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How Poverty Can Impact AOT Participants

Funding for SMI Adviser was made possible by Grant No. SM080818 from SAMHSA of the U.S. Department of Health and Human Services (HHS). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, SAMHSA/HHS or the U.S. Government.

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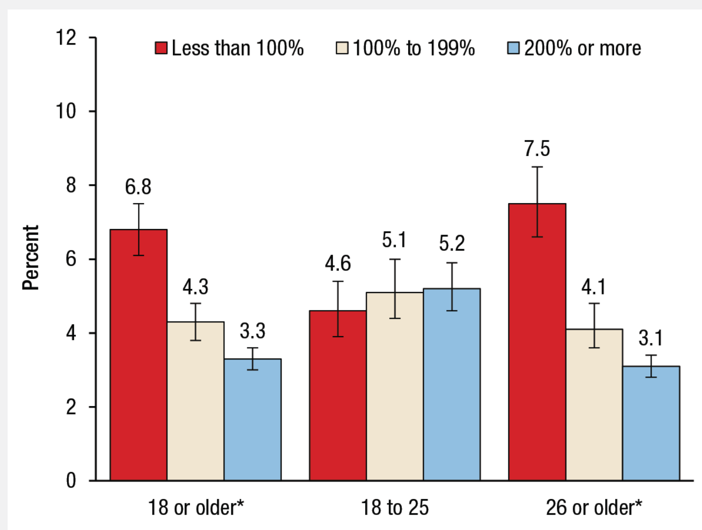
An APA and SAMHSA Initiative
AMERICAN PSYCHIATRIC ASSOCIATION
SAMHSA
Substance Abuse and Mental Health Services Administration

There are over 2.5 million adults with serious mental illness (SMI) who are living below the poverty line.[1] The relationship between mental illness and poverty is complex and bi-directional. People living in poverty tend to live in more disadvantaged neighborhoods, which are characterized as having low levels of safety, high exposure to environmental dangers, severe food insecurity, and an overall lack of social organization. Living in such an environment is associated with a lack of access to mental health resources, poor social networks, and minimal community engagement— all of which can worsen mental health and exacerbate SMI.[2] These poverty ridden environments can lead to mental health and developmental challenges that in turn interfere with individuals and families from escaping poverty.[3]

Adults aged 26 or older living below the poverty line were more likely to experience SMI (7.5%) than those living at (4.1%) and above (3.1%) the poverty line.



Note: Error bars visually represent the variability or uncertainty in the percentages.

People who have SMI are also especially vulnerable to poverty in part because they experience significantly lower rates of employment compared to the general population. Only one-third of all people who have SMI are employed full-time, and more specifically, only 10 to 15 percent of people who have schizophrenia participate in the workforce, including both part-time and full-time employment.[4,5] The low employment rate among this demographic is likely caused by several factors. For example, the onset of symptomatology may have led to missed or delayed higher education, having a negative impact on employment opportunities. For some people who have SMI, internalized stigma can discourage them from entering the workforce altogether due to a lack of confidence in their ability to thrive at a job. If employed, both disclosure and non-disclosure of one's mental illness can lead to job loss, especially if the employer possesses stigmatizing beliefs about

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people who have SMI.[6] These factors all contribute to low rates of employment and higher rates of underemployment for people who have SMI, worsening their economic outcomes and maintaining their impoverished status.

It is also difficult for people who have SMI to escape poverty because of the inadequate social safety net that is provided to people with mental illness and other disabilities.

For example, Supplemental Security Income (SSI)— a government-run program that is meant to assist low-income seniors and people with disabilities who receive very little or no Social Security— has extreme limitations that reduce its effectiveness. For example, SSI beneficiaries are removed from the program if they have more than $2,000 worth of gross assets, including the value of their home.[7] While SSI has work incentives built into the program, other income-based benefits such as housing subsidies and supplemental nutrition assistance programs (food stamps) are not, which makes it difficult for beneficiaries to sustain economic stability and may result in a disincentive to work as to avoid a reduction in benefits. This negatively affects the individual with SMI and their family members who are dependent on those benefits for survival. Additionally, this disincentive generally causes employment rates to be low among SSI beneficiaries, including people who have SMI.

Low employment rates among people who have SMI are partially responsible for the high rate of homelessness among this population. By the late 1990s, people who have SMI were reported to be 10 to 20 times more likely than the general population to be homeless.[8]

Currently, people who have untreated SMI comprise about one-third of the total homeless population in the U.S.[9]

People who experience homelessness also have a mortality rate that is 4 to 9 times higher than the general population and an increased likelihood of being arrested and caught up in a cycle of homelessness, hospitalization and incarceration.[10] This poor quality of life that is associated with experiencing poverty and homelessness only worsens the state of one's mental illness and makes it more difficult for people with SMI who are experiencing homelessness to access the mental health services they need to survive.

