

# Poverty, low income and mental health problems

Dr Jed Boardman

ISPRA conference, Jerusalem

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# Poverty, low income and mental health problems

- Poverty – what is this?
- The multidimensional nature of poverty – social exclusion and inequalities
- Why is poverty bad?
- Why should we be interested in Poverty and Social Inclusion
- Poverty, social inequalities and health – and mental health
- Consequences of poverty
- Income inequalities and the effects of the Recession
- What can be done?

# Poverty

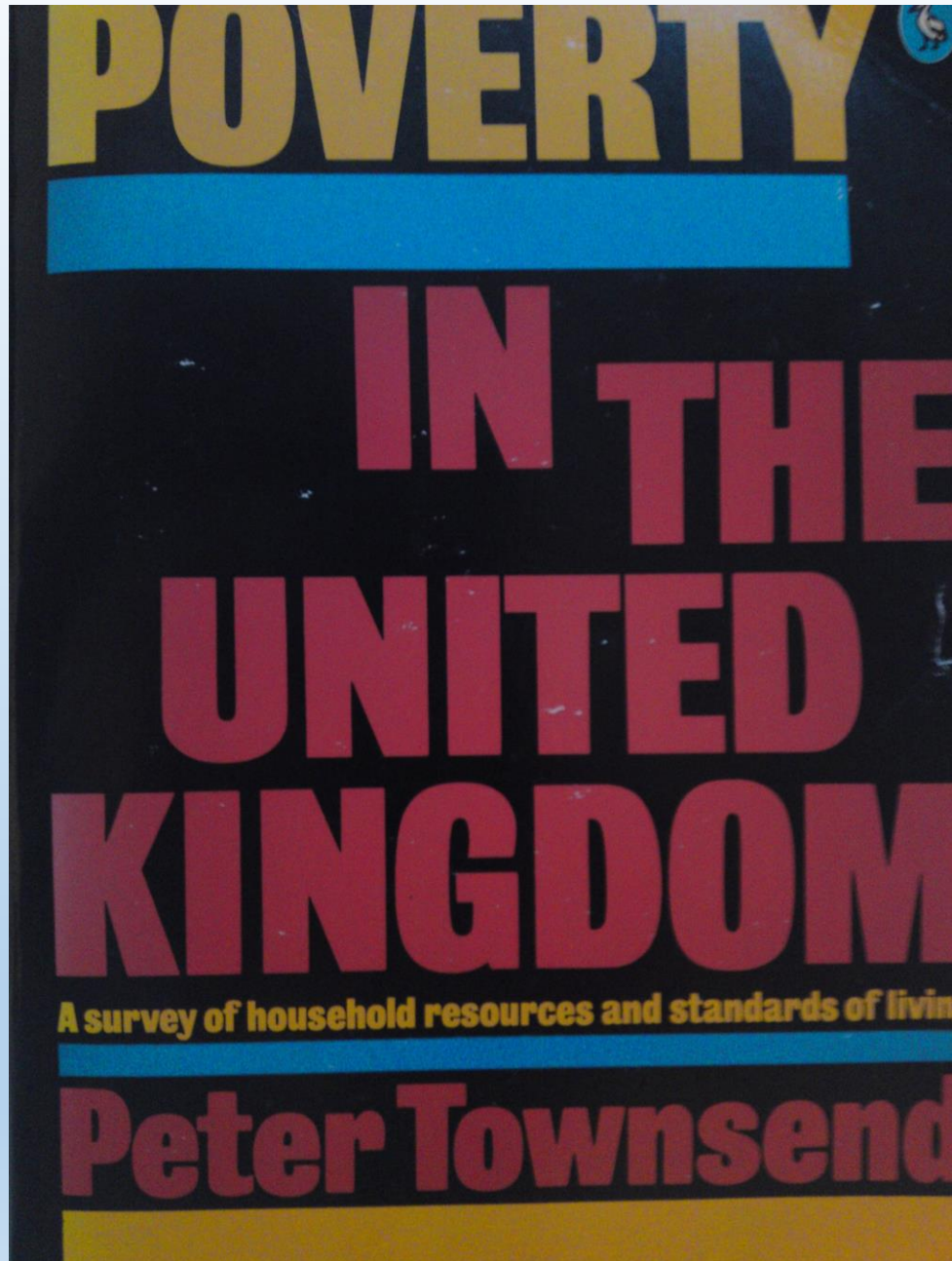
800 million  
people go to bed hungry everyday

300 million  
are children



Youth Against Poverty

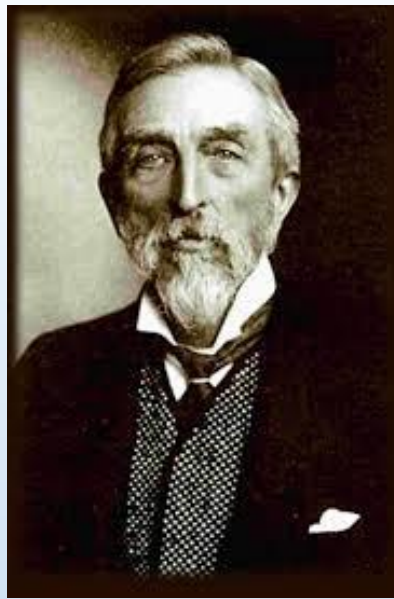




“Individuals, families and groups in the population can be said to be in poverty when they lack resources to obtain the type of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged and approved, in the societies in which they belong”.

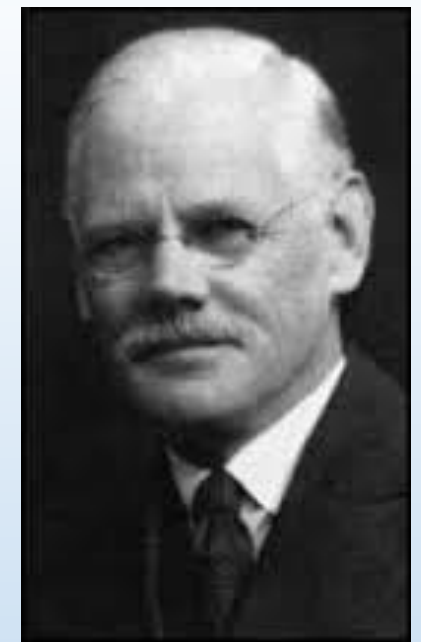
(Peter Townsend, 1979 *Poverty in the United Kingdom*)

**Charles Booth**  
**1840-1916**



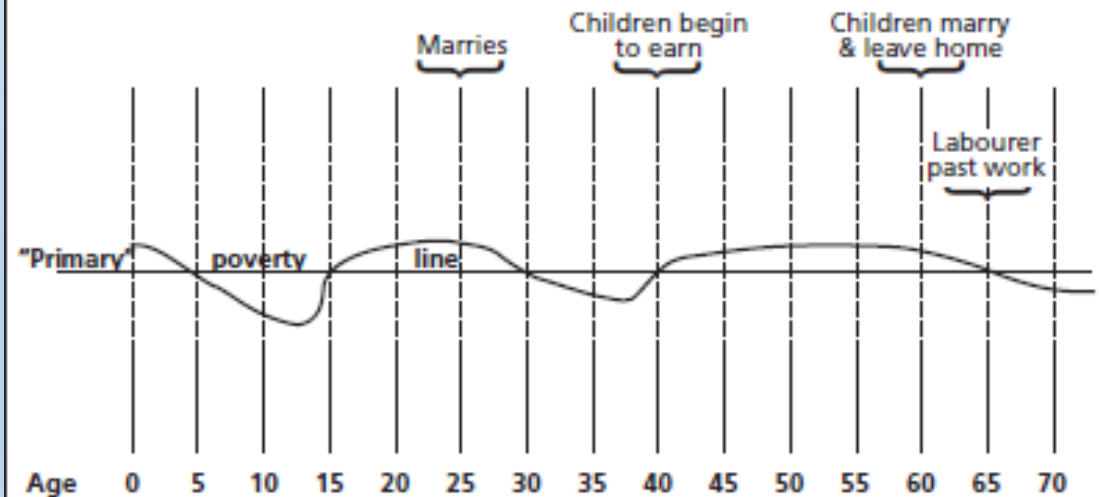
”By the word poor I mean to describe those who have a fairly regular though bare income, such as 18s to 21s per week for a moderate family, and by ‘very poor’ those who fall below this standard, whether from chronic irregularity of work, sickness, or a large number of young children.”  
(Booth’s account of his methods given at a meeting of the Royal Statistical Society, May 1887, *Journal of the Royal Statistical Society*, June 1887; Simey and Simey, 1960, p. 184)

