Working on the Helpline

This section covers the information you need in order to work on the helpline in a way that is safe and appropriate.

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Helpline remit

The OCD Action helpline is a confidential and unbiased service offering help, information and support for people living with OCD and related conditions, as well as people in their lives. This includes anyone who is concerned that they or a loved one has the condition.

We describe the helpline as a 'listening and information' service, as these two terms best describe what we do, and don't provide.

Listening refers to the fact that we provide a space to talk about how someone is feeling, regardless of what information they might also be looking for. We do not offer any 'active' emotional support such as counselling, sharing personal experiences, or guiding someone through what they 'should' talk about. The initial training covers listening skills and how we listen on the helpline, and these will continue to develop as you gain experience.

This element of the helpline is very important to the work we do, as without it many of our service users wouldn't be able to engage with the information we provide. Active and understanding listening lets them know that we do get what they are going through and that we are a safe and trustworthy source of information. Someone might speak to us more than once before deciding what actions they want to take towards treatment.

That being said, we do not provide a regular space to just talk. If someone asks for this or you get the impression it might be helpful, you can signpost them to our many support groups. Through these, they can get more regular talking support.

Information distinguishes what we offer from advice. Generally, it can be fairly easy to identify the difference – is what you are telling the person coming from a factsheet or official source, or from your own opinion?

This can feel a little more complicated to differentiate when supporting someone with an advocacy issue or when they have more than one option to choose from. As a guideline, what can help is to make sure you've covered all the relevant options and that you are giving factual information about the likely outcomes, rather than your own opinion on which would be best.

For example, we cannot make a clinical assessment of a person's needs, so you couldn't tell someone that the correct choice for them is a more specialised service. What you could do, though, is explain their options to them and which service is recommended for certain criteria. If the person objectively matches the criteria for the more specialised service you can tell them that, too.

We also cannot suggest coping or symptoms management strategies, as we don't have any training in assessing which ones might be helpful or harmful to an individual.

You might have personal experience of OCD recovery through your own journey or that of a loved one, and it's understandable to want to share what helped you/them with callers who are struggling with what sounds like a similar situation. You should never, though, be giving advice based on what you have seen work or what you think might be best for the person, because the right circumstances and support for one person might be unhelpful or even harmful to another. For this same reason, you shouldn't go into detail about the treatment you received and what worked for you.

The golden rule of information giving is that we never provide **medical or legal advice**. We can only provide basic information, which is covered in the factsheets.

Be especially clear on this with **medication**. All decisions should always be referred back to speaking with a doctor, we can only list what is recommended generally and proven to help.

Lone and remote working

The helpline is now a fully remote service, which means that volunteers must be able to do every element of their shift from home. At the time of writing this handbook, the OCD Action office is not in use due to COVID-19. When the office is open for use, London volunteers will have the option of doing their shift in the office, but this would be dependent on desk availability.

Lone working does not mean working alone and shouldn't feel like it. There will always be a member of staff who is on-call and available for questions or concerns. If you join a shift in which multiple volunteers are working, you will also be able to speak to the group (including the supervisor) after your shift.

Despite this, there are some things that you will be more responsible for than if you were working in the office with a member of staff in the room with you. Technology is a big part of this. You will receive training on how to use all of our forms and apps, and you can also find in-depth instructions on all of them in this handbook, but you still need a degree of IT literacy in order to use them all independently. Never hesitate to ask a member of staff if you want to check something, but they will not be able to watch you do the work or check it over on a regular basis.

Your working space is also very important. If you share your home with other people, make sure that you can have a quiet and calm space without interruptions for your full shift. You also need to keep a careful eye on your self-care, as lone working can cause volunteers to 'push through' a shift, as the organic pauses or conversations that would usually come up in an office are missing. Make sure to take breaks, adjust your environment for comfort, and speak to the shift supervisor if you are feeling affected by a call or email. You can also read the OCD Action volunteer handbook for information on how to work safely and protect your health.

Never take part in a shift without having agreed to it with a member of staff, whether this is by email or over the phone. This is necessary for reasons of safeguarding, confidentiality, and helpline co-ordination. Taking part in work on the helpline that has not been agreed to might result in us ending your volunteer role.

Speaking to young people

Your DBS and the helpline insurance both cover you to work with children, so if you find out that you are speaking to a young person you don't need to panic.

