Mental Health: Exclusion to Inclusion?

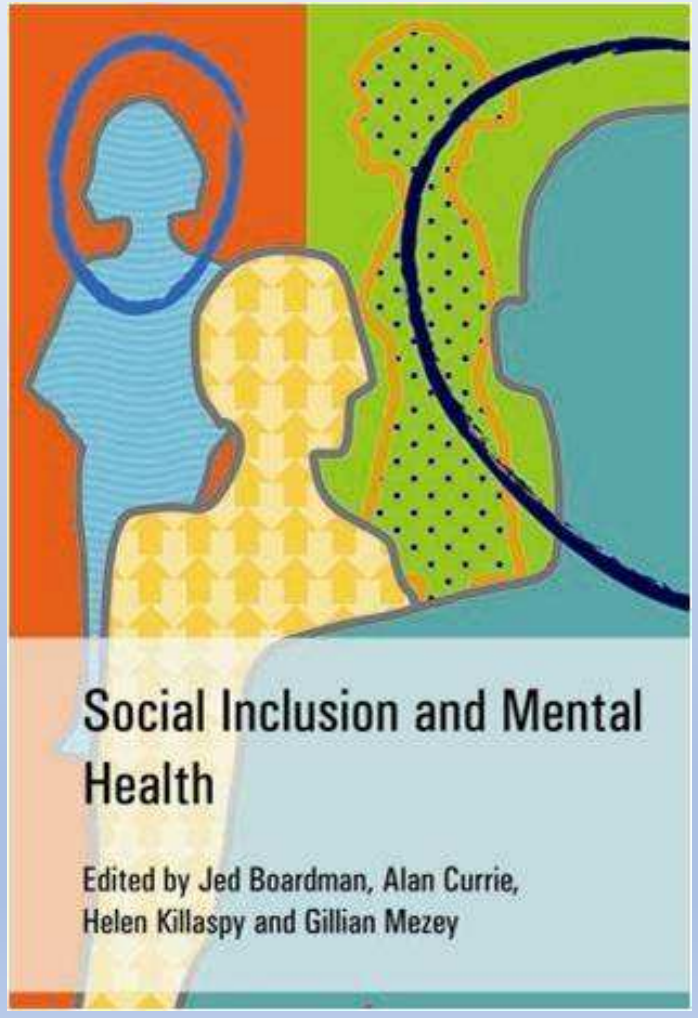
Jed Boardman

Recovery Research Network Meeting

Oxford

21 November 2017

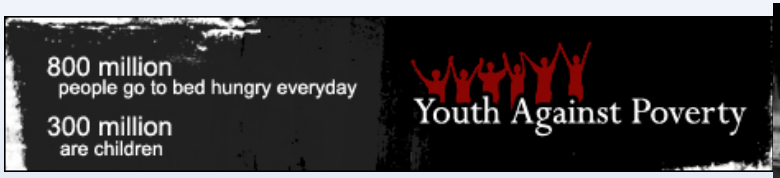
"An individual is socially excluded if he or she does not participate in key activities of the society in which he or she lives"



Domains of Participation

- *Consumption* (exclusion from material resources) – Capacity to purchase goods and services (income poverty)
- *Production* (exclusion from (socially valued) productive activity) - Participation in economically or socially valuable activities (employment, education etc.)
- *Social interaction* (exclusion from social relations and neighbourhoods) – Interaction with family, friends, community (isolated networks)
- *Political engagement* (exclusion from civic participation) -Involvement in local or national decision making (having a voice, choice and control).
- *Health and service engagement* (Service exclusion) – Having good health and accessing appropriate services

Poverty



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Poverty and Mental Health: International Perspectives

Soc Sci Med. 2010 August ; 71(3): 517–528. doi:10.1016/j.socscimed.2010.04.027.

Poverty and common mental disorders in low and middle income countries: A systematic review☆

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Abstract

In spite of high levels of poverty in low and middle income countries (LMIC), and the high burden posed by common mental disorders (CMD), it is only in the last two decades that research has emerged that empirically addresses the relationship between poverty and CMD in these countries. We conducted a systematic review of the epidemiological literature in LMIC, with the aim of examining this relationship. Of 115 studies that were reviewed, most reported positive associations between a range of poverty indicators and CMD. In community-based studies, 73% and 79% of studies reported positive associations between a variety of poverty measures and CMD, 19% and 15% reported null associations and 8% and 6% reported negative associations, using bivariate and multivariate analyses respectively. However, closer examination of specific poverty dimensions revealed a complex picture, in which there was substantial variation between these dimensions. While variables such as education, food insecurity, housing, social class, socio-economic status and financial stress exhibit a relatively consistent and strong association with CMD, others such as income, employment and particularly consumption are more equivocal. There are several measurement and population factors that may explain variation in the strength of the relationship between poverty and CMD. By presenting a systematic review of the literature, this paper attempts to shift the debate from questions about whether poverty is associated with CMD in LMIC, to questions about which particular dimensions of poverty carry the strongest (or weakest) association. The relatively consistent association between CMD and a variety of poverty dimensions in LMIC serves to strengthen the case for the inclusion of mental health on the agenda of development agencies and in international targets such as the millenium development goals.

Poverty and common mental disorders in developing countries

Vikram Patel[1] & Arthur Kleinman[2]

Abstract A review of English-language journals published since 1990 and three global mental health reports identified 11 community studies on the association between poverty and common mental disorders in six low- and middle-income countries. Most studies showed an association between indicators of poverty and the risk of mental disorders, the most consistent association being with low levels of education. A review of articles exploring the mechanism of the relationship suggested weak evidence to support a specific association with income levels. Factors such as the experience of insecurity and hopelessness, rapid social change and the risks of violence and physical ill-health may explain the greater vulnerability of the poor to common mental disorders. The direct and indirect costs of mental ill-health worsen the economic condition, setting up a vicious cycle of poverty and mental disorder. Common mental disorders need to be placed alongside other diseases associated with poverty by policy-makers and donors. Programmes such as investment in education and provision of microcredit may have unanticipated benefits in reducing the risk of mental disorders. Secondary prevention must focus on strengthening the ability of primary care services to provide effective treatment.

Keywords Mental disorders/etiology/prevention and control; Poverty; Educational status; Socioeconomic factors; Cost of illness; Review literature; Developing countries (*source: MeSH, NLM*).
Mots clés Troubles mentaux/étiologie/prévention et contrôle; Pauvreté; Niveau instruction; Facteur socio-économique; Coût maladie; Revue de la littérature; Pays en développement (*source: MeSH, INSERM*).
Palabras clave Trastornos mentales/etiología/prevención y control; Pobreza; Factores socioeconómicos; Escolaridad; Costo de la enfermedad; Literatura de revisión; Países en desarrollo (*fuente: DeCS, BIREME*).

Bulletin of the World Health Organization 2003;81:609-615.

Poverty in the UK

Poverty is bad for you – and society

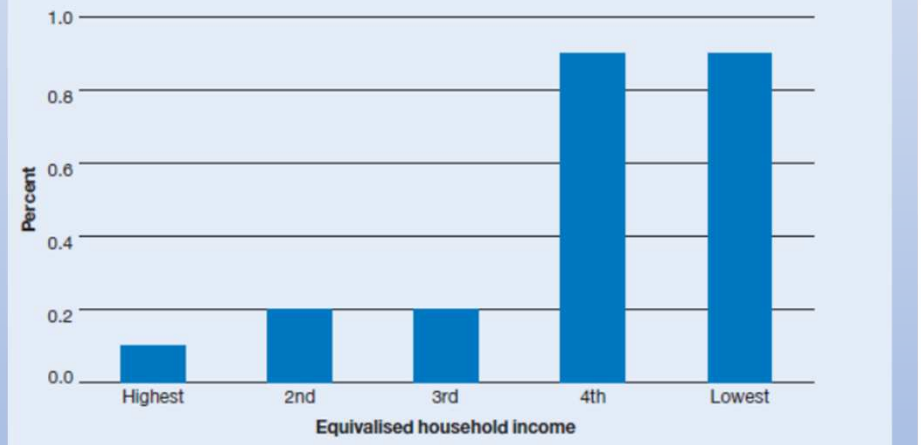
Income and Benefits: Psychosis
Adult Psychiatric Morbidity in England, 2007 and 2014

Income 2007

Figure 5C

Prevalence of psychotic disorder in the past year (age-standardised), by equivalised household income

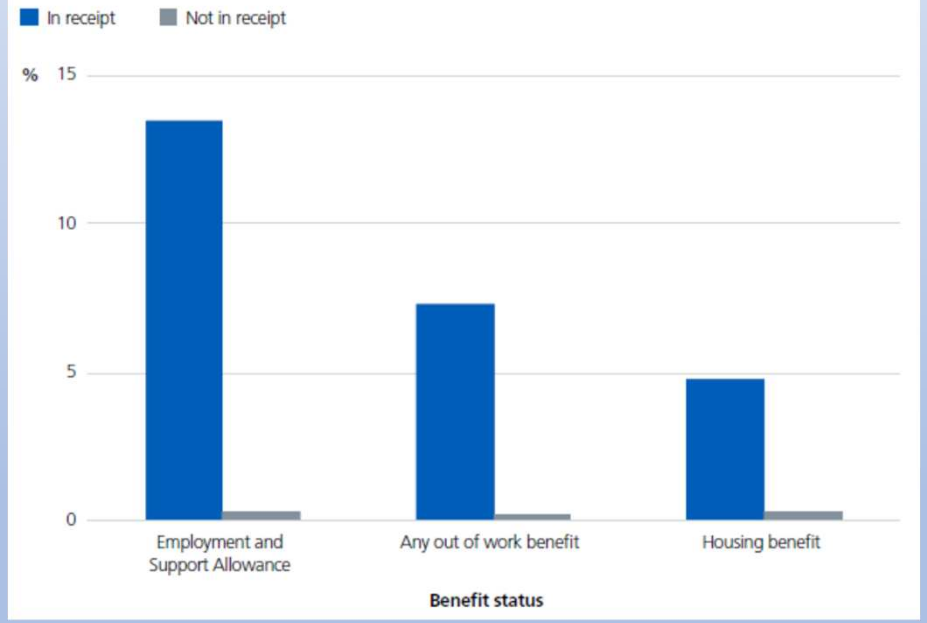
Base: all adults



Benefits 2014

Figure 5E: Psychotic disorder in the past year (2014), by benefit status

Base: 16–64 years (out of work benefits); all adults (housing benefit)



McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

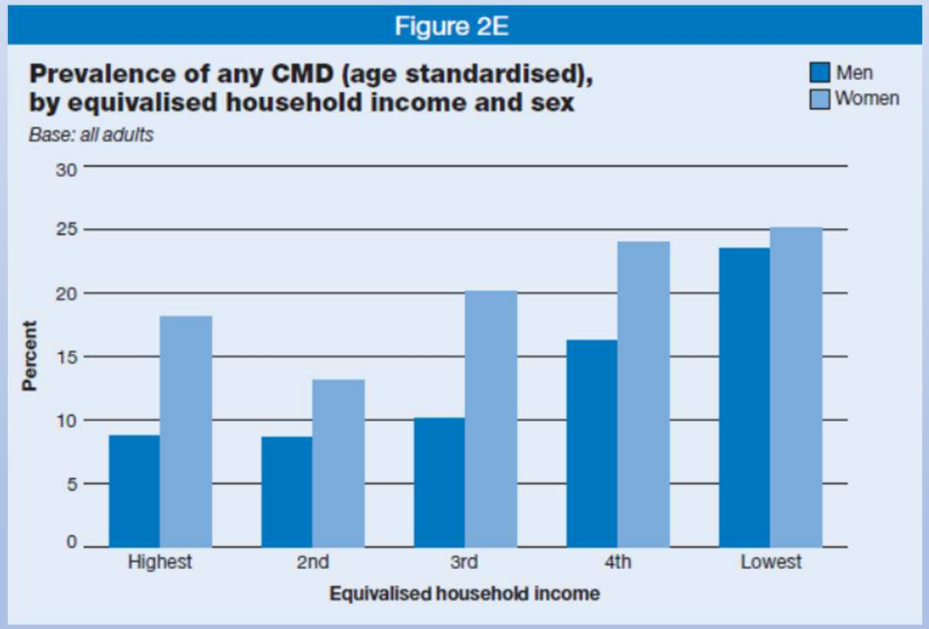
Income and Benefits: Common Mental Health Problems
Adult psychiatric morbidity in England, 2007, 2014

Income 2007

Figure 2E

Prevalence of any CMD (age standardised), by equivalised household income and sex

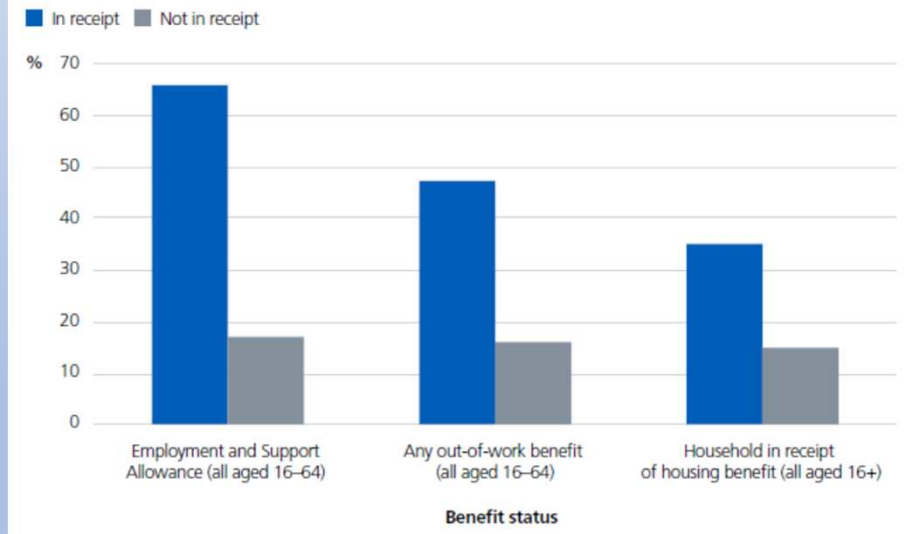
Base: all adults



Benefits 2014

Figure 2N: Prevalence of common mental disorder (CMD), by receipt of benefits (age-standardised)

Base: adults aged 16–64/all adults

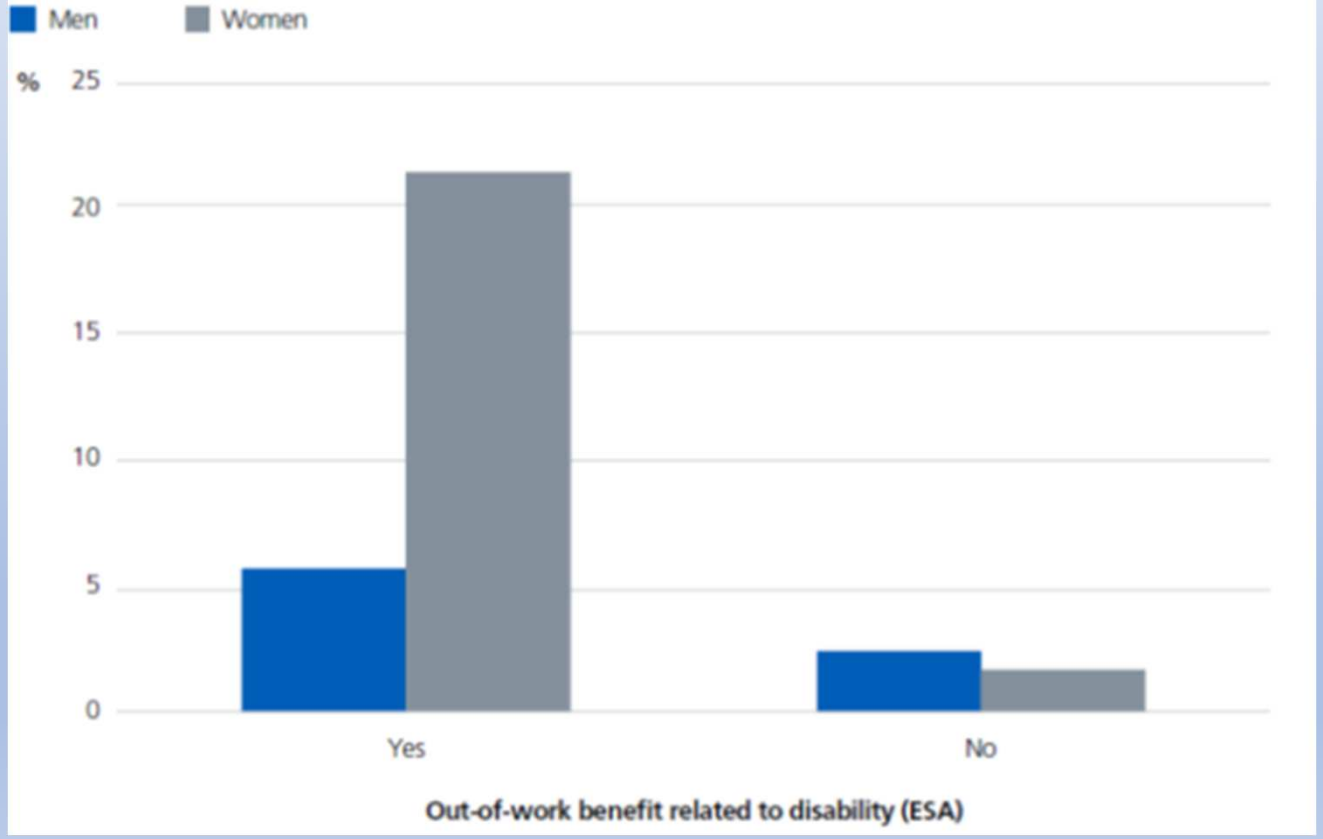


McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

Benefits: Bipolar Disorder
Adult Psychiatric Morbidity in England, 2014

Figure 9D: Positive bipolar disorder screen, by receipt of Employment and Support Allowance and sex

