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“Poverty, low income and mental health problems”
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Summary
Worldwide the majority of people with mental and psychosocial disabilities are living in poverty. Even in richer nations, including the United Kingdom, people with mental health problems, particularly those with severe and enduring problems, are among the lowest income groups. Poverty for these groups does not exist in isolation and is associated with other factors that exclude them from participating in mainstream society. They are not only poor, but lack employment, are socially isolated, experience prejudice and discrimination, lack a voice in civic society and suffer poor physical health. In many parts of the world they may be subject to human rights violations. These factors not only affect the outcomes of people in this group but are also a cause of poor health and well-being and contribute to premature mortality. They are a determinant of health inequalities.

Poverty and its association with mental ill-health will be reviewed using recent findings and personal narratives. The position of people with mental health problems can be improved through attention to welfare and social policies. Mental health services can play a part through developments that are designed to support the social recovery and inclusion of people with mental health problems.

Introduction

The film of Waldo Roeg's talk will be shown first – his account of his mental health problems, homelessness and lack of resources – and his recovery journey.

I will comment briefly on this and try in my talk to illustrate aspects of Waldo's story in relation to the literature on poverty and mental health problems.

In the talk I will aim to build a case for the importance of the social context in the understanding of mental health problems, particularly in relationship to social inequalities and mental health.

I will cover:

1. Poverty – what is this?
2. The multidimensional nature of poverty – social exclusion and inequalities
3. Why is poverty bad?
4. Why should we be interested in Poverty and Social Inclusion
5. Poverty, social inequalities and health – and mental health
6. Consequences of poverty
7. Income inequalities and the effects of the Recession
8. What can be done?

POVERTY

When we think about poverty many of us may see images from low income countries around the world: of famine, of shanty towns, people living on the streets or of children dying from preventable diseases. Indeed around 1.2 billion people around the world live in extreme poverty (less that one dollar per day).

But poverty exists all around the world – in low and middle income countries and in more affluent industrial economies – It is a global phenomenon. It can be absolute but in reality it exists on a relative scale

Peter Townsend, sociologist and expert on poverty defined poverty as:

"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".
(P Townsend, Poverty in the United Kingdom, Allen Lane, 1979)

In this sense poverty can be understood in relation to the typical living standards in society. It is relative.

Poverty is about a lack of resources - lack of adequate financial resources is the decisive characteristic of poverty. It is the consequences of this lack of resources that is important. It is a way of conceptualising disadvantage – traditionally seen in terms of poverty, hardship, destitution – all terms that focus on material deprivation, want and its consequent personal distress – misery for many.

To understand some aspects of poverty it is worth looking at the changes that have occurred in the United Kingdom over the twentieth century. This helps us take a longer view of poverty and change – it helps "to understand the present, in the light of the past, for the purposes of the future" (John Maynard Keynes).

The slide shows two figures who were important in measuring and describing the poverty in England at the end of the nineteenth century – Charles Booth and Seebohm Rowntree. Poverty had been an obvious part of the growing English cities during the 1800s and poverty was often blamed on the feckless poor. But it was becoming increasingly obvious that there were growing numbers of people whose poverty could not be blamed on their individual failings.

Charles Booth documented poverty in the East end of London and other parts of London by interviewing people and defining their situations. His results were published in two books published in 1889 and 1891. He found that around 31% of people in the London were living in abject poverty. He identified a 'line of poverty' below which lay the poor:

"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 did similar investigations in York (in the north west of England) in 1899. He found that 28 per cent of the total population of York were living in 'obvious want and squalor'.

Rowntree did something important for future research into poverty – he identified people whose income was so low that even if they followed complete sobriety and total purchasing efficiency they would not be able to live at a level of 'physical efficiency'. He looked at the food budgets of the York families, and concluded that '*the labouring classes on whom the bulk of the muscular work falls, are seriously underfed'* (1901, p. 259). He was questioning whether families could be expected to live on less than this?' It was this that he called 'primary poverty'. He distinguished this from 'secondary poverty', which was a level defined by total earnings that would be "*sufficient for the maintenance of merely physical efficiency were it not that some portion of it is absorbed by other expenditure, either useful or wasteful*" (Rowntree, 1901, p. 115).

Rowntree found that 10 per cent of York's population were living in 'primary poverty'. In addition 18 per cent were living in 'obvious want and squalor' (or 'secondary poverty'). Giving a total of 28 per cent living in poverty.

Of course, no one could really be expected to live on his primary poverty income in real social life. Social pressures, to drink in the local pub, to buy presents for the children, to be a normal social being especially in adversity, required a higher budget.

Rowntree also described the causes of poverty and illustrated these in the 'Life cycle of Poverty'. At the time, low wages were the main culprit and he showed that the rewards the labour market generated in normal times were ill adapted to meet the basic needs of family life for many of the working population, notably during childrearing and widowhood, sickness and old age.

Rowntree repeated the surveys in 1935 and 1951. These showed a changing picture of poverty in the 20th century. His 1936 survey found that absolute poverty in York had decreased by 50% since 1899 and at that time the main driver for poverty was unemployment. By 1951 absolute poverty was uncommon, but still remained in the elderly. This was thought to be a result of the welfare state developments after 1945.

The early surveys also showed the burden of poverty fell on women.

The Fabian pamphlet by Mrs Pember Reeves' (1914) "*Family Life on a Pound a Week*" examined 'How does a Lambeth working man's wife with four children manage on a pound a week?' (Lambeth is in South east London). Poverty was clearly feminised. It has been recognised for a long time that the main burden of poverty falls on women.

These early pioneers began the systematic study of poverty.

In the second half of the twentieth century the picture of poverty changed. The largest group in poverty in the 1950s and 1960s were the elderly, In the 1960s, public attention was drawn to the number of children in poverty. Pensioner poverty declined in the 1970s, due to increases in the retirement pension. At this time, many people with disabilities were recognised to be living in poverty. But in the 1980s, many groups were affected by the great rise in poverty. Unemployment and lone parenthood rose and the risk of poverty was very high for both of these groups.

The UK now defines poverty as a household income that is 60% or less of the median household income for that year.

Poverty in the UK, as measured by the proportion of household income, reached a historic high in the 1990s. In 1979 there were 7 million poor people in Britain but by 1997 this rose to 13.8 million and, despite some annual variations, has remained roughly at this level since. Today around 21% of the population – 13 million people, of whom 3.7 million are children – live in poverty. These are official figures and are monitored by the Joseph Rowntree Trust (named after Joseph, Seebohn's father).

Currently, about 8% of people experience persistent poverty (poor in 3 or more years of a 4-year period), and being poor in the past increases the chances of being poor in the future. Both pensioner poverty and child poverty have fallen in the past 15 years, but not sufficiently to meet the targets set by successive governments.

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.

