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Poverty and mental health a stigma to a country

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Abstract
Recent research has focused on the relationship between different forms of poverty and mental health, but real change in the area of mental health care has been sluggish to materialise. This publication presents a variety of perspectives on the link between poverty and mental health, as well as future research. There is a substantial association between socioeconomic level and the incidence of mental health problems (MHD), which makes MHD an increasing global public health issue. Eighty per cent of the world's mental disease burden is concentrated in low- and middle-income nations (LMICs). The stigma associated with mental health results in a lack of assistance, limited access to health facilities, inefficient treatment, subpar outcomes, and an increased risk of human rights violations. In addition, the frequent co-occurrence of physical illnesses, such as non-communicable diseases and mental health disorders, complicates treatment and worsens the prognosis for these conditions. According to the yearly Global Burden of Disease study, over 15% of the world's population, or approximately 750 million people, experienced mental health issues that year. Depression is the leading cause of poor health or disability, and according to the World Health Organization, mental health concerns cost the worldwide economy one trillion dollars every year. Poor people are disproportionately affected by mental health issues. According to the United Nations (UN), people living in poverty have limited access to several necessities. Obtaining social support is also a significant factor.

Keywords: poverty, stigma, mental health, diseases, society, illness

Introduction

Approximately 750 million individuals worldwide suffer from mental health problems, with 80% of them residing in low- and middle-income countries. In 2010, there were 2,319,000 fatalities attributable to mental and behavioural disorders. According to one research, mental health issues accounted for 13% of the total disease burden and 31% of all years of disability. Mental or substance-related impairments account for 7.4% and 7.0% of disorder living years, respectively (Alloh *et al*., 2018) [1]. The prevalent biological therapy strategy for serious mental illness (SMI) is neither unique nor comprehensive since it fails to address the relationship between mental health, stigma, and poverty.

On the interrelated causes and consequences of stigma (unequal treatment or discrimination due to having a mental health condition), mental illness, and poverty, there has been little study undertaken, especially in low-income countries (Shrivastava & Shrivastava, 2019) [4]. Low income is a significant risk factor, including common mental disorders, for individuals living in high-income countries. During the present financial crisis, those with mental illness in medium or low-income countries were more likely to be destitute, unemployed, and poorly educated than the general population. Unquestionably, a fuller understanding of the connection between mental health and economic hardship might lead to insights that influence public health programmes that enhance biomedical treatment or improve recovery rates.

There are five interrelated facets of the stigmatisation process. First, the branded minority experiences injustice in the form of division caused by unfavourable attitudes or biases resulting from society's branding of cultural stereotypes of the excluded group (Kleinman & Hall-Clifford, 2009) [5].

This study investigates how bias reveals itself via personal experience. Due to the confluence of self-stigma and social isolation, which may result in low self-esteem, persons with SMIs (PSMIs) may be exposed to unfair treatment or discrimination. When persons with mental illness are subjected to discrimination, as well as when they are driven into poverty, a 'gate to rehabilitation' may be created, and the situation may improve substantially (Rosa & Lima, 2019) [6].

Even though the processes of poverty, prejudice, and mental health have not yet been completely investigated, the factors defining poverty, such as mental illness-related prejudice, may deprive individuals of several assets. Biological therapy may decrease the stigmatising impacts of mental illness, according to healthcare studies. Rather, we argue that stigma-related rejection increases the likelihood that PSMI patients would continue to suffer in several aspects of life even after receiving therapy.

Although several studies have studied the effect of poverty on mental health, few have examined the role stigma associated with mental illness may have in aggravating already terrible economic conditions. Using a multidimensional poverty index (MPI) to study poverty in a range of places, we evaluated the gap in poverty prevalence or severity between the PSMI and a reference sample. We examined non-economic elements of poverty, such as lack of access to appropriate healthcare, poor housing, inadequate nutrition, and restricted political participation, so broadening the discourse about poverty beyond the bounds of standard welfare statistics.

Literature review

A. Stigma

When people treat you differently because of anything that is seen as bad or negative, this is stigma. Regrettably, many persons have erroneous beliefs or attitudes towards those with mental illness.

