MENTAL HEALTH AND SERVICE USER EXPERIENCES

LITERATURE REVIEW

JULY 2018

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1.1. ABSTRACT

This literature review explores how people with mental health problems engage with mental health services in England and Wales. More specifically, it investigates the barriers to, and experiences of, mental health services among different groups. It is framed by the publication of the *Five Year Forward View for Mental Health* policy report, and subsequent debates about the document's influence on mental health service delivery. It also speaks to a moment in which experts, legislators, and the general public are becoming increasingly vocal about the need to prioritise that mental health within national health policy.

In exploring barriers to, and experiences of, mental health services, this literature review places a particular focus on the barriers twenty one different demographic or social groups thought to be at heightened risk of mental ill health. The study is grounded on a systematic review of relevant literature, with texts selected for inclusion via a multi-stage search process, beginning with the development of search blocks, leading to online database searches, and concluding with snowball sampling.

Building on this search process, the review identifies intersections between the experiences and risks encountered by the twenty one groups, and gathers recommendations for improved service delivery.

Crucially, this review also seeks to highlight gaps in the existing literature where further attention is required. As such, it concludes with a discussion of recommendations for further research.

1.2. KEY POINTS

AGE

The focus of most research on mental illness in relation to age or age discrimination is youth/adolescence and old age.

Young people (aged 16-24) are thought to be the age group that is most at risk from experiencing mental health difficulties. However, there are significant barriers to help-seeking among this group as a result of stigma, a lack of trust in relation to professionals, and a preference for self-reliance. Furthermore, lack of understanding about symptoms and service availability constitutes another major barrier. It is noted that positive past experiences of mental health services facilitate help-seeking because they challenge all of these barriers. Poor experiences of mental health services are exacerbated by underfunding, leading to long waiting times, relocation, and heightened detention rates.

Older people on average wait slightly longer to receive mental health treatment, despite facing heightened vulnerability to anxiety, depression and dementia. A major barrier that older people face, according to research, is a widespread view that takes for granted that mental ill health is an inevitable part of growing old. Other barriers include disproportionately long waiting times, higher recourse given to medication as a form of treatment on the part of health care professionals, and age-discriminatory treatment and decisions. There is something of a research gap in relation to older people's experiences of mental health services.

Intersections: gender, disability, ethnicity, poverty.

ETHNICITY

The correlations between belonging to a minority ethnic group and exposure to poor mental health outcomes are partially accounted for with reference to "minority stress theory" whereby mental health disparities between BME groups and white groups are attributed to an internalisation of stigma, victimisation, and harassment.

Barriers to treatment or help-seeking behaviour faced by BME individuals with mental health difficulties include the high levels of cultural stigma around disclosure of mental illness which are characteristic of some ethnic groups, as well as discriminatory attitudes and a lack of cultural competence among healthcare professionals. In the latter case, these attitudes and knowledge gaps create an additional barrier, in that BME individuals may be less inclined to engage with mental health professionals when they are aware of such service experiences.

Intersections: gender, poverty.

SEXUALITY

There is an overwhelming consensus that there is an increased risk of mental health disorder symptoms among lesbian, gay, bisexual, and otherwise non-heterosexual adults compared to heterosexual adults. "Minority stress theory" is widely believed to apply to non-heterosexual adults: their exposure to stigma and discrimination entails a heightened risk of mental ill health. Some suggest that discrimination against bisexual adults is worse.

Despite increased prevalence of mental health disorder symptoms in this group and increased service usage, research shows that they are also less likely to have favourable health outcomes following treatment. Key reasons for this are communication barriers between service users and healthcare professionals, particularly with regard to disclosure of sexual orientation, which can have a negative impact on diagnosis and delay access to treatment.

Intersections: age and substance misuse, marital status, poverty and ethnicity, ethnicity.

PERINATAL

Mental health research in relation to the perinatal period is typically focused on mental health problems experienced by mothers, specifically anxiety, depression, and psychosis, though paternal mental health is beginning to be explored in scholarship.

Among the barriers to access faced by parents in the perinatal period, it has been shown that a large proportion of cases of perinatal mental illness go undetected due to inadequate screening. There is also evidence that women are less likely to disclose symptoms when their experience of mental health services is inconsistent, and when it does not involve the development of trustworthy relationships with familiar health care professionals. One further barrier is that women may choose not to adhere to courses of pharmacological treatment due to concerns around perceived harms of medicines.

Intersections: abuse, ethnicity, gender.

DISABILITY

Most research related to disability and mental health focuses on people with long term physical health conditions or those with general learning disability; both groups that are considered to be at a higher risk of mental ill health than the general population. While there may be a direct correlation between the

precise nature of one's disability or the experience of being disabled and mental illness, it may also be the case that mental illness derives from circumstances resulting from disability (such as financial pressures, discrimination, unemployment, etc.).

Disabled people can be faced with several major barriers to accessing mental health services, including not only (in some cases) communication difficulties and limited access information about available services, but also discrimination and lack of knowledge and understanding among healthcare professionals. As such, several studies have demonstrated that the experience of mental health services among disabled people can be vastly improved.

Intersections: age, poverty, unemployment.

GENDER

There is a level of disagreement in the academic literature about whether women or men are more susceptible to mental health issues and for what reasons, as well as the nature of the correlations between gender and mental ill health more broadly.

With regards to barriers to accessing treatment, research suggests that cultural norms around masculinity compound existing stigma around disclosing mental health problems and therefore further lower help-seeking behaviour among men. There is scope for more research into barriers to accessing mental health services among women specifically, which might complement the work around barriers faced by men, as well as studies into how both men and women actually experience these services.

Intersections: abuse, age, gender, ethnicity, prisoners.

TRANSGENDER

Plenty of studies attest to the fact that transgender people are faced with higher levels of physical and mental health inequalities in comparison to cisgender people (those whose gender identity is associated with the sex they were assigned at birth), yet there is a notable dearth of research conducted on the mental health experiences of the trans population of the UK.

Research indicates that some of the primary barriers to accessing mental health services faced by trans people include stigma, problematic attitudes of health professionals, and a lack of knowledge around trans issues. As a result of the very same factors, trans people who *do* engage with mental health services are often exposed to unnecessarily discomfort, as well as inadequate diagnoses and treatment.

Intersections: age, sexuality, adolescence, disability, unemployment.

RELIGION

There is a divide in the literature about the extent to which religious people are more or less vulnerable to mental health problems in comparison to their non-religious counterparts. Faith or spirituality in some studies was shown to benefit individuals in mental health treatment.

Nevertheless, research identifies several major barriers to accessing mental health services among religious people, including high levels of stigma in relation to mental illness which are prevalent in some religious traditions, as well as patterns of help-seeking that prioritise religious figures and practises over medical intervention. Religious people may also be exposed to religious-specific discrimination and abuse, this not only being a stressor on mental health, but also a barrier to engaging with healthcare

professionals who may have no religion or belong to a different religious group. More broadly, there is a clear information gap with regards to how religious groups, (and notably Jewish, Hindu, Sikh, and Buddhist groups) engage with and experience mental health services.

Intersections: age, ethnicity.

MARITAL STATUS

Overall, scholarship into marital status and its relationship with mental health is very limited, and there is little clarity as to whether improved or worsening mental health is the result of marital status, or vice versa. There is no evidence to suggest that married or single people are discriminated against in terms of mental health access or provision. However, one area that has more conclusive evidence in terms of marital status and mental health is the effect of family breakdown, this heightening the risk of mental ill health among both adults and children.

Intersections: ethnicity, isolation.

WORKPLACE

Government and employers have in recent decades focused more attention on the subject of mental health in the workplace. Research shows that there is a heightened risk of mental ill health among employees who experience low job security, high work demands, low support from employers, and low decision-making capacity.

Despite there being a wide variety of experiences and support options across workplaces, research has identified some common barriers to mental health care, the most notable one being perceived stigma from colleagues around disclosure, as well as concerns about losing one's job or stalling progression. There is scant research about employees' experiences of processes and adjustments as a means of supporting those with mental health problems.

Intersections: visibility.

UNEMPLOYMENT

Associations between mental health problems and unemployment are well-established, along with underemployment, job insecurity, and precarious employment. Research suggests there was a significant increase in prevalence of people reporting mental health problems from the 2008 financial crisis onwards.

A key barrier to help-seeking among unemployed people, either with regard to associates or health professionals, derives from a sense of shame or reduced social capital. However, there is ample scope for further research around barriers to, and experience of, mental health services among unemployed people.

Intersections: age, gender, educational attainment, disability, discrimination.

POVERTY

Individuals experiencing conditions of poverty or socioeconomic inequality are at heightened risk of mental ill health, and those who have existing mental health problems are at greater risk of poverty. In fact, socioeconomic deprivation is one of the most significant predictors of mental illness.

Research has identified that those experiencing socioeconomic deprivation are more likely to experience barriers to access to mental health services, including low levels of registration. However, it is notable that

this literature forms only a small portion of the large body of literature on the relationship between poverty and mental illness. Furthermore, there is very little research on how people confronted with socioeconomic deprivation experience mental health services.

Intersections: ethnicity, age, adolescence.

STUDENTS

Recent years have seen heightened levels of awareness about mental health problems among UK students, in part due to an increase in suicides and the fact that higher numbers of students are disclosing a mental health condition to their higher education institution and using their counselling services. Students are at greater risk of mental health problems in part because of the experience of transitioning to higher education learning environments.

There are three main barriers to access to mental health services among students. The first concerns insufficient student support services to meet the demand. The second is due to poor understanding on the part of students around mental ill health and the availability of services. Finally, there is poor integration of primary care and student support services. There is a gap in the literature with regards to student experience of mental health services.

Intersections: age, poverty, gender.

VETERANS

Ex-servicemen and women are at heightened risk of mental health problems, and most notably those of Post Traumatic Stress Disorder, depression, and anxiety. Research has demonstrated that a large proportion of veterans who experience mental health problems do not seek support from mental health services. This lack of help-seeking is a key barrier to accessing mental health services, and research suggests that it derives from internal stigma on the part of veterans about disclosing mental ill health. Another key barrier is a perceived lack of specialised knowledge about military experience and terminology on the part of healthcare professionals, as well as the specific demands of re-acclimatisation following combat.

Intersections: gender, isolation, alcohol/substance misuse.

HOMELESS PEOPLE

Homeless people are more likely to experience mental ill health compared to the general population and their health needs are also likely to be more complex. People with existing mental health problems are at heightened risk of homelessness, and those who are homeless are at heightened risk of mental illness.

A barrier to accessing services that exists among homeless people is that this group is more likely to place a low value on their health as a result of low self-esteem and more pressing priorities. Other key barriers include a sense of distrust in relation to healthcare practitioners, practical difficulties concerning registering for a GP arising from life circumstances, and a lack of integration between mental health services and community care services.

Intersections: gender, ethnicity, refugee/asylum seekers, prisoners.

SUBSTANCE MISUSE

Substance misuse and mental health problems can co-occur in numerous ways: a primary health problem may provoke the use of substances; substance misuse and/or withdrawal may lead to psychiatric symptoms or illnesses; a psychiatric problem may be worsened by substance misuse; substance misuse and mental health problems may co-occur but remain unrelated to one another.

There is very limited research on the subject of the barriers to access faced by those with co-occurring disorders, nor their experience of mental health services. This is in large part because mental health problems and substance misuse have traditionally been addressed separately, both by researchers and by mental health services.

Intersections: age, prisoners, multiple needs.

ASYLUM SEEKERS

Although not a homogenous group, asylum-seekers and refugees are at a heightened risk of mental health problems because of stress factors relating to either to their decision to migrate or their experience of migration. These experiences could involve bereavement or separation from family and friends, imprisonment and or detention, torture, trafficking, sexual violence, and various forms of discrimination and prejudice.

Some of the key barriers that asylum-seekers and refugees face with regards to accessing health services concern cultural and linguistic factors, as well as uncertainty and fear around interacting with formal services when their immigration status is uncertain. A further barrier concerns widespread uncertainty about who is and who is not eligible for specific services on account of their specific legal status. There is very limited research about how asylum-seekers and refugees experience mental health services.

Intersections: ethnicity, age, sexuality, religion, isolation, homelessness.

PRISONERS

Government has directed greater attention at improving mental health services for prisoners in recent years, with services moving from the remit of the Home Office to the NHS, as well as making a commitment to ensuring 'equivalence of care' across the prison and non-prison populations. This is significant because a high proportion of prisoners have mental health difficulties, with research demonstrating that prisoners are more likely to experience multiple conditions compared to the general population (arising not least from stressors associated with their experiences prior to prison, and in some cases connected to the circumstances of their sentencing).

While prisoners might be expected to face fewer barriers to services because of the regular health screenings that they undergo, research suggests that inadequate health care service provision and interventions constitutes a major barrier to accessing support. While research has produced evidence that the treatment received by prisoners with mental health problems is less effective than that received by the general population, there is considerable scope for further research about prisoners' experience of mental health services.

Intersections: unemployment, isolation, unemployment, homelessness.

SEX WORKERS

There is a distinct lack of research in relation to sex workers and mental health services, particularly in the UK setting, which indicative of differing legal landscapes internationally. Although prostitution or commercial sex is technically not illegal in the UK, many practical elements surrounding it are. As a result, research suggests that sex workers seeking to access mental health services face a major barrier to mental health services in the form of stigma. Because a sex worker may be less likely to tell healthcare professionals about the difficulties that they are experiencing due to this stigma, and indeed less likely to confide in others more generally, research suggests that sex workers are at heightened risk of mental health problems. More broadly however, research on the barriers to access and experience of mental health services on the part of sex workers is very scarce, with targeted services supported by the NHS demanding particular attention.

Intersections: gender, substance misuse, prisoners, employment, social isolation.

ISOLATION

Academic and policy research in relation to isolation and loneliness has grown steadily in recent years. Most research to date has focused on the subject of isolation and loneliness among older people, but the present literature review has revealed that a wide variety of characteristics and issues intersect with these are themes. The relationship between loneliness and mental health difficulties is thought to be bidirectional: those who are socially isolated are more likely to experience mental health difficulties, and those with mental health problems are for various reasons more likely to face difficulties when it comes to establishing and maintaining relationships and are therefore more at risk of isolation.

Individuals that are socially isolated or lonely face two key barriers to mental health services. The first is that individuals that are isolated are less likely to have someone to talk with about their mental health. The second is that isolated and lonely people face a considerable amount of stigma and shame when it comes to talking about their experience of loneliness, and this may compound stigma around mental illness. Beyond this, there is a lack of research about how isolated and lonely people experience mental health services.

Intersections: poverty, migrants, old age, geographical isolation, homeless people, substance misuse.

CARERS

Carers are unpaid members of a household or informal support network who assist or look after someone else. They are thought to make up one in ten of the UK population. Many carers are exposed to a heightened risk of mental health difficulties, and specifically psychological distress. This is in part because they receive an inadequate amount of formal support and acknowledgement, in addition to stressors directly associated with the carer role itself and in particular the transition into and out of this role.

A key barrier to access to mental health services faced by carers is that they may not perceive themselves to be carers nor the support they provide as "care". This is part of the reason that levels awareness of the mental health risks of providing care, and indeed the availability of support, are low. There remains considerable scope for research on carers' experience of mental health services.

Intersections: age, gender, transitions, ethnicity.

2. BACKGROUND & INTRODUCTION

Recent years have seen the publication of a landmark policy document by the NHS on the subject of mental health service provision in England: the *Five Year Forward View for Mental Health*. This document, together with the activity that it is catalysed, is indicative of mounting concerns about the shortcomings of existing mental health service provision, and a firm sense that mental health should be recognised as a priority area for national health policy. Importantly, this sense of alarm is not restricted to health practitioners and experts; it is increasingly shared by the general public whose awareness, knowledge, and willingness to talk about mental health issues has grown remarkably over the last decade, in part because of the work of mental health awareness campaigns such as Time to Change.[1]

In short, this report marks a major point of transition for mental health service provision in England. By way of an introduction to this literature review and the contemporary mental health policy landscape, we present a brief overview of the report and its subsequent reception, including two policy documents that have followed in its wake.

2.1. FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

In March 2015, NHS England set up an independent Mental Health Taskforce which was charged with delivering a national strategy for mental health in England. The taskforce engaged with over 20,000 people and sought to spotlight the experience of people with mental health problems in particular. This process resulted in the publication of a landmark report in February 2016 entitled *Five Year Forward View for Mental Health for the NHS in England*.[2]

In its assessment of the current state of mental health service provision, the report places a particular focus on social inequalities. It spotlights a series of demographic groups within the English population that are especially vulnerable to mental health problems and their effects:

- Children and young people (particularly those from low income families);
- Mothers;
- Middle-aged men;
- People with long term physical illnesses;
- Disabled people or people with a learning disability or difficulty;
- People without stable employment or housing;
- Veterans from the armed forces;
- Older people;
- Groups who are marginalised or facing discrimination (including BAME, LGBT, and disabled people);
- Prisoners;
- People who have experienced traumatic events, poor housing, or homelessness.

The report proposes that three quarters of those with mental health receive no support whatsoever, while those that do face long waiting times, as well as inadequate access to crisis care and appropriate interventions. A key consequence of this, it argues, is that pressure on already limited inpatient psychiatric beds is further intensified, often necessitating out of area placements.

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[1] https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20171101_-_healthwatch_england_annual_report_2016-17_-_speak_up.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

The report presents a total of 58 concrete recommendations for improving the delivery of mental health services, some of which are directed at the six NHS arm's length bodies (NHS England, Public Health England, the Care Quality Commission, NHS Improvement, Health Education England, NICE), while others address wider social matters that entail cross-government collaboration. The key recommendations are as follows:

- Provide 24/7 access to care for those facing mental health crises;
- Integrate mental and physical health services so that those with mental health problems have their physical health needs met;
- Focus prevention efforts at key moments in life (e.g. childhood and adolescence);
- Improve access to mental health care among those living in poverty, those who are unemployed, those from Black and Minority Ethnic communities, and others who face discrimination;
- Foster mentally healthy communities led by Local Government;
- Get more adults with mental health problems into employment;
- Focus on reducing the suicide rate;
- Challenge stigma around mental ill health;
- Develop new research around mental health;
- Improve data and transparency on spending and performance;
- Tailor services to each person's individual needs, providing a choice of interventions.

The report concludes that mental health support and services in England are "chronically underfunded," making a case for an additional investment of £1bn on the basis that it will relieve pressures on other areas of the health system, as well as the economic and social costs of mental ill health more generally.

Throughout the report, there is a focus is on "hardwiring" mental health into the way in which the NHS delivers care. The Taskforce is committed to ensuring "parity of esteem" between mental and physical health across all ages. As the report details, this will require a "triple approach" which not only ensures that mental and physical health are given equal status, but also that mental health staff are given equal status, and that funding earmarked for mental health services is given equal status.

The Taskforce report was welcomed by NHS England and various national stakeholder organisations who seek to deliver on its recommendations.[3] It was also accepted in full by the Government, with the Department of Health pledging to invest a further £1.3 billion annually into mental health provision by 2020/21, as well as seeking to help a further 1 million people over the same time period.[4] These plans to transform mental health services are also expected to be accompanied by legislative changes in the same area: in 2017, Prime Minister Theresa May pledged to overhaul the Mental Health Act 1983, as recommended by the 2016 report.

IMPLEMENTING THE REPORT

In July 2016, a document entitled *Implementing the Five Year Forward View for Mental Health* was published, outlining concrete plans to deliver on the commitments in the initial document ahead of 2020/21.[5] A particular focus is granted to workforce requirements, areas for investment and savings, and opportunities to track performance and harness data. The document presents five "common principles" to guide the implementation process:

- Co-production with those who have lived experience of services and their carers;

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[3] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582120/FYFV_mental_health__government_response.pdf

[5] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

- Partnership with local organisations, be they public, private, or voluntary;
- Identifying needs and staging interventions at the earliest opportunity;
- Designing and delivering person-centric and evidence-driven care;
- Outcome-focused, intelligent, and data-driven commissioning.

The priority areas that the document highlights are as follows:

- Children and young people's mental health;
- Perinatal mental health;
- Adult mental health: common mental health problems;
- Adult mental health: community, acute and crisis care;
- Adult mental health: secure care pathway;
- Health and justice;
- Suicide prevention.

In addition to the implementation document, a further report was published in February 2017 entitled *Five Year Forward View for Mental Health: One Year On*. The document acknowledges that progress has been better in some areas than others, but ultimately takes a positive tack, as well as advising caution about expectations in the years ahead in view of longer term challenges and needs.

2.2. BREAKING DOWN BARRIERS

The findings of the *Five Year Forward View for Mental Health* have since been reaffirmed and supplemented by a British Medical Association (BMA) report, *Breaking Down Barriers: The Challenge of Improving Mental Health Outcomes*.[6] The foremost barriers that the BMA identify include:

- Inadequate funding despite rising demand;
- Poor access;
- Lack of integration of mental health services with other services at local scale;
- Lack of focus on prevention and early intervention;
- Resource pressures faced by GP practices which serve the majority of adults with mental health problems;
- Notably poor provision of care for children, adolescents, mothers, and older people;
- Stress on mental health beds leading to out of area placements;
- Understaffing of psychiatrists and mental health nurses;
- Insufficient provision of mental health training among health workforce, and particularly GPs.