**Seebohm Rowntree**  
**1871-1954**



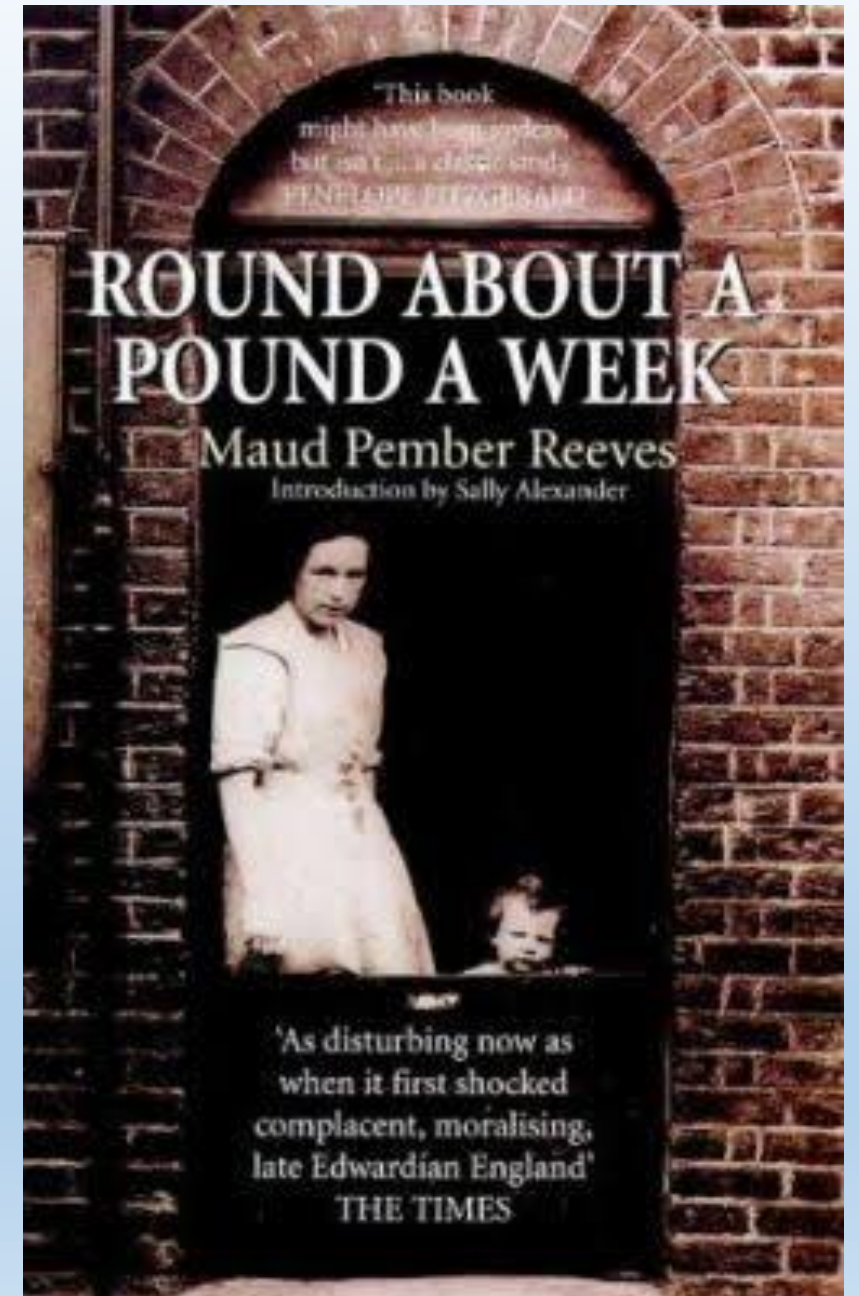
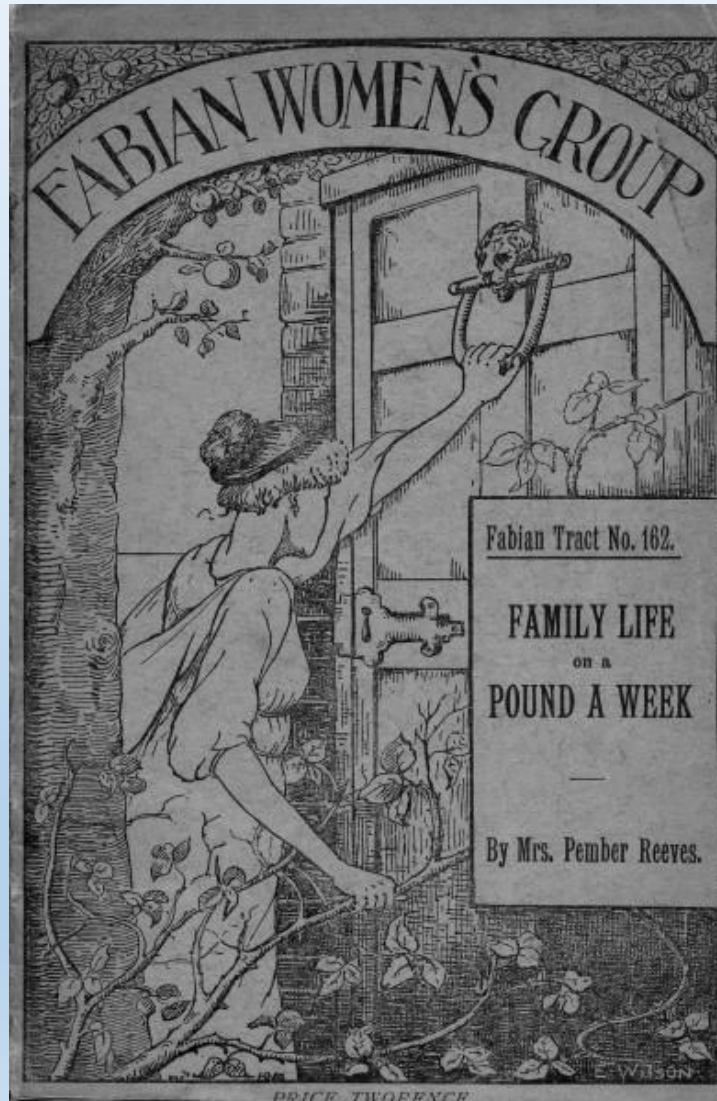
(Box 1 continued)

Rowntree’s picture of poverty over the life cycle



Source: Rowntree (1901), p.137.

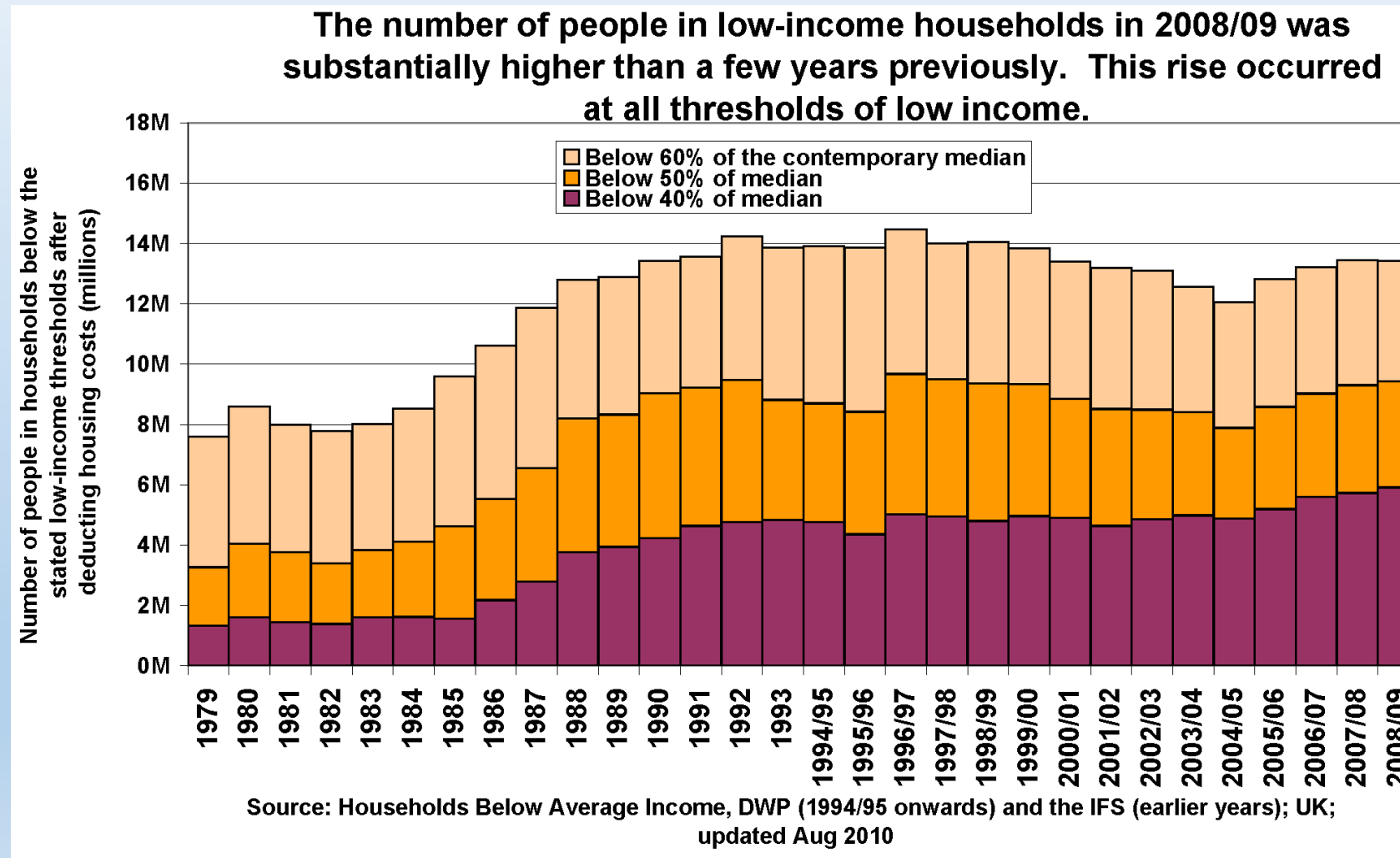
# Women and Poverty (1912)