We advertise ourselves as a service for adults. This is because we don't have any specific training in working with or safeguarding young people. Occasionally, though, we might end up speaking to young people, especially older teenagers.

If find out that you are speaking to someone who is under 18, please follow these guidelines:

1. Ask whether someone in their life knows about their issues. We are not asking this because they need to have told someone, and it is not our role to try to convince them to. It just helps us to assess any possible concerns that can come up.
   Keep in mind that anyone 16 or over can make decisions about their health independently.

2. Close the call as soon as possible, using your judgement. For example, if the young person is in crisis don't shut them down or rush them.

3. If the person is 14 or older, let them know about the youth service and offer to send them information about OCD and the youth service by email or in the post. You can also let them know that we can speak to an adult of their choice, if this is appropriate to the situation.

4. If the person is 13 or younger, explain that we can't speak to children on this helpline, but we would be happy to speak to an adult of their choice about things.

5. Speak to your shift supervisor about the call.

Confidentiality

The OCD Action helpline is a confidential service. Outside of very specific safeguarding situations (see Safeguarding section below), anything that is said to you as a volunteer remains confidential <u>between the service user and the charity</u>.

Please make sure you are confident with all the helpline procedures around confidentiality. It is important to know these in order to protect service user privacy and in case you are asked questions about them.

Anything said to you might be shared with a member of staff if appropriate – you cannot promise to keep something between just yourself and the service user.

Confidentiality is not just about data, but about respect. You might share information to ask a question, to raise a concern, or as part of your regular supervision – this may include speaking about frustrations and judgements, but with the aim of offering the best possible support. It is never appropriate to speak about calls and service users as gossip or to ridicule them.

No one from the charity – volunteer or staff – will share any information given by a service user outside of OCD Action *unless* for safeguarding reasons. You can describe this with something like "We won't share anything you say with anyone outside OCD Action, unless we are very concerned that someone is at risk of real and serious harm".

Our calls are not recorded but there might be a volunteer or member of staff listening as part of our training and quality control.

Any handwritten notes you might take during a call that have any personal information on them must be destroyed at the end of a shift. If you are working from home and don't have a shredder, you can soak written notes in a bowl of water for 5 minutes and squish them into a ball of mush before throwing them away.

We cannot contact someone or speak to them unless we have heard from them that they want us to. If a service user gives you the number or address of another person, explain that you cannot use these unless the person contacts us themselves. They can do this by email, by leaving a message, or by filling out the online form.
You should generally avoid speaking to someone who wasn't the original caller, as a lot of the time they might feel under pressure to do so. Instead, you can encourage the caller to ask their family member to contact us themselves. If it is absolutely clear that the other person wants to speak to you, that might be appropriate. It can help to ask the question "Were they expecting to speak to me?".

We cannot make referrals for people or fill out a form on their behalf. We cannot share their details with other organisations, even if they ask.

Handling private information

In order to simplify complying with the GDPR, every piece of data we work with is through a specific online platform that is, itself, GDPR compliant.

Basically, what this means is that you should never hold **any** service user data yourself, it is all through websites and apps. If you follow these few rules you will not have to worry about GDPR:

1. As per the confidentiality policy, any handwritten notes should be destroyed at the end of each shift.

2. Only ever send service user information from the Helpline inbox, never from your personal email.
   If you accidentally send details from your personal email, immediately delete it from your Sent folder.

3. Do not discuss calls or service users by text, only through the 3CX app or the Helpline email.

4. Never download any attachments sent by service users or the voicemail attachments unless it's absolutely necessary.
   If you do download a file, delete it immediately from the folder **and** from your recycle bin.

5. If you ever share your computer, you must have separate accounts on it. You can either make a separate account for guests or a separate one for OCD Action.

6. If you have passwords written down anywhere, make sure these are hidden safely and never near information on what they are for. You must let us know straight away if someone might have gotten access to them.

7. If writing notes for Next Steps, do not use identifying information like name, age, or where someone lives.

Safeguarding

You should have already read the OCD Action Volunteer Handbook, which includes the full safeguarding policy. You will have confirmed in writing that you have read and understood it.

If you don't remember the policy, please go read it again before carrying on with reading this handbook.

This section can be used as a quick-reference version of the safeguarding procedures as they apply to the helpline, which you can use to track your steps in case of a concern. This <u>does not</u> replace reading and understanding the full policy.