2.3. THE STATE OF CARE IN MENTAL HEALTH SERVICES

In the second half of 2017, the independent regulator of all health and social care services in England, the Care Quality Commission (CQC), published the outcome of its comprehensive inspection of all specialist mental health services in England (both NHS and independent) between 2014 and 2017.[7] As with the BMA report, this document reaffirms many of the findings set out in the *Five Year Forward View for Mental Health*. The document explicitly reports "too much poor care, and far too much variation in quality and access across different services." Some of the foremost challenges faced by mental health services are high and rising demand for mental health services, long waiting times for assessment and treatment, and a decline in the number of NHS mental health nurses. It goes on to outline four key areas of concern:

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[6] https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/policy%20research/public%20and%20population%20health/mental%20health/breaking-down-barriers-mental-health-briefing-apr2017.pdf?la=en

[7] http://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017

- The safety of services, including factors such as building design, ward staffing, and management of medicines;
- Overly restrictive practice, including factors such as high levels of use of physical restraint, isolating people from friends and families, risking institutionalisation, and minimising independence;
- Limited access and overlong waiting times, resulting in unmet needs;
- Poor clinical information systems, including factors such as siloed clinical record systems.

While the CQC have sought to balance the more critical outcomes of its inspection with more optimistic soundings, the report indicates that the state of care in mental health services has actually *declined* between 2014 and 2017.

2.4. WIDER RESPONSES

Plans for the reform of mental health legislation and services that were set into motion by the publication of the *Five Year Forward View for Mental Health* have been welcomed by professionals, service users, and campaigners — at least in principle.

On the first anniversary of the initial report, the NHS issued an assessment of how successfully this agenda had been implemented to date, striking a hesitantly optimistic tone.[8] However, with the second anniversary of the report now having passed, there are serious doubts in some quarters about whether we can expect to see the state of care in mental health services undergo any improvement at all.

Questions have been asked about how many CCGs are actually meeting the commitments to increase spending on mental health services.[9] One particular concern is that funding earmarked for mental health is being increasingly diverted to other areas of the health system as a result of financial pressures, further frustrating attempts to achieve "parity of esteem" between mental and physical health.[10]

In addition to questions about whether these investment pledges are having any effect at the level of frontline services, there also remain concerns about whether mental health providers are any closer to realising the new forms of patient engagement and models of care that were recommended by the Taskforce report in order to break down traditional divisions.

2.5. APPROACH

The structure of this literature review is shaped by the recent policy literature in three important ways.

First, the literature identifies a need to attend to distinct demographics and social groups, and especially those that are shown to be more at risk of mental ill health or who face more barriers to care.

Second, the literature identifies a need to attend to mental health across the lifetime: people are more at risk of mental ill health, more likely to face barriers to care, and more in need of different types of service provision depending on where they are with respect to the life cycle or life course.[11] As Alison Petch shows in her introduction to her edited volume, *Managing Transitions: Support for Individuals at Key Points of Change*, this is particularly true in the case of "transitions": not only the transition from childhood to

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[8] https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf

[9] http://nhsproviders.org/media/3281/state-of-the-nhs-provider-sector_07-17.pdf

[10] https://www.kingsfund.org.uk/blog/2016/10/trust-finances-mental-health-taskforce

[11] https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf

adulthood, but also "transitions between different housing and support situations […], transitions in status […], transitions across different organisational structures," and so on.[12]

Third, the literature indicates that two areas of particular concern with respect to the delivery of mental health services are *access to* and *experience of* services.

With this in mind, this literature review was conducted using JSTOR, Science Direct, and Google Scholar. Original research was included if it applied to English populations and if it was published between 1st January 2008 and 1st May 2018.

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[12] https://www.jstor.org/stable/j.ctt9qgv5d

3. METHODOLOGY

This literature review shares the characteristics of more than one literature review "type", as set out by Grant and Booth.[13] First, it is a systematic review, in that it provides a review of existing literature according to clear criteria (detailed below). Second, it is a scoping review, in that it addresses broad research questions and highlights gaps in the literature. Third, it is conceptual review, in that it provides an overview of the current "lay of the land" in this field of research.

3.1 SEARCH STRATEGY

Basic search blocks were developed for each characteristic (e.g. gender, sexuality) or group (e.g. homeless people, carers) and then tested through an initial search process using Google. For example, when reviewing literature on age as a characteristic, we conducted a search using the following terms:

Age	"Mental health services" AND "access" OR "experience" OR "experiences" AND "age"

This process produced a more refined set of search blocks incorporating synonyms and neighbouring terms. These were used for the primary literature search which was conducted using Google Scholar, JSTOR, Project Muse, and SAGE online databases. To take the age example once again, we developed three search blocks from the initial search block:

Younger people	"Mental health services" AND "access" OR "experience" OR "experiences" AND "England" OR "Great Britain" OR United Kingdom" OR "UK" AND "children" OR "young people" OR "youth" OR "teenagers" OR "under 18" OR "adolescence" OR "early family formation years" OR "girls" OR "boys"
Older people	"Mental health services" AND "access" OR "experience" OR "experiences" AND "England" OR "Great Britain" OR United Kingdom" OR "UK" AND "old age" OR "old people" OR "older people" OR "over 65s" OR "65 and over" OR "65 plus" OR 65+ OR "older adults" OR "later life"
Age itself	"Mental health services" AND "access" OR "experience" OR "experiences" AND "England" OR "Great Britain" OR United Kingdom" OR "UK" AND "age" OR "ageism" OR "age discrimination"

Additional texts were also identified for inclusion via two modes of snowball sampling of literature. First, texts were identified using bibliographic analysis. This involved examining the bibliography of a research paper which has already been identified for inclusion, and then using Google Scholar to find how many citations these texts have in turn received. Those with high impact and relevance were considered for inclusion. Second, texts were identified via citation analysis. This involved entering the details of a text already identified for inclusion into Google Scholar, and then exploring which research papers have already cited that text. Again, those with high impact and relevance were considered for inclusion.

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[13] Grant, M. J. and A. Booth. 2009. A typology of reviews: an analysis of 14 review types and associated methodologies. *Health information & Libraries journal*, 26(2): 91–108.

ELIGIBILITY

The literature search was conducted between February and May 2018 and was limited to studies that met the following selection criteria:

- Studies relevant to the stated research topic;
- Studies related to people within the UK, or mental health services in the UK;
- Studies which had been peer reviewed or derived from an otherwise trustworthy source (e.g. policy documents, internal reports delivered by prominent organisations with an interest in health);
- Studies published between 2008 and 2018 (to ensure relevance);
- Studies that make an original contribution to the literature, either by producing original research by independently collecting and analysing new data or by compiling and re-interpreting existing studies;
- Studies written in English language.

COLLATION METHOD

Relevant literature and document references were stored as progress developed, being logged on a specifically designed Excel project document using section headings according to each characteristic/group. Each of the factors were then allocated an initial traffic light colour according to the availability of the literature according to this initial search: red = low, orange = moderate, or green = high. This list was subsequently used as a basis for snowball sampling methods of literature search, as discussed above. This was developed and refined to ensure that the most contemporary, useful, and relevant sources were incorporated. We have included a final version of the excel document in the appendix.

3.2 REPORT GUIDE

Below, we have set out the structure of the report. As discussed, this report is designed to be a practical document. As such, its structure and use of short sections was established so that information can be quickly referenced by those seeking specific and succinct insight into mental health and access to, or experience of services, in addition to the gaps highlighted in research according to each characteristic/ group.

REPORT STRUCTURE

The main body of this report consists of 22 sections, each of which is centred on a specific characteristic or group. Each section of the report is divided into five sub-sections, the contents of which can be described as follows:

Overview	- Contextualises the literature; - Note on which specific parts within, or subsections of, each group are more at risk of mental health problems; - Comment on factors structuring association between group and poor mental health outcomes; - Points of disagreement among researchers; - Thematic discussion of barriers to access and experience of services.

Intersections and trigger points	• Findings demonstrating that poor mental health outcomes or experiences faced by one group overlap with those of another (intersections); • Findings demonstrating that a particular group is more at risk of poor mental health outcomes at a particular juncture in the life course (trigger points).
Recommendations for improved provision	• Recommendations for improved provision of services and removing barriers to access.
Research coverage	• Assessment of volume of research on group at hand and research on their access to and experience of services; • Assessment of coverage of this research, for instance diverse areas and risk factors; • Discussion of gaps in literature and interesting areas for further research.
Citations	• Full academic citation with URL hyperlink to source provided.

KEY TERMS

This section provides, clear definitions for key terms that are used regularly across the literature review.

Mental health	Mental health refers to the overall state of one's psychological wellbeing.
Mental health problems	We favour the term mental health problems in this report to denote the diverse ways in which mental health can depart from norms of psychological wellbeing. The report occasionally uses closely related terms such as "mental health issues", "mental health disorders", "mental health illnesses", "mental health conditions", and "poor mental health outcomes" when they appear in the literature under review.
Mental health symptoms	Mental health symptoms indicate the explicit presence or the 'signs' of one or more mental health problems. Symptoms can be highly diverse, and could entail a heightened or extended experience of an emotion (e.g. anxiety, depression) or an impaired perception of reality (e.g. delusions, hallucinations).
Mental health services	Mental health services here are taken to refer to the services (public or private) that provide medical, or more broadly, support or care, to people with mental health problems. Different mental health services are tailored to the needs and circumstances of different groups, with each mental health service (e.g. Older people's services, Hospital services) subdivided by mental health care pathways (e.g. eating disorders team, mother and baby units).
Access	Access denotes the means by which an individual can obtain the health care services that they require and is often used to mean the level of ease or difficulty that they face in doing so. This can vary according to several factors, including availability of services, levels of awareness that services exist, or

	confidence and trust in the services; all of which might impact on the initial approach. "Barriers" denote the obstacles that individuals face with respect to accessing health care services. Again, these can be practical or psychological.
Engagement with services	Engagement with services is used to refer to participatory between individuals with mental health problems and mental health care practitioners or support workers.
Cross cutting (or re-occurring) themes	These are prevalent themes and threads that re-appear in at least several sections (characteristics/ groups).
Intersections	These are areas of overlap between the barriers to access and mental health service experiences encountered by more than one group, and which heighten the risk of mental health problems. For example, the barriers to access faced by a transgender person may overlap and compound/be compounded by those faced by an asylum seeker.
Trigger points	These are junctures in the life course where a particular group is more at risk of mental health problems.
Volume of research	This concerns the amount of literature that exists on mental health and access to services in relation to a given characteristic or group.
Coverage	This concerns the quality and scope of the research, and particularly the matter of whether it is subject to any blind spots.
Research gaps	This specifically refers to areas where there is little to no research or data, and particularly areas that are in need of attention.

4. AGE

4.1. OVERVIEW

The majority of research on the subject of age or age discrimination focuses on two stages of the life course, namely youth and adolescence and old age. For the purposes of this section, youth is taken to refer to people between 0 and 25 years old, though some sources use this in reference to 0–16 years or 0–18 years, with others specifying between childhood (0–11 years) and adolescence (11–18 years). Similarly, this section takes older people to refer to those aged 65 and over, though it should be noted that some sources such as the World Health Organisation define an "older person" as someone whose "age has passed the median life expectancy at birth" (presently around 81 years old in the UK), whereas others such as the Mental Health Foundation (2015) use the term "later life" to refer to people aged 50 and above (BMA 2017).

While there is a more established body of academic and policy literature on the mental health of young people, a report by the Mental Health Foundation (2015) notes that "data for Children's and Adolescent mental health in the UK is grossly outdated." While national statistics on prevalence of mental health conditions among young people is available through Public Health England,[14] the Mental Health Foundation identifies that there is a particular dearth of information at the preschool stage. In addition to limited I.T. infrastructure and records, when it comes to the experiences of children and parents who engage with mental health services, there is a no "commonly agreed method for analysing data at a national level" (Wolpert et al. 2016).

Between the ages of 16–24 years, the prevalence of mental disorders is at its greatest (Plaistow et al. 2013; Gulliver et al. 2010; Mental Health Foundation 2015). More specifically, two of the most prevalent disorders at this age are depression and anxiety. Despite this, this age group is also less likely to seek help from mental health services than any other age group. Some of the foremost barriers to help-seeking are stigma and embarrassment (not only with respect to associates and wider society, but also from help-providers), a lack of "established and trusting relationships with professionals," and a preference for self-reliance during difficult periods (Gulliver et al. 2010; see also Rickwood et al. 2007; Farrand et al. 2006). Other barriers include a lack of awareness around symptoms of mental illness, as well as mental health services (e.g. low likelihood of considering a "general practitioner an appropriate source of help for mental distress", and an even lower likelihood to seek help from a school councillor) (Gulliver et al. 2010). In contrast, research indicates that "positive past experiences" of mental health services (whatever they might be) facilitate help-seeking, and specifically because those that have good experiences have fewer issues of trust and higher overall mental health "literacy" (Gulliver et al. 2010).

The BMA (2017) reports that underfunding of Child and Adolescent Mental Health Services has led to bed closures which has seen children and young people exposed to long waiting times, relocation to different parts of the country, and even detention in police cells under the Mental Health Act. In addition to these waiting times, the BMA (2017) notes that early intervention services are being cut, despite this period being a critical time to identify mental health problems (see also Mental Health Foundation 2015).

Older people are particularly at risk of anxiety and depression, and in the latter case those who are residents of care homes are most notably at risk (Mental Health Foundation 2015). Despite this, only 6% of older people with depression are referred to mental health services, compared to 50% of younger people (BMA 2017). Furthermore, older people on average wait slightly longer for mental health treatment than other people. The BMA (2017) also flags that "older people are six times as likely to be on medication as

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[14] https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/0

younger people," while being only a fifth as likely as other people to access talking therapies. In the specific case of depression in older people, it is "often seen as just a part of ageing" (Lievesley et al. 2009). With respect to dementia (which older people are particularly vulnerable to), the quality of hospital care is uneven across the country, and evidence suggests that those admitted to hospital are more likely to die, to decline functionally, and to experience delirium (BMA 2017).

Ageism and age discrimination is not only relevant to health care settings where older people may be subject to age-biased decisions and poorer treatment and service, but is also important insofar as it can limit the employment opportunities and career progression of older people, both of which may heighten the risk of mental health problems (Lyons et al. 2017). Furthermore, just as prejudice and discriminatory treatment has been seen to be damaging to the mental health of women, ethnic minorities, and homosexual people, the same is also true of age discrimination in relation to older people. There is very limited research on ageism or age discrimination outside of the United States (Lyons et al. 2017).

4.2. INTERSECTIONS & TRIGGER POINTS

- **Gender:** The Mental Health Foundation (2015) cites ONS data from 2004 (the latest study, conducted in 2016, has yet to be published) which shows that there is a higher prevalence of conduct disorders (e.g. aggressive or anti-social behaviour), hyperkinetic disorder (e.g. hyperactivity, inattention), and autism spectrum disorder among boys aged 5-10, and a higher prevalence of emotional problems among girls of the same age.
- **Transitions:** The transition from children's and young people's services to adult health care services is a notable trigger point (Swift et al. 2013). Not only is research more likely to focus on physical health as opposed to mental health, in practice there are no "accepted universal model" to aid transition.
- **Disability:** Young people diagnosed with ADHD are particularly vulnerable to mental health problems (Swift et al. 2013).
- **Ethnicity:** The perspectives of young people from minority ethnic groups, and particularly those that have disengaged from services, are consistently under-represented in the literature (Plaistow et al. 2013).
- **Older people**: 60% of older people suffer from a long-term illness, and mental health problems (particularly depression and dementia) are more common among this group (BMA 2017). Despite this, 40% of the mental health trusts in England have no "overarching strategies" to address these comorbidities (BMA 2017).
- **Disability:** People with learning difficulties and disabilities are at a greater risk of developing dementia at a younger age, and at a faster rate (Mental Health Foundation 2015).
- **Poverty:** The impact of socio-economic deprivation "can continue all the way through to older ages," with "neighbourhood environment" having a significant bearing on the wellbeing of older adults (Mental Health Foundation 2015).
- **Intimate partner violence**: McGarry et al. (2016) shows that older women have been largely "marginalised or invisible" when it comes to discussion of intimate partner violence, with the boundaries between age-specific vulnerability and intimate partner violence being somewhat "blurred". "

4.3. RECOMMENDATIONS FOR IMPROVED PROVISION

The Mental Health Foundation (2015) references five key factors that shape the mental health of older people: age discrimination, participation in meaningful activities (e.g. employment, volunteering, interests, hobbies, etc.), relationships (isolation and loneliness), poverty, and physical health. Each of these factors has a significant bearing on the health and longevity of older people which could be build upon to develop programmes and support services.

Among older people, mental health problems are often coupled with physical dependency (e.g. incontinence, feeding) and behavioural problems (e.g. aggression, wandering). Many nurses report that they lack the experience and training to tackle these complex problems, and for this reason Goldberg et al. (2012) advise that services work to improve the "understanding and management of distress behaviour through staff training" and by "integrating mental health expertise with general nursing." More generally, they propose that services which "optimise detection and management of older patients with mental health problems" need to be "developed and evaluated". These include making improvements to ward environments, providing "opportunities for purposeful activity", and developing "partnerships with family carers" (Goldberg et al. 2012).

The BMA (2017) draws on data from discussion groups with patients, which shows that "clinics may not be the most child-friendly," and advises that Child and Adolescent Mental Health Services be provided in a non-clinical setting. A similar point is made with respect to older people who, as has been seen, are more at risk of mental health problems if they are admitted to hospital. While non-hospital treatment options are increasingly available (Goldberg et al. 2012).

Wolpert et al. (2016) recommend that "achieving parity of esteem between physical and mental health requires parity of data", meaning records and available information on mental health services. For this reason, it is argued that there is a need for significant investment in data collection and research related to how young people and their parents experience mental health services.

One study recommends strategies that address the observed preference among young people for self-reliance (e.g. self-help resources), that increase mental health literacy, and that reduce stigma around mental health problems and help-seeking (Gulliver et al. 2010).

Swift et al. (2013) note that it is important for clinicians to come across as supportive, non-judgemental, and good listeners. They also advise that transitions from child and adolescent services to adult services can be facilitated by planning and preparation, joint working, and consistency of personnel. The same study underscores the fact that information about young people's experiences of adult mental health services is especially valuable, specifically because young people are in a good position to reflect on how it compares to Child and Adolescent Health Services (Swift et al. 2013).

4.4. RESEARCH COVERAGE

The majority of research around the area of age or age discrimination in delivery of mental health services focuses on two stages of the life course, namely youth and adolescence and old age. While this is intended to draw attention to younger and older people whose health needs have been historically overlooked, there is a distinct gap in the literature when it comes to the mental health needs of adults as a population at other particular key or transitionary stages in their lives. Adult mental health tends to be addressed via other characteristics (e.g. gender, ethnicity) or categories (e.g. as new parents, as employees, or as people living in poverty, and so on). Despite the increased interest and awareness, including by charities and in policy on the subject of mental health problems among older people in recent years, it remains the case that there is considerably less research on the subject of older people's experience of mental health services in comparison to that of younger people.

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5. ETHNICITY

5.1. OVERVIEW

For the purposes of this section, the term black and minority ethnic (BME) groups is used to refer to diverse communities of people who are of non-white descent or origin.

The association between ethnicity and poor mental health outcomes is partially accounted for with reference to "minority stress theory" which attributes mental health disparities between BME groups and white groups to an internalisation of stigma, victimisation, and harassment. As Farrelly et al. (2015) show, "the experience of discrimination is experienced as a stressor that exceeds coping resources, leading to a negative self-image and a perception of decreased supportive networks/social structure." As such, "the anticipation of further negative events and treatment" along with "the perception of a lack of supportive networks" can leave people at greater risk of hopelessness and suicidality (Farrelly et al. 2015). Gabbidon et al. (2014) show that a significant proportion of mental health service users are also at risk of discrimination on the basis of race-ethnicity *as well as* their mental illness, thus compounding the issue (see also Gary 2005).

Barriers to mental health service access for BME patients include "racist and discriminatory attitudes" among some healthcare professionals, such as requesting the documents of patients before providing care, as well as providing poor diagnoses (for example, as a result of failing to appropriately examine a patient, or failing to take their medical history) (Raibee et al. 2014). In addition, Raibee et al. (2014) suggest that some healthcare professionals lack "cultural competence" and fail to respect "individuals' explanatory beliefs about the nature of illness," again leading to poor diagnoses (see also Gupta et al. 2009). Another barrier to access among BME people relates to stigma (Hackett 2008; Gary 2005; Memon et al. 2016). For example, Kapadia et al. (2015) demonstrate that Pakistani women often exist as part of "networks which display high levels of stigma towards mental illness and use of mental health services." A related issue to this is that of help-seeking behaviour: Greenwood et al. (2015) note that help-seeking behaviour may differ depending on ethnicity and cultural background, particularly with regard to attitudes to disability (including mental health). There is a clear dearth of literature on help-seeking attitudes among BME people with mental health problems.