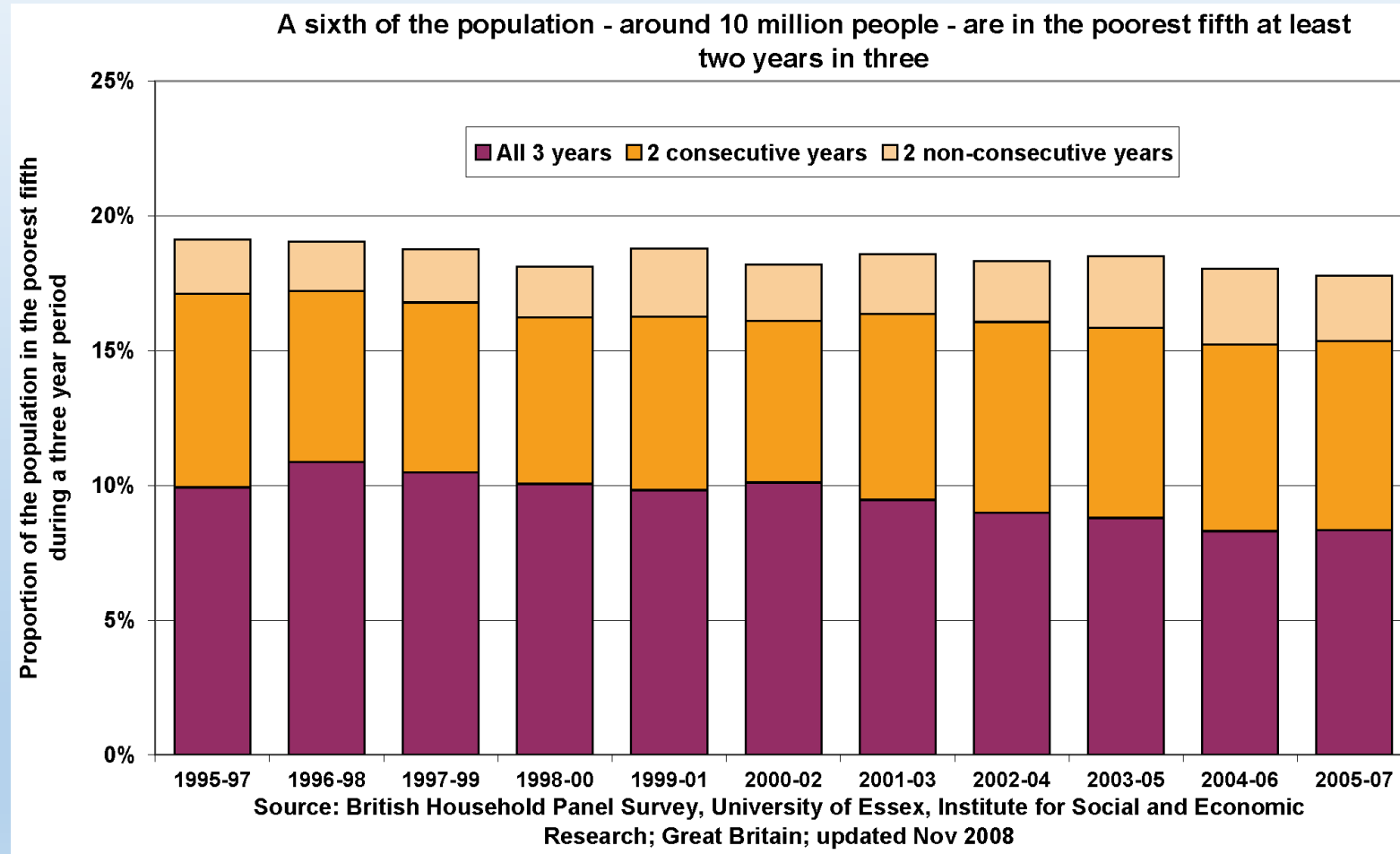
# Poverty in the UK



The number of people in poverty was unchanged in 2008/09 after 3 years of rises. The number living with very low incomes rose to a new high and now accounts for more than two-fifths of those in poverty.



# Around 10% of the population live in poverty over at least 3 years

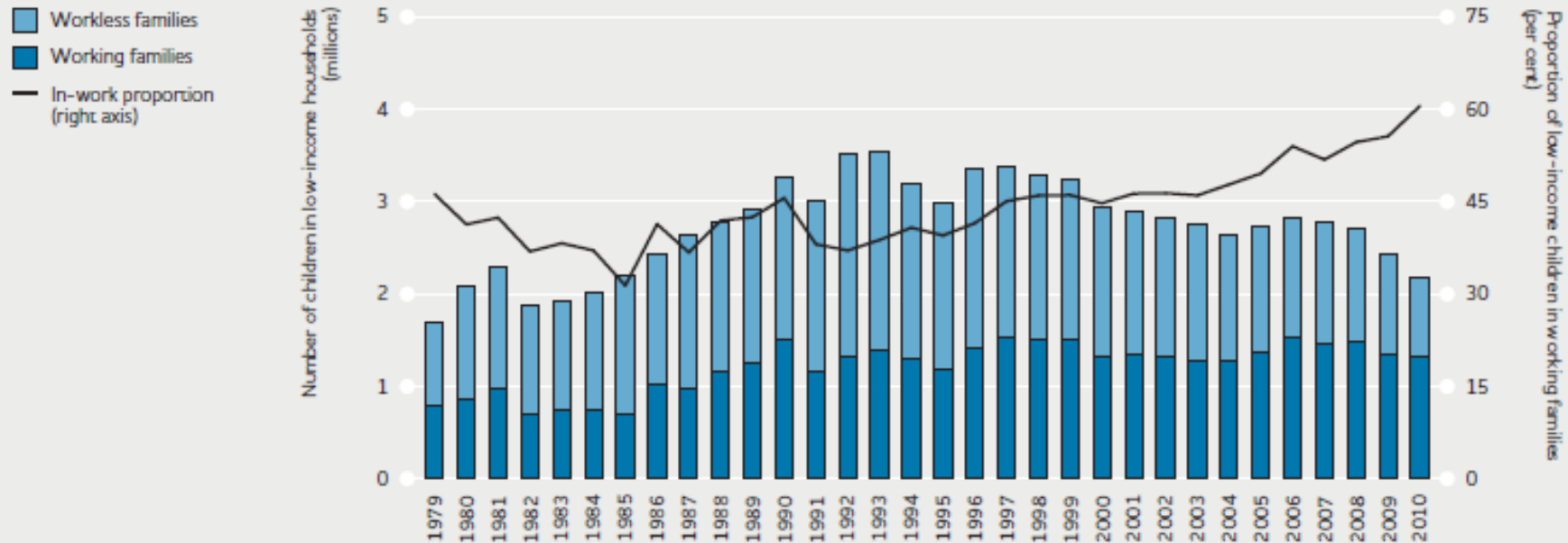


# Monitoring Poverty and Social Exclusion 2012

## Child Poverty

Indicator: 8A

The number of children in low-income households peaked in the early 1990s. The proportion of those children in working families is at a peak now.



