Creating a Mentally Healthy City Strategy Literature Review

Executive summary

Birmingham faces notable mental health disparities, with elevated rates of mental health conditions and pronounced inequalities among marginalized groups, such as LGBTQ+ communities. Contributing factors such as poverty, unemployment, crime, and fuel insecurity exacerbate these challenges. To address these issues, the Mental Wellbeing Team is developing the Creating a Mentally Healthier City strategy—a holistic, prevention-focused approach designed to meet Birmingham's unique mental wellbeing needs.

The strategy is underpinned by evidence-based research and engagement, with this comprehensive literature review serving as its foundation. This review explores key factors alongside four thematic priorities which include individual, family, community, and place-based levels. Key themes include defining mental health and wellbeing within the Birmingham context, examining the wider determinants of mental health, and reviewing global best practices. It considers factors such as resilience, social cohesion, access to resources, economic stability, and the influence of structural inequalities.

Additionally, the review analyses international strategies to identify adaptable best practices for Birmingham. Examples include integrating mental health into policy planning, promoting green spaces, enhancing housing quality, and fostering workplace wellbeing. This evidence will inform a tailored strategy aimed at addressing Birmingham's mental health disparities through sustainable, equitable, and inclusive solutions.

Global urban strategies focus on the integration of mental health into broader policies and practices. Examples include:

- **Data and Policy Integration**: Cities like Toronto and New York track mental health outcomes, while Barcelona and Catalonia adopt evidence-based planning and "mental health in all policies" approaches.
- **Climate Resilience and Green Spaces**: Tokyo, Vancouver, and Barcelona incorporate green and blue spaces into urban design to enhance physical activity and mental well-being.
- **Housing and Urban Design**: Affordable and supportive housing is a priority in Toronto, Vancouver, and Tokyo, with innovations like Tokyo’s super blocks promoting active transport and social interaction.
- **Workplace Wellness**: Catalonia and Toronto focus on destigmatizing mental health in the workplace, while Vancouver links job growth with housing and childcare support.
- **Education and Learning**: Cities such as Barcelona and Vancouver emphasize resilience-building through educational environments and lifelong learning opportunities.
- **Community Connections**: Strategies foster inclusion and belonging, with Vancouver supporting community hubs and New York integrating mental health into community services.
- **Early Intervention and Health Services**: Cities prioritize reducing stigma, expanding access, and supporting vulnerable populations, with tailored approaches in Catalonia and New York.

- **Food and Nutrition**: Vancouver ties mental health to sustainable food systems, promoting access to healthy, affordable, and culturally diverse food.

The Birmingham strategy aspires to reduce inequalities, foster resilience, and create equitable, supportive environments for mental well-being across all demographics. It leverages insights from global best practices to integrate mental health into urban design, policy, and community engagement, shaping a healthier and more inclusive city for future generations.

The literature review has highlighted several recommendations around the co-creation of the Creating a Mentally Healthy City. The recommendations include:

- Creation of a mental health wellness card, with metrics that are measured yearly by citizen data to determine how the strategy is working to create a city that is mentally healthier
- Work with organisations, companies, industry and other businesses to ensure there is adequate promotion of effective mental health and wellbeing plans, policies and procedures which guarantee support for employees and increase productivity.
- Work with a range of educational institutions to ensure that students are equipped with knowledge, tools and resources to develop resilience to promote positive mental health and wellbeing.
- To work with the Council's housing department, West Midlands Combined Authority and stakeholders across the city to develop a growth housing strategy for affordable, secure and healthy housing.
- Promote the equal development and access to green spaces across the city. Including the introduction of green assets to public-owned buildings and incentivise residents to introduce green spaces in urban spaces
- Work with the Combined Authority, Physical Activity Team, Public Health, and private transport enterprises to develop affordable, efficient and reliable active transport options
- Work to educate and instil a wellbeing lens on urban designers, planners and licensing.
- Work with family hubs, community hubs and libraries to provide tools and training resources to promote positive wellbeing to citizens at all stages of life
- Create an educational strategy that works to offer residents and citizens opportunities to learning, and development opportunities using the city's resources.
- Work with vulnerable groups to cultivate social connections, peer groups and intergenerational communities to tackle isolation.
- Support the NHS service partners to recognise the significance that wider determinants can have on accessing mental health services.

In conclusion, the literature review has provided a comprehensive overview of the factors impacting mental health and wellbeing in Birmingham. There is an important need to address both social and environmental determinants of mental health by highlighting a range of strategies that have been implemented in different countries. Effective mental health and wellbeing interventions must consider the interconnected nature of individual, community, and environmental factors to improve well-being at both local and broader levels.

Chapter 1: Introduction

To promote better mental health and wellbeing within Birmingham, the Mental Wellbeing Team in the Public Health Division at Birmingham City Council will be leading the development of a Creating a Mentally Healthy City Strategy on behalf of the Health and Wellbeing Board.

Nationally and internationally, the focus of mental health strategies is on the clinical elements of service provision to address symptoms of depression, anxiety, and further diagnosable conditions. In in many cases the wider social factors that underline poor mental health are omitted.

In the Creating a Mentally Healthy City Strategy, the key focus will be on addressing the wider determinants of mental health and wellbeing with the clinical aspects of treatment for people with mental ill health being addressed by the NHS Mental Health Provider Collaborative Strategy which Public Health will contribute to. Individual factors can impact a person's mental wellbeing but there are also a wide range of social and structural determinants that influence an individual's mental wellbeing. A social determinant is a factor external to the individual such as economic stability and safety and security.

To inform the development of the strategy, the Mental Wellbeing Team will be developing a suite of documents. This document provides a review of the literature for effective approaches to maintain population mental wellbeing. It aims to set out the evidence base for the individual, family, community, and place based factors which impact positively or negatively on citizens' mental wellbeing in Birmingham and gathers evidence of best practice on approaches taken by cities internationally.

The findings from the literature review will be explored within workshops with citizens and partners to assess the relevance and applicability to Birmingham.

Chapter 1 of this literature review discusses how mental health and wellbeing has been defined by a variety of organisations and institutions. Then we look at the mental health and wellbeing context in Birmingham.,

Chapter 2 focuses on the wider determinants that contribute to poor mental health and wellbeing. The review identifies some of the factors that contribute to the risks of poor mental health and the protective factors that support people to thrive. We then look at how we can minimise these risk factors and amplify the protective factors. Within this review, we focus on factors fitting into the four themes of individual, family, community, and place.

Chapter 3 summarises the national and international evidence of effective interventions to mitigate risk factors at each level and amplifies protective factors.

The final Chapter examines examples of other strategies that have been implemented by national or local governments across the globe.

Methodology

A scoping search was conducted through multiple databases and digital journal articles including Open Athens, Google Scholar, Sage Journals, SpringerLink, Taylor & Francis Online,

Trip Medical database and PubMed. A search strategy of terms utilised via data bases are highlighted in appendix 1. Literature identified was picked from academic articles, other literature reviews and systematic literature reviews. The timescales of the review search focused on research between 2010-2024. Older research may have been utilised based on references within those research pieces which were relevant to the literature topic.

As the terms “mental health” and “mental wellbeing” are used interchangeably within research, this literature review covers factors that affect both mental health and mental wellbeing.

A literature search was conducted by the UK Health Security Agency (UKHSA), with the topic title search being cities' impact on mental health and including keywords or topics that included ‘individual factors,’ ‘place-based factors’ and ‘community-based factors.’ The search covered the period of 2012-present, in total 602 pieces of research collated associated with the perimeters applied. A summary of the search strategy is shown in Appendix 2 below.

The studies focused on protective and risk impacts of individual, community, and place-based factors in England. When looking at policy and research on how to create a Mentally Healthy City, articles were picked at national levels from Spain, Canada, Australia and Japan.

Life Course Approach

This literature review adopts a Life Course Approach, recognizing the unique influence of physical and mental health across life stages. Social, economic, and environmental factors shape risk and protective behaviours, clustering within populations.

The approach focuses on critical stages and transitions, targeting interventions to minimize risks and enhance protective factors at key life stages (Public Health England, 2019). It values the health and well-being of current and future generations, addressing stages such as preconception, early years, adolescence, working age, and older adulthood (Public Health England, 2019).

This strategy focuses on three life stages:

- **Children and young people (0–17)**
- **Working-age adults (18–64)**
- **Older adults (65+)**

Key principles include:

- The interplay of protective and risk factors across the lifespan.
- Emphasizing good functional ability as the main outcome.
- Creating supportive environments to enhance function and well-being.

- Reducing inequalities by altering policies, environments, and societal norms, benefiting populations and future generations.

What is Mental Health & Wellbeing?

There is a lack of consensus on the definition of mental health which has huge ramifications on research, strategy, and policy development (Whiteford, Degenhardt , Rehn, & Et Al, 2010) (Patel, et al., 2013) (WHO). Mental health is often described as the absence of mental illness (Cattan & Tilford, 2006). However, more recently, some useful definitions have emerged, although the terms mental health and mental wellbeing are often used interchangeably as shown in and Table 2 below.

Table 1: Definitions of mental health

Organization	Definition of mental health
World Health Organisation (WHO) (2022)	'Realising one's abilities, coping with normal life stresses, working productively, and contributing to the community'
Public Health Canada (2014)	'The capacity of each and all of us to feel, think and act in a way that enhances our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual wellbeing that respects the importance of culture, equity, social justice, interconnections, and personal dignity.'
Take Action for Mental Health (Nd)	"Mental health and wellbeing is a spectrum which includes our emotional, psychological, and social wellbeing. Mental health and wellbeing affects our daily lives by how we feel, how we see ourselves, make choices, relate with our peers and communities and how we deal with stress."
Scottish Government in their Mental Health and Wellbeing Strategy (2023)	Mental health is a part of our overall health, alongside our physical health. It is what we experience every day, and like physical health, it ebbs and flows daily. Good mental health means we can realise our full potential and feel safe and secure. It also means we thrive in everyday life.
Mind (2011)	"Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."

Table 2: Definitions of mental wellbeing

Organisation	Definition of mental wellbeing
Weich, et al. (2011) (Weich, et al.) cited in Gautam, et al. (2024) (Gautam, Rahman, Hashmi, Lim, & Khanam, 2024)	Mental health and mental well-being are different phenomena. Ill mental health or mental disorders are characterized by abnormal psychological patterns, emotional distress, and impaired functioning. The Adult Psychiatric Morbidity Survey 2007 showed that mental well-being has relatively independent associations with symptoms of mental illness. It is possible for mental well-being to persist even when experiencing mental suffering.”
Scottish Government in their Mental Health and Wellbeing Strategy (2023) (Scottish Government, 2023)	Mental wellbeing is our internal positive view that we are coping well psychologically with the everyday stresses of life and can work productively and fruitfully. We feel happy and live our lives the way we choose.
Mind (Nd) (Mind, N.D)	“Mental wellbeing doesn't have one set meaning. We might use it to talk about how we feel, how well we're coping with daily life or what feels possible at the moment. Good mental wellbeing doesn't mean that you're always happy. Or that you're unaffected by your experiences. And having good wellbeing doesn't always mean that you don't have a mental health problem. You may live with a mental health problem but have good wellbeing right now. Or you might not have a mental health problem but be struggling with your wellbeing at the moment. Poor mental wellbeing can make it more difficult to cope with daily life.”

As shown above, “mental wellbeing” is framed as a more positive state than the term “mental health”, as it focuses on individuals being able to thrive and flourish in their community (Wren-Lewis & Alexandrova, 2021). The term “mental health” often emphasizes clinical elements which can often steer the conversation away from mental wellbeing support and focuses conversations too heavily on mental health services.

The Mental Health Picture in Birmingham

The Mental Health, Learning Disabilities and Autism Provider Collaborative as part of the Birmingham & Solihull Mental health trust created a Mental health Needs Assessment which highlights the mental wellbeing inequalities across Birmingham. It can be accessed here: The Mental Health, Learning Disabilities and Autism Provider Collaborative - Birmingham and Solihull Mental Health NHS Foundation Trust

Chapter 2: Creating a Mentally Healthy City

The long-term health ramifications of urbanisation are profound as over 50% of the global population currently resides in cities, a figure expected to rise by another 20% by 2050 (World Health Organisation (WHO), N.D). This shift exposes individuals to various risk factors stemming from the physical and social aspects of urban environments, exacerbating stress levels, and negatively impacting mental health.

Cities therefore need to implement successful policies and interventions to maximise the positive assets that cities have and to tackle some of the negative implications of city living.

Key strategies include:

1. **Affordable Housing and Transport**: Providing affordable urban housing and enhancing public transit, walking, and cycling infrastructure to reduce financial stress and discomfort (Centre for Disease Control and Prevention, 2024) (Urban Design, N.D).
2. **Independent Mobility**: Ensuring mobility options for diverse communities, including people with disabilities, children, adolescents, and the poor (CDC, 2025) .
3. **Community-Oriented Public Spaces**: Designing streets, parks, and public buildings that foster community interaction, especially for vulnerable groups such as the poor, disabled, migrants, youth, and seniors. Residents should be involved in creating these spaces and activities (The Mayors Office for Economic Opportunity , ND)
4. **Safety and Crime Prevention**: Minimising urban dangers through traffic safety programs, crime prevention through environmental design (CPTD), proper lighting, passive surveillance, and other community safety initiatives (Wen, Long, & Zhang, 2025).
5. **Physical Activity Integration**: Promoting physical activity by providing good walking and cycling conditions, high-quality public transport, mixed-use neighbourhoods, local parks, and recreational facilities, including community sports programs (Priyadarshini, 2023).
6. **Pollution Reduction**: Implementing programs to reduce noise, air, light, and toxic pollution (Makinde, Idowu, Pokauh, & Priscilla, 2023) (Majumdar, 2024).
7. **Greenspaces**: Designing cities with ample greenspaces, including local and regional parks, with 15-25% of urban land dedicated to public parks and ensuring most homes are within a five-minute walk of a neighbourhood park (Huang, Li, Ma, & Xiao).

Factors Impacting Mental Health and Wellbeing

This literature review takes a holistic approach to researching how potential determinants have an impact, both positive and negative, on individuals' mental health and wellbeing. The table below highlights the factors based on the theme's lens in which the literature review has focused on.

Summary table of factors based on theme

Individual level	***Family Level***	***Community level***	***Place level (including built and natural environment)***
	Attachment	*Social cohesion / networks*	*Poverty & deprivation*
Resilience	*Parenting*	*Discrimination: Ableism, Transphobia, Homophobia, Racism*	*Access to Education*
Health status	*Relationships*	*Socioeconomic status*	*Access to Green and Blue space*
Diet/ Health behaviours	*Household income*	*Stigma*	*Climate and air pollution*
Disability	*Substance use*	*Access to resources*	*Housing quality and security*
Social Capital	*Domestic violence*	*Quality spaces*	*Access to health and care services*
Physical activity	*Household composition*		*Transport access*
Self-efficacy	*Household health status (e.g. caring responsibilities)*		*Employment*
ACE			*Quality of spaces*
Income			*Security & safety*
Sexual Violence			*Urbanisation*

Life course approach overview

Factor	Children & young people	Adulthood	Older Age
ACE's	☑	☑	☑
Health Status	✗	☑	☑
Resilience	☑	☑	✗

✓ = evidence available; ✗ = limited or no evidence

Individual factors

The individual-level factors affecting mental health are multifaceted and interact in complex ways. Each factor contributes to a person's overall psychological wellbeing. These factors are expanded upon below:

Adverse Childhood Experiences (ACE)

Individuals' childhood experiences can strongly influence their future health and well-being. With adverse experiences in childhood such as abuse, and dysfunctional home environments showing strong relationships with physical and mental illness (Hughes, Lowey, Quigg, & Bellis, 2016). Individuals who have experienced an increased number of ACEs are more likely to have low life satisfaction scores and low mental well-being score in adulthood (Hughes, Lowey, Quigg, & Bellis, 2016). ACE's most linked to low mental wellness markers were people who grew up in households affected by mental illness and suffering sexual abuse (Hughes, Lowey, Quigg, & Bellis, 2016).

Children who experience and survive traumatic experiences often exhibit alcohol and drug dependency issues, deny the negative impact of their adversities, particularly if it was a result of their parents, and or construct false self-images to cope and mask their vulnerabilities, rather than self-isolate. Early onset of trauma was found to contribute to low self-esteem, depression and anxiety often surfaced due to feelings of inadequacy (Downey & Crummy, 2022).

Early childhood exposure to multiple ACEs, including child physical abuse, child sexual abuse, psychological or emotional abuse, caregiver substance misuse or exposure to domestic violence had significant negative impacts on children's social, behavioural, emotional and physical wellbeing. Exposures to ACE's in early childhood were associated with increased likelihood of behavioural problems and below-average academic abilities including literacy, social studies, science and math skills (Liming & Grube, 2018) (Jimenez, Wade, Lin, Morrow, & Reichman, 2016).

Nursery children with poor academic skills and behavioural outcomes had reported higher experiences of ACE rates in early childhood compared to nursery counterparts with no reported behavioural issues and on-schedule academic abilities (Liming & Grube, 2018) (Jimenez, Wade, Lin, Morrow, & Reichman, 2016). Exposure to three or more ACEs was significantly associated with social issues, attention problems and aggressive behaviours in nursery children. After controlling for age, gender, maternal race, ethnicity, marital status and household income, it was found that children with three or more ACEs were 3.5 times more likely to have attention issues, three times as likely to have social delays and 2.3 times more likely to have aggressive tendencies (Liming & Grube, 2018) (Jimenez, Wade, Lin, Morrow, & Reichman, 2016).

Children with scores greater than the clinical symptom range on the Child Behavioural Check List (CBCL), a standardised assessment used to evaluate emotional and behavioural problems in children and adolescents aged 6 to 18, had more ACE exposures than their counterparts who has scores below the CBCL cutoff (Liming & Grube, 2018) (Kerker, et al., 2015). Childhood trauma and family adversity significantly increased vulnerability to serious mental health problems in later childhood and adolescent years (Reay, et al., 2015).

For adolescents, those who experience ACEs were significantly associated with an increase in likelihood of current mental health diagnoses, including depression, anxiety, conduct and behavioural problems, attention-deficit / hyperactivity disorder (ADHD), and substance use disorder (Bomysoad & Francis, 2020). These associations were particularly strong for adolescents exposed to four or more ACEs (Bomysoad & Francis, 2020).

Exposure to childhood adversity has a significant impact on adult mental health, increasing the risks of depression and suicide ideation. In adulthood, the more ACEs an individual experienced during childhood, the higher the likelihood of moderate-to-heavy drinking, drug use, depressed affect and suicide attempts in adulthood (Merrick, et al., 2017). Individuals who have experienced an increased number of ACEs are more likely to have low life satisfaction scores and low mental wellbeing score in adulthood (Hughes, Lowey, Quigg, & Bellis, 2016). ACE's most linked to low mental wellness markers were growing up in households affected by mental illness and suffering sexual abuse (Hughes, Lowey, Quigg, & Bellis, 2016).

There is very limited research on the impact of adverse childhood experiences on the mental health outcomes of older adults.

Health Status

Health status refers to an individual's physical health condition. Health conditions can include cancer, cardiovascular conditions, dementia, diabetes, kidney and liver disease, musculoskeletal conditions, and respiratory conditions (Office for National Statistics, 2022). Research has shown that people with mental health conditions are at higher risk of developing physical illness, and in turn, people with a physical illness, especially cardiovascular disease, diabetes and cancer, are at a greater risk of developing a mental health problem (Doherty & Gaughran, 2014). This signifies a co-occurrence between both physical and mental problems in producing a knock-on effect and negatively affecting an individual's health status (Doherty & Gaughran, 2014).

The relationship between cardiovascular disease (CVD) and mental health is complex as heart conditions can precede mental health issues due the psychological challenges attached to them such as stress, anxiety, sleep problems, limited ability to exercise, and feelings of frustration and loss of hope, which in turn may lead to depression (Borkowski & Borkowska, 2024). Additionally, mental health problems can exacerbate or increase the risk of CVDs due to the physical effects of anxiety and panic attacks (Borkowski & Borkowska, 2024).

Older adults

A cross-sectional survey sampling 406 older adults aged between 65 and 99 years old found significant differences in life satisfaction scores determined by the number and type of disease, restrictions in daily life activities and subjective health (Dumitrache, Rubio, & Rubio-Herrera, 2017). Perceived health and perceived social support predicted life satisfaction, and the research concluded that older people who do not rate their health status positively and indicate low levels of social support have a higher risk of being dissatisfied with their lives (Dumitrache,

Rubio, & Rubio-Herrera, 2017). This highlights a link between health status, age and overall wellbeing.

Young People

The 2021 census found higher percentages of people in very good health within younger age categories and higher percentages on those in poor health within older age groups (Office For Nationale Statistics, 2023). Furthermore, the 2021 census found that in both England and Wales the most deprived areas were less likely to rate their health as ‘very good’ compared to the least deprived areas, and a higher percentage of people in the most-deprived areas reported being in fair, bad or very bad health compared with the least-deprived areas (Office For Nationale Statistics, 2023). This shows a link between deprivation and an increased likelihood of having a poor health status.

Resilience

Resilience is a process involving multiple biological, psychological, social and ecological systems interacting to help individuals maintain or improve their mental wellbeing when facing adversity (Ungar & Theron, 2020). Resilience depends not only on individual thoughts, feelings and behaviours but on culturally relevant resources available in the social, built and natural environments (Ungar & Theron, 2020).Resilience emerged from the interplay between individuals and various systems, including family, community and broader societal structures. This perspective shifts the focus from individual attributes to the quality of resources and support available across these systems (Ungar & Theron, 2020).

Resilience is a widely used concept, but studies vary in terms of their definitions and measurements of resilience (Davydov, Stewart, & Smirnov, 2010). Additionally, for some people resilience can be a problematic term due to its focus on the individual and detraction from widespread issues. In some contexts, ‘resilience’ may frame individuals or groups as ‘not resilient’ enough to cope in situations which are societal issues (Bryant & Aggleton, 2025). There may be a need for conceptual unification in the field of how resilience is defined and measured (Davydov, Stewart, & Smirnov, 2010).

Resilience can be seen as a defence mechanism allowing individuals to thrive in the face of adversity (Davydov, Stewart, & Smirnov, 2010). Resilience is not a static trait but rather a capacity that can be developed and strengthened over time. The study identifies various protective factors at different life stages that contribute to resilience such as supportive relationships, adaptive coping skills and access to resources (Masten & Wright, 2010).

Children and young people

Developing resilience in young people is essential to be able to protect their well-being and life challenges. A whole school approach can be used for resilience building. This involves integrating resilience-building strategies into the school’s culture, policies and practices to establish supportive environments (Department of Education and Training, 2016).

Within schools, a number of protective factors were identified to boost resilience including positive peer and teacher relationships, a sense of belonging and connectedness to school communities, opportunities for meaningful participation and decision-making and development of social and emotional skills (Department of Education and Training, 2016). Schools have the opportunities to create supportive environments, promote social and emotional learning (SEL) and encourage student participation which aids the building of resilience which will contribute to be able to combat mental health and wellbeing outcomes (Department of Education and Training, 2016).

A number of risk factors that can impede resilience included negative school experiences such as bullying or social exclusion, lack of supportive relationships within the school environment, and limited opportunities for engagement and participation (Department of Education and Training, 2016).

Working age adults

Problem-focused coping strategies positively predict resilience in adults. Individuals who actively address and manage stressors are more likely to develop resilience. Being able to adapt resilience is found to be a significant positive predictor of psychological well-being (Mayordomo, Viguer, Sales, Satorres, & Melendez, 2021). Adults with higher resilience levels tend to experience better mental health outcomes. Emotional coping strategies which involve managing emotional response to stress are negatively associated with psychological well-being in adults (Mayordomo, Viguer, Sales, Satorres, & Melendez, 2021).

Encountering adversity is a common aspect of ageing, and resilience plays a pivotal role in how individuals manage these challenges. Many people advocate for the inclusion of resilience in key public health strategies aimed at elderly populations. Fostering resilience provides the capacity of older adults to cope with adversity, thereby promoting healthier ageing and maintaining wellbeing in the face of challenges. This shows that even in older age, resilience is a key skill that can tackle adversities in later life (Cosco, Howse, & Brayne, 2017).

Culture

Culture is a multi-layered concept influenced by a range of issues such as gender, class, religion, language, and nationality, just to name a few (Tribe, 2005). In western models and cultures, mental health and wellbeing tend to be medicalised; with provision of therapy and professional services which are accessible and relatively destigmatised (Trinh, Bernard-Negron, & Ahmed, 2019).

In Eastern / non-Western models and cultures, illness often conceptualised spiritually, attributed to bodily imbalances or supernatural causes (Trinh, Bernard-Negron, & Ahmed, 2019). Stigma remains high; mental disorders may be somatised or resolved via family or community support (Trinh, Bernard-Negron, & Ahmed, 2019).

Cultural diversity across the world has significant impacts on many aspects of mental health. Culture underpins how health and illness can be perceived, motivations to seek treatment and to cope with symptoms and how supportive their families and communities are (Gopalkrishnan, 2018). Health-seeking behaviours, attitudes to mental health systems and practitioners are impacted by individuals' cultural practices (Gopalkrishnan, 2018). Culture can also influence

what is considered as poor mental health and wellbeing and acceptable interventions that can tackle poor mental health and wellbeing (Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009).

Cultures can have a big impact on how individuals seek treatment from mainstream Western health systems. Research in high-income countries (HIC), including USA, Canada and Australia emphasise that diverse cultures in these countries seek help later on, most likely when experiencing a crisis, than majority communities (Hampton, Hampton, & Sharp, 2013). Shame is viewed as a key factor where medical professionals need to recognise and mediate the effects of shame on individuals from diverse cultures if they wish to manage poor mental health issues (Hampton, Hampton, & Sharp, 2013).

Mainstream mental health systems are increasingly acknowledging the intersection of cultural diversity by exploring cultural identity, conceptualisation of illness, psychosocial stressors, vulnerability, resilience and the relationship between the clinician and patient (Gopalkrishnan, 2018).

