BC AL/336/6/3

ISSUES in MENTAL HEALTH

Project: The Contribution of Social Factors to the onset of Mental Illness

Analyse admissions to your placement ward(s) during a specified period such as one month.

Build up a profile of hospital admissions by collecting the following data for each patient.

Survey approach

SOCIAL FACTORS:

- Diagnosis
- Age
- Sex
- Occupation
- Civil Status
- Family History and Background

Case Study Approach — Select a limited number of patients

DISEASE CHARACTERISTICS: and ILLNESS BEHAVIOUR:

- Date of onset of illness
- Type of help first sought
- Date of first hospital admission
- No. of subsequent admissions
- Whether all at St. Lukes'
- Predominant symptoms at the time of seeking help
- Type of treatment received
- Patient choice

CAUSATIVE FACTORS:

- Factors contributing to the onset of illness
  - Patient, Nursing, Medical perceptions
  - Your view:

Source: Nursing, medical records. Patient Interview(Nursing Process Framework) Observation during placement.

Are you able to draw any conclusions from your data ?

Pam. Smith
Feb. 1984

Bits of Black

from the 'Black Report', DHSS, 1980

TERMS OF REFERENCE

1. To assemble available information about the **differences in health status** among the social classes and about factors which might contribute to these, including relevant data from other industrial countries.
2. To analyse this material to identify possible **causal relationships,** to examine the hypotheses that have been forrmulated and the testing of them, and to assess the implications for policy.
3. To suggest what **further research** should be initiated.

GOVERNMENT REACTION (1980)

'. . . it is disappointing that the group were unable to make greater progress in disentangling the various causes of inequalities in health . . .

'I must make it clear that additional expenditure on the scale which could result from the report's recommendations — the amount involved could be upwards of £2 billion a year — is **quite unrealistic** in present or any foreseeable circumstances, quite apart from any judgement that may be formed of the effectiveness of dealing with the problems identified. I cannot, therefore, endorse the group's recommendations . . .'
Patrick Jenkin, Secretary of State for Social Services

AUTHORS

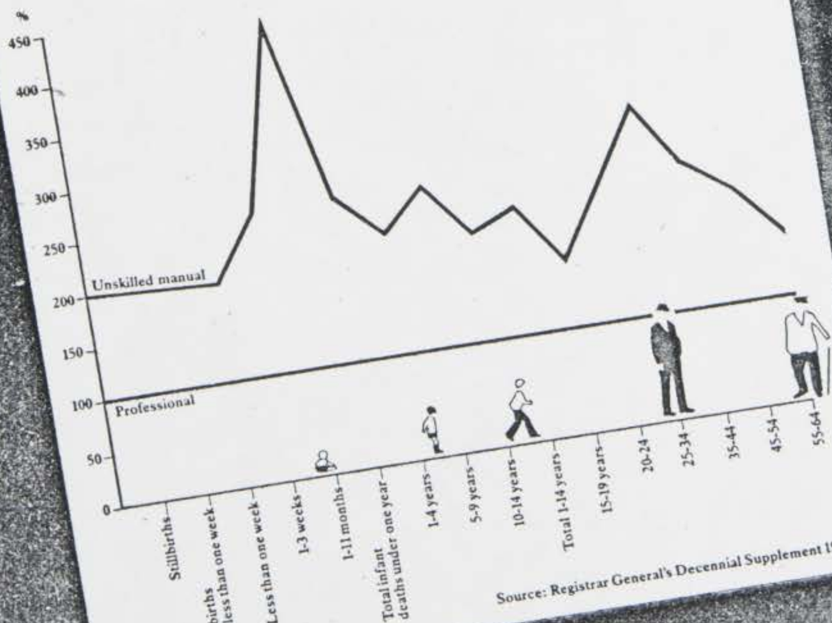
Sir Douglas Black (chairman), chief scientist at the DHSS to April 1978, and president of the Royal College of Physicians
Professor J. N. Morris, professor of community health, University of London
Dr Cyril Smith, secretary of the Social Science Research Council
Professor Peter Townsend, professor of sociology at Essex University

BASICS

The problem of inequalities in health, (we) believe, lies at the heart of the problem of better integrating British society . . .

