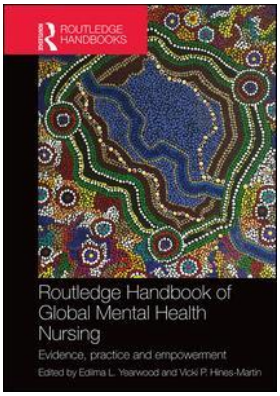

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Social Determinants Of Mental Health

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SOCIAL DETERMINANTS OF MENTAL HEALTH

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Introduction

Social determinants of health (SDH) are, circumstances in which people are born, grow, live, work, and age, and the absence or presence of systems available to deal with overall health and illness of its citizenry (WHO, 2008). Structural drivers are the circumstances that affect distribution of power; income; ability to obtain goods and services; ability to access health care and the ability to attend school to earn an education, with the knowledge that doing so has the potential to propel individuals out of low socio-economic status (WHO, 2008). Economics, politics and social policies are key drivers of environmental conditions that either support or impede healthy or unhealthy living conditions. Health and mental health are determined by multiple factors including individual characteristics, genetics, and the effects of SDH factors. SDH are increasingly recognized as modifiable and complex social factors that must be examined when looking at both protective factors and barriers to mental health and well-being. Cumulative exposure to negative SDH factors is known to take its toll on individuals and groups primarily in low- and middle-income communities.

As health and mental health are linked, the focus of this chapter will be on exploring how SDH affects mental health in low-resource communities, describing why awareness of exposure to SDH factors should be incorporated in routine assessment of individuals and families with mental, neurological and substance use vulnerabilities, describing how SDH is linked to SDMH and examining the evidence related to global mental health research incorporating elements of SDH.

Elements of SDMH

Social determinants of health are conditions and circumstances that are dynamic and complex. Prolonged and cumulative exposure to poor or negative SDH factors place individuals at risk for physical and mental ill health. The conceptual framework illustrating the SDMH developed by Lund, Stansfeld, and De Silva (2014) is found in Figure 4.1 and provides a clear illustration of this concept. The researchers identified six categories in both distal and proximal factors that comprise SDMH.

Distal or macro level categories include:

1 *built environments* (adequate and safe housing, recreational structures/facilities, transportation, access to affordable and healthy foods);
2 *community economic status* (such as deprivation/inequality, jobs);
3 *community social capital* (access to social relationships and memberships in groups, health care services, human and other resources, culture, language/interpreter services);
4 *community stability*, diversity and density;
5 *Biological characteristics*; and
6 *Environmental conditions* such as natural disasters, presence of toxic or hazardous conditions, climate change, migration (acculturation challenges), and exposure to prolonged war or conflicts.

Proximal or micro factors include:

1 household/family structure;
2 employment, under-employment or unemployment status;
3 access to education and early childhood enrichment opportunities;
4 access to social capital and social support;
5 being a victim of stigma;
6 gender, ethnicity, race and age including experience of bias and discrimination;
7 genetics and physical health status; and
8 trauma exposure/victimization.

(Marmot & Allen, 2014; Swartz, Kilian, Twesigye, Attah, & Chiliza, 2014; WHO, 2008)

It has long been recognized that mental health is supported by healthy relationships, social inclusion and the absence of stigma victimization. Mental health recovery models embrace social integration and opportunities for those with either vulnerabilities or disabilities to lead a normalized existence within their own communities. Grand Challenges in Global Mental Health identified the second most complex challenge in low-, middle-, and high-income countries as being the development of culturally informed methods to eliminate stigma, discrimination, and social exclusion across multiple settings (Collins *et al.*, 2011). Characteristics of social integration include personal capacity and social opportunity to: (a) engage in relationships and dialogue with familiar and unfamiliar community members; (b) participate in activities; and, (c) have a voice in civic and other community building actions (Baumgartner & Susser, 2013). For example, researchers in India strongly urge attention to economic and political forces within poorly resourced countries to better understand globalized mental health and well-being and further state that it is only through redistribution of resources that impactful changes in prevention and mental health promotion will occur (Das & Rao, 2012).

