



Mind the gap: evidence that child mental health inequalities are increasing in the UK

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The aim of this editorial is to highlight an important paper published by Collishaw and colleagues in the current edition of the journal [1]. It examines changes in child mental health inequalities in the UK over a period of 13 years by analysing data from three population-based cohorts, the British Child and Adolescent Mental Health Surveys (1999 and 2004) and the Millennium Cohort Study (2012). In each case, parent- and teacher-report data on mental health problems were collected using the same measure—the Strengths and Difficulties Questionnaire (SDQ). The authors focused on the total problems scale which is a composite of the hyperactivity, conduct, emotional, and peer problems scales, and compared the children in the lowest income quintile with those above this income threshold (the wealthiest 80%). The picture that emerges from these analyses is stark and concerning—that whether assessed by parent-report or teacher-report, the mental health gap between the poorest children in society and the rest of the population is increasing. The effect size for the difference in overall mental health problems between the children from the lowest income families compared with those from the wealthiest families increased from 0.35 in 1999 to 0.54 in 2012 (as assessed by parent-report), and from 0.41 in 1999 to 0.57 in 2012 (as assessed by teacher-report). This gave rise to a cohort-by-income interaction for parent-reported mental health problems ($p=0.01$), with a clear trend towards a similar interaction for teacher-reported problems ($p=0.09$). This study had a number of methodological strengths, including the population-based nature of the samples used in the analyses, the similarity between the samples in terms of age (all were 11 years of age), the use of consistent measures to assess mental health over the sampling period (the SDQ), and the collection of data on the children's mental health from multiple informants.

The findings are also unlikely to be driven by increasing awareness of mental health problems in the poorest children over this period, because the data were not based on referrals or related to help-seeking, and overall levels of mental health problems did not change significantly across the measurement period—instead, the increase in problems was restricted to the poorest children in the sample.

The authors discuss the impact of austerity policies as a possible source of the increases in mental health problems, but these were relatively recent developments in the UK in 2012, and it will be important to assess child mental health disparities in similar, population-based samples from more recent years—as the effects of austerity are likely to have increased over time [2]. It would also be of interest to investigate the mental health of children and mental health inequalities in European countries which have implemented even more drastic austerity policies, such as Greece.

What proportion of the population is receiving effective, evidence-based treatments for mental health problems and does this vary according to family income? Given that less educated and affluent families are less likely to seek help for a mental health condition than their more educated and affluent counterparts [3], it seems likely that there could be a 'double hit' whereby children from lower socioeconomic status groups are both more likely to develop a mental health problem and less likely to receive help for such mental health problems. This unmet mental health need is likely to have become more acute in the UK and other European countries that have implemented austerity policies over the last decade.

What are the causes and mediating mechanisms of such increases in mental health inequalities? This is the crucial question that the study by Collishaw et al. unfortunately cannot address. In the UK, Child and Adolescent Mental Health Services (CAMHS) have increasingly assumed the role of crisis intervention services and entry thresholds have gone up year on year, such that children who do not yet have very serious mental health problems often remain untreated. A

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2017 Freedom of Information request to the UK Department of Health showed that many patients were waiting over a year after their first assessment to receive treatment (6/30 CAMHS services for whom data were available); the majority of patients across the 30 services waited between 18 and 52 weeks to receive treatment [4]. The CAMHS data also showed that many children have to wait long periods before being assessed in the first place (22.6% waited between 18 and 52 weeks, and 5% over a year). Therefore, it seems that there are unacceptably long waiting times for child mental health treatment at every step of the process in the UK—unless the family has the financial resources to pay for private treatment.

Collishaw et al.'s important findings could be extended in several ways: by investigating whether such mental health inequalities are amplified in older children (e.g., 15- or 18-year olds) who would be expected to have a higher base rate of problems [5]; by disaggregating the SDQ total problems score into its component subscales to examine whether the effects are similar across different types of psychopathology, or whether emotional or conduct problems are disproportionately affected by economic inequality; and by assessing service use within the same samples to explore the influence of psychological and psychiatric treatment in terms of either mitigating against or contributing to the effects of economic inequality. It would also be of interest to contrast the effects of absolute versus relative income, given recent work showing that mental health problems are more common in those living in less equal societies—especially amongst those in the lower strata of such societies [6].

In conclusion, Collishaw et al.'s findings should serve as a wake-up call to researchers and clinicians working in the field of child and adolescent psychiatry that mental health inequalities are increasing, and there is an urgent need to put measures in place to mitigate against such inequalities, which in the long-term will exacerbate and entrench economic inequalities and stifle social mobility. We need to lobby governments, policy makers, and clinical commissioners to invest properly in child mental health training and

treatment, and to take mental health as seriously as they take physical health (the concept of 'parity of esteem'). In particular, it is crucial that low family income is not a barrier to children and adolescents obtaining effective, evidence-based treatments for their mental health problems in a timely fashion. Outreach efforts that increase awareness of mental health problems and highlight that effective help is available will be important in this respect. In addition, much more work needs to be done to develop and implement effective prevention strategies—addressing the early signs of problems, rather than waiting until the children or adolescents are already very ill to provide treatment. This may be more cost effective and is likely to reduce the economic burden associated with mental health problems, as well as being a more ethical way to treat children in our societies.

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