This has two implications for this talk:

1. When considering the associations of poverty with health and mental health we often have to look at a range of socio-economic variables that can measure not only income, but provide an indicator for the measurement of deprivation or disadvantage. These can help us to look at the inequalities in health status across our societies.
2. We need a short-hand way of summarising disadvantage that captures this multidimensional aspect of poverty and allows us to illustrate clearly the disadvantages that groups of people, including those with mental health problems, may experience. One useful summary term is that of *Social Exclusion*.

What do we mean by social exclusion?
The slide shows two definitions of Social Exclusion:

One a definition from the Social Exclusion Unit (a UK government body set up in the 1990s):
"*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).
This is a flexible definition that lists only some of the many problems associated with exclusion. The key point here is the perceived linkage between these listed problems: '*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). The definition does not, however, identify a concept or element that brings these indicators or putative causal factors together.

The Centre for Analysis of Social Exclusion (CASE) at the London School of Economics adopted a working definition of social exclusion (Burchardt et al, 2002b):
"An individual is socially excluded if he or she does not participate in key activities of the society in which he or she lives."
This working definition emphasises the central idea of participation and recognises that social exclusion is a concept relative to the time and place in question. In addition, there is an emphasis on lack of participation as being due to constraint, rather than choice.

Social exclusion may be seen as a further way of conceptualising disadvantage. It extends the scope to the examination of multiple deprivations and broadens the range of indicators, while retaining the objective of identifying individuals who lack the resources to participate. Any indicators or measures of social exclusion should identify those whose non-participation arises in other ways, for example, through discrimination, chronic illness or cultural identification – all of which are important when we think of mental ill-health.

In our book on Social inclusion and Mental Health we considered the dimensions of Social Exclusion as:

- 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 health service engagement (exclusion from health and health services) – having good health and accessing appropriate services.

All of these are relevant to people with mental health problems.

Why is poverty so bad?
The short answer to this is that it is bad for individuals and bad for society.

For Individuals:

- It is bad for health and wellbeing – it is a cause of infant mortality, premature death, and is associated with higher occurrence of disease – it is detrimental to peoples well-being and quality of life
- It is bad for peoples day to day lives – associated with huger, lack of employment, poor housing, poor education, poor neighbourhoods, violence and crime.
- It is bad for peoples life chances and limits their potential – being born into poverty has effects on peoples later development, experiences and outcomes
- It is bad for families – its negative effects can be passed on to subsequent generations

For society:

- It restricts the value of human capital and the contribution of a significant section of the population to the economic and social life of the nation
- It is linked to crime, social unrest, unemployment etc. which are costly to the nation.

This is a crude overview of the damaging effects of poverty – but it emphasises the damaging effects of poverty worldwide and also points to the effects that it may have for people with mental health problems.

Why should people in this room be interested in the relationship of poverty and social exclusion to mental health and to people with mental health problems?

1. *It is a relative concept* – it can be applied to the UK in the 21st century as well as a 100 years ago. It can be applied across all nations; high, middle and low income countries
2. *The concepts have been applied to a range of specific groups*, including people who are unemployed, single parents, the homeless, prisoners, refugees and asylum seekers, and people living in deprived areas. It has also been extended to people with disabilities and thus includes people with mental health problems and learning disabilities. People from specific social identity groups (e.g. women, people from Black and minority ethnic groups, gay and lesbian people) who also have mental health problems are likely to experience social exclusion
3. *The ideas of social exclusion are based on concepts of poverty and deprivation*, but represent an extended concept which can be readily applied to disability and its multifactorial causal components which relate to social exclusion. Many people with mental ill health or learning disability are materially deprived, but many recognise that they are excluded in other important ways which relate to such matters as stigma and discrimination, and these multiple factors can readily be seen to interact
4. *It emphasises agency and processes*. This allows us to identify those institutions and social processes which play a part in exclusion. This corresponds to the 'social model of disability' which, as you know, stresses the role of social and environmental barriers in producing disability. This model provides the same helpful framework for describing the experiences of people with mental health problems and learning disabilities and the social barriers that they face. The social model of disability places the problems of disability within society, rather than the individual:
5. *It has several dynamic dimensions*. For example, the causal models of exclusion are complex, involving factors at several levels and feedback loops. In addition, exclusion is not viewed as fixed state, but rather as one that people move in and out of as the conditions that lead to exclusion change, as can be seen in the earlier life cycle of poverty. A further dynamic component of exclusion may be seen within families, through early life experiences which may provide the basis for an individual's later exclusion and also by the transmission of exclusion across generations. Importantly, viewing the dynamic of exclusion in this way means that possible causal factors can be identified, which makes these states potentially amenable to intervention.
6. *Central role of participation*. This makes intuitive sense to people, and the lack of participation, and thus exclusion, has a subjective component which is readily recognised by people. Each of the dimensions mentioned earlier point to objective ways of measuring exclusion. Importantly, the dimensions interact. Exclusion on any of the dimensions is not likely to be absolute, but rather is a matter of degree – the less the participation, the greater the degree of exclusion. The dimensions each represent an outcome for measurement purposes. What are often regarded as indicators of exclusion (e.g., having a mental illness or

disability, being a member of an ethnic minority, living in a deprived area) are the causes of, or risk factors for, exclusion.

7. *Causality* - life course and longitudinal perspective. The causal framework for understanding social exclusion reveals complex and multifactorial influences acting on individuals. To understand these influences it is helpful to take a life course and longitudinal perspective to examine the effects of early variables in determining exclusion and the examination of important intergenerational and intragenerational aspects of transmission of social exclusion. Put simply, all present influences are products of the past and the past is 'the starting point for the present' (Burchardt et al, 2002a).
8. *Choice and access are implicit in social exclusion*. Choice refers to the power to make decisions and as such is a key part of agency and the political engagement dimension of participation. Choice may be seen in a more limited, consumerist way, as a way of making services more responsive to the needs and demands of the people who use them and making these services more accessible – in this sense it is a means to an end. In a wider sense, choice is a manifestation of the rights and responsibilities of adult citizens which goes beyond the use of health services, to people's life choices and engagement in wider politics, and being treated with dignity and respect – in this sense it is an end in itself. Both these aspects of choice must be taken into account when considering the social inclusion of people with mental health problems and learning disability
9. *Stigma and discrimination* represent one of the most widely recognised barriers to participation for people with mental health problems. Stigma has often been interpreted as locating the problem within the individual rather than in the social world. To clarify the importance of social factors in stigma, we need to consider ignorance, prejudice and discrimination as the important components of stigma to allow us to examine its importance as a barrier to participation and inclusion.
10. *Equality and human rights*. The notion of discrimination points to a need for a focus on human rights and injustice experienced by people with mental health problems and learning disabilities. Associated with social exclusion are the concepts of equality and human rights. Equality of some kind is important in its own right and this places a value on people getting the same or being treated the same in some respects. The human rights approach, although not necessarily eschewing equality, is unconditional as entitlement is on the basis of one's humanity. Both equality and human rights are matters that fit in the scope of social exclusion.
11. *Citizenship*. People with disabilities should be seen as having the same rights to active citizenship as everyone else in society. This is related to, and implied by, the rights approach and the social disability model. In the context of social exclusion, the idea of citizenship offers several advantages. For example, it allows service users to challenge the narrow disease-based definitions of disability and to highlight the social barriers that create disability, and acts as a point of reference in calls for social change. It also supports the assumption that the human rights of people with mental health problems and learning disabilities

should be respected, and offers a benchmark to assess the success of measures of self-determination. Finally, it fixes responsibility with governments to respond to legitimate demands for parity of treatment and to respond by committing resources.

