

## Inequalities in mental health

### If you only read four things:

1. Suffolk's Joint Health and Wellbeing Board has made reducing health inequalities a fundamental principle underpinning the Joint Health and Wellbeing Strategy priorities for 2019-22.
2. Suffolk's emergency admission rate for self-harm is much higher for girls and women than men and boys.
3. Over a third of trans people are reported to have attempted suicide at some point in their lives (national data).
4. Most minority (non-White) ethnic groups have lower levels of reported 'wellbeing' (national data).

## 1 Introduction

Health inequalities are unfair, unacceptable and avoidable differences in the health of people or groups of people<sup>1</sup>.

Many inequalities are rooted in poverty and deprivation. Social mobility is low in some parts of Suffolk, meaning that it can be much harder to overcome a disadvantaged start in life and fulfil your potential in some areas of Suffolk compared to other areas of the country.

Prevention activities targeted at our more deprived communities (such as people who find it most difficult to gain employment, those living with disabilities, people with long term mental or physical health conditions) have the potential to reduce health inequalities<sup>1</sup>.

In 2010 the Equality Act created a legal framework to protect the rights of individuals and promote equality of opportunity to enable a fair, more equal society in England. The Act created protected characteristics, making it against the law to discriminate against someone because of:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

In Suffolk, we also consider the impact of rurality as a potential driver of inequalities, as parts of Suffolk are very rural and remote.

## 2 Sex

Sex is described by World Health Organisation as ‘characteristics that are biologically defined, whereas gender is based on socially constructed features’. People are assigned to a sex (male or female) based on the physical characteristics they are born with<sup>2</sup>.

### 2.1 Sex: General differences

The suicide rate is higher in men than women in Suffolk and England: there were 15.2 deaths by suicide per 100,000 men in Suffolk in 2016-18, compared to 4.7 per 100,000 women<sup>3</sup>.

The prevalence of physical and mental health comorbidity is higher in women than in men<sup>4</sup>.

More women are affected by personality disorders than men, although the prevalence of different types of personality disorder varies between the sexes<sup>5</sup>.

Women aged 16-24 are more than twice as likely to self-harm than young men (19.7% compared to 7.9%)<sup>6</sup>.

Studies show that about 90% of those affected by eating disorders are female<sup>7</sup>. However, recent research suggests up to 25% of people with an eating disorder are male<sup>8</sup>, and that under-diagnosis of men<sup>9</sup> may be due to:

- a historical perception that eating disorders are a ‘female disorder’<sup>10</sup>
- bias in assessment tests<sup>11</sup>
- studies focusing on females<sup>12</sup>
- reliance on clinical data rather than community studies<sup>10</sup>
- eating disorders in men being hidden by excessive sports activity<sup>13</sup>
- men not coming forward through fear of being stigmatised<sup>10,14</sup>

### 2.2 Sex: Suffolk differences

83% of Suffolk emergency hospital admissions for intentional self-harm in 15-18-year olds (2013/14-2015/16) were female<sup>15</sup>.

Suffolk’s emergency admission rate for self-harm is statistically significantly higher for women than men: age-standardised emergency admission rate for self-harm in 2017/18 were 258.5 admissions per 100,000 for female residents compared to 143.5 per 100,000 for men<sup>3</sup>.

## 3 Gender identity and gender reassignment

Gender is usually self-identified and may not match the sex someone was assigned at birth. Gender is increasingly understood as not binary but on a spectrum<sup>2</sup>.

### 3.1 Gender identity: General differences

Life satisfaction is lower for transgender people in the UK<sup>16,17</sup>: the average score for life satisfaction for trans people was 5.40 compared to 7.66 for the general UK population<sup>16</sup> (where a high score is good).

Trans people have a high incidence of anxiety and depression<sup>18,19</sup>. A survey of trans people found 88% reported previous or current depression, 80% reported stress and 75% reported anxiety<sup>20,21</sup>.

Trans people are at high risk from self-harm<sup>20,22,23</sup>: an estimated half (53%) of trans people have self-harmed at some point<sup>21</sup>.

Transgender people have a greater risk of eating disorders with prevalence up to 16%, higher than cisgender people<sup>24</sup>. Some young people may use disordered eating to manage their body dissatisfaction: dieting can delay puberty and suppress development of sex characteristics such as breasts and menstruation<sup>25,26</sup>.

Trans people are more likely to attempt suicide than members of the general population<sup>20,27</sup>. Over a third of trans people are said to have attempted suicide at some point in their lives, compared with only 1.6% of the general population<sup>21,28-35</sup>. Suicide attempts appear to occur more frequently among transgender adolescents and young adults than among older age groups<sup>33</sup>. Suicide attempts are associated with higher rates of depression, anxiety and substance abuse<sup>29,33</sup>.

### 3.2 Gender identity: Suffolk differences

Trans people in Suffolk report poor mental wellbeing<sup>36</sup>, and experiencing discrimination by mental health services<sup>37</sup>. Local mental health services sometimes see gender identity as a symptom of mental illness, or assume mental ill health is caused by gender identity (and so refer people to a gender identity clinic not mainstream mental health services)<sup>20</sup>. General Medical Council (GMC) guidance recommends trans people experiencing mental ill health should be supported, including by referral to local mental health services<sup>38</sup>.

### 3.3 Gender identity: Risk factors for mental ill health

Isolation, discrimination and delays in accessing gender identity clinics are believed to contribute to poor mental health among people who identify as transgender<sup>20,21,39</sup>. Structural discrimination and stigma have been associated with an increased risk of suicide attempts among transgender adults<sup>39</sup>.

Prevalence of smoking, and of alcohol and drug misuse, may be higher for trans people than the general population<sup>20,21,23,40</sup>. Trans survey respondents have commented they misuse drugs and alcohol as a coping mechanism, particularly to deal with discrimination and with the waiting times to access gender identity clinics<sup>16</sup>.

Transgender people are at a higher risk of abuse or hate crime<sup>41</sup>. Hate crime has increased in recent years<sup>20</sup>. 41% of trans people and 31% of non-binary people have experienced a hate crime or incident because of their gender identity in the last 12 months<sup>42</sup>. There is a positive association between discrimination (experienced by over 40% of transgender respondents) and depression<sup>39</sup>. Suicidal thoughts and attempts may reduce post-transition.<sup>21</sup>

## 4 Sexuality

### 4.1 Sexuality: General differences

People who are lesbian, gay, bisexual (LGB) are at greater risk from self-harm than the population as a whole<sup>20,22</sup>.

