

The substantial problems with the WCA discussed above provide the background to the UK MHWRG's submission to the Work and Pensions Select Committee Welfare to Work Inquiry (August 2015). The UK MHWRG has described the entrenched fear and negativity towards the DWP and the Work Programme felt by ESA recipients. This negativity is explained by the poor support that is offered, the constant focus on conditionality, the pressure that people are put under and the delays to support that people face. People are anxious about exposing themselves to a distressing process, receiving sanctions, being pushed into inappropriate work and disrupting their income by engaging with the Work Programme. This removes claimants further from work.

Attempts to revise the Work Programme to date have not delivered substantial change, and the UK MHWRG concluded

that fundamental reform is necessary using the IPS model (described in section 4.5) and made six proposals.

1. The DWP should offer a new programme of support for the mental health cohort on ESA. This programme should be locally provided, with only specialist providers at the forefront of delivery. This support should be integrated with local services such as Improving Access to Psychological Therapies (IAPT), housing and community groups.
2. The DWP should introduce the use of personal budgets in back-to-work support.
3. Support for this cohort should be delivered within a healthcare setting similar to the IPS model in order to lead to a greater focus on supporting someone's health condition (the main barrier to work), a break in the link between benefit eligibility and support (which, in turn, leads to a heavy focus on conditionality), and more successful support. Pre-existing employment indicators for health bodies could be used in conjunction with this support.⁴³
4. The use of current conditionality for people with mental health problems should be reviewed immediately, with a reduction in conditionality

until the full impact of the policy is understood. Providers and Jobcentre Plus, who continue to show high levels of inaccurate sanction referrals (alongside poor success rates), should be penalised.

5. Health outcomes should be used for this cohort. These outcomes should be used to acknowledge progress, but also to hold providers and Jobcentre Plus to account where people's health is negatively affected by support.
6. People with mental health problems should be directly included in the design of any new back-to-work support.^{cclxii}

The 'Five Year Forward View for Mental Health report' recommends that the DWP should ensure that, when it tenders for the Health and Work Programme, it directs funds currently used to support people on ESA to commission evidence-based, health-led interventions that are proven to deliver improved employment and health outcomes at a greater rate than the current Work Programme contract. It has called for DWP to invest in ensuring that qualified employment advisers are fully integrated into expanded psychological therapies services.

⁴³Employment is a key indicator that many health bodies can be held accountable for. This includes the Public Health Outcomes Framework – Indicator 1.8ii: gap in employment rate of people in contact with secondary mental health services versus unemployment rate; the Adult Social Care Outcomes Framework – Indicator I (F): proportion of adults in contact with secondary mental health services in paid employment; the NHS Outcomes Framework – Indicator 2.5: employment of people with mental health problems; and the CCG Outcomes Indicator Set – Indicator C3.17: Improving recovery from mental health conditions.

4.7 Advice

Mental ill health is much more common among people experiencing welfare problems, and welfare problems are more common among people who have poor mental health. Parsonage concluded that the causal relationship between mental ill health and welfare problems worked in both directions.

“Because most live on low incomes, people with mental health [problems] are more likely than average to run into financial or housing difficulties and their capacity to deal with such problems is often compromised by their illness. At the same time, welfare rights problems are a major cause of stress, which can precipitate or worsen diagnosable mental health conditions. A particular risk is that welfare problems and mental illness interact with each other, one problem aggravating the other and leading into a downward spiral into crisis.” ^{cclxiii}

Using data from the English and Welsh Civil and Social Justice Survey of 2006–07, the Centre for Mental Health found that 56% of people who scored over the GHQ threshold for having a clinically diagnosable mental health disorder reported one or more welfare rights problems, compared with 36% of people scoring below the threshold. Among those whose GHQ score indicated a severe mental illness, 83% reported welfare rights problems. Compared to the general population, the rates of money or debt problems of people who had a clinically diagnosable mental disorder were 2.3 times as high; the rates of welfare benefit problems were 2.4 times as high; and problems

relating to homelessness were 2.8 times as high. ^{cclxiv} Using the same data set, a Youth Access study reported that, among 18–24 year olds, 44% of young people with mental health problems had welfare rights problems (compared with 16% among those who did not have mental health problems); 62% of those reporting homelessness also reported having mental health problems; and, among all young people with welfare rights problems, 36% said that they worried “all or most of the time”, and 22% said that their problems had led to stress-related illness. ^{cclxv}

The provision of timely, sensitive and accessible advice services to people who experience cognitive, communication and emotional barriers is essential for them to realise their entitlements and protections, and to manage social security issues. People with mental health problems have particularly high rates of non-claiming. Reasons for this low take-up of entitlements include the complexity of the system, the lack of knowledge among claimants, and that the social security system is not well adapted to the episodic and fluctuating characteristics of some mental health problems. ^{cclxvi} A welfare benefits outreach project for people with diagnoses of severe and enduring mental health problems provided benefit assessments to 153 people and found that only 34% were receiving their correct entitlement, and the remainder were under-claiming. Those who were under-claiming who accepted help received additional benefits of £3,079 (just over £4,000 in 2013 figures). Further, the outreach project found that claimants had been given wrong or inadequate advice by mental health professionals, highlighting

the importance of staff training and the signposting of specialist advice provision within mental health services.^{cclxvii}

People with mental health problems may need advice – and advocacy – in order to access the range of public services they require; and those with complex needs may need support in navigating multiple service systems. They may require legal advice if they are subject to specific mental health legislation – for example, if they have experienced detention, some form of deprivation of liberty or coercive treatment. They may want to formalise their will and preferences in a legal advanced planning document so that their human rights will be protected if they become unwell. Mental health and mental capacity legislation varies across the UK, although all legislation must come into line with the UNCRPD as well as be compliant with the European Convention on Human Rights. The services discussed in this review are subject to equality legislation (noting that Northern Ireland has not updated its legislation in line with the Equality Act 2010). Advice services should be in a position to support people with mental health problems to realise their human and equality rights, including signposting them to specialist services.

Mental health services should support service users to access advice by signposting to advice services, or siting specialist welfare provision within secondary services. A small exploratory study by the Centre for Mental Health in 2013 analysed the Sheffield Mental Health Citizens Advice Bureau, which was one of two such services in England dedicated to the advice needs of people with severe

mental health conditions. Provision of specialist welfare advice for people using secondary mental health services cut the cost of healthcare by reducing the length of stay (for example, by enabling discharge through resolving a housing problem), preventing homelessness (by negotiating with landlords and creditors), and preventing relapse (by acting on an immediate cause of stress or reducing vulnerability to future problems). The study found that only a small number of successful welfare advice interventions by a specialist service was necessary to generate sufficient savings to be good value for money. (This business case for specialist advice provision is discussed in section 4.7.)

Advice provision is an important preventative measure for supporting people who are at risk of developing mental health problems due to financial strain caused by debt, housing, employment and discrimination. Given the body of evidence around debt and mental health, and the discussion of welfare reform in section 4.6, this section focuses on debt advice. It considers the lessons that can be learnt to support advice-service users with existing mental health problems, as well as identifying people who are developing mental health problems.