One of the repercussions of stigma is racism. An example of injustice is making open and apparent comments about a person's mental health or treatment. Negative treatment may be overt and visible, such as when someone purposefully avoids you out of fear of your perceived unpredictable, violent, or dangerous mental health-related behaviour (Ungar & Knaak, 2021) [2].

B. Poverty and mental illness

Most respondents identified poverty as one of the key causes of mental illness. Poverty is a key contributor to emotional pain, which may have severe effects on one's mental health, as is well known. Respondents said that many of the poor or unemployed, especially the illiterate, resort to alcohol and other illicit drugs to cope with their emotions or social problems, but that these actions just made them more susceptible to mental health problems (Purtell & Gershoff, 2016) [3].

Several respondents described the relationship as a "vicious cycle," stating that although poverty is a factor in the development of mental health illnesses, it is also a result of such conditions. Consumers of mental health care services said that guardians spend a considerable amount of time attending to the needs of loved ones who are hospitalised or undergoing mental health treatments. As a result, their performance declines, and the economy suffers tremendously (2022).

In addition, it was said that people with mental illness may show harmful behaviours, which may damage relationships with friends and family and demand expensive legal action to resolve disputes with neighbours. This is a further burden on their already limited resources. Nonetheless, several respondents did not reject the link between the two, and they also believed that the wealthy are equally as prone as the poor to have mental health concerns.

Stigma in mental health & services availability

This is true regardless of socioeconomic status: the stigma associated with mental health continues. It was revealed that attitudes and ideas about the causes of the mental condition are strongly connected to the stigma that surrounds its sufferers. Several individuals said that the general public generally believes that people with mental illness have been taken by demons or are suffering as punishment for their wrongdoings. Several seemingly competent people used negative language while discussing the mental hospital or the patients, demonstrating the pervasiveness of the stigma towards mental illness (Ottewell, 2016) [8].

The majority of respondents who participated in the survey indicated that stigma associated with mental health was a significant factor in the uneven distribution of services. People stated that mental health gets an inadequate proportion of healthcare expenditures relative to the disease burden. This arose due to the significant stigma and ignorance around mental health. When seeking to distribute finances and supplies for mental health treatment in several public hospitals, CEOs have reported experiencing strong opposition from non-medical institution leaders. (Clarke *et al.*, 2012) [9].

Discrimination across cultures

Views of health and illness, assistance-seeking behaviour, attitudes of both individuals and experts, and attitudes toward mental health facilities are significantly impacted by cultural factors (Cheon & Chiao, 2012) [10]. Five pillars comprise the paradigm for examining cultural diversity and its implications on mental health (Table 1). Cultural factors such as the stigma associated with an MHD diagnosis, the desire to protect one's family's honour, and a feeling of personal pride influence treatment seeking. Those diagnosed with MHD in LMICs such as India are more likely to have physical symptoms than mental symptoms. In LMICs, the lack of family care due to stigmatisation may end in the total abandonment of a person with MHD, while government aid for MHD is insufficient. Several low- and middle-income nations depend on traditional doctors and religious community cohesiveness to address mental health issues (George Anarwat, 2022) [11].

Table 1

S. No	Element	Descriptions
1	Shame	The importance of family in people's lives, as well as the assumption that MHD diagnoses might influence families
2	Collectivistic	A hazard factor for mental illness
3	Religious and spirituality	MHDs play a double function in terms of illness causation or recovery mechanisms.
4	Energy separation	There are significant energy disparities among therapists & clients. Defines the therapeutic group's scope.
5	Manifestation of emotions	The belief that an absence of emotional balancing causes MHDs, which could be exacerbated by discussing the concerns

Implications

It may be intimidating to ponder how to address such a large issue. This is especially true today, in the face of increasing poverty, socioeconomic inequality, and unpredictable political conditions. In this section, we consider how psychiatry may react on several fronts, including practice, legislation, activism, and research, to address the complexity or endurance of these concerns. We recommend that this response should address three important concerns.