Homosexual people are more likely to have an eating disorder than heterosexuals; gay and bisexual men may be at a higher risk<sup>24</sup>.

Members of the lesbian, gay and bisexual communities are reported to smoke and drink alcohol more heavily than the general population<sup>43-45</sup>.

### 4.2 Sexuality: Suffolk differences

In Suffolk there appear to be some inequalities in treatment by IAPT services (Suffolk Wellbeing), with smaller percentages of gay, lesbian and bi-sexual people moving to recovery (Figure 1).

Table 1: Sexual orientation: Referrals finishing a course of IAPT treatment in the year<sup>46</sup>

	Heterosexual		Gay/ Lesbian		Bi-sexual		Unknown / not sure / not stated	
	Count	% total	Count	% total	Count	% total	Count	% total
<b>England</b>	396,684	69.9%	10,715	1.9%	7,008	1.2%	567,106	26.9%
<b>Ipswich &amp; East Suffolk</b>	2,865	83.9%	70	2.0%	60	1.8%	3,415	12.3%
<b>West Suffolk</b>	1,900	85.4%	40	1.8%	25	1.1%	2,225	11.7%
<b>Gt Yarmouth &amp; Waveney</b>	1,410	55.2%	30	1.2%	20	0.8%	2,555	42.9%

Figure 1: Moved to recovery (%) by sexual orientation 2016/17<sup>46</sup>



### 4.3 Sexuality: Risk factors for mental ill health

Lesbian, gay and bi-sexual people appear to worry more about hate crime than other minority groups, and have higher expectations of harassment than heterosexual people.<sup>20</sup> This fear can create anxiety and worry, which can lead to poor mental health, stress, self-harm and suicide. Self-harm is linked to bullying at school, and to hate crime and fear of hate crime among adults<sup>20</sup>.

## 5 Age

### 5.1 Age: General differences

#### 5.1.1 Children and young people

Around half of lifelong mental health problems develop before the age of 14, with 75% developing before 25<sup>47</sup>. Only 25-40% of those children and young people will receive support from a mental health professional<sup>48</sup>.

Symptoms of eating disorders are beginning at a younger age<sup>7,49,50</sup>. The risk of developing an eating disorder is highest for young people aged 13 to 17<sup>8</sup>.

#### 5.1.2 Middle age

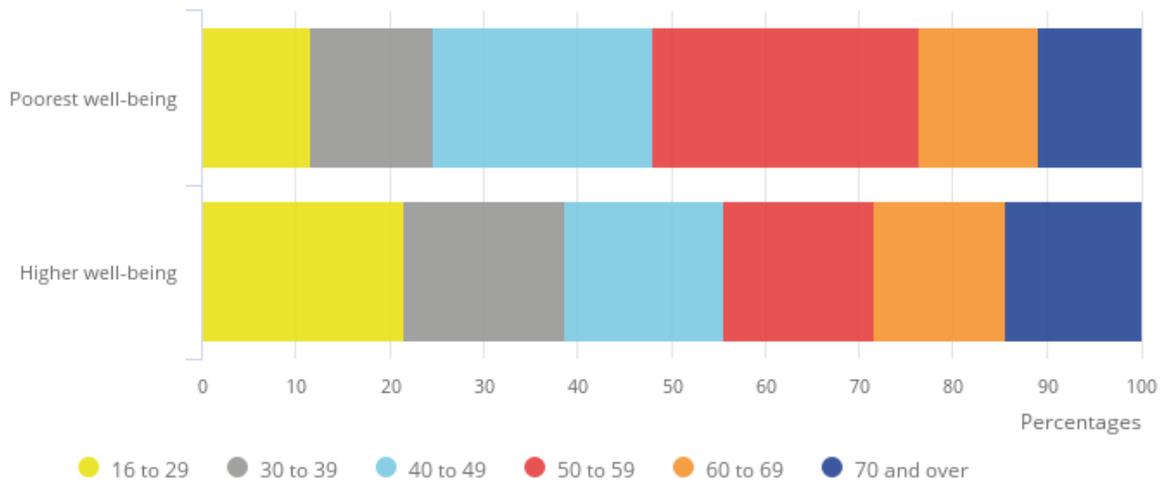
Personal wellbeing tends to be lowest among those in middle age: about half of those reporting the poorest personal wellbeing (51.7%) were aged 40 to 59 years. People aged 40 to 49 years and 50 to 59 years were 3.0 and 2.8 times more likely to report the poorest personal wellbeing when compared with people aged 70 and over<sup>51</sup>.

People under 60 who live on their own are at greater risk from self-harm.<sup>6</sup>

Maternal mental illness affects up to 20% of women, and can affect children’s emotional development<sup>52</sup>.

People of working age are at risk of unemployment and its impact on mental health (see the section below on the impact of deprivation and socio-economic factors on mental health).