4.7.1 Debt

A clear relationship between debt and mental health has been established. The last Psychiatric Morbidity Survey in the UK showed that one in eleven British adults was in debt (defined as being seriously behind with at least one bill or commitment).^{cclxviii} One in two adults in such debt has a mental health

condition.^{cclxix} A large-scale UK study found that housing arrears negatively impacted on mental health in men (if arrears had occurred in the last year) and among women (if arrears were long term).^{cclxx} Studies have found significant relationships between consumer debt and mental wellbeing,^{cclxxi} and between debt and major depression.^{cclxxii} A high proportion of people with mental health problems who are in debt choose not to tell creditors because they think creditors will not understand or will not believe them.^{cclxxiii} A large-scale review of evidence concluded that, although there is an association between debt and mental health problems, there was no conclusive evidence of a causal relationship; the researchers commented that debt “may have indirect effects on household psychological wellbeing over time, as it impacts on feelings of economic pressure, parental depression, conflict based family relationships and potential mental health problems among children”.^{cclxxiv, cclxxv}

4.7.2 Good Practice in Advice Provision

The ‘Foresight Review of Mental Capital and Wellbeing in England’ drew together stakeholders from health and social care, money advice, banking and government agencies in order to address the recession’s impact on mental health, and proposed an integrated framework for action across health, social care, financial and advice services, and government.

In health and social care, Foresight recommended that:

- all health and social care professionals should ask service users about financial difficulties in routine assessments; where debt is reported, primary care professionals should assess for depression and other common mental health difficulties; and
- health and social care professionals should receive basic ‘debt first aid’ training: knowing how to refer to and support debt counsellors, but without having to become experts in debt and money management themselves.

The Royal College of Psychiatrists delivered a research programme on debt and mental health, which informed a guide with eight steps for action by health and social care, summarised as ‘CARE’:

- C – Consider debt as a possible underlying determinant of ill health.
- A – Ask about debt – the person may be too embarrassed to bring it up.
- R – Refer consenting clients to a money adviser.
- E – Engage with financial advisers.^{cclxxvi}

A standardised Debt and Mental Health Evidence Form was developed in England to inform creditors with the service user’s consent. Health and social care professionals also have a role in signposting service users to appropriate agencies for specialist advice.



Foresight recommended that financial sector code, as a minimum, should recognise the existence of customers with mental health problems and define 'best practice' in working with such customers; that these (and mental health resources) should be readily available to workers and customers; and that frontline workers in financial services organisations should receive regular, appropriate mental health training. The Council of Europe made recommendations to assist policy-makers in dealing with indebtedness, which recognised that indebtedness frequently led to social and health problems, social exclusion of families, and could put children's basic needs at risk. Thus, they called for social, as well as financial, legal and political, solutions to combat poverty and financial illiteracy, promoting social inclusion (including access to the labour market), attending to human rights and dignity. Indebted households should have effective access to impartial financial, social and legal advice and counselling.^{cclxxvii}

A recent evidence review and mapping study of the role of advice services in health outcomes reported that the effects of welfare advice on health outcomes were significant. These include lower stress and anxiety, better sleeping patterns, improved health behaviours (smoking cessation, diet and physical activity) and more effective use of medication. It found that direct commissioning of advice services within health settings was most effective, as it targeted the most vulnerable individuals and engaged them in trusted settings where their health needs are understood. In primary care, welfare advice provision

reduced GPs' time spent on benefits issues by an estimated 15% and resulted in fewer repeat appointments and prescriptions. Welfare advice to people who use secondary mental health services could reduce hospital stays, reduce the risk of relapse and prevent homelessness. Within secondary and tertiary care, welfare advice supported discharge planning and freed up clinical staff time.^{cclxxviii}

4.8 Planning the Built Environment

Reports from the Marmot Review of health inequalities and the Sustainable Development Commission have evidenced how people with mental health problems experience area inequalities. The populations of deprived areas are characterised by concentrations of disabled people, including people with mental health problems,^{cclxxix} and studies have found that prevalence of mental illnesses maps closely with deprivation.^{cclxxx} Poor people are concentrated within communities that have a poor-quality built environment, housing that is substandard and insecure, and poor access to open spaces and green environments.

The relationship between the built and natural environment and health, including mental health, has been established. Access to green space has a therapeutic benefit as well as providing access to 'green exercise' and play space.^{cclxxxii} The relationship between physical exercise and mental health is well established,^{cclxxxii} but studies suggest that green exercise can have more positive



effects than other kinds of exercise.
^{cclxxxiii} Design for mental health, including natural spaces, should be promoted as good practice for architecture in town and country planning.^{cclxxxiv} The increased physical activity^{cclxxxv} and social cohesion^{cclxxxvi} associated with green space are known to increase resilience to stress.

This is evident across the life course, with school-age children's attitudes and behaviours affected by the quality of the built environment and local neighbourhoods, and the poor physical condition of neighbourhoods adversely affecting schools.^{cclxxxvii} The lack of outdoor play has been found to be a causative factor in increased mental health problems among children and young people.
^{cclxxxviii} As for adults, children's contact with natural environments can reduce stress,^{cclxxxix} enhance their emotional development,^{ccxc} and improve concentration in children with a diagnosis of Attention Deficit Disorder and self-discipline among inner-city girls.
^{ccxci}

Green space is beneficial for social cohesion through facilitating higher levels of social contact and social integration,^{ccxcii} particularly in deprived neighbourhoods.^{ccxciii} Access to the natural environment creates a meeting space for all age groups and positively affects their social interaction and cohesion.^{ccxciv} Nearby natural space has been related to crime reduction^{ccxcv} and increased neighbourliness.^{ccxcvi} Opportunities for socialising and the strengthening of neighbourhood ties are provided by community gardens and club or group green activities.
^{ccxcvii} Building communities through participation in local nature activities increases a sense of community pride and strength.^{ccxcviii}

5. Growing the Evidence Base: Data and Research



There is much that we already know about what works to tackle poverty and mental health in policy and services, but we need to continue to build the evidence base for change. The historical underinvestment in mental health means that there is an urgent need to invest in broad-based research, evaluation and data agendas that are co-produced with people experiencing poverty and mental health.

The WHO's 'Mental Health Action Plan 2013–2020' called on member states to invest in health information systems⁴⁴ and evidence and research.⁴⁵ The ROAMER study^{cccix} was published in March 2015. ROAMER outlines a mental health research agenda that is in alignment with the European Commission's '2020 Vision', including its targets on poverty reduction (by addressing the ways in which mental disorders contribute to poverty and poverty exacerbates mental health problems), social inclusion (by tackling stigma that leads to disengagement or exclusion from society), employment (by increasing opportunities to work, and

addressing workplace discrimination and effects on productivity), and education (by revisiting missed educational opportunities and changing limited expectations). It highlights the relevance of mental health research to the seven EU flagship initiatives, including poverty.^{ccc}

The authority and credibility of the ROAMER approach and the clarity of its roadmap mean that it is an excellent resource for developing a mental health and poverty research agenda within JRF's Anti-Poverty Strategy for the UK, which will resonate internationally.

5.1 Research

Because the relationship between poverty reduction and mental health inequalities has been established, ROAMER calls for a broadened scientific scope in order to build the public mental health evidence base and to incorporate socio-economic contexts into new models of mental healthcare, including recovery.

⁴⁴ Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age in order to provide data for the Global Mental Health Observatory (as a part of the WHO's Global Health Observatory) (2013, p. 19).

⁴⁵ Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation, and the exercise of human rights by persons with mental disorders. This includes the establishment of centres of excellence with clear standards using the input of all relevant stakeholders, including persons with mental disorders and psychosocial disabilities. (2013, p. 19).



ROAMER presents five priority areas for mental health: supporting mental health for all, addressing societal values and issues, building research capacities, taking a life course perspective, and personalised care. It recognises that there is a need to address the contextual factors that result in mental health disparities, with particular reference to under-researched groups, including at-risk, disadvantaged and marginalised populations – specifically relating to economic inequality, and the effects of public and economic policy.