12. *Social capital*. Social capital is a complex theory with a number of definitions. Essentially, it is a way of describing the linkages, psychological and structural in society that allow it to work for the common good. Both social inclusion and social capital focus, to varying degrees, on participation in social networks, which may facilitate or frustrate access to different kinds of resources. Social capital may refer to the benefits that arise from membership of social networks and other kinds of social structures. In this way social capital may promote social inclusion by tying people to others in the wider community. In general, social networks are viewed as positive; people with smaller social networks may experience disadvantage and have worse health and general well-being. Lower social involvement in the community may produce adverse health effects and adverse effects on people whose poverty acts as a barrier to social involvement. Social networks give access to a range of material and psychological resources and to social capital and in this way help you stay healthy.
13. *Recovery*. Although recovery is not a concept that is part of the general literature on social exclusion, it does have particular currency within the field of people with mental health problems and learning disabilities, and may operate as a means of promoting inclusion for people in these groups. The ideas of hope, agency and opportunity overlap with many aspects of social inclusion. There is a creative synthesis between these two approaches: recovery both requires and allows social inclusion and social inclusion helps to promote recovery. Both are key concepts for modern consultant roles and for modern psychiatric practice. Recovery-oriented practice should promote social inclusion and challenge marginalisation and stigmatising views/behaviours within our own services and in wider society. Many of the 'markers of recovery' are, in reality, markers of social inclusion: working, studying and participating in leisure activities in mainstream settings; good family relationships; living independently; having control of one's self-care, medication and money; having a social life; taking part in the local community; and satisfaction with life (Liberman & Kopelowicz, 2002). If we promote social inclusion, we will also be promoting opportunities for service users to achieve their full potential as they recover, and, in so doing, the service will be embracing some of the core components of recovery-oriented practice.

Poverty, social inequalities and health – and mental health

Let us look at some aspects of poverty and socioeconomic factors and how they relate to people with mental health problems.

We know that socioeconomic conditions are significant risk factors for physical diseases and mortality. In the UK we have had several reports over the past 40 years that have highlighted this.

1. *The Black Report*.

In August 1980 the United Kingdom Department of Health and Social Security published the Report of the Working Group on Inequalities in Health, also known as the Black Report (after chairman Sir Douglas Black, President of the Royal College of Physicians). The Report showed in great detail the extent of which ill-health and death are unequally distributed among the population of Britain, and suggested that these inequalities were widening. The Report concluded that these inequalities were not mainly attributable to failings in the NHS, but rather to many other social inequalities influencing health: income, education, housing, diet, employment, and conditions of work. The Report recommended a wide strategy of social policy measures to combat inequalities in health. These findings and recommendations were virtually disowned by the then Secretary of State for Social Services, very few copies of the Report were printed, and few people had the opportunity to read it.

This perhaps reminds us that “Medicine is a social science, and politics is nothing else but medicine on a large scale” (Rudolf Virchow, 1821-1902). It illustrates the sensitivity of governments to charges that health is a political and economic matter.

2. *The Acheson Report* 1998 “Inequalities in health: report of an independent inquiry”

Chaired by Donald Acheson – CMO.
This report again demonstrated the existence of health disparities and their relationship to social class. This did influence the government.

3. *'Fair Society Healthy Lives'* (The Marmot Review, 2010)

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010.

I will return to the key messages of the Marmot review later.

World Health Organisation (WHO) - developed a Commission on Social Determinants of Health, which in 2008 published a report entitled "*Closing the Gap in a Generation*".
This report identified two broad areas of social determinants of health that needed to be addressed.

The first area was daily living conditions, which included healthy physical environments, fair employment and decent work, social protection across the lifespan, and access to health care.

The second major area was 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.

These reports all point to large changes in people's health across the socioeconomic gradient that exists within countries. The gap at the ends of the gradient is very large. For example, in the London Borough of Westminster, England UK, there is an 18 year gap in male life expectancy between the most and least affluent parts of the borough, across Glasgow there is a 28 year gap in life expectancy. In Baltimore, USA there is a 20 year gap at the ends of the gradient.

These are enormous gaps - 20 years is also the gap in life expectancy between women in India and in the USA.

Mental Health and poverty/low income

Studies from several countries indicate that people with mental health problems are likely to be living with low incomes. The slide shows figures from national surveys in Great Britain, - you will find similar differences in income distribution in USA and Swedish studies.

To make life easier I have generally divide mental health conditions into the psychoses or long-term severe conditions and common Mental Health Problems (mainly anxiety and depression)

People with severe mental illness often live in material poverty; they have less income and more debt and financial hardship than those without mental health problems. Figures from the 1993 and 2007 National Adult Psychiatric Morbidity surveys illustrate this

In Britain about 90% of people with psychoses have control of their own finances and in 1993, the median gross weekly income of people with psychoses who had control of their own finances was £60–79, compared with £80–99 for people with common mental disorders and £140–159 for the general population.

The percentage of people with psychosis rises significantly as gross weekly household income decreases. Although these actual income levels will have now changed, there is no reason to expect the relative incomes levels to have reduced as most people with psychoses get their income from welfare benefits, with only about 17% receiving it from earned income.

However, those with an earned income do have a higher median weekly income (£120–139) than those on benefits (£60–79).

In addition, many of those with severe mental health problems who are on benefits may not be receiving the full range of benefits to which they are entitled. For example, in a survey of patients in contact with community mental health services in England that was true for about half the sample. Access to welfare benefits for which people are eligible can be significantly improved by the provision of specialist benefit workers in CMHTs.

The low incomes of this group of people with mental health problems places many of them firmly in the relative poverty bands of those described in my earlier slides and means that they may not be able to afford many of the basic necessities such as healthy food, clothes, domestic appliances and holidays or usual social activities. They may also be in debt or be unable to afford insurance or other financial services. People with schizophrenia who have low income are also very likely to be disadvantaged on multiple measures of exclusion.

People with common mental health problems are less likely to receive benefits than those with psychoses and generally have higher incomes, but compared with the general population they are 2 to 5 times as likely to be on welfare benefits. They are also less likely to have an earned income (47% v. 58% in the general population).

