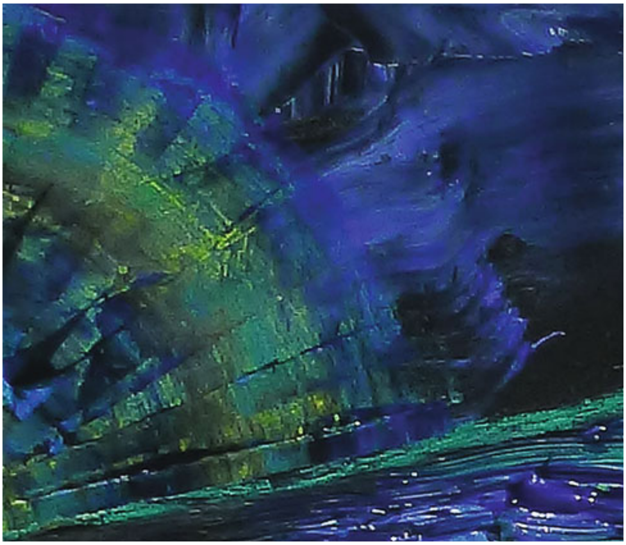
Sabine Bährer-Kohler
Francisco Javier Carod-Artal *Editors*

Global Mental Health

Prevention and Promotion

Springer

Global Mental Health



Sabine Bährer-Kohler
Francisco Javier Carod-Artal
Editors

Global Mental Health

Prevention and Promotion

Springer

Editors
Sabine Bährer-Kohler
Dr. Bährer-Kohler & Partners
Basel
Switzerland

Francisco Javier Carod-Artal
International University of Catalonia
Barcelona
Spain

ISBN 978-3-319-59122-3   ISBN 978-3-319-59123-0 (eBook)
DOI 10.1007/978-3-319-59123-0

Library of Congress Control Number: 2017940540

© Springer International Publishing AG 2017
This work is subject to copyright. All rights are reserved by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed.
The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.
The publisher, the authors and the editors are safe to assume that the advice and information in this book are believed to be true and accurate at the date of publication. Neither the publisher nor the authors or the editors give a warranty, express or implied, with respect to the material contained herein or for any errors or omissions that may have been made. The publisher remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Printed on acid-free paper

This Springer imprint is published by Springer Nature
The registered company is Springer International Publishing AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

We are grateful to the publishers and all co-authors, especially Prof. Amering for their valuable contributions and their cooperation with us.

Many thanks to our families for their understanding and their cordial support.

Foreword I

The process towards and the adoption of the 2030 Global agenda for sustainable development has enabled mental health to finally emerge as an international priority to secure health, well-being, and human development. This political recognition of mental health is an indication of the growing awareness and agreement amongst a global set of stakeholders including governments, policymakers, mental health professionals and scholars, human rights advocates, and individuals who use mental health services that there is a need to meaningfully invest in the mental health and well-being of individuals and societies.[1]

At the conceptual level, there appears to be a consensus that more focus on the current global state of mental health is necessary and for the need to develop a more robust set of responses to promote and address mental health at the community level. Over the past two decades, the World Health Organization and various international, regional, and national stakeholders have fortified the understanding of mental health gaps, needs, and challenges, developing guidance and tools for community-based interventions based on a modern public mental health framework that holistically addresses promotion, prevention, treatment, rehabilitation, and recovery. Concurrently, international human rights standards have normatively developed, exposing the grossly unmet global need for rights-based responses and services that respect, protect, and fulfill the right to mental health in law, policy, and practice. These converging public health and human rights developments point towards a human rights framework to understand, respond to, and secure mental health that is informed by modern public health interventions, clear scientific evidence, and the active participation of individuals and communities as the road ahead.

Regrettably, in the everyday reality, we still bear witness to policies and practices that ignore a growing evidence base in support of social psychology and

---

[1] Report of the UN Special Rapporteur on the right to the highest attainable standard of mental and physical health, Dainius Puras, A/71/304, August 2016, http://ap.ohchr.org/documents/dpage_e.aspx?si=A/71/304. Accessed 11 December 2016.

psychiatry, mental health promotion and prevention, and community led voluntary mental health services. Likewise, these same policies and practices contribute to systemic and widespread human rights abuse, failing individuals, families and communities, deepening stigma and social exclusion, and undermining the highest attainable standard of health for a growing population of individuals desperately in need (Drew et al. 2011).

Despite a strong evidence base and human rights requirements to address underlying determinants of mental health through health promotion and prevention, it is relegated to the periphery. Policymakers often consider promotion and prevention as not requiring public investment (Saxena et al. 2007), as though mental health and well-being can be promoted just by good will. In public policy decision-making, particularly when it comes to prioritization, promotion and prevention are often on the losing side to a powerful lobby of biomedical interventions that are focused on diagnostics at the individual level for those already thought to have mental health conditions and intended to produce a curative outcome (Bracken 2014). Interestingly, evidence has shown that these expectations based on promises from biomedical paradigm are not being realized and troublingly, many of biomedical interventions, especially when excessively used, might be causing more harm than good (Kleinman 2012; Tyrer and Kendall 2009). The experiential evidence of an increasingly mobilized group of former and current users of certain excessive biomedical interventions paints a powerful picture of egregious violations of human rights and medical ethical obligations to do no harm (Newman et al. 2015).

The power asymmetries, which favor a biomedical set of technocratic gatekeepers at the policy level, lack of transparency, and other factors, predetermine low status and insufficient allocation of human and financial resources for interventions which can effectively promote well-being and prevent mental ill-health. The right to health must be understood to serve a rich sense of health as defined by the World Health Organization—the narrowly constructed biomedical model currently favored in mental health policy is therefore, not compliant with the right to health and other human rights. Human rights, and the right to health specifically, offers a powerful normative counterweight to this imbalance and demands parity for prevention and promotion interventions.

The author would like to especially highlight the principles of non-discrimination and equality and the need to protect everyone from all forms of violence. The world seems to have forgotten why the Universal Declaration of Human Rights was adopted in 1948, giving birth to later UN Human Rights Treaties, which legally protect the rights of children, women, older peoples, persons with disabilities and many other groups in vulnerable situations. Today we witness different creative ways of departing from universal human rights obligations, tolerating, justifying, and even condoning violence and discrimination of certain groups, and thus escalating vicious cycle of discrimination, exclusion, stigma, and helplessness (Zeid Ra'ad Al-Hussein 2016).

Evidence has shown one of the most effective ways to promote mental health and well-being of individuals and populations is to invest in healthy, respectful, and non-violent relationships. The right to health also normatively binds States to take targeted, concrete steps to progressively securing this objective. This requires policy-makers to tackle health promotion in a sustainable, cross-sectorial manner, including through policies and programs that promote competent parenting, support families, particularly those in vulnerable situations, and prevent any forms of violence in families, schools, workplaces, communities, and all other settings. All this requires continuous investment in evidence-based measures, informed through a participatory process, and calls for an end to tolerating and condoning violence, addressing violence with other forms of violence, or investing in retrogressive approaches that are informed by ideology and political expediency rather than science, evidence, and human rights.

The same obligations that apply to investing in enabling environments and non-violent relationships in families, schools, workplaces, and communities, and thus promote mental health, must also apply to healthcare settings, including all facilities which provide mental health services. However, there is abundant evidence that too often mental health services are provided in a manner which violates the rights of service users, disempowers them, and hence fail to promote their mental health and prevent their mental ill-health (World Health Organization and The Gulbenkian Global Mental Health Platform 2015). Too often mental health facilities, instead of promoting mental health and applying the principle “first do no harm”, use coercion, force, degrading and inhuman treatment and thus facilitate stigma, discrimination, exclusion, and helplessness (Mendez 2013).

Poverty, discrimination, and violence are both causes and consequences of mental ill-health. They disempower children and adults from having ability to constructively control their lives and thus may destroy fundamental elements of human dignity, self-esteem, resilience, and quality of life. This is why addressing poverty, violence, and other major risk factors by investing in universal human rights and public health principles is the basis which should guide all activities aimed to promote mental health.

The book “Global Mental Health: Prevention and Promotion” edited by Prof. Dr. Sabine Bährer-Kohler and Prof. Francisco Javier Carod-Artal in this regard is a very timely and needed step in advancing and disseminating knowledge about up-to-date approaches in mental health promotion and prevention. I can recommend this book as a multiplier, to bring the topic out of the shadow—all over the globe.

Dr. Dainius Pūras
Professor of Vilnius University
Faculty of Medicine Vilnius University
Vilnius, Lithuania

References

Bracken, P. (2014). Towards a hermeneutic shift in psychiatry. *World Psychiatry*, *13*(3), 241–243.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S. et al. (2011). Human rights violations of people with mental health and psychosocial disabilities: and unresolved global crisis. *The Lancet*, *378*(9803), 1664–1675.

Kleinman, A. (2012). Rebalancing academic psychiatry: why it needs to happen and soon. *British Journal of Psychiatry, 201*, 421–422.

Mendez, J. E. (2013). Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Retrieved December 11, 2016, from http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

Newman, D., O'Reilly, P., Lee, S.H., Kennedy, C. (2015). Mental health service users' experience of mental health care: and integrated literature review. *Journal of Psychiatry and Mental Health Nursing*, *22*(3), 171–182.

Saxena, S., Thornicroft, G., Knapp, M., Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *Lancet, 370*, 878–889.

Tyrer, P., Kendall, T. (2009). The spurious advance of antipsychotic drug therapy. *Lancet*, *373* (9657), 4–5.

World Health Organization and the Gulbenkian Global Mental Health Platform. (2015). Promoting rights and community living for children with psychosocial disabilities. Geneva, World Health Organization. Retrieved December 11, 2016, from http://apps.who.int/iris/bitstream/10665/184033/1/9789241565004_eng.pdf.

Zeid Ra'ad Al-Hussein (2016). Human Rights Day 2016: Statement of the High Commissioner for Human Rights Zeid Ra'ad Al-Hussein. Retrieved December 11, 2016, from http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21004&LangID=E.

Foreword II

At the beginning of the twentieth century, Sigmund Freud and his follower psychoanalysts brought about a movement with a great hope that mental illness could be cured or prevented. That optimism was based on the principle that early intervention in childhood could prevent mental illness in the adult. The movement never accomplished its prevention goals, but it stimulated interest and ambitious efforts to apply psychological and health theories to a broad spectrum of mental illnesses.

In the 1950s and the 1960s, it was widely hoped that major mental illnesses could be prevented from ever occurring. The belief was that, if children were properly cared for from conception to maturity with the application of proper psychosocial developmental principles, they would develop with healthy "egos", not subject to the ravages of mental illnesses. To achieve these goals, mental health prevention programs were directed toward educating all persons who could influence child development, from the obstetrician and the pediatrician to the schools and other social institutions, with the greatest efforts being directed toward parents themselves. Efforts to disseminate these programs were made through the media, books on child rearing, and lectures and seminars.

Unfortunately, efforts to prevent the development of mental illnesses through the application of psychological principles failed because the theory of causation of many of the illnesses was incorrect. As genetic patterns and biological abnormalities have been discovered, past failures in primary prevention became understandable. Mounting evidences indicate that physical and sexual abuse in childhood can cause lifelong symptoms due to psychological turmoil. Similarly, adults experiencing psychological stress for various reasons are likely to incur physical and mental illnesses, have accidents, and be unproductive in their job. Consequently, educational efforts to help people handle and reduce stress in their lives are well-directed primary prevention efforts beside efforts to reduce stigmatization.

Secondary prevention is the early detection and treatment of an illness to avoid or reduce permanent damage. Healthcare systems identify warning signals of emotional, cognitive, and behavioral problems and carefully target interventions to mitigate the development of illness through coordinated work of all the agencies most likely to come into contact with high-risk groups. Once risk is identified, the multidisciplinary care agencies with the integration of cultural aspects use their resources to address the needs of the at-risk person and their family. Whenever possible during secondary prevention initiatives, family structures are preserved, and out-of-home placement is avoided so that social development and integration of the individual are not disrupted. With regards to tertiary prevention, its core premise is rehabilitation. Because most serious mental illnesses follow a long and relapsing course, it is not appropriate to delay rehabilitation until treatment is complete. In this way, treatment and tertiary prevention are often concurrent processes.

Mental and physical health are often conceptualized as opposites. This originated from the traditional dichotomy of mind and body dating back to Plato. The dominance of the soul has its basis on the immortality of the soul against the mortality of the body. This viewpoint is now challenged because we recognize the impact of physical disability and illness on mental health and vice versa; therefore, physical and mental health must be considered together.

An individual-based approach has been the preferred approach in modern health care. Each individual over the lifespan exists in ‘networks of relation’ while maintaining an independent and distinct identity. In mental health, we need to consider the context of the wider relationships of an individual in a family or partnership, among friends, at work, in society, in a race or nation, and even in the global village. When we understand an individual’s networks of relation, we can look for disconnected, weak or undesirable relationships that produce emotional turmoil and need change or intervention. From this point of view, focusing on global mental health will enable us to hierarchically consider all networks of relation relevant to an individual.

Dementia and suicide are two notable examples of problems that affect both physical and mental health and reflect relation problems in individuals. Depression—the main cause of suicide—and dementia are global leading causes of disability and major contributors to the overall global burden of disease. Both dementia and suicide are on the increase with the aging population (Suh and Shah 2001; Shah 2010). The longer the people live, the higher the incidence of dementia and suicide is. If an individual can find a reason to live, they can bear almost any situation. A meaningful life can be extremely satisfying even in the midst of hardship, whereas a meaningless life can be a terrible ordeal no matter how comfortable it is.

Since the Industrial Revolution 200 years ago, states and markets have taken over the responsibility of providing for the individual—whether a man, a woman or a child, which was traditionally the role of families and communities. States and the markets now provide food, protection, shelter, education, health, welfare, employment, pension, and insurance for the individual. Nowadays many of us realize the loss of strong families and communities and feel alienated and threatened by the impersonal power of states and the markets. This phenomenon has been observed more frequently in developed countries, especially in the countries where industrialization is rapidly accomplished. The more industrialized the society, the weaker the traditional bonds of families and communities. However, many more people living in developed countries feel autonomous and independent, with more choices compared to individuals in less developed countries.

In modern societies, parents are obliged to send their children to be educated by the State. Their children are educated to become individuals, to marry whomever they desire without asking permission from their parents, to take up whatever job suits them, to live wherever they wish, and to be no longer dependent on their family or community. In less developed countries, where traditional bonds of families and communities still remain relatively strong, parents prioritize their limited resources to raise and educate their children, rather than save money, with the expectation that their children will take care of them when the parents are older. As children become their own individuals, older parents soon realize that their previous expectation is void because they are left alone and more likely to feel that life is meaningless.

In many developed countries, the single-individual household has become the most common type of household. This is real proof of the collapse of the family. Very few individuals are included in a community where they know one another well and depend on each other for survival. All problems, such as abandonment and death in a nursing home or suicide attempts thinking of no reasons to survive, may be related to the collapse of the family and the community as support networks (Suh 2015). This makes the individual vulnerable not only to hardship in life, but also more likely to feel that life is meaningless.

In sum, once we recognize that an individual's physical and mental health are associated with disconnected, weak or undesirable relationships in families, communities, markets, or the State, we can find a direction of necessary change to solve problems in networks of relation. The problems of an individual are not limited within the individual. Mental and physical health can be improved and maintained by promoting stronger and desirable relationships for those who, as global citizens, influence and are influenced by numerous networks of relation.

Guk-Hee Suh, M.D., Ph.D.
Professor of Psychiatry
Department of Psychiatry, School of Medicine
Hallym University, Dongtan Sacred Heart Hospital
Hwaseong-si, Gyeonggi-do
South Korea

References

Suh, G. H., & Shah, A. (2001). A review of the epidemiological transition in Dementia—cross-national comparisons of the indices related to Alzheimer's disease and vascular dementia. *Acta Psychiatrica Scandinavica*, *104*(1), 4–11.

Shah, A. (2010). The possible evidence for an epidemiological transition hypothesis for elderly suicides. *International Psychogeriatrics*, *22*(2), 219–226. doi:10.1017/S104161020999130X.

Suh, G. H. (2015). It is time to take action to reform long-term care insurance. *International Psychogeriatric Association Bulletin, 32*(2), 10–11.

The original version of the book was revised:
Post-publication corrections have been incorporated.

Contents

Editors and Contributors

About the Editors

Prof. Dr. Sabine Bährer-Kohler is Invited Professor for Mental Health at Tropical Neurology and Neuroinfection Master, International University of Catalonia (UIC), Barcelona/Spain. Doctor of Social Science. Managing Director Dr. Bährer-Kohler & Partners, Switzerland. President, Association for Mental Health—Global Mental Health, Switzerland.

Prof. Dr. Francisco Javier Carod-Artal is Consultant Neurologist and Neurology Service Lead, Neurology Department, Raigmore hospital, NHS Highlands, UK; Visiting Professor of Neurology, UIC University, Barcelona, Spain; Social and Cultural anthropologist; and Director, International Master in Tropical Neurology and Neuroinfection, UIC University, Barcelona, Spain.

Contributors

Michaela Amering Department of Psychiatry and Psychotherapy, Medical University of Vienna, Vienna, Austria

Priya Ranjan Avinash Department of Psychiatry, Himalayan Institute of Medical Sciences, Dehradun, Uttarakhand, India

Sabine Bährer-Kohler Dr. Bährer-Kohler & Partners, Basel, Switzerland; International University of Catalonia (UIC), Barcelona, Spain

Gary Bailey School of Social Work Urban Leadership Certificate Program, Boston, MA, USA; Dynamics of Racism and Oppression Sequence, Boston, MA, USA; Simmons College School of Social Work, Boston, MA, USA; School of Nursing and Health Sciences, Boston, MA, USA; Center for Primary Care-Harvard Medical School, Boston, MA, USA

Olusegun Baiyewu College of Medicine, University of Ibadan Nigeria, Ibadan, Nigeria

Bidemi Bello Babcock University, Ilishan Remo, Ogun, Nigeria

Blanca M. Bolea-Alamanac Department of Academic Psychiatry, School of Social and Community Medicine, Bristol, UK

Francisco Javier Carod-Artal International University of Catalonia (UIC), Barcelona, Spain; Neurology Department, Raigmore Hospital, Inverness, UK

Colleen S. Conley Loyola University Chicago, Chicago, IL, USA

David K. Conn Baycrest Health Sciences and University of Toronto, Toronto, ON, Canada

Bulent Coskun Kocaeli University Medical School Department of Psychiatry Umuttepe, Kocaeli, Turkey

Sariah Daouk Department of Psychiatry, American University of Beirut, Beirut, Lebanon

Joseph A. Durlak Loyola University Chicago, Chicago, IL, USA

Lia Fernandes Faculty of Medicine, Department of Clinical Neurosciences and Mental Health, University of Porto (FMUP), Porto, Portugal; Center for Health Technology and Services Research (CINTESIS), University of Porto, Porto, Portugal; Psychiatry and Mental Health Clinic, São João Hospital Centre (CHSJ), Porto, Portugal

Margret Föppl-Georg The Association Global Mental Health, Basel, Switzerland; A member of the World Federation for Mental Health, Occoquan, USA

Khachatur Gasparyan Department of Medical Psychology, Intra MHC, Yerevan State Medical University, Yerevan, Armenia

Lars Hansson Mental Health Services Research, Department of Health Sciences, Lund University, Lund, Sweden

Angelica Hüsser School of Applied Linguistics, IAM Institute of Applied Media Studies, ZHAW Zurich University of Applied Sciences, Winterthur, Switzerland

Venu Gopal Jhanwar Deva Institute of Healthcare and Research Pvt. Ltd, Varanasi, UP, India

Said Mohammed Jidda Department of Psychiatry, College of Medicine, University of Maiduguri, Maiduguri, Nigeria

Aleksandra Milićević Kalašić Institute of Gerontology, Belgrade, Belgrade, Serbia; Faculty of Media and Communications, Department of Social Work, Belgrade, Serbia

Brigitte Khoury Department of Psychiatry, American University of Beirut, Beirut, Lebanon

Martin Knapp Personal Social Services Research Unit, London School of Economics and Political Science, London, UK

Jeroen Luyten Leuven Institute for Healthcare Policy, KULeuven, Leuven, Belgium; Personal Social Services Research Unit, London School of Economics and Political Science, London, UK

Annette Pfeiffer Männedorf, Switzerland

Michael Schanne Former-School of Applied Linguistics, IAM Institute of Applied Media Studies, ZHAW Zurich University of Applied Sciences, Winterthur, Switzerland

Armen Soghoyan Centre of Psychosocial Recovery, Yerevan State Medical University, Yerevan, Armenia

Richard Uwakwe Faculty of Medicine, Nnamdi Azikiwe University, Ifite Awka, Nigeria

Katherine Weare University of Southampton, University of Exeter, Minehead, Somerset, UK

Chapter 1
Introduction to the Book: Global Mental Health: Promotion and Prevention

Sabine Bährer-Kohler

1.1 Introduction

Why is it necessary to write a whole book about Global Mental Health? Or to conclude, why is it necessary beside all other existing books (Springer 2016; Elsevier 2016)? Because the treatment of people with mental illness worldwide is until today not sufficient, in all countries; there is a significant gap between the prevalence of mental disorders and the number of people in all countries receiving adequate treatment and care (Mental Health Foundation UK 2015; WHO 2008).

To clarify, global health (Koplan et al. 2009) is an area on health and achieving health for all people around the globe. Global mental health is the transformation to the domains of mental ill-health (Patel and Prince 2010).

Kleinman summarized that mental health needs have to be much more a global humanitarian and development priority and a priority in every country in the world and that in the past a moral failure of communities in all parts of the world existed (Kleinman 2009; WHO 2016a).

Invited Professor for Mental Health/Mental Health & Social Determinants at Tropical Neurology and Neuroinfection Master, International University of Catalonia (UIC), Barcelona/Spain

Managing Director Dr. Bährer-Kohler & Partners, Switzerland

President, Association for Mental Health-Global Mental Health, Switzerland

IFSW Representative at the World Health Organization, Switzerland
Former member, World Health Organization International Advisory Group on the Revision of ICD-10, Mental and Behavioural Disorders, Switzerland

---

S. Bährer-Kohler (✉)
Dr. Bährer-Kohler & Partners, Birstrasse 58, 4052 Basel, Switzerland
e-mail: sabine.baehrer@datacomm.ch

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_1

1.2 Keypoints and Current Status

Estimated 1 in 4 people around the globe will be affected by mental or neurological disorders at some point in their whole lives (WHO 2001), and it is estimated that mental diseases will grow all over the globe (WHO 2016a).

In a current publication, WHO stated that there are tens of millions of people in the world who live in extremely difficult circumstances, conditions, and suffer emotionally (WHO 2016b). Data of the WHO Mental Health Survey underlines that mental disorders are widespread, disabling, and often go untreated, and that the prevalence of any mental disorders (96% CI—Confidence Interval/constructed at a confidence level) are, e.g., in France 18.4%, Ukraine 20.5%, and in the United States of America 26.4% (WHO 2008, p. 23; WHO 2004).

More specifically depression and/or anxiety disorders increased between 1990 and 2013; the number of people suffering from these diseases increased by nearly 50%, from 416 million to 615 million humans (WHO 2016a).

Estimated is that about 10% of the world's population is affected, and mental disorders account for about 30% of the global nonfatal disease burden (WHO 2016a).

Mental health across lifespan is influenced by several factors. For example, around the globe about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression (WHO 2016e).

It is important to take stock of and to push *Global Mental Health Engagement*, and to improve *Mental Health and Mental Health Care Quality*.

- For example, with mental health laws/mental health legislations. People with mental illness, especially with severe mental illness have to be better protected, with better mental health laws, like the Chinese citizens from possible abuses of compulsory psychiatric treatment and unnecessary hospitalization (Yeung 2012).
- For example, with inclusion of ethics and neuroethics, as an international endeavor, means to integrate areas of neuroscience, psychiatry, neurology, and bioethics, including functional brain imaging and neurogenetic screenings (Stein and Giordano 2015; Lombera and Illes 2009).
- For example, with more mental health services. Not only in the UK mental health services can have long waiting times and in some regions of the UK exist a lack of specialist services (Mental Health Foundation UK 2015, p. 7). In China the lack of provision of mental health care for vulnerable groups seems serious (Qian 2012). In Nepal, mental health services are only located and concentrated in the big cities, with an average of 0.22 psychiatrists and 0.06 psychologists per 100,000 population (Luitel et al. 2015). In 1976, the Ministry of Health in Sudan adopted a primary healthcare strategy for the future (Abdelgadir 2012). Nevertheless in 2009 were two mental hospitals available in Sudan with a total of 0.86 beds per 100,000 population (WHO 2009, p. 11). The Ministry of Health of Costa Rica developed a Mental Health Policy for the years 2013–2020. Mental disorders in Costa Rica are generally treated by psychiatrists who work in only two specialized psychiatric hospitals (Contreras et al. 2014). In Peru existed for documented 29,496,120 million people only 3 mental hospitals with

all together 1067 beds (Mental Health Atlas-Peru 2011). In India the population is about 1,214,464,312, they have in 2011 43 mental hospitals with only 17,835 beds in mental hospitals, the rate per 100,000 population, for these beds, is 1.469 (Mental Health Atlas-India 2011). Data about the health professionals working in the mental health sector in India and a rate per 100,000 is documented for social workers with only 0.033.

- For example, with enough mental health professionals, well trained, educated, with skilled health workers. Mental health professionals have an important role to play in improving especially the evidence on prevention and promotion in mental health settings (Saxena et al. 2006).
  There is a need for mental health professionals, and a need to reduce the lack of education and training opportunities in mental health care. The median rate of psychiatrists in low-income countries is only.05 per 100,000 population, versus 8.59 psychiatrists per 100,000 population in high-income countries and in the average .42 psychiatric nurses per 100,000 population in low-income countries versus 29.15 nurses per 100,000 population in HICs—high-income countries are documented (WHO 2011 in Fricchione et al. 2012).
  Based on the Mental Health Atlas 2005 in Africa the median numbers of psychiatrists can vary, but the average per 100.000 population in WHO regions is estimated by 0.04 in Africa, in Americas 2.00, 0.32 in Western Pacific, and Eastern Mediterranean 0.95 (WHO 2008 p.36).
  In Liberia 1 in 5 Liberians suffer a mild to moderate mental disorder, according to WHO estimates, yet this country has only one registered psychiatrist (WHO 2016c) for a population of approximately 4.4. million people (Auswärtiges Amt 2016). Likewise, the same situation is documented for the Chad and Eritrea, both affected by serious conflicts, and both countries have only one psychiatrist for their populations of 9 million and 4 million, respectively. In addition, similarly in Afghanistan (with a population of 25 million), Rwanda (8.5 million), and Togo (5 million) each country had two psychiatrists (Fricchione et al. 2012).
  In every community mental health team, it is necessary to enhance the resilience and capacity (Marie et al. 2016).
  Also grass roots workers need to acquire relevant knowledge and skills to recognize, refer, and support people experiencing mental disorders in their own communities and settings (Amstrong et al. 2011).
  A concrete example for not being understaffed, Hynan et al. recommended that NICUs (neonatal intensive care units) with 20 or more beds shall have at least one full-time masters' level social worker and one full-time or part-time doctoral level psychologist embedded in the NICU staff (Hynan et al. 2015).
  It is always important to train mental health professionals, e.g., in the cultural context (Ponterotto and Austin 2005) and within other areas like counseling competencies (Sheu and Lent 2007), general psychiatric training as an integral part of the global health agenda should be globally recognized and is e.g., articulated and published in the *Lancet* series on global mental health.

- For example, with better access to and treatment in general: The WHO Mental health action plan 2013–2020 documented that between 76 and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; in high-income countries the rate is between 35 and 50% (WHO 2013, p. 8).
- For example, with better financial investments. The WHO underlined that the current investment in mental health services is far lower than what is needed (WHO 2016a). For example, in the UK, the estimated costs of mental health problems are estimated between £70 and £100 billion each year and account for about 4.5% of GDP (Davies 2013). The WHO's Mental Health Atlas 2011 provides data in detail about the scarcity of resources within countries to meet mental health needs. The annual spending in average on mental health is less than US$ 2 per person and less than US$ 0.25 per person in low-income countries (WHO 2013, p. 8).
- For example, with better awareness, knowledge to reduce ignorance, misbelief, and negative attitudes (Parikh et al. 2016). Further effort is required to educate, e.g., the public (Sorsdahl and Stein 2010), the individual, stakeholders, politicians, decision-makers, but as well multipliers like teachers (Parikh et al. 2016), who have a unique position of transmitting knowledge and perpetuating it, e.g., about stigma and mental diseases or mental health prevention and promotion. It is required to develop programs and actions to fight stigma and discrimination against people living with mental disorders (Jouet et al. 2014); with the integration or the use of mass media and other social media (Clement et al. 2013), which may reduce prejudice.

1.3 Conception of the Book

From the beginning, it was clear for the editors to involve colleagues from all over the globe, to participate in the book project, to support the aims. This is one possibility, that professionals like us can do. To give the topic substance, faces, to announce missing issues and best practices, and to avoid that wheels have to be created again. We have to be multiplicators and actors in our field, to transmit knowledge, experiences. and perpetuating it.

The conception of each chapter in the book is similar. Brief and with takeaway messages at the end. These contain references to topical additional scientific literature, projects, networks and they should support the readership of the book to step forward and to intensive areas, focus areas.

1.3.1 Potential reader groups

Potential reader groups are professors, lectures, teachers, trainers at institutions, colleges, universities, etc., they will be multipliers today and in the future. They can transform knowledge, our experiences, which will be presented in this book.

But also organizations, associations which are involved in the area and field, often confronted with influences, far away from their influences like social and environmental crises, global trade and politics, and major epidemics, which are making public health a pressing global concern (Kickbusch et al. 2013).

And other colleagues who are working at the front, like primary care workers, mental health workers, and public health workers.

1.3.2 This book is written

This book is written to be useful and not be forgotten in a library et al.

So long people need mental health treatment in developed countries and other countries, but they, for e.g.,

- have no access
- cannot reach mental health services, because they do not exist in their community, and country
- cannot pay for the necessary treatment or no health& social insurance will cover it, so long we will need many books like this book, and we will need e.g., engagement, actions, and sustainable networks.

One of the most important issues in this field is to be engaged to avoid stigmatization. By the people themselves, in the family, in the society, and within responsible institutions.

People who are facing a mental disease need support. And especially the support of us professionals. More than a half-dozen professionals are working in the field, often interdisciplinary (Grohol 2016).

And very important is that we produce visions. *What would we like* to achieve or accomplish for the future in mental health issues. We need short-term engagement and long-term engagements and actions (Collins et al. 2011). We need awareness, knowledge, and we need mental health promotion largely with intersectoral strategies. The WHO factsheet (2016d) Mental health: strengthening our response is so often cited and used in many publications around the world (Steen and Thomas 2016), e.g., in the curriculum guide for qualifying social work education (Anderson and Sapey 2011). Implemented in the factsheet are ways that are specific to promote mental health all over the globe, with

- early childhood interventions (e.g., integrating home visits for pregnant women, and pre-school psychosocial activities);
- support to children (e.g., with skills building programs);
- socioeconomic empowerment of women (e.g., improving information about and access to education);
- broad support for elderly populations (e.g., with community and day centers for the aged); and others (WHO 2016d).

1.4 Take Away Messages

- Mental diseases will grow (WHO 2016a), often seriously impairing in many countries throughout the world (Kessler et al. 2009).
- One in four people around the globe will be affected by mental or neurological disorders at some point in their whole lives (WHO 2001).
- Between 76 and 85% of people with mental disorders receive no treatment for their disorder in low-income and middle-income countries; in high-income countries the rate is between 35 and 50% (WHO 2013, p.8).
- The current investment in mental health services is far lower than what is needed (WHO 2016a).
- Short-term and long-term engagements all over the globe are necessary.

1.5 Conclusion

I hope that this book will help to push and to convince stakeholders, decision-makers like the ministries of health to take more a leadership role together with WHO, with international, national, and regional partners, including civil societies and the individuals. At the end, everybody and we professionals are requested to be engaged for a better Global Mental Health (Bährer-Kohler 2016).

References

Abdelgadir, E. (2012). Exploring barriers to utilization of mental health services at the policy and facility level in Khartoum Sudan. Thesis (master's)-University of Washington 2012.

Anderson, J., & Sapey, B. (2011). Curriculum guide—mental health and distress. Retrieved August 28, 2016, from http://cdn.basw.co.uk/upload/basw_105525-6.pdf.

Armstrong, G., Kermode, M., Raja, S., Suja, S., Chandra, P., & Jorm, A. F. (2011). A mental health training program for community health workers in India: Impact on knowledge and attitudes. *International Journal of Mental Health Systems, 5,* 17.

Auswärtiges Amt. (2016). Liberia. Retrieved September 29, 2016, from http://www.auswaertiges-amt.de/DE/Aussenpolitik/Laender/Laenderinfos/01-Nodes_Uebersichtsseiten/Liberia_node.html.

Bährer-Kohler, S. (2016). Engagement for and investment in Global Mental Health. *Mathews Journal of Psychiatry & Mental Health, 1*(2), 007.

Clement, S., Lassman, F., Barley, E., Evans-Lacko, S., Williams, P., Yamaguchi, S., et al. (2013). Mass media interventions for reducing mental health-related stigma. *Cochrane Database System Review, 23*(7).

Collins, P. Y., Patel, V., Joestl, S. S., March, D., & Insel, Th. R. (2011). Grand challenges in global mental health. *Nature* 6, *475*(7354), 27–30.

Contreras, J., Raventós, H., Rodríguez, G., & Leandro, M. (2014). Call for a change in research funding priorities: The example of mental health in Costa Rica. *Revista panamericana de salud pública, 36* (4). Retrieved August 25, 2016, from http://www.scielosp.org/pdf/rpsp/v36n4/08.pdf.

Davies, S. C. (2013). Chief Medical Officer's summary. In N. Metha (Ed.), Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence London: Department of Health, pp. 11–19. Retrieved August 27, 2016, from https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health.

Elsevier. (2016). Search. Results. Retrieved August 24, 2016, from http://store.elsevier.com/searchResults.

Fricchione, G. L., Borba, C. F. C., Alem, A., Shibre, T., Carney, J. R., & Henderson, D. C. (2012). Capacity Building in Global Mental Health: Professional Training. *Harvard Review of Psychiatry, 20*(1), 47–57.

Grohol, J. (2016). Types of mental health professionals. *Psych Central*. Retrieved August 27, from, http://psychcentral.com/lib/types-of-mental-health-professionals.

Hynan, M. T., Steinberg, Z., Baker, L., Cicco, R., Geller, P. A., Lassen, S., et al. (2015). Recommendations for mental health professionals in the NICU. *Journal of Perinatology, 35* (Suppl 1), S14–8.

Jouet, E., Moineville, M., Favriel, S., Leriche, P., & Greacen, T. (2014). A mental health awareness anti-stigma program including user-trainers has a significant impact on knowledge, beliefs and attitudes of job centre professionals in Paris. *Encephale, 40*(2), 136–42.

Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., Ormel, J., et al. (2009). The global burden of mental disorders: An update from the WHO World Mental Health (WMH) Surveys. *Epidemiologia E Psichiatria Sociale, 18*(1), 23–33.

Kickbusch, I., Lister, G., Told, M., Drager, N. (Eds.). (2013). Global health diplomacy, concepts, issues, actors, instruments, fora and cases. Springer. Retrieved August 28, 2016, from http://www.springer.com/fr/book/9781461454007.

Kleinman, A. (2009). Global mental health: A failure of humanity. *Lancet, 374,* 603–604.

Koplan, J. P., Bond, T. C., Merson, M. H., et al. (2009). Towards a common definition of global health. *Lancet, 373,* 1993–1995.

Lombera, S., & Illes, J. (2009). The international dimensions of neuroethics. *Developing World Bioethics, 9,* 57–64.

Luitel, N. P., Jordans, M. J. D., Adhikari, A., Upadhaya, N., Hanlon, C., Lund, C., et al. (2015). Mental health care in Nepal: Current situation and challenges for development of a district mental health care plan. *Conflict Health, 9,* 3.

Marie, M., Hannigan, B., & Jones, A. (2016). Mental health needs and services in the West Bank, Palestine. *International Journal of Mental Health Systems, 10,* 23.

Mental Health Foundation UK. (2015). Fundamental facts about mental health 2015. Retrieved August 24, 2016, from https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf.

Parikh, N., Parikh, M., Vankar, G., Solanki, C., Banwari, G., & Sharma, P. (2016). Knowledge and attitudes of secondary and higher secondary school teachers toward mental illness in Ahmedabad. *Indian Journal of Social Psychiatry, 32*(1), 56–62.

Patel, V., & Prince, M. (2010). Global mental health—a new global health field comes of age. *JAMA* 2010, *303*(19), 1976–1977.

Ponterotto, J. G., & Austin, R. (2005). Emerging approaches to training psychologists to be culturally competent. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1). Hoboken, NJ: Wiley.

Qian, J. (2012). Mental health care in China: Providing services for under-treated patients. *The Journal of Mental Health Policy and Economics, 15*(4), 179–86.

Saxena, S., Llopis, E. -J., & Hosman, C. (2006). Prevention of mental and behavioural disorders: Implications for policy and practice. *World Psychiatry, 5*(1), 5–14.

Sheu, H. B., & Lent, R. W. (2007). Development and initial validation of the multicultural counseling self-efficacy scale–racial diversity form. *Psychotherapy (Chic), 44*(1), 30–45.

Sorsdahl, K. R., & Stein, D. J. (2010). Knowledge of and stigma associated with mental disorders in a South african community sample. *The Journal of Nervous and Mental Disease, 198*(10), 742–747.

Springer. (2016). Generic. Search. Retrieved August 24, 2016, from http://www.springer.com/generic/search/.

Steen, M., & Thomas, M. (2016). *Mental health across the lifespan: A handbook*. Routledge.

Stein, D. J., & Giordano, J. (2015). Global mental health and neuroethics. *BioMed Central Medicine, 13,* 44.

World Health Organization/WHO. (2001). Mental disorders affect one in four people. Retrieved August 25, 2016, from http://www.who.int/whr/2001/media_centre/press_release/en/.

World Health Organization/WHO. (2004). WHO World Mental Health Survey Consortium. Prevalence, severity and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of the American Medical Association*, *2004*(291), 2581–2590.

World Health Organization/WHO. (2008). Integrating mental health into primary care: a global perspective. Retrieved August 28, 2016, from http://www.who.int/mental_health/resources/mentalhealth_PHC_2008.pdf.

World Health Organization/WHO. (2009). Who-aims report on mental health system in Sudan. Retrieved August 25, 2016, from http://www.who.int/mental_health/who_aims_report_sudan.pdf.

World Health Organization/WHO. (2011). Mental health Atlas. India. Retrieved September 29, 2016, from http://www.who.int/mental_health/evidence/atlas/profiles/ind_mh_profile.pdf.

World Health Organization/WHO. (2011). Mental health Atlas. Peru. Retrieved September 29, 2016, from http://www.who.int/mental_health/evidence/atlas/profiles/per_mh_profile.pdf .

World Health Organization/WHO. (2011). Mental health Atlas. Retrieved August 27, 2016, from http://www.who.int/mental_health/publications/mental_health_atlas_2011/en/.

World Health Organization/WHO. (2013). Mental health action plan 2013–2020. Retrieved August 26, 2016, from http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf.

World Health Organization/WHO. (2016a). Investing in treatment for depression and anxiety leads to fourfold return. Retrieved August 6, 2016, from http://www.who.int/mediacentre/news/releases/2016/depression-anxiety-treatment/en/.

World Health Organization/WHO. (2016b). Problem management plus (pm +). Individual psychological help for adults impaired by distress in communities exposed to adversity. Retrieved August 27, 2016, from http://apps.who.int/iris/bitstream/10665/206417/1/WHO_MSD_MER_16.2_eng.pdf.

World Health Organization/WHO. (2016c). Mental health services in Liberia: Building back better. Retrieved August 26, 2016, from http://www.who.int/features/2016/mental-health-liberia/en/.

World Health Organization/WHO. (2016d). Mental health: Strengthening our response. Retrieved August 27, 2016, from http://www.who.int/mediacentre/factsheets/fs220/en/.

World Health Organization/WHO. (2016e). Maternal mental health. Retrieved October 20, 2016, from http://www.who.int/mental_health/maternal-child/maternal_mental_health/en/.

Yeung, A. (2012). A new mental health law to protect patients' autonomy could lead to drastic changes in the delivery of mental health services: Is the risk too high to take? *Shanghai Archives of Psychiatry, 24*(1), 41–43.

Chapter 2
Mental Health Priorities Around the World

Bulent Coskun

2.1 Introduction

In this chapter, global mental health priorities will be discussed. Some examples from different parts of the world will be presented including difficult conditions at some areas and examples of good practices at others.

Three perspectives will be used to discuss the priorities regarding the needs and possibilities for mental health services: “service users”, “service providers” and the “decision-makers”.

Although there are some positive developments, it is still considered as a fact that globally, the needs are much more than what is available both in terms of treatment, preventive and rehabilitative dimensions of mental disorders and also mental health promotion activities (WHO 2013, 2014; Petersen et al. 2016; UN 2015).

Just to give an example, globally, annual spending on mental health is stated in the WHO action plan (2013) as less than US$ 2 per person and less than US$ 0.25 per person in low-income countries, with two-thirds of the financial resources reserved for mental hospitals. Keeping this in mind, redirecting the funding towards community-based services seems to be a global priority (WHO 2013).

The median number of mental health workers is given as 9 per 100,000 population, with extreme variation (from below 1 per 100,000 population in low-income countries to over 50 in high-income countries) (WHO 2014).

It is stated in WHO (2013) document that health systems have not adequately responded to the burden created by mental disorders and that the gap between the need and what is provided is large all over the world. The situation about mentally ill persons not receiving treatment in low-income and middle-income countries is

---

B. Coskun (✉)
Kocaeli University Medical School Department of Psychiatry Umuttepe,
41 380 Kocaeli, Turkey
e-mail: 8bulentcoskun@gmail.com

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_2

between 76 and 85%. For the high-income countries, figures are still high: between 35 and 50%.

Due to stigmatization, mental disorders are believed to be untreatable, prevention unlikely and mental health promotion is almost neglected (Herrman 2001).

On the other hand, Petersen et al. (2016) states that there is sufficient evidence from low- and middle-income countries about the effectiveness and feasibility of some activities such as parenting programmes to improve mother child interaction during infancy.

2.2 Current Status with Examples from Various Areas from the Globe

Mainly in developed areas of the globe, stigma, poor understanding of mental health and illness have been changed and relatively better approach has emerged due to more realistic measure of health burden. But still there are several issues to be considered regarding global mental health.

It is hoped that after the adoption of the Sustainable Development agenda at the UN General Assembly in September 2015, where mental health have been included in UN Sustainable Development Goals (part 3.4 of the 17 Sustainable development goals), there will be a positive impact on communities and countries for the people in need of help on mental health issues (UN 2015).

It is increasingly recognized that mental disorders cause serious vulnerabilities and people with severe mental illness are among the most disadvantaged people in the community (diminished ability to function, experiencing discrimination, unemployment, poverty, social isolation, homelessness, limited access to health facilities, high risk for various physical diseases, substance abuse, facing with violence, maltreatment, sometimes ending with suicide and much more frequently finalizing with premature death) (Herrman 2001; Funk 2010). Other than having severe mental illnesses, there are many people living in poverty, unemployed, facing various disasters (natural, man-made, complex emergencies), experiencing discrimination (due to being among minority groups, living with consequences of politically or economically unstable situations, having difficulties because of their sexual orientation) for whom mental well-being is under serious challenge.

Currently, at different parts of the world, developed and developing areas of the countries, people are facing many of the conditions listed above—due to increasingly unbalanced economic situations, uncontrallable investments in “how to destroy others” (wars and forced migrations), political and economical sharpening causing threatening nationalistic, fundamentalistic approaches (terrorism), natural disasters at least some of which can be considered to be related with rapid climate change (global warming). Anyone thinking over priorities in global mental health cannot put aside these realities of our time.

Mental health promotion, awareness on the effects of environmental conditions on total human well-being (well-being in the sense that “no health without mental health”), should be recognized more than declared principles at international conferences (Bährer-Kohler 2016). Those shiny declarations can hardly be turned into resources needed to improve existing undesirable conditions.

Below, two cases are given as reported in the document mental health and development (Funk 2010). It may not be easy to guess from which countries the given figures have been taken from. One study revealed that “people with mental health conditions were 11 times more likely to be targets of violent crime (completed or threatened violence), and 140 times more likely to be victims of personal theft” (Teplin et al. 2005). In another study, 88% of those admitted to a psychiatric ward was found to have experienced victimization at some point in their lives: 84% having experienced physical assault, and 57% having experienced sexual assault (McFarlane et al. 2004). First one from United States, second one from Australia. These findings may lead to think that making decisions to protect mentally ill people should be a priority at all parts of the world, even at highly developed countries.

As stated earlier, there are positive developments also, it has been demonstrated that legislation and regulations can control alcohol demand and reduce alcohol consumption in low- and middle-income countries (LMICs) at minimal cost. Another positive step through laws and regulations has been shown that by restricting access to lethal means of suicide can reduce suicide rates in LMICs (Petersen et al. 2016). Schools and workplaces have also been shown as important settings for mental health promotion and prevention interventions such as stress reduction programmes and awareness raising activities on alcohol and drug misuse issues (Petersen et al. 2016).

Conditions at the workplaces have not reached the expected level yet even in high-income areas. As stated in the document of United Kingdom (UK) Department of Health, “poor mental health precipitates premature job loss.” Not having a job is said to be associated with the onset or recurrence of mental health problems. Having these in mind, work led by Public Health England has achieved some progress but it is stated that not enough difference could be reached to enough people (Department of Health 2014). This situation in a highly developed country such as UK may lead to think that there is much to do in global terms.

Below, in Box 1, there are some brief examples from various parts of the world.

Box 1 Examples on mental health conditions from different parts of the world (Funk 2010).

* In some places, mental health conditions are commonly believed to be caused by Jinns, witchcraft, possession, the evil eye, or saya. At the traditional healing centres, “treatment” consists of chaining the individuals concerned to a wall for 40 days.

* In 2001, a group has surveyed 52 social care homes and documented “residents experiencing restrictions in their freedom of movement, invasion of their privacy, inadequate communication facilities, a lack of access to

medical treatment. Restraint devices, consisted of metal cages or plastic netting around and on top of a standard hospital bed (cage-beds), preventing people from standing."

* In one report, people with severe mental health conditions were told to be subjected to a so-called 'hyena cure' where the village practice involved dropping the ill person into a pit with one or more hyenas that have been starved of food. It was thought that the hyenas would scare away the jinns, or evil spirits, that inhabit the person.

* In another study, an interesting paradox was observed: A programme, which sought to provide food to the ultra-poor, required that recipients be "mentally and physically sound" to qualify for the programme, which showed that the vulnerable group was not only neglected but also specifically excluded from development interventions.

* At a country classified as developed one, "… a young woman with an intellectual impairment was refused citizenship on the basis that she was incapable of supporting herself financially, and would require support from social services." The good part of the event was that "in its examination of this case, the Federal Tribunal of the country found that the decision was discriminatory".

* Again from a region where almost all countries are developed ones, a study showed that just under half (48%) of people in need of mental health care accessed services, in contrast to 92% of people with diabetes who accessed care for their physical condition.

* An example from a conflict area. A psychiatric hospital was attacked, lots of things were burnt other than those which were stolen. The hospital director reported that some residents were raped. Living conditions were dire. The hospital lacked sufficient drinking water; it had no water for washing or cleaning.

* At another conflict area, most health workers from the psychiatric institute fled the area, leaving the institute without supervision. Residents were left locked in their wards and rooms; some died from hunger or cold.

* Following a natural disaster, it was reported that people with psychiatric disabilities were discriminated against in their access to disaster relief during and after the event. Some survivors with mental health conditions were excluded from the trailers because of concerns that the individuals' mental health condition might make them dangerous, despite assurances from mental health professionals that the individuals were not dangerous.

* A recent study revealed two important reasons why people with mental health conditions are denied access to microcredit services. The first is that they are believed to have impaired functioning, unable to meaningfully engage in productive work, and hence incapable of repaying loans. Second, it was believed that people with mental health conditions would not be charged before the law if they defaulted on their loans, leaving lenders without recourse in case of non-payment…

* Another study, gives hope. It reveals that, children from impoverished backgrounds attended a half-day preschool intervention and received weekly home visits. There was a long-term benefit documented up to the age of 27 years. Evidence collected over 22 years showed that the preschool programme cut crime in half, reduced high school dropout and demand for welfare assistance, increased participants' adult earnings and property wealth, and provided tax- payers with a return of US$ 7.16 for every dollar invested in the programme (Funk 2010).

* A note from closing the gap document draws attention to a situation in need of being changed. In that document, it is stated that it will be made clear that the practices of deliberately holding people on the floor or restraining people in a way that impacts on their airway, breathing or circulation are high-risk approaches and that it is not wanted to see such implementations as an accepted part of normal health and care. These efforts to improve the conditions, in a way can be considered that currently there are such observations (or have been observed recently) which need to be corrected (Department of Health 2014).

The examples in Box 1 from different areas should not be viewed as assessment of countries or their overall mental health systems, these and other examples are provided as to see different faces of realities of the globe. It can be concluded that, in different parts of any country, different implementations can be observed.

2.3 Discussion on Priority Setting for Mental Health Services

There may be various ways to discuss setting priorities. Here in this chapter, a "people focused" grouping will be used. Three related groups of people will be taken into consideration: (1) service users, (2) service providers and (3) people in charge of decision-making or management of the system (overall system of mental health services is considered under this item).

2.3.1 Service Users

Most of the time, service users do not have the chance or proper channels to articulate their needs. Usually advocates, family members and those who once were service users may express their views. Those actively under the effect of some cognitive problems may have difficulty in assessing their real problems and may be in disadvantageous states to defend their rights. The concept of being a "service user" usually connotes with having some kind of mental problem or being a family member of a person with mental health condition. But it should not be forgotten that service providers and also those people in charge of managing the overall system are at least *potential users* of mental health services (anyone may need such assistance at any time).

The results of a study show that mental health service users are regarded mostly as objects of care and support rather than as active participants in the recovery process (Shek et al. 2011).

It would not be a surprise that preventive programmes and mental health promotion activities can only be demanded, if service users would be aware of such needs and possibilities.

Other than the family members, ex-service users and responsible mental health workers, the role of advocacy for service users, should be carried out by opinion leaders of communities, educators, managers and leading figures of media channels (including social media).

A few notes may be added about various priority possibilities for service users or potential service users (especially for mental health promotion and prevention programmes). These programmes may include, improvement of sports organizations for adolescents at schools (Liddle et al. 2016), organizing school mental health programmes on prevention of illicit substance use targeting both non-users and users (Abbo et al. 2016), focusing on digital technologies to reach younger generations whose preferences are related with this type of communication (Hayes et al. 2016), providing telemental health programmes especially for youngsters who may have difficulties to access community care. It is also suggested in the latter study to have hybrid programmes for some adolescents meaning telemental health services added to usual face-to-face interventions (Stephan et al. 2016). In another study, where special attention was paid to the women's mental health in Iran, has demonstrated that providing training courses to improve the skills to deal with stress was found useful as an important intervention for mental health promotion in women (Eftekhari et al. 2014).

Although there are some promising developments from some parts of the globe, the major devastating reality of our current time is the wars and forced migrations or trials of escaping from conflicting areas. These issues are under consideration at various international groups or programmes such as Research Group Transcultural Psychiatry from Germany (2016), Mental Health Commission of Canada (2016), European Commission on Consumers, Health, Agriculture and Food Executive Agency (2016). Another longitudinal study from Sierro Leone has focused on internalizing (depression/anxiety) and externalizing problems of children suffering from the effects of the war. They have observed a significant association between internalizing problems and posttraumatic symptoms (Betancourt et al. 2015).

Depending on the awareness about the objective situation of the services (state of the art), having information about what can be provided and to what extent, being capable of how to convince the decision-makers, being aware of the power of the people, may all effect the position and activity level of the service users.

Sometimes improvement of the treatment facilities, treatment methods, availability of drugs, accessibility to services, costs of the services may have priority.

Having a serious mental problem or being a caregiver for a person with such a condition might also be affected differently by the stage, severity and emergency of the problem. A person with unclear symptoms at an early phase or in an egodystonic state with his/her symptoms would not act similarly with someone who has gone through various psychiatric educational programmes and is more aware of her/his disorder and needs. And if there would be supportive caregivers having information about what are available, the service users would be much more conscious and as a consequence of which, would be fortunate.

2.3.2 Service Providers

It might be helpful to try to define who the service providers are. In simple terms, mental health service providers are the mental health workers or mental health specialists. They are trained persons in different specialties of mental health (psychiatry, psychology, social work, nursing and also in other disciplines of medicine and health services), they usually practice in diagnosing, treating, rehabilitating activities. They should also be responsible in mental health promotion and prevention of mental problems. Most of the mental health professionals should also be responsible in educational activities and awareness training (Baron and Coskun 2011).

The distribution of psychiatrists across regions is irregular. The median number of psychiatrists per 100,000 population varies from 0.05 in the African to 9.0 in the European Region. There are 1195 psychiatrists in the African Region for 626 million people compared to 77,242 psychiatrists for 841 million people in the European Region (WHO 2001). Almost half the world's population lives in countries where, on average, there is one psychiatrist to serve 200,000 or more people; other mental healthcare providers who are trained in the use of psychosocial interventions are even scarcer (WHO 2013).

An example from a low resource country, Malawi, shows that village based health workers can be useful to cover the treatment gap. These people have recognized and responded to the needs of people suffering from mental health problems and in addition to this they have taken part in 850 mental health promotion events targeting 40,000 people in their communities (Wright and Chiwandira 2016).

Mental health professionals practice within the framework of the mental health policies (if they exist), where the tasks are defined. Usually decision-makers make the plans, define the targets and limits of the tasks, make the outline of the working conditions and also the design of the working settings and the functioning procedures. Sometimes, some of the decision-makers may get the advices of some of the mental health specialists. It should be one of the essential functions of the mental health professionals to work on the needs assessment, evaluation of existing situations, searching for possible implementation alternatives, planing and implementing researches and focusing on educational and developmental projects (Foresight Mental Capital and Wellbeing Project 2008).

There are national associations of different mental health professionals, through which the opinions can be provided to the central and local governments for the decisions to be made. Depending on the governing systems, sometimes the decisions or the plans are discussed among various stakeholders (governmental, non-governmental organizations, sponsors, etc.). In some cases international councelling may also be received.

The position of the international organizations such as WHO, World Psychiatric Association (WPA), World Federation for Mental Health (WFMH), World Organization of Family Doctors (WONCA) and others, would be in two dimensions. First one may be related with the governments or the leaders in charge of making decisions and allocating the resources. These people should be provided with recommendations backed up with evidence based information. Similar to the documents produced by WHO, World Health Assembly (WHA) resolutions, various action plans, updated Mental Health Atlas (WHO 2005, 2011, 2013, 2014). Second one may directly target mental health professionals. This may include producing educational material both for undergraduate, postgraduate and continuous education and encouraging collaborated researches both for needs assessment and evaluation of the implementations (WHO's Collaborating Centers and WPA's Scientific Section activities may be considered as examples).

In principle, it would be expected that the service providers or the bodies representing them would advocate priorities in line with scientific approaches, evidence based findings, ethical principles, sociocultural realities and mainly for the benefits of service users and their caregivers. Bodies talking on behalf of service providers would also support the improvement of assessment, treatment and rehabilitation conditions both for the service users (respecting principles of equity, fairness and fighting against stigmatization) and also for better and more effective working conditions (taking into consideration physical security conditions, being free from all kinds of formal or informal pressure and burnout problems) of the service providers. From this perspective, it would be important to have better training (including undergraduate, postgraduate and continuous education), better social and economical conditions, allocation of necessary funds for education, research and effective treatment, prevention, promotion activities.

Service providers would also need to be encouraged to invest on improvement of their personal development and professional satisfaction. Murray et al. (2016) focus on psychological well-being of general practitioners and says that the research are limited with stressors and that systematic attention to the development of positive mental health is lacking. This observation worths to think about all other health professionals including those working in mental health area.

2.3.3 People Responsible for the Decision-Making Process

People responsible for the decision-making process may be the law makers or the people who have the power of designing the resource allocations–politicians, members of decision-making committees, sponsors, opinion leaders at various levels etc.

It should also be kept in mind that mental health, and health system in general can hardly be considered apart from the overall development level of nations, regions or areas (Rutz 2001; Foresight Mental Capital and Wellbeing Project 2008). In the report published by the government of UK, it is stated that the report is prepared for UK but the issues would be relevant for other countries. It is a document on mental capital and well-being where the relationship of mental health professionals and the policy makers is reflected as a useful source for decision-makers (Foresight Mental Capital and Wellbeing Project 2008). Among the underlined issues or priorities, better use of scientific and other evidence to plan and link interventions, better economic analysis of interventions to take longer-term benefits and improvement of cross—government action and central coordination are emphasized. Sensitivity of different age groups (needs of children during early development and the growing number of elderly at risk of dementia) and importance of balance of roles and responsibilities between the State, the individual and employers are also underlined so that clear principles for the division of resources may be achieved. Five principles are mentioned in detail in the document: “Connect”, “be active”, “take notice”, “keep learning” and “give” (Foresight Mental Capital and Wellbeing Project 2008).

According to Rutz (2001), the type of mental health services offered and how mentally ill people are treated and integrated into society is one of the most sensitive indicators of the level of democracy, pluralism, and tolerance in a society.

(Mihalopoulos et al. 2013) draws attention to the decision-making dilemma between the specialists in mental health sector who are more interested in treatment interventions and the specialists in primary care and public health sector whose tendency is to focus more on preventive interventions.

It has been stated in WHO Action Plan (2013) that higher proportion of high-income countries (92%) has mental health legislation compared to low-income countries (36%). In his review about the mental health budget in Korea, Roh et al. (2016), reminds the recommendation of the WHO (2001) that the mental health budget takes up 50–15% of health care expenditures. He then compares the situation in Korea which is 3%, falling short of meeting the recommendation of WHO.

In 2014, the new approach was related with inclusion of at least two functioning mental health promotion and prevention programmes, defined in detail in the 2014 Atlas. It is reported that “41% of WHO Member States have at least two functioning mental health promotion and prevention programmes; out of more than 400 reported programmes, over half were aimed at improving mental health literacy or combating stigma”. Another new development in the recent Atlas is providing baseline values for agreed Action Plan targets to follow in the coming years. It is planned that further rounds of mental health Atlas will enable monitoring of progress towards meeting these targets by the year 2020 (WHO 2013, 2014).

Integration of mental health services into primary care has been under discussion for a long time. The WHO and WONCA in their common publication have emphasized ten valuable principles for the consideration of most of the related parties. Decision-makers and service providers are mentioned and tasks defined but one of the essential components, the service users are not stated in this document. It might be useful to encourage collaboration with this group for the first two and also it would be very helpful to motivate the service user organizations to be involved and advocate for the improvement of the mental health services as being the target of all these efforts (WHO and WONCA 2008).

According to Shek et al. (2011) although social inclusion is recommended in respected policy development documents, the way it is implemented is carried out in institutional settings whereas the community should be the real target. And at that step, stigmatization is the most important inhibiting factor against social inclusion (Sartorius and Schulze 2005).

Finally, it might be helpful to make a general comment about the figures presented in all versions of the documents named as Mental Health Atlas. The figures for the countries would better be considered with caution for at least some of those figures may not necessarily represent the real situation, due to several reasons (difficulties in data collection and sharing and also due to sociocultural issues—in some places data about literacy and suicide rates may not reflect the real situation). Even if the figures would be confirmed as they are correct for a special country, there should be no doubt that the overall figures would not be representing the situation at different parts of that country. For this reason, in this chapter, the terms “developed areas” or “developing areas” are suggested instead of “developed countries” or “developing countries”.

2.4 Take Away Messages

1 Persons with mental disorders are considered as members of **vulnerable groups**. Making services available for them should not be sufficient, looking at ways to overcome inequalities about service usage and about the outcome of those services must be taken into consideration (present situations of migrants may be an example, founding mental health centres would not be enough, it should be followed up how effective those centres are being used).

2 Not only the mentally ill people are under heavy risk, people who do not have any diagnosis as a mental disorder but **living in poverty, unemployed, facing various disasters, experiencing discrimination** are also among the vulnerable groups, for whom mental health service providers and decision-makers should be considerate about.

3 **Integration** into primary care and general health services is essential for the improvement of mental health services. Only the efforts of mental health professionals would not be sufficient for this task even at developed areas of the globe. Involvement of different **sectors** (education, media, finance, justice, NGOs, etc.) and **disciplines** (various branches of medicine, nursing, social work, etc.) is a must.

4 Importance of **promotion of mental health** (including fight against **stigma**) and **prevention** of mental disorders should have priority not only in some declarations or principles but they should also have real actions at all levels of **decision-making processes** and be **reflected at implementations**.

5 Mental health specialists should have the lead in convincing the public and the decision-makers (by evidence based and culturally adapted facts) that **mental health issues are essential components of all kinds of development** of the nations and the globe as a whole.

References

Abbo, C., Okello, E. S., Muhwezi, W., Akello, G., & Ovuga, E. (2016). Alcohol, substance use and psychosocial competence of adolescents in selected secondary schools in Uganda: A cross sectional survey. *International Neuropsychiatric Disease Journal, 7*(2), 25387.

Bährer-Kohler, S. (2016). Engagement for and investment in global mental health. *Mathews Journal of Psychiatry & Mental Health, 1*(2), 7.

Baron, D., & Coskun, B. (2011). Psychiatrist Educators in Teaching Psychiatry Putting theory into practice. L. Gask, B. Coskun, & D. Baron, (Eds). Chichester: Wiley—Blackwell. pp. 247–259.

Betancourt, T. S., Gilman, S. E., Brennan, R. T., Zahn, I., & VanderWeele, T. J. (2015). Identifying priorities for mental health interventions in war-affected youth: A longitudinal study. *Pediatrics, 136*(2), 344–350.

Department of Health. (2014). Closing the gap: priorities for essential change in mental health. Retrieved October 22, 2016, from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf.

Eftekhari, M. B., Forouzan, A. S., Mirabzadeh, A., Sajadi, H., Dejman, M., Rafiee, H., et al. (2014). Mental health priorities in Iranian women: Overview of social determinants of mental health. *Iran Journal of Psychiatry, 9*(4), 241–247.

Foresight mental capital and wellbeing project. (2008). Final project report—Executive summary. The Government Office for Science, London. Retrieved October 20, 2016, from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292453/mental-capital-wellbeing-summary.pdf.

Funk, M. (Ed.). (2010). *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva: WHO.

Hayes, J. F., Maughan, D. L., & Grant-Peterkin, H. (2016). Interconnected or disconnected? Promotion of mental health and prevention of mental disorder in the digital age. *British Journal of Psychiatry, 208*(3), 205–207.

Herrman, H. (2001). The need for mental health promotion. *Australian and New Zealand Journal of Psychiatry, 35*(6), 709–715.

Liddle, S. K., Deane, F. P., & Vella, S. A. (2016). Addressing mental health through sport: a review of sporting organizations' websites. *Early intervention in psychiatry*. doi:10.1111/eip.12337. [Epub ahead of print].