The Convention on the Rights of Persons with Disabilities was convened by the United Nations and in 2006 developed a position statement to "promote, protect and ensure" human rights and freedom of individuals with disabilities. Individuals with mental ill health are recognized as having a disability and therefore have fundamental rights to access social inclusion, social integration and civic engagement opportunities (Baumgartner & Susser, 2013).

Brazil is recognized as one of the countries with a more developed, sensitive, and progressive social policy history. In 2002 Brazil developed the National Policy of Health for People with Disabilities, which provides guidelines of care for individuals with disabilities. Fiorati and Elui (2015) conducted a small study looking at social inclusion of individuals with disabilities in Ribeirao Preto, SP, Brazil between 2011 and 2012. Disabilities included stroke, cerebral palsy,

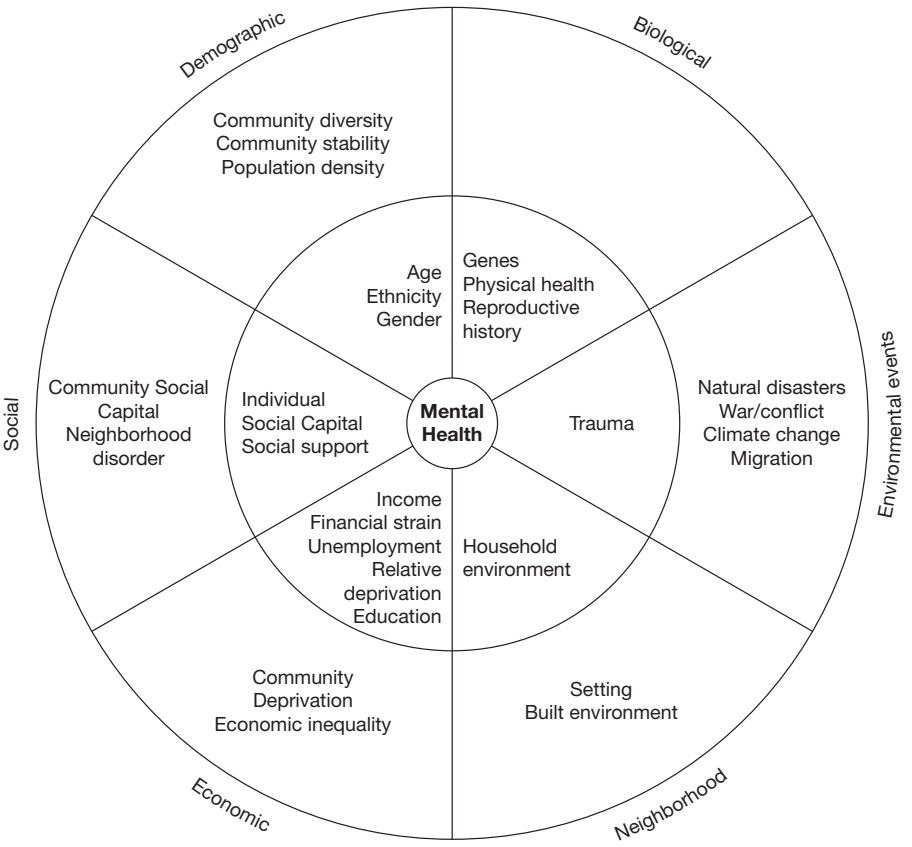

Figure 4.1 Social determinants of mental health: a conceptual framework

Source: From *Global Mental Health – Principles and Practice* edited by Patel, Minas, Cohen, and Martin (2014) Fig. 7.1 p. 119. By permission of Oxford University Press.

traumatic brain disease and cognitive deficits secondary to childhood meningitis. There was no indication from the sample that any of the participants had a mental or substance use disorder. Analysis of the 10 individuals included in the study determined that participants had challenges centered on accessing health care services, that there was a lack of specific health care services to meet their unique needs, and that there was poor coordination across services. The researchers concluded that inclusion is linked to SDH, specifically social equality, ability to access care, and opportunities for participation in social integration activities.