As with psychoses, the proportion of people with common mental health problems rises significantly as gross weekly household income decreases. The risk of common mental disorders is high among the poor –several studies have found an association between poor mental health and the experience of poverty. Here poverty has been seen as a trigger to poor mental health, a factor in maintaining common mental disorders and as part of the key experience of poor mental health. A 12 year longitudinal study in Belgium showed that a lowering of material standards of living was associated with an increase of depressive symptoms and an increase in the number of cases of depression.

Several studies have measured a range of sociodemographic variables that indicate disadvantage and generally find an association with Common Mental disorders. For example, Fryers et al (2003) reviewed 9 large scale epidemiological studies in UK, Canada, USA, Australia and Holland and of which eight showed an association between one or more markers of less privileged social position and higher prevalence of common mental disorders. The more consistent associations were with unemployment, less education and low income or material standard of living. Occupational social class was the least consistent marker.

We also know from several studies that more deprived local populations show a greater prevalence of psychiatric problems. In addition, more deprived groups are:

- Less likely to present to mental health services
- Less likely to start therapy if referred for psychological care
- More likely to have poorer outcomes to psychological therapies.

These associations between poverty variables and common mental disorders are also found in Low and Middle Income countries. The variables include: education, food insecurity, housing socioeconomic status, income, employment (Lund et al 2010).

Child mental health problems

It is now well established that poor children are much more likely to experience mental health problems than those living in more affluent strata of society.

- The likelihood of having a diagnosable mental health problem is 3 times higher for children in the lowest income household than in the highest earning group (Slide).
- Children living in households where an adult is in receipt of state benefit payments are 2.5 times more likely to have a mental health problem than is the average child. Diagnosable mental health problems in children are highly associated with physical illness, accidental injury and neurological problems, all of which occur more commonly in economically disadvantaged groups.
- Many of the parents of these children have a background of adversity in their own childhoods which may also be reflected in previous generations, the so-called 'cycle of deprivation'. The concept of a self-perpetuating cultural group defined by poverty and relationship difficulties has become familiar to those working with these populations and may give rise to low expectations of advancement.

Let us just look at some other important aspects of the exclusion of people with mental health problems:

Debt

The experience of debt is a particular problem for people with mental ill health: They are three times as likely to be in debt and twice as often have problems managing their money compared with the general population.

This high proportion of people in debt applies to individuals with any type of mental health problems; for example, a quarter of people with common mental health problems, a third of those with a diagnosis of psychosis, a quarter of those with alcohol dependency and over a third with drug dependency had debts compared with 8% of the general population (Jenkins et al, 2008).

Debt can be both a cause and consequence of mental health problems. What is often seen is a 'debt spiral' where there are missed payments and penalties, the

attempts to juggle personal finances or borrow additional money, the increasing pressure from creditors, the attempts to make unrealistic arrangements to repay the debts and the threat or occurrence of legal proceedings, lead to an entrenchment of the problems and to the eventual loss of important resources such as accommodation. These matters are not only associated with feelings of worry, anxiety and low mood, but also feelings of shame, social embarrassment and a sense of personal failure.

Neighbourhoods

Personal poverty and deprived neighbourhoods tend to go together and are associated with mental health problems.

A UK national Poverty and Social Exclusion survey found higher than average rates of poor mental health are found among people who live in a poor environment

Several studies have found an association between deprived neighbourhoods and contact with mental health services for people diagnosed with psychoses and those with common mental health problems, and for suicide.

Some of the reasons for this may be downward mobility and the impact of poor areas: poor social ties, social space which discourages the formation of friendships, and wider urban processes which promote divisions and inequalities. Rates of criminal victimisation are higher, which lead to increased fear of crime, social withdrawal and mental health problems among both direct victims and non-victimised residents. Poor housing is often an obvious feature of these neighbourhoods.

Housing

Only a small proportion of people with mental health problems live in sheltered or residential housing schemes and most live in mainstream housing. This is true of almost all people with common mental health problems. Four out of five people with severe mental health problems live in mainstream housing, with the rest living in supported housing or other specialist accommodation, and half of those with their own home or tenancy live alone.

Good-quality housing represents not only shelter, but also the stability of a home and relates to mental health through its physical design, meaning and control, social support and financial security.

In the UK, most people with severe mental health problems live in social housing (owned by local authorities or registered social landlords). Compared with the general population, people with common mental health problems are one and a half times more likely to live in rented housing – with higher uncertainty about how long they will remain in their current home. They are twice as likely to say that they are

very dissatisfied with their accommodation or that the state of repair is poor, and four times more likely to say that their health has been made worse by their housing.

Transport

As most people with severe mental illness depend on welfare benefits for their basic and everyday needs, this may restrict their travel opportunities as most will not be able to afford a car or discretionary transport, such as holidays. Other problems may arise as, for example, travel insurance may be hard to obtain.

In addition, access to services may be difficult. Up to one in four people have been unable to get help from mental health services due to an inability to pay for transport.

Poor access to transport may contribute to isolation.

Education

In general there is an association between low levels of education and mental health problems. In a review of epidemiological studies of common mental disorder four out of five key studies showed positive associations with higher rates of common mental health problems and less education, whether measured by qualifications achieved, years of completed education or age at completion.

In the British Psychiatric Morbidity Survey those who left school before 16 years of age or had no qualifications had the highest levels of common mental disorder.

Many diagnosable mental health problems begin early in life and as a consequence may have an impact on educational attainment.

Population-based studies in the USA and New Zealand show that mental disorders beginning in early life or adolescence are associated with an increased risk of early termination of education. This often results in disadvantages in acquiring skills, impairment of life chances during adulthood and loss of human capital.

Low education attainment in early years may be difficult to make up for later in life and adults with mental health difficulties face barriers to participating in learning, not least because of gaps in the provision of adult education.

Employment

The poor labour market position of people with mental health problems is well known.

- In the main they are less likely to be in employment and are at more than double the risk of losing their jobs than people without mental health problems
- They have a high rate of unemployment and represent the highest number of those claiming sickness and disability benefits.

Many people experience their first episode of a mental health problem in their late teens or early 20s, which can have serious consequences for their education and employment prospects. In an economic downturn they have a lower re-entry rate into the labour market.

The rate of employment for people with schizophrenia appears to have dropped over the years: studies show that between 10 and 20% are in some form of employment. Before 1990, employment rates of 20–30% were reported.

For people with Common Mental Health problems, employment rates may be higher but, in the UK:

- Adults with neurotic disorder are four to five times more likely than those without mental health problems be permanently unable to work
- Overall, 61% of men and 58% of women with a common mental health problems were working, compared with 77% of men and 65 % of women no disorder

Social networks

Poor social networks have long been recognised as a risk factor for mental health problems. People with common mental health problems often have poor social networks, and those of people with severe mental health problems are often severely restricted.

