Is There a Connection Between Mental Health Issues and Poverty? AService Evaluation of East Norfolk/Suffolk Youth Service Patients

Dr Dawn Collins[1] and Dr Jo Lowe[2]

[1]NSFT, Great Yarmouth, United Kingdom and [2]NSFT, Norwich, United Kingdom

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Aims: It is well established that living, or growing up, in poverty has a negative impact on both physical and mental health. The area our service covers includes Great Yarmouth and Lowestoft, two of the most economically impoverished areas of the UK. The vast majority of our patient group will have grown up in relative poverty. While there are associations between poverty and impaired physical health and increased risk of some mental health conditions, the actual causal link is unclear.

This evaluation tried to consider the impact of poverty on future mental health, by evaluating current patient case load (this stood at 122 in Feb 2024). We considered all patients, their demographics (age, gender, diagnosis) and the factors listed above. This patient group is young people (18–25 years old), living in this area, under Mental Health Services, with or without a formal mental health diagnosis.

Methods: An analysis of current case load, recording demographics and noting diagnoses and factors associated with poverty, specifically:

Parental drug or alcohol abuse.
Parental mental health problems (if these are not well managed).
Early/premature death of a parent.
Exposure to domestic violence.
Physical abuse.
Going into the Care System.
Early drug or alcohol use.
Early separation or loss of a parent.

NB – Many of these factors will affect those who do not grow up in poverty (e.g. domestic violence and physical abuse) but they are noted to have a class and poverty association. Many, if not most, of our patients will have grown up in poverty but their mental illness does not have a specific association with poverty (e.g. OCD, Bipolar disorder).

Results: Our findings show that a significant percentage of our patient group have mental health issues directly related to poverty. Total number of patients =122. Number who have a specific factor associated with poverty =56. This equates to 46% of our current caseload. Gender: 35 female (62.5%), male 21 (37.5%).

Conclusion: "The poor bear the greatest burden of mental illness" (Office of National Statistics).

It is worth noting that the vast majority of our patient case load grew up in poverty, due to the demographics of the area we work in (a quick analysis suggests about 97% are from working class, impoverished backgrounds). We abandoned recording "parental unemployment" in this analysis, because for all but a few, this was the case. Unemployment is an entrenched issue in this area, with the demise of the shipping and offshore industries, currently standing at 5.4% in Yarmouth and 3.5% in Lowestoft (3) (National average 3.8%). For those that are employed, poverty is a significant issue with many in low paid jobs. I have also not included here factors associated with poverty, such as poor diet, smoking, malnutrition, poor dentition, and obesity, but we know these are the case for many patients seen here.

Recommendations: Given that this is the case, what can we recommend, in term of service planning and delivery? We have multiple issues here that affect our service delivery to this vulnerable patient group: geography (we cover a large geographical area, the need of this population, limited public transport – patient often have to travel some distance to be seen), staff recruitment (it would seem this area holds little appeal for new staff, especially Medics and Psychologists and recruitment uptake is low) and funding (do we need extra funding per head population, as this is such a deprived area?).

Impact of Change of Length of Admission During COVID-19 for Inpatient Alcohol Detoxification on Relapse to Daily Alcohol Use With 1 Year: A Service Evaluation

Dr Aled Davies

Swansea Bay University Health Board, Swansea, United Kingdom. Cardiff University, Cardiff, United Kingdom

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Aims: We reviewed the impact of reducing length of admission during COVID-19 for planned inpatient medically assisted alcohol withdrawal (MAAW) on relapse to daily alcohol use within one year.

We aimed to describe the demographic, social and medical characteristics of patients admitted for a planned MAAW, rate of relapse to alcohol use over time, and identify good aspects of care that improved outcomes.

Methods: A retrospective cohort methodology was used using electronic health records. Patients included were identified as alcohol dependent, admitted for a planned inpatient MAAW to a specialist unit within Swansea Bay University Health Board between January 2019 and June 2023.

Patients admitted from March 2020 to April 2022 were identified as the exposed group, and those admitted between January 2019 and February 2020 and May 2022 and June 2023 as the control group.

Results: 311 admissions for MAAW were identified (125 in the exposed and 186 in the control group). Demographic and medical characteristics were evenly matched. Mean length of admission in the exposed and control group was 6 and 10 days respectively. 57.2% of admissions had relapsed to daily alcohol use by 52 weeks, comparable with existing research.

Time-to-event analysis identified the median time to relapse as 22 weeks and 26 weeks in exposed and control groups respectively.

Hazard ratio of 1.20 (95% confidence interval 0.89–1.61, p-value 0.22) was found in the risk of relapse in the exposed group compared with the control group, suggesting a 20% higher risk of relapse in the exposed group compared with the control by 52 weeks. However, this was not statistically significant.

The hazard ratio for relapsing if discharged on relapse prevention medication (RPM) was 0.50 (95% CI 0.31–0.78, P-value 0.002), suggesting a 50% benefit to remaining abstinent at 52 weeks if discharged on RPM. Similarly, prescribing disulfiram after MAAW, had a hazard ratio of 0.39 (95% CI 0.26–0.58, P-value 0.000004), reducing the risk of relapse by 61%.

Conclusion: We were able to characterise the demographic and medical background of patients receiving planned inpatient MAAW, which will help in future design and delivery of specialist MAAW units. No evidence was found to support a reduction in the length of admission for an inpatient MAAW. RPM significantly reduced the risk of relapse, especially the use of disulfiram. Several combinations

of RPMs were prescribed, highlighting the need to standardise prescribing of RPMs post MAAW.