Three types of safeguarding reports

If the caller is disclosing information that you think might result in a safeguarding report, flag this to the shift manager through the 3CX app (see relevant guidelines). Unless this is not possible because of a simultaneous issue, the manager will start listening in to the call.

Urgent disclosure: If the caller tells you they are planning on taking harmful action in that moment, or that someone else will be, you will need to make a decision yourself about calling the emergency services. You would then report this to the shift manager or the safeguarding lead immediately afterwards to hand this over to them.

"Because it's part of my job to keep you physically safe, I am going to have to contact the emergency services about this and pass on your phone number. They will probably give you call. Is there anything else you would be happy for me to pass on?"

Non-urgent disclosure: If the caller tells you they are planning on taking harmful action, or that someone else is, but this is not currently happening, ask for consent to call the emergency services. If they do not consent, instead report to the shift manager or the safeguarding lead.

<u>Note</u>: This includes past events of abuse or harm – we will need to report if it involves a child. The safeguarding lead will make a decision if it only involves adults.

"I'm very concerned for your safety because of what you've said. I'm wondering whether you would be ok with me contacting the emergency services for you."

"I am going to have to speak to my manager about this so that we can help you stay safe. They might give you a call back to speak a bit more about this to you, how would you feel about that?"

Concern: If the caller says something that makes you worried that someone is at risk of harm, report this to the shift manager. If the manager feels this might need further action, they will take it to the safeguarding lead or ask you to do so.

Consent

If there is an **immediate risk of significant harm**, such as the person making an attempt on their life while on the phone, always call emergency services as a first action, regardless of consent (If this happens, make sure to give your name and number to the service you contact, and to get the same information from them to pass on to the safeguarding lead).

If the caller is an adult but the risk **isn't** immediate, the decision about whether to break confidentiality will be taken by the safeguarding lead. Ask them for their consent for the charity to contact emergency services, as this will be part of the decision making.

If you do get consent, this will likely be a good opening into a more in-depth conversation (if there is time) about who can support them to keep safe and how, including who we might contact.

If the caller is under 18, we have a legal duty to report a concern, so you should not be asking for consent to do so. It will still be appropriate in most cases to have a conversation about your concerns and tell them you will have to report to a manager, as in the examples above.

What we mean by harmful action

Remember we are talking about risk and keeping people safe, so anything that puts either the caller or another person at serious risk of harm can fall under this category:
Suicide or unsafe self-harm
Compulsions that bring a risk of harm
Any form of abuse

We would **never** report a safeguarding concern based on intrusive thoughts.