Children and Young People –

A review conducted by Dogra, Vostanis, Abuateya, and Jewson, (2007) examined the prevalence and severity of mental health problems differ between ethnic groups in the UK (Dogra, Vostanis, Abuateya, & Jewson, 2007). Black African and Indian children often examined fewer or similar common mental disorder compared to White British peers, whilst black Caribbean, Pakistani and Bangladeshi experience similar prevalences (Dogra, Vostanis, Abuateya, & Jewson, 2007).

Children from different ethnic backgrounds may experience similar symptoms but interpret, express or report them differently based on cultural upbringing and norms. Individual children in the review tended to show fewer behavioural problems and more emotional symptoms , aligning with cultural expectations that encourage externalising behaviour and emphasise emotional control (Dogra, Vostanis, Abuateya, & Jewson, 2007; Goodman, Ford, Richards, Gatward, & Meltzer, 2000).

Conversely, Black Caribbean and mixed-heritage children were more often reported with conduct-related issues, reflecting cultural misunderstandings or biased interpretations by educators or service providers (Dogra, Vostanis, Abuateya, & Jewson, 2007; Bhui, et al., 2005).

Cultural pressures surrounding academic performance, gender roles or family reputation can influence how children internalise distress. With south Asian girls, Pakistani and Bangladeshi reported higher eating disorder symptoms related to body image ideals and gendered expectations within traditional family structures (Dogra, Vostanis, Abuateya, & Jewson, 2007; Tiffin, Pearce, & Parker, 2005).

Migration history and acculturation pressure due to navigating dual identifies also affect mental health depending on community integration. Black children especially recent migrants showed lower reported mental health problems. Due to protective family structures and different conceptual understanding of distress (John Aspinall & Chinouya, 2008; Dogra, Vostanis, Abuateya, & Jewson, 2007).

In adolescents and young people, a study conducted by Tsiboe, Raghuraman, and Marshall (2024) examined cultural stigma surrounding mental health and wellbeing (Kwegyir Tsiboe,

Raghuraman, & Marshall, 2024). Acknowledging that cultural beliefs govern social responses ranging from family handling to community reactions towards youth mental health. Four themes emerged surrounding stigma including public stigma from family shame, community exclusion, fear of unpredictability and madness. Cultural stigma can often lead young people to avoid disclosure or turn to traditional healers rather than formal mental health services.

Without cultural competence and understanding, clinicians may inadvertently reinforce stigma or fail to offer culturally resonant support (Kwegyir Tsiboe, Raghuraman, & Marshall, 2024).

Working age adults –

Culture can impact the way adults perceive their mental health and wellbeing. In working age adults, south Asian participants were significantly more likely to attribute depression to supernatural causes such as gods will or moral failing or seen as a character flaw (Britel & Mitchell, 2023). White British participants endorsed biological explanations far more than South Asian's such as chemical imbalances in the brain (Britel & Mitchell, 2023). The divergence matches broader cross-cultural research showing Eastern communities emphasize spiritual, moral or religious to frame mental health conversations (Lloyd & Fernyhough, 2009; Jorm, Blewott, Griffiths, Kitchener, & Parslow, 2005; Bhugra & Becker, 2005).

South Asians expressed higher perceived dangerousness of adults with depression compared to white British (Birtel & Mitchell, 2023). South Asians reported a lower willingness to be close to someone with depression and exhibit a greater desire for social distance, reinforcing findings surrounding mental health stigma (Birtel & Mitchell, 2023; Knifton, 2012; Bhugra & Becker, 2005)

In working age young people, at the country level, highly individualistic Western societies show greater average subjective wellbeing and quality of life, largely due to freedom, autonomy, economic opportunity and civic rights (Humphrey & Bliuc, 2021). Through collectivist cultures, emphasize relational support, Western individualism at a societal scale still correlates to higher life satisfaction on average (Humphrey & Bliuc, 2021).

At an individual level, the positive impacts of individualism diminished or reverse, where collectivistic orientations at the personal level, consistently correlate with better individual wellbeing (Humphrey & Bliuc, 2021). Competitiveness and hierarchy as elements of collectivism were linked to poor psychological wellbeing in young people (Humphrey & Bliuc, 2021). Collectivist values, such as co-operation and group belonging links to higher life satisfaction and reduced loneliness (Humphrey & Bliuc, 2021).

Adults with higher levels of community cultural events, like attending cultural events, museums or heritage sites were consistently linked with greater life satisfaction, better mental health functioning and lower mental distress (Mak, Coulter, & Fancourt, 2021). The effects of attending community cultural events were stronger for residents in high-deprivation neighbourhoods (Mak, Coulter, & Fancourt, 2021). This suggests greater potential mental health gains from cultural activities in underprivileged communities.

Older adults

In older adults, a study conducted by Bedi and Case (2014) examined how cultural backgrounds influence happiness and subjective wellbeing. British older adults tend to define wellbeing through individual autonomy, self-expression and life satisfaction derived from personal

achievement and leisure (Bedi & Case, 2014). Individual older adults, by contrast, ground their wellbeing in interdependence, family roles and spiritual alignment (Bedi & Case, 2014).

Individual older adults reported deeper emotional connections with family as central to their wellbeing (Bedi & Case, 2014). Happiness seen as a collective state. Religious activities were described as a stabilising force during periods of loss or illness (Bedi & Case, 2014). British elders reported more subdue emotional sates often regulated through emotional distancing or pragmatic optimism (Bedi & Case, 2014). Emotional stability was maintaining daily structure, hobbies and community participation (Bedi & Case, 2014). Loneliness was acknowledged particularly for widowed individuals but mitigated through support systems (Bedi & Case, 2014).

Indian elders expressed mental distress due to erosion of traditional values – away from joint families and the rise of elderly isolation resulting in anxiety (Bedi & Case, 2014). British elderly individuals were more accepting of independence, described as emotional flatness or chronic loneliness despite greater access to formal support services (Bedi & Case, 2014).

Diet

Maintaining a balanced and nutritious diet is crucial not only for physical health but also for mental health and wellbeing. Emerging research in the field of nutritional psychiatry has highlighted the strong links between dietary patterns and various mental health outcomes, including depression and anxiety (Sarris, et al., 2015).

Food and its nutritional composition play a pivotal role in brain functioning and overall mental health and wellbeing. A growing body of research has examined the relationship between dietary patterns and various mental health outcomes. Cross-sectional and longitudinal studies have consistently demonstrated that a Western or highly processed diet (characterised by a high intake of refined carbohydrates, unhealthy fats, and processed foods) is associated with an increased risk of developing psychiatric symptoms, such as depression and anxiety (Owen & Corfe, 2017). Conversely, a Mediterranean-style diet, rich in fruits, vegetables, whole grains, legumes, and healthy fats, has been shown to have a protective effect against the development of mental disorders (Owen & Corfe, 2017).

Caffeine, particularly in the form of coffee and energy drinks, is one of the most widely consumed stimulants globally due to its energizing properties (Klevebrant & Frick, 2022). However, research has shown a link between caffeine consumption and negative effects on mental health. Klevebrant and Frick (2022) found that caffeine intake induces panic attacks in a large proportion of individuals with panic disorders after examining 237 patients, of which 51.1% had a panic attack following caffeine, but none after placebo (Klevebrant & Frick, 2022). Klevebrant and Frick (2022) also found caffeine intake to cause an increase in anxiety levels among those with panic disorders. When exploring the effect of caffeine intake on under-18-year-olds, frequent consumption of caffeinated energy drinks (5 or more days per week) was associated with low psychological, physical, educational and overall well-being (Klevebrant & Frick, 2022). Additionally, Khouja et al., (2022) found that boys consume more energy drinks than girls, and energy drink consumption was associated with more headaches, sleep problems,

alcohol use, smoking, irritability, and school exclusion (Khouja, et al., 2022). Caffeine consumption has also been found to result in sleep problems and mental health problems, particularly among the student population (Aboelnaga, 2021). Knychalska (2025) argues that whilst moderate amounts of caffeine can have positive effects such as an improvement on mood and alertness, higher amounts of caffeine can increase anxiety symptoms such as heart palpitations and restlessness (Knychalska, et al., 2025). Therefore, individuals with anxiety disorders should minimise or limit their caffeine consumption completely. Caffeine can also increase stress levels by increasing cortisol production, possibly leading to long-term issues (Knychalska, et al., 2025).

Regarding the availability and accessibility of fresh, nutritious foods between urban and rural areas, rural communities often face greater challenges in obtaining a diverse range of healthy food options (Hepsomali & Groeger, 2021). Additionally, socio-economic factors, such as income and education levels, can play a crucial role in shaping dietary patterns and their subsequent impact on mental health (Hepsomali & Groeger, 2021). Existing research has suggested that individuals residing in rural areas may be more susceptible to experiencing food insecurity, which is defined as individuals lacking consistent access to sufficient healthy and affordable foods, compared to their urban counterparts (Wattick, Hagedorn, & Olfert, 2018). In major cities in the UK, such as Birmingham, Manchester, and London, there is often a greater availability and variety of fresh, nutritious food options, while rural regions may face more limited access and higher prices for such products (Wattick, Hagedorn, & Olfert, 2018).

Socio-economic factors have a significant impact on food access and its quality, particularly in cities with concentrated poverty. In low-income urban areas, food insecurity is driven by low income, unemployment and benefit cuts, resulting in poor access to good quality and healthy food (Loopstra R. T., 2013; Loopstra, Reeves, & Tarasuk, 2019). Food insecurity impacts economically deprived groups such as those unemployed, disabled and those with low educational attainment. In many of these situations, food banks have become safety nets for those on low incomes or in poverty (Loopstra R. T., 2013).

Children

In children and adolescent’s adherence to the Mediterranean diet was significantly linked to better quality of life (Estenban-Gonzalo, et al., 2019). Older children with greater Mediterranean diet adherence reported significantly richer emotional wellbeing and higher perceived quality of life (Estenban-Gonzalo, et al., 2019). Adolescents with healthy dietary patterns exhibited lower negative affect and continues positive affectivity (Estenban-Gonzalo, et al., 2019).

Children and adolescents with better diet quality with intakes of healthy, nutrient-dense foods had better mental health (Jacka, et al., 2011). With an association between lower diet quality, including the higher in-take of unhealthy foods such as processed foods, sugary drinks and fast food is associated with higher prevalence of depression symptoms, anxiety and overall emotional distress in young people (Jacka, et al., 2011; O'neil, et al., 2014).

Conversely, nutrient-dense diets such as mediterranean-style, rich in vegetables, fruits, whole grains and lean proteins show consistent links with lower level of depression and higher mental well-being (Francis & Stevenson, 2013).

Working-age adults

In working age adults, a meta-analysis conducted by Ejtahed et al., (2024) found that junk food was associated with a 16% increased risk of developing depression and stress (Ejtahed, et al., 2024). The study linked poor dietary habits to imflammation and oxidative stress known to contribute to mental health disorders (Ejtahed, et al., 2024). In the context of working adults who face high levels of stress and limited time, they may be more likely to rely on convenient foods, including junk food.

Adults with higher energy dietary inflammatory index was associated with increased risk of depressive symptoms, increased risk of anxiety and lower likelihood of good wellbeing (Phillips S. M., 2017). Working age women had higher odds of depressive symptoms, anxiety and lower odds of good wellbeing (Phillips S. M., 2017). High-inflammatory diet which is characterized by high intake of processed foods, saturated fats and low intake of fruits, vegetables and omega-3 fatty acids lead to poor mental health (Phillips S. M., 2017).

Older adults

In older adults, a Mediterranean diet was consistently associated with improved memory, processing speed and delaying cognitive ageing (Seabrook, et al., 2025). Dietary Approaches to Stop Hypertension (DASH) showed benefits for vascular health, indirectly supporting brain functions (Seabrook, et al., 2025). Western diets which are high in processed foods and saturated fats were associated with poorer cognitive outcomes in older adults. Diets rich in omega-3, fatty acids, polyphenols, fiber and antioxidants reduce neuroinflammation and oxidative stress in older adults (Seabrook, et al., 2025).

Disability

Disability is a growing public health concern due to the growth of an ageing population. Individuals with disabilities have lower average ratings for happiness, worthwhile and life satisfaction levels than non-disabled individuals (Jones J. , 2019).Similarly, disabled individuals with a mental health or long-term health condition have the poorest wellbeing related ratings (Jones J. , 2019). Individuals with disabilities are also more likely than others to experience financial hardship and low social support, which has been associated with declining mental health outcomes (Honey, Emerson, & Llewellyn, 2011).

Under low financial hardship and high social support, there is no difference in terms of mental health outcomes compared to non-disabled peers. Disabled individuals with lower social support and higher financial hardship are associated with poorer mental health outcomes (Honey, Emerson, & Llewellyn, 2011). This shows that financial and social support can be protective to those living with a disability.

The literature suggests that high perceived social support has a protective role for mental health and wellbeing outcomes. People with disabilities are more likely to experience loneliness and social isolation, contributing to poorer mental wellbeing (Emerson et al, 2016). Younger adults with disabilities are more prone to loneliness if they are economically inactive or live alone in rented/unstable accommodation with a low level of access to environmental assets (Emerson, et al., Overt acts of perceived discrimination reported by British working-age adults with and without disability, 2021)

Social relationships play a crucial role in the mental health and wellbeing of individuals with physical disabilities. Unwanted or unnecessary social support may have negative consequences among people with disabilities, as it can lead to reduced autonomy, self-worth and personal responsibility for disabled individuals (Tough, Siegrist, & Fekete, 2017). Increased social support during the time when a person is adapting to a disability could also lead to higher levels of psychological distress. Moreover, social relationships of disabled individuals are complex as increased support may be positive during times of distress however unwanted support can have a negative impact. To promote mental health and wellbeing in people with disabilities, high quality relationships must be established and maintained to provide adequate support (Tough, Siegrist, & Fekete, 2017).

Children and Young People

Young people with disabilities have poorer mental health than their non-disabled peers. A study identified multiple mental health trajectories amongst young adults following the onset of a disability (Honey, Emerson, & Llewellyn, 2011). Whilst some individuals maintained stable mental health, other experiences significant declines. Individuals with poorer mental health priority to onset were more likely have decline in mental health trajectories. For a subset of individuals, mental health problems persisted over time, highlighting the long-term impact of disability. Disability acted as an additional major life stressor, making it harder for some individuals to cope and more likely for them to experience worsening mental health. For those with good pre-existing mental health, had stronger coping mechanisms, social support and emotional resilience meaning they may be more capable of adjusting psychologically to the limitations of a disability onset.

Working age adults

Working aged adults with disabilities face numerous obstacles in working environments compared to able bodied individuals. These are Individuals with disabilities often face significant barriers to entering the workforce, including limited access to suitable job opportunities, transportation challenges and discriminatory attitudes from employers and job placement agencies. These obstacles can lead to prolonged unemployment or underemployment, adversely affecting mental health. Working aged adults with disabilities are three times more likely to than their non-disabled peers to experience discrimination (Emerson, et al., Overt acts of perceived discrimination reported by British working-age adults with and without disability, 2021).

When employed, people with disabilities are more likely to occupy lower-skilled positions characterised by high job demands, low control, job insecurity, and inadequate support. Such adverse working conditions are linked to increased stress and mental health issues. (Coli & Rissotto, 2014).

Individuals with disabilities are at a higher risk of exiting the workforce prematurely due to factors like health deterioration, lack of workplace accommodations, and economic downturns. This premature exit can lead to financial instability and social isolation which further negatively impacts mental wellbeing (Coli & Rissotto, 2014).

Older adults

For older adults with depression, anxiety and stress significantly impact their Quality of life. Higher levels of these mental health conditions are associated with lower life satisfaction and quality of life (Yadav, et al., 2024). Emotional distress such as anxiety and depression negatively correlates with QOL, while psychological well-being (e.g personal growth and purpose in life) enhanced it (Lopez, et al., 2024).

Older adults with mental disorders, such as anxiety or somatoform disorders often report poorer quality of life levels of functioning. Sociodemographic factors, such as age, financial situation and social connection influence quality of life and disability functioning levels (Lopez, et al., 2024).

Older adults with disabilities were found to report more heath conditions, poorer physical and mental health, higher depression scores, higher loneliness scores and to have less sense of purpose in life and fewer capabilities than the group of midlife and older people without a disability.

Income

Individuals in the lowest income bracket were more likely to experience various mental health disorders compared to those in the highest income bracket. This association was significant across several mental health conditions, indicating a robust link between lower income and poorer mental health and wellbeing (Sareen, Afifi, McMillan, & Asmundson, 2011).

Higher levels of income were associated with better mental health outcomes, including lower rates of anxiety and depression (Shields-Zeeman & Smit, 2022).There may be a threshold beyond which additional income has diminishing returns on mental health improvements. Lower-income individuals are more likely to experience financial stress, job insecurity and housing instability, all of which negatively affect mental health (Jiménez-Solomon, Irwin, Melanie, & Christopher, 2024).

Some studies suggest that income directly influences mental health and wellbeing whilst others present a bidirectional relationship, that poor mental health can result in lower income due to

work impairments and the lower ability to access high-paying jobs (Jiménez-Solomon, Irwin, Melanie, & Christopher, 2024).

Some studies found that income is not significantly associated with the prevalence of common mental disorders when controlling for socioeconomic variables. This can suggest that income levels alone may not be a determining factor for mental health status and other contextual factors such as geographic location and population characteristics may influence income inequalities (Ribeiro, et al., 2017).

Working age adults

Particularly in working adults, increases in income was associated with small but statistically significant improvement in mental health (Thomson, et al., 2022). A 10% increase in income corresponded to a minimal improvement in mental health. The greatest improvements were seen when income increases moved individuals across the poverty threshold. Income decreases were linked to a more profound deterioration in mental health, suggesting loss of income for working adults had a greater impact than the gain of income (Thomson, et al., 2022).

Older Adults

In older adults, older men aged 65 and over living alone who experiences financial strain and low income reported higher levels of depressive symptoms and decreases in life enjoyment ((Steptoe & Zaninotto, 2020). Elderly adults in lower income quintiles exhibited higher average depression scores compared to those in the highest income quintiles (Sánchez-Moreno & Gallardo-Peralta, 2021). The association intensified as income decreased, with the lowest quintile showing the strongest link to increased depressive symptoms. Social support is generally beneficial which presented at reducing levels of depression scores (Sánchez-Moreno & Gallardo-Peralta, 2021).

Self-efficacy

Self-efficacy is defined as an individual's ability to organise and execute the courses of action required to produce given attainments (Gull, 2016). These are evaluations of what can be achieved with those skills in specific contexts.

Self-efficacy plays a crucial role in the mental health. Enhancing self-efficacy may lead to improved mental health outcomes, including increased positive affect and psychological wellbeing, as well as reduced behavioural issues and psychological distress (Gull, 2016)

Children & Young people

Higher levels of self-efficacy in academic, social and emotional domains are positively correlated with increased wellbeing amongst adolescents. Adolescents reported greater confidence in their academic abilities, social interactions and emotional regulation which presented higher levels of life satisfaction. Those with moderate self-efficacy had average wellbeing scores and those with low self-efficacy had the lowest levels of wellbeing characterised by lower life satisfaction (Andretta & McKay, 2020). In adolescence, self-efficacy

is developed through personal achievements such as completing tasks that boost confidence (Schunk & Meece, 2006). Meanwhile, repeated failures can diminish it. High levels of anxiety and stress negatively impact self-efficacy (Schunk & Meece, 2006).

Working age adults

Self-efficacy was also demonstrated to have a positive relationship with wellbeing in employees, suggesting that employees with greater confidence in their abilities tend to experience higher levels of mental wellness (Hwang & Jo, 2021). This helps to enhance worker wellness; organisations and workplaces should utilise interventions to improve self-efficacy to combat stress, depression and anxiety (Hwang & Jo, 2021).

Older adults

Self-efficacy was found to have a positive relationship with quality of life in elderly populations, improving their psychological wellbeing (Bagheri, Asgharnejad Farid, & Nasrolahi, 2022); (Sharma, 2013). Older adults with greater self-efficacy experience lower levels of anxiety, depression and stress which contribute to positive mental health outcomes (Remm, Halcomb, Hatcher, Frost, & Peters, 2023).

Higher levels of self-efficacy were associated with greater life satisfaction, reduced stress and improved emotional well-being (Bagheri, Asgharnejad Farid, & Nasrolahi, 2022). It also increases confidence in elderly individuals and allows them to manage daily life challenges (Sharma, 2013).

Immigration

Immigrants and refugees across different life stages face unique mental health challenges influenced by acculturation stress, socioeconomic hardship, discrimination, and barriers to healthcare access. These experiences contribute to heightened risks of anxiety, depression, post-traumatic stress disorder (PTSD), and other psychological distress.

Acculturation-related stressors are key contributors to poor mental health among immigrants and refugees. Adapting to new cultural norms, including dietary habits, can negatively affect physical health and contribute to depressive symptoms, and a weaker orientation towards the host culture is linked to higher rates of depression, particularly among older adults (Srirangson, Thavorn, Moon, & Noh, 2013). Identity conflicts and cultural dissonance can further exacerbate psychological distress (George, Thomson, Chaze, & Guruge, 2015). Refugees who have experienced trauma may have reduced coping capacities when facing acculturation-related changes (Matheson, 2008).

Immigrants often encounter difficulties in securing employment that aligns with their qualifications due to credential recognition barriers, discrimination, and limited work experience (De Vroome & Van Tubergen, 2010). Underemployment, low-income jobs, and job insecurity heighten financial strain, contributing to anxiety and depression (Alegría, NeMoyer, Falgàs Bagué, Wang, & Alvarez, 2018).

Language barriers, cultural differences, and limited social networks can lead to social isolation, further affecting mental health outcomes (George, Thomson, Chaze, & Guruge, 2015).

Discrimination based on ethnicity or immigration status contributes to lower self-esteem and increased anxiety and depression (Priest, et al., A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people, 2013). Refugees, in particular, face heightened risks of social exclusion, which hinders their ability to access services and rebuild support systems (Beiser, et al., 2011)

Migrant populations face multifaceted barriers to accessing mental health services, including language barriers, cultural stigma, and mistrust of healthcare systems. Limited awareness of available services and healthcare professionals' lack of cultural competence further delay access to care, particularly for children and young people (Guruge, Thomson, George, & Chaze, 2015)

Children and young people

When looking across a life course approach, refugee children are especially vulnerable to mental health problems due to pre-migration trauma, including war, forced displacement, and family separation (Bronstein & Montgomery, 2011). Adjusting to new educational systems, experiencing discrimination, and forming peer relationships present further challenges (Priest, et al., A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people, 2013). Positive peer connections can enhance resilience; while bullying and exclusion exacerbate distress and hinder academic performance (Pieloch, 2016).

Working age adults

Socioeconomic hardship, employment barriers, and workplace discrimination are significant stressors for working-aged immigrants and refugees (De Vroome & Van Tubergen, 2010). Underemployment and precarious working conditions heighten financial insecurity, increasing vulnerability to anxiety and depression (Gonzalez, 2020).

Older adults

Older immigrants face greater challenges in adapting to a new environment due to language barriers, loss of social networks, and economic insecurity (Dong, 2022). Acculturation stress, coupled with dependence on family members, contributes to identity loss, loneliness, and low self-esteem (Jang, Kim, & Chiriboga, 2019). Financial insecurity and difficulty accessing welfare support further increase psychological distress (Victor, Burholt, & Martin, 2012) (Salma, 2020).

Social Capital

Social capital is a multifaceted construct encompassing various dimensions, including social networks, trust, and norms of reciprocity. These elements interact in complex ways that influence mental health in both positive and negative ways. Overall, higher levels of social capital are generally associated with better mental health outcomes. Individuals with strong social networks and high levels of trust within their communities tend to report lower levels of psychological distress and mental health disorders (Almedom, 2005).

A lack of social networks and limited sense of community can lead to mental health problems such as loneliness and depression, and this is particularly the case for at risk groups such as older people, teenagers, and new parents. Social networks are important in maintaining positive mental health during life transitions involving the exit from one role and entry into another or a significant redefinition in an individual's role or status (Hatch, et al., 2013). Life transitions occur regularly during the life course, and they include going to university, childbearing, children leaving home and moving out, marriage, cohabitation, widowhood and/or divorce. New parents often experience feelings of depression, isolation, and loneliness due to a change in their social networks as they adapt to their new role (Toombs, et al., 2018). However, new parents who use social media to connect with other parents found a sense of community, fulfilment and made new friendships, although some new parents felt judged and a sense of competition amongst other parents (Toombs, et al., 2018). This shows that social media can have a powerful impact both positively and negatively.

Some evidence does indicate that social capital can have a detrimental impact on mental health, for example, strong in-group cohesion may lead to exclusion or discrimination against outsiders, potentially increasing stress and mental health issues, particularly amongst marginalised groups (Almedom, 2005).

Children and young people

In children, social capital positively affects children's development, including educational attainment, behavioural adjustments and overall mental health and wellbeing. Strong social networks within families and communities provided emotional support, role models and access to resources, all of which contribute to better developmental outcomes (Ferguson, 2006).

The cultural and socio-economic context of children's social capital affects wellbeing outcomes. Factors such as community cohesion, trust and norms of reciprocity can have differing impacts depending on the specific environment which a child is raised in (Ferguson, 2006).

Working age adults

Despite there being no evidence explicitly mentioning adults – with many not stating participant age ranges, longitudinal studies around social capital are assumed to have monitored the adult life span. A longitudinal study investigated the social capital impact on individual health across a 25-year period. Individuals who reported better general health were more likely to participate in civic, community and social organisations. Good health enables physical and emotional capacity to engage socially (Downward, Rasciute, & Kumar, 2020).

Poor mental health was linked to lower levels of social capital. Mental distress can reduce motivation, confidence and energy to engage socially resulting in withdrawal and isolation. Downward, Rasciute and Kumar, (2020) found regarding causality that health, especially mental health influences social capital stronger than the other way around.

