Determinanti Sociali di Salute

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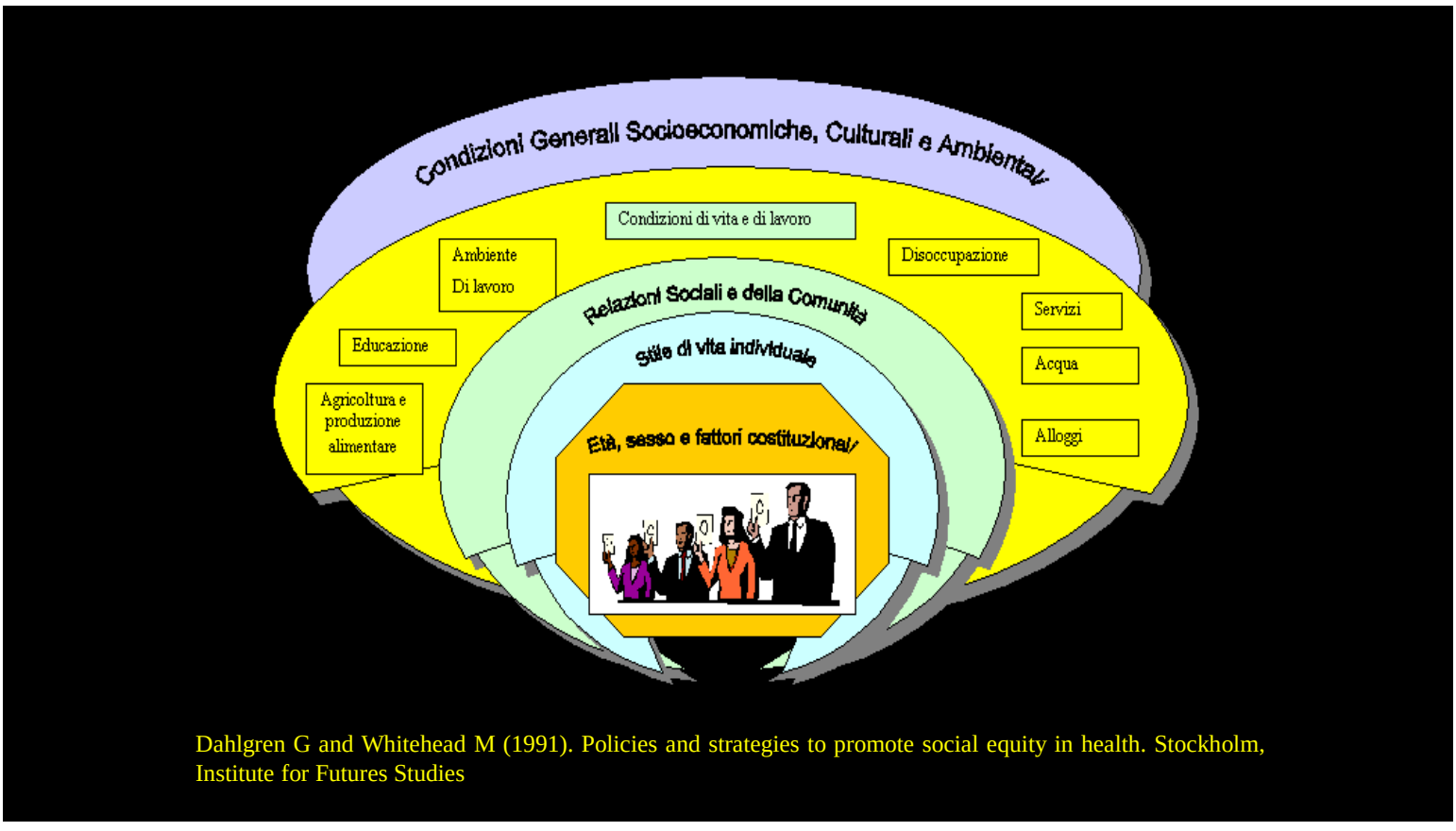
Determinanti sociali di Salute

- **I fattori ambientali, sociali, culturali e comportamentali, come il reddito, l'occupazione, l'abitazione e l'istruzione**
- **che influenzano lo stato di salute degli individui e delle comunità**