Gathering information

You will need to use your helpline skills to find the right balance of gathering information without it feeling like an interrogation. Remember, the most important thing is to let them speak about what they are experiencing, without feeling judged or like they can't trust you.
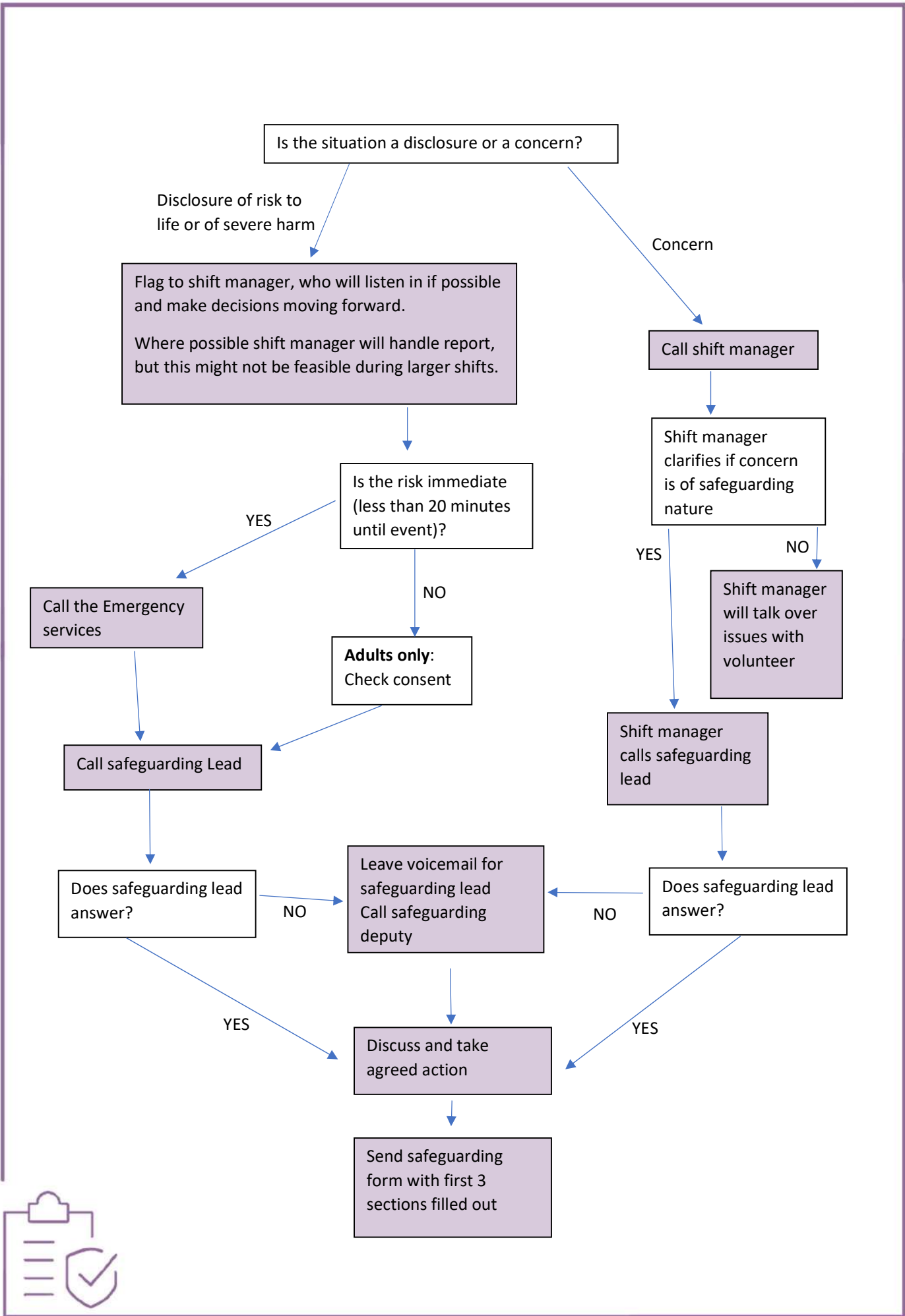
If the person is suicidal and talks about it in a way that concerns you, ask them about whether they have made any plans or have an idea of when they might do this.

If a caller is disclosing abusive behaviour from someone in their life, do not attempt to give safety advice and do not try to convince the caller to end the relationship. Just take down notes about the situation as accurately as possible, using the caller's own words preferentially. Don't ask any questions outside of checking to see you've understood correctly. Let them know they have done the right thing by being honest about what is happening.

Depending on what the concern/disclosure is, it can help to find out:

- What has happened
- Age (specifically over or under 18, though young adults and older people might also be at higher risk of abuse)
- Where they are
- Whether there is a mental health or social care team involved
- Who else knows about the risk (family, professionals...)
- What is already in place to help to keep someone safe

Is the situation a disclosure or a concern?

Disclosure of risk to life or of severe harm

Concern

Flag to shift manager, who will listen in if possible and make decisions moving forward.

Where possible shift manager will handle report, but this might not be feasible during larger shifts.

Call shift manager

Shift manager clarifies if concern is of safeguarding nature

Is the risk immediate (less than 20 minutes until event)?

YES

NO

YES

NO

Call the Emergency services

Adults only: Check consent

Shift manager will talk over issues with volunteer

Call safeguarding Lead

Shift manager calls safeguarding lead

Does safeguarding lead answer?

NO

Leave voicemail for safeguarding lead Call safeguarding deputy

NO

Does safeguarding lead answer?

YES

YES

Discuss and take agreed action

Send safeguarding form with first 3 sections filled out

Working inclusively

Inclusivity is the practice of actively including people. This of course means not putting barriers in place for any group, but it also means working in a way that reduces the barriers that are already in place. In order to do that we need two main things:

1. To know what the barriers are
2. To work in a way that is informed by this knowledge

There is no one perfect way to work inclusively – we can only really do these things by listening to the person and what they need. You'll remember that listening is about putting yourself in the other person's shoes and not bringing any judgements to what they are saying. That being said, having some awareness of different ways or reasons a person might be excluded can help, as long as you're not making assumptions from it.