The Hidden Majority? Exploring the Neurodiversity in CAMHS Eating Disorder Caseloads

Ms Rachel Lewis and Dr Megan Davies-Kabir

Aneurin Bevan University Health Board, Caerleon, United Kingdom

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Aims: Emerging research indicates a higher prevalence of Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD) among individuals with eating disorders (EDs) compared with the general population. Understanding this overlap is crucial for service planning, as neurodiversity assessments and tailored interventions require additional clinical resources. This study aimed to quantify the incidence of neurodiversity within a community specialist Child and Adolescent Mental Health Services (CAMHS) ED caseload to better predict workload demands and inform clinician training and treatment adaptations.

Methods: A cross-sectional survey was conducted among clinicians in a specialist CAMHS ED service. Clinicians were asked to report the number of patients on their current caseload with a formal diagnosis of ASD and/or ADHD, as well as those identified as requiring further assessment for these conditions. This methodology provided a snapshot of the prevalence of neurodiversity within active caseloads at the time of data collection.

Results: The total caseload was 96 patients. Of these, 22 (23%) had a confirmed diagnosis of ASD and/or ADHD, while 40 (42%) were identified as needing an assessment for neurodevelopmental conditions. In total, 65% of the caseload had either a diagnosis or a suspected diagnosis of ASD, ADHD, or both.

Conclusion: Our findings highlight a substantial overlap between eating disorders and neurodiversity in a community specialist CAMHS setting. The high proportion of young people requiring assessment underscores the need for integrated neurodevelopmental screening within ED services. Additionally, these results emphasize the importance of upskilling clinicians in neurodiversity-informed care and adapting treatment models to meet the needs of this population. Addressing these factors will be essential for optimizing clinical outcomes and resource allocation within specialist ED services.

Identification and Diagnosis of Foetal Alcohol Spectrum Disorder (FASD) in Children at High Risk of Prenatal Alcohol Exposure: A Service Evaluation

Mx Holly Dawson[1], Ms Suvidhi Khurana[2], Ms Milla McNally[3], Dr Amanda Waldman[1] and Dr Rani Samuel[1]

[1]South London and Maudsley NHS Foundation Trust, London, United Kingdom; [2]Kings College London, London, United Kingdom. and [3]University of Geneva, Geneva, Switzerland

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Aims: Prenatal alcohol exposure (PAE) is a leading preventable cause of neurodevelopmental, mental health, and cognitive difficulties. This study evaluates the identification of Foetal Alcohol Spectrum Disorder (FASD) in a high-risk cohort of adopted and Children In Care (CIC) of the local authority, referred to Symbol Team, a specialist Tier 3 service for Children Looked After (CLA) and Adopted young people within Lewisham Child and Adolescent Mental Health Service (CAMHS).

Methods: Retrospective service evaluation was conducted on 91 children referred to Symbol Team in June 2023, who were assessed for mental health and neurodevelopmental concerns. Children were categorised based on confirmed Prenatal Alcohol Exposure (PAE) and other reported risks, including maternal alcohol misuse, drug misuse, tobacco use, mental health concerns, reduced antenatal care and a family history of substance misuse. Risk factors were identified through various reports including social service records.

Very High Risk (VHR): Confirmed PAE based on parental reports or hair strand tests.

High Risk (HR): Uncertainty regarding PAE but with 5 or more risk factors.

Moderate Risk (MR): Uncertainty regarding PAE with 3–4 reported risk factors.

Results: Of the 91 children referred, 58% (n=53) were categorised as high or moderate risk of PAE. Of these, 16% (n=15) were Very High Risk (VHR), 18% (n=16) were High Risk (HR), and 24% (n=22) were Moderate Risk (MR).

Neurodevelopmental concerns were high across categories, with symptoms related to Autism Spectrum Disorder (ASD) in 43% (n=39) and Attention-Deficit/Hyperactivity Disorder (ADHD) in 46% (n=42). In the VHR group ASD 14% (n=13) and ADHD 15% (n=14) concerns overlapped and similarly the HR group exhibited ASD 11% (n=10) and ADHD 12% (n=11).

Cognitive difficulties were reported by 52% (n=47) of children, with 15% (n=14) in VHR, 15% (n=14) in HR, and 21% (n=19) in MR groups. Mental health concerns like depression were seen in 2% (n=2) VHR, 2% (n=2) HR and 3% (n=3) MR groups. A total of 33% (n=30) received medication treatment, with 11% (n=10) VHR, 8% (n=7) HR and 14% (n=13) in MR groups.

Conclusion: Despite the high prevalence of neurodevelopmental concerns and risk factors, FASD identification and diagnosis rates were low. The study also highlights gaps in knowledge, diagnostic tools and clinician training across agencies. Some barriers include under-reporting and stigma associated with the diagnosis. Improved access to reliable records and standardised diagnostic pathways are needed to facilitate early identification of FASD in at-risk children.

Healthy Minds, Healthy Bodies: Enhancing Physical Health in Serious Mental Illness – BSW (Bath, Swindon and Wiltshire) Physical Health Evaluation

Dr Elizabeth Ewins, Mr Ian Burgess, Ms Alison Kinge and Dr Josephine Raffan-Burnett

AWP, Bath, United Kingdom

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Aims: The BSW (Bath, Swindon and Wiltshire) Community Physical Health Evaluation aimed to assess the implementation and outcomes of annual physical health checks for individuals with Serious Mental Illness (SMI) within the BSW region. BSW offer an