Thrive LDN

Mapping mental health in London

Produced by

Mental Health Foundation

For

Thrive LDN

A report into the prevalence of determinants and mental health inequalities in the city

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Executive summary

Background

Health inequalities are defined as differences in health status or distribution of health determinants between different population groups; a broad range of them represent risk factors (determinants or mediators) of poor mental health. Certain inequalities, or their indirect impact, can be modifiable, but attempting to modify risk factors needs to be done on the basis of evidence and need.

Findings

In this context, this report represents a rapid review of evidence and available data in order to map a range of principal poor mental health risk factors and inequalities affecting Londoners, in a bid to identify priority areas for attention. London has unique demographics and structure compared to the rest of the UK, which call for targeted approaches. Evidence has been split in 5 categories:

1. **Children and young people:** the highest risk was mapped in Barking & Dagenham and Tower Hamlets, with domestic violence, family poverty, persistent school absenteeism, and first time entrants to youth justice system being the main factors.
2. **Employment and mental health:** the highest risk was mapped in Newham, Southwark and Greenwich, with young people not in education, employment or training, unemployment rates, and people on benefits being the main factors.
3. **Community strength and resilience:** the highest risk was mapped in Tower Hamlets, Newham and Brent, with multiple deprivation, ethnic minorities at high risk, and overcrowded households being the main factors.
4. **Crisis care and complex needs:** the highest risk was mapped in Islington, Tower Hamlets and Newham, with access to mental health services, alcohol use disorders, and chronic cardiovascular disease being the main factors.
5. **Suicide reduction:** the highest risk was mapped in Southwark, Tower Hamlets and Islington, with unemployment, addiction, and access to mental health services being the main factors.

Recommendations

Key areas of focus for London, as far as modifiable risk factors are concerned, will be:

- family and parental approaches
- social discrimination
- working across non-health policies (particularly criminal justice, education and employment)
- improving systematic recording and transparency of lesbian, gay, bisexual and transgender (LGBT) rates, long term conditions (especially skin diseases), and sickness absence rates by local authority
- improving integration of physical and mental health services

Solutions

Given the high incidence of poor mental health (1 in 6 adults present with a common problem every week) as well as its wide reach, it makes sense to take a whole systems approach to preventing it, whether this be within the family system, a particular setting, or across a whole community. This reflects the principle of proportionate universality, which suggests starting from universal approaches and focusing down on targeted solutions for those facing the most significant inequalities.

Introduction

This brief report has been prepared by the Mental Health Foundation to support the developmental work of Thrive LDN. It brings together and maps a range of principal mental health risk factors and inequalities affecting Londoners in a bid to identify priority areas for attention.

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. These determinants in mental health are correlated with each other and many are associated in a cause and effect way. They may act as mediators or moderators rather than primary determinants. Thus, mental health needs to be considered as a dynamic state whereby, individual genetic makeup may be brought to bear but then influenced by a wide range of environmental factors. This can start in utero, in relation to the health status of mothers during pregnancy and can extend into early years influenced by parental bonding in infancy. Thereafter, factors such as exposure to adversity in childhood, financial and health status in adulthood, and levels of social connectedness in later life can all have a part to play and can have a cumulative effect across the life course. In attempts to improve public mental health, it therefore makes sense to take a whole systems approach whether this be within the family system, within a setting, or across a whole community, under the concept of proportionate universality, which suggests starting from universal approaches and focusing down on targeted solutions for those facing the most significant inequalities.

Some of these inequalities or differences, such as ethnicity, though fixed, impart risk mainly through discrimination which can be mitigated. Similarly, inequalities caused by social or geographical factors can be avoided. Attempting to modify some of these risk factors should be done on the basis of evidence and need. It should be noted that some individual factors, for example abusive parenting, drug and alcohol misuse or bullying in workplaces or schools, are more difficult to measure, record and map compared to social factors such as income, education or marital status.

In this context, we have sought to bring together a broad range of risk factors and inequalities data and illustrate how these overlay in multiple layers, forming a complex but rich overview of where strategic action and structured programmes of work in London could enable the greatest impact.

Principal mental health risk factors and inequalities affecting Londoners

There is a long list of determinants and inequalities that are classified as risk factors for mental illness. These include, among others, demographic (gender, age and generation, childhood abuse); social (ethnicity, poor housing conditions, job quality and insecurity, unemployment and welfare receipt, domestic violence, caring responsibilities); cultural (religion, and religious discrimination); economic (neighbourhood deprivation, debt, poverty) and health-related (disability, learning impairment, long term physical conditions) factors.

We have sourced data on the key risk factors and inequalities outlined in Table 1. We have used the best and most up-to-date maps of inequalities across London as proxies for certain determinants. In selecting these indicators, we were partly guided by experts and the 2010 London Health Inequalities Strategy published by the Mayor of London. We have mapped these indicators geographically across the 32 Local Authorities of London and The City of London (where data was available).