Source: DWP Family Resources Survey and Households Below Average Income, via IFS analysis; the figures are for Great Britain

# The multidimensional 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.

# What do we mean by social 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)

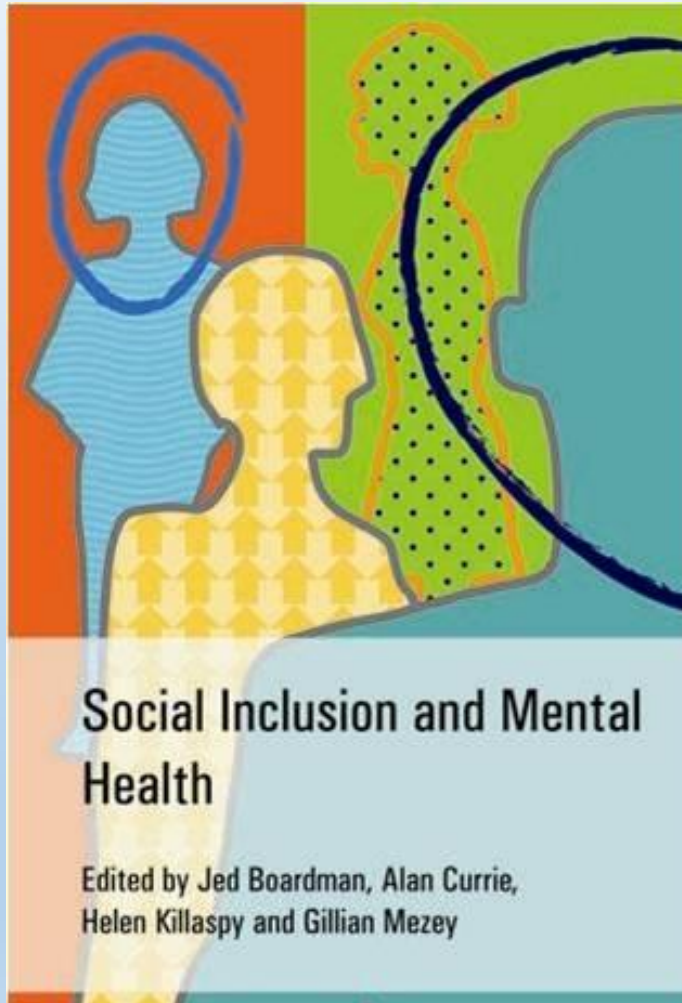
*‘The most important characteristic of social exclusion is that these problems are linked and mutually reinforcing, and can combine to create a complex and fast moving vicious cycle’*

(Social Exclusion Unit, 2001: p. 11)

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

(Centre for Analysis of Social Exclusion - Burchardt et al, 2002)

***“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 is bad for you – and society



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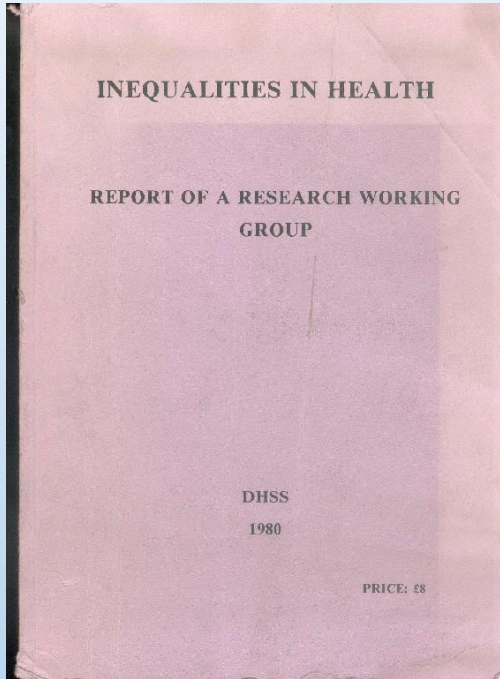


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# Elements of social exclusion

- a relative concept
- has been applied to a range of specific groups – including those with disabilities
- based on concepts of poverty and deprivation
- emphasises agency and processes
- has a dynamic dimension
- central role of participation
- multifactorial causal framework
- life course and longitudinal perspective
- links to choice and access
- stigma and discrimination
- equality and human rights
- citizenship
- social capital
- recovery

