The impact of poverty on mental health and well-being and the necessity for integrated social policies

Raluca Sfetcu[1], Carmen Beatrice Pauna, Marioara Iordan

Institute for Economic Forecasting – Romanian Academy

Abstract

On almost every account people with mental health problems are among the most excluded groups in society and they consistently identify stigmatisation, discrimination and exclusion as major barriers to health, welfare and quality of life. The links between poverty and ill health are well known. Poverty and illness together make people much more vulnerable and needy at all stages of their lives, and even more so in old age. Mental health is often both a cause and a consequence of poverty, compromised education, vulnerability, difficulty accessing housing, health care and employment, and lack of access to welfare, social security, and community public services. Inequalities between social classes in the incidence of chronic illness and mental illness and in life expectancy are also well documented. The working class poor with health problems are a particularly vulnerable group. Moreover people with mental health problems are more likely to experience physical health problems, which can further compromise the efforts of the individual in an already disadvantaged situation. When the experience of mental illness is the cause or a factor in the experience of exclusion, the effects can be still more damaging. This mutual interaction linking mental health and development can work positively with good mental health facilitating the active and successful involvement of individuals and communities in development, and negatively with poor mental health increasing the risk of descending into a vicious cycle of poverty and adverse social and health outcomes. Designing social policies and interventions - both within and outside the health sector - which strengthen social inclusion, represent a key action recommended by the European Pact for Mental Health and Wellbeing. This paper explores the situation of persons affected by severe mental illness on regional level in Romania. The need for policy development and improvement strategies are also highlighted.

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[1] Institute for Economic Forecasting – Romanian Academy, corresponding address: ralu_sf@yahoo.com

Background

One of the most consistently replicated findings in the social sciences has been the negative relationship of socio-economic status (SES) with mental illness (MI): the lower the SES of an individual is, the higher is his or her risk of mental illness. Epidemiological data on this issue indicate that people with the lowest socio-economic status (SES) have 8 times more relative risk for schizophrenia than those of the highest SES, that schizophrenic people, in comparison with people without mental disorders, are 4 times more likely to be unemployed or partly employed, one-third more likely not to have graduated from high school, and 3 times more likely to be divorced. Poverty, from an epidemiological perspective, means low SES, unemployment, and low levels of scholarship and family standing (Figure 1).
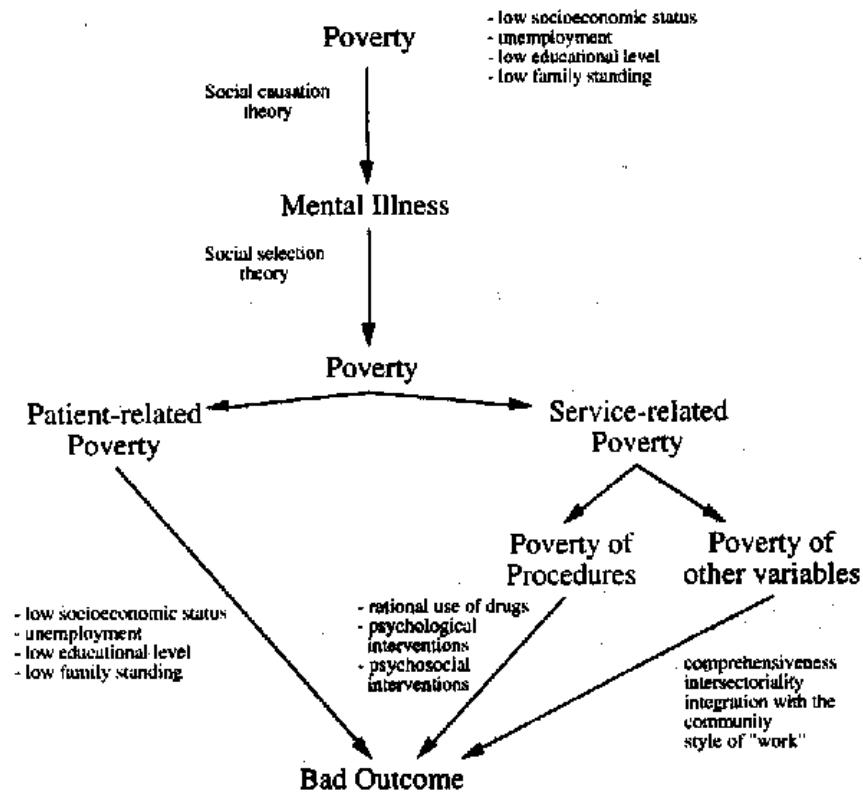

Figure 1. The 3 different levels of the relationship between poverty and mental illness: poverty as a risk factor for the development of mental illness, as a prognostic factor for the outcome of mental illness, and poverty of the mental health service as a determinant of outcome (source: Saraceno & Barbui, 1997)