Actions targeting SDMH can promote awareness, advocacy, change, and ideally should result in responsive social policy development and enforcement. The ultimate goal of these actions is social justice and equity in order to intentionally support mental health and well-being (Embrett & Randall, 2014; Friel & Marmot, 2011). Health equity can be fostered when disparities in health between advantaged and less advantaged individuals are minimized or eliminated.

Knowledge of SDMH is critical for all health care workers (professional and non-specialist) because it provides a realistic context of additional factors (in addition to their psychological symptoms) that individuals who are struggling with mental, neurological, and substance use

disorders are navigating. It may explain issues of recidivism, non-adherence, mistrust, lack of social scaffolds, and poor mental health literacy in this population. Awareness of these vulnerabilities can inform interventions that can be individually tailored to reflect consumer-specific realities.

Research needs

Given the complexity of factors associated with SDMH, research conducted in this area has not received adequate financial support and has not been conducted in the most applicable environments such as low- and middle-income countries. Most data obtained to date have been conducted in high-income countries and cannot be generalized to low resource environments and diverse cultures. Researchers have recommended that research on SDMH be longitudinal, descriptive, focus on the impact of social policies impacting mental health and assess effectiveness of non-specialist health workers in delivering interventions for mental, neurological and substance use disorders (Braveman, Egerter, & Williams, 2011; Patel, 2012). Given the significant influence of culture on community environments in low- and middle-income countries, community-based participatory research (CBPR) is a recommended research methodology and would be congruent with tenets of social justice, respect and inclusion when working with vulnerable individuals and populations. While it is acknowledged that the highest standard of research is randomized clinical trials that are deemed rigorous evidence of intervention effectiveness, poorly resourced environments require research methods that answer relevant clinical questions and incorporate realistic consumer experiences, which can be complex and multi-faceted.

Few robust tools exist to measure social integration in low- and middle-income countries, and this offers another potential area for conducting inquiry. A useful tool must provide data on communication, interactions with people known and not known within communities, participation in one's community and a perceived sense of belonging and connectedness. The DSM-5 does include the World Health Organization Disability Assessment Schedule WHODAS-2.0, which offers a potentially useful tool to obtain some elements of social integration (2013).

SDH and SDMH influence individuals across the life span. The negative impact can be cumulative and result in disparities in health, health decision-making and health outcomes. Central to understanding how SDH influence these outcomes is recognizing that all of the SDH are affected by the *social position* (associated with amount of resources/supports, level of education, degree of political influence/power, etc.) of individuals and communities. The WHO in their publication *Social Determinants of Mental Health* (2014) report using the growing body of international literature to clearly identify that the more compromised the social position experienced by individuals and populations, the higher the risk for health disparities and negative health outcomes especially poor mental health. Some population subgroups (e.g. refugees/immigrants/minority ethnic/racial and sexual orientation populations, etc.) experience a higher risk of mental health challenges because of greater exposure and vulnerability to detrimental social and ecological circumstances. This higher risk is further exacerbated for women regardless of the setting (WHO & Calouste Gulbenkian Foundation, 2014).

Mental health and many common mental disorders are influenced by socioeconomic and contextual factors that are encountered beginning before birth and progressing into early and older childhood, adolescence, during family building and working years, and into aging. The greater the inequality in those socioeconomic and contextual factors throughout the life span, the higher the inequality in risk for the development of mental and physical health conditions (Fisher & Baum, 2010; Paananen, Ristikar, Merikukka, & Gissler, 2013; Victorino & Gauthier, 2009; WHO, 2013).

Because SDH affect individuals and communities across the life span, the WHO and most nations that strive to improve the health of their citizens have identified *health equity* as their guiding principle. Health equity is "defined as the absence of unfair and avoidable or remediable differences in health among social groups . . . In essence, health inequities are health differences that are socially produced, systematic in their distribution across the population, and unfair" (Solar & Irwin, 2010, p. 14). The realization of the human right to health implies the empowerment of deprived communities to exercise the greatest possible control over the factors that determine their health (Solar & Irwin, 2010).