# Health Inequalities

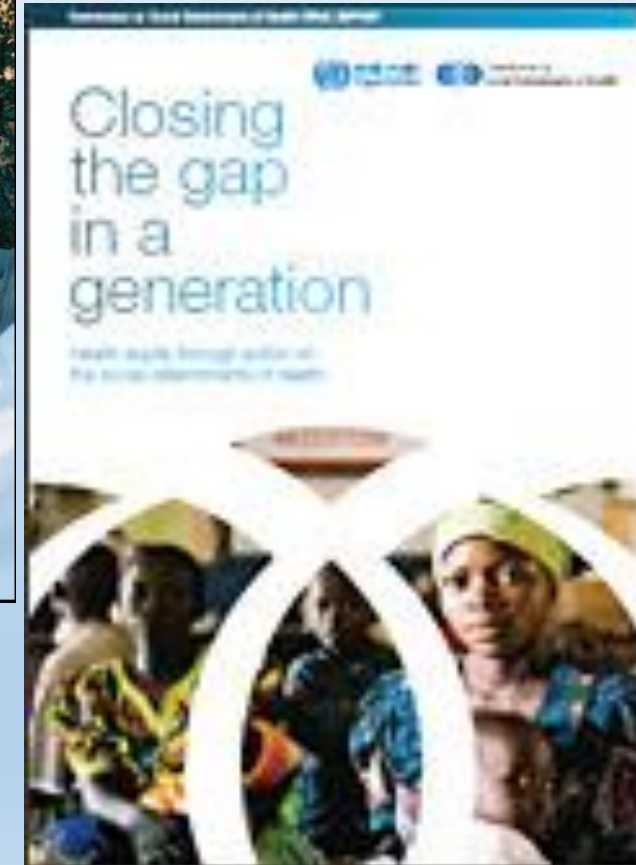


## Independent Inquiry into Inequalities in Health Report

*Chairman: Sir Donald Acheson*

£19.50

published by The Stationery Office  
as ISBN 0 11 322173 8



# Income: Psychosis and Common Mental Health Problems

## Adult psychiatric morbidity in England, 2007

Figure 5C

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

Base: all adults

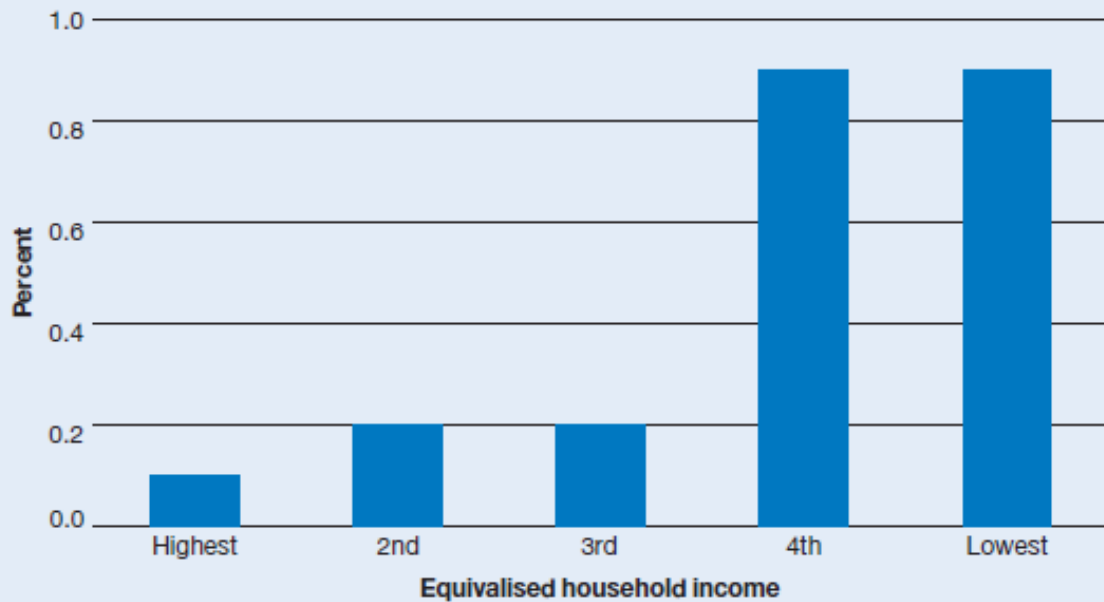


Figure 2E

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

Base: all adults

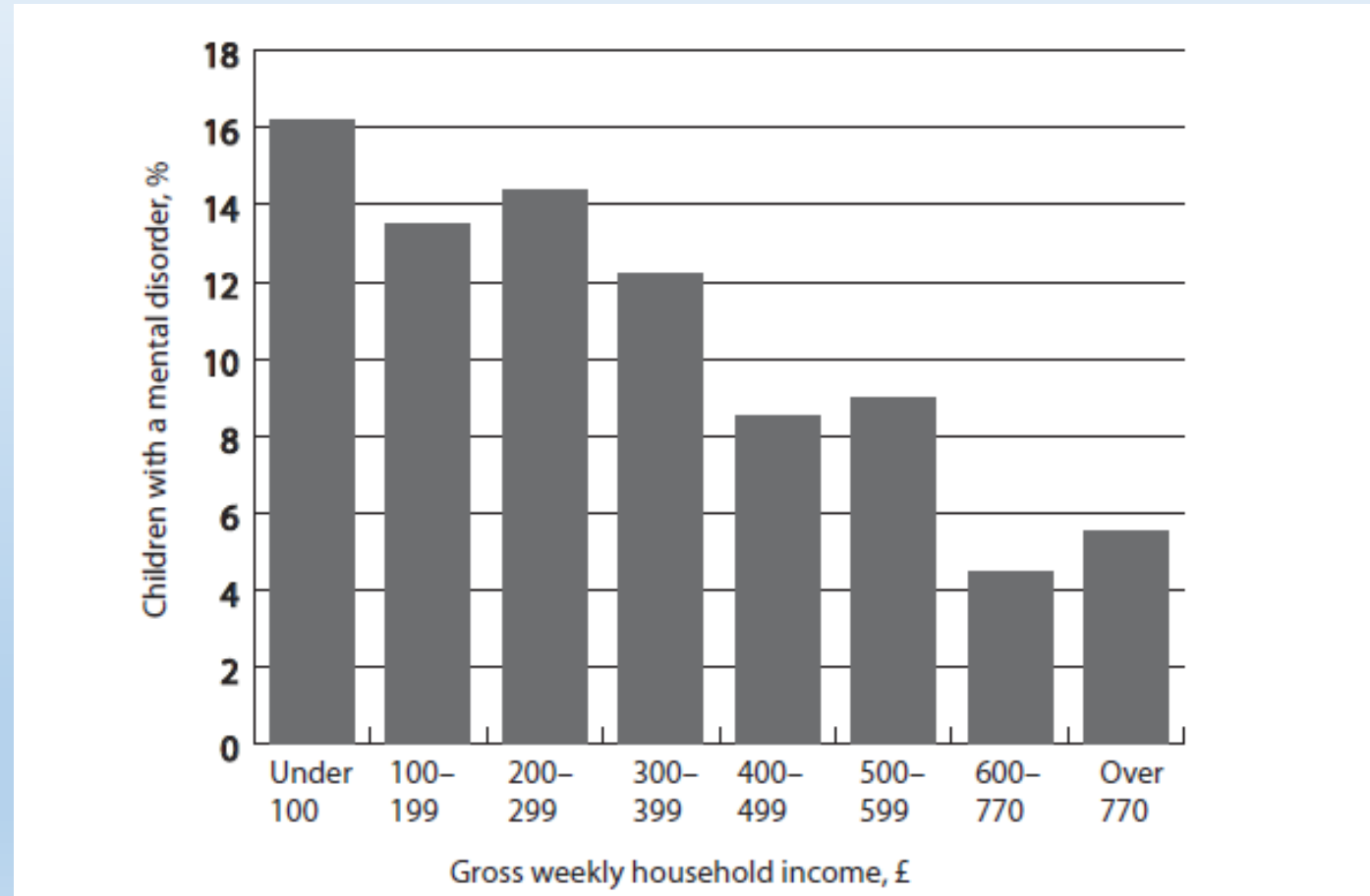


# Lack of necessities and poor mental health as experienced by people with common mental disorders

- 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, 2006

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



# Mental Health – some areas of exclusion

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

# 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
- parents' 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

# Individuals with multiple needs compared with those who did not have multiple needs (Schneider, 2007)

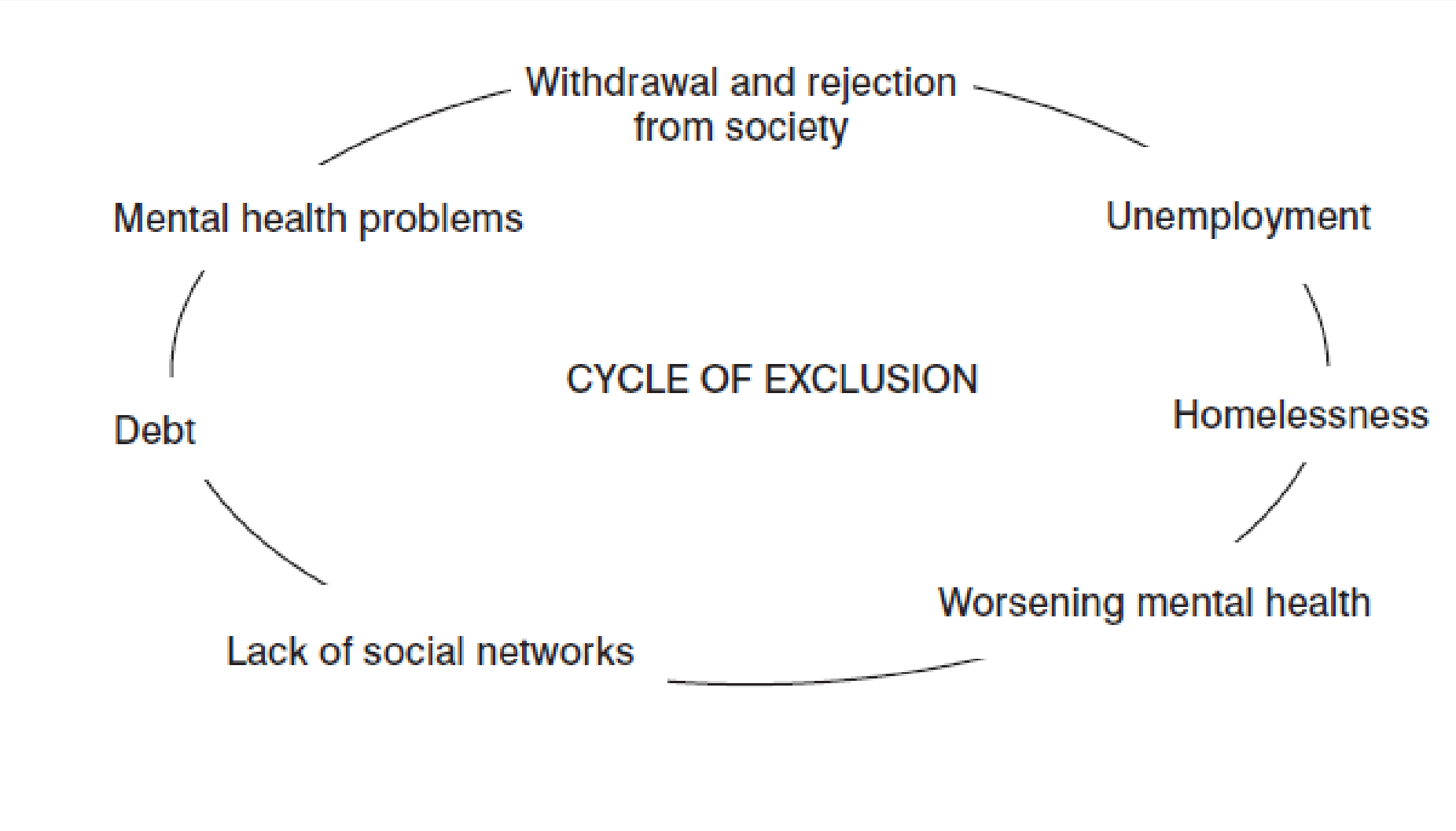
	Multiple needs	No multiple needs
Difficulty dealing with paperwork	27.3%	7.3%
Difficulty managing money	26.5%	3.6%
No qualifications <u>&lt;0.001</u>	35.7%	26.0%
How many adults cohabiting do you feel close to?	mean=1.3	mean=1.4
How many adults generally do you feel close to?	mean=4.23	mean=5.9
How many people would you describe as good friends?	mean=4.82	mean=6.78
How many friends have you spoken to in the last week?	mean=4.55	mean=5.93
Economically inactive	37.1%	30.6%
Unemployed	7.8%	2.6%
Accommodation moves in past year	mean=2.54	mean=1.63
Lowest personal income group	35.5%	27.9%

# Psychoses – Multiple Disadvantages

## Aetiology and Ethnicity in Schizophrenia and Other Psychoses (AESOP study) (Morgan et al, 2008)

- 390 people with first ever contact with mental health services for schizophrenia
- More likely to be socially disadvantaged or isolated than matched controls (eg 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.

# A Cycle of Exclusion



# 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 necessities, 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)

# 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”

# 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.”

# Ordinary Resilience – making small positive steps

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

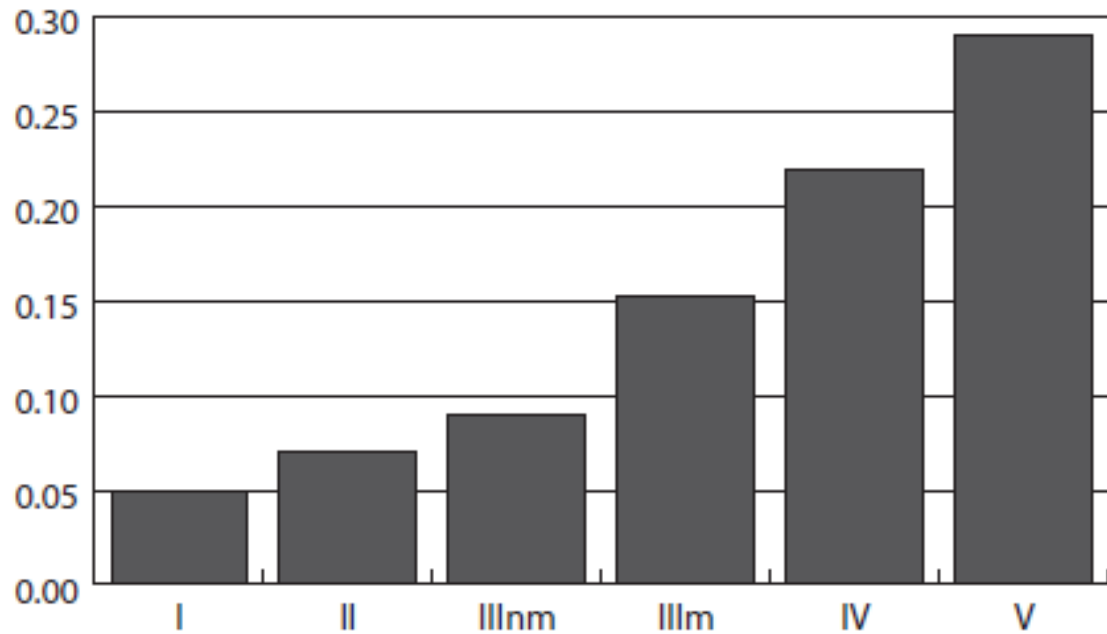
“The success for Nina.....she suffered herself very much with depression, so it was very much about getting herself out of bed, the kids to school, house clean and meals cooked.but [it's taken] the four years. Her actual confidence has come on leaps and bounds and she's [now] actually a member of the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