Base: all adults aged 16–64



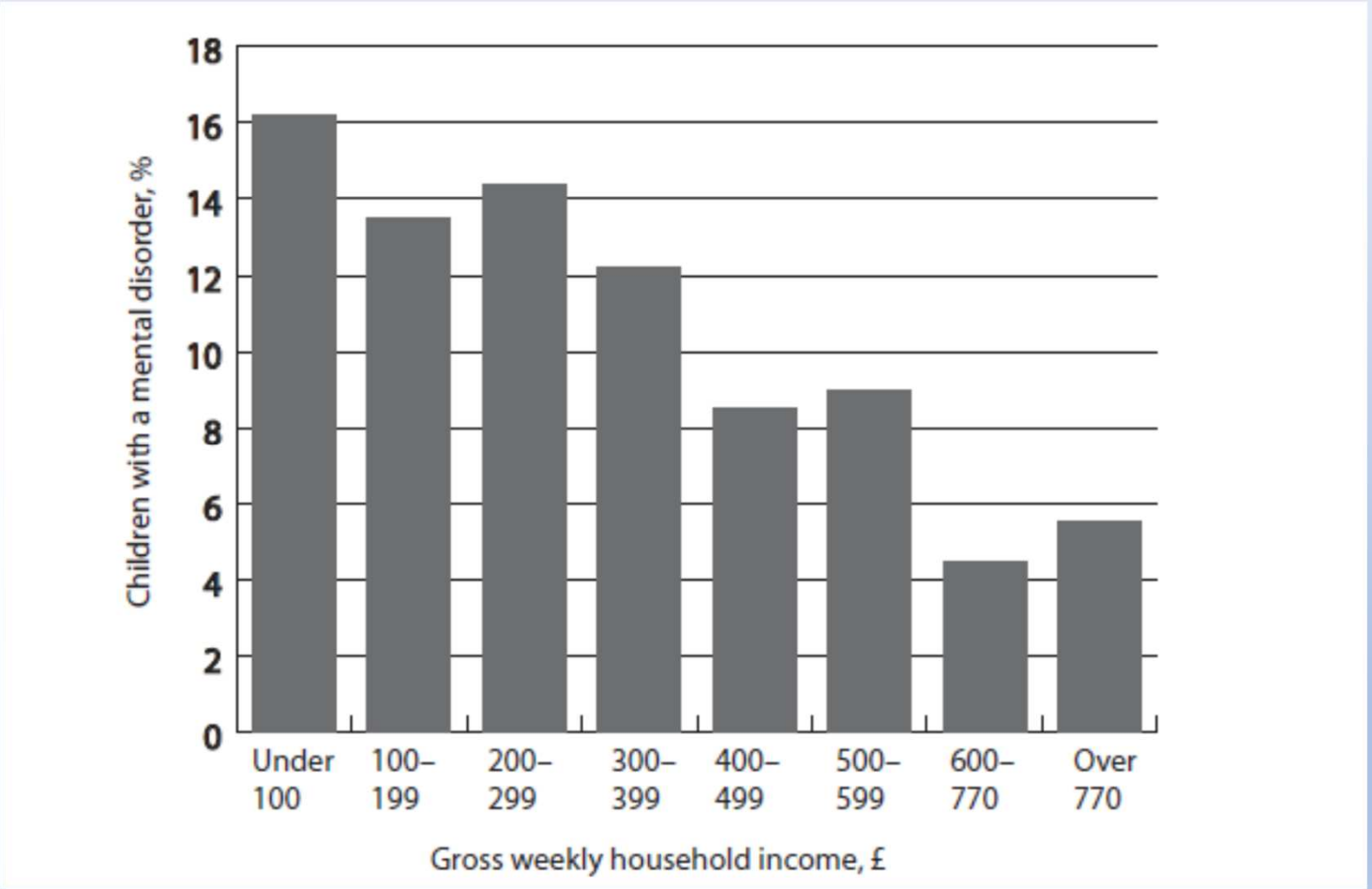
McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

Lack of necessities and poor mental health as experienced by people with common mental disorders

- Fresh fruit and vegetables, 71%
- Warm waterproof coat, 65%
- Two pairs of all weather shoes, 54%
- Special outfit, 49%
- Money to spend on self weekly, 46%
- Money to spend to keep the home decorated, 45%
- Roast joint, 45%
- Replace broken electrical goods, 42%
- Home insurance, 40%
- Damp-free home, 37%
- Appropriate clothes for job interviews, 37%
- Replace worn out furniture, 35%
- Regular savings, 34%

Source: Payne, S. (2006) Mental Health, Poverty and Social Exclusion. (In *Poverty and Social Exclusion in Britain eds P. Pantzalis, D. Gordon & R. Levitas*). Policy Press.

Prevalence of childhood mental disorders by gross weekly household income in Great Britain, 2004 (Green et al 2005)



Green, H., McGinnity, A., Meltzer, H., *et al* (2005) *Mental Health of Children and Young People in Great Britain, 2004*. Palgrave Macmillan.

The multidimentional nature of poverty

Poverty is a multidimensional phenomenon, encompassing inability to satisfy basic needs, lack of control over resources, lack of education, lack of work, isolation and poor health. What poverty means to people will vary across nations, definitions of poverty and its causes vary by gender, age, culture, and other social and economic contexts.

Mental Health – some areas of exclusion

- *Debt*
- *Neighbourhoods*
- *Housing*
- *Transport*
- *Education*
- *Employment*
- *Social networks*
- *Personal safety*
- *Political engagement*
- *Physical health inequalities*

Experiences of Poverty – Sweden (Torpor et al 2014)

"A week before you get your money, you're usually broke. But it's hard because then I have to borrow some money from a friend. This weekend I'm going home to my mom and dad so I'll have my meals there." "You know, I can't make ends meet. So I'd like to find a way to get more money so that I have a more decent life every month."

"I feel so ashamed that I haven't succeeded better in life. It feels like I'm just going round in circles. I think that's what makes me so tired, like I can never get ahead no matter what I do, you know. I see myself as a patient first and foremost; it's got the upper hand instead of my having a profession, like."

"I don't have the money to buy expensive stuff; I was looking around for a pair of shoes, for example, and found these which are really pretty good and cost only 90 kronor! It's stuff like this that I can sometimes buy …"

"I have only two teeth left and they're getting rotten. I want a set of false teeth; I can't put up with these any more, they're all gonna go. I had a tooth infection and within three weeks half of my teeth were gone. Medication also affects your teeth."

"After I've paid the rent, I have about 3000 kronor left and it's usually not enough, so I borrow from my mom sometimes; that's no fun, I mean, at my age you want to be self-sufficient. She's not so happy about it either"

"It's a good idea to have people around you can spend time with but that leaves me with less money for myself because it costs money to invite people. But I find it hard to be stingy, I want to invite people home. We have a lot of fun together"

Torpor et al (2014) Psychosis and poverty: Coping with poverty and severe mental illness in everyday life. *Psychosis*, Vol. 6, No. 2, 117–127

Experiences of Poverty – Scotland (SAMH, 2014)

"I see a lot of people who for example have bipolar and have accumulated debts while in 'manic' phases, or people who suffer a setback like a partner dying which impacts on mental health and this spiralling mental ill health can lead to not bothering about financial payments or debts accumulating." (Debt advisor, Glasgow)

"If you're having a bad time, [you're] not checking your bank and making sure the money's there to cover everything.'

"Often that's something, if you're not well, your normal routines go, your hygiene goes. If you've got family around you they can notice that that's not the norm. But if not. " (Peer Support Worker, North Lanarkshire)

"I just haven't got enough money to feed myself, that is the biggest one. […]The stress hasn't helped, I've been in hospital twice and the specialist said to me that with my Crohn's disease as soon as you get stressed it gets worse."

"Stupid things like boots. I had a hole in my boots so every time it was raining my feet were getting soaking wet so I had to put carrier bags in my boots. It's little things like that that make you think, 'God, have I sunk this low?' All these little things they just build up…"

"I've been homeless, maybe, twenty years on and off. Your environment has got a lot to do with your mental health and your physical health. My mental and physical health has improved immensely since I got my flat.

"Nowadays we're finding people in [this area of Fife] don't have a network, so they feel significantly isolated and obviously they may be aware they need help but might be ashamed or wary of asking for that help. […] We've also got some clients who live in a local estate and there's no services there so that increases the feeling of isolation when people are stuck in their flat, maybe staying in one room but aren't able to heat it properly. And that lack of network or support group just increases that feeling of isolation." (Family Support Worker, Fife)

"Out of my benefits at the moment I must be spending £20-£25 a week on getting around and that's just on public transport, tomorrow I have to get to Gartnavel hospital so that's two trains. That's got to come out of my benefit, some of the costs are down to me as I'm trying to get out there and attend classes and do things but I won't get a bus pass."

"I left school with no qualifications. I felt like people were reading [my CV] thinking, 'this boy's got no qualifications, he must be stupid or something.' […] I was in [care] homes a lot, I moved about a lot and I just didn't get the chance to, you know, do it. […] I went to [a college in Glasgow], they were like that, ' have you got a learning difficulty or something?' I thought, what's the point in me coming here? I felt worse."

"When I had my bus pass and I was getting on the bus to go to the hospital the bus driver said to me "people like you make me sick, there's nothing wrong with you and you've got a bus pass!" I just said to her "I've got cancer and just because you can't see it doesn't mean I'm not ill" and her face! I haven't got cancer but I got off the bus and I was so upset and I thought, what right do they have to say that, especially because it's unseen they automatically stigmatise you and think that there's nothing wrong with you. And you get that with mental health problems too and I think there's more and more of that people judging without knowing. Especially people who are in work because they're suffering they need a scapegoat."

SAMH (2014) *Worried Sick: Experiences of Poverty and Mental Health across Scotland*

Stigma and Poverty

"Most striking has been the distancing of those who receive social assistance from the rest of society – with welfare recipients always seen as a separate stratum in society, often with deviant behaviours and different living conditions – and an individualisation of the causes and consequences of social assistance" (Jones et al, 2006: p. 438).