Present social inequalities in health in a country with substantial resources like Britain are **unacceptable,** and deserve so to be declared by every section of public opinion.

We have no doubt that greater equality of health must remain **one of our foremost national objectives** and that in the last two decades of the twentieth century a new attack upon the forces of inequality has regrettably become necessary, and now needs to be concerted.
Black, introduction



READ ON . . .

The hard way: *Inequalities in health, report of a research working group,* DHSS, 1980, £8. The original report — 417 typed pages and sold out long ago! You might find a copy in a professional library — the Rcn has a reference copy at its library, 1 Henrietta Place, Cavendish Square, London W1M 0AB (tel: 01-580 2646) which non-members can consult.

Not an easy read, and extremely scrupulous in pointing out gaps in data, the complexity of the arguments, etc. If you are pursuing a particular topic, no summary can replace the real thing.

The easy way (1): *The unequal health of the nation, a TUC summary of the Black Report,* 1981, £1.20 (inc post) from TUC Publications, Congress House, Great Russell Street, London WC1B 3LS. 24 pages.

Very attractive and easy to read. Lots of excellent graphics, charts etc. Tends to cut out Black's prevarications and discussions and present a very clear and simple picture. Supplemented by material not found in Black. Explains clearly all the terms used.

The easy way (2): *On the Black Report, a summary and comment by Alastair Gray,* £1.70 (inc post) from Mrs I. Tudhope, Health Economics Research Unit, University Medical Buildings, Foresterhill, Aberdeen AB9 2ZD. 45 pages.

Probably the next best thing to reading Black, so far. Takes you step-by-step through the report, summarising discussions (with page references so you can consult the original) and the thinking behind the findings. Has a reading list culled from the Black references, plus a discussion of Black at the end which is not all praise and is aimed to stimulate debate.

The easy way (3) *Inequalities in health,* edited by Peter Townsend and Nick Davidson, due out in April 1982, from Pelican.

An unkown quantity at the moment (even price is not yet fixed). But will be longer than the other summaries, and will have the advantage of being co-edited by one of Black's original authors (Townsend).

THE NHS

The absence of reliable statistics . . . obstructs any attempts to examine the effectiveness of the NHS as an agent of equality in contemporary Britain . . . If rates of mortality are used to evaluate its achievements, then **recent experience** would not appear to be particularly favourable.
Black, para 2.50

Bits of Black

PROFESSIONALS

All professions tend to become over-committed to existing practice and their **receptivity to the need for change is liable to become weak.** The medical, nursing and other professions are like other professions in this respect ... society cannot look to the professions working in the health services for an account of illness and health which is always as detached or as full as it might be . . .
Black, paras 1.7-8

CHILD DEATHS

(In) class gradients for different causes of death . . . the steepest curves are found for **accidents and respiratory disease,** causes of death which are associated with the socio-economic environment . . . For most other causes, there is less clear evidence of class disadvantage.
Black, paras 2.24-25

ADULT DEATHS

Class differences in mortality for all adults aged 15-64 are somewhat less marked than in childhood, but this conceals a **large difference for those in their twenties and thirties,** and a smaller disadvantage for those approaching pension age, ie class disadvantage becomes less extreme as men and women grow older and the frequency of death increases. **The risk of death in class V** is between one-and-a-half to two times the risk in class I for adult males and females.
Black, paras 2.26-27

ILLNESS

Available data on (self reported) morbidity tend to reflect those on mortality. Rates of 'long standing illness' . . . rise with falling socio-economic status and tend to be **twice as high among unskilled manual males and about two-and-a-half as high among unskilled manual females** as in the professional classes. Inequalities are smaller in childhood and early adulthood and larger in middle age. On the other hand, measures of . . . acute or short-term illness are less unequal (or less unequally reported) between classes.
Black, paras 2.69-70

TRENDS

Perhaps the most disturbing general finding (on trends) is the **lack of improvement,** and indeed in some respects deterioration, of the health experience not merely of occupational class V but also class IV in health, relative to occupational class I, as judged by mortality indicators, during the 1960s and early 1970s.
Black, para 3.56

