Good example of article review on how poverty impacts mental health: a look at fo...

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While it remains debatable that money cannot buy happiness, money certainly can buy quality mental health medications and services. It also may buy a sense of feeling good about one’s self – or at least feeling better in comparison to poorer people. Living in poverty and living with a mental health issue are often comorbidities. Common mental disorders (CMD) such as major depression and anxiety are treatable only if a person suffering from these disorders is able to get access to mental health care. Sadly, this is not often the case for those living at the poverty level or homelessness, no matter what country they live in, whether it is a First World or Third World country. Unlike physical problems with signs like bleeding or broken limbs which can be easily seen, mental health signs are invisible. Poor and homeless people may be reluctant to seek out or stick with mental health services offered, if there any available, because they cannot see any obvious signs of distress.

This paper will look at four articles in all dealing with studies about how poverty impacts mental health, particularly with persons suffering from CMDs. It shows that lack of money does not seem to be the problem so much as the individual’s own perception of how low they fall in the social order. Thinking that they are “ low class” equates to feelings of personal worthlessness. This perception seems to impact people of all races, ages and gender and particularly impacts the poorest of the poor – the homeless. Getting basic needs like food and housing fulfilled seems to help how a person perceives his or her own self-worth. This can then help with the person’s overall mental health since a person who believes he or she is worth getting help may go to the trouble of actually getting help.

The 2011 paper “ Barriers to mental health treatment: results from the National Comorbidity Survey Replication" was published in the journal Psychological Medicine. It aimed to find out why people with CMD often cannot get the help that they need. The paper points out that even people who start treatment often suddenly stop before their doctors or mental health professionals want them to stop. Reasons for a patient stopping mental health treatment were called “ barriers” as these reasons prevented a patient from getting treatment. Barriers listed included:

- A false belief that the individual did not need treatment, which the paper called “ low perceived need” (Ramin, et al. 2011)
- Lack of money or lack of transportation to a mental health facility, which the paper called “ structural barriers” (Ramin, et al. 2011)
- Feeling persecuted or inferior for having a mental illness or believing that treatment will not work, called in the paper “ attitudinal/evaluative barriers” (Ramin, et al. 2011).

The study was in two parts. Part one took face-to-face interviews of 9, 282 American adults (over the age of 18) from 2001 to 2003. All adults were given a diagnosis using DSM-IV criteria to check for mental health problems. The adults also filled out a survey. Part two only looked at adults that were positively diagnosed with one or more mental health problems for at least twelve months, which left about 5, 962 adults. 55. 2% of these adults either did not seek treatment or stopped their treatments. These patients were then asked why. The most common answer was low perceived need, especially among patients with low to moderate disorders. When all of the data was crunched, only some predictive factors for a person hitting a barrier

to treatment was shown. Males were more likely to not get treatment, for example. However, Poverty was a contributing factor. People over 65 were more likely to start or continue treatment if their treatment was covered by Medicare. People burdened with a job and family commitments were also less likely to get the help they need. The paper suggested more public education programs to make it more socially acceptable for anyone who needs mental health care to try and get it – even if they think that they cannot afford treatment.

Another study that backs up the hypothesis that poverty and CMDs are comorbidities is “ Socioeconomic status and adolescent mental disorders” published in the American Journal of Public Health in September of 2012. This paper suggests that the reason why poverty and mental health often go together is that a poor person is considered a lower member of society than a richer one. The paper called this public perception “ low social economic standards” or “ low SES.” The paper found that adolescents with a low SES often suffered from mental health problems. Other factors such as race were considered as comorbidities with mental health problems. Latino-Americans and Caucasians were found to be more prone than Black Americans. Just why was not known although discussed in a few paragraphs under the heading “ Discussion.”

The paper extrapolated their findings using the National Comorbidity Survey Adolescent Supplement. Teenagers aged 13 – 17 were interviewed during the years of 2001 to 2004. Each adolescent received $50 for their participation. Each adolescent also had to submit a form signed by their parent or guardian allowing them to participate. Of the thousands of

adolescents interviewed, the paper looked only at the 6, 483 adolescents that submitted to the Composite International Diagnostic Interview and filled out a questionnaire. The authors of the paper did note that they had problems getting cooperation from schools to help interview their students. Parents and guardians were also asked to fill out a questionnaire about their education, their income and their children's mental health (McLaughlin, 2012.)