One particularly contentious area of debate relates to reports that BME people are disproportionately detained under the Mental Health Act. As Gajwani et al. (2016) show, "detentions amongst BME groups is statistically greater than those from a White British ethnicity amongst adolescent psychiatric admissions, first-episode psychosis, and severe and enduring mental health conditions." This is particularly true of African Caribbean and Black African groups. The debate turns on the question of whether BME status is an "independent predictor of psychiatric detention", or whether this disparity is absent when other factors are controlled (e.g. age, gender, diagnosis of mental illness, differences in rates of illness, presence of risk, level of social support, differences in pathways to care, kind of site and service provision) (Gajwani 2016; Singh et al. 2014). Gajwani et al. suggest that there is "a complex and multi-faceted relationship between ethnicity and detention," choosing not to rule out the possibility of "institutional racism" and overall "discriminatory" services, but placing more weight on the evidence of "higher rates of serious mental illness in the BME population." They also highlight that "Black African and African Caribbean ethnic groups […] are more likely to make contact with early intervention services through criminal justice involvement," whereas White British patients "access care through GP's in the case of first episode psychosis."

The NHS is the largest employer of BME people in the UK (Bécares 2009). BME health care practitioners and staff report "disproportionate experiences of bullying and harassment" compared to their white

counterparts, and given that BME staff have been seen to be less likely to report such incidents compared to their white counterparts, it can be assumed that these experiences are on a much wider scale than the reported incidents suggest (Bécares 2009). Experiences of bullying and harassment have been shown to cause poor organisational and health outcomes, for example "higher levels of job-induced stress, higher sickness absenteeism, lower productivity, and intention to leave the job" (Bécares 2009). Again, because BME staff are less likely to report such incidents compared to their white counterparts, they are particularly vulnerable to mental health problems associated with such experiences of bullying and harassment.

5.2. INTERSECTIONS & TRIGGER POINTS

- **Gender:** Kapadia et al. (2015) identify Pakistani women as being at a particular disadvantage with respect to accessing mental health services, but also as being particularly at risk of mental health problems. Reasons include the fact that "Pakistani women tend to be socially isolated and have networks which display high levels of stigma towards mental illness and use of mental health services."

5.3. RECOMMENDATIONS FOR IMPROVED PROVISION

When it comes to BME health care practitioners and staff, Bécares (2009) proposes that support be offered to those facing bullying and harassment, as well as integrating this kind of training into more general NHS initiatives to tackle bullying and harassment.

Kapadia et al. (2015) recommend that research around service use be more sensitive to the needs of specific ethnic minority groups rather than taking a regional focus (e.g. Pakistani vs. South Asia) which may be misleading, as well as avoiding an "individualistic paradigm" which discounts the importance of social networks when it comes to help-seeking behaviour.

Research has suggested that: "more needs to be done to improve mental health service engagement and assertive outreach to reduce the imposition of police involvement with minority ethnic groups" (Gajwani et al. 2016).

Several texts propose that health practitioners would benefit from greater levels of cultural awareness training and "building better relationships with communities" (Raibee et al. 2014; Gabbidon et al. 2014; Aggarwal et al. 2016). Working through these relationships to "de-stigmatise" mental health problems may serve to "increase help-seeking behaviour and promote mental health at the individual and community level" (see also Memon et al. 2016).

5.4. RESEARCH COVERAGE

There is an impressive amount of research on the subject of ethnicity and mental health services. However, as the short list of intersection and trigger points below attests, there is limited engagement with subsets of BME groups, not only along the lines of different ethnicities but also other characteristics (e.g. gender, religion, sexuality, age). Furthermore, as identified above, while there is important research on the subject of stigma around mental health among BME groups, there is a clear lack of research on the subject of patterns of help-seeking behaviour among and between BME groups. More specific research looking at intersecting (and potentially compounding factors) and the engagement with services would be would be welcome.

It should be noted that while we refer to 'ethnicity' broadly here as a factor, the impact on mental health would vary according to different ethnicities in different contextual settings and the focus, and even how to define the ethnic 'category' would need to be decided on as a fundamental step in the research process.

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6. SEXUALITY

6.1. OVERVIEW

In this section, the term LGB+ is used to refer to people who are lesbian, gay, bisexual, or who otherwise identify with a sexuality that is not heterosexual. While the mental health of trans people is addressed in a later section, we§ occasionally use the term LGBT in accordance with the text under discussion.

There is an overwhelming consensus that there is an increased risk of mental disorder symptoms among lesbian, gay, bisexual, and otherwise non-heterosexual adults compared to heterosexual adults (Elliot et al. 2014; King et al. 2008; Semlyen et al. 2016). Several studies suggest that bisexual men and women are more at risk of mental health problems than gay men and lesbian women (Colledge et al. 2015; Hickson et al. 2017).

Knowledge of the "mechanisms and mediating variables" that structure this association between LGB+ orientation and poor mental health outcomes is limited, but a common hypothesis is "minority stress theory" which attributes these mental health disparities to an internalisation of stigma, victimisation, and harassment (Semlyen et al. 2016: 8-9; Chakraborty et al. 2011). Such processes may be particularly pronounced in the case of bisexual people as a result of biphobia (prejudice directed at bisexual people or an aversion to bisexuality itself) (Elliot et al. 2014: 14; Hickson et al. 2017).

While studies indicate that non-heterosexual people report higher levels of mental health service usage than heterosexual people, they are also less likely to have a favourable experience of primary health care than heterosexual people, and most notably in the area of communication between patients and nurses (Elliot et al. 2014: 12). For example, Semlyen et al. (2016) identify among LGB+ people low levels of disclosure of sexual orientation to healthcare professionals which: "could delay access to treatment". Similarly, a Healthwatch Nottinghamshire (2017: 23) report on LGBT+ experiences of **mental** health care found that a third of the 76 people that they surveyed (35%) felt that their experiences of health had been effected by sexual orientation, gender reassignment or both.

6.2. INTERSECTIONS & TRIGGER POINTS

- **Age and substance misuse:** Young LGB+ people may be at particular risk of poor mental health because of bullying, as can be those leaving care (Fish 2015: 9-10; Hickson et al. 2017). In addition, young LGB+ people are considerably more likely to use drugs and alcohol compared to heterosexual people (Marshal 2008).
- **Marriage**: While marriage and co-habitation can dramatically reduce risk of mental health problems (Hickson et al. 2017), LGB+ people who experience loss of a partner may be at greater risk of poor mental health because they do not conform to the "recognised social role of widow/er" (Fish 2015: 9-10).
- **Poverty and ethnicity:** Gay and bisexual men with lower education or lower income are at significantly higher risk of mental health problems compared to their straight counterparts, as are those from minority ethnic groups relative to their white counterparts (Hickson et al. 2017).
- **Ethnicity:** A "substantially higher proportion of racial/ethnic minority than white [mental health] patients reported bisexual or 'other' orientation," potentially reflecting "different socio-cultural norms about acceptability or disclosure of minority sexual orientation among racial/ethnic minorities" (Elliot et al. 2014: 14).

6.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Semlyen et al. (2016) recommend that sexual orientation becomes a more routine part of data collection to assist attempts to better understand inequalities in poor mental health among the LGB+ population group, and to help inform the design of interventions to remove such inequalities (see also Semp and Read 2014). Due to apparent mental health inequalities between groups of sexual minority patients, several sources recommend the development of programmes and services tailored to the needs of discrete populations (Elliot et al. 2014: 14).

Hughes et al. (2018: 1) demonstrate that mental health staff who receive LGBT awareness training are "significantly more likely to report [...] that they routinely [discuss] issues of sexuality and gender" with LGBT youth, indicating that awareness training can "impact positively on practice." A Stonewall report from 2015 demonstrated that almost three quarters of patient-facing staff had not been given training on the health needs of LGBT people.

Hickson et al. (2017) argue that existing services for young LGBT people are insufficient, and national policy decisions need to take this into account.

6.4. RESEARCH COVERAGE

Seven years ago, Chakraborty et al. (2011: 1) wrote that "there has been little research into the prevalence of mental health problems in lesbian, gay and bisexual (LGB) people in the UK." While this state of affairs has changed considerably in recent years, most research still relies on small samples which may not be representative of national populations, nor sensitive to the discrete experiences of individual sexual minority groups (Elliot et al. 2014: 9). The increasing awareness and societal 'acceptability' of the LGB+ population should make it easier to conduct research with people in this group (or subsets of this group) in terms of finding willing participants (particularly with regards to qualitative research). However, it could be argued that if the linked mental health issues are in part caused by social stigma, rather than social difference this causal factor is likely to be reduced as social awareness and acceptability continue to increase.

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7. PERINATAL

7.1. OVERVIEW

The perinatal period is a term that is used to denote the phase of pregnancy (from conception) and the first year after childbirth (the postpartum period).

Research into mental health problems relating to the perinatal period is typically focused on mental health problems experienced by mothers, and more specifically the following three conditions: anxiety, depression, and psychosis (e.g. bipolar disorder) (Bauer et al. 2014: 11). Ford et al. (2017) propose that perinatal anxiety disorders and PTSD have generally received less scholarly attention than perinatal depression. Additionally, there is less research on the subject of prevention of perinatal mental illness in comparison to research on the use of psychological and pharmacological interventions. This is concerning given that it is estimated that at least 10% of pregnant women and new mothers experience perinatal mental illness, but only "approximately half of cases […] go undetected in routine clinical practice" (NHS 2015).

There is considerable literature on the subject of the mental health service experiences of mothers. In a major systematic review of this literature, Megnin-Viggars et al. (2015) indicate that women are more likely to disclose symptoms when they have access to an integrated and continuous care context and a trustworthy professional who is familiar to them (see also Fox 2012).

Despite the majority of studies on the subject of perinatal mental health being focused on maternal mental illness, a few recent publications have broken new ground in the area of paternal mental illness (e.g. Darwin et al. 2017; Fletcher et al. 2015; Nath et al. 2016). One particularly important study demonstrates that paternal depressive symptoms follow a similar pattern to that of mothers, though the prevalence is not as significant, and the symptoms are likely to extend for considerably longer among fathers (Nath et al. 2016). The study shows that fathers (like mothers) are more likely to be at risk of mental health problems "if their partner also has depression," as well as if there is marital conflict (Nath et al. 2016). Notably, there is less UK-specific research available on the subject of "non-resident fathers", though the international studies that do exist indicate that the prevalence of depression may be higher among non-resident fathers (Nath et al. 2016).

Several studies have demonstrated that there is a greater risk of "transmission of psychological and developmental disturbances" from parents with perinatal disorders to children and young people (from foetal development to adolescence) (Stein et al. 2014). Furthermore, foetuses and infants may be at risk of harms due to exposure to psychotropic medicines. For this very reason, women may choose not to adhere to courses of pharmacological treatment.

7.2. INTERSECTIONS & TRIGGER POINTS

- **Abuse:** Several studies indicate that perinatal mental illness is commonly associated with a personal history of mental illness, lack of support from partner or other social support, experience of abuse or adverse events in life, unplanned pregnancy, and pregnancy loss or complications (Biaggi et al. 2016).
- **Ethnicity:** While it is unclear whether women from black and ethnic minority groups are more likely to be at risk of perinatal mental health disorders (Biaggi et al. 2016), they are more likely to have "potentially missed common mental disorders" compared with white British women (Prady et al. 2016).

- **Gender:** Young women, women with low education, unemployed women, and "housewives" are potentially more at risk of antenatal depression and anxiety (Biaggi et al. 2016).
- **Gender:** Men with lower education or who are facing "socioeconomic deprivation" and unemployment are more at risk of depressive symptoms in the perinatal period (Nath et al. 2016).
- **Ethnicity:** Men from a South Asian background (India, Pakistan, and Bangladesh) are more likely to have higher depressive symptoms in the perinatal period compared to white British men (Nath et al. 2016).

7.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Ford et al. (2017) argue that while screening tools have been used in primary care populations, "a majority of GPs are not using these particular tools routinely," suggesting that this should happen more consistently. They go on to recommend that future research be directed towards GPs' perspectives on barriers to symptom disclosure among perinatal women, as well as existing "GPs' communication skills training." Biaggi et al. (2016) recommend that screening tools be developed which incorporate knowledge of more specific risk factors, as well as that screening take place across the perinatal period rather than at one isolated moment. Haynes (2018) advocates the development of an "early, integrated detection and care system" which uses the existing booking-in process as an opportunity to discuss prior and current mental health concerns with women, as well as associated stigmas.

Several studies recommend that women be given access to an integrated and continuous care context where they have access to a trustworthy professional with whom they are familiar (e.g. Fox 2012; Megnin-Viggars et al. 2015).

Ford et al. (2017) and Haynes (2018) propose that primary care for women with perinatal mental illness could provide greater access to non-pharmacological interventions, such as psychological therapy.

Nath et al. (2016) propose that "the healthcare cost of depressed fathers is comparable to mothers but interventions are still primarily tailored for mothers." As such, they recommend that primary health care services and professionals adopt a more "family-centred" approach to perinatal care, partnering with unemployment officers and job centres to spread awareness and develop interventions for fathers of young children, as well as screening new fathers in the systematic way that new mothers are (see also Darwin et al. 2017).

7.4. RESEARCH COVERAGE

There is a wealth of literature on the subject of perinatal mental health, with a growing interest in paternal mental health to match that of maternal mental health. It would be interesting to look deeper into the various ways that maternal and paternal mental health manifest and look for similarities and divergences, both in terms of what are the trigger points as to when the mental health issues arise and peak. Research could also focus on engagement with services and which interventions proved to be useful for each group.

It would also be interesting to look at whether, and if so how, family, friendship and community support structures positively (or negatively) impact on mental health in the situation of maternal or paternal mental health. It might consider social or geographical isolation and whether stigma could have an impact, for example related to the non-traditional role of the primary male primary carer in particular. Ethnicity might also be considered here as a related factor to explore.

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8. DISABILITY

8.1. OVERVIEW

As defined by the Equality Act 2010, a mental health condition that has a "long-term effect" on one's "normal day-to-day activity" is considered to be a disability. For the purposes of this section, the focus will be on the co-occurrence of mental health conditions and other disabilities.

Most research on the subject of disability and mental health focuses on people with long term physical health conditions or those with general learning disability (sometimes referred to as intellectual disability, e.g. Down syndrome or fragile X syndrome). Less research appears to have been conducted about the mental health of people with developmental disability (e.g. Autism Spectrum Disorder, ADHD) or specific learning difficulty (e.g. dyspraxia, dyslexia).

It is widely acknowledged in the literature that people with long term physical health conditions are subject to a heightened risk of mental health problems, and particularly depression and anxiety disorders (Naylor et al. 2016: 8). This may be because of the experience of living with the condition, the side effects of medication or hormone imbalances, social isolation, and financial pressures faced by those who are out of work (Naylor et al. 2016: 8-9). In regard to financial pressures specifically, a study by Barr et al. (2016) shows that claimants of the key out-of-work disability benefit who are exposed to routine eligibility reassessments are more likely to report experiencing mental health problems, more likely to commit suicide, and more likely to be prescribed antidepressants.

In considering the mental health of people with long term physical health conditions, it is important that this group is not approached in isolation from those with learning disabilities and difficulties, specifically because people with learning and developmental disabilities are more likely to experience increased physical health needs (Burke 2014: 12). Furthermore, in the case of people with "medically unexplained symptoms" (e.g. those who experience certain forms of chronic pain or tiredness) it is sometimes impossible to distinguish between "mental" and "physical" health (Naylor et al. 2016: 9).

With respect to people with general learning disability specifically, numerous studies demonstrate that this group has an increased overall risk of poor mental health outcomes, and most notably in the case of Down syndrome (Hosking et al. 2016). The mechanisms and mediating factors that structure this association can in part be determined by biological factors, but there is strong evidence that people with general learning disabilities are "at greater risk of exposure to poverty, poor housing, unemployment, discrimination, and other common social determinants of ill health," all of which contribute to a heightened risk of mental health problems (Allerton et al. 2011: 273-274).

As several studies indicate, the increased risk of poor mental health outcomes among disabled people not only reflects the challenges and social barriers which they face when seeking to manage their personal mental health needs (e.g. communication difficulties, discrimination), but also the shortcomings of existing health care services (Naylor et al. 2016; Royal College of Psychiatrists 2012). For example, a study by Hosking et al. (2016) found that "a third of deaths among adults with general learning disability were amenable to health care." Research shows that people with general learning disability are more likely to face barriers to access and poor patient management which lead to delays in diagnosis. More specifically, these barriers to access include instances of "diagnostic overshadowing" (where symptoms are interpreted as part of the general learning disability or as "challenging behaviour"), being passed between different services, and simply a failure to listen to people with general learning disabilities (Burke 2014: 11). In addition, there is a lack of reasonable adjustments to make information on mental health and services accessible (Burke 2014: 16).

8.2. INTERSECTIONS & TRIGGER POINTS

- **Age:** Young people with general learning disability are considerably more likely to experience psychiatric disorders, including depression, ADHD, Autism Spectrum Disorders, and Sleep Disorders. Crucially, these different conditions are often comorbid (Allerton et al. 2011). Children and young people with mental health problems that are comorbid with physical health disability are "associated with high additional costs" for their families, and particularly in the case of those from disadvantaged backgrounds (Solmi et al. 2018).
- **Poverty:** As identified, those with learning disabilities are more likely to experience poverty and unemployment, which have been shown to compound mental health issues. Allerton et al. 2011

8.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Research has shown (e.g. Naylor et al. (2016) that people using services "commonly find that their physical and mental health needs are addressed in a disconnected way." As such, they identify areas of improvement from across the health care system which include further integration of mental and physical services, such as establishing "physical health liaison within mental health services" and vice versa (see also Burke 2012). This could also see better primary care for the "physical health needs of people with severe mental illnesses."

Hosking et al. (2016) advise that health care interventions which target people with general learning disabilities focus not solely on prevention, but do more to attend to "access to and quality of health care," where disparities between adults with general learning disability and other adults are most stark. Particularly important here is the need to identify risks and lifestyle factors that people with general learning disability face which may not be generally prioritised in high-income countries (e.g. respiratory diseases).

Elias et al. (2018) highlight that adolescents and young adults with Autism Spectrum Disorders who are moving to postsecondary education are particularly at risk of mental health problems, and recommend that they are provided with "individualized transition planning and in-college supports." Similarly, Hall et al. (2013) propose that for young people with ADHD, the transition between child to adult mental health services is a particularly vulnerable time, with adult services often poorly informed about ADHD.

It has also been recommended that health care professionals work harder at listening to people with general learning disabilities and developmental disorders Burke (2012: 16), making reasonable adjustments to improve access to services, and ensuring that transitions between services are managed more efficiently. In addition, she advises that practitioners receive better training on their needs, with specialist clinical leads installed in different health care settings (Burke 2012: 29).

While, Jacobs et al. (2015) recommend that in order to improve the effectiveness of mental health services for young people with learning disabilities, they indicate that there needs to be research which links "population need to available resources, and service models to services users' outcomes."

It should be noted that the NHS England Mental Health Taskforce has been engaging with some of these recommendations (see Parsonage et al. 2016).

8.4. RESEARCH COVERAGE

While there is considerable literature in this area that focuses on people with long term physical health conditions and those with general learning disability, there is clearly scope for more research on the barriers and experiences of mental health services among people with developmental disability or specific

learning disability. In addition, the literature repeatedly fails to acknowledge mental health problems as disabilities, despite them being defined as such in the Equality Act 2010.

There are a wide range of disabilities that can be identified and the research design should consider which disabilities are of the main interest and priority, how to define and group the participants appropriately, and whether the type of methodology in place is suitable for the group in question. Research amongst those with severe learning disabilities for example, could be observation research, or assisted via the carers if less severe. While research amongst physically disabled, is more likely to incorporate a survey or interview based design directly with those affected.

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9. GENDER

9.1. OVERVIEW

The difficulty experienced by patients in accessing mental health provision and services in relation to gender is complex, both in access to treatment and in the disorders themselves. The role of gender in mental health research has also been suggested by some to be lacking as Howard et al. state: "there is limited a priori investigation of sex and gender differences in the causes and treatment of mental disorders". Howard et al. do not indicate why this might be, though one potential reason may be that because the groups are so large it means they cannot be homogenous or determined conclusively as being the result of gender compared to other factors.

That said, research suggests that women may be more susceptible to mental health issues than men. For example, a survey for NHS Digital found that "one in five women reported symptoms of common mental disorder (e.g. depression and anxiety) compared to one in eight men. Women were also more likely than men to report severe symptoms of common mental disorder". The survey, which is undertaken every seven years, found that the proportion of men who report this remained stable since 2000, whilst for women it increased.

Kuehner (2016) "identifies potential risk factors such as the influence of sex hormones, women's blunted hypothalamic–pituitary–adrenal axis response to stress, girls' and women's lower self–esteem and higher tendency for body shame and rumination, higher rates of interpersonal stressors, experienced violence, childhood sexual abuse, and—on a societal level—lack of gender equality and discrimination". Since these findings were released, the Government has set up a Women's Mental Health Task Force to seek to address the issue.

However, there is also some evidence to suggest that stigma felt surrounding mental health is more apparent in men than women. This aspect of the debate is inherently gendered as society's perception of masculinity is at odds with expressing emotion and asking for help and therefore suggests that men are less likely to report feelings of common mental disorders and are less likely to access treatment services due to a reluctance to visit a GP or acknowledge a problem. Suicides rates amongst men were also significantly higher with 78% of all suicides being male, this is also potentially linked to men being less likely to talk about their feelings and ask for help (ONS, 2013 data).