MOTHERS

In the case of family planning and maternity services, substantial evidence shows that **those social groups in greatest need make least use of services** and (in the case of antenatal care) are least likely to come early to the notice of the service. Similar differences have been found in presentation for post-natal examination, immunisation, antenatal and postnatal supervision and uptake of vitamin foods.
Black, paras 4.22-23

Death rates by sex and social (occupational) class (15-64 years)

(rates per 1000 pop. England and Wales, 1971)

Social (occupational) class	Male	Female*	Ratio M/F
I (Professional)	3.98	2.15	1.85
II (Intermediate)	5.54	2.85	1.94
IIIN (Skilled non-manual	5.80	2.76	1.96
IIIM (Skilled manual)	6.08	3.41	1.78
IV (Partly Skilled)	7.96	4.27	1.87
V (Unskilled)	9.88	5.31	1.86
Ratio V/I	2.5	2.5	

Source: Occupational Mortality 1970-72. (Microfiches and 1978, p.37)

* Women with husbands have been classified by their husband's occupation. women of other marital statuses are attributed to their own occupational class.

Another kind of inequality — by sex

DISABILITY

Few would deny that class (as reflected not only in the accumulated financial resources and, to some extent, in the availability of a supportive social network, but also in the narrow sense of occupation) mediates the effects of a given impairment. The slight, and unfortunately somewhat old, empirical evidence available does indicate that **class inequalities** are indeed to be found here.
Black, paras 4.31-32

WHY INEQUALITY?

Some of the evidence on class inequalities in health is adequately understood in terms of specific features of the **socio-economic environment:** features (such as accidents at work, overcrowding, smoking) which are strongly class-related ... Since such features are recognised objectives of various areas of social policy we feel it sensible to offer them as contributory factors to be dealt with in their own right.

The same is true of other aspects of the evidence which we feel show the importance of **measures related to the health services** (eg) antenatal care . . . the importance of preventive health within health policy. . .

But beyond this there is undoubtedly much which cannot be understood in terms of the impact of so specific factors. Much, we feel, can only be understood in terms of the more **diffuse consequences of the class structure**: poverty, work conditions (and what we termed the social division of labour) and deprivation in its various forms.
Black, para 6.93

INFORMATION GAPS

The importance of the problem of inequalities in health and their causes as an area for further research needs to be emphatically stated. We recommend that it be adopted as a **research priority** by the DHSS. The five areas in which further research is essential are: (1) surveillance of the **development of children** (especially in relation to nutrition and to accidents); (2) better understanding of the health effects of such aspects of **individual behaviour** as smoking, diet, alcohol consumption, exercise; (3) the development of area **social condition and health indicators** (for use in resource allocation); (4) health hazards in relation to **occupational conditions** and work; (5) study of the interaction of the **social factors** implicated in ill health — over time, and within small areas.
Black, paras 7.45-46

BLACK'S PRIORITY

It is our view that **early childhood** is the period of life at which intervention could most hopefully break the continuing association between health and class. Not only may subsequent health (or propensity to ill health) be to some degree determined in early life, but there may be some co-determination of subsequent educational (and hence to some degree occupational) achievement and future health status at that time.
Black, para 6.95

From: Janet Frame: Faces in the Water
Women's Press (1980)
First published 1961.

VIII

MY MOTHER AND I waited on the railway station for the Limited to arrive. I remembered how often, when I had been traveling past Cliffhaven and the train stopped to unload and collect mail and water the engine, I had looked out to see the "loonies" standing on the platform. Now, as the train halted, I watched the faces of the people staring from the carriages and I wondered if I had any distinguishing marks of madness about me, and I wondered if the people understood or wanted to understand what lay beyond the station, up the road over the cattle stop and up the winding path and behind the locked doors of the gray stone building.

I thought as I climbed into the carriage, "Now Mrs. Pilling is putting the bread on the table for tea and Mrs. Everett is boiling the eggs over the dining room fire. Mrs. Ritchie in the dayroom is telling an interested but skeptical audience of the operation in which part of her body "just came away like that. It was a mistake in the operation. Part of my body, a secret part that I cannot name, just came away like that." Gesturing and with her cheeks flushed she emphasizes the deplorable mistake which has made her

different from everyone else in the world, and condemns the doctors for their refusal to admit to theft of part of her body. And Susan is standing still and silent in the corner; her limbs are blue and cold. She has taken off her cardigan and shoes and will not be persuaded to put them on again.