McFarlane, A. C., Schrader, G. D., & Bookless, C. (2004). The prevalence of victimization and violent behaviour in the seriously mentally ill. Adelaide, Australia, Department of Psychiatry, University of Adelaide. Retrieved August 15, 2016, from http://www.criminologyresearchcouncil.gov.au/reports/200203–16.pdf.

Mental Health Commission of Canada. (2016). Retrieved October 22, 2016, from http://www.cbc.ca/news/politics/immigrants-refugees-canada-mental-health-1.3808089.

Mihalopoulos, C., Carter, C., Pirkis, J., & Vos, T. (2013). Priority-setting for mental health services. *Journal of Mental Health, 22*(2), 122–134.

Murray, M., Murray, L., & Donnelly, M. (2016). Systematic review of interventions to improve the psychological well-being of general practitioners. *BioMed Central Family Practice, 17,* 36. doi:10.1186/s12875-016-0431-1.

Petersen, I., Evans-Laco, S., Semrau, Maya, Barry, M. M., Chisholm, D., Gronholm, P., et al. (2016). Promotion, prevention and protection: interventions at the population- and community-levels for mental, neurological and substance use disorders in low- and middle-income countries. *International Journal of Mental Health Systems, 10,* 30. doi:10.1186/s13033-016-0060-z.

Roh, S., Lee, S. U., Soh, M., & Vos, T. (2016). Mental health services and R&D in South Korea. *International Journal of Mental Health Systems, 10,* 45.

Rutz, W. (2001). Mental health in Europe: Problems, advances and challenges. *Acta Psychiatrica Scandinavica, 104*(410), 15–20.

Shek, O., Pietila, I., Graeser, S., & Aarava, P. (2011). Redesigning mental health policy in post-soviet Russia a qualitative analysis of health policy documents (1992–2006). *International Journal of Mental Health, 39*(4), 16–39.

Sartorius, N., & Schulze, H. (2005). *Reducing the stigma of mental illness—A report from a global programme of the World psychiatric association* (pp. 1–12). New York: Cambridge University Press.

Stephan, S., Lever, N., Bernstein, L., Edwards, S., & Pruitt, D. (2016). Telemental health in schools. *Journal of Child and Adolescent Psychopharmacology, 26*(3), 266–272.

Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). Crime victimization in adults with severe mental illness. *Archives of General Psychiatry, 62,* 911–921.

UN. (2015). Resolution adopted by the General Assembly on 25 September 2015 UN Resolution 70/1. Transforming our world: The 2030 Agenda for Sustainable Development. Retrieved September 1, 2016, from http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E.

WHO. (2001). Mental Health Atlas. Geneva: World Health Organization

WHO. (2005). Mental Health Atlas. Geneva: World Health Organization

WHO. (2011). Mental Health Atlas. Geneva: World Health Organization

WHO. (2013). Comprehensive Mental Health Action Plan 2013–2020. Geneva: World Health Organization

WHO. (2014). Mental Health Atlas. Geneva: World Health Organization

WHO & WONCA. (2008). Integrating mental health into primary care: a global perspective. Geneva: World Health Organization

Wright, J., & Chiwandira, C. (2016). Building capacity for community mental health care in rural Malawi: Findings from a district-wide task-sharing intervention with village-based health workers. *International Journal of Social Psychiatry*. pii: 0020764016657112. [Epub ahead of print].

Chapter 3
Access to Mental Health

Richard Uwakwe, Said Mohammed Jidda and Sabine Bährer-Kohler

3.1 Introduction

Access to mental health services differs around the globe for several reasons. Overall attitudes and beliefs of individuals and people are shaped by many factors e.g. personal information and knowledge about mental illness, interacting with someone living with mental illness, media influences, and family experiences, but as well restrictions e.g. health insurance restrictions (Choudhry et al. 2016). Cultural stereotypes about mental illness and the understanding of mental health and the interpretation about mental health vary from culture to culture (Choudhry et al. 2016), cultural differences exist regarding e.g. the etiology of mental health issues and the influencing factors and for intervention efficacy and adaptation (Harper Shehadeh et al. 2016).

For the single person and the society at whole it is urgently important that access in general for everybody to mental health services is guaranteed and it is important to support people to timely access and receive adequate evidence-based treatments (NHS 2014), well aware that many countries around the globe have inadequate mental health systems and services (WHO 2009).

It seems that the discovery of more humane and affordable approach to treatment of mental health conditions had led to a relative increase in the number of people who can have access to mental health services (Fabrega 1990). The pioneering

R. Uwakwe
Faculty of Medicine, Nnamdi Azikiwe University, Ifite Awka, Nigeria
e-mail: ruwakwe2001@yahoo.com

S.M. Jidda (✉)
Department of Psychiatry, College of Medicine, University of Maiduguri, Maiduguri, Nigeria
e-mail: msjidda@gmail.com

S. Bährer-Kohler
Dr. Bährer-Kohler & Partners, Birsstrasse 58, 4052 Basel, Switzerland
e-mail: sabine.baehrer@datacomm.ch

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_3

work of Pinel and the discovery of the use of chlorpromazine, (Delay et al. 1952) in the treatment of psychosis are all historical events that have shifted the boundaries of psychiatry by increasing the possibility of cure, treatment and re-integration back into the society.

However, despite these strides there is a relatively poor access to mental health care by individuals and communities in need of them. For instance, about 50% of individuals in need of services within industrialized countries and about 80% in the developing countries could not get adequate access to mental health care services (Demyttenaere 2004).

The promotion of access to mental health services at parity to physical health services, and by specifying that services need to be provided through primary health care centers and in general hospitals, mental health legislations in all countries are the basements and they are fundamental (WHO 2009, p. 13).

3.1.1 Mental Health Gap Action Programme (mhGAP) WHO Access Improving Model

Accessibility is a service characteristics experienced by users, their carers, and networks, which enable them to use health care where and when it is needed (Thornicroft and Tansella 1999).

The Mental health Gap Action Programme (mhGAP) was developed by World Health Organization (WHO) in order to help and support non-specialist health workers identify, assess and manage mental health needs (WHO 2016). The guide provides practical, first-line management recommendations for mental, neurological and substance use conditions where access to specialists, care and treatment options is limited. Contents include e.g. modules and information on assessing and managing conditions such as acute stress, grief, moderate-severe depressive disorder, post-traumatic stress disorder, epilepsy, and harmful use of alcohol and drugs.

3.2 Current Status/Data

People with mental health problems are disadvantaged in many ways that particularly limits their access to mental health care. Several reasons have to be described e.g. that the way mental health services are designed and configured is very complex, variable and often difficult to navigate (House of Commons 2016, p. 5) or that necessary mental health services do not exist or are not reachable for people, because the distance is too far. Other reasons are concerns, e.g. Dixon-Woods et al. (2005) contend that common discussions about access to mental healthcare for mental health disorders seem to have largely been confined to concerns about recognition of mental health disorders by non-psychiatrists working in general medical settings and the difficulties associated with capacity enhancement for this cadre of health professionals. It is the view of the authors that such a perspective deals with a small part of a more complex experience of gaining access to healthcare for the individual.

According to Dixon Woods et al. (2005), access may be conceived as consisting of six stages. They posited that an individual interacting with the health system is inevitably destined to pass through these stages, which try to define all the aspects that constitute the fundamental issues regarding access to mental health. The authors outlined the stages as follows: The individual passes through the stages of 1. *candidacy* which is 'how people's eligibility for healthcare is a jointly negotiated interaction between individuals and healthcare services', 2. *appearance*, which 'involve a number of different approaches, including appearing before healthcare services through individual-initiated actions or through invitations (where people respond to healthcare services)'. 3. *adjudication*, which 'refers to professional judgments about the presentation of an individual for an intervention or service, influenced by categorizations made by professionals with reference to current services and relationships. Adjudication leads to offer'. 4. '*Offer (or non-offer)* of a healthcare service, which may be accepted or rejected'. 5. "*Recursivity* which is a concept that 'captures how the response of the system to individuals may reinforce or discourage future health behaviours" (National Collaborating Centre for Mental Health (UK) 2011; Dixon-Woods et al. 2005; Rogers et al. 1999).

Mental disorders account for 14% of disease burden worldwide; but they receive an average of only half of one percent (0.5%) of health spending in low-income countries (WHO Mental Health Atlas 2005). Moreover, three quarters (73%) of the money spent on mental health by national governments is spent on psychiatric hospitals and for in-patients, rather than on community care and services (Jidda et al. 2012). These hospitals are located in urban centers where majority of the world population cannot access. It is also not where most of the needs for mental health care and services are needed (WHO Mental Health Atlas 2005). The situation in the developed world is not remarkably different from the average global picture with funding reductions for mental health. Research suggests that NHS trusts' income for mental health services has dropped by 8.25% in real terms over past five years despite rising mental health care and service demand (The Guardian 2016). Although many countries have made great efforts to boost the funding for mental health services across population groups, this has not led to a remarkable improvement in the percentage of individuals who need mental health care and services and, are able to access it. Overall, mental health budgets as a portion of the health budgets hovers around 2% (WHO Mental Health Atlas 2005). This is inadequate when the burden of disease due to mental health is considered. In relation to policies also, the lack of clear and appropriate health insurance to meet unique needs of mental health service users can be seen by some as a form of structural discrimination against mental and neurological diseases. The result is a rise in the individual cost of mental health care directly affecting access to services and treatment (WHO Mental Health Atlas 2005).

Mental health manifests in social space in which language occupies an important and influencing part and is considered significant whenever formulating treatments for mental health disorders. It is therefore not surprising the rise in evidence suggesting linguistic barriers as determinants for accessing mental health care (Bährer-Kohler 2016). People living in societies that use languages other than their mother tongue can have difficulties in the different stages of the accessing process for mental health care; this was e.g. evident among a culturally diverse female populations in Australia (Wohler and Dantas 2016).

3.2.1 *Factors Affecting Access to Mental Health in the General Population*

Factors that affect access to healthcare exist at different points in the mental health system and can be classified into four factors. The NICE (National Institute of Clinical Excellence) guideline grouped factors that affect access around a number of themes, as identified in a clinical review protocol: Common Mental Health Disorders: Identification and Pathways to Care (NICE Clinical Guidelines 2011).

- Individual-level factors (gender, the attributes, beliefs, cultural differences, behaviours and characteristics of the individual) that may result in reduced access to healthcare;
- Practitioner-level factors (the characteristics, beliefs, cultural differences, attitudes and behaviours of the healthcare professional) that may contribute to disparities in access to healthcare for the individual;
- System- and process-level factors (such as policy, norms, service-organizational and structural factors) that may reduce access to healthcare for certain population groups;
- And resource-based or practical factors (such as transportation, program scheduling and childcare issues) that may reduce people's ability to access healthcare services.

3.2.1.1 Factors Operating at the Individual Level

Stigma due to mental illness:

Stigma is by far the most significant operating at the level of the individual in reducing access to mental health care, it is substantial (Hernandez et al. 2014) and often a prejudice and discrimination for individuals and family members (Pescosolido 2013). The word stigma referred originally to a mark, a mark of disgrace or brand on Greek slaves clearly separating them from free men. In common usage the word signifies disgrace or a form of defect. Pioneering workers such as Goffman (1963) defined stigma as a trait that is deeply discrediting.

Scambler (1998) developed the terms felt stigma and enacted stigma: Felt stigma refers to the shame and expectation of discrimination from others and enacted stigma refers to the experience of unfair treatment by others and networks.

It is considered as the negative effect of a label (Hayward and Bright 1997) or the process of establishing a deviant identity (Schlosberg 1993) while Haghighat (2001) considered it as a device to allow for the pursuit of self-interest. This list is by no means exhaustive which reflects the difficulty in the subject. All agree however, on the negative nature of the phenomenon and it multiply effects in the health is of people with mental disorders.

The consequences of stigma can be profound. It creates a vicious cycle of rejection and disadvantage that surrounds all those who live with a mental disorder, as well as the health and social system designed to support them. Stigma can influence and destroy self-esteem, can disrupt normal family and social relationship, can influence recovery and can promote social disability and disadvantage.

Fear of disempowerment and sense of denial:

Previously stigma, shame and fear of being diagnosed with a mental health disorder can be a possible factors affecting access to healthcare, however, another factor in terms of disparities in power have also been identified, with some people with mental disorders refusing to access mental health service in order to avoid feeling disempowered and excluded, because they may view seeking help and support as way of confirming their illness (Harrison and Gill 2010).

The delay in seeking help and support usually results in further harm and difficulty in recovery. People have also been found to normalize symptoms of mental health disorders and view mental health disorders not as an illness but as a sign of weakness, helplessness or as not worthy of investigation. In the detailed review by Dennis and Chung-Lee (2006), women from a variety of cultural and ethnic backgrounds viewed depression in the postnatal period as an inability and lack of power to perform as a woman and a mother, and as an implied weakness or perceived failure. Cultural influences and migration factors have documented influences how mothers cope with postnatal depression (Wittkowski et al. 2016).

Lack of awareness and knowledge:

Lack of knowledge about mental health disorders, services and available treatment options have also been identified as factors that affect access to treatment and support (Hailermariam et al. 2016).

Some individuals may not be aware enough they have symptoms of a mental health disorder. For mental healthcare services in particular, individual perceptions as to how much a healthcare service can help may also influence a person's decision to access healthcare services. In nations where child care protection is an issue and when an individual receives a diagnosis on mental health disorder, entertaining fear of their children 'being taken away following diagnosis of a mental health disorder, may discourage individuals from accessing healthcare services' (Rodriguez et al. 2009; Scheppers et al. 2006).

3.2.1.2 Practitioner Related Factor

Non-recognition:

Healthcare professionals can play significant role in either promoting help-seeking behaviour or in acting as a barrier to patient access to available mental health care service and treatment (Dixon-Woods et al. 2005).

Rodriguez et al. (2009) observed that most non-psychiatrists who manage general medical conditions do not actively look for mental health disorders such as depression. 'This in turn acts as a factor that affects access to mental healthcare services'.

The curricula of most medical schools are often not adequately designed to educate health professionals who would be able to easily recognized majority of the major mental health disorders that are commonly seen in the general hospital settings coexisting with other physical health conditions and symptoms.

Evidence suggests that non-recognition of professionals may be at a rate that is about 75 percent implying less than a quarter of people with mental health problems get a referral after consulting with a general practitioner (Abdulaziz et al. 2014). This is a serious limitation to access.

Attitude of Practitioner:

The classical teaching of unconditional positive regard, adopting a position of tolerance, adopting a non-judgmental and non-punitive approach to patients care and treatment is important in determining recursivity in the process of accessing health care service. Practitioners' communication style may also be a factor affecting diagnosis and consequently access to treatment and care. Excessive formalism, authoritative and confrontational practitioner and e.g. with negotiating styles can lead to shame and discomfort (Scheppers et al. 2006). In addition, conveying medical information to the individual and family members in a formal manner using medical jargon can act as a factor that limits access because they may not understand (Scheppers et al. 2006).

3.2.2 Mental Health System and Organizational Factors—Aspects

There may be healthcare systems and processes in place that affect access to appropriate care. The twin lack of provision and capacity in the services being provided can be factors that affect access to care and support for all individuals in need of these services (WHO-AIMS Nigeria Report 2006).

Poor organization of services characterized by e.g. long waiting-times for outpatient appointments was also documented to influence help-seeking behavior (Dixon-Woods et al. 2005).

Absence of policies and strategies and disruptions due to changes in the healthcare system and poor ways of communication about referral procedures both between primary, secondary and tertiary healthcare, and across different other service sectors may also have an effect on access to healthcare for individuals and may result in the individual impression ‘shuffled around services’ (Dixon-Woods et al. 2005).

3.2.3 Available Resources and Logistics Factors

Logistics and availability of important resources play roles in determining access to mental health care service and care. Since many mental health care facilities are concentrated in urban tertiary health centers, transportation becomes critical. This is particularly so for the elderly, handicapped people and those living in distant rural areas.

3.2.4 Black and Minority Ethnic Groups, Language Barriers, and the Elderly

There is a double disadvantage that comes with being from a Black and Minority Ethnic Group (BME) group, as well as having a mental health diagnosis, since both identities can be associated with stigma, discrimination, and restriction. As a result these groups tend to have additional barriers in accessing mental health services and support.

‘Language barriers between the individual and practitioner can impair communication’ (Dixon-Woods et al. 2005), the outcome is usually a poor therapeutic alliance between patient, his network and health care professional since clear and accurate information concerning diagnosis, treatment and side effects are necessary for effective participation of the patient in the therapeutic relationship and process (Das et al. 2006; Vanvoorhes et al. 2007).

In the elderly, ‘self-characterisation of symptoms such as low mood, anxiety and memory problems as inevitable and related to old age, may affect help-seeking behaviour’ (Dixon-Woods et al. 2005). The classical symptoms of depression such as low mood, lack of enjoyment, loss of interest or pleasure in activities, and diminished energy which clinicians may search in making a diagnosis of depression is not immediately obvious in the elderly who commonly present with many somatic symptoms. Depressive symptoms may also be masked where there are physical comorbidities (Dixon-Woods et al. 2005).

3.3 Discussion

The approaches being used to improve access to mental health across the broad range of countries and their unique challenges from the poorest to the richest country are diverse.

One approach to improving access to services has been to focus on the systems and conceptions for the organisation and delivery of interventions. These approaches have fallen into two broad categories.

- First, attempts to alter the configuration of services, for example by delivering a service in a community center away from traditional healthcare settings, or by using novel methods of service delivery, for example computers and web-based information (Gulliford et al. 2007).
- Second, to alter the nature of the intervention provided, for example by changing the structure and content of a psychological intervention in the light of information about the cultural beliefs and interpretations or presentations of a disorder within a particular ethnic group (Bernal and Saez-Santiago 2006; Griner and Smith 2006).

3.3.1 Efforts to Combat Stigma and Improve Access

Reducing stigma and discrimination has become an important goal for professional organizations worldwide (WHO 2002). In 1996, the World Psychiatric Association launched a global programme to reduce stigma and discrimination associated with schizophrenia, which was operating in over 20 countries (Sartorius 2004). In 2001, the World Health Organization, WHO focused their World Health Report on mental illness in an attempt to develop international momentum for reducing the burden caused by mental health disorders (World Health Organization 2001). This was followed by a call to action to health ministers at the 54th World Health Assembly through ministerial round-table focusing on mental health (World Health Organization 2001), a global advocacy programme for world health day (World Health Organization 2001) and a global action programme designed to raise a better awareness of the importance of investing in mental health and enhancing accessibility.

3.3.2 The Future of Access to Mental Health

The number and the breadth of approaches being deployed in different countries and global health administration systems like the World Health Organization all aimed at improving access to mental health services gives room for hope and optimism about the possibility for significant change and better solutions. The huge advances in internet and communication technology can predict a future with improved access of the populations to available mental health services (Boydel et al. 2014).

Past experience suggest that when there is a global political farsightedness, engagement, will and commitment to a cause, difficult issues can be resolved for the benefit of the entire human race. This has been the case with eradication and near eradication of severe debilitating diseases. Early signs of this global commitment to improving access evidenced by the rapid expansion of the mhGAP and its successful implementation and adaptation in developing countries with huge populations and mental health access challenges give hope of a bright future.

However, the rising mental health burden especially in the rapidly growing populations in the developing world and the not adequately awareness suggest that maintaining and improving on the current efforts is necessary and worsening access likely if not maintained.

Take Away Messages

- In all countries of the world, developed and developing, access to mental health service is severely limited. Staff strength of mental health professionals, organization of mental health services, stigma of mental disorders, sociocultural beliefs and capacity of other health professionals to detect and manage/refer mental disorders, among many other factors and influences, act as barriers to accessing mental health services.
- The Mental Health Action Plan 2013–2020 offers further information's in the overall context (WHO 2013) and with the input, that persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation et al., means to be so far as possible a partner in the field.
- For more information about principles for organizing mental health services, means e.g. about accessibility, comprehensiveness, continuity and coordination of care and support see e.g. the publication: Improving health systems and services for mental health of the World Health Organization (2009).

References

Abdulaziz, M., Jidda, M., Wakil, M. A., Isah, B., Taiwo, S., & Samuel, A. (2014). Unrecognized psychiatric disorder among patients admitted into general hospital in Maiduguri Northeastern Nigeria. *Pan African Medical Journal, 19,* 197.

Bährer-Kohler, S. (2016). Person-first language—Aspects of communication in health and mental health settings. *International Journal of Community and Family Medicine, 1,* 116.

Bernal, G., & Saez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology, 34*(2), 121–132.

Boydell, K. M., Hodgins, A., Pignatiello, A., Teshima, J., Edwards, H., & Willis, D. (2014). Using technology to deliver Mental Health services to children and youth: A scoping review. *Journal of Canadian Academy of Child Adolescent Psychiatry, 23*(2), 87–99.

Choudhry, F. R., Mani, V., Ming, L. C., & Khan, T. M. (2016). Beliefs and perception about mental health issues: A meta-synthesis. *Neuropsychiatric Disease and Treatment, 12,* 2807–2818.

Delay, J., & Deniker, P., & Harl, J. M. (1952). Therapeutic use in psychiatry of phenothiazine of central elective action (4560 RP). *Annals of Medical Psychology,* Paris. *110*(21), 112–117.

Das, A. K., Olfson, M., McCurtis, H. L., & Weissman, M. M. (2006). Depression in African Americans: Breaking barriers to detection and treatment. *Applied Evidence, 55,* 30–39.

Demyttenaere, K. (2004). Unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys: The WHO World Mental Health Survey Consortium. *JAMA, 291*(21), 2581–2590. doi:10.1001/jama.291.21.2581.

Dennis, C., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth, 33,* 323–331.

Dixon-Woods, M., Kirk, D., Agarwal, S., Annandale, E., Arthur, T., Harvey, J., et al. (2005). Vulnerable groups and access to health care: A critical interpretive review. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO). London: National Co-ordinating Centre for NHS Service Delivery and Organisation. 2016. Retrieved August 10, 2016, from http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08–1210-025_V01.pdf.

Fabrega, H., Jr. (1990). Psychiatric stigma in the classical and medieval period: A review of the literature. *Comprehensive Psychiatry, 31*(4), 289–306.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs: Prentice-Hall.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A metaanalytic review. *Psychotherapy: Theory Research, Practice, Training, 43,* 531–548.

Gulliford, M., Figueroa-Munoz, J., Morgan, M., et al. (2007) What does 'access to health care' mean? *Journal of Health Services Research and Policy,* 7, 186–188.

Haghighat, R. (2001). A unitary theory of stigmatisation. Pursuit of self-interest and routes to destigmatisation. *British Journal of Psychiatry, 178,* 207–215.

Hailemariam, M., Fekadu, W., Selamu, M., Medhin, G., Prince, M., & Hanlon, C. (2016). Equitable Access to Integrated Primary Mental Healthcare for People with Severe Mental Disorders in Ethiopia: A formative study. *International Journal for Equity in Health, 15,* 121. doi:10.1186/s12939-016-0410-0.

Harper Shehadeh, M., Heim, E., Chowdhary, N., Maercker, A., & Albanese, E. (2016). Cultural adaptation of minimally guided interventions for common mental disorders: A systematic review and meta-analysis. *Journal of Medical Internet Research, 3*(3), e44. doi:10.2196/mental.5776.

Harrison, J., & Gill, A. (2010). The experience and consequences of people with mental health problems, the impact of stigma upon people with schizophrenia: A way forward. *Journal of Psychiatric and Mental Health Nursing, 17*(3), 242–250.

Hayward, P., & Bright, J. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health, 6,* 345–354.

Hernandez, S. H., Bedrick, E. J., & Parshall, M. B. (2014). Stigma and barriers to accessing mental health services perceived by Air Force nursing personnel. *Military Medicine. International Journal of AMSUS, 179*(11), 1354–1360. doi:10.7205/MILMED-D-14-00114.

House of Commons–Committee of Public Accounts. (2016). Improving access to mental health services. Clerk of the Committee of Public Accounts, House of Commons, London. Retrieved November 25, 2016, from http://www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/80/80.pdf.

Jidda, M.S., Rabbebe, I.B., Omeiza, B., Wakil, M.A., Ibrahim, A.W., & Pindar, S.K. (2012). The Mental Health system in North-Eastern Nigeria. A WHO-AIMS generated assessment of the state of Mental Health in a Sub-Saharan African region. *Nigerian Journal of Psychiatry*, *10*(3), 2–7.

National Collaborating Centre for Mental Health-UK (2011). *Common Mental Health Disorders: Identification and Pathways to Care. National Clinical Guidelines, No. 123.* Commissioned by the National Institute for Health & Clinical Excellence. Published by The British Psychological Society and The Royal College of Psychiatrists, 1–310. Retrieved November 20, 2016, from https://www.nice.org.uk/guidance/cg123/evidence/full-guideline-181771741.

NHS England. Department of Health (2014). Achieving Better Access to Mental Health Services by 2020. Retrieved November 25, 2016, from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf.

Pescosolido, B. (2013). The public stigma of mental illness: What do we think; what do we know; what can we prove? *Journal of Health and Social Behavior*, *54*(1), 1–21.

Rodríguez, M., Valentine, J. M., & Son, J. B. (2009). Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. *Trauma Violence Abuse, 10,* 358–374.

Rogers, A., Hassell, K., & Nicolaas, G. (1999). *Demanding Patients? Analysing the use of primary care*. Milton Keynes: Open University Press.

Sartorius, N. (2004).The World Psychiatric Association global programme against stigma and discrimination because of stigma. In A. H. Crisp (Ed.), *Every Family in the Land* (pp. 373–75, Revised edition). London: Royal Society of Medicine Press.

Scambler, G. (1998). Stigma and disease: Changing paradigms. *Lancet, 352,* 1054–1055.

Scheppers, E., van Dongen, E., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: A review. *Family Practice, 23,* 325–348.

Schlosberg, A. (1993). Psychiatric stigma and mental health professionals (stigmatizers and destigmatizers). *Medicine and Law, 12,* 409–416.

The Guardian News. (2016). NHS mental health funding is still lagging behind, says report. Retrieved November 28, 2016, from https://www.theguardian.com/society/2016/may/09/nhsmentalhealth-funding-is-still-lagging-behind-says-report.

Thornicroft, G., & Tansella, M. (1999). *The mental health matric: A manual for improve services*. Cambridge: Cambridge University Press.

Van Voorhees, B. W., Walters, A. E., & Prochaska, M. (2007). Reducing health disparities in depressive disorders outcomes between non-Hispanic whites and ethnic minorities: A call for pragmatic strategies over the life course. *Medical Care Research and Review, 64,* 157–194.

Wittkowski, A., Patel, S., & Fox, J. R. (2016). The experience of postnatal depression in immigrant mothers living in western countries: A meta-synthesis. *Clinical psychology and psychotherapy*. doi:10.1002/cpp.2010.

Wohler, Y., & Dantas, J. A. (2016). Barriers accessing Mental Health services among culturally and linguistically diverse (CALD) immigrant women in Australia: Policy implications. *Journal of Immigrant and Minority Health*. doi:10.1007/s10903-016-0402-6.

World Health Organization. (2001). *The World Health Report 2001—Mental health: New understanding, new hope*.

World Health Organization (2002). Reducing stigma and discrimination against older people with mental disorders. Retrieved November 28, 2016, from http://www.who.int/mental_health/media/en/499.pdf.

World Health Organization. (2005). *Mental health atlas: 2005*. Geneva: World Health Organization.

WHO-AIMS Report on Mental Health System in Nigeria. (2006). Ibadan: WHO and Ministry of Health. Retrieved November 28, 2016, from http://www.who.int/mental_health/evidence/nigeria_who_aims_report.pdf.

World Health Organization. (2009). Improving health systems and services for mental health. Retrieved November 24, 2016, from http://apps.who.int/iris/bitstream/10665/44219/1/9789241598774_eng.pdf.

World Health Organization. (2013). Mental health action plan 2013–2020. Retrieved November 17, 2016, from http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf.

World Health Organization. (2016). *Mental Health Gap Action Plan: 2016*. Geneva: World Health Organization.

Chapter 4
Social Determinants of Mental Health

Francisco Javier Carod-Artal

4.1 Introduction

Mental health is an integral part of health and well-being, and is determined by a range of biological, socioeconomic and environmental factors. Although mental disorders have clear biological correlates (Chaudhury et al. 2015; Gottschalk and Domschke 2016), they are also influenced and shaped by social, economic and environmental factors. These conditions may affect individuals, families, communities, societies and populations. The importance of social factors in mental health is that they are modifiable factors and this opens a door for prevention. New emphasis on mental health promotion and prevention of mental disorders has emerged by action on social determinants of health.

(a) Epidemiological perspective on mental disease

Mental health disorders are among the most common, chronic and disabling health conditions. The global burden of the Disease 2010 study estimated that 400 million people worldwide suffered from depression, 272 million from anxiety disorders and 24 million from schizophrenia (Ferrari et al. 2013). More than 80 million children have behavioural disorders including attention deficit hyperactivity disorder, and 140 million people have alcohol and drug abuse disorders. According to World Health Organization (WHO), depression is the single largest contributor to years lived with disability globally (WHO 2016). Many other people suffer from poor mental health that does not reach the threshold for diagnosis of mental disorder.

F.J. Carod-Artal (✉)
Neurology Department, Raigmore Hospital, Old Perth road, IV2 3UJ Inverness, UK
e-mail: javier.carodartal@nhs.net; fjcarod-artal@hotmail.com

F.J. Carod-Artal
Health Science Faculty, International University of Catalonia (UIC), Carrer de la Immaculada, 22, 08017 Barcelona, Spain

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_4

People with severe mental disorders suffer from higher rates of disability and mortality. A 40–60% greater chance of premature death has been observed in persons suffering from major depression and schizophrenia in comparison with general population (WHO 2013a). Factors that explain this fact include physical problems often unattended and suicide. Suicide is the second most common cause of death among young people worldwide. Mental disorders are expected to increase worldwide and also as consequence of demographic changes in developing countries. Further information can be found on previous chapters of the book.

(b) Historical perspective

In the XIX century, the "miasma theory" led to focus on interventions in public health to improve living conditions of individual and populations. The social and economic circumstances that could affect health of human populations were studied. Early in twentieth century, pioneer research studies focused on social causes that could be major factors to trigger physical and mental diseases. Social factors that could contribute to schizophrenia and suicide were evaluated (Shim et al. 2014).

In the 1990s, the "decade of the brain" stimulated the research on genetic, molecular and functional neuroimaging correlates of mental diseases. The focus on biological psychiatry may have helped to decrease part of the stigma associated with depression but not with other mental disorders like schizophrenia. A progressive neurobiological understanding of mental illness has occurred; however, this public perception has been translated into support for mental health services but not into a decrease in stigma (Pescosolido et al. 2010; Angermeyer et al. 2013). Unfortunately there is still a widespread stigma around mental illness across the world and this fact may mark individuals with severe mental disorders as virtually "non-human" (Kleinman 2009).

In the last two decades, enormous investment in the field of neurobiology research has been done in western countries. Unsurprisingly, as the neurosciences have grown in size, prominence and prestige, so has critical sociological, philosophical and historical analysis grown up around their foothills (Martin 2000; Dumit 2004; Ortega and Vidal 2007; Fitzgerald et al. 2014). At the same time there is an increased perception about the importance of social determinants of mental health (SDMH) in western countries. Nevertheless, there is a gap: sociological and anthropological studies about SDMH are still absent in many low- and middle-income countries.

Pioneering reports performed by the WHO on mental health promotion and mental disorder prevention were only published in 2004 (WHO 2004a, b). The WHO established the Commission on Social Determinants of Health in 2005 to provide advice on how to reduce them and the final report was published in 2008 (WHO 2008). The Marmot Review Team (2010) and the WHO Review of Social Determinants of Health and the Health Divide (2013b) published other authorised reports about SDMH. The last conference held by WHO was hold as recent as April 2016.

4.2 Current Status/Data

(a) Conceptual definitions and models. A multilevel framework

There are multiple biological, psychological and social factors that may determine the level of mental health and the prevention of mental disorders. The determinants of mental health include not only individual or personal attributes such as the ability to manage one's emotions, thoughts, behaviours and interactions with others. They also include social, economic, cultural, political and environmental factors such as national policies, social protection, living standards, working conditions and family and community social support (WHO 2013b).

SDMH were defined by the WHO as those conditions in which people are born, grow, live, work and age that impact health and well-being, and the health systems that they can access, which are shaped by economic, social, environmental policies and politics (WHO and Calouste Gulbenkian Foundation 2014).

Several models have been proposed to describe social determinants: the Dahlgren and Whitehead model, the WHO multilevel framework model, and socioeconomic models about health inequality.

Dahlgren and Whitehead (1991) proposed a pioneer model to describe social determinants that features individual lifestyle factors, social and community networks, and socioeconomic, cultural and environmental conditions. They described four levels: personal pattern of life and behaviour; support by and influence of the social living environment; living and working conditions; economic, cultural and physical environmental conditions.

The WHO (2014) proposed a multilevel framework to organize and analyse the evidence about SDMH:

- A life-course approach across life stages. Pre- and perinatal periods, early and later childhood, the working and-family-building period of life, and older years are included.
- The community-level context. The natural and built environment, primary healthcare, and humanitarian settings are considered.
- The country-level context, which includes social, economic, political and environmental factors, and the cultural and social norms acting within a specific society. The strategies and policies to reduce social inequalities and to promote access to education, healthcare, housing, services and employment are included in this level.

Evidence from this multilevel framework will be reviewed in this chapter.

Socioeconomic models: Differences in social, economic and environmental circumstances can lead to health and mental health inequities. Health disparities are defined as those differences in health that are unnecessary and avoidable, unfair and unjust. Health equity can be defined as the absence of health disparities. Health inequities exist between and within countries, and usually follow a social gradient (Allen et al. 2014). Ethnic, socioeconomic and geographic disparities in health care are responsible for bad outcomes in many chronic diseases.

(b) Epidemiological studies about SDMH

Certain subjects and specific groups in society may be at higher risk of mental health disorders. Vulnerable groups include not only families living in poverty but also persons with chronic health conditions, children exposed to neglect and abuse, young/adolescents exposed to substance abuse, minority and indigenous populations, elderly people, and people suffering discrimination (including ethnic, gender and sex discrimination) and human rights violations. Other vulnerable groups are prisoners, and communities exposed to war, conflict, natural disasters and humanitarian emergencies (WHO 2013b).

SDMH are summarized in Table 4.1. Poverty, low educational level, stressful work conditions, unemployment, gender discrimination, unhealthy lifestyle, violence, physical ill-health, social exclusion and social isolation and human rights violations are recognized factors associated with poor mental health. New vulnerable groups are emerging as consequence of global financial crisis (unemployed young, immigrants, refugees). Macroeconomic factors and austerity politics leading to cuts in health and social care may have an influence (WHO 2013a).

Poor mental health is strongly associated with poverty and low education levels (Fryers et al. 2005). Poor and disadvantaged people suffer disproportionately from mental disorders. These population subgroups are at higher risk of mental disorders due to greater exposure and vulnerability to unfavourable social, economic and environmental circumstances, and gender has a major role. Socioeconomic position is persistently associated with increased rates of depression (Patel et al. 2010), and anxiety and depression are distributed following a gradient of economic disadvantage across society (Campion et al. 2013).

The relationship between social determinants and mental health is bidirectional, because social factors affect mental health, and vice versa (Bährer-Kohler 2012). Mental disorders may lead to reduced income and unemployment in affected

Table 4.1 Social determinants of mental health

Poverty and inequality
Household income
Low educational attainment
Unemployment
Social isolation
Social exclusion
Racism and other forms of discrimination
Lack of social participation
Social change
Gender
Adverse life events
Domestic violence, abuse, neglect, illness
Institutional care in childhood
Limited access to health care services
Migration

individuals and their families, entrenching poverty and in turn increasing the risk of mental disorders. Social consequences such as homelessness and inappropriate incarceration are more frequent in persons with mental disorders and exacerbate their marginalization and vulnerability. Persons with mental health disorders often have their human rights violated due to stigmatization and discrimination and as consequence they live in vulnerable situations and remain excluded and marginalized from society. They may be subject to poor human living conditions, neglect, physical and emotional abuse and even degrading healthcare in health facilities. Their rights to work and education and their reproductive rights are also affected (WHO 2013a).

Around 80% of global population lives in low- and middle-income countries and the majority of global burden of mental disorders is located there. A systematic review of literature found that 70% of the 115 analysed studies had a positive association between common mental disorders and poverty in low- and middle-income countries (Lund et al. 2010).

Gender differences were found. Mental disorders affect more deeply to females compared to males at every level of household income. Increased impoverishment, domestic violence and abuse, and overwork affect women’s health. Domestic violence has an adverse impact on women’s mental health worldwide. Sexual violence within marriage, a taboo subject, was a risk factor for depression in an Indian population-based study (Patel et al. 2006). Being married during adolescence, being widowed or separated were experiences associated with gender disadvantage and risk factors for low mood.

(c) SDMH through life span

Social determinants can be experienced on an individual level and across a life span. Adverse early life experiences, poor family and social networks, and social exclusion due to ethnicity, disability, gender or sexual orientation are common determinants on individual level. Exposure to adversity at young age is a well-established preventable risk factor for mental disorders (WHO and Calouste Gulbenkian Foundation 2014).

A life-course perspective is crucial to understand the impact of SDMH, as continuing stressors may affect mental health at various stages of life. These include perinatal period, pregnancy, early childhood, adolescence, working and family-building years, and older age. At every stage in life course of individuals, vulnerability exposure to harmful processes and stressors can be disruptive. The differential impact of SDMH throughout these life periods will be reviewed.

Socioeconomic and environmental disadvantages start before birth and tend to accumulate throughout entire life. This is not a pure deterministic phenomenon because not all individuals with similar exposure have the same vulnerabilities, and some people are more resilient and have access to buffers and social support that mitigates the harmful effects of poverty on their mental health (WHO 2013b). Social support in the family and community network and other factors such as self-esteem and sense of control buffer the effect of psychological stressors (Taylor 2010).

Negative and positive factors accumulate over time and throughout life. They influence behavioural and psychosocial attitudes among individuals and social conditions in families, communities and social groups including gender.

Family-building and parenting affects children's mental and physical health. A meta-analysis of studies on maternal depression and childhood growth in developing countries found that children of depressed mothers had low birth weight, which is by itself a risk factor for later life depression (Surkan et al. 2011). Another systematic review of studies in low- and middle-income countries found that prevalence of mental disorders in mothers after delivery was 20%. Risk factors included low socioeconomic status, unintended pregnancy, lack of support from partner and suffering intimate partner violence (Fisher et al. 2012). Suicide is also an important cause of death among pregnant and post-partum women.

Family conditions and quality of parenting in early life may have deep impact on mental health. Poverty and conflict between parents affect social and educational outcomes, and mental and physical health in children. Other risk factors of mental disorders include neglect, physical and psychological abuse and growing up in families with domestic violence (Fryers and Brugha 2013).

Inequity pattern in social distribution emerge before adult life. Worldwide around 20% of the world's children and adolescents have mental disorders, and children living in poverty are five times more likely to suffer from mental diseases (WHO 2014). A systematic review showed that prevalence of depression or anxiety was 2.5 times higher among people aged 10–5 years with low socioeconomic level compared to youths with high socioeconomic status (Lemstra et al. 2008). Proper education and schooling are important in this stage of life, and children and adolescents from poorer background are likely to get greater exposure to poor environments and stressful family context. Depression in adolescence has also been linked with adverse childhood experiences (Bell et al. 2013).

Mental health disorders are increasingly prevalent in adult life and among the global adult population (Ferrari et al. 2013). Poverty, poor self-reported economic status of the whole family, the fact of not obtaining a minimum wage for healthy living, low education, low social cohesion and negative life events are major risk factors for mental health in adult age (Marmot Review Team 2010). Unemployment and poor quality employment are strong risk factors for mental disorders in adult life. Job loss and long-term unemployment are associated with depression and anxiety (Marmot Review Team 2010). During the working age, major depression is the leading cause of years lived with disability in women, while anxiety disorders ranked 6th; among men, major depression ranked 2nd, and drug use disorders ranked 7th (Ferrari et al. 2013).

Mental health in elderly has been linked to earlier life experiences and also to specific conditions and contexts around ageing and the post-retirement period. Cultural factors and attitudes about the process of ageing may influence the level of social support. Older individuals are at higher risk of suffering depression, and some life events related to ageing such as bereavement, loss of status, poor physical health, chronic pain, poor or limited mobility and reduction of social contacts are strong risk factors (McCrone et al. 2008). Depressive mood in elderly men has been linked with chronic ill-health and lack of exercise whereas for women depression in elderly is related to social factors including social isolation and reduced contacts with family (Grundy et al. 2013). Approximately 10% of older adults are socially isolated, and loneliness in the elderly is a risk factor for poor mental health and depression, poor cognition, alcohol dependence, suicidal ideation and even death (Grundy et al. 2013). A social gradient for mental health is noted in older people, and high educational level seems to be protective particularly in women (Ploubidis and Grundy 2009). Ageing of population is growing, and 2 billion people older than 60 are expected in 2050.

(d) SDMH through community-level context and country level

Community-level context includes the impact of natural and built environment, neighbouring, geographical accessibility to primary care and community, housing quality, water and sanitation systems and transportation system, which may affect direct or indirectly to mental health (WHO 2013b).

Disparities regarding primary health provision exist between countries. In developing countries, lack of staff to deliver primary health care is noted. In many poor countries, primary health care is the only source of care available for low-income population (Rao and Pilot 2014).

At country level, deleterious effects on physical and mental health are observed in citizens living in countries with restricted political freedom, unstable policy environment and poorly developed services (Marmot et al. 2012). Following the collapse in former Soviet Union, increased deaths in middle aged adults and higher levels of psychological distress were found (Roberts et al. 2010). An increased suicide rate was reported following the 2008 European banking crisis (Stuckler et al. 2011).

4.3 Discussion

(a) Interventions on SDMH to promote mental health

Actions on SDMH can prevent mental disorders and improve mental health in the population. Implications for action will be reviewed following a life-course perspective, community and country levels.

Effective actions include schooling and education, reduction in long-term unemployment, support strategies for family-building, interventions for maternal mental health, and active programmes to avoid social isolation in elderly. The focus on family-building stage and maternal and perinatal stages are crucial to avoid intergenerational transfer of disadvantage (WHO and Calouste Gulbenkian Foundation 2014).

On individual level, learning coping strategies, developing self-confidence and self-efficacy, and sense of coherence and resilience are significant aspects. Family support, wider networks and communities, and positive thinking about promotion of mental health are needed among employers, public health authorities, policy-makers and stakeholders. People should be engaged in practices that promote mental health, and avoid stigmatization (WHO and Calouste Gulbenkian Foundation 2014).

Promotion of mental health has been linked with ease access to natural environment and outdoor spaces. Integration of mental healthcare into primary healthcare is necessary. Strong social welfare systems are protective for unemployment and offer additional protection for mental disorders linked to unemployment and social exclusion/isolation (WHO 2013b).

(b) Politics and Economics

Power, institutions, ideologies, and political interests affect mental health within different political and sociocultural systems (Kickbush 2015). Health itself is political because is unevenly distributed, it is a critical dimension of human rights and citizenship, and many health determinants are dependent on political action (Bambra et al. 2005).

The 2008 report of the Commission on SDMH emphasized that health is shaped ultimately by socioeconomic and political factors such as the differential distribution of money, power and resources at local, national and global levels. These factors are tackled only in sectors other than health (WHO 2008). As a consequence, SDMH identification is necessary to improve health equity in disadvantaged groups of society. This fact may have an impact on policy-making processes to reduce global health inequalities and poverty (Ottersen et al. 2014).

Politics, interests and ideologies permeate society and encompass all stages of negotiation and conflict in taking decisions about use and distribution of health resources. When used in the wrong direction, political decisions may lead to growing health inequalities and increased rates of disease and death. Austerity policies and primacy of economic over social policies have health effects and lead to growing health inequalities. Different political decisions may result in significant variation of health and political effects across countries (Stuckler and Basu 2013).

Mental health policy comprises several aspects including mental health promotion, prevention, treatment, rehabilitation and advocacy. Other policy priorities are social promotion and protection, anti-discrimination, health promotion, intersectoral and occupational policies and large-scale socioeconomic development interventions (Pedrana et al. 2016).

To be effective, mental health policy should be accompanied by an action plan specifying the actions to be out in place to achieve the policy objectives. Mental health policies and actions plans should be clear, consensual and realistic (WHO 2007). The WHO enumerated a series of principles and actions to reduce inequalities in mental health and reduce the global burden of mental disorders (Table 4.2). A mental health action plan for 2013–2020 was proposed (WHO 2013a).

Universalism is a key principle and policies should be universal. There is a concern that focusing only in the most disadvantaged sectors of society could fail to

Table 4.2 Principles and actions to reduce global burden of mental disorders

Proportionate universalism
Action across sectors
Life-course approach
Early intervention
Healthy mind and healthy body
Prioritizing mental health
Avoid short-termism
Mental health equity in all policies
Knowledge for action at the local level

achieve the desired reduction in health inequalities. Policy actions should be universal although calibrated proportionality to the level of disadvantage (WHO and Calouste Gulbenkian Foundation 2014). The multilevel framework of SDMH can be applied to interventions to promote mental health and prevent mental disorders.

The delivery of an SDMH approach requires action across multiple sectors including education, health, welfare, transport and housing sectors (Table 4.3). Mental health is a business of all. Participation of government, social institutions, community and service providers are required. The empowerment of individuals and communities is the main heart of action on SDMH (WHO World Health Organization 2013b). Sustainability of mental health policies, in a multilevel, multisectoral and multiprofessional framework is required.

Promotion of mental health and prevention of mental disorders should be a public health priority. The 2014 Mental Health Atlas found an inequitable distribution and inefficient use of resources. Only 60% of countries had mental health policies (WHO 2015). Only one-third of people living in low-income countries are covered by mental health legislation, and poor quality of care was identified in those receiving treatment (Lund et al. 2011).

Implementation of mental health policies is weak and involvement of people with mental disorders and their families is limited. A substantial gap exists between the need of mental healthcare and its availability and quality of care provided. Annual investment in public mental health is globally less than US$ 2 per person, and less than US$ 0.25 in low-income countries. Variation in median number of mental health workers worldwide is extreme and ranges from below 1/100,000 in low-income countries to over 50/100,000 in rich ones (WHO 2015).

Promotion of mental health and well-being was included now in the 2015–2030 Sustainable Development Goals at the United Nations General Assembly in September 2015 (United Nations 2015a). The net value of investment needed over the period 2016–30 to substantially scale up effective treatment coverage for depression and anxiety disorders is around US$147 billion (Chisholm et al. 2016).

The Mental Health Gap Action programme has the objective of providing guidance to policy-makers and health stakeholders about scaling up mental health care. The allocation of economic and human resources in mental health care in low- and middle-income countries are emphasized (Patel 2012). There is an urgent need to redirect funding to community-based services. The WHO recommends the

Table 4.3 Areas of intervention to reduce mental disorders

Life-course: - Pregnancy and prenatal period, childhood, adolescence, working and family building years, older age - Gender issues
Parents, families and housing - Parenting attitudes - Income, and employment conditions - Social support - Food, water, sanitation, housing
Community - Neighbourhood safety, and violence and crime - Community-based participation - Natural environment
Local services - Schooling and education services - Health care and social services
Country level - Poverty, inequality and discrimination reduction - War, migration, ethnic minorities and refugees - National policies to promote education access, employment, health care and housing

Adapted from WHO and Calouste Gulbenkian Foundation (2014)

integration of mental health into general healthcare settings to allow better and more cost-effective interventions in mental health.

(c) Monitoring

There is a growing recognition for the importance of monitoring trends in health inequalities and the impact of socioeconomic and political actions to tackle those (Pedrana et al. 2016). The Millenium Development Goal programme recognized the importance of monitoring social determinants of health and recommended the definition of priorities and strategies to support countries in the collection and analysis of data (United Nations United Nations 2015a). Key measures of social determinants of health monitoring include socioeconomic, sociocultural, health and gender inequities, among others (Pedrana et al. 2016).

Most published studies used traditional indicators such as income per capita and illiteracy rates (Pedrana et al. 2016). So, there is a need for reliable measures of SDMH to implement more inclusive policies sensitive to the different needs of populations. The WHO "Equity-oriented analysis of linkages between health and other sectors" (EQuAL) project proposed monitoring equitable progress towards universal health coverage analysing specific social determinants of health and intersectoral barriers (Blas et al. 2015). Cases studies and interviews from Bangladesh, Vietnam, Brazil and South Africa were used. The EQuAL-WHO framework included three cluster domains (environment quality; accountability and inclusion; and livelihoods and skills), 12 domains and 32 indicators (Table 4.4).

Table 4.4 The EQuAL-WHO framework

Cluster (n = 3)	Domains (n = 12)	Some examples of indicators (n = 32)
Environment quality	Amenities	Travel time to outpatient/inpatient facility
	Community spaces and products	Safety in the neighbourhood
	Housing	% of population with access to structurally sound, climate resilient housing
	Working conditions	% of workplaces in public/private sectors that comply with occupational health and safety standards, by economic sectors
Accountability and inclusion	Accountability and participation	Involvement in decision making in the health system
	Discrimination	Access to health services for migrants
	Gender equality	% of total working age females employed in labour's force
	Social capital	Gini's coefficient
Livelihoods and skills	Education and skills	% of people confident about using health system
	Employment relations	Share of informal employment in total employment
	Income, wealth and social protection	% of population having the right to income protection due to unemployment, old age, sickness and disability
	Intergenerational equity	Extend of coverage of poor families with social programmes

Adapted from Blas et al. (2015)

Most studies focused on social condition of marginalized or discriminated groups, so there is a need for further research on individual social conditions. Monitoring of social indicators is considered now an important issue in development, and two specific goals referred specifically to data monitoring were elaborated in the 2030 Agenda for Sustainable development (United Nations 2015b). The WHO's 2014 Mental Atlas may be a useful tool to track progress in the implementation of the WHO's Mental Health Action Plan 2013–2020.

Take Away Messages

- Mental health and mental disorders are shaped by social, economic and environmental factors.
- Gender is an important determinant in mental health. Gender has a deep impact on access to care, and mediates the influence of socioeconomic factors on it. Females suffer disproportionally from mental disorders at each level of social and economic level.
- Poverty and social inequalities are linked with poor mental health and increased risk of mental disorders.

- A life-course approach across life stages is proposed.
- Policies that reduce social inequalities and stimulate actions to improve conditions of daily living from before birth, early childhood, family-building, working and older ages may improve mental health of the individuals and reduce mental disorder risk.
- Effective actions to reduce mental disorders throughout life course are needed at community and country levels.
- Monitoring of policies is needed.
- Mental health needs to be give priority especially in developing countries.
- WHO-EQuAL project is an example of monitoring progress towards universal health coverage analysing specific SDMH.

References

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26,* 392–407.

Angermeyer, M. C., Matschinger, H., & Schomerus, G. (2013). Attitudes toward psychiatric treatment and people with mental illness: Changes over two decades. *British Journal of Psychiatry, 203,* 146–151.

Bambra, C., Fox, D., & Scott-Samuel, A. (2005). Towards a politics of health promotion. *Health Promotion International, 20,* 187–193.

Bährer-Kohler, S. (2012). *Social determinants and mental health*. New York: Nova Biomedical Publishers.

Bell, R., Donkin, A., Marmot, M. (2013). *Tackling structural and social issues to reduce inequalities in children's outcome in low and middle income countries*. Florence: office of research, UNICEF.

Blas, E., Ataguba, J. E., Huda, T. M., Bao, G. K., Rasella, D., & Gereck, M. R. (2015). The feasibility of measuring and monitoring social determinants of health and the relevance for policy and programme a qualitative assessment of four countries. *Global Health Action, 8,* 29002. doi:10.3402/gha.v8.29002.

Campion, J., Bhugra, D., Bailey, S., & Marmot, M. (2013). Inequality and mental disorders: opportunities for action. *Lancet, 382,* 183–184.

Chaudhury, D., Liu, H., & Han, M. H. (2015). Neuronal correlates of depression. *Cellular and Molecular Life Sciences, 72,* 4825–4848.

Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., et al. (2016). Scaling-up treatment of depression and anxiety: A global return on investment analysis. *Lancet Psychiatry, 3,* 415–424.

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

Dumit, J. (2004). *Picturing personhood: Brain scans and biomedical identity*. Princeton, NJ: Princeton University Press.

Ferrari, A., Charlson, F., Norman, R., Patten, S. B., Freedman, G., Murray, C. J. L., et al. (2013). Burden of depressive disorders by country, sex, age, and year: findings from the global burden of disease study 2010. *PLOS Medicine, 10,* 1–12.

Fisher, J., de Cabral, M. M., Patel, V., Rahman, A., Tran, T., Holton, S., et al. (2012). Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: A systematic review. *Bulletin of the World Health Organization, 90,* 139G–149G.

Fitzgerald, D., Matusall, S., Skewes, J., & Roepstorff, A. (2014). What’s so critical about Critical Neuroscience? Rethinking experiment, enacting critique. *Frontiers in Human Neuroscience, 8*, 365. Retrieved October 22, 2016, from http://journal.frontiersin.org/article/10.3389/fnhum.2014.00365/full.

Fryers, T., Melzer, D., Jenkins, R., & Brugha, T. (2005). The distribution of the common mental disorders: Social inequalities in Europe. *Journal of Public Mental Health, 1,* 1–12.

Fryers, T., & Brugha, T. (2013). Childhood determinants of adult psychiatric disorder. *Clinical Practice and Epidemiology in Mental Health, 9,* 1–50.

Gottschalk, M. G., & Domschke, K. (2016). Novel developments in genetic and epigenetic mechanisms of anxiety. *Current Opinion in Psychiatry, 29,* 32–38.

Grundy, E., van Campen, C., Deeg, D., Dourgnon, P., Huisman, M., Ploubidis, G., et al. (2013). *Health inequalities and the health divide among older people in the WHO european region: The European review on the social determinants of health and the health divide (report of the task group on older people)*. Copenhagen: World Health Organization Regional Office for Europe.

Kickbusch, I. (2015). The political determinants of health-10 years on. *British Medical Journal, 350,* h81. doi:10.1136/bmj.h81.

Kleinman, A. (2009). Global mental health: a failure of humanity. *Lancet, 374,* 603–604.

Lemstra, M., Neudorf, C., D’Arcy, C., Kunst, A., Warren, L. M., & Bennett, N. R. (2008). A systematic review of depressed mood and anxiety by SES in youth aged 10–15 years. *Canadian Journal of Public Health, 99,* 125–129.

Lund, C., Breen, A., Flisher, A., Kakuma, R., Corrigall, J., Joska, J., et al. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Social Science and Medicine, 71,* 517–528.

Lund, C., De Silva, M., Plagerson, S., Cooper, S., Chisholm, D., Das, J., et al. (2011). Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. *Lancet, 378,* 1505–1514.

Marmot, M., Allen, J., Bell, R., Bloomer, E., & Goldblatt, P. (2012). WHO European review of social determinants of health and the health divide. *Lancet, 380,* 1011–1029.

Marmot Review Team. (2010). *Fair society, healthy lives: strategic review of health inequalities in England post-2010 London*: Marmot Review. Retrieved July 11, 2016, from http://www.instituteofhealthequity.org.

Martin, E. (2000). AES presidential address—mind-body problems. *American Ethnologist, 27,* 569–590.

McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., & Lawton-Smith, S. (2008). *Paying the price: the cost of mental health care in England to 2026*. London: King’s Fund.

Ortega, F., & Vidal, F. (2007). Mapping the cerebral subject in contemporary culture. *RECIIS: Electronic Journal of Communication Information & Innovation in Health, 1,* 255–259.

Ottersen, O. P., Dasgupta, J., Nlouin, C., Buss, P., Chongsuvivatwong, V., Frenk, J., et al. (2014). The political origins of health inequity: Prospects for change. *Lancet, 383,* 630–667.

Patel, V., Kirkwood, B. R., Pednekar, S., Pereira, B., Barros, P., Fernandes, J., et al. (2006). Gender disadvantage and reproductive health risk factors for common mental disorder in women: a community survey in India. *Archives of General Psychiatry, 63,* 404–413.

Patel, V., Lund, C., Hatheril, S., Plagerson, S., Corrigall, J., Funk, M., et al. (2010). Mental disorders: equity and social determinants. In E. Blas & A. S. Kurup (Eds.), *Equity, social determinants and public health programmes* (pp. 115–134). Geneva: World Health Organization.

Patel, V. (2012). Global mental health: From science to action. *Harvard Review of Psychiatry, 20,* 6–12.

Pedrana, L., Pamponet, M., Walker, R., Costa, F., & Rasella, F. (2016). Monitoring health determinants with an equity focus. Scoping review: National monitoring frameworks for social determinants of health and health equity. *Global Health Action*, *9*, 28831. doi:10.3402/gha.v9.28831.

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). A disease like any other? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry, 167,* 1321–1330.

Ploubidis, G., & Grundy, E. (2009). Later-life mental health in Europe: A country-level comparison. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 64B,* 666–676.

Rao, M., & Pilot, M. (2014). The missing link—the role of primary care in global health. *Global Health Action, 7,* 23693.

Roberts, B., Abbott, P., & McKee, M. (2010). Levels and determinants of psychological distress in eight countries of the former soviet union. *Journal of Public Mental Health, 9,* 17–26.

Shim, R., Koplan, C., Langheim, F. J. P., Manseau, M. W., Powers, R. A., & Compton, M. T. (2014). The Social determinants of mental health: an overview and call to action. *Psychiatric annals, 44,* 22–26.

Stuckler, D., Basu, S., Suhrcke, M., Coutts, A., & McKee, M. (2011). Effects of the 2008 recession on health: A first look at European data. *Lancet, 378,* 124–125.

Stuckler, D., & Basu, S. (2013). *The body economy. Why austerity kills*. New York: Allen Lane.

Surkan, P. J., Kennedy, C. E., Hurley, K. M., & Black, M. M. (2011). Maternal depression and early childhood growth in developing countries: systematic review and meta-analysis. *Bulletin of the World Health Organization, 89,* 608–615.

Taylor, S. E. (2010). Mechanisms linking early life stress to adult health outcomes. *Proceedings of the National Academy of Sciences USA, 107,* 8507–8512.

United Nations. (2015). *The millennium development goals report*. New York: United Nations.

United Nations. (2015b). *Transforming our world: The 2030 agenda for sustainable development*. New York: United Nations. Retrieved July 10, 2016, from https://sustainabledevelopment.un.org/post2015/transformingourworld.

World Health Organization and Calouste Gulbenkian Foundation. (2014). Social determinants of mental health. Geneva: World Health Organization.

World Health Organization Commission on Social Determinants of Health. (2008). *Closing the Gap in a Generation—Health Equity through action on the social determinants of health*. Geneva: World Health Organization.

World Health Organization. (2004a). *Promoting mental health: Concepts, emerging evidence, practice: Summary report*. Geneva: World Health Organization.

World Health Organization. (2004b). *Prevention of mental disorders: Effective interventions and policy options, summary report*. Geneva: World Health Organization.

World Health Organization. (2007). *Mental health policies and action plans*. Geneva: World Health Organization. Retrieved July 10, 2016, from http://www.who.int/mental_health/policy/services/en/index.html.

World Health Organization. (2013a). *Mental health action plan 2013–2020*. Geneva: World Health Organization.

World Health Organization. (2013b). *Review of social determinants and the health divide in the WHO European region: Final report*. Copenhagen: World Health Organization.

World Health Organization. (2014). *Mental health: A state of well being*. Geneva: World Health Organization. Retrieved October 22, 2016, from http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/.

World Health Organization. (2015). *Mental health ATLAS 2014*. Geneva: World Health Organization. Retrieved August 1, 2016, from http://www.who.int/mental_health/evidence/atlas/global_results.pdf.

World Health Organization. (2016). *Out of the shadows. Making Mental Health a global development priority*. Retrieved August 1, 2016, from http://www.who.int/mental_health/WB_WHO_meeting_2016.pdf.

Chapter 5
Mental Health and Carers

Lia Fernandes

5.1 Introduction

People are progressively ageing all over the world. Currently most of the elderly people are living in high-income countries. Japan is home to the world's most aged population (33%), followed by Germany (28%), Italy (28%) and Finland (27%) (World Health Organization 2015a).

The number of elderly has reached 900 million today (12% of the world population) and is estimated to increase to 2 billion (22% of the world population) by 2050 (World Health Organization 2015a). This emerging population will experience an inevitable rise in chronic conditions including dementia, chronic mental disease, intellectual disability as well as comorbid physical illness (Fernandes et al. 2015).

All of these factors contribute to greater morbidity and mortality (Scheil-Adlung 2015) and in most cases have addictive and potentiating effects. The management of these complex combinations of chronic conditions poses a great challenge. In many Organization for Economic Co-operation and Development (OECD) countries, more than half the individuals aged over 65 years have more than one chronic condition and from age 75 many people will have three or more. Taking this into consideration, health care systems are still working out how to cope with the

---

L. Fernandes (✉)
Faculty of Medicine, Department of Clinical Neurosciences and Mental Health,
University of Porto (FMUP), Alameda Professor Hernâni Monteiro, 4200-319 Porto, Portugal
e-mail: lfernandes@med.up.pt

L. Fernandes
Center for Health Technology and Services Research (CINTESIS), University of Porto,
Alameda Professor Hernâni Monteiro, 4200-319 Porto, Portugal

L. Fernandes
Psychiatry and Mental Health Clinic, São João Hospital Centre (CHSJ),
Alameda Professor Hernâni Monteiro, 4200-319 Porto, Portugal

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_5

diversity, uniqueness and complexity of these combinations of diseases and care needs in an effective way (Colombo 2015). This ageing population requires a new approach directed at chronic conditions with continuity of care across different health and social care structures and providers, by prioritizing primary care with multidisciplinary teams, instead of acute assistance and hospital-centric care (World Health Organization 2015a; Fernandes et al. 2015). This should involve better coordination from these different sectors, equipping them with better tools to access the needs of the elderly population. In this equation, in order to improve the quality of life and effectiveness of responses, the role of carers is becoming crucial.

Bearing in mind that caregiving means providing assistance to another person with activities of daily living, and/or emotional support (Zarit et al. 2016), it is important to note that 70–80% of the care provided to the elderly is assumed by a family member (World Health Organization 2015a). This assistance is primarily supplied by women, spouses who are mostly also elderly, followed by children (sometimes a *sandwich generation*, caring simultaneously for their own children and dependent parents) and less frequently other relatives, friends or neighbours (Brodaty 2009).

This frames what has been defined as informal caregiving that requires the existence of a personal relationship with the care recipients. On the other hand, formal caregiving is associated with a formal service system, whether a paid worker or a volunteer is providing the care (Family Caregiver Alliance 2014).

Caregiving as mainly a *family affair*, has always been a normative experience in a person's life (Zarit et al. 2016). In spite of this, the majority of families and carers report a substantial burden on their physical and psychological well-being, economic overload and negative social and personal repercussions, particularly in relationships (Young and Snowden 2016). However, even in developing countries with larger extended and often three-generational families, this experience is not free of stress and burden in different areas of a person's life (Prince 2009).

Nevertheless, some authors have highlighted positive aspects that have sustained this role over time, including acceptance, gratification, intimacy, assertiveness, sense of control and social-emotional support (Chen and Greenberg 2004; Gilhooly et al. 2016).

