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Social determinants of mental health

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Abstract
A person’s mental health and many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. The poor and disadvantaged suffer disproportionately, but those in the middle of the social gradient are also affected. It is of major importance that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood, older childhood and adolescence, during family building and working ages, and through to older age. Action throughout these life stages would provide opportunities for both improving population mental health, and for reducing risk of those mental disorders that are associated with social inequalities. As mental disorders are fundamentally linked to a number of other physical health conditions, these actions would also reduce inequalities in physical health and improve health overall. Action needs to be universal: across the whole of society and proportionate to need. Policy-making at all levels of governance and across sectors can make a positive difference.

Introduction
It is increasingly known that people’s social and economic circumstances affect their health. These social determinants include the conditions in which people are born, live, work, and age, and the health systems they can access, which are in turn shaped by a wider set of forces: economics, social, environmental policies, and politics. The landmark report of the Commission on Social Determinants of Health (2008) – as well as a number of other seminal reports and reviews (Marmot Review Team, 2010; WHO, 2013d) – have described the evidence base linking social determinants to a range of health outcomes.

Differences in social, economic, and environmental circumstances lead to health inequities, which are defined as health inequalities that are systematic, socially produced (and therefore modifiable), and unfair (Whitehead & Dahlgren, 2006). There are clear variations in longevity not only across countries but also within the same nation. Thus, a child who lives in a slum in Nairobi, Kenya is far more likely to die before the age of five than a child from another part of the city (WHO, 2008b). In Glasgow, Scotland, male life expectancy varies from 54 to 82 years, depending on the part of the city in which the person lives (Hanlon et al., 2006). These variations are a result of many factors including, in particular, socio-economic status, living conditions, and other social and environmental determinants. Health inequities exist both between and within countries and often follow a social gradient, thus occurring both along a continuum and affecting everyone in the population, not only the poorest or most disadvantaged. Those in the ‘middle’ – typically defined as those of average socio-economic status – generally experience worse outcomes than the best-off in society, but better outcomes than the worst-off.

The World Health Organization (WHO) defines mental health as ‘a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’ (WHO, 2013e). Importantly, the absence of mental disorder does not necessarily mean the presence of good mental health (Barry, 2009; Keyes, 2005) which raises significant and important issues in managing mental illness as well as mental well-being.

The Global Burden of Disease 2010 study estimates that 400 million people across the globe suffer from depression (including dysthymia), and a further 272 million from anxiety disorders; 59 million suffer from bipolar disorder and 24 million from
schizophrenia; 140 million people are affected by alcohol and drug use disorders; and 80 million children have behavioural disorders (conduct disorder or attention deficit hyperactivity disorder (Whiteford et al., 2013). These estimates do not include those who may have sub-threshold mental disorders. Some psychiatric and psychological illnesses are precipitated by stressful experiences and life events, though not always (Patten, 1991).

In this paper we make the case that mental health and many common mental disorders are shaped to a great extent by social determinants. We provide evidence that strategic action on people’s social, economic, and environmental circumstances and effective interventions at different stages of the life-course have considerable potential for improving mental health and in preventing and alleviating mental disorders in countries irrespective of their stages of economic development.

Methods

Following the method of analysis completed by the WHO Commission on Social Determinants of Health (Commission on Social Determinants of Health, 2008), the Marmot Review in England (Marmot Review Team, 2010), the WHO Review of Social Determinants of Health and the Health Divide (WHO, 2013d), as well as pioneering WHO reports on mental health promotion and prevention of mental health (WHO, 2004a;WHO, 2004b) and a number of recent, well-researched resources, two key issues were identified and explored: (1) the social determinants of common mental disorders; and (2) action on social determinants that can prevent mental health disorders and/or improve population mental health. The work was undertaken in collaboration with staff members of the WHO’s Department of Mental Health and Substance Abuse and with advice from an international panel of experts (WHO & Gulbenkian Mental Health Platform (2014)). A draft of the original paper was presented at the Gulbenkian Global Mental Health Platform’s International Forum on Innovation in Mental Health, and modified taking into account comments received from mental health experts

A multilevel framework was applied to organize the evidence:

- **The life-course approach** across various life stages including pre- and perinatal periods, early childhood, later childhood, working and family-building years, and older age
- **Community-level contexts**, including the natural and built environment, primary healthcare, and humanitarian settings

- **Country-level contexts**, including political, social, economic, and environmental factors, cultural and social norms operating within a specific society, and whether specific policies and strategies to reduce social inequalities and to promote access to education, employment, healthcare, housing and services exist

Main findings

The poor and disadvantaged suffer disproportionately from common mental disorders and their adverse consequences (Campion et al., 2013; Melzer et al., 2004; Patel & Kleinman, 2003; Patel et al., 2010a), but middle classes are also affected. Gender also plays a major role and women tend to have higher levels of common mental disorders compared to men at every level of household income (Fig. 1).