Yet there have been remarkably inconsistent findings concerning the causal structure of this relationship. Some support theories of social causation, poor socioeconomic conditions predisposing people to mental disability (Ritsher, et al. 2001; Lind, Lennon, and Dohrenwend, 1993; Welch & Lewis, 1998; Franz, M., Lensche, H., & Schmitz, N., 2003), while others have supported theories of social selection or drift, that biologically-based mental illnesses result in the drift of individuals into poor socioeconomic circumstances (Dembling et al 2002; Rodgers and Mann, 1993; Murphy 1991; Munk & Mortensen 1992; Loeffler & Haefner 1999). While a large number of studies have been conducted in order to clarify the causal relationship between SME and MI, very little research specifically examines the role of formal mental health services in moderating this relationship.

The most prevalent perspective on the question of the role of services in the SES-MI relationship is the belief that they are either less available, sought out, and/or less effective with persons of low-SES status, and thus, they serve to aggravate the disparities. One version of this theory involves the idea that low-income individuals are less likely to seek out services, in part, because they are less likely to define deviant behaviors in terms of mental disability (Heller, 1979; Diala et al., 2000). Other studies have provided some evidence that low-income individuals are older at the time of first contact with mental health services (Brown, et al. 2000), and perhaps for this reason, tended to have less favorable service outcomes (Ronalds, et al, 1997; Swindle, et al., 1998). Hospital service use research also indicates that low level of education and lack of social or family support are also strong predictors of psychiatric readmissions. Social and behavioral factors, such as homelessness and being single or living alone, were also found to be related to readmission rates over a longer period of time (from one to seven years) after discharge in adult patients.

A study by Kent et all. (1994) found that social factors contribute to 38.9 percent of admissions, followed by factors related to psychiatric and physical illness (31.1 percent), dangerousness to self or others (20.3 percent), and substance abuse (9.7percent)

In this study, we will explore the structure of the population of patients hospitalized across Romania (on 1st July 2007) in relation to SES indicators as well as the relationship between SES (occupation, income, educational level) and readmission rates of hospitalized persons with mental health problems.

Methods

Data used for this study have been collected by the National Centre for Mental Health (NCMH) on 1st July 2007. NCMH sent to all psychiatric hospitals, subordinated at the moment of data collection to the Health Ministry, a form with the request to be filled up at a six month interval with questions about patients and services provided. The information requested referred to all inpatients and addressed demographic (age, sex, level of education, job status, marital status, living area), and socio-economic data (income, insurance status, housing). Other data requested referred to diagnosis, previous admissions, the length of hospitalization up to the census moment, type of ward (open/closed), legal status (voluntary, committed) and pathways to hospital admission.

Besides data referring to patients, each hospital had to provide some basic data regarding: the number of beds (total number of beds; beds in close/open wards), qualified staff (psychiatrists, psychologists, social workers, and nurses) and the type of services and programs within the hospitals. In this study we have included data for a group of 5.176 adult patients admitted at the moment of data collection in a psychiatric hospital or psychiatric department in a general hospital

Results

Socio-demographic structure of the study population

The rural-urban distribution of the population is rather balanced, with 55.8% coming from urban and 44.2% from rural areas. The same is valid for the gender distribution, with 52.2% of the persons admitted in psychiatric hospitals being male and 47.8% female. The mean age of the population investigated is 43,64 years with 25% of the them falling in the interval 18 -36yrs, 25% in the interval 36-46 yrs., 25% aged between 46-52 yrs., with the rest of the group being over 52 yrs.

The educational level of the group is rather low, 42.6% having finished less than 8 years of education and 34.1% 12 years of education (high school). Only 6.9% have a bachelor degree, whereas 5.2% have no education at all. Concerning the occupational status of the population hospitalized at the moment of the CENSUS, only 15.2% were employed (3.6% unqualified work, 8.8% qualified work and 2.8 high qualified work) while 50.1% are on early retirement due to illness and 24.4% have no occupation; the rest of the group consists of students, housewives and

people on retirement due to age. Only 42.5% of the patients were married and 12.2% were divorced, while 36.5% of the group were single; 54.5% have 1 (20.3%), 2 (22.5%) or more children. While the persons who are married live with their partner, the rest may live with their parents (30%), in a residential facility (1.9) or have no place to go (7.6%). Most frequent diagnosis schizophrenia and schizotypal disorders (34.7%), followed by affective disorders (24.4%) as indicated in Table 1, below.