"…it is evident that the consequences of an individualised view of poverty can often be devastating, or at least make the struggle to survive more difficult. The sheer lack of respect and understanding given to the disadvantaged in Britain is highly corrosive of wellbeing, and all the more so because it is constant and overwhelming. We have had welfare recipients tell us how every interaction they have with the official welfare world is negative: no one has a good word to say to them; they spend hours shuttling between agencies in grimy offices that reinforce their powerlessness. Their time is of no account because they are considered to be of no account". (Jones et al, 2006: p. 439).

"By necessaries, I understand not only the commodities which are indispensably necessary for the support of life, but whatever the custom of the country renders it indecent for creditable people, even the lowest order to be without … a creditable day labourer would be ashamed to appear in public without a linen shirt". (Adam Smith)

Jones, C., Burstrom, B., Marttila, A., et al (2006) Studying social policy and resilience in families facing adversity in different welfare state contexts – the case of Britain and Sweden. *International Journal of Health Services*, 36, 425–442.
Friedli, L. (2009) *Mental Health, Resilience and Inequalities*. WHO Regional Office for Europe.
Zavaleta, D. (2007) *The Ability to go about without Shame*. Oxford University OPHI WORKING PAPER NO. 03

Ordinary Resilience – making small positive steps

Nina's story (described by Ann, a community project worker):

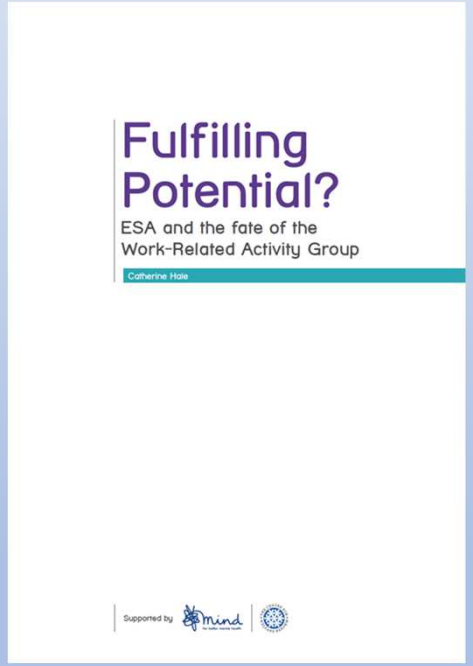
"The success for Nina……she suffered herself very much with depression, so it was very much about getting herself out of bed, the kids to school, house clean and meals cooked but [it's taken] the four years. Her actual confidence has come on leaps and bounds and she's [now] actually a member of the residents' group."

(From Canvin et al 2009)

Faced with depression, the small positive steps that Nina took were highly significant for her life.

Canvin et al (2009)Tales of the unexpected? Hidden resilience in poor households in Britain. *Social Science & Medicine* 69, 238–245

Welfare Reform



'First, do no harm': are disability assessments associated with adverse trends in mental health? A longitudinal ecological study

B Barr,[1] D Taylor-Robinson,[1] D Stuckler,[2] R Loopstra,[2] A Reeves,[2] M Whitehead[1]

Barr B, *et al. J Epidemiol Community Health* 2015;**0**:1–7. doi:10.1136/jech-2015-206209

- Shows strong association between the reassessment rates for ESA, carried out through WCA process, in local areas of England, and the local trends in suicide, self-reported mental health problems and antidepressant prescribing.
- For every additional 10,000 people reassessed for ESA, there was an associated additional 6 suicides in each area amounting to 600 additional suicides in England between 2010-2013.

Regime of conditionality and sanctions has left participants in the WRAG fearful, demoralised, and further away from achieving their work-related goals or participating in society than when they started

Debt

MONEY AND MENTAL HEALTH
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JUNE 2016

MONEY AND MENTAL HEALTH
POLICY INSTITUTE
IN CONTROL
A CONSULTATION ON REGULATING SPENDING DURING PERIODS OF POOR MENTAL HEALTH

Joining the dots
Integrating practical support in mental healthcare settings in England
Mette Isaksen and Richard Williams
citizens advice

The relationship between personal debt and mental health: a systematic review
Chris Fitch, Sarah Hamilton, Paul Bassett and Ryan Davey
MENTAL HEALTH REVIEW JOURNAL | VOL. 16 NO. 4 2011

Financial hardship impedes recovery

Soc Psychiatry Psychiatr Epidemiol (2008) 43:947–952 DOI 10.1007/s00127-008-0392-3

ORIGINAL PAPER

Maria Mattsson · Alain Topor · Johan Cullberg · Yvonne Forsell

Association between financial strain, social network and five-year recovery from first episode psychosis

- 5-year outcome of people with first episode psychosis (Recovered vs non-recovered)
- Matched with general population controls
- Financial strain and social network (quality and quantity) were associated with outcome

BRITISH JOURNAL OF PSYCHIATRY (2007), 190, 293–298. doi: 10.1192/bjp.bp.105.020040

Depression and socio-economic risk factors:

7-year longitudinal population study

VINCENT LORANT, CHRISTOPHE CROUX, SCOTT WEICH, DENISE DELIÈGE, JOHAN MACKENBACH and MARC ANSSEAU

- Prospective cohort study using the annual Belgian Household Panel Survey
- A lowering in material standard of living between annual waves was associated with increases in depressive symptoms and caseness of major depression

Can giving people more money help?

ORIGINAL CONTRIBUTION

Association of Family Income Supplements in Adolescence With Development of Psychiatric and Substance Use Disorders in Adulthood Among an American Indian Population

E. Jane Costello, PhD
Alaattin Erkanli, PhD
William Copeland, PhD
Adrian Angold, MRCPsych

Context In a natural experiment in which some families received income supplements, prevalence of adolescent behavioral symptoms decreased significantly. These adolescents are now young adults.

Objective To examine the effects of income supplements in adolescence and adulthood on the prevalence of adult psychiatric disorders.

Design Quasi-experimental, longitudinal.

Population and Setting A representative sample of children aged 9, 11, or 13 years in 1993 (349 [25%] of whom are American Indian) were assessed for psychiatric and substance use disorders through age 21 years (1993-2006). Of the 1420 who participated in 1993, 1185 were interviewed as adults. From 1996, when a casino opened on the Indian reservation, every American Indian but no non-Indians received an annual income supplement that increased from $500 to around $9000.

Main Outcome Measures Prevalence of adult psychiatric disorders and substance use disorders based on the *Diagnostic and Statistical Manual of Mental Disorders* in 3 age cohorts, adjusted for age, sex, length of time in the family home, and number of Indian parents.

Results As adults, significantly fewer Indians than non-Indians had a psychiatric disorder (106 Indians [weighted 30.2%] vs 337 non-Indians [weighted 36.0%]; odds ratio [OR], 0.46; 95% confidence interval [CI], 0.30-0.72; $P=.001$), particularly alcohol and cannabis abuse, dependence, or both. The youngest age-cohort of Indian youth had the longest exposure to the family income. Interactions between race/ethnicity and age cohort were significant. Planned comparisons showed that fewer of the youngest Indian age-cohort had any psychiatric disorder (31.4%) than the Indian middle cohort (41.7%; OR, 0.43; 95% CI, 0.24-0.78; $P=.005$) or oldest cohort (41.3%; OR, 0.69; 95% CI, 0.51-0.94; $P=.01$) or the youngest non-Indian cohort (37.1%; OR, 0.66; 95% CI, 0.48-0.90; $P=.008$). Study hypotheses were not upheld for nicotine or other drugs, or emotional or behavioral disorders. The income supplement received in adulthood had no impact on adult psychopathology.

Conclusion Lower prevalence of psychopathology in American Indian youth following a family income supplement, compared with the nonexposed, non-Indian population, persisted into adulthood.

JAMA. 2010;303(19):1954-1960 www.jama.com

In 2003 we published the results of a natural experiment in which an income supplement given to all members of one community but to none in another predicted significantly fewer adolescent psychiatric symptoms in the income-supplement group.[1] At the time of the earlier study, the participants were adolescents living at home. They are now adults and in receipt of their own income supplement. This article assesses whether the effects of the family income supplement persist into adulthood, controlling for past and current risk and protective factors, including poverty.

METHODS

Setting and Population

The Great Smoky Mountains Study is a longitudinal study of the development of psychiatric and substance use disorders in rural and urban youth.[2,3] In 1993, a representative sample of 1420 children aged 9, 11, and 13 years at intake was recruited from some 12 000 children of these ages living in 11 counties in western North Carolina, using a household equal probability, accelerated cohort design.[4] Parents of a random sample of 3896 non-Indian youth responded to a brief telephone questionnaire about their child's behavioral problems (FIGURE).[3] All those scoring in the top 25% (1009) and 1 in 10 of those scoring in the lower 75% (337) were invited to joint the study.

American Indian children were oversampled. Potential participants were

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BRIEF REPORT

Money and Mental Illness: A Study of the Relationship Between Poverty and Serious Psychological Problems

Ingemar Ljungqvist[1] · Alain Topor[2,3] · Henrik Forssell[4] · Idor Svensson[5] · Larry Davidson[6]

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© Springer Science+Business Media New York 2015

Abstract Several studies have indicated a co-occurrence between mental problems, a bad economy, and social isolation. Medical treatments focus on reducing the extent of psychiatric problems. Recent research, however, has highlighted the possible effects of social initiatives. The aim of this study was to examine the relation between severe mental illness, economic status, and social relations. Method: a financial contribution per month was granted to 100 individuals with severe mental illnesses for a 9-month period. Assessments of the subjects were made before the start of the intervention and after 7 months' duration. A comparison group including treatment as usual only was followed using the same instruments. Significant improvements were found for depression and anxiety, social networks, and sense of self. No differences in functional level were found. Social initiatives may have treatment and other beneficial effects and should be integrated into working contextually with persons with severe mental illnesses.

