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Austerity, inequality and mental health

In February 2010, the Marmot Review into health inequalities in England was published ([Marmot *et al.*, 2010](#)). This report demonstrated that life expectancy for people living in the poorest neighbourhoods is seven years less than that of people living in the richest areas. They also spend an average of 17 years longer living with ill health or disability.

Faced with data of this sort, two responses are typical:

1. to regard this disadvantage as being of people's own making – their “unhealthy lifestyles” – they just need to stop drinking, smoking, get exercise and lose weight; and
2. to blame the disadvantage on lack of health services and to call for bigger and better health services.

This is a mistake.

It is undoubtedly the case that stopping smoking, drinking less, losing weight and getting more exercise are good for people. However, for example, [Holt-Lunstad *et al.* \(2010\)](#) showed that social isolation is worse for your chances of survival than obesity, lack of exercise and alcohol and on a par with smoking, stronger social networks and social integration increase your likelihood of survival by 50%. This does not mean that there is no role for personal responsibility, rather that:

[...] personal responsibility should be right at the heart of what we are trying to achieve. But people's ability to take personal responsibility is shaped by their circumstances. People cannot take responsibility if they cannot control what happens. [Marmot \(2015, p. 51\)](#)

[Pye \(2018\)](#) cites the example of a boy brought to A&E several times with stomach pain, but his investigations were normal. She concluded that his symptoms resulted from poor diet and recommended healthy eating, drinking plenty of water and doing exercise. However, the critical question should have been what was preventing the boy from eating well and exercising.

If I had asked, I would have found out that Jacob's mum works 14 hours a day split between two cleaning jobs. She's a good cook, but doesn't have time to buy or prepare meals. Money is a significant problem, and often the quick, affordable food that her children resort to eating has low nutritional content. Jacob likes playing outside with his friends after school, but his mum doesn't think it is safe, so tells him and his siblings to stay in the [small two bedroom] flat while she is at work. [Pye \(2018, p. 1\)](#)

She goes on to say that:

Jacob's family's circumstances are shaping his opportunities to eat healthier food and be more active. The social, cultural, economic, commercial and environmental factors, the social determinants of health, shape the conditions in which people are born, grow, live, work and age.

Good physical and mental health care is, of course, important. However, it accounts for as little as 10% of a population's health and well-being ([Pye, 2018](#)). Social determinants of health are more, much more, important:

People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. [Marmot et al. \(2010, p. 3\)](#)

[Marmot et al.'s \(2010\)](#) report concluded that health inequalities arise from a complex interaction of housing, income, education, employment and social isolation all of which are strongly influenced by a person's economic and social status. The review recognised this disadvantage and made six policy recommendations for decreasing health inequalities:

1. give every child the best start in life;
2. enable all children young people and adults to maximise their capabilities and have control over their lives;
3. create fair employment and good work for all;
4. ensure healthy standard of living for all;
5. create and develop healthy and sustainable places and communities; and
6. strengthen the role and impact of ill health prevention.

It is important to note that people living with longer-term mental health problems are often particularly disadvantaged in relation to these: we know that people with mental health challenges are often living in poverty, in unstable and unsuitable housing; have little control over their lives; have often had difficult childhoods, are more likely to be bullied in school and excluded from school; have extremely high rates of unemployment and too often find themselves in poor quality work; and are often socially isolated and cut off from their communities (for example, [EHRC \(2017\)](#):

What good does it do to treat people and send them back to the conditions that made them sick?
We need to address the conditions that make people sick. [Marmot \(2017, p. 1\)](#)

In February 2020, a follow-up to the 2010 Marmot Review was published: *Health Equity in England. The Marmot Review ten years on* [Marmot et al. \(2020\)](#).