Household income is only one of the factors leading to common mental disorders; low educational attainment, material disadvantage, unemployment (Fryers et al., 2005), and for older people social isolation, are other factors, along with gender as noted above.

Prevalence of depressed mood or anxiety has been shown to be 2.5 times higher among young people aged 10 to 15 years with low socio-economic status than among youths with high socio-economic status (Lemstra et al., 2008). Household wealth affects children’s emotional and behavioural difficulties even at ages 3–5 years (Kelly et al., 2011).

Similar observations have been reported from low and middle income countries. Of 115 studies reviewed, more than 70% reported clear and positive associations between poverty and common mental disorders (Lund et al., 2010).

Inevitably those who are lower in the social hierarchy are more likely to experience less favourable economic, social, and environmental conditions throughout life and may have access to fewer buffers and may experience accumulative stress as a result, leading on to mental disorders. Financial debt is also associated with psychiatric disorders and has a gradient effect (Jenkins et al., 2008).

A life-course perspective

It is crucial to follow a life-course approach as individuals will have on-going and continuing stressors affecting their health at various stages of life such as pregnancy and perinatal periods, early childhood, adolescence, working and family building years, and older ages (Kieling et al., 2011; Marmot Review Team, 2010). Fig. 2 illustrates this approach.

As mentioned above, exposure to stressors can be accumulative and will affect epigenetic, psychosocial, physiological, and behavioural attributes of
individuals, as well as social conditions in which families, communities, and social groups live and work. It is possible that such an accumulation of advantage and disadvantage may well contribute to social and economic inequities and consequently to inequitable mental health outcomes. These processes are not static, and keep changing in response to a whole host of factors. It is well known that a greater number of adverse events in childhood is associated with increased likelihood of developing mental illness in adulthood (Kessler et al., 2010; Oladeji et al., 2010).

At every stage in the life course, vulnerability and exposure to harmful processes or stressors can be disruptive, which is why any public mental health intervention needs to take a life course approach. A life course approach implies that institutions such as kindergartens, preschools, schools, universities and colleges, employers all need to be involved for building healthier and happier societies. This needs national policies but local actions.

**Prenatal and perinatal experiences**

The prenatal period often gets ignored, but is a critical period. The perinatal period has a significant impact on a newborn’s physical, mental, and cognitive health. Maternal health is particularly important and poor environmental conditions, poor health and nutrition, tobacco use, alcohol and drug misuse, stress, and highly demanding physical labour can all negatively affect the development of the foetus and later life outcomes (Joint Commissioning Panel for Mental Health, 2013; WHO, 2013d). Children of depressed mothers are at a greater risk of being underweight and stunted. Pre-term and low birth weight babies may well themselves develop depression in later life (Surkan et al., 2011). It has been suggested that reducing maternal depression in Pakistan by 25%, 50%, or 75% would result in reductions in children born underweight by 7%, 26%, and 36% respectively (Rahman et al., 2008). Education, particularly targeting women and new mothers, can help manage problems such as infant mortality, stunting and malnutrition, conduct problems, and emotional and mental health problems (Bicego & Boerma, 1993; Case et al., 2005; Gleason et al., 2011; Schady, 2011).

**Early childhood**

Not surprisingly, adverse conditions in early life are associated with higher risk of mental disorders (Jensen et al., 2013; WHO, 2013d). Again, it is well known that quality of parenting and family conditions affect children’s physical and emotional growth. Poor secure attachment, neglect, lack of quality stimulation and conflict all negatively affect future social behaviour, educational outcomes, employment status and mental and physical health (Bell et al., 2013). Physical and emotional neglect, abuse, and growing up in the presence of domestic violence can all damage children (Fryers & Brugha, 2013). It has been noted that children of mothers with mental ill-health are five times more likely to have mental disorders themselves (Melzer et al., 2003). As noted above, social gradients in social and emotional difficulties have been shown among children as young as three years which can be offset by protective parenting activities (Kelly et al., 2011).

Inequities in early years’ development are potentially remediable through family and parenting support, maternal care, childcare, and education. Wider family and strong communities can act as buffers and
Social determinants of mental health

Additional evidence-based actions are provided in Box 1.