(From Canvin et al 2009)

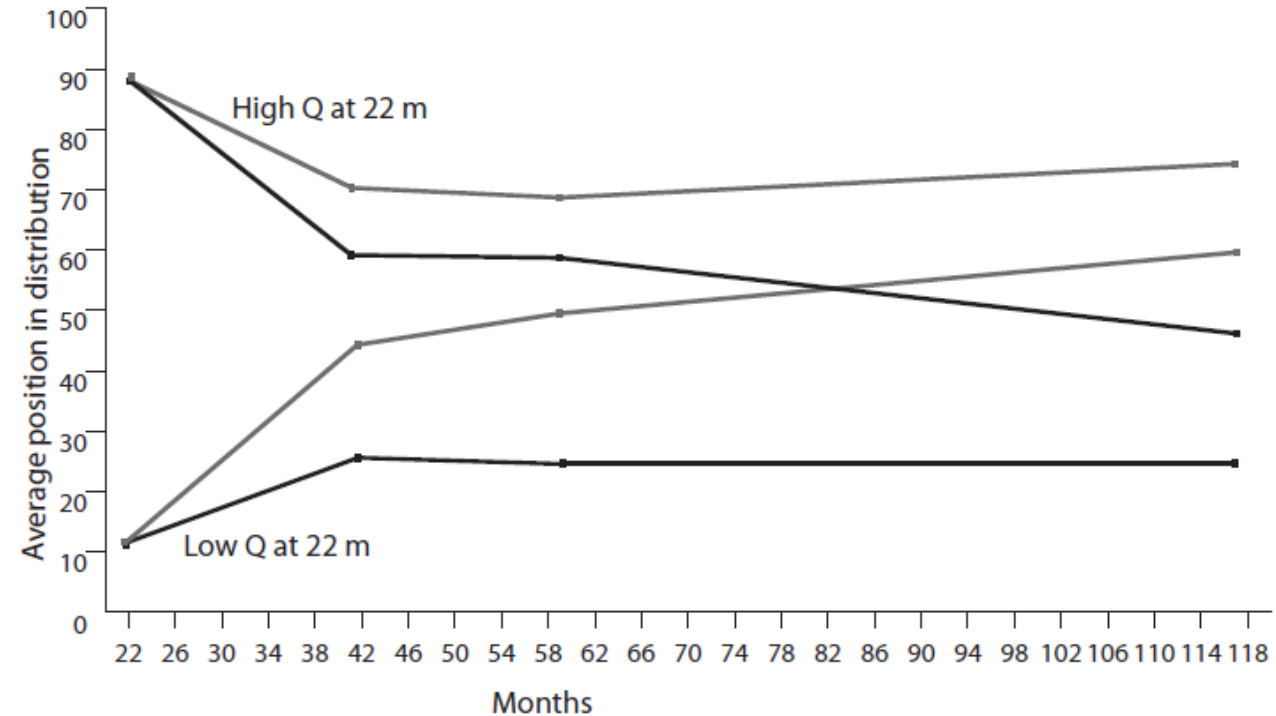
Faced with depression, the small positive steps that Nina took were highly significant for her life.

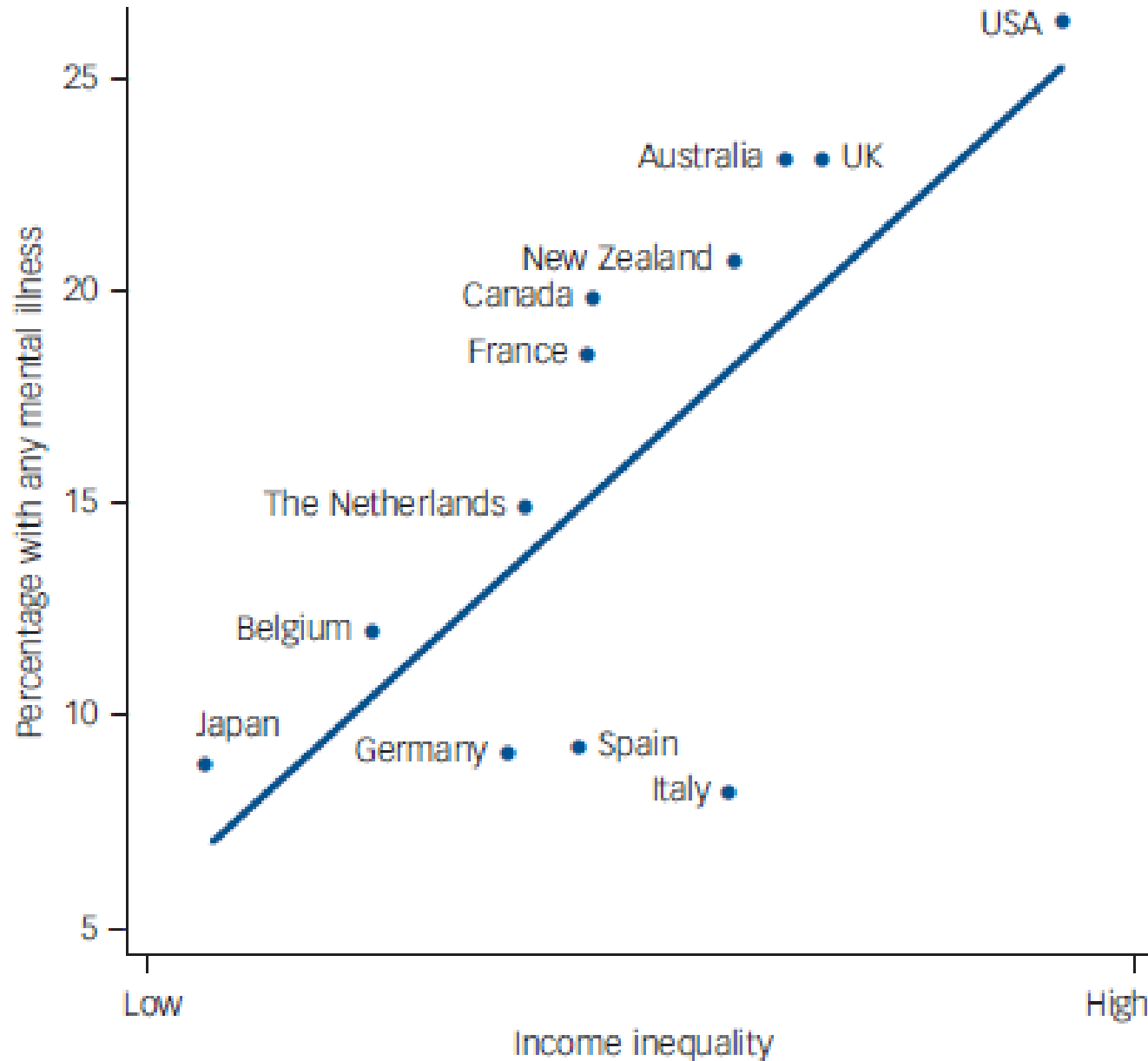
# Disadvantage matters: future outcomes and future generations

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



Relative to 10-year-old (Feinstein, 2003) cognitive shifts in children, from 22-month-old