Older adults

A systematic review looking at eleven studies explored the relationship between social capital and mental wellbeing in individuals aged 50 and above. All studies found a positive association between various elements of social capital and aspects of mental wellbeing in older adults. Higher levels of social capital are linked to better mental health outcomes in older adults. Interactions with family and friends at the micro level were identified as key factors in generating social capital and enhancing well-being amongst older individuals (Nyqvist, Forsman, Giuntoli, & Cattan, 2012). These close-knit relationships provide emotional support, companionship, and a sense of belonging in older adults, which is crucial for positive mental well-being (Nyqvist, Forsman, Giuntoli, & Cattan, 2012).

Substance Misuse

In the UK, substance misuse significantly impacts mental health. The relationship between substance misuse and mental health issues is well-documented nationally and internationally. Public Health England (PHE) reports that individuals with substance use disorders are more likely to experience mental health problems such as depression, anxiety, and psychosis (Public Health England, 2017).

Compared to the US, European research is lagging regarding studies that investigate the impact of substance abuse on mental health in urban settings. Two studies conducted in urban areas with high levels of social deprivation have revealed substance misuse rates of 36.3% compared to 14% in rural areas of those with severe mental health diagnoses (Graham, et al., 2001); (Menezes, 1996); (Virgo, Bennett, Higgins, Bennett, & Thomas, 2001).

Cities are increasingly organised according to socio-spatial divisions, where traditionally areas of disadvantage have been identified as associated with increased risk of harmful substance use (Pedersen & Bakken, 2016). For example, it was found that individuals in the poorest areas of Oslo reported the highest levels of daily smoking, alcohol problems and cannabis use and individuals in the most affluent area reported the highest levels of recreational smoking, snus use and alcohol use. Individuals from affluent areas reported the highest use of psychoactive substances in a manner compatible with a health-oriented lifestyle (Pedersen & Bakken, 2016). By contrast, those from socio-economically disadvantaged areas use substances in a manner with greater social marginalisation and mortality.

Children and young people

Adolescents with Alcohol and Drugs problems (ADP) were significantly more likely to experience poor academic performance, high absenteeism and increased risk of school dropout. These associations were stronger among adolescents with co-occuring mental health problems.

Children with externalising problems such as ADHD and conduct disorders in childhood were strong predictors of adolescent alcohol and drug problems. Internalising problems such as anxiety and depression also predicted ADP (Skogen, 2014). Those with co-morbidity of mental

health conditions significantly increased the likelihood of substance misuse. This emphasized the developmental trajectory from early mental health issues to later substance misuse.

Working-age adults

Many adults using substances began with peer pressure, curiosity or coping with trauma. Early exposure to drugs or alcohol was often linked to family environments where substance use was normalised.

Many adults began using substances due to peer pressure, curiosity or coping with trauma (Spencer, 2023). Early exposure to drugs or alcohol was often linked to family environments where substance abuse was normalised. A significant number reported adverse childhood experiences (ACEs), including abuse or neglect, parental substance misuse and bereavement, which are strongly associated with later substance use and mental health challenges. There is a bidirectional relationship between mental health and substance use (Spencer, 2023).

Older adults

Substance abuse in older adults is increasing especially amongst the baby boomer generation. A study conducted by Badrakalimuthu, Rumball, and Wagle (2010) found that older people with substance misuse issues often present with co-morbid mental health conditions including depression, anxiety, cognitive impairment and alcohol-related brain damage. These individuals experience psychosocial adversity such as bereavement, isolation and financial stress. (Badrakalimuthu, Rumball, & Wagle, 2010).

Older adults often face polypharmacy, complicating diagnosis and treatment. Substance misuse may be masked by age-related symptoms or misattributed to dementia or frailty. Presentation is often in non-specialist settings such as A&E and primary care where staff lack the training in addiction psychiatry (Badrakalimuthu, Rumball, & Wagle, 2010).

Physical activity

A lack of physical activity is now a major cause of disease in wealthier countries. The World Health Organisation (WHO, Physical activity: Fact sheet, 2024) has called physical inactivity a global public health issue and set minimum activity levels for people at different stages of life. According to WHO, only 1/3 of working age adults across the globe meet those targets, and it’s not clear how the disjunction between the recommendations of policy makers and the behaviour of ordinary individuals (Prior, Scott, & Hunter, 2014).

Physical activity provides various significant health benefits, such as preventing chronic illnesses and premature mortality (Mahindru, Patil, & Agrawal, 2023). Exercise also helps with numerous substance misuse disorders like reducing or quitting smoking (Mahindru, Patil, & Agrawal, 2023). There is also an increasing amount of evidence that both brief episodes and extended periods of physical exercise have positive mental health outcomes, with physical activity being both a preventative activity for poor mental health and a treatment for it.

(Mahindru, Patil, & Agrawal, 2023). Exercise can improve attention, focus, memory, cognition, language fluency and decision-making for up to two hours (Hallam, Bilsborough, & De Courten, 2018), alongside enhancing mood and self-esteem whilst decreasing stress tendencies which tend to result in mental and physical disease (Ghosh & Datta, 2012; Mahindru, Patil, & Agrawal, 2023).

Children and young people

From a life course perspective, taking part in physical activity earlier in life, such as during school years, is a strong predictor of whether a person will stay active or participate in sports later in life (Hirvensalo & Lintunen, 2011).

Research has shown that young people feel more comfortable being active in spaces that are easier to navigate, especially outdoor spaces (Dodd-Reynolds, Griffin, & Kyle, 2024) Local gyms, sports clubs and school environments were spoken about in negative terms and as spaces that were experiencing insecurity, unsafe and discomfort (Dodd-Reynolds, Griffin, & Kyle, 2024). These young people were often excluded from physical activity due to their gender or sexuality, with lived experiences of being bullied or harassed in many activity spaces.

Working age adults

The World Health Organisation (WHO) has found that physical activity contributes to the prevention and management of non-communicable diseases, such as cardiovascular diseases, cancer, and diabetes, and reduces symptoms of depression and anxiety, thereby enhancing brain health and improving overall well-being (WHO, Physical activity: Fact sheet, 2024).

Strong evidence shows that regular physical activity significantly improves quality of life and subjective well-being in the general adult population. The benefits of physical activity also include enhanced mood, increased energy, better sleep and improved social functioning (Marquez, 2020).

Adults at the working age who engaged in moderate to vigorous exercise experienced lower levels of perceived stress and improved overall mood. The benefits of exercise increased adults' motivation which has implications of improved productivity in the workplace, social life and boosted life satisfaction (Grimani, Aboagye, & Kwak, 2019).

Older adults

In older adults, there is a strong association between physical exercise and mental health, indicating that older adults who engaged in physical activity had better mental health outcomes and alleviated psychological problems compared to those who did not engage in physical activity (Hou, Wu, & Huang, 2024). Whilst physical activity is found to have positive outcomes on the mental health of older adults, individuals socio-economic background was a determinant for engagement levels (Hou, Wu, & Huang, 2024).

A study looking at the accessibility of physical activity ‘Parkruns’ found that deprivation was a key indicator if individuals engaged with that physical activity type. With more individuals engaging in park runs in more affluent locations (n=584) compared to deprived locations (n=63) (Goyder, Edmonds, & Sabey, 2018). However, smaller events were seen to encourage a more supportive and friendly social experience for participants (Goyder, Edmonds, & Sabey, 2018).

Sexual Violence

The WHO defines sexual violence as "any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting”, and this includes rape, attempted rape, unwanted sexual touching and other non-contact forms (WHO, Violence against Women, 2024).

Sexual violence is a gendered crime due to it most likely being perpetrated by men, as 91% of those prosecuted for sexual offenses were men (Rape Crisis England & Wales, 2024) and most victims are commonly women and girls. The most recent Crime Survey data for England and Wales estimated that 798,000 women and 275,000 men aged 16 years and over were victims of sexual assault (including attempts), equating to an estimated 1.1 million adults (Office For Nationale Statistics, 2023). However, the true number of sexual assaults that take place is most likely to be higher due to feelings of shame and embarrassment amongst victims preventing them from making a report, leading to 5 in 6 women and 4 in 5 men who are raped not reporting it to the police (Rape Crisis England & Wales, 2024). Furthermore, sexual violence against men and boys is a very sensitive topic due to the stigma attached to it and as a result, it is a neglected area of study (WHO, Understanding and Addressing Violence against Women: Overview, 2012).

Children and Young people

Whilst everyone can experience sexual violence, teenage girls are most likely to become victims of sexual violence. A survey exploring the perceptions of just over 800 children and young people aged 13 regarding sexual harassment and sexual violence found that 92% of girls experienced sexist name-calling; 88% were sent unsolicited pictures or videos; 80% were put under pressure to send sexual images of themselves; 73% had pictures or videos that they sent being shared more widely without their knowledge or consent; 79% experienced sexual assault of any kind; and 64% experienced unwanted touching (Ofsted, 2021).

Young people who have experienced sexual violence are more likely to suffer from worse mental health problems compared to young people who have not experienced sexual violence (Bentivegna & Patalay, 2022). This is especially the case for girls who have experienced sexual violence research shows that they are at a greater risk of experiencing high psychological distress, a higher risk of self-harm, and a higher risk of attempting suicide compared to their male counterparts (Bentivegna & Patalay, 2022).

Young people who have experienced sexual violence are also likely to face long-term mental health problems, which negatively impacts their education and development into adulthood. Adolescents who completed a questionnaire about their physical and mental health, use of health services, and education 6 weeks and 14-16 months after their sexual assault reported

being at risk for depressive, anxiety and post-traumatic stress disorders (Clarke, et al., 2021). The young people also reported persistent absence from education, which doubled from 22% to 47% between the entry and end of the study (Clarke, et al., 2021). Qualitative data also found connections between poor mental health, physical health problems and disengagement from school, and poor understanding from schools regarding how to support young people post-assault (Clarke, et al., 2021). Baseline levels of smoking, alcohol and drug use also increased during the study period, and there was an increase in physical symptoms of poor sleep and appetite change following the assault (Clarke, et al., 2021).

Working age

For working-age adults, survivors of sexual assault and violence experienced significant disruptions to their wellbeing, including economic wellbeing. For female employed adults, 33.5% reported experiencing workplace sexual violence at some point in their lives ((Jonsdottir, et al., 2024). Exposure to workplace sexual violence was significantly associated with increased prevalence of various adverse health outcomes including increased rate of experiencing depression, general anxiety, social phobia, self-harm, suicidal ideation and attempts (Jonsdottir, et al., 2024).

There is increase of absenteeism due to having to take time off work to cope with trauma or attend legal proceedings regarding sexual violence (Loya, 2015). Following sexual assault, victims often face a reduction in work-place productivity due to psychological distress which can result in job loss (Loya, 2015). This creates a further long term economic impact on victims such as reduced earning power, economic instability, and altered career trajectories all of which have knock on implications of individuals mental wellbeing (Loya, 2015).

Older adults

Typically, victims of sexual violence are often stereotyped as young, attractive, able-bodied women, with perpetrators being motivated by sexual desire. However, this is a rape myth, and older-aged individuals are likely to experience sexual violence but research focusing on older adult victims remains an under-researched topic (Nobels, et al., 2020). Ageist beliefs and attitudes can create barriers for older people to report and gain access to support services for sexual violence due to myths presenting sexual violence as being linked to sexual desire and the view that older people are sexually undesirable (Bows, 2017).

Nobels et al (2020) argues that there is an underestimation of the prevalence of sexual violence in older age groups and almost all studies exclude cognitively impaired/ disabled older adults who are known to be at higher risk for abuse. (Bows & Westmarland, Rape of Older People in the United Kingdom: Challenging the ‘Real-rape’ Stereotype, 2015) found that most sexual assaults against older aged victims occur within the home (54%) or in a care home (21%) and the perpetrator most likely to be a partner/husband, a carer, or an acquaintance, making it difficult for the victim to report the crime if the perpetrator is in a position of care.

Furthermore, many older adults have a different perception of sexual violence compared to younger age groups and are less likely to view themselves as a victim making sexual violence among older adults under reported (Nobels, et al., 2020).

Families

Attachment styles

Attachment is a construct of ‘lasting psychological connectedness’ that is transmitted from one generation to the next (Bowlby, 1988). Mental health is related to attachment security, but less is known about how mental health and more contemporary conceptualisations of wellbeing might help to understand attachment transmission. From the moment we enter the world, our interactions with carers lay the foundation for how we perceive intimacy, trust and emotional connection.

At the heart of attachment theory lies how infants form emotional bonds with primary carers. These attachment styles, which shape and develop in childhood, persist into adulthood and can be categorised into secure and insecure attachments (Khan, 2024).

Secure attachment is developed when carers respond promptly and consistently to their child’s needs, offering a secure base for exploration and emotional expression. Children raised in such environments develop a secure attachment style which is characterised by trust, emotional resilience and a positive view or self and others (Khan, 2024).

Insecure attachments characterised by anxious, dismissive–avoidant, fearful avoidant attachment styles are developed by inconsistent caregiving, resulting in uncertainty about caregiving reassurance and proximity, emotional distance or unavailable, abuse, neglect or extreme inconsistencies. These result in behaviours such as clinginess, fear of abandonment, suppressing emotional needs and downplaying intimate connections, fear of vulnerability and having deep-seated trust issues (Khan, 2024).

Strong relationships with primary carers, as well as the development of emotional competencies, are protective factors against stress and other physical, mental and relational health symptoms.

Parents impacting attachment style

Parental and primary carers mental health and wellbeing play a role in the intergenerational transmission of attachment (Risi, Pickard, & Bird, The implications of parent mental health and wellbeing for parent-child attachment: A systematic review, 2021). Maternal depression mediated the relationship between mothers and children’s attachment insecurity. Mothers’ depression levels are likely associated with disturbances in the mother – child relationships resulting from less than optimal parenting (Risi, Pickard, & Bird, The implications of parent mental health and wellbeing for parent-child attachment: A systematic review, 2021). Lower levels of depression were associated with greater infant attachment security. Mothers diagnosed with depression were more likely to have an insecure state of mind regarding attachment and their infant were more likely to have an insecure attachment (McMahon, Barnett, Kowalenko, & Tennant, 2006). The longer the mother is depressed, the longer the child has an insecure attachment. Briefly depressed mothers were no more likely than never depressed mothers to have insecure attachment relationships with their children, while chronically depressed mothers were significantly more likely to have insecure attachment relationships with their children (McMahon, Barnett, Kowalenko, & Tennant, 2006).

Mothers who had experienced physical abuse, emotional neglect, sexual abuse or more than one type of trauma were less likely to have a secure attachment compared to mothers without a history of abuse. There was no significant difference between the attachment of mothers with and without a history of abuse to their infants. This could be due to mothers with a history of abuse demonstrating higher levels of awareness during one-to-one interviews, that mothers have the intention not to pass their past experiences to the next generation (Risi, Pickard, & Bird, The implications of parent mental health and wellbeing for parent-child attachment: A systematic review, 2021)

Mothers with psychiatric disorder were more likely to have an insecure attachment with their infant compared to mothers without psychiatric disorders. Psychiatric disorders affect care behaviours, especially during acute phases of psychiatric illness, resulting in a lack of protection for the child and a deterioration in thew parent-child relationship during this time.

Attachment style impacting wellbeing

Early attachment experiences shape individuals' emotional regulation abilities throughout their lifespan (Khan, 2024). Parenting literature has analysed the relation between parent-infant relationships and children's outcomes (Pedersen, et al., 2019); (Garcia & Serra, 2019). Amongst the social-emotional factors associated with adolescent wellbeing, parental attachment relationships stand out (Acun-Kapikiran, Körukcü, & Kapikiran, 2014); (Herrera-López, Romera, & Ortega-Ruiz, 2017). Parent-infant relationship is built on trust, communication and lack of alienation, which indicate secure relationships, related to the dimensions such as warmth and communication (Koehn & Kerns, 2018); (Axpe, Goñi, & Antonio-Agirre, 2019).

The emotional bonds established between a baby and its primary carer during early childhood may influence the future mental ideas teenagers form about themselves and the world around them (Bowlby, 1988); (Groh, et al., 2014).

Children and young people

Adolescents with insecure attachment to parents are more likely to engage in risky behaviours, present behavioural problems and experience difficulties with emotional regulations, such as impulsivity (Holt, Mattanah, & Long, 2018); (Rawatlal, Pillay, & Kliewer, 2016).

Adolescents who develop a secure attachment relationship with their parents report a greater satisfaction with life, greater positive affect, less stress, stronger self-esteem and more interpersonal skills (Acun-Kapikiran, Körukcü, & Kapikiran, 2014); (Sabri, Khoshbakht, & Golzar, 2015). In addition, attachment security is also associated with emotional competence, such as a greater ability to perceive label express and regulate their emotions (Rawatlal, Pillay, & Kliewer, 2016).

Adolescents' attachment to their parents was measured through trust, communication and alienation. These attachment dimensions were found to significantly influence wellbeing indicators such as complaints, stress levels, life satisfaction and affectivity (Mónaco, Schoeps, & Montoya-Castilla, 2019).

Working age adults

Attachment to parents developed earlier in life were found as protective factors against stress and other physical, mental and relational health symptoms (Mónaco, Schoeps, & Montoya-Castilla, 2019). Secure attachment was also associated with improved development of emotional competencies or perceiving, expressing and managing emotions (Mónaco, Schoeps, & Montoya-Castilla, 2019). Strong attachment relationships with parents act as protective factors during adolescence, a period marked by reduced levels of wellbeing compared to childhood.

In adulthood, individuals who have a secure attachment style demonstrate superior emotional regulation abilities. They presented higher levels of resilience when faced with stressful situations and maintained healthier interpersonal relationships. Securely attached individuals reported higher levels of psychological wellbeing, including greater life satisfaction and emotional stability (Khan, 2024).

Adults with insecure attachment styles exhibited behaviours associated with anxiety, avoidant attachments were more prone to maladaptive emotional responses. Due to this, attachment style behaviours such as avoidance, aggression or manipulation were more common, leading to heightened relational tensions. Those with insecure attachments experienced increased psychological distress, potentially due to their compromised emotional regulation strategies (Khan, 2024).

This reinforces the notion that attachment style is a significant predictor of an individual's capacity for emotional regulation and overall psychological health. Whilst attachment styles play a pivotal role in emotional and wellbeing development, other factors such as social support systems, cultural norms and personal experience play key roles in psychological wellbeing (Khan, 2024).

Income

Income levels significantly influence the mental health of families, affecting both parents and children. Economic hardship, such as low income and financial instability, can lead to increased psychological distress in caregivers. A decrease in household income was associated with an elevated risk of poor mental wellbeing resulting in the development of new mental health disorders (Thomson, et al., 2022). Income is not only a risk factor for poor mental health and wellbeing, but downward economic mobility also contributes to the onset of this (Thomson, et al., 2022). Downward economic mobility goes further than income loss, but also examines how individuals move into occupation groups (Social Mobility Commission, 2020).

Working age adults

Moderate levels of family income during adolescence are associated with the highest likelihood of financial independence, while both low and very high incomes levels are associated with lower financial independence as an adult. In working-age adults, a 10% increase in income is associated with only small improvements in mental health, suggesting even though there are modest impacts of a 10% increase in income (Thomson, et al., 2022). There is very limited

research on how income of working age adults can impact a family unit in terms of wellbeing outcomes.

Children and young people

Children who experience family income volatility were more likely to have negative mental health and wellbeing outcomes in adulthood compared to children who were not exposed to family income volatility (Cheng, et al., 2020). While children from low-income families exhibited the greatest likelihood of mental disorders, children from middle-income families experienced the greatest negative impact of income validity (Cheng, et al., 2020). Furthermore, children from low-income families were more likely to experience difficult times at school compared to children from middle-income families because of school uniform costs and limited access to nutritious food which can affect their concentration and places them at risk of being bullied (Mahony, 2017). In addition, children from low-income families were more likely to experience digital poverty and they may struggle to maintain friendships due to a lack of communication technologies (Mahony, 2017).

A relationship was found between family income and self-esteem - when family income increased so did self-esteem. A similar trend was found in life satisfaction, with higher incomes correlating with greater life satisfaction and lower incomes correlating with poorer life satisfaction. Family income was found to be an important factor impacting self-esteem and life satisfaction (Bannink, Pearce, & Hope, 2016).

Older adults

There is very little research surrounding the impact of family income on older adults' wellbeing.

Domestic Violence

The Domestic Abuse Act 2021 defines domestic abuse and violence (DAV) as any incident or pattern of incidents involving controlling, coercive, threatening behaviour, violence, physical and/or sexual abuse between individuals aged 16 or over who are, or have been, personally connected irrespective of their gender or sexuality (GOV.UK, 2021). Domestic violence is a gendered crime because women make up most survivors, with 74% of domestic abuse calls made to the police in Birmingham being from women (Birmingham City Council, 2024). However, domestic abuse can affect anyone regardless of age, sex, sexuality, gender, race, religion, socioeconomic circumstances or disability at any point during an individual's life (Birmingham City Council, 2024).

Data from the Crime Survey for England and Wales for 2024 found that an estimated 1.6 million women and 712,000 men aged 16 years and over experienced domestic abuse in the last year, equalling 6.6% of women and 3.0% of men (Office for National Statistics, 2024). The Crime Survey also found a higher percentage of people aged 16 to 19 years were victims of domestic abuse in the last year compared with those aged 55 years and over, and a higher proportion of people aged 16 years and over with a disability experienced domestic abuse in the last year more than those without (Office for National Statistics, 2024).

Those who have experienced domestic violence have an increased risk of living with depression, anxiety, drug and/or alcohol addictions, and suicidal thoughts resulting from complex trauma (Birmingham City Council, 2024). 36% of women who have experienced severe physical and sexual violence have attempted suicide, and women experiencing significant domestic abuse are more than twice as likely to have a dependency on alcohol and are eight times more likely to have a dependency on drugs (Birmingham City Council, 2024).

Children and young people

1 in 5 children in the UK are affected by domestic abuse, and the Domestic Abuse Act 2021 shifted to recognise children who have seen, heard or experienced DA as victims rather than witnesses. This acknowledgement of 'victims' rather than 'witnesses' occurred to better support children and to provide them with the necessary mental health support needed as the impact of DA can negatively affect victims over their life course (McTavish, MacGregor, Wathen, & MacMillan, 2016).

GPs and nurses have an important role in recognising and referring children who are victims of DA to support services, further highlighting the importance of integrated care and a whole system approach to preventing DAV and supporting survivors (Roy, Williamson, & Pitt, 2022).

Children exposed to domestic violence are at increased risk of emotional, physical and sexual abuse (Holt S. B., 2008). There is a strong correlation between domestic violence and co-occuring forms of maltreatment. Exposure often leads to complex trauma especially when abuse is chronic. Domestic violence often undermines the caregiving abilities of the non-abusive parent, usually creating mental health struggles, reduced emotional availability, and consistency in parenting. This diminished capacity can negatively affect the child's sense of safety and attachment (Holt S. B., 2008).

Children may experience a wide range of emotional and behavioural problems when exposed to domestic violence. These include anxiety, depression, aggression, social withdrawal and poor academic performance.

Carter et al (2022) conducted a systematic review looking at the psychological effects of domestic abuse on children. Emotional intelligence, extracurricular activities, maternal warmth and family support were seen as protective factors. Meanwhile relational victimisation, negative parenting and parenting stress were all seen as risk factors for poor wellbeing (Carter, Paranjothy, Davies, & Kemp, 2022).

Working age adults

Domestic abuse is linked to a wide range of mental health issues in adults, including depression, anxiety, PTSD, Psychosis, Bipolar disorder and eating disorders (Baukaite, 2025). Domestic abuse is also linked to an increased risk of suicidal ideation; substance use and chronic mental illness. There is a bidirectional relationship with mental health issues, increasing the vulnerability to domestic abuse, and domestic abuse can exacerbate mental health conditions (Baukaite, 2025).

A study conducted by (Dokkedahl, 2022) found that individuals who experienced psychological intimate partner violence (IPV) were more likely to experience PTSD symptoms. This did not differ across genders. Significant associations were found with the onset of depression and anxiety due to intimate partner violence. The severity and chronicity of psychological IPV were more predictive of mental health harm than isolated incidents. Coercive control which is a subtype of IPV was particularly damaging to adults' mental health and significantly contributed to PTSD.

Older adults

Adults aged 65 and over are a demographic that often get overlooked in domestic violence research. A study conducted by Knight and Hester (2016) examined the relationship between domestic violence and mental health in adults aged 25 and older. The prevalence of domestic violence amongst women aged 65+ is between 20-30%. Emotional abuse remains consistent across the life span. Physical abuse tends to decline with age, possibly due to changes in relationship dynamics or underreporting (Knight & Hester, 2016).

Strong associations between domestic violence and mental health issues such as depression, anxiety, post-traumatic stress symptoms (PTSS). Older victims may experience less psychological distress than younger victims, but greater physical health deterioration including chronic illness and disability.

There is a poor recognition of domestic abuse in older adults by health and social care professionals and limited referral pathways. Many older individuals tend not to report due to growing up in time periods where such behaviour was not taken about of viewed as the norm.

Family status

Caring for family member with disability

Families who care for a child with a disability often experience higher levels of stress and increased time demands due to the need for additional care and support. This also results in higher levels of anxiety, depression and emotional strain due to the caring process by as due to social isolation from the challenges of a child’s care and lack of support. Supporting a child with a disability also has additional financial costs which can put further strain and stress on a family and can result in poorer mental health and wellbeing (Reichman, Corman, & Noonan, 2008).

Family members providing informal carers were more likely to experience negative mental health and wellbeing implications, especially regarding young carers (Lacey, Xue, & McMunn, 2022). Carers was investigated on its implications for both positive and negative affects on mental and physical health. Carers were found to be at risk of suffering from a lack of mental and physical wellbeing due to the stress and demands of providing care. This was particularly distinct in female, elderly carers and those who provide intensive care (Phillips, Durkin, Engward, Cable, & Iancu, 2023). Carers who lacked in social support were more at risk of poor mental health and wellbeing outcomes as they tended to face high levels of stress without appropriate social networks.

There was noted to be some positive impacts of caring for a family members which includes potential opportunities for additional social support, religious or spiritual beliefs and extraversion which at times balanced out the negative implications (Phillips, Durkin, Engward, Cable, & Iancu, 2023).