Figure 2: Personal well-being by age, UK, 2014 to 2016<sup>51</sup>



### 5.1.3 Older people

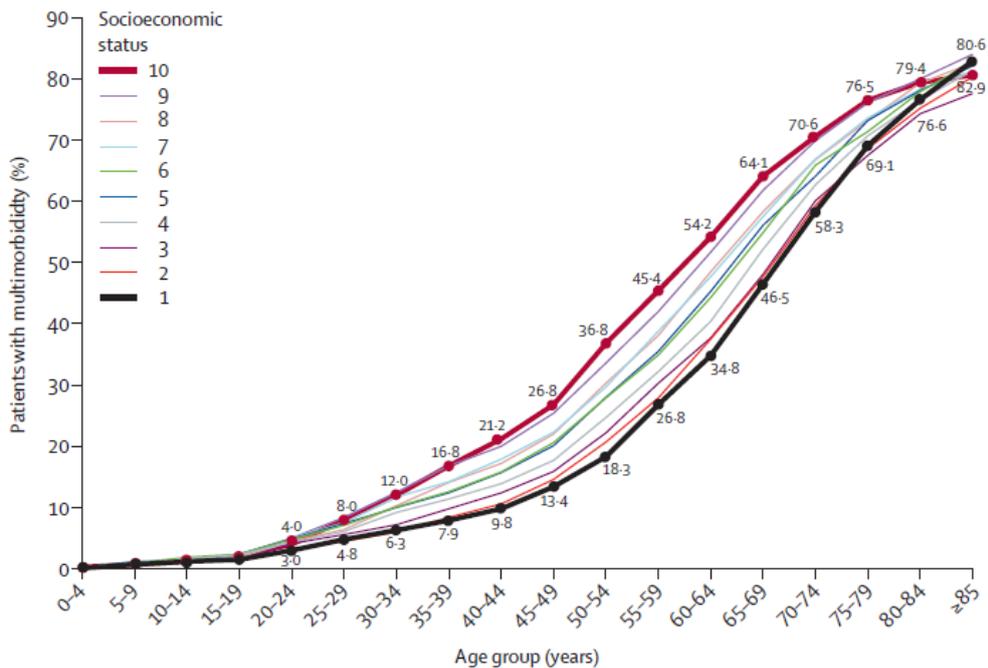
The prevalence of physical and mental health comorbidity (or multimorbidity) increases with age<sup>4</sup>. Suffolk has a higher (than England) percentage of residents aged over 65, and the number of older people living in the County is projected to increase over the next twenty years.

Age is the largest risk factor for dementia, although the condition is not an inevitable part of getting older<sup>53</sup>. England recorded prevalence is 4.33% of the population aged 65 and over, compared to 0.8% prevalence in all ages<sup>54</sup>.

The risk of depression increases with age and ill health, affecting around one in four people aged 65 or over (around 22% of men and 28% of women) however it is underdiagnosed: with an estimated **85%** of older people with depression receiving no NHS support<sup>55,56</sup>.

People over 65 years old who self-harm are much more likely to continue to self-harm, and to attempt suicide, than younger adults.<sup>57,58</sup>

Figure 3: Number of chronic disorders by age-group<sup>4</sup>



Note: Socioeconomic status scale: 1 = most affluent to 10 = most deprived

## 5.2 Age: Suffolk differences

### 5.2.1 Young people

Suffolk has a lower proportion of children and young people (age bands 0-4, 5-9, 10-14, 15-19) than England<sup>59</sup>.

In 2015, it was estimated that around 5,750 Suffolk children (aged 5-16) had conduct disorders. Conduct disorder is often expressed through behavioural difficulties, so children and their families may experience difficulty accessing services<sup>60</sup>.

The highest levels of self-harm in Suffolk are seen in Ipswich, and among women aged 16-24 years old<sup>15</sup>. 13% of Suffolk emergency hospital admissions for an accident or injury were due to intentional self-harm in 15-18-year olds<sup>61</sup>.

Young people who are overweight are more likely to develop eating disorders<sup>62</sup>. Suffolk prevalence of overweight (including obese) children in year 6 is better (lower) than England, and Public Health Suffolk’s key areas of focus include “reduce the current 17.6% of children aged 10-11 who are obese” (17.2% 2016/17 PHOF)<sup>63</sup>.

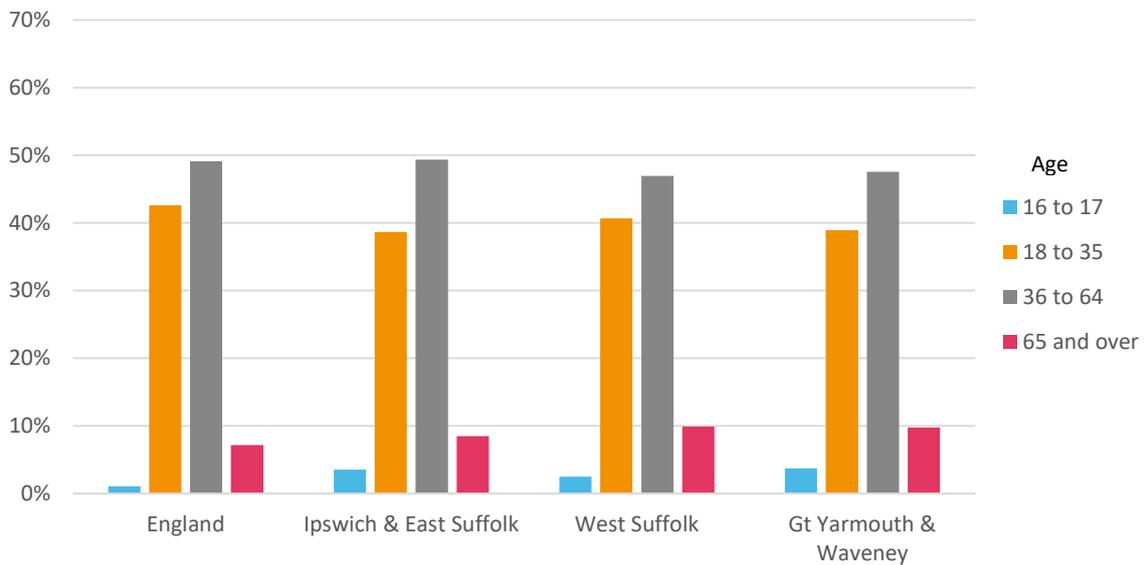
### 5.2.2 Older people

The proportion of older people in the County is increasing, from one in five people aged 65 or over in 2016 to one in three by 2041<sup>53</sup>.

The recorded prevalence of dementia (all ages) in Suffolk is higher than England (0.9% compared to 0.8%), but recorded prevalence in people aged 65 years and over is lower (7,521 people, 4.13% compared to 4.33%)<sup>54</sup>. It is estimated that around 13,000 people in Suffolk have dementia as not everyone living with the condition has been formally diagnosed<sup>53</sup>.