- Adults with severe mental health problems are five times, and those with common mental health problems two times, as likely to report a personal severe lack of support as those with no illness.
- People in contact with mental health services are relatively isolated and are likely to derive many of their social contacts from other service users

Personal safety

Despite the fact that much of the literature has focused on violence by people with mental illness, it is more likely that they will be victims of violence or other crime than members of the general population

About half of people treated at community mental health services in north London described experiences of verbal and physical abuse. Physical abuse was more commonly experienced by people with psychoses than other disorders.

Patients on psychiatric in-patient units may also experience violence towards them

Some of this violence and crime may be associated with the more impoverished neighbourhoods that people with severe mental illness live in.

Political engagement

There is a general lack of information about the involvement of people with any sort of mental health problems in local or national decision-making (having a voice, choice and control).

The list of civic activities and involvement in civic organisations used in the UK Poverty and Social Exclusion Survey is shown in the slide. For many people with severe mental health problems it is unlikely that they would have engaged in many of these activities.

Although there is a lack of information about the engagement of service, there is some evidence about curtailment of citizenship, political and human rights for people with mental illness.

Physical health inequalities

People with all forms of mental health problems are at increased risk of premature death, both from natural and unnatural causes, and a range of inequalities in physical health is seen in people with mental health problems.

People with significant mental health problems experience a 'triple jeopardy' – they are more likely to get heart disease, diabetes and some cancers, especially when young and, once diagnosed, are more likely to die within 5 years. Generally, they experience poorer quality healthcare than people without mental health problems.

People with a diagnosis of schizophrenia, bipolar disorder or depression die younger than other people; they have significantly higher rates of obesity, smoking, heart disease, hypertension, respiratory disease, diabetes, and stroke and breast cancer than other citizens.

People with multiple diagnoses

Many people who come into contact with mental health services may have more than one diagnosis and may have multiple problems Health and Social Services find these groups challenging.

People may have combinations of diagnoses such as psychotic or non-psychotic mental illness, alcohol and/or drug dependence, learning disability, personality disorder and adult neurodevelopmental disorders (Asperger's syndrome, autism, attention-deficit hyperactivity disorder).

Few accurate figures exist as to the numbers of people with these multiple diagnoses ('multiple needs'), but a review in 2007 using UK surveys of these disorders found that in the UK adult population living in private households, 3.5% of

individuals had two or more of the categories of disorders listed above, mostly a mental disorder in association with one of the other categories.

There were high concentrations of people with multiple needs in prisons and among the homeless population.

Some of the variables defining these groups are listed in the slide.
People with a combination of four or more of these problems were defined as leading 'chaotic lifestyles'. She found that 0.9% of the general population and 6.5% of people with multiple needs have chaotic lifestyles, and 23% of people with chaotic lifestyles also have multiple needs. People with mental disorders alone account for an additional 18%, learning difficulty alone a further 10% and schizoid personality alone a further 9% of those who have chaotic lifestyles.

Mental health, poverty and exclusion - Conclusion
The figures that I have quoted show clear associations between poverty, exclusion and mental well-being and ill health. In general terms, mental ill health can be a cause and consequence of social exclusion. Anyone can be affected by mental ill health but people from disadvantaged backgrounds are at significantly greater risk. This cuts across all types of mental health problems and all age groups and is a phenomenon of universal significance.

People with mental health problems may be excluded in any one of the five areas of exclusion discussed earlier, but these categories are not independent and people are more often excluded across several of the dimensions.

The excess of common mental disorders in disadvantaged people, whether measured by occupational social class, education, unemployment, income or material possessions is now well established. People with common mental disorders are not universally excluded but there are specific groups who are most disadvantaged in this context and who are defined by combinations of factors including education, income, social support and physical illness or disability

There is a relationship between the seriousness of the mental health problems, certain broad diagnoses (in particular schizophrenia and schizoaffective disorder) or people who fall into multiple diagnostic categories and are excluded in multiple areas.

These conditions are associated with a number of related problems which interact with, and exacerbate, social exclusion: poor or abusive family backgrounds; poor social and functional skills; poverty; poor housing and homelessness; poor educational attainment and unemployment; social isolation with impoverished and non-reciprocal social networks and a high probability of lack of partner or cohabitee;

lack of access to leisure activities; stigma (external and internalised) and discrimination; risk of criminality and victimisation.

This multiple exclusion can be seen in the Aetiology and Ethnicity in Schizophrenia and Other Psychoses (AESOP study) of 390 people with first ever contact with mental health services for schizophrenia who were more likely to be socially disadvantaged or isolated than matched controls as measured by a number of indicators, such as having no educational qualifications, being unemployed, living in rented accommodation and living alone (Morgan et al, 2008). They were between 2.7 and 3.5 times more likely to be in these circumstances than other members of the population and were 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, and 34% had four or more indicators compared with 13% of controls.

Other groups who fall into this multiply-excluded category include those with contact with forensic services.

Those people who come into contact with forensic mental health services are likely to have been socially excluded even before entering mental healthcare, independent of mental health considerations but rather related to deeply entrenched socioeconomic and cultural indicators of deprivation and disadvantage. Compared with users of general psychiatric services, mentally disordered offenders are over-represented by young men, people from Black and minority ethnic groups, people from low socioeconomic classes, those with high rates of childhood deprivation, abuse and institutionalisation, those with low educational and vocational attainments (and with high rates of school exclusion) and people who are homeless. In addition, many mentally disordered offender patients have no previous experience of mature, intimate and non-abusive relationships, and have already got extensive forensic histories (convictions) before entering mental healthcare. Many male offenders are detained specifically because of their risk to women and children.

It does seem that the more severe or complex the illness, the greater the risk of social marginalisation experienced by service users. In addition, large numbers of service users with high support needs, particularly those with learning disability or long-term schizophrenia, are placed in community residential and nursing homes which are often a long way from their local area of origin and families (so-called out-of-area treatments). This further exacerbates their social dislocation.

This multiple exclusion has economic consequences, but is of concern for more than economic reasons. There is strong evidence that health outcomes are heavily influenced by disadvantage, for example, unemployment is damaging to health whereas work is generally good for health and well-being. There is also evidence that the great majority of people who use secondary mental health services aspire to

live more fulfilling lives, including entering into paid employment. The barriers to achieving their ambitions are, however, significant. Active symptoms, cognitive impairment and episodic illness all present hard, but not insuperable, challenges for the individual and the clinician. Good clinical outcomes are important, if often difficult to achieve, but perhaps even more difficult to overcome are the social barriers: low expectations by clinicians and family, the effects of treatment, stigma and discrimination, and disincentives in the welfare system that put basic income at risk.

What are the consequences?

1. *Direct effects on people* - Psychological effects

From what I have outlined we can see that, in addition to the challenges posed by a person's mental health problems, people face a range of structural barriers including poverty, debt, stigma, lack of affordable accommodation, limited employment opportunities.

Poverty has serious implications for people's health, education, social relations and social inclusion.

