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EDITORIAL

Social vulnerability and schizophrenia: a neglected problem requiring immediate action

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Schizophrenia disproportionately affects those who are most vulnerable. People living with the disorder generally have lower income and educational attainment, and their families also tend to be poorer and less educated compared with the general population.[1] In our recent study, these inequalities were even more striking in Brazil. The prevalence of schizophrenia among individuals earning up to one minimum wage was nearly twice that observed among those earning more than one minimum wage. Furthermore, among individuals with schizophrenia, low educational attainment was almost three times more prevalent than among those without the diagnosis.[2]

Traditionally, this vulnerability has been interpreted either as a risk factor for developing the disorder or as a moderator of treatment outcomes. We believe, however, that this issue requires a clearer and more assertive stance.

Social vulnerability can be understood as a condition in which individuals, families, or groups are more exposed to risks that restrict their opportunities for development and heighten their likelihood of exclusion. Beyond exposure to risks, it also entails a reduced capacity to protect oneself or to mobilize the resources needed to face adversity. In schizophrenia, this dual dimension is evident in both structural and intermediary social determinants of health. While poverty, violence, and stigma have been widely documented, less attention has been given to the diminished ability of people with schizophrenia to defend themselves from such adversities. When individuals cannot mobilize available resources, their vulnerability deepens, treatment outcomes worsen, and cycles of disadvantage are perpetuated across generations.

The need for high-quality treatment is undeniable. Psychiatrists, psychologists, social workers, and occupational therapists must work in an integrated manner, combining humanized clinical care with evidence-based, scientifically informed interventions. Yet social disadvantage drastically limits the impact of even the best available treatment. Perhaps it is precisely this vulnerability that explains why, despite the large number of people affected – 24 million worldwide and over 500,000 in Brazil –, this group continues to receive insufficient investment and care.

Recent evidence indicates that structural barriers, such as distance from treatment centers and residence in areas marked by social exclusion, directly affect clinical outcomes.[3] In other words, treatment effectiveness is constrained by modifiable environmental factors, including transportation and access to essential services. Although Brazil provides certain transportation and income benefits, do these data reflect greater difficulty in accessing available resources, or that these resources are still insufficient to meet actual needs? Such findings may also help explain why, despite advances in pharmacological and psychosocial care, mortality rates and educational disparities among individuals with schizophrenia have not improved – and, in some cases, have worsened.[4]

In addition to barriers to accessing social assistance, failures of treatment to reduce severity and promote recovery may aggravate social vulnerability, creating a continuous downward cycle. Brazil's public health system (Sistema Único de Saúde, SUS) provides care for roughly 75% of the population. However, there are few standardized process or outcome indicators for treatment within the SUS, and care for severe mental illness rarely incorporates diagnosis-specific considerations. Challenges such as limited access to services, reintegration of patients who discontinue treatment, poor adherence, psychiatric emergencies, treatment-resistant schizophrenia, and the need for educational, occupational, and social support exemplify unmet needs in schizophrenia care.

Such a situation reveals a problem in addressing one of the core principles of the SUS: equity. Equity means providing differentiated care in accordance with individual needs. Thus, the absence of specific care tailored for people with schizophrenia and their families represents a failure to put this principle into practice. Barriers to implementation of better care practices in SUS include the absence of long-term mental health plans, insufficient financing, poor management practices, lack of mental

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health professionals, fragmented integration between health services, and political issues.[5] Despite underfunding, the existing SUS infrastructure – around 3,000 mental health community centers across Brazil – could be adapted, taking advantage of its large coverage and articulating initiatives with primary care and emergency services.

As previously discussed, treatment is a fundamental tool to reduce vulnerability, but it cannot be confined to mental health or even general health centers – it must reach the community. In terms of outreach, several promising strategies have been developed and tested internationally. The Assertive Community Treatment model, for instance, has shown that multidisciplinary teams providing intensive, community-based follow-up can improve both clinical stability and social functioning, with evidence of favorable outcomes in low- and middle-income countries.[6,7] Other examples include Clubhouses, which emphasize psychosocial rehabilitation and peer support, and Mobile Crisis Teams, which deliver immediate, on-site intervention during acute crises. Nevertheless, most of the evidence for these initiatives comes from high-income countries[8]; data supporting large-scale implementation in lower-income settings remain limited.

Interventions to directly address social vulnerability are equally essential. Conditional cash-transfer programs have demonstrated effectiveness in reducing mortality among hospitalized psychiatric patients. Supported employment programs – including training and individualized job placement – increase employment rates, improve occupational functioning, and reduce hospitalizations. Housing-first models such as Permanent Supportive Housing offer stable housing and promote community integration within a recovery-oriented framework, especially when combined with ongoing clinical and social support. Strategies like Permanent Supportive Housing are more widely implemented in better-financed health systems across the globe, although studies suggest that they are feasible even in less wealthy countries.[9]

Another paradigm shift is needed in how schizophrenia-related indicators are conceptualized and used. Indicators constitute a tool for continuous assessment of effectiveness and for promoting long-term improvement.[10] Most proposed indicators have focused on treatment outcomes or structure assessments (e.g., number of beds or community centers per unit of population).[11] In line with our concerns, socially oriented indicators should be adopted alongside treatment-based measures. Unemployment rates, independent living, educational achievement, and family and individual income represent reasonable starting points; these can be further refined through broad stakeholder discussion and adapted to local contexts.

In sum, there is no meaningful way to discuss real improvement in schizophrenia without placing social vulnerability on the agenda of managers, researchers, and clinicians. Health managers need to develop policies, promote intersectoral programs, and incorporate social measures as outcomes of interventions. From a research perspective, implementation studies that address how social vulnerability affects interventions – and identify effective strategies to mitigate it – represent a major unmet need. Clinicians, in turn, should routinely assess social vulnerability and adapt evidence-based practices to the lived contexts of people with schizophrenia and their families, adopting a socially sensitive approach to care.

Addressing this agenda will require both innovation and co-development involving people living with schizophrenia, as well as health and social-care professionals. No matter how difficult the task, we urgently need new solutions that, while aligned with the principles of public health, are above all capable of providing real and sustained support to those who are most vulnerable.

Disclosure

The authors report no conflicts of interest.

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