Later childhood
Continued and appropriate forms of support are needed throughout childhood and adolescence. Depression in adolescence is linked with adverse childhood experiences (Bell et al., 2013; Wickrama et al., 2008) and risk taking in adolescence (including substance misuse) which affects development (Campion, 2013; Casey et al., 2008). Emotional support from peers and families can help mitigate risk behaviours. Poor environmental conditions such as overcrowding and unhealthy living can add to stress leading to poor educational achievements.

Implications for action
Schools are important in education but also for providing a safe environment for personal development and growth, the effects of which can influence both short- and long-term mental health (Barry, 2013). Schools allow access to a large number of children to teach about various matters including managing stress (Jane-Llopis & Barry, 2005). Universal approaches include changes to the school ethos, liaising with parents, special teacher training, educating parents, community involvement, and collaborating with external agencies (Weare & Nind, 2011). Country examples are provided in Box 2.

Working age
Unemployment, irregular and poor-quality employment (such as employment with no or short-term contracts), and jobs with low reward and low control affect mental ill-health. A close association exists between job loss and symptoms of common mental disorders such as depression and anxiety (Catalano et al., 2011; UCL IHE, 2012) especially in those individuals who are long-term unemployed.

Job security and a sense of control at work are protective factors (Anderson et al., 2011; Bambra, 2010). Employers who promote greater job control and decreased demand can positively influence mental health by reducing stress, anxiety and depression, and increasing self-esteem, job satisfaction and productivity (Bambra et al., 2007; Barry & Jenkins, 2007; Egan et al., 2007).

Box 1. Examples of interventions supporting mental health in the early years.

- In Jamaica a home-based intervention based on educating mothers about child-rearing including play activities and discussion of parenting issues helped individuals cope better (Baker-Henningham et al., 2005).
- The Triple P – Positive Parenting Program has been implemented in numerous countries. It focuses on children’s behaviour and development by altering the family environment to help reduce children’s risk of poor mental health (Sanders et al., 2008). Originally from Australia, this programme has been used in China (Hong Kong), the Islamic Republic of Iran, Japan, and Switzerland (Bodenmann et al., 2008; Leung et al., 2003; Matsumoto et al., 2007; Tehrani-Doost et al., 2009).
- The Sure Start initiative in England is a good example of a scaled-up approach to early years intervention by engaging with parents, pregnant mothers, infants and preschool age children to promote child development in an easily accessible manner (Goff et al., 2013; Jane-Llopis & Anderson, 2006).
- In the USA, studies have shown effectiveness of preschool interventions on young children living in low income and poverty stricken settings. The High/Scope Perry Preschool Project, the Nurse–Family Partnership and the Incredible Years series have helped improve children’s educational achievement, economic success, and mental health outcomes in later life (Kitzman et al., 2010; Schweinhart, 2006; Webster-Stratton et al., 2008). Incredible Years programmes have been implemented in 20 countries and territories, including Denmark, Finland, the occupied Palestinian territory, and the Russian Federation (Incredible Years, 2013).

Box 2. Examples of school settings supporting mental health in later childhood.

- School-based interventions can support mental health and address mental disorders in children and adolescents around the world (Collins et al., 2014; Holen et al., 2012; Katz et al., 2013) especially in poor countries and war and disaster affected countries
- The Social and Emotional Learning programme in the USA has consistently improved children’s social-emotional skills, attitudes about self and others, school engagement, positive social behaviour, academic attainment, social conduct, and emotional distress (Payton et al., 2008) by promoting supportive relationships which help develop children’s social and emotional skills (Mart et al., 2011).
- In Sri Lanka, post-civil conflict, a school-based intervention improved mental health and conduct behaviour, including improvements in children’s ability to settle disputes in a non-violent way (Tol et al., 2012). This was based on models from other war-afflicted countries, such as Indonesia (Tol et al., 2008).
Implications for action

A reduction in long-term unemployment can reduce risk of developing mental disorders, especially among working age adults (Marmot Review Team, 2010) but equally importantly minimum wage can enable people to live better and thus reduce risk of mental illness. Those who are employed require support from their employers to promote and sustain mental health.

Box 3 describes a programme in China that reduced workers’ anxiety and depression, among other positive outcomes.

It has been argued that every £1 spent on a workplace mental health promotion programme would generate £10 in economic returns (Knapp et al., 2011).

Microfinance programmes are other potential mechanisms to improve mental health by helping people earn a living and enable communities to work their way out of poverty (PATH, 2011). These are underutilized resources with the potential to deliver health-related services to large and hard-to-reach populations (Leatherman et al., 2012). Nonetheless, only limited research (see Box 4) has examined the effects of these programmes on mental health.

Family-building

Families are often the basis of social support and provide safe environments in which people grow up and develop. Families and cultures are crucial in developing cognition as well as attachment patterns. Postnatal depression can affect women’s mental health, but also family functioning.