Poverty and unemployment themselves have damaging effects on peoples mental health and are associated with feelings of despair and apathy, aimlessness, low self-esteem, despondency, reduced social contact, loss of self-confidence, status and prestige, demoralisation and feelings of incompetence – all these are familiar to people with mental health problems.

Poverty may mediate the impacts of mental health problems, for example:

- Social relations made difficult by reduced interpersonal functioning may be further strained by poverty.

- The negative connotations of poverty and welfare use may exacerbate the stigma of their mental health problems – Poverty and the receipt of welfare itself carries a stigma

This has not been helped by public attitudes, which have become increasingly negative towards people who receive benefits – they are often perceived as 'scroungers':

People who are poor often feel abused and disrespected by welfare provision, and receive inadequate payments in an unpleasant and dehumanising context. The way in which politicians frame and portray economic inequality provides some of the context within which public attitudes are formed, and the public attitudes influence how governments act to address poverty. The press, while glorifying the members of The Sunday Times's 'rich list', stigmatise the poor. The exclusion of the poor is explicit:

“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).

Jones et al go on to point out the effects of this on well-being:
“…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” (p. 439).

The issue of social exclusion and mental health problems is concerned with substantive freedoms, in this case the ‘ability to go about without shame’ (Sen, 1999). To quote the philosopher Adam Smith:
“*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*”.

Here again we see that material conditions are important for more than their value in providing for the basics of our day-to-day existence and, in this case, the absence of the shirt is an indicator of not only poverty, but shame “that erodes the self-esteem, self-worth, agency and confidence that are essential to flourishing wellbeing” (Friedli p. 37).

We also know that the strain of poverty can inhibit the recovery process - Quality of life is reduced – areas of finance, work and social life are the most likely to be complained of by people with mental health problems.

Here are some quotes from people with mental health problems in Sweden and Scotland

“*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*.” (Torpor et al 2014)

“*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*.” (Torpor et al 2014)

"*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*." (Torpor et al 2014)

"*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* …" (Torpor et al 2014)

"*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*." (Torpor et al 2014)

"*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*" (Torpor et al 2014)

"*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)

"*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*.'
Female, Dundee

"*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

"*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

"*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."*
David, Glasgow

"*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*."
Male, Inverclyde

"*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*."
Male, Glasgow

"*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*."
Female, Glasgow

"*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*."
Female, Glasgow

"*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…*"
Female, Glasgow

What this means for us all is that you cannot ignore the social and economic context that people with mental health live in and in which we work. Poverty and Social exclusion are the causes and consequences of mental health problems and moderate the relationship between mental health problems and outcomes.

These quotes and studies show how people with SMI were affected by and dealt with their difficult financial situation and underlines the importance of widening the focus of psychiatry to include people's social context in professional assessments and in our knowledge base. Changing our perspective would mean viewing some of the difficulties these people face in the community no longer as individual symptoms and failures alone, but also as a consequence of the actual circumstances in which they live. Consequently, these difficulties should not automatically be assumed to be symptoms of mental disorder but require other approaches to explain them.

Whilst I have focussed on the negative effects of poverty and the vulnerability of people with mental health problems, we should not forget that people have strengths and find their own ways of managing difficult situations, sometimes with the help of significant others and sometimes not. This 'resilience' is not a matter of extraordinary achievements by remarkable individuals, but part of managing life for many people with mental health problems – such that relatively small steps towards living an ordinary life will be regarded as resilient outcomes and resilience will be seen as a common phenomenon.

This is illustrated by 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*." (Canvin et al 2009)

Nina's story illustrates the difficulties of defining and describing resilient outcomes. Faced with depression, the small positive steps she took were highly significant for her life.

2. Disadvantage matters: future outcomes and future generations

The evidence is that poverty and other forms of disadvantage in early life increase the likelihood of disadvantages in later life and that these may be transmitted across generations. People who have grown up poor are more likely to face adverse social and economic circumstances well into adulthood. Even before children reach school, the effects of class differences are already apparent, differences that may be hard to break later.

Poverty, as we have seen, is associated with worklessness, financial problems and debt, which may lead to housing problems, relationship conflict and breakdown and ill health caused by stress.

- Lack of education and skills increases the chances of being unemployed and having a poor earning capacity.
- Poor housing is associated with ill health, family and school disruption and increased risk of being on the Child Protection Register.

These may reinforce barriers to children getting ahead in later life and contribute to experiences of worklessness, offending behaviour, mental health problems or institutionalisation.

Children born into the particularly disadvantaged households identified by the Social Exclusion Task Force may be at particularly high risk of these problems. In a study in New Zealand (Fergusson et al, 1994), 22% of children born to the 5% most disadvantaged families had multiple problems at age 15, compared with 0.2% of children born to the 50% most advantaged families.

The consequences of harm caused by poverty to children's development seem to be growing in the long term. Successive cohort studies (following up over time, people born in a certain year) indicate an exacerbating effect on people's life chances. The relative impact on adult outcomes of experiencing poverty as a teenager doubled between the cohort who were children in the 1970s (now in their 40s) and those ten years younger (now in their 30s) – the latter became adult in a riskier world.

There is a strong association between parental income and the child's subsequent earnings as an adult. A study of a group born in 1958 (the 1958 National Child Development Survey), showed that young adults who as children had lived in poor households, were in trouble with the law or played truant, had significantly greater than average chances of earning low wages, being unemployed, spending time in prison (men) or becoming a lone parent (women).

Of the family-based measures of childhood disadvantage, poverty was found to be the most important factor link in childhood development with subsequent social and economic outcomes. For example, being brought up in a lone parent family does not seem to matter in the absence of family poverty.

The link between a person's social class and birth and the probability of multiple deprivations by age 30 years has also been shown in the 1970 cohort (Slide).

Family disadvantage can also affect children's cognitive ability. Poor cognitive performance at 22 months can improve in children born into more privileged families,

but not in those from disadvantaged families, and indeed cognitive functioning of more able children in these families at 22 months may decline by 10 years.

Income Inequality and the effects of the Recession

In addition, I would like to raise two further related matters:

1. The effects of Income Inequality on Mental Health Problems
2. The effects of the economic recession

The effects of Income Inequality on Mental Health Problems

In the UK since the 1970s the income gap between rich and poor has widened, making the UK one of the most income-unequal nations (Wilkinson & Picket, 2009).

In rich countries, high income inequality is associated with high levels of mental health problems, mortality, drug misuse, child ill-health, teenage pregnancy, homicide and imprisonment (Wilkinson & Pickett, 2009).

The graph on the slide shows a strong association in rich countries between income inequality and the proportion of adults who have been mentally ill in the 12 months prior to being interviewed.

Inequality is associated with threefold differences in prevalence: in Germany, Italy, Japan and Spain, fewer than 1 in 10 people have been mentally ill within the past year; in Australia, Canada, New Zealand and the UK it is more than 1 in 5 people, and in the USA more than 1 in 4. Anxiety disorders, impulse–control disorders and severe illness are all strongly correlated with inequality. Anxiety disorders represent the largest subgroup in all these countries, and the percentage of all mental illnesses that are anxiety disorders is itself significantly higher in more unequal countries.