Research by Men's Health Forum (2015) has also suggested that the environment and language used when making a diagnosis leans more towards female than male vocabulary: "some academics and practitioners now believe that the international symptomology for depression is inclined to emphasise a more 'typically female' form of presentation".

Additionally, a study by Swami (2012) which researched the mental health literacy around depression by asking respondents to rate the vignettes along a number of attitudinal dimensions and completed measures of attitudes toward seeking psychological help, psychiatric scepticism, and anti–scientific attitudes found: "respondents – particularly men – rated the case of the female vignette as significantly more distressing, difficult to treat, and deserving of sympathy than they did the case of the male vignette" and therefore conclude that this "may impede optimal help–seeking for symptoms of mental ill–health". Oliver et al also corroborate this in a study which found "Males, young people and people living in affluent areas were the least likely to seek help."

Recent data from Psychological Therapies: reports on the use of IAPT (Improving Access to Psychological Therapies) services in England from December 2017 found that across all CCGs 161,926 female and

85,872 male referrals entering treatment were made. However, these statistics do not take into consideration other important statistical variables such as severity of psychological distress, which may be separate from gender.

9.2. INTERSECTIONS & TRIGGER POINTS

- **Abuse:** Women who have experienced domestic or sexual abuse may be particularly at risk of developing mental health problems as well as those (overwhelmingly men) who perpetrate it (Trevillon et al, 2016; Ferrari, 2014). The reason for this, linked to the trauma experienced.
- **Age (youth)/gender:** The NHS Digital survey identified young women as the most at-risk group of developing mental health problems as "one in five women aged 16-24 had self-harmed at some point; almost double the rate for men of the same age". The authors of the report pointed out that this cohort were the first to come of age with social media, though more research would be needed to establish a link.
- **Prisoners:** Men make up 95% of the prison population and 72% of male prisoners suffer from two or more mental disorders (Men's Health Foundation, 2015). In this instance, the two factors are likely to be bidirectional and some studies suggest that the prison environment can have a negative impact on mental health.
- **Ethnicity:** Compared with White British women, minority ethnic women were twice as likely to have potentially missed common mental disorders and half as likely to have a marker of screening for common mental disorders (Prady, 2016). The reason for this is unknown but in Prady's study it may be related to culture or social economic status.

9.3. RECOMMENDATIONS FOR IMPROVED PROVISION

To improve not only access to treatment but also to encourage those who need it to seek it, Swarmi (2012) believes 'Initiatives that consider the impact of gender stereotypes as well as individual differences may enhance mental health literacy, which in turn is associated with improved help-seeking behaviours for symptoms of mental ill-health'. Given the findings of the research this would seem to be particularly useful for men.

Scholarship recommends a holistic approach towards mental health provision that is inclusive of gender for both men and women. This includes consideration of the needs of patients in the service planning process, an inclusive use of language, recognising and listening to symptoms and taking into consideration life events e.g. ensuring that staff are asking service users whether they have experienced domestic violence and abuse. (Malna, 2017; Agenda, 2017; Men's Health Foundation, 2015; Howard, 2016).

9.4. RESEARCH COVERAGE

It was difficult to find research directly related to gender in and of itself as opposed to linking it to another group e.g. domestic abuse. In one sense this is understandable as when looking at gender and mental health it is difficult to say whether or not the mental health difficulty is a direct result of gender per se, as opposed to other associated factors. In addition, policy documents were often focused on one specific gender rather than comparing the two. It would be interesting to see research that considers whether and if so, what which ways men and women experience mental health services differently as a result of their gender and whether some services are more accommodating of one gender e.g. eating disorders are more common among women and therefore may be more experienced with treating women. Interviews with

users of services or conditions which tend to be used by one gender may be a fruitful avenue for this type of research.

Greater exploration of measures that could practically be put place to encourage, men in particular to identify and seek help for mental health issues when they arise could also be very useful.

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10. TRANSGENDER

10.1. OVERVIEW

The term transgender or trans is used here in reference to those whose gender identity is not associated with the sex that they were assigned at birth. There is one instance in which an author is quoted that uses the term trans*, a term that is intended to function in the same manner as LGB+ insofar as it is inclusive of a diversity of groups. Though a subject that is under-researched, recent years have seen a sharp increase in diverse research on the subject of the experiences and needs of trans people, including in the area of mental health.

Many studies attest to the fact that transgender people are faced with physical and mental health inequalities in comparison to cisgender people (those whose gender identity is associated with the sex they were assigned at birth), yet there is a notable dearth of research conducted on the mental health experience of the trans population of the UK.

Research suggests that this association between trans identity and poor mental health outcomes can be attributed to "violence, stigma, discrimination, [and] social rejection" on the one hand, and "inadequate specialized healthcare facilities" on the other (Sweileh 2018).

Research indicates that the attitudes of health practitioners constitute a frequent barrier to access for trans people, with negative attitudes being more prevalent among "male, Caucasian, heterosexual, religious, conservative mental health professionals" (Brown et al. 2017:1). As Ellis et al. (2015) argue, the mental health and wellbeing of trans people is also further jeopardised by lack of knowledge around trans issues among health care practitioners, leading to "untreated gender dysphoria[15] (due to delays or refusals of treatment), unnecessary and intrusive questioning/tests, prejudicial attitudes by service providers, and restrictive treatment pathways." There is also a risk of "diagnostic overshadowing" (where mental health symptoms are treated as a result or symptom of being trans) (Ellis et al. 2015).

All of this is "particularly problematic" because "mental health practitioners are gatekeepers to gender identity treatment (i.e. hormones; surgery)" (Ellis et al. 2015). Likewise, the fact that waiting times for hormones and surgery have been shown to be long is especially concerning given the impact that this has on the mental health and wellbeing of trans people.

10.2. INTERSECTIONS & TRIGGER POINTS

- **Age:** Page et al. (2016) spotlights the importance of ensuring that the mental health needs of older transgender people are met, specifically because they face barriers to access on account of both their age (e.g. ageism, dementia) and their trans identity (e.g. transphobic discrimination).
- **Sexuality:** The challenges of coming to terms with gender nonconformity can be complicated or compounded by a process of coming to terms with sexual orientation (McCann et al. 2017).
- **Adolescence** "can present additional stressors for trans* young people," specifically because they are often subject to "increased incidences of discrimination and transphobic abuse," as well as violence (McCann et al. 2017). As a result, trans youth report "high incidences of mental distress,

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[15] "Gender dysphoria" is used to refer to a condition where a person experiences distress as a result of the lack of congruity between their gender identity and their biological sex. Despite its prevalence in clinical settings, the term is controversial because some perceive it to frame transgender as a pathology, as noted in the discussion below.

including depression, anxiety, substance use, and suicidality, are evident among this group" (McCann et al. 2017; Arcelus et al. 2016).

- **Disability/ Unemployment:** Disabled or unemployed trans people face additional barriers to accessing gender reassignment treatment due to highly stringent requirements, such as the need to be in full time employment or study, and a requirement to change one's name (Ellis et al. 2015).

10.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Brown et al. (2017) echo several studies when they recommend introducing "direct and targeted interventions for attitudinal change." More specifically, they suggest that mental health practitioners be provided with "psycho-education […] focusing on an empathetic understanding of gender flexibility and the social construction of gender roles" (see also Ellis et al. 2015). At a more fundamental level, Ellis et al. (2015) recommend that more be done to inform health care practitioners about trans issues and experiences. Such interventions could be more targeted if there was more research into the variables that structure some of the negative attitudes that trans people report (Brown et al. 2017).

It has also been recommended that waiting times for hormones and surgery be reviewed, as well as the current treatment approach which "positions trans within a framework of pathology" in a way that fails to acknowledge the diverse and complex ways in which people experience gender identities (e.g. use of the category "gender dysphoria"). They advise that such decisions are made with the involvement of trans people themselves (Ellis et al. 2015).

10.4. RESEARCH COVERAGE

Despite there being a growth of attention about the experiences and needs of trans people, including in the area of mental health, there is a clear focus in the literature on MTF (male-to-female) transgender experiences. It is recommended that more is done to capture the experiences of people from across the transgender spectrum (Brown et al. 2017: 16).

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11. RELIGION

11.1. OVERVIEW

In this section, unless indicated otherwise, the terms "religion" and "religious" are used interchangeably with those of "faith", "spirituality", and "belief". The subject of religion raises several points of discussion in relation to mental health, but this section will focus on the question of the associations that exist between religious identity or practice and mental health.

There is a divide in the literature about the extent to which religious people are more or less vulnerable to mental health problems in comparison to their non-religious counterparts. For example, some studies have shown that religious practice provides valuable coping strategies to those with schizophrenia, and others have suggested that religiosity can serve as a "buffer" against stressors and also reduce symptoms of depression and substance abuse (Dein et al. 2012). Similarly, other studies suggest that religion is an "important factor in mental health recovery" (Starnino et al. 2014), or a predictor of psychological (as opposed to subjective) wellbeing (relating to a sense of meaning and fulfilment of potential rather than happiness and quality of life) (Lewis et al. 2005). However, the picture is more complicated with regard to anxiety, with some studies reporting higher levels of anxiety among more religious people, with others report lower levels or no correlation at all (Dein et al. 2012). One study suggests that "spiritual" people are more likely than others to be dependent on drugs, to have generalised anxiety disorder, or a neurotic disorder, though these findings relate to people defined as "spiritual" in distinction to "religious" (King et al. 2018). Overall then, it can be concluded that the literature is divided on the vulnerability of religious people to mental health problems.

One particular issue with research around religion and mental health concerns definitions, and specifically the heterogeneity of terms such as "religion", "non-religion", "spiritual", and so on, as well as the diverse ways in which people identify with such categories. For example, whether studies claim to be engaging "religious" people or a single individual group, they often privilege Christian or Muslim groups over others (Fruehwirth et al. 2016). Accordingly, there is a gap in the literature when it comes to exploring how Jewish, Hindu, Sikh, and Buddhist groups (among others) engage with and experience mental health services, the individual needs of these groups, and cross-cutting themes across these communities. Another concerns directions of causality and selection effects: for example, people with substance abusive problems may be less likely to participate in religious activity, or conversely more likely to do so; they may be less likely to acknowledge substance abuse, or may be actively excluded from religious groups (Dein et al. 2012; Fruehwirth et al. 2016).

Religion can serve as a barrier to access in more than one way. For example, there may be treatment delays as a result of a preference for seeking support from religious groups or figures before medical intervention, and a lack of collaboration between mental health services and religious organisations in this area (Islam et al. 2015). Similarly, there may be a level of shame or stigma attached to mental health problems in certain religious traditions or groups (Weatherhead et al. 2010). To give a very different example, there may be a lack of awareness around religious matters and "explanatory models of illness" among health practitioners which can lead to a sense of uncertainty or even discomfort around these issues (Islam et al. 2015; McSherry and Jamieson 2013; Raibee et al. 2014; Starnino et al. 2014). Finally, religious people might be exposed to religion-specific discrimination and abuse, for instance as in the case of Islamophobia, and as such may be at higher risk of mental health problems associated with such stressors (Hussain 2009; Weatherhead et al. 2010).

11.2. INTERSECTIONS & TRIGGER POINTS

- **Age:** Some studies indicate that young religious people are less vulnerable to depression, anxiety, and psychotic symptoms (Dein et al. 2012).

- **Ethnicity**: Islam et al. (2015) propose that black and minority ethnic (BME) service users experience barriers to mental health care, and are more likely to seek support from "faith/spiritual healers" ahead of "seeking medical intervention," potentially leading to delays in treatment (Islam et al. 2015).

11.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Several studies highlight some of the methodological problems that come into play when researching the mental health of religious people, and specifically with regard to definitions, directions of causality, and selection effects (Dein et al. 2012; Fruehwirth et al. 2016).

Islam et al. (2015) indicate that more collaboration between mental health services and religious organisations would be in the best interests of "person-centred care"; an insight that Heffernan et al. (2014) echo in the specific case of hospital chaplaincy services.

Several studies propose that health practitioners receive greater levels of religious awareness training, not least because religious people often "interweave" religious and secular matters into their accounts of mental distress and recovery, as well as assessing the religious needs of service users (Heffernan et al. 2014; Islam et al. 2015; McSherry and Jamieson 2011; Weatherhead et al. 2010). Despite there being some acknowledgement of this need among health institutions (Department for Health 2010; RCP 2013), some studies question the extent to which these initiatives have been implemented successfully (Raibee et al. 2014).

Forrester-Jones et al. (2012) highlight how spirituality support groups can "provide a useful outlet for individuals to talk about spiritual matters and gain from them in a non-stigmatising setting."

11.4. RESEARCH COVERAGE

Given the well-documented decline of institutional religious activity in the UK in recent decades, it is perhaps surprising that there is a considerable amount of research on the subject of religion and mental health. However, because this body of literature is somewhat dispersed and uneven in quality, there is a clear information gap in this area, with a particular dearth of research with religious groups beyond Christian and Muslim populations. Furthermore, the existing literature is generally more focused on the question of the extent to which religion can be associated with mental distress or wellbeing, with a clear gap in terms of experiences of services (Dein 2014). This would be interesting to explore.

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12. MARITAL STATUS

12.1. OVERVIEW

Scholarship into marital status and its relationship with mental health is scarce and it is also quite difficult to tell whether improved or worsening mental health is the result of marital status or vice versa (Bulloch AG, 2009). There is no evidence to suggest that married or single people are discriminated against in terms of mental health access or provision.

Some studies suggest that being married has a positive impact on mental health because of "the sense of security provided by these spousal safety nets" and its ability to facilitate mutual trust and emotional support (Williams K et al, 2010). From a social perspective, marriage also has the potential to guard against social isolation. However, Breslau also suggests a link between premarital mental health conditions and divorce or reduced chances of marriage (Breslau, 2011).

However, the one area that has more conclusive evidence in terms of marital status and mental health is the effect of family breakdown, both adults and children. Among the public, polling by the Centre for Social Justice found that "half of those surveyed thought family breakdown was a major cause of poor mental health and more than 60 per cent thought poor mental health was a contributor to family breakdown (whereas fewer than a third thought poverty was a major cause of poor mental health). About half said that childhood and family factors were a major cause of their or their relative or friends' poor mental health" (CSJ, 2011).

Studies also corroborate this idea as Williams et al. notes that "Numerous longitudinal studies have provided convincing evidence that the transition to divorce is associated with increases in depressive symptoms and declines in well-being". Whether this a decline in wellbeing following divorce or separate is a temporarily stressful time of life or has a more permanent impact on mental health is unclear. Interestingly, in widowhood, studies suggest that there is an increase in symptoms of mental distress but temporarily which might suggest that the breakdown of a relationship rather than the loss may have more of an impact on mental health. However, more research into this area is needed before this can be firmly concluded.

12.2. INTERSECTIONS & TRIGGER POINTS

- **Ethnicity:** "Little research has considered whether the relationship between marital status and mental health differs by race/ethnicity. This is an important and timely question, especially given striking race/ethnic variations in patterns of family formation" (Williams et al, 2010).
- **Social networks/ isolation:** "Social networks and social support can promote a sense of belonging and well-being and may prevent mental health problem" (CSJ, 2011).
- **Religion/cultural expectations:** the individual's perception of a marriage separation/divorce may affect the extent of the impact on mental health. This is particularly relevant in religious or cultural settings where divorce may be less accepted (Williams et al, 2010).
- **Gender:** Strohschein's research in India supports the "Received wisdom says marriage correlates with better health, but men derive a greater benefit than do women" (Strohschein, 2017). Other studies suggest that as women generally tend to value commitment, conflict or marital strain may have more of a negative impact on the wellbeing of women, however, one study which predicted this result later found it disproved in the research findings as 'conflict in intimate relationships seems to have a similar impact on men and women's mental health' (Symoens et al,

2014). The impact of economic factors following family breakdown on mental health would be worth exploring.

12.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Research is lacking with regards to whether marriage or cohabitation affects a person's willingness to seek out mental health services and whether their experiences of these services differ as a result.

Based on current research, it may be advisable for healthcare professionals to consider the family unit when patients access mental health services as the CSJ found that "patients are often treated as individuals unconnected to a family system".

12.4. RESEARCH COVERAGE

Academic research into marital status and its relationship with mental health is very limited overall. Accordingly the remit and focus on any research undertaken could explore many avenues. Although aspects of this are apparent in research, the transition into and out of marriage over a life trajectory in relation to mental health could prove a good start. Remarriage and new relationships following divorce have been explored by Symonens et al.

Interestingly, while we are considering this in a UK context, the impact of marital 'status', as opposed to marriage itself, and how this is perceived might vary with cultural context (ethnicity and religion for example) as to how stigma of being married, or not, affects the mental health of the person in question.

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13. WORKPLACE

13.1. OVERVIEW

Government and employers have in recent decades focused more attention on the subject of mental health in the workplace. Though the same level of attention is not evident in the academic literature, recent years have seen the emergence of several studies on workplace mental health in the UK (Brohan et al. 2012).

Research has indicated that a significant proportion of employees have experienced symptoms of poor mental health (Deloitte 2017). This reality not only has negative effects on the lives and physical health of employees, but also the performance of businesses and organisations because of absenteeism and presenteeism (working while unwell).

Certain psychosocial job characteristics or work environments may heighten the risk of symptoms of depression (Butterworth et al. 2013; Madsen et al. 2017; Yiengprugsawan et al. 2015). For example, UK workers with low job security, inability to cope with work demands, low support from employers, and low decision capacity are all more likely to experience psychological distress.

While research suggests that experience of and support for mental illness varies across UK workplaces, health care practitioners report that stigma and discrimination between colleagues is common in these environments and thus operate as a clear barrier to disclosure of mental illness (Waugh et al. 2017; Brohan et al. 2012). In addition, there is often a concern among employees about "losing one's job or not getting promoted," as well as "being seen as unable to cope" and not wanting to "let the team down" (Waugh et al. 2017; Ridge et al. 2017). This is of particular concern because the protection provided by the Equality Act 2010 is "dependent upon whether the employee/potential employee has disclosed their mental disability to the employer" (Brohan et al. 2012: 12).

13.2. INTERSECTIONS & TRIGGER POINTS

- **Visibility:** Brohan et al. (2012) propose that those who display no mental health symptoms at work are significantly less likely to disclose their illness than those who have visible symptoms at work.

13.3. RECOMMENDATIONS FOR SERVICE PROVISION

Deloitte (2017) advise that employers give more priority to mental health and wellbeing by appointing "health and wellbeing leads" and subscribing to corporate pledges, which engage employees. They also propose that employers quantify and track how successfully these initiatives are being implemented.

In addition to advocating greater confidence around mental health problems in workplaces, several studies propose that the role of the manager is paramount with respect to disclosure of mental health illness, with the implication that training for managers would assist them in supporting employees and facilitating the work of health care professionals (Waugh et al. 2017). Also important in this regard is the recruitment of professionals who have experience of poor mental health, specifically because they are more likely to be able to identify and offer support to people experiencing mental health problems (Waugh et al. 2017).

Little et al. (2011) suggest that more can be done with respect to formalising reasonable adjustments for those facing mental health problems (see also Brohan et al. 2012).

Madsen et al. (2017) recommend that trials be conducted "to determine the potential of reducing job strain as a preventive measure for more common depression-related conditions," as well as increasing awareness of these associations amongst health practitioners.

13.4. RESEARCH COVERAGE

While recent years have seen the publication of several studies on workplace mental health, Brohan et al. (2012) recommend that more research be conducted on the subject of workplace mental health, and specifically longitudinal research that tracks attitudes and conditions over time. Furthermore, there is a clear gap in the academic literature on this subject. In particular, there is considerable scope for research on the subject of the extent to which those in the workplace engage with mental health services via their workplace, as well as their availability across different organisation sizes and sectors of employment (e.g. public, private, charity). In addition, which services re most suitable. There is also space for research concerning the identification of groups that are particularly vulnerable to mental health problems, and who face particular barriers in the workplace, especially in relation to accessing services.

13.5. CITATIONS

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14. UNEMPLOYMENT

14.1. OVERVIEW

There are well-established associations between mental health problems and unemployment, as well as similar situations such as underemployment (where workers who work part time would prefer to work full time, or who are highly skilled are employed in low skill roles), job insecurity, and precarity (lack of stability and security). Indeed, it is widely recognised that there was been a significant increase in prevalence of people reporting mental health problems from the 2008 financial crisis onwards (Barr et al. 2015).

Of the mental health symptoms that are associated with unemployment, the most common are depression and stress, as well as alcohol use disorders and suicidal ideation and behaviour (Wahlbeck et al. 2013).

The associations between unemployment and mental health problems relate to at least two dimensions of experience of financial difficulties: on the one hand, there is the psychological pressure of meeting household needs on a restricted budget; on the other hand, the experience of unemployment may be accompanied by feelings of shame, perceived stigma, and reduced social capital (Curl et al. 2015: 3).