We have also done further sub-mappings under the headings from the Thrive LDN Steering Group key lines of enquiry. Factors were compiled into maps of risk for each issue (a map that prioritises areas of focus on the basis of accumulation of risk factors).

We also compiled an overall heat map of risk combining the information in quintiles across all lines of the enquiry. We have followed a mixed research methodology of literature review, hand searches, online searches and expert advice.

Table 1
Indicators of mental health inequalities in London

- Rates of Domestic Violence, 2016
- % of children living in poverty, 2012
- Family homelessness, 2016
- Rough sleeping, 2015
- % of children in need due to abuse, neglect, 2016
- % of young people who have been bullied in the past couple of months, 2014
- Areas with high concentration of families with separated or divorced couples, 2014
- Children health admissions as a result of self-harm, 2016
- % of persistent school absenteeism, 2015
- Numbers of children involved in family court cases
- Prevalence of eating disorders among young people, 2016
- Number of young people not in educations, employment or training (NEETs),
- Unemployment rates, 2014
- Long-term unemployment, grouped by deprivation, 2016
- Caseload of Employment and Support Allowance claimants, 2016
- % of people with low scores on self-reported well-being, 2016
- Crime rates, 2016
- Deciles of Index of Multiple Deprivation, 2015
- Overcrowded households (proxy for poor housing conditions), 2011
- Ethnicity (% of population from Black, Asian and minority ethnic (BAME) groups), 2016
- All age learning disability prevalence, 2015
- Access to mental health services, 2016
- Access to social care services for people with existing mental health problems, 2016
- % of people who can't speak English, 2016
- Age-standardised death rates from cardiovascular disease in men and women under 75, 2013
- Prevalence of diabetes, 2016
- Persons admitted to hospital for alcohol-specific conditions, 2016
- Prevalence of unpaid carers, 2011
- Suicide age-standardised rates, 2016

Key groups and issues

The key risk factors and inequalities data can be grouped under the headings from the Thrive LDN Steering Group key lines of enquiry; which emerged from the initial phase of peer and stakeholder engagement:

1. **Children and young people;** early years – first 1,000 days; and place based emotional and mental health improvement in schools

2. **Employment and mental health** Supporting people with mental ill health into sustainable employment

3. **Community strength and resilience**

4. **Crisis care and people who have multiple and complex needs**

5. **Suicide reduction**

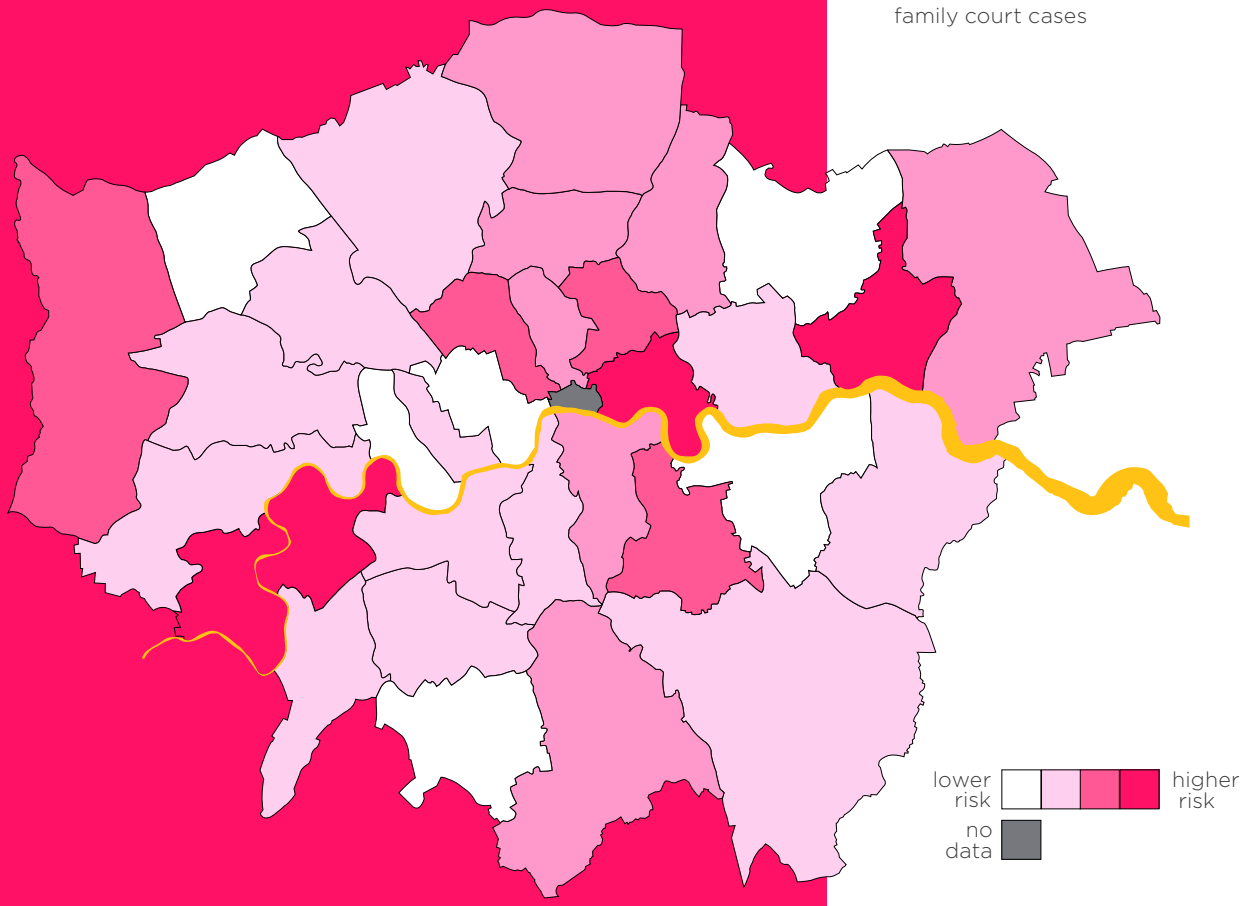
These are outlined in the following pages. The results and complete data have not been included in this report for reasons of brevity, but the accumulation of those is summarised through maps of risk across London Local Authorities. Where the colour gets darker, the corresponding risk of higher population levels of poor mental health is higher. White areas are not free of risk, but the accumulation of inequalities in them is much smaller to achieve a noticeable effect compared to the rest.