Because SDH affect can be chronic stressors across an entire lifetime, early childhood risk factors are critical to recognize and rectify if at all possible. For example, significant stressors or depression experienced by the mother in sensitive development periods prior to a child's birth affect the development of the child in terms of a greater risk of being underweight and underdeveloped, with low birth weight itself being identified as an increased risk factor for depression in later life (Forsyth *et al.*, 2013; Nugent, Tyrka, Carptenter, & Price, 2011).In utero, exposure to the mother's stress affects development of the child's biological stress regulatory systems through which stress responses are controlled. This prenatal effect places the child at higher risk for dysregulation of the stress response after birth (DiPietro, 2004; Uher, 2014).

Although children may have disadvantages based on prenatal exposure, the effects this exposure has on the child can be cushioned to some degree by social support from a caring individual and a stable environment, which is essential for healthy social and emotional growth. Secure attachment to a constant care provider in the early years is essential for the child as a mediator against mental health concerns and to support healthy coping with stressors (Russell, Ford, Tamsin, Rosenberg, & Kelly, 2014).

Persistent exposure to stressors over time as the child grows results in stress response changes that have physiological effects on multiple body systems including the brain, and affect physical functioning in ways that are damaging to health (Chetty, *et al.*, 2014). This accumulation of exposure to stress results in inequitable mental and physical health outcomes.

The impact of the mother on the emotional and mental development of the child cannot be overstated.

The WHO (2014) reports that

> [a] systematic review of studies in low- and middle-income countries estimated prevalence of common perinatal mental disorders among women to be 16 percent before birth and 20 percent postnatally. Risk factors for common perinatal disorders include socioeconomic disadvantage; unintended pregnancy; being younger; being unmarried; lacking intimate partner empathy and support; having hostile in-laws; experiencing intimate partner violence; having insufficient emotional and practical support; in some settings, giving birth to a female, and having a history of mental health problems. Protective factors include having more education, having a permanent job, being a member of the ethnic majority and having a kind, trustworthy intimate partner. A large body of research has emphasized the importance of maternal education and emotional wellbeing for a wide range of outcomes for children, with lower maternal education and depression relating to increased infant mortality, physical problems (such as low birth weight and malnutrition, overweight children, and infections) and cognitive and emotional problems (such as lower scores on vocabulary tests, conduct problems, behavioral problems, lower cognitive scores, and mental health problems).
>
> *(WHO and Calouste, 2014, p. 19)*

The critical nature of the mother–child interaction in early childhood was further emphasized by the UCL Institute of Health Equity, which reported that

> lack of secure attachment, neglect, lack of quality stimulation, and conflict, negatively impact on future social behaviour, educational outcomes, employment status and mental and physical health. Children's exposure to neglect, direct physical and psychological abuse, and growing up in families with domestic violence was particularly damaging.
> *(Bell, Donkin, & Marmot, 2013, p. 24)*

For the older child and adolescent, education is also crucial in fostering emotional resilience and affecting future outcomes as adults that are associated with greater risks for mental health conditions such as jobs, income, and social engagement. Schools are also important as institutions for engagement of youth and for mental health promotion during critical periods of development. The literature on older children and adolescents also identifies that those who are from poorer backgrounds are more likely to have greater exposure to and experience within poor environments and stressful family contexts (Bell *et al.*, 2013). Poverty has a direct impact on learning as it can lead to poor/inadequate housing with no place to do homework or study. Without needed resources to learn, adequate nutrition and non-stressful family dynamics in which a child can focus on the learning process, their risk of failure is high, and likelihood of success is low. Parents who are employed not only diminish the likelihood of poverty, but also improve family dynamics, and provide a role model for children to emulate. Schools may also engage parents and collaborate to develop needed support and guidance on parenting strategies through the child and adolescent years (Huang, Cheng & Theise, 2013).

As individuals become adolescents, and begin the journey toward independence, they may engage in behaviors that are physically and emotionally risky (Victorino & Gauthier, 2009). During this stage of development the critical task for parents is to ensure that adolescents have important information to make informed decisions, and that they have protective factors including social and emotional support, and positive interactions with peers, family, and the community at large. Depressive symptoms among adolescents are associated with their history of adverse childhood experiences as well as their current experiences such as individual, community, and armed conflict; bullying, physical and sexual trauma; social isolation/upheaval; adolescent marriage and childbearing; and chemical misuse/abuse among others (Bell *et al.*, 2013). The potential layering of negative life experiences significantly erodes the foundation for adaptive coping during adult years. Further discussion of factors related to child and adolescent mental health can be found in Chapter 18.