Working inclusively can mean:

- Sending varied resources
- Giving information in a different way
- Exploring reasonable adjustments around accessing the helpline
- Believing someone's experience of the NHS, even if it was different from your own
- Listening out for what is and isn't working for this person

It can also help to have an understanding how different situations, backgrounds, and forms of oppression can impact on a person's OCD, mental health, and access to treatment.

Below, you can find some informally written-up information and articles about how OCD and mental health are affected by different elements of oppression – please read through everything that's actually in this document, and then click on any links if you want. The point is not to learn facts, but rather to gain insight on what are often invisible or unexpected impacts on care and mental health. These are by no means an extensive list of ways in which they manifest.

> **Challenge:** Pick a section from below, ideally one that you don't know much about or that you're not convinced by. Look for your blind spots. Then do 15 minutes of Googling about how that form of marginalization or oppression happens in the field you work or have an interest in.
> (This isn't compulsory, but it's only 15 minutes!)

Oppression

Wadsworth, Potluri, Schreck, and Hernandez-Vallant (2020) did a study with people getting intensive treatment for OCD. They measured symptoms of depression, symptoms of OCD, quality of life, and levels of marginalisation (based on how many oppressed or minority groups a person was a

part of). They found that, both at the start and the end of treatment, higher levels of marginalisation were correlated to worse symptoms and quality of life.

The conclusion they made is that oppression has a negative impact on mental health – which I'm sure we can all agree with.

It could also be (though I don't know if they mention this themselves) because people from marginalised groups have to have worse symptoms in order to be offered intensive treatment, which is something that has definitely been found in the physical health sector.

Did you know, most psychological research is done with wealthy white participants, but the findings are generalised for everyone?
https://www.spectrumnews.org/opinion/psychology-research-skews-mostly-white-and-wealthy/

In fact, I remember hearing once that a huge percent of psychology research participants are psychology students!

The International OCD Foundation also have a piece about working with English as a second language (there isn't a section this would go best in, so I'm just putting it here):
https://iocdf.org/expert-opinions/challenges-of-treating-spanish-bilingual-patients-in-a-primarily-english-speaking-setting/

You will probably notice when reading below that a lot of these elements of oppression aren't fully separate from each other, and I hope this helps you see how they might stack up and combine in different situations.

Age

A major issue that older people come across when trying to access support for their mental health is the stereotype that depression is inevitable. This results in mental health and support services not offering the same services to them as they would to others, because part of their distress and low quality of life is assumed to just be a part of getting older. We have heard from service users about medical professionals asking them if it's really worth it to go through treatment, and the stereotype becomes internalised even if nothing like this was directly said to them – we speak to a number of people who have made the decision on their own that it's not worth it.
https://www.mentalhealthtoday.co.uk/blog/older-people/depression-isn-t-an-inevitable-part-of-ageing-challenging-ageist-stereotypes-in-the-mental-health-field

Older people are also affected by the ableist use of health economics, which assigns a monetary value to the health, needs, and life of every person (more on this in the Disability section):
https://pubmed.ncbi.nlm.nih.gov/10694760/

This articles explore ageism and access to mental health:
https://www.mindpathcare.com/blog/theyre-people-too-ageism-and-mental-health/

Disability

Ableism is discrimination based on how an individual's body or mind works. It's founded on the idea of a fully able-bodied and neurotypical person being the general normality, and everyone else being an outlier. It affects people with physical conditions, learning disabilities, invisible disabilities, neurodivergence, mental health conditions, as well as bodies or genetics that don't conform

with the norm (but are not disabled). All of these things could have an effect on how their OCD presents, how it affects their life, and how it is responded to by those around them.

Physical conditions are exacerbated by anxiety and trauma, and the pain and/or physical barriers of the condition are likely to have a negative effect on the person's OCD, meaning a flare-up of either condition can turn into a strong downward spiral. Neurodiversity and mental health conditions also interact directly with OCD and might cause the OCD to go unnoticed or be misunderstood. People struggling with both OCD and any other disability will have more complex support needs, yet they're most likely to be ignored. Other neurodivergence like ASD, ADHD, or LD are even used as reasons to not offer therapy for OCD, even though there is guidance out here on how to adapt the therapy to them.