ROAMER advocates empowering service users and carers in decisions about mental health research using a human rights-based approach. Mental health research, including its dissemination, should enhance service user autonomy, investigate human rights protection and discrimination, promote social inclusion, remove stigma, and advance public awareness and participation in mental health promotion.^{ccci} Research outcomes should be expanded to include wider outcomes linked to the social and economic determinants of mental health, and interventions developed to target these directly.

NHS England's Mental Health Taskforce recommended that the Department of Health produce a ten-year mental health research strategy by 2017, including a co-ordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence.

5.2 Data

Mental health data varies significantly across the UK. This limits our ability to compare the prevalence of mental health problems, service activity and outcomes, and the degree to which the UK Government's anti-poverty, human rights and equality commitments are being realised. Within the UK, England has the strongest mental health data administered through the National Mental Health Intelligence Network (NMHIN), which is hosted by PHE and co-funded through PHE and NHSE. The NMHIN manages the Mental Health, Neurology and Dementia 'fingertips' online resource.^{cccii} England's Mental Health Taskforce recommended the development of a five-year data plan. The Health Poverty Index⁴⁶ is a web-based tool covering all local authority districts in England. It allows comparisons across geographical areas and different ethnic groups, and provides a high-level visual summary of an area's health poverty, drawing on 60 indicators of health and the wider determinants.^{ccciii}

There is a particular need for investment in data improvement, and a welcome interest from governments and public bodies to improve mental health data, intelligence and dissemination in England, Scotland, Wales and Northern Ireland.

The key questions facing mental health data are: (i) What qualitative and quantitative data are available and how can these be disaggregated? (ii) What is

⁴⁶ www.hpi.org.uk



the quality of that data (including how fully data completion requirements are complied with)? (iii) What is the scope for comparison (for example, across demographic groups, and geographic and service areas)? and (iv) What geographical level can the data be read to? Many data sets do not 'talk' to each other, and so it is very difficult to generate comprehensive presentations of current health statuses, trends and relationships.

The poor quality of mental health data presents an opportunity to develop it with populations that are affected by poverty and mental health.

Measurements of mental health and poverty need to be part of a broader suite of measurements that relate data to the social determinants, including economic performance and progress, to realise equity and human rights. Much of public policy is focused on growth using the measure of gross domestic product (GDP). However, the use of GDP has been problematised – for example, within the Report by the Commission on the Measurement of Economic Performance and Social Progress.^{ccciv} The Human Development Index has been employed by governments in the Global North, including the UK's Equality and Human Rights Commission, as a framework for promoting human rights and equality using capability theory.^{cccv}

6. Costings



6.1 Challenges of Undertaking Mental Health Economic Analysis

There is a growing body of evidence around both the costs of mental ill health for society and the case for investment in mental health prevention and provision. However, robust cost–benefit and return on investment analysis is limited by poor-quality data (discussed above). Further, it is difficult for voluntary and community organisations to make the economic case for investment in innovative and novel approaches because of challenges involved in comparing the costs and benefits of novel approaches in their sectors with interventions delivered in the public sector.

Cost-effectiveness assessment can be used for resource allocation across the continuum of care, using effectiveness measures that extend beyond health outcomes to include quality of life, wellbeing, equity and social justice. Resources can include professional, physical, social and psychological interventions, and technological treatments.^{cccv}

Cost of illness studies estimate all the resource consequences associated with a particular mental health problem, and can calculate the use of health and social care resources, premature mortality, monetary consequences of a reduction in quality of life and the loss of ability or opportunity to earn income or engage in meaningful activities

such as employment and leisure. By highlighting the cost burden of mental health problems for society, cost of illness calculations have significantly raised the profile of mental health in the last decade and secured significant UK policy commitments to invest equitably in mental health.^{cccvii}

The economic impacts of mental health problems are wide ranging and, in many cases, long lasting because of the character of the condition and/or the lack of early and effective interventions. They are associated with ability to work, personal income and the utilisation of health, social care and other support services. These impacts extend beyond the individual experiencing them to encompass family members and wider society. Family and friends who care for people with mental health problems may incur significant opportunity and direct costs in doing so. The wider social and economic costs to society include higher unemployment rates, lower participation rates and higher health and social care costs. For individuals, the costs include mental distress and the negative impacts of treatment – including those of medication, co-morbid physical health conditions, stigmatisation, reduced social functioning, social isolation and reduced self-esteem.^{cccviii}

Economic evaluation (including cost-effectiveness analysis, cost–utility analysis and cost–benefit analysis) refers to the comparative analysis of alternative courses of action in terms



of both their costs and consequences.^{cccix} Funders often ask for comparisons with public services from voluntary and community organisations that are innovating new approaches to mental health support and treatment. However, there are significant methodological and capacity barriers to such organisations, including cost comparisons in their evaluations. Increasingly, there are calls for government departments to invest in developing accessible cost comparison models that can be readily used by the voluntary and community sectors.

6.2 Mental Health Economics Evidence Base

The King's Fund undertook a review of evidence-based, local public health interventions, including those for mental health, and made an economic case for each one. Those directly related to mental health confirm recommendations made elsewhere in this report on early intervention and whole-place approaches (in education, employment and communities).^{cccx} Health Scotland's summary of effective public mental health interventions includes economic evidence.^{cccxi} A range of studies has developed a good economic case for a number of interventions that are linked with poverty. Urgent investigation of other promising areas is required in order to establish the evidence base for cost-effective intervention.

6.2.1 Life Course: Maternal Mental Health^{cccxi}

The Maternal Mental Health Alliance's⁴⁷ Everyone's Business campaign commissioned the LSE Personal Social Services Research Unit and the Centre for Mental Health to undertake an economic study into the costs of perinatal mental health problems. There are NICE-recommended interventions for perinatal mental health. This report creates the economic base for investing in NICE-recommended perinatal mental health services.

Perinatal mental health problems affect up to 20% of women at some point during the perinatal period (pregnancy and the first year after birth). Perinatal mental health problems can include ante- and postnatal depression, anxiety, psychosis, and post-traumatic stress disorder. In addition to the adverse impact on the mental health of the woman, perinatal mental health problems compromise the child's emotional, cognitive and physical development, with serious long-term consequences. There is a growing body of evidence of the adverse effects on the mental health and wellbeing, and economic activity, of fathers.

Bauer et al. estimated the costs of three major perinatal mental health problems: depression, anxiety and psychosis

⁴⁷ A coalition of over 60 organisations, including professional bodies across the UK <http://maternalmentalhealthalliance.org.uk/>

(mainly bipolar and schizophrenia). The total long-term cost to society was £8.1 billion per one-year birth cohort in the UK – just under £10,000 per single birth – with nearly 75% of the cost relating to the adverse impacts on the child.⁴⁸ A fifth of these costs (£1.7 billion) are borne by the public sector, and £1.2 billion by the NHS and social services. The cost of one case of perinatal depression is £74,000 (£23,000 for the mother and £51,000 for the child); one case of anxiety is £35,000 (£21,000 for the mother and £14,000 for the child); and one case of psychosis is £53,000 (£47,000 for the mother).

Only around half of perinatal cases of depression and anxiety are detected, and many of those detected cases do not receive the full level of care recommended by national guidance. Across the UK, 80% of Northern Ireland, 70% of Wales, 40% of Scotland and 40% of England have no specialist perinatal care within their health and social care areas.

