

# Mental health and poverty in the UK – time for change?

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**Poverty and income inequality have increased in the UK since the 1970s. Poverty and mental ill-health are closely associated and disadvantage can have long-term consequences. In addition, the recent recession and austerity measures have had a detrimental effect on people with mental health problems and the mental health of the population. Mental health services can play a role in addressing the problems of poverty and inequality.**

Poverty affects people worldwide and is seen at its worst in low-income countries. However, in the UK, despite a developed welfare state and the huge improvements seen in the 20th century in the quality of life for its citizens, today around 21% of the population – 13 million people, of whom 3.7 million are children – live in poverty (MacInnes *et al.*, 2014a). This may not be the absolute poverty of the 19th century still prevalent in many parts of the world, but it is real and pernicious. Poverty, though, is not inevitable. Poverty in the UK means living on a household budget below 60% of the median national income, with insufficient resources to meet minimum needs.

In the UK, the number of people living in poverty increased from 7 million to 13.8 million between 1979 and 1998 and, despite some annual variations, has remained roughly at this level since (MacInnes *et al.*, 2014a). About 8% of people experience persistent poverty (poor in 3 or more years of a 4-year period), and being poor in the past increases the chances of being poor in the future (Hills, 2014). Both pensioner poverty and child poverty have fallen in the past 15 years, but not sufficiently to meet the targets set by successive governments (MacInnes *et al.*, 2014a). Moreover, during the same period, the income gap between rich and poor has widened, making the UK one of the most income-unequal nations (Wilkinson & Pickett, 2009). High income inequality is associated with high levels of mental health problems, mortality, drug misuse, child ill-health, teenage pregnancy, homicide and imprisonment (Wilkinson & Pickett, 2009).

The recession that began in 2008 changed the context in which poverty persists. The UK has not seen the high levels of unemployment seen in previous recessions, but wages have stagnated, resulting in earnings falling relative to prices. Having a job is no longer a route out of poverty; 40% of all people in poverty are in paid employment (MacInnes *et al.*, 2014a). Jobs are often insecure, more people are underemployed, 4.8 million people earn less than the living wage, housing costs have

risen, debt has increased, and pay-day lenders and food banks have proliferated (MacInnes *et al.*, 2014a). The austerity measures taken by many European governments, including the UK government, are known to have had a detrimental effect on the physical and mental health of populations (Wahlbeck & McDaid, 2012). In the UK, people in poverty bear 39% of all cuts to welfare and local government spending (Duffy, 2013). Austerity measures and their effects are likely to persist.

## Poverty and mental health

There is a clear association between poverty and mental health. Low-income groups have higher rates of mental health conditions, particularly severe and enduring problems, than high-income groups (Boardman *et al.*, 2010). For children, these differences are particularly pronounced, with a threefold difference in prevalence of any mental disorder between rich and poor households (Green *et al.*, 2005). Adults in contact with mental health services are likely to be on welfare benefits and may not receive their full benefit entitlement. Children living in households where an adult is in receipt of benefit payments are 2.5 times more likely to have a mental health problem than the average child (Meltzer *et al.*, 2000).

People with mental health problems are at increased risk of economic hardship. They are likely: to be in debt; to live in poor neighbourhoods with high rates of crime, environmental neglect and poor transport; to live in social housing or poor-quality housing; to be unemployed; to have limited education or training; to have small social networks; to be in poor physical health; and to have less access to essential services (Boardman *et al.*, 2010). People with first ever mental health service contact for schizophrenia are between 2.7 and 3.5 times more likely to experience multiple features of disadvantage than the general population. These disadvantages are risk factors for the whole range of mental health problems, including intellectual disabilities, substance misuse and suicide.

Some groups are at particular risk of both poverty and mental health problems: migrants, asylum seekers, refugees, the homeless, looked-after children and those with disabilities. People with long-term mental health problems, intellectual disabilities and those with complex needs, in common with people with other chronic health conditions, face additional costs as a consequence, which further strains their low incomes. It is likely that poverty among these groups is underestimated (MacInnes *et al.*, 2014b) and many have faced higher living costs in recent years.

## Why does poverty matter?

Poverty is bad for people's health, wastes human resources and potential, is economically costly and represents a failure of the welfare state. Mental health problems are both the cause and the consequence of poverty. Living under the constraints of poverty has short- and long-term sequelae (Hills *et al*, 2009). For example, being brought up in poverty affects children through its association with deficits in cognitive, emotional, social and physical development, the consequences of which may be lifelong. Poverty has inter-generational as well as intra-generational effects: early life experiences such as family disruption, educational disadvantage and poverty contribute to poor health and social outcomes, which then contribute to further disadvantage in the future. Children born into poor families have worse life outcomes than those born into better-off households.

Poverty implies a lack of material resources, which reduces the likelihood of living a valued and healthy life. But also detrimental is the stigmatising impact of poverty, which in turn reinforces prejudice, discrimination and humiliation, leading to those experiencing poverty being further undermined and shamed. The loss of dignity and pride further damages health and well-being.

Importantly, poverty is dynamic: people move into and out of it (Hills, 2014). At some points in the development and course of mental health problems, people may be particularly vulnerable to experiencing loss of income, job, home, family and support. These risks can be mitigated by timely interventions and paying due attention to financial, employment and other social interventions. However, people are also vulnerable to changes in social and welfare policies.

## A way forward?

While there is no easy single solution to poverty, the UK lacks a coherent anti-poverty strategy. At the policy level, the solutions are dependent on a coordinated response from central government and an effective anti-poverty strategy linked to economic policy, which requires political commitment, clear lines of accountability, dedicated institutions and systems of governance, coordination across government, external stakeholder involvement, and monitoring and review (MacInnes *et al*, 2014c). Current priorities include reducing conditionality, the provision of a 'living wage' and a focus on the costs of living, including housing costs and child care (MacInnes *et al*, 2014a). Policies need to focus on the life span and the effects on families.

We need to rethink our current austerity initiatives and focus on the need to increase investment in key areas of public spending. People in poverty are highly dependent on education, housing, health and social services. Wahlbeck & McDaid (2012) suggest that the recession may offer an opportunity to strengthen policies that support mental health. Policy decisions that harm population mental health and well-being may hamper a return to a healthy economy.

Poverty is a collective responsibility and requires a collective response in which employers, landlords, local authorities and service providers all have a role (MacInnes *et al*, 2014a). Is there a role for mental health services and the National Health Service in tackling poverty? We must first acknowledge that poverty is a health issue. The association between mental health and poverty must become a key priority for research. We need to be aware of: the pathways into and out of poverty; the impact of poverty on service users and their experiences; the associated forms of exclusion; and the barriers to life chances. Mental health workers need to act as advocates for the users of services. Within mental health services there needs to be a greater focus on ways to try to ensure socially inclusive outcomes, harnessing people's lived experience and utilising interventions that have economic payoffs through direct savings to the public sector, employers and wider society (Boardman *et al*, 2010; Knapp, 2012). These interventions include early intervention services, supported employment schemes, supported housing schemes, welfare benefit advice, peer support workers, and parenting programmes for children with conduct disorder.

Poverty and income inequality affect us all. There is not only a moral case but also a compelling business case to be made for eradicating poverty and creating a more just society. This raises fundamental questions about how we value human life and the kind of society that we wish to live in. The question is whether there is a political will for change and whether, as mental health professionals, we are willing to challenge those actions and policies that compound disadvantage.

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Further references are available on request from the authors.