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Discussion Comments on Mental Health and Inequality Among Youth

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Alegria, Green, McLaughlin and Loder (2015) provide a most informative review of four key factors shaping disparities in mental health outcomes among children and adolescents, focusing on the role of socio-economic status, childhood adversities, family structure and neighbourhood factors. The paper concludes with recommendations for a future research agenda, and a plea for a multilevel intervention model addressing the intersection of various forms of inequality, attacking inequity as a whole instead of focusing only on single mechanisms. Their argument confirms the call for broad scope preventative actions by the World Health Organization based on findings from the 2009/2010 Health Behaviour in School-aged Children (HBSC) Study comprising many European countries (WHO, 2010). Yet, in Europe the discussion of social inequality in health is less focused on ethnicity and minority status but on socio-economic position (Braveman, 2012). It is however recognised that attributing all ethnic differences in health to socioeconomic factors is not satisfactory, that for some health outcomes socio-economic gradients vary between ethnic groups, and not adequately accounting for socio-economic circumstances when examining ethnic group differences in health can reify ethnicity and its supposed correlates (Bartley, 2004; Davey Smith, 2000).

In this discussion paper I first consider the conceptualisation of the processes that underlie social inequalities in health. Then I discuss the role of social change and trends in mental health problems among children and adolescents, and lastly I reflect about how the recommendations made by Alegria et al. translate into the European context. My discussion touches only briefly on some key issues, and is largely informed through evidence from the UK.

Conceptualising the relationship between social inequality and health

The conceptualisation of socio-economic position in Europe comprises different indicators, such as social class, social status, income or education which are often used interchangeably. Lack of attention to the definition and measurement of socio-economic position does however bring with it difficulties in understanding the mechanisms by which social circumstances may affect health (Bartley, 2004). Distinct dimensions of socio-economic position may differently shape distinct health outcomes. When considering social differentials in health status it is useful to categorise models of explanations. In this context ethnic inequality or gender differentials are understood in terms of where members of different groups are situated within social structures and the ways in which they have been discriminated against (often over a long period of history), rather than cultural or biological differences between groups. Racial or ethnic differences (or gender differences for that matter) manifest in different places and societies for different reasons in history, reasons which are linked to economic and political forces.

Explanatory models. Bartley (2004) differentiates five potential explanations for the relationship of social inequality to health involving material, cultural/behavioural, psycho-social, life course and political processes. It is not intended to suggest that one explanatory model is sufficient or adequate to account for the health differentials, and it is likely that most, if not all, explanatory categories make some contributions to observed patterns in health. Exposure to *material* hardship brings with it a lack in resources to provide for basic needs, such as nutrition, housing and safety, which can also include access to health care. The *cultural-behavioural* explanation refers to the possibility that different cultures might be prevalent in lower income groups or less privileged social groups. For example, families in low income groups appear to share a culture that promotes behaviours and beliefs (for example regarding smoking, drinking alcohol, diet, exercise, sexual behaviour, concepts of health, etc) or the organisation of family and kinship (affecting child rearing, parenting styles, gender roles, patterns of social support, etc). Why these behaviours and beliefs might differ for different groups is rarely asked, and to attribute health differences to culture or implied deficits such as less effective parenting is less challenging than tackling inequality in assets and material resources. The *psycho-social* model focuses on the way social inequality makes people feel, and how these feelings may themselves change the body chemistry. It refers to perceptions of one's own status, the balance between effort and rewards, available social support, as well as feelings of being in control which can affect health through

their influence of body functions, such as cortisol production and stress experience. Additional evidence for the importance of psycho-social factors has come from research that has compared health in populations with different degrees of income inequality showing that health is generally better in more economically equal societies (Wilkinson & Pickett, 2009). According to this argument health is not necessarily influenced by the amount of money you earn, but how this makes you feel about the status that this gives you in society. The psycho-social model bridges individual and group-level studies with *social ecology* studies that examine differences in health between nations. In particular ‘neo-materialist’ explanations pay less attention to the individual but to whole societies and how they differ for example regarding the provision of public health services, education, housing and transport that enable individuals on lower incomes to fully participate in society (Bartley, 2004). This shifts the focus to the political processes and distribution of power that affect provision of services, the quality of the physical environment and social relationships.