To bring the NHS's perinatal mental health provision to the level and standard of NICE guidance would cost £400 per

average birth, compared to the current cost of £10,000 to society (£2,100 to the NHS) of not providing perinatal care in line with NICE guidance. In England, this would equate to £280 million a year to bring perinatal care up to the level and standard recommended in national guidance, equivalent to £1.3 million extra spending in an average CCG. The cost to the public sector of not providing adequate perinatal mental healthcare is five times the cost of improving services.

6.2.2 Life Course: Children and Young People

Conduct Disorder^{cccixiii}

About 5% of children aged 5–10 years display behavioural problems that are sufficiently severe, frequent and persistent that they justify a diagnosis of 'conduct disorder'. This is equivalent to around 30,000 children in each one-year cohort in this age range in England. Boys are more than twice as likely to be affected as girls in the 5–10 age range (6.9% of all boys compared to 2.8% of all girls). Conduct disorder is three times as common among children from unskilled and workless households as among children from professional and managerial parent groups.

⁴⁸ The study's economic modelling looked at the additional costs associated with perinatal mental health conditions – that is, costs over and above those that would have been incurred anyway, such as children's education costs. These costs included increased use of public services, losses of quality-adjusted life years (QALYs) and productivity losses (measured in 2012/13 prices), and whole-life costs for lives lost through suicide or infanticide. For outcomes for the whole family, the study costed for the public sector and society as a whole. Public sector costs covered those that fall on health, social care, education and criminal justice budgets (and included the costs of publicly funded services provided through the voluntary and private sector). Wider costs to society included productivity costs, QALY losses, costs to victims of crime, out-of-pocket expenditure and unpaid care. Costs were either short term (related to the mother during the perinatal period and linked to the child's pre-term birth) or longer term (typically linked to the children but also the mother's outcomes linked to long-term remission). The researchers aimed to evaluate lifetime costs, if possible, with the available data.

Taking into account the extra costs falling on health, social care, education and – from age 10 onwards – the criminal justice system, the broad annual cost per child with severe behavioural disorder is £5,000 to the exchequer. From a societal (rather than public sector) perspective, the overall lifetime costs of severe behavioural problems are around £260,000 per case. (The lifetime costs of moderate problems are around £85,000 per case.) Crime-related costs are the biggest single component (more than two-thirds).

These figures omit many costs. Bullying is a common behaviour of people with severe behavioural problems; one study estimated that the lifetime earnings of a single victim of serious bullying are reduced by around £50,000.

Parenting programmes that improve the quality of parent–child relationships and the parent’s skill in managing child behaviour are a recommended intervention. The cost per child of a parenting programme is £1,300. The aggregate returns from early interventions are underestimated – for example, by the omission of benefits such as benefits to parents’ and siblings’ mental health and wellbeing, and of victims of behaviours such as bullying and criminal activity. However, the relatively low-cost and high-potential benefits mean that studies suggest that bringing a child below the clinical threshold as a result of a parenting programme is around £1,750 per case. Every £1 invested in parenting programmes yields measurable benefits to society of at least £3.

Sixty per cent of the expenditure on parenting programmes is recovered within two years, largely through savings to health and education budgets. In order to maximise participation in such programmes, it is worth investing in measures that enable participation, such as free childcare and transport.

As the estimated number of children in each year cohort with conduct disorder is 30,000, if the government were to provide group parenting programmes to all of these children’s parents (at £1,270 per child) it would cost £38 million a year. It is estimated that the societal benefits of parenting interventions exceed their costs by 14:1 over 25 years. The largest part of this saving would be in reduced crime, but savings will also be accrued by schools (it costs £3,000 a year extra to teach a child with a conduct disorder), children’s services, the NHS and other public sector budgets.

Parenting Programmes: Family Nurse Partnerships^{cccxiv}

It is not possible to identify how much money is spent on parenting programmes, as this is not recorded systematically.

The Family Nurse Partnership is a preventive programme for first-time young mothers with particular vulnerabilities that provides home visiting by trained nurses from early pregnancy until the child is 2 years old. The support addresses a wide range of issues, including child and parent behaviour. The programme was developed over 30 years ago in the US and was introduced on a pilot basis



to the UK in 2007; it will be scaled to increase the overall number of families in the programme at any one time to 13,000 families in 2015.

Three large, randomised controlled trials have been conducted in the US and demonstrated positive results for the mothers and children; longitudinal data continues to be published. The Department of Health published the following benefits of the Family Nurse Partnership programme.

- 48% reduction in verified cases of child abuse and neglect by age 15;
- 50% reduction in language delay at 21 months;
- 67% reduction in behavioural and emotional problems at age 6;
- 28% reduction in anxiety and depression at age 12;
- 67% reduction in use of cigarettes, alcohol and marijuana at age 15; and
- 59% reduction in arrests by age 15.

Benefits to the mothers include increased employment, reduced welfare dependency and reduced offending (61% fewer arrests and 72% fewer convictions among mothers by the time children were age 15).

Using a threshold analysis to assess the minimum level of effectiveness needed for a programme to pass a value for money test, illustrative costings for bringing a child with conduct disorder below a clinical cut-off as a result of a

parenting programme from one study were £1,875 per child in a community-based group parenting programme and £1,315 for a clinic-based group parenting programme.^{ccxv} This is set against the lifetime costs of a child with conduct disorder and a child with moderate problems £175,000 (£260,000 minus £85,000). A Cochrane evidence review estimated the cost of achieving this for a child with the highest level of conduct problems at £6,650 (in 2012/13 prices), meaning that lifetime costs only need to be reduced by 4% to cover the outlays on the intervention. The Centre for Mental Health concluded that the costs of effective intervention for conduct disorder are very small compared to the potential benefits.

In its review of the cost–benefit analysis of parenting programmes from both societal and (narrower) public sector perspectives, the Centre for Mental Health stressed the importance of retaining fidelity to the programme in order to gain full benefit, and made the case for resourcing additional supports – such as childcare and travel – to reduce drop-out. Further research is required to provide a more comprehensive picture of the long-term benefits of programmes, the benefits of programmes to third parties, and the impact of programmes being scaled up, embedded in service systems and transferred to other populations. However, the evidence base for certain programmes is already strong.

Conducting cost–benefit analysis is challenging, as most evaluations have not collected economic data; characteristically, the benefits of programmes accrue over long periods

and to a wide range of public sector agencies, and many of the benefits of the programmes are not included – particularly third-party benefits (to parents, siblings, and victims of bullying and crimes). The ‘Building a better future’ report provides a detailed discussion of the economic modelling conducted on parenting programmes, drawing on UK and US studies, which could inform future evaluation design.

Within current financial constraints, funders may choose to target these programmes. In the case of Family Nurse Partnerships, targeting could be towards families where there are risk factors, such as parental mental health problems, alcohol and drug misuse, family discord or domestic abuse. For parenting programmes more generally, this could be for families where children are displaying severe behavioural problems or where there is one or more adverse childhood experiences (as discussed in section 3.1).