One reason ableism is so entrenched and systemic is the model of health economics, mentioned above. This was introduced as a way to improve cost-effectiveness and, with it, the NHS' ability to offer high quality treatment. Instead, it is often used as a tool to offload people with high support needs to the cheapest possible option, causing more costs overall: https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity#:~:text=People%20with%20long%2Dterm%20conditions,those%20with%20a%20single%20condition.

Ableism also affects OCD directly in several ways, as you have all experienced while working on the helpline.

The article about 'socioeconomic status' in the Social background section below found that "A final result of the survey showed that patients with OCD frequently utilized healthcare services. While the number of hospitalizations per year was similar to the control population, people with OCD were more likely to report needing but not receiving help for emotional and mental health problems or problems with substance abuse. The study investigators suggest that this finding exposes a gap in treatment and resources available to help patients with OCD."

Ethnicity

Ethnicity means a lot of things – it holds within it a relationship to culture, to one's own identity, to stereotypes that are part of the social structure, and to the body. While ethnicity is not a genetic reality (we could also differentiate people by hair colour, height, or earlobe shape!), it is a long-standing social one and so its significance is personal, societal, and systemic. The effect it can have on mental health ranges from stigma around mental health, to fewer resources, to what kind of symptoms might manifest.

Psychology has not been inclusive around ethnicity. The IQ test, which was created to measure special needs in schools, was quickly turned into a tool for racism. Even though we know now that the test is culturally biased, there are still people who point to lower scores in non-white immigrants as proof of white superiority.

This research article is about a study that found that racial discrimination correlated to more severe symptoms of OCD, but other discrimination wasn't. It also talks about the experience of OCD in black participants of various studies:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6200143/

The International OCD Foundation has a page about OCD in the black community:
https://iocdf.org/expert-opinions/african-americans-with-ocd-a-hidden-population-and-new-research/

and has recently written a piece in response to the Black Lives Matter movement:
https://iocdf.org/expert-opinions/african-americans-with-obsessive-compulsive-disorder-black-lives-matter/

Racism is experienced in different way by different groups, yet it sometimes also manifests in research, writing, and resources for people of colour being generalised, so that the two 'categories' are white and non-white instead of reflecting the actual diverse needs and experiences of people from different backgrounds.

Wu and Wyman (2016) have pointed out within their research that most ethnicity-based research done around OCD only compares Black and White participants. They tested previous results of a Black and White only study and didn't find the same split when the participants were more ethnically diverse. I can also confirm that I couldn't find anything else that wasn't black-focused under a few different search terms.

Gender

It is very well researched and widely accepted that stereotypes and pressure towards gender-confirming behaviour has a negative impact on the mental health of both men and women.

This article explores differences between men's and women's experiences of mental health:
https://ramh.org/guide/gender-differences-in-mental-health/

An interview with four men about their OCD and the pressure of sucking it up to "be a man":
https://metro.co.uk/2018/02/22/five-men-open-up-about-what-its-like-to-live-with-ocd-7334705/

Mizock and Russinova (2016) wrote about the disadvantages that women struggling with their mental health encounter. These "include higher rates of victimization, unemployment, poverty, homelessness, and inequities in clinical care", and are deeply tied with other, overlapping elements of stigma and oppression.

This article talks about the writer's experience of being a woman with OCD, and how stereotypes about women and mental health combine into the particular way people around her act:
https://feminisminindia.com/2018/06/20/living-ocd-not-instagrammable/

This much more in depth article explores the same, with reference to the book "Because We Are Bad", and talks about social effects on OCD:
https://slate.com/technology/2018/05/lily-baileys-because-we-are-bad-made-me-rethink-ocd.html

Religion

Religious discrimination is also a barrier to getting treatment for both mental and physical health. This is not only in the more obvious way of not being offered the same level of support and understanding, but also because clashes between religious beliefs might affect what the support looks like. For example, not having a female practitioner available to examine a woman who doesn't feel comfortable being alone with a man. Another example is a patient who refuses a certain

treatment for religious reasons, and the doctor not only dismisses and shames this decision, but does not make any effort to find and alternative.