Last but not least *life course* models of health inequalities take into account that the chances for good or poor health can be influenced by events that take place even before birth and continue throughout childhood, adolescence and the adult years. This influences might not show their effect immediately, as there can be time-lagged or sleeper effects (Schoon, Sacker, & Bartley, 2003). Life course theory does not only account for continuity or cumulation of adversity but also for discontinuity and change, and considers the role of timing of events and critical periods in development. For example, some young people are able to ‘beat the odds’ and show resilience despite the experience of adversity (Rutter, 2006; Schoon & Bartley, 2008). The observation of positive outcomes in the face of adversity has led to a paradigm shift away from a deficit model, based on expectations of strong unidirectional effects towards adjustment problems or ill health, to the consideration of developmental processes leading to health and well-being instead. The manifestation of resilience is however not the result of distinct personality characteristics but has to be understood as a dynamic process which is shaped by the opportunities available to individuals and the choices they can exercise (Schoon, 2006)

The review by Alegria et al. addresses most of these processes, yet uses race or ethnicity as a ‘master status’ (Williams, 1997), as a central determinant of social identity and consequently of social position. The approach outlined by Bartley (2004) and Davey Smith (2000) regards race as a socially and politically constructed concept and ethnicity is defined in terms of geographical

origin, linguistic and/or religious differences from the ‘majority’ or dominant population. Furthermore, regarding the contribution of socio-economic circumstances to ethnic group health differentials, an understanding of the historical antecedents to the interlinkage between social and ethnic group membership is required. Where both approaches meet is the need to comprehensively quantify the risks and resources in the social environment linked to social inequalities and race/ethnicity and to examine how they cumulate over the life course and combine with other factors to affect health. For a better understanding of health inequalities researchers have to take account of the social and economic environment in which people live, as well as the wider historical and political context.

Trends in mental health problems among children and young people

A number of social changes have occurred in the 21st century, such as increasing income inequalities and changes in the family environment that could influence the manifestation of mental health problems. A recent review of the literature suggests that there was no worsening of mental health problems among children and toddlers, but among adolescents there seems to be a trend for increasing internalizing problems especially among females, while externalizing problems appear to be stable (Bor, Dean, Najman, & Hayatbakhsh, 2014). For example in England the proportion of adolescent boys and girls reporting frequent anxiety or depression doubled between 1986 and 2006, especially among females (3 to 7 per cent among males and 10 to 23 per cent among females). Suggestions regarding increased readiness to report symptoms appear not to be supported by the literature (Collishaw, Maughan, Natarajan, & Pickles, 2010), and overall trends in conduct and emotional problems have been large unaffected by changes in the ethnic composition of the population (Collishaw, Maughan, Goodman, & Pickles, 2004; Collishaw, et al., 2010; Tick, van der Ende, & Verhulst, 2007). Indeed, using evidence from the Health Survey in England for young people aged 16 to 24 years, Fagg and colleagues found no significant associations between ethnicity and mental health as measured by the General Health Questionnaire after controlling for socio-economic background, except that South Asians were less likely to report distress than White British (Fagg et al., 2008). There has however been an increasing income differential for parent reported adolescent emotional problems, suggesting that mental health-related processes might stem from an increasing gap between the rich and the poor

and associated psychosocial pathways specified in socio-ecological approaches (Elgar et al., 2015; Langton, Collishaw, Goodman, Pickles, & Maughan, 2011).

Formulating a new research agenda

On the basis of the evidence reviewed Alegria et al. propose an integrated research agenda for a better understanding in tackling mental health disparities in children and adolescents. This involves several key pillars that are similarly important in the European context.

1. *A developmental focus on key periods of developmental risk and vulnerability.* The European findings regarding trajectories of mental health differ depending on symptom type, gender and developmental stage. Interventions aiming to support children and young people should thus adopt a clear developmental focus, as suggested by Alegria et al.. Early interventions are of obvious preventative value, yet in most cases accumulating risk appears to derive less from any irreversible effect in early life than from continuing disadvantaging circumstances, and well as concurrent risk effects in later life, especially during key transition points such as entry into secondary schooling or reaching compulsory schooling age (Schoon, et al., 2003). For example young people's health choices, identity and social roles change during adolescence, marking it as a crucial period of the development of health differentials that may carry forward into adulthood. Without appropriate support it will be more difficult to maintain or consolidate earlier levels of adjustment. There is thus a need to extend support throughout childhood to adolescence and early adulthood. Moreover, gender differences in health behaviours, values and life styles make it important to adopt a gendered approach which in turn might have the potential to reduce gender health differentials in adulthood.

2. *Socioeconomic disparities.* It is indeed vital to target social inequalities in general in order to reduce risk levels, and more systematic research into the underlying processes is needed. This should however not stop at the family level, but also take into account relative inequality, that is the gap between low, middle and high income groups which has widened over time. For example, while the UK experienced considerable improvements in average household disposable income, there has been a steep increase of the UK's Gini coefficient (a measure of income inequality), which appears to be associated with a trend towards increased emotional problems among adolescents (Langton, et al., 2011) (see also (Elgar, et al., 2015).