In low and middle income countries, the prevalence of common mental disorders among women in the perinatal period is estimated to be 16% before birth and 20% postnatally (Fisher et al., 2012). In England, postnatal depression shows a clear social class gradient: from 2003 to 2004 just over 20% of those in the lowest quintile for socio-economic status had experienced postnatal depression, compared with 7% in the highest socio-economic quintile (Marmot Review Team, 2010). Similar gradients may well exist in other countries. Additional risk factors for common mental disorders in the perinatal period included socio-economic disadvantages, unintended pregnancy, being younger and unmarried, hostile in-laws and female child, while protective factors included education, being employed and trustworthy partner.

Primary and community health workers can intervene successfully to improve maternal mental health, thereby buffering risk for children (Rahman et al., 2013). Box 5 illustrates with an account from South Africa.

Implications for action

Interventions supporting maternal and postnatal mental health benefit parents as well their children and can disrupt the intergenerational transfer of inequities (Marmot Review Team, 2010). Long-term

Box 3. A workplace intervention in China to promote mental health.

- In China, a workplace health promotion programme reduced depression and anxiety among the workforce, improved work performance, and reduced absenteeism.
- It also provided employees with the ability to manage work demands more effectively (Sun et al., 2013).
- Initiated by one of the largest retail companies in China, Credibility Retail Enterprise.
- Interventions occurred at the organizational level (by teaching managers skills and training to promote mental health, create a good working environment, and develop an organizational health policy) and at the employee level through better communication skills, stress management, problem solving, conflict management, and self-awareness.

Box 4. Evidence of microfinance supporting mental health in working age.

- In South Africa, Fernald et al. (2008) demonstrated that small individual loans reduced depressive symptoms among men, but not among women (Fernald et al., 2008). However, other studies have shown that microfinance interventions can improve the lives of women, including their mental health.
- The Intervention with Microfinance for AIDS and Gender Equity (IMAGE), which combined group-based microfinance with a gender and HIV/AIDS training programme, significantly reduced levels of interpersonal violence in villages taking part in the intervention with direct benefits to interpersonal, familial, and wider social relations along with a reduction in violence (Jan et al., 2011).
- Type of microfinance repayment scheme influenced levels of anxiety among clients in India, with 51% less experience of anxiety about repayment than clients on a weekly repayment scheme (Field et al., 2012).
Interventions can help throughout the vulnerable periods of childhood and adolescence.

**Intergenerational transfer of disadvantage**

As mentioned above, the family-building stage is related closely to the perinatal and early years and intergenerational transfer of disadvantage and inequity which can lead to further disadvantages through the perpetuation of disadvantage. See Fig. 2.

**Older ages**

Not surprisingly, older people’s mental health is influenced by earlier life experiences and also related to experiences, conditions, and contexts specific to ageing and the post-retirement period which may be strongly influenced by cultural and social factors. With this group too, there will be a social gradient in mental disorders among older people. Certainly in high-income countries, inequalities in older people’s mental health have been shown to be related to socio-economic status, educational status, gender, ethnicity, age, level of physical health (itself related to cultural, social, and economic factors) (Allen, 2008; McCrone et al., 2008). These experiences also vary by country, related to social, political, and economic arrangements, and to levels of social protection (Grundy et al., 2013). Cultural factors and attitudes to ageing will also affect social support.

Depressive mood in older men is related to chronic ill-health, whereas for older women social factors such as levels of isolation, contact with family, and belonging to faith or other community groups play a role (Grundy et al., 2013). Once again, higher levels of education appear to be a protective factor, particularly for women (Ploubidis & Grundy, 2009). Older individuals have a higher risk of developing depression (McCrone et al., 2008). Indeed, life events related to ageing such as bereavement and loss, loss of status, poor physical health and poor social contacts can all contribute to depression. The Survey of Health, Ageing and Retirement in Europe (SHARE study) noted that there are cross-national differences in depression and well-being among the elderly (Grundy et al., 2013). The Scandinavian countries appear to be best for older individuals as they have the lowest rates of depression, whereas Mediterranean countries such as Italy, Greece and Spain show the highest levels of late-life depression. This variation is related to levels of state provision managing mental health and pensions (Grundy et al., 2013). Interestingly, rates of depression among older adults in Japan are lower than those among younger adults (Donovan & Halpern, 2002); whether this can be explained by attitudes to ageing and filial piety needs further exploration.