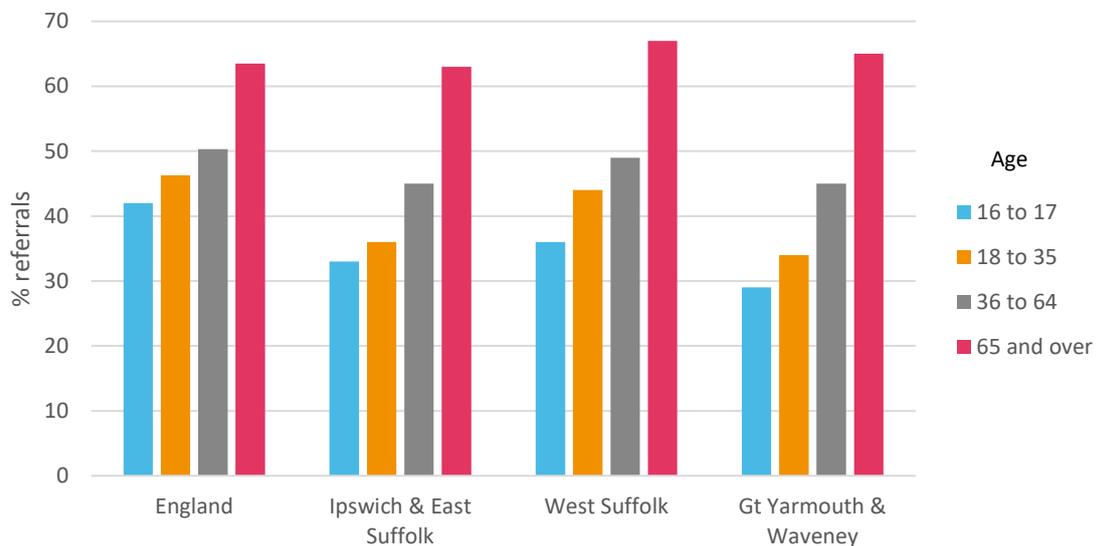
Although Improving Access to Psychological Therapies (IAPT) services are open to all adults, older people in Suffolk are underrepresented amongst those accessing services (Figure 4). Psychological therapies are as effective for older people as for those of working age<sup>64</sup> (Figure 5).

Figure 4: Referrals finishing a course of treatment in 2016/17, Suffolk CCGs compared to England, by age (%)<sup>46</sup>



Source: NHS Digital. Psychological Therapies: Annual report on the use of IAPT services England, further analyses on 2016-17 (2018).

Figure 5: Referrals moved to recovery in 2016/17 by age (%)<sup>46</sup>



Source: NHS Digital. Psychological Therapies: Annual report on the use of IAPT services England, further analyses on 2016-17 (2018).

### 5.3 Age: Risk factors for mental ill health

#### 5.3.1 Children and young people

The Social Mobility Index looks at the impact of local area on the chances of a disadvantaged young person growing up to do well as an adult, compared to other areas in England. A combination of

rural isolation, lower educational attainment, lower skill levels and low job density all contribute to low social mobility in some areas of Suffolk, with Babergh, Forest Heath, Ipswich and Waveney ranked in the worst 20% of local authorities for social mobility (2017 data)<sup>65</sup>.

Younger adults (aged 16 to 24 and 25 to 34) report experiencing loneliness more often than any other age group<sup>66</sup>. Loneliness can increase the risk of depression and reported sleep problems<sup>67</sup>.

Adverse childhood experiences (ACEs) increase the risk of mental illness. However, not everyone exposed to ACEs will go on to experience negative consequences. Protective factors against ACEs include: having supportive parents who read and talk to their children; having healthy relationships with parents, family members and friends; learning good communication skills<sup>65</sup>.

Figure 6: Examples of Adverse Childhood Experiences<sup>68</sup>

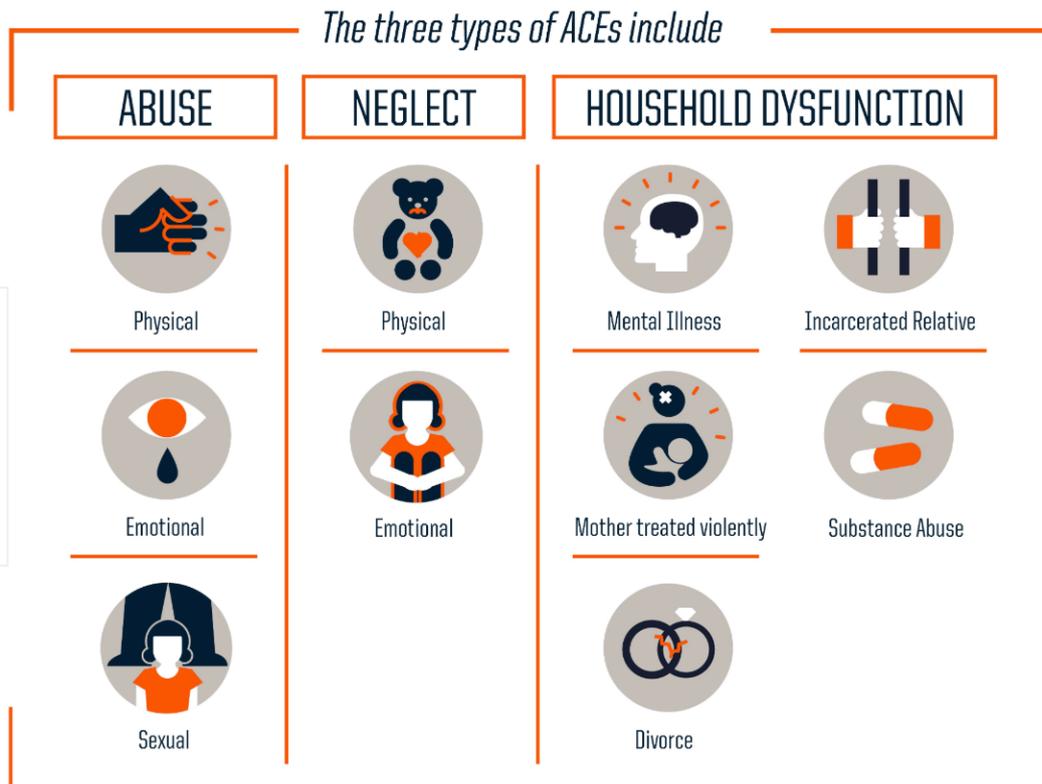
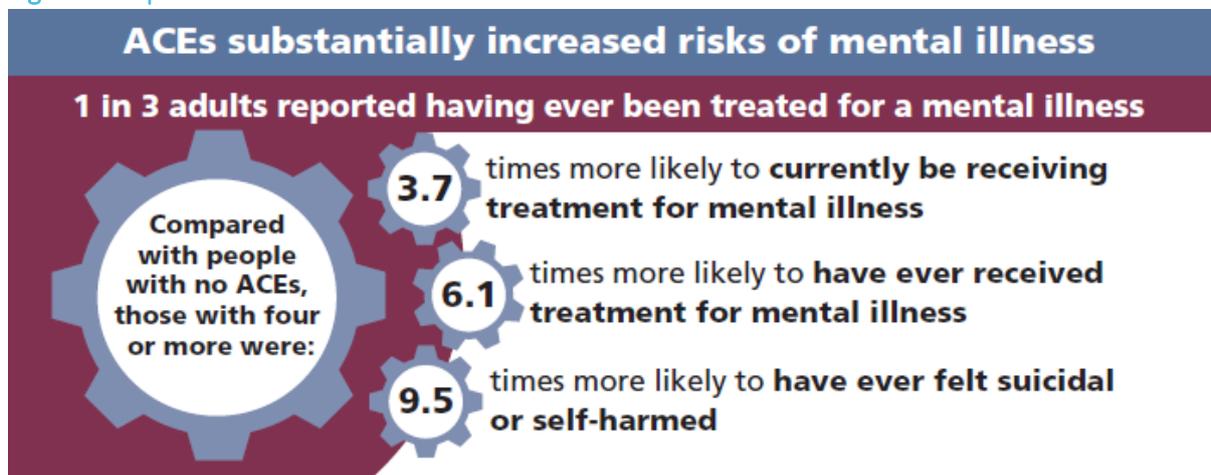