Basically caregivers may be confronted with two kinds of stressors, which have been more deeply studied in the field of dementia care. Primary stressors referring to tasks and challenges directly resulting from the illness and/or disabilities of the person they are caring for, and secondary ones defined as tasks and challenges emerging in work, family relationships or other areas of a person's life associated with providing care (Zarit et al. 2016).

Primary stressors include the patient's characteristics, particularly medical conditions and behavioural problems (Pinquart and Sörensen 2003a), but also the duration (months or years) and the intensity of care (hours/day and number of tasks), characteristics of the carers and their unmet needs, such as help with tasks, information and family support (Gaugler et al. 2004; Sörensen et al. 2006).

Additionally, secondary stressors that can contribute to carer burden include any work interference (missing work, early retirement and loss of job opportunities and promotions), financial strain, family conflicts (e.g. disagreement and division of care) (Lieberman and Fisher 1999; Ingersoll-Dayton et al. 2003), reduced leisure and quality of relationships with resultant social isolation.

These stressors can influence the carer, mediated by other important factors such as the subjective assessment of the carer role. This appraisal differs according to the person's coping strategies and capacities to match the demands of the caring situation, namely the perception of the situational control, role conflict, resources adequacy (Pinquart and Sörensen 2003a; Williams 2005), positive evaluation and finding meaning for care. These appraisal differences may also be influenced by exacerbating and mitigating factors such as race, ethnicity (Coon et al. 2004; Depp et al. 2005) and culture, personality traits (Shurgot and Knight 2005), physical illness (McKibbin et al. 2005) and personal and contextual resources (DiBartolo and Soeken 2003; Shurgot and Knight 2005).

Ethnicity, culture and socioeconomic status are also likely to influence burden itself and depressive symptoms (Pinquart and Sörensen 2005; Caqueo-Urízar et al. 2014). Black carers usually report lower burden and better adaptation to depression and life satisfaction (Roth et al. 2001) than white ones. Conversely, Asian and Latin American carers do not differ from white carers in burden, even though they report more depression (Sörensen et al. 2006). On the other hand, there are also ethnic differences in coping styles. Black (Haley et al. 2004) and Latin American carers (Coon et al. 2004) are more likely to use religion as a coping mechanism and usually present more benign appraisal of stress than white people (Sörensen et al. 2006). In some way, these differences may be attributed to factors like larger social networks and mutual aid systems among African-American families compared with white families (Lefley 1998). In spite of the better mental health outcomes reported by ethnic minority carers, they report worse physical health related to their socioeconomic status (Pinquart and Sörensen 2005).

5.2 Dementia Carers

Dementia affect a growing number of people across the world, currently estimated at 47.5 million (World Health Organization 2016). This reality is particularly worrying if one considers that the total number of new cases of dementia is 9.9 million per year which implies a new case every 3.2 s (Prince et al. 2015). The number of people with dementia will double every 20 years (75.6 million in 2030) and almost triple by 2050 to 135.5 million (American Psychiatric Association 2013).

Dementia due to Alzheimer's disease or other degenerative brain disorders is defined as a progressive cognitive decline from a previous level of performance in one or more cognitive domains (attention, executive function, learning and memory, language, perceptual motor or social cognition). The cognitive deficits interfere with independence in everyday activities and according to Diagnostic and Statistical

Manual of Mental Disorders (DSM-5), presently called Major Neurodegenerative Disorder (Miranda-Castillo et al. 2013).

In the absence of a cure or even treatments that can effectively modify the disease, development of efforts into innovations improving care and support are equally needed.

The base of these interventions should be structured from community settings and primary care, and professionals should be trained to detect dementia in earlier stages in order to introduce appropriate and person-centred interventions based on the needs assessment of the elderly and carers (Miranda-Castillo et al. 2013).

The majority of care is provided by the family to the person with dementia which is characterized by a diversity of interventions according to the particular needs of the patients, covering different aspects of health and well-being of the elderly such as psychological, emotional and financial support, and assistance in the activities of daily living. The duration, frequency and intensity of this care are strictly related to the objective demands of the evolution stage of the dementia. Namely, it can range from a focus on cognitive deficits in the initial stages, on behavioural and psychological symptoms (BPSD) in middle stages, or on functional impairment with autonomy loss in the late stages of the disease (Brodaty 2009).

Particularly considering BPSD, 30% of the costs of dementia patient care in the community are directly attributable to their management (Beeri et al. 2002), and one or two of these symptoms are associated with an additional ten hours per week of active help from a carer (Okura and Langa 2011). As opposed to core cognitive symptoms of dementia, BPSD often create major difficulties for patients, carers and providers and lead to earlier institutionalization (e.g. nursing home) (Yaffe et al. 2002; Maust et al. 2016).

Bearing this in mind, caregiving for people with dementia or other neurological diseases (e.g. Stroke, Parkinson's disease) (Carod-Artal et al. 2013), is associated with important psychological distress (care burden, depression, anxiety, sleep problems, decreased well-being and quality of life) (Weinbrecht et al. 2016) and physical ill-health (dysregulation of stress hormones, immune and metabolic malfunction, cardiovascular reactivity, among other diseases) and overuse of medication and service utilization and, finally, greater mortality (McKibbin et al. 2005; Pinquart and Sörensen 2006).

In order to face the huge challenge posed by the global increase in dementia and mental disorders, it is crucial to develop more specialized geriatric and psychiatric services and centres of excellence, as well as establish expertise in hospitals, departments of geriatric psychiatry, primary care, community-based mental health services, consultation-liaison services, mental health services in long-term care, nursing homes and memory clinics (Fernandes et al. 2015).

5.3 Chronic Mental Health Carers

Following the current mental health reform across the world, particularly in developed countries, with the deinstitutionalization of psychiatric care from hospital-based care to community-based care (Leff 1997), the number of patients being cared for in the community has increased (Thornicroft and Tansella 2013). The expectations on carers, particularly on family caregivers, have also increased as a result of this change. They play a central role in the care of persons with severe mental illness.

In spite of the lack of an internationally agreed definition for severe mental illness (Ruggeri et al. 2000), the most common one is based on the *three-dimensional definition* proposed by the National Institute of Mental Health (1987): diagnosis, duration and disability. This diagnosis covers all patients with any non-organic psychosis (Schizophrenia, Bipolar Disorder, Schizoaffective Disorder and Major Depression). The duration requires a prolonged illness and long-term treatment of two years or more. Finally, the disability implies a significant impact on the family, as well as social and occupational, professional and vocational functions (Bachrach 1988; Schinnar et al. 1990).

These severe mental illnesses are associated with significant consequences for patients, relatives and carers, as well as for societies with a great economic burden measured as direct costs (e.g. hospitalization, medication, social services use, technical support or rehabilitation services) and indirect costs (e.g. loss of productivity, unemployment or absenteeism) due to the chronic development of the diseases.

According to a recent meta-analysis (Walker et al. 2015), people suffering from a chronic mental disorder present higher rates of adverse health behaviours that include smoking, substance abuse, physical inactivity and poor diet, that in turn are contributors to their high rates of chronic medical conditions and mortality, when compared with the general population. This is important because most of these patients do not die from their mental condition, but from chronic illnesses, heart disease, infections, suicide and other causes (Laursen et al. 2014; Walker et al. 2015).

Caring for a family member with a severe mental health condition has been associated with adverse outcomes such as reduced quality of life and decreased mental health of the carers themselves (Boydell et al. 2014). Carers usually report emotional costs related with unusual and unpredictable behaviours (Landon et al. 2016), particularly in schizophrenia with a great burden, expressed emotions (Butzlaff and Hooley 1998) and psychological morbidity. These consequences for carers can range from stress, anxiety, depression, feelings of loss and grief, economic strain (Addington et al. 2005), as well as significant restriction on leisure and on levels of social support if compared with that received by carers of equally long-term physical conditions (Magliano et al. 2006; Boydell et al. 2014). Additionally, a chronic mental health condition is prone to stigma that also affects families with frequent conflict, embarrassment, low self-esteem, substance use and separation (Awad and Voruganti 2008).

On the other hand, not only does a severe mental condition have an impact on families, but also family involvement is an important predictor of compulsory and other kinds of treatment (Boydell et al. 2014). In fact, families and family carers can have an instrumental role in the patient's recovery, co-operation with pharmacotherapy and community integration (Addington et al. 2005), and several studies have reported that relapse rates in psychosis can be substantially reduced by family interventions (Yesufu-Udechuku et al. 2015).

At present, as there is no curative treatment for most of these severe chronic mental disorders, patients require long-term support and care. In this context, the current purposes of intervention include the recognition of the disease as early as possible, the treatment of symptoms and the development of skills and competences in patients and their families and carers, in order to enable them to know how to deal with the disease. It is also essential to promote recovery and relapse prevention, as well as to contribute to the rehabilitation of these patients and their integration in the community to help their well-being and allow them a better quality of life (Thornicroft and Tansella 2009; Slade et al. 2012).

5.4 Intellectual Disability Carers

The life expectancy of those with intellectual disability (ID) has increased following the demographic changes in the general population (Bittles et al. 2002), leading to a generation of older individuals with such disabilities (Eady et al. 2015). According to a recent meta-analysis its global prevalence may be lower than 1% (McKenzie et al. 2016).

Intellectual disability (intellectual developmental disorder), formerly named as mental retardation, is a lifelong condition that involves impairments of general mental abilities that impact adaptive functioning in three domains, conceptual (e.g. skills in language and memory), social and practical (e.g. self-management in personal care, job responsibilities and work tasks), that must have their origin in the developmental period (American Psychiatric Association 2013; Eady et al. 2015).

The construct of intellectual disability is contained in the broader concept of disability, sharing the same assessment and intervention as well as its impact (Schalock et al. 2007), which affects the individual, immediate family and carers and the community (Maulik et al. 2011). In this context, ageing individuals with ID are more likely to suffer from multimorbidity, chronic conditions (McCarron et al. 2013) and other mental health issues, suggesting that their health is more complex as they age compared to those without ID (Haveman et al. 2010). They also present an increased risk of behavioural problems that include aggression towards themselves, others or property, severe stereotypical behaviour and hyperactivity, as well as an increased risk of death.

As another outcome of increased life expectancy, the health needs of those with ID are now a cumulative result of the effects of the normal ageing process and specificities of this population (Gath and McCarthy 2012). It is not uncommon that an adult or older person with ID lives with an elderly carer, usually a parent or a sibling (Grant and Ramcharan 2001) since families continue to be their primary care providers (Williamson and Perkins 2014). This reality is prone to elicit a complex and joint set of care needs (Gath and McCarthy 2012) due to the multifaceted interplay of factors that becomes evident in the response of family caring for adults with ID (Iacono et al. 2016). Both carers and care recipients are likely to be vulnerable at this late stage of life (Seltzer et al. 2001) and frailty and death of one of the carers can impede the continuity of care, raising concerns about who will take on the carer role, that altogether can become important stress contributors (Iacono et al. 2016). It is not unusual that many caring parents believe that only they are able to provide quality care for their child, and avoid institutionalization from the early stages of their child's life.

Typically, there are no specific treatments for the causes underlying the disability, and also inequities in accessing the health services. Consequently, the management of a co-occurring medical or behavioural condition should be the focus of care (Weedon et al. 2015).

5.5 Chronic Physical Illnesses Carers

Lifestyle patterns are changing following recent great demographic changes, with an ageing population, as well as with increasing urbanization, changes in diet leading to an increasing prevalence of chronic diseases in many countries. Thus, a great number of illnesses, disabilities and mortality account for 60% of all deaths and 43% of the global burden of disease. Together, the four main chronic ailments, cardiovascular disease, cancer, diabetes and chronic respiratory diseases, kill three in five people worldwide (World Health Organization 2015b). In Europe, chronic diseases represent 86% of all deaths and 77% of the total disease burden, affecting more than 80% of people aged over 65 (Busse et al. 2010).

Typically, chronic diseases are long-lasting, generally progress slowly and have persistent effects. They can vary in multiple ways, including their stage of presentation, clinical symptom characteristics and their natural history (time course). The majority of chronic disease is caused by risk factors which are mostly preventable. Smoking tobacco, alcohol abuse, physical inactivity and unhealthy diet have been identified as the major behaviours that contribute to the development of biomedical risk factors (e.g. overweight, obesity, high blood pressure), which in turn lead to more chronic diseases (World Health Organization 2015b).

The increasing prevalence of chronic diseases is posing considerable challenges to health and social systems, with a significant economic burden on society. People with chronic health problems are more likely to use healthcare services, particularly when they have multiple problems. This also leads to a range of needs, which imply a delivery model that involves coordinated inputs from a wide range of health professionals over an extended period of time, placing patients at the centre as co-producers of care to optimize health outcomes (Nolte and McKee 2008; Bährer-Kohler 2009).

It is also important to highlight that chronic diseases often coexist and are linked by a common risk factor. Notably many of the same risk factors for heart diseases, cancer and diabetes can increase the risk of dementia. The evidence for other causative factors is suggested but not yet conclusive. Besides, they are increasingly being seen as acting together to determine the health status of patients, which makes it important to integrate prevention and care, and treat selected chronic diseases together, to keep people healthy for as long as possible (World Health Organization 2015b).

Chronic diseases also represent a major source of burden to patients and their family members, in particular those involved in caregiving. Family caregivers are more frequently called upon to use daunting and complex medical equipment at home or to deal with extensive coordination of care, as well as manage activities of daily living. In addition, some of them may frequently miss work, and even have to quit their jobs or retire early to provide care (Institute of Medicine 2012).

Caregiver burden has been widely documented as a predictor of anxiety, depression and low quality of life, which is corroborated by a meta-analysis that also reported significant differences in depression, stress, self-efficacy and subjective well-being among caregivers of elderly people with various illnesses versus non-caregivers (Pinquart and Sörensen 2003b). More recently, in the field of cancer, a study (Goren et al. 2014) with a wide representative survey across several EU countries found that caregivers versus non-caregivers reported substantial impairment across all health outcomes (quality of life, work productivity, healthcare resource use, depression, anxiety, insomnia, headache, migraine and gastrointestinal problems).

Diverse risk factors for caregiver burden are: the caregiver is a woman, has low educational attainment, lives with the care recipient, spends a greater number of hours caregiving, suffers from depression, social isolation, financial stress and lack of choice in being a caregiver (Adelman et al. 2014).

Bearing in mind the negative impact of caregiving experience, the early identification of caregiver burden, providing appropriate resources and effective interventions have been increasingly emphasized.

Acknowledgements With special thanks to Ana R. Ferreira and Sónia Martins.

Take Away Messages

Carers form a highly mixed group, caring for all manner of disabilities. The challenges imposed by the ageing population with dementia, chronic mental disease, intellectual disability as well as comorbid physical illnesses comprising different specificities must be addressed with new policies with effective social and health interventions in order to promote mental health in the elderly, their carers and families.

In particular, some interventions, directed to both caregivers and elderly, have been proven to be effective (Sörensen et al. 2006; Pinquart and Sörensen 2007):

- Consultation or Case Management (including advice, information and referrals) (Roberts et al. 1999)
- Psychotherapy (individual or group-based, mostly cognitive-behavioural) (Vernooij-Dassen et al. 2011; Chien et al. 2011)
- Family Therapy (Benbow and Sharman 2014)
- Psychoeducational Programmes (structured information, behaviour and stress management) (Bourgeois et al. 2002; Fernandes 2012; Jensen et al. 2013)
- Support Groups (dealing with personal feelings, emotions and social isolation) (Gonyea and Silverstein 1991; Brodaty et al. 2003)
- Respite Offers (relief of the carer in day-care, home or institutions) (Gottlieb and Johnson 2000)
- Training for the patients (to improve social and everyday competence) (Quayhagen and Quayhagen 1989)
- Pharmacotherapy for the patients (particularly for behavioural problems and stabilization of cognitive impairment) and for carers (e.g. for depression, anxiety and insomnia) (Lingler et al. 2005; Sleath et al. 2005)
- Multicomponent Interventions (combining education, support and respite) (Dröes et al. 2004)
- Others such as patients and family associations, new technologies,[1] telephone support and some approaches such as yoga (Beauchamp et al. 2005; Bank et al. 2006; Waelde et al. 2004).

In the near future, and supported by the development of new heath care polices, families, carers, clinicians and researchers must address their actions to the development of more effective and preventive interventions (Sörensen et al. 2006). Early diagnosis and customized interventions based on a timely needs assessment (Orrell and Hancock 2004; Sörensen et al. 2006) will be much more cost-effective than the usual solution based only on institutionalization, which has proved to be an adverse and expensive outcome for elderly, families, carers and community.

---

[1] These new technologies also include other resources for carers offered by Associations and online organizations, e.g.: Alzheimer's associations, Alzheimer's Disease Education and Referral Center, Alzheimer Europe, Administration on Aging Eldercare Locator, Family Caregiver Alliance, National Alliance for Caregiving, National Family Caregivers Association, National Institute on Aging, International Caregivers Association, International Alliance of Carer Organizations, The Caregiver's Voice.

References

Addington, J., Collins, A., McCleery, A., & Addington, D. (2005). The role of family work in early psychosis. *Schizophrenia Research, 79*(1), 77–83.

Adelman, R. D., Tmanova, L. L., Delgado, D., Dion, S., & Lachs, M. S. (2014). Caregiver burden: a clinical review. *Journal of the American Medical Association, 311*(10), 1052–1060.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, DSM 5*. Washington, DC: American Psychiatric Association.

Awad, A. G., & Voruganti, L. N. (2008). The burden of schizophrenia on caregivers: A review. *Pharmacoeconomics, 26*(2), 149–162.

Bachrach, L. L. (1988). Defining chronic mental illness: a concept paper. *Hospital Community Psychiatric, 39*(4), 383–388.

Bährer-Kohler, S. (2009). *Self management of chronic disease*. Heidelberg: Springer.

Bank, A. L., Argüelles, S., Rubert, M., Eisdorfer, C., & Czaja, S. J. (2006). The value of telephone support groups among ethnically diverse caregivers of persons with dementia. *The Gerontologist, 46*(1), 134–138.

Beauchamp, N., Irvine, A. B., Seeley, J., & Johnson, B. (2005). Worksite-based internet multimedia program for family caregivers of persons with dementia. *The Gerontologist, 45*(6), 793–801.

Beeri, M. S., Werner, P., Davidson, M., & Noy, S. (2002). The cost of behavioral and psychological symptoms of dementia (BPSD) in community dwelling Alzheimer's disease patients. *International Journal of Geriatric Psychiatry, 17*(5), 403–408.

Benbow, S. M., & Sharman, V. (2014). Review of family therapy and dementia: twenty-five years on. *International Psychogeriatrics, 26*(12), 2037–2050.

Bittles, A. H., Petterson, B. A., Sullivan, S. G., Hussain, R., Glasson, E. J., & Montgomery, P. D. (2002). The influence of intellectual disability on life expectancy. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 57*(7), 470–472.

Bourgeois, M. S., Schulz, R., Burgio, L. D., & Beach, S. (2002). Skills training for spouses of patients with Alzheimer's disease: outcomes of an intervention study. *Journal of Clinical Geropsychology, 8*(1), 53–73.

Boydell, J., Onwumere, J., Dutta, R., Bhavsar, V., Hill, N., Morgan, C., et al. (2014). Caregiving in first-episode psychosis: social characteristics associated with perceived 'burden' and associations with compulsory treatment. *Early Intervention in Psychiatry, 8*(2), 122–129.

Brodaty, H. (2009). Supporting the person with dementia and the caregiver. In G. Waldemar & A. Burns (Eds.), *Alzheimer's disease* (pp. 77–86). New York: Oxford University Press Inc.

Brodaty, H., Green, A., & Koschera, A. (2003). Meta-analysis of psychosocial interventions for caregivers of people with dementia. *Journal of the American Geriatrics Society, 51*(5), 657–664.

Busse, R., Blümel, M., Scheller-Kreinsen, D., & Zentner, A. (2010). *The European observatory on health systems and policies. Tackling chronic disease in Europe: Strategies, interventions and challenges*. Copenhagen: World Health Organization.

Butzlaff, R. L., & Hooley, J. M. (1998). Expressed emotion and psychiatric relapse: a meta-analysis. *Archives of General Psychiatry, 55*(6), 547–552.

Caqueo-Urízar, A., Miranda-Castillo, C., Giráldez, S. L., Maturana, S. L. L., Pérez, M. R., & Tapia, F. M. (2014). An updated review on burden on caregivers of schizophrenia patients. *Psicothema, 26*(2), 235–243.

Carod-Artal, F. J., Mesquita, H. M., Ziomkowski, S., & Martinez-Martin, P. (2013). Burden and health-related quality of life among caregivers of Brazilian Parkinson's disease patients. *Parkinsonism & Related Disorders, 19*(11), 943–948.

Chen, F. P., & Greenberg, J. S. (2004). A positive aspect of caregiving: the influence of social support on caregiving gains for family members of relatives with schizophrenia. *Community Mental Health Journal, 40*(5), 423–435.

Chien, L. Y., Chu, H., Guo, J. L., Liao, Y. M., Chang, L. I., Chen, C. H., et al. (2011). Caregiver support groups in patients with dementia: A meta-analysis. *International Journal of Geriatric Psychiatry, 26*(10), 1089–1098.

Colombo, F. (2015). *Health systems are still not prepared for an ageing population*. OECD Insights: Debate the Issues. Retrieved May 02, 2015, from http://oecdinsights.org/2015/04/29/health-systems-are-still-not-prepared-for-an-ageing-population/.

Coon, D. W., Rubert, M., Solano, N., Mausbach, B., Kraemer, H., Arguelles, T., et al. (2004). Well-being, appraisal, and coping in Latina and Caucasian female dementia caregivers: Findings from the REACH study. *Aging & Mental Health, 8*(4), 330–345.

Depp, C., Sorocco, K., Kasl-Godley, J., Thompson, L., Rabinowitz, Y., & Gallagher-Thompson, D. (2005). Caregiver self-efficacy, ethnicity, and kinship differences in dementia caregivers. *The American Journal of Geriatric Psychiatry, 13*(9), 787–794.

DiBartolo, M. C., & Soeken, K. L. (2003). Appraisal, coping, hardiness, and self-perceived health in community-dwelling spouse caregivers of persons with dementia. *Research in Nursing & Health, 26*(6), 445–458.

Dröes, R. M., Meiland, F., Schmitz, M., & van Tilburg, W. (2004). Effect of combined support for people with dementia and carers versus regular day care on behaviour and mood of persons with dementia: results from a multi-centre implementation study. *International Journal of Geriatric Psychiatry, 19*(7), 673–684.

Eady, N., Courtenay, K., & Strydom, A. (2015). Pharmacological management of behavioral and psychiatric symptoms in older adults with intellectual disability. *Drugs and Aging, 32*(2), 95–102.

Family Caregiver Alliance. (2014). *Caregiver definitions*. Retrieved August 1, 2016, from https://www.caregiver.org/definitions-0.

Fernandes, L. (2012). Psychological factors in asthma and psychoeducational interventions. In C. Pereira (Ed.), *Allergic diseases—highlights in the clinic, mechanisms and treatment* (pp. 313–338). Croatia: INTECH Open Access Publisher.

Fernandes, L., Mateos, R., Engedal, K., von Gunten, A., Stek, M. L., Ramakrishnan, A., et al. (2015). The state of psychogeriatrics in Europe: Challenges and opportunities in six European countries. *International Psychogeriatrics, 27*(08), 1243–1246.

Gath, A., & McCarthy, J. (2012). Families with a member with intellectual disability and their needs. In M. G. Gelder, N. C. Andreasen, J. J. López-Ibor Jr., & J. R. Geddes (Eds.), *New Oxford textbook of psychiatry* (pp. 1883–1887). Oxford: Oxford University Press.

Gaugler, J. E., Anderson, K. A., Leach, C. R., Smith, C. D., Schmitt, F. A., & Mendiondo, M. (2004). The emotional ramifications of unmet need in dementia caregiving. *American Journal of Alzheimer's disease and Other Dementias, 19*(6), 369–380.

Gilhooly, K. J., Gilhooly, M. L. M., Sullivan, M. P., McIntyre, A., Wilson, L., Harding, E., et al. (2016). A meta-review of stress, coping and interventions in dementia and dementia caregiving. *BMC Geriatrics, 16*(1), 106.

Gonyea, J. G., & Silverstein, N. M. (1991). The role of Alzheimer's disease support groups in families' utilization of community services. *Journal of Gerontological Social Work, 16*(3–4), 43–56.

Goren, A., Gilloteau, I., Lees, M., & DaCosta Dibonaventura, M. (2014). Quantifying the burden of informal caregiving for patients with cancer in Europe. *Supportive Care in Cancer, 22*(6), 1637–1646.

Gottlieb, B. H., & Johnson, J. (2000). Respite programs for caregivers of persons with dementia: a review with practice implications. *Aging & Mental Health, 4*(2), 119–129.

Grant, G., & Ramcharan, P. (2001). Views and experiences of people with intellectual disabilities and their families. The family perspective. *Journal of Applied Research in Intellectual Disabilities, 14*(4), 364–380.

Haley, W. E., Gitlin, L. N., Wisniewski, S. R., Mahoney, D. F., Coon, D. W., Winter, L., et al. (2004). Well-being, appraisal, and coping in African-American and Caucasian dementia caregivers: findings from the REACH study. *Aging & Mental Health, 8*(4), 316–329.

Haveman, M., Heller, T., Lee, L., Maaskant, M., Shooshtari, S., & Strydom, A. (2010). Major health risks in aging persons with intellectual disabilities: an overview of recent studies. *Journal of Policy and Practice in Intellectual Disabilities, 7*(1), 59–69.

Iacono, T., Evans, E., Davis, A., Bhardwaj, A., Turner, B., Torr, J., et al. (2016). Family caring of older adults with intellectual disability and coping according to loci of responsibility. *Research in Developmental Disabilities, 57,* 170–180.

Ingersoll-Dayton, B., Neal, M. B., Ha, J. H., & Hammer, L. B. (2003). Collaboration among siblings providing care for older parents. *Journal of Gerontological Social Work, 40*(3), 51–66.

Institute of Medicine. (2012). *Living well with chronic illness: a call for public health action*. Washington (DC): The National Academies Press.

Jensen, M., Agbata, I. N., Canavan, M., & McCarthy, G. (2013). Effectiveness of educational interventions for informal caregivers of individuals with dementia residing in the community: Systematic review and meta-analysis of randomised controlled trials. *International Journal of Geriatric Psychiatry, 30*(2), 130–143.

Landon, J., Pike, B., Diesfeld, K., & Shepherd, D. (2016). The experiences of parents providing support to adult children with schizophrenia. *International Journal of Mental Health and Addiction, 14*(4), 385–399.

Laursen, T. M., Nordentoft, M., & Mortensen, P. B. (2014). Excess early mortality in schizophrenia. *Annual Review of Clinical Psychology, 10,* 425–448.

Leff, J. (Ed.). (1997). *Care in the community: Illusion or reality*. London: Wiley.

Lefley, H. P. (1998). The family experience in cultural context: implications for further research and practice. *New Directions for Mental Health Services, 1998*(77), 97–106.

Lieberman, M. A., & Fisher, L. (1999). The effects of family conflict resolution and decision making on the provision of help for an elder with Alzheimer's disease. *The Gerontologist, 39* (2), 159–166.

Lingler, J. H., Martire, L. M., & Schulz, R. (2005). Caregiver-specific outcomes in antidementia clinical drug trials: a systematic review and meta-analysis. *Journal of the American Geriatrics Society, 53*(6), 983–990.

Magliano, L., Fiorillo, A., Rosa, C., Maj, M., National Mental Health Project Working, G. (2006). Family burden and social network in schizophrenia vs. physical diseases: Preliminary results from an Italian national study. *Acta Psychiatrica Scandinavica, 113*(429), 60–63.

Maulik, P. K., Mascarenhas, M. N., Mathers, C. D., Dua, T., & Saxena, S. (2011). Prevalence of intellectual disability: a meta-analysis of population-based studies. *Research in Developmental Disabilities, 32*(2), 419–436.

Maust, D. T., Langa, K. M., Blow, F. C., & Kales, H. C. (2016). Psychotropic use and associated neuropsychiatric symptoms among patients with dementia in the USA. *International Journal of Geriatric Psychiatry*.

McCarron, M., Swinburne, J., Burke, E., McGlinchey, E., Carroll, R., & McCallion, P. (2013). Patterns of multimorbidity in an older population of persons with an intellectual disability: results from the intellectual disability supplement to the Irish longitudinal study on aging (IDS-TILDA). *Research in Developmental Disabilities, 34*(1), 521–527.

McKenzie, K., Milton, M., Smith, G., & Ouellette-Kuntz, H. (2016). Systematic review of the prevalence and incidence of intellectual disabilities: Current trends and issues. *Current Developmental Disorders Reports*, 1–12.

McKibbin, C. L., Ancoli-Israel, S., Dimsdale, J., Archuleta, C., von Kanel, R., Mills, P., et al. (2005). Sleep in spousal caregivers of people with Alzheimer's disease. *Sleep, 28*(10), 1245–1250.

Miranda-Castillo, C., Woods, B., & Orrell, M. (2013). The needs of people with dementia living at home from user, caregiver and professional perspectives: a cross-sectional survey. *BMC Health Services Research, 13*(1), 43.

Nolte, E., & McKee, M. (Eds.). (2008). *Caring for people with chronic conditions: a health system perspective*. UK: McGraw-Hill Education.

Okura, T., & Langa, K. M. (2011). Caregiver burden and neuropsychiatric symptoms in older adults with cognitive impairment: The aging, demographics, and memory study (ADAMS). *Alzheimer Disease and Associated Disorders, 25*(2), 116–121.

Orrell, M., & Hancock, G. (2004). *CANE: Camberwell Assessment of Need for the Elderly*. London: Gaskell.

Pinquart, M., & Sörensen, S. (2003a). Associations of stressors and uplifts of caregiving with caregiver burden and depressive mood: A meta-analysis. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 58*(2), 112–128.

Pinquart, M., & Sörensen, S. (2003b). Differences between caregivers and noncaregivers in psychological health and physical health: A meta-analysis. *Psychology and Aging, 18*(2), 250–267.

Pinquart, M., & Sörensen, S. (2005). Ethnic differences in stressors, resources, and psychological outcomes of family caregiving: a meta-analysis. *The Gerontologist, 45*(1), 90–106.

Pinquart, M., & Sörensen, S. (2006). Helping caregivers of persons with dementia: Which interventions work and how large are their effects? *International Psychogeriatrics, 18*(4), 577–595.

Pinquart, M., & Sörensen, S. (2007). Correlates of physical health of informal caregivers: A meta-analysis. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 62*(2), 126–137.

Prince, M. J. (2009). The 10/66 dementia research group—10 years on. *Indian Journal of Psychiatry, 51*(suppl 1), 8–15.

Prince, M., Wimo, A., Guerchet, M., Ali, G. C., Wu, Y. T., & Prina, M. (2015). *World Alzheimer Report 2015. The global impact of dementia. An analysis of prevalence, incidence, cost and trend*s. London: Alzheimer's Disease International.

Quayhagen, M. P., & Quayhagen, M. (1989). Differential effects of family-based strategies on Alzheimer's disease. *The Gerontologist, 29*(2), 150–155.

Roberts, J., Browne, G., Milne, C., Spooner, L., Gafni, A., Drummond-Young, M., et al. (1999). Problem-solving counseling for caregivers of the cognitively impaired: Effective for whom? *Nursing Research, 48*(3), 162–172.

Roth, D. L., Haley, W. E., Owen, J. E., Clay, O. J., & Goode, K. T. (2001). Latent growth models of the longitudinal effects of dementia caregiving: a comparison of African American and White family caregivers. *Psychology and Aging, 16*(3), 427–436.

Ruggeri, M., Leese, M., Thornicroft, G., Bisoffi, G., & Tansella, M. (2000). Definition and prevalence of severe and persistent mental illness. *The British Journal of Psychiatry, 177*(2), 149–155.

Schalock, R. L., Luckasson, R. A., Shogren, K. A., Borthwick-Duffy, S., Bradley, V., Buntinx, W. H. E., et al. (2007). The renaming of mental retardation: understanding the change to the term intellectual disability. *Intellectual and Developmental Disabilities, 45*(2), 116–124.

Scheil-Adlung, X. (2015). *Long term care protection for older persons: a review of coverage deficits in 46 countries*. Geneva, Switzerland: International Labour Organization.

Schinnar, A. P., Rothbard, A. B., Kanter, R., & Jung, Y. S. (1990). An empirical literature review of definitions of severe and persistent mental illness. *American Journal of Psychiatry, 147*(12), 1602–1608.

Seltzer, M., Greenberg, J. S., Floyd, F. J., Pettee, Y., & Hong, J. (2001). Life course impacts of parenting a child with a disability. *American Journal on Mental Retardation, 106*(3), 265–286.

Shurgot, G. R., & Knight, B. G. (2005). Influence of neuroticism, ethnicity, familism, and social support on perceived burden in dementia caregivers: pilot test of the transactional stress and social support model. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 60*(6), 331–334.

Slade, M., Leamy, M., Bacon, F., Janosik, M., Le Boutillier, C., Williams, J., et al. (2012). International differences in understanding recovery: systematic review. *Epidemiology and Psychiatric Sciences, 21*(4), 353–364.

Sleath, B., Thorpe, J., Landerman, L. R., Doyle, M., & Clipp, E. (2005). African-American and White caregivers of older adults with dementia: differences in depressive symptomatology and psychotropic drug use. *Journal of the American Geriatrics Society, 53*(3), 397–404.

Sörensen, S., Duberstein, P., Gill, D., & Pinquart, M. (2006). Dementia care: mental health effects, intervention strategies, and clinical implications. *The Lancet Neurology, 5*(11), 961–973.

Thornicroft, G., & Tansella, M. (2009). *Better mental health care*. Cambridge: Cambridge University Press.

Thornicroft, G., & Tansella, M. (2013). The balanced care model: the case for both hospital- and community-based mental healthcare. *The British Journal of Psychiatry, 202*(4), 246–248.

Vernooij-Dassen, M., Draskovic, I., McCleery, J., & Downs, M. (2011). Cognitive reframing for carers of people with dementia. *Cochrane Database of Systematic Reviews*, *11*(11).

Waelde, L. C., Thompson, L., & Gallagher-Thompson, D. (2004). A pilot study of a yoga and meditation intervention for dementia caregiver stress. *Journal of Clinical Psychology, 60*(6), 677–687.

Walker, E. R., Mcgee, R. E., & Druss, B. G. (2015). Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis. *Journal of the American Medical Association—Psychiatry, 72*(4), 334–341.

Weedon, D., Wilson, B., Jones, K. B., & Bilder, D. (2015). Care of adults with intellectual and developmental disabilities: developmental disabilities. *FP Essentials, 439,* 11–19.

Weinbrecht, A., Rieckmann, N., & Renneberg, B. (2016). Acceptance and efficacy of interventions for family caregivers of elderly persons with a mental disorder: A meta-analysis. *International Psychogeriatrics, 28,* 1615–1629.

Williams, I. C. (2005). Emotional health of black and white dementia caregivers: A contextual examination. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 60*(6), 287–295.

Williamson, H. J., & Perkins, E. A. (2014). Family caregivers of adults with intellectual and developmental disabilities: Outcomes associated with US services and supports. *Intellectual and Developmental Disabilities, 52*(2), 147–159.

World Health Organization. (2015a). *First WHO ministerial conference on global action against dementia: meeting report*. WHO Headquarters, Geneva, Switzerland, 16–17 March 2015.

World Health Organization (2015b). *Noncommunicable diseases*. Retrieved August 1, 2016, from http://www.who.int/mediacentre/factsheets/fs355/en/.

World Health Organization (2016). *Dementia*. Retrieved August 1, 2016, from http://www.who.int/mediacentre/factsheets/fs362/en/.

Yaffe, K., Fox, P., Newcomer, R., Sands, L., Lindquist, K., Dane, K., et al. (2002). Patient and caregiver characteristics and nursing home placement in patients with dementia. *Journal of the American Medical Association, 287*(16), 2090–2097.

Yesufu-Udechuku, A., Harrison, B., Mayo-Wilson, E., Young, N., Woodhams, P., Shiers, D., et al. (2015). Interventions to improve the experience of caring for people with severe mental illness: systematic review and meta-analysis. *The British Journal of Psychiatry, 206*(4), 268–274.

Young, J., & Snowden, A. (2016). A systematic review on the factors associated with positive experiences in carers of someone with cancer. *European Journal of Cancer Care (Engl),* 1–18.

Zarit, S. H., Femia, E. E., & Whitlatch, C. J. (2016). Caregiving. In H. S. Friedman (Ed.), *Encyclopedia of mental health* (pp. 233–238). Oxford: Academic Press.

Chapter 6
Mental Health and Stigma

Armen Soghoyan and Khachatur Gasparyan

6.1 Introduction

The use of the term “stigma”, reflecting a mark of shame or degradation, is thought to have appeared in the late sixteenth century (Mora 1999). Prior to that, stigma was more broadly used to indicate a tattoo or mark that might have been used for decorative or religious purposes, or for utilitarian reasons, such as a brand placed on criminals or slaves so that they could be identified and to indicate their inferior social position (Stuart 2008), the evolution of the term although, negative societal responses to the mentally ill have been ubiquitous throughout history, even though the rise of medical theories and biologically based explanations for most mental disorders (Allport 1979). Contemporary notions of stigma are grounded in sociological and psychological theoretical traditions. People who live with mental illnesses are among often stigmatized groups in society (Stuart 2008).

It is estimated that more than 75% of people with severe mental disorders in low- and middle-income countries receive no treatment for their disorders, and even in high-income countries, 35–50% of such individuals never receive care, (Pike et al. 2014). Stigma and practical barriers, such as distance and transportation to treatment centres for rural villagers, contribute to the existing gap between suffering and service.

Conversely, people with mental disorders may become impoverished by loss of income due to inability to work, increased health expenditure and the exclusionary

---

A. Soghoyan (✉)
Centre of Psychosocial Recovery, Yerevan State Medical University,
2 Koryunstreet, 025 Yerevan, Armenia
e-mail: soghoyan@yahoo.com

K. Gasparyan
Department of Medical Psychology, Intra Mental Health Centre, Yerevan State Medical
University, 2 Koryun Street, 0025 Yerevan, Armenia
e-mail: kvgaspar@yahoo.com

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_6

impact of stigma. Integration of mental health services into other healthcare platforms offers the promise of reducing stigma Pike et al. (2014).

Growing support for stigma reduction is also evident in the number of government declarations, mental health system reviews and action plans that have highlighted the disabling effects of stigma and the importance of reducing discrimination (Druss and Goldman 2003).

Many children do not receive treatment for mental health problems due to lack of awareness, fear of stigma, or lack of access to appropriate services (Babloyan et al. 2008). Over the last decade, public health interest in both the burden of mental illness and the hidden burden of mental health-related stigma has grown. The following organizations, amongst others, have all recognized stigma as a major public health challenge, e.g. World Health Organization Sartorius (2004), the World Psychiatric Association (Sartorius and Schulze 2005) and the Kobe Declaration of World Association for Social Psychiatry.

6.2 Current Status/Data

6.2.1 Stigma Levels

6.2.1.1 Individual, Auto-Stigma, Social Isolation

In perhaps the best-known work on the concept of stigma, Goffman referred to it as a “spoiled identity” (Goffman 1986). This identity may be private, involving internalized feelings about oneself, or public, involving negative perceptions or behaviours of others. The desire to avoid labelling oneself negatively, or to conceal one’s problems from others, is thought to cause treatment avoidance, increase dropout from treatment and reduce treatment adherence. Mental illness stigma may also reduce the well-being of persons experiencing mental illness. The internalization of negative views has been linked to low self-esteem, self-blame and negative emotional states (Clark et al. 2013). In addition, there are cases when perception of stigma arises from within the individual who has internalized those negative views to such an extent that exhibits symptoms of stigmatized individual in the absence of external stimulus. In such cases the individual could be said to feel pain from auto-stigma.

6.2.1.2 Family

The stress of concealing one’s mental illness may also harm a person’s family and relatives. Goffman discussed the phenomenon of “passing” (Khurshudyan 2015) in which individuals and their family members with a characteristic that is stigmatized by society attempt to hide it from others.

According to the study on people with schizophrenia and their family members in China (Phillips 2002) the family members reported that stigma had a moderate to severe effect on the lives of patients and on the lives of other family members in 26% of the interviews.

The other study related to the stigma among mental health patient's and family members in Armenia (Khurshudyan 2015) indicating that 72% respondents reported their family member at some point feel the negative attitude because of his or her mental disorder. Almost 80% of respondents mentioned that the quality of their life changed because of the mental illness of their family member and 85% of them themselves or a member of their family had never out loudly defended the rights of psychiatric patients. The longer the illness persisted, the more difficult it was for families to keep the 'family secret'; as more community members became aware of the illness, the negative social consequences for the family increased.

Clinicians should assess the effect of stigma as part of the standard work-up for patients with mental illness, and help patients and family members reduce the effect of stigma on their lives. The most remarkable finding of the study in China (Phillips et al. 2002) was the extremely strong relationship between high expressed emotion and the reported effect of stigma on both the patient and the family.

Concerning to stigma and family it needs to be acknowledged that cultural factors in this case have an important role and there is a need to further study existing relationships between family and stigma in multicultural level.

6.2.1.3 Community

At the level of community the issue of stigma is mostly related to stereotypes, which are a set of beliefs about members of a group and typically represent society's shared beliefs about that group. Community stereotypes can include beliefs such as persons with mental illness are violent and dangerous as well as beliefs related to the causes of mental health problems. Further stereotypes may include beliefs that mental illness is brought about by a person's action or inaction or are due to moral character flaws (Pescosolido et al. 2010). As part of mental illness stigma there are beliefs in society that people do not recover from mental illness or that treatment is ineffective. Prejudice is a negative attitude toward a person or group (Allport 1979) and they may be exhibited by the degree of willingness one expresses in engaging in interpersonal interactions with persons with mental illness (Pescosolido et al. 2010). Discrimination is the behavioural aspect of stigma and is presumed to result from prejudice or stereotypes. It includes the social exclusion and negative social interactions previously noted and also encompass laws, policies and practices that treat persons with mental illness unfairly (Hemmens et al. 2002).

Shortages of affordable housing, inadequate income and exclusion from quality education and employment alienate individuals with serious mental health problems from life in the community.

Moreover, in some societies the social expectations for men are greater than for women, so the effect of stigma is greater on men: women who marry but do not work are in the acceptable role of ‘house-wife’. Female mothers and wives are more attuned to the negative consequences of stigma on the emotional and social lives of their family members with mental illness than are fathers and husbands (Phillips et al. 2002).

In most of cases, the stigma is also “transmitted” to close family members who could be expressed in community via that members and secondary stigmatization took place, which could generate more negative responses from their associates and the community at large. Consequently, the community mental health services, primary health, public health and mental health professionals and social workers should organize their work with integrating gender aspects according to anti-stigma programs, preventive measurements and ethical standards.

6.2.1.4 Health Professionals and Policy-Makers

At its worst, this stigma nullifies personhood and constitutes an abuse of human rights. Mental Health professionals are not the only specialists who are targets of discrimination, the health policy experts are also adversely affected by stigma, with the result that many shy away from making mental health care a priority.

The social stigma that is attributed to people living with mental disorders translates to its treatment as a policy issue through the attitudes of the general public and the behaviour of policy-makers.

As described in (Thornicroft et al. 2008), it is generally understood to be a combination of problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination).

6.2.1.5 Stigma and Mass Media

Stigma due to negative media coverage triggers discrimination and prejudice, and creates barriers to seeking and finding decent housing, employment and education. Negative media images can promote negative attitudes, and ensuing media coverage feeds off an already inaccurate perception.

Mass media interventions may reduce prejudice, but there is insufficient evidence to determine their effects on discrimination. Very little is known about costs, adverse effects, or other outcomes. The review by (Clement et al. 2013) found few studies in middle- and low-income countries or with employers or health professionals as the target group; and none targeted at children or adolescents (Sartorius 2004). Currently, the “shape” of mass media is also in transition: from TV sources people are gradually moving towards the internet sources and more research is required to establish the effects of mass media interventions on discrimination, to better understand which types of mass media intervention work best and to fill evidence gaps about types of mass media not covered in this review.

Besides, it is vital to highlight stories of successful recovery and treatment results. Intentional or not, naive assumptions, stereotyping and discrimination can have damaging effects on an individual's course of recovery from mental illness. However, the idea of "people can and do recover from mental illness" should be provided properly by mass media with the supports and services necessary to facilitate and nurture a sense of hope, wellness and a belief that tomorrow will be better than today. Accurate and positive messages and stories about mental illness and people living with mental illnesses can become more common place.

Mass media representatives also need to pay more attention to public education on mental health issues to prevent stigmatizing behaviour in society.

6.2.2 Economic Consequences

Due to barriers such as stigma and discrimination from one hand and recurrence of symptoms, people with serious mental illness may have difficulty over their lifetime securing adequate education and employment. As a result, individuals with a serious mental illness may drift into poverty. All mentioned barriers affect person's ability to have an adequate income.

According to J. Mackenzie (2014), financial resources are required to help generate policy changes. Essentially low investment prevents the research and advocacy needed to change the status quo (Mackenzie 2014).

As well as having a deeply negative impact on community and society in general and the individual in particular, stigma also costs the state financially. If people are too ashamed or worried to talk or to use mental health services, they may not themselves approach the services to seek help. The delay can cause even more distress and result at a higher cost to the health service.

It has been discussed many times that the estimate cost of the burden of mental disorders each year is more than 1 trillion United States dollars (WHO and World Bank joint news release 2016). To give a comparative analysis of the costs in two countries, the estimated total cost of schizophrenia in Ireland for 2006 was €460.6 million. The direct cost of care was €117.5 million, while indirect costs were €343 million. The cost of lost productivity due to unemployment, absence from work and premature mortality was €277 million (Behan et al. 2008). Mental ill health is the single largest cause of disability in the United Kingdom, contributing up to 22.8% of the total burden, compared to 15.9% for cancer and 16.2% for cardiovascular disease (WHO 2008). The wider economic costs of mental illness in England have been estimated at £105.2 billion each year. This includes direct costs of services, lost productivity at work and reduced quality of life Centre for Mental Health (2010).

To overcome the mentioned burden it is highly significant to diagnose and detect the problem as early as possible for early intervention and reducing further complications: late treatment increases the risk of ineffective results and/or disability. Furthermore, as a barrier to use the mental health services, the stigma is responsible for the level of maltreatment and disabilities. Accordingly, due to stigma, direct and indirect costs are also increased. Nonetheless, even with these improvements, 40%

of people with serious mental illness had not received care (SAMHSA 2012) suggesting that the effects of stigma remain troublesome. All mentioned above eventually lead to the following conclusions: stigma is not only a moral and psychological issue for individuals, their families, community and general public, but also a serious financial and economic cause starting from the level of human being up to governmental and global levels. Various studies (McCrone et al. 2008; Parcesepe and Cabassa 2013; Hanisch et al. 2016) indicate that anti-stigma programs are cost-effective for society and for the government.

6.3 Conclusion/Discussion

The basic cultural and moral barrier to the improvement of global mental health problems continues to be stigmatized, especially if it is attached to serious mental illnesses, to patients with a mental illness and their families, and to mental health caregivers.

With increasing acknowledgment of the public health significance of stigma, and growing knowledge about how to fight stigma and discrimination both locally and internationally, the future of applied stigma research holds a number of exciting prospects. The importance of focusing on a specific illness, e.g. schizophrenia, rather than mental illnesses in general, should be considered in light of the need for a clear program focus, the fact that the general public uses schizophrenia as a paradigm for mental illness, and the idea that any gains made in this difficult area would certainly be useful to those working to eradicate stigma related to other mental illnesses.

As it was mentioned stigma is not only a moral and psychological issue for individuals, their families, community and general public, but also a serious financial and economic cause starting from the level of human being up to governmental and global levels.

Even though people with mental illnesses are among the most stigmatized groups in society, mental illnesses are not the only stigmatized health conditions. Leprosy, HIV/AIDS, tuberculosis and cancer are among the many stigmatized health conditions for which advocates have battled social stigma, some more successfully than others. It is important that lessons be shared across groups. This will not only improve our understanding of the general social and psychological conditions that give rise to health-related stigmas, but also allow learning from each other’s finding. Other collaborative means include initiating and developing international scientific projects and contributing to the scientific literature dealing with mental health stigma and discrimination.

A systematic review is needed to evaluate financial impacts through effects on employment, income, public views about resource allocation and healthcare costs stigma and discrimination related to mental illness.

Take Away Messages

- Mental illness stigma reduces the well-being of persons experiencing mental illness. The internalization of negative views has been linked to low self-esteem, self-blame and negative emotional states.
- Concerning to stigma and family it has to acknowledge that cultural factors in this case have an important role and there is need to further study existing relationships between family and stigma in multicultural level.
- The community mental health services, primary health, public health and mental health professionals, and social workers should organize their work according to anti-stigma programs, preventive measurements and ethical standards.
- Mass media representatives are also need to pay more attention to public education on mental health issues to prevent stigmatizing behaviour in society.
- Stigma is not only a moral and psychological issue for individuals, their families, community and general public, but also a serious financial and economic cause starting from the level of human being up to governmental and global levels.
- The World Psychiatric Association (WPA 2016) has a section for stigma and mental health in collaboration, e.g. with the Health Service and Population Research Department King's College in London/United Kingdom.

References

Allport, G. W. (1979). *The nature of prejudice*. London: Addison-Wesley Publishing Company.

Babloyan, A., Gasparyan, K., Melkumova, A., Movsesyan, M., Sargsyan, N., Sargsyan, S. et al. (2008). Armenia: Experiences of a country in transition, WHO publication. Social cohesion for mental well-being among adolescents, WHO and Health Behaviour in School-Aged Children, pp. 67–78. Retrieved August 1, 2016, from http://www.euro.who.int/__data/assets/pdf_file/0005/84623/E91921.pdf.

Behan, C., Kennelly, B., & O'Callaghan, E. (2008). The economic cost of schizophrenia in Ireland: A cost of illness study. *Irish Journal of Psychological Medicine, 25*(3), 80–87.

Centre for Mental Health. (2010). The Economic and Social Costs of Mental Health Problems in 2009/10. Retrieved Mental Health Strategies 2009/10 from https://www.centreformentalhealth.org.uk/economic-and-social-costs.

Clark, W., Welch, S. N., Berry, S. H., Collentine, A. M., et al. (2013). California's historic effort to reduce the stigma of mental illness: The Mental Health Services Act. *American Journal of Public Health, 103*(5), 786–794.

Clement, S., Lassman, F., Barley, E., Evans-Lacko, S., Williams, P., Yamaguchi, S. et al. (2013). Mass media interventions for reducing mental health-related stigma. *The Cochrane Database of Systematic Reviews*, *7*, CD009453. doi:10.1002/14651858.CD009453.pub2.

Druss, B. G., & Goldman, H. H. (2003). Introduction to the special section on the President's New Freedom Commission Report. *Psychiatric Services, 54,* 1465–1466.

Goffman, E. (1986). *'Frame Analysis' An essay on the Organization of Experience*. Boston: Northeastern University Press.

Hanisch, S. E., Twomey, C. D., Szeto, A., Birner, U. W., Nowark, D., & Sabariego, C. (2016). The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. *Biomedical Journals Psychiatry, 16,* 1. doi:10.1186/s12888-015-0706-4.

Hemmens, C., Miller, M., Burton, V. S., & Milner, S. (2002). The consequences of official labels: An examination of the rights lost by the mentally ill and mentally incompetent ten years later. *Community Mental Health Journal, 38,* 129–140.

Khurshudyan, M. D. (2015). Stigma among MH patient's family members in Armenia. *Armenian Journal of Mental Health, 6*(2), 43–49. http://www.apnet.am/journal/datas/articles/170.pdf.

Lopez, A. D., Mathers, C. D., Ezzati, M., Murray, C. J. L., & Jamison, D. T. (2006). *Global burden of disease and risk factors*. New York: Oxford University Press.

Mackenzie, J. (2014). Global mental health from a policy perspective: A context analysis characterizing mental health and recommending engagement strategies for the Mental Health Innovation Network Report. Overseas Development Institute publication. Retrieved August 1, 2016, from https://www.odi.org/publications/8926-global-mental-health-policy-perspective.

McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., & Lawton-Smith, S. (2008). Paying the price. The cost of mental health care in England to 2026, pp. 117–128. London: the King's Fund. Retrieved August 1, 2016, from https://www.kingsfund.org.uk/sites/files/kf/Paying-the-Price-the-cost-of-mental-health-care-England-2026-McCrone-Dhanasiri-Patel-Knapp-Lawton-Smith-Kings-Fund-May-2008_0.pdf.

Mora, G. (1999). Stigma during the Medieval and Renaissance periods. In P. J. Fink & A. Tasman (Eds.), *Stigma and mental illness* (pp. 41–52). Washington: American Psychiatric Press.

National Survey of Investment In Adult Mental Health Services. Report prepared for the Department of Health. (2011). 2010/11 working age adult and older adult National Survey of investment in Mental Health Services. Policy paper. Retrieved October 31, 2011 from https://www.gov.uk/government/organisations/department-of-health.

Parcesepe, A., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: A systematic literature review. *Administration and Policy Mental Health and Mental Health Services Research*, *40*(5), 384–399. doi:10.1007/s10488-012-0430-z.

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). Adisease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *The American Journal of Psychiatry, 167*(11), 1321–1330.

Phillips, M. R., Pearson, V., Li, F., Xu, M., & Yang, L. (2002). Stigma and expressed emotion: a study of people with schizophrenia and their family members in China. *The British Journal of Psychiatry, 181,* 488–493.

Pike, K. M., Susser, E., Galea, S., & Pincus, H. (2014). Towards a Healthier 2020: Advancing mental health as a global health priority. *Public Health Reviews*, *35*(1), 7–18.

Rutz, W., Walinder, J., Eberhard, G., Holmberg, G., von Knorring, A. L., von Knorring, L. et al. (1989). An educational program on depressive disorders for general practitioners on Gotland: background and evaluation. *Acta Psychiatrica Scandinavica*, *79*, 19–26.

Sartorius, N. (2004). The World Psychiatric Association Global Programme against stigma and discrimination because of stigma. In A. H. Crisp (Ed.), *Every family in the land* (pp. 373–375). London: Royal Society of Medicine Press.

Sartorius, N., & Schulze, H. (2005). *Reducing the stigma of mental illness*. Cambridge: Cambridge University Press.

Simon, B. (1999). Shame, stigma, and mental illness in Ancient Greece. In P. J. Fink & A. Tasman (Eds.), *Stigma and mental illness* (pp. 29–39). Washington: American Psychiatric Press.

Stuart, H. (2008). Fighting the stigma caused by mental disorders: past perspectives, present activities, and future directions. *World Psychiatry, 7*(3), 185–188.

SAMHSA–Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Mental health findings (NSDUH Series H-45, HHS Publication No. [SMA] 12-4725).

Thornicroft, G., Brohan E., Kassam, A., & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: candidate interventions. *International Journal of Mental Health Systems, 2*(3). Retrieved August 1, 2016, from http://www.ijmhs.com/content/2/1/3.

World Association of Social Psychiatry. Kobe Declaration. Retrieved October 11, 2007, from www.wpanet.org/bulletin/wpaeb2103.html.

World Health Organisation. (2008). Global burden of disease report. Retrieved April, 2011, from http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html.

WHO and World Bank Joint news release (2016). Investing in treatment for depression and anxiety leads to fourfold return. Retrieved April 13, 2016, from http://www.who.int/mediacentre/news/releases/2016/depression-anxiety-treatment/en/.

Chapter 7
Mental Health and Stigma—Aspects of Anti-Stigma Interventions

Lars Hansson

7.1 Introduction

Negative public attitudes towards persons with mental illness have been identified as an important obstacle for recovery from illness and from becoming full participants in the society (Thornicroft 2006). The concept of stigmatization has been described and operationalized by many researchers (Link et al. 2001). The term was originally used to refer to a brand or scar burned or cut into the body, used to identify slaves and criminals.

In modern times stigma has often been used to denote some form of community sanction that marks an individual as being unacceptably different from the general population with whom she or he interacts (Goffman 1963). Stigmatization should therefore be seen as a social psychological phenomenon that originates in the relationships between individuals and between groups and constitutes a threat to the targeted individual's self-esteem and identity (Link et al. 1989). Even if a clear consensus about the conception of stigma is lacking, it is usually used in mental health research as a complex of problems that emanates from a lack of knowledge about mental health problems, negative attitudes and excluding or avoiding behaviour towards individuals with mental illness. Link and Phelan (2001) made an important contribution in response to the criticism that the stigma concept had been too vaguely defined and individually focused. They further developed the existing "labelling theory" of stigma and defined the stigmatization process as the co-occurrence of several components. A first component is the distinction and labelling of human differences. A second phase is that cultural beliefs link labels and persons to certain undesirable characteristics or negative stereotypes, in the case of mental illness such characteristics may be violence and dangerousness. Labelled

---

L. Hansson (✉)
Mental Health Services Research, Department of Health Sciences, Lund University,
PO Box 157, 221 00 Lund, Sweden
e-mail: lars.hansson@med.lu.se

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_7

persons are in a third step placed in distinct categories in order to establish a separation of “us” from “them” which may lead to that labelled persons experience status loss, discrimination and social exclusion. An important feature of Link and Phelan´s model is that stigmatization is linked to access to social, economic and political power which is necessary for these processes of disapproval, rejection, exclusion and discrimination to occur.

7.2 Current Status

7.2.1 Public Stigma and Discrimination

Stigma and discrimination are still prominent features of the life situation of persons with mental illness, adding to the burden of living with a mental illness. The vision that the deinstitutionalization of mental health services and the development of community-based services would lead to an integration of people with mental illness and thereby diminish stigma and discrimination have not come true (Angermeyer et al. 2006). Stigma and discrimination in many ways affect people with a mental illness causing a lowered self-esteem and quality of life, affecting possibilities of adequate housing, work and financial situation in a negative way (Sharac et al. 2010; Link et al. 1989; Yanos et al. 2001). Common misconceptions are that people with mental illness are violent, dangerous and unpredictable. Independent factor analyses of responses to population surveys have revealed three recurring attitude themes: (a) fear and exclusion, indicating a wish for social distance from people with mental illness; (b) authoritarianism, people with mental illness are irresponsible and cannot take care of themselves; (c) benevolence, people with mental illness are childlike and need to be cared for (Brockington et al. 1993). The relationship between gender and stigmatizing attitudes is inconsistent, and this goes for educational level and urban/rural setting as well (Schomerus et al. 2012). The only consistent finding is that familiarity with mental illness, in terms of having kins or friends with a mental illness, is related to more positive attitudes.

Stigma is also a major barrier to help-seeking causing not seeking treatment, delays, dropout and non-adherence to treatment (Gulliver et al. 2010). This is particularly problematic in the light of the development of a number of evidence-based interventions for people with mental illness, including supported employment, family interventions, illness management and integrated services for the most severely ill (Kuipers et al. 2014). Barriers may exist on a person-level, provider- and system-level. Person-level barriers include stigma related attitudes and behaviour leading to avoiding treatment. Provider level barriers may include access and availability of effective services and attitudes and beliefs of health service staff (Corrigan et al. 2014). Reviews of studies focusing attitudes of mental health staff have shown that attitudes of a wish for social distance and treatment outcome pessimism are common among staff, and in some studies more common than in the general public (Schulze 2007).

Although stigma has been an issue since early research in the 1960s (3), there is no evidence of major changes in stigma and discrimination. Negative attitudes, stereotypes and discrimination are still highly prevalent and at least in the Western world remarkably stable between various national surveys (Angermeyer et al. 2006; Crisp et al. 2000; Heather et al. 2001). There seem to be some evidence that, although a great variation between countries exists, stigma of mental illness seem to be less severe in non-Western cultures (Fabrega 1991). For western countries the main conclusion is that public attitudes have not changed during the last two decades, or even turned worse in the case of people with schizophrenia (Schomerus et al. 2012). Although stigma is based on the expression of generalizations and stereotypes, there seem to be a gradient in for example the wish for social distance between different mental health conditions. Stigmatizing responses seem to appear along a gradient from "troubled person" to depression to schizophrenia to alcohol dependence, and finally, to drug dependence, which is exposed to the most severe negative attitudes of social distance (Pescosolido 2013).

The generally expanding scientific literature on mental illness stigma has so far no correspondence in studies on discrimination, where there still is a lack of studies. Discrimination deals with people's behaviour as captured by observational studies, by studies of structural discrimination, for example related to the judicial system, or by studies focusing on the experiences of people with mental illness. The International Study of Discrimination and Stigma Outcomes study (INDIGO) performed a quantitative cross-sectional study of people with schizophrenia covering 27 countries which showed that perceived discrimination was common in a number of areas and most prevalent in areas of making or keeping friends, family members, and in finding and keeping a job (Thornicroft et al. 2009). A majority of the participants also reported anticipated discrimination in applying for work/education and making close relationships. Almost 75% of the participants concealed their diagnosis to their social network. A study made in cooperation with the Global Alliance of Mental Illness Advocacy Networks including people with schizophrenia and bipolar disorder focused more on perceived anticipated stigma and self-stigma (Brohan et al. 2010, 2011). They reported, for both conditions, that a majority had moderate or high perceived discrimination, that almost half of people with schizophrenia reported moderate or high levels of self-stigma, and that the equivalent figure for people with bipolar disorders was around one fifth of the participants. Referring to stigma as a barrier to treatment there is also evidence from some discrimination studies that people with mental illness feel patronized, humiliated and punished in contact with services and that patients point out mental health staff as one of the groups which are the most stigmatizing (Thornicroft et al. 2007; Hansson et al. 2014). The scarcity of studies investigating perceived discrimination makes further studies of perceived discrimination an urgent task in order to gain knowledge of the user perspective of discrimination.

7.2.2 Anti-stigma Interventions Challenging Public Stigma

The rising concerns about the multi-faceted negative consequences of mental illness stigma have led to an increase in the scientific interest of the stigma issue. This holds both for descriptive cross-sectional population surveys, qualitative studies with people with own experience as informants and for intervention studies focusing outcome and process of the rising number of national, regional or local anti-stigma programmes launched during the last decades. A summary of the research performed reveals that approaches to change public stigma seem to follow three strategies or combinations of these: protest, education and contact (Corrigan et al. 2012). Protest actions highlight misconceptions of mental illness for example in media or the injustice in various stigmatizing descriptions and presentations. Education is focusing an exchange of myths about mental illness with facts in order to improve mental health literacy. The assumption is that replacing myths with facts will improve attitudes and intended behaviour towards people with mental illness. Social marketing campaigns, including books, videos and webpages are examples of this, as well as more targeted educational strategies to specific target groups such as the police or health care staff. Contact strategies includes interpersonal contact with persons with own experience of mental illness. These contacts may be divided into personal face to face contacts and contacts via video or other audiovisual media. The hypothesis is that personal contact will disconfirm stereotypes and lessen levels of negative attitudes. Outcome measures in this research may mainly be divided into three categories, changes in attitudes, mental health literacy and behaviour, in most studies measured as intended behaviour.