ICD 10 Diagnosis	N	%
F20-F29 Schizophrenia	1805	34.7
F30-F39 Affective disorders	1270	24.4
F04-F09 Organic mental disorders	610	11.7
F10Alcohol related disorders	437	8.4
F40-F48 and F50-F59 neurotic and behavioral disorders	425	8.2
F70-F79, Q90 mental retardation	332	6.4
F60-F69 personality disorders	177	3.4
Dementia (F00-F03)	54	1
G00-G99 neurological disorders (mainly epilepsy)	44	0.8
F11-F19 other disorders due to psychoactive substance use	19	0.4
F80-F89 and F90-F98 developmental disorders	2	0

Table 1 – Distribution of the population by diagnosis

Analysis of SES in relation to readmission rates

In order to explore the relationship between SES and readmission rates, we have operated a distinction between patients who were for the first time admitted in the hospital and patients who have been admitted in the previous year (we have not further divided this category according to the period of time between the present readmission and the previous one). We have selected occupational status and type of income, housing situation and educational level as SES indicators.

Occupational status and readmission

When looking at the frequency distribution of hospitalized patients in relation to their occupational status and readmission rates, we observe that most of the patients who are on retirement due to illness (93%) or age (79%) have been admitted before on the hospital while only 55% of patients who are employed as qualified workers have returned in a psychiatric hospital (in max. 1 year.). Percentages of readmitted patients who are unemployed persons, housewives and students vary between 60 – 70%. The results are consistent with findings of other authors (Oiesvold et all, 2000), showing that the less "occupied" a person is, there is a higher chance that he/she is readmitted to the hospital. A study by Kammerling & O'Connor (1993) has discovered that unemployment rates alone can explain over 90% of the variation in standardized admission ratios. These findings support the community services approach, where creating and offering a time structure to persons suffering from severe mental illness represents an important component of the intervention plan.
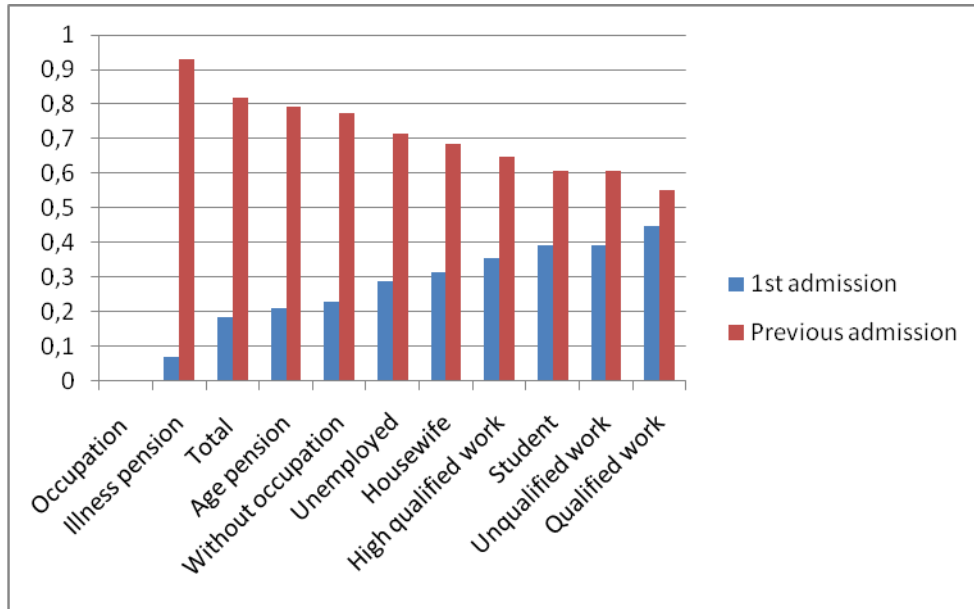
Figure 2. The distribution of patients by occupation and readmission

Educational levels and readmission

When looking at the relationship between educational levels and readmissions, only little variation can be observed in the percentages of different categories of patients who are admitted for the first time vs. a repeated admission. The results are consistent with other studies (Lewis & Joyce, 1993; Hoffman, 1994; Haywood et all., 1995), although results to support such a relationship also exist in the literature (Thompson & all, 2003). The lack of association may be a function of the limited variation in level of education in this study.
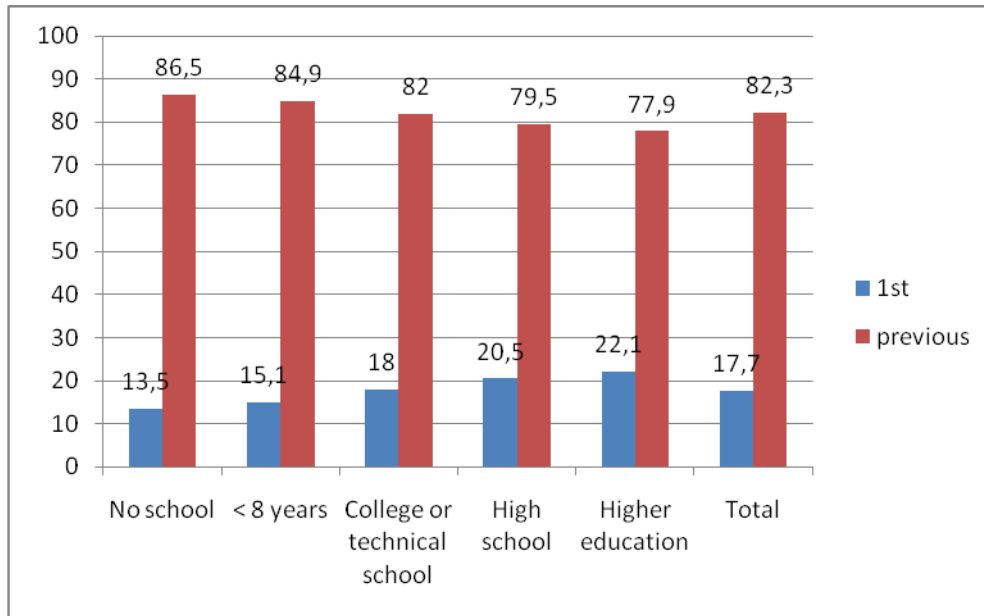
Figure 3. The distribution of patients by educational levels and readmission