Dahlgren G and Whitehead M (1991). Policies and strategies to promote social equity in health. Stockholm, Institute for Futures Studies

Determinanti sociali di Salute

Determinanti Strutturali della salute: stratificazione sociale

(contesto politico e socio-economico e posizione socio-economica)

Determinanti Intermedi di salute

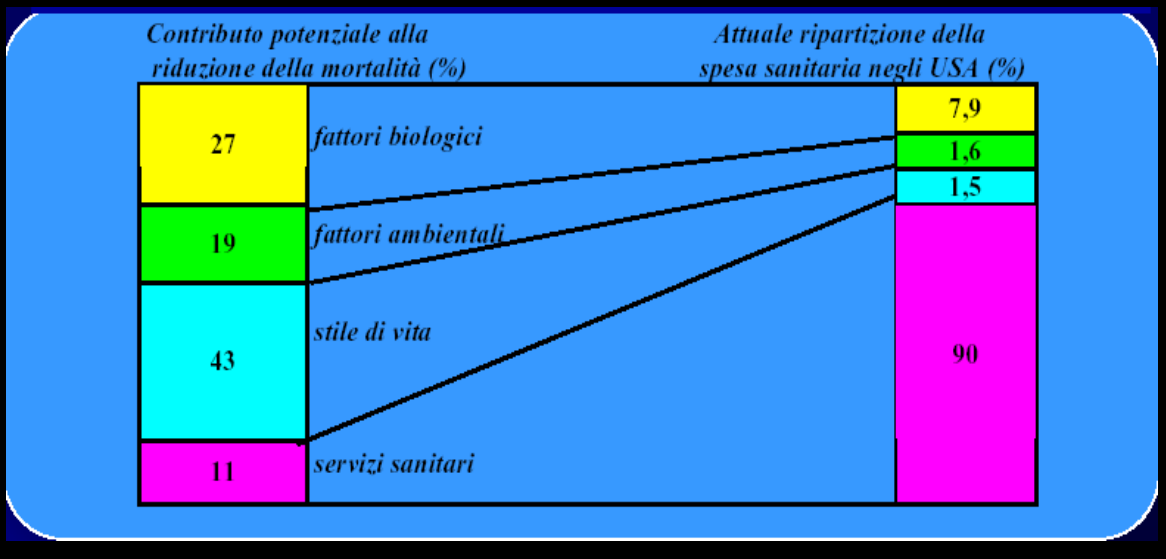
(condizioni di vita e di lavoro, reti sociali, stili di vita e accesso ai servizi)

Determinanti non modificabili

(sesso, età, ereditarietà)

Da Commission on Social Determinants of Health, OMS

…E i Sistemi Sanitari ?



Determinanti Sociali di Salute Mentale

- I determinanti sociali (SDoMH) hanno un impatto significativo sulla salute mentale.
- I SDoMH più rilevanti includono abusi infantili, traumi, discriminazione, isolamento sociale, bassa istruzione, disoccupazione, insicurezza alimentare, instabilità abitativa e incarcerazione.
- Affrontare I SDoMH richiede un approccio duplice: strategie pragmatiche per valutare e gestire i SDoMH e impegno in iniziative di giustizia ed equità sociale a livello comunitario e sociale.

The social determinants of mental health and disorder: evidence, prevention and recommendations

James B. Kirkbride[1], Deidre M. Anglin[2,3], Ian Colman[4], Jennifer Dykxhoorn[1], Peter B. Jones[5,6], Praveetha Patalay[7,8], Alexandra Pitman[1,9], Emma Soneson[10], Thomas Steare[7], Talen Wright[1], Siân Lowri Griffiths[11]

REVIEW ARTICLE OPEN

Check for updates

Addressing social determinants of health in individuals with mental disorders in clinical practice: review and recommendations

Dilip V. Jeste[1,2], Jeffery Smith[2], Roberto Lewis-Fernández[3,4], Elyn R. Saks[5], Peter J. Na[6,7], Robert H. Pietrzak[8,9], McKenzie Quinn[10] and Ronald C. Kessler[11]