Studies in the USA and Wales have also shown a relationship between income inequality and depression.

Picket and Wilkinson suggest that this association is related to our anxieties about social status. They point out that internationally and in the USA, income inequality is strongly related to low levels of trust, to weaker community life and to increased violence. Mental health is profoundly influenced by the quality and sufficiency of social
relationships and all these measures suggest that both are harmed by inequality.

The effects of the economic recession

The 2008 global financial crisis affected economies around the world. It led to the deepest UK recession since World War II, with rises in unemployment, debt and

home repossessions. Young people experienced particularly high levels of job losses and unemployment.

The 2008–2010 economics recession was associated with a significant rise in suicides
in many European countries and American states. In Greece, a country particularly severely affected by the recession, suicides rose by almost 60%.

In England we had begun to see a fall in suicide rates, but this was reversed around the time of the recession. We also saw increases in suicide attempts and depression, particularly in males.

There were an estimated 1000 excess deaths from suicide in the UK between 2008 and 2010. In addition there were possibly 30-40,000 additional suicide attempts during the first three years of the recession. Areas of England experiencing the greatest rises in unemployment experienced the largest increases in the number of suicides.

In England, as in the rest of the world, the greatest rise in the incidence of suicide appeared to be in young men.

Unemployment, financial difficulties, debt and loss of a home increase an individual's risk of depression, suicide attempt and suicide. Rises in unemployment appear to account for less than half of the increase in suicide deaths during recessions; debt and the impact of austerity measures are likely to be other important contributors to the rises.

Other financial stressors that were identified as contributing to suicidal behaviour included disputes over benefits, wage cuts or demotions and reduced hours. A range of sources of debt were identified, including loans (e.g. hire purchase and student loans), mortgage/rent arrears, gambling and debts to friends and family. Many individuals were not in contact with mental health services or their GP.

Several studies have shown that the people most vulnerable to job loss and debt are individuals with pre-existing mental health problems or past psychiatric illness. Thus vulnerable individuals may become more vulnerable during periods of recession.

Unemployed interviewees reported the negative impact on their mental health of Job Centre targets for the number of job applications they should make; often they received no response to these applications and this contributed to their stress and sense of low self-worth due to failure to find employment. Despite being given suggestions about appropriate agencies to go to for advice and support, people experiencing mental health problems as a result of their financial and employment

difficulties often lacked the motivation and support to navigate the benefits and advice systems, further exacerbating their problems.

One man reported:
"…it was always down to me to sort out the finances and obviously if I'm ill and on a real low I don't do it and then things don't get paid and things get forgotten… Finances. It was the ultimate trigger. Obviously I was feeling low anyway and I missed- I had forgotten to make a [council tax] payment [and they put me] onto a bailiff. It was just a genuine slip, a genuine slip and they were threatening to come and take our belongings, which they didn't do – as it turns out they were trying to scare me but that tipped me over the edge."
- 35 year old man who had attempted suicide

What can be done?

The general conclusion that I will make is not novel, we need a combined approach of policies, progress and services to improve the position of people with mental health problems and their outcomes.

Let us consider some conclusions from others

Regarding health inequalities, the Marmot Review, 'Fair Society Healthy Lives', which I mentioned earlier came up with the following key messages:

1. *Reducing health inequalities is a matter of fairness and social justice*. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
2. There is a social gradient in health – the lower a person's social position, the worse his or her health. *Action should focus on reducing the gradient in health*.
3. Health inequalities result from social inequalities. *Action on health inequalities requires action across all the social determinants of health*.
4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health*, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.*
5. *Action taken to reduce health inequalities will have economic benefits in reducing losses from illness associated with health inequalities* – that is productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
6. *Economic growth is not the most important measure of our country's success*. 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.
7. *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.

8. *Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups*. National policies will not work without effective local delivery systems focused on health equity in all policies.
9. *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:
The first, was daily living conditions, which included healthy physical environments, fair employment and decent work, social protection across the lifespan, and access to health care.
The second was 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.

Both these reports cover the broad approaches to tackling health inequalities

Can giving people with mental health problems more money help?
There is some evidence that moving people out of poverty can improve the mental health of young people. Half way into a longitudinal study of children aged 9, 11, and 13 in North Carolina, USA, a gambling Casino opened up in a Native American Reservation that was part of the study. As a consequence of this, every Native American family received an income that rose every year (this was in the terms of agreement for opening the Casino).

They found that families moving out of poverty was associated with a decrease in the frequency of psychiatric symptoms - by the 4th year the symptom level was the same in children who moved out of poverty as in children who were never poor. However, adding to the income of never poor families had no effect on the frequency of symptoms. This effect was strongest for behavioural symptoms and there was little effect on emotional symptoms. This effect of relieving poverty was mediated by one factor – the level of parental supervision (which improved).

More importantly, when these children were followed up into adulthood, they had less adult disorder. Exposure to increased income in an American Indian population, compared with an unexposed non-Indian population, was associated with fewer psychiatric disorders in adulthood. The effect was strongest for alcohol and cannabis abuse, dependence, or both and was specific to the youngest cohort (that is those children with the longest exposure to improved income).

This also is supported by some family interventions studies in the UK which showed that parenting training in families with a child who had conduct disorder, significantly reduced the likelihood of contact with criminal justice services when they reached adulthood.

In addition there is some evidence that providing people with long-term adequate budgets can improve some of their social outcomes.

In a Swedish study (Ljungqvist et al 2015) – 100 people with long-term mental health problems (50% had a diagnosis of schizophrenia) were given an extra allowance of 500 Swedish Kroner (about 200 Shekels) per month for 9 months. They found that after 6 months, compared to a similar group not given the allowance, that they experienced a drop in reported symptoms, and an increase in quality of life, sense of self and their social networks.

What this improvement entailed for this group can be gleaned from the qualitative part of the study (Topor et al. 2015). Several participants intensified relationships they had already acquired. Others resumed earlier social relationships. The common ground of these categories was that their improved economic status had enabled them to improve the mutuality of their relationships, as they were now able to offer something like returning invitations for coffee and other pleasures. A few had started completely new relationships, and several of the participants had started attending various new social contexts that might lead to new relationships in the long run. This result calls into question the long-standing belief that social isolation among persons with SMI is a symptom of their illness.

In a small UK study, giving £800 per year and a personal co-ordinator to people who were sleeping rough was found to be important in them maintaining their tenancies.

What this suggest is that raising people out of their poverty can have significant effects on their mental health and social outcomes. It points to the need to have a strong welfare state that can offer a safety net to people with mental health problems in vulnerable situations.

In addition, in the UK the provision of Welfare Benefit advisors can help people with mental health conditions navigate the difficult bureaucratic world of the welfare state and obtain the benefits to which they are entitled. This can also have knock on effects to mental health services by reducing acute relapses and the subsequent costs of admissions.