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Impact of Poverty on Treatment Engagement

Experiencing poverty, unemployment, homelessness, and/or living in a disadvantaged neighborhood can have negative consequences for the treatment engagement of people who have SMI. For example, people who have SMI and who live in geographically concentrated poverty and experience disproportionately higher exposure to stressors tend to have less access to mental health services compared to their wealthier counterparts.[11] Yet, it is this underprivileged demographic that has a greater need for mental health services. This is in part because geographic inaccessibility and financial barriers lessen access to mental health services, resulting in lower treatment engagement. Additionally, people who have low incomes may be less likely to have personal cars or may be heavily dependent on unreliable public transportation, and therefore face even greater difficulty accessing treatment. For instance, they may struggle to attend appointments if they lack readily available transportation.

Assisted Outpatient Treatment (AOT) as an Example of Treatment Engagement with Culturally and Linguistically Appropriate Mental Health Services

To address the barriers to treatment created by the conditions of poverty, an emphasis needs to be put on recovery oriented AOT that prioritizes personal goals, empowerment and respect for participants experiencing poverty. This involves a culturally and linguistically appropriate implementation of AOT that:

- Employs program coordinators, case managers, directors and monitors with trauma-informed experiences
- Uses participants' current life circumstances to guide their treatment plans
- Refrains from using technical treatment jargon, which may be new to many participants and can make them feel disconnected from their service or cause them to be inadequately briefed about treatment expectations

Terrence, age 28, was diagnosed with schizophrenia when he was 20 years old. After finishing high school, he had several jobs but was usually let go after a few months for missing work. He lived with his mother because he could not afford to live on his own. Terrence did not believe that he was ill, so his adherence to treatment was sporadic at best. This often resulted in short term stays in the hospital to stabilize him. Due to a lack of treatment engagement, Terrence lacked disability benefits and medical insurance.

Six months ago, he decided to stop taking his medication altogether and his behavior became increasingly unpredictable and volatile. One night, Terrence

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threatened to decapitate his mother, convinced she was a clone. His mother called the police and told them her son was experiencing a mental health crisis and asked them to please send trained officers. The police successfully deescalated the situation and transported Terrence to a nearby hospital.

Terrence was stabilized, discharged with a court order to participate in an AOT program, and taken to a homeless shelter. His case manager, Suzy, met with him at the shelter to develop his AOT treatment plan. While discussing goals, Terrence made it very clear that getting out of the shelter was his first priority, which became the overarching goal of his treatment plan. Typically, the program required participants to meet with their case manager twice a week; attend group; pick up their medications weekly at the center; and meet with the nurse practitioner monthly for medication management. Due to Terrence's lack of financial resources and access to transportation, they made the following adjustments to his treatment plan:

- **Meetings with the case manager would occur in an office at the shelter or at a location that Terrence could reach without paying for transportation.**
- **After he was stabilized on his medication, the nurse practitioner suggested a long-acting injectable preparation so he wouldn't need to pick up meds once a week.**
- **Terrence would have access to bus passes to allow some independence in obtaining benefits and housing.**
- **Engagement strategies will focus on meeting basic needs including housing.**

Most importantly, facilitators of AOT need to engage in practices that consider social determinants of health, especially as they relate to participants' income, educational, economic, and vocational training and access to adequate transportation, community-based resources and basic daily living needs, such as housing. According to Maslow's hierarchy of needs, an individual's safety needs must be met to successfully tend to their emotional needs.[12] Thus, the ability to fully engage people who have SMI in treatment for their emotional and psychological needs depends on having their most basic needs met.

Research shows that access to housing is positively associated with treatment adherence among formerly homeless individuals who have SMI.[13] Supportive housing, such as Individual Placement and Support programs, also offer a sense of stability that can improve other life circumstances, such as successfully obtaining and maintaining employment.[14]

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A commitment to understanding how social and economic factors shape the lived experiences of people with SMI who experience poverty is essential to increasing this demographic's engagement with mental health treatment services. In addition, as illustrated in the AOT example above, health care providers should aim to challenge stigmatizing narratives that surround experiences of poverty. They should educate themselves about class-based health disparities and how trauma impacts how people with SMI who experience poverty interact with the mental health system.

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