Children and young people; early years – first 1,000 days; and place based emotional and mental health improvement in schools

It is noted that persistent absentees (PAs) from school are more likely to come from lone parent households or households with no parents, compared to their non-PA peers. Evidence suggests that persistent absentees are more likely to be bullied, excluded from school and be involved in risky behaviours (experiment with drugs, alcohol etc.) than non-PAs.

Indicators used:

- Rates of Domestic Violence
- % of children living in poverty
- Family homelessness
- % of children in need due to abuse, neglect
- Child health admissions as a result of self-harm
- Prevalence of eating disorders among young people
- % of young people who have been bullied in the past couple of months
- % of persistent school absenteeism
- Numbers of children involved in family court cases

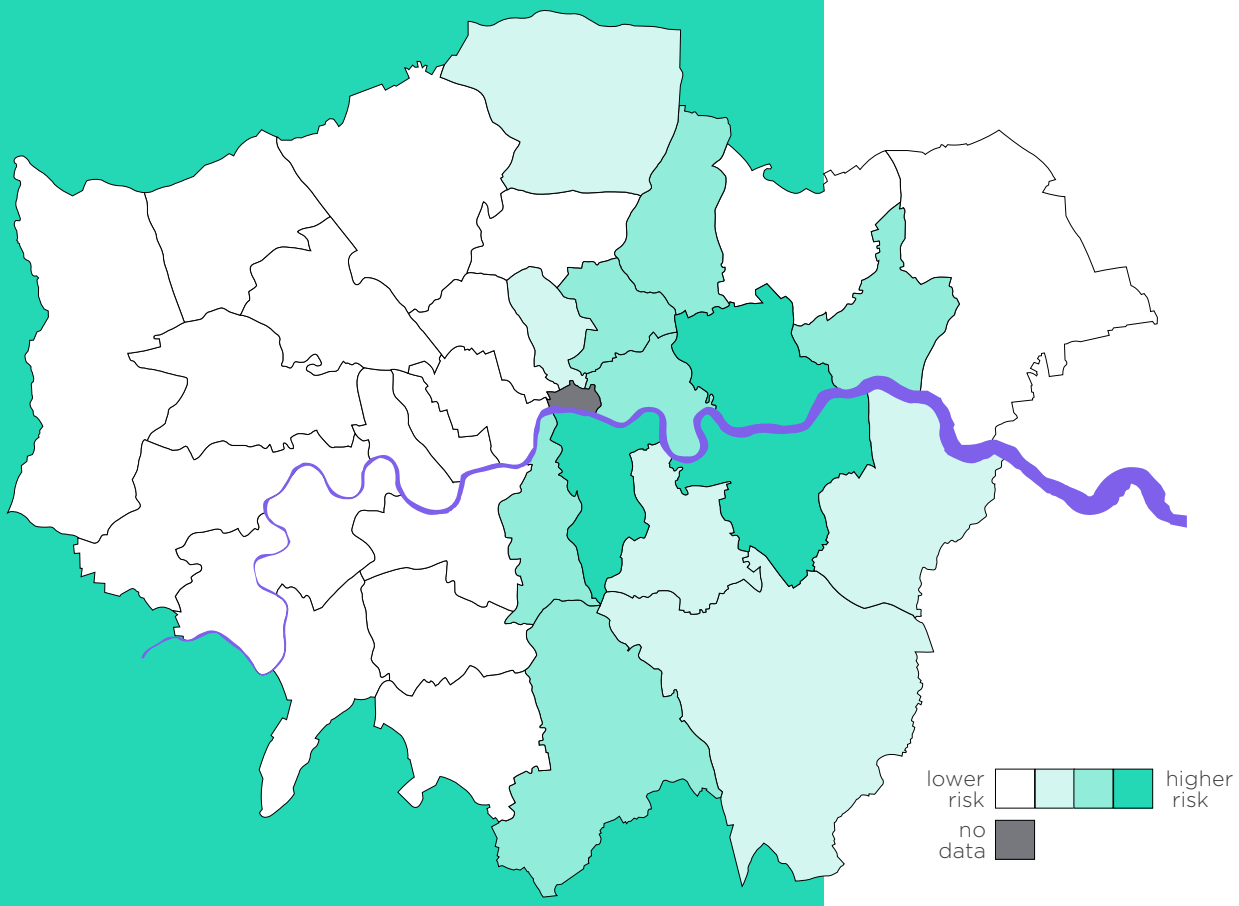


Employment and mental health – Supporting people with mental ill health into sustainable employment

It should be noted that according to the latest data from the Office for National Statistics (2014), workers in London had the lowest percentage of hours lost to sickness, at 1.5%. This may be down to the fact that the London workforce when compared to other parts of Great Britain has a younger work force and more self-employed people. Compared to the rest of Great Britain, London also had a higher than average percentage of workers in the managers, directors and senior officials and professional occupations. These characteristics are associated with lower than average sickness absence rates.

Indicators used

- Number of NEETs (young people not in education, employment or training)
- Unemployment Rates
- Long-term unemployment, grouped by deprivation
- % of people with low scores on self-reported well-being
- Caseload of Employment and Support Allowance claimants