Keywords Severe mental illness · Poverty · Social network · Symptoms · Functional level

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Background

Several studies have found a relationship between mental health problems and relative poverty. A large number of people who live in poor economic circumstances display such problems (Read 2010; Saraceno and Barbui 1997) but this may be both a cause and effect of their living situation (Muntaner et al. 2007; Robichaud 1994). Although hypotheses have been formulated regarding both directions in such a relationship, different studies have produced contradictory results (Cohen 1993; Saraceno and Barbui 1997). The social drift hypothesis views mental health problems as the cause of financial problems, whereas the social causation hypothesis looks upon financial circumstances as crucial for the emergence and development of mental health problems. A further hypothesis emanates from the cultural role played by diagnostic practices. Behaviours linked to poverty, gender, and ethnicity may all be made into symptoms in psychiatric practice (Read 2004). These hypotheses are not necessarily mutually exclusive.

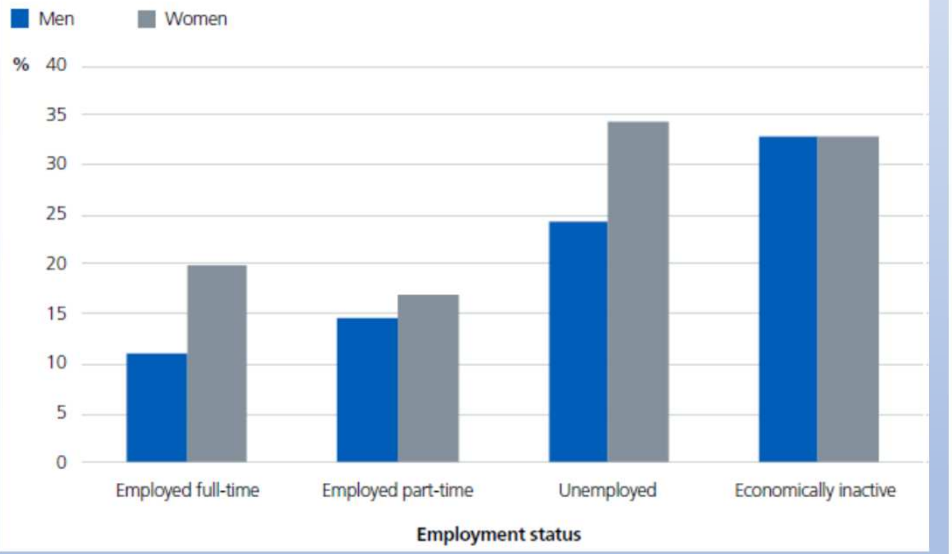
Poverty has been mentioned by mental health service users themselves as one of their primary concerns

Employment: Psychosis and Common Mental Health Problems
Adult psychiatric morbidity in England, 2007, 2014

Common Mental Health Problems

Figure 2L: Prevalence of common mental disorder (CMD), by employment status (age-standardised) and sex

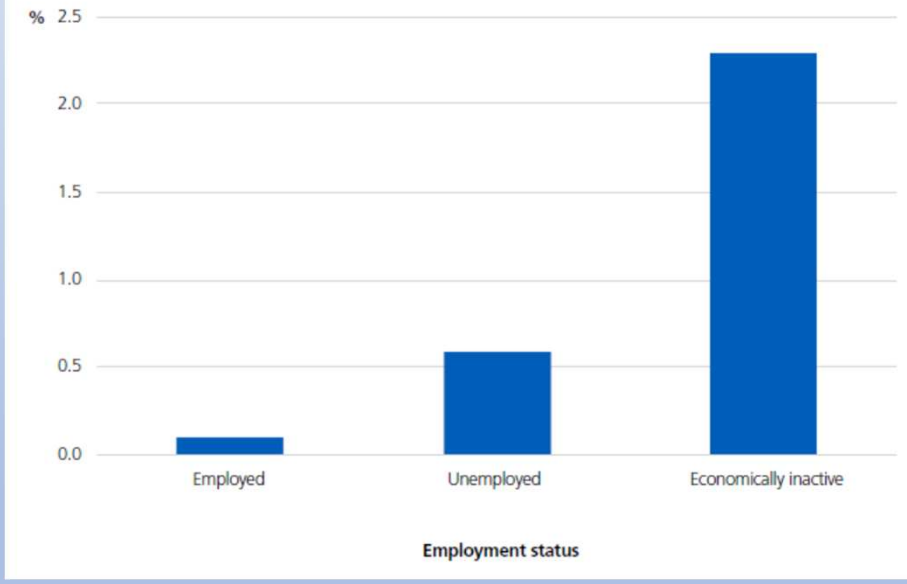
Base: adults aged 16–64



Psychosis

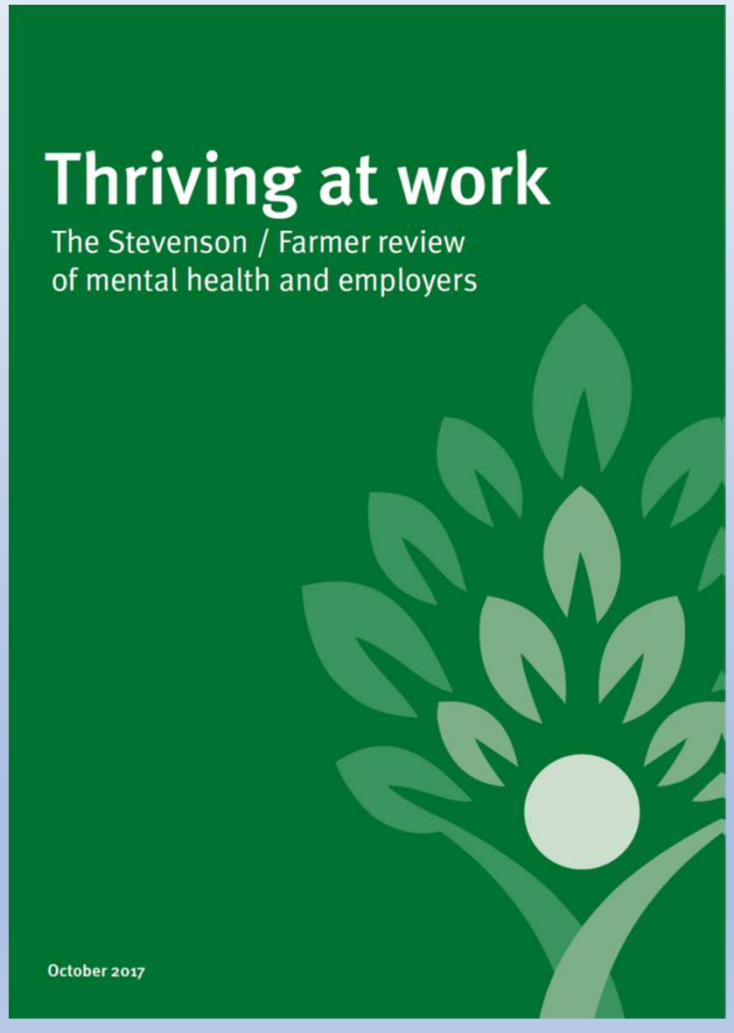
Figure 5D: Psychotic disorder in the past year (2007 and 2014 combined), by employment status

Base: aged 16–64



McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

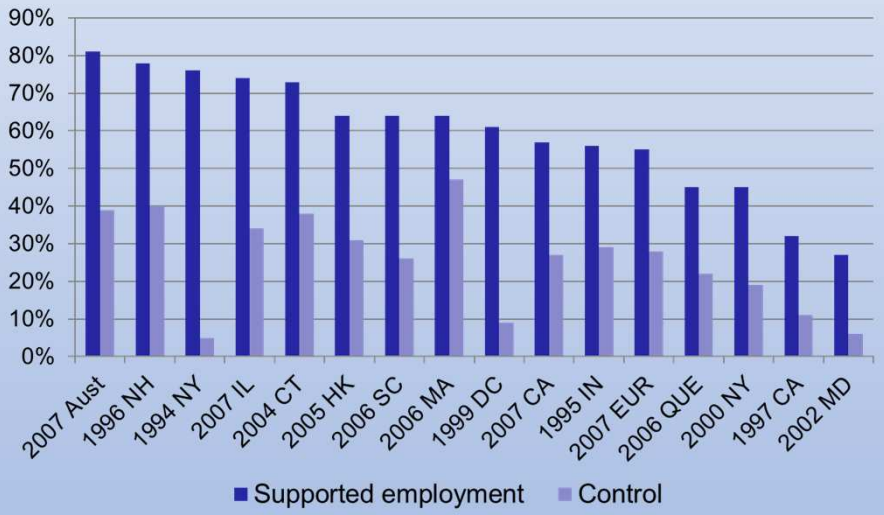
Mental Health at Work



- 300,000 people with a long-term mental health problem lose their jobs each year
- Poor mental health costs employers up to £42 billion a year, with an annual cost to the UK economy of up to £99 billion.
- Review showcases good practice employers and makes 40 recommendations for employers, Government and regulators.
- All employers to commit to six core standards around mental health, with further recommendations for large employers and the public sector, improved regulation, and changes to legislation.