Sadly, it shows that ten years of austerity policies in England has taken its toll. Data presented in the report clearly show that, between 2010 and 2020, there has been deterioration in health and a widening of health inequalities. Increases in life expectancy have stalled – the UK has had lower increases in life expectancy than most other high-income countries – and inequalities in life expectancy have widened. In the 10% of most deprived areas, the life expectancy of women has fallen and the life expectancy for men has increased by negligible amounts, while life expectancy for those in the least deprived 10% of areas has increased. There are also growing regional inequalities in life expectancy which is lower in the north than the south of the country – lowest in the North East and highest in London. There is also a strong relationship between deprivation and “healthy life expectancy”; the poorer the area, the worse the health, both mental and physical. In poorer areas, people spend more of their shorter lives in ill health:

There is no biological reason for the stalling of life expectancy and widening health inequalities. Other countries are doing better [...] The slowdown in life expectancy is not down to exceptionally cold winters or virulent ‘flu, and cannot be attributed solely to problems in NHS or social care – although declining funding relative to need in each sector will undoubtedly have played a role. The increase in health inequalities in England points to social and economic conditions, many of which show increased inequalities, or deterioration since 2010. [Marmot et al. \(2020, p. 4\)](#)

The report shows that:

The lives of people towards the bottom of the social hierarchy have been made more difficult. Some of these difficulties have been a direct result of Government policies, some have resulted from a failure to counter adverse trends such as increased economic inequalities or market failures. [Marmot et al. \(2020, p. 31\)](#)

For example:

- In work poverty and food insecurity have increased (most people in poverty are now working), as have inequalities in wealth (which includes savings and assets such as property): the top 30% hold 76% of the wealth, while the bottom 30% hold just 2%.
- The effect of tax and benefit reforms has been to make the rich richer and the poor poorer: there have been negative effects of benefit reforms on the poorest 50% of the population, with the most negative impact for the poorest 20%. Meanwhile benefit changes have been most positive for the top 40%, and when combined with tax reforms, the top 30% have benefitted the most.
- At the same time, housing costs have increased: the cost of social renting has increased by 40%, and one third of households in private rented accommodation have fallen into poverty as a result of their housing costs. In total, 21% of adults said that a housing issue had negatively impacted their mental health.
- Sure Start and Children's Centres, and funding for children and youth services, have been cut significantly (particularly in deprived areas), school exclusions have increased and youth crime has increased.
- Rates of child poverty have increased “[...] largely the result of political and policy choices in areas including social protection, taxation rates, housing and income, and minimum wage policies. Many OECD countries have considerably lower rates of child poverty than England [...] In England the proportion of children in poverty is projected to increase under current policies”. [Marmot et al. \(2020, p. 18\)](#).

There is considerable evidence that the government policy that impacts upon the social determinants of health has an impact on mental health.

On the positive side, research shows that the introduction of the minimum wage in 1999, and the increase in wages it resulted in, significantly improved mental health (as measured by the General Health Questionnaire, [Reeves et al. \(2017\)](#)). Interestingly, in this context, the authors point out that improvement amounted to 0.37 of a standard deviation, which is a comparable size to the effect of antidepressants (0.39 of a standard deviation) on depressive symptoms ([Moncrieff et al., 2004](#)). In a similar vein, employment legislation relating to dismissal regulations can have an impact on mental health. Longer notice periods and more generous severance payments reduce the likelihood of a decline in mental health for those who lose work ([Barlow et al., 2018](#)).

However, the policies that have characterised a decade of austerity in the UK have had a negative impact on mental health.

In an effort to reduce the nation's budget deficit, in 2011, the government made large cuts in housing benefit. It was estimated that this resulted in an average loss of income for people renting in the private sector of an average of £1,220 per year and affected about 1.35 million people ([Fenton, 2010](#)). [Reeves et al. \(2010\)](#) explored the impact of this on the mental health of the people affected. Their data suggested that these cuts to housing benefit were associated with the development of depressive symptoms in around 26,000 people in private sector rented accommodation:

[...] the costs incurred in treating person's whose mental health has deteriorated may offset any potential savings resulting from cutting HB. [Reeves et al. \(2016, p. 428\)](#)

Between 2010 and 2013, around 1 million people receiving disability benefits had their eligibility reassessed using the new Work Capability Assessment. Research shows that for every 10,000 people reassessed, there were 6 additional suicides, 2,700 cases of reported mental health problems and 7,020 prescriptions for anti-depressant medication ([Barr et al., 2016](#)). The authors conclude that:

In assessing the costs and benefits of policies that introduce tougher medical assessments for disability benefits, policy makers need to take into account not only the effects on employment, but also the impact on health and the risk of poverty of people with disabilities [...] as austerity measures designed to reduce public spending increasingly target social protection systems [...] the cumulative impact of these developments needs to be assessed [...] Although the explicit aim of welfare reform in the UK is to reduce 'dependency', it is likely that targeting the people living in the most vulnerable conditions with policies that are harmful to health, will further marginalise already excluded groups, reducing, rather than increasing, their independence. [Barr et al. \(2016, p. 343\)](#)

Similarly, for those who are not disabled, the introduction of Universal Credit, a welfare benefit reform that began to be phased in in 2013, [Wickham et al. \(2020\)](#) found that psychological distress (as measured by the General Health Questionnaire – 12) increased by 6.57 points. They estimate that, owing to the introduction of Universal Credit, between April 2013 and December 2018, an additional 63,674 unemployed people will have experienced levels of psychological distress that are clinically significant, and 21,760 of these people could reach the diagnostic threshold for depression. Again, the authors conclude that “[...] it is crucial that the UK government includes a robust evaluation of the health impact in its evaluation of Universal Credit and other welfare changes”. [Wickham et al. \(2020, p. 163\)](#)

It is not only researchers who have drawn attention to the negative effect of welfare changes on mental health. In February 2020, the National Audit Office produced a report about the information held by the Department for Work and Pensions on death by suicide of claimants. In response to a question raised by RT Hon Frank Field MP, the Department of Work and Pensions said that it did not hold data centrally on suicide by benefits claimants ([National Audit Office, 2020](#)). This report attracted considerable media attention:

'Disgraceful' surge in suicides among benefit claimants prompts condemnation of DWP. Government has investigated 69 suicides of benefits claimants in last five years – which is 'highly unlikely' to be overall number of self-inflicted deaths, says National Audit Office. [Bulman \(2020\)](#), Independent, 7 February 2020, p. 1)

DWP benefit process linked to 69 suicides - and there's a warning there are many more. A National Audit Office report reveals the scores of tragic cases that have been quietly investigated since 2016 - and warns even that total could be the tip of the iceberg. [Bloom \(2020, D. Mirror, 7 February 2020\)](#)

But it is not only deaths by suicide that have occurred, as can be seen by the tragic case of Errol Graham reported in *The Guardian*:

Disabled man starved to death after DWP stopped his benefits [...] A disabled man with a long history of mental illness starved to death just months after welfare officials stopped his out-of-work and housing benefits. Errol Graham, 57-year-old grandfather, and in his younger days a keen amateur footballer, weighed just four and a half stone (28.5kg) when his emaciated body was discovered by bailiffs who had broken down his front door to evict him for non-payment of rent [...] When he was found, his Nottingham flat had no gas or electricity supply. There was no food in the property except two tins of fish that were four years out of date. [Butler \(2020, p. 1\)](#)

So what does this mean for mental health workers? Well, as [Pye \(2018\)](#) says, we can ask about people's situation, understand the role of social determinants, actively help people to address specific issues around such things as finances and welfare benefits, housing and work, know what people's rights are and where help with such things is available and assist people to access this.

In addition to this, we may be well advised to go back to the words of former Prime Minister, Clement Attlee. It was the post-war Attlee Government that introduced the welfare state, but prior to entering politics, he had been a social worker and social work lecturer (Dickens, 2018). In 1920, he wrote a book called *The Social Worker*, in which he talked about:

- the social worker as pioneer of social reform “the social reformer or revolutionary [who may] advocate on changes and may create new public opinion [...] they must look for practical experimentation on which action can be taken”. Attlee (1920, pp. 220–221);
- the social worker as investigator “adding to the collection of observed facts on which action can be taken [...] watching the effects of different pieces of social legislation” (Attlee, 1920, 229–230); and
- the social worker as agitator and campaigner for change whose “particular function is to concentrate attention on particular aspects of a social problem [...] agitates for one particular piece of reform [...] investigating facts and supplying others with ammunition” and/or having more general views about “a complete change for the basis of society” and campaigning for this.

Maybe all mental health workers should follow Attlee’s guidance for the social worker and become pioneers for social reform, investigators and campaigners for change?

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