Parent with mental health condition

Children raised by parents with mental health conditions are at an increased risk of developing a mental health condition themselves (Rusengamihigo, Mutabaruka, Biracyaza, Magalakaki, & El'Husseini, 2021). Children of mothers experiencing depression exhibited more emotional and behavioural problems compared to those whose mothers were not depressed (Riley, et al., 2009). The impact of maternal depression suggests the importance of developing and funding services to address the need of affected families (Riley, et al., 2009).

The impacts on the children are not solely dependent on parents' specific diagnosis but influenced by parent's behaviour, other key adults responses and degree in which child is able to develop resilience due to witnesses mental health crisis (Risi, Pickard, & Bird, The implications of parent mental health and wellbeing for parent-child attachment: A systematic review, 2021). In children this can result in cognitive and emotional development interruptions due to parents mental illness having long-term implications for their own future wellbeing.

Parents caring for a child with a severe mental health condition

A study conducted by Godress, Ozgul and Foley-Evans (2005) found that parents can often feel loss and grief that they endure due to their child being diagnosed with a mental health condition. The grief is often non-finite, ongoing and lacks closure as the child's condition persists over time. The increased grief results in parents experiencing lower psychological wellbeing and health status, with those reporting higher levels of grief experiences higher levels of distress.

Parents with children with severe mental health conditions are more likely to have an increased care capacity (Park & Seo, 2016). Children with psychiatric symptoms and reduced social functioning significantly increased parents care burden. Parents may feel stigmatised due to their associations with their mentally ill child.

There is very limited research surrounding the mental health outcomes of parents who care and support a child who may struggle / live with a severe mental health condition (Park & Seo, 2016).

Child / adolescent carers

Children and young people under 18 who provide, or intent to provide care, assistance or support to another family member(s), due to an illness or disability, mental health or substance misuse issues (Janes, Forrester, Reed, & Melendez-Torres, 2022). Being a young carer can have profound effects on mental health and wellbeing. Research indicates that young carers

often experience heightened stress, anxiety and depression due to emotional and physical demands of their caregiving responsibilities (Dharampal & Ani, 2020).

Young people with caring responsibilities for family members tend to have increased psychological distress. Reporting feelings of being overwhelmed, anxious and emotionally drained. Young carers are at a higher risk of developing mental health difficulties, particularly when caring for an adult with a mental health condition or substance misuse issue (Dharampal & Ani, 2020).

Many young carers struggle to maintain friendships and participate in social activities, leading to feelings of isolation. The emotional burden of caregiving can make it difficult for them to relate to peers who do not share similar responsibilities (The Children's Society, 2020).

The Young carers report by the Scottish government found that more young carers have worst self-reported health than non-carers and fever have ‘very good health’. A long-term health condition or disability is more common amongst young carers and young adult carers. It is unknown if and how this may relate to their caring role. Tiredness, feelings of being ‘run down’ and burnout is a physical impact that many young carers have reported. Young carers and young carers are twice as likely as young people generally to report a mental health condition – particularly from anxiety, stress and depression.

The stress and exhaustion associated with caregiving can result in physical health issues such as sleep deprivation, headaches and other stress related conditions (The Children's Society, 2020). This highlights that young carers may report poor physical health which may impact their poor wellbeing.

Young carers also struggling with balancing schoolwork with their caregiving duties, often resulting in lower academic performance and reduced educational aspirations. Young carers may experience fatigue and difficulty concentrating in school due to their responsibilities at home (ScottishGovernment, 2017).

Despite the highlighted challenges, some young carers develop a range of skills to be able to cope with poor mental health and wellbeing through their role as a carer. The development of resilience, empathy and strong problem-solving skills. When provided with adequate support they can experience personal growth and a sense of accomplishment (Dharampal & Ani, 2020).

Suicide and Carers

Carers are likely to experience depression, anxiety, stress and exhaustion, all of which place them at a high risk of experiencing suicidal ideation or attempting suicide. Research focusing on carers of people with dementia found a high prevalence of suicide ideation, equating to one in three carers (Solimando, et al., 2022). This is further confirmed by O’Dwyer, Moyle and van Wyk (2013) whose in-depth qualitative research exploring the experiences of nine family carers of people with dementia found that four of the nine carers had suicidal thoughts, and two carers had prepared for a suicide attempt. This highlights the particular risk of suicide amongst carers of people with dementia and the need for preventative interventions for this group (O’Dwyer, Moyle, & van Wyk, 2013).

Furthermore, a survey of 750 parent carers in England measuring suicidal thoughts and behaviours found that 42% of parent carers had suicidal thoughts whilst caring for a disabled or chronically ill child, and only half of those parent carers had sought help or support (O'Dwyer, et al., 2025). This presents parent carers as a high at-risk group, especially when caring for a child with a long-term disability or illness as it is often a life-long commitment for parent carers compared to an illness such as cancer which is often time-limited (O'Dwyer, et al., 2025).

Whilst carers present as a group at-risk for suicide and suicide ideation, there are aspects of the caring role which provide protective factors for suicide. A major protective factor is a sense of fulfilment amongst carers as caring can be a very meaningful role, resulting in a sense of responsibly and reason to live (Mobilise, 2019). Some carers are motivated to care for the positive aspects such as togetherness with the person being cared for, having a reciprocal bond and developing personal and spiritual growth (Brodaty & Donkin, 2009).

For carers experiencing suicidal ideation or suicide attempts, it is essential that they receive emergency respite. To prevent suicide ideation amongst carers there needs to be a focus on positive coping methods, such as making time for oneself and engaging in hobbies and interests outside of caring their responsibilities to nurture personal goals, a sense of purpose and overall life satisfaction.

Substance misuse

Substance misuse by young people

Adolescent substance abuse significantly affects the mental health and wellbeing of family members. Families often experience increased stress, anxiety and depression due to the challenges of substance misuse. For example, parents of adolescence with substance use disorders reported heightened levels of psychological distress including symptoms of depression and anxiety (Dykes & Casker, 2021). The potential legal issues and unpredictable nature of the condition tends to contribute to elevated stress (Dykes & Casker, 2021).

Most of the families were not aware of the impact of substance misuse on young people or their siblings. Parents often believe that young people's behaviours naturally change as they grow older and with the passage of time (Kendler, et al., 2018). However, when their children are involved in substance misuse, normal family functions can be disrupted. Many parents expressed distress and some choose to cut communication with other family members as not wanting to inform anyone of the substance misuse issue due to humiliation of embarrassment of their child (Kendler, et al., 2018).

Parents of adolescent's substance abuse can lead to a decline in family functioning and overall quality of life. Family members can experience feelings of helplessness, guilt, and social isolation which resulted in negative mental health outcomes (Hamza, Gladding, & Moustafa, 2022).

A literature review conducted by Monari, Booth, Forchuk and Csiernik, (2024) highlighted the experiences of family members with relatives with substance misuse disorder. The literature highlighted family members experience emotional and psychological distress due to their relatives substance misuse which make them feel helpless, worried and a sense of loss (Monari, Booth, Forchuk, & Csiernik, 2024).

The aggression and violent behaviour associated with substance misuse disorders impacted family dynamics such as physical harm, emotional trauma and a breakdown of trust in the family unity. The aggression created an environment of fear and instability (Monari, Booth, Forchuk, & Csiernik, 2024).

Substance misuse by parents / working age adults

A breadth of research highlights that children of parents with substance use disorders (SUDs) are at a higher risk for emotional, behavioural and developmental challenges. This can also result in low self-esteem and emotional distress which results in poor mental health outcomes including a higher risk of the onset of anxiety and depression (Smith & Wilson, 2016).

Alongside this, there are other consequences of SUD that may result in worsening mental health outcomes. These consequences include the risk of domestic conflicts, financial stress, neglect and child welfare interventions (Smith & Wilson, 2016). Parental substance misuse can create an intergenerational cycle where the children of those with SUD's are more likely to develop substance use problems themselves (Velleman & Templeton, 2016).

Children may face unpredictability in care and support from their parents and disrupted home environments. This puts higher responsibility on children's shoulders, resulting in parentification earlier on in their life (Velleman & Templeton, 2016).

Substance misuse in older adults

Family members often experience stress, anxiety, guilt, frustration and helplessness due to their older relative's substance misuse (Blow & Barry, 2012). Substance misuse can strain family dynamics, leading to conflict, breakdowns in communication and feelings of isolation, all of which can worsen mental health outcomes. Other determinants such as financial burden due to relatives' substance abuse, where costs relate to medical care, housing or legal issues, can take their toll on family members' mental health and wellbeing (Blow & Barry, 2012).

Family members often take unpaid caregiving roles to support their relatives who misuse substances, struggling with how to support their loved one whilst maintaining their wellbeing (Blow & Barry, 2012).

It is important to note that there is very limited academic research on the impacts of substance misuse among elderly adults on family members/units and how this has implications for mental health outcomes.

Parenting styles

Parenting styles represent parents' consistent attitudes toward their children and are based on certain attitudes and patterns of behaviour which help shape their children's long-term development (Crockett & Hayes, 2011). Parenting styles play a significant role in shaping children's and adolescents' mental health outcomes, but also their children's development (Azman, et al., 2021).

Authoritative parenting styles, which show high warmth and high control, are linked to better mental health outcomes, lower levels of anxiety, depression and behavioural problems (Azman, et al., 2021).

Authoritarian parenting styles, which show low warmth, high control, are linked to increased risks of anxiety, depression and poorer self-esteem in children. Children showed higher stress levels and emotional difficulties due to strict discipline and lack of warmth (Azman, et al., 2021).

Permissive parenting styles, which show high warmth but low control, are associated with higher externalising behaviours, such as aggression and rule breaking. Children reported lower self-discipline and increased risk-taking behaviours such as substance misuse and delinquency (Azman, et al., 2021).

Neglectful parenting, which shows low warmth and low control, is strongly associated with poor mental health outcomes, including depression, anxiety and conduct disorders. This provides higher risks of social withdrawal, academic difficulties and risk-taking behaviours (Azman, et al., 2021).

Positive parenting which includes emotional warmth, clear expectations and consistent discipline, significantly improves adolescent mental health outcomes (Smith, Jones, & Reed, 2021). Whilst negative parenting practices, including harsh discipline and neglect, increase the risk of depression, anxiety and behavioural problems in adolescents

Parenting styles had varying effects across different cultural groups, with some racialised groups showing greater resilience to strict parenting due to strong familial and community support (Lopez, Singh, & Chen, 2022). Positive parenting emerged as a protective factor across all cultural backgrounds, demonstrating that warmth and consistency universally support adolescent mental health (Nguyen, Brown, & Carter, 2022).

Working age adults

Authoritative parenting is widely recognised in developmental psychology as the most effective and balanced approach to child-rearing. It combined high levels of responsiveness, such as warmth, support and communication (Muraco, 2020). Authoritative-like parents balance a level of responsiveness, demandingness and autonomy support (Jensen, 2024). Adults with indulgent and authoritative-like parents reported better psychological wellbeing; with lower levels of depression and anxiety (Jensen, 2024). Adults who grew up with authoritative parents

tended to be more independent, better self-regulation and higher social responsibility (Muraco, 2020).

Authoritarian parenting styles is characterised by high levels of control and low levels of emotional warmth, often involving strict rules, expectations of obedience and limited open communication (Vega, 2023). This parenting style tend to have negative psychological impacts which persist into adulthood (Vega, 2023). Whereas Authoritative styles were associated with higher levels of anxiety and depression in adulthood (Vega, 2023).

Older adults

Parenting styles exhibited by grandparents tend to follow the same trends as found by evidence already examined, with authoritative parenting styles having the significant influence on children's emotional and behavioural outcomes. Children raised by grandparents were at greater risk of emotional and behavioural difficulties due to inconsistent caring practices and intergenerational discipline conflicts (Hayslip, Jr Rodriguez, & Fassi, 2026).

In terms of research examining the impact of parenting styles in childhood impacting older adults' well-being, that research is limited. Studies outside the UK have found that individuals who experienced authoritative parenting styles with high affection and high discipline were associated with better self-reported health, higher cognitive functioning and fewer depressive symptoms later on in life. Authoritarian parenting, with low affection and high discipline, was associated with worse self-reported health, lower cognitive functions and more depressive symptoms in older adults. Early parenting behaviours have a long-lasting effect on physical and psychological wellbeing into late adulthood.

Relationships

Research by Thomas, Lui, and Umberson (2017) focuses on a life course approach which draws attention to the interdependence of relationships within the family, and the impact they have on an individual's mental health and wellbeing. Family member relationships are a key source of social connection and social influence for individuals, particularly during the developing years through primary socialisation and helping to develop a sense of self (Thomas, Lui, & Umberson, 2017); (Grevenstein, Bluemke, Schweitzer, & Aguilar-Raab, 2019).

The quality of family relationships, including social support, such as providing love, advice, and care, and strain, such as arguments and being critical, can influence well-being through psychosocial, behavioural, and physiological pathways (Thomas, Lui, & Umberson, 2017).

As a result, growing up within positive or negative family dynamics has a major effect on children, which is carried into their adulthood. Research has shown that people with better family relations reported less psychological distress, better health and well-being, and greater overall life satisfaction (Grevenstein, Bluemke, Schweitzer, & Aguilar-Raab, 2019). Grevenstein et al (2019) also highlighted the potential benefits of preventative strategies and family therapy to enhance the quality of relationships and initiate positive change within families to combat generational cycles of trauma.

Marital Status

Research has shown that being married, especially happily married, is associated with better mental and physical health, as well as increased access to economic resources, greater self-esteem, and healthier behaviours generally (Thomas, Lui, & Umberson, 2017). Married people, on average, enjoy better mental health, physical health, and longer life expectancy than divorced/ separated, widowed, and never-married people (Lawrence, Rogers, & Zajacova, 2019). However, an unhappy marriage can increase stress levels and have negative impacts on wellbeing (Thomas, Lui, & Umberson, 2017).

Using the General Social Survey–National Death Index, Lawrence et al (2019) compared individuals who were “very happily” married and “not too happy” in their marriages and found that those who were “not too happy” in marriage were over twice as likely to report worse health and almost 40% more likely to die over the follow-up period, irrespective of socioeconomic, geographic, and religious factors. Those “not too happy” in marriage also had equal or worse health and mortality risk compared to those who were never married, divorced or separated, or widowed, highlighting the importance on the quality of the relationship in improving wellbeing (Lawrence, Rogers, & Zajacova, 2019).

Marital relationships are also argued to become more important with advancing age, as other social relationships such as those with family members and friends are often lost due to geographic relocation and death in the later part of the life course (Thomas, Lui, & Umberson, 2017).

Intergenerational Relationships

In 2022, people aged 65 and older made up 19% of the population in the United Kingdom, and this is projected to increase to 27% by 2072 (Barton, Sturge, & Harker, 2024). With this ageing population, there is a greater pressure on adult children to take on a caring role for their parents in later life. Research on the impact of becoming a carer and the effect it has on the carer’s wellbeing is generally mixed. Unpaid carers are potentially at increased risk of poor well-being due to the all-consuming demands of caring, however caring often makes the carers feel closer to the care recipient and assures them that the recipient is receiving quality support (Schulz, Beach, Czaja, Martire, & Monin, 2020). Research has shown that adult children who become carers express satisfaction for their role if they feel a sense of acknowledgement, appreciation, and support from their closest family members, friends, and the aging parents themselves while performing caregiving tasks (Charenkova, 2023). A feeling that one is appreciated for taking care of parents and having their difficulties acknowledged makes carers feel motivated to continue, as long as a balance between taking care of their parents and themselves is maintained (Charenkova, 2023).

However, adverse psychological effects of caring can be dispersed throughout the family and not just among active caregivers, as research has found that that longer-term unpaid carers were significantly less happy in their marriages than those who had recently assumed the caring role (Schulz, Beach, Czaja, Martire, & Monin, 2020). Caring can also interfere with work performance, leading to the carer quitting their job or turning down promotions, resulting in

reduced wages and potential financial issues for the family and a strain on their wellbeing (Schulz, Beach, Czaja, Martire, & Monin, 2020).

Chosen families

A chosen family, or a family of choice, is defined as a nonbiological kinship bond purposely chosen due to mutual support and love (Gates, 2017). Chosen families have become more popular in recent years due to an increase in family estrangement, with 1 in 5 families in the UK experiencing estrangement (Blake L. , 2015). Family estrangement occurs when at least one family member voluntarily and intentionally distances themselves from another family member(s) because of an ongoing negative relationship (Scharp, 2023). The increase in family estrangement is argued to be due to an increase in individualism, a reduction in the reliance upon family members, and greater awareness of mental health (Savage, 2021). The charity Stand Alone found that 80% of people who had estranged from their family said it has a positive effect on their lives as individuals were happier and less stressed after cutting off toxic families (Blake L. , 2015). However, 90% of individuals who had been estranged from their families found Christmas and the festive period to be a particularly difficult time of year (Blake L. , 2015). This shows how family estrangement has both positive and negative outcomes for individuals' wellbeing.

Chosen families have increased importance for people in the LGBTQ+ community who are more likely to experience family disownment due to homophobia and rejection resulting from cultural and/or religious beliefs (Kim & Feyissa, 2021). However, despite facing rejection or self-determined estrangement from their biological families, LGBTQ+ chosen families have been shown to buffer against stigma, isolation, stress, promote positive identity, and improve health and wellbeing outcomes (Chandler & Tasker, 2024). For older LGBTQ+ individuals, chosen families are utilised to provide care and wellbeing support that is otherwise missing due to limited-to-no relationships with their biological families (Jackson Levin, Kattari, Piellusch, & Watson, 2020). Older lesbians and gay men would rely upon their family of choice for emotional and practical support. However, for more intensive and potentially intrusive forms of support, most older lesbians and gay men said they would turn to a spouse or partner (if they had one) or they indicated that they had no-one to turn to, showing how a family of choice can be problematic for some during older age when they are most in need of medical care (Lottmann & King, 2020).

Household composition

Family structures significantly influence children's mental and physical health. With factors such as stability, parental support and socio-economic factors playing a role within this

Children from two-parent households generally have better mental health outcomes, including lower levels of anxiety, depression and behavioural issues compared to children who are growing up in single-parent families (Smith, Cooper, & Lee, 2020). Children from single parent families showed higher rates of emotional and behavioural difficulties associated with financial stress, reduced parental supervision and emotional strain.

A meta-analysis highlighted that children of parents who are separated were at increased risks of growing up in households with lower incomes and poorer housing conditions, experience behavioural problems, lower educational attainment and qualifications, needing more medical treatment, leaving school and home when younger, becoming sexually active, pregnant or a parent at an early age, and higher risk of reporting more depressive symptoms and higher levels of substance abuse as an adolescence (Mooney, Oliver, & Smith, 2009).

Looking at a life-course approach, parental separation during childhood has serious implications for later on in life. Adults who experienced parental separation during their childhood have higher probability of problems which included poorer mental health and wellbeing, alcohol misuse, lower educational attainment and problems with forming relationships themselves (Mooney, Oliver, & Smith, 2009).

Blended and step-families were associated with higher levels of stress for children, especially during the transition periods of becoming a family, resulting in difficulties that require emotional adjustment (Brown, Green, & Harrison, 2021).

For biological parents who are co-parenting, the quality and positivity of co-parental communication positively predicted their own relational satisfaction and mental health outcomes. So, when biological parents perceive co-parental interaction as supportive and effective, they tend to experience higher satisfaction in their relationship and better mental health (Schrodt & Braithwaite, 2011).

Step-parents who reported higher quality co-parental communication also reported greater relational satisfaction and improved mental health outcomes (Schrodt & Braithwaite, 2011).

There is very limited research investigating how household compositions vary across different cultures and racialised communities on the implications of family mental health.

Community Factors

Mental health and wellbeing are not solely determined by individual or family factors. While individual characteristics play a role, the communities in which we live, work and interact significantly impact our mental wellbeing. This review explores the relationship between community factors and mental health.

Discrimination

Discrimination in its various forms whether based on race, ethnicity, gender, sexual orientation, or disability significantly impacts mental health. Discriminatory experiences and microaggressions result in chronic stress, lower self-esteem, and increased incidence of mental health disorders which all perpetuate inequalities resulting in poor mental wellbeing outcomes in marginalised groups (Kattari S. K., 2020). Some of the different forms of discrimination are explored further, below but this list is not exhaustive.

Stigma and Discrimination

Mental health stigma within communities can prevent individuals from seeking help for mental health concerns. Mental illness stigma continues to attract and warrant attention from the government, the public, patients and health researchers due to undeniable evidence that shows people facing mental illness stigma have worse life challenges than those not affected by mental illness or affected with mental illness but without stigma (Corrigan, Druss, & Perlick, 2014). In the UK, there is greater mental illness stigma in ethnic minority communities, largely to Black, both African and Caribbean, and South Asian, including Pakistani, Indian and Bangladeshi populations.

Fear of discrimination, judgment, and social isolation can lead to untreated mental health problems and exacerbate existing conditions. Communities that promote mental health awareness and reduce stigma create a more supportive environment for individuals seeking help (Kapadia, Stigma, mental illness & ethnicity: Time to centre racism and structural stigma, 2023).

Individuals with mental illness or poor mental health faced significant stigma within their communities, which impacted their willingness to seek help. Cultural constructs played a crucial role in shaping perceptions of mental health, with stigma manifesting differently across Pakistani, Indian and Chinese communities. Community-led interventions that acknowledged and incorporated cultural beliefs were positively received, suggesting the need for culturally sensitive approaches to reduce stigma (Knifton, 2012).

Racialised communities' experiences of racism at the interpersonal and structural level are a fundamental driver of mental health disparities. Models of stigma fail to capture the impacts of systemic racism and structural barriers on mental health outcomes (Kapadia, 2023). Racialised communities experience layered stigma, not just associated with mental illness but the additional burden of racial discrimination, which further exacerbates the challenge of accessing and receiving mental health care (Kapadia, Stigma, mental illness & ethnicity: Time to centre racism and structural stigma, 2023).

Ableism

Ableism, the discrimination against people with disabilities, contributes to a culture that devalues and marginalises disabled individuals. This can result in social exclusion, reduced opportunities, and negative self-perception, all of which are detrimental to mental health. It has been observed that the visibility of disability/impairments are correlated with experiencing ableist microaggressions and the experiences of microaggressions are associated with poor mental health outcomes (Kattari S. K., 2020).

Children and young people

The internalisation of ableism – where disabled individuals adopt society's negative perceptions of disability has profound psychological social and physical consequences. Young people internalising ableism reported feelings of shame, low self-esteem and internal conflicts regarding their identifies. Many individuals felt isolated and distanced themselves from other disabled individuals to align with society norms. A study conducted by Hodge and Runswick-Cole, (2013) examines the experiences of disabled children and their families. In mainstream spaces intended for all children, disabled children often face exclusion unless they can 'pass' as non-disabled, adhering to normative behaviours and abilities. Segregated spaces designed for disabled children can inadvertently reinforce separation and stigma and limit opportunities for inclusive social interactions (Hodge & Runswick-cole, 2013).

In leisure activities ableism manifests in leisure settings through exclusionary practices such as disabled children often being left out of group activities highlighting social isolation. There is an implicit demand for disabled children to exhibit better behaviour than their nondisabled peers to be accepted, placing undue pressure on them. In many circumstances parents frequently need to accompany their children to ensure inclusion, indicating a lack of systemic support within leisure programs. This can result in emotion strain particularly feelings of frustration, sadness, helplessness amongst both children and their parents.

Children with physical disabilities are seen as less capable, helpless or dependent. This perception limits opportunities in education, employment and social engagement (Mustapha, 2021). It lowers self-esteem and creates internalised ableism in children who are repeatedly told they are 'less than' (Mustapha, 2021).

Further common stereotypes include that children and young people with disabilities are seen as asexual, non-romantic or socially awkward (Mustapha, 2021). These assumptions limit social development and hinder the ability to form romantic or peer relationships. In adolescence, this can cause severe sense of exclusion and abnormality.

Visible disabilities such as the use of assistive devices including wheelchairs, braces, walkers which mark these individuals as 'different' which gives society permission to stare, question and patronise (Mustapha, 2021). Children with disabilities learn early that their appearance invites scrutiny or pity (Mustapha, 2021). This visibility can result in social withdrawal, anxiety or shame.

Working age adults

Working aged adults with disabilities were over three times more likely to report experiencing discrimination compared to their non-disabled peers (Emerson, et al., Overt acts of perceived discrimination reported by British working-age adults with and without disability, 2021). The most common sources of discrimination for individuals with disabilities were strangers in public settings and healthcare professionals.

Adults with disabilities reported significantly higher levels of perceived discrimination in employment settings than their non-disabled counterparts (Emerson, et al., Overt acts of

perceived discrimination reported by British working-age adults with and without disability, 2021). The discrimination was not subtle or overt. The discrimination was overt which had further impact on mental health, self-worth, and career progression. Discrimination in employment based on disability was based on denied opportunities or promotion, unequal treatment by employers and colleagues, and job insecurity and dismissals (Emerson, et al., Overt acts of perceived discrimination reported by British working-age adults with and without disability, 2021).

Older adults

In 2015, 5% of Australians aged 55 and over with a disability reported experiencing an instance of disability discrimination and one in four reported avoiding a situation or context due to their disability (Temple, Kelaher, & Williams, 2019). Older adults who lived with sensory or speech disabilities, physical disabilities, neurological conditions experience higher instances of discrimination and were more susceptible to exclusionary experiences and subsequent psychological distress (Temple, Kelaher, & Williams, 2019). Exposure to disability discrimination in older age resulted in 1.7 times higher prevalence of psychological distress compared to those who did not.

Transphobia

The Trans and gender non-conforming (TGNC) community continues to represent a notably marginalised community exposed to pervasive discrimination, victimisation and microaggressions (Austin & Goodman, 2016). Transgender people who access clinical services have been found to have increased levels of depression, anxiety, low self-esteem, self-harm, disordered eating and poor body image compared to the general public ((Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013); (Bouman, et al., 2017); (Millet, Longworth, & Arcelus, 2017); (Warren, Smalley, & Barefoot, 2016).