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Social determinants of mental health in major depressive disorder: Umbrella review of 26 meta-analyses and systematic reviews

Noy Alon[a,b,1], Natalia Macrynikola[b,1], Dylan J. Jester[c], Matcheri Keshavan[b], Charles F. Reynolds III[d], Shekhar Saxena[e], Michael L. Thomas[f], John Torous[b,2], Dilip V. Jeste[g,2,*]

DETERMINANTI SOCIALI E SCHIZOFRENIA

THEME INTRODUCTION (INVITED)

Review of Major Social Determinants of Health in Schizophrenia-Spectrum Psychotic Disorders: I. Clinical Outcomes

Dylan J. Jester[1], Michael L. Thomas[2], Emily T. Sturm[2], Philip D. Harvey[3], Matcheri Keshavan[4], Beshaun J. Davis[5], Shekhar Saxena[6], Rajesh Tampi[7], Heather Leutwyler[8], Michael T. Compton[9], Barton W. Palmer[1,10], and Dilip V. Jeste[*,1]

Schizophrenia Bulletin vol. 49 no. 4 pp. 837–850, 2023
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Table 1. Summary of Meta-analyses, Umbrella Reviews, and Systematic Reviews for Selected Social Determinants of Health in Schizophrenia

Author (Year) *Study type	# Studies included	Sample size	Social determinants of health	Outcome(s)	Methods	Findings
Social connection/isolation						
Degnan et al. (2018) Meta-analysis	16	1,929	Social network size	Overall psychiatric symptoms Positive symptoms Negative symptoms	Measured: Between-study variance? Yes Publication bias? Yes Quality assessment? Yes Sensitivity analyses? Yes	Social network size was inversely associated with overall psychiatric symptoms (Hedge's $g = -0.53$ [−0.88, −0.18]) and severity of negative symptoms ($g = -0.75$ [−1.00, −0.51]), but not with positive symptoms ($g = -0.19$ [−0.49, 0.11]) or social functioning ($g = 0.36$ [−0.08, 0.80]).
Ku et al. (2021) Systematic review	19	N/A	Social fragmentation	Incidence of first episode psychosis Schizophrenia prevalence	Measured: Between-study variance? N/A Publication bias? N/A Quality assessment? Yes Sensitivity analyses? N/A	There were 4- and 12-times higher rates of schizophrenia prevalence and first admission for psychosis, respectively, in areas with the highest compared to the lowest measures of social fragmentation.
Life experiences/events						
Fazel and Seewald (2012) Meta-analysis	25	33,588	Incarceration	Prevalence of psychosis	Measured: Between-study variance? Yes Publication bias? Yes Quality assessment? No Sensitivity analyses? Yes	The pooled prevalence of all forms of psychosis was 3.6% [3.1%, 4.2%] in male-identifying incarcerated individuals and 3.9% [2.7%, 5.0%] in female-identifying incarcerated individuals.
Prins (2014) Systematic review	28	>200,000	Incarceration	Prevalence of schizophrenia	Measured: Between-study variance? N/A Publication bias? N/A Quality assessment? No Sensitivity analyses? N/A	The prevalence of schizophrenia ranged from 2.0% to 6.5% in incarcerated individuals.
Radua et al. (2018) Umbrella review	First-generation immigrant = 42 Second-generation immigrant = 26	First-generation immigrant = 25,063 Second-generation immigrant = 28,753	Immigration	Incidence of psychosis	Measured: Between-study variance? Yes Publication bias? Yes Quality assessment? Yes Sensitivity analyses? Yes	Second generation immigrants and racial/ethnic minorities living in low ethnic density areas were considered to be two of the six "highly suggestive" risk factors, while first generation immigrants and racial/ethnic minorities living in high ethnic density areas were two of the nine "suggestive" risk factors.
Bardol et al. (2020) Meta-analysis	17	33,211	Racial/Ethnic discrimination	Psychotic experiences Psychotic symptoms	Measured: Between-study variance? Yes Publication bias? Yes Quality assessment? Yes Sensitivity analyses? Yes	Perceived racial/ethnic discrimination was associated with psychotic symptoms (OR = 1.82 [1.41, 2.36]) and psychotic experiences (OR = 1.94 [1.42, 2.67]).
Davies et al. (2020) Meta-analysis	Maternal psychopathology = 9 Maternal psychosis = 6 Paternal psychopathology = 5	N/A	Maternal psychopathology Maternal psychosis Paternal psychopathology	Psychotic disorder diagnosis of offspring	Measured: Between-study variance? Yes Publication bias? Yes Quality assessment? Yes Sensitivity analyses? Yes	Maternal (OR = 4.60 [2.74, 7.73]) or paternal (OR = 2.73 [2.33, 3.19]) psychopathology, especially maternal psychosis (OR = 7.61 [6.29, 9.21]) was associated with offspring developing a psychotic disorder.
