Editorial: Poverty and Psychiatric Disorders: A Case for Action

> וכי ימוך אחיך ומטה ידו עמך והחזקת בו (ויקרא כה:לה)
>
> "And if your brother becomes poor and his means fail with you, then you shall relieve him" (Leviticus 25:35)

The National Insurance Institute (NII) has published worrisome statistics on the proportion of families and individuals in Israel in 2004 living below the poverty line, 20.3% and 23.6%, respectively. The NII also reported that poverty is deepening, and that the gap between the have and the have-not is increasing. The mean household income in the top decile rose to 12.3 times that of the lowest decile (1). The Taub Center Public Opinion Survey, conducted in 2005 on a representative sample of 1,000 individuals, and which includes items on changes in income, fears of unemployment, ability to cover household needs and related issues, showed that the social confidence among those with lower than average income reached 43.7 points, while those with higher than average income reached 69.4 (2).

Should mental health professionals react to these figures beyond their concern as involved citizens? In our opinion they should; there are a number of importantreasons for this. These reasons are based on both the determinants of psychiatric morbidity, attitudes to care and service utilization, as they have been shown by local studies.

Levinson et al., in a major community-based epidemiological study, run as part of the World Mental Health Survey launched by WHO in 27 countries, conducted and funded by the Ministry of Health with the support of the Israel National Institute for Health Policy and Health Services Research and the NII, found that men respondents with the lowest income had the highest 12 month-prevalence rate of mood and anxiety disorders (3). Earlier, Iancu et al., who had surveyed a representative sample of the Jewish adult population in Israel, showed that those with below average income had significantly higher mean scores of depressive symptoms than respondents with average or above average income (4). A study jointly conducted by the Myers-JDC-Brookdale Institute and the Ministry of Health, with funding from the Institute for Health Policy and Health Services Research, that explored stigma in the Israeli public, found that respondents with lower income compared to respondents from higher income brackets indicated less openness towards mental health services, knew fewer people under mental health care and their proportion among the treated was lower (5). In addition, poverty affects other aspects of service utilization. Levinson et al. found a clear correlation between the SES level of Israeli localities and the psychiatric hospitalization rates, the length of the inpatient episode and time spent in the community. Residents of poorer localities had higher hospitalization rates, longer hospital stays and shorter community stays (6).

How is the mental health system responding to these facts? Lerner et al. have shown that psychiatric services are less available in the Northern and the Southern regions of the country, precisely those with higher proportions of poor residents. The figures speak louder than words: while the rates of community-based mental health personnel per 1,000 population reached 0.14 and 0.23 in the center of the country and in the area of Tel Aviv, respectively, the rates in the Southern and the Northern regions were considerable lower, 0.11 and 0.07, respectively (7). Paradoxically then, the distribution of psychiatric services in the country, in lieu of contributing to equity, as prescribed by current literature on health (8), seems to be reinforcing the socio-economic forces responsible for inequality.

Are there mental health policies and programs in place that contribute to inter-sectoral poverty-reduction efforts, in addition to their curative and rehabilitative aims? One such example does exist thanks to the activities mandated by the recent legislation "Rehabilitation of Persons with Psychiatric Disabilities in the Community" (9). The inclusion of programs promoting work and education (10) for persons with mental disorders, as included in the basket of services of the law, enables the acquisition of instrumental and cognitive skills that may prevent

further social drift or, hopefully, lift them out from severe poverty. Full evaluation data are not yet in, but, to us, the orientation of the programs is correct. What remains is to promote full coverage of poverty reduction efforts by the community-based mental health services, in partnership with other sectors, for all those needing them. It has been argued that mental health care that is not accompanied by such efforts falls short of contributing to an improvement in quality of life, and leaves the socio-economic determinants of psychiatric morbidity totally untouched (11, 12). Among us, Levinson et al. have recommended that poor localities be allocated the extra health and welfare resources to be able to keep their psychiatric patients in the community. Given the ultimate difference in costs between psychiatric hospitalization and community-based care, it is likely that the inadequate supply of public community services in poorer localities results in an over-demand of the more costly psychiatric hospitalization services. Therefore, planning with equity in the distribution of community public mental health resources seems to be not only ethically correct but also more cost-effective.

Action by psychiatrists in other professional domains remains equally wanting. As an illustration, the production and circulation of research findings on the subject of poverty and psychiatric disorders falls short of responding to the concerns presented here. A review of the 2000-2004 issues of this Journal showed that almost no article directly addressed this subject, nor it is prominent in the continuous educational program of the Jerusalem branch of the Israel Psychiatric Association. In recent years, not a single session was devoted to the role of poverty, despite the fact that Jerusalem is the second poorest Jewish city in the country.

The time has come to amend the partial failure of the mental health professionals to actively and forcefully engage themselves in advocacy efforts seeking to reverse national policies that have widened income differentials, and of the mental health system to plan and deliver joint programs purported to reduce poverty. The case for action has been established.

Acknowledgement

Dr. N. Shtruch critically reviewed a previous draft of this editorial.

References

1. www.BTL.gov.il. Last accessed October 30/2005.
2. Taub Center: Social economic update. October 2000, Jerusalem.
3. Levinson D. The prevalence of common mental disorders in Israel. Report to the Ministry of Health. In preparation.
4. Iancu I, Horesh N, Lepkifker E, Drory Y. An epidemiological study of depressive symptomatology among Israeli adults. Isr J Psychiatry Relat Sci 2003;40:82-89.
5. Shtruch N. Personal communication, 2005.
6. Levinson D, Lerner Y, Lachman M. The SES setting of psychiatric hospitalization in Israel. Soc Psychiatry Psychiatr Epidemiol (In press).
7. Lerner Y, Elisha D, Elitzur A. The distribution of ambulatory psychiatric services by district in Israel. The Committee for the Structure and the Distribution of the Ambulatory Health Services, Internal Document, July 2005, Jerusalem.
8. Wilkinson RG. Unhealthy societies. The afflictions of inequality. London: Routledge, 1996.
9. Lachman N, Hadass-Lidor N. Rehabilitation of persons with psychiatric disabilities in the community: From de-hospitalization to recovery and inclusion. *Hadea Harevaha*. ICSW. November 2003;35:14-17 (Hebrew).
10. 10. Ponizovsky A, Grinshpoon A, Sasson R, Levav I. Stress in adult students with schizophrenia in a supported education program. Compr Psychiatry 2004;45: 401-407.
11. Saraceno B, Barboui C. Poverty and mental illness. Can J Psychiatry 1997;42:285-90.
12. Saraceno B, Levav I, Kohn R. The public mental health significance of the research on socio-economic factors on schizophrenia and depression. World Psychiatry 2005;4:181-185.

Itzhak Levav, Daphna Levinson and Yaacov Lerner
Ministry of Health, Jerusalem