Research shows that transgender people have almost a threefold increased risk of probable anxiety disorder compared to the general population, and trans men in particular experience higher levels of anxiety compared to trans women (Bouman, et al., 2017). Bouman, et al., (2017) also highlights the importance of transgender people in receiving timely access to transgender healthcare services in order to reduce the risk of developing mental health problems. Transgender people who accessed gender-affirming hormones during early or late adolescence had lower risk of experiencing suicidal ideation and psychological distress in adulthood compared to those who did not access gender affirming hormones (Turban, King, Kobe, Reisner, & Keuroghlian, 2022). This further highlights the negative impact restrictive legislation surrounding transgender medical care can have on their mental health. Research generally on the life course of transgender people and their mental health is limited.

Children and young people

Transgender and non-binary youth experience disproportionately high rates of verbal and physical attacks, particularly within school settings. Non-binary individuals are especially

vulnerable to cyberbullying, and they tend to receive the least amount of support from family and friends. This group also reports lower levels of participation in social activities. Transgender youth, in general, exhibit elevated levels of psychological distress, including persistent feelings of isolation and unhappiness. Alarmingly, approximately 70% of transgender adolescents have reported experiencing suicidal thoughts (Aparicio-García, Fernández-Castilla, Giménez-Páez, Piris-Cava, & Fernández-Quijano, 2018).

A growing body of research has identified societal and institutional transphobia—including denial, rejection, and hostility toward gender and sexual diversity—as a significant threat to the physical and mental health of transgender and non-binary adolescents (Gallardo-Nieto, Espinosa-Spínola, Ríos-González, & García-Yeste, 2021) (Guz, et al., 2021); (Cover, 2016). In educational contexts, this discrimination manifests in various harmful ways: verbal abuse (e.g., insults, misgendering, and derogatory language), social exclusion (e.g., peer ostracism and lack of support from educators), and physical aggression (e.g., bullying and assault). These experiences are often compounded by institutional neglect, wherein schools fail to address or prevent such violence effectively (Gallardo-Nieto, Espinosa-Spínola, Ríos-González, & García-Yeste, 2021).

The impact of this discrimination on transgender and non-binary students is profound. It contributes to an increased prevalence of mental health challenges, including anxiety, depression, and suicidal ideation. Additionally, these students often experience social withdrawal, feelings of isolation, and a diminished sense of belonging within the school community. Academically, they face considerable barriers, including higher rates of absenteeism, lower academic achievement, and increased school dropout rates (Gallardo-Nieto, Espinosa-Spínola, Ríos-González, & García-Yeste, 2021); (Guz, et al., 2021); (Cover, 2016)

Working age adults

Transgender adults experiencing mental health challenges are disproportionately more likely to be unemployed or underemployed, often due to pervasive workplace stigma and discrimination—despite a strong interest in gaining and maintaining employment (Mizock & Fleming, Professional Psychology: Research and Practice, 2011). Many face overt discrimination, job loss, difficulty securing employment, restroom-related harassment, and the reinforcement of gender stereotypes in professional environments (Budge, Tebbe, & Howard, 2010).

To navigate these barriers, some transgender individuals report compensating by working harder within their roles (Budge, Tebbe, & Howard, 2010). Engaging in active coping strategies—such as resilience-building and self-advocacy—has been linked to reduced mental health burden among those who are employed (Budge, Tebbe, & Howard, 2010). However, persistent encounters with transphobia in the workplace can undermine self-confidence and contribute to psychiatric distress. When compounded by employment instability and resulting financial insecurity, these stressors can further exacerbate mental health issues (Willging, Salvador, & Kano, 2006).

Transgender individuals are subject to both external stigma (prejudice, discrimination, and exclusion from others) and internalized stigma (self-directed negative beliefs), which together interfere with employment outcomes and significantly increase the risk of depression and suicidality (Kidd, Veltman, Gately, Chan, & Cohen, 2011). Employed transgender individuals reported higher levels of both internalized and external stigma compared to their unemployed peers, likely due to increased exposure within workplace settings (Mizock & Mueser, Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. , 2014).

While employment can provide critical financial and social benefits, the presence of discrimination and transphobic environments can negate many of the typical protective effects of stable work. As a result, transgender individuals often experience elevated rates of anxiety, depression, psychological distress, low self-esteem, and suicidal ideation, even when employed (Mizock & Mueser, Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. , 2014).

Older adults

There is very little research on the wellbeing implications of experience of transphobia on trans older adults. In older adults who are trans, social support networks were important in coping with the challenges of transphobia and ageism (Arruda, et al., 2025). Relationships with family, friends and partners were identified as crucial for wellbeing. The loss of support due to transitioning, such as estrangement from family or friends have a negative impact. Trans older adults who faced discrimination in medical settings were five to eight times more likely to report memory problems, increased incidents of depression and other health challenges underscoring the detrimental effects of healthcare discrimination (Lambrou, et al., 2022). In older trans adults, the study found that gender-related discrimination and frequent everyday discrimination experiences were associated with increased depressive distress (White Hughto & Reisner, 2018).

Homophobia

Stonewall defines homophobia as prejudice or negative attitudes, beliefs or views about gay people, including the fear or dislike of someone because they are perceived to be gay. Within the section, as highlighted by Stonewall, we will focus on discrimination towards male gay individuals. Experiences of homophobia, including bullying, social exclusion, and family rejection, contribute to higher rates of mental health issues within this community (Newcomb & Mustanski, 2010).

Those who identify as LGB experience more severe harassment and maltreatment than their straight counterparts (Russell, Bishop, Saba, James, & Ioverno, 2021). It has been reported that maltreatment of children based on their identification of LGBTQ+ has occurred in educational institutions as early as eight and nine years old (Evans-Polce, Veliz, Boyd, Hughes, & McCabe, 2020). This may result in further experiences of low self-esteem and stress based on concealment of their sexual and gender identity thus generating internalised homophobia based on internalising homonegativity towards themselves (Delozier, Kamody, Rodgers, & Chen, 2020); (Ocasio, Tapia, Lozano, Carrico, & Prado, 2020). Both the experiencing of discrimination and internalising homophobia have negative mental health outcomes on LGBTQ+ community

members such as increased prevalence of depression, anxiety, stress-related trauma and are more likely to contemplate suicide (Higbee, Wright, & Roemerman, 2020).

This experience of discrimination can make it all more difficult for LGBTQ+ members to be able to come out, making it difficult to forge and establish meaningful social connections and if they can trust the individual with a declaration of their sexuality, which further exacerbates stress (Daniele, Fasoli, Antonio, Sulpizio, & Maass, 2020); (Kachanoff, Cooligan, Caouette, & Wohl, 2020).

Young people

In gay adolescents and young people, there was higher reports of experiences of various forms of violence including physical, verbal, psychological and sexual abuse (Natarelli, Braga, Oliveira, & de, 2015). Homophobic experiences led to diminished self-esteem and adverse health behaviours such as poor nutrition, lack of physical activity, disrupted sleep patterns and suicidal ideation (Natarelli, Braga, Oliveira, & de, 2015). Adolescents and young people who experienced homophobic name-calling exhibited higher levels of depressive symptoms and lower levels of self-esteem by the end of the academic year (DeLay, et al., 2016). This highlights the direct link between homophobic name calling and declines in mental health and wellbeing (DeLay, et al., 2016).

Working age adults

In homosexual adults, internalisation of societal homophobic attitudes results in psychological distress such as depression, anxiety disorders, stress and trauma-related disorders, obsessive-compulsive behaviours, eating and dissociative disorders (Van Beusekom, Bos HM, Overbeek, & Sandfort, 2018); (Newcomb & Mustanski, 2010). People who report lower levels of homophobic discrimination have less mental health distress (Ventriglio, Castaldelli-Maia, Torales, De Berardis, & Bhugra, 2021). These tend to be exacerbated by individuals struggle with self-acceptance and the societal pressure to conform to heteronormative standards. Homophobic experiences have been linked to decreased life satisfaction amongst LGBTQ+ adults (Wen & Zheng, 2019). With the psychological toll of homophobia directly diminishes overall wellbeing (Ventriglio, Castaldelli-Maia, Torales, De Berardis, & Bhugra, 2021). Homophobia is also recognised as a risk factor for suicidal behaviours. The persistent exposure to discrimination and societal rejection contributes to feelings of hopelessness and despair, increasing the risk of suicide (Saletine, Hilt, Muehlenkamp and Ehlinger, 2019).

Homophobia significantly affects the self-esteem of young adult males, leading to diminished self-worth and greater psychological vulnerability (Duggal, 2024). Higher levels of homophobia corresponded with lower levels of self-esteem (Duggal, 2024).

Older adults

In older adults, older gay men who reported high levels of perceived stigma, such as anticipated discrimination, experienced more depressive symptoms and lower positive affect (Wight,

LeBlanc, de Vries, & Detels, 2012). Stigma was measured in terms of how much they believed others devalued or reject them due to their sexual orientation. Discrimination was considered a chronic stressor that interacts with aging-related stress such as financial worries or declining health, which compounded its impact on mental health (Wight, LeBlanc, de Vries, & Detels, 2012). The dual burden of ageism and homophobia was particularly detrimental, especially to unpartnered, lower-income or HIV positive individuals (Wight, LeBlanc, de Vries, & Detels, 2012). Homophobia contributed to increased depression and anxiety, reduced emotional resilience and lower levels of satisfaction and self-worth (Wight, LeBlanc, de Vries, & Detels, 2012).

Biphobia

Biphobia is defined by Stonewall as prejudice or negative attitudes, beliefs or views about individuals who are bisexual or those who are perceived to be bisexual. Bisexual people have consistently been found to have poorer mental health than their gay, lesbian or heterosexual counterparts (Puckett, Dyar, Maroney, Mustanski, & Newcomb, 2023). They are more likely to be diagnosed with a mental health disorder have symptoms of depression and anxiety and report suicide ideation (Loi, Lea, & Howard, 2017); (Persson, Pfaus, & Ryder, 2015).

Bisexual individuals are further at risk of developing psychological problems compared to their gay or lesbian counterparts due to the experience of double discrimination-related stress. (Savin-Williams, 1989). In many cases bisexual individuals experience discrimination and a lack of acceptance from both heterosexual and homosexual communities.

Young people

Adolescence and young people who are bisexual are more likely to conceal their sexual orientation and experience identity uncertainty compared to their lesbian and gay peers (Marzetti, McDaid, & O'Connor, 2022). This concealment is associated with higher levels of depression and anxiety. Bisexual young people often experience less supportive social environments highlighting the importance of families and social networks in acceptance of young people sexual identity (Pollitt, Muraco, Grossman, & Russell, 2022).

Working age adults

In working age adults, studies have consistently shown that working age bisexual adults experience elevated rates of depression, anxiety and substance use disorders more than their gay, lesbian or heterosexual peers (Puckett, Dyar, Maroney, Mustanski, & Newcomb, 2023). Biphobia within workplace settings, manifesting as microaggressions, exclusion and overt discrimination negatively impact job satisfaction and mental health.

Older adults

Research by Jones, Almack and Scicluna (2018) addresses the unique experiences and needs of older adults with bisexual relationship histories. This group tends to be underrepresented in research. In older adults, Biphobia had lasting impacts on their mental health and wellbeing. Experiences of invisibility and marginalisation within both heterosexual communities contributed to feelings of isolation and stress later on in life. Older bisexual individuals expressed

apprehension about accessing health and social care services, fearing discrimination or misunderstanding due to their sexual history (Jones, Almack, & Scicluna, 2018).

Lesbophobia

Experiences of lesbophobia can result in higher rates of depression, anxiety and suicidality and substance use compared to the general population (Müller & Daskilewicz, 2018). Lesbophobia significantly contributes to increased levels of anxiety and psychological distress amongst lesbian individuals. Negative attitudes towards gays and lesbians have a great impact on these individuals, not only on the physical level, but also on the psychological level, such as increased levels of anxiety, somatic distress and even post-traumatic stress symptoms which may impact quality of life (García-Sánchez, et al., 2024).

Lesbians are exposed to higher levels of discrimination in healthcare than gay and bisexual cisgender men (EL*C, 2023). This indicates that misogyny can play a role in experiences within the healthcare system (EL*C, 2023). Lesbians were generally more likely to than total respondents to report that their specific needs were ignored (EL*C, 2023).

Young people

A study conducted by García-Sánchez et al, (2024) examined lesbophobic attitudes amongst Spanish youth. It found lesbophobia contributes to poorer mental health outcomes, with factors such as education levels, sexual orientation and political ideology influencing attitudes towards lesbian individuals (García-Sánchez, et al., 2024). people, lesbophobia contributed to social exclusion, limited access to supportive networks and increasing feelings of loneliness. The study found that lesbian individuals often experience barriers in social and professional environments due to negative stereotypes and discrimination.

Working age adults

There are limited studies on implied mention of lesbophobia impact on adult mental health. However, studies examining how homophobia impacted women's mental health identified that homophobia lowers self-esteem in women, particularly those who experience direct discrimination or societal stigma (Duggal, 2024). These women tend to internalise the negative discrimination which diminishes their self-worth and confidence. This also increases emotional struggles which can affect their overall mental health and wellbeing (Duggal, 2024).

Older adults

There is very limited data on the impacts of lesbophobia specifically on older lesbian community. Despite this a report conducted by identified that inadequate services and discrimination are still common for lesbians when in contact with medical professionals (EL*C, 2023). Therefore, lesbians who have a greater need for healthcare could be at greater risk of discrimination (EL*C, 2023). In terms of health and wellbeing, cis older lesbians generally experience poorer health when compared with cis older heterosexual women, which is attributed to minority stress and exclusionary heteronormative healthcare experiences. For senior lesbians, they are likely to experience mental health issues such as depression, mainly

related to isolation, invisibility and loneliness and a lack of inclusive health services (EL*C, 2023).

Racism

Racism and racial discrimination are increasingly receiving attention as determinants of racial and ethnic inequalities in health (Braveman, Egerter, & Williams, 2011). Racism can be expressed through belief, emotions or behavioural practices that can be deeply embedded in social systems and structures. Racism occurs at three levels (Jones J. M., 1997): individual, institutional and cultural. Individual racism is where a person experiences face-to-face discrimination. Institutional racism refers to policies, practices of organisations and societal norms. Cultural racism refers to a thinking or worldview that perpetuates the belief in cultural values. Any form of racial discrimination and marginalisation threatens an individual's wellbeing and impairs their ethnic identity formation (Surko, Ciro, Blackwood, Nembhard, & Peake, 2005); (Utsey, Chae, Brown, & Kelly, 2002); (Zayas, 2001). Racial discrimination leads to common stress-related disorders such as depression (Gaylord-Harden & J.A, 2009)).

Due to racism being deep-rooted in institutions and our society, the experience of racism is based on the dehumanisation of a group of people, with stressors related to racism threatening an individual's life (e.g. police brutality and poorer quality healthcare), livelihood (ethnic pay gap, economic differences) and ability to thrive such as having to adjust speech, appearance and behaviour to navigate interracial interactions (Brownlow, 2023).

Experience of racism often results in culturally based coping strategies of high emotional and behavioural suppression, distress tolerance and vigilance in the face of racial threats (Brownlow, 2023). These coping strategies may elicit poorer mental wellbeing implications such as depression, anorexia and obsessive-compulsive personality disorder, greater drug use, social anxiety, and generalised anxiety (Gorey, Rojas, & Bornovalova, 2018); (Brandes & J., 2006). These strategies can be transmitted across generations via transactions on how to cope with experiences of individual and systematic understanding of racism (Brownlow, 2023).

Children and Young people

There is emerging research examining the impact of racial discrimination on the health and wellbeing of children and young people who are considered vulnerable to its harm (Williams & Mohammed, 2009). In the UK there is a significant gap in the literature concerning the impact of racism on the mental health of children and young people in the UK (Ghezae, 2025).

A systematic review by Priest et al. (2013) examined 121 empirical studies investigating the relationship between reported experiences of racism and health and wellbeing outcomes among children and young people aged 0–18 years. The review found strong and consistent evidence that racism is significantly associated with negative mental health outcomes, including increased levels of depression, anxiety, psychological distress, and behavioural problems. Furthermore, racism was shown to adversely affect social and educational domains, with affected individuals

experiencing lower self-esteem, reduced academic performance, and weaker peer relationships (Priest, et al., A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people, 2013).

Similarly, Trent et al. (2019) identified racism as a chronic stressor that contributes to poorer mental health outcomes in children and adolescents. These outcomes include elevated rates of depression, anxiety, low self-esteem, and aggressive behaviour. Racism-induced chronic stress can lead to behavioural dysregulation and the internalisation of negative racial messages. The authors also noted that early exposure to racism contributes to toxic stress, which disrupts the neuroendocrine, immune, and metabolic systems during critical stages of development (Cohen, et al., 2012). These biological disruptions can alter brain architecture, impair immune function, and increase allostatic load, thereby heightening the risk for chronic physical conditions such as asthma, obesity, and cardiovascular disease (Trent, et al., 2019).

Several studies have identified a direct association between racism and elevated psychological distress among children and adolescents. These distress responses were triggered by both overt racist acts (e.g. name-calling, bullying) and more covert forms of discrimination (Fortune, Sinclair, & Hawton, 2008). The review found that children and young people who reported experiences of racial discrimination exhibited significantly higher levels of depressive symptoms, such as hopelessness, persistent sadness, and social withdrawal. Notably, depression was more pronounced in adolescents, likely due to greater self-awareness of racial identity and sensitivity to external judgments (Astell-Burt, Maynard, Lenguerrand, & Harding, 2012).

In addition, participants—especially those in secondary school environments—reported increased anxiety related to the anticipation of future racist experiences. This included anticipatory anxiety, hypervigilance in public and educational settings, and symptoms associated with generalised anxiety disorder (Ghezae, 2025).

Children who encountered racism, particularly in school settings, also frequently reported lower self-esteem (Ghezae, 2025). Some studies documented signs of racial identity confusion or distress, especially among children in predominantly White environments (O'Neill, Stapley, Stock, Merrick, & Humphrey, 2021). These experiences were linked to the internalisation of negative stereotypes and feelings of shame or discomfort about one’s racial or ethnic background.

Working age adults

In working age adults, persistent exposure to racial discrimination is strongly linked to increased rates of mental health issues such as depression, anxiety, PTSD and psychological distress amongst ethnic minorities (Wallace, Nazroo, & Bécares, 2016). The mental health burden are often greater when racial discrimination interests with socioeconomic disadvantage, immigration status, gender or religion. Both overt racism such as slurs and microaggressions and structural / institutional racism such as inequality treatment in healthcare or policing contributing to psychological harm (Wallace, Nazroo, & Bécares, 2016).

A study conducted by (Bhui, et al., 2005) assessed perceived racial discrimination at work and the implications on risk of common mental health disorder. Unfair treatment at work due to

ethnicity was associated with roughly double the risk of developing a common mental health disorder. Racial insults elevated risk of poor mental health, with higher rates amongst Bangladeshi, Indian, Irish and Black Caribbean population (Bhui, et al., 2005).

Older adults

There is very limited research on the impacts of racial discrimination on older adults' mental health in the UK. Racialised and ethnic minority older adults including Black, Latino, Asian, and mixed heritage individuals (Trinh, Bernard-Negron, & Ahmed, 2019). These groups often face unique and compounding mental health challenges stemming from a lifetime of exposure to racial discrimination, economic hardship, social marginalisation and limited access to culturally appropriate care (Trinh, Bernard-Negron, & Ahmed, 2019).

In older adults, 45% of black older adults reported at least one major lifetime discriminatory event. Everyday discrimination showed a stronger link to poor mental health than major lifetime discrimination across all groups (Ayalon & Gum, 2011). Black elders may have developed cultural or social buffers which moderate mental health impacts despite increasing exposure to racial discrimination (Ayalon & Gum, 2011).

Racialised and ethnic minority older adults including Black, Latino, Asian, and mixed heritage individuals (Trinh, Bernard-Negron, & Ahmed, 2019). These groups often face unique and compounding mental health challenges stemming from a lifetime of exposure to racial discrimination, economic hardship, social marginalisation and limited access to culturally appropriate care (Trinh, Bernard-Negron, & Ahmed, 2019).

Socioeconomic Status

Communities with high levels of poverty, unemployment, and low-quality housing are associated with poorer mental health outcomes. These factors create chronic stress, limit access to resources, and reduce feelings of control over one's life. Economic hardship within a community can negatively impact mental health, leading to higher rates of mental illness (Adler & Ostrove, 1999). Socioeconomic disparities are evident in mental health outcomes, with communities of lower socioeconomic status often having limited access to quality mental health services, educational opportunities, and safe, healthy living environments.

There is a significant interaction whereby the negative mental health impact of low individual socio-economic status is magnified in communities marked by high socioeconomic deprivation. Communities with robust resources and social cohesion can partially buffer the adverse effects of individual economic disadvantage, suggesting a potential mitigating role of the broader social environment (Riazi, Cochrane, & Moloney, 2026).

Social Cohesion and Networks

Strong social connections within a community play a vital role in promoting mental wellbeing by fostering resilience, reducing stress, and enhancing overall life satisfaction. Social cohesion, described as the "glue" that binds society together, is a critical determinant of public health and economic stability (UNECE, 2023). Societies with higher levels of social cohesion experience

better health outcomes and greater economic growth, while also developing stronger capacities to navigate challenges such as globalisation, social inequalities, and barriers to mobility. Though not directly observable, social cohesion can be measured through key dimensions such as trust, civic engagement, institutional legitimacy, and shared values (Coleman, 2024).

Research demonstrates that social networks serve as protective buffers against stress, promoting feelings of security and self-esteem. Communities that cultivate belonging and inclusion significantly improve mental wellbeing, while enhanced social cohesion strengthens community support systems and facilitates the dissemination of health-related information (Palència, et al., 2018). However, neighbourhoods with weak social cohesion and low trust among residents are linked to diminished community support and increased mental health challenges (Mair, Roux, & Galea, 2008). Individuals in socially disconnected environments face a heightened risk of depression, anxiety, and chronic stress-related conditions. Adolescents in low-cohesion neighbourhoods who experience stressful life events are over three times more likely to report symptoms of depression and anxiety compared to their peers in high-cohesion neighbourhoods, while suicide ideation is more prevalent in adults living in socially fragmented communities (Kingsbury, Clayborne, Colman, & Kirkbride, 2020).

Community social networks provide crucial emotional support, mitigating the negative effects of stress and fostering resilience (Holt-Lunstad, 2010). A strong sense of belonging within a community helps prevent social isolation and loneliness, both of which are associated with poor mental health outcomes (Cacioppo & Cacioppo, 2014). Individuals embedded in robust social networks report lower psychological distress and greater life satisfaction (Thoits, 2011), while socially integrated communities experience reduced levels of depression and anxiety due to the emotional and practical support provided by strong networks. Social cohesion also fosters stability and a sense of security, further promoting overall community well-being (De Silva, 2005).

Children and Young people

For children and adolescents, positive social relationships are essential for emotional support and resilience. Strong peer networks help young people develop effective coping mechanisms, reducing psychological distress (Cohen & Wills, Stress, social support, and the buffering hypothesis, 1985). However, negative peer influences, such as bullying and social comparison, can exacerbate mental health difficulties, leading to depression, anxiety, and diminished self-esteem (Prinstein & Dodge, 2008). Adolescents who perceive themselves as falling short of their peers may experience feelings of inadequacy and isolation, contributing to increased mental health risks (Frost & McKelvie, 2004). Social isolation during childhood and adolescence deprives young people of opportunities to develop essential social skills and emotional regulation strategies, further increasing the likelihood of poor mental health outcomes.

Older adults

In older adults, perceived social cohesion such as trust, mutual support and connectedness was significantly associated with better psychological health was significantly associated with

psychological health amongst older adults with physical impairments. Social cohesion buffered against feelings of unsafe neighbourhoods, meaning strong community ties were less psychologically impacted by safety concerns (Choi & Matz-Costa, Perceived neighborhood safety, social cohesion, and psychological health of older adults, 2018). Community cohesion and safety significantly mediated impacts between built environment, with the focus on accessible parks, communal spaces and public transport, on mental health.

In the digital era, online communities offer alternative spaces for social connection, providing young people with a sense of belonging and access to mental health resources (Pantic, 2014). However, digital platforms also pose risks such as cyberbullying and social comparison, which can heighten anxiety and depression (Best, Manktelow, & Taylor, 2014).To counteract these challenges, community-based activities, such as local clubs, educational programs, and recreational initiatives, have been shown to enhance mental wellbeing by fostering social engagement, skill development, and a sense of purpose (Pinfold, et al., 2015).

Addressing social isolation and strengthening social cohesion in deprived neighbourhoods could significantly reduce the public health burden of poor mental health (Fone, et al., 2014). By reinforcing social networks and promoting community engagement, society can create an environment where individuals—especially young people—feel supported, resilient, and connected, ultimately leading to better mental health outcomes.

Access to resources

Access to mental health resources plays a crucial role in determining psychological wellbeing, particularly in underserved communities. Limited availability of mental health services, financial constraints, cultural stigma and systemic barriers often exacerbate mental health disparities. In contrast, increased access to appropriate resources, including healthcare, social support and education has been linked to improved mental health outcomes and reduced psychological distress (Patel, et al., 2018).

Minoritised communities often encounter significant barriers to accessing mental health services. Long wait times and bureaucratic complexities further deter individuals from seeking timely interventions exacerbating mental health issues (Bailey, et al., 2017) and time-consuming application procedures for community programs deter families from seeking assistance. Strict eligibility criteria often exclude families in need particularly those with mixed immigration statuses.

Ethnically diverse communities face often deep-seated stigma surrounding mental health within certain cultures leading to reluctance in seeking help. This stigma is often compounded by historical mistrust of healthcare systems, especially when past experiences of discrimination or inadequate care exist (Lawrence H. R., 2023).

Racialised communities may face language and communication challenges, such as limited proficiency in English and the lack of culturally sensitive communication methods can result in misunderstandings, making it difficult for racialised communities to engage services effectively (Lawrence H. R., 2023).

Resource limitation such as a shortage of community programs and services leads to long waitlists, delaying critical support for mental health needs. Inadequate funding for existing programs hampers capacity to support communities effectively.