A recent meta-analysis of 72 outcome studies focusing public anti-stigma interventions showed that both education and contact strategies had positive effects on reducing stigma both for adults and adolescents (Corrigan et al. 2012). Comparisons between contact and educational interventions showed that contact was more effective than education in reducing stigma for adults, while the opposite was found for adolescents. The meta-analysis also showed that interventions including social and personal face to face contacts with people with lived experience were more effective than video contacts. Only few studies included protest actions which showed not to be effective. The lack of evidence for effectiveness of protest actions is probably the main explanation why this research field has not expanded. This review mainly included short-term outcomes of interventions which is a drawback. To be more inclusive and informative for future action longer term outcome would be more interesting. A recent systematic review focusing medium- and long-term outcome of intervention studies to reduce stigma show less optimistic results (Thornicroft et al. 2016). This review showed only modest evidence for the effectiveness of anti-stigma interventions beyond 4 weeks follow-up, in terms of increased knowledge or reduced stigmatizing attitudes. In contrast with the meta-analysis by Corrigan et al. (2012) social contact strategies did not show to be more effective in the medium to long term for improving attitudes. The authors conclude that methodological strong research is highly needed as a basis for investment in further anti-stigma interventions.

During the last decades a number of national and international campaigns and anti-stigma programmes have been launched. Rather few of these have been the subject of systematic evaluations in order to investigate outcomes of these programmes. An attempt to evaluate Beyondblue: the national depression initiative in Australia showed that high exposure regions had greater positive changes in beliefs about treatment and benefits of help seeking in general (Jorm et al. 2005). Recent evaluations of the Time to Change programme focusing whether public knowledge, attitudes, desire for social distance and reported contact in relation to people with mental health problems had improved in England during 2009–2015 showed that there were small but significant improvements during the period in all outcomes (Henderson et al. 2016). The campaign had more impact on the attitudes of the target age group, 25–45, than those aged over 65 or under 25. Women's reported contact with people with mental health problems increased more than did men's. Likewise, yearly population surveys in connection to a Swedish national anti-stigma programme running between 2010–2014 showed that a campaign primarily based on social contact theory and involving people with lived experience of mental illness may, even in a rather short-term perspective, have a significant positive impact on mental health literacy, attitudes and intentions of social contact with people with mental illness (Hansson et al. 2016).

7.2.3 Self-stigma and Anti Self-stigma Interventions

The internalization of negative stereotypes about mental illness occurs early in life throughout childhood and adolescence and may lead to the development of self-stigma for people afflicted by mental illness later on in life (Corrigan et al. 2006). Self-stigma (or internalized or felt stigma) exists on the individual level and indicates that the individual endorses stereotypes of mental illness, finds these stereotypes relevant and anticipates social rejection. Self-stigma is highly prevalent in people with longstanding and severe mental illness; a review of studies investigating prevalence of self-stigma showed prevalence rates in the range of 27–49% (Livingston et al. 2010). Self-stigma may also be a response to actual experiences of public stigma and discriminatory behaviour, which could result in consequences in a number of psychosocial life aspects: refraining from applying for work, avoiding contact with mental health care and social contacts. A recent review showed that public stigma and self-stigma was found to be the most important perceived barrier for people with mental health issues to actually seek help (Gulliver et al. 2010).

Despite the substantial evidence for the negative effects of self-stigma, the development of interventions to address it is a relatively new area of research. One recent review of self-stigma reduction interventions included 14 studies, of which eight reported significant improvement in self-stigma outcomes (Mittal et al. 2012). Six self-stigma reduction strategies were identified; of which psychoeducation was the most frequently tested intervention. Two prominent approaches for self-stigma reduction emerged: interventions that attempt to alter the stigmatizing beliefs and attitudes of the individual; and interventions that enhance skills for coping with self-stigma through improvements in self-esteem, empowerment and help-seeking behaviour. A second recent narrative review, using slightly different inclusion criteria, also identified six approaches (Yanos et al. 2015). The authors concluded that the status of evidence for the effectiveness of these interventions is encouraging in both in terms of already conducted studies showing positive impacts and that several interventions are in the process of performing more rigorous and large scale randomized controlled trials.

Take Away Messages

- Stigma and discrimination are still important aspects of the lives of people with mental illness with negative consequences in a number of life domains.
- The stigma issue has been highlighted for several decades without any significant improvements in levels of stigma.
- A rather large number of anti-stigma programmes have been launched; although rather few have been systematically investigated which calls for future methodologically strong studies the settle the evidence base for specific interventions.
- Self-stigma derived from public stigma is also quite prevalent with negative life consequences for those afflicted. A conclusion is that although anti-stigma campaigns focusing the public may be of some value they must be accompanied by interventions to address self-stigma and anticipated discrimination.
- The scientific literature on anti self-stigma interventions is scarce and it is an urgent task to develop such interventions and investigate their evidence.
- Some candidate areas of intervention against self-stigma have been proposed, including psychoeducative approaches, CBT oriented approaches and reduction of self-stigma via disclosure.
- Current main activities
    (a) Time To Change campaign in England: http://www.time-to-change.org.uk/
    (b) The Opening minds campaign in Canada: http://www.mentalhealthcommission.ca/English/initiatives/11874/opening-minds
    (c) The See Me campaign in Scotland: https://www.seemescotland.org/
    (d) The Global Alliance Against Stigma: http://www.time-to-change.org.uk/globalalliance
    (e) Shatter the stigma on World health day 2016: http://www.mhe-sme.org/fileadmin/Position_papers/Joint_Press_Release_-_WHD_MHE_ILGA.pdf

References

Angermeyer, M., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatrica Scandinavica, 113,* 163–179.

Brockington, I., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry, 162,* 93–99.

Brohan, D., Elgie, R., Sartorius, N., & Thornicroft, G. (2010). Level of Self-stigma, empowerment and perceived discrimination among people with schizophrenia in 14 European countries the GAMIAN: Europe studies. *Schizophrenia Research, 122,* 232–238.

Brohan, D., Gauci, D., Sartorius, N., Thornicroft, G., & For the GAMIAN–Europe Study Group. (2011). Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN–Europe study. *Journal of Affective Disorders*, *129*, 56–63.

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology, 25,* 875–884.

Corrigan, C. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric services, 63,* 963–973.

Corrigan, C. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest, 15* (2), 37–70.

Crisp, A. H., Gelder, A. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry, 177,* 4–7.

Fabrega, H. (1991). Psychiatric stigma in non-western countries. *Comprehensive Psychiatry, 32,* 534–551.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New Jersey: Prentice-Hall.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10,* 113. doi:10.1186/1471-244X-10-113.

Hansson, L., Stjernswärd, S., & Svensson, B. (2014). Perceived and anticipated discrimination in people with mental illness—An interview study. *Nordic Journal of Psychiatry, 68,* 100–106.

Hansson, L., Stjernswärd, S., & Svensson, B. (2016). Changes in attitudes, intended behaviour and mental health literacy in the Swedish population 2009–2014. An evaluation of a national anti-stigma campaign. *Acta Psychiatrica Scandinavica*, *134* (Suppl. 446): 71–79.

Heather, S., & Arboleda-Florez, J. (2001). Community attitudes toward persons with schizophrenia. *Canadian Journal of Psychiatry, 46*(3), 245–252.

Henderson, C., Robinson, E., Evans-Lacko, S., Corker, E., Rebollo-Mesa, I., & Rose, D. (2016). Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009–2015. *Acta Psychiatrica Scandinavica, 134*(Suppl. 446), 23–33.

Jorm, A. F., Christensen, H., & Griffiths, K. M. (2005). The impact of Beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Australian and New Zeeland Journal of Psychiatry, 39,* 248–254.

Kuipers, E., Yesufu-Udechuku, A., Taylor, C., & Kendall, T. (2014). Management of psychosis and schizophrenia in adults: Summary of updated NICE guidance. *British Medical Journal, 348,* g1173.

Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labelling theory approach in the area of mental disorders; An empirical assessment. *American Sociology Review, 54,* 400–423.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27,* 363–385.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Social Science and Medicine, 71,* 2150–2161.

Mittal, D., Sullivan, G., Chekuri, L., Allee, E., & Corrigan, P. W. (2012). Empirical studies of self-stigma reduction strategies: A critical review of the literature. *Psychiatric Services, 63,* 974–981.

Pescosolido, B. A. (2013). The public stigma of mental illness: What do we think; what do we know; What can we prove? *Journal of Health and Social Behavior, 54*(1), 1–21.

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., et al. (2012). Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica, 125,* 440–452.

Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry, 19,* 137–155.

Sharac, J., McCrone, P., Clement, S., & Thornicroft, G. (2010). The economic impact of mental health stigma and discrimination: A systematic review. *Epidemiologia e Psichiatria Sociale, 19,* 223–232.

Thornicroft, G. (2006). *Shunned: discrimination against people with mental illness*. Oxford: Oxford University Press.

Thornicroft, G., Rose, D., & Kassam, A. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry, 19,* 113–122.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., Leese, M., & The INDIGO Study Group. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. *Lancet*, *373*, 408–415.

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., et al. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *Lancet, 387,* 1123–1132.

Yanos, P. T., Rosenfield, S., & Horwitz, A. V. (2001). Negative and supportive social interactions and quality of life among persons diagnosed with severe mental illness. *Community Mental Health Journal, 37,* 405–419.

Yanos, P. T., Lucksted, A., Drapalski, A. L., Roe, D., & Lysaker, P. (2015). Interventions targeting mental health self-stigma: A review and comparison. *Psychiatric Rehabilitation Journal, 38*(2), 171–178.

Chapter 8
Primary Mental Health Prevention—A Public Health Priority Around the World

Olusegun Baiyewu and Bidemi Bello

8.1 Introduction

The WHO Constitution includes “the highest attainable standard of health as a fundamental right of every human being” (WHO 2015).

Mental health prevention is widely known as an aspect of global mental health that aims at reducing the occurrence, prevalence, and recurrence of mental health disorders as well as decreasing the impact of illness in the affected person, their families, and the society (Mrazek and Haggerty 1994). The goal of prevention in mental health is to achieve reduction in mental disorders in susceptible individuals or populations by identifying risks and protective factors and interventions at these levels through the application of evidence-based interventions. Prevention of mental health disorders should be a public health priority around the world (WHO 2004a, b, p. 13).

Prevention in mental health has a long history of over 100 years (WHO 2004a, b, p. 7).

- Primary prevention was categorized as interventions to keep the disease process from becoming established by eliminating causes of disease or increasing resistance to disease,
- Secondary prevention interrupts the disease process after it becomes symptomatic while
- Tertiary prevention limits the physical and social consequences of symptomatic disease (Leavell and Clark 1965).

O. Baiyewu
College of Medicine, University of Ibadan Nigeria, Ibadan, Nigeria
e-mail: olusegun_baiyewu@yahoo.com

B. Bello (✉)
Babcock University, Ilishan Remo, Ogun, Nigeria
e-mail: abigirl26@yahoomail.com

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_8

Stakeholders in the mental health field were concerned with the simplistic model assuming a clear chain of events which did not accurately reflect the multiple, interacting pathways, and contextual factors related to development of mental health disorders (Springer and Phillips 2006).

The Mental Health Intervention Spectrum for Mental Disorders came into being as a result of the difficulties ascribed to the above classification where researchers in the field of mental health chose not to use the public health classification system of primary, secondary, and tertiary prevention. Rather Gordon introduced the terms, universal, selected and indicated to better define the broad term primary prevention (Gordon 1983). These distinctions reflected the needs of dynamic subpopulations that presented different levels of risk for developing diagnosable behavioral health problems. Different individuals having diverse environmental risks as precursors, and are characterized by probabilistic and complex relations between risk and the progression to mental health disorders. It was also recognized to have a great potential for guiding the identification of population groups and individuals with varying prevention needs, and aligning these needs with appropriate policies, programs, and practices (Gordon 1983, 1987).

The Institute of Medicine (IOM) model divided the continuum of services into three parts; prevention, treatment, and maintenance (IOM 1994). The IOM recognized the need for a framework for health planning that went beyond the distinction between primary (prevention), secondary (intervention), and tertiary (treatment) phases then in use and proposed a new framework for classifying prevention based on Gordon's (1987) operational classification of disease prevention. This continuum of care model for mental health adapted by the Institute of Medicine has several advantages over the older primary, secondary, and tertiary phased model. The intervention phases are divided into prevention, treatment, and maintenance with clear distinctions between each of these three broad phases. The IOM framework also places prevention in a graded continuum of care that distinguishes between prevention, treatment, and maintenance, and shows their interrelation. The classification distinguishes between three levels of prevention services according to the risk levels of the target population (Springer and Philipps 2006).

The model of universal, selective, and indicated preventive strategies embedded in the primary prevention have been well described. Universal prevention has to do with interventions targeted at the whole population or general public. Selective prevention on the other hand refers to the interventions targeted at individuals or subgroup of the population whose risk of developing mental disorder is significantly higher than the average, while indicated prevention has as its focus people who are identified as having minimal but detectable signs or symptoms pointing to mental disorder or with biological markers indicating predisposition for mental disorders but not meeting the diagnostic criteria at that point in time (Mrazek and Haggerty 1994). Primary mental health prevention thereby addresses proactive interventions in preventing mental health issues before they arise but not only this, it actively modifies behaviors or risk factors identified as associated with mental disorders.

Primary mental health prevention can be described as the intentional interventions in reducing risk factors for mental health disorders; increasing protective factors, and preventing psychiatric symptoms and new cases of mental disorders in currently normal population (Durlak and Wells 1997). It is the aspect of preventive mental health that strives to avert the initial occurrence of mental disorders pivotal in the intervention of health care preventive strategies. This approach is the foundation in any preventive setting and can be compared to "turning off the tap" effect rather than other approaches which utilize expending resources to "mop the spills" while ignoring the running tap.

8.2 Current Status

Presently, 5 of 10 leading causes of disability worldwide are psychiatric conditions (Murray and Lopez 1996), with a projected estimate that by the year 2020 neuropsychiatric conditions will account for 15% of disability worldwide, with unipolar depression alone accounting for 5.7% of Disability Adjusted Life Years (DALYs) and the second leading cause of diseases globally by the year 2030 (WHO 2008). This statistics is sobering and calls for urgent interventions among all stakeholders.

Recent development in self-management procedure and other methods indicates that it is possible to truly operationalize primary prevention in mental health (Wolf 2012). Starting from the premises of managing chronic physical illnesses, the procedure is now applicable to mental ill health like prevention of post-partum depression (Smith et al. 2016) and conversion of sub threshold depression to major depressive disorder (Buntrock et al. 2016). Prevention of alcohol and drug use in children and adolescents (Champion et al. 2016). Some of these studies are internet-based programs while others are trainer led; but all produce positive prevention characteristics.

Globally, currently available opportunities for prevention of mental disorders generally are unevenly distributed around the world.

8.3 Discussion

8.3.1 Strategies to Include Primary Mental Health Prevention Within the Community

The role of advocacy as a strategy of primary prevention cannot be overemphasized in integrating primary mental health within our communities (Hetzel 2002). Many people in various Low and Middle Income Countries (LMIC) regardless of education, social, and economic status are ignorant in recognizing symptoms of mental ill health or the need for treatment. Despite the large burden of mental illness within the community, the awareness of what these symptoms represent and the need to access care is still very primordial. There is a need for creating awareness at every level of society; what constitutes mental health disorders, how to prevent, and the need for early intervention. In addition to this, the problem of nonexistent and frequently outdated mental health policies cannot be overlooked if any impact would be made, especially in the LMIC.

Thus, to successfully integrate primary mental health prevention into the communities, there is a need for advocacy at every strata of the government to make an impact at the national and grass root level. Formulating national policies that will engender the welfare of the citizenry and improving the quality of life of population across board will be an offshoot of such advocacy. Modifiable socioeconomic factors which can be influenced by strong political will such as nutritional interventions in socioeconomically disadvantaged children, growth monitoring, improved education, counseling, psychosocial care, all known to decrease the onset of mental health disorders can be employed (WHO 1999).

Another strategy proposed by the WHO in incorporating primary prevention in mental health is establishing partnerships between relevant stakeholders (Hetzel 2002). This involves mental health needs assessment and implementing relevant and effective program within the community. Creating awareness, advocacy and inter-sectoral linkages between mental health professional, other stakeholders and the populace will achieve the necessary impact within the community. Relevant stakeholders within the developing nations will include the local and national government agencies, government parastatals, traditional rulers, schools and other institutions, social welfare services, nongovernmental agencies, and professional bodies of mental health specialists.

Intentional education of the girls is also a critical tool in the strategy of implementing primary prevention of mental health disorders in developing countries. Although this seems to be the paradigm shift in low-income countries, however, the advantages accrued from education of girls are tremendous. A popular saying goes thus: “Educating a girl child is educating a nation” with the simultaneous effect of raising the bar of mental health status. This is because both the mental health of the mother and children will be secured. Literacy assures a sense of purpose, pride, and self-worth. This has a positive impact on the mental health of the individual as well as the offspring of such a mother. There is an increased opportunity of acquiring skills that promote mental health such as literacy and numeracy skills, reduction in barriers to health, being cheated, greater confidence, and increase in accessing opportunities. All these yield the dividend of positive mental health and reduction in risks for mental health disorders.

Strengthening community network in achieving primary prevention of mental disorders is also a critical strategy. This is because one’s environment is a major determinant of mental health and mental illness. The environment we find ourselves; has modifiable risk factors that can be controlled in primary prevention of mental health disorders. This can be achieved by having a community that is socially responsible for maintaining the mental well-being of every individual in that community. Such communities will be educated on risk factors for mental health disorders such as using addictive psychoactive substances, the role of ease of access or availability of these substances, and the role of advertisement of psychoactive substances. In addition the role of maternal well-being during pregnancy, smoking and use of psychoactive substances during pregnancy and effects of such postnatally, in childhood, adolescence and young adulthood. The community will also have social amenities which promote good mental health such as safe housing facilities, health care facilities, recreational facilities, and other resources which promote mental health and well-being of the society (Hetzel 2002).

8.3.2 Primary Prevention Program for Specific Mental Health Disorders

In the more advanced countries of the world, some progress has been achieved in primary prevention programs in mental health over the last decade. This includes evidenced-based interventions in reducing the risk factors of mental health disorders (Jané-Llopis et al. 2005; Hosman et al. 2005). Some of these programs are adaptable to local communities in developing countries.

Across the age distribution of the population within the communities, there are primary prevention programs for specific mental health disorders. Childhood mental health disorders such as pervasive developmental disorders, conduct disorder, early onset psychosis, depression in the young can be prevented by promoting a healthy start in life (Brown and Sturgeon 2005). This is achievable by ensuring primary prevention programs during antenatal care with pragmatic programs teaching maternal well-being during pregnancy, adequate follow up during pregnancy, cessation and prevention of maternal smoking, parental skills training, and early child–parent relationships. All these measures have been identified as a primary prevention tool in mental health disorders (Hetzel 2002; Looney et al. 1994; WHO 1998).

Studies have shown the impact of regular home-visits by health professionals during pregnancy till the age of 15 years. The goals of the such studies were to assess indices of mental health prevention vis-à-vis improved maternal and child functioning, better parenting practices, providing social support and encouraging the use of community support; helping the mothers to achieve higher educational and employment levels and reduce unwanted pregnancies; improvement of cognition and language development in children along with decrease in psychological and behavioral problems. The reported mental health related outcomes in the study were reduced smoking of psychoactive substances, reduced child abuse, better social support for the mothers, better vocational adjustment, and better educational achievement in the children which were all indices of primary mental health prevention (Olds et al. 1988; McCowan et al. 2009; Satyanarayana et al. 2011; Bickerstaff et al. 2012).

Specific interventions to increase resilience in children and adolescents through parenting style and early interventions, and programs for children at risk for mental disorders such as those who have a mentally ill parent or have suffered parental loss or family disruption, have also been shown to increase mental well-being and decrease depressive symptoms and the onset of depressive disorders (Clarke et al. 1995). These programs have been offered to groups of patients in primary care, adolescents, and some other indicated groups with good outcome (Clarke et al. 1995, 2001).

Prevention programs for suicide which is a major cause of mortality in psychiatry across age distribution calls for critical attention. Mental health disorders such as depression and schizophrenia account for the majority of suicide seen all over the world (Sokero et al. 2005; Almeida et al. 2016). Studies have shown that suicide can be prevented through educational programs on risk factors for suicide, recognition of symptoms, diagnosis, prevention, and treatment of mental health disorders (Rutz et al. 1989, 1992). These preventive strategies for suicide are adaptable in low-income countries with well-informed professionals and stakeholders even at the current available level of resources.

Depression has been recognized to have some malleable risk factors such as biological, psychological, social, and societal factors which are unevenly distributed but concentrated in a wide range of vulnerable individuals in populations at risk. This has been known to span parental depression, inadequate parenting, child abuse and neglect, negative life events, stressful life events, and bullying (WHO 2004a, b). Specifically for depression, programs which strengthen protective factors in at risk individuals and vulnerable groups can be adapted. Such programs incorporate improving problem solving abilities, teaching self-mastery, stress management skills, building self-esteem, social support, and in particular instances a more formal approach of individual psychotherapeutic measures such as cognitive-behavioral therapy. These are adaptable primary preventive programs that are practicable. The beauty of these preventive programs is that they are basic and easily adaptable as primary prevention tools in the prevention of mental health disorders even in resource poor settings.

For anxiety disorders, reduction of preventable traumatic events such as level of violence in the community, child abuse, sexual assault, wars, and terrorism at every level. This is achievable through deliberate safety measures put in place in communities, ensuring safety on the roads, workplace, as legislation protecting these rights. School-based programs which address aggressive behavior, delinquency, bullying, child abuse, and safety legislations have been recognized to reduce the incidence of anxiety disorders in communities (WHO 2004a, b).

Another major strategy that has proven to be effective in prevention of anxiety disorders is the Australian FRIENDS program. FRIENDS in an acronym for skills taught throughout the program recognized by the World Health Organization as an evidence-based program which is effective at all levels of intervention (Dadds et al. 1997; WHO 2004a, b; Barret et al. 2006). This was developed in Australia and focuses on strengthening the emotional resilience and cognitive skills needed to avoid the development of anxiety disorder in children aged 7 to 16 years. It has also been implemented in Sweden, Netherlands, and USA. The FRIENDS program is widely used in their schools, health centers, and hospitals. It has been translated into a prevention format and is available in universal, selective, and indicated prevention versions. FRIENDS is a cognitive-behavioral program of 10 sessions that teaches children skills to prevent anxiety disorders. Controlled studies have shown that when the program was offered to universal school populations and to selected groups of children and adolescents at risk; it resulted in a significant drop in anxiety symptoms (Dadds et al. 1997; Lowry-Webster et al. 2001; WHO 2004a, b).

Primary prevention programs for substance abuse are widely recognized to be one of the most effective methods of prevention in substance use disorder. Evidence abound that giving information, psycho-education, and brief intervention significantly decrease substance use disorder in population at risks (Kenkel and Chen 2000; Lancaster and Stead 2004). Therefore, programs targeting the population at risk within the community could incorporate the strategy of education about the effect and consequences of these psychoactive substances as a tool for primary prevention of mental health. This provision of information and teaching the consequences and dangers of psychoactive drugs is critical as a primary prevention strategy. School-based programs aimed at changing the beliefs, attitudes and behavior toward addictive psychoactive substances are also recognized as building blocks in primary prevention of mental health disorders due to psychoactive drug use. Actively developing social skills in adolescents and young adults, building their self-esteem and positive affirmation for good behavior are recognized effective tools in vulnerable individuals. Furthermore, school-based primary prevention programs such as multiple session psycho-education programs, mass media educational programs as well as parent education programs. A number of times selected or indicated intervention such as brief intervention or nick of time therapy is required.

In the elderly, primary prevention programs such as regular exercise, social support, or community participation have been shown to improve mental health of elderly people. Also reminiscence therapy and organized care program within the community in which the care of the elderly is assigned to specific individuals such as relations, or social group members can be used specifically for the elderly (Stevens and van Tilburg 2000; Li et al. 2001; Shapiro and Taylor 2002).

Of crucial importance are the primary prevention strategies of dementia in the geriatric age group. Prevention can be achieved before the onset of the illness or in the delay of the onset by ameliorating exposure to environmental neurotoxins and reduction of modifiable risk factors.

Secondly, vascular disease is an evidence-based risk factor for dementia. This has been documented in a double-blind clinical trial conducted in Europe which was able to prove that reductions of high systolic blood pressure through antihypertensive therapy in elderly at risk can reduce the onset of dementia by over 50% (Forette et al. 1998, 2002).

Take Away Messages

- The highest attainable standard of health is a fundamental right of every human being (WHO 2015). The integration of a human rights-based approach to health is at the basement.
- Prevention of mental health disorders should be a public health priority around the world (WHO 2004a, b).
- There is evidence that primary prevention is now possible in psychiatric disorders, but studies in this area are limited and most are from industrialized societies.
- Applicability of such programs to patients in the developing world is yet to be determined.
- Mental health professionals have a crucial task in providing evidence on prevention of mental health across the globe, engaging relevant stakeholders, and offering professional care in their practice at international standard practice.
- Obvious deterrents to mental health issues such as stigma, ignorance, poor organization of health system facilities, and other sociocultural factors in low-income countries need to be addressed.
- Determinants of mental health such as improving maternal and infant health, adequate nutrition, qualified schools providing a nurturing environment and equal opportunity to learn, intentional education of both genders, enhanced socioeconomic securities, and safe living environments as well as policies to ensure these are to be put in place.

References

Almeida, O. P., McCaul, K., Hankey, G. J., Yeap, B. B., Golledge, J., & Flicker, L. (2016). Suicide in older men: The health in men cohort study (HIMS). *Preventive Medicine, 93,* 33–38.

Barret, P. M., Farrell, L. J., Ollendick, T. H., & Dadds, M. (2006). Long term outcomes of an Australian universal prevention trial of anxiety and depression symptoms in children and youth: an evaluation of the friends program. *Journal of Clinical Child and Adolescent Psychology, 35*(3), 403–411.

Bickerstaff, M., Beckmann, M., Gibbons, K., & Flenady, V. (2012). Recent cessation of smoking and its effect on pregnancy outcomes. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 52*(1), 54–58.

Brown, H., & Sturgeon, S. (2005). Promoting a healthy start of life and reducing early risks. In C. Hosman, E. Jané-Llopis, & S. Saxena (Eds.), *Prevention of mental disorders: effective interventions and policy options*. Oxford: Oxford University Press.

Buntrock, C., Ebert, D.D., Lehr, D., Smit, F., Riper, H., Berking, M., et al. (2016). Effect of a web-based Guided self-help intervention for prevention of major depression in adults with subthreshold depression: a randomized clinical trial. *Journal of American Medical Association 315*(17),1854–1863.

Champion, K.E., Newton, N.C., Stapinski, L.A. & Maree Teesson, M. (2016). Effectiveness of a universal internet-based prevention program for ecstasy and new psychoactive substances: a cluster randomized controlled trial, *Addiction 111*(8), 1396–1405. doi: 10.1111/add.13345

Clarke, G. N., Hawkins, W., Murphy, M., Sheeber, L. B., Lewinsohn, P. M., & Seeley, J. R. (1995). Targeted prevention of unipolar depressive disorder in an at-risk sample of high school adolescents: a randomized trial of a group cognitive intervention. *Journal of American Academy of Child and Adolescent Psychiatry, 34*(3), 312–321.

Clarke, G. N., Hornbrook, M., Lynch, F., Polen, M., Gale, J., Beardslee, W., et al. (2001). A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. *Archives of General Psychiatry, 58,* 1127–1134.

Dadds, M. R., Spence, S. H., Holland, D., Barrett, P. M., & Laurens, K. (1997). Prevention and early intervention for anxiety disorders: A controlled trial. *Journal of Consulting and Clinical Psychology, 65*(4), 627–635.

Durlak, J. A., & Wells, A. M. (1997). Primary prevention mental health programs for children and adolescents: a meta-analytic review. *American Journal of Community Psychology, 25*(2), 115–152.

Forette, F., Seux, M.L., Staessen, J.A., Thijs, L., Birkenhäger, W.H., & Babarskiene, M.R., et al. (1998). Prevention of dementia in randomised double-blind placebo-controlled systolic hypertension in Europe trial. *Lancet*, 24; 352 (9137), 1347–1351.

Forette, F., Seux, M. L., Staessen, J. A., Thijs, L., Birkenhäger, W. H., Babarskiene, M. R., et al. (2002). The prevention of dementia with antihypertensive treatment: new evidence from the Systolic Hypertension in Europe study. *Archive Internal Medicine, 162*(18), 2046–2052.

Gordon, R. (1983). An operational classification of disease prevention. *Public Health Reports, 98,* 107–109.

Gordon, R. (1987). An operational classification of disease prevention. In J. A. Steinberg & M. M. Silverman (Eds.), *Preventing mental disorders: a research perspective* (pp. 20–26). Rockville: Department of Health and Human Services.

Hosman, C., Jané-Llopis, E., & Saxena, S. (2005). *Prevention of mental disorders: effective interventions and policy options*. Oxford: Oxford University Press.

Hetzel, B.S. (2002). Eliminating iodine deficiency disorders-the role of the International Council in the global partnership. *Bulletin of the World Health Organization*, *80*, 410–413. Retrieved 28 November, 2016, from http://www.who.int/bulletin/archives/en/80(5)410.pdf.

Institute of Medicine (IOM). (1994). *Reducing risks for mental disorders: frontiers for prevention intervention research*. Washington, DC: National Academy Press.

Jané-Llopis, E., Muñoz, R., & Patel, V. (2005). Prevention of depression and depressive symptomatology. In C. Hosman, E. Jané-Llopis, & S. Saxena (Eds.), *Prevention of mental disorders: effective interventions and policy options* (p. 37). Oxford: Oxford University Press.

Kenkel, D., & Chen, L. (2000). Consumer information and tobacco use. In P. Jha & F. Chaloupka (Eds.), *Tobacco control in developing countries* (pp. 177–214). Oxford: Oxford Medical Publications.

Lancaster, T., & Stead, L.F. (2004). Individual behavioural counselling for smoking cessation (Cochrane Review). *The Cochrane Library*, *2*.

Leavell, H. R., & Clark, E. G. (1965). *Preventive medicine for the doctor in his community* (3rd ed.). New York: McGraw-Hill Book Company.

Li, F., Duncan, T., Duncan, S., McAuley, E., Chaumeton, N., & Harmer, P. (2001). Enhancing the psychological well-being of elderly individuals through Tai Chi exercise: A latent growth curve analysis. *Structural Equation Modelling, 8*(1), 53–83.

Loney, E. A., Green, K. L., & Nanson, J. L. (1994). A health promotion perspective on the House of Commons' report "foetal alcohol syndrome: a preventable tragedy". *Canadian Journal of Public Health, 85,* 248–251.

Lowry-Webster, H.M., Barrett, P.M., & Dadds, M.R. (2001). A universal prevention trial of anxiety and depressive symptomatology in childhood: Preliminary data from an Australian study. *Behavior Change*, *18*(1), 36–50.

McCowan, L.M., Dekker, G.A., Chan, E., Stewart, A., Chappell, L.C., & Hunter, M., et al. (2009). Spontaneous preterm birth and small for gestational age infants in women who stop smoking early in pregnancy: prospective cohort study. *British Medical Journal, 338*, b1081.

Murray, C., & Lopez, A. (1996). *The Global Burden of Diseases*. Boston: Harvard School of Public Health, WHO and World Bank.

Mrazek, P. J., & Haggerty, R. J. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington: National Academy Press.

Olds, D.L., Henderson, C.R., Tatelbaum, R., & Chamberlin, R. (1988). Improving the life-course development of socially disadvantaged mothers: A randomized trial of nurse home visitation. *American Journal of Public Health*, *78*, 1436–1444.

Petteri-Sokero, T., Melartin, T. K., Rytsälä, H. J., Leskelä, U. S., Lestelä-Mielonen, P. S., & Isometsä, E. T. (2005). Prospective study of risk factors for attempted suicide among patients with DSM–IV major depressive disorder. *The British Journal of Psychiatry, 186*(4), 314–318.

Rutz, W., von Knorring, L., & Wålinder, J. (1992). Long-term effects of an educational program for general practitioners given by the Swedish Committee for the prevention and treatment of depression. *Acta Psychiatrica Scandinavica, 85,* 83–88.

Rutz, W., Walinder, J., Eberhard, G., Holmberg, G., von Knorring, A. L., et al. (1989). An educational program on depressive disorders for general practitioners on Gotland: Background and evaluation. *Acta Psychiatrica Scandinavica, 79,* 19–26.

Satyanarayana, V., Lukose, A., & Srinivasan, K. (2011). Maternal mental health in pregnancy and child behavior. *Indian Journal of Psychiatry*, *53*(4), 351–361.

Shapiro, A., & Taylor, M. (2002). Effects of a community-based early intervention program on the subjective well-being, institutionalization, and mortality of low-income elders. *Gerontologist, 42*(3), 334–341.

Smith, E.K., Gopalan, P., Glance, J.B., & Azzam, P.N. (2016). Postpartum depression screening: a review for psychiatrists. *Harvard Review of Psychiatry, 24*(3), 173–187

Springer, F., & Philipps, J. L. (2006). The IOM Modell: A tool for prevention planning and implementation. *Prevention Tactics, 8,* 13.

Stevens, N., & van Tilburg, T. (2000). Stimulating friendship in later life: A strategy for reducing loneliness among older women. *Educational Gerontology, 26*(1), 15–35.

Wolf, H. (2012). Self- Management and Mental Health. In Bährer-Kohler, S., (Ed.) (2012). *Social Determinants and Mental Health*. Nova. USA.

World Health Organization. (1998). Improving mother/child interaction to promote better psychosocial development in children. Geneva: WHO/MSA/MHP/98.1.

World Health Organization. (2004). Promoting mental health: concepts, emerging evidence, practice: summary report. Geneva: World Health Organization.

World Health Organization. (2004). Prevention of mental disorders: effective interventions and policy options: summary report/a report of the World Health Organization Department of Mental Health and Substance Abuse; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. Retrieved 28 October, 2016, from http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf.

World Health Organization. (2008). The global burden of disease: 2004 update. Geneva: World Health Organization.

World Health Organization. (2015). Health and human rights. Fact sheet n°323. December 2015. Retrieved 14 November, 2016, from http://www.who.int/mediacentre/factsheets/fs323/en/.

Chapter 9
Mental Health Promotion-Overview

Venu Gopal Jhanwar and Priya Ranjan Avinash

9.1 Introduction

Health is defined by the World Health Organization (WHO) as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’ (WHO 2001a). Mental health is clearly an integral part of this definition. The goals and traditions of public health and health promotion can be applied just as usefully in the field of mental health as they have been in heart health, infectious diseases, and tobacco control. Neither mental nor physical health can exist alone. Mental, physical, and social functioning are interdependent. Furthermore, health and illness may coexist. They are mutually exclusive only if health is defined in a restrictive way as the absence of disease (Sartorius 1990). Recognizing health as a state of balance including the self, others, and the environment helps communities and individuals understand how to seek its improvement. Mental health promotion builds individual and community capacity by enhancing people’s own innate ability to achieve and maintain mental health, and by creating supportive environments that reduce barriers to mental health. As an approach to wellness, it focuses on the positive aspects of health such as assets and strengths rather than focusing on deficits and needs, and it emphasizes the value inherent in mental health. It aims to achieve wellness for the entire population by addressing the determinants of mental health by applying the health promotion strategies of the *Ottawa Charter*. Health

---

V.G. Jhanwar (✉)
Deva Institute of Healthcare and Research Pvt. Ltd, B 27/70 MN, Durgakund,
Varanasi 221005, Uttar Pradesh, India
e-mail: vgj.dihr@gmail.com; venugj@hotmail.com
URL: http://www.devainstitute.com

P.R. Avinash
Department of Psychiatry, Himalayan Institute of Medical Sciences,
Jolly Grant, Dehradun 248140, Uttarakhand, India
e-mail: drpriyaranjan.avinash@gmail.com

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_9

promotion and illness prevention are distinct concepts, but they are complementary and overlapping (Lahtinen et al. 2005). The focus of health promotion is to strengthen and enhance the capacity for health that already exists; the focus of prevention is to avoid illness, which is seen as a lack of health. Within the field of mental health promotion, there are differing views about the degree to which promotion and prevention overlap and the point at which these concepts converge.

9.2 Current Status/Data

Mental illnesses are common and universal. Worldwide, mental and behavioral disorders represented 11% of the total disease burden in 1990, expressed in terms of disability-adjusted life years (DALYs) (WHO 2001b). The burden of mental and substance use disorders increased by 37.6% between 1990 and 2010, which for most disorders was driven by population growth and aging (Whiteford et al. 2013). Depression was the fourth largest contributor to the disease burden in 1990 and is expected to be the second largest after ischemic heart disease by 2020. Yet, mental illness and mental health have been neglected topics for most governments and societies.

Recent data collected by WHO demonstrates the large gap that exists between resources that are available in countries for mental health and the burden caused by mental health problems (WHO 2001c). In contrast to the overall health gains of the world's populations in recent decades, the burden of mental illness has grown (Eisenberg 1998; Desjarlais et al. 1995). The twin aims of improving mental health and lowering the personal and social costs of mental ill-health can only be achieved through a public health approach (Sartorius 1998; VicHealth 1999; Hosman 2001; Herrman 2001; Walker et al. 2004). Within a public health framework, the activities that can improve health include the promotion of health, the prevention of illness and disability, and the treatment and rehabilitation of those affected. These are different from one another, even though the actions and outcomes overlap. They are all required, are complementary, and one is no substitute for the other.

There is mounting evidence that it is possible to intervene at several levels, from local to national, to improve health (Benzeval et al. 1995). The factors over which individuals have little or no control require the collective attention of a society as encapsulated by the Ottawa Charter of Health Promotion (WHO 1986). Two of the five strategies set out in the Ottawa Charter for Health Promotion 'strengthen community action' and 'develop personal skills' (WHO 1986)—essentially refer to mental health promotion activities: for example, programs aimed at reducing social inequality and building social capital (WHO 2004).

Inequalities in health are related to a wide range of social factors, including those already noted. Inequalities also result to a degree from individual differences in genetics, health-related behavior, and choices regarding education, work, and play. According to WHO, health promoting policies are needed not only in the health-care sector, but also in the economic, environmental, and social sectors for positive impact on the determinants of health and improved health equity (WHO 1998).

Despite diverse settings, health promotion work exhibits common features based on collaboration and recurrent cycles of program planning, implementation, and evaluation. Influential models (Tones and Tilford 2001; Raeburn and Rootman 1998) emphasize the intention to build people's capacity to manage their own health and to work collaboratively. Virtually all health promotion practice models include:

1. A careful study of a community's needs resources, priorities, history, and structure in collaboration with the community: "doing with" rather than "doing to;"
2. Agreement on a plan of action, gathering of resources, implementation, and monitoring of action and change processes. Fluidity is needed in planning and acting to meet the demands of new or changing conditions, as well as constant surveillance of and reflection over practice; and
3. An emphasis on evaluation and dissemination of best practices, with attention to maintaining and improving quality as dissemination unfolds.

9.2.1 The Nature of Health Promotion Evidence

Generating evidence of the effectiveness of health promotion can be challenging. Much of the evidence of health promotion's effectiveness must be derived from community-based research. There cannot be total reliance on traditional, quantitative measures. Including qualitative methods gives a better understanding of what works and what does not. Although such "real world" research is a complex undertaking, it is nevertheless possible to develop a body of dependable knowledge. Major successes in health promotion over recent decades have occurred in several areas of action, including tobacco control and heart health (WHO 2003a, b). There are two focal issues with regard to health promotion evidence: the strength of the evidence and its implications for research, practice, and policy development. A useful strength-of-evidence typology that has reference to three elements of scientific enquiry—falsifiability, predictability, and repeatability—results in four types of evidence (Tang et al. 2003b):

Type A: What works is known, how it works is known, and repeatability is universal.
Type B: What works is known, how it works is known, but repeatability is limited.
Type C: What works is known, repeatability is universal, but how it works is not known.
Type D: What works is known, how it works is not known, and repeatability is also limited (Tang et al. 2003).

Complexities are involved that rarely resolve sufficiently to produce Type A evidence. Health promotion strives, therefore, for Type B evidence, and this has important implications for practice. In mental health promotion, evidence is necessary for policy makers to justify their spending, for practitioners to plan and implement programs, and for those affected to know if the interventions will benefit them (Barry and McQueen 2005). Mental health promotion interventions aim to reduce the risk factors that contribute to poor mental health and enhance the protective factors, which contribute to mental health, but they also produce many other health, social, and economic benefits. Examples of effective interventions to promote mental health include: strengthening parenting skills in early childhood; preventing or reducing bullying in schools; addressing workplace stress and creating a work-life balance; and providing opportunities for meaningful community.

The Victorian Health Promotion Foundation (VicHealth) in Australia developed a conceptual framework for action to guide its mental health promotion efforts In VicHealth's view, to be successful in this, efforts need to:

- Focus on social and economic determinants of mental health;
- Involve the full range health promotion methodologies that work at the population and subpopulation levels; and
- Engage those working across sectors and settings.

Due to the relationship between social and economic factors and mental health, success in promoting mental health and well-being can be achieved and sustained by the involvement and support of the whole community, and the development of partnerships between a range of agencies in the public, private, and nongovernment sectors.

9.3 Discussion

The personal, social, and environmental factors that determine mental health and mental illness may be clustered conceptually around three themes (HEA 1997):

- Each person's ability to the development and maintenance of healthy communities
- Each person's ability to deal with the social world through skills like participating, tolerating diversity, and mutual responsibility
- Each person's ability to deal with thoughts and feelings, the management of life, and emotional resilience

The fostering of these individual, social, and environmental qualities, and the avoidance of the converse, are the objectives of mental health promotion.

9.3.1 Evidence of Effective Interventions

Evidence exists for the effectiveness of a wide range of exemplary mental health promotion programs and policies. Their outcomes show that mental health promotion is a realistic option within a public health approach across the lifespan and across settings such as perinatal care, schools, work, and local communities (Saxena et al. 2006).

9.3.1.1 Improving Nutrition

There is strong evidence that improving nutrition and development in socioeconomically disadvantaged children can lead to healthy cognitive development and improved educational outcomes, especially for those living in impoverished communities. The most effective intervention models are potentially those which combine nutritional interventions (such as food supplementation) with counseling on psychosocial care (e.g., warmth, attentive listening) (WHO 1999).

9.3.1.2 Improving Housing

Poor housing has been used as an indicator of poverty and as a target to improve public health and reduce inequalities in health (Saxena et al. 2006).

9.3.1.3 Improving Access to Education

Low literacy is a major social problem in many countries, particularly in south Asia and sub-Saharan Africa. Ethnographic research in India suggests programs aimed at improving literacy, in particular for adults, have tangible benefits in promoting mental health (Cohen 2002). Better education increases female cognitive-emotional and intellectual competencies and job prospects, and might reduce social inequity and risks of certain mental disorders such as depression (Saxena et al. 2006).

9.3.1.4 Pre-school Educational and Psychosocial Interventions

There are many community programs for families with young children, such as family reading programs in libraries, health screening clinics, organized recreation, and television programs that teach elementary reading skills and socioemotional values (Saxena et al. 2006). Moreover, interventions having a simultaneous impact on the physical and mental health of parents and their babies might prolong their impact throughout children's lives and between generations.

9.3.1.5 Reducing Violence and Improving Emotional Well-Being in the School Setting

Many countries are committed to universal systems of primary education. Although this is not the case in all developing countries, the number of youth attending school is increasing. In addition to their central role of fostering academic development, schools serve an important role in the health and social-emotional development of students (WHO 1997a, b; Weare 2000).

9.3.1.6 Strengthening Community Networks

Community interventions have focused on developing empowering processes and building a sense of ownership and social responsibility within community members (Saxena et al. 2006).

9.3.1.7 Reducing Misuse of Addictive Substances

A strong evidence base indicates the negative impact of alcohol, tobacco, and drug use during pregnancy. These effects include an increased likelihood of premature deliveries, low birth weight, restricted long-term neurological and cognitive-emotional development of children (e.g., lower intelligence, temperament, Attention Deficit Hyperactivity Disorder, conduct problems, poorer school achievements), and perinatal mortality (e.g., Tuthill et al. 1999). Educational programs to stimulate pregnant women to abstain from or reduce substance use can therefore have long-term mental health benefits.

9.3.1.8 Reducing the Strain of Unemployment

Retrenchment and job loss can cause serious mental health problems. Counseling or job search training for low-income unemployed groups can be an effective strategy to reduce the negative outcomes of unemployment for mental health (Saxena et al. 2006).

9.3.1.9 Stress Prevention Programs at the Workplace

There is evidence that work characteristics may cause or contribute to mental health problems (e.g., burnout, anxiety disorders, depression, sleeplessness), gastrointestinal disorders, cardiovascular illness, and musculoskeletal disease, and produces social and economic burden to health and human services (Price and Kompier 2004). Interventions to reduce work stress may be directed either at the coping capacity of employees or at the working environment. Stress management training, stress inoculation techniques, relaxation methods, and social skills and fitness training can increase coping capacity. Several meta-studies show that such environments methods are effective in preventing adverse mental health outcomes in workplace (Murphy 1996).

9.3.1.10 Improving the Mental Health of the Elderly

In the year 2000 more than 600 million people were aged over 60 in the world. This figure is expected to increase by 70% in the next 20 years. This rapid increase in the aging population brings an increase of age-related physical and mental health problems, including an increased risk of dementia (Levkov et al. 1995) and age-related chronic diseases, and decreases in general mental well-being and quality of life. Different types of universal interventions have been successful in improving the mental health of elder populations.

9.3.1.11 Intervening After Disasters

Psychological and social interventions during the reconsolidation phase after disasters have been recommended to improve the mental health of the affected populations and to prevent psychopathology (WHO 2003c).

9.3.1.12 Preventing Violence

Community-based efforts to prevent violence include public education campaigns, improved urban infrastructure, and community policing (WHO 2002a).

9.3.2 Mental Health Promotion in Developed Countries

The costs of mental health problems have been estimated at between 3% and 4% of gross national product of most of the developed countries. Mental health promotion can be an effective strategy to reduce the burden of mental disorders, and have shown to bring about health, social, and economic development. In the developed world like in European countries, the most common professional backgrounds include mental health, public health, or health promotion specialists, although many other professions, including those in other sector (e.g., teachers, social workers, police, etc.) are involved to a certain extent in the implementation of prevention and promotion activities. Some countries, such as the Netherland have specialized “mental health promotion and prevention workers.” Other developed countries include mental health professional such as psychologists, psychotherapists, psychiatrists or psychiatric nurses who are charges with prevention and promotions part of their activities. Some countries, for example as in Turkey, aim to “integrate the prevention of mental health services into primary health care” (Jané-Llopis and Anderson 2006).

9.3.3 Developing Countries and its Uniqueness

The biggest challenge is that the number of mental health professional in the developing world (psychiatrists, clinical psychologists, psychiatric nurses, and social workers) is inadequate in responding to the treatment gap four hundred and fifty million people worldwide currently suffer from of mental disease or brain condition but almost half the countries in the world have no explicit mental health policy and no program for coping with the rising tide of brain related disabilities. According to a statement by former United Nations Secretary General Kofi Annan “It is time for governments to make mental health a priority and to allocate the resources, develop the policies and implement the reforms needed to address this urgent problem. One in four people will suffer from mental illness at some time in life” (United Nations Daily Highlights 2006).

The WHO also launched a new worldwide effort called project Atlas to catalog mental health resources around the world. In its initial survey, the project found that, of the countries it surveyed:

41% have no mental health policy.
25% have no legislation on mental health.
28% have no separate budget for mental health.
41% do not have treatment facilities for severe mental disorders in primary health care.
37% have no community health-care facilities.
About 65% of the beds for mental health care are in mental hospitals.

9.3.4 Effective Mental Health Promotion in Low-Income Countries

Mental health is inextricably linked with human development, both because the social and economic determinants of human development are strongly associated with mental health and because poor mental health will compromise longevity, general health, and creativity. Here we focus on only three areas of action:

9.3.4.1 Advocacy

Advocacy aims to generate public demand for mental health and to persuade all stakeholders to place a high value on mental health. The Global Burden of Disease study showed that alcohol abuse is a leading cause of social and family disruption, and morbidity and mortality, especially in men in developing countries. In India, the scale of social problems related to alcohol abuse has propelled the problem into a political issue: in recent years, entire elections have been fought, and won, on this issue (Patel 1998).

9.3.4.2 Self Empowerment

Empowerment is the process by which groups in a community who have been traditionally disadvantaged in ways that compromise their health can overcome these barriers and can exercise all the rights that are due to them, with a view to leading a full, equal life in the best of health. The economic vulnerability of farmers in developing countries suggests the potential for mental health promotion in revising the process by which local banks assess the credit-worthiness of people who belong to the poorest sectors of society (WHO 2004). Some cooperative banks in India—have been involved in setting up loan facilities in areas where they did not exist and making loans to poor people who formerly did not have access to such facilities and services.

9.3.4.3 Social Support

Social support strategies aim to strengthen community organizations to encourage healthy lifestyles and promote mental health. Intersectoral alliances prove effective. An example of this is the promotion of maternal mental health. Poor maternal mental health has been shown to compromise the mother and development of babies (WHO 2000). Interventions to improve the mother's health will improve the mother–child relationship and outcomes for the child. For example, a trial from Zambia showed that mothers who received supportive and counseling interventions took more action to solve infant health problems, which is an indicator of maternal empowerment.

9.3.5 Generating Evidence on Effectiveness and Cost-Effectiveness

9.3.5.1 The Need for Evaluation of Policies

The evidence currently available on the health outcomes of government policies is patchy, at best. In short, there is good evidence for some interventions, particularly for individual-level interventions, but not for others (Centre for Review and Dissemination 2000). Interventions for which there was evidence of effectiveness included home-based social support for pregnant women at high risk of depression, and social support and problem-solving or cognitive-behavioral training for unemployed people. Some interventions appeared to be harmful, including psychological debriefing after trauma (WHO 2004). Other interventions appeared to be effective in addressing the determinants of poor mental health, rather than poor mental health itself, by offering educational, employment, welfare, or other supportive interventions. This “absence of evidence” should not be mistaken for “evidence of absence.”

9.3.5.2 Cost-Effectiveness

Primary economic data on the relative costs and benefits of interventions is sparse. Economic evaluations are likely to be of key importance to decision-makers when determining whether or not to implement interventions (Michie and Williams 2003). Economic evaluations aim to answer questions about the best use of resources. Yet, as a methodology economic evaluation has not been extensively applied to health promotion (Cohen 1984; Shiell and Hawe 1996; Godfrey 2001; Byford and Sefton 2002; Hale 2000).

9.3.6 Mental Health is Everybody’s Business

The scope and outcome of mental health promotion activities is potentially wide. At the conceptual level, mental health can be and should be defined broadly. At a more practical level, it is useful to distinguish between interventions that have the primary goal of improving the mental health of individuals and communities, and others that are mainly intended to achieve something else but which enhance mental health as a side-benefit. An example of the former is policies and programs that encourage schools to prevent bullying and that improve parenting skills; policies and resources that ensure girls in a developing country attend school and programs to improve public housing could be considered examples of the latter. Bearing in mind the intimate connection between physical and mental health, many of the interventions designed to improve mental health will also promote physical health and vice versa. Health and mental health are affected by non-health sector policies and a range of community interventions. The actions that promote mental health will often have as an important outcome the prevention of mental disorders. The evidence is that mental health promotion is also effective in the prevention of a whole range of behavior-related diseases and risks. It can help, for instance, in the prevention of smoking and of unprotected sex, and hence of acquired immunodeficiency syndrome (AIDS) or teenage pregnancy.

9.3.7 Developing Sustainable Interventions

Sustainability in health promotion refers to the capacity of an intervention to continue to deliver benefits or health gains beyond the initial funding or "demonstration project" stage. Programs are said to be sustainable if, given limited resources, efforts toward achieving the benefits continue.

9.3.8 International Collaboration and the Role of WHO

There is a clear need for advocacy, since mental health issues are often implicit rather than explicit and hidden rather than in the open. The need for international collaboration, hence, is crucial. The role of World Health Organization in mental health promotion can be briefly summarized as follows.

- To generate, review, compile, and update evidence on strategies for mental health promotion, especially from low and middle-income countries
- To develop appropriate strategies and program
- To facilitate partnership and collaboration

Take Away Messages

Mental health promotion is the need of the time. We would like to drive our point further by suggesting these take away messages

A. Health promotion and prevention is incomplete without including mental health as an integral part of it.
B. Policies at the level of global, national, and local levels for the promotion of mental health are required.
C. Needs to be integrated with the existing primary healthcare model.
D. Use the communities' knowledge and competencies.
E. Include all stakeholders in framing and administering policies and actions.
F. Train Scientists and professional to translate research findings and experiences.
G. Strengthen the manpower and train the existing one in mental health promotion strategies.
H. Sustain and evaluate effective mental health treatment and promotions.
I. Focus on social and economic determinants of mental health.
J. Determine which innovation or promotion will scale up.

References

Barry, M., & McQueen, D. (2005). The nature of evidence and its use in mental health promotion. In H. Herrman, S. Saxena, & R. Moodie (Eds.), *Promoting mental health: concepts, emerging evidence, practice* (pp. 108–118). Geneva: World Health Organization.

Benzeval, M., Judge, K., & Whitehead, M. (Eds.). (1995). *Tackling inequalities in health: an agenda for action*. London: Kings Fund.

Byford, S., & Sefton, T. (2002). First aid: lessons from health economics for economic evaluation in social welfare. [Discussion paper.] London, London School of Economics, Health and Social Care.

Cohen, A. (2002). Our lives were covered in darkness. The work of the National Literary Mission in Northern India. In A. Cohen, A. Kleinman, B. Saraceno (Eds.), *World mental health casebook: social and mental health programs in low-income countries* (pp. 153–190) New York, London, Dordrecht: Kluwer Academic/Plenum Publishers.

Cohen, D. (1984). Utility model of preventive behaviour. *Journal of Epidemiology and Community Health, 38,* 61–65.

Centre for Review and Dissemination. (2000). Evidence from systematic reviews of research relevant to implementing the 'wider public health' agenda. Centre for Reviews and Dissemination, http://www.york.ac.uk/inst/crd/wph.htm.

Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1995). *World mental health: Problems and priorities in low-income countries*. Oxford: Oxford University Press.

Eisenberg, L. (1998). Public health importance. In R. Jenkins & T. B. Ustun (Eds.), *Preventing mental illness: Mental health promotion in primary care* (pp. 141–154). Chichester: Wiley.

Godfrey, C. (2001). Economic evaluation of health promotion. In: I. Rootman, M. Goodstadt, B. Hyndman (Eds.), *Evaluation in health promotion: principles and perspectives*. WHO Regional Publications, European Series, No. 92. Geneva: World Health Organization.

Hale, J. (2000). What contribution can health economics make to health promotion? *Health Promotion International, 15,* 341–348.

Health Education Authority. (1997). *Mental health promotion: a quality framework*. London: Health Education Authority.

Herrman, H. (2001). The need for mental health promotion. *The Australian and New Zealand Journal of Psychiatry, 35,* 709–715.

Hosman, C. (2001). Evidence of effectiveness in mental health promotion. In: *Proceedings of the European conference on promotion of mental health and social inclusion*. Ministry of Social Affairs and Health (Report 3).

Jané-Llopis, E., & Anderson, P. (Eds). (2006). *Mental health promotion and mental disorder prevention across European Member States: a collection of country stories.* Luxembourg: European Communities. ISBN-10: 92-79-01160-X © European Communities.

Lahtinen, E., Joubert, N., Raeburn, J., & Jenkins, R. (2005). Strategies for promoting the mental health of populations. In H. Herrman, S. Saxena, & R. Moodie (Eds.), *Promoting mental health: concepts, emerging evidence, practice* (pp. 226–242). Geneva: World Health Organization.

Levkoff, S., MacArthur, I., & Bucknall, J. (1995). Elderly mental health in the developing world. *Social Science Medicine, 41*(7), 983–1003.

Michie, S., & Williams, S. (2003). Reducing work-related psychological ill health and sickness absence: a systematic literature review. *Occupational and Environmental Medicine, 60*(1), 3–9.

Murphy, L. R. (1996). Stress management in work settings: a critical review of the health effects. *American Journal of Health Promotion, 11,* 112–135.

Patel, V. (1998). The politics of alcoholism in India. *British Medical Journal, 316,* 1394–1395.

Price, R., & Kompier, M. (2004). Work stress and unemployment: Risks, mechanisms, and prevention. In C. Hosman, E. Jané-Llopis, & S. Saxena (Eds.), *Prevention of mental disorders: an overview on evidence-based strategies and programs*. Oxford: Oxford University Press.

Raeburn, J., & Rootman, I. (1998). *People-centred health promotion*. Chichester: Wiley.

Sartorius, N. (1990). Preface. In D. Goldberg & D. Tantam (Eds.), *The public health impact of mental disorders*. Toronto: Hogrefe and Huber.

Sartorius, N. (1998). Universal strategies for the prevention of mental illness and the promotion of mental health. In R. Jenkins & T. B. Ustun (Eds.), *Preventing mental illness: mental health promotion in primary care* (pp. 61–67). Chichester: Wiley.

Saxena, S., Jané-Llopis, E., & Hosman, C. (2006). Prevention of mental and behavioural disorders: Implications for policy and practice. *World Psychiatry, 5*(1), 5–14.

Shiell, A., & Hawe, P. (1996). Health promotion community development and the tyranny of individualism. *Health Economics, 5,* 241–247.

Tang, K. C., Ehsani, J., & McQueen, D. (2003). Evidence based health promotion: recollections, reflections and reconsiderations. *Journal of Epidemiology and Community Health, 57,* 841–843.

Tones, K., & Tilford, S. (2001). *Health promotion: effectiveness, efficiency and equity*. Cheltenham: Nelson Thornes Ltd.

Tuthill, D., Stewart, J. H., Coles, E. C., Andrews, J., & Cartlidge, P. H. (1999). Maternal cigarette smoking and pregnancy outcome. *Paediatric and Perinatal Epidemiology, 13*(3), 245–253.

United Nations daily highlights, The United Nations Home Page at. Retrieved November 3, 2016, from http://www.un.org.

VicHealth. (1999). *Mental health promotion plan foundation document 1999–2002*. Carlton South, Victoria: Victorian Health Promotion Foundation.

Walker, L., Moodie, R., & Herrman, H. (2004). Promoting mental health and wellbeing. In R. Moodie & A. Hulme (Eds.), *Hands on health promotion*. IP Communications: Melbourne.

Weare, K. (2000). *Promoting mental, emotional and social health: A whole school approach*. London: Routledge.

Whiteford, A., Degenhardt, L., Rehm, J., Baxter, J., Ferrari, A., Erskine, H., et al. (2013). Global burden of disease attributable to mental and substance use disorders: Findings from global burden of disease study 2010. *The Lancet, 382,* 1575–1586.

WHO. (1986). *Ottawa charter of health promotion* Geneva: World Health Organization.

WHO. (1997a). *Life skills education in schools*. Geneva: Programme on Mental Health, World Health Organization.

WHO. (1997a). *Partnerships for health in 21st century: 2 + 2=5*. Conference working paper on partnerships. Geneva: World Health Organization.

WHO. (1998). *Health promotion glossary*. Geneva: World Health Organization.

WHO. (1999). *A critical link: interventions for physical growth and child development*. Geneva: World Health Organization.

WHO. (2000). *Women's mental health: an evidence based review*. Geneva: World Health Organization.

WHO. (2001a). *Strengthening mental health promotion*. Fact sheet. Geneva: World Health Organization.

WHO. (2001b). Mental health: new understanding, new hope. The World health report. Geneva: World Health Organization.

WHO. (2001c). *Atlas: Mental health resources in the world*. Geneva: World Health Organization.

WHO. (2002). *World report on violence and health: Summary*. Geneva: World Health Organization.

WHO. (2003a). *Investing in mental health*. Geneva: World Health Organization.

WHO. (2003b). WHO framework convention on tobacco control. World Health Assembly. Retrieved November 10, 2016, from www.who.int/tobacco/fctc/text/final.

WHO. (2003c). *Mental health in emergencies*. Geneva: World Health Organization.

WHO. (2004). *Promoting mental health: Summary report*. Geneva: World Health Organization.

Chapter 10
Promotion of Mental Health—Recovery

Michaela Amering

10.1 Introduction/History

Recovery-orientation is part of state-of-the-art mental health policy in influential English speaking countries gaining substantial traction in Europe and around the globe. The rapid development from a bottom-up movement to collaborative and top down policy approaches originated with people willing to share their experience of living with severe mental illness (Amering and Schmolke 2009).

One of the first recovery advocates was Ron Coleman with his 1999 publication 'Recovery—an alien concept?' (Coleman 2011). He deplored the fact that everybody seems to have forgotten that people can and do recovery from what is diagnosed as schizophrenia. He himself certainly had not been told about it before his own development 'from victim to victor.' His life changed dramatically from severe disability, long-term unsuccessful efforts by the professional services including repeated and long-term involuntary inpatient treatment to great health. He accomplished success in life in many roles such as father, bread-winner, and internationally acclaimed activist and mental health consultant. Many other authors and publishers of their own instructive life stories give evidence of very ill as well as very good mental health in diverse sequences and patterns. Among the most prominent examples are mental health professionals with the additional experience of the mental health patient role, such as Helen Glover, Pat Deegan, Mary Ellen Copeland, Dan Fisher. Taking ownership of the experience (Coleman 2011), the call for moving beyond the patient role and for a 'conspiracy of hope' (Deegan 1996) are central elements of models and concepts for recovery derived from lived experience. This body of recovery narratives includes the life story of Dorothea Buck, the grand old lady of the German user movement. Born in 1907, she

---

M. Amering (✉)
Department of Psychiatry and Psychotherapy, Medical University of Vienna,
Waehringer Guertel 18-20, 1090 Vienna, Austria
e-mail: michaela.amering@meduniwien.ac.at

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_10

experienced psychiatric inpatient treatment between 1935 and 1959 under the diagnosis of schizophrenia and became victim and witness of some of the worst forms of human rights violations Violations, including forced sterilization and the murder of people with disabilities, especially also people with mental health problems, at the time of the Nazi regime in Germany. Since then her amazing achievements and decorations made her life an inspiring tale of recovery graced by an impressive amount of resilience and health. Her experience turned her into a fighter for a 'paradigm shift toward a psychosocial system based on the wealth of patients' experiences' and provides alternatives to a system, which too often rejects communication with patients (www.bpe-online.de/english/dorotheabuck.htm). In order to never let the dialog between the people, who work in the mental health system and their patients and their families and friends break down again she invented the Trialogue. In Trialogue these three main groups of individuals who deal with psychiatric problems and disorders and with the mental health system meet outside familial, institutional, and therapeutical hierarchies and clinches on neutral ground and communicate on equal footing, an exercise of high actuality in times of recovery-orientation and a human rights-based approach in psychiatry (Amering 2016).

Individual recovery narratives and the ascending recovery movement as well as consistent findings of heterogeneity of the course of illness including long-term symptomatology and disabilities as well as full remission (e.g., Warner 2004; Lang et al. 2013) did bring leading US schizophrenia-researchers together in a working group on “Remission in Schizophrenia” in 2005, at a time when for almost all other diagnoses remission criteria had already been formulated and had inspired therapeutic vigor toward this goal (Andreasen et al. 2005). Scientific evidence for the fact that negative prognostic estimations for the course of schizophrenia have been overstated was presented. The European answer to this proposal (van Os et al. 2006) also attacks the widespread ignorance and misjudgements concerning the course and outcome of schizophrenia and concur with the effort by the highest caliber researchers to clarify that remission of symptoms in schizophrenia has to be an important goal and should serve as a marker for treatment success. While, as both papers clearly point out, recovery is defined as considerably more than symptomatic remission, moving from 'demoralizing pessimism to rational optimism' (Knuf 2008) in the health and mental health field as well as in society in general is a necessary prerequisite for recovery. This core element for recovery has been made especially clear also by the consensus statement of the Section on Preventive Psychiatry of the World Association of Psychiatry: 'Conventional, illness-based treatment should be broadened to a comprehensive, multidimensional approach to mental health and mental disorders. This includes the enhancement of positive attitudes and reduction of prevailing skepticism regarding the possibility of prevention and cure' (Lecic-Tosevski et al. 2003).