The study also looked at how the adolescents felt about themselves. They were asked to make an X to mark where they thought they fit on a scale as compared to other young people in their school or community. This gave the researchers the subjective socioeconomic status of each participant (McLaughlin, 2012.) The researchers found a direct correlation with an adolescent's low SES and a high chance of being diagnosed or already been diagnosed with a mood disorder, anxiety disorder, substance disorder or disruptive behavioral disorders. Oddly enough, the actual amount of money made by the adolescent's parent or parents made no impact on predicting whether the child had a mental health problem. It was the child's own perception of how poor or low-class he or she was that was the predicting factor. Like all good studies, it states that more studies need to be done before drawing a strong conclusion between the relation of how a poverty-stricken person views himself or herself and whether he or she will have mental health problems.

A meta-analysis of 131 medical articles published between the years 2000 and 2008 was undertaken for the 2011 Lancet article to try and pinpoint the reasons why poverty impacts the mental health of low to middle income

countries. The studies were done in 33 countries. Data was entered into a spreadsheet that particularly focused on five “ dimensions” – study characteristics, how poverty was measured, how mental illness was determined, proportion analysis and how well two reviewers rated the article’s quality (Lund, 519).

Of those studies, six focused on low SES and mental illness, particularly CMDs. Five of these studies showed a direct relationship between low SES and CMDs. 53 studies looked at educations levels, where less education are other words for poverty-stricken individuals. These studies showed that less education also was linked to people suffering from CMDs (Lund, 521.)

The paper suggested that in order to reduce mental health in low to middle income countries, housing or business development projects need to be aware of how their buildings and operations impact the mental health of the community. The paper also notes that programs to help fulfil the basic needs of a country’s citizens (such as food, shelter and education) help to contribute to the overall mental health of the population. Welfare or government programs often get criticized for being expensive. However, the paper points out that programs that helps bring basic needs to people also helps to improve mental health. This helps reduce the cost of paying for public mental health treatment or lost time at work due to mental health issues.

Despite these self-depreciating points, the study does show that there is a link between how a person views himself or herself and if he or she has mental health disorders. Although how much a person makes does not necessarily correspond to their worth in society, try telling that to a poor or

impoverished person. Being poor can bring on feelings of shame or unworthiness. Imagine how being the poorest of the poor, homeless, can ignite feelings of shame or worthlessness. It would have been interesting if this study had factored in homelessness and not just income levels as a possible cause for the comorbidity between poverty and mental illness. Being homeless is the lowest class a person can be in many societies. Even impoverished people tend to have roofs over their heads. Homeless people not only have to deal with rejection from people in higher income levels but also with poor people. After being told by so many people that they are losers, homeless people may come to believe that they do not deserve care for their mental health problems.

Many homeless people self-medicate with illegal drugs and alcohol in order to manage their physical and mental health symptoms. For example, many homeless people smoke because smoking kills hunger pains and makes them feel good. This self-medication often leads to addiction, which greatly increases the homeless person’s life. Drugs and alcohol are not allowed in many shelters, so anyone caught using is promptly kicked back on the streets. Housing program rules may insist on only housing clean and sober homeless people. This makes meeting basic needs harder, which can lead not only to more self-medication but an increase in low self-worth.

As the previous study showed, meeting basic needs of its citizens can help strengthen the mental health of a country. Another study which points this out is " Substance use outcomes among homeless clients with serious mentalillness: Comparing Housing First with treatment first programs" published in the April 2011 issue of Community Mental Health Journal. A

Housing First (HF) program gets a homeless person housed before they are sober while Treatment First (TF) programs aim to get the client sober before they are allowed to get housing.