When examining impacts of accessing resource, children and adolescents from racialised communities are more likely to attend underfunded schools with fewer mental health services, contributing to higher stress, low self-esteem, and academic struggles (Gibson, Sandhu, & Callender, 2022).

Children and Young people

Racialised children may also face barriers to mental health services due to cultural stigma and a lack of culturally competent mental health professionals, which prevent young people from accessing early psychological support (Bhui K. H., 2021).

Racialised children are more likely to experience economic hardship and reduced access to these resources which may increase vulnerability to stress and anxiety (Marmot M. A., 2020).

Working age adults

In adulthood, disparities in employment income and healthcare access continue to affect mental wellbeing. Racialised communities often encounter employment discrimination and unstable work conditions, resulting in financial insecurity and constraints which may cause chronic stress and an inability to access necessary mental health services. These stressors and inability to access culturally competent healthcare contribute to higher rates of mental health disorders (Nazroo & Bécares, 2021).

Adults in racialised communities tend not to recognise and accept that they have mental health problems which tends to hinder timely help-seeking behaviours. Despite family and community support can play a positive role, they can sometimes discourage external help-seeking due to community cultural norms. Adult men may also be more reluctant to seek help due to cultural expectations surrounding masculinity (Memon, 2016).

For adults in racialised communities extended delays for initial assessments acted as a barrier for engagement in mental health service. Communication and language barriers, and the lack of culturally competent provision of services often left to poor interpretation and misunderstandings between the adults and service providers. Cultural insensitivity where adults from racialised communities reported experiences of discrimination and a lack of cultural understanding from healthcare providers which increased feelings of mistrust (Memon, 2016).

Older adults

In older adults, racialised communities were less likely to use mental health services compared to white participant communities. Older adults faced similar barriers to other life stages, such as language barriers reducing the likelihood of older adults seeking mental health services due to preventing effective communication (Teo, et al., 2022). Older adults face further challenges in accessing professional healthcare due to stigma and mistrust in healthcare professionals.

Older adults tend to rely on family, friends or community members for informal support. This preference can be influenced by cultural norms, desire for privacy and that informal support is more accessible and understanding (Teo, et al., 2022).

Some older individuals tend to misattribute symptoms to normal aging or underestimating their severity, leading to delays in help seeking care. Limited awareness of available healthcare services, coupled with logistical challenges such as transportation difficulties and financial constraints may hinder older adults getting the necessary support (Teo, et al., 2022).

Place Factors

Economic instability including food insecurity

There is evidence from both medical and social sciences that external economic uncertainty and instability from crises such as the 2008 financial crash, the Covid-19 pandemic and the cost-of-living crisis have a negative impact on individual mental health (Di Quirico, 2023). Greater economic instability results in food insecurity, particularly for lower income households who are more at risk of eating a poor diet and facing challenges purchasing nutritious food compared to higher income households (Stone, et al., 2024). Economic instability and food insecurity are strongly linked as 53% of adults in Great Britain reported an increase in their cost of living in the month of October in 2024 compared with the previous month, with 90% stating an increase in the price of their food shopping (Francis-Devine, 2024)

Food insecurity is defined as the inability and/or uncertainty that one will be able to purchase an adequate quality of nutritious food (Shinwell, Bateson, Nettle, & Pepper, 2021). Food insecurity is associated with income and perceived stress and well-being, as Pepper et al (2023) found that people on lower incomes reported greater perceived stress and poorer well-being. Meaningful proportions of the effects of income on both stress (44%) and well-being (37%) were accounted for by food insecurity when controlling for age, gender, relationship status, and the number of children in the household (Pepper, Defeyter, Stretesky, & Mann, 2023).

Food insecurity is a complex issue that is impacted by geography, deprivation, and individual circumstances (Blake & Cromwell, 2022) and it is also linked to an increased risk of obesity (Brown, et al., 2019). This is something which seems paradoxical as being food insecure suggests a reduced amount of food rather than an excess (Stone, et al., 2024). However, research has found that food insecure participants consumed a less diverse diet, evidenced by fewer distinct foods per meal, and had more variable time gaps between meals, suggesting that the consequences of food insecurity for weight gain are not due to increased energy intake but rather increased intake in lower quality energy dense foods (Shinwell, Bateson, Nettle, & Pepper, 2021).

Food insecurity has also been linked to poor mental health among young people and, if unresolved, this can be damaging to young people’s transition to adulthood by negatively impacting their socioemotional development, academic success, employment and life opportunities (Elgar, Sen, & Gariépy, 2021).

Education

Education achievement, a characteristic established at a young age has significant implications on mental health and wellbeing. Lower educational attainment is associated with poor mental health in younger age cohorts but also had implications for later on in life (Milner, et al., 2018).

In the UK, higher educational attainment is associated with better health behaviours such as lower smoking rates, healthier diets and increased physical activity. Adults with higher educational attainment experience lower rates of chronic diseases and longer life expectancy (Raghupathi & Raghupathi, 2020). Education enhances health literacy, enabling individuals to

make informed decisions about their wellbeing (Raghupathi & Raghupathi, 2020). Education fosters resilience, critical thinking and problem-solving abilities which contribute to better mental health outcomes (Chye, Kok, & Chen, 2024). Higher educational attainment is linked to better mental health outcomes, including employment opportunities, higher income, and elevated social status, all of which contribute to enhanced mental wellbeing (Davies, Dickson, Davey Smith, Van Den Berg, & Windmeijer, 2018).

A study investigating the causal evidence that minimal compulsory education increases can yield long-term health improvements by behaviour shaping (Davies, Dickson, Davey Smith, Van Den Berg, & Windmeijer, 2018). The study found that each additional year of education causally reduces depression risk and anxiety risk (Davies, Dickson, Davey Smith, Van Den Berg, & Windmeijer, 2018).This strengthens the argument that education has a protective role on mental health and wellbeing.

Individuals with graduate or professional degree had the lowest overall prevalence rates across the assessed psychiatric disorder (Erickson, et al., 2016). Lower levels of education had greater odds of a new-onset psychiatric disorders including mood disorders, anxiety disorders and substance use disorders. Education improves health literacy, enabling individuals to make informed health decisions and access mental health resources more effectively. Additionally, higher education levels are associated with greater self-efficacy and problem-solving skills, which protect against mental health disorders, Therefore, educational achievement appears to have a protective, prospective effect against developing psychiatric conditions (Erickson, et al., 2016).

Individuals with higher levels of education can develop skills that enhance their ability to solve problems that may be detrimental to their mental health. This allows individuals to buffer the negative life events, stress exposure and other risk factors that onset poor mental health (Lorant, et al., 2003).

There is limited research on the implications of UK urbanisation on educational attainment and its influence on mental wellbeing. Studies have shown that increased classroom sizes in cities result in decreased educational attainment compared to suburban or rural areas (Leathwood & Archer, 2004).

In the UK, there is a rural-urban poverty gap, with urban residents experiencing higher levels of poverty compared to rural inhabitants (Vera-Toscano, Shucksmith, L. Brown, & Brown, 2024) which can influence the how much educational attainment impacts an individual’s mental health and wellbeing. The impacts of poverty, deprivation, and social class negatively affect educational attainment and a child's life course (Maarseveen, 2021). Poverty and deprivation are typically more pronounced in metropolitan and urban areas (Lee, Sissons, Hughes, & al, 2014); (Walsh, Bendel, Jones, & al, 2010); (Glasmeier, Martin, Tyler, & Dorling, 2008). Transitions to higher education in Britain are largely influenced by prior academic achievement, indicating that social class inequalities need to be addressed early on.

Children and young people

There is very limited research on the implications of educational attainment on wellbeing in children and adolescence. Educational outcomes and attainment are associated with later-life chances with well-established links to employment, income, housing, offending and physical and mental health (Smith, Jones, & Reed, 2021); (Chowdry & McBride, 2017). If poor mental health diminishes the capacity for young people to fulfil their academic potential, mental health itself is a driver of education inequality and consequent on on-going social inequalities.

Adolescents with atypical total mental difficulty scores were over 3 times more likely to fail to achieve more than 5 GCSEs A* - C including maths and English (Smith, Jones, & Reed, 2021). Hyperactivity disorders stood out as a major predictor for poor educational attainment. Mental health difficulties were found to be an independent variable and thus a powerful predictor of later academic success or failure (Smith, Jones, & Reed, 2021).

In Children and adolescents who had positive mental health literacy resulted in better mental wellbeing scores with better self-rated health (Bjørnsen, Espnes, Eilertsen, Ringdal, & Moksnes, 2019). This shows that knowledge about how to foster and maintain positive mental health is a meaningful contributor to the adolescent's mental wellbeing (Bjørnsen, Espnes, Eilertsen, Ringdal, & Moksnes, 2019).

Working age adults

In adulthood engaging or continuing to engage with formal education has been seen to have a number of benefits including enhances knowledge, skills and general employability alongside mental health benefits. These include further health improvements including help ward off dementia, and contributing to a reduction in depression, anxiety and loneliness (Drake & Wallach, 2020). Engagement is adult learning, formal and informal leads to notable improvements in life satisfaction and self-confidence (Field, 2018). These benefits often rival those seen from employment, effectively reducing depression symptoms and GP visits (Field, 2018).

Non formal community courses such as arts and crafts help adults with mental health issues build confidence, social engagement and purpose (Field, 2018). Participants in Further education and recovery college programs reported improvement sin hope, achievement and distraction from negative thoughts which impact wellbeing (Allard, et al., 2024). The department for educations community learning mental health pilot (2018) showed 29% of participants had significant improvements in depression and saw anxiety decrease (Field, 2018). Benefits included 94% reported courses kept their minds active, reduced stress levels and 74% noted mental health improvements (Department for Education, 2019); (Field, 2018).

Older adults

In older adults, lower education attainment resulted in higher psychological distress. Low education group had 46% higher odds of distress, whilst intermediate education group had 26% higher odds of psychological distress (Sperandei, Page, Spittal, & Pirkis, 2021). Lower education correlates with greater mental distress later on in life. This is strongly mediated by

socioeconomic factors such as income and employment status (Sperandei, Page, Spittal, & Pirkis, 2021).

Employment

There is a plethora of evidence that highlights mental illness as a leading cause of sickness absence, work impairment and longer-term disability which have highlighted a relationship between identified workplace risk factors that are harmful to a workers mental health (Harvey S. G.-E., 2011); (Knudsen A. H., 2013); (Knudsen A. Ø., 2010); (Henderson, 2011); (Harvey S. J., 2014)

Insecure employment has been shown as a factor which results in declining mental health and wellbeing, where more days of worker under temporary contract and frequent changes in temporary contract significantly increased the probability of developing mental health problems (Moscone, 2016). Zero-hour contracts have been found to result in staff being twice as likely to report mental ill health (Farina, Green, & McVicar, 2024). Additionally, young people aged 16 to 19 are most likely to be in insecure work compared to older age groups (The Health Foundation, 2023).

Research by Butterworth et al (2011) found that unemployed respondents had poorer mental health than those who were employed however those in the poorest quality jobs showed greater decline in mental health than those who were unemployed. This research ultimately shows that the health benefits of becoming employed depend on the quality of the job, as moving from unemployment into a high-quality job (i.e. contracted hours, liveable wage, positive work environment) is most likely to lead to improved mental health yet the transition from unemployment to a poor-quality job is more detrimental to mental health than remaining unemployed (Butterworth, Leach, & Strazdins, 2011).

On the other hand, emerging research is highlighting the role of employment on benefits to an individual's mental health. Where positive mental health and wellbeing can have profound impacts on productivity and job performance (Bryson, 2017). Paid employment provides financial security alongside daily structures, sense of worth and social connections (Modini, 2016). Multiple longitudinal studies have found that engagement in the workforce is associated with better mental wellbeing, lower prevalence of depression and lower incidence of suicide (Boardman, 1999); (Claussen, 1993).

Work has been found to have profound positive benefits on individuals with mental ill-health including greater autonomy, status and acceptance within society, opportunities for personal development and a sense of wellbeing (Modini, 2016); (Fossey, 2010). The psychosocial impacts that work provide support the recovery of poor mental wellness, but in reflection unemployment is associated with decreased psychological wellbeing and distress (Waddell & Burton, 2006).

Work factors such as supportive supervision, supervisory interpersonal interaction, and task assistance correlated with reduced levels of depression and anxiety symptoms (Modini, 2016).

Research has highlighted the relationship between the average level of job satisfaction at the workplace and workplace performance. Staff wellbeing and problem-solving can help raise an individual's level of creativity and may encourage pro-social behaviour and greater levels of engagement at work (Bryson, 2017).

Children and young people

In adolescence and young people, there is little research on the impact of employment on adolescent mental health and wellbeing. Research tends to focus surrounding implications of mental health on prediction of employment and not in employment, education or training (NEET) during later in life.

Mental health in children and adolescent can have predictive implications on employment, education or training status (Rodwell, et al., 2018). Persistent common mental health disorders such as depression and anxiety during adolescent were key predictors of not being in education, employment or training in early adulthood (Gariépy, Danna, Hawke, Henderson, & Iyer, 2021); (Rodwell, et al., 2018).

Youth with poorer health in early adolescence faced higher odds of poor GCSE outcomes at 16 and being NEET at 19. Mental health issues were linked to NEET status where chronic physical conditions were not (Hale & Viner, 2018).

Working age adults

In adults, those who experience severe mental health conditions, employment is seen as having a positive relationship with positive mental health and wellbeing status (Gibbons & Salkever, 2019). Unemployment in adults has been seen as having a negative impact on psychological wellbeing and population levels of psychiatric illness. Employment leads to better mental health, with finding by Gibbons and Salkever (2019) showing modest but meaningful positive effects across overall mental health, daily functioning and interpersonal relationships.

Employment positively impacts individual wellbeing, especially under conditions of good supervision and favourable workplace environments (Modini, 2016). The mental health advantages of employment are especially evident when compared to the adverse consequences of unemployment which increases psychological distress, depression and anxiety (Paul & Moser, 2009). Thus, despite employment playing a massive implication on mental health, ‘good work’ matters. It is not just about having a job, but also quality of the job. This is categorised by a supportive supervisor, job control and safe, fair working conditions which amplify the mental health gains (Mor Barak, Travis, Pyun, & Xie, 2009).

Older adults

There is limited research on the implications of employment on older adults’ mental health and wellbeing within the UK. There is mixed research surrounding the implications, A study conducted by Zhan, Wang, Liu and Shultz, (2009) explored the effects of bridge employment

post-retirement on retirees' health. Older individuals who engaged in bridge employment reported better mental health outcomes and fewer functional limitations compared to those who fully retired (Zhan, Wang, Liu, & Shultz, 2009). Chia and Hartanto, (2021) found that employment status in older adults did not predict future levels of social, psychological or subjective wellbeing. This remains after examining depression, life satisfaction, quality of life, affect, autonomy, social integration and purpose in (Chia & Hartanto, 2021).

Poverty & deprivation

Developing countries measure poverty in different ways; with the main focus being on absolute terms and using a poverty line determined by the monetary costs of a predetermined set of indicators. Relative poverty is where an individual's income is much smaller than the median or standard income in society. Relative poverty depends on the income of the considered society (Decerf, 2021). The cost of social participation changes with the standard of living, meaning those in relative poverty may become socially excluded (Decerf, 2021).

Absolute Poverty is where an individual's income is insufficient to cover their basic life needs, where cost of subsistence does not depend on standard of living (Decerf, 2021).

Poverty remains an imperative issue in the UK with rates amongst those out of work standing at 47% and those in-work poverty, including a family with one working individual, standing at 60%. Poverty is highly concentrated in cities (Green, Sissons, Broughton, & al, 2015).

Growing international evidence shows that mental ill health and poverty interact in a negative cycle (Patel, Lund, Hatherill, & al., 2010) with poverty and urban deprivation becoming a primarily inner-city problem. Income levels are a key determinant of mental health and wellbeing, particularly a key driver of mental health inequalities, where the population's mental health is sensitive to national economic events, such as recessions and policy decisions (Marmot M. , 2005). At an individual level, income changes are linked to mental health, particularly when individuals move below a level of income considered necessary to maintain an adequate standard of living (Thomson, et al., 2022) (McCartney, et al., 2019) (Kromydas, Thomson, Pulford, Green, & Katikireddi, 2021).

The social causation hypothesis shows conditions of relative poverty increase the risk of mental illness through heightened stress, social exclusion, decreased social capital, malnutrition and increased obstetric risks, violence and trauma (Lund, et al., 2011); (Patel & Kleinman, 2003).

People with mental illness are at an increased risk of drifting into or remaining in poverty through reduced productivity, stigma and loss of employment and associated earnings (Lund, Breen, Flisher, & al, 2010).

Children & adolescents

A study conducted by Yoshikawa, Aber and Beardslee (2012) looks how absolute poverty implicated children and young people's mental health and wellbeing. Poverty influences child outcomes through multiple interacting mechanisms including chronic stress, disrupted family dynamics, reduced parental mental health and diminished parenting quality (Yoshikawa, Aber, & Beardslee, 2012). Poverty is linked to higher rates of mental health problems in children and youth, including internalising disorders such as anxiety and depression, externalising disorders such as aggression and conduct problems and behavioural difficulties such as impulsivity and poor emotional regulation. Children in poverty experience more unpredictability, chaos and exposure to violence. These conditions exacerbate toxic stress, which negatively impact the brains development and emotional regulation (Yoshikawa, Aber, & Beardslee, 2012).

Persistent poverty is strongly associated with increased risk of internalising / externalising problems, lower emotional regulation and development delays (Yoshikawa, Aber, & Beardslee, 2012). They also result in more severe and enduring mental health difficulties than short term or less severe poverty. Subsequently, economic hardship increases parental distress, which in turn leads to harsher or inconsistent parenting practices Such negative family environments may drive children's emotional and behavioural problems. Children who grow up in poverty across multiple developmental stages show the most compromised mental health outcomes (Yoshikawa, Aber, & Beardslee, 2012).

Working adults

A study conducted by Marchi et al., (2024) investigated causal effect of poverty on common mental health disorder (CMDs). Working adults in relative poverty, defined as having household income less than 60% of the national median, were more likely to experience CMD (Marchi, et al., 2024). Absolute poverty increases Common Mental Health Disorders (CMD) in working age adults by 2.15% points. Being in poverty has a causal link to worst mental health (Marchi, et al., 2024). Entry into poverty exerts a larger negative effect than the mental health gains seen on exiting poverty. Loss-of-Income impacts mental health more severely than equivalent gains ((Marchi, et al., 2024). This is further confirmed as those entering poverty, defined as relative poverty, were associated with a 1.8% increase point in common mental disorders. (Kromydas, Thomson, Pulford, Green, & Katikireddi, 2021)

Poverty and mental ill health have a bidirectional effect in adults, where mental illness can lead to poverty and poverty can result in poor mental wellbeing (Marchi, et al., 2024). Poverty was found to have causal increases in risk for ADHA, Major Depressive Disorder and Schizophrenia (Marchi, et al., 2024).

Older adults

Older people in poverty frequently experience anxiety, depression and chronic stress. Financial insecurity leads to constant vigilance, such as obsessively bank balances or rationing essentials (Independent Age., 2022). Older individuals described their mental state with terms of despair, depressing and struggle. One individual described a constant headache reflecting the mental burden of financial insecurity (Independent Age., 2022).

A study conducted by Osuafor (2023) looking at the implications of fuel poverty on older adults found that 41% of elderly respondents prioritised paying energy bills over food and clothing. Regarding fuel poverty is defined as spending more than 10% of net household income on heating to meet adequate warmth (Osuafor, 2023). 43% agreed that high energy prices were a key contributor and 39% agreed that low incomes were key contributors. These all result in decreasing mental health, with prioritising heating over basic needs, such as food, medicine and clothes which created chronic financial stress. Constant worry about heating bills, falling into debt or being unable to stay warm is linked to increased anxiety and mental distress (Osuafor, 2023).

In Birmingham more families are in fuel poverty (23.2%) compared to England (13.1%). Additionally, there are more families in poverty due to Employment deprivation (15.2%) compared to the rest of England (9.9%) (Department of Health and Social Care (DHSC), 2023). Birmingham has the second highest rate of child poverty in the UK, with more than 100,000 children living in poverty which is reflective of 37% of all children in the city (Council, 2015)).

Housing

Good housing is a protective factor for health (Shaw, 2004); (Thomson & Thomas, 2015). Poor housing conditions such as dampness, leaks and inadequate heating increases the risk of developing respiratory infections and asthma (Bonnefoy, Braubach, Moissonnier, Monolbaev, & Röbbel, 2003); (Shaw, 2004); (Walker, Mitchell, Platt, Petticrew, & Hopton, 2006); (Bonnefoy X. , 2007). The persistence of poor housing may be due to a lack of autonomy in the housing market and an inability to have enough financial resources to find stable and affordable housing (Kemp, 2011). With renters reliant on landlords to fix housing problems, with the low-cost end of the housing market landlords have little incentives to make costly repairs leaving renters forced to choose between poor quality housing or finding better quality housing which is more expensive (Kemp, 2011).

Those living in problematic housing have a greater likelihood of experiencing mental ill health (Pevalin, Reeves, Baker, & Bentley, The impact of persistent poor housing conditions on mental health: A longitudinal population-based study, 2017) with physical modifications to housing improving mental health.

Studies consistently reveal a significant connection between inadequate housing conditions and adverse mental health effects. Continuous exposure to issues such as overcrowding, dampness, and substandard living environments is linked to deteriorating mental health over time and psychological distress (Pevalin, Reeves, Baker, & Bentley, ‘The impact of persistent poor housing conditions on Mental Health: A longitudinal population-based study’, 2017); (Burdette, Hill, & Hale, 2011).There are negative health outcomes associated with living in poor quality housing such as mold, carbon monoxide, rodents, cockroaches, dust mites and cigarette smoke which are linked to sometimes fatal health outcomes such as childhood asthma, hypothermia, fevers and further infectious diseases, all of which have a negative impact on mental health (Bashir, 2002); (Shaw, 2004).

In children, a relationship has been established between poor quality housing and lower social emotional health and higher levels of psychological distress (Gifford & Lacombe, 2006); (Evans, Saltzman, & Cooperman, 2001).

Tenants in social housing frequently encounter various stressors, including poor housing quality, safety concerns within their communities, and financial hardships, all of which can negatively affect their mental wellbeing (Holding, Blank, Crowder, Ferrari, & Goyder, 2020). Individuals living in social housing are 1.5 times more likely to suffer from poor mental health and four times more likely to report that housing conditions worsened their health. Individuals living in social housing are particularly vulnerable and an analysis in England showed that 45% of social housing occupants earn the lowest fifth of income (Holding, Blank, Crowder, Ferrari, & Goyder, 2020).

Those living in rural areas were found to be more satisfied with their housing and life than individuals residing in urban settings (Alidoust & Huang, 2023). Those living in urban areas had lower satisfaction living in urban areas due to the higher cost of living in cities (Alidoust & Huang, 2023); (Tran & Van Vu, 2018).

On the other hand, enhancements in housing aesthetics, personal development, and satisfaction with landlords are associated with improved mental wellbeing in disadvantaged areas (Bond, et al., 2012). Housing improvements which helped increase warmth during winter and cold periods were associated with less pain, and increased feelings of comfort amongst those with chronic illnesses (Walshaw, 2011).

Tackling these challenges necessitates a comprehensive strategy from housing providers, merging conventional housing management with extensive support services (Holding, Blank, Crowder, Ferrari, & Goyder, 2020). Research indicates that policies focusing on empowerment, proactive intervention, and community-based initiatives can enhance mental health outcomes (Jenkins, Bungay, Patterson, Saewyc, & Johnson, 2018).

Children and young people

Poor housing conditions is characterized by dampness, noise, overcrowding and instability (Clair, 2019). These conditions tend to link to emotional distress, behavioral problems, poorer peer relationships and reduced educational outcomes. House instability and security such as temporary accommodation, forced relocation can result in increased anxiety and uncertainty in children (Gambaro & Joshi, 2016).

Living in damp, cold, noisy or overcrowded housing contributes to increased anxiety and stress, emotional dysregulation (e.g anger, withdrawal, sadness) and behavioral problems in schools and at home (Clair, 2019). These environments make it harder for children to rest, study and feel safe, undermining their emotional security and sense of control (Clair, 2019).

Frequent relocations, temporary accommodation and eviction risk leads to loss of routine and peer connection, disrupted schooling and feelings of instability, fear and displacemen (The Children's Society, 2020). These experiences foster chronic uncertainty, damaging children’s trust in their environment and increasing feelings of helplessness which is a known risk factor for depression and anxiety (Mustafa, 'This Is No Place for a Child’: The Experiences of Homeless Families in Emergency Accommodation, 2015).

Housing security also results in chronic anxiety and stress about where they will live next (Mustafa, ‘We’ve Got No Home’: The Experiences of Homeless Children in Emergency Accommodation, 2017). Children worry about losing friends due to moving schools and areas. Safety in unfamiliar or temporary environments (The Children's Society, 2020). Watching their parents struggle and not know how to help. Many report symptoms like frequent crying, withdrawal, irritability and difficulty concentrating.

Frequent housing moves and overcrowded conditions can result in sleep loss, nightmares and bedwetting in younger children (Hock, et al., 2023); (The Children's Society, 2020); (Mustafa, 'This Is No Place for a Child’: The Experiences of Homeless Families in Emergency Accommodation, 2015). Sleep problems contribute to daytime fatigue, academic difficulties and emotional dysregulation.

Living in unstable and substandard housing fosters feelings of hopelessness, shame and embarrassment (Hock, et al., 2023). Children often avoid inviting friends over, contributing to isolation and low self-esteem.

Working adults

Adults living with housing problems have a greater risk of mental ill health. Adults living in housing with more problems have a greater likelihood of experiencing mental ill health (Pevalin, Reeves, Baker, & Bentley, ‘The impact of persistent poor housing conditions on Mental Health: A longitudinal population-based study’, 2017). Physical improvements to housing improve mental health. Many adult renters are reliant on their landlords to fix housing problems. In the low-cost end of the housing market, landlords have few incentives to make costly repairs and so renters may be forced to choose between poor quality housing and trying to find better quality housing, which may require moving and be less affordable (Pevalin, Reeves, Baker, & Bentley, ‘The impact of persistent poor housing conditions on Mental Health: A longitudinal population-based study’, 2017); (Kemp, 2011).