And the confused elderly ladies are wandering up and down in their crumpled dresses, with concertina ripples in their lisle stockings, because when they were dressed in the early morning perhaps their garters were missing from their "bundle." They are rattling on the locked door, trying to get out, to "see to" things or make sure of something which has intruded from their past and demands their immediate attention; they need to talk to people who are not there, to minister to the long dead—to make cups of tea for tired husbands who are beyond the dayroom and the grave. Voices convey to them urgent messages; they are beside themselves with anxiety; no one will listen to them or understand.

The very new nurses in their first few days of scrubbing, making beds and filling coal buckets, as if the purpose of their work were to establish relationship with the domestic property of the ward, to heal bucket and blanket and corridor, find it somehow soothing to stand in the dayroom and comb the hair of the old ladies with the coarse-toothed ward comb. It is thinning white hair trailing in wisps over the transparent blue-veined skull. Later, the same nurses will become impatient with their charges; but at first they are full of sympathy; the old ladies are obviously suffering; and their strayed appearance is emphasized by their clothes, the overlong cardigans wrapped over their shrunken bodies, and the seemingly shapeless dresses that husbands or

daughters have brought them on visiting day with the words, "I hope it fits but somehow I couldn't think of your right size," perhaps inwardly realizing that for the old ladies there is no "right size," that the deception of their inner world has reached their body and in some way removed it from ordinary forms of measurement.

These old people sit at the special table, have cream on their pudding, and are hurried early to their rooms, undressed, put to bed and locked in. Immediately the nurse is gone they get out of bed and potter around the room making sure looking for things seeing to things. They continue thus, restlessly, most of the night, and in the morning after only fitful sleep, sometimes with their beds wet and dirty, they begin again to try to solve the daily puzzle of being where they are, of not being allowed to go outside, of losing their garters and their handkerchiefs and of being involved in the complexities of going from one place to another, of going to the lavatory and remembering to wipe themselves, of being led from dayroom to meal table and back again. After some weeks, if they do not improve, they will be sent in the big black government car to "Kaikohe" by the sea where the old people go, or will be transferred to Ward One which is also the children's ward with an inner courtyard where yellow grass grows through the cracks in the asphalt and where pale slobbering children play, consoled by their few wooden toys in the daytime and at night sleeping in cots in small damp rooms with concrete floors.

In this ward the old women will eventually be put to bed for the last time; they will lie in the dreary sunless rooms that stink of urine; they will be washed and "turned" daily, and the film, the final deception, will grow over their eyes.

And one morning, if you walk along the corridor through Ward One, you will see in the small room where one of the old women has been sleeping, the floor newly scrubbed smelling of disinfectant, the bed stripped, the mattress turned back to air; the vacancy created in the night by death.

The train drew slowly out of Cliffhaven, gathering speed as it passed the banks untidy with wild sweet peas and gorse and the back gardens with their slapping soapsud-reeking lines of washing and their henhouses, where fat snow-white hens, their behinds in the air, pecked and scratched at the stony soil. I gave up trying to discern the hospital towers through the gaps in the receding hills, and settled into the slothful smoke-tasting attitude of a railway traveler, gazing dreamily at the dead contorted trees and the obsessedly nibbling sheep and the cows, tails aswish, clustering already for milking. Cliffhaven slipped from my mind as easily as the sun was slipping down the sky into the gap between cloud and horizon.

When the train stopped in a wilderness of grass and gum trees and was switched to a siding to give clear passage to the southbound express, and stayed there waiting and waiting, until it seemed that it had been abandoned and would be overtaken by the rust and weeds and silence that threaten all men and machines in rest and motion, I was reminded once more of Cliffhaven and the people there. Did their life in a siding give right-of-way to more urgent traffic? And what was its destination?

But the train moved, and I slept, and did not care. Cliffhaven was far far away, and I would never be sick again.

Would I?