Whole-School Approaches

The economic evidence reviewed by The King’s Fund made the following business case:

- Supporting and challenging schools to achieve social, emotional and health outcomes and to support children to make healthy lifestyle choices delivers significant individual, societal and public sector benefits. Lleras and Culter estimated the overall health benefits of a good education to provide returns of up to £7.20 for every £1 invested.^{cccxi}

- The development of students’ emotional health and social skills supports the development of healthy adults. School-wide anti-bullying programmes can return almost £15 for every £1 invested through higher earnings, productivity and public sector revenue,^{cccvii} and interventions to address emotional-based learning problems paid for themselves in the first year through reduced costs to the public sector (social service, NHS and criminal justice) and recouped £50 for every £1 spent over five years.^{cccviii}
- School-based behaviour change programmes are very cost-effective in terms of long-term returns. For every £1 spent on contraception to prevent teenage pregnancy, £11 is saved through fewer terminations and savings on antenatal and maternity care, highlighting the value of sex education within schools.^{cccix}

Data is not collected on how many schools have adopted a whole-school approach or components of this approach. The challenge of identifying how many schools use a whole-school approach is illustrated by a study commissioned by the Department of Education for Northern Ireland, which found that fewer than one in five post-primary schools that responded to a survey used audit tools to measure activity across five domains of whole-school approaches: school policies, school practices, use of established programmes, school provision for pupils and school provision for teachers.^{cccxx}



6.2.3 Life Course: Working Age

Whole Workplace Approach^{ccccxi}

Mental health problems cost the UK economy £26 billion per year – that is £1,035 per employee in the UK workforce. This figure covers the following costs:

- £8.46 billion sickness absence (seven days of sick leave is the average per worker each year and 40% of these are reported as mental health related, accounting for 70 million lost working days per year, including one in seven lost days directly caused by the person's work or working conditions).
- £15.1 billion lost productivity (presenteeism costs 1.5 times as much as working time lost to absenteeism and is more expensive, as it is more common among senior staff).
- £2.4 billion replacing staff that leave due to mental ill health.

The whole-workplace approach discussed in this paper includes a wide range of activities that are supported by 2009 NICE guidance and the 'Promoting mental wellbeing at work' care pathway, and 2015 'Workplace Health: policy and management practices' guidance.^{ccccxii} The Centre for Mental Health assessed that 30%, or £8 billion per year, could be saved through the following measures:

- awareness training for line managers;

- prevention of mental health problems through workplace conditions and processes;
- better access to help for employees – particularly with regard to psychological health; and
- effective rehabilitation.

IPS

The IPS approach is an established and evaluated model for supporting people with mental health problems getting into work. It is described in more detail in section 4.5.2, and case studies from IPS centres of excellence illustrate its operation.⁴⁹ The EQOLISE^{ccccxiii} project compared IPS with other vocational/rehabilitation services in six European countries. It concluded that:

- IPS clients were twice as likely to gain employment (55% versus 28%) and IPS worked for significantly longer than those using other interventions (which achieve, at best, 20–30%);
- the total costs for IPS were generally lower than standard services over the first six months;
- clients who had worked for at least a month in the previous five years had better outcomes; and
- individuals who gained employment had reduced hospitalisation rates. (NICE estimates that supported employed has a QALY of £5,723.)

⁴⁹ <http://www.centreformentalhealth.org.uk/ips-centres-of-excellence>



Over time, a third of IPS participants become regular workers (that is, mostly in full-time, sustained employment), a third become occasional workers, and a third do not get work. Data about earnings was not identifiable. The Centre for Mental Health has outlined the following business case for investment in IPS, stressing the importance of compliance with the IPS Fidelity Scale.^{cccxxiv} To implement IPS at the level of provision recommended in government commissioning guidance would cost around £67 million per year in England. This compares with current spending on day and employment services at £184 million per year, and implies that IPS could be implemented within existing provision but through diverting resources from less effective services. The evidence base and cost for implementing the IPS approach is contextualised by the issues with the Work Programme (discussed in section 4.6), including ongoing difficulties in reaching people with mental health problems.

Official commissioning guidance on vocational services for people with severe mental health problems recommends caseloads per employment specialist of up to 25 people at any one time.^{cccxxv} In broad terms, the cost of an employment specialist (including overheads and support) is thus in the range of £45,000–50,000 a year, and recommended caseloads are in the range of 20–25. These figures confirm that an estimate of £2,000 a year per IPS place is broadly appropriate for financial planning purposes. Although it is not known how many people are currently receiving IPS, the

estimate is that 10,000–20,000 people benefit (within secondary mental health services). The Centre for Mental Health recommended that everyone have access to IPS, and called for the coverage of IPS to double in England to reach 40,000 people.

Health: Co-Morbidities^{cccxxvi}

Co-morbid mental health problems raise total healthcare costs by at least 45% (with some studies putting the figure at 75%) for each person with a long-term condition and co-morbid mental health problem. This analysis suggests that between 12% and 18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year (using 2010 Department of Health figures showing that around 70% of total health spending is on long-term conditions, and subtracting for expenditure on research and training). The lower figure equates to £1 in every £8 spent on long-term conditions. The presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year (using the more conservative 45% estimate for excess costs). International research suggests that these excess costs are mainly associated with people who have severe long-term conditions or multiple co-morbidities.

As discussed in section 4.2.1, co-morbid mental health problems costs are incurred through care for their physical health problems – that is, increased service use and additional health service costs (accident and



emergency, primary care, pharmacy, laboratory, x-ray inpatient, outpatient and pharmaceutical). There are wider economic costs, including people being unable to work, reduced productivity or increased absence at work, and the economic impact on family members who provide informal care and support.

Based on this evidence, section 7 outlines a number of actions regarding preventative health checks and integrated care pathways for people with co-morbid mental health problems. In their economic analysis, Naylor et al. found that:

- collaborative care⁵⁰ arrangements between primary care and mental health specialists can improve outcomes with no, or limited, additional net costs;
- innovative liaison psychiatry approaches that provide support for co-morbid mental health needs can reduce physical healthcare costs in acute hospitals; and
- illustrative examples of savings from integrating mental health support into chronic disease management are that: introducing a psychological component into a Chronic Obstructive Pulmonary Disease breathlessness clinic reduced accident and emergency presentations and hospital bed days, and yielded savings of £837 per person (around four times the

upfront cost);^{cccxxvii} and a Cognitive Behavioural Therapy-based programme for angina reduced hospital admissions and saved £1,337 per person.^{cccxxviii, cccxxix}

Criminal Justice: Liaison and Diversion

The Centre for Mental Health has summarised the business case for liaison and diversion for both children and young people, and adults within the criminal justice system. It comments that, although initial upfront investment is required to establish dedicated liaison and diversion teams located in police stations and courts, most, if not all, of these direct costs would be covered by short-term cost savings in the criminal justice system.^{cccxxx}

The Centre for Mental Health outlines the cost comparisons of custodial and community sentences. A typical six-week stay in prison costs about £5,000 per case. In comparison, a typical one-year community order involving probation supervision and drug treatment costs £1,400. A highly intensive two-year community order, involving twice-weekly contact with a probation officer, 80 hours of unpaid work and mandatory completion of accredited anti-offending programmes, costs less than six weeks in prison, at £4,200.^{cccxxxi}

It notes that well-designed interventions can reduce reoffending by 30% or more. The economic and social cost of crime committed by recently

⁵⁰ Collaborative care is a NICE-recommended approach for supporting people with long-term conditions and co-morbid depression in primary care (2009). <https://www.nice.org.uk/guidance/cg90/chapter/guidance>



released prisoners serving short sentences amounts to £7–10 billion a year. Much of this cost falls directly on the victims of crime, but 20–30% is borne by the public sector – mainly the criminal justice system and NHS. The total lifetime cost of crime committed by an average offender following release from prison is in the order of £250,000.

^{cccxxii}

Liaison and diversion should be available in all police stations and courts. It would appear that liaison and diversion teams tend to identify needs, including mental health and learning disability-related needs, in about 10% of people who come through the criminal justice system.

