Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar anghydraddoldebau iechyd meddwl

This response was submitted to the Health and Social Care Committee consultation on mental health inequalities

MHI 77

Ymateb gan: | Response from: Professor Ann John and Mental Health Data Science Team, Swansea University

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Poor mental health is associated with a range of inequalities (preventable and unfair differences) in opportunity (e.g. access to care, quality of care) and outcomes (e.g. quality of life, mortality). Inequalities in mental health are largely due to inequalities in society i.e the unequal distribution of social determinants of health such as parenting, family structure, experiences of adversity, education, housing, employment and poverty/depivation. The mechanisms underlying these determinants are complex and often bi-directional and inter-related. People with mental illness are more likely to have higher rates of poverty, homelessness, experience of the criminal justice system, health risk behaviours, unemployment and physical illness. Stigma, discrimination, isolation and exclusion play a part preventing people from seeking help and also underly negative responses by family, friends and professionals to those seeking help. As does diagnostic overshadowing, where physical health symptoms are deemed to be a symptoms of pre-existing mental health problems, rather than a genuine physical health factors interact and operate at an individual, family, community and structural level and interventions need to be directed using a systems approach at all these levels. The overall population impact of any of these factors depends on both the size of impact at individual level and the proportion of population affected and evidence based interventions to address mental health inequalities should be directed at a universal, selective and indicated level recognising that addressing treatment gaps requires a recognition of prevention, early intervention and policy based interventions addressing the wider social determinants of mental ill health. Many of the key determinants of mental health are beyond provision of mental health services. Given that 75% of mental illness presents before the age of 18 years pre-natal, infant, childhood and adolescence are important stages to address mental health inequalities.

Below we present a number of studies conducted in the Adolescent Mental Health Data Platform at the SAIL Databank based on Wales data to highlight mental health inequalities in Wales

John et al., Association of school absence and exclusion with recorded neurodevelopmental disorders, mental disorders, or self-harm: a nationwide, retrospective, electronic cohort study of children and young people in Wales, UK, The Lancet Psychiatry, Volume 9, Issue 1, 2022, Pages 23-34, ISSN 2215-0366, https://doi.org/10.1016/S2215-0366(21)00367-9

School absence and exclusion is associated with range of poor outcomes later in life - educational attainment, employment, and poverty. We conducted a Wales-wide retrospective electronic cohort study in academic years 2012/13- 2015/16. We define 'being absent' here as missing more than 10% of school sessions in one year. We defined 'being excluded' as having any record of an exclusion in a specific academic year.

Children and young people with neurodiversity, mental health diagnoses, substance use and self-harm recorded in health records up to age 24 were more likely to miss school than peers even after adjusting for age, sex, and deprivation.

We found that the likelihood of being absent or excluded increased with deprivation for pupils with a record of any of ADHD, ASD, learning difficulties, conduct disorder, depression, anxiety, eating disorders, drug or alcohol misuse or self-harm the likelihood to be absent increased with deprivation. Specifically, those with a record of self-harm or anxiety were twice or almost three times as likely to be absent if they lived in the most deprived quintiles compared to the least deprived, respectively. Those with a record of self-harm were almost twice as likely to be excluded and those with a record of anxiety were more than three times as likely to be excluded in the most deprived quintiles compared to the least deprived.

Children with neurodiversity, mental disorders, or self-harm spend less time at school. across diagnoses. Increased absences and exclusion were seen with increased age, mental health co-morbidities and deprivation. The effect is likely bi-directional. Absences and exclusions are a potential indicator for current/ future poor mental health, routinely collected by schools and Local Education Authorities that could be used to target assessment and early intervention.School-based mental health provision and integration with mental health services is a major strategic priority in the Wales and absences and exclusions should be a part of this. SEN status decreased the likelihood of being absent or excluded demonstrating interventions matter.School-based mental health prevention strategies (whole school approach) to promote self-help strategies, awareness of when to seek help and resilience will potentially address some mental health inequalities.

Lee, . et al. Area deprivation, urbanicity, severe mental illness and social drift — A population-based linkage study using routinely collected primary and secondary care data. Schizophr. Res. (2020) doi:10.1016/J.SCHRES.2020.03.044.

John. et al. Premature mortality among people with severe mental illness — New evidence from linked primary care data. Schizophr. Res. (2018) doi:10.1016/j.schres.2018.04.009.

Inequalities across demographic, socioeconomic and geographical domains, as well as premature mortality in severe mental illnesses (SMIs), including schizophrenia and bipolar disorders, have been well documented. We examined inequalities in SMIs between 2004 and 2015 in Wales. While males are about 50% more likely than females to be diagnosed with schizophrenia, risks of bipolar disorder are higher in females (~1.7 times). SMIs, especially schizophrenia, are more prevalent during early-adulthood (< 35 years). Socioeconomic inequality is evident as SMIs are more likely to be associated with the most deprived (~2-3 times) than the least deprived areas. Inequality is also present in urban areas (~10-30% more than in rural areas). Our another study provided a comprehensive assessment of all-cause and cause-specific mortality in SMIs between 2004 and 2013. Regardless of healthcare settings, there exists a mortality gap between individuals with SMIs and the general population, with all-cause mortality in SMIs being ~2-3 times higher. Such differences in mortality are larger for males and younger individuals. While natural causes (e.g., cancer) are the most common causes of death (>80%) in individuals with SMIs, excess in mortality compared to the general population for unnatural causes (e.g., suicide) are the highest.

In order to narrow inequalities and close the mortality gap for SMIs, these studies provide ample opportunity to facilitate effective implementation of strategies to redistribute resources for prevention and management of SMIs, health promotion and suicide prevention to t vulnerable individuals and communities. Ongoing surveillance of inequalities and mortality/mortality gap could help identify the potential impacts associated with both short- (public health crisis) and long-term (intergenerational trends) societal changes and help facilitate timely planning of relevant infrastructure.