14.2. INTERSECTIONS & TRIGGER POINTS

- **Age:** The transition from school to work is a trigger point for heightened risk of mental health problems among young people, though existing mental health problems can themselves increase the likelihood of disengagement from education or labour (Oliver et al. 2014: 2).
- **Gender:** Men, and particularly men from poor socioeconomic backgrounds, are particularly at risk of mental health problems. This is specifically because of "the embedding of work as fundamental to a positive male identity," as well as the demands of changing patterns of employment (i.e. from manufacturing to services) (Robertson et al. 2017). As a result, unemployed men or men experiencing job insecurity are at greater risk of death due to suicide and alcohol use (Wahlbeck et al. 2013).
- **Education:** People with low educational attainment, and particularly men, are at greater risk of mental health problems (Wahlbeck et al. 2013).
- **Disability:** While poor mental health can be a consequence of unemployment, it can also be a cause insofar as "people who are experiencing mental distress, and those who have been labelled with mental health problems," are more exposed to "risks around discrimination in the workplace preventing people from being able to secure and maintain employment" (Mattheys et al. 2016). Brohan et al. (2012) suggest that employers are less likely to hire applicants with mental health problems were rated as less employable "than either a candidate with a physical disability or a candidate with no disability."
- **Discrimination:** More broadly, all vulnerable groups or groups facing discrimination are at risk of increased social exclusion during recessions, and are therefore the risk of mental health disorders is heightened (Wahlbeck et al. 2013).

14.3. RECOMMENDATIONS

Oliver et al. (2014) recommend that interventions be developed to target young people transitioning from school to work.

Several studies propose that "improved provision of mental health services in primary care" should be accompanied by a series of cross-sector interventions (Wahlbeck et al. 2013). As Cooper et al. (2014: 12) propose, "reducing the extent of socioeconomic inequality and enhancing the likelihood of gainful

employment" would not only improve the health of the population, but also further improve labour market participation.

It is also argued that not only can the maintenance of "social benefits and services" act as a buffer against the structural pressures of recession, but that active labour market programmes ought to promote mental health and re-employment. Wahlbeck et al. (2013) These could be embedded into the redundancy packages that employers offer, as well as being targeted at young people transitioning from school to work.

14.4. RESEARCH COVERAGE

There is a considerable amount of literature on the subject of unemployment and mental health. Unsurprisingly, this body of literature has grown substantially in the aftermath of the 2008 financial crisis and the government austerity programme that was implemented from 2010, but has also resulted from previous recessions in the 1980s and 1990s (Bambra 2010). Likely because of the policy debates that have accompanied these shifts, much of this literature is focused on establishing the associations between unemployment and mental health problems and designing interventions. As a result, there remains a gap in the literature when it comes to the question of the barriers to mental health services that unemployed people face, as well as their experience of these more generally.

14.5. CITATIONS

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15. POVERTY

15.1. OVERVIEW

There is a significant amount of literature on the subject of poverty or socioeconomic inequality and mental health, and indeed these are themes that can be seen to intersect with numerous other characteristics and groups discussed in this report. Despite the large body of literature however, some studies express concern that mental health research and policy has been dominated by "psychiatric and psychological perspectives" at the expense of socioeconomic factors (Macintyre et al. 2018).

Research firmly indicates that "poor mental health is both a cause and a consequence of social inequality" (Mattheys et al. 2016). In other words, not only does the experience of living in poverty (e.g. problem debt, poor living conditions and deprived wider environment) increase vulnerability to mental health problems such as chronic stress and depression, but so too are those who have existing mental health problems at greater risk of poverty (e.g. because of workplace discrimination) (Mattheys et al. 2016). Furthermore, this relationship between poverty and mental illness can form part of a negative cycle which can extend across generations (BMA 2017). In terms of demographics, socioeconomic factors can be counted among the most significant with respect to predictors of mental health problems (Mental Health Foundation 2017).

A specific barrier to access experienced by people who are suffering from poverty is that of low levels of registration (BMA 2017).

15.2. INTERSECTIONS & TRIGGER POINTS

- **Ethnicity:** Macintyre et al. (2018) highlight that "while racism has been identified as a social determinant of health," this focus has largely been on "interpersonal discrimination" rather than addressing structural racism and socioeconomic inequalities experienced by BME groups. Put differently, more attention needs to be directed at the intersection of ethnicity, socioeconomic inequality, and mental illness.

- **Age:** Several studies emphasise the need for interventions throughout every life stage, and specifically because the intersections between socioeconomic inequality and mental health problems are evident across the life course (Elliot 2016; WHO 2014). Older people who are facing fuel poverty are particularly at risk of mental health problems deriving from the negative impact of the cold on physical mobility and overall comfort (BMA 2017). While there is a wide spread of policy literature on this subject, there is very limited academic literature available.

- **Adolescence:** Young people are particularly at risk of the poor mental health outcomes associated with poverty and socioeconomic inequality, specifically because of the "stress and worry caused by poverty," environmental factors (e.g. overcrowded or dangerous living circumstances), less opportunities to develop and build resilience (e.g. less time spent with parents, fewer opportunities to engage in leisure activities), and the social impact of knowing "that you have less than your peers" (RCPCH 2017; see also BMA 2017; Reiss 2013).

15.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Reports by the British Medical Association (BMA) (2017) and the World Health Organisation (WHO) (2014) highlight a need for more cross-sector and cross-government awareness and interventions in order to tackle socioeconomic inequalities and the mental health problems that accompany them. For example, "national and transnational policies" have a role to play in terms of shaping "social arrangements and

institutions" such as education, employment, and social care (WHO 2014). To this end, the BMA (2017) advise that the NHS engages more with sectors beyond the health system, and does more to integrate its services with public and third sector services.

In terms of reducing the impact of poverty on the mental health of people, the BMA (2017) advises that the NHS spends more on prevention, including amongst its own employees, and that doctors serve as "advocates against the negative impacts of poverty on health." In addition, they advise that more is done to ensure that people suffering from poverty are registered to access health care services.

Macintyre et al. (2018) argue that more interdisciplinary research be conducted into the "impact of economic policies on mental health," as well as the barriers to professional awareness and advocacy in this area.

15.4. RESEARCH COVERAGE

There is a significant amount of literature on the subject of poverty or socioeconomic inequality and mental health. However, much of this has overlooked the concrete ways in which socioeconomic factors can cause mental health problems, and furthermore there are far fewer studies which look at access to services. Visible research which focuses on poverty and mental health has been found which addresses intersections with age and ethnicity. There is ample scope for academic research on the negative relationships that can develop between poverty and mental health problems not only over a single life course, but over generations; a theme that appears in the policy literature. Similarly, it is surprising that the benefits of integrating health services with other public and third sector services are discussed in policy literature and not in the academic literature.

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16. STUDENTS

16.1. OVERVIEW

Recent years have seen heightened levels of awareness about mental health problems among UK students. Part of the reason for this increased concern is that the number of students who disclose a mental health condition to their higher institution has grown considerably over the past decade, with university counselling services also reporting increased referrals (Macaskill 2012; Thorley 2017). Another reason for this is that the number of student suicides rose between 2007 and 2015 by 79 per cent (from 75 to 134) (Thorley 2017). However, this heightened concern has not yet been accompanied by substantial research on the subject (Macaskill 2012; Thorley 2017).

Research suggests that the association between higher education students and mental health problems is in part a matter of age: the majority of those enrolled in higher education are aged 18–24, a time in the life course when mental health problems are particularly prevalent due to the transition to adulthood (Macaskill 2012). However, the experience of transitioning to university introduces additional risk factors because of stressors (e.g. leaving home, making new friends, adjusting to new learning environments) (Macaskill 2012; Pitt et al. 2017). These stressors can lead to symptoms of depression, anxiety, and homesickness (Thorley 2017). Unsurprisingly then, undergraduates (and specifically those studying for their first undergraduate degree) are significantly more likely than postgraduates to disclose a mental health condition (Thorley 2017).

Back in 2011, the Royal College of Psychiatrists (2011) raised the possibility that mental health problems could proliferate among UK students due to greater numbers of less economically privileged people attending higher education institutions. In addition, reduced government funding in this area means greater financial pressure on these student groups, as well as consequences for funding of mental health services.

Barriers to access for higher education students include underfunded and overburdened student support services (Macaskill 2012) and low mental health literacy, meaning low levels of understanding around mental health problems, symptoms, and services (Gorczynski 2016). Furthermore, communication between primary care practitioners and student support services is uneven.

16.2. INTERSECTIONS & TRIGGER POINTS

- **Gender:** Women students are considerably more likely than men students to disclose a mental health condition, but this should not be taken to mean that they are more vulnerable to mental health problems (Thorley 2017).
- **Age:** As seen above, young students are significantly more at risk of mental health problems than those over the age of 24 (Macaskill 2012).
- **Poverty:** Students from more economically disadvantaged backgrounds are more at risk of mental health problems than those who come from more economically advantaged backgrounds; a dynamic which is exacerbated by the greater financial pressure on these groups due to reduced government funding (Thorley 2017).

16.3. RECOMMENDATIONS FOR IMPROVED PROVISION

It has been advised that, higher education institutions invest more in their student services to reflect higher numbers of students, and channelling more resources into preventative measures for mental health generally (Macaskill (2012).

One study identified, found that individuals saw online resources as most accessible, and as such the resulting advice recommended that more anonymous online resources are made available to improve literacy and encourage the seeking of support. (Gorczynski (2016)

Student Minds (2017) recommend that universities and student accommodation providers do more to share information and integrate referral pathways, as well as providing mental health training to accommodation staff.

Interestingly, it was observed in one study that optimism helps to "buffer the impacts of stress over time" among students, proceeding to advise that: "offering interventions to develop optimism may significantly improve new students' ability to cope with stress at university." (Denovan and Macaskill, 2016)

16.3. RESEARCH COVERAGE

There is a good amount of literature on the subject of students and mental health, with a good proportion of these studies considering access to services. Similarly to other risk factors for mental health that are defined in the context of being part of an institution; the university in this case, or the workplace or prison in others, where there are likely to be a greater number of institutionally related and coordinated services, therefore there is likely to be more research as a result which assesses access.

The most prominent research focuses on the heighted vulnerability that students who are young and who come from a background of poverty face to mental health literature. It would be valuable to see more academic research being delivered on this subject, with far more of an appetite for the issue among policy researchers.

16.4. CITATIONS

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17. VETERANS

17.1. OVERVIEW

After leaving the Armed Forces, the healthcare of ex-servicemen and women comes under the remit of the NHS. This is supported by specialist charities, such as Combat Stress, although there may be changes to come as NHS England recently announced the launch of 'The Veterans' Mental Health Complex Treatment Service' with £3.2 million in funding per year (NHS England, 2018). These changes perhaps demonstrate that veterans' mental health is on the Government's agenda and suggests that veterans are seen as an important group in terms of mental health provision. Indeed, NHS England states that "While waiting times for veterans are excellent, with 88.3 per cent waiting less than six weeks, NHS England is determined to continually improve care" (NHS England, 2018). This is higher than the national standard for mental health provision that "75% of people referred to IAPT services should start treatment within 6 weeks of referral". In wider culture, mental health provision for veterans has influential advocates such as Johnny Mercer MP and Prince Harry, both ex-servicemen themselves. However, these factors do not exclude barriers to veterans seeking mental health services as "Less than half of those who return from combat with mental health problems in the Armed Forces seek help for their disorder" (Iverson 2011). Macmanus highlights that in "Studies of UK military personnel have shown that depression, anxiety and alcohol misuse disorders are most prevalent... but among UK clinical veteran samples Posttraumatic Stress Disorder (PTSD) is a more frequent" (Macmanus, 2013).

Scholarship around public stigma and veterans' mental health has been written about extensively. Interestingly, much of this research focuses on veterans in the United States rather than in the United Kingdom, where the healthcare landscape is very different. Research into access to services and other barriers are less frequent; for example, Mellotte found that "research into the enablers of help-seeking remains scarce" (Mellotte 2016).

From UK-based research, two themes that affect veterans' access to mental health services become clear. First is the perceived lack of understanding in the NHS around the pressures and culture of the military and structural issues (e.g. transport difficulties). There is the impression that "historically mainstream NHS mental health services have often been ill-equipped to identify and respond to the needs of veterans" (Macmanus, 2013). This is corroborated in other studies where, although a small qualitative study, Mellotte noted "The majority of participants described negative past experiences related to accessing mainstream NHS services" and "Among all of the participants there was a perception that health professionals within mainstream NHS services lacked necessary military specific knowledge and terminology to help veterans". Along a similar vein, one study found that "veterans were more likely to report 'I don't know where to get help' than regular personnel and that 'I don't have adequate transport'" (Iverson 2011). Although slightly different from the knowledge and specialism of NHS staff, this highlights structural difficulties that some veterans experience in accessing mental health services.

Second, although contested by some scholars, others highlight public stigma (or perceived stigma) as a barrier to help-seeking behaviour: "research has shown that disclosing a psychological problem in the military is perceived as more stigmatizing than having a physical medical problem" (Sharp, 2015). When the ex-servicemen/women leave the armed forces it is possible that they carry this perception of stigma with them into civilian life. The masculine culture has also been cited by some scholars to contribute to this, though this may be similar to men in general populations (Sharp, 2015).

17.2. INTERSECTIONS & TRIGGER POINTS

- **Gender**: As veterans, and the Armed Forced more generally, are overwhelmingly male there is very likely to be some overlap in the way these groups interact with mental health services. Macmanus (2013) states "veterans have been shown to be reticent to seek help for mental health problems though whether this is worse than men in general or other occupational groups is unclear". A study comparing the two groups (military/non-military men) would be interesting.

- **Alcohol/substance misuse**: Sharp (2015) notes the link between veterans and military personal and alcohol abuse whilst Iverson (2011) further states that "rates of help-seeking for alcohol misuse are particularly low and yet alcohol problems have a high prevalence in military populations". This may be connected to the increased susceptibility that veterans face to conditions such as PTSD.

- **Isolation**: Social isolation (or loneliness) and veterans accessing mental health would provide useful further research as Sharp notes "social support could explain how individuals who are disinclined to seek help subsequently seek help, and it could be an important variable to include in future analyses." This is not exclusive to veteran populations but seems potent given their need to acclimatise back into civilian life following departure from active service.

17.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Scholarship and policy provides some debate over whether veterans should have a separate healthcare service from the mainstream NHS with some studies calling for "further research to determine the effectiveness of dedicated services and identify how they should be deployed" (Fraser, 2016). That said, there is not a consensus on this issue but there is agreement that under the current system a focus on "health professionals' knowledge regarding [veterans'] mental health difficulties" would be worthwhile (Mellotte, 2017).

Helping veterans to identify their own mental health difficulties is also recommended given that there is some evidence to suggest that military populations have "poor recognition of the need for treatment" (Sharp, 2015). Sharp further notes a potential need to "learn from successful anti stigma campaigns aimed at general populations to then adapt these methods to the context of military populations" (Sharp, 2015).

17.4. RESEARCH COVERAGE

The volume of research for veterans is fairly good, with a mixture of qualitative and quantitative studies asking veterans about their access and experience of mental health services. This is greatly helped by veterans' charities and more specialised services available. However, as an area with a fast-changing policy landscape, with announcements made to changes in the funding of veterans' mental health services happening even in April 2018, research has the challenge of assessing the usefulness/benefit of policy changes.

It should also be appreciated that any research design set up to explore this area ought to consider the *types* of veterans and how this group might be sub-categorised. Where, when and how the veteran served, including their specialism may impact on their resulting mental health. Stigma experienced by groups or individuals according to other mental health 'risk' factors (e.g. sexuality, gender, transgender, ethnicity) might also be considered, whilst in the army, that has been, and continues to be a male dominated institution.

17.5. CITATIONS

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Mellotte H et al. Pathways into mental health care for UK veterans: a qualitative study 2017 [LINK]

18. HOMELESS PEOPLE

18.1. OVERVIEW

It is widely accepted that homeless people (legally defined as someone who does not have a legal right to occupy accommodation, or if their accommodation is unsuitable to live in) are more likely to experience mental ill health compared to the general population. Indeed, an audit carried out by Homeless Link found that "80% of [homeless] people reported some form of mental health issue and 45% have been diagnosed with a mental health issue, compared to 25% of the general population." Despite this, "it has been suggested that less than one third of homeless people with mental health problems receive treatment." It is also very likely that in some circumstances the two are connected i.e. someone may lose their job or housing because of mental health issues.

From this, it seems that more needs to be done to help homeless people access mental health treatment. Current scholarship points to two main studies in this area (Hwang SW et al, 2005 and Fitzpatrick-Lewis D, 2011), however these are US/Canadian studies and from a few years ago so there may be cultural or structural differences that apply. This is reinforced by PJ Archard who writes: "there is a paucity of research into mental health service delivery to homeless persons and the influence it imparts in individual lives".

From available UK scholarship, barriers explored were often interlinked. For example homeless people were seen as not prioritising their health and "may place a low value on health generally in the face of poverty and their day-to-day difficulties" (Rees S, 2009). This could correspond with the mental health difficulties themselves e.g. having a low self-esteem or self-worth. Along a similar vein, this could also interlink with a perceived sense of stigma from others (for example having to give an address to the GP receptionist) and therefore impact on whether or not they seek help.

Alongside this, homeless people were found to have a sense of distrust (whether perceived or based on previous experience) with health care professionals: "[they] expect a hostile response or have a previous bad experience of accessing health and social care services" (Patient and Client Council, 2015).

This means that homeless people would be less likely to present to primary care, which may also be connected to a difficulty of access as the Patient and Client Council further note that "The problems with GP access focus on the individual not having proof of identity or a permanent address" as well as difficulty maintaining a GP due to unstable in living arrangements.

Furthermore, Hanlon states "Many people who are homeless have multiple physical and mental health problems and experience multi morbidity earlier and with greater severity" (Hanlon, 2017). Because of this, healthcare for homeless people has comprised of an "assertive community treatment (ACT) approach involving a multidisciplinary team who actively outreach to the streets, soup kitchens, shelters and hostels. These teams provide initial assessments and longer-term care with the ultimate aim of rehousing and re-engaging patients with appropriate local mental health services" (Perry J and Craig TKJ, 2015).

18.2. INTERSECTIONS & TRIGGER POINTS

- **Gender**: Perry and Craig note that the majority of homeless people are male, who may also be more reluctant to seek help (Perry J and Craig TKJ, 2015).
- **Ethnicity**: "The proportion of homeless people who are mentally ill from BME groups is disproportionate[ly] [higher] in relation to their proportion in the general population" (Rees, 2009). The reason for this is not given but worth exploring further.

- **Refugees/ asylum-seekers**: "Refugees and asylum seekers also have high rates of mental disorder and are at risk of being in unstable housing" (Rees, 2009). This is another example of barriers being interlinked as refugees and asylum seekers may also be at higher risk of mental health difficulties due to trauma and therefore has the potential to become a vicious cycle.
- **Prisoners**: There are also intersections with homelessness and offenders: "Research has found evidence which highlights the challenges faced by ex-offenders accessing accommodation" (Patient and Client Council, 2015) and there is reason to believe that both are vulnerable groups in relation to mental health. This may be due to challenging life experiences.

18.3. RECOMMENDATIONS FOR IMPROVED PROVISION

One study evaluated the experiences of homeless people who experienced psychological trauma with social support work found a need "to minimise the hoops service users must jump through to access services, allow informal time with homeless clients and offer gestures of concrete assistance in order to forge working partnership" (Archard PJ, 2015). From this angle, more time and care may be needed with homeless people than those in the general population who access mental health services.

In terms of recommendations, further research would be welcome to assess the balance between homeless versus mainstream services and the coordination between the two i.e. would a homeless person benefit from specific services or mainstream NHS services in the long-term. However, most see homeless specific services as a way to engage homeless populations who might not otherwise engage. These services tend to include providing practical needs. Canavan found that "homeless-specific services are more responsive to the initial needs of homeless people with mental health problems, while generic services tend to be more conducive to long term care" (Canavan R, 2012). Additionally, in the long-term, "the disadvantage of specialist schemes is that homeless people are further marginalised and segregated from mainstream services" (Perry J and Craig TKJ, 2015).

18.4. RESEARCH COVERAGE

Research addressed reasons why there was a higher prevalence of mental ill health among this group, but the complex and potentially multi-faceted barriers that homeless people face in accessing mental health care is could be the subject of more detailed research. Very little research was found in relation to the experience of homeless people using mental health *services* in the UK.

Research might consider, homeless people's experiences of mainstream NHS services as opposed to social support and how the two can complement one another. That said, more research directly asking homeless people about their experiences of different types of mental health services, whether specific or general, would be beneficial. It would also be interesting for this group the extent to which barriers were physical or psychological.

18.5. CITATIONS

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19. SUBSTANCE MISUSE

19.1. OVERVIEW

The focus of this section spans drug misuse or abuse and drug addiction or dependence (be it physical or psychological). References to drug or substance misuse should be taken to refer to the consumption of intoxicant and psychoactive substances, including the misuse of alcohol and tobacco.

Co-occuring disorders, dual disorders, and dual diagnosis are all terms that typically denote a condition whereby an individual is diagnosed with both a mental health disorder and a substance use disorder. Individuals with severe mental illness are at heightened risk of comorbid substance misuse, and individuals with substance misuse disorders are at heightened risk of comorbid mental illness.

Depression, anxiety, and schizophrenia are all predictors of substance abuse, with the prevalence of individuals with schizophrenia who are substance misusers exhibiting particular growth in recent years (RCP 2017).