Henssler et al. (2020) Meta-analysis	First-generation immigrant = 20 Second-generation immigrant = 13 Both generations combined = 2	N/A	Immigration	Incidence of schizophrenia or non-affective psychosis	Measured: Between-study variance? Yes Publication bias? Yes Quality assessment? Yes Sensitivity analyses? Yes	Restricting analyses to low risk-of-bias studies, the RR of incident non-affective psychosis was 1.81 [1.62, 2.02] in immigrants compared to non-immigrants. Among first-generation immigrants specifically, RR was 1.81 [1.59, 2.07] compared to the native population, and 1.82 [1.66, 1.99] among second-generation immigrants.
Varchmin et al. (2021) Umbrella review	11 meta-analyses	N/A	Emotional abuse Physical abuse Sexual abuse Neglect Bullying in childhood Parental death Variations in parental communication	Incidence of psychosis	Measured: Between-study variance? Yes Publication bias? Yes Quality assessment? Yes Sensitivity analyses? Yes	Experiencing childhood adversities was associated with developing non-affective psychosis later in adulthood (OR = 2.81 [2.03, 3.83]), with a medium effect size ($d = 0.57$ [0.39, 0.74]). Emotional abuse displayed the strongest association with psychosis ($d = 0.77$ [0.53, 1.01]), followed by physical abuse ($d = 0.63$ [0.51, 0.74]), sexual abuse ($d = 0.50$ [0.39, 0.62]), and neglect ($d = 0.47$ [0.34, 0.60]). Other predictors were variations in parental communication ($d = 0.97$ [0.76, 1.18]), bullying in childhood ($d = 0.49$ [0.37, 0.62]), and parental death ($d = 0.12$ [0.04, 0.21]).
Access						
Castillejos et al. (2018) Meta-analysis	Urbanicity = 8 Socioeconomic area = 4	N/A	Living in an urban versus rural area Living in a socioeconomically deprived area	Incidence of psychotic disorders	Measured: Between-study variance? Yes Publication bias? No Quality assessment? Yes Sensitivity analyses? No	For overall psychosis, the incidence rates for urban and rural settings were 30.46 [17.20, 43.72] and 17.80 [14.95, 20.65] per 100,000, respectively. The IRR for living in an urban setting was 1.64 (1.38, 1.95). The incidence rates for living in a lower or higher socioeconomic area were 34.40 [20.89, 47.90] and 24.74 [10.03, 39.46] per 100,000, respectively; the IRR for living in a lower socioeconomic area was 1.78 [1.43, 2.22]

Table 1. Continued

Author (Year) *Study type	# Studies included	Sample size	Social determinants of health	Outcome(s)	Methods	Findings
Ayano et al. (2019) Meta-analysis	31	51,925	Homelessness	Prevalence of schizophrenia and other psychotic disorders	Measured: Between-study variance? Yes Publication bias? Yes Quality assessment? Yes Sensitivity analyses? Yes	Among adults experiencing homelessness, prevalence rates were: overall psychosis (21.2% [13.7%, 31.3%]), schizophrenia (10.3% [6.4%, 16.0%]), schizophreniform disorder (2.5% [6.2%, 28.1%]), schizoaffective disorder (3.5% [1.3%, 9.1%]), and psychotic disorders not otherwise specified (9% [6.9%, 11.6%]).
Gutwinski et al. (2021) Meta-analysis	Schizophrenia = 35	N/A	Homelessness in high-income countries as classified by the World Bank	Prevalence of psychiatric disorders	Measured: Between-study variance? Yes Publication bias? No Quality assessment? Yes Sensitivity analyses? Yes	The pooled prevalence of a current mental disorder was 76.2% [64.0%, 86.6%]. Schizophrenia spectrum disorders was found in 12.4% [9.5%, 15.7%] of homeless persons.
Teasdale et al. (2021) Meta-analysis	31	N/A	Food insecurity	Food insecurity was measured in persons with schizophrenia and related psychoses	Measured: Between-study variance? Yes Publication bias? Yes Quality assessment? Yes Sensitivity analyses? Yes	The prevalence of food insecurity in schizophrenia and related psychoses ranged from 25.3% to 71.4% (median 45%). Adults living with serious mental illness were 2.71 [2.27, 3.24] times more likely to report food insecurity than non-psychiatric controls/general populations.