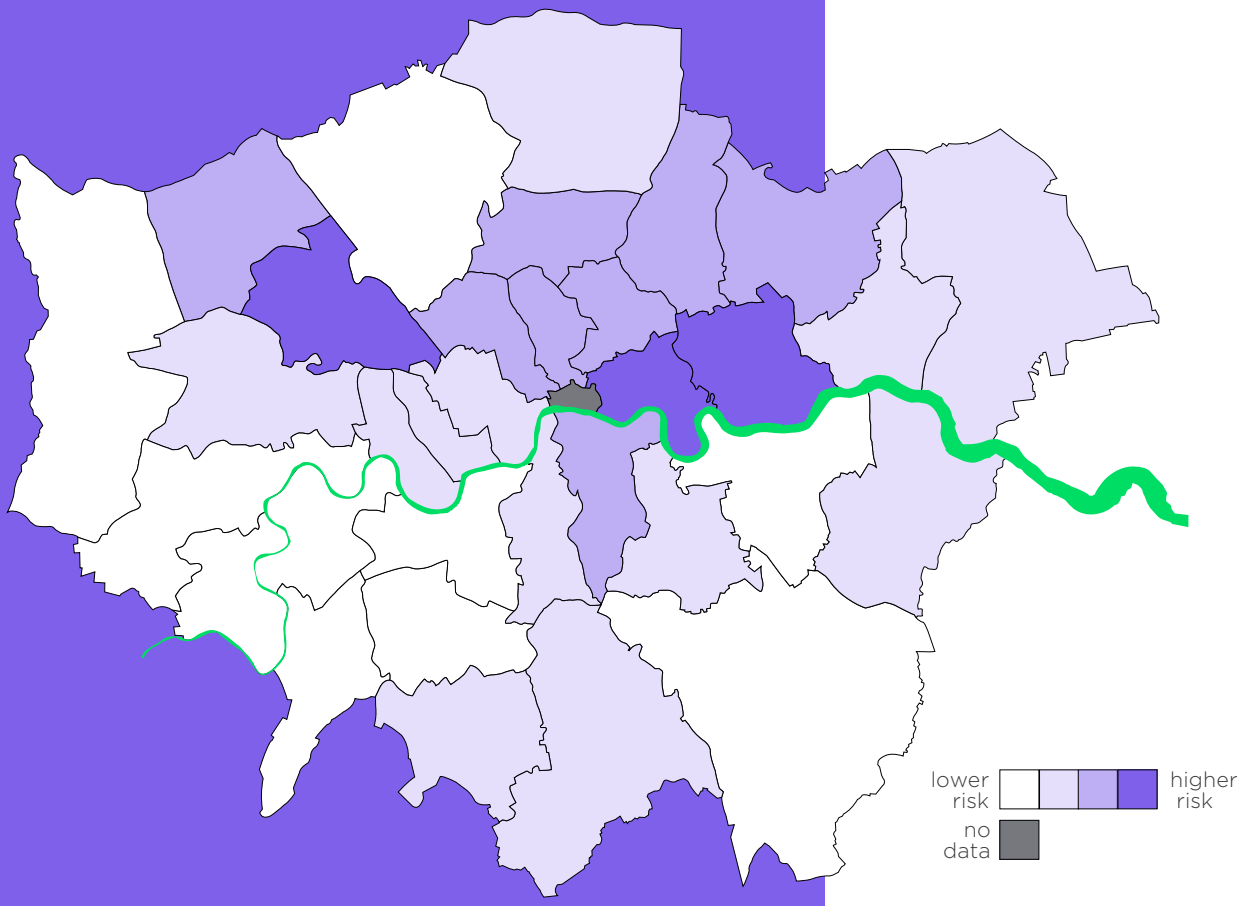


Community strength and resilience

It is noted that the Office for National Statistics does not routinely report lesbian, gay, bisexual and transgender (LGBT) rates by local authority in the census publications.

Indicators used:

- Crime Rates
- Deciles of Index of Multiple Deprivation
- Ethnicity (% of population from Black, Asian and minority ethnic (BAME) groups)
- Areas with high concentration of families with separated or divorced couples
- Overcrowded households (proxy for poor housing conditions)