Persistent housing issues, which lasted for one year negatively affect mental health in the present (Pevalin, Reeves, Baker, & Bentley, ‘The impact of persistent poor housing conditions on Mental Health: A longitudinal population-based study’, 2017). Adults who experienced the density of housing problems increased over a four year period, people reported having poorer mental health and wellbeing (Pevalin, Reeves, Baker, & Bentley, ‘The impact of persistent poor housing conditions on Mental Health: A longitudinal population-based study’, 2017).

Housing payment problems, in terms of falling into rent and mortgage arrears increased the risk of common mental disorders by 2.5% in adults (Mason, Alexiou, Li, & Taylor-Robinson, The impact of housing insecurity on mental health, sleep and hypertension: Analysis of the UK Household Longitudinal Study and linked data, 2009-2019., 2024). The largest impact is seen on renters, younger adults (25-39), lower educated individuals and households with children. Housing payment problems are associated with a 2% increase in risk of sleep problems due to worry

Older adults

The duration of exposure to poor housing appears to exert a toll on mental health in older adults. Marmot et al. (2017) found that cold, damp, overcrowded or unsafe housing contributes significantly to both physical and mental ill-health. Older adults are particularly susceptible

because they spend more time to home, and poor housing can exacerbate pre-existing conditions and contribute to social isolation, anxiety and depression (Marmot, Allen, Boyce, Goldblatt, & Morrison, 2017).

Renting was initially associated with worse mental health compared to homeownership; this effect diminished once socioeconomic variables were accounted for. Continued exposure to poor housing quality, such as damp conditions and structural issues were consistently linked to higher psychological distress. These associations got stronger with age, highlighting that housing conditions are a key determinant to older adults' mental wellbeing (Howden-Chapman, Chandola, Stafford, & Marmot, 2011).

A systematic review conducted by Falecki, Ory & Smith (2024) examined housing characteristics and mental health in older people. Dwelling features such as home size, availability of elevators in multi-storey buildings, access to clean cooking and heating facilities were associated with better mental wellbeing Functional and comfort-orientated housing design features are more impactful on mental health than aesthetic or structural attributes alone. (Falecki, Ory, & Smith, 2024).

Housing accessibility also plays a pivotal role. Heller, Thompson, & Baird (2024) reviewed 15 studies and found that modifications such as ramps, stair redesigns, and accessible bathrooms could support mental well-being among older adults. Homes which are not accessible to the physical needs of older adults result in poor mental wellbeing (Heller, Thompson, & Baird, 2024). Accessibility-oriented housing improvements thus represent a promising avenue for mental health promotion, though further high-quality research is needed to confirm these effects.

Transport

Transport and individual mobility are associated with several public health factors including social inclusion, stress, cognitive workload, anxiety, and satisfaction which impact citizens' mental states. For example, research has demonstrated that public transportation can significantly enhance mental wellbeing, especially among older adults. Evidence indicates that regular use of public transport correlates with improved mental health outcomes, such as decreased feelings of depression and loneliness (Feng, Astell-Burt, & Feng, 2017).

The implementation of free bus passes for seniors in England has resulted in increased public transport usage and greater social interaction, including more frequent volunteering and connections with family and friends (Reinhard E. , Courtin, van Lenthe, & Avendano, 2018). Public transport encourages active travel, which benefits both physical and mental health by integrating incidental exercise into daily life and fostering social connections (Rambaldini-Gooding, et al., 2021).

Living within a short walking distance (500m) of public transport networks, both bus and light railway stations, contributed to greater life satisfaction, influencing passengers' perceptions of time and reducing their anxiety and fatigue (Teng, Pan, & Zhang, 2020). For drivers, the quality of road infrastructure is important, such as reduced potholes and irregular or unpaved narrow roads and tight corners, which influence drivers' stress (Rodrigues, Kaiseler, Aguiar, Cunha, &

Barros, 2015). Challenges such as roadworks, difficult junctions and lack of parking were also perceived to increase motor stress (Pykett, Chrisinger, & Kyriakou, 2020).

Relationships between congestion and delays and higher levels of stress, anger, frustration, and mental wellbeing (Wang, et al., 2019). Individuals' mood and emotional state deteriorate when facing congested conditions, mostly resulting in increased stress (Emo, Matthews, & Funke, 2016).

Nonetheless, the perceived quality of public transport systems is essential, as negative perceptions can adversely affect the mental health of regular users (Feng, Astell-Burt, & Feng, 2017). Although research in this field is somewhat limited, findings suggest that accessible public transport is crucial in alleviating social isolation and enhancing mental wellbeing for older adults (Conceição, et al., 2022); (Rambaldini-Gooding, et al., 2021).

Children and Young People

For children and young people, higher urban density and mixed land use are consistently linked to more out-of-school walking (Giles-Corti, Kelty, Zubrick, & Villanueva, 2009); (Sallis, 2006). Safe and well-connected footpaths along with high street network design support independent walking behaviours (Giles-Corti, Kelty, Zubrick, & Villanueva, 2009); (Sallis, 2006). Unreliable and unaffordable transport can restrict children and adolescents from school, mental health services, community or extracurricular activities (Faulkner, et al., 2023). Lack of access may exacerbate educational inequalities and mental health disparities.

For adolescents the ability to travel independently either by bus or walking is closely tied to developing autonomy, building social skills and enhancing self-esteem (Faulkner, et al., 2023). Unsafe or inaccessible transport systems can delay or limit this developmental milestone, increasing dependence on parents and guardians which reduces mental resilience.

Young people rely heavily on public transport to maintain peer relationships, especially in urban or suburban areas (Faulkner, et al., 2023). When transport is infrequent, unaffordable or perceived as unsafe, it can result in social isolation which is a risk for depression and anxiety.

Adults

A systematic review on transport infrastructure and mental wellbeing found that congestion and delays are consistently linked to negative affective states and psychological distress (Conceição, et al., 2022). Poor transport reliability has been associated with increased stress. For adults living near good public transportation, up to 500m from a bus stop or within a short walking distance from home or work contributed to greater life satisfaction scores (Lades, Kelly, & Kelleher, 2020); (Lunke, 2020). Adults living around a rail station with easy access and good services show greater life satisfaction scores (Cao, 2013).

Elements of public transportation areas such as walking distance, level of service, queuing and walking areas can influence passengers’ perceptions of time, which has implications for anxiety, fatigue and satisfaction (Teng, Pan, & Zhang, 2020).

Stress increased for adults due to small, old, dirty buses in bad state with little legroom, minimal and uncomfortable seating and the state of the roads (Dorantes-Argandar, Rivera-Vázquez, & Cárdenas-Espinoza, 2019).

Regarding driving, the quality of road infrastructure such as potholes, irregular or unpaved roads, tight corners influence driving stress (Rodrigues, Kaiseler, Aguiar, Cunha, & Barros, 2015). Adults with highest anger scores were living in neighbourhoods with narrower and more mountainous roads (Hernández-Hernández, Siqueiros-García, Robles-Belmont, & Gershenson, 2019).

Living in cities with high congestion was associated with lower mental wellbeing in adults (Smyth, et al., 2011). Living in a more congested city was associated with higher levels of anger and lower life satisfaction amongst bus / coach communities, despite lower mental distress for bus / coach commuters (Li, Yao, Jiang, & Li, 2014). Road traffic congestion also decreased commute wellbeing for cars and public transport, particularly in over-crowded public transport (Smith O. , 2017).

Older adults

In older adults active transport enables them to maintain social networks, positively impact their mental and physical health and reduce social isolation (Barnes, et al., 2016); (Musselwhite, 2015); (Shrestha, McDonald, Millonig, & Hounsell, 2017). Accessible local transport is important for preventing social isolation and its accompanying problems (Aged Communities Services Australia, 2015).

In older adults, being a bus pass holder and increasing of physical activity and significantly lowered depressive symptoms (Laverty, Webb, Vamos, & Millett, 2018); (Webb, Laverty, Mindell, & Millett, 2016). There is a positive association between using public transport and lower feelings of loneliness with greater contact with family and friends (Reinhard E. , Courtin, van Lenthe, & Avendano, 2018). In Scotland, concessionary bus transport resulted in more active travel and public transport use for shopping and social activity (Rye & Mykura, 2009).

Older adults tend to find challenges with using public transport which impacts their usage. These including boarding and alighting, inadequate seat reservation for older passengers, overcrowding, driver behaviour, poor bus design, difficulty reading passenger information and communication with service personnel (Ramachandran & D'Souza, 2016). Despite these challenges, older adults who use public transport consistently report fewer depressive symptoms, particularly with social engagement facilitating the reduction of depression scores (Dilian, Beckers, Davidovitch, & Martens, 2024).

Green Space and Blue Spaces

Access to green space is linked to better mental health outcomes such as reduced stress, anxiety and depression. Some research suggests green space can be as effective as a prescription for some mental health issues (van den Bosch & Ode Sang, 2017).

There are further positive outcomes associated with green space, which act as protective factors for good mental wellbeing. These include increased physical activity, mitigating the

urban heat island effect, fostering social interactions, and a sense of community (van den Bosch & Ode Sang, 2017).

Green Space, however, does not have equal access and quality, as high-quality green spaces are not usually accessed by those living in deprived communities. The types of green spaces offered in deprived communities are usually less maintained, less safe and less appealing. They are more likely to be areas where crime occurs, reducing residents' use of those spaces (Sreetheran & van den Bosch, 2014).

Blue spaces are outdoor environments with prominent water features such as rivers, lakes, ponds, and seas. Exposure to blue spaces has been associated with various health benefits, including stress reduction, improved mood and enhanced overall wellbeing. Studies have shown that people who live closer to blue spaces have higher levels of life satisfaction compared to those who live further away (Brereton, J.P, Clinch, & Ferreira, 2008); (Alcock, et al., 2015). Nature connectedness is an inherent trait of feeling connected to the nature and the state of being in natural environments can influence the health benefits derived from blue spaces ((White, Elliott, Gascon, Roberts, & Fleming, 2020). Visits to blue spaces may be moderated by socio-economic and or ethnic status (Haeffner, Jackson-Smith, & Buchert, 2017).

Not all research has shown positive effects for mental health, especially those with more serious conditions such as Schizophrenia (Boers, Hagoort, Scheepers, & Helbich, 2018). This may be due to evidence suggesting the effects of living near blue space on health and wellbeing tend to be significantly stronger for people living in poor regions, or having lower socio-economic status (Wheeler, White, Stahl-Timmins, & Depledge, 2012).

Despite the positive impact blue spaces have on individuals' health and wellbeing, there are further public health concerns surrounding blue spaces. These include estimated drownings per year, water-borne diseases such as cholera alongside storms and floods contaminating supplies and sanitations of drinking water (White, Elliott, Gascon, Roberts, & Fleming, 2020)

Children and young people

In young people, access to green and blue spaces reduce anxiety and depression in those aged from 14-24 years old living in urban environments. Natural environments contributed to stress reduction by enhancing physiological relaxation responses and lowers cortisol levels. Greater levels of residential greenness when participants were aged 16-18 years was associated with lower levels of work stress when they reached aged 20-23 suggesting protective effects during life transitional periods (Bray, Reece, Sinnett, Martin, & Hayward, 2022).

Green and Blue spaces also improve mood and emotional regulation, improved mood and a reduction in negative emotional states amongst adolescents and young adults facing stressful life events (Bray, Reece, Sinnett, Martin, & Hayward, 2022). Green spaces were found to promote social interaction and stronger community ties, which acted as a protective factor for young people's mental health and wellbeing. Young people from lower socioeconomic backgrounds had less access to high-quality green and blue spaces which hinders the ability to benefit from these spaces (Bray, Reece, Sinnett, Martin, & Hayward, 2022).

Given that adolescents often lack access to private gardens and transportation, neighbourhood green space is critical for promoting their well-being, aligning with the Sustainable Development Goals (Nations, 2020).

Older adults

A study conducted by (Serra & Feio, 2024) examined mental health and wellbeing impacts in older adults who engaged with green and blue spaces. In older adults, those that had regular access to green and blue spaces reported lower levels of anxiety, depression and psychological distress (Jarosz, 2023). Exposure to nature contributed to stress reduction and emotional regulation, with self-reported increased levels of relaxation.

Blue spaces such as lakes and rivers were found to have stronger calming effect, promoting feelings of peace and tranquillity (Jarosz, 2023). Green spaces were associated with mental restoration and attentional recovery. Regular visits to green and blue spaces were associated with slower decline in cognitive abilities and reducing the risk of dementia. Nature exposure providers older adults with opportunities for meaningful engagement and reflection which enhanced their sense of purpose and life satisfaction. Activities such as gardening, birdwatching, or simply spending time in nature contributed to improved mood and positive affect (Jarosz, 2023).

Pollution

Urbanisation processes have led to a significant increase in pollution levels, with relevant consequences on global health (Tortorella, et al., 2022). Pollution is a major public health concern due to its direct effects on the health and wellbeing of individuals and communities by increasing the risk of respiratory and cardiovascular disease, mental health and wellbeing conditions such as depression and anxiety (Boogaard, Walker, & Cohen, 2019); (Pfleger, Adrian, Lutz, & Drexler, 2023). The impacts of pollution on public health target vulnerable populations, particularly children, the elderly and individuals with pre-existing health conditions (Boogaard, Walker, & Cohen, 2019); (Giovanis & Ozdamar, 2018).

Air pollution

Air quality is a major public health threat linked to poor birth outcomes, respiratory and cardiovascular disease and premature mortality. From a life course approach, growing evidence suggests that air pollution and exposure may be associated with the onset of psychiatric problems, including mood, effective and psychotic disorders (Newbury, et al., Air and noise pollution exposure in early life and mental health from adolescence to young adulthood, 2024); (Braithwaite, Zhang, Kirkbride, Osborn, & Hayes, 2019).

Prolonged exposure to nitrogen dioxide (NO_2) and fine particulate matter ($PM_{2.5}$) was significantly associated with increased symptoms of anxiety and depression amongst adolescents. Adolescents residing in areas with higher air pollution levels demonstrated higher rates of emotional distress, mood disturbances, and a greater likelihood of developing internalizing disorders over time (Thompson, et al., 2024); (Bhui K. N., 2023). Those who were exposed to NO_2 and PM for long periods were associated with increased psychological distress, particularly in middle to late adulthood (Canning, et al., 2025).

Exposure to elevated levels of air pollution was linked to slower cognitive development, particularly in executive functions such as working memory, processing speed and attention which has implications on development of poor mental wellness (Thompson, et al., 2024).

A number of cities in the UK including Birmingham have implemented a Clean Air Zone (CAZ) or an Ultra-low emissions zone (ULEZ) in the case of London to reduce pollution. Research has found that the Birmingham CAZ resulted in significant but modest reductions of N02 and N0x, whilst monitors outside of the clean air zone detected no changes in levels (Liu, 2023). This shows the short-term effectiveness of Clean Air Zone policies to improve air quality. However, it is important to note that there was no impact on Pm2-5 levels within the CAZ.

Children and young people

Children and infants are thought to be especially vulnerable to air pollution, for example, exposure to particulate matter (PM2.5) during pregnancy and childhood was associated with an increased risk of psychotic experiences and depression during adolescence and young adulthood (Silbereis, Pochareddy, Zhu, Li, & Sestan, 2016). This highlights that early exposure to environmental pollutants, particularly during critical development periods, has significant impacts for mental health outcomes later in life (Newbury, et al., Air and noise pollution exposure in early life and mental health from adolescence to young adulthood, 2024). At a foetal or infant level, exposure to air pollution can result in restricted foetal growth (Schembari, de Hoogh, Pedersen, & al, 2015); (Bekkar, Pacheco, Basu, & DeNicola, 2020) and premature birth which are both risk factors for psychopathology. There is a public health need to reduce exposure to air pollution during pregnancy and early childhood to mitigate long-term mental health risks.

Working age adults

At an adult population level, the negative effect of air pollution on mental wellbeing has also been noted. Higher levels of pollutants like NO2, SO2, PM10 and PM2.5 were associated with increased odds of poor mental wellbeing amongst UK adults (Ahad, Demšar, Sullivan, & Kulu, 2022). Poorer mental wellbeing was observed with every 10µg/m3 of each identified air pollutant. Spatial-temporal effects show that residents in areas with higher air pollution levels have a more significant impact on mental wellbeing, with ethnic minorities, particularly Pakistani/Bangladeshi individuals and non-UK born residents, showing higher vulnerability to the negative effects of air pollution compared to White British natives.

Older adults

In older adults, a study in Europe highlighted those higher levels of pollutants, such as sulphur dioxide (SO2) and ground-level ozone (O3) were associated with poorer general health and mental wellbeing amongst pensioners (Giovanis & Ozdamar, 2018). An increase in PM2.5 (ambient fine particulate matter- one of the most common sources of environmentally induced inflammation and oxidative stress) was significantly associated with anxiety symptoms, with the largest increase for a 180-day moving average. PM2.5 exposure was also positively linked to depressive symptoms in older adults, with the association being significant for 30-day moving average (Pun, Manjourides, & Suh, 2017).

Noise pollution

Noise pollution was associated with an increase in cardiovascular, metabolic and respiratory diseases (Tortorella, et al., 2022). The World Health Organisation (WHO) estimates, exposure to traffic-related noise was associated with the loss of 1.5 million years of healthy life, mainly due to sleep disturbances, cognitive problems and cardiovascular disease, which all have implications on mental wellbeing (WHO Regional Office for Europe, 2011).

Noise pollution reflects an element of the urban setting and contributes to the development of psychiatric symptoms (Hunter & Hayden, 2018). Noise pollution, particularly from road, rail and air traffic, is identified as a risk factor for affective disorders such as anxiety and depression, but also influences the severity of the symptoms (Generaal, Timmermans, Dekkers, Smit, & Penninx, 2019). Road traffic noise was investigated with its impacts on circadian rhythms, where traffic noise was associated with insomnia symptoms, with issues of falling asleep, and waking up too early, which resulted in negative wellbeing outcomes (Evandt, et al., 2017).

Children and young people

Pregnant women and children are especially vulnerable to the mental health impacts of noise pollution (Tortorella, et al., 2022). Noise exposure during critical developmental periods can increase the risk of psychopathology. Chronic exposure to traffic noise was associated with heightened psychological distress, leading to increased stress, irritability and emotional deregulation (Tortorella, et al., 2022). Adolescents exposed to high levels of traffic noise reported poorer sleep quality, which contributed to emotional instability and increased susceptibility to anxiety-related symptoms (Thompson, et al., 2024).

A study highlighted by Newbury et al, (2024) found higher levels of noise pollution during childhood and adolescence was significantly associated with increased anxiety symptoms in young adulthood. Adolescents exposed to higher levels of noise pollution (above 60 dB) showed elevated risks for anxiety. Noise pollution also disrupts sleep patterns, impacting one's circadian rhythm which critical for mental health and cognitive development during adolescence transitional periods. Noise pollution exposure during early life was linked to psychotic experiences in adolescence, although the associations were less pronounced compared to anxiety (Newbury, et al., Association of early-life exposure to air and noise pollution with youth mental health: findings from the ALSPAC cohort, 2024).

Adults

Long-term exposure to noise pollution was associated with declines in global cognitive function, including verbal and nonverbal learning and memory. Chronic exposure was linked to increase nuisance and annoyance which can further exacerbate psychological distress (Tzivian, Vossoughi, Fuks, Weinmayr, & Hoffmann, 2015). Research found that higher residential noise was associated with higher feelings of annoyance, which then resulted in higher sleep disturbances, which has implications for mental wellbeing (Dzhambov, 2018).

Despite intensive research on the implications of air pollution on public mental health, studies on the impact of noise pollution on public mental health are lacking (Tsimpida & Tsakiridi, 2025).

There are also limited results on the implications of noise pollution on the mental health of elderly populations specifically.

Access to Resources

The availability of mental healthcare services, social programs, and healthy lifestyle resources within a community significantly impacts mental health. Limited access to these resources creates barriers to seeking help and promoting wellbeing. Economic recessions are often accompanied by increased levels of psychological distress and suicidal behaviour. Interventions to identify those in need and provide reliable, free advice from support agencies could help mitigate the impact on mental health of benefit, debt, and employment difficulties for vulnerable sections of society (Barnes, et al., 2017).

Research has shown that there are perceived barriers among different age groups and ethnicities which affect their likelihood of accessing adequate and timely support services. Ethnic minority groups are more likely to have undiagnosed and untreated mental health problems. They are more likely to access mental health support during a mental health crisis, and they are more likely to receive a diagnosis of severe mental illness compared to White British counterparts (Bansal, et al., 2022). A major reason why ethnic minority groups are less likely to receive mental health support is due to the everyday experiences of racism, which cause ethnic minority groups to have a lack of trust in the health care system, resulting in delayed or minimal help-seeking behaviours (Bansal, et al., 2022). For many ethnic minorities, mental health is a highly stigmatised topic within their culture which places an additional barrier to their support seeking (Memon, 2016).

Language is also a common barrier to accessing health care as some ethnic minority groups, especially recent migrants with little to no understanding of English, struggle to communicate effectively with health care professionals (Memon, 2016). Memon (2016) also found that cultural naivety and insensitivity amongst health care members led to ethnic minority groups feeling disregarded, especially when talking to white professionals.

Young people and adults

Age is a factor which impacts an individual's likelihood of reaching out to mental health services. Individuals aged between 18 and 25 years are less likely to access their GP and other health services compared to other age groups, due to barriers which impact young adults, such as inconvenient hours around work and study (Davey, Carter, & Campbell, 2013). Life transitions from childhood to adulthood can result in issues surrounding continuity of care for young adults with chronic illnesses, special needs, or who are 'hard to reach' such as asylum seekers, those previously in care, or contact with the criminal justice system (Davey, Carter, & Campbell, 2013). Some young adults report feeling rushed during appointments, and some find doctors to be unfriendly and insensitive, especially regarding the subject of mental health (Davey, Carter, & Campbell, 2013). It is also increasingly recognised by young people that there are high demands on specialist services and long waiting lists, which present barriers to accessing child

and adolescent mental services (CAMHS), alongside stigma and a general lack of awareness around the types of support available (Radez, et al., 2021).

Considering intersectional identities, LGBTQ+ (lesbian, gay, bisexual, transgender and queer/questioning) young people face significant mental health inequalities, experience higher rates of poor mental health and worse mental health outcomes compared to heterosexual people (Pattinson, et al., 2021). Pattinson et al, 2021 found an absence of mainstream NHS support that address the needs of LGBTQ+ young people and as a result, the majority of LGBTQ+ youth mental health support in the UK is provided by the voluntary and community organisations. Pattinson et al (2021) found that partnerships between NHS trusts and voluntary services were able to bridge the gap between the knowledge of the voluntary/ community sector and the stability of the statutory sector, through a CAMHS partnership model. This type of collaborative service encourages knowledge sharing, facilitated safe and inclusive environments for LGBTQ+ young people (Pattinson, et al., 2021).

To improve relationships between young people and mental health support services, health promotion strategies must emphasise early intervention, management and referral of emotional and psychological problems within the school environment to ensure positive mental health support especially during life transitions (Leavey, Rothi, & Paul, 2011). Interventions to improve young people's experience of accessing support must focus on improving young people's knowledge and understanding of mental health problems particularly within schools, equip them with self-help skills and strategies, normalise mental health problems, and inform young people about where to find help and what to expect from it (Radez, et al., 2021).

Loneliness and social isolation are significant risk factors for poor mental health and the onset of mental health conditions in later life. Providing mental health resources and access to services, both clinical and non-clinical, can mitigate this poor wellbeing (WHO, Mental health of older adults, 2025). Providing elderly individuals with the ability to live independently allows them to enhance their overall quality of life and better overall emotional and psychological health.

Older adults

Older adults face a range of challenges when trying to access mental health services. Stigma and personal beliefs are a key barrier that hinder the process of mental health help-seeking. Such as embarrassment and worry about what others would think, perceptions of seeking help would imply the individual is weak and that the individual should not require help (Elshaikh, Sheik, Saeed, Chivese, & Alsayed Hassan, 2023). These include attitude and knowledge barriers due to older adults having negative attitudes towards mental health care and lack of awareness about the need for treatment.

Quality of Public Spaces

The access to good quality open spaces is found to result in an improvement in well-being, user satisfaction, quality of life, and increased social inclusion by creating safe, clean and welcoming spaces in which people can access and socialise with others (Abbasi, Alalouch, & Bramley, 2016). The quality of the physical features of public spaces, along with the spatial structure of the layout, has a direct impact on how open spaces are used regarding the types of activities,

the duration of activities and the number of people visiting the public spaces (Abbasi, Alalouch, & Bramley, 2016). Additionally, spaces that have received more positive aspects in terms of their qualities (i.e., pedestrianised streets) are found to have more significant effects on citizens' mental health (Hematian & Ranjbar, 2022).

However, open spaces in the most deprived areas appear to be of lower quality and often experience less maintenance when compared with wealthier areas (Abbasi, Alalouch, & Bramley, 2016).

Good quality public spaces are also linked to positive mental health and wellbeing for children. Research has found that children with access to child-friendly public open spaces (e.g. having both a playground and public toilet nearby) within 800 metres of home had the highest likelihood of demonstrating competence and promotion of optimal mental health (Alderton, et al., 2022).

Children and young people

Children and young people are becoming less tolerated within public spaces, viewed as a risk and antisocial behaviours (Vivoni, 2013); (Day & Wagner, 2010). Children seek inclusive public spaces for all ages, ethnicities and interests with an expressed desire to enhance and care for nature and built environment within public spaces (Freeman & Tranter, 2011). Children want to participate and be heard regarding the development of public spaces to have influences on their communities (Chawla, 2009); (Malone, 2013) (Derr & Kovács, 2015). A study conducted by which examines how children would develop public spaces. Children identified six visionary themes including play spaces for all ages, Hanging out spaces for social networks, safety, nature, water features and public art (Krishnamurthy, 2019). These themes identified by children would help develop public spaces based on the needs of children and young people.