10.2 Current Status/Data

The most frequently quoted definition of recovery in the scientific literature is the one by Bill Anthony (1993, p. 13), eminent rehabilitation specialist from Boston University: '… a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.' Jan Wallcraft, researcher with a lived experience of recovery, steps in to remind us of the often forgotten second part of this prominent recovery definition: 'Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process. Recovery is what people with disabilities do. Treatment, case-management and rehabilitation are what helpers do to facilitate recovery,' (Wallcraft 2012).

Wallcraft places 'the ownership of the process of recovery firmly with the person recovering' and addresses new responsibilities for professional help in facilitating recovery providing practitioners and policy makers with a message on the process of working together with users of services in partnership. Recovery values do differ from those of traditionally informed mental health treatments and services and individual preferences and choices matter. However, even access to—let alone choice among a set of—offers, many of which could be chosen from more or less traditional evidence-based interventions, is still far from granted and in dire need for advocacy efforts from all stakeholders (Killackey et al. 2015).

According to the US-American Substance Abuse and Mental Health Services Administration (SAMSHA)'s most recent 'working definition of recovery' recovery is 'a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential' (http://www.samhsa.gov/recovery). Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

- ***Health***: overcoming or managing one's disease(s) or symptoms and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- ***Home:*** a stable and safe place to live;
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society; and
- ***Community***: relationships and social networks that provide support, friendship, love, and hope.

SAMSHA concludes that ‘Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.’

Commenting on the evidence base presented in the most recent PORT (Patient Outcome Research Team) recommendations for the psychosocial treatment for schizophrenia (Dixon et al. 2010) ‘through a recovery lens,’ Larry Davidson (2010) stresses the fact that the interventions with ‘the most robust effect sizes were those that supported people in occupying normative adult roles.’ This body of evidence is in line with the ambitious goal for what treatment and supports are supposed to offer to people with mental health problems as set out by the 2003 New Freedom Commission on Mental Health in the USA (U.S. Presidential Commission on Mental Health (2003): ‘We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community,’ clearly stating that persons with psychiatric problems and disabilities should have all the support they need to overcome any barriers to living in the community on an equal basis with others. However, this future has certainly not yet arrived and the then emphasized obstacles still wait to be overcome all around the globe: stigma and discrimination, unfairly limited access, and fragmented mental health service delivery systems. The 2007 diagnosis on ‘resources for mental health: scarcity, inequity, and inefficiency’ (Saxena et al. 2007) is unfortunately in no way outdated.

The fight for access to health and social support, empowerment and equality of opportunity has recently gained a significant push with the UN-Convention on the Rights of Persons with Disabilities (UN-CRPD 2006; Schulze 2010), which by September 2016 has been ratified by 166 State Parties, thereby making it applicable in their countries. The UN-CRPD formulates ‘rights to non-discrimination in key areas, including employment, housing, education, health, standards of living, and social, political, and cultural participation, along with the right to be free from exploitation, violence and abuse’ (Bartlett 2012) for persons with disabilities. In a historic first person with a lived experience of disability were part of the negotiating process at the United Nations (Sabatello and Schulze 2014). As another milestone, persons with a lived experience of disability from mental health problems had joined the movement of disability activists and were equal partners in the process of drafting the UN-CRPD. The Convention now obliges States to involve persons with disabilities including psychosocial disabilities in all policy developments concerning their care and their lives in their communities as well as activities of international and national monitoring bodies with regards to UN-CRPD. Not only do the goals of recovery and its central elements intersect with those of the CRPD, also most conceptual and political considerations as well as research and evaluation efforts around recovery-orientation have evolved from collaborations between people with and without a lived experience of mental health problems and the psychiatric service system. In order to successfully implement the formulated entitlement rights on an individual as well as on the health care system level including effects of these rights on implementation of recovery-orientation of services these collaborations are essential.

Models of collaborations between users and providers of services have been developed in the areas of policy-making, training, practice and evaluation, and research during the last decades. Practice and evidence base for peer support are growing (Davidson et al. 2012; Moran et al. 2012). Scientific collaborations and user-led research contribute significantly to the knowledge base (Wallcraft et al. 2009) and develop in significant ways along the trajectories of the recovery paradigm (Stratford et al. 2016). Evidence as well as policies already in place to further the implementation of a recovery-oriented model of collaborative practices are not only in need of funding and resources, but changes of beliefs and attitudes, which can only come about by sharing expertise and joining efforts of all groups concerned (Davidson. 2016).

Analyzing mental health system transformation processes an international group of recovery experts from different backgrounds (Slade et al. 2014) identified seven "abuses" of the recovery concept, such as the notion that recovery-orientation means closing services or that recovery is about making people "normal." Importantly, they clarify that, while there is a focus on psychosis, 'empirical investigation of recovery has begun in many non-psychosis clinical populations' (Slade et al. 2014). The examples they cite include different diagnoses such as borderline personality and eating disorders as well as different demographics such as children, older adults, and ethnic minorities. Ten empirically validated interventions, which support recovery are presented and include recovery colleges, the wellness recovery action plan (WRAP), individual placement and support, supported housing, and advance directives for crisis interventions. The identified scientific challenges emphasize the broadening of cultural understanding of recovery, the implementation of organizational transformation, and the promotion of citizenship (Slade et al. 2014).

10.3 Discussion

Recovery-oriented research is auspicious and should provide the mental health field with a multi-perspective evidence base for policy and development (Rose et al. 2006) in order to strengthen its position within the health system and society at large. At the same time, recovery as a civil rights movement exerts important influence on the strategies of the big global professional organizations. The WHO Mental Health Action Plan 2013–2020 relies on human rights as one of six cross-cutting principles: 'Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments' (WHO 2013). Consequently, WHO proposes actions for collaborations with users and family carers and to ensure the involvement of people with a lived experience through formal mechanisms giving them the 'authority to influence the process of designing, planning and implementing policies, laws and services' (WHO 2013). The World Psychiatric Association (WPA) in its recommendations on best practices in working with service users and carers (Wallcraft et al. 2011) sets out the notion that 'Respecting human rights is the basis of successful partnerships for mental health.' WPA's recommendations include the call to include users and carers in the development of policy and practice as well as to promote and support the development of service users' and family carers' organizations. On the basis of these recommendations the WPA Madrid Declaration on Ethical Standards for Psychiatric Practice was amended in 2011.

Also in support of a global perspective, a review of international recovery publications resulted in the suggestion that the CHIME (Connectedness, Hope, Identity, Meaning, Empowerment) framework (Slade et al. 2012) encompasses the most prominent notions of recovery with differing focus in different countries and policies. CHIME refers to Connectedness—with other people, but also with the wider community and to society as a whole; Hope, usually defined as vital for recovery and referring to one's own outlook as well as that of people around and mental health services; Identity referring to a process of redefining and rebuilding a positive sense of self; Meaning in terms of finding meaning in life and also meaning associated with the mental illness experience and ways to find meaning through social roles, goals, employment, and meaningful activities; Empowerment relating to a sense of empowerment within mental health services as well as in personal life and life in society. One major result of this review are the similarities across the international recovery literature. This is in line with personal experience with contact to the user/survivor communities in different cultures as well as trialogue experiences in different parts of the world (www.trialogue.co; Amering et al. 2012) with amazing and sometimes overwhelming similarities in the midst of very diverse circumstances.

In Trialogue groups, users, carers, and mental health workers meet regularly in an open discussion forum that is located on "neutral terrain"—outside any therapeutic, familial, or institutional context—with the aim of communicating about and discussing the experiences and consequences of mental health problems and ways to deal with them. Topics typically include controversial issues such as coercion as well as topics of consent and cooperation such as health promotion. Trialogue groups also function as a basis and starting point for trialogic activities on different levels (e.g., serving on quality control boards) and different topics (e.g., a work group on anti-stigma interventions) and activities (e.g., trialogic training seminars for police officers). Trialogue groups can serve large parts of communities. Reaching out to all persons with a first-hand lived experience—that is a lot of people as we know from epidemiological research, to friends and family—is there anybody who is not at some point during their life?—, and people working in mental health and mental health related fields, Trialogue is really for everybody. The learning opportunities in Trialogue strengthen the communities' mental health capacities and improve mental health literacy for everybody. Communities become aware and can grow their expertise with regard to secondary and tertiary prevention for community members with mental health problems. The currently often hidden knowledge of a large part of the community—namely that of families and friends of people with mental health problems as well as the expertise of those who are dealing with or have overcome such problems in their own lives—can be shared with the wider community thereby enhancing primary prevention efforts for the benefit of all (Amering 2016).

Take Away Messages

- Recovery-orientation is here to stay. The emerging evidence base for recovery-orientation includes the urgent call for a partnership approach to psychiatric practice and service developments.
- The current WHO Mental Health Action Plan and the World Psychiatric Association's (WPA) recommendations on best practices in working with service users and family carers formulate essential suggestions for shared efforts. Data clearly show that cooperative efforts together with service users and carers offer the best chances to reduce stigma, discrimination, and social exclusion, currently seriously limiting efforts toward recovery (Gaebel et al. 2016).
- Scientific consequences of recovery-orientation include not only novel approaches to data on the long-term perspectives of people experiencing common as well as severe mental health problems, but also demand new research policies, methods, and topics around recovery and resilience.
- Current challenges essentially include the integration of different perspectives as well as different methodologies.
- Recovery policies and the human rights movement share important features and goals. A central paradigm is the need for collaborative efforts between people with a lived experience of mental health problems and services, their friends and loved ones, people, who work in the mental health field and the wider community as well as society at large.
- Recovery-oriented collaborative models of care including policy-making and system transformation efforts, practice, and evaluation of care, training, supervision, and research are supported by new rules of law, such as the UN-Convention on the Rights of Persons with Disabilities (CRPD) and the obligation to implement person-centered care in the community in a framework of empowerment, non-discrimination and citizenship.
- The necessary transformation processes bring about opportunities for changes of the role of all people involved with the vision of a new place of mental health within the health system as well as within a society striving for better mental health for all.

References

Amering, M. (2016). Trialogue: An exercise in communication between users, carers, and professional mental health workers beyond role stereotypes. In W. Gaebel, W. Rössler, & N. Sartorius (Eds.), *The stigma of mental illness—End of the story?* (pp. 581–590). Switzerland: Springer.

Amering, M., Mikus, M., & Steffen, S. (2012). Recovery in Austria: Mental health trialogue. *International Review of Psychiatry, 24*(1), 11–18.

Amering, M., & Schmolke, M. (2009). *Recovery in mental health. Reshaping scientific and clinical responsibilities*. London: Wiley-Blackwell.

Andreasen, N. C., Carpenter, W. T., Kane, J. M., Lasser, R. A., Marder, S. R., & Weinberger, D. R. (2005). Remission in schizophrenia: proposed criteria and rationale for consensus. *American Journal of Psychiatry, 162,* 441–449.

Anthony, W. (1993). Recovery from mental illness. The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16,* 11–23.

Bartlett, P. (2012). The united nations convention on the rights of persons with disabilities and mental health law. *The Modern Law Review, 75,* 752–778.

Coleman, R. (2011). *Recovery—an alien concept* (2011th ed.). UK: P & P Press.

Convention on the Rights of Persons with Disabilities, United Nations General Assembly Resolution, 13 December 2006, A/RES/61/106.

Davidson, L. (2016). The recovery movement: implications for mental health care and enabling people to participate fully in life. *Health Affairs, 35*(6), 1091–1097.

Davidson, L. (2010) PORT through a recovery lens. *Schizophrenia Bulletin 36*(1), 107–108.

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11,* 123–128.

Deegan, P. (1996). https://www.patdeegan.com/pat-deegan/lectures/conspiracy-of-hope. Retrieved June 01, 2017.

Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., et al. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophr Bull*, *36*(1), 48–70.

Gaebel, W., Rössler, W., & Sartorius, N. (Eds.). (2016). *The stigma of mental illness—End of the story?*. Switzerland: Springer.

Killackey, E., Harvey, C., Amering, M., & Herrman, H. (2015). Partnerships for meaningful community living: Rehabilitation and recovery-informed practices. In: A. Tasman, J. Kay, J. Lieberman et al. (Eds.), *Psychiatry* (4th ed., Chap. 97, pp. 1959–1982). UK: Wiley-Blackwell.

Knuf, A. (2008). Recovery: Wider den demoralisierenden Pessimismus. In *Kerbe*, S (pp. 8–11).

Lang, F. U., Kösters, M., Lang, S., Becker, T., & Jäger, M. (2013). Psychopathological long-term outcome of schizophrenia—a review. *Acta Psychiatrica Scandinavica, 127*(3), 173–182.

Lecic-Tosevski, D., Christodoulou, N., Herrman, H., Hosman, C., Jenkins, R., Newton, J., et al. (2003). WPA consensus statement on psychiatric prevention. *Dynamic Psychiatry, 36,* 307–315.

Mental Health Trialogue Network, Ireland. Retrieved October 30, 2016, from www.trialogue.co.

Moran, G. S., Russinova, Z., Gidugu, V., Yim, J. Y., & Sprague, C. (2012). Benefits and mechanisms of recovery among peer providers with psychiatric illnesses. *Qualitative Health Research, 22*(3), 304–319.

Rose, D., Thornicroft, G., & Slade, M. (2006). Who decides what evidence is? Developing a multiple perspectives paradigm in mental health. *Acta Psychiatrica Scandinavica, 113*(Suppl 429), 109–114.

Sabatello, M., & Schulze, M. (2014). *Human rights and disability advocacy*. University of Pennsylvania Press.

Schulze, M. (2010). Understanding the convention on the rights of persons with disabilities, Handicap International. http://hiproweb.org/uploads/tx_hidrtdocs/HICRPDManual2010.pdf.

SAMHSA. Recovery Support. Retrieved August 29, 2016, from www.samhsa.gov/recovery.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *Lancet, 370*(9590), 878–889.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., et al. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12–20.

Slade, M., Leamy, M., Bacon, F., Janosik, M., Le Boutillier, C., Williams, J., et al. (2012). International differences in understanding recovery: Systematic review. *Epidemiology and Psychiatric Sciences, 21*(4), 353–364.

Stratford, A., Brophy, L., Castle, D., Harvey, C., Robertson, J., Corlett, P., et al. (2016). Embedding a recovery orientation into neuroscience research: involving people with a lived experience in research activity. *Psychiatric Quarterly, 87*(1), 75–88.

U.S. Presidential Commission on Mental Health. (2003). Achieving the promise: transforming mental health care in America. Final Report. DHHS Pub N: SMA-03-3832. Rockville, Maryland: Department of Health and Human Services.

van Os, J., Burns, T., Cavallaro, R., Leucht, S., Peuskens, J., Helldin, L., et al. (2006). Standardized remission criteria in schizophrenia. *Acta Psychiatrica Scandinavica, 113,* 91–95.

Wallcraft, J. (2012). Consumer models of recovery: can they survive operationalism? *World Psychiatry, 11*(3), 166–167.

Wallcraft, J., Amering, M., Freidin, J., Davar, B., Froggatt, D., Jafri, H., et al. (2011). Partnerships for better mental health worldwide: WPA recommendations on best practices in working with service users and family carers. *World Psychiatry, 10*(3), 229–236.

Wallcraft, J., Schrank, B., & Amering, M. (2009). *Handbook of service user involvement in mental health research*. Chichester: Wiley-Blackwell.

Warner, R. (2004). Recovery from schizophrenia. Psychiatry and political economy. 3rd edn. Brunner-Routledge, New York.

WHO (2013) Mental Health Action Plan 2013–2020. Retrieved August 7, 2016, from www.who.int/mental_health/action_plan_2013/bw_version.pdf.

www.bpe-online.de/english/dorotheabuck.htm Retrieved October 30, 2016.

Chapter 11
Promoting Social and Emotional Wellbeing and Responding to Mental Health Problems in Schools

Katherine Weare

11.1 Introduction, History and Context

11.1.1 A New Focus on Wellbeing

There is a new emphasis on the positive in approaches to human development. It is discernible in the increasingly widespread use of terms such as ‘positive psychology’, ‘positive mental health’, ‘thriving’ and ‘flourishing’. This shift recognises that the focus of enquiry has for too long concentrated almost entirely on what is wrong with people by way of their problems and suffering, rather than also exploring the strengths and resilience that can help us address these challenges, including and particularly mental health difficulties.

There is increasing emphasis on the expanding role of schools, away from a narrow focus on academic learning only, to help people experience health and wellbeing, and to thrive and flourish. Terms in current use include ‘pro-sociability’, ‘connectedness’, ‘emotional intelligence’, ‘character’, ‘values’, ‘social and emotional skills’, ‘personal and social learning’, ‘non cognitive/soft skills’, ‘lifeskills’, ‘sense of coherence’ and ‘happiness’. Research is establishing a clear link between this agenda and all kinds of health and behavioural outcomes, including career success and academic attainment.

K. Weare (✉)
University of Southampton, University of Exeter, Woodcombe Farmhouse,
Woodcombe, Minehead, Somerset TA24 8SB, UK
e-mail: skw@soton.ac.uk

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_11

11.1.2 Mental Health and Young People

A focus on wellbeing must not ignore the reality of the serious mental health problems, which so mar human life. In 2007, The Lancet Series on Global Mental Health drew together leading experts around the world to highlight the extent of mental health needs and the gaps in mental health services worldwide, and to formulate a clear call to action (Lancet 2007). The linked papers in the series concluded that globally mental health problems, such as depression, anxiety, bipolar affective disorders, alcohol and substance abuse, self-inflicted injuries, suicide, schizophrenia and post-traumatic stress disorder, form a '*hidden epidemic'* and "*a substantial proportion of the world's disease burden"* including for the young. They suggested that such disorders are "*deeply stigmatised across our societies*" and "*often neglected, especially in low and middle-income countries, many of which have no resources to tackle mental health concerns*" (Lancet 2007). Most mental disorders in the adult population begin between 12–24 years of age (Hagell et al. 2013), so it is vital to take a preventive attitude and look to all agencies, to act, particularly schools which are found in all parts of the world, including those with low levels of mental health service.

Getting an overview of the epidemiology of the mental health problems worldwide is tricky as research is almost non-existent in some countries, and there is no internationally agreed benchmark. An overview paper in *the Lancet* series by Patel et al. (2007) found national estimates of mental disorders ranged from 8%, in the Netherlands, 14% in Australia to 57% in San Diego, California, USA. The authors concluded that overall, in developed countries, at least, one out of every four to five young people in the general population will suffer from at least one mental disorder in any given year. They were unable to give any clear picture for developing countries, due to lack of data.

Low levels of wellbeing and mental health disorders underlie many of the social and educational problems young people experience across the world, including anti-social behaviour, crime and violence, educational failure and substance abuse (Catalano et al. 2002). Addressing young people's mental health needs is crucial if they are to fulfil their potential and contribute fully to the development of their communities. Given the massive shortfall between need and provision, the school has a vital potential role to play in all countries and circumstances in bridging this gap.

11.1.3 Tackling Social Risk Factors as Well as Building Resilience

Mental health and wellbeing are not individual matters: everywhere children and young people are exposed to range of social factors which support or undermine their wellbeing and mental health. This is particularly the case in low income countries, where sadly the ability to respond is likely to be far weaker than in more affluent nations (Patel et al. 2007).

Those who are most at risk include those from disadvantaged groups and from families under stress, through problems such as poverty or social marginalisation, one parent or divided families, or where parents suffer from mental illness. Some young people will experience traumatic events such as abuse, violence, accidents and injuries. Migration, asylum seeking, war, conflict and natural disasters inevitably take their toll, often on whole populations. Gender is often an issue, girls and women are particularly vulnerable, especially in more traditional societies. In all parts of the world, young people who identify as different to the mainstream, being lesbian, gay, bisexual or and trans for example are very likely to have their mental health compromised through stigma and discrimination (Almeida et al. 2009): schools could do a good deal more to improve the climate for the acceptance of differences in sexuality and sexual orientation (Russell and McGuire 2010).

Schools can be seriously challenged in their ability to respond to these levels of overwhelming need, which they often find hard to perceive, identify and understand. Those who work in schools need to inform themselves of the needs of the groups they serve, understanding to recognise the reality of social risk is not a recipe for fatalism, but a call to action in helping reduce risk factors by actively tackling disadvantage, and the resultant stigma and prejudice inevitably accompany it. Rather than going for a ‘one size fits all’ approach, schools need energetically to take account of the stresses and disadvantages their students arrive with, provide an energetic, tailored and non-discriminatory response, and show non-judgmental understanding and concern to their students and their families and the pressures they are under. Some risk factors are in school’s province to reduce, such as low achievement, which is a known link with problems such as drug use, teenage pregnancy, behaviour problems and crime (Rutter et al. 1998).

Schools can also help to build a protective sense of ‘resilience’ which can, partially at least, help some young people and social groups and communities have the inner strength and skills to face their disadvantage and risk (DfE 2014a). Resilience refers to the ability to continue to develop in difficult circumstances, to face, overcome and ultimately be strengthened by, life’s adversities and challenges. It can be fostered by the school experience: for example, having a ‘sense of connectedness’ with school is a recognised protective factor for improved mental health, while helping students develop their social and emotional skills and capacities has a direct impact on their ability to face difficulties (Catalano et al. 2002). The intervention of an effective school can be the turning point for children with few other supports (Gross 2008). Building resilience is a school wide activity, and the approaches and principles that follow in this chapter can all help children and young people to rise above their circumstances and start to thrive.

11.1.4 Building on the Developing Evidence for School-Based Approaches

In many countries, in affluent nations at least, schools are increasingly taking seriously their role in promoting wellbeing and tackling mental health issues. The last thirty years has seen an exponential growth in programmes and interventions in schools in many parts of the developed world, under a wide range of overlapping and related titles. This field has been the focus of a considerable amount of evaluation, including by randomised control trials, and there have been over 50 comprehensive reviews and meta-analyses (Weare and Nind 2011).

Taken together, well-conducted reviews undertaken in developed countries demonstrate that there is a solid group of evidenced-based approaches, programmes and interventions. These, when well implemented, show repeated and clear evidence of positive impacts on a range of outcomes including academic learning (Zins et al. 2004), teacher/staff wellbeing (Greenberg and Jennings 2009, student wellbeing (Adi et al. 2007), the development of the social and emotional skills and attitudes that promote wellbeing and success in school and throughout life (Durlak et al. 2011), the prevention and reduction of mental health problems (Shucksmith et al. 2007) and the improvement of difficult and risky behavior (Catalano et al. 2002).

This research emanates almost entirely from the developed world: its findings may well be of value in the context of developing countries, where there is currently much less known about the levels of need and the state of wellbeing and mental health of the young, or how to best address these issues. There is a need for caution, however, in simply assuming that approaches that fit the individualised cultures and ways of developed countries will be applicable in the settings of more traditional societies, where approaches based on the family and community may well work better. There is a long way to go in fully understanding the role and potential of the school in promoting wellbeing in different societies.

11.2 Current Status/Data: ‘What do we Know Works?

11.2.1 Start with a Positive and Universal Focus on Wellbeing

This chapter already talked about the expansion of the role of school into positive approaches, those that focus on wellbeing, not just on problems. It follows that a key starting point for the school is a positive broad-based focus, which emphasises strengths and capacities. A positive approach has been shown to be more effective than approaches that focus only on mental ill-health, problems and weaknesses (Greenberg et al. 2001). The impact of interventions has routinely proved to be significantly greater in higher risk children, but to be optimally effective they also need a solid foundation of universal approaches for all on which specialist interventions can build (Weare and Nind 2011). Without that universal base, specialist interventions can stigmatise rather than help. Positive, universal, approaches develop a culture in which talking about mental health, emotions and feelings is the norm, where it is acceptable to acknowledge difficulties and ask for help, where extra input to those with more serious problems can be provided in a coherent and non-stigmatising way, and where the whole school population has the skills and attitudes to support those with greater needs (Greenberg and Jennings 2009).

11.2.2 Take a Whole School Approach—and Implement it Carefully

So called ‘whole school’, ‘comprehensive’ or ‘multi-component’ approaches are more effective than those which focus on only one or two parts of school life (Catalano et al. 2002). Wellbeing and mental health involve everyone who works and learns in the school, and in the surrounding community, working together in a joined up, coherent way.

Whole school approaches are not easy to realise effectively, and need careful implementation (Lendrum et al. 2013) They need to be developed incrementally, starting small and proceeding strategically with strong and committed leadership, staff training, evaluation and monitoring, clarity and programme fidelity (Durlak et al. 2011). Without this whole school approaches can become chaotic, diluted and fragmented.

11.2.3 Promote the Wellbeing of School Personnel and Tackle their Stress

In contexts where research has been carried out, school personnel are reporting high levels of stress, anxiety and depression at work (NUT 2013). The adult personnel who work in school are in the front line of this work, and it is hard for them to be motivated to promote the mental health of others if they feel uncared for and burnt out themselves.

Schools do well to carry out regular reviews of the levels of stress their staff are under. Schools can help reduce stress and build a greater sense of control through professional development, mentoring and counselling for their staff, to develop key stress reduction skills such as self-efficacy, and resilience (Weare 2014). Adult personnel need to be able to seek support and help for their mental health without fear of stigma. In some schools, particularly in high achieving societies, a culture of overwork, particularly at senior management levels, generates a sense of driven-ness, isolation and not taking time to celebrate and reward achievement and effort. Schools need to ensure those who work there are encouraged to make realistic demands on themselves, and achieve a sound work–life balance.

11.2.4 Develop a Supportive School and Classroom Climate and Ethos

A climate and ethos which supports wellbeing and learning is one which builds school ‘connectedness’ (Millings et al. 2012), which refers to a feeling of feeling bonded to the school environment. Connected schools and classrooms have low levels of conflict and disruptive behaviour, appropriate expressions of emotion, respectful communication and problem-solving, a sense of warmth, supportiveness and responsiveness to students’ individual needs (Greenberg and Jennings 2009). They are environments where everyone feels listened to, understood and empowered.

11.2.5 Provide Clear Boundaries and Robust Policies

Supportive school climates include a sense of strong and positive discipline and boundaries, with clear and high expectations. Particularly key are the school’s policies and practice around diversity, and the challenging of prejudice around ability, disability, gender, race, sexual orientation and perceived social status (National Healthy Schools Programme 2006). Anti-bullying and homophobia policies and practice usually need to be strengthened. Schools could usefully engage in specific work around attitudes towards those with mental health problems, addressing prejudice, stigma and the use of language. Everyone needs to know what is acceptable and unacceptable behaviour and consequences, with a consistent and proportionate response (DfE 2014b).

11.2.6 Understand the Causes of Behaviour

Poor behaviour is a problem in many schools. Responses which focus on the negative, which see the behaviour in isolation or where adults take challenges personally or see poor behaviour as always intentional and under the student’s control can make things worse (Green et al. 2005). Appropriate responses both provide logical and proportionate consequences for poor behaviour and also look more deeply to see the whole child behind the behaviour, focus on their positive characteristics, and understand and address the underlying meanings and feelings the behaviour represents. They recognise that behaviour may stem from previously undisclosed causes, such as an unmet mental health, bullying, issues in the home, or medical or learning difficulties, all of which can be addressed. Poor behaviour and difficult incidents can be seen as golden opportunities to teach better alternatives (Luiselli 2005) with adults modelling the skills and attitudes they wish to impart. Staying open minded, calm and reflective help adults not take challenges personally, and better manage the associated emotional stress in themselves and remain in professional mode (Boyatzis 2005).

11.2.7 Teach Social and Emotional Skills

Social and emotional skills help young people build some resilience to risk and disadvantage, negotiate the challenges of growing up and making transitions, and act as protective factors by helping prevent the development of mental health problems and risky behaviour (Catalano et al. 2002). They are directly connected with learning, and lead to increased school attainment and completion, less involvement in the criminal justice system, lower costs to public services, higher earning potential and resilience for life (Zins et al. 2004). They are also demonstrably linked with adult wellbeing and effectiveness (Jennings and Greenberg 2009).

Schools have key roles in explicitly teaching key skills, such as self-awareness, emotional regulation, motivation, social skills and empathy, and the accompanying attitudes and values that lie at the heart of emotional and social wellbeing. These skills provide confidence, competence and the ability to engage. This involves the school taking a conscious, planned and explicit approach through the taught curriculum, supported by the rest of the school experience, and underpinned by complementary work in teacher skill development. Although the skills are ultimately generic and universal, they need to be applied in particular contexts, and attention needs to be paid to how they relate to social and cultural differences, and the various types of need, norms, values and forms of expression found in the student population. Care needs to be taken to ensure the skills learned are seen as relevant by the students, their families and their communities, to the real life challenges they face.

There is considerable knowledge on how those skills are best transmitted. SEL (social and emotional learning) needs to be taught by well-trained teachers who grasp the relevance of social and emotional skills for themselves and their students. Learning needs to be experiential and stimulating if it is to reach hearts as well as minds, and impact on attitudes, values and feelings (Browne et al. 2004). Fear, behaviour change and information are not effective motivators to achieve changes at any kind of deep or long-term level (Merry et al. 2004). Social and emotional skills only start to have real impact on school environments, and on school learning, when they are reinforced in all interactions across the school (Diekstra 2008).

11.2.8 Respond Actively to Problems and Difficulties

There needs to be proactive additional work on targeted approaches for higher risk students, with whom interventions are likely to have their most dramatic impacts. Schools need to have a clear awareness of the extent and nature of levels of risk, disadvantage and the consequent mental health problems in children and young people. They need to recognise their responsibility to be part of the response, not least because these problems do not go away: half of lifetime mental illness starts by the age of 14 (Hagell et al. 2013).

In developed countries, it has been estimated that one in ten children and young people have a clinically diagnosed mental health disorder and/or emotional and behaviour problems (often the same children) and around one in seven has less severe problems that interfere with their development and learning. Many problems are multiple and many remain undetected by anyone, and thus will go untreated unless agencies such as schools take an active role in attempting to identify and respond to students' difficulties.

Children and young people with greater mental health need to be taught the same core skills as the mainstream, but in more targeted, intensive, extensive and explicit ways. They may well benefit from working in a small therapeutic group on a particular skill or theme. Such targeted and skills-based work has been shown to impact clearly on the familiar mental health problems of youth, especially when taught in small groups (Shucksmith et al. 2007).

There are many evidence-based targeted programmes to choose from (CASEL 2016) and effective approaches often have the same basic mixture of cognitive behavior therapy (helping students to reshape their thinking, learn skills and alter behaviors), better classroom management, and support for parents: it appears not to matter a great deal which one is chosen, provided it is of good quality, fits the context and is implemented with conviction (Shucksmith et al. 2007).

11.2.9 Promote Student Participation

Student participation can help all students build a protective sense of school connection, take responsibility for and improve their own learning and development through reflection and inquiry, enhance their sense of self-efficacy, develop their social skills and help them feel that they have a stake in school life. Schools need to resist the urge to involve and listen to only the most motivated and able, when it is young people who are struggling or at the margins who may be the most important to involve and consult.

Peer education empowers young people to work together, drawing on the positive strength of the peer group. By means of appropriate training and support, young people can become active players in the educational process rather than passive recipients. Students have been shown to be effective peer educators in teaching social and emotional skills: there has been particularly success with buddying and conflict resolution (Rones and Hoagwood 2000).

11.2.10 Involve Parents, Families and Communities

Work with parents, families and communities can add strength and depth to efforts to promote wellbeing, help young people experience a sense of coherence across their lives and feel genuine sense of, well rooted, belonging which is highly protective for mental health. The importance of links between home and school has been consistently promoted, for example by the World Health Organisation with its international network of Health Promoting Schools (WHO 2016). However, at present the empirical evidence comes from small pockets of activity in some developed countries: in much of the world there is no clear activity or strategy at all for relating home and school.

Schools can help encourage a sense of pride and cohesion which can promote the wellbeing of the whole community. Schools can strengthen family life through helping parents and carers develop their own parenting skills and attitudes (Adi et al.2007). The involvement of school with home is, however, a sensitive area. It is important that a rift does not develop between the culture of the school and the home, and that parents and carers do not feel patronised, stigmatised and blamed for their children's difficulties, and that schools look for strengths in families and try to build on them. This can encourage parents, who may themselves have had a poor experience of school life, to feel accepted and welcome.

In the vital early identification of students with difficulties, parental input is invaluable: it is often their expressed concerns that are the first sign that something is amiss. Parents should then find that their views, wishes and feelings are taken into account by the school, so they can participate in decisions taken about their children, with information and support.

11.2.11 Take a Long-Term Approach

Schools often do not provide interventions that are intense or lengthy enough to make a long-term difference. Single brief interventions, and 'one offs', have never been shown to make any sustained impact. Some short interventions lasting for 6–10 weeks have sometimes been shown to be effective for promoting some aspects of wellbeing, such as social skills, emotional control and milder versions of problems such as conflict and anxiety. More intense interventions, with more sessions per week, generally work better than more diluted ones (Garrard and Lipsey 2007). However, the overwhelming evidence is that interventions generally need substantial time and regular practice to produce benefits, on average at least 9 months to a year, especially for deeper and broader areas such as wellbeing, improving behaviour and in response to more severe problems such as violence and bullying, anger and preventing mental disorders (Weare and Nind 2011). Early intensive intervention followed by regular revisiting of core learning in a developmentally appropriate way, and with booster/top up sessions with older students would appear to be the optimum approach (Browne et al. 2004).

11.2.12 Identify Difficulties and Intervene Early

Early identification and prompt help ensure that problems can be resolved with the least fuss and disruption (Browne et al. 2004): the most effective interventions are those that target preschool and early primary years (Greenberg et al. 2001). Schools often wait too long before taking action, sometimes from an understandable wish not to 'label', but based on a misguided belief that children 'grow out' of these problems: the opposite is usually the case (DfE 2014a). Simple, low key, early intervention measures can prevent minor mental health problems from escalating and becoming of clinical significance.

Teachers need to be clear about their responsibility for identifying students in difficulty and spotting the early signs of mental health problems. Class teachers are well placed to spot changes in behaviour, patterns of attainment or attendance which may suggest a problem, and it is helpful to keep and monitor reliable data on this.

In supporting students identified as having difficulties there needs to be a graduated approach to provide appropriate help with a clear pathway, systems and processes for making decisions, to provide support within the school and from outside services. In the developed world, where supportive agencies such as school counselling, school-based clinics, psychology, and child and adolescent psychiatry exist, schools should work closely with other professionals to have a range of support services in place in and linked to schools, and ensure easy and transparent pathways to such services. All students, and their parents, need to be encouraged to seek and receive appropriate specialist help, and it may be that some groups, such as girls and ethnic minorities, find this more of a challenge and need affirmative action (Thomas et al. 2011). It is important to smooth pathways, by ensuring that any commissioned counselling or mental health services are fully integrated into the policies, procedures and referral processes of the school. The young person, and their family, should feel at the centre of the process, experiencing co-ordinated, wrap around response and care that is responsive to their needs and culture.

11.2.13 Summary and Conclusions: Mental Health and Wellbeing are Central to Schools

To summarise, work in developing countries on the role of the school in promoting wellbeing and tackling mental health issues is giving rise to some clear evidence-based principles on ‘what works’. These principles may have relevance in the context of developing countries too, although they should be applied with caution in what may be very different contexts.

Schools need use a ‘whole school approach’, provide a base of universal work to promote wellbeing of all staff and students, and ensure a supportive school and classroom climate and ethos. Schools need to encourage student participation and engage positively and easily with parents, families and communities from all the cultures and groups in their population. Programmes and interventions need to be properly implemented, start early and carry on for the long term, and both address the social risk factors that undermine mental health while helping students to develop the resilience to resist adverse circumstances, and tackle stigma and prejudice. Young people and adults need to be taught the social and emotional skills that underpin wellbeing and promote mental health. There needs to be robust and clear processes to identify, refer and treat those with greater levels of difficulty, with close liaison with and easy pathways to specialist services, where they exist.

Schools can feel confident that a focus on wellbeing and mental health not only enables them to provide healthy and happy school environments for students and staff, and nurture and develop the skills, character and values of tomorrow’s citizens, it also directly supports their more immediate mission, the promotion of effective learning. Mental health and wellbeing is at the heart of the effective school.

Take Away Messages

Useful Websites

- CASEL, Collaborative for Academic, Social and Emotional Learning. http://www.casel.org/
- ENSEC, European Network for Social and Emotional Competence http://enseceurope.org/
- Mental Health Australia https://mhaustralia.org/tags/young-people
- Mental Health Europe http://www.mhe-sme.org/
- Mental Health Foundation https://www.mentalhealth.org.uk/
- SAMSHA (substance abuse and mental health services administration) http://www.samhsa.gov/
- Schools for Health in Europe http://www.schools-for-health.eu/she-network
- World Health Organisation/Mental Health http://www.who.int/mental_health/en/

- World Health Organisation/Global Schools Health Initiative http://www.who.int/school_youth_health/gshi/en/
- Young Minds http://www.youngminds.org.uk/

References

Adi, Y., Killoran, A., Janmohamed, K., & Stewart-Brown, S. (2007). *systematic review of the effectiveness of interventions to promotion mental wellbeing in primary schools*. London: National Institute for Clinical Excellence.

Almeida, J., Johnson, R. M., & Corliss, H. L. (2009). Emotional distress among LGBT youth: The influence of perceived discrimination based on sexual orientation. *Journal of Youth Adolescence, 38*(7), 1001–1014.

Boyatzis, R. (2005). *Resonant leadership*. Boston: Harvard Business School.

Browne, G., Gafni, A., Roberts, J., Byrne, C., & Majumdar, G. (2004). Effective/efficient mental health programs for school-age children: A synthesis of reviews. *Social Science and Medicine, 58*(7), 1367–1384.

CASEL. (2016). CASEL program guides: Effective social and emotional learning programs. Retrieved August 1, 2016, from http://www.casel.org/guide/.

Catalano, R., Berglund, M.L., Ryan, G.A.M., Lonczak, H.S., & Hawkins, J.D. (2002). Positive youth development in the United States: Research findings on evaluations of positive youth development programs. *Prevention and Treatment*, 5, Article 15.

DfE. (Department for Education). (2014a). *Mental health and behaviour in schools: Advice for school staff*. London: Department for Education. Retrieved August 1, 2016, from https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools–2.

DfE. (Department for Education). (2014b). *Behaviour and discipline in schools: Advice for headteachers*. London: Department for Education. Retrieved August 1, 2016, fromhttps://www.gov.uk/government/uploads/system/uploads/attachment_data/file/353921/Behaviour_and_Discipline_in_Schools_-_A_guide_for_headteachers_and_school_staff.pdf.

Diekstra, R. (2008). Effectiveness of school-based social and emotional education programmes worldwide. In *Social and emotional education: An international analysis. fundacion botin report 2013* (pp. 255–284). Santander: Fundacion Marcelino Botin. Retrieved August 1, 2016, from http://www.fundacionbotin.org/89dguuytdfr276ed_uploads/EDUCACION/ANALISIS%20INTERNACIONAL/Full_Report_EN_2013.pdf.

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82,* 474–501.

Garrard, W., & Lipsey, M. (2007). Conflict resolution education and anti-social behavior in US schools. *A Meta-Analysis. Conflict Resolution Quarterly, 25*(1), 9–37.

Green, J., Howes, F., Waters, E., Maher, E., & Oberklaid, F. (2005). Promoting the social and emotional health of primary school aged children: Reviewing the evidence base for school based interventions. *International Journal of Mental Health Promotion, 7*(3), 30–36.

Greenberg, M.T., Domitrovich, C., & Bumbarger, B. (2001). Preventing mental disorders in school aged children. A review of the effectiveness of prevention programmes. Prevention Research Center for the Promotion of Human Development, College of Health and Human Development Pennsylvania State University. Retrieved August 1, 2016, from http://scripts.cac.psu.edu/dept/prevention/CMHS.PDF.

Greenberg, M., & Jennings, T. (2009). The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. *Review of Educational Research, 79*(1), 491–525.

Gross, J. (2008). *Getting in early*. London: Smith Institute and the Centre for Social Justice.

Hagell, A., Coleman, J., & Brooks, F. (2013). *Key data on adolescence*. London: Public Health England.

Lendrum, A., Humphrey, N., & Wigelsworth, M. (2013). Social and emotional aspects of learning (SEAL) for secondary schools: Implementation difficulties and their implications for school-based mental health promotion. *Child and Adolescent Mental Health, 18*(3), 158–164.

Luiselli, L., Putnam, R., Handler, M., & Feinberg, A. (2005). Whole-school positive behaviour support: effects on student discipline problems and academic performance. *Educational Psychology., 25*(2–3), 183–198.

Merry, S.N., McDowell, H.H., Hetrick, S.E., Bir, J.J., Muller, N. (2004). *Psychological and/or educational interventions for the prevention of depression in children and adolescents. Cochrane Database of Systematic Reviews, Issue 2.* Art. no: CD003380.

Millings, A., Buck, R., Montgomery, A., Spears, M., & Stallard, P. (2012). School connectedness, peer attachment, and self-esteem as predictors of adolescent depression. *Journal of Adolescence., 35*(4), 1061–1067.

National Healthy Schools Programme. (2006). Guidance for Schools on Developing Emotional Health and Wellbeing. Retrieved August 1, 2016, from http://www.healthyschoolslondon.org.uk/sites/default/files/EHWB.pdf.

NUT (National Union of Teachers). (2013). *Tackling teacher stress.* Retrieved August 1, 2016, from http://www.teachers.org.uk/node/12562.

Patel, V., Flisher, A.J., Hetrick, S., McGorry, P. (2007). Mental health of young people: a global public-health challenge. *The Lancet*. 369 (91569), 1302–1313.

Rones, M., & Hoagwood, K. (2000). School-based mental health services: a research review. *Clinical Child and Family Psychological review., 3*(4), 223–241.

Rutter, M., Hagel, A., & Giller, H. (1998). *Anti-social behaviour and young people*. Cambridge: Cambridge University Press.

Stephen, T., Russell, S. T., & McGuire, J. K. (2010). The school climate for lesbian, gay, bisexual, and transgender (LGBT) students. In M. Shinn & H. Yoshikawa (Eds.), *Towards positive youth development: transforming school and community programs* (pp. 133–149). New York: Oxford University Press.

Shucksmith, J., Summerbell, C., Jones, S., & Whittaker, V. (2007). *Mental wellbeing of children in primary education (targeted/indicated activities)*. London: National Institute of Clinical Excellence.

The Lancet. (2007). Global mental health, 2007. *The Lancet*. Retrieved August 1, 2016, from http://www.thelancet.com/series/global-mental-health.

Thomas, J. F., Temple, J. R., Perez, N., & Rupp, R. (2011). Ethnic and gender disparities in needed adolescent mental health care. *Journal of Health Care for the Poor and Underserved, 22*(1), 101–110.

Verhulst, F. C., Achenbach, T. M., van der Ende, J., Erol, N., Lambert, M. L., Leung, P. W. L., et al. (2003). Comparisons of problems reported by youths from seven countries. *American Journal of Psychiatry, 160,* 1479–1485.

Weare, K., & Nind, M. (2011). Mental health promotion and problem prevention in schools: What does the evidence say? *Health Promotion International, 26*(S1), 26–69.

Weare, K. (2014). *The evidence for mindfulness:* Impacts *on the wellbeing and performance of school staff.* Retrieved August 1, 2016, from http://mindfulnessinschools.org/research/research-mindfulness-adults-education/.

World Health Organisation. (2016). *Global school health initiative*. Retrieved August 1, 2016, from http://www.who.int/school_youth_health/gshi/en/.

Zins, J., Weissberg, R., Walberg, H., Zins, J. R., Weissberg, M. Wang, & Walberg, H. (2004). *Building academic success on social and emotional learning: What does the research say?*. New York: Teachers College Press.

Chapter 12
Universal Mental Health Promotion and Prevention Programs for Students

Colleen S. Conley and Joseph A. Durlak

12.1 Introduction: The Need for Universal Prevention

Half of all mental disorders start by age 14 (Kessler et al. 2005). Mental health needs are a growing concern for youth across the globe, yet the majority of youth with adjustment problems do not receive appropriate services (e.g., Kovess et al. 2015; Lund et al. 2010; Saxena et al. 2007; WHO 2005). A recent report by a consortium of global researchers, advocates and clinicians calls for improving youth's access to mental health care globally, especially in low- and middle-income countries (Collins et al. 2011). Universal mental health prevention and promotion programs (MHPPPs) target all youth, regardless of risk factors or warning signs. From a public health perspective such programs are essential for improving mental health and reducing the future incidence and prevalence of adjustment problems. Further, they reduce the possible stigmatization that occurs when only some are identified and targeted for intervention.

There are three primary reasons why schools are an ideal context for delivering MHPPPs. First, schools generally provide access to broad populations, as needed for universal prevention. Second, as noted by the World Health Organization (WHO 2004) schools are "the primary institution for socialization in many societies" (p. 30) and such socialization can extend beyond academic content into social and community realms as well. Third, students spend considerable time at school, in an environment that is geared toward learning, and thus schools offer repeated opportunities for students to learn and apply adaptive skills with peers and adults.

To appear in: *Global Mental Health: Prevention and Promotion.*

C.S. Conley (✉) · J.A. Durlak
Loyola University Chicago, 1032 W. Sheridan Road, Chicago, IL 60660, USA
e-mail: cconley@luc.edu

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_12

12.2 History and Overview of MHPPPs

Prevention in mental health has over a 100-year history (WHO 2004). In the United States, administrators in charge of the first mental health services believed that children were at risk for later problems and that their upbringing and education should receive prime attention (for a discussion, see Durlak 1997). In 1924, the League of Nations endorsed the Declaration of the Rights of the Child (League of Nations 1924), which laid the groundwork for the United Nations' Convention on the Rights of the Child, a human rights treaty that emphasizes children's right to "social, spiritual and moral well-being and physical and mental health" (Article 17), noting that the focus of education should include "the development of the child's personality, talents and mental and physical abilities to their fullest potential" (Article 29) and that governments have a responsibility to "undertake all appropriate legislative, administrative, and other measures for the implementation of the[se] rights" (Article 4) (The United Nations 1989). A few years later, WHO developed a model framework for promoting mental health in schools worldwide (Hendren et al. 1994) and since then, the international organization has developed numerous reports and policy documents to stimulate MHPP around the world (see Additional Resources, below). A decade later, the United Nations Educational, Scientific and Cultural Organization (UNESCO), through the International Bureau of Education, articulated the importance of teaching students social-emotional skills "in every school, worldwide" (Elias 2003, p. 3). Translating these ideals into practice, in the last few decades scholars and practitioners of prevention science and school mental health promotion have proliferated and evaluated a vast array of theories, conceptual frameworks, and programs in student MHPP (e.g., Matjasko et al. 2012; Stephan et al. 2015; Weist and Murray 2008; Wigglesworth et al. 2016), in two general arenas:

- **Promotion programs** focus on enhancing the positive side of adjustment, that is, developing skills, competencies, resources, and environmental supports that help youth meet developmental challenges and that will lead to subsequent intrapersonal, interpersonal, and academic success (e.g., CASEL 2016). These programs also might be called character education, life skills education, emotional intelligence, positive youth development, or social and emotional learning (SEL).
- **Prevention programs** aim to reduce the incidence of certain specific problems, such as conduct problems, anxiety, depression, or drug use, and are usually labeled in terms of what problem they target.

In practice, there is considerable overlap across many promotion and prevention programs. For example, there are many promotion programs that have been able not only to increase the skills and resources of young people but also to reduce future problems (i.e., these programs both promote *and* prevent). Similarly, many successful prevention programs emphasize the development of various skills and resources as a way to preclude future problems (i.e., these programs *prevent by promoting*). Nevertheless, school-based MHPPPs include a great variety of interventions that vary in timing, duration, the number and type of components they contain, and their specific theoretical and conceptual basis. For example, although most MHPPPs intervene directly in some way with students, usually through classroom-wide interventions, others also involve parents or community members, or take a broad ecological approach and try to improve the climate and organizational practices of the school.

12.3 Current Status and Impact of MHPPPs

Many MHPPPs have demonstrated their effectiveness across a great range of student populations, settings, and program goals. There now have been many systematic reviews and meta-analyses, involving over a thousand controlled studies and hundreds of thousands of participants, indicating that students in MHPPPs demonstrate significantly greater improvement than controls on a range of outcomes (Durlak 1997; Durlak et al. 2011; Matjasko et al. 2012). In the largest project of its kind, Weare and Nind (2011) summarized the outcomes from 46 narrative reviews and meta-analyses of universal MHPPPs for elementary and secondary students around the world, with "clear and repeated evidence of positive impact" (p. i163) and very few indications of adverse effects. More recently, Sancassiani and colleagues (2015) reviewed 22 school-based randomized controlled trials of MHPPPs from countries spanning the globe, and found "promising outcomes that are relatively far-reaching for children and youth wellbeing" (p. 21).

The above reviews and meta-analyses indicate that many important aspects of student adjustment have been affected by MHPPPs, including improvements in academic achievement, school bonding, self-perceptions, positive social behaviors, relationships with peers and teachers, and reductions in school dropouts, depression, drug use, aggression, bullying, and other conduct problems. Not all of these outcomes are achieved in every program and not every program has been equally effective, but the overwhelming evidence indicates that MHPPPs are a viable and evidence-based approach for improving positive aspects of student adjustment and reducing the future likelihood of several adjustment difficulties.

Although most research has been conducted in primary and secondary school settings, MHPPPs also have been found to be effective for postsecondary students. Meta-analytic reviews have demonstrated the success of MHPPPs for preventing a variety of mental health and behavioral problems in higher education students, including alcohol use (Scott-Sheldon et al. 2014), smoking (Rodgers 2012), body image and eating disorders (Yager and O'Dea 2008), sexual assault (Vladutiu et al. 2011), and general mental health (Conley et al. 2015, 2016). The latter two meta-analyses included universal interventions from around the world, finding overall effectiveness for both technology-delivered (Conley et al. 2016) and face-to-face (Conley et al. 2015) interventions, which did not vary based on the country in which the programs operated.

Effects by demographic and socioeconomic characteristics. Research suggests that MHPPPs can be beneficial for a variety of students, across demographic and socioeconomic characteristics. Given evidence of gender differences in social and emotional experiences, skills, behaviors, and processes (e.g., Rose and Rudolph 2006), it is important to examine the differential impact of MHPPPs by gender. One recent Australian study demonstrated gender differences in all four areas assessed—social-emotional well-being, problem behaviors, social-emotional competence, and social skills—both before and after an SEL intervention, but gender-by-time analysis revealed that the MHPPP was equally effective for boys and girls (Ashdown and Bernard 2012). Although possible gender effects should always be examined, most evidence indicates neither gender nor age has been consistently associated with differential outcomes. In sum, overall MHPPPs appear to be equally successful for males and females, members of various ethnic minority groups, and students from lower and upper socioeconomic classes (Domitrovich et al. 2017); further, students at all educational levels, from preschool (Bierman and Motamedi 2015) through higher education (Conley 2015), have benefited.

Long-term effects. Data also are accumulating on the beneficial long-term effects and the cost-effectiveness of some types of MHPPPs. For example, Taylor and colleagues (2017) reviewed SEL programs, which involve efforts devoted to enhancing student skills in five areas: self-awareness, self-management, social awareness (e.g., empathy and perspective-taking), interpersonal relationships, and responsible decision-making (e.g., relating to ethical and safe behaviors). The authors found that the effects of SEL programs on multiple outcomes were durable over follow-up periods ranging from 1.3 to 3.8 years depending on the particular outcome, and long-term effects were highest for measures of academic achievement.

Cost-effectiveness. Cost analyses also are beginning to appear on the positive impact of MHPPPs. Belfield and colleagues (2015) conducted a detailed economic cost analysis of seven commonly used SEL programs and found these interventions were each cost-effective and collectively returned $11 (US dollars) in benefits for each $1 in costs. Furthermore, MHPPPs can be highly cost-effective if they can influence certain important developmental outcomes. For example, the lifetime monetary benefits of achieving positive outcomes such as high school or college graduation are considerable (i.e., in US dollars, these benefits are $367,702 and $1,138,054, respectively, *for each graduating student*). Preventing the occurrence of negative outcomes such as the diagnosis of a *single* conduct disorder or a single arrest in the United States can reduce the costs to society by $3,950,000 and $175,702, respectively. Notably, there are now follow-up data indicating that SEL programs can significantly modify each of the above outcomes, leading to substantial benefits for participating students and reduced costs for society (Taylor et al. in press). Studies that have included such data are still in the minority and the financial savings and benefits will vary depending on the country in which intervention occurs. Nevertheless, examples from some programs suggest the substantial benefits that can accrue to youth and society in general through successful intervention.

Characteristics of effective programs. Analysis has suggested ten characteristics that are associated with many effective MHPPPs. Each individual program may not reflect all ten of these features but across several bodies of literature successful MHPPPs tend to:

- be theory-based
- recognize that multiple risk and protective factors influence adjustment
- emphasize skill development and behavior change
- promote various mental health competencies
- be well-timed
- use program materials and intervention techniques that are appropriate for the developmental status of the target population
- stress the importance of quality implementation
- be tailored as needed for the target population and setting
- be realistic about their effects
- be carefully evaluated

(for further details see Durlak 2014). Notably, these characteristics were derived from a conceptual overview of MHPP research and need empirical confirmation.

Global efforts for student MHPP. While mental health promotion efforts have proliferated in industrialized, high-income countries, these efforts have lagged behind in countries that struggle with poverty, socio-political instability, human rights violations, and civil unrest, where schools struggle to meet basic literacy and numeracy standards, let alone mental health needs of students (Kutcher et al. 2015; WHO 2009). However, current reviews that have compared SEL programs developed in one country and evaluated in another generally support the notion that the country in which the program is offered is not a significant factor (Sklad et al. 2012; Taylor et al. in press). Although the majority of research and programs for promoting student mental health are based in North America, Europe, and Australia, there are emerging MHPP efforts on both the policy and practice front, in countries spanning all six inhabited continents.

- In **North America**, the U.S. Collaborative for Academic, Social, and Emotional Learning (CASEL) provides a wealth of resources for MHPP research, practice, and policy (casel.org; see Additional Resources below). CASEL partners with school districts around the country and offers benchmark standards for teaching SEL skills to all K-12 students, which the Illinois State Board of Education has adopted (isbe.net/ils/social_emotional/standards.htm). The Pan-Canadian Joint Consortium for School Health (jcsh-cces.ca), “a partnership of 25 Ministries of Health and Education across Canada” provides numerous resources on promoting student wellness and well-being at the primary and secondary levels. At the postsecondary level, the Canadian Association of College and University Student Services (CACUSS) and the Canadian Mental Health Association

(CHMA) have partnered together to provide guidelines for a systemic, mental health promotion approach to well-being in higher education students (CACUSS/CHMA 2013; MacKean 2011). There has been an extensive array of MHPPPs successfully implemented in North America (see reviews cited above). Particularly noteworthy from a global and socio-cultural perspective, a recent study showed promise for a culturally relevant MHPPP for First Nations (i.e., aboriginal, native) students in Canada (Crooks et al. 2015).

- In **Australia**, the Australian Department of Education and Training oversees the National Safe Schools Framework (education.gov.au/national-safe-schools-framework-0), which offers the Student Wellbeing Hub, a database of information and resources for educators, parents, and students, aligned with the national curriculum "for the promotion of student wellbeing and the development of respectful relationships" (studentwellbeinghub.edu.au). The Australian Institute of Health and Welfare sponsors KidsMatter (kidsmatter.edu.au), an initiative for promoting mental health and well-being for children in early childhood education and primary school, with various guidelines and tools for MHPP planning and implementation. The New Zealand Ministry of Health funded the Mental Health Foundation of New Zealand to investigate and produce *Guidelines for Mentally Healthy Schools: A Resource to Assist Schools in the Implementation of Mental Health Promotion Initiatives in the School Community* (Dickinson 2001). With these and many other governmental and non-governmental organization (NGO) supports in place, it is not surprising that there are various examples of successful MHPPPs in Australia (e.g., MindMatters) and New Zealand (e.g., Wellbeing at School) (see Kutcher et al. 2015).
- **Europe** has produced several international collaborations centered on student MHPP programming and policy, including the European Pact for Mental Health and Well-Being (2008), the Joint Action on Mental Health and Well-Being (Rampazzo et al. 2016), and Schools for Health in Europe (SHE), a network of 45 European countries, with a mission of promoting student well-being and a positive social environment through policy and education (schools-for-health.eu). Many European countries have developed MHPP policies and programs at the national level (see Braddick et al. 2009), and research has established the success of MHPPPs across Europe, including Finland, France, Germany, Ireland, Norway, Portugal, Spain, Sweden, and the United Kingdom (for reviews, see Sancassiani et al. 2015; Torrente et al. 2015).
- In **Asia**, the Asian Society of Child and Adolescent Psychiatry and Allied Professions (ASAPAP) is the pan-Asian organization of the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP), which fosters "prevention of mental and emotional disorders" and "promoting the mental health and development of children and adolescents through policy, practice and research" (iacapap.org), through international study groups, international congresses, and a database of programs and campaigns. Research has demonstrated the effectiveness of several MHPPPs in Asian countries, including India, Nepal, Palestine (Barry et al. 2013), Taiwan, Thailand, and Hong Kong (reviewed in Sancassiani et al. 2015; Siu 2009).

- In **South America**, less than 20% of schools have an assigned mental health professional, but some schools do have MHPPPs, particularly in "countries of the non-Latin Caribbean" (Pan American Health Organization 2013). Some South American countries also have government-sponsored initiatives that promote mental health, social-emotional learning, or civics education (e.g., Brazil, Chile, Colombia, Mexico; reviewed in Torrente et al. 2015; also see Barry et al. 2013, Sancassiani et al. 2015). However, there is room for growth in MHPP in many South American countries (e.g., Espinola-Nadurille et al. 2010).
- In **Africa**, mental health policies and programs lag behind other global regions (WHO 2005, 2009), but WHO is helping to make strides in this realm (WHO Regional Office for Africa 2016). The African Mental Health Foundation (africamentalhealthfoundation.org) is an NGO dedicated to research in mental health to inform policy and advocate best practices, including mental health promotion in schools through the KIDS project in Kenya. A report from WHO (2006) indicated that in Egypt, a new policy prompted school psychologists and social workers to be trained in MHPPPs, a great improvement over the existing 1% of school health professionals who were trained in mental health at the time of the report. The South African Ministry of Education has developed several policies that promote student social and emotional learning, and the governments in some other African countries, such as Botswana, Kenya, Namibia, and Rwanda, also include policies that promote psychosocial strengths and skills (Torrente et al. 2015). Yet, with the preponderance of African countries classified as low- and middle-income (World Bank 2016) and low on the Human Development Index (Patel et al. 2005), it is not surprising that the majority of African countries lack dedicated child and adolescent mental health policies (WHO 2005, 2009). Despite these challenges, researchers have tested the effectiveness of MHPPPs for students in some African countries, including South Africa (reviewed in Sancassiani et al. 2015), Mauritius and Uganda (reviewed in Barry et al. 2013).

In sum, although more programming and evaluations are needed, particularly in low- and middle-income regions (Patel et al. 2005; WHO 2009), successful MHPP research and practice have appeared in many different cultural settings and geographical locations around the globe.

Successful implementation. Multiple reviews have found that with the proper training and support, school staff can conduct effective MHPPPs, indicating that these programs can become successfully integrated into the standard practices and routines of many different educational contexts (Durlak et al. 2011; Sancassiani et al. 2015; Wigglesworth et al. 2016). However, implementation practices are the key as noted in Weare and Nind's (2011) review of reviews: "Interventions were only effective if they were completely and accurately implemented" (p. i29).

12.4 Discussion: Expanding MHPPP Reach and Implementation

Although some MHPPPs have been evaluated in multiple studies, it is not possible to identify precisely which programs merit wide-scale application. This is because there have been few studies directly comparing the relative impact of different programs. It also is clear that effective program implementation is an important factor affecting outcomes, and that school staff need training and ongoing support to achieve effective levels of implementation when offering new interventions (Durlak and DuPre 2008). Moreover, it has been found that school personnel usually make some adaptations when they conduct new programs instead of focusing exclusively on fidelity, which refers to conducting the program as intended (Ringwalt et al. 2003). These adaptations may increase, have no effect on, or diminish program impact depending on what types of adaptations occur (Durlak and DuPre 2008).

Therefore, every new application of a program requires careful evaluation by school personnel, in collaboration with knowledgeable experts, to assess its effects in a new environment. An essential part of these program evaluations should include documenting if and how the program was adapted, and assessing how the level of implementation that was achieved may have affected different outcomes.

Moreover, collaboration among multiple stakeholders is necessary to further the spread of effective MHPPPs and this collaboration needs to occur in various ways, such as through:

- **International collaborations and national policies** that recognize the potential value of universal MHPP as part of standard educational practice for all students;
- **State, provincial, and local** educational districts supplying **legislative, administrative, and financial** support to implement and evaluate programs and sustain those found to be successful;
- **Qualified MHPP consultants** to assist schools in the effective implementation of new programs;
- **Strong leadership** at the local level, so that new programs are conducted and evaluated fairly, and so that school staff who deliver MHPPPs receive support and recognition for attending to the mental health needs of their students;
- **Program developers and researchers** assessing the active ingredients that account for outcomes of different interventions, so that empirical decisions can be made regarding which program components should be implemented with fidelity and which can be modified for better program fit.

12.5 Conclusions and Resources – Take Away Messages

In sum, the evidence suggests that MHPPPs generally are effective for students at all educational levels, in both the short- and long-term, can be highly cost-effective, and can be effectively conducted in many different school settings around the world. Further, although much of the existing research and programs are based in the United States and other industrialized, high-income countries, recent efforts from around the globe show promise for implementing MHPPPs in under-resourced regions, "applying what is ideal to existing circumstances that can create the possible" (Kutcher et al. 2015, p. 300; also see Patel et al. 2005).

Despite the success of many MHPPPs, there are still several major research questions that have to be addressed in terms of understanding what types of programs are most effective, for achieving what types of short- and long-term outcomes, for which groups or sub-groups, and at what educational levels. We also need more information on how impact may vary with the cultural and social characteristics of students and various school structures. There is also a need for more follow-up investigations and cost analyses of the benefits of different interventions and clarification of which strategies are most helpful in promoting the wider-scale application of successful MHPPPs.

Below are several resources pertinent to the implementation, evaluation, and dissemination of MHPPPs.

- The **Canadian Association of College and University Student Services** (CACUSS) and the **Canadian Mental Health Association** (CMHA) (cacuss.ca/current_projects_mental_health_report.htm) have partnered to provide *Post-Secondary Student Mental Health: A Guide to a Systemic Approach* and related resources for promoting mental health in post-secondary students.
- The **Character Education Partnership** (character.org) promotes evidence-based character education, including SEL, in schools to improve student behavior, academic outcomes, and school climate. The website offers publications, assessment tools, lesson plans, trainings, conferences, and other useful resources for educators, students, parents, and communities.
- **Child Trends** (childtrends.org/research-topic/social-and-emotional-learning) is a US-based nonprofit research organization focused on improving the lives of youth and families. Their website contains a searchable database of over 700 empirically evaluated programs on social-emotional development and related topics.
- The **Clifford Beers Foundation** is a UK-based charitable organization with collaborations around the world, advancing the goal "to promote mental health and prevent mental disorders through dissemination of knowledge, training partnerships and consultation." The foundation hosts international conferences on MHPP and publishes two academic journals, *Advances in School Mental Health Promotion* (tandfonline.com/rasm) and *International Journal of Mental Health Promotion* (tandfonline.com/rijm).