3. *Addressing childhood adversities through implementation of parent training programmes.* Parenting plays a crucial role in shaping children's and adolescent's behaviour and psycho-social adjustment. Despite considerable changes in family size and structures as well as the working lives of parents, there was little evidence in the UK studies to support the assumption that parenting quality as a whole had declined, or that it had declined more in the most disadvantaged groups in society (Collishaw, Gardner, Maughan, Scott, & Pickles, 2012; Gardner et al., 2012). Parents were responding to social change by spending more time with their children, exerting increasing levels of supervision and control and demonstrating warm and positive relationships, although single parents reported more difficulties in parenting their adolescent children compared to two-parent families. These findings provide material for a more nuanced debate about the role of parenting. Investing in parent interventions remains a very effective way of improving outcomes in children, and not investing in parenting improvement might render the average outcomes for children and young people even worse. We should thus ask what is going on in families, how much variation is there in parenting behaviour, what is the role of social norms and expectations, what are the strains of parents due to an extended adolescence and prolonged dependence, and how can we provide positive and constructive support for parents who may have an increased need. During the early years nurse-family partnerships might play such a key role and have now been implemented in the UK context.

4. *Improving neighbourhood conditions and reducing violence.* Also in the UK there is evidence to suggest that measures of neighbourhood disadvantage map onto measures of children's emotional and conduct problems (Fagg, et al., 2008). Moreover, there have been increasing inequalities in local economic conditions across England in recent decades and the gap between richer and poor areas has widened. However, there is still a lack of understanding about how neighbourhoods affect the mental health of children and young people, and the effects tend to be small. In particular the issue of selection effects, i.e. why certain groups of people live in certain neighbourhoods has not been resolved, and it is not clear exactly what it is about neighbourhoods that affects mental health outcomes. Attempts to conceptualize neighbourhood effects differentiate between the material aspects of neighbourhood, which refer to socio-demographic features such as poverty, unemployment, drug use or ethnic mix; social aspects, in particular social capital and social fragmentation, i.e. the lack of social networks; and stressful

events, such as area violence, crime, shootings, property damage, drug dealing and police harassment (Curtis et al., 2013; Hagell, 2012).

5. *Expanding access to care.* Unlike in the USA, in most European countries, including the UK, public health insurance is universal and it is free at the time of use. Nonetheless, in the UK there are similar disparities in the access and use of mental health services, especially by ethnic minority groups, and the strategies discussed to tackle mental health problems are similar (Hatch & Thornicroft, 2012). There is a need for improvements in services for ethnic minority groups, including access to talking therapies and better recording of ethnicity. Moreover, response can vary for different aspects of the treatment, as reported in a study by (Boydell et al., 2012) who found that black patients were less satisfied with treatment involving medication, but were equally satisfied with nursing and social care. Innovative interventions have been developed that adopt localized community approaches, recognizing the heterogeneity within ethnic groups, aiming for a needs-led package of care and ethnically matched therapists (Hatch & Thornicroft, 2012). Yet more research is needed about how to reach and address the needs of different ethnic minority groups in a multiethnic environment, and how to provide an integrated service delivery. A young person has to be viewed from various perspectives, including psychological and physiological wellbeing, interpersonal relations, life situation, future plans, etc. It is necessary to support the young person comprehensively, instead of focusing on a single symptom or problem behaviour.

In addition I would suggest that we need to pay increased attention to the definition and the assessment of mental health. The studies reviewed by Bor et al. (2014) comprised different instruments to assess and measure mental health, which might partly explain variations in findings. Moreover, there have been changes in the conceptualisation of depression and mental disorder, which now take little account of whether symptoms reflect normal reactions to external stressors, and every day emotions such as sadness have become ‘medicalised’ (Horwitz & Wakefield, 2007).

References

Bartley, M. (2004). *Health inequality. An introduction to theories, concepts, and methods.* Cambridge: Polity Press.

