



Editorial

Mental health in an unequal world

The theme for the 2021 World Mental Health Day ‘Mental Health in an Unequal World’ chosen by global vote, reflects not only a world that is increasingly polarized but also the resultant inequalities that increase the risk of mental health conditions and limit the access to mental health care. The gap between the poor and the rich continues to grow and income inequality has increased in all countries. The World Inequality Report 2018¹ shows that in 2016, the top 10 per cent income earner’s share ranged from 37 per cent in Europe to 55 per cent in Brazil and India and 61 per cent in the Middle East. The increasing income inequality trajectory is influenced by inequalities in education, wage policies as well as globalization and open trade policies pursued by the different countries. It has been noted that while the poorest half of the world’s population has seen a growth in the income, the “top one per cent richest individuals in the world captured twice as much growth as the bottom 50 per cent individuals since 1980”¹.

In their book, *‘The Spirit Level: Why More Equal Societies Almost Always Do Better’*² published in 2009 which elaborated on an earlier seminal article³, Wilkinson and Pickett identified an association between inequality and higher rates of mental health conditions. Writing on the ‘pernicious effects that inequality has on societies’ such as eroding trust, increasing anxiety and, encouraging excessive consumption, they argued that these led to adverse outcomes across multiple health and social domains including physical and mental health, drug use, imprisonment, education, violence and child well-being. Since then, several studies have highlighted the significant association between income inequality and mental health conditions^{4,5}.

Several putative mechanisms have been proposed to explain this association between mental health and income inequality. Among these are psychological stress, social defeat, perceived loss of control and erosion of social trust and social capital⁶⁻⁸ operating

at the individual and societal level. According to the neo-material hypothesis⁹, the association between income inequality and health reflects both the impact on the private resources that are available to the individual and the lack of investment across a wide range of public infrastructures such as education, housing, transport, health services and environmental regulations. The income inequality is hence seen as a legacy of this historical lack of investment in these infrastructure⁹. The hypothesis premises that the association between income inequality and health is due to the lack of vital public infrastructure with the implication that investments in this would mitigate the disparity between income and health.

Other inequalities related to gender, ethnicity, rural-urban, education, caste and sexual orientation have an equally important impact on the mental health of the population. Socially and culturally constructed gender norms affect health and access to health. While gender equality is a goal of the 2030 Agenda for Sustainable Development¹⁰, certain gender norms endanger the mental health of men and women across the life course. For women, factors like the preference for a male child, child marriages, intimate partner violence and educational disparity increase the risk of poor health¹¹. Studies have shown that domestic violence increases the likelihood of depressive, anxiety, eating, substance use and post-traumatic stress disorders in women^{12,13}. An analysis using data from the Global Burden of Disease database has shown a significant association between the gender inequality and the increased gender disparities in depressive disorders¹⁴. The same socio-political system that assigns higher status to boys could lead to ‘toxic masculinity’ with its attendant risks of violence, alcohol and substance use disorders, as well as reluctance in help-seeking¹¹.

Racial discrimination (which is another egregious form of inequality) both overt or in the form of

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micro-aggressions causes chronic stress, and adversely affects mental health, leading to depression and anxiety¹⁵. A recent study among the US adults found that those identifying themselves as multiracial and non-Hispanic adults of other races/ethnicities experienced stigma or discrimination from being blamed for spreading COVID-19 (4.1%), which led to significant psychosocial stress during the COVID-19 epidemic¹⁶. Ethnic minority groups also have an increased risk of the first diagnosis of severe mental illnesses, especially psychoses, higher rates of contact with the criminal justice system, compulsory treatment and less contact with community services¹⁷. Those identifying themselves as lesbian, gay, bisexual, transgender, queer (or sometimes questioning) and others (LGBTQ+) have been shown to experience poorer mental health than heterosexuals¹⁸. While causality is difficult to establish, discriminatory and stigmatizing experiences and increased risk of harassment and victimization are likely important contributory factors^{19,20}.

Income, gender, ethnic and other inequalities either alone or in combination with each other result in unequal access to mental health services. There is overwhelming evidence that both costs of treatment and insurance coverage are important barriers to access to care²¹. There exists greater inequity in the unmet need for mental healthcare - more than for physical healthcare even in the developed countries²². Another important factor that limits access to care among minority communities is the lack of affirming and culturally sensitive care by mental health providers who consistently fail to recognize symptoms, invalidate psychological distress and even deny care^{23,24}.

The way forward

While there is an abundance of research on mental health inequity among high-income countries, the magnitude of social inequity's contribution to mental health conditions and access remains at low priority in developing countries that needs to be addressed as a first step. Identifying the gaps is the first step to innovative and focussed solutions given the political will and resources.

A societal level intervention to provide mental healthcare to the marginalized homeless as described by Narasimhan *et al*²⁵ that is user-centred and resonant and has the traction to translate the knowledge acquired to wider implementation and the relevant formulation of policies is a good example of a successful ground

up initiative that can provide equitable access. There is also good evidence that psychosocial interventions developed in high-income countries can be culturally adapted and effectively delivered by non-physician health workers in low- and middle-income countries²⁶. Peer support specialists are another resource that is increasingly being recognized for the unique contribution they bring to mental healthcare. These individuals with lived experiences help their peers journey to recovery by sharing their experiences and supporting them during and after a mental health crisis²⁷.

At the national level, the income gap needs to be addressed through tax policies as well as wage and educational policies. At the same time, nations need to commit more budget to mental healthcare. At the international level, there is the World Bank's Human Capital Project that aims to promote social capital formation to reduce poverty²⁸. This effort supports nations to "prioritise transformational investments in health, education and social protection" to promote more equity and economic growth, however, the success of this programme has yet to be fully realized.

While solutions are not easy, individuals, societies, and governments should work together to address these challenges to make the world more equal and promote mental health. It might be unreasonable and impossible to make it an equal world for those with mental illnesses, but it is reasonable and possible to strive towards that.

Conflicts of Interest: None.

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