Budget cuts and austerity have significantly reduced youth services and spaces including closures of adventure playgrounds, parks and youth centres (Edwards, 2015); (Lincoln, 2012). There is also no legislation to protect or prioritise public spaces for youths unlike Wales with its Children and Families measure of 2010 (WelshGovernment, 2014)There is a lack of provision of public spaces to meet the development and social needs of adolescents including unsupervised space for peer interaction, opportunities for risk-taking and exploration and self-expression (Edwards, 2015). The disconnect between what young people need and what is provided leads to underuse of space, loitering elsewhere and conflict with authorities (Edwards, 2015).

Residents in areas with high-quality public open spaces were significantly more likely to report low psychological distress compared to those with low quality public open spaces (Francis, Wood, Knuiman, & Giles-Corti, 2012). The quantity of public open spaces, such as the total number of parks or leisure activities was not associated with mental health outcomes (Francis, Wood, Knuiman, & Giles-Corti, 2012). This indicates that quality of public spaces matters more than quantity for increasing psychological wellbeing. Rich amenities, safety, aesthetics and maintenance in local public spaces have a stronger link to psychological wellbeing than just having many green spaces nearby. Environmental cues also matter, with adults who use open public spaces preferring them being well-maintained, and inviting which highlights the

importance of visual and sensory qualities on mental health (Francis, Wood, Knuiman, & Giles-Corti, 2012).

Older adults

A scoping review conducted by Younes, Marques, and McIntosh (2024) examines how public spaces affect quality of life in older adults in urban contexts. Safe, walkable and visually appealing neighbourhoods with good access to destination support mobility and independence in older adults (Younes, Marques, & McIntosh, 2024). Quality public spaces allow better engagement in outdoor activities such as strolling, gardening and group exercises which improves physical function, mental health and life satisfaction (Schehl & Leukel, 2020); (Eronen, von Bonsdorff, Rantakokko, & Rantanen, 2013).

Public sector spaces designed to foster social interaction, such as seating, lighting, green vistas increase neighbourhood cohesion, reduce loneliness and improve emotional wellbeing (Kemperman, van den Berg, Weijs-Perrée, & Uijtdewillegen, 2019). Proximity to and accessibility of green and open spaces correlate with lower anxiety, stress and depression (Sugiyama & Thompson, 2007); (Diener, Seligman, Choi, & Oishi, 2018).

Overall, social interaction in public spaces were significantly linked to higher functional ability, leading to greater independence in daily tasks and lower depression scores (Lum, Ng, Zhang, & Leung, 2023). In the long-term, older adults who lived near public open spaces with greater quality that offered diversity of leisure facilities and vibrant social activity had a slower decline in functional ability (Lum, Ng, Zhang, & Leung, 2023).

Safety and Security

Feelings of safety and security are essential for mental health and wellbeing. Exposure to violence in one's community, whether directly or indirectly, can have a profound impact on mental health. Studies have shown a correlation between neighbourhood violence and increased rates of post-traumatic stress disorder (PTSD), depression, and substance abuse (Kessler, 1997). Issues of crime are of major concerns due to their high societal cost, with incidence of crime produce health damages to a victim’s wellbeing but also often associated with considerable psychological distress in non-victims leading to alterations in their behaviour due to changes in perceived risk for their safety (Dustmann & Fasani, 2016); (Braakmann, 2012).

Additionally, the fear of violence can create a sense of unease and limit participation in community activities, further hindering mental wellbeing. Social circumstances, such as concerns about neighbourhood safety and antisocial behaviour, significantly influence mental health and wellbeing (Quinn & Biggs, 2010). The indirect impact, such as psychological distress and anxiety generated by the fear of crime and victimisation risks, can be seen as having a more significant impact than the direct impact of crime (Cornaglia, Feldman, & Leigh, 2014). Changes in behaviour like choosing a different mode of transportation, improving house protection and making the decision to carry a weapon due to victimisation risks (Pak & Gannon, 2023).

Residents of areas marked by concentrated disadvantage are more likely to express concern about social and economic threats, as indicators such as high unemployment and poverty reflect a marginalized position within the social hierarchy and contribute to diminished feelings of personal control among lower socioeconomic groups (Kraus, Piff, Mendoza-Denton, Rheinschmidt, & Keltner, 2012). In this context, social conditions—and inequality in particular—play a critical role in shaping perceptions of neighbourhood reputation and security (Sampson, 2009).

Increase in property crime rates within a resident's immediate neighbourhood (SA2) was associated with a 1.5% decrease in mental wellbeing index scores. Property rates in contiguous neighbourhoods also negatively affected the mental wellbeing index by a 0.5% reduction. The impact of violent crimes in neighbouring areas had a notable impact, where a standard deviation increase in violent crime resulted in a 0.8% decrease of mental wellbeing index scores (Pak & Gannon, 2023)

Individuals who have experienced violent crime victimisation in the past 12 months reported a 15.6% decrease in mental wellbeing index scores, whilst property crime victimisation did not show significant long-term effects (Pak & Gannon, 2023).

Children and young people

In children and young people, perceptions of neighbourhood safety and trustworthiness were strongly linked to their mental health, particularly emotional disorders. However, children’s personal perceptions of safety had a greater impact than actual neighbourhood characteristics (Meltzer, Vostanis, Goodman, & Ford, 2007). This is particularly the case for young people and children as fears around being a victim of crime were found to be a consistent predictor of mental health, indicating the essential role of young people's subjective experience of their neighbourhoods for their mental health and well-being (Mueller, Flouri, & Kokosi, 2019).

Violent neighbourhoods impacted children’s brain development, focusing on the amygdala, which is a key region in processing threats and emotions. Children and adolescents exposed to higher levels of community violence presented heightened amygdala responses, suggesting an increased sensitivity to potential threats, which influence socioemotional functioning and mental health (Suarez, Burt, Gard, Klump, & Hyde, 2024).

Older adults

In older adults, perceived neighbourhood safety is positively associated with better general health status, Higher perceived safety is linked to lower levels of depression and anxiety ((Won, Lee, Forjuoh, & Ory, 2016). Conversely, higher crime rates and perceived danger are associated with increased mental health issues (Cromley, Wilson-Genderson, & Pruchno, 2012); (Wilson-Genderson & Pruchno, 2013) .

In disadvantaged neighbourhoods, older individuals exhibited similar levels of fear for their safety and security. In more affluent neighbourhoods, older adults displayed higher levels of fear

for their safety compared to their younger counterparts (Köber, Oberwittler, & Wickes, 2022). Older adults who reported fewer neighbourhood problems such as noise, crime or litter had better mental wellbeing (Gale, Dennison, Cooper, & Sayer, 2011). Those living in the most disadvantaged in terms of their socioeconomic factors, long term illness or disability were more likely to live in an area with more neighbourhood problems (Gale, Dennison, Cooper, & Sayer, 2011). Perceived neighbourhood safety was significantly associated with psychological health, although the effect was greater among older adults with functional limitations due to disability. Amongst physically impaired older adults, social cohesion acted as a protective factor of any negative impacts of unsafe neighbourhoods (Choi & Matz-Costa, Perceived Neighborhood Safety, Social Cohesion, and Psychological Health of Older Adults, 2018)

Urbanisation

Urbanisation is a demographic trend in which society sees a rise in urban areas as well as an increase in the number of people living in urban regions (Sahadevan & Mathews, 2023). Urbanisation has advantages, such as economic growth and job opportunities. Urbanisation is associated with some disadvantages, including increased stressors and factors such as loneliness, high crime rates, homelessness, noise, overcrowded and polluted environments, high levels of violence, reduced social support and insufficiency of mental health services (Srivastava, 2009); (Okkels, Kristiansen, Munk-Jørgensen, & Sartorius, 2018).

Urbanisation is only going to excel in future years; by 2050 it is predicted that metropolitan regions will be home to around 66% of the total population of the developed world (Sahadevan & Mathews, 2023). Urbanisation has been highlighted as one of the most important health challenges of the 21st century (Cox, Shanahan, Hudson, Fuller, & Gaston, 2018).

Living in urban spaces or experiencing urbanisation within one's local area can increase levels of loneliness. This is due to excessive worry and stress from the urban environment, including noise and light pollution, congestion, and an increase in competition for employment and schools (Srivastava, 2009). Mental health, however, can be positively affected by the development of neighbourhood cohesion such as feeling pride in the local area and being a part of the neighbourhood (Ochnik, Buława, Nagel, Gachowski, & Budziński, 2024). Ochnik et al (2024) also found that architectural improvement of neglected buildings can indirectly improve mental and physical health. Therefore, it's important to provide better architectural conditions and remove vandalism such as graffiti from the buildings in the neighbourhood. Spatial cohesion is critical for mental health through improving physical health, so green public spaces creation and maintenance is crucial (Ochnik, Buława, Nagel, Gachowski, & Budziński, 2024).

Urban tensions result from physical irritations like high frequency audios and the continuous disharmony or machinery sounds, strain caused by daily commuting, continual visual attacks on the eyes by glaring multi-coloured lights, crowd congestions in public places which produce unnecessary anxiety and extra tension on urbanite's mind which goes beyond their mental capacity to endure (Hiremath, 2021).

Urbanisation also sees strains from competition such as jobs, seats in educational institutions, business orders, customers, patronage memberships in clubs to secure anything or everything

in life. Urban competition puts further strain on a person's mentality (Hiremath, 2021). Urbanism also results in insecurity which is a sense of loneliness and isolation are typical features of urbanising which break up cohesive community life. Urbanisation has been associated with heightened risk of mental health issues amongst young people including increased instances of depression, anxiety and other psychological disorders (Hiremath, 2021).

Build features of urban environments such as dependence on motor vehicles, high levels of traffic noise increase poor mental wellbeing in young people and children (Ramanathan, O'Brien, Faulkner, & Stone, 2017) (Westman, Olsson, Gärling, & Friman, 2017).The growing influence of digital and social media contexts recognises them as integral components that interact with urban environments to affect young people's mental health. Interventions to target urbanisation can have moderating effects, such as active transportation and physical activity (Ahn & Fedewa, 2011) street connectivity, narrow street width, environmental greenery, playground features, and pavement presence can all have positive impacts.

Working age adults

Factoring age, loneliness has become a widespread issue among university students which is significantly associated with urban built environment factors (Deng, Su, Yang, Liang, & Zhu, 2025). Service facilities such as dining, shopping, transportation, tourist attractions, leisure and entertainment, healthcare, and sports and fitness, as well as road network density and land use mix, have a significant effect on university students' loneliness (Deng, Su, Yang, Liang, & Zhu, 2025). This provides important insights for urban planners and architects by suggesting that optimising the built environment and design strategies can effectively reduce university students' loneliness and improve their mental health (Deng, Su, Yang, Liang, & Zhu, 2025).

Older adults

Family dynamics have shifted due to urbanisation as increasing numbers of younger generations decide to move away from rural areas to cities in pursuit of education and jobs. This leads to an increase in older individuals who live in rural areas experiencing loneliness. As a result of urbanisation, the shift of the nuclear family, and multiple employment, loneliness and mental health issues among older people has emerged as a significant issue in contemporary society (Sahadevan & Mathews, 2023).

Urban living exposes older adults to higher air pollution, noise, heat islands, unsafe traffic and crowded built environments (Zhang, Zhao, & Liu, 2022). Heat exposure, caused by heat islands due to urbanisation increases cardiovascular, respiratory, renal and poor mental health such as stress and anxiety in elderly individuals (Mason, Alexiou, Li, & Taylor-Robinson, The impact of housing insecurity on mental health, sleep and hypertension: Analysis of the UK Household Longitudinal Study and linked data, 2009-2019., 2024); (Zhang, Zhao, & Liu, 2022).

Good transport access and neighbourhood infrastructure showed positive effects on older adults, with cities with poor public transit or unsafe pedestrian environments can isolate older individuals reducing social interaction and access to healthcare (Zhang, Zhao, & Liu, 2022).Urbanisation, urban growth and high population density negative impact older adults', the pace and unpredictability or urban life can elevate psychological distress due to perceptions of

insecurity, fear of crime (Mason, Alexiou, Li, & Taylor-Robinson, The impact of housing insecurity on mental health, sleep and hypertension: Analysis of the UK Household Longitudinal Study and linked data, 2009-2019., 2024).

Conclusion & Recommendations

Conclusion

In conclusion, the literature review has provided a comprehensive overview of the factors impacting mental health and wellbeing in Birmingham. There is an important need to address both social and environmental determinants of mental health by highlighting a range of strategies that have been implemented in different countries. Effective mental health and wellbeing interventions must consider the interconnected nature of individual, community, and environmental factors to improve well-being at both local and broader levels.

The purpose of this literature review was to investigate two substantial themes:

1) to investigate wider determinants of mental health and to examine their protective and risk influence on wellbeing,

2) to examine examples of other strategies from across the globe as elements of best practice.

The findings highlight the critical factors impacting mental health in urban environments, specifically within Birmingham. Key challenges include higher-than-average rates of common mental health conditions, lower life satisfaction scores, and socio-economic disparities such as poverty, poor housing, employment deprivation, and exposure to crime. These issues significantly affect individual mental health outcomes, emphasising the urgent need for targeted strategies.

The review also emphasises the importance of viewing mental health through a more holistic lens rather than solely focusing on detecting clinical conditions. Definitions provided by the World Health Organisation (WHO) and Canadian Public Health reinforce this broader perspective. The WHO emphasises an individual's ability to cope with life stress and contribute to the community while the Canadian approach delves deeper into emotional and spiritual well-being, highlighting the role of culture, equity, social justice, and personal dignity. Given the complex nature of social determinants, the Canadian definition offers a more nuanced understanding of well-being and stresses the need for a holistic approach beyond clinical intervention.

In examining broader determinants, the literature categorises risks and protective factors into individual, community, and environmental themes. At the individual level, life course, culture, poverty, housing, diet, disability, discrimination, and employment play significant roles in shaping mental health. Early experiences, cultural norms, education, and socio-economic status are especially influential in determining long-term mental health trajectories. Factors like poverty, poor diet, and disability can create cycles of poor mental health, especially when combined, while limited access to resources exacerbates disparities.

Education and employment are key to mental health outcomes, as higher educational attainment often leads to better job prospects and stability, reducing risks to well-being. However, urban education faces challenges like overcrowded classrooms and socio-economic disparities, leading to lower academic achievement.

Discrimination, whether based on race, gender, sexual orientation, or disability, has profound effects on mental health. Experiences of discrimination, whether overt or subtle, cause chronic stress, reduce self-esteem, and contribute to mental health disorders, perpetuating inequality.

Environmental factors such as housing, transport, green spaces, and climate change also significantly influence mental health. Poor housing conditions, including overcrowding and substandard living environments, are linked to negative mental health outcomes, especially among vulnerable populations. Improvements in housing quality, like better insulation, can enhance well-being.

Transport and mobility impact mental health, with accessible public transportation supporting social inclusion and reducing stress, particularly for older adults. However, traffic congestion and negative perceptions of transport systems can increase stress and anxiety.

Access to green spaces is associated with reduced stress and enhanced social interaction, but disparities exist, with deprived communities often lacking safe, well-maintained green areas. Coupled with climate change and pollution, this exacerbates anxiety and mental health issues.

Community factors, including strong social networks and cohesion, are essential for buffering stress and enhancing self-esteem. Conversely, social isolation contributes to depression and anxiety. Community-wide challenges like poverty, unemployment, and inadequate housing impact both collective and individual mental health by increasing chronic stress and limiting access to mental health resources.

In communities affected by violence and discrimination, poor mental health outcomes such as substance abuse, PTSD, and depression are prevalent. These issues can lead to decreased community participation and a reduced sense of belonging. Stigma and cultural norms can also prevent individuals from seeking help, making access to culturally competent mental health services and social programs critical in addressing disparities.

Lastly, communities with better access to nature and clean environments experience lower levels of mental distress due to reduced exposure to stressors like noise pollution and poor air quality. Overall, the review emphasises that community factors are integral to mental well-being, underscoring the need for comprehensive approaches that address both social and environmental determinants of mental health.

There are however gaps in the literature that have been identified, for many of the factors investigated there has been no or limited research on urban impacts on those factors, these include impacts on substance abuse, discrimination, housing, employment, disability and more. Some of the literature around these factors is then looked at on a regional or national level than

in an urban context. Therefore, more research and deep dives into the impacts of these factors in an urban context would be useful.

The final objective of this literature review was to examine strategies implemented across various cities to cultivate mentally healthy environments that promote resilience and positive well-being.

The reviewed strategies, primarily from Western contexts, include examples from cities like Toronto (Canada), New York (USA), Tokyo (Japan), Barcelona (Spain), Catalonia (Spain), Townsville (Australia), and Vancouver (Canada). These strategies address challenges aligned with the individual, community, and environmental factors discussed earlier. Common approaches focus on enhancing urban design, housing affordability, and infrastructure with mental health considerations. Examples include improving access to safe green spaces, promoting physical activity, and implementing workplace initiatives that support employee mental well-being.

Education and awareness campaigns around mental health, resilience, and stigma reduction are prioritised, emphasising the role of mental health in overall quality of life. Food strategies are also highlighted, focusing on creating sustainable systems that provide healthy, local, and affordable food while promoting dietary diversity.

Community partnerships are essential for mental health, fostering a sense of belonging and inclusion, especially for vulnerable groups. Initiatives include crime prevention measures, community safety policies, and civic engagement efforts to boost public participation.

Healthcare services and resources are other key factors. Strategies aim to address barriers like inadequate infrastructure and cultural disparities in care. Many emphasise early detection and prevention to mitigate the impact of social determinants on mental health.

These global strategies demonstrate a multi-faceted approach to creating mentally healthy environments, highlighting the importance of integrated policies that address urban design, education, food systems, community engagement, and accessible healthcare.

It's imperative to note that these strategies have not been evaluated or measured in terms of their achieved outcomes and how successful the strategies and policies they discuss have been in impacting the factors they intended to change. Thus, we are unable to conclude in this literature review how successful the strategies were at creating mentally healthy environments in their retrospective cities.

Recommendations

The literature review has highlighted several recommendations around the co-creation of the Creating a Mentally Healthy City. The recommendations include:

- Regularly review the progress of the Creating a Mentally Healthy City Strategy. This can be done through creation and monitoring of a mental health and wellbeing dashboard, as well as monitoring citizen feedback through a regular citizen survey.
- Influence partners to adopt a mental health in all policies approach to ensure there is adequate promotion of effective mental health and wellbeing plans, policies and procedures which guarantee support for employees and increase productivity.
- Promote the equal development and access to green spaces across the city, including the introduction of green assets to public-owned buildings.
- Implement trauma-informed approaches throughout mental health services.
- Work with the Combined Authority, Physical Activity Team, Public Health, and private transport enterprises to develop affordable, efficient and reliable active transport options.
- Work with regularly accessed community spaces, such as faith settings, libraries, family hubs and community hubs to provide tools and training resources to promote positive wellbeing to citizens at all stages of life.
- Work with education partners to maximise mental health and wellbeing resources and consider how educational settings can better support student and teacher wellbeing.
- Work with vulnerable groups to cultivate social connections, peer groups and intergenerational communities to tackle isolation.
- Support the NHS service partners to recognise the significance that wider determinants can have on accessing mental health services.

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Appendices

Appendix 1: Search Strategy

Mental health & Wellbeing definitions
General: ‘Mental Health’ or Mental Wellbeing and ‘Urban settings’ or ‘Urban context’ or ‘in cities’ **Specific:** ‘Definition’ or ‘defining’ of ‘mental health’ or ‘wellbeing’
Individual factors impacting Mental health & Wellbeing

General:

'Mental Health' or Mental Wellbeing and 'Urban settings' or 'Urban context' or 'in cities'

Specific:

•Life course approach-
'Life course approach' or 'Adverse childhood experiences' and 'impacts on' or 'impacting' and 'mental health' or 'wellbeing'

•Culture
'culture' or 'cultural' or 'western culture' or 'cultural practices' and 'positive effects' or 'negative effects' and 'mental health' or 'wellbeing'.

•Poverty
'poverty' or ' low socio-economic status' or 'deprivation' or 'low income' and 'positive effects' or 'negative effects' and 'mental health' or 'wellbeing'

•Diet
'Diet' or 'nutrition' or 'food' or 'balanced diet' or 'western diet' and 'food access' or 'food availability' and 'low socio-economic status' or 'social class' or 'working class' and 'Mental health' or 'wellbeing'

•Disability
'Disability' or 'individuals with disabilities' and 'mental health' or 'wellbeing'.

•Faith & Spirituality
'Faith' or 'Religion' or 'spirituality' and 'positive impacts' or 'negative impacts' and 'mental health' or 'wellbeing' and 'urban context' or 'cities' or 'urban setting'.

•Discrimination
'Discrimination' or 'Ableism' or 'transphobia' or 'homophobia' or 'Racism' and 'mental health' or 'wellbeing' and 'urban context' or 'urban setting' or 'cities'

•Substance abuse
'substance abuse' or 'substance misuse' or 'alcohol abuse' or 'alcohol dependence' or 'drug abuse' or 'drug dependence' and 'urban context' or 'urban setting' or 'cities' and 'Mental Health' or 'wellbeing.

•Education
'Education' or 'Higher education' or 'Education qualifications' or 'Educational attainment' or 'Educational achievement' and 'cities' or 'urban context' or 'urban setting' or 'urban / rural gap' or 'poverty' and 'mental health' and 'mental wellbeing'.

•Employment

Mental health & Wellbeing definitions
‘Employment’ or ‘secure employment’ or ‘insecure employment’ or ‘productivity’ and ‘positive impacts’ or ‘negative impacts’ and ‘mental health’ or ‘wellbeing’.
Environmental factors impacting Mental health & Wellbeing
General: ‘Mental Health’ or Mental Wellbeing and ‘Urban settings’ or ‘Urban context’ or ‘in cities’ **Specific:** • **Housing** ‘Housing’ or ‘housing conditions’ or ‘housing stock’ or ‘social housing’ or ‘private housing’ and ‘negative health outcomes’ or ‘positive health outcomes’ and ‘mental health’ or ‘mental wellbeing’ or ‘public health outcomes’ • **Transport** ‘transport’ or ‘public transport’ or ‘active transport’ and ‘mental health’ or ‘mental wellbeing’ or ‘public health outcomes’ • **Green Spaces** ‘Green space’ or ‘Green Space access’ or ‘quality of green space’ and ‘deprived communities’ and ‘mental health’ or ‘wellbeing’ or ‘public health outcomes’ • **Climate or pollution** ‘Climate change’ or ‘ecologically prone’ and ‘positive impacts’ or ‘negative impacts’ and ‘mental health’ or ‘mental wellbeing’
Community factors impacting Mental health and Wellbeing

General:

'Mental Health' or Mental Wellbeing and 'Urban settings' or 'Urban context' or 'in cities'

Specific:

Social Cohesion and Support
'Social cohesion' or 'social support' or 'social networks' or 'social community' or 'social belonging' and 'positive impacts' or 'negative impacts' and 'mental health' or 'mental wellbeing'

Socioeconomic Status

'Socioeconomic status' or 'wealth disparities or 'wealth' or 'financial poverty' and 'positive impacts' or 'negative impacts' and 'mental health' or 'mental wellbeing'.

Safety and Security

'Safety' or 'security' or 'neighbourhood safety' or 'anti-social behaviour' or 'community violence' and 'positive impact' or 'negative impacts' and 'mental health' or 'wellbeing'.

Stigma and Discrimination

'Stigma' or 'discrimination' or 'mental health discrimination' or 'social isolation' and 'mental health' or 'mental wellbeing'.

Cultural Factors and Community Supports

'Cultural factors' or 'culture' or 'community' or 'support' or 'community support' or 'culture norms' or 'cultural values' and 'mental health' or 'mental wellbeing'

Discrimination and Racism

'Discrimination' or 'experiences of discrimination' or 'race' or 'ethnicity' or 'sexual orientation' and 'mental health' or 'wellbeing' or 'public health outcomes'

Access to Resources

'Resources' or 'access to resources' or 'mental healthcare services' or 'mental healthcare' or 'healthcare services' and 'positive impact' or 'negative impact' and 'mental health outcomes' or 'mental wellbeing outcomes'.

Quality of the Physical Environment

Mental health & Wellbeing definitions
‘Quality’ and ‘physical environments’ or ‘green spaces’ or urban settings’ and ‘positive impacts’ or ‘negative impacts’ and ‘Mental Health’ or ‘mental wellbeing’.
City Strategies that have been implemented to tackle wider determinants of Mental Health and Wellbeing
General: ‘Mental health’ or ‘Mental wellbeing’’ and ‘strategy’ or ‘strategic plan’ or ‘policy’. ‘Creating a Mentally Healthier City Strategy’ or ‘a Healthier City’ **Specific:** ‘Thrive Toronto’ and ‘Thrive’ and ‘Thrive NewYork’ and ‘Barcelona Mental Health Strategy’ and ‘Catalonia mental health strategy’ and ‘Townsville’

Appendix 2: UKHSA Search Strategy

Knowledge and Library Services: Literature search results (Local Authority Public Health)

Search question:

Creating a mentally healthy city. To examine individual, place and community factors that impact individuals' mental health, particularly those who live in cities.

Search strategy:

Full search strategies are located in the **Appendix**.

Screening considerations:

Age group	Language	Publication type	Time limit	Geography
	English		2014-2024	UK

Summary of resources searched and results:

Number of results:

Source (in order searched)	**Before removing duplicates and screening**	**After removing duplicates, before screening**	**After removing duplicates and screening**
Medline	332	332	123
Embase	306	290	42
Emcare	278	104	38
Global health	203	90	32
Google			12
PsycInfo	207	137	40

Source (in order searched)	**Before removing duplicates and screening**	**After removing duplicates, before screening**	**After removing duplicates and screening**
Medline	332	332	123
Embase	306	290	42
Emcare	278	104	38
TOTAL	**1326**	**953**	**287**