John, A., Marchant, A., Demmler, J., Tan, J., & DelPozo-Banos, M. (2021). Clinical management and mortality risk in those with eating disorders and self-harm: e-cohort study using the SAIL databank. BJPsych open, 7(2).

John, A., Wood, S., Rees, S., Wang, T., Marchant, A., Allsopp, M., Wilkinson, K., Freeth, H., Kelly, K., & Maclean Steel, K. (2019). Mental healthcare in young people and young adults. Report 2.

Marchant, A., Turner, S., Balbuena, L., Peters, E., Williams, D., Lloyd, K., Lyons, R., & John, A. (2019). Self-harm presentation across healthcare settings by sex in young people: an e-cohort study using routinely collected linked healthcare data in Wales, UK. Archives of disease in childhood, archdischild-2019-317248.

Self-harm

There is a steep deprivation gradient for individuals attending emergency departments for self-harm or psychiatric conditions, with 50% of attendances from the two most deprived quintiles (John et al., 2019). When looking specifically at self-harm, rates of self-harm are more than double in the most deprived compared with the least deprived areas across

primary care, emergency departments and hospital admissions (Marchant et al., 2019). This deprivation gradient is greater than males than in females with self-harm being more than three times in the most compared with the least deprived areas (Marchant et al., 2019). Re-attendance rates for self-harm are higher for those from the most deprived areas (John et al., 2019). People from the most deprived areas are more likely to be admitted to intensive care for self-harm than people from the least deprived areas (John et al., 2019).

Males aged 10-24 are less likely than females to be admitted to hospital following emergency department attendance for self-harm. This sex difference is most evident in those aged 10-15, with 76% of females being admitted compared to just 49% of males. Guidance states that young people aged under 16 attending with self-harm should be admitted in order for a risk assessment to be conducted. Boys and young men were also less likely to be admitted following self-harm by poisoning where admission is often necessary to monitor levels (Marchant et al., 2019). Consideration should be given to differential responses to to males and females in distress exacerbating inequalities.

All mental health

The proportion of referrals from primary care to secondary care for children and young people was highest for people from the least deprived areas despites levels of mental health conditions being in the most deprived areas. Children and young people from the most deprived areas were not only less likely to be referred but also attended fewer follow-up appointments for every new appointment than people from the least deprived areas (John et al., 2019).

When exploring referrals from primary to secondary care for all mental health conditions proportionally more males than females were referred from primary to secondary care. This may reflect severity of presentation to primary care given the known sex differences in help-seeking behaviour. Despite the higher rate of referrals males aged 21-24 consistently had the higher 'did not attend' rates for outpatient appointments. (John et al., 2019).'

John, A., DelPozo-Banos, M., Gunnell, D., Dennis, M., Scourfield, J., Ford, D. V., ... & Lloyd, K. (2020). Contacts with primary and secondary healthcare prior to suicide: case–control whole-population-based study using person-level linked routine data in Wales, UK, 2000–2017. The British Journal of Psychiatry, 217(6), 717-724.

John A, Reilly R, Price L, Okolie C, Heatman B (2019). Public Health Wales – Child Death Review Programme's Thematic Review on Deaths of Children and Young People through Probable Suicide 2013-2017

Main report
https://phw.nhs.wales/news1/news/averting-tragedy-suicide-prevention-in-welsh-children-and-young-people/thematic-review-of-deaths-of-children-and-young-people-through-probable-suicide-2013-2017-main-report/

https://phw.nhs.wales/news1/news/averting-tragedy-suicide-prevention-in-welsh-children-and-young-people/thematic-review-of-deaths-of-children-and-young-people-through-probable-suicide-2013-2017-summary/

Suicide

There are around 350 annual deaths by suicide in Wales. Of these, 1 in 10 are from children and young people between 10 and 24 years old, representing one of the leading causes of death in this age group. Self-harm, being known to social services and being from more deprived communities were all risk factors identified where improved quality of care and investment could prevent mental health inequalities. Policy and practice recommendations include:

- Management of self-harm: Full implementation of NICE guidance for the management of self-harm relating to children and young people.
- Prevention of alcohol and substance misuse: Ongoing action to restrict access of children and young people to alcohol, and full implementation of NICE guidance to prevent substance misuse.
- Mitigation of ACEs: Optimising provision and access and ensuring continued engagement with interventions for children who have experienced adverse childhood experiences such as sexual abuse, sexual assault or domestic violence; and engagement with safeguarding boards to raise awareness of the importance of protecting children from the effects of 11 domestic violence and sexual abuse to prevent suicide and self-harm.
- Raising age of participation in education, employment or training: Exploration of mechanisms to ensure children and young people between the ages of 16 and 18 are supported in education, employment or training including work based training.
- Better information sharing: Exploration of how information can be shared between non-state education settings (such as private schools) and statutory services.
- Better knowledge and awareness: Exploration of evidence-based ways of increasing knowledge and awareness of: self-harm and other risk factors for suicide; safety planning; help seeking and accessing services; and tackling stigma.

Despite females being more likely than males to present with self-harming behaviours, 3 of every 4 of those who die by suicide are men. Differences in help seeking behaviours between the general population and those who die by suicide are larger in females than males, with a larger gradient in female presentations with alcohol and drugs misuse, prescription of psychotropics, and emergency department presentations in general. 1 in 4 of those who died by suicide in Wales between 2001 and 2017 lived in most deprived areas while less than 1 in 7 lived in least deprived areas (WIMD quintile 1). Unemployment and recession are strongly associated with suicidal behaviours and economic protections for those in our most deprived communities will be protective with regards to mental health inequalities.