The use of Personal Budgets can also be useful in this regard.

In times of recession we may need to pay increased attention to income and debt:
Reducing the impact of recessions on mental health and suicide (Gunnell, 2015):
• Other research indicates that countries with more generous unemployment benefits and that invest more in active labour market programmes (e.g. job search assistance, apprenticeships, subsidised employment) 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 rein 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.

Improving employment

We know that rates of employment are low for people with a diagnosis of psychosis. However we are also aware that supported employment schemes, such as Individual Placement and Support can improve the chances for people with mental health problems to get a job in the open market.

Systematic reviews of Supported Employment trials all conclude that IPS is effective in achieving open employment for people with severe mental disorders and recent overviews of the randomised trials of IPS conclude that the evidence for its effectiveness is strong and consistent.

IPS has been internationally evaluated in a diverse group of randomised control trials. The results of sixteen randomised trials have been reported and all the trials show a positive effect of IPS over control services in attaining open employment. There is a variation in the rates of success of IPS, with two trials achieving weak results.

Overall, IPS delivers rates of open employment of just over 60% compared to rates of around 25% in the control services across a range of countries including the USA, Canada, Australia, Europe and Hong Kong. IPS has also been shown to be effective in delivering positive employment outcomes in people with first episode psychosis.

In addition:

- The IPS trials have low drop-out rates.
- IPS improves several employment outcomes: getting people into work quicker, working more hours per week, and achieving longer job tenure. Many remain in steady employment or make successful transitions between jobs.
- IPS schemes are well regarded by service users.
- People successfully placed in employment produces good personal outcomes, including better self-esteem, relationships, social functioning and personal management of their illness.
- The schemes can be cost saving. The European multicentre trial of IPS (EQOLISE trial – Burns et al, 2007) showed significantly lower admissions during follow-up in the IPS group and consequently, for health and social services costs, compared to standard vocational services IPS was cost effective as a means of getting people with severe mental disorders into open employment.

Housing

Support and housing are closely linked for people with severe mental health problems; having somewhere to live is a stabilising force for people allowing them to establish daily routines, to receive support and access to services. Having a stable tenure allows them to develop a sense of security and control over their lives. People with severe mental health problems often cite income and housing as the most important factors in their recovery. Of central importance is 'having one's own place': a secure tenure and a safe environment.

Most people with mental health problems in the UK live in independent housing – some live in support housing or will need support to maintain their tenancies in their independent homes.

In general, residents prefer independent living in ordinary housing and value flexible support rather than living with staff. Qualitative studies suggest that successful approaches to supported housing involve a person-centred, personalised approach which is flexible and respectful of choice and autonomy, which employs a range of supports and develops high quality relationships between the staff and tenants. Residents also value stability and permanence of their tenancies. The location of the housing is important, people preferring safer and more supportive communities. Residents are split in their opinions as to whether the accommodation should be integrated with mainstream housing or provided in clusters with others who have experience of mental health problems. This perhaps reflects their differing experiences of rigid living environments, stigma, prejudice, loneliness and support from peers.

Many of these aspects of the supported housing are associated with the satisfaction of residents. Other aspects such as choice and control and the physical quality of

housing are associated with a better subjective quality of life. Long-term support and case management are associated with retention of housing.

For people who are street homeless there is increasing evidence that Housing First Schemes are effective in getting people into stable tenancies. It is generally accepted that Housing First is successful in getting people off the streets and out of shelters into more permanent and independent housing. Over a four year period, 78% of the Housing First clients remained continuously housed.

Improving mental health services – taking a Recovery Orientated approach

Over the last 15 years Recovery has had a central place in mental health policy in the UK. One project, initially funded by the Department of Health, Implementing Recovery through Organisational Change (ImROC) was set up to address the problem of how to assist services to better support mental health clients' recovery, with a particular emphasis on organisational change. This programme was initially funded by the Department of Health and supported by the Mental Health Network of the NHS Confederation and the Centre for Mental Health. The programme began in April 2010 and worked with 29 NHS Trusts in England, using a set of 10 Key Challenges for creating 'Recovery Orientated Services'. The programme was popular with Trusts and is still running today as a self-funding programme. The programme has been particularly successful in supporting Trusts to develop co-produced training for staff and service users, the establishment of Recovery Colleges, the training, employment and management of peer support workers, developing local policies for risk assessment and management, improving care planning and methods of outcome measurement.

The project used a 10 point plan for changing services: 10 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' (e.g. IPS)

Ensuring mental health services have 'Parity of Esteem'

There is a long-standing and continuing lack of equity (or parity) between mental and physical health. This 'mental health treatment gap' is socially unjust and can be seen in:

- lower treatment rates for mental health conditions,
- premature mortality of people with mental health problems
- and underfunding of mental healthcare relative to the scale and impact of mental health problems

It falls short of government commitments to international human rights conventions which recognise the rights of people with mental health problems to the highest attainable standard of health.

However, this lack of parity is so embedded in healthcare and in society that it is tolerated and hardly remarked upon. It also affects people with physical health problems who also have mental health needs that may not be recognised in more physically healthcare-orientated settings. The poorer outcomes that result are considered by many, both within and outside mental healthcare, as all that can be expected.

The Royal College of Psychiatrists and other have campaigned for a Parity of Esteem.

Now the 2012 Health and Social Care Act in England has an explicit recognition of the Secretary of State for Health's duty towards both physical and mental health. In conjunction with a clear legislative requirement to reduce inequalities in benefits from the health service, these place an obligation on the Secretary of State to address the current disparity between physical and mental health.

The current English mental health strategy, *No Health Without Mental Health*, also made a commitment to 'parity of esteem between mental and physical health services'.

The importance of parity of esteem for mental health has been emphasised consistently, by both government ministers and key mental health organisations. It is a principle that is as important for professionals working in social care as in health, and for those predominantly treating physical health problems as it is for those whose main focus is mental health.

Parity is ultimately, a mind-set: government, policy-makers, commissioners, providers, professionals and the public are urged always to think in terms of the whole person – body and mind – and to apply a 'parity test' to their activities and attitudes.

Taking an Early Intervention approach

Early intervention has been emphasised as an important approach to reducing the log-term effects of disorders. The report by Martin Knapp and others examined the economic case for a range of interventions in the mental health field that can reduce later handicaps.

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

Conclusions

Poverty and inequality are bad for us. Poverty is not inevitable.

It is bad for health and we live in a world where health is stratified – disadvantaged people have the poorest health – we have a situation that makes it harder for the disadvantaged, but easier for the advantaged, to reach their full potential.

Michael Marmot points out that if we were we to find a chemical in the water, or in food, that was damaging children's growth and their brains worldwide, and thus their intellectual development and control of emotions, we would clamour for immediate action. However, he points out that this 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)