Advice: Specialist Provision in Secondary Mental Health Services

The business case for investing in welfare advice for people who use mental health services was set out in a 2013 Centre for Mental Health study. ^{cccxxiii} Parsonage analysed the work of the Sheffield Mental Health Citizens Advice Bureau, which is based in a hospital's grounds and supports about 600 people with a diagnosis of a severe mental illness throughout the city each year. Just under half of these are seen as inpatients, with the remainder living in community settings. This is one of two such services in England specifically dedicated to the advice needs of people with a diagnosis of a severe mental illness. The average cost of advice per client was £260 per year.

The study found that specialist welfare advice:

- reduced the inpatient lengths of stay (costed at £330 per day);

- prevented homelessness (costed in the range of £24,000–30,000 per year to the public sector, including the NHS); and
- prevented relapse (using the example of schizophrenia with a probability of relapse of 40% a year – a cost of £18,000 per episode).

Parsonage notes that the about one million adults of working age are seen by secondary mental health services, and the average annual cost of mental healthcare for this group is £6,600 per head. He recognises the significant variation around this figure – for example, only about 7% of people receiving secondary mental healthcare spend any time in hospital during the course of a year, but, for those who, do the average cost of inpatient care is £23,000.

In addition to reducing health and social care costs, specialist welfare rights advice increased the numbers of people with mental health problems who are claiming entitlements and receiving the correct amount of entitlement. Parsonage quoted one study in which claimants with mental health problems who were under-claiming, and who accepted assistance following a benefits assessment, received an average additional income of £4,000 per year (in 2013 prices). ^{cccxxiv}

7. Recommendations



Recommendations are made in seven areas:

- regarding cross-cutting agendas of data and research, stigma and discrimination, and MHiAP;
- at life course stages: perinatal, early years, children and young people; working age; and in later life; and
- across all stages of the life course.

7.1 Investment in Data and Research

- Develop a UK mental health and poverty data plan that addresses data development, intelligence and dissemination, ensuring that this data:
 - can be disaggregated by demographic characteristics under equality legislation and compared across the UK; and
 - provides information on mental health service provision across the life course with regards to funding, activity, and access to and quality of care across all types of providers, disaggregated into types of health and social care services, and drilled down to service provision areas that reflect the arrangements for health and social care in England, Scotland, Wales and Northern Ireland.

This work can be informed by the development of a five-year data plan in England.

- Implement the ROAMER mental health research agenda with a specific programme on mental health and poverty.
- This work can be informed by the ten-year mental health research strategy to be developed in England by 2017.
- Undertake a systematic review on mental health, poverty and social care.
- Undertake a systematic review on mental health, poverty and later life.

7.2 Stigma and Discrimination

- Integrate anti-stigma interventions around mental health and poverty using social contact approaches within current anti-stigma campaigns and initiatives.

7.3 Mental Health in All Policies

- Include poverty in MHiAP frameworks.
- Improve planning of the built environment by including mental health in all renewal, regeneration, and sustainable development within disadvantaged communities.

7.4 Life Course Stages

7.4.1 Perinatal, Early Years, Children and Young People

The following work can be informed by the work of the Oversight Boards for both 'Future in Mind' and 'The Five Year Forward View for Mental Health'.

- Implement the NICE perinatal care pathway across the UK.

This work can be informed by the implementation of the Five Year Forward View for Mental Health target to support 30,000 more women each year to access evidence-based specialist mental healthcare during the perinatal period by 2020/21.

- Provide access to Family Nurse Partnerships for low-income families.
- Fund evidence-based programmes that encourage positive parenting for parents in disadvantaged areas delivered in community settings, including schools.
- Fund evidence-based parenting programmes for families whose members have existing mental health problems, particularly:
 - families in which a child has moderate or severe behavioural problems; and
 - families in which a parent has a mental health problem.
- In England, implement the 'Future in Mind' and 'Five Year Forward View for Mental Health' recommendations for vulnerable children, including children from low-income families,

and share this approach with policy-makers in Scotland, Wales and Northern Ireland to inform the development of their mental health strategies.

- Implement the whole-school approach informed by NICE and Ofsted guidance for schools in disadvantaged communities, with a particular emphasis on engaging parents and caregivers in the school-based mental health and wellbeing programmes, and provide targeted supports for children who are at a high risk of developing mental health problems or who are experiencing mental distress – particularly children with multiple mental health problems, with moderate and severe behavioural problems and those diagnosed with conduct disorders.
- Include mental health in assessments of needs and support planning for children who are outside of the education system – particularly children who have experienced multiple adverse experiences – for example, homeless children, young offenders, looked-after children, members of the Gypsy and Traveller communities, and refugee and asylum-seeking children.

7.4.2 Working Age

- Develop a national programme of IPS to support people who have experienced mental health problems in gaining and sustaining employment.



- Promote the adoption of whole-workplace approaches in all sectors, informed by NICE guidance, including:
 - positive human resource and business policies that support the recruitment, retention and promotion of people with mental health problems and their family members;
 - training for line managers to identify risks/signs of mental distress and to intervene early through the use of reasonable accommodations and referral to employee assistance programmes and workplace counselling;
 - mental health and wellbeing activities; and
 - use of Access to Work, Fit for Work and IPS programmes.
- Develop mental health guidance and support for owner-managers and employees in SMEs, including access to occupational health and employee assistance schemes.

This work can be informed by the implementation of the Five Year Forward View for Mental Health target: that, by 2020/21, each year up to 29,000 people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to IPS.

- Increase the use of social security benefits and programmes by people with mental health problems by:
 - undertaking a national benefit take-up programme tailored to people with mental health problems;
 - promoting the Access to Work programme for claimants with mental health problems, informed by the proposals of the UK MHWRG; and
 - undertaking a fundamental reform of the Work Programme to develop a tailored programme for claimants with mental health problems, informed by the proposals of the UK MHWRG.

This work can be informed by the implementation of the Five Year Forward View for Mental Health recommendations around the tendering of the Work Programme, and DWP investment in qualified employment advisers who are fully integrated into expanded psychological therapies services.

- Improve the DWP's customer service to people with mental health problems by:
 - providing regular mental health training to all frontline workers involved in each stage of the social security process;
 - regularly reviewing and strengthening guidance on vulnerable claimants and audit adherence by DWP staff and contractors; and
 - providing claimants with comprehensive and accessible information about what the claim



process will involve and their rights with regard to information and support.

- Improve access to advice on social security and wider rights by providing advice services with mental health trained staff in health and social care settings (including secondary mental health services) and in disadvantaged communities.
- Develop a national programme of social prescribing within primary care services in disadvantaged communities.
- Provide lifelong learning opportunities for people whose education, training and entry into or continuance in employment has been disrupted by mental health problems.

7.4.3 Later Life

- Scale and test evidence-based programmes that provide opportunities for older people in disadvantaged communities to participate in social and cultural networks and activities, and reduce their experience of isolation – particularly at key transitions and pressure points in later life, such as redundancy, retirement, caring, bereavement and moving home.
- Screen for mental health problems (particularly depression and dementia) in primary care services within disadvantaged areas and provide early intervention support.
- Develop integrated care pathways for children and adults who have co- and multiple morbidities (both people with mental health problems who develop physical health problems and people with long-term physical health conditions who develop mental health problems).

This work can be informed by the implementation of the Five Year Forward View for Mental Health target: that at least 280,000 people living with severe mental health problems should have their physical health needs met by 2020/21; its recommendation that the Cabinet Office ensures that recipients of Life Chances Funding demonstrate how they will integrate assessment, care and support for people with co-morbid substance misuse and mental health problems, and be clear about the funding contribution required from local commissioners; and its recommendation that the increased investment to provide integrated evidence-based psychological therapies – for an additional 600,000 adults with anxiety and depression each by 2020/21 (resulting in at least 350,000 completing treatment) – should focus on people living with long-term physical health conditions.