There are a number of ways that substance misuse and mental health problems can co-occur, with different sources attributing more weight to one or another (DrugScope 2015; see also Elison et al. 2016):

1. "A primary health problem that provokes the use of substances," for example, consuming substances in order to reduce symptoms;
2. "Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses," for example, the emergence of depression in a person going through a "detox";
3. "A psychiatric problem that is worsened by substance misuse," for example, an individual with anxiety who uses a substance and finds that it increases the symptoms of anxiety;
4. "Substance misuse and mental health problems that do not appear to be related to one another," for example a situation where one's substance misuse has no apparent effect on one's mental health disorder.

There is very limited research on the subject of the barriers to access faced by those with co-occurring disorders, nor their experience of mental health services. Indeed, Elison et al. (2016) note that "traditionally, substance use and mental health difficulties have been treated separately," with the consequence that "treatment services and interventions [are] commissioned and designed separately." This can result in inappropriate or ineffective service provision, and can see individuals "falling between the gaps in service provision."

19.2. INTERSECTIONS & TRIGGER POINTS

- **Age**: Chrome et al. (2014) and Rao (2015) identify growing issue of substance abuse among older people, including dual diagnosis conditions, but there is no sustained discussion about why this is.
- **Age**: Children with conduct disorder, defined as "persistent, disobedient, disruptive and aggressive behaviour," are "four times more likely to become dependent on drugs."
- **Age**: Children and young people who face adversity (e.g. abuse, neglect) at this stage of their lives may be at more risk of dual diagnosis and offending behaviour, particularly if they have used substances at an earlier point (Elison et al. 2016).
- **Prisoners**: While the mechanisms that link these different factors are unclear, there is clear evidence that a large proportion of prisoners with "identified substance dependence may have comorbid mental health issues such as anxiety or depression" (Elison et al. 2016).

- **Multiple needs**: Other possible predictors of dual diagnosis relate to multiple and complex needs, for instance: coming from a background of socio-economic deprivation, being "removed from biological parents", being a "looked after child" within the care system, and a background of homelessness (Elison et al. 2016).

19.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Stott and Priest (2017) identify a need for more research with people who are undergoing a process of recovery from co-occurring mental health and substance misuse disorders outside of formal health care services.

As seen above, there has for some time been talk of designing interventions which integrate diagnoses of substance misuse and mental health problems simultaneously, or indeed the multiple and complex needs of individuals, and yet there is limited evidence of this bearing fruit (Elison et al. 2016). A similar situation is evident in the case of both adult and children's social work practitioners, where professionals need to be better "engaged, equipped and supported to identify and assess substance use at a level appropriate to their role" in order that they "know how and where to make an appropriate referral for specialist services" (Galvani et al. 2014).

Elison et al. (2016) highlight the overall lack of availability of psychosocial interventions for dual diagnosis conditions, despite evidence of their effectiveness in this area. As such, it would be worthwhile programmes to improve mental health services considering this evidence in their design.

19.4. RESEARCH COVERAGE

There is a limited amount of literature on this intersection between substance misuse and mental health problems. While there is a good amount of research that highlights intersections between other characteristics and these diagnoses, there are far fewer studies which look at access to services, and particularly gaps between mental health and drug and alcohol services. There is also scope for more research into what concrete improvements can be made to mental health services in this area, and how to ensure recommendations are implemented when services are being designed.

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20. ASYLUM-SEEKERS

20.1. OVERVIEW

This section is focused on the specific experience of mental health services among asylum-seekers, refugees, and vulnerable migrants in England, and no hard distinction is made between these often overlapping categories. However, this is not intended to suggest that the individuals who fall within these categories are a homogenous group: they may have very different experiences, backgrounds, motivations for migration and health needs (Bradby et al. 2015). The vulnerability that different migrants face is not "an attribute of people themselves" but is rather because they "have been adversely affected by circumstances leading to or resulting from migration" (Fassil and Burnett 2015).

Asylum-seekers and refugees are at a heightened risk of mental health problems as a result of stress factors relating to their experience before migration, during migration, and upon arrival in a host country. These experiences could involve multiple bereavement or separation from family and friends, imprisonment and or detention, torture, trafficking, sexual violence, and various forms of discrimination and prejudice (Fassil and Burnett 2015). Migrant groups are thus particularly vulnerable to PTSD, anxiety, and depression, as well as having increased mortality and morbidity rates (Mangrio et al. 2017).

While many of the barriers to access that asylum-seekers face overlap with those experienced by BME groups (e.g. cultural and linguistic barriers, institutional mistrust, stigma), one major barrier to access has been found to be that of legal "status", and more specifically the question of who is and is not designated an asylum-seeker, migrant, or refugee, and therefore the matter of who is eligible for specific services (or even participate in research such as that under review) (Mangrio et al. 2017). Furthermore, asylum-seekers and migrants are more likely than non-migrants to delay seeking help from mental health services because of fear in relation to their immigration status (despite people being entitled to free NHS care while their asylum application is pending) (Mangrio et al. 2017).

20.2. INTERSECTIONS & TRIGGER POINTS

- **Age**: Curtis et al. (2018) report that children who are asylum seekers who have been exposed to traumatic events either before or during migration are at heightened risk of PTSD.
- **Age**: Young migrants are more at risk of depression and anxiety than their non-migrant counterparts (Curtis et al. 2018).
- **Sexuality**: LGBT asylum seekers who have experience of "persecution and oppression in their countries of origin" are particularly vulnerable to mental health problems, and require appropriate "sensitivity in assessment and provision of support" (Karban and Sirriyeh 2015).
- **Ethnicity:** Reports suggest that migrants that are from non-white or non-English ethnic and cultural backgrounds are increasingly exposed to perceived discrimination by host communities, and are therefore at heightened risk of mental health problems (Curtis et al. 2018).
- **Religion**: Cultural or religious norms may protect migrant individuals from some of the mental health harms that they are at risk of being exposed to, for example "lower rates of alcohol use for young people from Muslim families" (Curtis et al. 2018).

- **Isolation**: Asylum-seekers and refugees are at heightened risk of social isolation because of restrictions on their right to work, language barriers, and an inability to afford public transport (Mateo 2017).
- **Homelessness**: Asylum-seekers and refugees are especially likely to face homelessness and destitution, which can further harm their mental wellbeing (Fassil and Burnett 2015).

20.3. RECOMMENDATIONS FOR IMPROVED PROVISION

One recent study recommends that child mental health services do more to "collaborate with all agencies in contact with refugee children, establish joint care pathways, and integrate trauma-focused interventions with family and community approaches" (Eruyar et al. 2017). In other words, there is a need to integrate mental health service delivery, and design interventions that both target trauma-related stress and build resilience.

It has been proposed by two studies that more needs to be done to ensure that asylum-seekers and refugees are adequately informed about their rights to healthcare, their decision-making capacity in such matters, and indeed where, when, and how they can access these services (Mangrio and Forss 2017; Mateo 2017).

There is demand among refugees and asylum-seekers for "link workers" as part of interpreter services who facilitate communication between communities and health care service providers (Ochieng 2012). More generally, "community based health awareness programmes" can be used to "reduce the stigma of mental health in migrant communities" and make health services easier to navigate (Fassil and Burnett 2015).

Bradby et al. (2015) suggest that adjustments be made to improve access to mental health services among asylum-seekers, for example by offering longer appointment times and offering transport assistance. Particularly important is the provision of a qualified interpreter who is trained to operate in mental health contexts, though "the relative anonymity of a telephone interpreter or advocate" may be seen as preferable over "someone from the person's own community" (Fassil and Burnett 2015).

20.4. RESEARCH COVERAGE

Following a decade of rising numbers of international migrants in Western European countries including England, recent years have seen a growing body of literature in this area, and particularly after the onset of the European migrant crisis in 2014-15. Despite this, there is a clear deficit of research around the health needs and health care service experience of migrants, and particularly research that is specific to England and the United Kingdom (with far more studies addressing the European region more broadly). Furthermore, while the subject of the mental health service experiences of child migrants and migrant youth (and particularly those that arrive in unaccompanied) has received a considerable amount of attention, far less has been directed at older migrants.

This group is of course, not homogenous. In addition to asylum seekers being particularly vulnerable to the heavy compounding of multiple risk factor intersections (e.g. ethnicity, isolation, religion, trauma) for mental health, they are likely to have arrived in the UK from a range of settings. Where research, considers asylum seekers as a single group, the design should be alert to the impact of differing experiences and cultural settings which might impact on access and engagement with mental health services.

20.5. CITATIONS

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21. PRISONERS

21.1. OVERVIEW

Mental health services for prisoners have made important strides forward in recent decades. Much of these changes appear to have been facilitated by the 2009 Bradley Report, a "comprehensive plan to reduce reoffending and improve public health by ending the revolving door to custody for mentally ill and learning disabled offenders" (Prison Reform Trust) and subsequent publications assessing progress. As Georgiou M et al recognise that: "Important developments and improvements in prison mental health services have taken place in the past few years and some of these have been evidenced in The Bradley Report Five Years".

However, these were much needed as 'equivalence of care', the idea that provision of healthcare in prisons should be equal to that of the general population, was adopted as late as 2006 when healthcare for prisoners moved from being the responsibility of the Home Office to the NHS. Add to this the fact that the prison population has been rising and that prisoners are more likely to experience mental health problems than the general population and the arguments for improving mental health services are poignant.

In theory, given health screenings for prisoners (which includes a mental health assessment), prisoners who experience mental health difficulties should be easier to identify and help than some in the general population who may not seek support. However, a Policy Exchange report in 2009 found that these health screenings could be more effective. This was also found by PPO in 2016. Other provisions to improve mental health services for prisoners, for example by giving all prison staff mental health awareness training (which was recommended in the Bradley Report) may not have gone far enough. This is demonstrated in the Health and Social Care Act 2012, which recognised that "insufficient training to identify prisoners with mental health problems and the knowledge to refer them for assessment, with primary mental health care services in 25 per cent of prisons [was] identified as being insufficient to meet the demand". Further research into whether this has changes since then would be welcomed. However, an increasing prison population, from 41,800 prisoners in 1993 to over 85,000 in 2015, has perhaps led to more stretched resources which in turn has an impact on areas such as mental health. A shortage of prison GPs has also been pointed out by media sources in the last two years.

In terms of the services themselves, the PPO and Georgiou M et al note that effectiveness of treatment is lower than generic mental health services. The PPO states that some talking therapies are not always readily available and have long waiting lists, though this is also the case for the general population. It may be that treatments are less effective due to the complexity of mental health issues experienced by prisoners rather than the treatment itself. That said, a literature review into the environment of the prison setting and the potential impact on mental health found that prisoners' felt that being in prison had a "negative influence upon their mental health. However, a small number regarded prison as a place of respite, which afforded structure and an opportunity to access health services" (Goomany A, 2015).

21.2. INTERSECTIONS & TRIGGER POINTS

- **Unemployment/isolation:** "Offenders with a mental illness are routinely excluded from vocational services due to their mental health. Employment has shown to be very important in improving mental health, reducing recidivism, and connecting people to society" (Hamilton IS, 2015). Considered together, these factors have the potential to have a cyclical impact of reoffending and linked worsening mental health problems.
- **Adolescence:** Studies have linked prisoner mental health with adolescent mental health as Mitchell (2015) has written that their needs are often unmet and with a poor prognosis and another study by Lennox found that up to half of adolescent boys' mental health difficulties were missed at an

initial screening. The reason for this is unclear but could be related to different services for children and adolescents with mental health services compared to adults.

22.3. RECOMMENDATIONS FOR IMPROVED PROVISION

The 2009 Bradley Report, and subsequent reports such as the five year review, made valuable contributions in the sphere of mental health access and service provision for prisoners. From the literature it appears that many of these recommendations need to be implemented to greater effect. These include the screening process, mental health training for staff and also provision for when prisoners leave prison and look for employment.

With respects to the initial screening, Inside Out, a report by the Policy Exchange recommended in 2009 that "resources should be better integrated in order for healthcare and mental health assessments to be more effective" (Georgiou M et al, 2015).

22.4. RESEARCH COVERAGE

There was a reasonable amount of literature for this section of the research that covered the topic fairly broadly. This may be the result of prisoners' mental health being an increasingly talked about area of policy and the changes to the way prisoners' healthcare has been treated (i.e. from Home Office to NHS). That said, the changing policy scene also meant that some research was no longer applicable to the way prisoners now experience mental health services and new policy had been stated or implemented. Literature generally focused on men rather than women; though, this may be reflective of the demographics of prisoners. However, there is an apparent research gap in the number of studies which have conducted qualitative research with prisoners and their direct experience with mental health services as opposed to having a mental health difficulty. This is almost certainly related to the challenges of access – as with any research undertaken requiring prison clearance to access the prison, and prisoners as a research subjects. As mental health services are incorporated as part of the general prison health programmes, so the 'barriers' to accessing mental health services may not factor to the extent that they would for other groups.

Given that few studies have been conducted so far have focussed on the experiences of prisoners in relation to mental health treatment they may have received, this could prove to be an interesting and valuable avenue for in-depth qualitative research. This research could be conducted retrospectively, so circumventing the access issue. Research might therefore explore experiences of mental health services whilst the former prisoner, were in prison, and the access and engagement of the same group with services after prison release.

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23. SEX WORKERS

23.1. OVERVIEW

Sex work has been defined by the World Health Organisation as "the provision of sexual services for money or goods" (World Health Organisation, 2012). This review seeks to assess the literature in relation to barriers to mental health services that patients may experience as a result of being part of this group. Therefore, though a hugely important and worthwhile topic of research, it is beyond the scope of this discussion to address individuals for whom their experiences in the sex industry might better be more accurately described as 'sex trafficking', that is, any form which is exploitative or not between consenting adults. Further, it should be acknowledged that the debate around whether prostitution is inherently exploitative is still ongoing, although more recently there seems to be a shift in support for organisations such as Amnesty International and the English Collective of Prostitutes that favour decriminalisation. One study also assessed whether other 'stigmatised professions' also experienced difficulty in access and treatment in mental health services, e.g. those working in the fast food industry, but the study found little evidence for this (Sanders T, 2017). This study was also conducted in Canada, not in the UK.

Prostitution is technically legal in England and Wales but many of the activities surrounding the exchange of sex for money or other goods are criminal offences (e.g. street prostitution or owning a brothel is illegal). Therefore, it is a difficult area to research and as such there is a scarcity of recent scholarship regarding sex workers' access and experiences of mental health services. It is worth noting that much of the literature discussed comes from countries which have different legal and cultural frameworks and practices.

Questions of stigma in relation to sex work have been explored by scholars in other cultural settings. In Canada, Benoit et al. found "positive associations between depression and the most highly stigmatized occupation—sex work—and between discrimination and depression" and describes abuse experienced by some women. This may in turn lead to Rossler's hypothesis that many sex workers felt they could not tell others about their circumstances and therefore feel more socially isolated. Additionally, a study in four African countries by Scorgie et al, found that in countries where prostitution was criminalised, participants felt extreme stigma by healthcare professionals and hospitals and as a result had unmet healthcare needs (a distinction between physical/mental health is not made). Culturally, the extent of stigma in the UK and the potentially associated mental health impact of this is not extensively researched. Other studies, such as Poliah, highlight the high rates of violence experienced by sex workers, which may make sex workers more vulnerable to symptoms of mental ill health.

In terms of access and services, there is little research apparent into sex workers' access and experience of services in the NHS. Some areas have NHS funding for healthcare sex workers (e.g. Open Doors in East London) although like other mental health services these may not have equal coverage across the UK. The BMJ has warned of the impact funding cuts may have on the health of sex workers, in particular sexual health, but the impact on mental health may also be an area for further research (BMJ editorial, 2016).

23.2. INTERSECTIONS & TRIGGER POINTS

- **Substance misuse:** Hengartner MP et al. have found a correlation between sex work and rates of substance misuse: "for example the study in Bangladesh reported that more than half of the sample had a substance use disorder including alcohol and other illicit drugs" (Hengartner MP et al, 2015). It is likely that this relationship is bidirectional.
- **Gender:** There is an imbalance of gender in the literature regarding sex work with more in relation to female sex workers than male. This may reflect the demographics of sex workers (though there

are no official statistics) or perhaps simply indicate that prostitution has been a topic of discussion for many feminists.

- **Prisoners/employment:** In a UK study, Bindel et al reported "Having a criminal conviction was identified as a major barrier to exiting the profession. 49% of the women had criminal convictions for prostitution related offences" (Bindel et al, 2012). This may in turn make it harder for prostitutes to gain employment and also increase their risk of going to prison, suggesting the potential for a vicious circle which makes it difficult for those who want to leave sex work.

- **Social isolation:** A study carried out by Rossler et al. in Zurich also found a link to social isolation: "More than half of the sex workers felt at least sometimes excluded from their circle of acquaintances because of their profession, and as many felt excluded from society" (Rossler W et al, 2010). This is likely to be the result of perceived stigma, whether personal or public, that sex workers have or fear they will experience.

23.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Recommendations for mental health service support for sex workers tend to depend on the authors' views on prostitution and sex work, particularly in relation to legalisation/decriminalisation.

However, there is a consensus that women should be supported, as Bindel et al recommend "Specific specialist support around sexual violence and trauma be made available for women seeking to leave or who have exited prostitution" as well as training for healthcare professionals in relation to its "prevalence, nature and patterns of physical and mental health problems amongst women involved in prostitution, including PTSD".

In addition to this, research that specifically addresses the mental health of sex workers would be valuable as in the UK studies of sex workers' experiences of mental health services in the UK were largely absent.

Scholars that see stigma as detrimental to the mental health of sex workers also call for a change in policy and law as Benoit argues that "Equity policies that improve their social determinants will contribute to better mental health for sex industry workers. Additional strategies aimed at reducing the formidable discrimination linked to their work are also urgently needed" (Benoit C et al, 2015).

23.4 RESEARCH COVERAGE

Research coverage of this area, particularly in the UK, is very limited. Much of the literature related to mental health and access to services has not been carried out in the UK and literature tends to focus on prevalence of the mental health conditions rather than experience of services. There is also little available research on other 'stigmatised professions' (a term that this section originated from), perhaps because the term itself is somewhat subjective. Definitions were also a challenge with regards to the literature, as the term 'sex workers' is somewhat ideological and not favoured by some groups. As a topic, this area is particularly difficult to research because the scale of sex work in the UK is not known, and also because aspects related to sex work are illegal. Quantitative research in this area is, of course, is very challenging, as it is with all illegal occupations and hard to reach groups in general so statistics are hard to establish. Exploratory qualitative research, using in-depth interviews, with sex workers in relation to their mental health and access to services would be interesting. It may prove useful to use women's shelters and mental health services as an access routes to contact sex workers who might otherwise avoid contact due to the illegality of their work.

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24. ISOLATION

24.1. OVERVIEW

Recent years have seen the subject of social isolation and loneliness move increasingly to the forefront of public debate and national health policy, despite being absent from the Five Year Forward View for Mental Health. Academic and policy research has steadily grown over this time, culminating in work of the Jo Cox Commission on Loneliness in 2017 and the appointment of a ministerial lead on loneliness in 2018. Anyone can experience isolation and loneliness, but social isolation and the experience of loneliness is distributed unevenly in society (Public Health England 2015). Most research to date has focused on the subject of isolation and loneliness among older people, but the present literature review has revealed that a wide variety of characteristics and issues intersect with these are themes.

For the purposes of this section, social isolation is defined as the "inadequate quality and quantity of social relations with other people" at different scales of human interaction, and loneliness is defined as "an emotional perception which can be experienced by individuals regardless of the breadth of their social networks" (Public Health England 2015). These two definitions are important insofar as an individual may report subjective indicators of loneliness but have a wealth of social contacts; alternatively, an individual may fail to report subjective indicators of loneliness and have very limited social contacts (Giacco et al. 2016).

Research indicates both that individuals with mental health problems are at heightened risk of social isolation and loneliness, and individuals who are socially isolated and lonely are at heightened risk of mental health problems. In the first instance, people with mental health problems often face difficulties when it comes to establishing new relationships or maintaining old relationships. As Sheridan et al. (2014) point out, most adults do this by "occupying educational, occupational and social roles and through parenting and intimate partnership relationships." This route is less open to some people with mental health problems for a combination of reasons: some illness-related, such as impaired social skills, medication, and specific symptoms; and others relating to a lack of opportunities to socialise, for instance living in restricted environments and unemployment (Sheridan et al. 2014).

In the second instance, people who are lonely are more likely to have symptoms of depression and anxiety and more likely to be "at increased risk of Alzheimer's disease and cognitive impairment," with loneliness also being "correlated with eating disorders, sleep problems, and both suicidal ideation and suicide attempts" (Mann et al. 2017). There is a deficit of research about the relationship between loneliness and psychosis, but the limited evidence from UK studies suggests that there is a correlation between these (Mann et al. 2017).

A major barrier to access for those experiencing social isolation and loneliness is stigma and shame when it comes to talking about loneliness (Mann et al. 2017). This can compound stigma around mental illness.

24.2. INTERSECTIONS & TRIGGER POINTS

- **Poverty:** People who are socio-economically disadvantaged, those with lower levels of education, and those who are unemployed are all more at risk of isolation and loneliness and associated mental health issues (Public Health England 2015).