Figure 7: Impact of ACEs on mental illness<sup>69</sup>



Conduct disorders are the most common type of mental or behavioural problem in children and young people. Conduct disorder is 2-2.5 times more common in: boys, children from low income families, mother-only households, families where the parents have no educational qualifications, children of a parent with an emotional disorder, and in households where someone receives a disability benefit<sup>60</sup>. Children with an identified conduct disorder are more likely to develop antisocial personality disorder, or other mental health problems as adults<sup>70</sup>.

### 5.3.2 Older people

Physical illness, the side-effects of medication, and adverse interactions between multiple prescriptions, are more likely to result in poor mental health in older people than in younger people<sup>56</sup>.

Dementia is associated with the same risks as cardiovascular disease, such as smoking, obesity and binge-drinking<sup>53,71</sup>.

Social isolation is common in older people, and increases the risk of depression<sup>56</sup>. Loneliness increases the risk of cognitive decline and Alzheimer's in older age<sup>67</sup>.

## 6 Ethnicity and race

### 6.1 Ethnicity: General differences

People most likely to report use of treatment are female, White British, and in midlife (especially aged between 35 and 54), according to the latest Annual Psychiatric Morbidity Survey (2014). Black adults had the lowest treatment rate (6.5% compared to 14.5% White British)<sup>72</sup>.

National data shows most minority (non-White) ethnic groups have lower levels of reported wellbeing than the general population, and that those identifying as Gypsy or Irish Traveller have much higher rates of anxiety and depression.<sup>73</sup>

People in the Black ethnic group are twice as likely to report low life satisfaction than the Asian ethnic group<sup>73</sup>. The Adult Psychiatric Morbidity Survey<sup>73</sup> found increased prevalence of psychotic disorder (in the preceding year) among Black men (3.2%) than men in other ethnic groups (for example, 0.3% White men, 1.3% Asian men). People from Black ethnic groups are:<sup>73</sup>

- 44% more likely to be sectioned under the Mental Health Act
- more likely to come into secondary care from the police and other non-health organisations
- have lower rates of recovery (this is particularly marked for Black ethnic groups, but rates are also lower among other minority ethnicities)

The incidence of eating disorders in the UK is increasing at the highest rate in young Asian females compared to other ethnic groups<sup>49</sup>.

Most migrants will not suffer from mental ill health that require medical intervention: "home sickness", sleep problems, and some anxiety may be experienced by anyone separated from friends and family or moving into a new community.<sup>74</sup>

Refugees and asylum seekers (adults and children) experience stressors (the situation in their home country, UK immigration process, their journey, arrival and settlement in the UK) and likely "trauma of various kinds, separation and loss, dislocation, rupture and uncertainty"<sup>75</sup>. These increase the likelihood of poor emotional wellbeing as well as clinical disorders such as post-traumatic stress disorder, depression and anxiety<sup>75,76</sup>.

## 6.2 Ethnicity: Suffolk differences

Data by Suffolk CCGs show that rates for finishing treatment are lower for BAME groups in Suffolk than England as a whole.

Table 2: Referrals received by CCG, by ethnic group, Suffolk CCGs, 2017-18<sup>77</sup>

CCG	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	Not stated/Not known/Invalid	White
Great Yarmouth & Waveney	15	15	60	15	2,205	4,570
Ipswich & East Suffolk	150	140	240	90	1,705	10,505
West Suffolk	25	25	55	25	625	5,645

Table 3: Referrals finishing a course of treatment in the year, Suffolk CCGs, 2017-18<sup>77</sup>

	Asian or Asian British		Black or Black British		Mixed - Multiple Ethnic Groups		Other Ethnic Group		White	
	Count	%	Count	%	Count	%	Count	%	Count	%
Great Yarmouth & Waveney	*	*	*	*	15	1	*	*	1,470	75
Ipswich & East Suffolk	40	0	55	2	60	2	25	1	3,100	89
West Suffolk	10	1	5	0	15	1	10	0	1,875	93
England		4.5		2.6		2.1		1.4		83.8

\*figure below 5

Figure 8a: CCG IPT data by ethnicity, Quarter 4 2018-19: Great Yarmouth and Waveney<sup>78</sup>

