Submission

Senate Standing Committees on Community Affairs inquiry on:
Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"

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Why mental illness is not (just) a health problem

Dear Senators,

This submission addresses the "scope for improving awareness of social determinants of health in the community, within government programs, and amongst health and community service providers." It focuses on the issue of social determinants of *mental health* in high-income nations with market economies such as Australia.

The WHO Commission on the Social Determinants of Health (CSDH) (1) exhaustively reviewed evidence on relationships between people's physical or mental health and their position within their society. That work reminded and informed us about the blunt reality of wide disparities in health both between and within countries, and nothing can really proceed in this space without those facts on the table.

However, what the CSDH did not do – understandably – is explicate in any depth the various ways in which the environments we occupy get 'under the skin' to affect people's health. And without some grip on these issues of the *causal links* between environment and health, one can see a lot of trees without seeing the wood. That is, until one knows something of *how* an environment is affecting health, it is difficult to know clearly *what the problem is* in the relevant way – one that allows of action to prevent or protect against those effects.

In this submission I wish to address the question of how social environments are able to affect mental health and illness; particularly in relation to the so-called high-prevalence mood, anxiety and substance abuse disorders. It is these conditions that the Australian Bureau of Statistics (ABS) measured, when it reported in 2007 that approximately 20% of Australian adults are subject to a mental disorder in any 12-month period (2). And it is comparable international data on these conditions that Wilkinson and Pickett assessed to note that 12-month rates of mental illness in Australia are up to *twice as high* as in some comparable OECD countries (3). It is primarily these forms of mental illness that are recognised to constitute a major part of the disease burden and the largest single cause of disability in Australia (4). It is these conditions that make up the bulk of the peak in mental illness rates in early adulthood, which has such negative impacts on education, workforce participation, relationships and parenting (4).

If *one in every five* adults in any one year is suffering significant mental health problems, and this is more than twice what occurs in other comparable countries, then surely it is time we seriously asked ourselves if we have some problems with our society, rather than just so many unrelated instances of 'chemical imbalance in the brain'. But we cannot really do that with understanding until we know something of *how* the social environments we occupy might be contributing to these adverse effects on mental health and well-being.

The evidence on social determinants of mental health (SDMH) in Australia and other high-income countries consistently shows that rates of high-prevalence conditions vary widely within national populations and often occur on a social gradient, where prevalence is inversely related to socioeconomic status (SES) (5, 6). Population groups subject to particular forms of social or economic disadvantage also typically display markedly worse average mental health outcomes compared to others (7, 8). Research also shows that higher levels of mental illness are associated with exposure to factors such as: poverty, socioeconomic disadvantage, unemployment or insecure employment, insecure neighbourhoods, family violence, lower status in the workplace, and social isolation (9).

This body of well-established evidence may, on the face of it, suggest that an effective cause of the problem is socioeconomic hardship or deprivation. In a crude sense this is partially

true, but one need only observe that the 12-month prevalence of these conditions in Australia, at around 20%, goes far beyond the 5% or so of the population who are subject to serious material poverty. The first crucial thing to understand here is that, while socioeconomic hardship in one form or another certainly *matters*, the greater majority of social-environmental effects on mental health do not have their roots in material conditions *per sé*, but in conditions giving rise to certain kinds of *psychological experience*, leading in turn to short and longer-term neurological, physiological and behavioural changes. Thus, in the parlance of public health literature, they are termed 'psychosocial' effects.

The point is this: the main way in which modern social environments contribute to adverse effects on mental health is by serving as a trigger for *chronic arousal of neuropsychological stress responses*. It is not appropriate or necessary here to spell out the nature and effects of these responses in detail. However, the essentials of the matter are as follows:

- 'Stress responses' are mediated by structures in the brain and body, and in the *short term* stimulate arousal in both the brain and body well-suited to facing short-term challenges.
- Normally, for all humans, *acute* (short-term) stress responses can contribute to social learning and rapid behaviour change in response to social cues (10, 11), including affiliative behaviour (12).
- We are all vulnerable to adverse effects on health under conditions of extreme acute stress or of *chronic* (long-term, repetitive) stress arousal.
- Chronic stress is most likely to occur when an individual faces a stressor 'challenge' in the social environment (see below), *and does not have or perceive a way to decisively solve the problem* (13). Thus, recognition of the problem recurs, and drives recurrent stress arousal.
- Chronic stress arousal has internal effects on structures in both the brain and body, which (over different time frames) can and do contribute to both the common forms of mental illness, and/or to chronic physical illness (10, 14-19). Chronic stress also increases the likelihood of engaging in behaviours that have a negative effect on health such as smoking and problem drinking, as a form of coping (20).

- Chronic stress is explicitly noted in the CSDH Report and a range of other relevant literature, as a key mediator of social effects of health in populations. Differences in exposure to social stressors across populations are seen as an important driver of health inequalities (1, 3, 9, 21, 22).

From a social and health policy perspective, some of the key salient points are these:

- Likely sources of chronic stress in childhood occur in the family environment and include all the various dimensions of abuse or neglect (23). Such stress can lead to the formation of maladaptive patterns of social behaviour as a response to (future) social challenges. (Alternatively, positive parent-child engagement and structured, consistent, non-violent methods of discipline develops children's capacities to *self-regulate* affiliative social behaviour.) Recent estimates suggest that addressing the early childhood environment could reduce adult mental illness by as much as 30%.
- Potential sources of chronic stress in adolescence tend to include both family and peer groups.
- Likely sources of chronic stress in adult environments include certain kinds of 'material' circumstances such insecure housing, unemployment or job insecurity, low control or monotony at work, and everyday financial pressures (21).
- However, potential sources also include more social-relational factors including social isolation (loneliness), relationship violence or abuse, perceived lack of safety, extended time periods navigating complex social environments, and fatalism or a low sense of self-efficacy (21).

In conclusion, there is a wealth of accumulated evidence from across a number of disciplines over several decades to show that *factors in the social environment contribute significantly and causally to the occurrence of most common forms of mental illness* in individuals and populations – and that chronic stress is a key mediating mechanism. Despite this, we continue as a society and in health policy to predominantly address these forms of mental illness as simply an organic condition of *individuals* – a 'chemical imbalance in the brain' – to be treated with drugs or behavioural therapies. Such treatments are of some benefit to many who receive them (and are often important for those who are subject to more severe,

psychotic forms of mental illness). However, simply increasing the availability of such treatments, in and of itself, is unlikely to significantly reduce the overall scale of the problem in the more common forms of mental illness, or the unequal distribution of these conditions across social groups. On these terms, we don't have (just) a health problem, we have a social development and wellbeing problem.

The appropriate policy responses are complex and various, but nevertheless achievable. However, we must also go beyond a quasi-medical model of discrete, targeted, time-limited *interventions*, and consider the need for more systemic change. Some of the answer does readily lie in addressing socioeconomic inequalities in areas such as income, housing, employment and education. As noted above, a focus on supporting parents and on early child development in the first five years of life is crucial. However, equally, we should look to the wider factors socio-cultural factors and values contributing to social stress in the population at large, well beyond the most disadvantaged segments of the population.

As one potential approach to explore, I believe we could and should aspire to reinvigorate, strengthen and remake the localised domain of 'community' as a place in which *all* Australians are able to: grow up and age in a secure, caring environment; feel connected with others; raise children; participate in economic and social activity; and feel their actions contribute positively to something larger than themselves.

This submission is made on an individual basis and does not represent the views of the Southgate Institute for Health, Society and Equity, or of Flinders University.

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