- **Migrants**: Those who are migrants and asylum-seekers face cultural and communication barriers which mean they are more at risk of isolation and loneliness, as well as related mental health risks. For example, Kapadia et al. (2015) highlight that social isolation is a "feature of the experiences of Pakistani depressed women," with their social networks dominated by family and close community links (see also Memon et al. 2016).

- **Geographical isolation/ old age**: People living in rural and geographically remote areas where social networks have been eroded are at heightened risk of loneliness and associated mental health risks, and particularly older people with limited mobility and without internet access, those with physical health conditions, and those who have experienced bereavement (LGA 2017).

- **Homeless people/ substance misuse**: People who are homeless are particularly at risk of loneliness and isolation, and are more likely to be exposed to physical and verbal abuse on a regular basis, as well as a sense that they are somehow undeserving of help (Sanders and Brown 2015). This can lead to substance misuse as a means of coping.

24.3. RECOMMENDATIONS FOR IMPROVED PROVISION

Several studies identify that "an impressively wide range of interventions to reduce loneliness and related constructs are already being run in various different communities" in the United Kingdom as well as in the Republic of Ireland (Mann et al. 2017; Sanderson et al. 2014). These may be targeted at the needs of individuals or more community-based. There is broad agreement that there needs to be more evidence of *precisely which* interventions are most effective by conducting trials among different groups in different contexts. There is also a sense that it is imperative that communities are involved in the "design of interventions and the way they are managed and implemented" (Sanderson et al. 2014). Some of the most promising "future approaches" include: "public health initiatives to create accepting communities, better designed psychological intervention studies, greater use of digital technology and programmes to link people with supportive social activities, and opportunities within local communities" (Mann et al. 2017).

Sanders and Brown (2015) whose report focuses on loneliness and isolation amongst homeless people, recommend that homeless people are provided with "more support services and better sign-posting to organisations that can help them to be available," as well as "challenging the stigma attached to homelessness."

24.4. RESEARCH COVERAGE

Despite growing policy interest in the subject of isolation and loneliness, most research to date has been specifically focused on older people experiencing isolation and loneliness. More research is needed on loneliness across different age groups (especially young people), as well as on whether individuals with specific mental health conditions (e.g. psychosis, agoraphobia, social phobia) are more at risk of loneliness than others. In addition, there is more scope to investigate how, if and when those who are isolated and lonely, access and experience mental health services. There is an obvious disadvantage to those who are geographically isolated in relation to mental health services as all public services, including shops, schools and the doctors involve transport and a greater effort to reach.

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25. CARERS

25.1. OVERVIEW

A carer is "an unpaid member of a household or informal support network who assists or looks after someone else" (Harris and White 2018). It is important to stress that the relationships between "carers" and "service users" are typically far more reciprocal than the terminology implies, with care recipients themselves often being crucial sources of "care and support to others" (Harris and White 2018).

Research from 2015 indicates that over one in ten people in the UK population are carers, and that they are saving the taxpayer twice as much as they were in 2001 (Buckner and Yeandle 2015). The two principal reasons for this are: first, growing care needs because of an increasingly ageing population, and second, a reduction of home care support from local authorities from 2010 onwards with carers increasingly framed as an "explicit resource" (Buckner and Yeandle 2015; Harris and White 2018).

Many carers are exposed to a heightened risk of mental health difficulties, and specifically psychological distress (e.g. anxiety, depression, low confidence and self-esteem) (Yeandle and Wigfield 2011; Thomas et al. 2015). Reflecting findings elsewhere relating to individual experiences of people with mental health problems, Dunne and Rogers (2012) reveal that carers of people with personality disorders found the attitudes of health practitioners damaging: not only with respect to the people within their care, but also towards them as carers. In other words, it impacts on the carer's wellbeing as well as the care that they provide. In addition, carers did not feel valued or involved, particularly with respect to the care recipient's care plan. Dunne and Rogers (2012) reveal that carers are at risk of burnout because formal support only arrives at times of crisis, and there is a reluctance to be seen as coping "too well" for fear of having services further withdrawn. Furthermore, carers may be exposed to "tension in their relationship with family caregivers" which could compound other stressors (Jancovic et al. 2011). As Rugkåsa and Canvin (2017) show, this can be because carers are expected to hold a series of different roles simultaneously: gatekeeper, proxy, advocate, as well as relationship-based roles such as parent, partner, and friend.

One important barrier to access to mental health services for carers is that they may not perceive themselves to be carers nor the support they provide as "care" (Harris and White 2018). This is a barrier insofar as these people will not be aware of the mental health risks of providing care, nor the support that is available to them as carers. More broadly, levels of awareness about the support available to carers are low (Harris and White 2018; Dunne and Rogers 2012).

25.2. INTERSECTIONS & TRIGGER POINTS

- **Age:** A significant proportion of older people are carers, particularly in areas of socio-economic deprivation, and are consequently exposed to "multiple and overlapping inequalities" (Harris and White 2018). As such, older people who are carers are exposed to heightened mental health risks.
- **Gender**: In addition a greater proportion of carers being women than men, women carers are also more likely to suffer from related mental health problems than their men carer counterparts (Carers UK 2004). Nevertheless, this is partly why men carers are often overlooked by care services, as are young carers (Yeandle and Wigfield 2011). Overall, carers who are men, younger, non-white, and from socially deprived areas report worse primary care experience than their counterparts (Thomas et al. 2015).

- **Ethnicity:** Greenwood et al. (2015) highlight the fact that carers belonging to minority ethnic groups and religious groups report barriers relating to the cultural and religious appropriateness of carer support services.
- **Transitions in and out of the care role:** Notable trigger points for mental health problems among carers include the outset of a period of caring as well as the end point of caring (Carers UK 2004).

25.3. RECOMMENDATIONS FOR IMPROVED PROVISION

In addition to relieving them of caring responsibilities, Harris and White (2018) suggest that social workers and others can help by "simply listening to carers and valuing what they do," including offering "emotional support and validation of the carer's role," recognising their experience, and harnessing this when "planning and monitoring support arrangements."

In addition, they emphasise the need for health practitioners to encourage carers to undergo a care assessment under the Care Act (2014) so that they can benefit from services designed to support "their health and wellbeing," however impoverished these services may be in an era of austerity (Harris and White 2018). The ideal scenario, as Jankovic et al. (2011) propose, is one in which a balance is struck between "welcoming and valuing [carers'] involvement in providing care for a patient and not overburdening them," and to do so by establishing a long-term, trusting relationship ensuring continuity of care (Rees Jones et al. 2009). Integral to achieving this level of relationship is clarity over carer roles and duties, "continuous and open communication," and a commitment to sharing information and knowledge (Rugkåsa and Canvin 2017).

Carers belonging to minority ethnic groups should, Greenwood et al. (2014) argue, be more involved in the "design and delivery" of carer support services in response to the needs and preferences of specific demographics to ensure that services provided meet their objectives with these groups.

25.4. RESEARCH COVERAGE

There is a moderate amount of literature on the subject of carers and mental health. While there has been some research that addresses intersections with ethnicity, age, and gender, there is a clear gap in the literature with respect to the mental health needs and service experiences of male carers. A greater and more specific understanding of the transition in and out of, and through the different stages of the carer role would be interesting to achieve through research.

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26. CROSS-CUTTING THEMES

26.1. INTRODUCTION

26.2. MENTAL HEALTH

CORRELATION AND CAUSATION

A recurring point of discussion is the extent to which associations that exist between characteristics (e.g. gender, sexuality) or groups (e.g. homeless people, carers) on the one hand, and poor mental health outcomes on the other, are causal or not. To take an example, it was seen in the section on sexuality that there is an overwhelming consensus that positive associations exist between LGB+ orientation and poor mental health outcomes. However, it is not possible to conclude from this that LGB+ orientation is a cause of poor mental health outcomes (nor the reverse).

Instead, the authors of the literature surveyed tend to prefer speaking about *plural* causal mechanisms and mediating variables that structure these associations.

To give another example, the associations that were shown to exist between being a higher education student and poor mental health outcomes are only partly attributable to stressors introduced by transitioning to university; they are also structured by a series of other factors, one being that most higher education students are at a stage in the life course when mental health problems are particularly prevalent. Here then, it is far more appropriate to speak of *multiple* mechanisms.

In sum, when discussing associations between characteristics or groups and poor mental health outcomes, it is important to avoid any suggestion that a given correlation can be attributed to a singular causal relationship.

MULTI-DIRECTIONALITY OF CAUSATION

Another, related point of discussion concerns the multi-directionality of these mechanisms and mediating variables. For example, it was seen in the section on substance misuse that people with existing mental health problems may misuse substances in order to reduce mental health symptoms. However, it was also seen that misuse of substances (or withdrawal from substances) may increase symptoms of mental health problems such as depression or suicidal ideation. Furthermore, the co-occurrence of substance misuse and mental health problems in an individual may not actually entail any causal relationship whatsoever.

In other words, despite the fact that substance misuse is a predictor of poor mental health outcomes, it is not possible to derive from this any conclusion that implies a causal relationship, nor that this relationship is unidirectional in character.

POVERTY

One theme that emerges repeatedly throughout this literature review is that of poverty or socio-economic disadvantage, explicitly intersecting with ten individual themes (in addition to that on poverty): Age, Ethnicity, Sexuality, Perinatal, Disability, Marital Status, Students, Substance Misuse, Isolation, and Carers. It is also an implicit feature of discussions in the Asylum Seekers and Homelessness sections. Low levels of education and unemployment are also recurring themes, appearing across five sections and intersecting with poverty in the sections on Perinatal, Disability, Poverty, and Isolation.

It is clear then that extremely strong associations exist between these three intersecting factors and mental health problems. Furthermore, these factors are notable because they are shown to repeatedly intersect with (and often compound) a large number of other associations between characteristics or groups and mental health problems. To give an example, it was seen that fathers are more at risk of mental health problems in the perinatal period, but that these risks are compounded among fathers with lower education, socio-economically disadvantage, and who face unemployment (Nath et al. 2016).

It is important to stress the multi-directionality of the mechanisms that structure the relationship between poverty and poor mental health outcomes. While the experience of living in conditions of socio-economic deprivation is a very clear stressor which heightens risk of poor mental health, poverty can itself be an outcome of existing mental health problems. For example, very poor mental health can mean inability to work (or at least barriers to work, e.g. workplace discrimination, lack of reasonable adjustments), and without money, one becomes poor.

MINORITY STRESS THEORY

A significant proportion of publications, particularly those focused on characteristics (e.g. age, ethnicity, sexuality, transgender, religion, sex work), draw on Minority Stress Theory in their analyses. The model of minority distress proposed by Ilan H. Meyer in relation to LGBT groups is arguably the best known iteration of this theory, but its influence has been extensive, having subsequently been adopted and developed by researchers working in diverse fields with other groups.

A core claim of Minority Stress Theory is that the health disparities experienced by stigmatised minority groups are partly caused by the disproportionate levels of stigmatisation, victimisation, and harassment that they face. These stressors are amplified by "the anticipation of further negative events and treatment" along with "the perception of a lack of supportive networks" can leave people at greater risk of hopelessness and suicidality (Farrelly et al. 2015).

Crucially, these stressors often intersect with and compound existing barriers that individuals face on the basis of their characteristics or group (e.g. discriminatory or prejudicial attitudes exhibited by healthcare professionals), as well as barriers to care associated with their mental illness itself.

It is clear that Minority Stress Theory has the greatest influence on conversations around the LGBT groups and mental health, as well as those on BME groups and mental health. However, there is plenty of scope for the model to be profitably extended to other areas of research.

STIGMA

While a theme that appears repeatedly throughout the review, this is also clearly a highly complex notion.

To give an example, stigma can be seen to relate to mental health problems or symptoms themselves, such as cases in which specific communities or groups associate mental illness with moral failure or spiritual inadequacy. However, stigma may also be attached to an individual's characteristics or group, quite apart from mental health, but as a consequence can become a stressor which heightens risk of poor mental health, as seen in the discussion of Minority Stress Theory above.

Another theme that emerged from the academic literature is the distinction between *perceived* and *actual* stigma. Perceived stigma can lead to "self-stigma" whereby an individual internalises perceived prejudices. Crucially, however, to say that someone perceives that they face stigma is not to suggest that this stigma is not real; merely that the object of analysis is the perception itself.

As such, any research or commentary which makes reference to stigma in relation to mental health issues needs to take into account these nuances. Accordingly, the *Five Year Forward View for Mental Health* identifies challenging stigma around mental health as a key priority.

26.3. ACCESS TO SERVICES

CULTURAL FACTORS

Another theme that straddles the numerous individual discussions is that of cultural difference, appearing most prominently in the sections on Asylum Seekers, Ethnicity, and Religion.

In each case, there are different ways in which cultural difference impacts on matters of access to services. One major observation is that different cultural norms clearly shape attitudes to mental health. For instance, it has been seen that specific communities may attach high levels of stigma to mental illness and mental health services, and also that people from specific religious groups may employ explanatory models of illness which diverge from normative clinical terminology. Cultural factors also shape modes of help-seeking behaviour. For example, people belonging to specific communities or religious groups may be more likely to explore non-clinical care pathways before approaching formal medical practitioners.

Cultural factors also have a significant bearing on those responsible for delivering mental health services. As has been seen in more than one case, lack of awareness about cultural diversity among mental health practitioners is a clear barrier to access: in cases where lack of awareness or understanding around cultural matters causes discomfort to patients, there is a strong likelihood that those patients will be more reluctant to access those services in future. For instance, a medical practitioner may not be aware of culturally-specific gender norms or religious commitments when examining a patient. It is important to note that many of these issues around lack of understanding and awareness also overlap significantly with those faced by other groups, for example in the cases of LGB and trans* people.

INSTITUTIONAL PROVISION OF SERVICES

The literature under review suggests that some groups of people are more likely to have had contact with mental health services than other groups, most notably if they have experienced poor mental health while being part of an institutional context (e.g. students of a higher education institution, people in the workplace, people in prison, or people in the army) or having since departed from such an institution (e.g. ex-offenders, military veterans). The reason for this is that mental health services are typically more prevalent and coordinated in these institutional environments.

It is also apparent that there is a correspondingly greater amount of literature regarding access to mental health services among these groups relative to those with no such institutional associations.

INTEGRATION OF SERVICES

A recommendation that repeatedly appears in the review is that of promoting the integration of different health care services. This is proposed at various different scales. For example, at a larger scale, several studies recommend the integration of NHS services and others administered by different public bodies or authorities, including drug and alcohol services and adult social care.

To give another example, this time within the NHS itself, several studies recommend further integration of services within the NHS, for instance between Child and Adolescent Mental Health Services and Adult Mental Health Services, or between mental and physical health services.

This emphasis on integration of mental and physical health services is reflected in the *Five Year Forward View for Mental Health* report, and the *Breaking Down Barriers* report identifies lack of integration of services at a local scale as a key barrier.

SERVICES TAILORED TO SPECIFIC GROUPS OR INDIVIDUALS

Another common recommendation is that of the need to tailor services to the needs of specific groups. There is an overriding concern that by simply flagging the need to attend to the needs of, for example, ethnic-cultural minorities, religious groups, and LGB+ people, there is a real danger that needs specific to ethnic-cultural sub-groups, discrete religious traditions and denominations, and sexualities (e.g. bisexuals).

While the *Five Year Forward View for Mental Health* report is highly interested in communities, it is notable that the document places a greater focus on person-centred care: namely, tailoring services and interventions to individuals' needs.

IMPROVING DATA

Numerous publications advise that patient data and information on barriers to access and experience of health care services among different groups of people could be improved (both in quantity and quality) and made available across health care services. Memorably, Wolpert et al. (2016) recommend that "achieving parity of esteem between physical and mental health requires parity of data."

Once again, this reflects a recommendation that appears in the *Five Year Forward View for Mental Health* report, though the focus on data in this document is more geared towards improving transparency around spending and performance.

TARGETED TRAINING OF NHS PRACTITIONERS

Several studies relating to diverse characteristics and social groups recommend that health practitioners receive great levels of awareness training, not only with respect to cultural differences, but also with regard to Religion, Sexuality, Gender, and Transgender.

As discussed above in the case of cultural diversity, lack of understanding and awareness among mental health practitioners can function as a clear barrier to access, specifically because it can cause discomfort to patients. Furthermore, improving understanding and awareness among mental health practitioners can improve early identification and prevention of mental health problems that are more prevalent, or less often detected, among specific populations or groups.

27. RECOMMENDATIONS FOR RESEARCH

27.1. INTRODUCTION

This literature review has explored different demographic or social groups in relation to mental health and their experiences of services. As a result of engaging in this analytical process, research gaps for each group in relation to the key objectives of this exercise have emerged and are explored in more detail below in this section. So, providing Healthwatch and other health and support services, with not only an overview into mental health across these groups, but also the opportunity to heighten, broaden or deepen the knowledge base upon which successful mental health provision is developed.

27.2. RESEARCH RECOMMENDATIONS

AGE

The majority of research around the area of age or age discrimination in delivery of mental health services focuses on two stages of the life course, namely youth and adolescence and old age. While this is intended to draw attention to younger and older people whose health needs have been historically overlooked, there is a distinct gap in the literature when it comes to the mental health needs of adults as a population at other particular key or transitionary stages in their lives. Adult mental health tends to be addressed via other characteristics (e.g. gender, ethnicity) or categories (e.g. as new parents, as employees, or as people living in poverty, and so on). Despite the increased interest and awareness, including by charities and in policy on the subject of mental health problems among older people in recent years, it remains the case that there is considerably less research on the subject of older people's experience of mental health services in comparison to that of younger people.

ETHNICITY

There is an impressive amount of research on the subject of ethnicity and mental health services. However, there is limited engagement with subsets of BME groups, not only along the lines of different ethnicities but also other characteristics (e.g. gender, religion, sexuality, age). Furthermore, while there is important research on the subject of stigma around mental health among BME groups, there is a clear lack of research on the subject of patterns of help-seeking behaviour among and between BME groups. More specific research looking at intersecting (and potentially compounding factors) and the engagement with services would be would be welcome. An assessment of whether areas with a greater proportion of BME doctors and healthcare professionals results in better mental health outcomes or service use and experience for BME patients would be interesting to investigate due to the reported discrimination experienced by BME patients. Similarly, assessing the impact of cultural understanding and training given to healthcare professionals may provide insight into how mental health pathways for BME patients can be improved. Research with a range of healthcare professionals as well as patients may be useful here, either in the form of in depth interviews or a discussion between the healthcare professionals and patients.

It should be noted that while we refer to 'ethnicity' broadly here as a factor, the impact on mental health would vary according to different ethnicities in different contextual settings and the focus, and even how to define ethnic 'categories' would need to be decided on as a fundamental step in the research process.

SEXUALITY

Most research amongst this group relies on small sample groups which may not be representative of national populations, nor sensitive to the discrete experiences of individual sexual minority groups (Elliot et al. 2014: 9). Interestingly, the increasing awareness and societal 'acceptability' of the LGB+ population should make it easier to conduct research with people in this group (or subsets of this group) in terms of finding willing participants (particularly with regards to qualitative research).

It could be argued that if the linked mental health issues are in part caused by social stigma, rather than social difference, this causal factor is likely to be reduced as social awareness and acceptability continue to increase. Assessing this would be an important avenue for further research and could be conducted by in depth interviews with LGB patients to help. Given that those experiencing mental health difficulties often feel marginalised and stigmatised for their mental health condition, it would also be worthwhile to determining how widespread stigma is felt for LGB patient with a mental health condition as a vital step forward to improving provision. For example if an LGB patient feels unable to share their sexual orientation with their GP this may in turn impact on their experience of mental health services. How this works in practice is worth exploring through further research. How this varies across age group and gender would also be interesting to address.

PERINATAL

There is a wealth of literature on the subject of perinatal mental health, with a growing interest in paternal mental health to match that of maternal mental health. It would be interesting to look deeper into the various ways that maternal and paternal mental health manifest and to look for similarities and divergences, both in terms of what are the trigger points as to when the mental health issues arise and peak. Research could also focus on engagement with services and which interventions proved to be useful for each group.

 It would also be interesting to look at whether, and if so how, family, friendship and community support structures positively (or negatively) impact on mental health in the situation of maternal or paternal mental health. Such research might consider social or geographical isolation and whether stigma could have an impact, for example related to the non-traditional role of the male primary parental carer in particular. Ethnicity might also be considered here as a related factor to explore.

The recent Government focus on perinatal mental health and the announcement of £23million towards community services to tackle the uneven distribution of services may also provide further opportunities for research. For example, assessing the effect of having to travel long distances to receive mental health care, and the impact of this on family life and wellbeing has not yet been explored and it would be interesting to then determine the effectiveness of Government spending in this area. Interestingly, the extra funding was focussed more on maternal than paternal perinatal mental health but with references to the family unit; research into how maternal and paternal mental health and its relationship to the roles they provide would be a fruitful area for future research. This is particularly relevant in terms of access to, and experience of services. Interviews with each parent, as to how effective the mental health services were in meeting their needs as a family would be welcome as often the focus is on the individual or the mother and child, for example.

DISABILITY

While there is considerable literature in this area that focuses on people with long term physical health conditions and those with general learning disabilities, there is clearly scope for more research on the barriers and experiences of mental health services among people with developmental disability or specific learning disability.