Social isolation reflecting lack of social contact and support can be a key factor in developing depression, especially in women; 10% or more older adults are noted to be socially isolated, and loneliness in older people has been linked to depressive symptoms, poor mental health and cognition, alcohol dependence, suicidal ideation, and death (Grundy et al., 2013).

**Implications for action**

It is apparent that interventions which help prolong levels of activity and reduce social isolation will help reduce depressive symptoms (Forsman et al., 2011). Reducing social isolation, increasing exercise and physical activity and lifelong learning programmes all help (see Box 6 for examples), along with a reduction in financial poverty (Campion et al., 2011). In cold climates, improving heating in the house (Critchley et al., 2007, Green & Gilbertson, 2008), help older people (Mead et al., 2010), and opportunities for older to people to volunteer (Lum & Lightfoot, 2005) are effective tools. Further work is required as a matter of urgency in low and middle income countries.

**Box 5. Evidence from South Africa on maternal depression.**

- Effective interventions in South Africa have reduced maternal depression and improved child attachment and interaction (Cooper et al., 2007).
- The Mother2Mothers programme helped communities develop peer support through education on how to access existing healthcare services. As a result, new mothers experienced more positive changes (Baek et al., 2007).

**Box 6. Examples of interventions supporting mental health during older ages.**

- In Auckland, New Zealand, the Meeting of the Minds was formed to promote positive ageing through a coordinated cognitive activity programme. Using libraries as a resource enabled people to socialize, share accounts, and be involved in other social activities to meet new people and develop social relationships (Saxena & Garrison, 2004).
- The Upstream Healthy Living Centre in the UK uses mentors to deliver tailored activities and improve social interaction, especially in rural settings, leading to improved psychological well-being and reduced depression (Greaves & Farbus, 2006) by reducing social isolation.
Community-level contexts

There is little doubt that the environment or communities in which people grow, live, work, and age have considerable influence upon mental health. These include both tangible aspects such as the natural and built environment, and intangible aspects such as neighbourhood trust and safety. In addition, geographical accessibility to primary care and community are also important.

We now describe three aspects of the community context in detail: the natural and built environment, primary healthcare, and humanitarian settings. General approaches to addressing the social determinants of mental health in communities also exist (see Box 7).

The natural and built environment

The natural and built environment includes both natural and human-made aspects of communities and includes geography and climate, housing quality, water and sanitation systems, air quality, and transportation systems. These factors affect direct and indirect aspects of mental disorders and poor mental health (Turley et al., 2013; Wright & Moos, 2007). Overcrowding, for example, can lead to stress and family violence, including child maltreatment, intimate partner violence and sexual violence, and elder abuse (ODPM, 2004; UN Centre for Human Settlements, 1998).

Implications for action

A number of specific interventions such as water, sanitation and waste management improvements, energy infrastructure upgrades, new transport infrastructure, mitigation of environmental hazards, and improved housing (Turley et al., 2013) can improve mental health and functioning. Box 8 provides some illustrations of the impact of housing upgrades on mental health. Ease of access to the natural environment and outdoor spaces is also vitally important for good mental health. Almost half the world’s population now live in urban areas away from natural environments and connections with nature (Haines et al., 2007). Living close to natural environments and engaging in outdoor activities such as walking, running, cycling and gardening reduces stress, anxiety and depression (Barton et al., 2009; Maller et al., 2009; Pretty et al., 2007) in addition to conferring the mental health benefits of physical activity (whether indoors or outdoors) (Coon et al., 2011). Connecting with the natural environment benefits mental health. Taking walks in parks improved concentration among children with ADHD, employee mood and performance improved after the introduction of plants into offices (Grinde & Patil, 2009; Kuo & Taylor, 2004; Mind, 2007; Shibata & Suzuki, 2002; Taylor & Kuo, 2009).

Primary healthcare

Primary healthcare should be the bed-rock of healthcare delivery, but different healthcare systems around the globe will provide different types of primary care. Primary healthcare has a significant role to play in promoting good mental health through direct provision and referrals to other more specialized services (Barry & Jenkins, 2007). Primary healthcare may be the only source of healthcare available in many countries, especially for people on low incomes (Rojas et al., 2007), and only physical health needs may be met (Patel et al., 2010b). Resources for mental health are in short supply in many countries (Kakuma et al., 2013).

If healthcare is organized around people’s needs and expectations and around the tenets of primary healthcare, it can produce a higher level of health for the same investment (WHO, 2008c). Uganda is one country that has done so (Box 9). The Mental Health and Poverty Projects in Mayuge, Uganda, and KwaZulu-Natal, South Africa, through multi-sectorial community collaborations, task shifting, and the development and support of self-help groups were particularly promising methods to address the

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Box 7. Examples of community-level interventions in Ghana, Kenya and India.