This is, granted, a small study done by focusing on a mere 83 subjects based only in the poorer sections of New York City. Of those 83, only 75 completed the study while the other dropped out of moved out of state. Only 27 were in a HF program, compared to 48 in TF programs. All of the participants were substance abusers and were also diagnosed with an Axis-I disorder such as schizo-affective disorder, bipolar disorder or major depression. Diagnosis of these mental health problems were based on the DSM-IV. 74 of the 75 homeless volunteers for this study gave “ informed consent” and were given a small payment for participating (Padgett, 2011.) Volunteers were first given a face-to-face interview and then phoned in for check-up interviews. Data was then taken from these interviews. Some questions could only have “ yes/no” answers, which helped to gather the data easier for the researchers. Data was gathered not only from clients, but from their case managers and the interviewer’s observation of how the client was during interviews.

Factors taken into consideration included race, baseline substance use (how heavily the individual was using when he or she entered a treatment program) and gender. Most of the volunteers, however were African-American males. The study tried to account for the large percentage of African-American males participating, but still notes that it is a limitation to the survey results (Padgett, 2011).

The study focused on data pertaining to the volunteer’s struggles with

substance abuse. Treatment was defined as participating in a rehabilitation or detoxification program. The study lasted one year in order to see how well the volunteers were keeping clean. The study showed that the HF participants had low to no incidents of using the substance they were addicted to in comparison with the TF participants. Only 8 of the 27 HF volunteers were classified as “ relapsed” or started using again. In comparison, 26 or 48 TF participants abandoned treatment during the course of the year. 14 of the 48 went back to using their preferred substance just as much as they had before they started treatment. This means that homeless people in a TF program were 3. 4 times more likely to go back to using than homeless people in a HF program (Padgett, 2011).

The study fully acknowledged that it had limitations, mainly due to the disproportionate amount of African-American males participating. They did note that gender was not a predictive factor in determining if a homeless addict with mental health issues would relapse. This conflicts with other studies of homeless people throughout America that indicate that homeless women were less likely to relapse than homeless men. They also noted that the volunteers could have been lying – especially when they were given phone interviews instead of having face-to-face interviews. HF participants even have a greater reason to lie, the study notes, because a relapse may mean losing their housing. However, the study authors argued that HF participants are more relaxed with their health care and social workers, which may make them more likely to tell the truth. This could help them not only recover from substance abuse, but get proper care for their mental and physical problems (Padgett, 2011). Formerly homeless people can fit in with

their communities when they have housing and have access to mental health treatment.

Another problem with this study is that the type of substance or substances a homeless person abused were not taken into account. The study authors noted that national studies of homeless people reported that they were mostly addicted to crack cocaine or heroin. It could be that some drugs are harder for homeless addicts to turn away from than others. This is a factor that should be considered and looked into for future studies of homeless with both mental illness and substance abuse problems.

Future studies should look at how the homeless person’s low social economic status impacts their predilection for substance abuse and/or mental illness. The implied and yet unwritten statement from the Housing First vs Treatment First study is that people feel better about themselves when they are housed. The home gives them a strong motivation to stay clean and stay in mental health treatment programs. It would have been better for this study to have actually written out the implications in order to help reinforce the notion that HF programs help homeless addicts stay sober better than TF programs.

In conclusion, the causes for just exactly how poverty impacts an individual’s mental health is a complicated issue, shown in these four studies. There could be a whole cluster of factors that need to work together rather than just one or two solid reasons. It would be interesting to see why there are any poverty-stricken persons without a diagnosable mental illness. In this way, perhaps the causes of a person’s not getting mentally ill could help point the way to show just how poverty-stricken people become mentally ill.

However, one thing seems to be clear – people need to feel secure somehow about an important aspect in their lives in order to feel good about themselves. Having a home to go to or knowing that there is enough to eat can help reduce the terrible stress of daily living which not only help increase the risk of getting a mental illness, but in seeking help for an already existing mental illness.

Mental illness, especially common mental illnesses, are treatable but invisible. It is ultimately up to the individual suffering from a mental illness to get outside help. More education about mental illness could also help reduce the stigma and shame of not only having a mental illness but having a mental illness while also being poor or homeless. Getting help for mental illness from any medical health professional is better in the long term than trying to ignore the problem or by self-medicating the symptoms. Education and programs to help people meet their most pressing needs may help to better reduce the chances of impoverished or homeless people suffering from one or more mental health problems.

Works Cited

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