In addition, the literature repeatedly fails to acknowledge mental health problems as disabilities, despite them being defined as such in the Equality Act 2010.

There are a wide range of disabilities that can be identified and the research design should consider which disabilities are of the main interest and priority, how to define and group the participants appropriately, and whether the type of methodology in place is suitable for the group in question. Research amongst those with severe learning disabilities for example, could be observation research, or assisted via the carers if less severe. While research amongst physically disabled, is more likely to incorporate a survey or interview based design, directly with those affected.

GENDER

It was difficult to find research about mental health directly related to gender in and of itself as opposed to linking it to another group e.g. domestic abuse. In one sense this is understandable as when looking at gender and mental health it is difficult to say whether or not the mental health difficulty is a direct result of gender per se, as opposed to other associated factors. In addition, policy documents were often focused on one specific gender rather than comparing the two. Men and women may well experience mental health services differently which have been tailored to 'treat' conditions more *associated* with their respective gender and whether some services could therefore be more accommodating of one gender for this reason e.g. eating disorders are more common among women and therefore may be more experienced with treating women. Although this has been explored by some research with regards to whether participants thought men or women were more deserving of treatment, given that mental health awareness and efforts to reduce stigma have been improving in recent years, testing perceptions would be useful. In addition to this, interviews with users of services or conditions which tend to be used by one gender may be a productive method for this type of research.

Greater exploration of measures that could practically be put place to encourage men in particular to identify and seek help for mental health issues when they arise could also be very useful. Interviews with men who have sought mental health treatment to determine factors which led them to seek help or recognise a problem, for example social factors or campaigns promoting awareness of mental health may also provide insight and understanding to improve service promotion, signposting and provision.

TRANSGENDER

Despite there being a growth of attention with regards to the experiences and needs of trans people, including in the area of mental health, there is a clear focus in the literature on MTF (male-to-female) transgender experiences. It is recommended that more is done to capture the experiences of people from across the transgender spectrum (Brown et al. 2017: 16). Within this, it would be interesting to hear from trans people about their experiences of services for mental health, particularly those seeking gender reassignment surgery. It would be useful to determine the extent of GPs' knowledge and understanding of transgender and the mental health risk factors associated with this group.

As the gender change process varies per patient, it would be good to identify key trigger points at which they would require support and assess how this support various stages effects a mental health treatment and outcomes. The potential ability of family and 'community' to aid this emotional process would also be an interesting avenue of inquiry. There could be a hidden intersection related to isolation that could be looked at in more detail.

RELIGION

Given the well-documented decline of institutional religious activity in the UK in recent decades, it is perhaps surprising that there is a considerable amount of research on the subject of religion and mental health. However, because this body of literature is somewhat dispersed and uneven in quality, there is a clear information gap in this area, with a particular dearth of research with religious groups beyond Christian and Muslim populations. Furthermore, the existing literature is generally more focused on the question of the extent to which religion can be associated with mental distress or wellbeing, with a clear gap in terms of experiences of services (Dein 2014).

Research may be worthwhile into whether disaffiliation with religion in the UK has had an impact on mental health and how people may now have a resulting greater need of mental health services and support, for example due to a loss of a social community (studies in the US on this topic are far more frequent and well documented).

Further research into religious groups in the UK other than Christians and Muslims would also be welcome, for example research that focuses on Jewish communities. This group may be of particular note given their likely experiences of at least some anti-Semitism, that Christians, for example would not face. Uncovering the experiences of religious people in this area would be particularly worthwhile, both those who have accessed mental health services and those who have not, perhaps because of their religious culture or beliefs.

It would also be interesting to explore whether being part of a religious group overall could help with mental health outcomes (perhaps because of being less likely to be socially isolated) or whether it may hinder treatment outcomes due to beliefs by some groups surrounding miraculous healing, for example. How religion and faith is understood by healthcare professionals would also be worth exploring, as an area which is a central part of many people's lives but may not always be discussed in a clinical setting.

MARITAL STATUS

Academic research into marital status and its relationship with mental health is very limited overall. Accordingly the remit and focus on any research undertaken could explore many areas. Although aspects of this are apparent in research, the transition into and out of marriage over a life trajectory in relation to mental health could prove a good start. Remarriage and new relationships following divorce have been explored by Symonens et al.

Interestingly, while we are considering this in a UK context, the impact of marital 'status', as opposed to marriage itself, and how this is perceived might vary with cultural context (ethnicity and religion for example) as to how stigma of being married, or not, affects the mental health of the person in question.

Because there are often lots of different variables with regards to mental health and marital status, qualitative interviews may prove the most fruitful method for further research to allow for greater space to explore recurring themes and sensitively address a personal aspect of family life. Looking at how the family plays a part in recovery from mental health problems and whether family centred care can be a more effective method would be interesting to explore. In this instance, interviews with various family members and how mental health experiences differed in terms of different therapies, as well as the impact of an individual's mental health on a family, could definitely be explored further. Seeing how this is worked out in different demographics, for example cultural or religious contexts, would be particularly worthwhile to gain a fuller picture. Further, research into the effects of cohabitation versus marriage in regards to mental health would be an interesting avenue of research in order to determine whether marriage breakdown is more traumatic than breakdown following cohabitation.

WORKPLACE

While recent years have seen the publication of several studies on workplace mental health, Brohan et al. (2012) recommend that more research be conducted on the subject of workplace mental health, and specifically longitudinal research that tracks attitudes and conditions over time. Furthermore, there is a clear gap in the academic literature on this subject. In particular, there is considerable scope for research on the subject of the extent to which employees engage with mental health services via their workplace or whether employees prefer to access services that are removed from their professional life. In addition, which services are most suitable and desirable in the workplace would be worthwhile. There is also space for research concerning the identification of groups that are particularly vulnerable to mental health problems, and who face particular barriers in the workplace, especially in relation to accessing services.

A mixed methodology approach may be effective here, using a quantitative survey to measure perceptions over time as well as help offered by employers with regards to physical and mental health e.g. sick leave, understanding with appointments etc. which may allow for determining the extent of parity of esteem in the workplace. Through this, there may also be scope to compare business size and sector, for example, as well as how far seniority and length of time in a workplace affect a person's perceptions of mental health provision. This may be useful if employers are aware, for instance, that younger employees may be particularly vulnerable or to help provide resources if smaller businesses were found to be less able to accommodate those with mental health issues. Following on from this, research through interviews could also be conducted among HR managers as well as those who have had experience of mental health support in the workplace to create a fuller picture and develop a framework for good practice of mental health in the workplace. Expanding this from the employer perspective to incorporate colleagues or in hiring practices would be useful.

UNEMPLOYMENT

There is a considerable amount of literature on the subject of unemployment and mental health. Unsurprisingly, this body of literature has grown substantially in the aftermath of the 2008 financial crisis and the government austerity programme that was implemented from 2010, but has also resulted from previous recessions in the 1980s and 1990s (Bambra 2010). Likely because of the policy debates that have accompanied these shifts, much of this literature is focused on establishing the associations between unemployment and mental health problems and designing interventions. As a result, there remains a gap in the literature when it comes to the question of the barriers to mental health services that unemployed people face, as well as their experience of these more generally. Qualitative research into how being in work affects mental health more generally would be worthwhile to determine whether symptoms are ameliorated by having a job. This relationship is likely to be bidirectional – i.e. that having a job may improve mental health but also that having a severe mental health problem may make it more difficult to continue being in work – determining the extent to which this is the case would provide a useful opportunity for future research. Also, determining how other socioeconomic factors play into and intersect with unemployment, for example financial worries, would provide interesting insight. Interviews with those who interact with unemployed people, for example those who work at job centres or in the benefits system, would also be interesting to speak to about how mental health and unemployment interact in their contexts.

POVERTY

There is a significant amount of literature on the subject of poverty or socioeconomic inequality and mental health. However, much of this has overlooked the concrete ways in which socioeconomic factors can cause mental health problems, and furthermore there are far fewer studies which look at access to services. Visible research which focuses on poverty and mental health has been found which addresses intersections with age and ethnicity. There is ample scope for academic research on the negative

relationships that can develop between poverty and mental health problems not only over a single life course, but over generations; a theme that appears in the policy literature. Similarly, it is surprising that the benefits of integrating health services with other public and third sector services are discussed in policy literature and not in the academic literature.

Poverty is a crosscutting theme across many areas in this literature review, and as such further research is particularly salient in this area. As much of the academic literature is from before the financial crash, an in depth research project determining how poverty interacts with these complex and interwoven factors would provide great insight into how best to accommodate those in poverty and see the vicious circle that can be created by the combination of these two characteristics. As well as assessing the financial implications of poverty on mental health, other factors such as whether poverty affects help-seeking behaviour or how patients interact with services and experience therapeutic interventions would also be worthwhile. Qualitative interviews with a range of socio-economic grades would be needed to make a comparison between those in poverty and others.

STUDENTS

There is a good amount of literature on the subject of students and mental health, with a good proportion of these studies considering access to services. Similarly to other risk factors for mental health that are defined in the context of being part of an institution; the university in this case, or the workplace or prison in others, where there are likely to be a greater number of institutionally related and coordinated services, therefore there is likely to be more research as a result which assesses access.

The most prominent research in the literature focuses on the heighted vulnerability that students from disadvantaged backgrounds face with regards to mental health at university. It would be valuable to see more academic research being delivered on this subject, to determine what may be the cause of this, be it economic, social difficulties or something else. That said, as students are a very transient group, exploring how and if students' mental health differs post-university is an important area of research, particularly for those form poorer backgrounds who experienced mental health problems, if research into mental health services are going to be comprehensive and equal to physical health.

It would also be interesting to differentiate between students who experienced mental health difficulties before going to university and how their experiences of mental health services differ between home and university settings. The impact of student specific services on mental health would be worth looking into in this context, along with stressors that the university experience may bring, such as exams and homesickness. This would also be relevant for how access and experiences differ when students are effectively living in two places during university term time and breaks as this may be more challenging than for the general population, for example if a student's GP was at university but they were experiencing mental health problems when at home over the summer. Qualitative research could provide interesting insight into these areas, or potentially focus groups with student mental health groups.

VETERANS

The volume of research for veterans is fairly good, with a mixture of qualitative and quantitative studies asking veterans about their access and experience of mental health services. This is greatly helped by veterans' charities and more specialised services available. However, as an area with a fast-changing policy landscape, with announcements made to changes in the funding of veterans' mental health services happening even in April 2018, research has the challenge of assessing the usefulness/benefit of policy changes.

It should also be appreciated that any research design set up to explore this area ought to consider the *types* of veterans and how this group might be sub-categorised. Where, when and how the veteran served, including their specialism may impact on their resulting mental health. Stigma experienced by groups or individuals according to other mental health 'risk' factors (e.g. sexuality, gender, transgender, ethnicity) might also be considered, whilst in the army, that has been, and continues to be a male dominated institution.

For example, hearing from female veterans, as a minority group within the army, would plug a knowledge gap that is apparent in UK literature and though the number may not be large enough to conduct quantitative research, their experience of mental health services upon leaving the army would be interesting to grasp. It would also be interesting to determine whether women in the armed forces are more or less likely than women in the general population to experience mental health difficulties.

HOMELESS PEOPLE

Research addressed reasons why there was a higher prevalence of mental ill health among this group, but the complex and potentially multi-faceted barriers that homeless people face in accessing mental health care is could be the subject of more detailed research. Very little research was found in relation to the experience of homeless people using mental health *services* in the UK.

Research might consider homeless people's experiences of mainstream NHS services as opposed to social support and how the two can complement one another. This should include assessing how far perceived stigma from healthcare professionals or others they come into contact with may impact on treatment outcomes. That said, more research directly asking homeless people about their experiences of different types of mental health services, whether specific or general, would be beneficial. It would also be interesting for this group the extent to which barriers were physical or psychological. For example, it would be interesting to note whether homeless people are more likely to access mental health services via A&E, for example, it would be worth exploring how prepared these healthcare professionals feel in terms of dealing with complex mental health problems experienced by vulnerable groups in the population. Similarly, looking at how social support can work to improve help-seeking behaviour for homeless people, who were particularly found not to highly value their health when compared with other barriers and life situations they face, would be worthwhile alongside looking at the more bureaucratic barriers that they may face, for example needing proof of address.

SUBSTANCE MISUSE

There is a limited amount of literature on this intersection between substance misuse and mental health problems. While there is a good amount of research that highlights intersections between other characteristics and these diagnoses, there are far fewer studies which look at access to services, and particularly gaps between mental health and drug and alcohol services. There is also scope for more research into what concrete improvements can be made to mental health services in this area, and how to ensure recommendations are implemented when services are being designed.

Assessing how substance misuse and mental health services relate to one another for patients with dual diagnosis would be an interesting approach for further research, specifically looking at how far these services are joined up and consistent across region, age and socio-economic status. Hearing from the experiences of those who have used both services conjointly and how stigma, be it perceived, internal or from healthcare professionals, may affect both treatment as well as help-seeking behaviours.

ASYLUM-SEEKERS

Following a decade of rising numbers of international migrants in Western European countries including England, recent years have seen a growing body of literature in this area, and particularly after the onset of the European migrant crisis in 2014-15. Despite this, there is a clear deficit of research around the health needs and health care service experience of migrants, and particularly research that is specific to England and the United Kingdom (with far more studies addressing the European region more broadly). Furthermore, while the subject of the mental health service experiences of child migrants and migrant youth (and particularly those that arrive in unaccompanied) has received a considerable amount of attention, far less has been directed at older migrants.

This group is of course, not homogenous. In addition to asylum seekers being particularly vulnerable to the heavy compounding of multiple risk factor intersections (e.g. ethnicity, isolation, religion, trauma) for mental health, they are likely to have arrived in the UK from a range of settings. Where research, considers asylum seekers as a single group, the design should be alert to the impact of differing experiences and cultural settings which might impact on access and engagement with mental health services. Looking specifically at barriers that asylum-seekers may experience in accessing healthcare in the UK, and taking into account their particular vulnerability to mental health difficulties based on often traumatic experiences, it would be worth interviewing healthcare professionals who work in settings with a high asylum seeker population. This would allow for insight into the experiences without the risk of sensitivities with individuals as well as circumventing language barriers. In doing so, interviewing a range of primary and secondary healthcare professionals as well as those who work in the community would be worthwhile, particularly if this group are less likely to access traditional health services or may be concerned about their immigration status.

PRISONERS

There was a reasonable amount of literature for this section of the research that covered the topic fairly broadly. This may be the result of prisoners' mental health being an increasingly talked about area of policy and the changes to the way prisoners' healthcare has been treated (i.e. from Home Office to NHS). That said, the changing policy scene also meant that some research was no longer applicable to the way prisoners now experience mental health services and new policy had been stated or implemented. Literature generally focused on men rather than women; though, this may be reflective of the demographics of prisoners. However, there is an apparent research gap in the number of studies which have conducted qualitative research with prisoners and their direct experience with mental health services as opposed to having a mental health difficulty. This is almost certainly related to the challenges of access – with any research undertaken requiring prison clearance to involve access the prison, and prisoners as a research subjects. As mental health services are incorporated as part of the general prison health programmes, so the 'barriers' to accessing mental health services may not factor to the extent that they would for other groups.

Given that few studies have been conducted so far in hearing the experiences of prisoners in relation to mental health treatment they have received, this could prove to be an interesting and valuable avenue for in-depth qualitative research. This research could be conducted retrospectively, so circumventing the access issue. Research might therefore explore experiences of mental health services whilst the former prisoner, were in prison, and the access and engagement of the same group with services after prison release. Similarly, surveying prison GPs or healthcare professionals to understand difficulties with mental health screenings and the pressures of the working environment as well as the most common factors which they believe contribute to mental ill health in the prison population. Within this, determining whether the changeover in care (i.e. a change of GP, for example) for former prisoners and the effect this may have on mental health would be interesting to assess.

SEX WORKERS

Research coverage of this area, particularly in the UK, is very limited. Much of the literature related to mental health and access to services has been carried out in other countries and literature tends to focus on prevalence of the mental health conditions rather than experience of services. As a topic, this area is particularly difficult to research because the scale of sex work in the UK is not known, and also because aspects related to sex work are illegal. Quantitative research in this area is, of course, is very challenging, as it is with illegal occupations and hard to reach groups in general so statistics are hard to establish. Exploratory qualitative research, using in-depth interviews, with sex workers in relation to their mental health and access to services would be interesting. It may prove useful to use women's shelters and mental health services as an access routes to contact sex workers who might otherwise avoid contact due to the illegality of their work. Within this, exploring any stigma or discrimination towards sex workers in a UK context would be worthwhile, whether this be from healthcare professionals, society or internalised (which may affect help seeking behaviour). Understanding how specialist services work within this context would be interesting to explore.

ISOLATION

Despite growing policy interest in the subject of isolation and loneliness, most research to date has been specifically focused on older people experiencing isolation and loneliness. More research is needed on loneliness across different age groups (especially young people), as well as on whether individuals with specific mental health conditions (e.g. psychosis, agoraphobia, social phobia) are more at risk of loneliness than others.

In addition, there is more scope to investigate how, if and when those who are isolated and lonely, access and experience mental health services. There is an obvious disadvantage to those who are geographically isolated in relation to mental health services as all public services, including shops, schools and the doctors involve transport and a greater effort to reach. However, as mentioned, this will also likely affect those who are socially isolated as a result of their mental health problem, e.g. anxiety, and their experience of mental health problems would be interesting to assess in terms of whether there are online resources available to them or whether their social isolation prevents them from having treatment for their condition.

CARERS

There is a moderate amount of literature on the subject of carers and mental health. While there has been some research that addresses intersections with ethnicity, age, and gender, there is a clear gap in the literature with respect to the mental health needs and service experiences of male carers. A greater and more specific understanding of the transition in and out of, and through the different stages of the carer role would be interesting to achieve through research.

Understanding how carers see their role, particularly given that many of them do not see themselves as carers, would be interesting to explore. Different caring relationships and how these impact on mental health would be particularly interesting, for example are parent-child caring relationships different from spousal caring relationships. Further, how this changes if the person being cared for no longer needs care would be interesting to assess i.e. how the mental health of the carer may deteriorate when coupled with the loss of their role and the loss of a loved one, for example. It would also be interesting to determine whether help seeking behaviour in carers is lower than the general population and whether any mental health problems that the carers themselves experience are not prioritised as highly due to, in some ways, their role being one of a provider and carer rather than being cared for themselves. Support systems for carers should also be assessed to understand how they can be improved, in order to provide care and prevent people who may be at heightened risk of experiencing mental health difficulties.
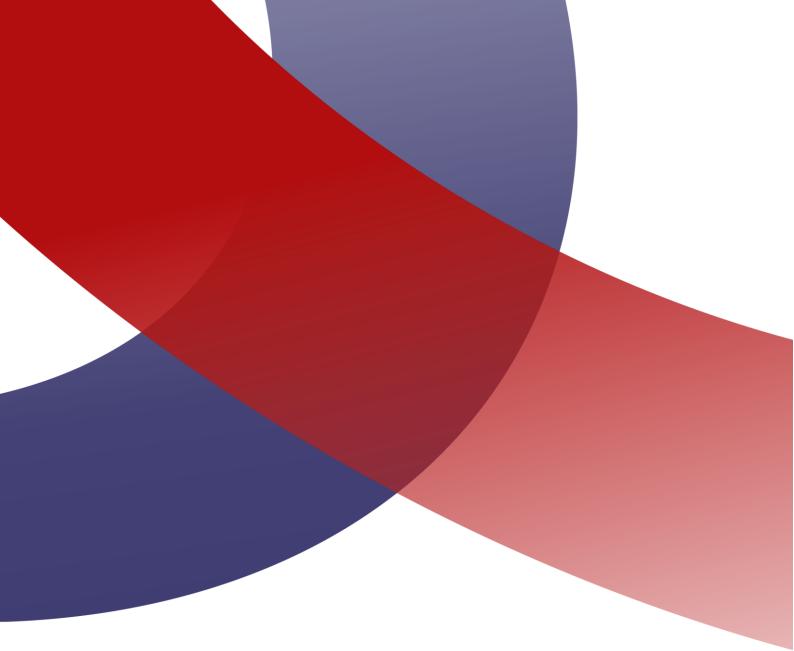
25. APPENDIX

25.1. GLOSSARY

'Parity of esteem' is a term used to mean an equality between physical and mental health in terms of access to treatment and standards. It has been a Government commitment since 2013, however, there are signs that there's still a long way to go in order to achieve parity of esteem, particularly in terms of funding, staffing and waiting times for mental health services as The King's Fund has pointed out.

NHS arms-length bodies: CQC (Care Quality Commission), NICE (National Institute for Health and Care Excellence), Public Health England, NHS Digital, Health Education England, NHS Improvement, NHS Resolution.

BME: Black and Ethnic Minority (also often now abbreviated to BAME)

BMA: British Medical Association

CAMHS: Child and Adolescent Mental Health Services

CCGs: Clinical Commissioning Groups

CQC: Care Quality Commission

HEE: Health Education England

MHA: Mental Health Act

IAPT: Improving Access to Psychological Therapies

NICE: National Institute for Health and Care Excellence

PHE: Public Health England

PTSD: Post-traumatic Stress Disorder

RCPsych: Royal College of Psychiatry

WHO: World Health Organisation

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