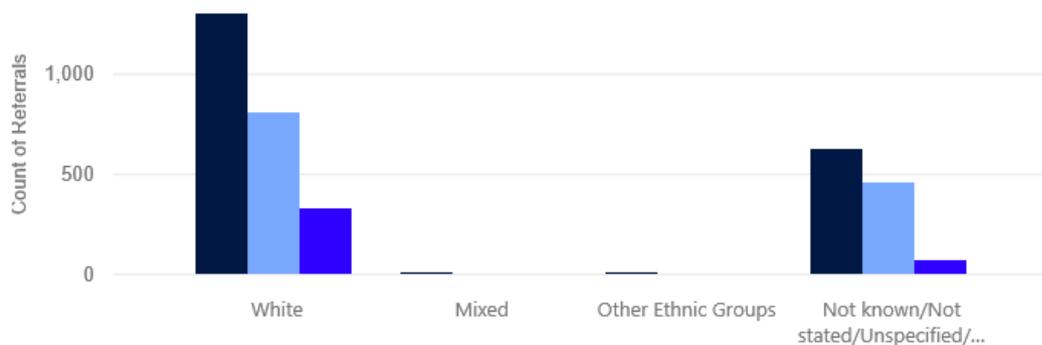


Figure 8b: CCG IAPT data by ethnicity, Quarter 4 2018-19: Ipswich and East Suffolk<sup>78</sup>

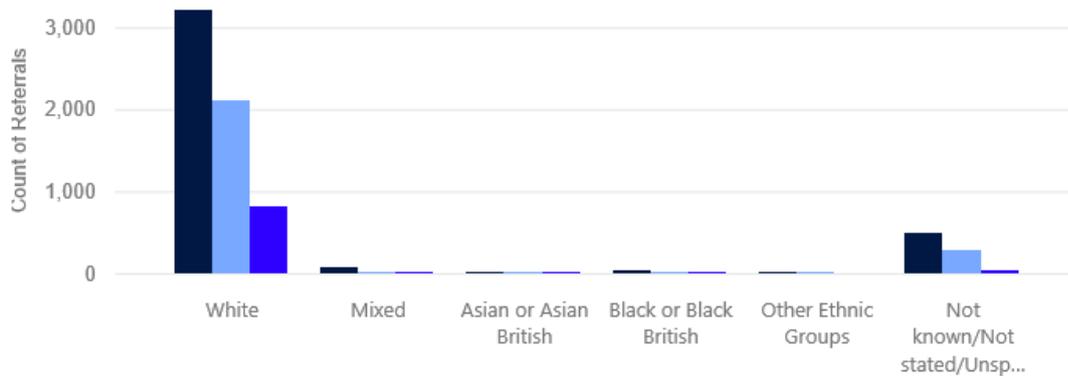
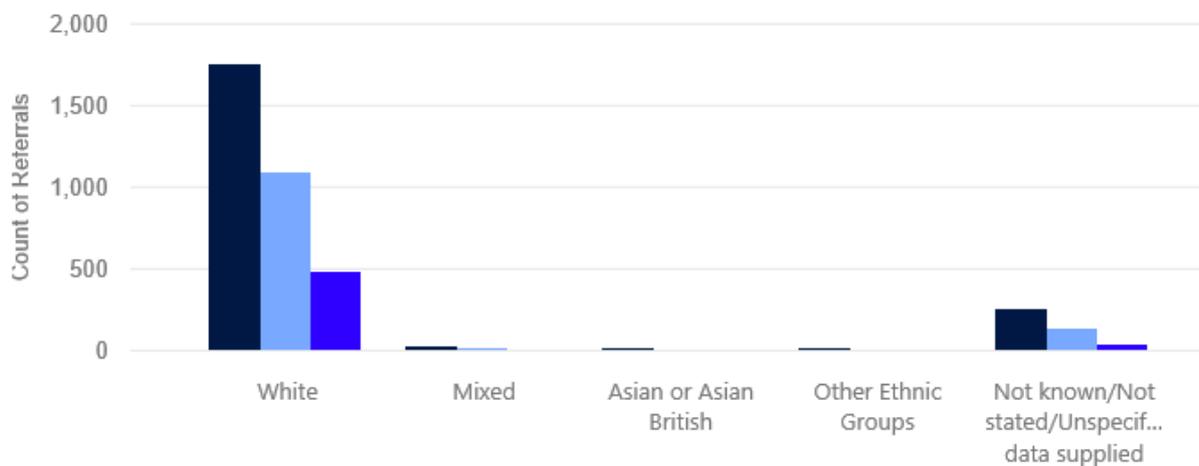


Figure 8c: CCG IAPT data by ethnicity, Quarter 4 2018-19: West Suffolk<sup>78</sup>



### 6.3 Ethnicity: Risk factors for mental ill health

There appear to be higher levels of stigma (“inability to recognise and accept mental health problems” and “negative perception of and social stigma against mental health”) in minority ethnic groups<sup>73</sup>.

Higher rates of mental ill health amongst Gypsy and Irish Traveller groups may be linked to higher levels of limiting long-term illness and of poor general health<sup>73</sup>.

Public Health England report (2018) that people from Black ethnic groups adverse experiences of hospital mental health services (including excessive restraint and medication) have persisted “over several decades”. This has led to mistrust of services and fear of inappropriate treatment and delays in seeking care.<sup>73</sup>

Some migrants may be at increased risk of mental illness due to their experiences prior to, during or following migration to the UK. For example:

- rates of PTSD are higher in people who have been forced to move (i.e. refugees rather than migrants), but still relatively low<sup>74</sup>
- the mental illnesses most commonly reported by people who have been trafficked are depression, anxiety and post-traumatic stress disorder (PTSD)<sup>79</sup>
- traumatic events, loss, and displacement increase the risk of depression, anxiety, and PTSD<sup>74</sup>.

## 6.4 Ethnicity: Protective factors for better mental health

Living in areas with higher ‘own-group’ ethnic density has been associated with significantly reduced risk of common mental health disorders among Irish, Black Caribbean, Indian, Pakistani, Bangladeshi and White British ethnic groups in England<sup>73</sup>.

## 7 Physical health & mental health

### 7.1 Physical health: General differences

Analysis of the Annual Population Survey shows that people with a self-reported health status of “fair, bad, or very bad” report lower levels of wellbeing than England as a whole<sup>73</sup>.

The more physical disorders a person has, the more likely they are to experience mental ill health<sup>4</sup>.