- Bor, W., Dean, A. J., Najman, J., & Hayatbakhsh, R. (2014). Are child and adolescent mental health problems increasing in the 21st century? A systematic review. *Australian and New Zealand Journal of Psychiatry*, *48*(7), 606-616. doi: 10.1177/0004867414533834
- Boydell, J., Morgan, C., Dutta, R., Jones, B., Alemseged, F., Dazzan, P., . . . Fearon, P. (2012). Satisfaction with inpatient treatment for first-episode psychosis among different ethnic groups: A report from the UK SOP study. *International Journal of Social Psychiatry*, *58*(1), 98-105. doi: 10.1177/0020764010382691
- Braveman, P. (2012). Health inequalities by class and race in the US: What can we learn from the patterns? *Social Science & Medicine*, *74*(5), 665-667. doi: 10.1016/j.socscimed.2011.12.009
- Collishaw, S., Gardner, F., Maughan, B., Scott, J., & Pickles, A. (2012). Do Historical Changes in Parent-Child Relationships Explain Increases in Youth Conduct Problems? *Journal of Abnormal Child Psychology*, *40*(1), 119-132. doi: 10.1007/s10802-011-9543-1
- Collishaw, S., Maughan, B., Goodman, R., & Pickles, A. (2004). Time trends in adolescent mental health. *Journal of Child Psychology and Psychiatry*, *45*, 1350-1362.
- Collishaw, S., Maughan, B., Natarajan, L., & Pickles, A. (2010). Trends in adolescent emotional problems in England: a comparison of two national cohorts twenty years apart. *Journal of Child Psychology and Psychiatry*, *51*(8), 885-894. doi: 10.1111/j.1469-7610.2010.02252.x
- Curtis, S., Pain, R., Fuller, S., Khatib, Y., Rethon, C., Stansfeld, S. A., & Daya, S. (2013). Neighbourhood risk factors for Common Mental Disorders among young people aged 10-20 years: A structured review of quantitative research. *Health & Place*, *20*, 81-90. doi: 10.1016/j.healthplace.2012.10.010
- Davey Smith, G. (2000). Learning to live with complexity: ethnicity, socioeconomic position, and health in Britain and the US. *American Journal of Public Health*, *90*, 1694-1698.
- Elgar, F. J., Pfortner, T.-K., Moor, I., De Clercq, B., Gonneke, W., & Currie, C. (2015). Socioeconomic inequalities in adolescent health 2002-2010: a time-series analysis of 34 countries participating in the Health Behaviour in School-aged Children Study. *The Lancet*, online February 4. doi: 10.1016/S0140-6736(14)61460-4
- Fagg, J., Curtis, S., Stansfeld, S. A., Cattell, V., Tupuola, A. M., & Arephin, M. (2008). Area social fragmentation, social support for individuals and psychosocial health in young adults: Evidence from a national survey in England. *Social Science & Medicine*, *66*(2), 242-254. doi: 10.1016/j.socscimed.2007.07.032
- Gardner, F., Collishaw, S., Maughan, B., Scott, J., Schepman, K., & Hagell, A. (2012). Trends in parenting: can they help explain time trends in problem behaviour? *Changing Adolescence: Social Trends and Mental Health*, 75-91.
- Hagell, A. (Ed.). (2012). *Changing adolescence. Social trends and mental health*. Bristol: Policy Press.
- Hatch, S. L., & Thornicroft, G. (2012). Report From England I Innovative Approaches to Reducing Mental Health Disparities Related to Ethnicity. *Journal of Nervous and Mental Disease*, *200*(10), 843-846. doi: 10.1097/NMD.0b013e31826b6d34
- Horwitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. Oxford: Oxford University Press.
- Langton, E. G., Collishaw, S., Goodman, R., Pickles, A., & Maughan, B. (2011). An emerging income differential for adolescent emotional problems. *Journal of Child Psychology and Psychiatry*, *52*(10), 1081-1088. doi: 10.1111/j.1469-7610.2011.02447.x

- Rutter, M. (2006). Implications of Resilience Concepts for Scientific Understanding. *Annals of the New York Academy of Science*, 1094(1), 1-12. doi: 10.1196/annals.1376.002
- Schoon, I. (2006). *Risk and Resilience: Adaptations in Changing Times* Cambridge: Cambridge University Press.
- Schoon, I., & Bartley, M. (2008). The role of human capability and resilience. *Psychologist*, 21(1), 24-27.
- Schoon, I., Sacker, A., & Bartley, M. (2003). Socio-economic adversity and psychosocial adjustment: a developmental-contextual perspective. *Social Science & Medicine*, 57(6), 1001-1015. doi: Pii s0277-9536(02)00475-610.1016/s0277-9536(02)00475-6
- Tick, N. T., van der Ende, J., & Verhulst, F. C. (2007). Twenty-year trends in emotional and behavioral problems in Dutch children in a changing society. *Acta Psychiatrica Scandinavica*, 116(6), 473-482. doi: 10.1111/j.1600-0447.2007.01068.x
- WHO. (2010). Social determinants of health and wellbeing among young people *Health behaviour in school-aged children (HBSC) Study*: World Health Organisation. http://www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf.
- Wilkinson, R., & Pickett, K. (2009). *The Spirit Level: Why More Equal Societies Almost Always Do Better* Allen Lane.
- Williams, D. R. (1997). Race and health: Basic questions, emerging directions. *Annals of Epidemiology*, 7(5), 322-333. doi: 10.1016/s1047-2797(97)00051-3