- All age learning disability prevalence
- Prevalence of unpaid carers

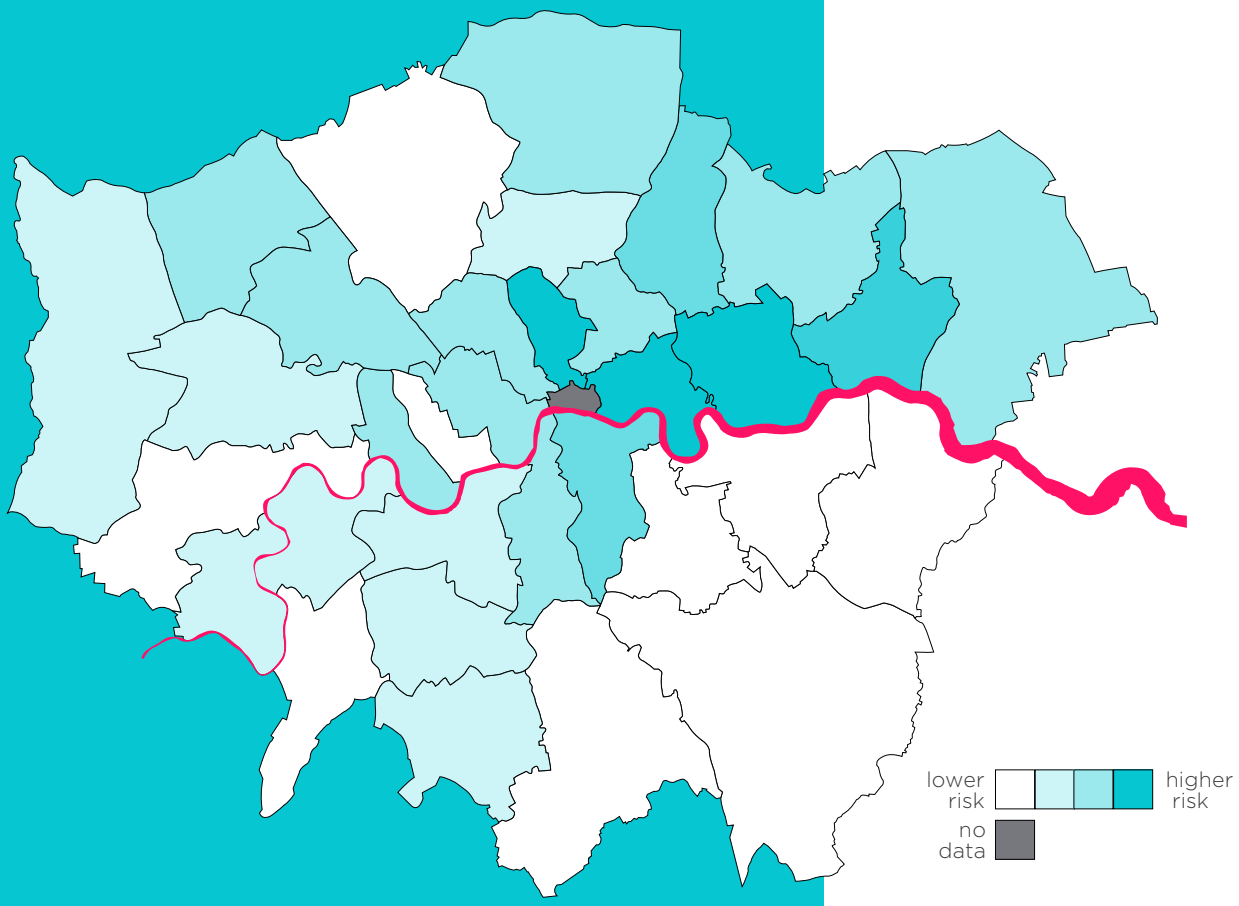


Crisis care and people who have multiple and complex needs

It should be noted that there are not good quality prevalence rates for long term skin diseases and psoriasis, which have been identified as risk factors for poor mental health and suicide. Of note, Westminster has a significantly higher number of rough sleeping counts, which, though not shifting the overall prioritisation, would be an inequality to take into account locally.