7.5 Across the Life Course

Establish accessible, integrated public service hubs in deprived communities that deliver evidence-based interventions across the life course – particularly at transition and pressure points to those individuals, families and groups who are most at risk of developing mental health problems.



- Develop a national programme of liaison and diversion available to all police stations and courts.

This work can be informed by the implementation of the Five Year Forward View for Mental Health recommendation for a national rollout of liaison and diversion (including for children and young people) by 2020/22, the increased uptake of Mental Health Treatment Requirements, and the development of a complete health and justice pathway.

- Scale and test the development of psychosocially informed environments in services for people with complex needs.

8. Methodology



This review asked the following question:

What public policies⁵¹ or services⁵² have been evidenced to effectively address mental health and poverty experienced by children and adults⁵³ through:

- preventing people in/experiencing poverty⁵⁴ from developing mental health problems;
- supporting people people in/ experiencing poverty with mental health problems to recover;
- preventing people with mental health problems from becoming poor; and
- supporting people in/experiencing poverty with mental health problems to move out of poverty?

It identified evidence using an amended version of the Mental Health Foundation's Stepwise approach to searching for research evidence.

Step 1: Search for high-quality reviews. Identify areas in which no such evidence exists.

Step 2: Search for other evidence (grey literature, unpublished reports). Identify areas in which no such evidence exists.

Step 3: Map the evidence into categories and select the best quality and most recent studies for inclusion.

Due to time and resource restrictions, the identified research and policy literature was not systematically reviewed. Therefore, it is important to distinguish this paper from the evidence papers that JRF commissioned to inform the development of its UK Anti-Poverty Strategy. Through the writing process, additional documents were identified in order to strengthen aspects of the paper.

Although the focus of the review is the UK, current literature in English from the European region and other

⁵¹ national and international

⁵² health, social care, education, employment, social security and advice

⁵³ including those with complex needs

⁵⁴ including individuals, families and communities

countries (New Zealand, Australia, the US and Canada) was also included. The transferability of the findings from the literature to the UK context was assessed by considering whether similar contextual circumstances and factors relevant to the paper exist in UK society.⁵⁵

Step 1: Search for high-quality reviews

Relevant databases⁵⁶ were searched to identify meta-reviews (systematic reviews, meta-analyses, synthesis, literature reviews, etc.) using the strategy outlined in Table A.

Table A: Search Strategy – Meta-Reviews

#	Search History
1	("mental health" or "mental ill*" or "distress" or "psycholog*" or "emotion*") AND ("poverty") AND ("review" or "synthesis" or "meta-analysis") Date range: 2010–2015 Limited to: articles, English only
2	("mental health" or "mental ill*" or "distress" or "psycholog*" or "emotion*") OR ("poverty") AND ("review" or "synthesis" or "meta-analysis") AND ("criminal justice" or "homelessness" or "substance misuse" or "alcohol misuse")
3	("mental health" or "mental ill*" or "distress" or "psycholog*" or "emotion*") OR ("poverty") AND ("review" or "synthesis" or "meta-analysis") AND ("health" or "social care" or "education" or "employment" or "social security" or "advice")

⁵⁵ These include cultural characteristics of the population; socio-economic status, geographical context; and current policies, service structures and interventions (and, if not, is there opportunity for innovation?).

⁵⁶ ASSIA, Barbour Index, CINAHL, Cochrane Library, EMBASE, Emerald, Health Business Fulltext Elite, OVID databases (includes Medline), RefWorks, Transfusion Evidence Library, TRIP: Turning Research Into Practice, Web of Science, EBSCO PsycINFO, WHO Health Evidence Network, Wiley CCTR, Wiley CDSR

An initial screening by title was performed online, and references were then downloaded into EndNote bibliographic software and screened by abstract.

After some databases that were expected to provide results did not, a quality check was undertaken by screening for abstracts on these databases in order to identify any additional papers missed in the initial title/keyword search.

A quality control check was conducted by two Mental Health Foundation staff on a random sample (5%) of the titles; disagreements in selections were negotiated and a final list of included references agreed.

Following these initial screenings by title and abstract, and the cross-checking of selections, the full papers of the references selected as a result of the screening were sourced and a final relevance check was made, enabling the review team to arrive at a final selection of papers.

All excluded studies from the abstract screening stage were recorded and the reasons for exclusion noted. These results are summarised in a QUOROM statement below.

The final selection of articles was mapped into categories and particular attention paid to identifying areas where gaps in the evidence emerge. It was not possible to address these gaps by searching for primary studies due to time and resource constraints. The most significant gap was around social

care, and a recommendation is made to undertake a systematic review of the literature around poverty, mental health and social care.

Step 2: Search for other evidence

In addition to searching for peer-reviewed published literature, the following internet search was undertaken in order to identify grey literature.

Free Text Search

A free text internet search for grey literature using the Google search engine was conducted. A set of unique searches using combinations of terms relating to poverty and mental health was used to recover reports and documents relating to social policies and organisations (alliances, coalitions and networks) working in this area. Due to the large number of returns using this approach, only the first ten pages of each search were scanned.

Search one:
 "mental health" AND "poverty" AND ("UK" or "England" or "Scotland" or "Wales" or "Northern Ireland" or "Europe" or "Canada" or "USA" or "Australia" or "New Zealand")

Search two:
 ("mental health" or "poverty") AND "health"

Search three:
 ("mental health" or "poverty") AND "social care"

Search four:
 ("mental health" or "poverty") AND "education"

Search five:
 ("mental health" or "poverty")

AND "employment"

Search six:
("mental health" or "poverty")
AND "social security"

Search seven:
("mental health" or "poverty")
AND "advice"

Search eight:
("mental health" or "poverty")
AND ("criminal justice" or
"homelessness" or "substance misuse" or
"alcohol misuse")

Search nine:
("mental health" and "poverty")
AND "strategy"

Search of Relevant Websites

The websites of up to 25 key organisations identified in the internet search were scanned for relevant publications/reports.

Finally, the reference lists and bibliographies included in the documents retrieved through Steps 1 and 2 were scanned for additional publications.

Step 3: Map evidence into categories and select the best quality and most recent texts for inclusion

Following the completion for the search phase, data was extracted from databases using Excel templates (one for peer-reviewed published (Step 1) and one for grey (Step 2) literature). After screening and mapping, the literature was subjected to quality assessment according to explicit criteria, which included methodological quality.