Epidemiology and Psychiatric Sciences

cambridge.org/eps

Original Article

The Early Psychosis Working Group

The impact of socioeconomic factors on the incidence and characteristics of first-episode psychosis

Martino Belvederi Murri[1], Alice Onofrio[1], Chiara Punzi[1], Nicola Caranci[2], Enrico Rubolino[3], Francesco Giovinazzi[4], Danila Azzolina[5], Federica Folesani[1], Luigi Grassi[1], Ilaria Tarricone[6] and Fabrizio Starace[4]

Results. The exposures and incidence of FEP displayed heterogeneous spatial distribution, with no spatially organized pattern. Accordingly, incidence and characteristics were best modelled as non-spatial, three-level hierarchical models. The incidence of FEP was influenced by population density (IRR, 1.14; 95% CrI, 1.03; 1.29), educational deprivation (IRR, 1.15; 95% CrI, 1.02; 1.31) and frequent cannabis use (IRR, 1.31; 95% CrI, 0.98; 1.82), more than socioeconomic deprivation. Higher migrant density in an area shortened the DUP on average by 3.4 months (95% CrI, −1.122; 0.76), while an increase of cannabis use of one standard deviation increased the DUP of 12.9 months (95% CrI, −2.86; 6229). Socioeconomic deprivation increased the likelihood of FEP cases being substance users (OR, 1.12; 95% CrI, 1.01; 1.26), while population density decreased it (OR, 0.91; 95% CrI, 0.83; 1.00).

Principali SDoMH per Persone con Disturbi Mentali

Effetti significativi

Recensioni di meta-analisi mostrano effetti da moderati a grandi per abusi infantili/trascuratezza e insicurezza alimentare.

Effetti moderati

Effetti da piccoli a medi per discriminazione razziale/etnica e status di immigrato nella schizofrenia, e violenza domestica infantile, disastri naturali e atti terroristici nel disturbo depressivo maggiore.

Prevalenza elevata

Elevata prevalenza di disturbi psicotici in persone incarcerate e senzatetto, e in aree con elevata frammentazione sociale.

Altri fattori

Altri SDoMH rilevanti includono stigma, discriminazioni specifiche, mancanza di connessioni sociali, uso dei social media e stato civile interrotto.

Molti studi sono osservazionali e trasversali, ma evidenziano associazioni significative tra SDoMH avversi e disturbi mentali. Le politiche governative e le strutture sociali come povertà, insicurezza alimentare, instabilità abitativa e discriminazione influenzano i SDoMH.

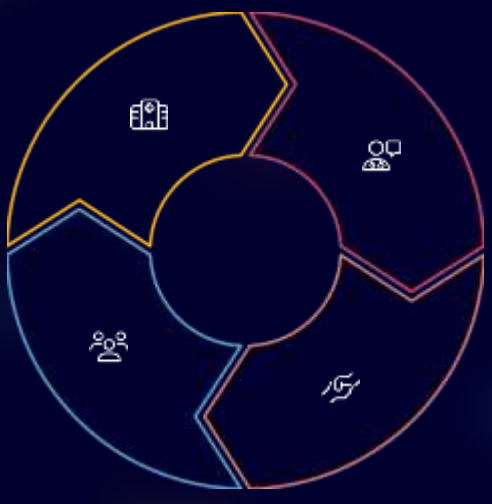
Collaborazione e Ruoli Professionali

Sistemi sanitari

È fondamentale che i sistemi sanitari collaborino con settori come istruzione, trasporti e alloggi.