Indicators used:

- Access to mental health services
- Access to social care services for people with existing mental health problems
- % of people who can't speak English
- Prevalence of unpaid carers
- Persons admitted to hospital for alcohol-specific conditions
- Age-standardised death rates from cardiovascular disease in men and women under 75
- Prevalence of diabetes
- Rough sleeping

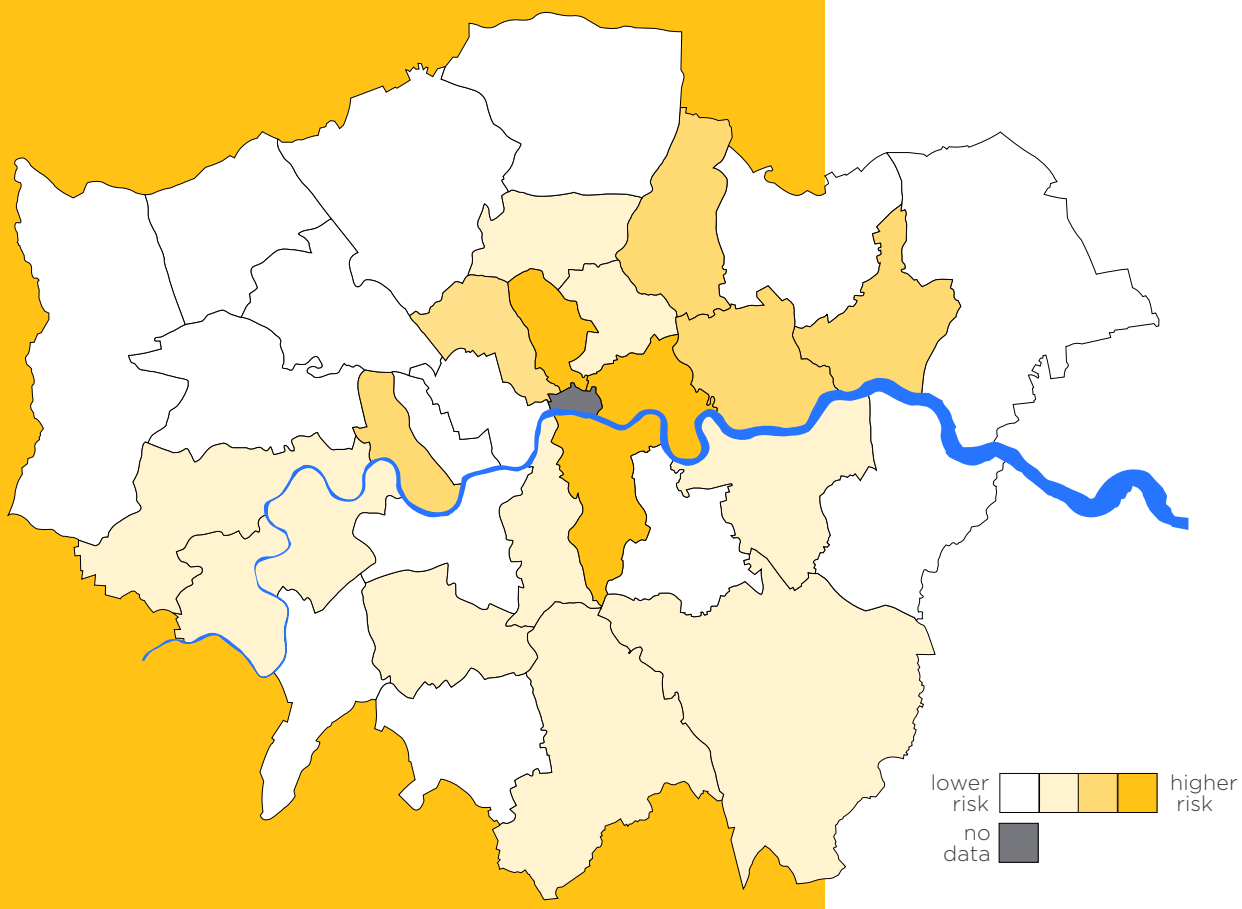


Suicide reduction

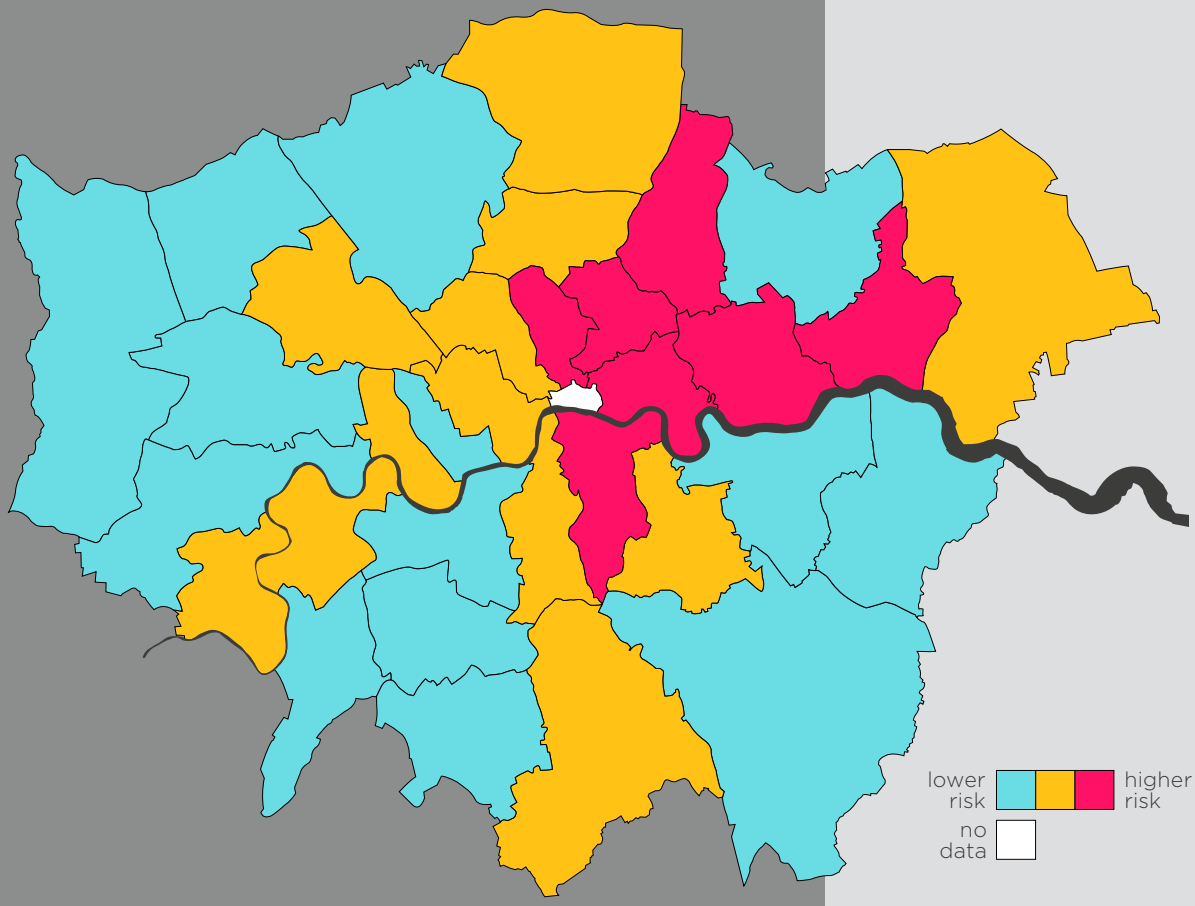
It is noted that the London region has the lowest suicide rate of all the regions of England and it appears that this has led to suicide prevention falling down the list of priorities for public health in the capital. In the January 2015 All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention Inquiry, only 12 out of the 33 local authorities in London confirmed that they had a suicide prevention plan.

Indicators used:

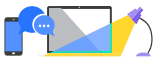
- Suicide age-standardised rate
- Children health admissions as a result of self-harm
- Unemployment Rates
- Access to mental health services
- Persons admitted to hospital for alcohol-specific conditions
- % of people with long-term disability



Overall summary heat map of risk of poor mental health in populations of local authorities in London on the basis of assessed inequalities.



Bringing it all together: major risk factors and inequalities matrix

Area of focus	Local Authorities to prioritise	Major risk factors & inequalities	Considerations
Children 	Barking & Dagenham, Tower Hamlets	Domestic violence, family poverty, school absenteeism, first time entrants (FTE) to youth justice system	Family and parental approaches, all policies engagement (especially social care, criminal justice)
Employment 	Newham, Southwark, Greenwich	NEETs, unemployment rates, people on benefits (employment and support allowance)	Unemployment link to deprivation, Department of Work and Pensions (DWP) engagement, all absence recording
Community 	Tower Hamlets, Newham, Brent	Multiple deprivation, BAME groups, overcrowded households	Ethnic groups, cultural and social discrimination, LGBT rates recording
Care 	Islington, Tower Hamlets, Newham	Access to mental health services, alcohol use disorders, chronic cardiovascular disease, people who cannot speak English	Mental and physical health integration, services engagement, co-production
Suicide 	Southwark, Tower Hamlets, Islington	Unemployment rates, alcohol use disorders, access to mental health services	Addiction, all policies engagement
Overall 	Tower Hamlets, Newham, Islington, Southwark, Hackney, Waltham Forest, Barking & Dagenham		