Supported Employment (Individual Placement and Support)

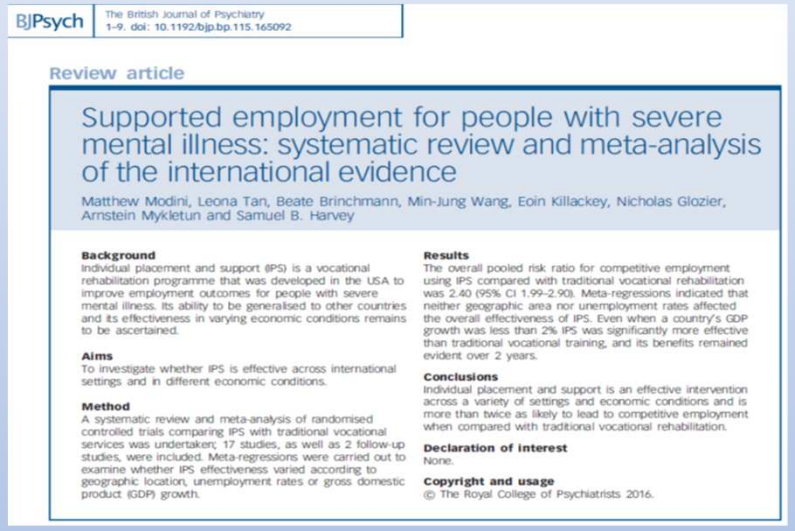
Competitive Employment Rates in IPS randomised controlled trials



Bond GR, Drake RE, Becker DR. Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. World Psychiatry 2012; 11: 32–9.

Systematic Review of IPS

(Modini, M et al 2016 British Journal Psychiatry)



BJPsych The British Journal of Psychiatry 1–9. doi: 10.1192/bjp.bp.115.165092

Review article

Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence

Matthew Modini, Leona Tan, Beate Brinchmann, Min-Jung Wang, Eoin Killackey, Nicholas Glozier, Arnstein Mykletun and Samuel B. Harvey

Background
Individual placement and support (IPS) is a vocational rehabilitation programme that was developed in the USA to improve employment outcomes for people with severe mental illness. Its ability to be generalised to other countries and its effectiveness in varying economic conditions remains to be ascertained.

Aims
To investigate whether IPS is effective across international settings and in different economic conditions.

Method
A systematic review and meta-analysis of randomised controlled trials comparing IPS with traditional vocational services was undertaken; 17 studies, as well as 2 follow-up studies, were included. Meta-regressions were carried out to examine whether IPS effectiveness varied according to geographic location, unemployment rates or gross domestic product (GDP) growth.

Results
The overall pooled risk ratio for competitive employment using IPS compared with traditional vocational rehabilitation was 2.40 (95% CI 1.99–2.90). Meta-regressions indicated that neither geographic area nor unemployment rates affected the overall effectiveness of IPS. Even when a country's GDP growth was less than 2% IPS was significantly more effective than traditional vocational training, and its benefits remained evident over 2 years.

Conclusions
Individual placement and support is an effective intervention across a variety of settings and economic conditions and is more than twice as likely to lead to competitive employment when compared with traditional vocational rehabilitation.

Declaration of interest
None.

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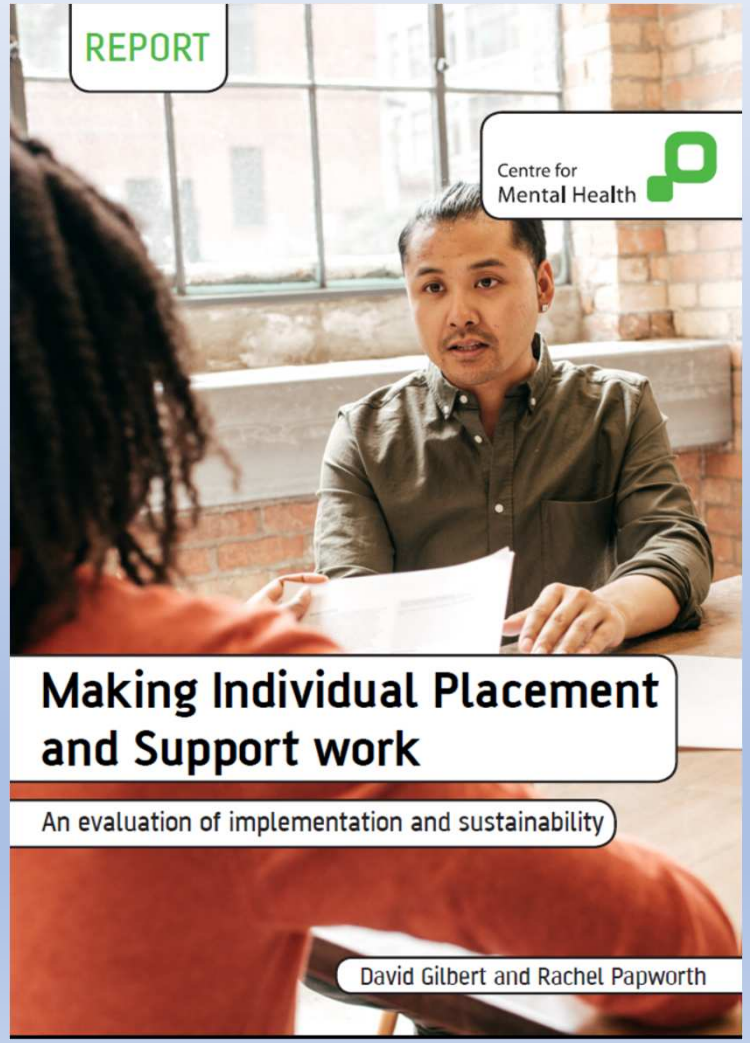
- 17 RCTs in Europe, USA, Canada, Australia, Japan, Hong-Kong
- Effective in wide range countries (even those with low GDP growth)
- People receiving IPS more than twice as likely to gain competitive employment than those given traditional vocational rehabilitation

Implementing Supported Employment (Individual Placement and Support)



Editorial

Difficulties in implementing supported employment for people with severe mental health problems†

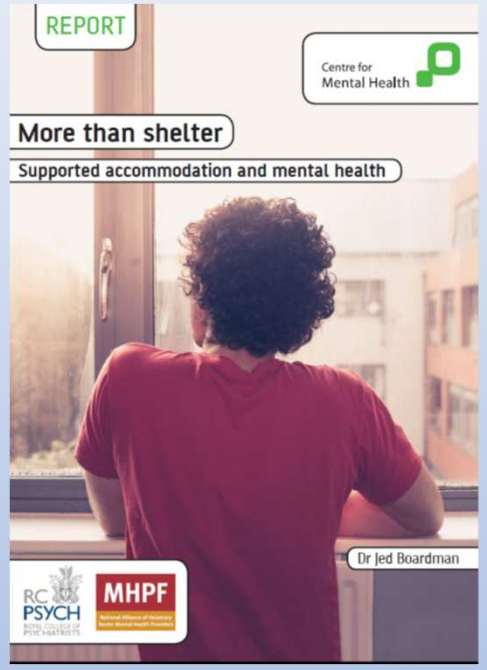
Jed Boardman and Miles Rinaldi

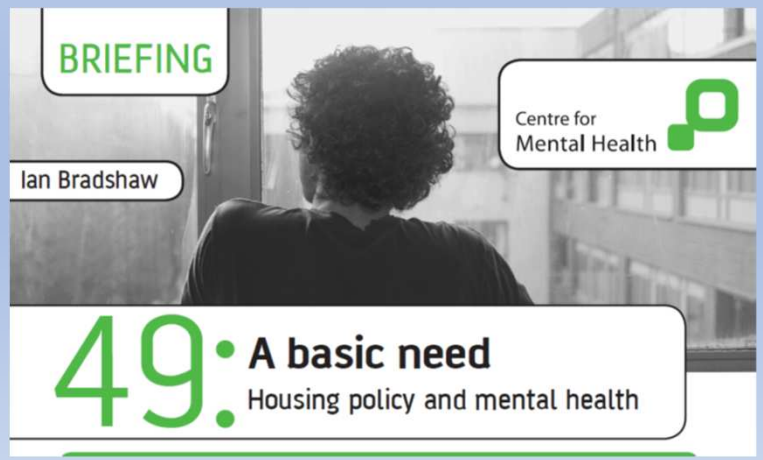
Summary
People with severe mental health problems have low rates of open employment. Despite good evidence for the effectiveness of Individual Placement and Support (IPS), these schemes are not widely implemented. Their implementation is hampered by clinician and societal attitudes and the effect of organisational context on implementing IPS schemes with sufficient fidelity.

Declaration of interest
J.D. and M.R. are members of the Implementing Recovery through Organisational Change (ImROC) team at the Centre for Mental Health/NHS Confederation. M.R. is an external consultant for the Catalyst Individual Placement and Support Programme with Janssen-Cilag UK.

BJPsych | The British Journal of Psychiatry (2013) 203, 247–249. doi: 10.1192/bjp.bp.112.121962

Supported Housing





Key elements of the Housing First approach

- Immediate provision of independent accommodation
- No requirement of 'housing readiness'
- Provision of permanent housing
- Open-ended access to support
- Respect for choice and self-determination ("Respect, warmth and compassion for all clients")
- Personalised approach targeting the most vulnerable people
- Provision of integrated and comprehensive community-based support by Assertive Outreach teams (ACT) or Intensive Case management (ICM)
- Harm-reduction approach to substance misuse

Tsemberis, S. (2010b) Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction. Minnesota: Hazelden.

Pleace, N. & Bretherton, J. (2013) The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness. European Journal of Homelessness, **7** (2), 21-41.