- Self-help groups in northern Ghana have helped facilitate access to the psychological services offered by the Ghanaian Health Service. These groups in their monthly meetings support each other by sharing tasks such as collecting wood and water, even visiting homes to cook for people and providing financial credit if needed (Cohen et al., 2012).
- In rural Kenya the BasicNeeds programme has also led to significant improvements in mental health, quality of life, social relations, and economic functioning (Lund et al., 2013).
- In India the Comprehensive Rural Health Project is a community-based intervention that integrates mental health into the primary healthcare setting with a strong focus on women, addressing the social and economic determinants of health and educating individuals. Using trained volunteers the intervention works with groups of women from the community to build competence and self-esteem, and to increase perceptions of personal control. These changes in lifestyle and circumstance improved their mental health (Kermode et al., 2007, 2009).
treatment gap in low income settings (Petersen et al., 2011).

Implications for action

Mental health integration into primary healthcare is important (WHO, 2001, 2009; WHO & World Organization of Family Doctors, 2008); and a companion thematic paper from the WHO/Gulbenkian mental health series (WHO, 2014) addresses this topic in detail. In addition, WHO’s Mental Health Gap Action Programme (WHO, 2008a) provides policy-makers, health planners, and other stakeholders with clear guidance on how to scale up mental healthcare. One key principle is that to be effective, primary health workers must be supported by secondary-level mental health specialists for supervision and referrals.

Humanitarian settings

Man-made or natural disasters can lead to mental disorders (Meffert & Ekblad, 2013; Tol et al., 2011). In addition, those with pre-existing mental health problems might experience worse symptoms, while at the same time structures delivering the services are under increased pressure (WHO, 2013a), and inevitably poorer and more marginalized members of communities tend to experience the most adverse effects (WHO, 2010). A humanitarian crisis, whether war, conflict, floods or other disasters, affects individuals as well as communities and social institutions, leading to the breakdown of families, social networks, and community bonds. It is vital that any interventions take into account the actual social environment as well as health and nutritional needs (see Box 10).

Implications for action

WHO provides guidance and examples of good practice (WHO, 2013c).

Country-level contexts

It is inevitable that the current political, social, economic, and environmental milieu, and cultural and social norms, as well as the historical context of a country, shape the conditions in which people live. Countries with few political freedoms, unstable policy environments, and poorly developed services create vulnerabilities among their populations, causing deleterious effects on mental health (Marmot Review Team, 2010). Poverty puts people at an increased risk of mental health problems through a number of intermediary factors.

The impact of political, social, and economic turbulence on mental and physical health was powerfully demonstrated by the decline and subsequent fluctuations in life expectancy in the Russian Federation after the collapse of the Soviet Union (Marmot et al., 2012). Deaths increased sharply among middle-aged adults in the Russian Federation from 1991 to 2001 (Men et al., 2003) possibly attributable to harmful use of alcohol (Leon et al., 2007). Alcohol plays a major role in contributing to mental ill-health, and various strategies can be used to manage this (see Box 11).

Across the former Soviet Union, psychological distress has varied between and within countries. Women have shown higher rates of distress than
men with risk factors including poverty, unemployment, low education, disability, lack of trust in people, and lack of personal support (Roberts et al., 2010). Across the Czech Republic, Poland, and the Russian Federation too, depression has been associated with social deprivation for both men and women. Socio-economic circumstances have been shown to be more strongly associated with depression than early life experience or level of education (Nicholson et al., 2008).

Following the 2008 banking crisis, rates of unemployment rose sharply in the European Union as did rates of suicide (Stuckler et al., 2011). Between 1970–2007, in 26 European countries, every 1% increase in unemployment was associated with a 0.79% rise in suicides at ages younger than 65 years (Stuckler et al., 2009). As mentioned above, it is well known that unemployment is associated with an increased risk of depression (Kaplan et al., 1987, Kasl & Jones, 2000) and job insecurity is associated with sub-optimal mental health (UCL IHE, 2012, Virtanen et al., 2011).

Strong social welfare systems seem to offer protection against unemployment risks for mental disorders. Over a 25-year period it was noted that in comparing Spain and Sweden, in the former there was a direct correlation between unemployment and suicide rates, but not in the latter, indicating that higher level of social spending on active labour markets in Sweden (average labour market protection US$362 per head) than in Spain ($88 per head) may have had an impact (Kasl & Jones, 2000).