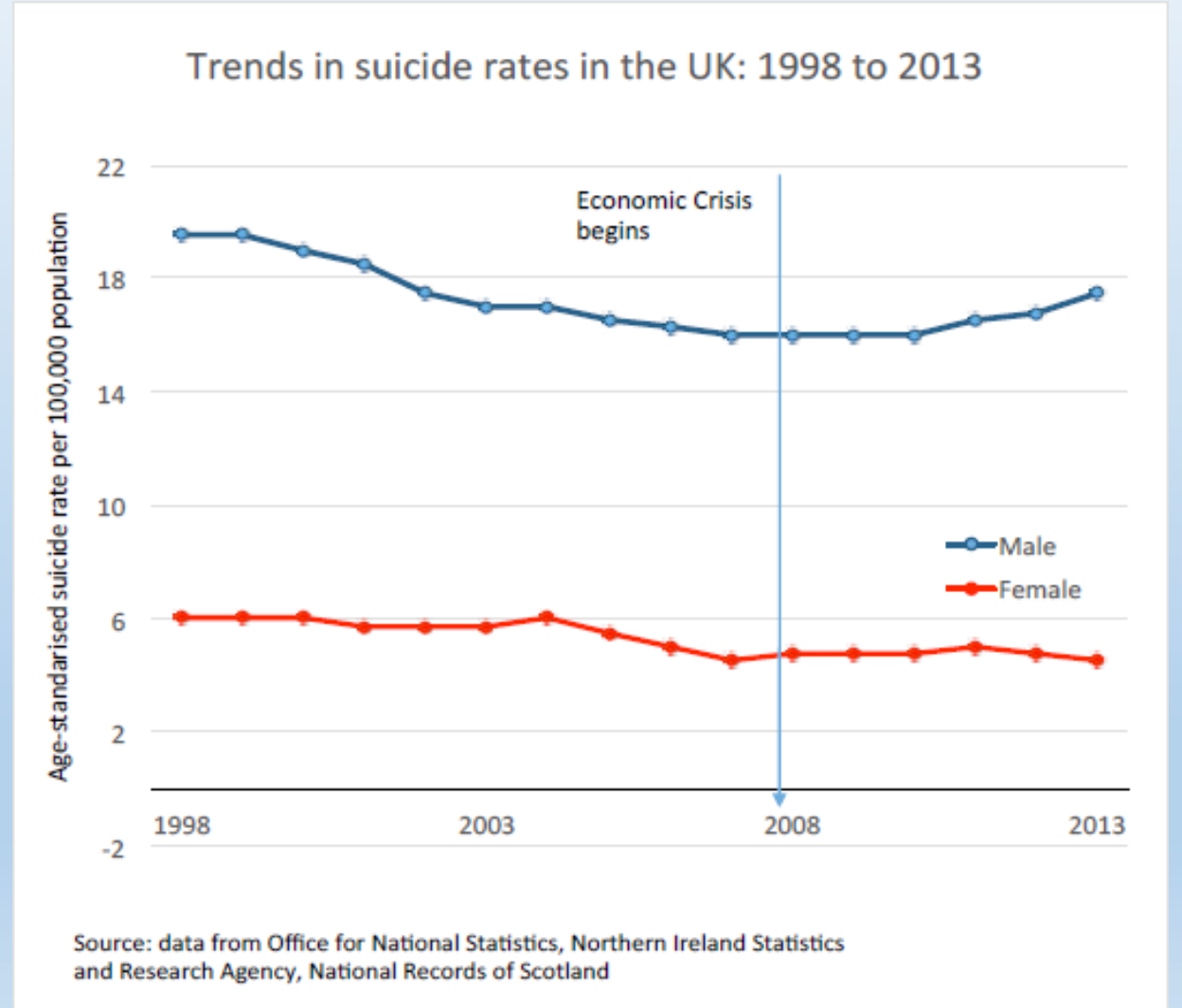


# Income Inequality and Mental Health Problems

More people have mental illnesses in more unequal countries.

(Pickett & Wilkinson, 2010)

# The 2008 Global Financial Crisis: effects on mental health and suicide



# Marmot Review, 'Fair Society Healthy Lives', key messages

- Reducing health inequalities is a matter of fairness and social justice.
- Action should focus on reducing the gradient in health.
- Action on health inequalities requires action across all the social determinants of health.
- Actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.
- Action taken to reduce health inequalities will have economic benefits in reducing losses from illness associated with health inequalities.
- The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.
- Reducing health inequalities will require action on six policy objectives:
  - Give every child the best start in life
  - Enable all children, young people and adults to maximise their capabilities and have control over their lives
  - Create fair employment and good work for all
  - Ensure healthy standard of living for all
  - Create and develop healthy and sustainable places and communities
  - Strengthen the role and impact of ill-health prevention.
- Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups.
- Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

# The World Health Organisation's (WHO) report "*Closing the Gap in a Generation*"

Identified two broad areas of social determinants of health that needed to be addressed:

- Daily living conditions, including healthy physical environments, fair employment and decent work, social protection across the lifespan, and access to health care.
- Distribution of power, money, and resources - including equity in health programs, public financing of action on the social determinants, economic inequalities, resource depletion, healthy working conditions, gender equity, political empowerment, and a balance of power and prosperity of nations.

# Can giving people more money help?

## 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

**I**N 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.<sup>1</sup> 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.<sup>2,3</sup> 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.<sup>4</sup> Parents of a random sample of 3896 non-Indian youth responded to a brief telephone questionnaire about their child's behav-

**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

ioral problems (FIGURE).<sup>3</sup> 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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# Reducing the impact of recessions on mental health and suicide

REPORT

Centre for  
Mental Health



**Welfare advice for people who  
use mental health services**

**Developing the business case**

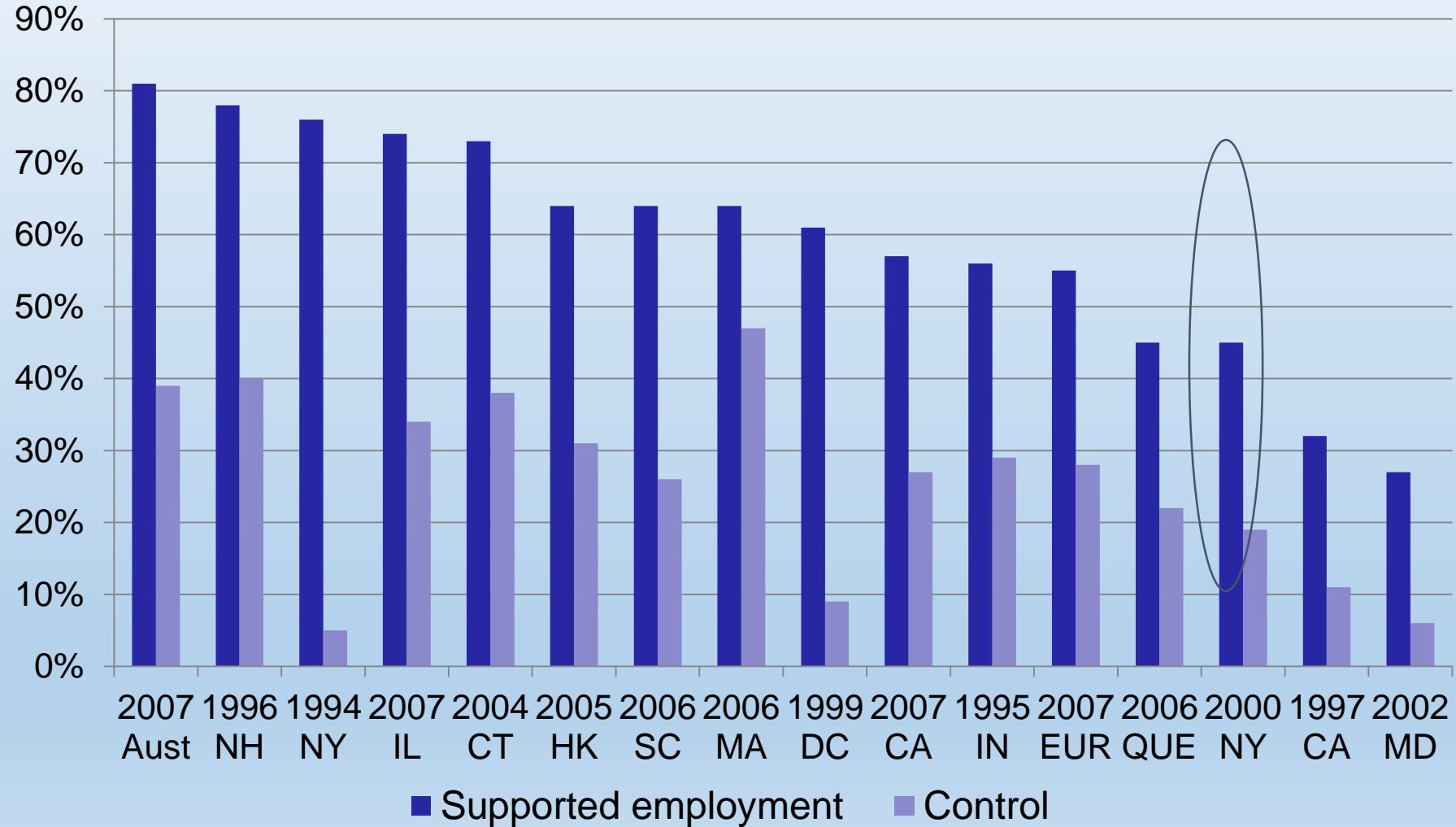
**Michael Parsonage**

with a foreword by Martin Lewis

- Countries with more generous unemployment benefits and that invest more in active labour market programmes experience the smallest rises in suicide during recession.
- A policy focus on creating work opportunities for young people is particularly important during periods of recession. Young people are the group most likely to be made redundant and experience difficulties finding work. Negative first experiences of job-seeking or the labour market may have a permanent scarring effect.
- Frontline staff most likely to be in contact with individuals whose mental health is affected by economic and employment difficulties should receive training in recognising and responding to risk. These include staff in advice agencies (e.g. Citizen's Advice Bureau), Job Centres, debt agencies, benefits systems, housing agencies, food banks and other such agencies, and also money lenders.
- Staff working in the NHS, social services and the advice sector need to be able to steer people affected by job loss, financial hardship and benefit changes towards appropriate help. They should be given regularly updated information on the key local and national statutory and third sector agencies (e.g. Citizens Advice Bureau (CAB), Job Centres, debt advice agencies, Samaritans).
- Timely funding should be given to advice agencies (e.g. Citizens Advice Bureau, debt advice agencies) operating in areas most affected by recession. Whilst Governments may wish to reign in spending during recession, strategic investment is needed to mitigate the worst effects of recession on mental health and to ensure, as far as possible, that the population has the emotional capacity to return to work when the recession ends.
- Provision of adequate welfare benefits will prevent people going further into debt; such debt is a potentially critical mediator of the impact of recession on mental health.