Pleace, N. & Wallace, A. (2011) Demonstrating the Effectiveness of Housing Support Services for People with Mental Health Problems: A Review. York: Centre for Housing Policy.

Pleace, N. & Quilgars, D. (2013) Improving Health and Social Integration through Housing First. A Review. York: Centre for Housing Policy.

Political Engagement

Civic activities included in the Poverty and Social Exclusion Survey (Gordon et al, 2000)

Civic activities undertaken in the past 3 years

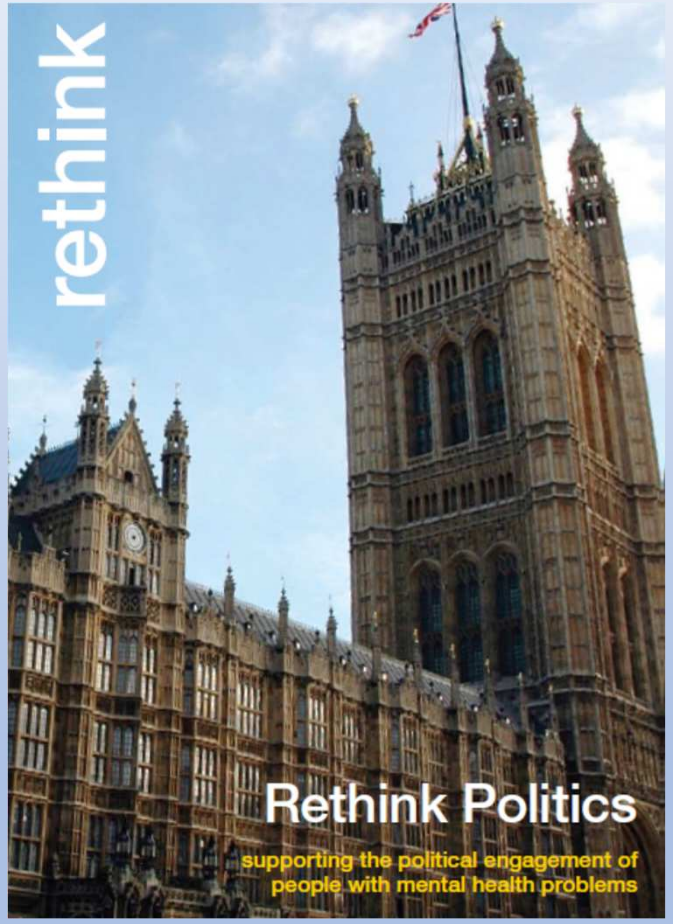
- voted in last general election
- voted in last local election
- helped on fundraising drives
- urged someone outside the family to vote
- presented views to a local councillor
- urged someone to get in touch with a local councillor
- been an officer of an organisation or club
- made a speech before an organised group
- written a letter to an editor
- taken an active part in a political campaign
- stood for civic office

Current active involvement in civic organisations

- sports club
- religious group or church organisation
- any other group or organisation
- trade union
- social club or working men's club
- tenants' or residents' association, neighbourhood watch
- voluntary service group
- patents' or school association
- environmental group
- other community or civic group
- women's group or organisation
- political party
- other pressure group
- women's institute or townswomen's guild

Gordon, D., Levitas, R., Pantazis, C., et al (2000) Poverty and Social Exclusion in Britain. Joseph Rowntree Foundation.

Political Engagement



ORIGINAL PAPER

Uptake and knowledge of voting rights by adult in-patients during the 2010 UK general election

James McIntyre,[1] Masum Khwaja,[1,2] Venkata Yelamanchili,[1] Sobia Naz,[1] Maria Clarke[2,3]

The Psychiatrist (2012), **36**, 126–130, doi: 10.1192/pb.bp.110.033662

[1]Gordon Hospital, London, UK; [2]Imperial College London, UK; [3]St Charles' Hospital, London, UK

Correspondence to James McIntyre (james.mcintyre1@nhs.net)

First received 24 Nov 2010, final revision 5 Sep 2011, accepted 13 Oct 2011

Aims and method This study explores knowledge and uptake of the voting rights of adult in-patients in the 2010 UK general election. A clinician-completed survey was used.

Results Eligible to vote psychiatric adult in-patients were half as likely to register as the general population and half as likely to vote if registered. Nine out of ten of those unregistered cited a lack of knowledge of their eligibility to vote or of the registration process. Long-stay patients were particularly disenfranchised.

Clinical implications Many patients and staff remain unaware of the new rules which have given a greater proportion of in-patients the right to vote and have simplified the registration and voting processes. This information barrier may be addressed in future elections by providing timely written information to both patients and staff. Once registered, patients may need further support to overcome practical and psychological barriers, and cast their vote.

Declaration of interest None.

Central and North West London NHS
NHS Foundation Trust

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Voting rights for mental health patients

Why is this guidance needed?

A study of the 2010 General Election found that psychiatric in-patients who were eligible to vote were half as likely to register as the general population and, if registered, were half as likely to vote.[1]

Nine out of ten of those unregistered cited a lack of knowledge of their eligibility to vote or of the registration process, with long-stay patients particularly disenfranchised.

Psychoses – Multiple Disadvantages

Psychological Medicine (2008), **38**, 1701–1715. © 2008 Cambridge University Press
doi:10.1017/S0033291708004534 Printed in the United Kingdom

ORIGINAL ARTICLE

Cumulative social disadvantage, ethnicity and first-episode psychosis: a case-control study

C. Morgan[1*], J. Kirkbride[2], G. Hutchinson[3], T. Craig[1,4], K. Morgan[5], P. Dazzan[4], J. Boydell[4], G. A. Doody[6], P. B. Jones[2], R. M. Murray[4], J. Leff[4] and P. Fearon[4]

AESOP study (Aetiology and Ethnicity in Schizophrenia and Other Psychoses)

- Study of First Episode Psychosis in London and Nottingham
- 390 people with first ever contact with mental health services for schizophrenia

- More likely to be socially disadvantaged or isolated than matched controls (e.g. having no educational qualifications, being unemployed, living in rented accommodation and living alone)
- Between 2.7 and 3.5 times more likely to be in these circumstances than other members of the population
- More likely to experience multiple features of social disadvantage
- Only 19% of those with schizophrenia did not have at least one indicator of disadvantage compared with 54% of the general population
- 34% had four or more indicators compared with 13% of controls.

AESOP study. 10 year follow-up

BJPsych The British Journal of Psychiatry (2017) 211, 88–94. doi: 10.1192/bjp.bp.116.193342

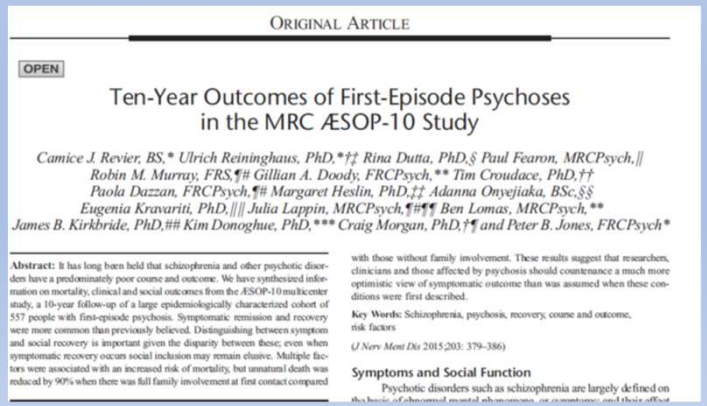
Ethnicity and long-term course and outcome of psychotic disorders in a UK sample: the ÆSOP-10 study

Craig Morgan, Paul Fearon, Julia Lappin, Margaret Heslin, Kim Donoghue, Ben Lomas, Ulrich Reininghaus, Adanna Onyejiaka, Tim Croudace, Peter B. Jones, Robin M. Murray, Gillian A. Doody and Paola Dazzan

Schizophrenia Bulletin vol. 41 no. 3 pp. 664–673, 2015
doi:10.1093/schbul/sbu138
Advance Access publication September 27, 2014

Mortality in Schizophrenia and Other Psychoses: A 10-Year Follow-up of the ÆSOP First-Episode Cohort

Ulrich Reininghaus[*,1–3], Rina Dutta[4], Paola Dazzan[5,6], Gillian A. Doody[7], Paul Fearon[8], Julia Lappin[5,6,9], Margaret Heslin[10], Adanna Onyejiaka[1], Kim Donoghue[11], Ben Lomas[7], James B. Kirkbride[12], Robin M. Murray[5,6], Tim Croudace[13], Craig Morgan[1,5], and Peter B. Jones[3]



ORIGINAL ARTICLE

OPEN

Ten-Year Outcomes of First-Episode Psychoses in the MRC ÆSOP-10 Study

Camice J. Revier, BS, Ulrich Reininghaus, PhD,*†‡ Rina Dutta, PhD,§ Paul Fearon, MRCPsych,‖ Robin M. Murray, FRS,¶# Gillian A. Doody, FRCPsych,** Tim Croudace, PhD,†† Paola Dazzan, FRCPsych,¶# Margaret Heslin, PhD,‡‡ Adanna Onyejiaka, BSc,§§ Eugenia Kravariti, PhD,‖‖ Julia Lappin, MRCPsych,¶#¶¶ Ben Lomas, MRCPsych,** James B. Kirkbride, PhD,## Kim Donoghue, PhD,*** Craig Morgan, PhD,†¶ and Peter B. Jones, FRCPsych**

Abstract: It has long been held that schizophrenia and other psychotic disorders have a predominately poor course and outcome. We have synthesized information on mortality, clinical and social outcomes from the ÆSOP-10 multicenter study, a 10-year follow-up of a large epidemiologically characterized cohort of 557 people with first-episode psychosis. Symptomatic remission and recovery were more common than previously believed. Distinguishing between symptom and social recovery is important given the disparity between these; even when symptomatic recovery occurs social inclusion may remain elusive. Multiple factors were associated with an increased risk of mortality, but unnatural death was reduced by 90% when there was full family involvement at first contact compared with those without family involvement. These results suggest that researchers, clinicians and those affected by psychosis should countenance a much more optimistic view of symptomatic outcome than was assumed when these conditions were first described.