Comunità

Il coinvolgimento della comunità è essenziale per affrontare i determinanti sociali in modo efficace.



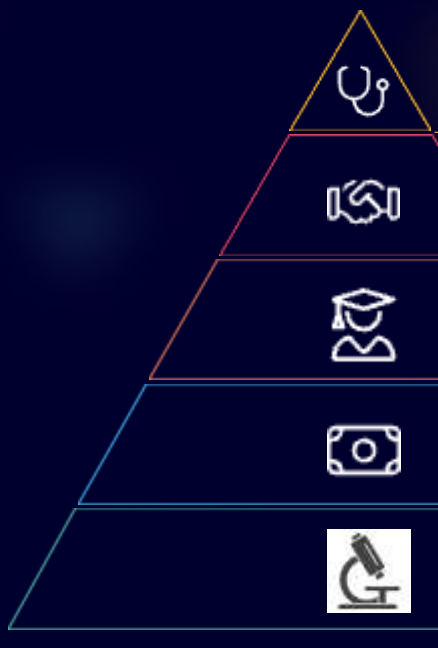
Operatori sanitari

Gli operatori sanitari devono aiutare attivamente le persone con disturbi mentali a ridurre gli effetti negativi dei SDoMH.

Assistenti sociali

Professionisti come assistenti sociali e volontari possono svolgere un ruolo importante.

Ostacoli per Affrontare i SDoMH in Persone con Disturbi Psichiatrici



Focus sulla diagnosi

Enfasi crescente sul legame tra diagnosi e trattamento, trascurando i fattori psicosociali.

Debole collegamento con i servizi sociali

Mancanza di rimborso per servizi sociali non medici e capacità limitata delle organizzazioni comunitarie.

Mancanza di formazione

Scuole di medicina non danno priorità all'educazione sui SDoH.

Risorse sanitarie

Mancanza di risorse per valutazioni e interventi sociali.

Ricerca

È necessario un **equilibrio tra ricerche biologiche e strategie di prevenzione psicosociale nei finanziamenti** per la ricerca.

Valutazione Pragmatica di SDoMH Selezionati

Identificazione dei SDoMH prevalenti

I sistemi sanitari devono identificare i SDoMH prevalenti nella comunità e determinare quali interventi sono fattibili.

Valutazione clinica

I clinici devono valutare quali SDoMH sono modificabili e di particolare preoccupazione per il paziente.

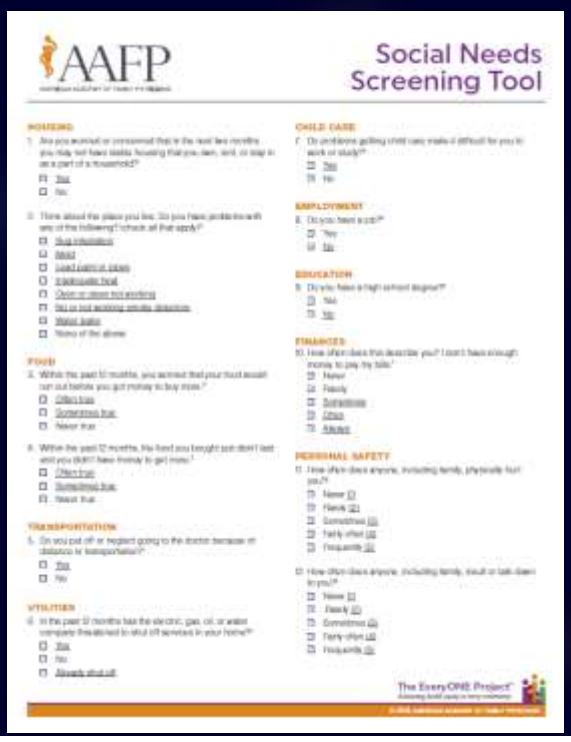
Standardizzazione del processo

È importante standardizzare e strutturare il processo di valutazione.