Also like other forms of discrimination, experiencing religious discrimination can have a very damaging impact on a person's mental health: https://www.researchgate.net/publication/281171630_Religious_discrimination_and_common_mental_disorders_in_England_a_nationally_representative_population-based_study

And like with culture, religious background can also be a source of stigma and shame around mental health, which reduces the chance of someone reaching out in the first place: https://medicalxpress.com/news/2019-04-mental-health-stigma-fueled-religious.html

One of the common themes in OCD is religious fears and scrupulosity, which is obviously hugely intertwined with the person's actual religious beliefs: https://ocdla.com/scrupulosity-ocd-religion-faith-belief-2107

Medical, mental health, and support professionals who have their own religious beliefs are likely to respond differently to the intrusive thoughts and compulsions of someone with the same beliefs than to those of a person with different ones. They might go along with compulsions more if they agree with the importance of that behaviour, or they might argue more aggressively against intrusive thoughts based on beliefs they don't share – both of these have a negative impact on the patient.

The NICE Guidelines for treatment of OCD say -

"2.6.3.1 Obsessive-compulsive symptoms may sometimes involve a person's religion, such as religious obsessions and scrupulosity, or cultural practices. When the boundary between religious or cultural practice and obsessive compulsive symptoms is unclear, healthcare professionals should, with the patient's consent, consider seeking the advice and support of an appropriate religious or community leader to support the therapeutic process."

Sexuality and gender identity

I've always wondered – why is it more often referred to as Homosexual OCD, rather than Sexuality OCD? Lots of gay and bisexual people struggle with intrusive thoughts about the opposite sex. The assumption of heterosexual and cisgender (straight and not trans) as the norm or starting point is very harmful to the LGBT community and individuals within it, especially when it interacts with a condition that is very heavily affected by shame, isolation, and social concepts. Within this assumption, straight and cis people are not questioned about their identity, while gay, bisexual, transgender, and nonbinary individuals live in a world in which those in power and in the media debate how early is too early for them to "be sure" of who they are. I expect you can imagine what effect that kind of pressure to be sure would have on someone with OCD.

There is also the added issue of homophobic and transphobic beliefs, still very alive today, that members of the LGBT community are sexual predators. This can impact on how sexually intrusive thoughts are responded to by professionals.

This article explores higher levels of anxiety in the LGBT community:
https://www.anxiety.org/lgbtq-anxiety-depression

This article is about the writer's experience of OCD ruining his hormonal transition, because of the pressure to "be sure":
https://letsqueerthingsup.com/2016/08/25/mental-illness-has-impacted-my-transgender-identity/

This research article starts - "Today's lesbian, gay, bisexual, and transgender (LGBT) youth come out at younger ages, and public support for LGBT issues has dramatically increased, so why do LGBT youth continue to be at high risk for compromised mental health?"
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4887282/

This research starts – "Transgender and nonbinary patients have a wide array of experiences when attempting to access healthcare, including discrimination and having to educate providers about trans people" and explores the effect this has on mental health:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6909214/

Personally, this reminds me of the similar issues people with OCD have, both when trying to access OCD treatment and when using other medical services. I imagine having to deal with that for two such big elements of your life would have exponential effects on mental health.

Social background

Social class has always been a strong influence in British social structure. Today, different things about someone might bring on classist discrimination, including context of birth, education, financial situation, visible appearance, or accent. On top of discrimination, low funds in the local area often reduce access to resources – fresh food, treatment, jobs, community spaces, public services, information – which has a direct and compounding effect on both physical and mental health. It can even have an effect on how likely someone is to seek free help:
https://www.independent.co.uk/news/uk/home-news/middle-classes-use-charity-services-far-more-than-britains-poor-9931689.html

Classism is one of the forms of oppression that are still largely considered part of the norm and reasonable by public opinion. Out of all of the groups in this document, it is the only part of someone's identity that is not protected against discrimination under the Equality Act 2010.
https://www.lawgazette.co.uk/features/classism-the-unseen-prejudice/5103455.article

This study found that, among other things, 'socioeconomic status' correlated with more severe symptoms of OCD:
https://www.psychiatryadvisor.com/home/topics/anxiety/obsessive-compulsive-and-related-disorders/ocd-associated-with-socioeconomic-factors-and-mental-health-comorbidities/

The charity Class Action is one place to learn more about the effects of class, but is written from an American perspective – here is an article from them about mental health:
https://classism.org/class-money-and-mental-health/