Key Words: Schizophrenia, psychosis, recovery, course and outcome, risk factors

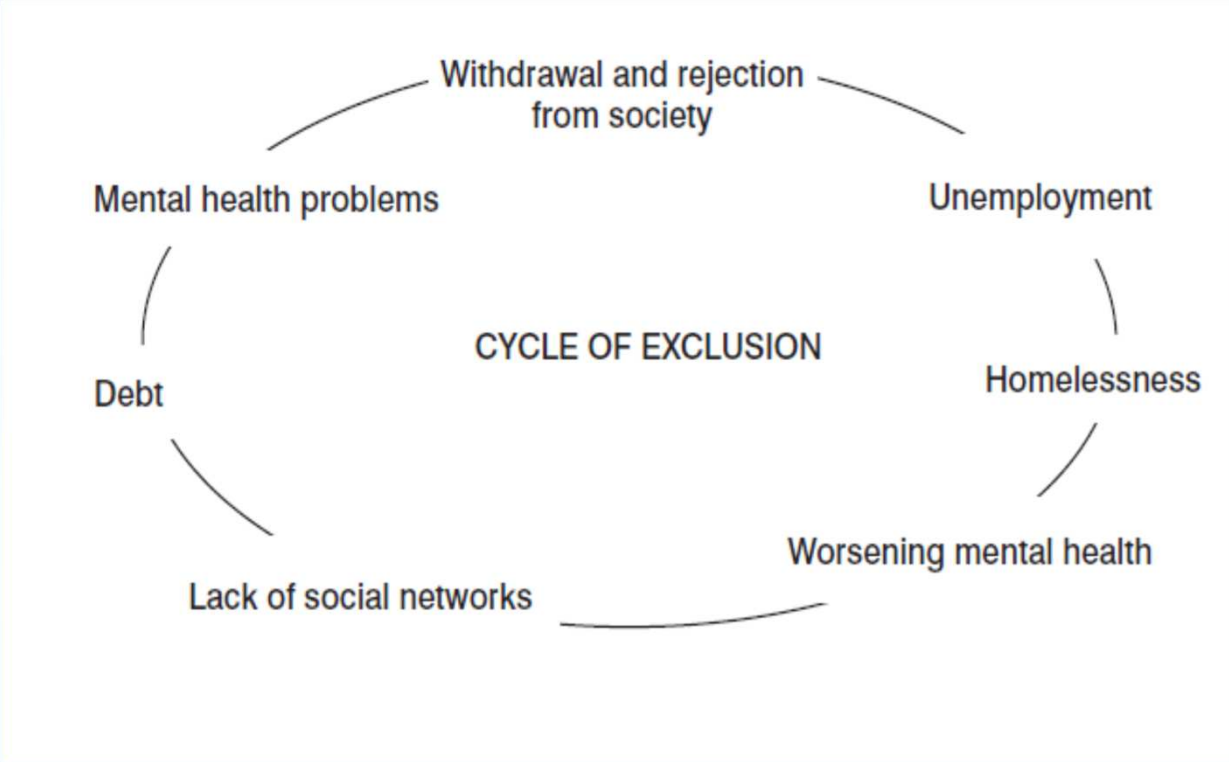
(*J Nerv Ment Dis* 2015;203: 379–386)

Symptoms and Social Function

Psychotic disorders such as schizophrenia are largely defined on

- Symptomatic recovery better than expected (46% free of symptoms for past 2 years)
- Social Recovery poor (72% employed for less than 25% of 10 year FU)
- Outcomes worse for Black Caribbean and Black African
- High mortality rates:
  - All Causes SMR=3.6
  - Natural Cause SMR=1.7
  - Unnatural Cause SMR=13.3
  - Suicide Cause SMR=20
  - Illicit drug use associated with increase risk of all cause mortality
  - Family involvement at first contact strongly reduced risk of unnatural cause mortality

A Cycle of Exclusion



"a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown" (Social Exclusion Unit, 2001: p. 11)

"…most important characteristic of social exclusion is that these problems are linked and mutually reinforcing, and can combine to create a complex and fast moving vicious cycle" (Social Exclusion Unit, 2001: p. 11).

"the dynamic process of being shut out, fully or partially, from any of the social, economic, political and cultural systems which determine the social integration of a person in society" (Walker & Walker, 1997).

Social Exclusion Unit (2001) Preventing Social Exclusion. TSO (The Stationery Office).

Walker, A. & Walker, C. (eds) (1997) *Britain Divided: The Growth of Social Exclusion in the 1980s and 1990s.* Child Poverty Action Group.

Childhood abuse and mental disorders

Associated with Childhood Maltreatment

- Drug/Alcohol Abuse
- Antisocial Personality DO
- Major Depression
- Psychotic Disorders
- Post-traumatic Stress
- Bipolar DO (early onset)
- Borderline Personality DO
- Dissociative Identity DO

Teicher MH, Samson JA, Anderson CM, and Ohashi K. Effects of childhood maltreatment on brain structure, function and connectivity. Nature Reviews Neuroscience, 2016, 17, 652-666.

Teicher MH, Samson, JA. Annual Research Review. Enduring neurobiological effects of childhood abuse and neglect. Journal of Child Psychology and Psychiatry, 2016, 57(3): 241-266.

Teicher MH, Samson JA. Childhood maltreatment and psychopathology: A case for ecophenotypic variants as clinically and neurobiologically distinct subtypes. Am J Psychiatry 2013, 170: 1114-1133.

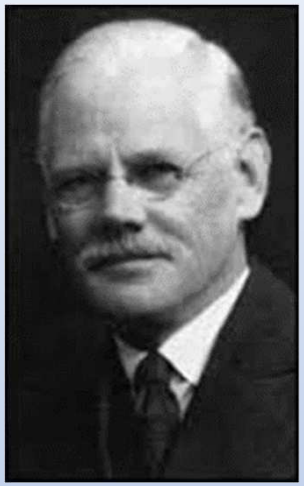
Population attributable risk associated with early adversity

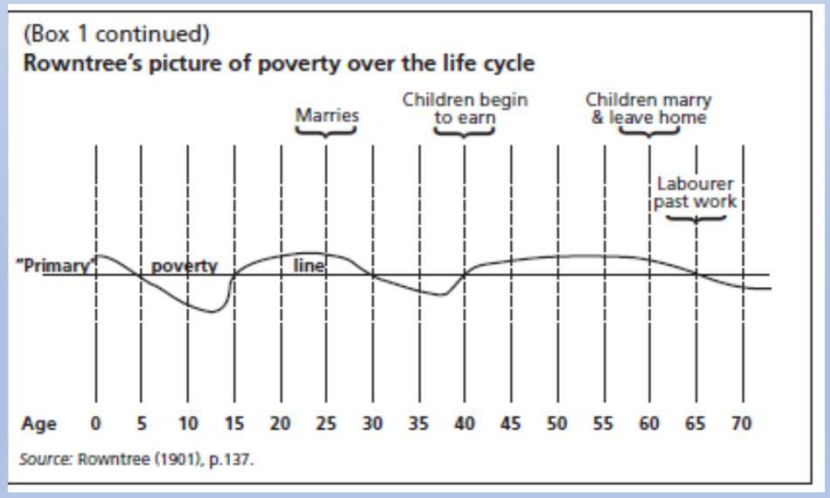
- 50% for drug abuse
- 54% for current depression
- 65% for alcoholism
- 67% for suicide attempts
- 78% for iv drug use

Dube et al (2003) Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. Pediatrics 111, 564-572

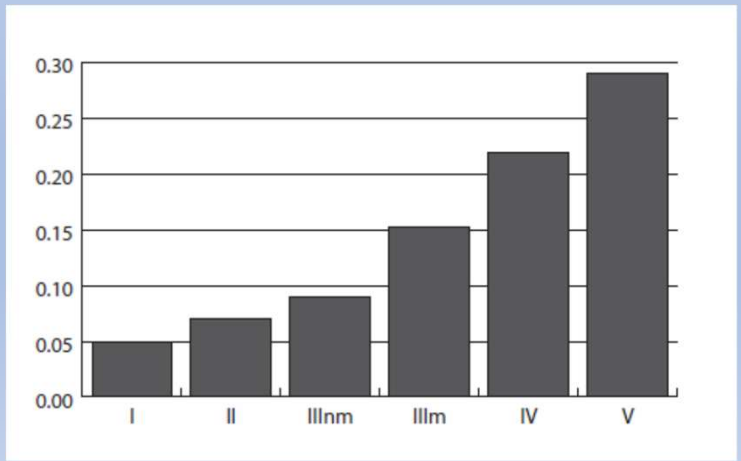
Poverty and Life course

Seebohm Rowntree
1871-1954





Probability of multiple deprivation at 30 years, by birth SES (1970 cohort)



Thank you