- The **Collaborative for Academic, Social, and Emotional Learning** (CASEL; casel.org) aids in making evidence-based SEL a vital part of the education system from primary through secondary schooling, with a clearinghouse of "practical guides, program reviews, videos, webinars, books, articles, and position papers" to assist students, families, educators, policymakers, researchers, and community leaders with MHPPP implementation.
- The **World Health Organization** (who.int/topics/mental_health/en) has an extensive database of research and guidelines for promoting mental health around the globe, such as:
  - *Atlas: Child and Adolescent Mental Health Resources: Global Concerns, Implications for the Future;*
  - *Child and Adolescent Mental Health Policies and Plans;*
  - *Health Promoting Schools: A Framework for Action;*
  - *Mental Health Action Plan 2013–2020;*
  - *Mental Health Atlas;*
  - *Mental Health Promotion: Case Studies From Countries;*
  - *Prevention of Mental Disorders: Effective Interventions and Policy Options;*
  - *Promoting Mental Health: Concepts, Emerging Evidence, Practice;*
  - Many additional reports and resources covering specific regions: African, the Americas, South-East Asia, European, Eastern Mediterranean, and Western Pacific.

References

Ashdown, D. M., & Bernard, M. E. (2012). Can explicit instruction in social and emotional learning skills benefit the social-emotional development, well-being, and academic achievement of young children? *Early Childhood Education Journal, 39*(6), 397–405.

Barry, M. M., Clarke, A. M., Jenkins, R., & Patel, V. (2013). A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries. *BMC Public Health, 13,* 835–854.

Belfield, C., Bowden, B., Klapp, A., Levin, H., Shand, R., & Zander, S. (2015). The economic value of social and emotional learning. *Journal of Benefit-Cost Analysis, 6*(3), 508–544.

Bierman, K. L., & Motamedi, M. (2015). SEL programs for preschool children. In J. A. Durlak, C. E. Domitrovich, R. P. Weissberg, & T. P. Gullotta (Eds.), *Handbook of social and emotional learning: Research and practice* (pp. 135–150). New York, NY: Guilford Press.

Braddick, F., Carral, V., Jenkins, R., Jané-Llopis, E. (2009). *Child and adolescent mental health in Europe: Infrastructures, policy and programmes.* Luxembourg: European Communities. Retrieved November 1, 2016, from http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/camhee_infrastructures.pdf.

Canadian association of college and university student services and canadian mental health association. (2013). *Post-secondary student mental health: Guide to a systemic approach.* Vancouver, BC: Author. Retrieved November 1, 2016, from http://www.cacuss.ca/_Library/documents/CACUSS_Handbook.pdf.

CASEL: The Collaborative for Academic, Social, and Emotional Learning. (2016). *What is SEL?* Retrieved November 1, 2016, from http://www.casel.org/what-is-sel/.

Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., & Daar, A. S. (2011). Grand challenges in global mental health: A consortium of researchers, advocates and clinicians announces here research priorities for improving the lives of people with mental illness around the world, and calls for urgent action and investment. *Nature, 475*(7354), 27–30.

Conley, C. S. (2015). SEL in higher education. In J. A. Durlak, C. E. Domitrovich, R. P. Weissberg, & T. P. Gullotta (Eds.), *Handbook of social and emotional learning: Research and practice* (pp. 197–212). New York, NY: Guilford Press.

Conley, C. S., Durlak, J. A., & Kirsch, A. C. (2015). A meta-analysis of universal mental health prevention programs for higher education students. *Prevention Science, 16*(4), 487–507. doi:10.1007/s11121-015-0543-1.

Conley, C. S., Durlak, J. A., Shapiro, J. B., Kirsch, A. C., & Zahniser, E. (2016). A meta-analysis of the impact of universal and indicated technology-delivered interventions for higher education students. *Prevention Science, 17*(6), 659–678.

Crooks, C. V., Burleigh, D., Snowshoe, A., Lapp, A., Hughes, R., & Sisco, A. (2015). A case study of culturally relevant school-based programming for First Nations youth: Improved relationships, confidence and leadership, and school success. *Advances in School Mental Health Promotion, 8*(4), 216–230. doi:10.1080/1754730X.2015.1064775.

Dickinson P. (2001). *Guidelines for mentally healthy schools: A resource to assist schools in the implementation of mental health promotion initiatives in the school community.* Auckland, New Zealand: Mental Health Foundation. Retrieved November 1, 2016, from https://www.mentalhealth.org.nz/assets/ResourceFinder/guidelines-for-mentall-healthy-schools.pdf.

Domitrovich, C., Durlak, J., Staley, K., & Weissberg, R. (2017). Social-emotional competence: An essential factor for promoting positive adjustment and reducing risk in school children. *Child Development*, *88*(2), 408–416.

Durlak, J. A. (1997). *Effective prevention programs for children and adolescents*. New York: Plenum.

Durlak, J. A. (2014). Programming for effective primary prevention and health promotion. In *Encyclopedia of Primary Prevention and Health Promotion*. (2nd ed., pp. 102–111). New York, NY: Springer.

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influences of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*(3–4), 327–350.

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*(1), 405–432.

Elias, M.J. (2003). *Academic and social-emotional learning,* Educational Practices Booklet# 11. Geneva: International Academy of Education and the International Bureau of Education (UNESCO). Retrieved November 1, 2016, from http://www.unicef.org/eapro/3A_Academic_SEL.pdf.

Espinola-Nadurille, M., Vargas-Huicochea, I., Raviola, G., Ramirez-Bermudez, J., & Kutcher, S. (2010). Mental health care reforms in Latin America: Child and adolescent mental health services in Mexico. *Psychiatric Services*, *61*(5), 443–445.

European Pact for Mental Health and Well-being. (2008). *Together for mental health and well-being*. Brussels: European Commission. Retrieved November 1, 2016, from http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf.

Hendren, R., Birrell Weisen, R., & Orley, J. (1994). *Mental health programmes in schools.* Geneva, Switzerland: World Health Organization, Division of Mental Health. Retrieved November 1, 2016, from http://apps.who.int/iris/bitstream/10665/62308/1/WHO_MNH_PSF_93.3_Rev.1.pdf.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity study replication. *Archives of General Psychiatry, 62*(6), 593–602.

Kovess, V., Carta, M. G., Pez, O., Bitfoi, A., Koc, C., Goelitz, D., & Kuijpers, R., et al. (2015). The school children mental health in Europe (SCMHE) project: Design and first results. *Clinical Practice & Epidemiology in Mental Health, 11* (Suppl 1: M7), 113–123.

Kutcher, S., Wei, Y., & Weist, M. D. (2015). Global school mental health: Considerations and future directions. In S. Kutcher, Y. Wei, & M. D. Weist (Eds.), *School mental health: Global challenges and opportunities* (pp. 299–310). Cambridge, UK: Cambridge University Press.

League of Nations. (1924). *Geneva declaration of the rights of a child*. Geneva, Switzerland: Author. Retrieved November 1, 2016, from http://www.un-documents.net/gdrc1924.htm.

Lund, C., Kleintjes, S., Kakuma, R., & Flisher, A. J., MHaPP Research Programme Consortium. (2010). Public sector mental health systems in South Africa: Inter-provincial comparisons and policy implications. *Social Psychiatry and Psychiatric Epidemiology, 45*(3), 393–404.

MacKean, G. (2011). *Mental health and well-being in post-secondary education settings: A literature and environmental scan to support planning and action in Canada*. Canadian Association of College and University Services and Canadian Mental Health Association. Retrieved November 1, 2016, from http://www.cacuss.ca/_Library/documents/Post_Sec_Final_Report_June6.pdf.

Matjasko, J. L., Vivolo-Kantor, A. M., Massetti, G. M., Holland, K. M., Holt, M. K., & Cruz, J. D. (2012). A systematic meta-review of evaluations of youth violence prevention programs: Common and divergent findings from 25 years of meta-analyses and systematic reviews. *Aggression and Violent Behavior, 17*(6), 540–552.

Pan American Health Organization. (2013). *WHO-AIMS: Report on mental health systems in Latin America and the Caribbean.* Washington, DC: Pan American Health Organization. Retrieved November 1, 2016, from http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=21325&Itemid=270.

Patel, V., Swartz, L., & Cohen, A. (2005). The evidence for mental health promotion in developing countries. In H. Herrman, S. Saxena, R. Moodie (Eds.), *Promoting mental health: Concepts, emerging evidence, practice* (pp. 189–202). Geneva, Switzerland: World Health Organization. Retrieved November 1, 2016, from http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf.

Rampazzo, L., Mirandola, M., Davis, R. J., Carbone, S., Mocanu, A., & Campion, J., et al. (2016). *Joint action on mental health and well-being: Mental health and schools: Situation analysis and recommendations for action*. Retrieved November 1, 2016, from http://www.mentalhealthandwellbeing.eu/assets/docs/publications/Mental%20Health%20and%20Schools_feb2316.pdf.

Ringwalt, C. L., Ennett, S., Johnson, R., Rohrbach, L. A., Simons-Rudolph, A., Vincus, A., et al. (2003). Factors associated with fidelity to substance use prevention curriculum guides in the nation's middle schools. *Health Education & Behavior, 30*(3), 375–391.

Rodgers, K. C. (2012). A review of multicomponent interventions to prevent and control tobacco use among college students. *Journal of American College Health, 60*(3), 257–261.

Rose, A. J., & Rudolph, K. D. (2006). A review of sex differences in peer relationship processes: Potential trade-offs for the emotional and behavioral development of girls and boys. *Psychological Bulletin, 132*(1), 98–131.

Sancassiani, F., Pintus, E., Holte, A., Paulus, P., Francesca, M., Cossu, G., et al. (2015). Enhancing the emotional and social skills of the youth to promote their wellbeing and positive development: A systematic review of universal school-based randomized controlled trials. *Clinical Practice & Epidemiology in Mental Health, 11*(1), 21–40.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. *The Lancet, 370*(9590), 878–889.

Scott-Sheldon, L. A., Carey, K. B., Elliott, J. C., Garey, L., & Carey, M. P. (2014). Efficacy of alcohol interventions for first-year college students: A meta-analytic review of randomized controlled trials. *Journal of Consulting and Clinical Psychology, 82*(2), 177–188. doi:10.1037/a0035192.

Siu, A. F. (2009). Promoting resilience in Hong Kong school children: A critical reflection. *Advances in School Mental Health Promotion, 2*(4), 19–27. doi:10.1080/1754730X.2009.9715713.

Sklad, M., Diekstra, R., Ritter, M. D., Ben, J., & Gravesteijn, C. (2012). Effectiveness of school-based universal social, emotional, and behavioral programs: Do they enhance students' development in the area of skill, behavior, and adjustment? *Psychology in the Schools, 49*(9), 892–909. doi:10.1002/pits.21641.

Stephan, S. H., Blizzard, A., & Connors, E. (2015). Increasing global knowledge exchange in school mental health. *Advances in School Mental Health Promotion, 8*(1), 1–3. doi:10.1080/1754730X.2015.992148.

Taylor, R., Oberle, E., Durlak, J. A., & Weissberg, R. P. (2017). Promoting positive youth development through school-based social and emotional learning interventions: A meta-analysis of follow-up effects. *Child Development 88*(4), 1156–1171. doi: 10.1111/cdev.12864.

Torrente, C., Alimchandani, A., & Aber, J, L. (2015). International perspectives on social and emotional learning. In J. A. Durlak, C.E. Domitrovich, R. P. Weissberg, T. P. Gullotta (Eds.), *Handbook of social and emotional learning: Research and practice* (pp. 566–588). New York, NY: Guilford Press.

The United Nations. (1989). Convention on the rights of the child. *Treaty Series*, *1577*, 3. Retrieved November 1, 2016, from http://www.ohchr.org/en/professionalinterest/pages/crc.aspx.

Vladutiu, C. J., Martin, S. L., & Macy, R. J. (2011). College- or university-based sexual assault prevention programs: A review of program outcomes, characteristics, and recommendations. *Trauma, Violence, & Abuse, 12*(2), 67–86.

Weare, K., & Nind, M. (2011). Mental health promotion and problem prevention in schools: What does the evidence say? *Health Promotion International, 26*(S1), i29–i69.

Weist, M. D., & Murray, M. (2008). Advancing school mental health promotion globally. *Advances in School Mental Health Promotion, 1,* 2–12. doi:10.1080/1754730X.2008.9715740.

Wigglesworth, M., Lendrum, A., Oldfield, J., Scott, A., ten Bokkel, I., Tate, K., et al. (2016). The impact of trial stage, developer involvement and international transferability on universal social and emotional learning programme outcomes: A meta-analysis. *Cambridge Journal of Education, 46*(3), 347–376. doi:10.1080/0305764X.2016.1195791.

World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options: Summary report.* Geneva, Switzerland: WHO. Retrieved November 1, 2016, from http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf.

World Health Organization. (2006). *AIMS report on mental health system in Egypt*. Cairo, Egypt: WHO and Ministry of Health. Retrieved November 1, 2016, from http://www.who.int/mental_health/evidence/who_aims_report_egypt.pdf.

World Health Organization. (2005). *Atlas: Child and adolescent mental health resources: Global concerns, implications for the future.* Geneva, Switzerland: WHO. Retrieved November 1, 2016, from http://www.who.int/mental_health/resources/Child_ado_atlas.pdf.

World Health Organization. (2009). *Mental health systems in selected low- and middle-income countries: A WHO-AIMS cross-national analysis*. Geneva, Switzerland: WHO. Retrieved November 1, 2016, from http://www.who.int/mental_health/evidence/WHO-AIMS/en/.

World Bank. (2016). *World Bank country and lending groups for the 2017 fiscal year*. Retrieved November 1, 2016, from https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.

World Health Organization Regional Office for Africa. (2016). *The work of WHO in the African region*. Brazzaville, Republic of Congo: Author. Retrieved November 1, 2016, from http://www.afro.who.int/en/rdo/reports/4996-the-work-of-who-in-the-african-region-2015-2016.html.

Yager, Z., & O'Dea, J. A. (2008). Prevention programs for body image and eating disorders on university campuses: A review of large, controlled interventions. *Health Promotion International, 23*(2), 173–189. doi:10.1093/heapro/dan004.

Chapter 13
Promotion of Mental Health: A Gender Perspective

Blanca M. Bolea-Alamanac

13.1 Introduction

This chapter aims to summarize the main issues surrounding promotion and provision of mental health care from a gender perspective. Gender is defined following the WHO (World Health Organization) guidelines as “the socially constructed characteristics of women and men—such as norms, roles and relationships of and between groups of women and men” (World Health Organization 2000a). Gender is a different construct from genetic sex, and is socially and culturally dependent. Gender norms can be modified and are in constant change. A gender-based perspective includes challenges pertaining to women and men and are not circumscribed to women’s issues. Though women and men face common obstacles in access to care, cultural and social characteristics may differentially impact access to care. These specific issues will be discussed in the chapter with an open and wide scope, from defining what the challenges are to describing successful interventions.

13.2 Epidemiological Differences

There are important gender differences in the prevalence of mental disorders These differences persist across countries and cultures (World Health Organization 2014):

- Women are twice as likely as men to develop depression, most anxiety disorders and post-traumatic stress disorder.
- Men show higher rates of alcohol abuse, substance dependence and antisocial personality disorders (Eaton et al. 2012).

B.M. Bolea-Alamanac (✉)
Department of Academic Psychiatry, School of Social and Community Medicine,
Oakfield House, Oakfield Grove, Bristol BS8 2BN, UK
e-mail: blanca.bolea@gmail.com

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_13

- Suicide rates in men worldwide are double those of women, while women have more parasuicidal behaviours (World Health Organization 2014).
- There are no sizable gender differences in the prevalence of schizophrenia but trajectories in men and women differ with earlier onset and worse functional outcomes in men.
- A similar distinction can be found in bipolar disorder while the general prevalence is roughly the same; men have more manic episodes, earlier onset and more comorbidity with substance disorder while women experience more depressive episodes and faster switches between depressive and manic episodes (also known as rapid cycling) (Vega et al. 2011).

Differences by gender in the prevalence of mental disorders are multifactorial (World Health Organization 2000a):

- First, women are more severely affected by poverty than men mostly because of lack of access to the means required to increase income (World Health Organization 2000b).
- Second, women are subjected to more negative life events (World Health Organization 2000a).
- Third, some cultures expect women to accept a passive role in society converting them into victims of their circumstances instead of active promoters of their own welfare.

Low social rank, lack of options to escape from poverty and adverse life events produce a “feeling of entrapment” in women that erodes resilience and increases stress, leading to depression (World Health Organization 2000a).

Men are not immune to social expectations either. In most cultures, men are presumed to be the main breadwinners, work outside the household and take risks to increase their income (Eckes and Trautner 2000). Families may accumulate resources to support the eldest male child in detriment of other children, pressuring this one sibling towards unrealistic goals (Banerjee and Duflo 2011). Equally, because of cultural perceptions of male strength, men may be reluctant to express their feelings, discuss their stresses or demand emotional support from parents; this may lead to a number of dysfunctional compensating behaviours such as substance abuse or violence (Wilsnack et al. 2000).

Biological considerations are relevant as well. Gonadal hormones, particularly drops in oestrogen levels, have been associated with increasing rates of depression (Albert et al. 2015). Discrepancies have been found in several neuronal pathways including the hypothalamic pituitary axis, cortico-limbic circuits and the Locus Coeruleus (Valentino et al. 2013). Cell signalling, peptide expression and neuronal morphogenesis also show sexual dimorphisms which affect the trajectory of illness particularly in anxiety and depression (Bangasser and Valentino 2014).

13.3 Treatment of Mental Health Problems from a Gender Perspective

Despite recent awareness of gender-based differences in the prevalence and trajectories of illness, there is still a paucity of research on the subject. While there has been an increase in funding on mental health during the perinatal period, most research has focused on the effects on children and only recently have these studies considered women's and men's mental health during the same period. Equally, there is evidence of gender bias in mental health research. Women are underrepresented in clinical studies of dementia (Baron et al. 2015) and attention deficit disorder (Pinkhardt et al. 2009). Despite clear directives by regulatory bodies (FDA 1993), many randomized controlled trials (RCTs) fail to recruit the same number of men and women (Phillips and Hamberg 2016) or fail to assess gender differences or the interactions of gender and socioeconomic circumstances in the final therapeutic intervention.

13.3.1 Psychopharmacology

Differences in the pharmacokinetics of psychotropic substances exist between men and women. It is generally accepted that women have slower stomach transit and less production of gastric acid, which could potentially lead to higher rates of absorption of base substances such as antidepressants. However, this larger bioavailability has only been substantiated for three antidepressants: Bupropion, Citalopram and Fluvoxamine (Bigos et al. 2009). Women have more adipose tissue which would affect distribution of lipophilic drugs such as Trazodone and Bupropion, producing longer half-lives and lower blood concentrations. Hepatic metabolism also varies in men and women, although because of the diversity in liver enzymes this effect is substance, ethnicity and individual-specific. Table 13.1 summarizes some examples of these effects. The clinical relevance of these differences is still understudied (Marazziti et al. 2013). If a drug has a larger bioavailability it may cause more side effects at the same dose but also be more efficacious. Dosing by size may help attenuate these effects, but differences may persist even after this adjustment (Marazziti et al. 2013).

13.3.2 Psychotherapy

Few studies have addressed gender differences in outcomes of psychotherapy. A recent systematic review of randomized controlled trials for interventions to prevent suicidal behaviour found that only 18% of studies reported or examined gender differences; of those that did, greater effectiveness was found in women

Table 13.1 Summary of known gender-specific effects of some frequently prescribed psychotropics (Bigos et al. 2009; Haddad and Wieck 2004; Montejo et al. 2015)

Psychotropic drug	Gender-specific effect
Citalopram	Larger bioavailability in women
Fluvoxamine	Larger bioavailability and higher half-life in women
Bupropion	Larger bioavailability in women
Mirtazapine	Higher plasma life in women
Fluoxetine	Better response in women
Antipsychotics	More side effects in women, and side effects appearing at lower doses Increased sexual dysfunction in men

compared to men (Krysinska et al. 2016). Equally, an assessment of a collaborative care intervention to reduce anxiety found greater effects in women compared to men (Grubbs et al. 2015). A small study on children and adolescents with antisocial behaviour using cognitive behavioural therapy (CBT) found larger effects in females (Koegl et al. 2008).

13.4 Gender, Stigma and Barriers to Mental Health Care

Barriers to access of care can be divided into three main types: structural (related to institutional or organizational issues), attitudinal or cognitive (related to users' perceptions of illness and health-care professionals) and financial (related to cost) (Carrillo et al. 2011).

13.4.1 Structural Barriers

The WHO survey of 25 countries found that young and middle aged women with moderate to severe disorders reported significantly more structural barriers in access to mental health care than men (Andrade et al. 2014). In developing countries, poverty exerts a vast effect on accessibility. Lack of transportation, paucity of services and absence of political will to improve mental health care are common findings (McDaid et al. 2008). Saraceno and colleagues identified five main challenges to the promotion of mental health in developing countries (Saraceno et al. 2007): Insufficient funding, excessive centralization of services in urban areas, lack of integration of such services, deficient training for health workers and inadequate public health skills in health-care leaders.

Experience in developed countries shows that men and women access mental health care differently. Women tend to discuss mental health issues more frequently with their primary care doctors (Harris et al. 2015), underlining the importance of primary care in promoting mental health. However, if primary care workers are not adequately trained, or are overburdened treating other illnesses, it is unlikely that any positive effect will happen (Othman et al. 2014; Williamson et al. 2015). It is then, crucial, that effective secondary care services specialized in mental health are developed. Countries that have failed to develop a secondary tier of care, have inevitably also failed to deliver efficient mental health interventions (Saraceno et al. 2007). Such is the case in Nigeria, where despite the development of a National Mental Health Action Plan in the early 1990s, less than 20% of people with mental health problems receive any type of service (Saraceno et al. 2007). Positive results have been achieved in other countries. Sri Lanka had one of the highest suicide rates in the world (49.6 per 100.000 males and 19 per 100.000 females); in the aftermath of the 2004 tsunami, the government decided to implement a consensus based mental health policy which included a wide array of stakeholders and prioritized education of health-care workers, while encouraging the development of decentralized specialized units (Jenkins et al. 2012). This model has proved successful (Epping-Jordan et al. 2015) and is proof that decentralization, enhanced education and political will are key factors to minimize structural barriers in access to mental health care.

13.4.2 Attitudinal Barriers

Negative perceptions of mental illness, including lack of information about the illness and misinterpretations of the consequences of treatment have been identified as the main barrier to accessing mental health services worldwide (Andrade et al. 2014). Attitudinal or cognitive barriers could be broadly included under the umbrella of stigma. Negative health beliefs differ according to culture, education and socioeconomic status, but also vary across gender. Men tend to report feelings of failure at having to receive care from a mental health professional (sometimes referred to as “self-stigmatization”), while women are more open and active in their health seeking behaviours (Reynders et al. 2015). Men with more severe illness are particularly reluctant to seek any type of medical consultation (Harris et al. 2015). It is likely that while structural barriers have a deeper impact in women, cognitive barriers are a greater concern for men (Alang 2015).

13.4.3 Financial Barriers

At the social level, women suffer more deeply from poverty than men (World Health Organization 2000b). Therefore, any barrier to care related to cost will, theoretically, have a greater impact on women. Mental health promotion can only be effective if improvements in the socioeconomic environment of the target population occur parallel to the development of services. Some countries have excellent services that the majority of the population cannot access adding healthcare inequality to economic inequality. In order to resolve unequal access to care, government based funding of services is essential (Alang 2015).

13.5 Gender-Specific Situations

Adequate care of patients with mental illness requires careful consideration of gender-dependent situations such as pregnancy, puerperium and menopause.

13.5.1 Pregnancy

Pregnancy is no longer considered a protective factor against mental illness. An American study found that 33% of affective disorders detected after delivery were already present during pregnancy and up to 27% had started before conception (Howard et al. 2014). Up to 50% of women will suffer from a transient low mood in the weeks following delivery (commonly known as “baby blues”); when the low mood persists for more than 2 weeks and is accompanied by at least four additional symptoms (such as changes in appetite or weight, sleep and psychomotor activity, decreased energy, feelings or worthlessness or guilt, difficulty thinking, concentrating or making decisions, or recurrent thoughts of death or suicidal ideation, plans or attempt), a diagnosis of post-partum depression is made (American Psychiatric Association 2013). Both major and minor postnatal depressions are more common in women from low and middle income countries. Current research has also found increased rates of anxiety disorders in the perinatal period which often go undetected (NICE 2014). Post-traumatic stress disorder following adverse events during pregnancy or delivery is particularly frequent in developing countries (Howard et al. 2014).

Regarding treatment, randomized controlled trials (RCTs) with antidepressants have shown great efficacy in post-partum depression. Psychological interventions delivered at the same time as perinatal care have proved useful at reducing symptoms of postnatal depression in women from middle income countries (Howard et al. 2014). In contrast, the treatment of mental health problems during pregnancy has emerged as being more complex. There is a paucity of research of psychological therapies during this period and pharmacological studies in humans are not ethically possible. Medical professionals need to evaluate each case individually, discuss possible foetal effects versus risks of worsening of mental health status with the patient and encourage women to make their own informed choices. It is important to highlight that untreated maternal depression during pregnancy and in the perinatal period also has detrimental effects on the child. Maternal anxiety and depression have been linked to reduced parental care, externalizing and internalizing behaviours and lower cognitive skills in children (Glover 2014; Beydoun and Saftlas 2008).

Paternal mental health in the perinatal period has traditionally been neglected both in research and in clinical practice. Paternal postnatal distress is linked to decreased warmth and higher hostility towards the child (Giallo et al. 2015) and a paternal postnatal depression syndrome has been postulated (Suto et al. 2016). It is possible that the effect of parental mental state is mediated or moderated by other factors such as maternal support, lack of attachment between the couple, or socioeconomic factors (Gutierrez-Galve et al. 2015).

13.5.2 Menopause and Perimenopause

Seventy percent of women will report low mood and increased irritability during the menopause (Kulkarni et al. 2016). There is also some evidence showing increased severity of depressive symptoms during the perimenopause compared to the premenopausal years (de Kruif et al. 2016). However, whether menopause per se causes an increase in mental health problems in women is still controversial (Rossler et al. 2016). The treatment of depression during the menopause is the same as in other stages of life, antidepressants being the first line treatment. There is no evidence of efficacy for hormonal replacements or other hormone based compounds (Sandilyan and Dening 2011).

13.5.3 Transgender and Non-binary Gender Identification

Despite a paucity of research on the subject, there is some evidence showing increased mental health problems in transgender youth including depression, suicidality and eating disorders (Connolly et al. 2016). Gender affirming therapy and social support have been identified as protective factors.

Non-binary gender identification occurs when the individual does not feel fully identified with any of the genders. A gender sensitive service requires an understanding of the variety of gender positions known in human nature. Gender is best perceived as a fluid concept. Medical staff needs to be aware that Western cultural constructs based on a dichotomizing sex paradigm may not fit all patients and that gender in itself is a personal and deeper concept than that reflected by social expectations.

13.5.4 Domestic Violence

Domestic violence is defined by the World Health Organization as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (World Health Organization 2000b). In this section, domestic violence will be considered as that perpetrated by a man on a woman; however, it is important to acknowledge that the opposite is also possible as is domestic violence between individuals of the same gender.

Domestic violence is common; lifetime estimates range from 16% in Cambodia and Mexico to a high of 42% in Kenya (Women's Health Department 1997). It is likely that the real numbers are larger since many incidents of violence committed by partners or relatives are not reported. This is particularly frequent when the victims are subjected to sexual abuse where cultural and social taboos may contribute to the lack of reporting (Sato et al. 2015; Krause et al. 2015). Another problem is the lack of awareness of psychological violence (World Health Organization 2000b).

Following physical assault women may acutely experience an array of psychological symptoms including numbness, withdrawal, dissociation, panic and low mood (Mason and Lodrick 2013). Abuse frequently leads to low self-esteem, learnt helplessness and suicidal ideation (Stewart et al. 2016). Sexual abuse in childhood is particularly harmful and has been linked to anxiety, depression and self-harm in adulthood. Severe child sexual abuse has also been associated with problems in executive function (Raskin 1997).

There is a growing body of evidence showing that domestic violence and particularly sexual abuse is one of the strongest predictors of depression in adulthood and of inpatient psychiatric care in women (World Health Organization 2000b). Other long term consequences of domestic violence include post-traumatic stress disorder, substance abuse, simple phobia, suicide attempts, higher rates of somatic or medically unexplained symptoms and general negative health behaviours (Follingstad 2009).

Five key areas have to be developed in a mental health service in order to help victims of domestic violence efficiently: 1–routine screening, 2–development of an inclusive safe atmosphere, 3–adequate treatment of psychosocial situations, 4–diagnosis and treatment of psychiatric comorbidity if present and 5–rehabilitation and support.

Despite increased awareness in society, professionals still have difficulty detecting and helping victims of domestic violence. It is vital to train all staff in contact with women subjected to domestic violence. Screening tools exist that may help detect those women who require referral to specific services (Miller et al. 2015). Services attending women must consider that victims frequently blame themselves and require a safe and understanding environment before they are able to disclose the situation and accept help. Treatment of domestic violence should be multidisciplinary. Depression and other mental health problems should be treated as they would be in the absence of partner abuse, with psychotropics and/or psychotherapy as required. In this group of women, a careful assessment of the psychosocial situation is crucial. Many pathological social dependencies support a violent relationship. It is common to find women that do not have access to their savings or have relinquished all economic power to their partners. Women are frequently geographically or socially isolated from their families or friends. In order to successfully help a victim, all these issues need to be addressed efficiently. Domestic abuse is insidious, partners may still keep contact and women may still feel threatened or traumatized. It is also common for victims to progress to another abusive relationship. Women who have been victims of violence as children will be more likely to progress to a situation of domestic abuse and may be re-victimized in subsequent relationships (Krahe and Berger 2016; Benedini et al. 2016). To that effect, it is important to continue the rehabilitation and support of these women over time.

Treatment of men who perpetrate domestic violence is also important. Unfortunately, most of these services are procured only in the forensic setting which is not ideal in terms of motivation and engagement. Prevention programs have started to arise as an alternative. Engaging men and boys in prevention of relationship violence and educating society towards healthier personal interactions is a priority to eradicate the domestic violence epidemic (Casey et al. 2016).

13.6 Promotion of Mental Health—Current Trends in Gender Sensitive Interventions

An effective and gender sensitive intervention to promote mental health needs to address the specific demands of the target population, be feasible with available resources, be measurable in terms of improvement of mental health and be reproducible. The first criterion requires a deep knowledge of population needs and of what the target individuals value. Interventions should start by surveying what men and women in the area find important in the context of mental health and what barriers to access they perceive. Surveys should include patients, relatives of patients, primary care professionals and secondary care staff. Interventions need to be realistic, use and support current resources if these exist and promote education of staff in gender related issues. A system to evaluate the effectiveness of the intervention needs to be included. Only recently have non-governmental organizations (NGOs) and funders started to include evaluation methods in the renewal of funding for their programmes (Banerjee and Duflo 2011). When funding is scarce, knowing what works and what does not is vital. Finally, many interventions are not reproducible because they have not been adequately documented. Though mental health interventions can be culture and situation bound, if they are recorded and shared in a protocolized manner they would be easier to reproduce in similar contexts or to adapt to other circumstances.

Following are two case studies of successful gender sensitive interventions. The Men's Health and Wellbeing Program (MHWP) in Ballybough, (Dublin, Ireland) is an integrative program to reach men considered difficult to engage (Lefkowich et al. 2015). This program is based on previous research regarding attitudes to access of services in the Irish population which showed a cultural barrier specific to men.

The program includes small groups centred about activities that are acceptable to Irish men (sport) and integrates those with life skills and health promotion (cooking classes and health coaching sessions). It was developed in partnership with the local football club and a community based charity. The program included clear endpoints that could be measured to assess its efficacy and once the pilot was deemed effective, it issued recommendations and adjustments for future programs based on accumulated experience (Richardson and Centre for Men's Health 2010).

Another interesting gender-based intervention was developed in the Limpopo province in South Africa. HIV positive women were specifically targeted in a program to reduce poverty, promote sexual health and reduce domestic violence (Pronyk et al. 2006). The intervention was a combination of microcredits and a training curriculum focused on sexual health and implemented during the loan centre meetings. It was developed in partnership with a local charity and included evaluation of outcomes through a well-designed randomized control trial. The program not only had an effect on the finances of the household but domestic violence events against women in the intervention arm reduced 55% compared to the control group (Pronyk et al. 2006). This is an example of how interventions that tackle several factors and not just health can have global positive effects.

13.7 Gender and Promotion of Mental Health—the Future

There are two current trends in mental health promotion that are likely to have an impact in the future of the field: new technologies and task shifting paradigms.

- Task shifting is defined by the World Health Organization as a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. This is the philosophy behind training nurses to use a limited vademecum of medications in those areas where doctors are not available or are oversubscribed. Mental health interventions rend particularly well to task shifting (Verdeli 2016), many programs can be implemented without instruments or tests that require specialized personnel, screening scales can be administered by lay staff and some psychological techniques can be taught in relatively short courses to health-care workers. A trial of interpersonal therapy delivered in a group setting in rural Uganda by high school graduates trained in the technique for two weeks but without any formal previous background in psychology found significant reductions in depression scores and better functioning in the intervention group (Bass et al. 2006). Task shifting has also proved important in post-conflict situations where specialized staff are scarce. A randomized single blinded study in Iraq of a cognitive based intervention delivered by community health workers for post-traumatic stress in survivors of torture and military violence showed good effect sizes (Weiss et al. 2015) and proved feasible in a severely deprived area.

- New technologies are the key to increasing awareness of mental health issues, battling stigma and improving access to services. Tele-psychiatry is defined as the use of videoconferencing technology for the provision of mental health assessment or treatment services (Hubley et al. 2016), tele-psychiatry has already been proven to be as effective as face to face consultation, and in many cases cheaper than sending specialized staff to remote areas (Hubley et al. 2016). Trials of home based tele-psychiatry care have already shown good results in depression (Hungerbuehler et al. 2016) and in children with ADHD and their caregivers (Myers et al. 2015; Vander Stoep et al. 2016).

Take Away Messages

- Current understanding of gender goes beyond the woman–man dichotomy.
- Gender is a social and cultural construct with an impact on risks of illness, socioeconomic status and access to services.
- Women have a higher risk for affective and anxiety disorders, while men have a higher prevalence of substance use, antisocial behaviour and suicide.
- Certain periods of women's lives may bring particular challenges to mental health such as pregnancy and the puerperium.
- Gender sensitive mental health services need to be particularly responsive towards domestic violence (World Health Organization 2000b).
- Adequate training and multidisciplinary support is necessary for successful gender-based interventions.
- Examples in both high income and developing countries prove that a gender-based approach can be effective and reach severely deprived populations (Saraceno et al. 2007).

References

Alang, S. M. (2015). Sociodemographic disparities associated with perceived causes of unmet need for mental health care. *Psychiatr Rehabilitation Journal, 38,* 293–299.

Albert, K., Pruessner, J., & Newhouse, P. (2015). Estradiol levels modulate brain activity and negative responses to psychosocial stress across the menstrual cycle. *Psychoneuroendocrinology, 59,* 14–24.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*, American Psychiatric Pub Incorporated.

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., et al. (2014). Barriers to mental health treatment: Results from the WHO world mental health surveys. *Psychological Medicine, 44,* 1303–1317.

Banerjee, A. V., & Duflo, E. (2011). *Poor economics: A radical rethinking of the way to fight global poverty*. New York: PublicAffairs.

Bangasser, D. A., & Valentino, R. J. (2014). Sex differences in stress-related psychiatric disorders: Neurobiological perspectives. *Frontiers in Neuroendocrinology, 35,* 303–319.

Baron, S., Ulstein, I., & Werheid, K. (2015). Psychosocial interventions in Alzheimer's disease and amnestic mild cognitive impairment: Evidence for gender bias in clinical trials. *Aging and Mental Health, 19,* 290–305.

Bass, J., Neugebauer, R., Clougherty, K. F., Verdelli, H., Wickramaratne, P., Ndogoni, L., et al. (2006). Group interpersonal psychotherapy for depression in rural Uganda: 6-month outcomes. *Randomised controlled trial, 188,* 567–573.

Benedini, K. M., Fagan, A. A., & Gibson, C. L. (2016). The cycle of victimization: The relationship between childhood maltreatment and adolescent peer victimization. *Child Abuse and Neglect, 59,* 111–121.

Beydoun, H., & Saftlas, A. F. (2008). Physical and mental health outcomes of prenatal maternal stress in human and animal studies: A review of recent evidence. *Paediatric and Perinatal Epidemiology, 22,* 438–466.

Bigos, K. L., Pollock, B. G., Stankevich, B. A., & Bies, R. R. (2009). Sex differences in the pharmacokinetics and pharmacodynamics of antidepressants: An updated review. *Gender Medicine, 6,* 522–543.

Carrillo, J. E., Carrillo, V. A., Perez, H. R., Salas-Lopez, D., Natale-Pereira, A., & Byron, A. T. (2011). Defining and targeting health care access barriers. *Journal of Health Care for the Poor and Underserved, 22,* 562–575.

Casey, E., Carlson, J., Two Bulls, S., & Yager, A. (2016). Gender transformative approaches to engaging men in gender-based violence prevention: A review and conceptual model. *Trauma Violence Abuse*.

Connolly, M. D., Zervos, M. J., Barone, C. J., 2nd, Johnson, C. C., & Joseph, C. L. (2016). The mental health of transgender youth: Advances in understanding. *Journal of Adolescent Health*.

De Kruif, M., Spijker, A. T., & Molendijk, M. L. (2016). Depression during the perimenopause: A meta-analysis. *Journal of Affective Disorders, 206,* 174–180.

Eaton, N. R., Keyes, K. M., Krueger, R. F., Balsis, S., Skodol, A. E., Markon, K. E., et al. (2012). An invariant dimensional liability model of gender differences in mental disorder prevalence: Evidence from a national sample. *Journal of Abnormal Psychology, 121,* 282–288.

Eckes, T., & Trautner, H. M. (2000). *The developmental social psychology of gender*, Lawrence Erlbaum Associates.

Epping-Jordan, J. E., Van Ommeren, M., Ashour, H. N., Maramis, A., Marini, A., Mohanraj, A., et al. (2015). Beyond the crisis: building back better mental health care in 10 emergency-affected areas using a longer-term perspective. *International Journal of Mental Health Systems, 9,* 15.

Fda. (1993). Guideline for the study and evaluation of gender differences in the clinical evaluation of drugs; notice. *Federal Register,* 58, 39406–39416.

Follingstad, D. R. (2009). The impact of psychological aggression on women's mental health and behavior: The status of the field. *Trauma, Violence, & Abuse, 10,* 271–289.

Giallo, R., Cooklin, A., Brown, S., Christensen, D., Kingston, D., Liu, C. H., et al. (2015). Trajectories of fathers' psychological distress across the early parenting period: Implications for parenting. *Journal of Family Psychology, 29,* 766–776.

Glover, V. (2014). Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. *Best Practice and Research: Clinical Obstetrics and Gynaecology, 28,* 25–35.

Grubbs, K. M., Cheney, A. M., Fortney, J. C., Edlund, C., Han, X., Dubbert, P., et al. (2015). The role of gender in moderating treatment outcome in collaborative care for anxiety. *Psychiatric Services, 66,* 265–271.

Gutierrez-Galve, L., Stein, A., Hanington, L., Heron, J., & Ramchandani, P. (2015). Paternal depression in the postnatal period and child development: mediators and moderators. *Pediatrics, 135,* e339–e347.

Haddad, P. M., & Wieck, A. (2004). Antipsychotic-induced hyperprolactinaemia: mechanisms, clinical features and management. *Drugs, 64,* 2291–2314.

Harris, M. G., Baxter, A. J., Reavley, N., Diminic, S., Pirkis, J., & Whiteford, H. A. (2015). Gender-related patterns and determinants of recent help-seeking for past-year affective, anxiety and substance use disorders: Findings from a national epidemiological survey. *Epidemiol Psychiatr Science*, 1–14.

Howard, L. M., Molyneaux, E., Dennis, C.-L., Rochat, T., Stein, A., & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *The Lancet, 384,* 1775–1788.

Hubley, S., Lynch, S. B., Schneck, C., Thomas, M., & Shore, J. (2016). Review of key telepsychiatry outcomes. *World Journaol of Psychiatry, 6,* 269–282.

Hungerbuehler, I., Valiengo, L., Loch, A. A., Rossler, W., & Gattaz, W. F. (2016). Home-based psychiatric outpatient care through videoconferencing for depression: A randomized controlled follow-up trial. *JMIR Mental Health, 3,* e36.

Jenkins, R., Mendis, J., Cooray, S., & Cooray, M. (2012). Integration of mental health into primary care in Sri Lanka. *Mental Health in Family Medicine, 9,* 15–24.

Koegl, C. J., Farrington, D. P., Augimeri, L. K., & Day, D. M. (2008). Evaluation of a targeted cognitive-behavioral program for children with conduct problems–the SNAP Under 12 Outreach Project: service intensity, age and gender effects on short- and long-term outcomes. *Clinical Child Psychology and Psychiatry, 13,* 419–434.

Krahe, B., & Berger, A. (2016). Gendered pathways from child sexual abuse to sexual aggression victimization and perpetration in adolescence and young adulthood. *Child Abuse and Neglect*.

Krause, K. H., Gordon-Roberts, R., Vanderende, K., Schuler, S. R,. & Yount, K. M. (2015). Why do women justify violence against wives more often than do men in Vietnam? *Journal of Interpersonal Violence*.

Krysinska, K., Batterham, P. J., & Christensen, H. (2016). Differences in the effectiveness of psychosocial interventions for suicidal ideation and behaviour in women and men: A systematic review of randomised controlled trials. *Archives of Suicide Research*, 1–21.

Kulkarni, P., Savitha Rani, B. B., Kumar, D. S., & Manjunath, R. (2016). Burgeoning menopausal symptoms: An urgent public health concern. *Journal of Midlife Health, 7,* 83–87.

Lefkowich, M., Richardson, N., & Robertson, S. (2015). If we want to get men in, then we need to ask men what they want: Pathways to effective health programing for men. American Journal of Men's Health.

Marazziti, D., Baroni, S., Picchetti, M., Piccinni, A., Carlini, M., Vatteroni, E., et al. (2013). Pharmacokinetics and pharmacodinamics of psychotropic drugs: Effect of sex. *CNS Spectrums, 18,* 118–127.

Mason, F., & Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practice and Research: Clinical Obstetrics & Gynaecology, 27,* 27–37.

Mcdaid, D., Knapp, M., & Raja, S. (2008). Barriers in the mind: promoting an economic case for mental health in low- and middle-income countries. *World Psychiatry, 7,* 79–86.

Miller, E., Mccaw, B., Humphreys, B. L., & Mitchell, C. (2015). Integrating intimate partner violence assessment and intervention into healthcare in the United States: a systems approach. *Journal of Womens Health (Larchmt), 24,* 92–99.

Montejo, A. L., Montejo, L., & Navarro-Cremades, F. (2015). Sexual side-effects of antidepressant and antipsychotic drugs. *Current Opinion in Psychiatry, 28,* 418–423.

Myers, K., Vander Stoep, A., Zhou, C., Mccarty, C. A., & Katon, W. (2015). Effectiveness of a telehealth service delivery model for treating attention-deficit/hyperactivity disorder: a community-based randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 54,* 263–274.

Nice. (2014). *national institute for health and clinical excellence: guidance,* Leicester (UK), British Psychological Society.

Othman, S., Goddard, C., & Piterman, L. (2014). Victims' barriers to discussing domestic violence in clinical consultations: a qualitative enquiry. *Journal of Interpersonal Violence, 29,* 1497–1513.

Phillips, S. P. & Hamberg, K. (2016). Doubly blind: a systematic review of gender in randomised controlled trials. *Global Health Action,* 9. 10.3402/gha.v3409.29597.

Pinkhardt, E. H., Kassubek, J., Brummer, D., Koelch, M., Ludolph, A. C., Fegert, J. M., et al. (2009). Intensified testing for attention-deficit hyperactivity disorder (ADHD) in girls should reduce depression and smoking in adult females and the prevalence of ADHD in the longterm. *Medical Hypotheses, 72,* 409–412.

Pronyk, P. M., Hargreaves, J. R., Kim, J. C., Morison, L. A., Phetla, G., Watts, C., et al. (2006). Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. *Lancet, 368,* 1973–1983.

Raskin, S. A. (1997). The relationship between sexual abuse and mild traumatic brain injury. *Brain Injury, 11,* 587–603.

Reynders, A., Kerkhof, A. J., Molenberghs, G., & Van Audenhove, C. (2015). Help-seeking, stigma and attitudes of people with and without a suicidal past. A comparison between a low and a high suicide rate country. *Journal of Affective Disorders, 178,* 5–11.

Richardson, N., Centre for Men's Health, I. O. T. C. (2010). Men's health and wellbeing programme: Evaluation report. The Larkin Unemployed Centre.

Rossler, W., Ajdacic-Gross, V., Riecher-Rossler, A., Angst, J., & Hengartner, M. P. (2016). Does menopausal transition really influence mental health? Findings from the prospective long-term Zurich study. *World Psychiatry, 15,* 146–154.

Sandilyan, M. B., & Dening, T. (2011). Mental health around and after the menopause. *Menopause International, 17,* 142–147.

Saraceno, B., Van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., et al. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet, 370,* 1164–1174.

Sato, K. N., Yount, K. M., & Schuler, S. R. (2015). Familial power and women's contradictory responses to attitudinal questions about intimate partner violence in rural Bangladesh. *Violence Against Women, 21,* 1171–1193.

Stewart, D. E., Vigod, S., & Riazantseva, E. (2016). New developments in intimate partner violence and management of its mental health sequelae. *Current Psychiatry Reports, 18,* 4.

Suto, M., Isogai, E., Mizutani, F., Kakee, N., Misago, C., & Takehara, K. (2016). Prevalence and Factors Associated With Postpartum Depression in Fathers: A Regional, Longitudinal Study in Japan. *Research in Nursing & Health, 39,* 253–262.

Valentino, R. J., Bangasser, D., & Van Bockstaele, E. J. (2013). Sex-biased stress signaling: the corticotropin-releasing factor receptor as a model. *Molecular Pharmacology, 83,* 737–745.

Vander Stoep, A., Mccarty, C. A., Zhou, C., Rockhill, C. M., Schoenfelder, E. N., & Myers, K. (2016). The children's attention-deficit hyperactivity disorder telemental health treatment study: Caregiver outcomes. *Journal of Abnormal Child Psychology*.

Vega, P., Barbeito, S., Ruiz De Azua, S., Martinez-Cengotitabengoa, M., Gonzalez-Ortega, I., & Saenz, M., et al. (2011). Bipolar disorder differences between genders: special considerations for women. *Womens Health (Lond),* 7, 663–674; quiz 675–666.

Verdeli, H. (2016). Global mental health: An introduction. *Journal of Clinical Psychology*.

Weiss, W. M., Murray, L. K., Zangana, G. A., Mahmooth, Z., Kaysen, D., Dorsey, S., et al. (2015). Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: a randomized control trial. *BMC Psychiatry, 15,* 249.

Williamson, E., Jones, S. K., Ferrari, G., Debbonaire, T., Feder, G., & Hester, M. (2015). Health professionals responding to men for safety (HERMES): feasibility of a general practice training intervention to improve the response to male patients who have experienced or perpetrated domestic violence and abuse. *Primary Health Care Research and Development, 16,* 281–288.

Wilsnack, R. W., Vogeltanz, N. D., Wilsnack, S. C., & Harris, T. R. (2000). Gender differences in alcohol consumption and adverse drinking consequences: cross-cultural patterns. *Addiction, 95,* 251–265.

Women's Health Department. (1997). Violence against women: A priority health issue. Geneva, Switzerland: Family and Reproductive Health, World Health Organization.

World Health Organization. (2000a). *Gender disparities in mental health*. Geneva, Switzerland: Department of mental health and substance dependence. Retrieved 2016.

World Health Organization. (2000b). *Women's mental health: an evidence based review*. Retrieved August 29, 2016, from http://apps.who.int/iris/bitstream/10665/66539/1/WHO_MSD_MDP_00.1.pdf.

World Health Organization. (2014). *Preventing suicide: A global imperative/World Health Organization*. Geneva: Switzerland, World Health Organization.

Chapter 14
Promotion of Mental Health of the Elderly

Aleksandra Milićević Kalašić and Annette Pfeiffer

14.1 Introduction/History

14.1.1 Starting Point

Health promotion in old age, and with it individual well-being, aims to maintain and improve autonomy and stability as long as possible. Today, medical care is still focused mostly on treatment of acute conditions. Moving away from a purely deficit-oriented point of view in which diseases are treated mostly separately, a patient centered integral approach is needed. This should aim to enable a healthy and active way to aging. There are humanitarian, social and economic reasons why we should pay more attention to these issues. Mental health and well-being in later life benefit each and everyone ensuring that the elderly is able to lead long and healthy lives that are enjoyable and fulfilling. "Promoting mental health is one of the ways to maximize the valuable inputs that older people can contribute to society and the economy, while minimizing the cost of care related to poor mental health" (Lee 2006, p. 10). Living longer, dying at an older age and being healthy for most of the lifetime or increased Healthy Life Years could lead to savings, as the cost of healthcare would be lower at very old ages compared to the one in childhood, youth or working age (Palangkaraya and Yong 2009).

A.M. Kalašić (✉)
Institute of Gerontology, Belgrade, Kralja Milutina 52, 11000 Belgrade, Serbia
e-mail: aleksandra.milicevic.kalasic@fmk.edu.rs; amkalasic@gmail.com

A.M. Kalašić
Faculty of Media and Communications, Department of Social Work,
Karadjordjeva 65, 11000 Belgrade, Serbia

A. Pfeiffer
Gerbeweg 45, 8708 Männedorf, Switzerland
e-mail: annette.pfeiffer@hotmail.com

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_14

All this is very important whilst facing demographic changes, which may lead to:

- An expected increase of human population older than 60 years of age by approximately 2 billion until 2050, as well as a larger portion of elderly people in countries with low and medium income (Yasamy et al. 2013);
- Feminization of old age (United Nations 2013);
- Insufficient allocation of care for mentally ill elderly people (Peterson et al. 2016);
- Increase of costs for healthcare.

The principal challenge in the future, however, will be to overcome non-infectious diseases. Approximately 38% of all Europeans suffer from at least one of the 27 covered psychological or neurological strains (total of 165.7 million people estimated), which appears to be a global phenomenon (Wittchen et al. 2011). Mental health issues often go undetected by both medical care and the affected person. This fact is connected with stigmatization, which keeps patients from getting help, often leading to social isolation and solitude, particularly among the female population (World Health Organization 2016b). There is a great variance in the mental health and functional ability of people older than 65 years of age. "The older age groups tend to be the most heterogeneous in terms of attitudes, social background, preferences, hobbies, political attachments, education and family background" (ProMenPol 2009, p. 4). Mental health issues of older people are influenced by individual factors such as individual coping skills, life span experiences, social support, structural factors such as adequate housing and transport, employment and financial security (Milićević-Kalašić et al. 2014).

14.2 Current Status/Data

14.2.1 Well-Aging Across the Life Span, Accompanied Dying

Because each biography differs vastly from all others, age needs to be put into the context of the respective lives, individual housing situation, education, cultural, economic circumstances as well as the migration status (Blaser and Amstad 2016). Development transitions and personal behaviour, in the context of social structure (Mechanic and McAlpine 2011) as well as all individual phases of life (including birth and death), play an important role (Ferraro 2011). Every one of these factors are directly influencing all health-related resources, strains, chances, risks and needs of elderly people. They largely determine their mental and physical health, as well as their subjective well-being (Thieme and Diettrich 2015).

Maintaining stability and autonomy in old age requires protective measures to either prevent diseases or avoid their development for as long as possible. Supporting measures are necessary to disband the identity for the end of life and help to appropriately steer life to this final destination (Dammer 1998). Mental health, as defined by the World Health Organization (2016a) does not only concern itself with corporeal declines, but also subjective perceptions of well-being, life satisfaction and furthermore includes social, physical and emotional success. Chronic stress during life accelerates the aging process (Zannas et al. 2015). Healthy aging is a multidimensional concept (Whitley et al. 2016). It concerns medicine, psychology, politics, socioeconomic status, cultural and linguistic background, gender, personality, personal life expectancy, life satisfaction and allows for an active role in and contribution to society (Remmers 2014; World Health Organization 2016a).

14.2.2 Mental Illnesses and Disorders

"Approximately 15% of the world's population older than 60 is affected by a variety of mental disorders. Dementia and depression are among the most commonly diagnosed conditions within this age group. Anxiety disorders affect approximately 3.8% of the elderly population and around 1% suffers from substance abuse" (World Health Organization 2016b). Mental health and physical health are strongly interrelated and this is particularly evident among the older age groups. High level of comorbidity is found (De Hert et al. 2009) while prevalence of psychological disorders is even higher (up to 49%) in a strictly selected sample that consisted of disabled, lonely and functionally dependent individuals (Milićević-Kalašić 2003).

Most mental conditions, however, show symptoms very early in life (Mechanic and McAlpine 2011). Traumatic experiences during childhood affect the mind, where they are often suppressed (Greve and Leipold 2012) and grow for the entire life (World Health Organization 2014) until old age, where they are further accentuated (Kruse 2014). This is relevant for proper intervention and promotion of mental health. Identifying mental disorders timely in life and in early stage of the disorder, the differential diagnosis, as well as the initiation of the appropriate therapeutic measures, is therefore of great importance through the whole life span. Many adults with psychological complaints and symptoms, especially the elderly, do not get the necessary help from the mental health service; less than 3% of the aged with some psychological disorder is referred to mental health specialists for getting help (Dallaire et al. 2009; Tucker et al. 2007).

Around 70% of the aging population has at some point in contact with their medical doctor, only one out of six complains about depressive moods, and only half of the population gets some kind of therapy (Craig and Mindell 2007; Regier 1993). In order to improve the situation, more attention should be paid to the neglected primary health services, home care institutions and nursing homes. This ought to be done through developing strategies of early detection and managing of mental disorders. Attention should be focused on vulnerable population with identified predisposing factors and thus proper preventive measures would be applied (Milićević-Kalašić 1993a; Milićević-Kalašić 2008; Ugolini and Angst 2013; Grundberg et al. 2016).

14.2.3 Mental Healthcare in High and Low—Income Countries

Today there are no effective solutions in healthcare systems to reduce the enormous amount of mental illnesses (World Health Organization 2016a). Between 76 and 85% of people with mental conditions in countries with low and medium income, do not receive proper treatment for their ailments. In highly developed countries, this percentage lies at 35 to 50% (World Health Organization 2016a); less than 3% of older adults accessing a mental health professional for their mental health problems (Tucker et al. 2007; Dallaire et al. 2009). “Low-income countries are defined by the World Bank as those with a Gross Net Income (GNI) per capita of $1,025 or less in 2015. High-income economies are those with a GNI per capita of $12,476 or more” (World Bank 2016).

Most people with dementia live in developing countries (India, China, South Asia and West Pacific) with an increased tendency within the years to come (Prince et al. 2007). Certain sections of the population are more vulnerable due to poor social, economic, environmental or gender-specific circumstances. Therefore, they are confronted with a higher risk of mental illness and often require social support (World Health Organization 2016a). The mental health of older adults, while a topic of increasing concern, still remains poorly addressed by healthcare systems, especially in East European countries where the diversity of services is rather low (Dallaire et al. 2009; Reifler and Cohen 1998; Tataru 2003; Milićević-Kalašić 2010).

Low-income countries, that suffer from a lack of economic and personnel resources and are unable to provide specialized care services, need to consider sociocultural and regional factors. This would help to create an understanding of health, disease and the connection between potential healthcare users and providers (World Health Organization 2016a).

14.2.4 Health and Healthcare in Relation to Gender

No matter whether they live in a developing country or not, if they suffer from a contagious or non-contagious disease, men and women can experience health differently (Vlassoff 2007). Scientists say that their everyday behaviour changes based on social, economic and biologic factors, which have a significant influence on societal and political conditions, as well as healthcare options.

Women are often excluded from educational programs. This problem is amplified since women usually take on the role of caregiver (Prince et al. 2007). Although women are less prone to alcohol and substance abuse, they tend to suffer from mental illness more often than men (Prince et al. 2007). Most commonly, these include depressions and anxiety disorders.

A Swedish study on women shows that personality has an influence on the risk of getting Alzheimer's disease (Johannsen et al. 2014). Women that were moody and dissatisfied in middle age are more likely to suffer from dementia in old age (Johannsen et al. 2014). Women may be more open to verbal expression of emotions. Men resort to suicide more often than women the older they get, especially if they are widowed, suffer from solitude, mental and/or physical illness or substance abuse (Cattell 2000). According to the results of a study on 2343 participants in preventive work, special attention should be paid to female patients with lower level of education (widowed or married) (Milićević-Kalašić 2003). Awareness about the importance of gender analysis to future health promotion in old age is rising in both developed and undeveloped countries.

14.2.5 Healthcare for Elderly Immigrants

Elderly immigrant people often encounter barriers or injustice when it comes to health or healthcare. A Swedish study (Lood et al. 2015) analysed multidimensional healthcare programs for elderly people with different cultural and linguistic backgrounds, before diseases were taking effect. Cultural background was found to have a significant influence on mental health, autonomy and the ability to live independently at home for as long as possible.

14.2.6 Individual and Family

The family is still the main source of support and care for elderly people, with elderly women commonly treating their husbands or younger women treating a parent while often suffering from mental strain (World Health Organization 2016a).

In undeveloped countries, only a small portion of elderly people receive a small pension, which causes them to often work well over the age of 65 and the extent of their physical capabilities, while still taking on domestic duties, doing volunteer work or educating younger generations (Prince et al. 2007).

Caregiving is an emotional, physical and at times a financial burden (Sanders et al. 2008; Milićević-Kalašić 2009). While caring can be rewarding, the strains and responsibilities of the role can have an impact on the caregiver's own psychological and physical health. "The chronic stress of providing in-home care to a loved one with dementia is associated with significantly higher levels of psychological morbidity, depression, stress, burden, long-term grief reactions and premature mortality" compared to "people who are not caregivers or those who are caring for the physically ill" (Proctor and Testar 2005; Sanders et al. 2008; Mahoney et al. 2005; Shulz et al. 1995; Milićević-Kalašić 2009 in Bährer-Kohler 2009). As they belong to the older generation as well, giving them support and therapy if it is necessary, can be good promotion of their mental health (Sanders et al. 2008; Milićević-Kalašić 2009).

14.3 Discussion

14.3.1 Goals of the Promotion of Mental Health in the Elderly

The promotion of mental health in elderly aims to stimulate aging people to live autonomously, or with little support in their familiar settings, and enjoy their life until the end. Creating awareness through communication, information and education helps combat stigmatization and stereotypes and allows for a change of behaviour of all entitlement groups (Yasamy et al. 2013). Because of a heterogenic aging society, this calls for appropriate political strategies and measures (Yasamy et al. 2013) aiming to strengthen the more easily influenced mental health and avoiding mental deficits (Ugolini and Angst 2013).

14.3.2 Benefits of Promotion of Mental Health in the Elderly

- Aging well can have a positive impact on individual life and therefore on society;
- Older people can bring their potential into society in order to allow a fruitful exchange;
- Although investments in health promotion can expand health costs, they reduce morbidity, (Wouterse et al. 2015) as investing in prevention and promotion activities costs less with rewarding cutting of expenditures of curative healthcare;
- Prevention is the best and most cost-efficient option (Prince et al. 2007; Verhaeghe et al. 2014).

In order to promote mental health of the elderly, a strong collaboration between public institutions, individuals and the economy is indispensable. This approach should be based on needs, gender and responsibilities. The following model was designed to outline this concept (Fig. 14.1).

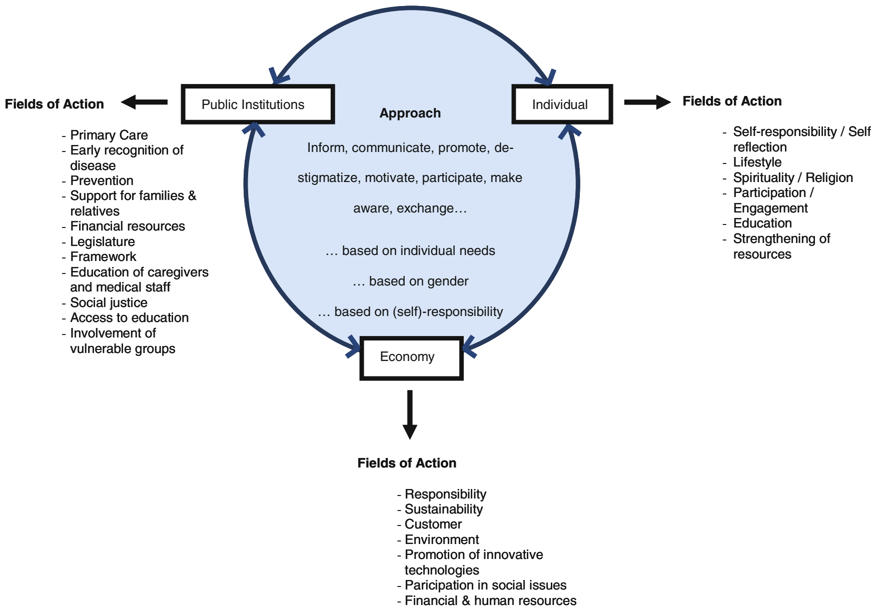


Fig. 14.1 Model of fields of action and main actors to bear the potential (Milićević-Kalašić and Pfeiffer 2016)

14.3.3 Fields of Actions to Promote Mental Health of the Elderly

14.3.3.1 Future Approaches

- **Based on individual needs** (regardless of cultural and/or linguistic background) (Lood et al. 2015);
- **Based on Gender** (gender analysis is key to creating understanding about how health is experienced and which measures need to be taken to avoid both infectious and non-infectious diseases) (Vlassoff 2007);
- **Based on (Self)-responsibility** (a person needs to independently and self-responsibly develop and use their potential for themselves and others) (Berner 2013).

14.3.3.2 Communication and Information

Continued interdisciplinary collaboration between all actors through exchange of information, networking and coordination is a compelling necessity aiming to identify and promote mental health in order to increase well-being as a mean of protection and preservation of health (Steptoe et al. 2015).

14.3.3.3 Main Actors (the Individual, the Public Institutions and the Economy)

The Individual

- ***Self-awareness*** (creating awareness of the aging process, improving the understanding for it and individual well-being as mental, emotional and physical health (Diehl et al. 2014). Promotion of active consideration of the end of life (Olligschläger 2011) and preparation for the process of dying;
- ***Lifestyle choices concerning nutrition, addictive substances, physical exercise, mobility, mental and emotional fitness*** (examination of concepts learned in childhood in order to heal possible emotional stress) (Olligschläger 2011);
- ***Spirituality/religion*** (important resources during difficult life events) (Filipp and Aymanns 2010).