Risk factors for diseases such as CVD, cancer and diabetes are also risk factors for mental ill health<sup>80</sup>:

- harmful alcohol consumption
- lack of physical exercise
- smoking<sup>81</sup>
- obesity
- unhealthy diet

Links between severe mental illness and metabolic syndrome are still being explored, but are thought to be a combination of lifestyle factors such as smoking and poor nutrition, reduced attention to physical health needs, and the side effects of necessary psychotropic medications (medicines used to treat severe mental illness)<sup>82-84</sup>.

Prevalence of mental health problems is higher amongst inpatients<sup>85</sup>; for example, 35%-70% of chronic heart failure inpatients have a depressive disorder<sup>86</sup>.

Not working due to disability was associated with an increased risk of an eating disorder<sup>10</sup>.

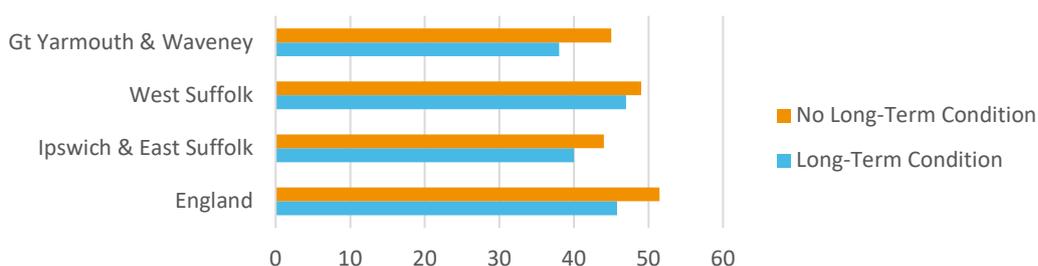
### 7.2 Physical health: Suffolk differences

Approximately a third of referrals to IAPT services (that finished a course of treatment in the year) were for people with a long-term condition. It is unclear whether the proportion of patients in Great Yarmouth and Waveney was actually lower (a quarter of patients) or whether this is a recording issue.

Table 4: Referrals finishing a course of treatment in the year<sup>46</sup>

	Long-Term Condition	No Long-Term Condition
<b>England</b>	132,507	334,541
<b>Ipswich &amp; East Suffolk</b>	1,215	2,105
<b>West Suffolk</b>	790	1,375
<b>Gt Yarmouth &amp; Waveney</b>	605	1,215

Figure 9: IAPT referrals moving to recovery within 2016/17 by Suffolk CCG<sup>46</sup>



## 8 Deprivation and socio-economic factors

### 8.1 Deprivation: General differences

Deprivation affects mental health:

- unemployed and economically inactive people report lower levels of wellbeing than England as a whole<sup>73</sup>
- employment status is strongly associated with self-harm for men<sup>6</sup>
- unemployment is associated with an increased risk of objective and subjective binge eating<sup>10</sup>

There can be a negative cycle between poverty and health: unemployment and poverty contribute to poor mental and physical health, which in turn makes it more difficult to find work, which contributes to poor mental health<sup>87</sup>.

Deprivation can also lead to inequalities in access to services: nationally, young people (aged 10-19) are 23% less likely to be referred to mental health services if they are registered at a practice in the most deprived areas<sup>88</sup>.

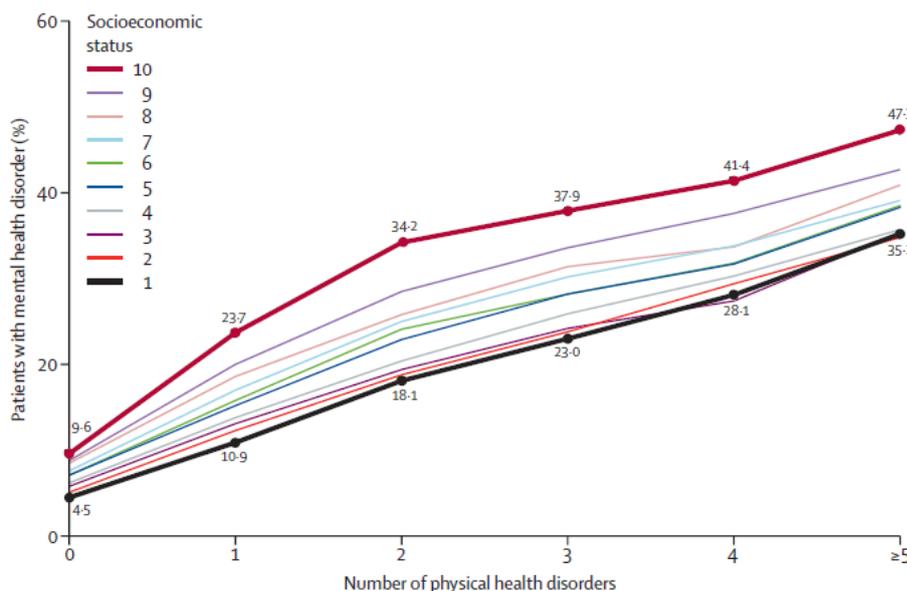
#### 8.1.1 Long-term health conditions and deprivation

Young and middle-aged people in deprived areas have a prevalence of multimorbidity similar to people who are 10-15 years older and living in affluent areas<sup>4</sup>. This may be because more people in deprived areas have comorbidities, and also because the impact of co-morbidities on mental health are greater in areas of deprivation.<sup>89</sup>

Social deprivation increases the risk of co-morbid mental health problems<sup>80,90</sup>. In more deprived areas:

- more people will have multiple long-term conditions<sup>91</sup>
- the effect of multiple illnesses on mental health increases<sup>86</sup>
- The most deprived areas have almost double the prevalence of physical and mental health comorbidity compared to the most affluent areas: 11% (CI 10.9–11.2%) compared to 5.9% (CI 5.8%–6.0%), difference 5.1% (95% CI 4.9-5.3)<sup>4</sup>.

Figure 10: Physical and mental health comorbidity and the association with socioeconomic status<sup>4</sup>



Socioeconomic status scale: 1 = most affluent to 10 = most deprived.