What works

Relevant approaches

Strategic, system-wide activity is necessary to take advantage of the opportunities to improve mental health at all stages of life, particularly at pressure points when individuals, families and communities experience adversity and during times of transition from one life stage to another. If we are to rise to the challenge of reducing the prevalence of poor mental health, we will need to revise the way we view mental health and where it is owned. We will need to move from a dominant deficit model to one where health is viewed as a universal asset to be strengthened and protected.

In this new way of thinking about mental health, managing poor mental health is still an important factor but not the central tenant, requiring commissioning that is expanded beyond specialist services to community and settings-based solutions. In practice, we need to balance this transition, ensuring high-quality services for those that need them, while also intervening early to reduce the need for specialist provision and to give individuals, families and communities the tools to protect and manage their own mental health.

A whole community approach

This will only be achieved through working alongside communities to understand the influences on their mental health, and to build on existing strengths, assets and resilience. This work can be advanced through a 'Whole Community Approach', which provides a framework that takes account of all the factors that influence mental health at an individual, family, community and structural level and allows for mental health to be considered across a wide range of local policies, services, systems and data that impact the mental health and wellbeing of communities.

Universal, tailored and proportionate approaches

Typically, much of mental health promotion and prevention activity has been implemented through adopting universal interventions for the whole population. Although this can be the least stigmatising option, taking a 'one size fits all' solution can leave those with the most challenging lives behind. A progressively tailored or a 'universally proportionate' approach allows for mental health to be protected overall, while ensuring that people at higher risk of mental health problems are proportionately prioritised. Applying a progressive or whole system approach creates a framework for working at three key levels:

1. Primary prevention to protect mental health by improving the social, emotional and physical environment for the whole population
2. Secondary prevention to identify and target support for selected groups at highest risk and at key transition and pressure points in people's lives
3. Tertiary prevention where people are experiencing distress or a pre-existing mental health problem to prevent escalation and negative socio-economic or health outcomes

Working systemically also has the benefit of creating an environment where mental health is an everyday consideration for all and, therefore, helps achieve the goal of producing an environment where it is possible to address mental health inequalities in a non-stigmatising way.

A life course approach

By taking a life course approach it is possible to intervene early to address developmental factors and neglected determinants that can increase risk (primary prevention) while working to identify those at heightened exposure to adversity to prevent mental health problems from resulting and reducing the impact of these when they do (secondary and tertiary prevention).

Key phases in an individual's life, 'pressure points' and the periods of transitions between these can be mapped against service provision to support whole place interventions, for example in schools and workplaces. This approach allows the identification of life stages and transitions, where risk is the highest or where opportunities to intervene successfully are the greatest. Currently, the delay in identifying children at risk and in providing effective early intervention means that many young people enter adulthood with untreated conditions; and for others symptoms only develop once they have reached adulthood.

Prioritising children and their families is therefore a worthwhile priority investment, although it will remain important to work to prevent poor mental health across the life course including in later life.

Socio-economic disadvantages place people at greater risk of developing poor mental health. Children and young people living in these circumstances are two to three times more likely to develop mental health problems.

This sets the scene for a spiral of disadvantage that all too often accumulates across life.

When mental health problems are established these can lead to a series of detrimental effects on people's life chances. Even when not born into disadvantaged circumstances, people who experience mental health problems are more likely to be workless, to live on benefits and to experience debt – all of which can stack up to produce a poorer quality of life that can worsen across the life course.

The stress attached to being reliant on social welfare can also compound existing mental health problems. Where risks are identified and problems prevented, a virtuous cycle of accessing the right support and recovery can be established, for example supporting young people to stay in education and adults to access and remain in employment.

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ThriveLDN

Thrive LDN is a citywide movement to improve the mental health and wellbeing of all Londoners. It is supported by the Mayor of London and led by the London Health Board partners.

Two million Londoners experience some form of poor mental health every year and Londoners' life satisfaction and feelings of self-worth are lower than the national average. Thrive LDN was established in response to this, with the aim of reducing the number of Londoners affected by poor mental health.

Mental Health Foundation

Good mental health is fundamental to thriving in life. It is the essence of who we are and how we experience the world. Yet, compared to physical health, so little is commonly known about mental ill health and how to prevent it. That must change. The Mental Health Foundation is the UK's charity for everyone's mental health. With prevention at the heart of what we do, we aim to find and address the sources of mental health problems. We must make the same progress for the health of our minds that we have achieved for the health of our bodies. And when we do, we will look back and think that this was our time's greatest contribution to human flourishing. 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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towards happier,
healthier lives

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