Valutazione Pragmatica di SDoMH Selezionati

- I Servizi per la Salute Mentale raramente dedicano attenzione ai SDoMH come parte delle visite mediche
- Alcune organizzazioni hanno sviluppato brevi strumenti di screening per valutare alloggio, cibo, trasporti, utenze, ecc.
- Negli USA la Joint Commission ha sottolineato l'importanza di valutare i bisogni sociali legati alla salute

Interventi a Livello Individuale


AAFP

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?
   - ☐ Yes
   - ☐ No
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.*
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.*
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?*
   - ☐ Yes
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?*
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?*
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?*
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?*
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills.*
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?*
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)
12. How often does anyone, including family, insult or talk down to you?*
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

The EveryONE Project


13. How often does anyone, including family, threaten you with harm?*
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)
14. How often does anyone, including family, scream or curse at you?*
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

ASSISTANCE

15. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14: _____
Greater than 10 equals positive screen for personal safety.

REFERENCES

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
8. [illegible]

The EveryONE Project

Interventi a Livello Individuale

Interventi a Livello Familiare

- Coinvolgimento Familiare: Includere la famiglia nel processo di valutazione e pianificazione degli interventi, considerando le loro prospettive e il loro supporto.
- Interventi Psicoeducativi: Fornire interventi psicoeducativi per aiutare le famiglie a comprendere l'impatto dei SDoMH sulla salute mentale e a sviluppare strategie di coping efficaci.

Interventi a Livello di Gruppi Sociali

- Interventi di Gruppo: Creare e facilitare gruppi di supporto o interventi di gruppo specifici per affrontare SDoMH comuni tra determinati gruppi sociali (ad esempio, gruppi per persone che vivono in condizioni di insicurezza abitativa o che hanno subito discriminazioni).
- Advocacy: Sostenere politiche e programmi che promuovano l'equità sociale e riducano le disuguaglianze che influenzano la salute mentale di specifici gruppi sociali.

Interventi a Livello Comunitario

- Collaborazioni Intersettoriali: Stabilire partnership tra sistemi sanitari e settori come istruzione, trasporti, alloggio e servizi sociali per affrontare i SDoMH in modo integrato.
- Iniziative di Screening: Implementare iniziative di screening a livello comunitario (ad esempio, nelle scuole) per identificare precocemente i bisogni sociali legati alla salute e indirizzare le persone ai servizi appropriati.
- Programmi di Supporto: Sviluppare programmi di supporto che affrontino i SDoMH prevalenti nella comunità, come programmi di assistenza alimentare, alloggi a prezzi accessibili e servizi di trasporto.

Interventi a Livello Sociale

Politiche Pubbliche

Sostenere politiche pubbliche che affrontino le cause profonde dei SDoMH, come povertà, discriminazione e mancanza di accesso all'istruzione e all'occupazione.

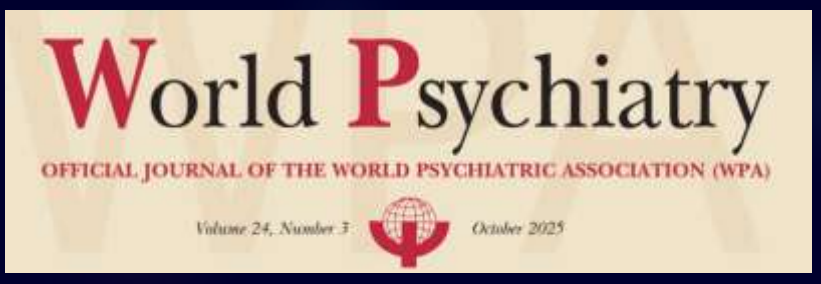
Sensibilizzazione

Promuovere campagne di sensibilizzazione per ridurre lo stigma associato ai disturbi mentali e ai SDoMH, e per promuovere la comprensione e il sostegno sociale.

Ricerca

Investire nella ricerca per comprendere meglio l'impatto dei SDoMH sulla salute mentale e per sviluppare interventi efficaci a tutti i livelli.

Conclusioni



EDITORIAL

"…In my mind, not dealing with social determinants in mental health care is equivalent to treating tuberculosis with only antitussive medication…"

Vikram Patel
Department of Global Health and Social Medicine, Harvard Medical School