### Box 11. Policies to reduce alcohol consumption.

- Alcohol consumption affects population mental health, increasing the likelihood of alcohol dependence, depression, and suicide, along with contributing to poor physical health, accidental injury, and domestic violence (Wahlbeck & McDaid, 2012).
- Political debate and policy changes have been growing in countries such as Australia, Malawi, the UK (England and Scotland) and Zambia (Collins & Lapsley, 2008; Scottish Parliament, 2012; UN Development Programme, 2013; Woodhouse & Ward, 2013).
- Minimum alcohol pricing has become a major issue in many countries. Evidence from British Columbia, Canada shows that as a result of minimum alcohol pricing over the last 20 years the price of alcohol has been adjusted incrementally over time.
- It has been estimated that a 10% increase in the minimum price of an alcoholic drink reduced consumption relative to other drinks by 16.1%, and overall consumption of alcohol by 3.4% (Stockwell et al., 2012).

### Box 12. Active labour markets.

- Active labour market programmes have been used in countries such as Denmark (Jespersen et al., 2008), Sweden (Sianesi 2002), and specific states within the USA and they take an active approach to getting people back to work (Stuckler & Basu, 2013).
- The Finnish programme promotes and facilitates re-employment through training and support, and participants showed significantly lower levels of depression and increased levels of self-esteem, relative to a control group, at two years (Vuori & Silvonen, 2005; Vuori et al., 2002).

Additional information about active labour markets is provided in Box 12.

### Policy measures

Several high-income countries, including Australia, New Zealand, and England and Scotland in the UK, have incorporated a social determinants of mental health approach into national policy and strategy using a multisectoral approach.

### Implications for action

It is self-evident that people’s mental health is influenced by a number of social, economic and environmental factors, therefore governments need to work across different departments, integrating mental health into a broad range of related policy areas.

### Discussion

There is considerable research evidence to show that social inequalities affect the public’s mental health, and urgent action is needed to improve the conditions of daily life throughout the life-course. Broader economic and political interventions have shown successful influences on the mental health of populations.

It is important to understand that good mental health is a core indicator of human development, and it is necessary to integrate a mental health and psychosocial perspective into development and humanitarian policies, programmes and services, particularly internationally agreed goals and commitments (WHO & UN, 2010). The WHO’s Mental Health Action Plan 2013–2020 (WHO, 2013b) calls for integration of mental health issues into multisectoral policies and laws, including education, employment, disability, the judicial system, human rights protection, social protection, poverty reduction and development.
Principles and actions

Proportionate universalism

A key principle to be taken forward from this paper is ‘proportionate universalism’, which is derived from the observation that mental health inequities affect everyone, not only the poorest or most disadvantaged in society. Thus actions must be universal, yet calibrated in proportion to the level of disadvantage; hence the term proportionate universalism.

Proportionate universalism needs to be differentiated from targeted programmes and services, whereby the most vulnerable or disadvantaged are singled out for specialized interventions. These services may exclude the neediest individuals who for whatever reason may not fulfill their inclusion criteria. Services for the poor often become ‘poor services’ and are easily ghettoized, reduced or stopped altogether because they may not have the support of the whole population.

Action across sectors

As explained above, successful interventions on the social determinants of mental health result from action across multiple sectors and levels, for instance health, education, judicial, employment, welfare, transport, and housing sectors. Effective leadership is essential to inspire and make the case, and to drive through the necessary negotiations. Multisectoral coordination is also needed outside of government, with potential participation and cooperation of international organizations, non-governmental organizations, social institutions and service providers, community and voluntary groups, and the private sector.

Life-course approach

The interplay of risk and protective factors changes over the life cycle; interventions and strategies must therefore be appropriate to different stages of life. Therefore, taking a life-course perspective recognizes that exposure to advantage and disadvantage at each stage of life has the potential to influence mental health in both the short term and long term. Hence, in many cases, organizations in which people are typically involved at different stages of life (e.g. schools, employers) are the most appropriate settings to deliver interventions.

Early intervention

Every child deserves to have the best possible start in life. Interventions at the earliest stages of a child’s life can prevent both short- and long-term mental disorders and enable them to maximize their potential and a healthy adulthood. Early intervention strategies are also useful in reducing maternal depression and disrupting intergenerational transmission of inequity.

Healthy mind and healthy body

A social determinants of health approach should consider both mental and physical health implications within all actions to tackle health inequalities. Mental and physical health conditions are fundamentally inter-related: sharing many underlying causes and overarching consequences, highly interdependent and tend to co-occur, and they are best managed using integrated approaches. Programmes aimed at improving water and sanitation, reducing unemployment, or mitigating the effects of climate change and increasing sustainability are likely to have a positive impact on both mental and physical health while addressing health inequities.