Examples of activities or measures of promotion of mental health in associations, organizations, by volunteers, peers and in generational projects are:

- ***Strengthening of participatory contribution*** in networks to reduce social isolation (Ugolini and Angst 2013) and ***promotion of programs spanning multiple families and generations*** in schools, enterprises and clubs to create a fruitful exchange and coexistence (Murayama et al. 2015) in areas like learning, living, sharing experiences, participating and supporting (between third and fourth generation) (Höpflinger 2008).

The Public Institutions, (mainly providing support/incentives in healthcare) (Prince et al. 2007).

This calls for multiprofessional education programs. Psychological resources based on the patient's needs are necessary for stationary and in-and-out patient care, day care, outreach service and regional networks (Bährer-Kohler and Hemmeter 2013). This program ideally includes:

- ***Support for relatives and close family, financial resources and law, external conditions*** to enable potential and its realization (Berner 2013);
- ***Structures*** to help with living, mobility, self-help groups, volunteer work, neighbourhood organizations, communal activities and communication (Ugolini and Angst 2013);

- ***Enabling access to further educational and support programs*** for caregivers and healthcare staff to better accommodate an aging society (Grundberg et al. 2016);
- ***Advocacy***—as health promotion should be anchored in all fields of activity of politics (legislative and executive), economy, associations, institutions and non-profit organizations with an approach in all health policies (Bundesamt für Gesundheit (BAG) 2015).

It necessitates the analysis of socio-demographics, disease patterns, cultural backgrounds, religious beliefs and practices, available resources, existing political rules and macro- as well as micro-economic conditions (World Health Organization 2016a). An example for this is in the field of dementia, where the approach focuses on education, upbringing and support of family caregivers as well as medical staff. Factors like observation, collaboration and social support of home care assistants play an important role for the timely discovery of mental problems (Grundberg et al. 2016).

Examples of activities or measures of promotion of mental health are:

- ***Promotion of qualified staff*** doing home visits: hospital staff, doctors (family doctors as key contact to relatives and families), opticians, hearing aid manufacturers, funeral services, hairdressers, psychologists, chauffeurs, visitor services, cosmetics vendors, etc. (Ugolini and Angst 2013);
- ***Institutions*** (Shared housing, day care centres for the elderly) promoting exchange;
- ***Nation-wide clubs and associations*** form the framework for an improvement of care, promote engagement between clinics, researchers, caregivers and patients, enable fundraising, share information and are strong partners in negotiations with governments and legislators (Prince et al. 2007);
- ***Information events and education programs*** organized by public institutions such as districts, municipalities, provinces, cities, using various media.

Activities that promote mental health include physical exercise, spirituality and creative activities, opportunities to strengthen social, coping or life skills, and access to social support and social networks (World Health Organization 2004). Opportunities to talk through problems, to relax, to ask for and receive help when needed and keeping in touch with friends are also important to enable people in coping with difficult times.

Older people themselves have identified several key factors that promote mental health and well-being in later life. For many older people, family is the most important factor in promoting mental health. “Having positive attitudes, such as a sense of value, being open and tolerant” to “new ways of doing things, and being willing to learn, can contribute to well-being” (NHS Health Scotland 2004; Jané-Llopis and Gabilondo 2008; Lehtinen 2008; Milićević-Kalašić et al. 2014). Keeping physically, mentally and socially active and interacting with others is essential to maintaining a sound mental health. In addition, retaining independence and choice in retirement and accommodation are important for promoting well-being.

Several forms of involvement in meaningful activities increase well-being and improve the mental health of older people. Creative activities include arts and performance, libraries, museums and other cultural events. Lifelong learning programs foster social and personal realization of the aged. Additional forms of beneficial participation include community development initiatives, involving older people and volunteering, which can increase the mental well-being of both the volunteer and those who receive the services. Age equality needs to be considered particularly within mental health promotion. It is important that older people have opportunity to participate in social, cultural, economical and political decision-making processes of society. Intergenerational activities can be used to promote the understanding and respect between younger and older people (Jané-Llopis and Gabilondo 2008; Lehtinen 2008; Milićević-Kalašić et al. 2014).

The Economy (change of a production-oriented to a functional service oriented economy (Staehl 1997).

- ***Sense of responsibility and sustainability*** to avoid low productivity levels of older people due to mental disorders (Igic et al. 2014) and change from activity based to a well-being based and measured economy (Costanza et al. 2009).

14.3.4 Scientific Results and Researches

Affordable systems are necessary to facilitate the transfer of knowledge between developed and undeveloped countries and make it accessible to politics and healthcare systems. This topic concerns crucial information about promotion, intervention and handling of different aspects of mental illness, dementia in particular. Such a transfer would help guarantee better service for patients and their caregivers (including relatives) (Prince et al. 2007). "Quality epidemiologic and health research is advised to create awareness for the development of social health policies and better service for people with mental ailments and their caregivers" (Prince et al. 2007, p. 8). In order to prevent this effectively, gender-specific studies about experiencing health are indispensable (Vlassoff 2007).

Take Away Messages

Mind changing on the complexity of aging is crucial, as negative and depreciating attitudes towards old age and older people still prevail in society today because of an aging population and an increasing tendency towards mental issues in old age. The benefits of promotional activities and strategies on mental health of an aging population should be visible and integral part of all training curricula of mental health professionals around the world. Age equality needs to be enlarged particularly within mental health promotion. Sensitization of the general population is also mandatory, as mental health and well-being in later life affects all human beings, and may be achieved through partnership and intergenerational understanding and solidarity.

At the level of the individual

- Lifelong strengthening of the individual's self-responsibility is crucial for the recognition, promotion and improvement of the awareness of one's behaviour, attitude and motivation. Increase subjective well-being can favour a healthy and active independent life until the end, by bringing potential into the societal sphere and an appropriate preparation for death (Pfeiffer 2016).

At the level of public institutions and economy

- Depending on the development of the country, responsible and sustainable political and economic conditions should be provided (Costanza et al. 2009).
- During difficult life situations, basic care, support for families and relatives, education, public sphere, security and legislature (including vulnerable groups) should be incorporated. Society needs to implement structures and financial resources, in order to allow the individual to have access to treatments and contribute self-responsibly and profitably to it until the end of their life (Prince et al. 2007; Ugolini and Angst 2013; Kessler 2014; Petersen et al. 2016).
- A useful and helpful tool to receive updated information is the European Network for Mental Health Promotion (European Mental Health Network 2016), developed from an European funded former project called ProMenPol.

Communication and awareness

Communication, awareness and solution-oriented interdisciplinary across countries are factors of success that are invaluable in order to overcome future challenges related to the mental health of aged people.

References

Bährer-Kohler, S., & Hemmeter, U. (2013). Aspects of mental health care provision of the elderly in Switzerland. *Geriatric Mental Health Care, 1*(1), 11–19. doi:10.1016/j.gmhc.2012.11.002.

Berner, F. (2013). Altersbilder, Gesundheit und Psychotherapie. Erkenntnisse aus dem Sechsten Altenbericht. *Psychotherapie im Alter, 10*(2), 191–201.

Blaser, M., & Amstad, F. T. (Eds.). (2016). *Psychische Gesundheit über die Lebensspanne*. Grundlagenbericht. Gesundheitsförderung Schweiz Bericht 6, Bern. Gesundheitsförderung Schweiz. Retrieved June 25, 2016, from https://gesundheitsfoerderung.ch/assets/public/documents/1_de/d-ueber-uns/5-downloads/Bericht_006_GFCH_2016-04_-_Psychische_Gesundheit_ueber_die_Lebensspanne.pdf.

Bundesamt für Gesundheit (BAG) (Ed.). (2015). *Psychische Gesundheit in der Schweiz. Bestandesaufnahme und Handlungsfelder*. Bericht im Auftrag des Dialogs Nationale Gesundheitspolitik. Bericht Psychische Gesundheit in der Schweiz. Retrieved June 15, 2016, from http://www.bag.admin.ch/themen/gesundheitspolitik/14149/14714/?lang=de.

Cattell, H. (2000). Suicide in the elderly. *Advances in Psychiatric Treatment, 6*(2), 102–108. doi:10.1192/apt.6.2.102.

Costanza, R., Hart, M., Posner, S., & Talbert, J. (2009). Beyond GDP: The need for new measures of progress. *The Pardee Papers*, 4(1), Bosten: Pardee Center for the study of the longer-range future. Retrieved August 28, 2016, from https://www.bu.edu/pardee/files/documents/PP-004-GDP.pdf.

Dallaire, B., Mc Cubbin, M., Carpentier, M., & Clement, M. (2009). The situation of elderly people suffering from mental health problems: prevalence, consequences and services. In S. Dumont, St-Onge (Eds.), *Social work and global mental health: Research and practice perspectives*. New York: Routledge.

Dammer, I. (1998). Die Störung als Ende der Störbarkeit. In I. Dammer & P. Franzkowiak (Eds.), *Lebensentwurf und Verwandlung*. Bonn: Bouvier.

De Hert, M., Dekker, J. M., Wood, D., Kahl, K. G., Holt, R. I., & Moeller, H. J. (2009). Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC). *European Psychiatry, 24*(6), 412–424. doi:10.1016/j.eurpsy.2009.01.005.

Diehl, M., Wahl, H. W., Barrett, A. E., Brothers, A. F., Miche, M., Montepare, J. M., et al. (2014). Awareness of aging: Theoretical considerations on an emerging concept. *Developmental Review, 34*(2), 93–113. doi:10.1016/j.dr.2014.01.001.

European Mental Health Network. (2016). The European network for promotion of mental health. Retrieved November 7, 2016, from www.mentalhealthpromotion.net.

European Union. (2011). Active ageing and solidarity between generations. A statistical portrait of the European Union 2012. 2012 Edition. Luxembourg: Publications of the European Union. doi:10.2785/17758. Retrieved January 15, 2015, from http://ec.europa.eu/eurostat/documents/3217494/5740649/KS-EP-11-001-EN.PDF/1f0b25f8-3c86-4f40-9376-c737b54c5fcf.

Ferraro, F. (2011). Health and aging: Early origins, persistent inequalities? In R. A. Settersten & J. L. Angel (Eds.), *Handbook of sociology of aging* (pp. 465–475). New York: Springer.

Filipp, S., & Aymanns, P. (2010). *Kritische Lebensereignisse und Lebenskrisen. Vom Umgang mit den Schattenseiten des Lebens*. Stuttgart: Kohlhammer.

Greve, W., & Leipold, B. (2012). Problembewältigung und internationale Selbstentwicklung. In W. Schneider & U. Lindenberger (Eds.), *Entwicklungspsychologie* (7th ed., pp. 563–578). Weinheim: Beltz.

Grundberg, A., Hansson, A., Religa, D., & Hilleras, P. (2016). Home care assistants' perspectives on detecting mental health problems and promoting mental health among community-dwelling seniors with multimorbidity. *Journal of Multidisciplinary Healthcare, 9,* 83–95. doi:10.2147/JMDH.S99388.

Höpflinger, F. (2008). Generationenbeziehungen. Generationen in Familien und Gesellschaft—Zusammenfassung des Generationenberichts Schweiz. Retrieved July 22, 2016, from http://www.hoepflinger.com/fhtop/Generationenfrage.pdf.

Igic, I., Keller, A., Brunner, B., Elfering, A., & Semmer, N. (2014). *Job-Stress-Index 2014. Erhebung von Kennzahlen zu psychischer Gesundheit und Stress bei Erwerbstätigen in der Schweiz.* Gesundheitsförderung Schweiz Arbeitspapier 26, Bern. Retrieved May 25, 2016, from https://gesundheitsfoerderung.ch/assets/public/documents/1_de/d-ueber-uns/5-downloads/Arbeitspapier_026_GFCH_2014-10_-_Job-Stress-Index_2014.pdf.

Jané-Llopis, E., & Gabilondo, A. (Eds.). (2008). Mental health in older people. Consensus paper. Luxembourg: European Communities.

Johansson, L., Guo, X., Duberstein, P. R., Hällström, T., Waern, M. Ostling, et al. (2014). Midlife personality and risk of Alzheimer disease and distress. A 38-year follow-up. *Neurology, 83* (17), 10538–10544. doi:10.1212/WNL.0000000000000907.

Kessler, E.M. (2014). Psychotherapie mit sehr alten Menschen. Überlegungen aus Sicht der Lebensspannenpsychologie. *Psychotherapie im Alter*, *11*(2), 145–161.

Kruse, A. (2014). *Die Grenzgänge des Johann Sebastian Bach.* Psychologische Einblicke. Vol 2E. Berlin: Springer.

Lee, M. (2006). Promoting mental health and well-being in later life. A first report from the UK inquiry into mental health and well-being in later life. Age concern and mental Health Foundation. London. Retrieved July 22, 2016, from https://www.mentalhealth.org.uk/sites/default/files/promoting_mh_wb_later_life.pdfl. ISBN: 1 903629 42 10.

Lehtinen, V. (2008). *Building up good mental health*. Jyväskylä: Stakes.

Lood, Q., Häggblom-Kronlöf, G., & Dahlin-Ivanoff, S. (2015). Health promotion program design and efficacy in relation to aging persons with culturally and linguistically diverse backgrounds: a systematic literature review and meta-analysis. *BMC Health Service Research, 15,* 560. doi:10.1186/s12913-015-1222-4.

Mahoney, R., Regan, C., Katona, C., Livingstone, G. (2005). Anxiety and depression in family caregivers of people with Alzheimer's disease. American *Journal of Geriatric Psychiatry*, *13*, 795–801.

Mechanic, D., & McAlpine, D. D. (2011). Mental health and aging: A life-course perspective. In R. A. Settersten & J. L. Angel (Eds.), *Handbook of sociology of aging* (pp. 477–493). New York: Springer.

Milićević-Kalašić, A. (2003). *Neuropsychiatric disorders in elderly at home treatment and care*. Doctoral Dissertation. Medical Faculty in Belgrade, Belgrade.

Milićević-Kalašić, A. (1993a). *Early detection and follow up of psychological disorders in the elderly at home treatment and care*. Medical Faculty in Belgrade, Belgrade: Master degree paper.

Milićević-Kalašić, A. (1993b). Home care and promotion of mental health for the elderly in Belgrade. *International Psychogeriatric Association Newsletter, 10*(1), 21–22.

Milićević-Kalašić, A. (2008). Mental health services of older people. *Gerontology, Review of Gerontological Society of Serbia, 1,* 218–228.

Milićević-Kalašić, A. (2009). Caregivers care with Alzheimer's disease, prevention of caregivers burn-out. In S. Bahrer-Kohler (Ed.), *Self nanagement of chronic disease, Alzheimer's disease* (pp. 67–71). Heidelberg: Springer.

Milićević-Kalašić, A., Kalašić, O., Vasović, O., Tasić, M., Ševo, G., Jovanović, L., et al. (2014). Mental health-condition of quality of life in aging process. Gerontology. *Gerontology, Review of Gerontological Society of Serbia, 1,* 182–188.

Murayama, Y., Ohba, H., Yasunaga, M., Nonaka, K., Takeuchi, R., Nishi, M., et al. (2015). The effect of intergenerational programs on the mental health of elderly adults. *Aging & Mental Health, 19*(4), 306–314. doi:10.1080/13607863.2014.933309.

NHS Health Scotland. (2004). Mental health and well-being in later life: older people's perceptions. Retrieved July 16, 2016, from http://www.healthscotland.com/uploads/documents/7924-WellbeingBook.pdf.

Olligschläger, U. J. (2011). *Die Gesundheit der Seele: Sokrates—Seneca—Epiktet. Antikes Denken, moderne kognitive Psychotherapie und die Biochemie unserer Gedanken*. Berlin: LIT.

Palangkaraya, A., & Yong, J. (2009). Population aging and its implications on aggregate health care demand: Empirical evidence from 22 OECD countries. *International Journal of Health Care Finance and Economic, 9*(4), 391–402. doi:10.1007/s10754-009-9057-3.

Petersen, I., Evans-Lacko, S., Semrau, M., Barry, M. M., Chisholm, D., Gronholm, P., et al. (2016). Promotion, prevention and protection: Interventions at the population- and community levels for mental, neurological and substance use disorders in low-and middle-income countries. *International Journal of Mental Health Systems, 10,* 30. doi:10.1186/s13033-016-0060-z.

Pfeiffer, A. (2016). Persönlichkeitsentwicklung mittels begleiteter Selbstreflexion im Alter 60 +. Was sind die subjektiven Auswirkungen einer begleiteten Selbstreflexion im Alter 60 +? Masterarbeit, Master of Advanced Studies in Gerontologie—Altern—Lebensgestaltung 50 +. Fachhochschule Bern: Institut Alter.

Prince, M., Livingston, G., & Katona, C. (2007). Mental health care for the elderly in low-income countries: A health systems approach. *World Psychiatry, 6*(1), 5–13.

Proctor, R., Testad, I. (2005). Carer stress-overview. In: BurnsA (Ed.), *Standards in dementia care* (pp. 241–247). New York: Taylor&Francis London.

ProMenPol. (2009). A manual for promoting mental health and wellbeing: older people's residences. Retrieved May 24, 2016, from http://www.mentalhealthpromotion.net/resources/toolitmanuals/manual-for-older-people-setting.pdf.

Remmers, H. (2014). Neue Lebenslaufkonzeptionen im Hinblick auf körperliche Gesundheit und Prävention. In H. W. Wahl & A. Kruse. (Eds.), *Lebensläufe in Wandel. Entwicklung über die Lebensspanne aus Sicht verschiedener Disziplinen* (pp. 238–259). Stuttgart: Kohlhammer.

Sanders, S., Ott, C. H., Kelber, S. T., & Noonan, P. (2008). The experience of high levels of grief in caregivers of person with Alzheimer's disease and related dementia. *Death Studies, 32*(6), 495–523. doi:10.1080/07481180802138845.

Shulz, R., O'Brien, A. T., Bookwala, J., Fleissner, K. (1995). Psychiatric and physical morbidity effects of dementia caregiving: prevalence correlates and causes. *Gerontologist*, *35*, 771–791.

Stahel, W. R. (1997). The Functional economy: The cultural and organizational change. In D. J. Richards (Ed.), National Academy of Engineering *The industrial green game. Implications for environmental design and management*, (pp. 91–100). Washington DC: National Academy Press. doi:10.17226/4982.

Steptoe, A., Deaton, A., & Stone, A. A. (2015). Subjective well-being, health and aging. *The Lancet, 385*(9968), 640–648. doi:10.1016/S0140-6736(13)61489-0.

Tataru, N. (2003). *Mental health services for the elderly in central and Eastern European countries*. Book of Abstracts IPA Regional Meeting, Geneva: IPA.

The World Bank. (2016). Data World Bank Country and lending groups. Retrieved October 15, 2016, from https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.

Thieme, P., & Dietrich, D. A. V. (2015). A life span perspective on life satisfaction. The German Soco-Economic Panel Study (SOEP). DIW Berlin. Retrieved May 24, 2016, from https://www.diw.de/sixcms/detail.php?id=diw_01.c.511705.de.

Tucker, S., Baldwin, R., Hughes, J., Benbow, S., Barker, A., Burns, A., et al. (2007). Old age mental health services in England: Implementing the National Service framework for older people. *International Journal of Geriatric Psychiatry, 22*(3), 211–217. doi:10.1002/gps.1662.

Ugolini, B., & Angst, S. (2013). Erhaltung und Förderung psychischer Gesundheit im Alter. Resource document. *Zentrum für Gerontologie der Universität Zürich*. Retrieved April 20, 2016, from http://www.zfg.uzh.ch/static/2013/ugolini_angst_psychische-Gesundheit_2013.pdf.

United Nations. (2013). World Population Aging 2013. Economic & Social Affairs. Retrieved June 12, 2016, from http://www.un.org/en/development/desa/population/publications/pdf/aging/WorldPopulationAgingReport2013.pdf.

Verhaeghe, N., De Smedt, D., De Maeseneer, J., Maes, L., Van Heeringen, C., & Annemans, L. (2014). Cost-effectiveness of health promotion targeting physical activity and healthy eating in mental health care. *BMC Public Health., 14,* 856. doi:10.1186/1471-2458-14-856.

Vlassoff, C. (2007). Gender differences in determinants and consequences of health and illness. *Journal of Health, Population and Nutrition, 25*(1), 47–61.

Whitley, E., Popham, F., & Benzeval, M. (2016). Comparison of the Rowe–Kahn model of successful aging with self-rated health and life satisfaction: The West of Scotland twenty-07 prospective cohort study. *The Gerontological Society of America*. doi:10.1093/geront/gnv054. Retrieved June 25, 2016, from http://gerontologist.oxfordjournals.org/content/early/2016/03/11/geront.gnv054.full.pdf+html.

World Health Organization (2004). Promoting mental health: concepts, emerging evidence, practice: Summary report/a report from the World Health Organization, Department of Mental Health and substance abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne. Retrieved July 10, 2016, from http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf.

World Health Organization. (2013). Investing in mental health: evidence for action. Retrieved July 15, 2016, from http://apps.who.int/iris/handle/10665/87232.

World Health Organization and Calouste Gulbenkian Foundation. (2014). Social determinants of mental health. Geneva: World Health Organization. Retrieved June 14, 2016, from http://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/.

World Health Organization. (2016a). Zusammenfassung Weltbericht über Altern und Gesundheit. Retrieved March 15, 2016, from http://apps.who.int/iris/bitstream/10665/186468/20/WHO_FWC_ALC_15.01_ger.pdf.

World Health Organization. (2016b). Mental health and older adults. Retrieved May 31, 2017, from http://www.who.int/mediacentre/factsheets/fs381/en/.

Wittchen, H. U., Jacobi, F., Rehm, J. Gustavsson, A., Svensson, M., Jönsson, B. et al. (2011). The size and burden of mental disorders and other disorders of the brain in Europe 2010. *European Neuropsychopharmacology*, *21*(9), 655–679. doi.10.1016/j.euroneuro.2011.07.018.

Wouterse, B., Huisman, M., Meijboom, B. R., Deeg, D. J. H., & Polder, J. J. (2015). The effect of trends in health and longevity on health services use by older adults. *BMC Health Service Research, 5,* 574. doi:10.1186/s12913-015-1239-8.

Yasamy, M. T., Dua, T., Harper, M., & Saxena, S. (2013). Mental health of older adults, addressing a growing concern. Mental health and older people, World Mental Health Day, October 10 2010, World Federation for Mental Health. Retrieved July 15, 2016, from http://docplayer.net/12999992-World-mental-health-day-October-10-2013-world-federation-for-mental-health.html.

Zannas, A. S., Arloth, J., Carillo-Roa, T., Lurato, S., Röh, S., Kerry, J., et al. (2015). Lifetime stress accelerates epigenetic aging in an urban, African American cohort: relevance of glucocorticoid signaling. *Genome Biology, 16,* 266. doi:10.1186/s13059-015-0828-5.

Chapter 15
Mental Health Promotion: How Does Education Contribute?

David K. Conn

Key Points

1. Multiple leading organizations including the World Health Organization (WHO) have recommended that education of health professionals and students provide greater focus on health promotion and disease prevention. In spite of this, progress has been relatively slow due to conflicting opinions about its importance and limited availability of qualified teachers and suitable placements.
2. A variety of Guidelines for the training of health professionals in mental health promotion are available. A good example is the PROMISE Guidelines funded by the European Commission.
3. Mental health promotion for children and adolescents in the school system is also proving to be of value in the prevention of mental disorders in this vulnerable population.
4. Teaching and informing patients in clinical practice about optimizing mental health is also developing, in parallel with a movement towards great engagement of patients in maintaining and improving all aspects of their own health.
5. The impact of public education campaigns to promote mental health and reduce the incidence of depressive disorders and suicide requires further study.

D.K. Conn (✉)
Baycrest Health Sciences and University of Toronto, 3560 Bathurst St.,
Toronto, ON M6A 2E1, Canada
e-mail: DConn@baycrest.org

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_15

15.1 Introduction

In an article on the education of health professionals for the twenty-first century, a global independent Commission noted that one of the major challenges for educational reform is “to provide a more balanced environment for health professionals through engagement of local communities, to proactively address population-based prevention, anticipate future health threats and to lead in the overall design and management of the health system” (Frenk et al. 2010). Health promotion is defined in the World Health Organization (WHO) (1986) Ottawa Charter as “a process of enabling people to take more control over and improve their health”. It shifts greater attention in public health from disease prevention to health promotion (Kobau et al. 2011). The approach emphasizes the view that health is more than the absence of illness and that deployment of social and individual resources can result in positive change among people, organizations and communities. In many countries governments have developed health promotion initiatives e.g. in the United Kingdom (UK), the USA, Netherlands and Australia. For example in the UK, local primary care trusts are required to meet health promotion targets and receive associated funding (Wylie and Thompson 2007). Within the mental health field, movements entitled “positive psychology” and “positive psychiatry” have developed with a focus on “positive mental health” (Seligman 2000; Jeste 2015). The approach broadly includes the study of four areas: positive emotions; positive individual traits; positive relationships and enabling institutions. Saxena and colleagues (2006) provide a useful explanation of the distinction between mental health promotion and prevention of mental disorders. They note that mental health promotion aims to promote mental health by increasing psychological well-being, competence and resilience and by creating supportive living conditions and environments. The target for mental disorders prevention is the reduction of symptoms and ultimately of disorders themselves. It utilizes promotion as one of the methods to achieve these goals. Mental health promotion may also decrease the incidence of mental disorders as a secondary outcome. They also explain that elements of prevention and promotion are often present within the same programs and strategies, involving similar activities and producing different but complementary outcomes (Saxena et al. 2006). This chapter will focus on how education and training can contribute to achieving the multiple goals associated with mental health promotion and prevention.

The Ottawa Charter identified 5 key strategies that have informed the development of health promotion: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills and reorienting health services (World Health Organization 1986). Mittelmark et al. (2005) in a WHO document entitled Promoting Mental Health: Concepts, Emerging Evidence and Practice, describe some of the challenges of developing and evaluating health promotion programs. They note that evaluation is fraught with methodological deficiencies and that political considerations color the decision-making process regarding funding. They also recommend key lessons from health promotion relevant to mental health:

- Combine individual and structural strategies with advocacy.
- Work with an array of public and private sectors, not just the health sector.
- Emphasize positive mental health as well as prevention and treatment.
- Use professional tools for program planning, implementation and evaluation.
- Strive to increase people's control over their own mental health.
- Avoid over-dependence on "expert-driven" approaches.
- Adopt a capacity building approach with individuals and communities.

Deehan and Wylie (2010) provide an excellent overview of the challenges associated with establishing an evidence base for health promotion as well as the difficulty in persuading health professionals to adopt new approaches in clinical practice.

15.2 Mental Health Promotion and Education—Current Status

15.2.1 Guidelines for Education of Health Professionals

A 2004 WHO Report on Prevention of Mental disorders emphasized the importance of capacity building and training of health professionals in the area of mental health promotion. Greacen et al. (2012) note that capacity building and training are important issues for program implementation and also for policy-making, research and advocacy. In 2008 the European Pact for Mental health and Wellbeing recommended as a priority action "promoting training of professionals involved in the health, education, youth and other relevant sectors in mental health and wellbeing". An international project which ran from 2003–2008 developed an internet database of evidence-based mental health promotion and mental health prevention programs and a training manual for primary care professionals on mental health promotion for adults with a focus on problem-solving skills (Jane-Llopis and Hosman 2005; Van Weel-Baumgarten et al. 2005). A project entitled PROMISE (Promoting mental health, minimizing mental illness and integrating social inclusion through education) funded by the European Commission (2009–2012) brought together a multidisciplinary committee from eight European sites with the goal of identifying quality criteria for training care professionals on mental health promotion (Greacen et al. 2012). The ten quality criteria are as follows: Embracing the Principles of Mental Health Promotion; Empowering all community stakeholders for effective involvement; Adopting an Interdisciplinary and Intersectoral approach; Including people with mental health problems; Advocating; Consulting the Knowledge Base; Adapting interventions to local contexts and needs in a holistic, ecological approach; Identifying and evaluating risks; Using the media; and Evaluating training, implementation and outcomes.

The Guidelines with resource kits in seven EU languages include applications for training needs of different professional groups (psychiatrists, psychologists, nurses and social workers) (Greacen et al. 2012). The kits include detailed descriptions of quality criteria, key policy documents, examples of existing training programs, a checklist for quality evaluation and links to multiple relevant resources. The PROMISE Guidelines for training psychiatrists note that traditional training for psychiatrists focuses on mental disorders and psychopathology. Programs that promote mental health are primarily educational rather than clinical in focus with an ultimate goal of increasing capacity to deal with stress and crises and taking steps toward improving resilience. Concepts of "positive mental health" are rarely seen in psychiatric textbooks. This document also comments on the European Psychiatric Association Guidance on mental health promotion which highlights the frequent misunderstanding regarding the difference between prevention and promotion. The guide emphasizes the fact that having to deal with a mental disorder may make it difficult to have positive mental health but that a person without mental illness can also have sub-optimal mental health. The guide suggests that during initial training, psychiatrists should be encouraged to promote, like other medical specialists, a healthy lifestyle that includes proper diet, regular physical activity, social and cultural interests. Psychiatrists should also work collaboratively with community partners to increase capacity and enhance relationships between professional organizations, community agencies and advocacy groups. The companion PROMISE Guidelines for training psychologists also highlight the idea that health promotion is also relatively new, noting that among the 56 divisions within the American Psychological Association, none focuses on this area. The document draws on work carried out in a number of European countries such as Denmark and Slovenia. As with each of the profession-specific Guidelines there are comments on how each quality criterion is meaningful to that group, with ideas for training modules and exercises. In the United States a Clinical Prevention and Population Health Curriculum framework for health professions was published by Allan et al. (2004).

15.2.2 Medical Education

Wylie et al. (2010) outline some of the challenges of teaching health promotion and public health to medical and other health professional students. Most students are focused on learning the skills required to diagnose and treat illness and very few students express an interest in a career in this field (Soethout et al. 2008). A report from the United Kingdom noted that although the majority of medical school has some public health content integrated into the curriculum, 50% report difficulty in finding teachers (Gillam and Bagade 2006). Suggestions for increasing student enthusiasm include: a focus on international public health and global burdens of disease, exploring the impact of politics on health and health inequalities and identifying physician responsibilities related to health protection (Gillam and Maudsley 2008). Wylie et al. (2010) outline training models in health promotion at a variety of medical schools including the VU University Medical Centre in Amsterdam, Monash University School of Medicine in Australia, Canadian medical schools and medical schools in Liverpool and King's College, London. The Amsterdam Program utilizes a model during the clerkship called PREPARE which has seven steps: Problem, Relevance, Evidence, Prevention (which preventive actions can be taken and why?), Advice, Records and Evaluation. The Monash program utilizes a 14-day community placement with partners such as welfare agencies, local government, schools and community health centers. Large numbers of teachers and facilitators from a variety of backgrounds are involved in the program. Students are evaluated on a broad range of criteria including some specific outcomes related to competence in health promotion and disease prevention. These include: understanding a range of health promotion theories of change; participating in program development, planning, implementation and evaluation through a project and ability to compare and contrast medical, behavioral and socio-environmental approaches to health promotion. The University of Liverpool utilizes a model based on Seven pointers towards a Population Perspective on health. King's College emphasizes a Stages of Change model encompassing: Contemplation, Commitment, Action, Maintenance and possible Relapse. It also focuses on Beattie's model of quadrants that include modes of intervention, modes of thought and a continuum from individual to collective approaches. Canadian medical schools all utilize the CanMEDS Framework which outlines seven physician abilities and behaviors (Royal College of Physicians and Surgeons of Canada 2005). These include being a medical expert, communicator, collaborator, manager, health advocate, scholar and professional. Within the section on being a medical expert six key competencies are described with one being "use preventative and therapeutic interventions effectively". Within the role of health advocate there are four key competencies as follows: 1. Respond to individual patient health needs and issues as part of patient care, 2. Respond to the health needs of communities they serve, 3. Identify the determinants of health of populations they serve and 4. Promote the health of individual patients, communities and populations. The issue of health promotion for students *themselves* is also of great relevance (Hassed and Wylie 2010). There are considerable opportunities to encourage health promotion among students and trainees. For example, the General Medical Council in the UK emphasizes in the document "The Trainee Doctor" that practitioners should at a minimum be able to maintain their own health, have a suitable work–life balance and know how to deal with personal illness (General Medical Council 2011).

15.2.3 Nursing Education

The WHO European Strategy for Nursing and Midwifery Education Report (2000) called for the inclusion and application of health promotion in all nursing curricula. Whitehead (2007) reviewed the status of health promotion in nursing education. The literature search found 19 articles focused on theory, which included curricula health promotion models and tool development, delivery of health promotion and the health promotion role of students. The empirical literature included 16 articles focused on student and lecturer's perceptions and practices of health promotion and health promotion activities related to personal student activity and behavior. Whitehead concluded that the implementation of this curriculum is often challenging and that the call for effective inclusion of health promotion has often gone unheeded. He presents a number of recommendations for consideration including the need for clear definition of what health promotion is and is not, the importance of linking theory to practice via appropriate health promotion placements, recognition of differences based on diverse clinical settings and the need for nurses to contribute to the development of related health policies and socio-political agendas. As noted above, the PROMISE project also created Guidelines for training nurses in mental health promotion.

15.2.4 Educating Patients in Clinical Practice

Many approaches for strengthening patient engagement have been developed including the provision of patient and family education. Coulter and Ellins (2007) reviewed the evidence regarding the effectiveness of informing, educating and involving patients in their care. Overarching goals were divided into four categories: to improve health literacy, to improve clinical decision-making, to improve self-care and to improve patient safety. They analyzed a total of 132 reviews and concluded that there is a substantial but somewhat imperfect evidence base on which to build strategies to strengthen patient engagement. They recommend that all strategies should aim to enhance health literacy and that health information materials, decision aids, self-management action plans and other tools are most effective when they supplement or augment interactions between patients and health professionals. A variety of strategies for promoting mental health among people with serious mental illness have been developed such as connecting individuals with accessible social support in the community, promoting recovery and well-being. Van Zoonen et al. (2014) in a recent meta-analysis identified more than 30 randomized prevention trials using psychological interventions among people of all ages. These studies showed that the incidence of depressive disorders was 21% lower in the prevention groups compared with the control groups. A program entitled Fountain of Health has been developed in Nova Scotia, Canada with the goal of bringing seniors' mental health promotion into clinical practice.

The program provides seniors and clinicians with practical behavioral tools designed to encourage behavior change. The five areas of focus include staying socially active, changing how to think about aging, staying physically active, taking care of one's mental health and continuing to learn new things (Thoo et al. 2015). Some programs target caregivers of older or chronically ill individuals who are at high risk of depression and burnout. Controlled studies suggest significant benefits of psychosocial and educational interventions with reduced depression, subjective sense of burden and improved sense of well-being (Sorensen 2002).

15.2.5 Education in Schools

For children and adolescents, a variety of programs targeting high-risk groups have shown promise. These include parent management training (Webster-Stratton et al. 2001), home-visiting programs and interventions aimed at reducing transgenerational transfer of mental disorders (Clarke et al. 2001). A variety of school-based programs have demonstrated a range of positive outcomes including improved academic performance, increased problem-solving skills and reduced depressive symptoms, anxiety and bullying (Saxena et al. 2006). The Canadian Mental Health Association has created an excellent Mental Health and High School Curriculum Guide, which provides detailed plans for six lessons. The following are lesson topics: 1. Understanding mental health and mental illness, 2. Information on specific mental illnesses, 3. Experiences of mental illness, 4. The stigma of mental illness, 5. Seeking help and finding support, and 6. The importance of positive mental health.

15.2.6 Public Education

The WHO and other organizations have recommended education campaigns targeting the general public with goals that include suicide prevention, awareness and early recognition of depression and reducing stigma associated with mental illness. A review of public education campaigns in eight countries was carried out by Dumesnil and Verger (2009). They identified 43 publications describing fifteen programs that met inclusion criteria. The countries included Australia, Canada, Germany, Hong Kong, New Zealand, Norway, Scotland and England. The authors concluded that these programs contributed to a modest improvement in public knowledge of and attitudes toward depression or suicide, although the sustainability of these changes was rarely studied. None of the studies clearly demonstrated that these programs improve care-seeking or decrease suicidal behavior. The authors suggest that guidelines regarding how to evaluate public education campaigns would be useful. There were some characteristics that appeared to be associated with a positive impact. Multiple simultaneous strategies were more effective and included distribution of educational tools, a media campaign, and training of health professionals and gatekeepers.

15.3 Take Away Messages

This chapter has provided an overview of educational aspects of mental health promotion. The focus is on student and health professional training and the aspirational goals of enhancing the curricula in training programs, to ensure that health promotion and prevention are adequately emphasized.

- There is now a body of useful work in the field including training guidelines and a variety of useful resources and educational tools.
  Examples:
  (a) Clinical Prevention and Population Health, Curriculum Framework for Health Professions (Allan et al. 2004)
  (b) European guidelines for training care professionals in mental health promotion (Greacen et al. 2012)
  (c) Health Promotion in Medical Education (Wylie and Holt 2010)
- During the earlier phases of the educational system, there is evidence that mental health promotion for children and adolescents within school systems can also be highly effective.
- Public education may play a role in increasing knowledge about mental health and reducing associated stigma but more work is required to determine how to maximize the impact of these programs.
- There is clearly a need for more champions of mental health promotion at local, national and international levels to ensure that adequate funding is made available and to ensure that effective knowledge mobilization occurs.

References

Allan, J., Barwick, Timi A., Cashman, S., Cawley, J. F., Day, C., et al. (2004). Clinical prevention and population health, curriculum framework for health professions. *American Journal of Preventative Medicine, 27*(5), 471–476.

Canadian Mental Health Association. Mental Health and High School Curriculum Guide. Retrieved August 18, 2016, from http://www.cmha.ca/highschool/.

Clarke, G. N., Hornbrook, M., Lynch, F., Polen, M., Galen, J., Beardslee, W., et al. (2001). A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed patients. *Archives of General Psychiatry, 58,* 1127–1134.

Coulter, A., & Ellins, J. (2007). Effectiveness of strategies for informing, educating, and involving patients. *British Medical Journal, 335,* 24–27.

Deehan, A., & Wylie, A. (2010). Health Promotion: the challenges, the questions of definition, discipline status and evidence base. In A. Wylie & T. Holt (Eds.), *Health promotion in medical education* (pp. 10–22). Oxford: Radcliffe.

Dumesnil, M. S., & Verger, P. (2009). Public awarness campaigns about depression and suicide: A review. *Psychiatric Services, 60*(9), 1203–1213.

Frenk, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, T., et al. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *Lancet, 376,* 1923–1958.

General Medical Council. (2011). The Trainee Doctor. Retrieved August 30, 2016, from http://www.gmc-uk.org/Trainee_Doctor.pdf_39274940.pdf.

Gillam, S., & Bagade, A. (2006). Undergraduate public health education in UK medical schools—struggling to deliver. *Medical Education, 40*(5), 430–436.

Gillam, S., & Maudsley, G. (2008). *Public health education for medical students: A guide for medical schools, department of public health and primary care*. London: University of Cambridge.

Greacen, T., Jouet, E., Ryan, P., Cserhati, Z., Grebenc, V., Griffiths, C., et al. (2012). Developing European guidelines for training care professionals in mental health promotion. *BMC Public Health, 12,* 1114–1124.

Hassed, C., & Wylie, A. (2010). Same objectives, different students: The practical challenges of health promotion teaching for the learner. In A. Wylie & T. Holt (Eds.), *Health promotion in medical education* (pp. 169–184). Oxford: Radcliffe.

Jané-Llopis, E., & Hosman, C. (2005). Integrating mental health interventions into countries' policies, practice and mental health care system (the IMHPA Project) I. Final Report to the European Commission. Nijmegen: Radboud University.

Jeste, D. V., Palmer, B. W., Rettew, D. C., & Boardman, S. (2015). Positive psychiatry: Its time has come. *Journal of Clinical Psychiatry, 76*(6), 675–683.

Kobau, R., Seligman, M. E. P., Peterson, C., Diener, E., Zack, M. M., Chapman,D., et al. (2011). Mental health promotion in public health: Perspectives and strategies from positive psychology. *American Journal of Public Health Government, Politics, and Law*, *101*(8), e1–e9.

Mittelmark, M. B., Puska, P., O'Bryne, D., & Tang, K.-C. (2005). Health promotion: A sketch of the landscape. In H. Herman, S. Saxena, & R. Moodie (Eds.), *Promoting mental health: Concepts, emerging evidence, practice*. Geneva, Switzerland: World Health Organization.

Royal College of Physicians and Surgeons of Canada. CanMEDS. (2005). Framework. Ottawa: The Royal College of Physicians and Surgeons of Canada.

Saxena, S., Jané-Llopis, E., & Hosman, C. (2006). Prevention of mental and behavioural disorders: Implications for policy and practice. *World Psychiatry., 5*(1), 5–14.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*(1), 5–14.

Soethout, M. B. M., ten Cate, O. J., & van der Wal, G. (2008). Development of an interest in a career in public health during medical school. *Public Health, 122*(4), 361–366.

Sorensen, S., Pinquart, M., & Duberstein, P. (2002). How effective are interventions with caregivers? An updated meta-analysis. *Gerontologist, 42,* 335–372.

Thoo, V., Freer, J., & Cassidy, K.-L. (2015). The fountain of health: Bringing seniors' mental health promotion into clinical practice. *Canadian Geriatrics Journal, 18*(4), 217–224.

Van Weel-Baumgarten, E., Mynors-Wallis, L., Jané-Llopis, E., & Anderson, P. (2005). *A training manual for prevention of mental illness: Managing emotional symptoms and problems in primary care*. Nijmegen: Radboud University.

van Zoonen K., Buntrock, C., Ebert, D. D., Smit, F., Reynolds, C. F., Beekman, A., et al. (2014). Preventing the onset of major depressive disorder: A meta-analytic review of psychological interventions. *International Journal of Epidemiology, 43,* 318–329.

Webster-Stratton, C., Reid, M. J., & Hammond, M. (2001). Preventing conduct problems, promoting social competence: A parent and teacher training partnership in head start. *Journal of Clinical Child Psychology, 30,* 283–302.

Whitehead, D. (2007). Reviewing health promotion in nursing education. *Nurse Education Today, 27,* 225–237.

Wylie, A., Soethout, M., & Holt, T. (2010). Facilitators and teachers: Are health promotion learning outcomes pragmatic? In A. Wylie & T. Holt (Eds.), *Health Promotion in Medical Education* (pp. 169–184). Oxford: Radcliffe.

Wylie, A., & Thompson, S. (2007). Establishing health promotion in the modern medical curriculum: A case study. *Medical Teacher, 29*(8), 766–771.

World Health Organization. (1986). The Ottawa Charter for Health Promotion: *First International Conference on Health Promotion*, Ottawa, 21 November 1986. Copenhagen: WHO Regional Office for Europe.

World Health Organization. (2000). *Nurse and midwives for health: A WHO European strategy for nursing and midwifery education*. Copenhagen: WHO Regional Office for Europe.

World Health Organization. (2004). Prevention of mental disorders: Effective interventions and policy options. Geneva: WHO.

Wylie, A., & Holt, T. (Eds.). (2010). *Health promotion in medical education*. Oxford: Radcliffe.

Chapter 16
The Promotion and Delivery of Mental Health Services in Primary Care Settings

Gary Bailey and Sabine Bährer-Kohler

16.1 Introduction

Primary health care is about providing an 'essential health care' (WHO 2007). Primary care settings are settings, where primary care is given by health care professionals/providers.

Primary care is an important part of the continuum of care of the whole population and there is a specific interrelationship which requires an intensive collaboration between health services. (Australian Commission on Safety and Quality in Health Care 2010).

Often the drive to improve the quality of care in general while reducing costs has led to widespread attempts to promote evidence-based care (Lau et al. 2016).

Many years ago the Alma-Ata Conference started to mobilize a "Primary Health Care movement" of experts, professionals and institutions, governments and civil

---

G. Bailey (✉)
School of Social Work Urban Leadership Certificate Program, 300 The Fenway,
Boston, MA 02115, USA
e-mail: gary.bailey@simmons.edu

G. Bailey
Dynamics of Racism and Oppression Sequence, 300 The Fenway, Boston, MA 02115, USA

G. Bailey
Simmons College School of Social Work, 300 The Fenway, Boston, MA 02115, USA

G. Bailey
School of Nursing and Health Sciences, 300 The Fenway, Boston, MA 02115, USA

G. Bailey
Center for Primary Care-Harvard Medical School, 635 Huntington Avenue, 2nd Floor,
Boston, MA 02115, USA

S. Bährer-Kohler
Dr. Bährer-Kohler & Partners, Birsstrasse 58, 4052 Basel, Switzerland
e-mail: sabine.baehrer@datacomm.ch

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_16

society organizations, researchers and grassroots workers and organizations. They undertook to tackle the health inequalities in all countries (WHO 2008). But until today a mismatch between expectations and performance exist (WHO 2008), e.g., until today there is no standardized model for the commissioning and provision of primary mental healthcare services. The current patterns of service provision can vary greatly (Royal College of Psychiatrists 2012).

The World Health Organization (2008) suggested that it will be important for the future, that, e.g., a transformation and regulation of existing health systems should happen, with the inclusion of universal access and social health protection of everybody. Beside these points, primary care should deal with the health of everyone in the community. And they postulated that primary care should act as a coordinator of a comprehensive response at all levels.

Mental health services are services that provide specialist care for people with mental illness. These can include specialized mental health care delivered in public acute and psychiatric hospital settings, specialized community mental healthcare services, and specialized residential mental healthcare services and other services like supported accommodation and social housing programs (Australian Institute of Health and Welfare 2016).

A significant number of people with mental illness do not use mental health services, e.g., to receive treatment for their symptoms and care (Maulik et al. 2010).

Early intervention and prevention are great opportunities, both to improve people's life chances. Primary care is where these investigations can happen (Royal College of Psychiatrists 2012).

The characteristics of families, neighborhoods, and communities can have as much influence on health as does the traditional healthcare system (Braverman 2014; Maulik et al. 2010). Important is that "social network" is a more objective concept corresponding to the number and frequency of contacts with support networks of a person, whereas social support is a more subjective concept of perceived support (Maulik et al. 2010).

Increased contact with the social network and higher levels of social support can be associated with greater use of general services. However for several reasons, more social support can also be associated with use of fewer services within the specialty psychiatric sector (Maulik et al. 2010). For psychiatric outpatients, a less cohesive social structure can be associated with a delay in accessing services because of a delay in recognizing psychological and other problems (Carpentier and White in Maulik 2002).

There can be many advantages for integrating mental health services into primary health settings and primary care settings like, e.g., reducing stigma and a better identification of comorbidity (WHO 2007).

Other determinants of mental health are for example environmental factors and influences. For instance, families living in poorer quality housing may be exposed to environmental factors such as have been seen in Flint Michigan (USA) with the presence of excessive levels of lead in the publics drinking water (Massey 2004). Asthma triggers caused by environmental degradation such as the dumping of hazardous materials in poor communities and areas of the world increased interpersonal violence that affects communities; and social isolation (Ross et al. 2016). Transportation systems affect access to health care, disease transmission, pollution, and traumatic injury rates. Income segregation, in which low-income individuals disproportionately reside in discrete areas, is also linked with poorer mental health and options for care (Ross et al. 2016), e.g., a lack of local supermarkets limits access to healthy foods, while higher convenience store concentrations can be associated with higher smoking rates and increased rates of obesity (Ross et al. 2016).

Furthermore, other factors like state and federal policies can have influences, even when those are not directly related to health they can have profound effects on health. For example, employees without paid sick days are more likely to send a sick child to school where their illness can worsen and spread to other children (Ross et al. 2016).

To conclude, primary mental healthcare services should have a focus on prevention and early identification and primary mental health care should integrate a holistic approach, because mental health has always physical, psychological, and social elements (Royal College of Psychiatrists 2012).

16.2 Changes in Health Care and Healthcare Education in the United States of America

Over the past 5 years, the evolution of America's healthcare systems has forever changed medical education. The "Affordable Care Act-ACA" (United States Government 2010), competency-based education requirements, shifting payment models, and patient expectations have drastically changed how we educate and assess competence of future physicians (Society for Teachers of Family Medicine 2015).

These changes have required the development of more progressive ideas and responses for:

- Innovative curriculum to educate physicians and allied health professionals for a new system of care
- Teaching about the patient-centered medical home and "Accountable Care Organizations-(ACO's)"
- Implementing and teaching about new payment models
- Meeting accreditation requirements
- Promoting student interest in family medicine
- Implementing emerging technologies in practice and in training programs
- Promoting faculty and resident scholarship
- Instituting effective faculty development
- Transitioning to interprofessional education
- Teaching about the triple aim: better care, better health, and lower cost (STFM 2015)

The US and its healthcare system face substantial challenges, including suboptimal outcomes, and poor value despite having some of the world's highest healthcare costs. There are widening health disparities, and an aging population with increasingly complex chronic conditions (The Commonwealth Fund 2014). To address these challenges greater integration of health-promoting activities and behaviors are needed into daily life instead of a narrow focus on episodic treatment of illness (The Commonwealth Fund 2014). Such a mindset represents a great shift for the US healthcare system and US culture, in general. It requires that policymakers, business people, and community leaders recognize how what they do affects health and incorporate potential health impacts as considerations in their decision-making, e.g., clinicians, who experience in day-to-day practice the impact of social and behavioral factors on health, are key players. Clinicians can have the potential to educate the public, advice policymakers, design and drive innovation, working with urban planners, the business community, attorneys, engineers, teachers, and a host of others to promote change (The Commonwealth Fund 2014).

More clinicians are needed who reflect and have ties to diverse populations, understand their issues, and possess the knowledge and skills to lead promotion and change. Newly trained clinicians need to comprehend the fundamental properties of societal institutions, conventions, and values that influence positive mental health outcomes. Traditional clinical training does not provide clinicians enough with the expertise and skills to achieve the community and system changes needed to address these factors (The Commonwealth Fund 2014).

16.3 Changes in the Understanding About Mental Health-Influences for Mental Health Services

In the United States throughout much of the twentieth century, the influence of Sigmund Freud was immense over psychiatry and other allied mental health disciplines (Vendantam 2005). Today many practitioners discuss interventions with their patients such as the use of serotonin reuptake inhibitors and brain functioning. In the mid-twentieth century psychiatrists and other allied mental health practitioners such as social workers and psychologists often evaluated their patients through the lens of Freudian concepts such as transference and repression. Without common definitions of the symptoms they encountered, psychiatrists often disagreed over what ailed their patients (Vendantam 2005). Columbia University psychiatrist Robert Spitzer led efforts to update American psychiatry’s manual of mental disorders in 1980 and again in 1987. Experts drew up lists of specific symptoms associated with particular mental disorders and gave the field a common lexicon. “The Diagnostic and Statistical Manual of Mental Disorders, commonly known as the DSM, became the bible of the medical model of psychiatry” (Vendantam 2005).

In response to increasing concerns about the persisting and widening inequities, the World Health Organization (WHO) established the Commission on Social Determinants of Health (CSDH) in 2005 to provide advice on how to reduce them. The Commission's final report which was launched in August 2008, contained three overarching recommendations:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess the impact of action.

The World Health Organization in its April 2016 fact sheet "Mental health: strengthening our response" states that multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time (WHO 2016).

Persistent socioeconomic pressures are recognized risks to mental health for individuals and communities (WHO 2016). The clearest evidence is associated with indicators of poverty, including low levels of education (WHO 2016). Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyles, risks of violence, and physical ill-health and human rights violations (WHO 2016).

Mental health services and for the conception for mental health services in general, it has to be taken into account that beside professional competence, e.g., in the medical field or diagnostic field,

- a broad perspective has to be included to reach the client/patient in primary care settings, to treat them adequately,
- to prevent mental diseases, and
- to promote mental health.

16.4 Interprofessional Education and Work

The US Children's Bureau in the 1970s called for the use of an "Interdisciplinary model" when caring for children with Special Health Care Needs. It is important to note that language is important when it comes to the use of the terms such as multidisciplinary; interdisciplinary; transdisciplinary; and interprofessional.

George Thibault of the Macy Foundation, a leader in this area of practice, states quite succinctly when asked why these changes are necessary: "The health care system will not be able to keep pace with explosive changes unless it moves to a team based model" (Thibault 2011).

Calls for interprofessional competency are not new (IPEC 2011).

The Institute of Medicine (IOM) in 1972 issued recommendations citing the obligation of academic health centers to conduct, e.g., interdisciplinary education and patient care (cf. Newhouse and Spring 2010). Producing health providers who are prepared for effective interprofessional collaboration has been recognized as essential to improving patient safety, providing patient-centered care, and effectively managing populations. In the intervening four decades, efforts to establish interprofessional curricula have occurred at individual institutions and within professions. The result is that islands of successful interprofessional training exist but there are no standards to ensure that this training becomes the norm (IPEC 2011).

In response to the Institute of Medicine's report in 2000, the Council on Graduate Medical Education (COGME) and the National Advisory Council on Nurse Education and Practice (NACNEP) came together to identify how to improve health professions education to reduce errors and improve patient safety. In their joint statement to the "Secretary of Health and Human Services and Congress," they asserted that "patient safety cannot be accomplished without interdisciplinary practice approaches." They recommended that health professionals from different disciplines should be trained together as part of a necessary step towards breaking down the historical divide between them and providing trainees with the knowledge and skills to collaborate for patient safety and they made several recommendations to guide the Interprofessional Education Curriculum (IPE), including:

1. Interdisciplinary training should be mandatory.
2. Use simulation and problem-based education, stressing that "collaborative team approaches should be stressed in both education and evaluation…the team should be graded, rather than individuals."
3. Evaluate learners on interdisciplinary collaboration in both exams and clinical practice. Training in "clinical settings should require the incorporation of interdisciplinary delivery of care focused on development and implementation of systems to enhance patient safety…Initial programs should emphasize interdisciplinary issues such as teamwork, conflict resolution, and practical use of informatics to promote collaboration in enhancing patient safety."(cf. Newhouse and Spring 2010).

In 2011 the "Interprofessional Education Collaborative Expert Panel" brought together the fields of nursing, medicine, pharmacy, and dentistry with the goal of bridging the gaps among these professions and laying out a learning continuum that from pre-licensure education through actual practice (Interprofessional Education Collaborative Expert Panel 2011).

The panel's report sets out four Competency Domains:

- Values/Ethics for Interprofessional Practice
- Roles/Responsibilities
- Interprofessional Communication
- Teams and Teamwork.

16.5 Definitions

Interprofessional Collaborative Practice
Interprofessional collaborative practice is defined as occurring: "When multiple health workers from different backgrounds work together with patients, families, caregivers, and communities to deliver the highest quality of care" (WHO 2010).

Interprofessional Education
"When students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (WHO 2010).

Unifying Core Concept of Inter-professional Collaborative Practice is defined as "the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population…it involves continuous interaction and knowledge sharing between professionals, organized to solve or explore a variety of education and care issues all while seeking to optimize the patients participation… Inter professionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working" (D'Amour and Oandasan 2005).

Interprofessional Collaborative Practice: Core Competencies
This section will discuss the necessary core competencies in facilitating an inter-collaborative model of delivery and will focus on the following areas

- Values/Ethics for Interprofessional Practice
- Roles/Responsibilities
- Interprofessional Communication
- Teams and Teamwork

(a) **Values and Ethics**:

Interprofessional collaboration places the interests of the patients and populations at the center of interprofessional health care delivery. Practitioners work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services (IPEC Expert Panel Report 2011).

(b) **Roles/Responsibilities**:

It is important that individual practitioners effectively communicate one's roles and responsibilities clearly to patients, families, and other professionals; that they recognize the limitations in their skills, knowledge, and ability; and use the full scope of knowledge, skills and abilities of available health professionals (IPEC Expert Panel Report 2011).

(c) **Interprofessional Communication**:

It is central to interprofessional collaboration that practitioners listen actively and encourage ideas and opinions from other team members; that they use respectful language appropriate to a given difficult situation, crucial conversation, or to rectify an interprofessional conflict. This is enhanced when practitioners choose communication tools and techniques, including information systems and communication technologies to facilitate discussions and enhance team function.

(d) **Teams and Teamwork**:

To ensure the effective development of “Teams and Teamwork”, it is essential to describe the process of team development and roles and practices of effective teams. That teams once they are developed come to a consensus on the ethical principles to guide all aspects of patient care and team work; reflect on individual and team performance for individual as well as team performance improvement (IPEC Expert Panel Report 2011).

Because the baby boomers continue to age, they will increasingly need, e.g., social work services, ranging from mental health and family counseling to health education, group programs, and case management.

Professional social workers counsel students to prevent high dropout rates, work with formerly incarcerated individuals to ensure positive community reentry, and help patients diagnosed with serious illness to make informed decisions about their care (Bailey 2008).

Professional social workers not only provide services and practice in a variety of settings including child welfare and foster care agencies, community action centers, hospitals, government offices, mental health centers, homeless shelters, and schools they also work with persons of diverse ethnic, cultural, racial, economic, sexual orientation and social backgrounds. Social workers can help people overcome some of life’s most difficult challenges including poverty, discrimination, abuse, addiction, physical illness, divorce, grief and loss, unemployment, underemployment, educational problems, disability, and mental illness (Bailey 2008).

Take Away Messages

- The promotion and delivery of mental health services in primary care settings is an ongoing process. Universal access for everybody has to be created and implemented.
- Primary care settings should be reachable for clients and should focus on the demands of the patients/clients, and should integrate high quality and professional standards in their professional work. This requires a broad perspective, in the inclusion of multidisciplinary and interdisciplinary approaches.
- The promotion and delivery of mental health services in primary care settings has to implement a holistic approach.

- Interprofessional collaboration has to place the interests of the patients and populations at the center of interprofessional health care delivery.
- In the United States or North America the interprofessional education collaborative (IPEC) exists. Its founding members were:
  - American Association of Colleges of Nursing (AACN)
  - American Association of Colleges of Osteopathic Medicine (AACOM)
  - American Association of Colleges of Pharmacy (AACP)
  - American Dental Education Association (ADEA)
  - Association of American Medical Colleges (AAMC)
  - Association of Schools and Programs of Public Health (ASPPH).
- The World Health Organization has published a framework for actions around the world on interprofessional education and collaborative practice in 2010. http://www.who.int/hrh/resources/framework_action/en/. (Accessed 17 November 2016).

References

Australian Institute of Health and Welfare's (AIHW). (2016). Overview of mental health services in Australia. Retrieved November 17, 2016, from https://mhsa.aihw.gov.au/background/.

Australian Commission on Safety and Quality in Health Care. (2010). Guidebook for primary care settings. Retrieved November 17, 2016, from https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/OSSIE_Toolkit-Guide-PrimaryCareSettings.pdf.

Bailey, G. (2008). United States Congress. Committee on education and labor, subcommittee for healthy families and communities. Hearings, July 29th 2008. 110th Congress, Washington: GPO. 2008 (statement of Gary Bailey, MSW, ACSW, past president, the National Association of Social Workers).

Braverman, P. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*, *129*(Suppl 2), 19–31. Retrieved November 17, 2016, from https://www.ncbi.nlm.nih.gov.

Carpentier, N., & White, D. (2002). Cohesion of the primary social network and sustained service use before the first psychiatric hospitalization. *Journal of Behavioral Health Services and Research, 29,* 404–418.

D'Amour, D., & Oandasan, I. (2005). Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. *Journal of Interprofessional Care, 19* (Suppl 1), 8–20.

Interprofessional Education Collaborative Expert Panel. (2011). Core competencies for interprofessional collaborative practice: Report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative. Retrieved November 17, 2016, from http://www.aacn.nche.edu/education-resources/ipecreport.pdf.

Lau, R., Stevenson, F., Ong, B. N., Dziedzic, K., Treweek, Sh., Eldridge, S. et al. (2016). Achieving change in primary care—causes of the evidence to practice gap: Systematic reviews of reviews. *Implementation Science, 11*, 40. Retrieved November 17, 2016, from https://implementationscience.biomedcentral.com/articles/10.1186/s13012-016-0396-4.

Massey, R. (2004). Environmental Justice: income, race, and health. Global development and environment institute. Tufts University. Retrieved November 17, 2016, from http://www.ase.tufts.edu/gdae/education_materials/modules/Environmental_Justice.pdf.

Maulik, P. K., Eaton, W. W., & Bradshaw, C. P. (2010). The effect of social networks and social support on common mental disorders following specific life events. *Acta Psychiatrica Scandinavica*, *122*(2), 118–128. doi:10.1111/j.1600-0447.2009.01511.x.

Newhouse, R. P. & Spring, B. (2010). Interdisciplinary evidence-based practice: Moving from silos to synergy. *Nursing Outlook, 58*(6), 309–317. Retrieved November 17, 2016.

Ross, T., Parsons, C., Vallas, R. (2016). Creating safe and healthy living environments for low-income families. Center of American Progress. Retrieved November 17, 2016, from https://cdn.americanprogress.org/wp-content/uploads/2016/07/14065816/SafeAndHealthyHomes-report.pdf.

Royal College of Psychiatrists. (2012). Guidance for commissioners of primary mental health care services. Retrieved November 17, 2016, from http://www.rcpsych.ac.uk/pdf/JCP-MH%20primary%20care%20(March%202012).pdf.

STFM. (2015). 49th Society of Teachers of Family Medicine (STFM) Annual Spring Conference, Minneapolis, Minnesota. MD Linx from https://www.mdlinx.com/family-medicine/conferences/49th-society-of-teachers-of-family-medicine-annual-spring-conference/237471/.

Thibault, G. (2011). Team-based competencies building a shared foundation for education and clinical practice. In: Interprofessional education collaborative expert panel. (2011). Core competencies for interprofessional collaborative practice: Report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative. Retrieved November 17, 2016, from http://www.aacn.nche.edu/education-resources/ipecreport.pdf.

The Commonwealth Fund. (2014). U.S. health care from a global perspective. Spending, use of services, prices, and health in 13 countries. Retrieved November 17, 2016, from http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective.

United States Government. (2010). The patient protection and affordable care act. Retrieved November 17, 2016, from https://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

Vedantam, S. (2005). Patients' diversity is often discounted. Washington Post. Retrieved November 17, 2016, from https://www.washingtonpost.com/archive/politics/2005/06/26/patients-diversity-is-often-discounted/2b64f99d-0b3a-4c82-a01d-4e9bd652f399/.

World Health Organization. (2007). Integrating mental health services into primary health care. Geneva. Retrieved November 17, 2016, from http://www.who.int/mental_health/policy/services/3_MHintoPHC_Infosheet.pdf.

World Health Organization. (2008). The world health Report 2008: Primary health care now more than ever. Retrieved November 17, 2016, from http://www.who.int/whr/2008/whr08_en.pdf.

World Health Organization. (2010). Health Professions Networks—Nursing & Midwifery—Human Resources for Health—World Health Organization—Department of Human Resources for Health. Retrieved November 17, 2016, from http://apps.who.int/iris/bitstream/10665/70185/1/WHO_HRH_HPN_10.3_eng.pdf.

World Health Organization. (2016). Mental health: strengthening our response retrieved. Retrieved November 17, 2016, from http://www.who.int/mediacentre/factsheets/fs220/en/.