Source: Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet (London, England). 2012; 380:37-43*

## 8.2 Deprivation: Suffolk differences

Deprivation may be hidden in Suffolk's rural areas<sup>92</sup>.

In Suffolk, most (85%) of the variation in emergency admission rates for self-harm (2013/14 – 2015/16 data) is due to deprivation. For each unit increase in deprivation, emergency admission rates for self-harm in Suffolk increase by 45.6 admissions per 100,000 residents<sup>15</sup>.

45.6% of the variation in prevalence of severe mental illness (SMI) across Suffolk is due to level of deprivation<sup>93</sup>. For each unit increase in deprivation, prevalence of severe mental illness increased by 23 cases per 100,000.

There is a moderate association between deprivation and depression in Suffolk (11.1%). For each unit increase in deprivation, prevalence of depression increased by 140 cases per 100,000 people.

## 9 Other groups at risk of disadvantage

"Groups at risk of disadvantage" is an umbrella term describing communities and groups of people who may experience health inequalities based on specific characteristics, conditions or beliefs. There is no singular, exhaustive list that identifies all groups at risk of disadvantage. Different geographic areas and localities will have different groups that may be at risk of health inequalities based on demographic, economic and social factors and influences.<sup>94</sup>

This section cannot cover all groups in Suffolk who might be at risk of disadvantage in experiencing poor mental health, or in accessing mental health services: the following gives examples of different groups and issues – there is more information on the Healthy Suffolk website ([www.healthysuffolk.org.uk](http://www.healthysuffolk.org.uk)).

The issues experienced by groups at risk of disadvantage, that may contribute to a reluctance or difficulty in accessing or receiving services/treatment, may include:<sup>94</sup>

- limited knowledge of their rights to services or how to access them appropriately
- language and communication difficulties
- incomplete data collection by the health sector e.g. ethnicity, means that the specific health needs of each community group cannot easily be assessed
- limited joint working between the health sector and community or advocacy groups means there are fewer chances to reach out to specific communities
- the perception among some communities is that providers of services have a limited awareness of important cultural issues
- specific health issues, which can contribute to health inequalities

Some examples of groups at risk of disadvantage include:

- people with or recovering from drug and alcohol problems are at greater risk of self-harm.<sup>22</sup>
- high levels of mental ill health among prisoners<sup>94</sup>
- nearly half (45%) children who are "looked after" could be diagnosed with at least one psychiatric diagnosis, with 70-80% having a recognisable problem, in comparison to around 10% of young people in general<sup>75,95</sup>
- people who have left the care system are likely to continue to experience poor mental health<sup>95</sup>

- children who have Adverse Childhood Experiences (harmful behaviours experienced by children) that can lead to poor health and social outcomes in adulthood. They appear to be linked to important outcomes in areas such as health and social care, criminal justice, and policing (see also the section above on age)<sup>65</sup>
- people living in rural areas may be more likely to experience unemployment, isolation and loneliness, which increase the risk of mental ill health. Rurality can make it harder for people to access mental health services. Public Health England research showed higher suicide rates in areas that are rural and sparsely populated<sup>96</sup>
- national survey data suggests higher levels of stress and poor mental health among people who work in the emergency services<sup>97</sup>

### 9.1 Example: People with learning disabilities

People with learning disabilities (LD) face health and social inequalities. Some of these can be attributed to genetic factors and to poorer access to health services<sup>98</sup>.

There is higher prevalence of mental ill health in adults with LD than the general population:

- incidence rates are significantly higher<sup>99,100</sup>
- more episodes “endure”<sup>101</sup>

Mental illness in people with LD is often not recognised because:<sup>99</sup>

- carers may miss changes in behaviour
- symptoms of mental illness may be attributed to LD (“diagnostic overshadowing”)
- co-morbidities may mean mental illness is missed or recognised late
- the person may find it difficult to communicate new symptoms (or medication side effects)
- supervision and support may mean common signs of mental illness do not present. If a person has carers to support washing and dressing, then failure to maintain personal hygiene or cleanliness cannot be seen; help at mealtimes can mean there isn’t weight loss<sup>102</sup>

People with learning disabilities may be at increased risk of metabolic syndrome: a study in the Netherlands recorded prevalence of 46% (against 29% in a population without learning disabilities or antipsychotic drug use)<sup>103</sup>. 19% of this variance can be attributed to increased age, poor nutrition and the use of conventional antipsychotics.

### 9.2 Example: UK armed forces and veterans

UK studies of military personnel suggest that the rates of common mental disorders may be in line with the general population, and that deployment does not significantly affect rates.<sup>104</sup> The prevalence of PTSD amongst British forces is around 6% in British combat troops, and 4% in personnel who have been deployed<sup>104</sup> (which is in line with the quoted APMS rate of 4.4%<sup>72,105</sup> The rates in personnel currently on operations are consistently lower than these<sup>104</sup>.

Protective factors include stronger cohesion within a unit, good leadership and high morale. Risk factors include boring and repetitive work, lack of sleep, low job control and high job demand (risk factors associated with mental ill health in non-military jobs).<sup>104</sup>

The Ministry of Defence reports 6,440 regular forces in Suffolk in October 2017, based in Mid Suffolk, St Edmundsbury and Suffolk Coastal<sup>106</sup>.

### 9.3 Example: People who have been trafficked

People who have been trafficked are at higher risk of poor mental health if they have experienced: childhood sexual abuse, violence and abuse (sexual, physical, emotional, labour), poor living and

working conditions, restrictions on movement, longer time being exploited, as well as unmet social needs after escaping exploitation.<sup>79</sup> Higher levels of post-trafficking support appear to reduce the risk of mental ill health.<sup>79</sup> Trafficked people appear to continue to experience symptoms of depression, anxiety and PTSD levels for at least six months after leaving the trafficking situation.<sup>107</sup>

## 10 Further information

Work to reduce inequalities in mental health continues to be delivered by the CCGs through their strategies to transform mental health services<sup>108,109</sup> and their commissioned services.

This document is collated from Public Health Suffolk's *Mental Health Needs Assessment*<sup>110</sup>, which has more detail on the different types of mental ill health, associated inequalities, services and recommendations.

The latest *State of Suffolk (2019)* section on communities<sup>94</sup> has more information on groups at risk of disadvantage.

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