a. Address inclusionary drawback & stigma

Realizing that stigma against mental health is part of a bigger societal problem has made it very evident that we must take a much more nuanced understanding, inquiry, and advocacy approach to this issue. Understanding the notion of intersecting stigma is crucial. Several traits, such as ethnicity, gender, sexual orientation, socioeconomic status, and health, may combine under the umbrella term "intersectional stigma," which explains how these elements interact. The ensuing impact on a person's life may be magnified. In this context, poverty dramatically raises the likelihood of getting a mental health condition (Dittrich & Schomerus, 2022) [12]. And when you do, you may anticipate further discrimination and exclusion. The repercussions on your life, such as uncertain employment, poor living circumstances, insufficient education, and diminishing resources, will intensify. It is more difficult to get back on your feet, and the impact on your family may be far more severe. While research on intersectionality stigma is in its infancy, the health effects of poverty stigma are becoming more relevant.

b. Incorporate poverty-aware practices & sourcing

Lastly, we provide our second suggestion, which strives to integrate poverty-aware practises into programmes via procurement, teaching, and training (2020). Consequently, poverty is considered and addressed in assessments and treatment programmes. Aspects of healthcare that must be made available include information on how to make the most of government assistance programmes, cope with debt, locate dependable childcare in the area, and get aid in the early stages of a job search. For the inverted care law to be addressed, major money for mental health services in low-income neighbourhoods must be included. People throughout the globe are putting these concepts into practice.

c. Resurrect social psychiatry & affect public policies

At a period when social disparities have already been growing, the decline of social psychiatry worldwide in past years has diverted attention aside from the socioeconomic origins and repercussions of mental health disorders. We are at a tipping point when a renaissance in social psychiatry in both the clinical as well as scholarly sectors is necessary. Partnerships with some other sectors, notably public mental health organisations or non-profits, have a lot of room to grow. The field of psychiatry must rally behind those fighting for more equitable social measures to alleviate poverty. Health inequities will endure and be repeated over time because we'll only address their intermediary origins instead of their basic origins. Legislators might well be persuaded to act through campaigning with groups like The Unity Trust that have brought attention to the connection among both poverty as well as mental health issues (Das, 2017) [14].

Future directions

Cognitive deficits Physical and mental health issues have a significant influence on global public health, while in LMICs this problem is worsened by a lack of facilities. To increase the number of presentations for widespread MHDs, it is essential to eliminate the stigma associated with mental health. Due to the complex multi-causal route connecting MHDs with chronic illnesses, integrative and comprehensive individual or systems-based approaches are necessary.

Incorporating civil society, indigenous remedies, and other organisations may successfully address concerns of information or stigma, ensuring better treatment and, ultimately, improved outcomes for individuals with comorbidity diseases, while professional healthcare practitioners continue to play a central role in this strategy.

These variables shift the focus from labelling people who are culturally or economically excluded to analysing the complex social processes that drive sensitive individuals to poverty and poor physical or mental health. The World Health Organization (WHO) created numerous theoretical models, including a three-tiered policymaking method based on the concept of "psychosocial factors," to address global health inequalities.

People are less likely to seek assistance for mental health concerns in the workplace if they are stigmatised, out of worry that doing so may harm their career chances. It has been shown that anti-stigma initiatives in the workplace increase employees' awareness of and empathy for persons with mental illness. Customized anti-stigma programmes at the workplace may be more successful than public campaigns because they may be conducted over a longer period, be more intensive, and even be mandated.

Conclusion

The findings of our study demonstrate how crucial it is for mental health professionals to consider the complexity of poverty and its consequences on people, families, and communities. In low-resource communities, it might be beneficial for physicians to interact with public healthcare or mobility networks in an attempt to minimise people's unfavourable views of SMI. Our findings link mental health to global development, which has implications beyond the realms of medicine and public health. Multiple consequences of poverty may be minimised by promoting employment and reducing social stigma for persons with PSMI. Numerous social and economic factors may influence people's mental health; these factors must be addressed by "health-in-all policies" that encompass comprehensive measures for promoting, protecting, treating, and rehabilitating. Stigma, represented in discriminatory social institutions, policy & legislation, or individual & interpersonal connections, reduces the affordability, affordability, and quality of care for mental health disorders. SMI is linked to pervasive societal stigma and complicated types of poverty. It is a dependable sign of economic difficulty, particularly for people of low caste and women.

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