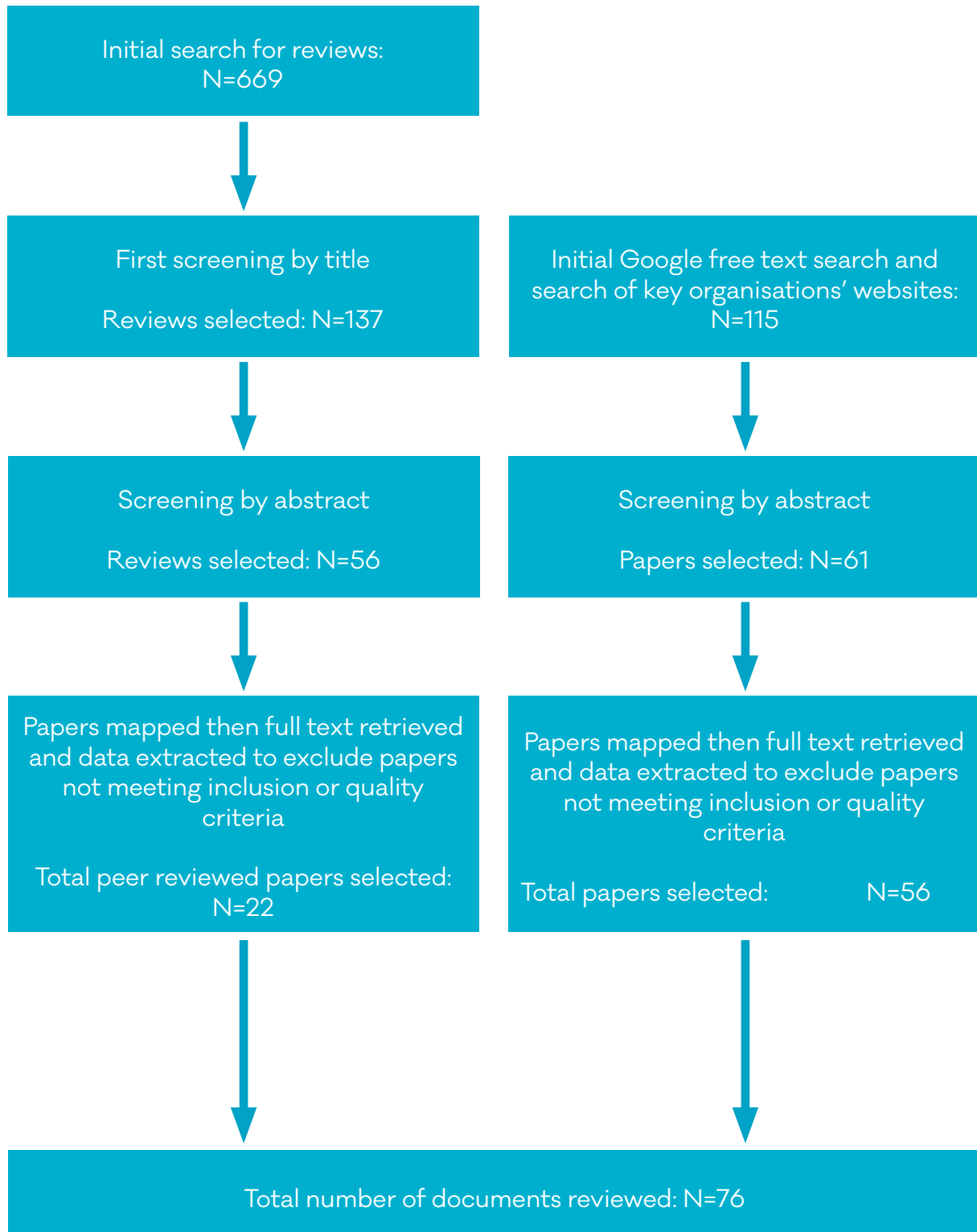
Contingency Plans

Where there were high-quality reviews in a particular area – for example, a stage of the life course, protected characteristics and public service – the results were synthesised and no further searches were conducted in that area. The remaining gaps in the evidence were noted but given time restrictions. There was no search for primary studies. Particular attention was paid to evidence in areas of particular interest to the review, such as:

- stages of the life course;
- protected characteristics (intersecting with poverty); and
- social policies relating to specific public services: health, social care, education, employment, social security and advice.

In order to produce a high-quality review (within the time and resource limitations), it was necessary to take a pragmatic approach to the synthesis of the search results. If there were more than a manageable number of relevant reviews, these were mapped into categories/topic areas of evidence, and, where there were several papers related to the same topic, the more recent and highest quality studies were selected for final inclusion in the review. Excluded studies were retained in iterations of the EndNote software.

QUOROM statement



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Glossary



Mental health

“is conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. With respect to children, an emphasis is placed in the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions, as well as to build social relationships, and the aptitude to learn and acquire an education, ultimately enabling their full active participation in society.”

(WHO (2013) *Mental Health Action Plan 2013–2020*. p. 6)

Mental Disorders

“is used to denote a range of mental and behavioural disorders that fall within the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)”. Although the psychiatric classification system, DSM, is more commonly used in the UK, the human rights grounded global disability movement uses ICD-10.

(WHO (2013) *Mental Health Action Plan 2013–2020*. p. 6)

Disability

is an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition)

and that individual’s contextual factors (environmental and personal). (WHO (2011) ‘World Report on Disability’ in WHO (2013) *Mental Health Action Plan 2013–2020*. p. 38)

Poverty

is “When a person’s resources (mainly their material resources) are not sufficient to meet their minimum needs (including social participation).”

(Goulden, C. and D’Arcy, C. (2014) *An explanation of JRF’s definition of poverty and the terms used in it*. York: Joseph Rowntree Foundation. p. 3)

Psychosocial disabilities

refers to people who have received a mental health diagnosis, and who have experienced negative social factors, including stigma, discrimination and exclusion; people living with psychosocial disabilities, including ex- and current users of mental healthcare services; and people that identify themselves as survivors of these services or with the psychosocial disability itself.

(Drew, N. et al. (2011) ‘Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis’ *The Lancet*, 378(9803), pp. 1664–75. In WHO (2013) *Mental Health Action Plan 2013–2020*. p. 39)

Recovery

means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active



life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. Recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by people who describe themselves as being in recovery – hope, healing, empowerment and connection – and external conditions that facilitate recovery – implementation of human rights, a positive culture of healing, and recovery-orientated services. (WHO (2012) 'QualityRights Tool Kit: assessing and improving quality and human rights in mental health and social care facilities'. In WHO (2013) *Glossary of Main Terms*. p. 39)

Public Mental Health

is "The art and science of promoting mental well-being and equality and preventing mental ill health through population-based interventions to: reduce risk and promote protective, evidence-based interventions to improve physical and mental well-being; and create flourishing, connected individuals, families and communities.' (Department of Health (2011) *No Health Without Mental Health*.)

Vulnerable Groups

"Certain groups have an elevated risk of developing mental disorders. This vulnerability is brought about by societal factors and the environments in which they live. Vulnerable groups in society will differ across countries, but in general they share common challenges related to their social and economic status, social supports, and living conditions, including:

- stigma and discrimination;
- violence and abuse;
- restrictions in exercising civil and political rights;
- exclusion from participating fully in society;
- reduced access to health and social services;
- reduced access to emergency relief services;
- lack of education opportunities;
- exclusion from income generation and employment opportunities;
- increased disability and premature death."

(WHO (2010) 'Mental Health and Development Report' in WHO (2013) *Mental Health Action Plan 2013–2020*. p.40)



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Our mission is to help people understand, protect and sustain their mental health.

Prevention is at the heart of what we do, because the best way to deal with a crisis is to prevent it from happening in the first place.

We inform and influence the development of evidence-based mental health policy at national and local government level. In tandem, we help people to access information about the steps they can take to reduce their mental health risks and increase their resilience. We want to empower people to take action when problems are at an early stage. This work is informed by our long history of working directly with people living with or at risk of developing mental health problems.

The Mental Health Foundation is a UK charity that relies on public donations and grant funding to deliver and campaign for good mental health for all.

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London Office:
Mental Health Foundation
Colechurch House
1 London Bridge Walk
London SE1 2SX

Glasgow Office:
Mental Health Foundation
Merchants House
30 George Square
Glasgow G2 1EG

Edinburgh Office:
Mental Health Foundation
18 Walker Street
Edinburgh
EH3 7LP

Cardiff Office:
Mental Health Foundation
Castle Court
6 Cathedral Road
Cardiff, CF11 9LJ