Prioritizing mental health

Mental health needs to be given greater priority across the world, but especially in low and middle income countries, where the issue is often poorly understood and/or not recognized as a major health concern. Increased awareness and understanding of mental health should be followed urgently by increased allocations of appropriate and sufficient financial, medical, and human resources towards tackling mental disorders and reducing inequalities.

Avoiding short-termism

Short-term thinking often obstructs progress. Thus long-term interventions are needed which will include community development, capacity-building, partnerships, and local institution-building across the life-course.

Mental health equity in all policies

Reducing inequalities in mental health is a task that must be taken on by the whole of government and across all sectors. It is important that all policies across all sectors do no harm to population mental health, but rather, reduce mental health inequities.

Knowledge for action at the local level

Information systems and processes are needed at local levels to inform action. Different kinds of information are needed depending on the intended action, but include:

- Information on the distribution of mental disorders at the local level
• Information on how many of those with mental disorders have access to effective therapeutic treatment, and on the unmet need for therapy i.e. what the mental health gap is
• Information about social, economic, and environmental stressors explored and understood through community engagement
• Knowledge of local assets and resources, including how local social, economic, and environmental factors contribute to or reduce psychological distress, understanding both precipitating and protective factors
• Triangulated knowledge about local assets and resources, and interventions that have worked in other settings and the lessons as well as strengths and weaknesses of each approach
• Assessments of all local development initiatives with respect to their potential impact on mental health equity (how different groups might be impacted), especially those with mental disorders
• Synergies between interventions: information about how mental health and its social distribution are influenced by interventions to improve aspects of the local educational services, healthcare services, built environment, natural environment, transport, income generating opportunities, and community development

Such information can lead to action at the local level. Ideally, national-level strategies should provide the framework and support for local-level action. For local-level action to be effective and sustainable over the longer term, country-wide strategies must be implemented to tackle deep-rooted structural issues arising from the unequal distribution of power, money, and resources.

Country-wide strategies

Country-level strategies are likely to have a significant impact on reducing mental health inequalities and have the greatest potential to reach large populations. These include the alleviation of poverty and effective social protection across the life-course, reduction of inequalities and discrimination, prevention of war and violent conflict, and promotion of access to employment, healthcare, housing, and education. Particular emphasis should be given to policies relating to the treatment of maternal depression, early childhood development, targeting families of people with mental disorders in poverty alleviation programmes, social welfare for the unemployed, and alcohol policies. These are areas that have particularly strong associations with mental disorders and have a clear social gradient.

Although mental health was not mentioned explicitly in the Millennium Development Goals (MDGs) (UN, 2000), progress towards these goals contributes powerfully to mental health promotion. In preparation for the 2015 expiry date of the MDGs, the United Nations (UN) is in the process of consultation and planning for the next phase of post-2015 sustainable human development (post-2015 agenda), leading on from existing unfinished MDGs and the Rio + 20 environmental sustainability agenda (UN, 2012).

Embedding the social determinants of health approach (UN Platform on Social Determinants of Health, 2013) and universal health coverage (WHO, 2013f) in the post-2015 agenda would create a transformative development framework for health. Specific inclusion of mental health is also necessary (Minas & Kwasik, 2013). The Movement for Global Mental Health, a network of individuals and organizations aiming to improve services for people with mental disorders, calls for three elements to be included in the post-2015 agenda (Movement for Global Mental Health, 2013): protecting human rights and preventing discrimination against people with mental disorders, bridging the massive mental health treatment gap and improving access to health and social care, and explicitly integrating mental health into development initiatives.

Conclusions

In this paper we have outlined how mental health and many common mental disorders are shaped by the social, economic and physical environments and social gradient in which people live and work. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the social inequality the higher the risk. The poor and disadvantaged suffer disproportionately, but everyone in society is affected to an extent.

People are made vulnerable to mental ill-health by deep-rooted poverty, social inequality, and discrimination. Social arrangements and institutions, such as education, social care, healthcare and work, also have a considerable impact on mental health, for better or for worse. To reduce inequities and promote good mental health, it is vital that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood, older childhood and adolescence, during family-building and working ages, and through to older age. Not only must such action be throughout these life stages, but also across various sectors within and outside the country, which will provide opportunities for both improving population mental health, and for reducing risk of those mental disorders that are associated with social inequalities. As mental disorders are fundamentally linked to a number of other physical health conditions, these
actions would also reduce inequalities in physical health and improve health overall.

The evidence is convincing that policy-making at all levels of governance and across sectors can make a positive difference to mental health outcomes. Action needs to be universal, across the whole of society and proportionate to need. Empowerment of individuals and communities is at the heart of action on social determinants.

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Social determinants of mental health


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