THE EFFECTS OF THE 2007–9 FINANCIAL CRISIS ON MENTAL HEALTH IN THE UK: A LONGITUDINAL ANALYSIS OF NON-SUICIDE MENTAL HEALTH TRENDS

[1]B Amies*, [2]L Munford, [2]M Sutton. [1]*Centre for Primary Care, University of Manchester, Manchester, UK*; [2]*Manchester Centre for Health Economics, University of Manchester, Manchester, UK*

Background Existing research using area-level data has identified big increases in suicides in the UK and elsewhere through the financial crisis of 2007–09. Areas with larger increases in unemployment tended to have greater increases in suicide rates. The evidence base in this area has two particular weaknesses that this study aims to address. Firstly, this study uses individual-level data rather than aggregated area data, and secondly it examines non-suicide mental health trends rather than suicide rates.

Methods A nationally-representative sample of 12 816 individuals from the British Household Panel Survey in England from 2000–2013. Data were not collected for 2009. Fixed effects models were used to examine the data for associations between 12-item General Health Questionnaire score (measuring mental health) and demographic features, employment status and equivalised household income on the unweighted sample. Dummy variables for 2008–2010 (the period from the start of recession up to the start of government budget cuts) and 2011–13 (from the start of budget cuts) separated out the influence of changing economic conditions. Lagged and advanced variables were used to explore associations between mental health and the loss of income or employment through time.

Results Poor mental health peaked in 2008, before the peak in unemployment in 2010. Women and poorer people had significantly worse mental health throughout (p<0.000, beta 1.24 (95% confidence interval 1.08–1.40), p<0.000, beta 0.129 (−0.192- −0.065) respectively). Unemployment was significantly associated with worse mental health (p<0.000, beta 1.84 (1.52–2.16)). The association between mental health and income was weaker, with the most persistent effects for the period 2008–2010 (p=0.000, beta −0.64 (−0.88- −0.40)). Worse mental health appeared to preced job or income loss (p=0.028, beta 0.46 (0.049–0.88); p=0.011, beta 0.23 (0.051–0.40), respectively) but mental health did not deteriorate following job-loss, while increasing income appeared to compromise mental health (p=0.006, beta −0.24 (−0.42- −0.069)). Weighted sensitivity analysis confirmed a persistent association between unemployment and mental health but significance was lost between income and mental health.

Conclusion Non-suicide mental health deteriorated during the 2007–2009 financial crisis. It appears that worse mental health preceded job loss or income loss. A possible explanation could be that poor mental health conferred weakness in the job market. There are a number of inferences to the research area, for example that a strong social safetynet may protect mental health (by maintaining income) and that in-work mental health support may benefit poorer workers.

DO RELIGIOUS PRACTICES AND BELIEFS MODERATE THE ASSOCIATION BETWEEN STRESSFUL LIFE EVENTS AND SUBSEQUENT MENTAL HEALTH AND WELLBEING?

[1]A Kaushal*, [2]D Cadar, [1]M Stafford, [1]M Richards. [1]*MRC Unit for Lifelong Health and Ageing, University College London, UK*; [2]*Research Department of Behavioural Science and Health, University College London, UK*

Background Religion may provide coping strategies for stressful life events (SLEs). Aspects of religious practices and beliefs, e.g. provision of meaning in life, interpretation of difficult events and supportive social contact can all contribute to successful coping strategies. The aim of this project was to investigate if SLEs are associated with mental health and wellbeing in early old age and if religious practices and beliefs moderate these associations.

Methods Participants were study members from the MRC National Survey of Health and Development (1946 British birth cohort) who participated in data collection at age 68–69 (n=2148). Mental health and wellbeing were measured using the 28-item General Health Questionnaire and the Warwick-Edinburgh Mental Wellbeing Scale. SLEs were measured using a checklist of events on five occasions from age 26 to 60–64. Religious practices and beliefs were ascertained from age 11 to 68–69 and included upbringing, beliefs and attendance. Initial analyses investigated associations between SLEs, and mental health and wellbeing. This was followed by analyses to determine if religious practices and beliefs were more common in people who had good mental health or high wellbeing despite experiencing a high number of SLEs compared to those with fewer SLEs and poor mental health or wellbeing. Analyses were conducted using linear and logistic regression models adjusted for gender and education.

Results Experiencing SLEs was associated with lower wellbeing (β=−0.31, CI=−0.46,–0.16) and worse mental health at age 68–69 (β=0.02, CI=0.02,0.03). High wellbeing at age 68 despite a substantial number of SLEs was associated with frequent religious attendance (for men only) from age 36 to 60–64 (OR=2.60, CI=1.10,6.14), religious importance (OR=1.83, CI=1.13,2.97) and meaning in life provided by religion (OR=2.07, CI=1.31, 3.29). There were no differences in religious practices and beliefs between study members with good mental health and a high number of SLEs compared to those with fewer SLEs and poor mental health.

Conclusion SLEs across the life course were associated with poor mental health and wellbeing in early old age. We also found evidence that religious practices and beliefs moderate the effect of SLEs on wellbeing but not mental health, and in particular that religious attendance is beneficial for men and not women. Future work will investigate if SLEs are associated with changes in religious attendance, mental health and wellbeing, and if this varies by different types of SLEs, e.g. personal and interpersonal, health and work-related events.