During adulthood, mental health and well-being is significantly associated with the ability to acquire resources (adequate food, safe housing, reliable transportation, etc.) for self and family along with a sense of security and control over one's work life. Employment with low compensation, low levels of control over the work environment by workers, and job insecurity and unemployment have a significant harmful impact on mental health, resulting in stress, anxiety, and depression (Cayuela, Malmusi, Lopez-Jacob, Gotsens & Rondo, 2015, Sousa *et al.*, 2010). In contrast, employment, job security and a perception of control at work are protective of mental well-being increasing self-esteem, job satisfaction and productivity. Most importantly, employment should be adequate for, and conducive to, the development of a healthy family unit to combat the risks inherent in impoverished and unstable living, which has been demonstrated to be strongly associated with poor mental health for all members of a family unit (Bell *et al.*, 2013; WHO & Calouste Gulbenkian Foundation, 2014). Family structure and parenting style influence children's mental health and future outcomes across the life span. Adult

mental health can be greatly influenced by the stressors encountered during adulthood especially when inequality is experienced in relation to barriers that affect the roles and tasks that are expectations as part of adulthood and family development (Liang *et al.*, 2012).

As adults age, they continue to bring with them all prior life experiences, both positive and negative. This cumulative life experience can function as a barrier to, or buffer for, satisfactory aging. The body of literature regarding mental health and aging has grown over the last 10 years, especially as it relates to factors that impact the mental health of this population worldwide (WHO, 2013). The available evidence that exists identifies inequalities in mental health related to gender, educational attainment, ethnicity/race, socioeconomic level, and physical health status. Women experience more negative mental health outcomes when experiencing social isolation and lack of interpersonal supports, and men are more vulnerable to negative outcomes based upon physical health. Extant research reports poorer outcomes for women than men across a range of mental health conditions (Kwan & mHealth Alliance, 2013; WHO & Calouste Gulbenkian Foundation, 2014). Life events that can trigger depression and are likely to be experienced in older age include loss and grief, poor physical health, loss of connection with family and friends, perceived loss of social position and identity, living alone, and lack of ability to be active in their physical environment (due to safety issues or health).

As stated throughout this book, mental health and physical health are interactive processes. For example, adults with physical health conditions such as heart disease and diabetes have higher rates of depression than those who are medically well. Also, untreated depression in a person with a chronic physical condition can have a negative effect on their physical condition and outcome (Alaba & Chola, 2013). These experiences are magnified in aging and can result in isolation, loss of independence, loneliness, poor self-concept, and psychological distress. Changes occurring during this period of life are further exacerbated by forces, which include personal, financial, access to resources, and presence or absence of applicable national policies (WHO & Calouste Gulbenkian Foundation, 2014). Some changes are occurring globally in this population, which are addressing the SDH and are known to impede improved mental health outcomes. These are more thoroughly discussed in Chapter 17.

Conclusion

The field of mental health is becoming increasingly aware that well-being and mental health are supported by multiple factors, and are not just driven by the individual's biology, genetic pool, or home environment. Individuals live in families, each family has its own unique characteristics and is situated in a community. In turn, communities have multiple characteristics, each of which can be eroded or supported by government actions, resources, collective actions of community members and the relationship between individual communities and their government and governing bodies. These systems are open and dynamic, and interrelate in both overt and covert ways. What is now known is that all of these proximal and distal factors can have an effect on the life experience of individuals and this in turn impacts their well-being. SDH and mental health are intertwined. In order to arrive at effective interventions across low, middle-, and high-income environments, mental health providers have to first assess and gain knowledge of the multiple factors that contribute to mental ill health. Our most useful action as health care providers in resource-poor environments may be directed at policy, advocacy, anti-stigma campaigns, and mental health literacy; all actions that target distal system factors that serve as barriers to positive mental health. All mental health providers must broaden their understanding of the drivers of poor mental health beyond the individual consumer and his or her family/immediate community.

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