Gunnell (2015)

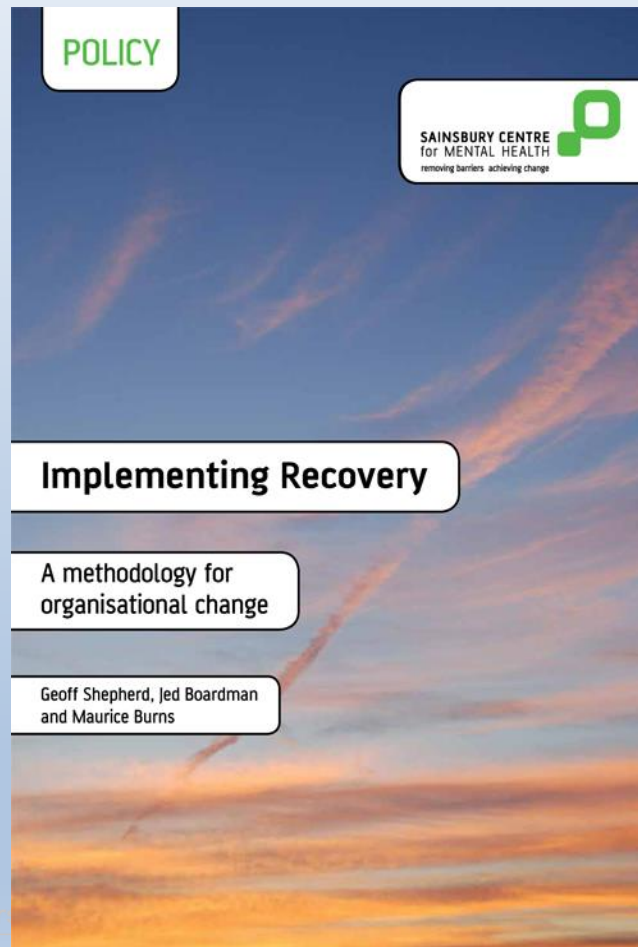
# Individual Placement and Support (IPS) trials



# Housing



## Recovery - Key organisational challenges



1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, user-led education and training programmes
3. Establishing a 'Recovery Education Unit' to drive the programmes forward
4. Ensuring organisational commitment, creating the 'culture'
5. Increasing 'personalisation' and choice
6. Transforming the workforce
7. Changing the way we approach risk assessment and management
8. Redefining user involvement
9. Supporting staff in their recovery journey
10. Increasing opportunities for building a life '*beyond illness*'

# Parity of Esteem

## **Whole-person care: from rhetoric to reality** **Achieving parity between mental and physical health**

Occasional paper OP88  
March 2013



# Mental health promotion and mental illness prevention: The economic case

Martin Knapp, David McDaid and  
Michael Parsonage (editors)

Personal Social Services Research Unit,  
London School of Economics and Political Science

April 2011

Report published by the Department of Health, London



## Early identification and intervention as soon as mental disorder arises

- Early intervention for conduct disorder
- Health visitor interventions to reduce postnatal depression
- Early intervention for depression in diabetes
- Early intervention for medically unexplained symptoms
- Early diagnosis and treatment of depression at work
- Early detection of psychosis
- Early intervention in psychosis
- Screening for alcohol misuse
- Suicide training courses provided to all GPs
- Suicide prevention through bridge safety barriers

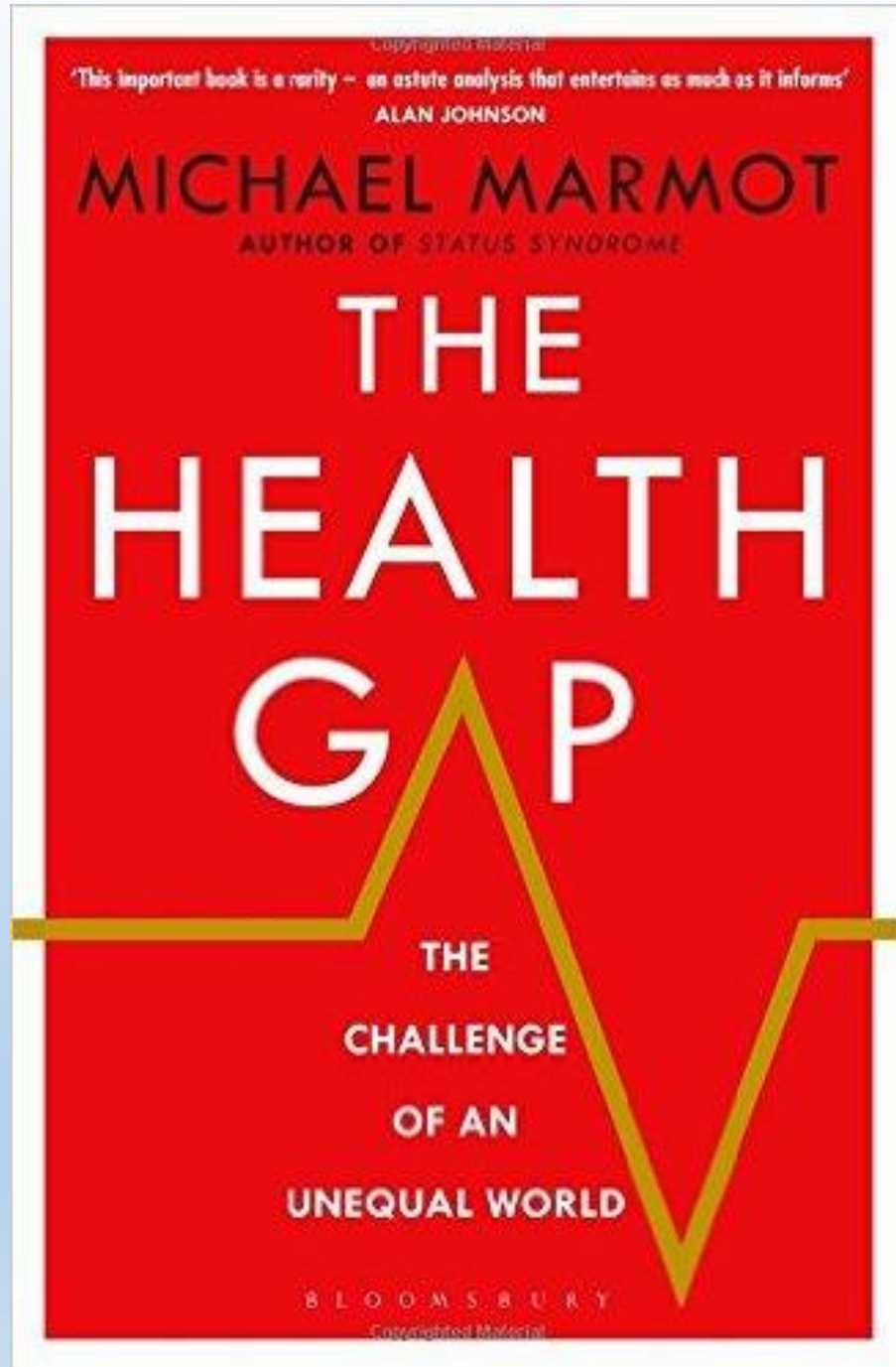
## Promotion of mental health and prevention of mental disorder

- Prevention of conduct disorder through social and emotional learning programmes
- School-based interventions to reduce bullying
- Workplace health promotion programmes

## Addressing social determinants and consequences of mental disorder

- Debt advice services
- Befriending for older adults





“The pollutant is called social disadvantage and it has profound effects on developing brains and limits children’s intellectual and social development. Note, the pollutant is not only poverty, but also social disadvantage. There is a clear social gradient in intellectual, social, and emotional development—the higher the social position of families the more do children flourish and the better they score on all development measures. This stratification in early child development, .....arises from inequality in social circumstances”.

Michael Marmot (2015)