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Understanding and responding to the drivers of inequalities in mental health

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BMJ Mental Health is delighted to announce a new section called *Experience, Ethics, Equity* that seeks submissions of primary research, systematic reviews, and perspectives and commentaries. We set out the case for such a section, and then give some guidance on article types and priority areas for research, practice and policy. Ethnic minorities and racialised groups are less likely to be represented in research and, with some exceptions, less commonly occupy higher management positions or have opportunities to influence policy and practice.[1–4] There are ethnic and gender disparities in academic research environments including in publishing. Much is being done to respond to these inequalities, including guidance on delivering inclusive research, commissioning research and on fair publication processes. *Lived experience* is central to such work. We hope this new section inspires all to contribute to progressive approaches to tackle inequalities.

CAUSAL COMPLEXITY

Mental illness affects the most vulnerable, those who have experienced multiple adversities from an early age, throughout their lives, where supports and coping styles no longer help.[5 6] Some people are exposed to a greater number of adversities, risk factors for mental illness, including poverty and deprivation and violence, while others are vulnerable given disadvantaged early childhood and family environments and adverse childhood experiences.[7–9] Poor mental health, and the lack to support and resource can be risk factors contributing to drifting into unemployment, poverty or housing crises. Indeed, given growing levels of global migration, natural disasters and conflict, it is likely there are many complex identities and contextual influences that come into play in the generation of inequalities globally and regionally.

CULTURE, IDENTITY AND PLACE

Mental illness presents in many ways. Across cultures and ethnicities, there are variations in explanatory models of causation and preferred care.[10] Globally, there is differential investment and variations in resources to support people with mental illness, especially in low/middle-income countries where most people in the world live in poverty and investment in protections and care is minimal.[11] There is a higher incidence of psychosis among ethnic minorities and refugees in the high-income countries, as well as among migrants more generally.[12 13] There are also greater risks for women and children exposed to disadvantage and violence.[14–16] Ethnic minorities and migrants receive more coercive care through crisis, emergency, police and criminal justice system contact, more risk of self-harm and suicide, with insufficient attention in prevention and treatment policy and practice.[16 17] They are also less likely to receive effective healthcare such as cancer or cardiac care, so health systems in general need review and reform.[18–20] Of course, intersectional and complex identities across vulnerable groups pose even greater risk as they are rendered invisible, not represented in routine data or ethnic and racial categories, or even in the full list of protected characteristics enshrined in law.

INNOVATION IN PARADIGMS OF RESEARCH

Understanding and responding to the drivers of inequalities require thoughtful engagement with progressive paradigms of research. These must capture multiple drivers of illness from individual to social to geographical and ecosocial influences, including the social and cultural determinants operating in society.[21 22] The interactions with health and social care and pathways to care warrant greater attention, as do filters that exclude some from effective care while engaging others in *coercive care escalators*.

There is now significant effort to tackle these inequalities, and more so since the COVID-19 pandemic and *Black Lives Matter* movement which exposed an interplay between structural, institutional and interpersonal types of racism.[23 24] These account for differential experiences and trajectories of mental illness outcomes and premature mortality by racialised groups.

Structural barriers in the past have undermined efforts to improve care; for example, due to cultural competency or clinical skills to tackle ethnic inequalities in the experience and outcome of mental illnesses, inckuding compulsory admission and treatment under the powers of mental health legislation. The production of knowledge, a process of generating evidence for implementation, must be cognisant of these structural and historical barriers, and promote more inclusive research practice. We must guard against an *inverse research law* mirroring the *inverse care law* in order to ensure sufficient representation in research of those most affected by poor health. We must develop better culturally optimised and adapted interventions, which are accessible, attractive, safe, empowering and effective even on narrow measures of symptoms as well as on quality of life and well-being. Researchers, ethicists, commissioners, authors, editors, policymakers and legislators will all have

to revisit their ethical values and practices. In contemporary research practices, in the UK and high-income countries, we can learn from the Global South, and lived experience testimonies in order to evolve better ways of engaging and involving the most marginalised groups. We should do this being mindful to not retraumatise and remaining cognisant of difficulty in verbalising and sharing stories of pain. A *trauma-informed approach* is also important for research teams including peer researchers to combat the risks of vicarious and secondary trauma. *Lived experience data* are central to new paradigms of research, revealing authentic biographical and care experiences. These real-world data are rich in complexities and nuances—new knowledge and clues about how we can prevent mental illness and improve care experiences. We do not exclude neurobiological, inflammatory or genetic pathways, as studies at the biosocial interface can explain how our environment and lived experience become embodied and represented.[22 25]

GUIDANCE

We welcome submissions for this new section, and despite laying out priority areas, we will consider all submissions carefully, as tackling inequalities is a challenging, contested and often undertheorised topic. We wish to see ambitious, well-designed studies, and thoughtful accessible writing suited to interdisciplinary and cross-sector audiences. We are especially interested in intersectional approaches, but will also consider progressive studies that reveal new mechanisms. In particular, we expect significant representation of lived experience in the research process and in the writing of the papers, as well as the foregrounding of lived experience to expose dilemmas of ethics and equity. We anticipate attention to labels and categories deployed, so we will ask all authors to justify the classifications they use, and why they are necessary for the specific hypotheses they are investigating. Similarly, models of lived experience and patient and public involvement require further iteration and testing and improvement, alongside models of inclusive research practice. We anticipate articles will expose new ways of understanding lived experience and related ethical perspectives when trying to address inequalities. We welcome interdisciplinary teams with a balance of senior and early career researchers and practitioners, as well as experiential experts and public representatives. We ask authors to make explicit the particular theoretical and ethical frameworks for understanding inequalities and that the methods and findings are presented in an accessible way to motivate actions and debate beyond mental health setting; we must influence the total system, including public policy, public health, prevention, primary care, the charity sector, as well as formalised specialist health and social care. Discursive handling of reflexivity and subjectivity is welcomed in the methods and discussion sections. The format for articles otherwise matches that for *BMJ Mental Health* in general; however, we welcome suggestions for new and creative formats where they aid in the effective communication of experiences and data (please contact the Section Editor; Kam.bhui@psych.ox.ac.uk if further advice or guidance is needed, and with proposals if you are uncertain of scope and style). As a gold open-access journal, *BMJ Mental Health* makes all its published content accessible to all and free to access under a CC-BY-NC licence. BMJ offers waivers for the full Article Processing Charge (APC) (100% discount of the APC) where all authors are based in low-income countries. Please see the journal's Instructions for Authors for more information.

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