Marital status and readmission

Previous research has also identified relationship status as a factor influencing readmission rates of mentally ill persons, recently widowed having more hospitalizations, and have greater use of mental health service (Prigerson, Maciejewski and Rosenheck, 1999) the same being valid for single persons, when compared with married or coupled individuals. These results are also confirmed by our study, patients who were in a couple (official or unofficial) being in a higher percent at their first admission in the hospital in comparison with single or divorced/widowed patients. Nevertheless, the difference is relatively small and, since we did not control for other factors, it cannot be generalized.
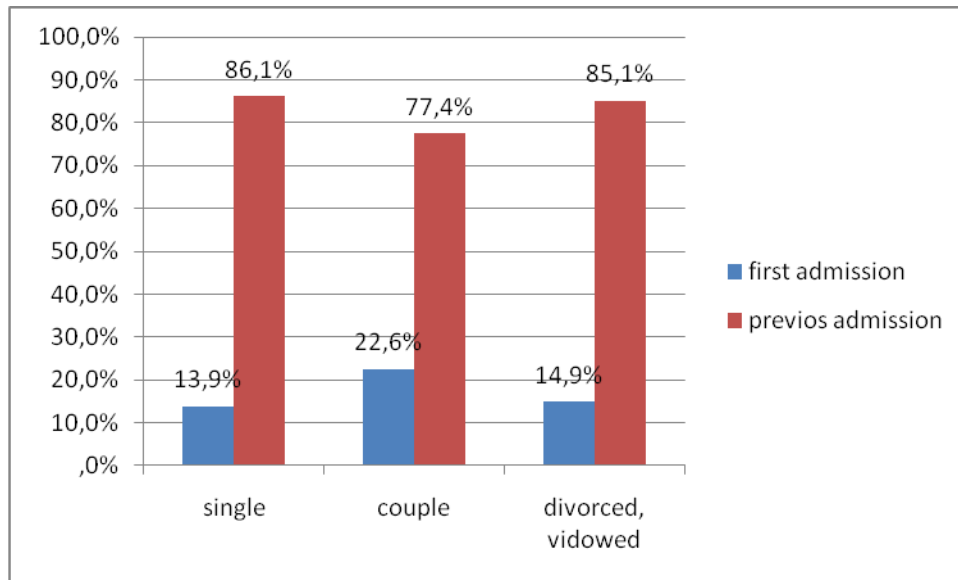
Figure 4. The distribution of patients by marital status and readmission

Limits

Since the study did not use a causal model for the analysis, we could not isolate the direct influence of each SES indicator on readmission, which could have offered more detailed information concerning the individual and cumulated impact of each factor. Nevertheless, we have only intended to conduct an exploratory study in order to identify whether socio-economic factors are in any way related to readmission in psychiatric hospitals. A more detailed research should be conducted in order to determine the relative influence of socio-economic factors, also taking into consideration other categories of predictors at service level (services offered) and individual level (diagnosis, severity of symptoms etc.).

Discussions

This study confirms previous work done in this area suggesting that an identifiable population of patients is repeatedly re-hospitalized. We have found occupational status as the main SES indicator which influences the readmission rates of hospitalized patients, with marital status having a only a reduced influence and educational factors no influence at all. The contribution of social factors to the readmission of psychiatric patients represents, therefore, strong evidence that the mental health system should provide appropriate targeted resources and assertive, continuous care management to avoid social crises. In the context of a health system reform in Romania (mental health care being included) this means that appropriate community mental health

services should be developed, these being proved to play a considerable role in the provision of a day structure outside hospitals to psychiatric patients.

In conclusion, in light of our findings, the model of care offered by community mental health services should be further explored to identify the specific components responsible for the reduction of psychiatric readmissions.

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