Chapter 17
Community Mental Health and Mental Health Promotion—Lebanon

Brigitte Khoury and Sariah Daouk

Key Points

- The progress of mental health systems is being halted by the following challenges: wide treatment gap, unequal distribution of mental health services, stigma, and discrimination (Abdulmalik et al. 2016).
- Community Mental Health (CMH) aims to promote mental health and prevent mental disorders within a local population. It is a population-based approach that relies on the participation and cooperation of its citizens in the planning, implementation, and evaluation process of the interventions.
- To use the community's knowledge and the participation of community members is essential for the success and sustainability of CMH.
- Regional crises and conflicts are resulting in an influx of refugees to Lebanon, a country with a poorly coordinated mental healthcare system.
- Continued efforts are being made to better integrate mental healthcare into the primary healthcare network in Lebanon.
- The majority of community mental health services tailored for refugees in Lebanon are provided by international NGOs, in coordination with local ones, and with the ministries of Public Health and of Social Affairs.
- Challenges of implementing sustainable community mental health interventions relate to unstable political climate, limited/intermittent funding, increasing number of incoming refugees, unequitable access or sporadic availability of services across the country, misconceptions about mental disorders and treatment modalities among members of the society, as well as difficulty with recruitment and maintaining qualified health and social workers trained in refugee and crisis management.

B. Khoury (✉) · S. Daouk
Department of Psychiatry, American University of Beirut, Beirut, Lebanon
e-mail: bk03@aub.edu.lb

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_17

17.1 Introduction

Globally, more than 2/3 of individuals with serious mental disorders are not receiving suitable care (Ngui et al. 2010). Mental health resources are scarce, not distributed equally, inefficiently used, particularly in low-income and middle-income countries (LAMIC) (Saxena et al. 2007). Limited access to treatment increases suffering to individuals, their families, and their communities. Mental health systems are not moving forward equally across countries due to the following obstacles: the wide treatment gap witnessed with the increasing number of individuals with mental disorders who are not accessing treatment, the unequal distribution and availability of mental health services, and the added layer of stigma and discrimination of mental disorders (Abdulmalik et al. 2016). As such, there is a need for mental health system reforms worldwide to scale up mental health care services provided. Evidence suggests that a balanced model of service delivery between hospital settings and community mental healthcare centers is what is required to have an optimal comprehensive mental healthcare system (Thornicroft et al. 2004). This paper will focus on the latter mental health services and focus on Lebanon.

Mental health promotion and prevention frameworks are set out to strengthen individuals and communities, to ensure supportive environments, and to enable better access by reorienting health services and removing structural barriers on a societal level (Herrman et al. 2005). Historically, the main philosophy behind "deinstitutionalization" was to move away from confinement in large asylum-based psychiatric institutions and to establish alternative mental healthcare and drug treatment services in the community to better facilitate social integration of people with mental disorders (Greenblatt et al. 1983). The movement was first witnessed in countries across Western Europe (such as Germany, Sweden, and the United Kingdom), North America, Australia, and New Zealand (Chow et al. 2013). In view of that, individuals with mental disorders are to be treated and rehabilitated within close proximity where they live without much restriction on their personal liberties. Visits to the community mental health centers might be less stigmatizing than to hospital settings. That being said, it should be noted that this model of care might not be optimal for a small portion of individuals suffering from acute disabling mental disorders and lacking support from family or friends.

17.2 Community Mental Health (CMH)

Thus, Community Mental Health (CMH) was a developmental community approach to promote the mental health status of a population through: "(a) addressing population needs in ways that are accessible and acceptable; (b) building on the goals and strengths of people who experience mental illnesses; (c) promoting a wide network of supports, services, and resources of adequate capacity; and

(d) emphasizing services that are both evidence-based and recovery-oriented" (Thornicroft et al. 2011).

A global clinical consensus points out that individuals receiving community-based mental health care have better overall health and mental health outcomes as well as better quality of life than individuals being treated in institutional psychiatric settings (Thornicroft et al. 2013). Studies revealed that effective and efficient mental health services are being delivered in primary community healthcare settings situated in low and middle-income countries (Weinmann et al. 2016; Wiley-Exley 2007). By integrating mental health and primary healthcare services, individuals suffering mental disorders have better access to outpatient care, and reduced costs of hospitalization and emergency department visits (Krupski et al. 2016). Adding to primary care mental health services, the World Psychiatric Association (Thornicroft et al. 2010) suggests that the following categories which need to be developed in a medium-resource setting such as Lebanon are: acute inpatient services; community-based residential care; outpatient/ambulatory clinics; community mental health teams; and work, occupation, and rehabilitation services.

Practically speaking, a variety of multidisciplinary outreach teams (specialists, professionals, and nonprofessionals) need to collaborate and divide the tasks to scale up community-oriented mental health services. Participation is a cornerstone of CMH (Murphy et al. 2014). Members of the community should assume responsibility for mental health service and be engaged in the planning, execution, and evaluation processes of these interventions. Genuine dialog and transfer of knowledge among members of the community and service providers is crucial. Mental health professionals ought to collaborate with key informants to better capture the local reasoning inherent in that society, the cultural norms, and the behavioral expectations.

17.3 The Case of Lebanon

Lebanon is an upper middle-income country located in the Eastern Mediterranean region (World Bank 2016). Lebanon has an estimated population of 6.2 million (Central Intelligence Agency 2016), among which the country hosts approximately 2 million refugees from Syria, Palestine, and Iraq (Central Intelligence Agency 2016; UNHCR 2016) as well as over 200,000 registered foreign migrant workers (Republic of Lebanon 2015). The poverty line was reported to fall under 27% (Central Administration for Statistics and World Bank 2012) and the total unemployment rate was recorded at 22.1% (Central Intelligence Agency 2016).

Due to the armed conflicts, political instability, and human rights violations in the Arab region, Lebanon is witnessing an increase of roughly 30% of its total population (Blanchet et al. 2016). As such, many displaced individuals are struggling to cope with the day-to-day hardships of impoverishment and security. The consequences of war-related exposure are resulting in higher rates of mental disorders and the inability of mental health services present to meet these needs (Amawi et al. 2014). This all adds up to the burden of mental disorders placed on individuals, families, communities in Lebanon.

17.4 Current Status of Mental Health in Lebanon

Studies have indicated that at least 25% of Lebanese individuals have suffered at some point of a mental disorder throughout their lifetime (Karam et al. 2008). Up to 17% suffered a mental disorder in the past year yet only 10.9% among those received treatment (Karam et al. 2006). The phenomenon of not receiving effective treatment is referred to as treatment gap" by the World Health Organization (WHO) (Dua et al. 2011). A delay of 6–28 years between onset of mental disorder and receiving suitable professional treatment was noted in Lebanon (Karam et al. 2008). In comparison to other countries, 30.5% of individuals in the USA receive treatment (Kessler et al. 2005) and 27% across Europe (Alonso et al. 2007). Community-based epidemiological study indicated that the lifetime prevalence of mental disorders in older adults was 17.4% (Karam et al. 2016) and this is lower than younger counterparts (25.7%). One in four adolescents residing in Beirut suffers a psychiatric disorder, mainly anxiety disorder and ADHD, yet only 6% of them sought professional treatment (Maalouf et al. 2016).

The Lebanese Mental Health system can be characterized as fragmented and poorly coordinated, such that the majority of mental healths services are offered in the capital, Beirut (Yehia et al. 2014).The majority of outpatient services are delivered in the private sector, mainly in clinics composed of psychiatrists and psychologists (World Health Organization 2015). Few mental health providers work in a multidisciplinary team, mostly found when working with children suffering learning disabilities. There is a lack of community mental health services oriented toward mental health promotion and prevention (Alameddine et al. 2015).

Lebanon has five active mental health hospitals; eight community-based psychiatric units in general hospitals; 42 outpatient mental health facilities; 5 day-treatment facilities; 7 community residential facilities; and 30 inpatient mental health beds in forensic facilities (World Health Organization 2015). The Lebanese government health departments and ministries allocate only 4.8% of the total health budget to mental health expenditures, such that more than half of that amount covers hospital inpatient admissions and the cost of psychotropic medications (World Health Organization 2011). The main source of financing of outpatient mental health services is personal payments and most insurance companies do not cover mental health services. (Yehia et al. 2014).

Only one broad legislative decree addresses mental health issues in Lebanon, more specifically, it stipulates the treatment and legal protection of individuals with mental disorders (Lebanese Act no 72/1983 1983). In 2014, a National Mental Health Program (NMHP) was launched by the Ministry of Public Health (MoPH), the World Health Organization (WHO), the United Nations International Children's

Emergency Fund (UNICEF), and International Medical Corps (IMC) to reform mental health care and to engage universities and scientific societies. Following that, in 2015, a national mental health and substance use strategy (2015-2020) was launched "to ensure the development of a sustainable mental health system that guarantees the universal accessibility to high quality mental health curative and preventive services through a cost-effective, evidence-based, multidisciplinary approach, with an emphasis on community involvement, continuum of care, human rights, and cultural relevance" (Ministry of Public Health 2015).

17.5 Community Mental Health Services in Lebanon

Despite the presence of a Lebanese mental health decree, not all components (Lebanese Act no 72/1983 1983) are being implemented (Lebanese Act no 72/1983 1983). Ideally, in order to promote community integration, access to treatment for a person with mental disorder should be available in their direct vicinities and not restricted to psychiatric institutions (United Nations General Assembly Resolution 62/170 2007).The Lebanese government has not yet created community mental healthcare follow-up centers which can operate alongside the existing psychiatric institutions, associations, or primary healthcare settings as cited in the mental health decree mentioned above (Kerbage et al. 2016).

Outside the private sector, mental health services are provided in an unstructured manner across dispensaries and in primary health care centers. In Lebanon, community mental health is still in its "formative stage" despite it being a collectivistic society, and it is predominated by civil society organizations which target community development goals (such as poverty alleviation, gender equity, youth development, etc.), human rights advocacy, and refugee services (Amer et al. 2015). The following ratios reflect the shortage of mental health providers working in public mental health facilities and NGOs with: 1.26 psychiatrists, 3.42 psychologists, 3.26 nurses; 1.06 occupational therapists, and 1.38 social workers per 100,000 inhabitants (World Health Organization 2015). Many of them also have their own private practice or work in for profit facilities.

Continued efforts by the MOPH and Ministry of Social Affairs (MOSA) are being made to better integrate mental health into the primary healthcare network in Lebanon by means of providing essential psychotropic medications to the centers and dispensaries, and by offering trainings to the healthcare no specialized staff on detection, management, and referrals based on the mental health Gap Action Programme—Intervention Guide (mhGAP-IG) developed by the World Health Organization (WHO). Also, 57 Social Development Centers (SDCs) received human resources, financial, and technical support as part of MOSA's "National Plan to Safeguard Women and Children in Lebanon" in collaboration with UNICEF and this European Union (EU) fund enabled 27,000 individuals to receive psychosocial care (UNHCR 2016). This initiative reinforces community-based prevention approaches.

17.6 Refugee Services and Community Health Centers

Displacement can alter the social roles and existing support networks and this can act as a risk factor for family tension, psychological distress, and identity crises (Hassan et al. 2015). In response to emergencies arising out of regional crises, the MOPH collaborated with WHO and UNICEF to develop the Mental Health and Psychosocial Support Services (MHPSS) taskforce to oversee and harmonize services designated for Syrian refugees at all levels. An assessment report by the UNHCR revealed that 36 organizations are following through with the MHPSS guidelines in Lebanon and many of the services provided were at the individual level (psychotherapy and psychotropic medications) and did not address the community's basic needs which contribute to the collective distress experienced by many due to violations of human rights (health services, shelter, food and education for children, safety, enabling access to family support) (El Chammay et al. 2013).

A systemic review in the Middle East which has found that children and adolescents living in such conflict zones are most at risk of developing mental and behavioral problems; however, community support and involvement have proved to help them with coping strategies in light of their traumatic experiences (Dimitry 2012). Alarmingly, around 79% of Syrian refugees in Lebanon are children and women (Interagency Information Management Unit 2016). On a community level, Child Protection and Gender-Based Violence, and Strengthening of Community and Family Support activities are the most disseminated in Lebanon (El Chammay et al. 2013). A national training program in Psychological First Aid (PFA) was implemented to increase Lebanese mental health field workers' readiness to respond to the needs of children and families affected by the Syrian crisis (Akoury-Dirany et al. 2015). They were trained to better screen for mental disorders and adopt a referral strategy.

Group interventions have also been found to be beneficial and resourceful to refugees. Hence, a group psychosocial interventions addressed to women refugees was developed, and included teaching them problem-solving skills. Several training sessions were conducted with health and social workers across Lebanon to facilitate these women's groups with the aim of teaching them problem-solving skills which in their turn they will use in resolving the issues they are facing, whether familial, personal, psychological, financial, social, etc. The groups were addressed for displaced adult Syrian Refugees women and Lebanese women residing in host communities. Outcome measures indicated significant improvements in both depression and anxiety scores post intervention. In addition, women reported gaining new friendships and better stress management skills (Khoury 2016).

The elderly are another vulnerable group. 65% of older refugees exhibit psychological distress symptoms, which is a much higher rate than other age groups (HelpAge, Handicap International 2014) and some of the most prevalent conditions revealed by elder Syrian refugees in Lebanon were anxiety, depression, feelings of unsafety, and loneliness (Strong et al. 2015).

The conflict in Syria drove many Palestinian refugees to relocate to neighboring countries such as Lebanon. The harsh living conditions in the 12 refugee camps scattered in Lebanon is associated with many physical and mental conditions among refugees such as depression, anxiety, and distress (Chaaban et al. 2010). Regrettably, Palestinian refugees residing in Lebanon are not eligible to the country's social services, including health care (US Department of State 2014). To address the healthcare needs of the Palestinian refugees in Lebanon, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) established 28 primary health care facilities which provide a Family Health Team (FHT) approach based on the World Health Organization values (UNRWA, Health in Lebanon). Services provided include general medical checkups, preventative maternal and child care, radiology, and dental care. The UNRWA also offers partial financial assistance for certain treatments in secondary and tertiary health care in agreed-upon hospitals (UNRWA 2016). Consider a 2-year community-based child protection project implemented with Palestinian refugees in the South of Lebanon (O'Leary et al. 2015). A referral social work service was set up to facilitate the collaboration of respective authorities, UNRWA, and community members.

17.7 Challenges in Community Mental Health

In a systemic review of mental health interventions in Middle Eastern Arab countries, the following major barriers to implementation were found: acceptability within cultural context, poor understanding of treatment modalities, and access to services and availability (Gearing et al. 2013). A portion of Arab individuals are skeptical about mental health professionals and find it difficult to establish trust because they might view them as lacking empathy, genuineness, and discarding religious beliefs (Al-Krenawi et al. 2000).

There is a lack of public knowledge of mental health conditions and possible psychosocial treatment options in Lebanon (Karam et al. 2006). Mental health awareness can dispel many supernatural myths and clarify misconceptions about the etiology of mental disorders. Awareness support networks, such as Embrace Fund associated with the department of Psychiatry at the American University of Beirut, are beginning to flourish with the hopes of dispelling misconceptions about mental health, support to break down the stigma of mental disorders, and making access to treatment easier (Embrace Fund 2016). It aims to do so by continuously consulting with policymakers, offering some financial assistance in acute psychiatric cases, and providing communities with mental health resources in Lebanon. Embrace Fund is also working on a fundraising campaign to establish a National Suicide Prevention Helpline for Lebanon. It is now in the detailed planning and development stage.

Knowledge in itself is not enough if it is not linked to practical actions sought to better one's overall well-being. Stigmatizing attitudes about mental health conditions, shame, and fear of discrimination, is some of the reasons why Arab individuals might find it difficult to seek professional help to an extent that many are more likely to first discuss mental health related issues with religious healers rather than healthcare professionals (Dardas et al. 2015). This can delay the proper trajectory of diagnosis and treatment of mental health conditions. As such, to combat the negative toll of stigma attached to mental health, it is vital to increase the mental health literacy through awareness-raising campaigns, to involve supportive community stakeholders, and to incorporate cultural customs and religious competency whenever adapting international evidence-based protocols designed for delivery.

Unfortunately, Lebanon does not have documented mental health policies or proper health legislation to support and integrate mental health promotion and primary prevention interventions (Kerbage et al. 2015). Even though community mental health services exist in Lebanon, particularly in response to the regional crises, it seems that they are not sustainable mainly because of financial constraints, poor long-term planning, and inadequate human resources (Amer et al. 2015). Furthermore, semi-structured interviews with Lebanese Primary Health Care (PHC) experts revealed that the current situation of care can be depicted as curative-oriented with a poor referral system for continued care as opposed to it being prevention oriented and promoting health (Alameddine et al. 2015). Some of the obstacles which emerged from the thematic analysis pointed out recruitment issues (gender imbalances, lack of qualified human resources in health, and poor management) and retention issues (financial constraints, lack of professional development, poor working environment) particularly in remote rural settings. There seems to be a lack of female healthcare providers in the Primary Health Care, and in the Lebanese workforce more generally, around 23% of total workforce (Tutelian 2016). This can be reflected negatively on access and satisfaction with the quality of care. Arab male patients reported to be more satisfied with outpatient psychiatric quality of care and had greater expectations as opposed to female, with significant difference, in a cross-sectional study (Bener et al. 2013). Arab women come from conservative backgrounds and many might prefer same-sex providers. With regards to the dearth of qualified human resources, academic institutions do not offer specialization in community psychology per se (Amer et al. 2015) and many career opportunities might seem more appealing and rewarding.

17.8 Future of Community Mental Health

The regional crises are resulting in a greater influx of Syrian refugees to Lebanon in addition to the already existing Palestinian refugees. In order to promote mental health and prevent mental disorders on a communal level, many additional strategies can be adopted. Public awareness campaign about war-related mental health difficulties can spread mental health literacy with the hopes of reducing the stigma attached to mental disorders, particularly when it involves topics such as suicide or chronic disabling mental conditions. Respective ministries and health authorities in the government ought to engage and collaborate with community field workers to promote self-reliance and encourage social support especially when it comes to marginalized groups such as people with mental disorders. Individuals with Serious Mental Illness (SMI) and belonging to certain disparity groups (women, elderly, refugees, racial, and sexual minorities, etc.) might face more challenges accessing health care services. A technical brief (Swinson Evans et al. 2016) mapped the available interventions in the United States and discussed the gaps in the available literature. It was highlighted that the use of collaborative care, case management approaches, telepsychiatry, and culturally adapted therapeutic models were effective in reducing disparities among patients with SMI and in ameliorating access and adherence to treatment.

A review of the psychosocial interventions held in the Eastern Mediterranean region indicated that family strengthening psychosocial programs and school-based interventions ameliorated life skills, resilience, coping, and prevent psychological distress among children (Barry et al. 2015). For instance, health and social workers can be trained in manual-based parenting skills interventions so that they can share knowledge acquired with mothers of children with behavioral problems in disadvantaged areas. A field study (Fayyad et al. 2010) used and adapted the manual for externalizing disorders "Helping Challenging Children" which was disseminated by the World Psychiatric Association (WPA) Presidential Global Program on Child Mental Health, WHO, and the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP). Findings from this study indicated a significant decrease in children's externalizing behavior, less corporal punishment by parents, and an improvement in positive parenting ratings in Lebanon. Training health care providers in local health dispensaries and primary care settings on screening for mental health disorders and ways to carry out referrals to specialized care is another way to provide equitable access to services. All this needs to be done with proper mapping and monitoring of services and capacities available to ensure long-term positive outcomes and reducing disability.

17.9 Conclusion

In Lebanon, mental health system is poorly coordinated and there are no documented law decrees to support the implantation of CMH and health prevention initiatives. Recent efforts are being made by the ministries of public health and social affairs to integrate mental health in primary healthcare settings. A Mental Health and Psychosocial Support Services (MHPSS) task force has been assigned to attend to the needs of the increasing number of Syrian refugees in the country. CMH centers are mostly run by international NGOs, in coordination with local. Implementation challenges include the limited funding, human resources, management issues, and the pervasive stigma of mental disorders.

17.10 Take Away Messages

- Community Mental Health (CMH) aims to promote mental health and prevent mental disorders.
    - Prevention initiatives are as important as treatment-based curative services.
    - CMH services enable individuals to receive affordable evidence-based treatment and rehabilitation services in the proximity of where they live.
    - CMH emphasizes strengthening people's capacities and opts to cater to the needs of the underserved and marginalized groups such as refugees, internally displaced persons, minorities, etc.
    - A cornerstone of CMH is the engagement of member of the community with the mental health interdisciplinary team and the use of already ingrained available networks of the socioeconomic context.
- Having a national mental health policy and laws which promote CMH can facilitate the following: identifying mental health research priorities, proper strategic planning and investments, mapping available resources and capacities, monitoring records on health information systems, and enabling dialog across sectors particularly when it relates to community mental health services.
- To better attend to refugees' mental health needs, several organizations are adopting the Mental Health and Psychosocial Support Services (MHPSS) guidelines.
- Existing mental health services in Lebanon are mostly treatment-oriented as opposed to being prevention-oriented and promoting mental health.
- Community, family, and child support activities are disseminated across the country; however, many are not sustainable due to unstable political climate in the country, limited funding, social stigma of mental disorders, staffing issues, and uneven distribution and availability of services.

17.11 Resources

- **2016**: To read more about the Lebanese National Mental Health Program, see the link below: http://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program.
- **2016:** To learn more about community mental health interventions from around the world, check out the Mental Health Innovation Network (MHIN). It is composed of a community of global mental health innovators (researchers, practitioners, policy-makers, service user, advocates, and donors). http://mhinnovation.net/community.
- **2016:** For representative epidemiologic projects, see Community Mental Health Journal. link.springer.com/journal/10597.

- **2016**: For a narrative review of range of community-oriented mental health interventions in the LAMIC area and which is the best practices being implemented, check out the article: Petersen, I., Evans-Lacko, S., Semrau, M., Barry, M.M., Chisholm, D., Gronholm, P., et al. (2016). Promotion, prevention, and protection: interventions at the population- and community-levels for mental, neurological, and substance use disorders in low- and middle-income countries. *International Journal of Mental Health Systems*, 10, 30. doi:10.1186/s13033-016-0060-z. eCollection 2016.
- **2016**: For an overview of the current status of CMH and the recent issues of planning and provision of mental health systems, check out the article entitled: Thornicroft, G., Deb, T., Henderson, C. (2016). Community mental health care worldwide: current status and further developments. *World Psychiatry*, 15, 276–286. doi:10.1002/wps.20349.
- **2010**: To read more about the WPA guidance points on implementing CMH care and obstacles to avoid, read the article entitled "WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care." https://www.ncbi.nlm.nih.gov/pubmed/20671888.

References

Abdulmalik, J., & Thornicroft, G. (2016). Community mental health: a brief, global perspective. *Neurology, Psychiatry and Brain Research, 22*(2), 101–104. doi:10.1016/j.npbr.2015.12.065.

Akoury-Dirani, L., Sahakian, T. S., Hassan, F. Y., Hajjar, R. V., & Asmar, K. E. (2015). Psychological first aid training for Lebanese field workers in the emergency context of the Syrian refugees in Lebanon. *Psychological Trauma: Theory, Research, Practice, and Policy, 7*(6), 533–538. doi:10.1037/tra0000028.

Alameddine, M., Khodr, H., Mourad, Y., Yassoub, R., & Abi Ramia, J. (2015). Upscaling the recruitment and retention of human resources for health at primary healthcare centres in Lebanon: A qualitative study. *Health &Social Care in The Community,* 1–10. doi:10.1111/hsc.12210.

Al-Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health and Social Work, 25,* 9–22.

Alonso, J., Codony, M., Kovess, V., Angermeyer, M. C., Katz, S. J., Haro, J. M., et al. (2007). Population level of unmet need for mental healthcare in Europe. *British Journal of Psychiatry, 190,* 299–306. doi:10.1192/bjp.bp.106.022004.

Amawi, N., Mollica, R. F., Lavelle, J., Ossama, O., & Nasir, L. (2014). Overview of research on the mental health impact of violence in the middle East in light of the Arab spring. *The Journal of Nervous and Mental Disease, 202,* 625–629. doi:10.1097/nmd.0000000000000174.

Amer, M. M., El-Sayeh, S., Fayad, Y., & Khoury, B. (2015). Community psychology and civil society: Opportunities for growth in Egypt and Lebanon. *Journal of Community Psychology, 43*(1), 49–62.

Barry, M. M., Clarke, A. M., & Petersen, I. (2015). Promotion of mental health and prevention of mental disorders: priorities for implementation. *Eastern Mediterranean Health Journal, 21*(7), 503–511.

Bener, A., & Ghuloum, S. (2013). Gender difference on patients' satisfaction and expectation towards mental health care. *Nigerian Journal of Clinical Practice, 16*(3), 285–291.

Blanchet, K., Fouad, F. M., & Pherali, T. (2016). Syrian refugees in Lebanon: The search for universal health coverage. *Conflict and Health*, 10(1). doi:10.1186/s13031-016-0079-4.

Central Administration for Statistics and World Bank. (2012). Snapshot of Poverty and Labor Market outcomes in Lebanon Based on Household Budget Survey 2011/2012. Retrieved August 30, 2016, from http://www.cas.gov.lb/images/Excel/Poverty/Snapshot%20of%20Poverty%20and%20Labor%20Market%20in%20Lebanon.pdf.

Central Intelligence Agency. (2016). The world fact book: Lebanon. Retrieved August 30, 2016, from https://www.cia.gov/library/publications/the-world-factbook/geos/le.html.

Chaaban, J., Ghattas, H., Habib, R., Hanafi, S., Sahyoun, N., Salti, N., et al. (2010). Socio-economic survey of Palestinian refugees in Lebanon. *American University of Beirut*, 8. Retrieved August 30, 2016, from http://server.multiframes.com/~psfund/public/uploads/files/AUB-%20UNRWA%20socio%20economic%20survey%20on%20the%20Palestinian%20people.pdf.

Chow, W. S., & Priebe, S. (2013). Understanding psychiatric institutionalization: a conceptual review. *BMC Psychiatry*, 13(1). doi:10.1186/1471-244X-13-169.

Dardas, L. A., & Simmons, L. A. (2015). The stigma of mental illness in Arab families: a concept analysis. *Journal of Psychiatric and Mental Health Nursing, 22*(9), 668–679.

Dimitry, L. (2012). A systematic review on the mental health of children and adolescents in areas of armed conflict in the Middle East. *Child: Care, Health and Development, 38*(2), 153–161. doi:10.1111/j.1365-2214.2011.01246.x.

Dua, T., Barbui, C., Clark, N., Fleischmann, A., van Ommeren, M., Poznyak, V., et al. (2011). Evidence-based guidelines for mental, neurological, and substance use disorders in low-and middle-income countries: summary of WHO recommendations. *PLoS Med, 8*(11), e1001122.

El Chammay, R., Kheir, W., Alaouie, H. (2013). UNHCR assessment of mental health and psychosocial services for Syrian refugees in Lebanon.

Embrace Fund. (2016). Retrieved August 30, 2016, from https://www.embracefund.org/page/suicide-prevention-helpline.

Fayyad, J. A., Farah, L., Cassir, Y., Salamoun, M. M., & Karam, E. G. (2010). Dissemination of an evidence-based intervention to parents of children with behavioral problems in a developing country. *European Child and Adolescent Psychiatry, 19*(8), 629–636.

Gearing, R. E., Schwalbe, C. S., MacKenzie, M. J., Brewer, K. B., Ibrahim, R. W., Olimat, H. S., et al. (2013). Adaptation and translation of mental health interventions in Middle Eastern Arab countries: a systematic review of barriers to and strategies for effective treatment implementation. *International Journal of Social Psychiatry, 59*(7), 671–681.

Greenblatt, M., & Norman, M. (1983). Deinstitutionalization: health consequences for the mentally ill. *Annual Review of Public Health, 4*(1), 131–154.

Hassan, G., Kirmayer, L. J., Mekki-Berrada, A., Quosh, C., & el Chammary, R. (2015). *Culture, context and the mental health and psychosocial wellbeing of Syrians: A review for mental health and psychosocial support staff working with Syrians affected by armed conflict*. Geneva: UNHCR.

HelpAge, Handicap International. (2014). Hidden victims of the Syrian crisis: disabled, injured and older refugees. London/Lyon. Retrieved August 30, 2016, from https://data.unhcr.org/syrianrefugees/download.php?id=5812.

Herrman, H., Saxena, S., & Moodie, R. (2005). *Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne*. Geneva: World Health Organization.

Interagency Information Management Unit. (2016). April Statistical Dashboard. Retrieved August 30, 2016, from https://data.unhcr.org/syrianrefugees/download.php?id=11076.

Karam, E. G., Mneimneh, Z. N., Dimassi, H., Fayyad, J. A., Karam, A. N., Nasser, S. C., et al. (2008). Lifetime prevalence of mental disorders in Lebanon: First onset, treatment, and exposure to war. *PLoS Med, 5*(4), e61. doi:10.1371/journal.pmed.0050061.

Karam, E. G., Mneimneh, Z. N., Karam, A. N., Fayyad, J. A., Nasser, S. C., Chatterji, S., et al. (2006). Prevalence and treatment of mental disorders in Lebanon: A national epidemiological survey. *The Lancet, 367*(9515), 1000–1006. doi:10.1016/S0140-6736(06)68427-4.

Karam, G., Itani, L., Fayyad, J., Karam, A., Mneimneh, Z., & Karam, E. (2016). Prevalence, correlates, and treatment of mental disorders among Lebanese older adults: A national study. *The American Journal of Geriatric Psychiatry, 24*(4), 278–286. doi:10.1016/j.jagp.2015.10.006.

Kerbage, H., El Chammay, R., & Richa, S. (2016). Mental Health Legislation in Lebanon: Nonconformity to international standards and clinical dilemmas in psychiatric practice. *International Journal of Law and Psychiatry, 44,* 48–53.

Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., et al. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine, 352,* 2515–2523.

Khoury, B. (2016). Running women's problem solving skills groups with Syrian refugees in Lebanon. In *Symposium presented at the International Congress of Psychology*. Yokohama, Japan.

Krupski, A., West, I. I., Scharf, D. M., Hopfenbeck, J., Andrus, G., Joesch, J. M., et al. (2016). Integrating primary care into Community Mental Health centers: Impact on utilization and costs of health care. *Psychiatric Services*. doi:10.1176/appi.ps.201500424.

Lebanese Act no 72/1983. (1983).Welfare act and protection and treatment of mentally ill patients.

Lebanese Parliament. Law No. 220: The Rights of Persons with Disabilities.

Maalouf, F. T., Ghandour, L. A., Halabi, F., Zeinoun, P., & Tavitian, L. (2016). Psychiatric disorders among adolescents from Lebanon: prevalence, correlates, and treatment gap. *Social Psychiatry and Psychiatric Epidemiology*, 1–12. doi:10.1007/s00127-016-1241-4.

Ministry of Public Health. (2015). *Mental Health and Substance Use- Prevention, Promotion, and Treatment- Situation Analysis and Strategy for Lebanon 2015–2020*. Beirut: Ministry of Public Health. http://www.moph.gov.lb/userfiles/files/National%20Strategy%20for%20Mental%20Health%20and%20Substance%20Use%20Promotion,%20Prevention%20and%20Treatment%20for%20Lebanon%202015-2020-%20ENGLISH.pdf.

Murphy, J. W., & Rigg, K. K. (2014). Clarifying the philosophy behind the community mental health act and community-based interventions. *Journal of Community Psychology, 42*(3), 285–298. doi:10.1002/jcop.21610.

Ngui, E. M., Khasakhala, L., Ndetei, D., & Roberts, L. W. (2010). Mental disorders, health inequalities and ethics: A global perspective. *International Review of Psychiatry, 22*(3), 235–244. doi:10.3109/09540261.2010.485273.

O'Leary, P., Hutchinson, A., & Squire, J. (2015). Community-based child protection with Palestinian refugees in South Lebanon: Engendering hope and safety. *International Social Work, 58*(5), 717–731. doi:10.1177/0020872815584427.

Republic of Lebanon. (2015). Ministry of Labor Annual Report. Retrieved August 30, 2016, from http://www.labor.gov.lb/_layouts/MOL_Application/AnnualReport.aspx?lang=en.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. *The Lancet, 370*(9590), 878–889.

Strong, J., Varady, C., Chahda, N., Doocy, S., & Burnham, G. (2015). Health status and health needs of older refugees from Syria in Lebanon. *Conflict and Health*, 9(1). doi:10.1186/s13031-014-0029-y.

Swinson Evans, T., Berkman. N., Brown, C., Gaynes, B., & Palmieri Weber, R. (2016). Disparities within serious mental illness. Technical Brief No. 25. *AHRQ Publication* No.16-EHC027-EF. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved November 14, 2016, from www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Thornicroft, G. (2011). *Oxford textbook of community mental health*. Oxford: Oxford University Press.

Thornicroft, G., Alem, A., Santos, R. A., Barley, E., Drake, R. E., Gregorio, G., et al. (2010). WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care. *World Psychiatry, 9*(2), 67–77.

Thornicroft, G., & Tansella, M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care. *The British Journal of Psychiatry, 185*(4), 283–290. doi:10.1192/bjp.185.4.283.

Thornicroft, G., & Tansella, M. (2013). The balanced care model for global mental health. *Psychological Medicine, 43*(04), 849–863. doi:10.1017/S0033291712001420.

Tutelian, M. (2016). Women status in Lebanon. Retrieved August 30, 2016, from http://www.cas.gov.lb/images/PDFs/Gender_statistics/Status%20of%20Women%20in%20Lebanon_Dr.%20Maral%20Tutelian.pdf.

UNHCR. (2016). Syria Regional Refugee Response - Inter-agency Information Sharing Portal. Retrieved August 30, 2016, from http://data.unhcr.org.

United Nations General Assembly Resolution 62/170. (2007). Convention on the rights of persons with disabilities and the optional protocol thereto. http://www.un.org/disabilities/convention/conventionfull.shtml.

UNRWA. (2016). Health in Lebanon. Retrieved August 30, 2016, from http://www.unrwa.org/activity/health-lebanon.

US Department of State. (2014). Country Reports on Human Rights Practices: Lebanon. Retrieved August 30, 2016, from http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/#wrapper.

Weinmann, S., & Koesters, M. (2016). Mental health service provision in low and middle-income countries: recent developments. *Current Opinion in Psychiatry, 29*(4), 270–275. doi:10.1097/YCO.0000000000000256.

Wiley-Exley, E. (2007). Evaluations of community mental health care in low-and middle-income countries: a 10-year review of the literature. *Social Science and Medicine, 64*(6), 1231–1241. doi:10.1016/j.socscimed.2006.11.009.

World Bank. (2016). Lebanon. Retrieved August 30, 2016, from http://data.worldbank.org/country/lebanon.

World Health Organization. (2011). Mental Health Atlas. Retrieved August 30, 2016, from http://www.who.int/mental_health/publications/mental_health_atlas_2011/en/.

World Health Organization. (2015). WHO-AIMS Report on Mental Health System in Lebanon. Retrieved August 30, 2016, from http://www.moph.gov.lb/userfiles/files/Programs%26Projects/NationalE-healthProgram/WHO_AIMS_Lebanon%202015.pdf.

Yehia, F., Nahas, Z., & Saleh, S. (2014). A roadmap to parity in mental health financing: the case of Lebanon. *Journal of Mental Health Policy and Economics, 17*(3), 131–141.

Chapter 18
Economic Evaluation of Mental Health Promotion and Mental Illness Prevention

Jeroen Luyten and Martin Knapp

18.1 Introduction

The more we understand the causes and mechanisms that underlie diseases around the globe, the broader the scope becomes for successful intervention. Since the days of Hippocrates in ancient Greece this optimistic, hopeful message has been practised by those in the field of medical science and public health, with spectacular results in terms of increased human longevity and health-related quality of life. Over recent decades however, this cheerful credo of progress has been tempered by the realization that the resources needed to implement these interventions are constrained by 'scarcity' and that difficult priority-setting choices are unavoidable. This is the basic premise of the 'dismal science' of economics. People who make resource allocation decisions—government ministers, health insurance fund managers, research and development scientists of pharmaceutical companies, and almost every purchaser, provider and professional in the field of health and social care—have to make tough choices about how best to use finite resources in the battle against the disease burden.

For many people these decisions are literally a matter of life and death, and it is in every citizen's interest that these often hugely important choices are made in a rational, reasonable, equitable and transparent manner. In this context, efficiency is an essential guiding principle for priority-setting. The concept of efficient resource allocation is connected to the concept of 'opportunity cost': the value of the best alternative use of a set of resources. For instance, the opportunity cost of funding a

---

J. Luyten (✉)
Leuven Institute for Healthcare Policy, KULeuven, Leuven, Belgium
e-mail: J.Luyten@lse.ac.uk

J. Luyten · M. Knapp
Personal Social Services Research Unit, London School of Economics and Political Science, London, UK
e-mail: M.Knapp@lse.ac.uk

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_18

drug could be the extra social housing that could be offered with that same amount of money (and the benefits that the alternative use would generate). Clearly, assessing the opportunity costs of a healthcare programme is a complex endeavour as it requires a lot of counterfactual information about the costs and consequences of competing health projects and strategies.

To assist decision-makers in this process of assessing the opportunity costs (and hence the efficiency) of a healthcare programme, economic evaluation has been developed as a standardized methodology to estimate the health and well-being gains achievable through an intervention relative to their cost, or, vice versa, how much health can be achieved per euro invested in a programme (Drummond et al. 2005; Gold et al. 1996; Drummond and McGuire 2001; Dolan and Olsen 2002). Such information allows comparison of the efficiency of competing healthcare interventions (but equally well, other ways of spending public or private money) in achieving a set social objective, e.g. maximizing health and well-being. Economic evaluation has become increasingly influential in many areas of health policy worldwide, often with a formal role in coverage decision-making (often called ‘health technology assessments’) (Clement et al. 2009; Dakin et al. 2014; Cerri et al. 2014).

There are two reasons why this evolution should be seen as a welcome opportunity to those who are involved in the field of mental health.

The first reason is *efficiency*. Large health gains are still achievable in the domain of mental health (Knapp and Iemmi 2016). Many services are chronically under-provided, and under-treatment often comes at a substantial individual and societal cost: individuals who are mentally ill can struggle to find or keep employment, for example, or they may face out-of-pocket payments for some services; and society more generally may have to fund costly, long-term care, pick up the impacts of reduced productivity because of disrupted employment or provide key support through family actions. Moreover, mental illness often has knock-on effects on patients’ physical health, e.g. higher risks of type II diabetes, obesity, various cardiovascular diseases and problems associated with substance abuse as well (Knapp and Iemmi 2016). Many of these problems are preventable through early detection and intervention. Instead of opting for a ‘wait and treat’ scenario for mental illnesses, which is often more expensive and less effective, there is a sound economic argument for investments to be made in prevention and promotion (Knapp et al. 2011). Economic evaluation can provide the necessary evidence to consider this argument.

Second, there is also an important *equity* argument. In most countries spending on mental health care does not exceed 5% of the total healthcare budget, despite the fact that it makes a much larger contribution to the total disease burden (WHO 2013). Even though many people are aware that mental health problems can be as harmful as physical health problems, solidarity appears to be much more difficult to establish in the former case. Economic evaluation presents an objective, evidence-based platform for comparing the costs and effectiveness of both mental and physical health care and it can help to counter inequitable dynamics and discrimination that work to the disadvantage of mental health.

Our aim in this chapter is to present a short overview of the methods of economic evaluation and their main elements.

18.2 Costs

An obvious starting point for any form of economic evaluation is gauging the costs that are linked to a disease or an intervention. Costs are the sacrifices that are required either by action (choosing to implement a programme) or by inaction (allowing illness to occur) and they can be calculated by combining information about the volumes of the resources consumed multiplied by their respective unit values.

18.2.1 Resource Use

Resource use can occur in more or less visible ways, by patients or public bodies, in different sectors of society and with different timings. It can be helpful to classify resource use as direct or indirect.

Direct costs, as the term is usually employed, represent the resources used by providing a programme: doctor hours, medications, hospital beds, overhead costs of running facilities, capital costs of buildings, training or equipment, etc. Typical resources that are used by providing a programme are consumables in the healthcare domain (e.g. drugs), labour (e.g. nursing), capital (e.g. hospital buildings) and overhead costs (e.g. electricity, management). In the domain of mental health, costs may also occur beyond the health sector, such as costs associated with crime and criminal justice, special housing, social care and extra provision in schools because of special educational needs (Knapp and Iemmi 2016). These non-medical, social costs can be difficult to estimate and they, therefore, complicate accurate cost assessment. They can nonetheless be crucial in gauging the economic impact of mental illness.

Indirect costs are the sacrifices made by patients, caregivers and the wider society through the time lost through being sick, undergoing treatment or providing unpaid care. These costs mainly represent productivity losses because of inability to work (although the provision of unpaid care does not necessarily or always take time away from paid employment, of course). The indirect costs associated with some mental illnesses can be substantial. For instance, the bulk of the cost burden related to depression is indirect, attributable to inability to work (unemployment, absenteeism and reduced productivity when at work) rather than costs associated with healthcare treatment. An English study estimated that 90% of the total societal cost of depression was due to unemployment and absenteeism from work (Thomas and Morris 2003). Nonetheless indirect costs remain a difficult area for economic evaluation because of the methodological difficulties that occur in estimating production losses and gains. Two methods are usually proposed: the 'human capital' and the 'friction cost' approach. The human capital method uses estimated lost earnings as an approximation of the value that would be lost by not being able to work. This can be estimated on an individual, sectoral or national basis (i.e. gross domestic product per capita) depending on the available information about gross salaries and how well they represent productivity. The friction cost method assumes that—given some degree of unemployment—absent employees can be replaced and that real productivity loss would be limited to the 'friction period' in which a new employee needs to be found and trained. As very few people are completely irreplaceable in their jobs, the friction cost method seems to be more appealing, but it is also the technically more demanding one, which is one reason why human capital estimates are more commonly used in empirical studies.

18.2.2 Unit Values

After listing all the resources that are used in various sectors affected by a disease or an intervention, they must then be valued. Generally, unit costs of resources are understood as the prices or charges of the various resources (such as the market price of a medication). However, some resources are more difficult to value. Overhead costs such as those from shared equipment, personnel or facilities can perhaps be attributed to individual interventions by relating the proportion of resource items used by the intervention relative to the total potential use of the resource; for instance, the number of hours a facility can be used to provide a treatment as a proportion of the total hours the facility is available for medical use. However, this is not always straightforward to do in practice. Some resources (e.g. unpaid time from caregivers) do not have market prices but are not without value (Drummond et al. 2005). In those cases, a value may be imputed that approximates the value of the resource should there be a market in which the resource could be bought. For instance, caregiver time can be valued at average market wage or at hourly wages for overtime. Several valuing techniques exist to put a monetary figure on non-market resources, most notably 'contingent valuation' (willingness-to-pay or willingness-to-accept studies) (McIntosh et al. 2010).

In most economic evaluations an average cost estimate (e.g. a constant unit price) is used as value per unit. This is correct when resources are actually bought at that price. However, when a programme that is being evaluated uses (or would use, if scaled up) a very large share of a resource, then this could change the demand and supply dynamics of the market for that resource, which could in turn alter the market price. It could increase scarcity, e.g. in an epidemic when hospital beds become more and more scarce and the unit value of additional beds goes up (Luyten and Beutels 2009). Or it could lead to lower unit values, e.g. when there is one big buyer with sufficient market power to force prices down, such as a government buying vaccines in bulk. Because unit costs can be complex (especially on a large, global scale) the next section will explain in more detail the economic background to them.

18.2.3 Scale Effects

In economic evaluation unit costs are often considered constant, and this leads to a total cost estimate of an intervention. In reality, however, most costs are not fixed but dependent on the scale at which production is organized. The unit cost of a used resource usually depends on the quantity needed, and consequently the total cost of the programme will also depend on the scale at which it is provided. Therefore, one should keep in mind that unit costs are variable and that high costs can also be the result of producing at a suboptimal scale.

To demonstrate this scale dependency of unit costs, we need to distinguish between fixed and variable cost elements, and between the average and marginal costs of producing units (see Fig. 18.1). *Fixed* costs do not vary with the quantity ‘produced’. Typically, these are start-up costs or investments in buildings or equipment but potentially also salaries of employees with long-term contracts: for a psychiatric facility these cost elements probably do not vary even when the number of patients treated in the facility changes quite a lot. *Variable* costs are the elements that change when more patients are treated, for instance the costs of medications or psychosocial treatments, the ‘hotel costs’ (of food and laundry, for example) or additional employees hired or fired on short-term contracts to respond to changing patient numbers. The total cost of running this facility is the sum of the fixed and variable elements. *Average* costs are defined as total costs per ‘unit produced’, or in our example the cost per patient treated in the facility. *Marginal* costs are defined as the change in costs ‘at the margin’ and they express how much total costs go up if the facility treats one additional patient. A typical pattern for these costs is represented in Fig. 18.1. Average fixed costs (AFC) always decrease when more patients are treated, whereas marginal costs (MC) typically increase. The latter is due to the ‘law of diminishing returns’: when we use more of an input in a production process, the additional contribution of that input usually becomes smaller. For instance, when more and more nurses are hired in a facility, their additional contribution to treating patients will decrease (e.g. because of lack of sufficient working space). When marginal costs increase (and new patients become more and more expensive), average variable costs (AVC) will follow. More specifically, the moment when the cost of treating one more patient exceeds the average variable cost, the latter will be pushed upwards. Ultimately, the average total cost (ATC) per patient will be the sum of the average fixed cost and average variable cost per patient. When costs follow this typical pattern there will be an optimal scale for the facility:

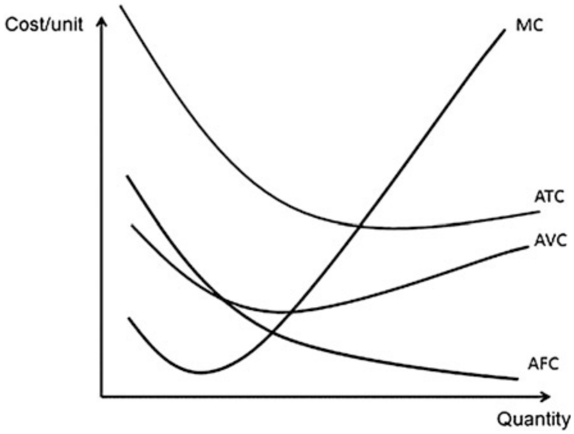


Fig. 18.1 Example of various cost curves

the one where the average total costs per patient are minimized. This is the point where the marginal cost equals the average cost per patient. When average costs are above marginal costs it is worthwhile to increase production. On the other hand, when the cost of an additional patient is above the average cost per patient it is better to scale down.

18.2.4 Costing Perspectives

Last but not least, the resource use that is to be considered in an economic evaluation and the unit costs that should be applied depend upon the perspective from which the analysis is undertaken. Costing analyses can be undertaken from different perspectives depending on the purpose of the study, and this will in turn capture the pattern of payment: is it the patient and their relatives, a third party payer (such as an insurance company), the hospital, the employer or the wider society (for example, through taxation)? The two perspectives that are most frequently adopted in published health economic evaluations are that of the healthcare payer [e.g. the National Health Service (NHS) in England] and that of society as a whole. If a *payer perspective* is adopted, only those costs that are incurred by the payer would be considered, and these would primarily include the direct costs of providing the programme (since other costs predominantly fall on other parties). If a *societal perspective* is adopted, all costs that are carried by society should be included in the analysis. This latter approach can be more complicated as more sectors will need to be included, and so a wider range of volume and unit cost data will be needed. A societal perspective is also likely to include a number of indirect costs, which—as we noted above—are generally not straightforward to value.

18.3 Partial Economic Analyses

Economic evaluations that limit themselves to an assessment of only the cost implications of diseases and health care programmes are called *partial economic analyses*. Cost-of-illness studies, for example, estimate the total cost attributable to a disease (e.g. how much does schizophrenia cost the national economy?). Cost comparisons look at competing intervention strategies in terms of their cost impact (their immediate budget impact or with consideration of financial consequences in the future). The main advantage of these analyses is that they are straightforward in their interpretation and they can present a convincing if partial economic case for or against an investment, especially when the course of action under evaluation can yield cost-savings. But they are only reporting part of the story if it is not known what outcomes will result.

This cost-saving argument is often used in the context of prevention, i.e. that the extra costs of prevention may be fully compensated by future reductions in treatment costs and productivity losses. However, research indicates that such generalizations are mostly untrue. A systematic review of 599 economic evaluations published between 2000 and 2005 showed that preventive measures and treatments are very similar in terms of their cost implications, that most of them cost rather than save money (although obviously they do generally generate health benefits, often substantial ones) and that only a minority of preventive measures lead to actual cost-savings (Cohen et al. 2008). However, in the specific domain of mental health the cost-savings argument seems to be much more powerful. In 2011, Knapp and colleagues were commissioned by the Department of Health for England to examine the economic pay-off in terms of direct (immediate or longer term) monetary savings to the public sector, to employers or to the wider society for fifteen interventions aimed at preventing mental illness or promoting mental health (Knapp et al. 2011). For all these interventions there was already a well-established evidence base of effectiveness—this was a crucial consideration to ensure that these analyses did not offer merely a partial (cost-only) view on the consequences of action. The study gave national and local decision-makers information on whether these fifteen interventions—which those decision-makers were keen to explore on the grounds of health improvement and quality of life gains—were also at least affordable or perhaps even cost-saving. Table 18.1 summarizes the findings from these evaluations. The 15 models used data from trials, surveys or administrative databases to estimate probabilities, outcomes, costs and projected savings. The authors tried to use a consistent approach across interventions in covering and measuring economic impacts. Interventions were examined from the perspective of either society as a whole, or the health system (the NHS in England), or the whole public sector. The overarching approach to the analysis was conservative, so the measures of net economic impacts that were obtained should be seen as minimum estimates of economic gain. The results indicate that for many promotion and prevention interventions there is a strong economic case to be made. Many interventions yield multiple pounds in savings for every pound that is invested, in addition to the previously established gains in health and/or well-being through averting mental health problems.

18.4 Full Economic Analyses

Partial evaluations can be informative from an accounting or financial perspective. They provide information about how to contain costs, how to sustain health budgets or even on how to save money, and they can be powerful arguments to convince decision-makers of the benefits of increasing investments in mental healthcare. However, from a policy point of view, focusing only on the costs and ignoring the effects of healthcare programmes is not defensible, although the study described above could be seen as a 'half-way house', building cost evidence on previously reported effectiveness evidence. In fact, if *only* costs matter, then in many cases the rational course of action would be to cut healthcare spending altogether. But, of course, the objective of healthcare spending is to improve health and well-being for the population served. A full economic evaluation will, therefore, not just focus on

Table 18.1 Total societal returns on investment (all years): economic pay-offs per pound expenditure

Intervention	Return on investment
Early identification and intervention as soon as mental disorder arises	
Early intervention for conduct disorder	7.89
Health visitor interventions to reduce postnatal depression	0.80
Early intervention for depression in diabetes	0.33
Early intervention for medically unexplained symptoms	1.75
Early diagnosis and treatment of depression at work	5.03
Early detection of psychosis	10.27
Early intervention in psychosis	17.97
Screening for alcohol misuse	11.75
Suicide training courses provided to all GPs	43.99
Suicide prevention through bridge safety barriers	54.45
Promotion of mental health and prevention of mental disorder	
Prevention of conduct disorder through social and emotional learning programmes	83.73
School-based interventions to reduce bullying	14.35
Workplace health promotion programmes	9.69
Addressing social determinants and consequences of mental disorder	
Debt advice services	3.55
Befriending for older adults	0.44

costs but aim also to assess the *value-for-money* that an intervention offers. This can be done by comparing not only the costs but also the outcomes of at least two alternative courses of action, one often being implementation of a new healthcare programme (or new therapy) and the other often chosen to be the currently implemented standard of care (or sometimes a 'do nothing' option). The comparison between interventions can be done within a particular field, e.g. which of two interventions is more efficient in treating or preventing postnatal depression? The comparison can also be made for interventions that target two completely different disease areas, or even different public policy areas. Depending on which of these two questions needs to be answered, a different economic evaluation technique will become relevant, as we discuss below. What the different types of evaluation have in common is that they provide insights into how much of a desired outcome we achieve per euro that we invest in a programme. This relationship between extra costs and extra benefits is summarized in an *Incremental Cost-effectiveness Ratio (ICER)*:

$$\boldsymbol{ICER\ for\ intervention\ A\ compared\ to\ intervention\ B} = \frac{(\boldsymbol{Cost\,A} - \boldsymbol{Cost\,B})}{(\boldsymbol{Effect\,A} - \boldsymbol{Effect\,B})}$$

An ICER can take four possible forms, represented in the cost-effectiveness plane in Fig. 18.2. Intervention A can be costlier and lead to lower health gains than B (quadrant IV). If so, A is said to be a strategy that is 'dominated' by B—it is the worse option on both counts (cost and effectiveness). In contrast, A can be less expensive than B and lead to better outcomes (quadrant II). This is, for instance, the case in many of the interventions summarized in Table 18.1. Given their effectiveness, the table shows that they will also lead to lower costs. If so, A is said to be 'dominant' over B. In cases where one strategy dominates or is being dominated, decision-making is straightforward (or at least it should be if efficiency is the only consideration). More difficult decisions arise when one intervention is both more expensive and more effective than the other (quadrant I). Here the decision-maker needs to judge whether paying more for better outcomes is 'worth it'. Are the additional resources that have to be used in order to deliver the intervention or strategy justified by the better effects (outcomes) that are achieved? Similarly, if an intervention is less costly but also less effective than the alternative with which it is compared, are the cost-savings worth the health losses (quadrant III)? These judgements are far from easy to make. One approach is to consider a cost-effectiveness 'threshold', a willingness-to-pay value per health effect, or, on the other hand, a minimal health effect per euro. In the diagram this threshold that separates cost-effective from cost-ineffective interventions is given by the dashed line.

In the following section, we will zoom in on how these outcomes associated with healthcare programmes are defined and measured.

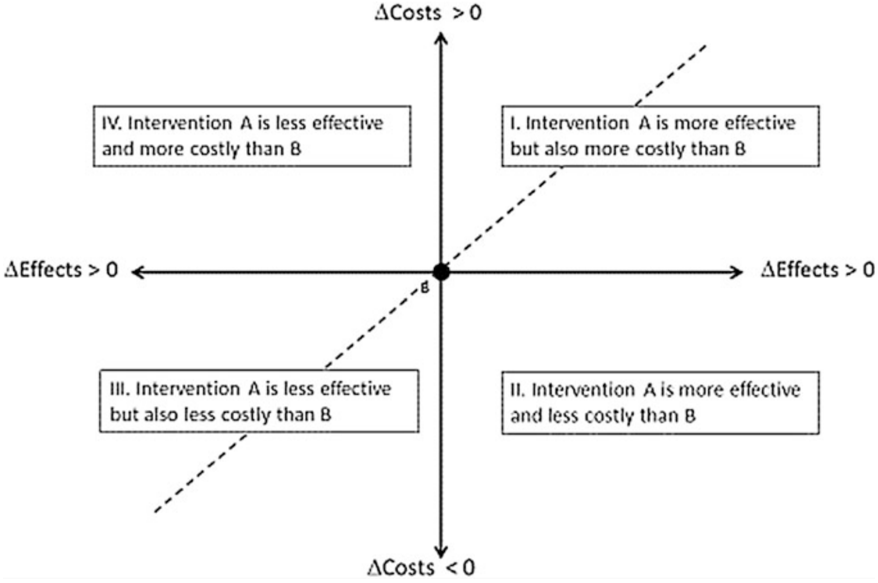


Fig. 18.2 The cost-effectiveness plane

18.5 Outcomes

Outcomes are the units in which the performance of interventions is made *commensurate*. Depending on which outcome measure is used to compare alongside costs, the appropriate economic evaluation technique will have a different label. Which method will be more appropriate depends on the particular piece of information that is needed (i.e. what question the evaluation is asked to address) and the context in which resource allocation decisions need to be made.

18.5.1 Cost-Effectiveness Analysis

In Cost-Effectiveness Analysis health outcomes are expressed in their 'natural' units or 'effects'. These are specific clinical or other natural endpoints that are considered important *in themselves* within a particular disease area (Luyten and Henderson 2017). For example in the field of mental health, relevant outcomes include 'depression-free days achieved', 'relapses prevented' or changes in the severity of symptoms, behaviours or functioning that are typically associated with a particular condition. An ICER expressing the cost per unit of effect allows comparison of the costs of achieving some disease-specific improvement with two or more alternative clinical or other strategies. The main advantage of expressing health outcomes in natural units is that these are often observable, relatively straightforward to measure and, generally, immediately meaningful to clinical staff. The main disadvantage is that they have more limited comparability. For example, cost-effectiveness analyses using outcomes such as 'depression-free days achieved' only allow comparisons with other interventions that can be expressed in terms of cost per depression-free day achieved, and they are not informative beyond that condition-specific context.

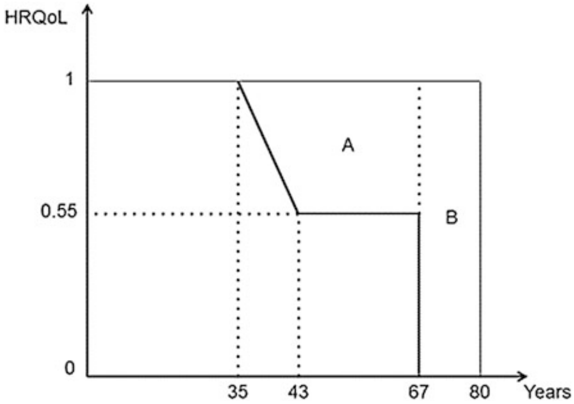
In contrast, outcomes such as 'life-years gained' allow comparisons of a much broader range of interventions in terms of their effect on mortality, but they disregard morbidity and quality of life. As the burden of mental health conditions can be one of long-term morbidity, mortality outcomes usually only have limited informative value. Another disadvantage with using natural units is that this type of measure does not take into account patient preferences, experiences or (ultimately) the impacts of interventions on patients' well-being. Outcome measures in cost-effectiveness analysis that are narrowly clinical in nature can ultimately only be instrumental to the personal experience of patients. Often, important value judgements need to be made when comparing treatments, e.g. when physical side-effects need to be traded-off against gains in mental health outcomes. These experiences become invisible when interventions are only monitored and compared on one particular dimension.

18.5.2 Cost–Utility Analysis

In Cost–Utility Analysis health outcomes are translated into a *generic* measure of health that expresses both the morbidity and mortality effects of an intervention in a single number that is not disease-specific. It therefore allows comparison of health effects across a wide range of conditions (Luyten et al. 2016). There are several of these generic outcome measures available, but the most widely used is the Quality-Adjusted Life Year (QALY) (Weinstein et al. 2009; Brazier et al. 2007). One QALY is equivalent to one year in full health. As illustrated in Fig. 18.3, a health problem can be expressed in terms of the QALYs that are lost due to premature mortality and due to reduced health-related quality of life (HRQoL), and the effect of an intervention can be translated into the number of QALYs gained. Figure 18.3 explains the concept of QALYs. The horizontal axis is the age of a patient. The vertical axis represents the HRQoL at different time points, with a value of one representing perfect health and zero being the equivalent of being dead. In the example presented, a patient is in full health until she contracts a disease at age 35, after which her HRQoL gradually declines until she stabilizes at age 43 at a 45% diminished HRQoL. She dies at age 67 and loses 25.6 of her 80 QALYs. The trapezoid A represents the QALYs she has lost due to morbidity [[(43-35)/2 + (67-43)]*(1-0.55) = 12.6 QALYs]; the rectangle B represents the QALYs lost through mortality [(80-67)*1 = 13 QALYs].

Similar to the natural units of cost-effectiveness analysis, QALYs capture observable health outcomes such as disease episodes and their duration, but they add a subjective appraisal of how bad it is to experience these outcomes. Therefore,

Fig. 18.3 Quality-adjusted life years



they are said to be '*preference-based*' health benefits. Obviously, a key challenge to calculate the QALYs associated with a condition is obtaining this HRQoL estimate, i.e. translating the pain or suffering experienced by people living in that particular health state into a number. One simple way of doing this is by asking respondents to rate the severity of a disease directly on a scale (a visual analogue scale with, at one end, the respondent's idea of perfect health and at the other end the worst imaginable health state).

Two other, choice-based methods that are widely used to elicit these subjective judgements are the 'Time Trade-Off' (TTO) and the 'Standard Gamble' (SG), summarized in Fig. 18.4 (Kaplan 1995; Dolan 2000). The TTO method asks for the number of life-years that someone is willing to sacrifice in order to live in perfect health rather than to live longer but with a particular health problem. As represented in the figure, the HRQoL h associated with that condition would consequently be x divided by t. The SG asks for the maximum mortality risk p that people are willing to take for a hypothetical treatment that would fully cure a state of incomplete health. Consequently, the HRQoL of that condition would be 1-p. These methods provide a common basis on which otherwise incomparable health states become comparable in terms of their severity.

Cost–utility analysis has important advantages over cost-effectiveness analysis, mainly because it extends the scope of comparison from one disease area to the whole health field. But it also has its limitations, especially in the field of mental health. Some researchers question whether the QALY model is adequate to capture the full impact of mental illness (Mulhern et al. 2014; Chisholm et al. 1997). There is a danger that quantifying mental health outcomes on the same scale as physical health outcomes could implicitly adopt the biases and prejudices that exist against mental health. Moreover, mental health problems affect many dimensions of life, some of them not immediately linked to health—for example, increased mental health of parents may translate into better educational support for children, better school performance and eventually better outcomes on labour markets—and these would be missed by the QALY.

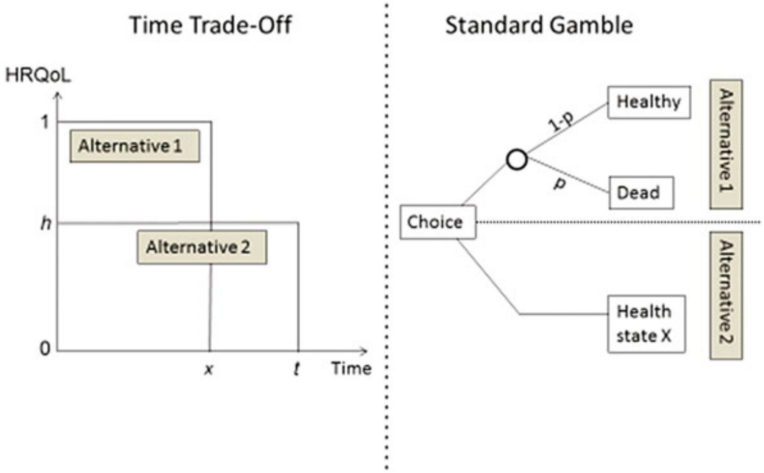


Fig. 18.4 Choice-based methods to assess Health-related quality of life

18.5.3 *Cost–Benefit Analysis*

With Cost–Utility Analysis, interventions are still compared in terms of how much they cost per unit of health gain they generate. Ideally however, one needs to know how valuable these health effects are to patients and societies *all things considered.* Non-health consequences of health gains (e.g. improved parenting) are also part of the value of an intervention. Moreover, to be complete, the value-for-money offered by a health programme needs to be assessed and compared to other forms of public investments as well, rather than with other projects within the health domain only. If so, resource use and its total impact on social welfare can be optimized across the various domains of public policy, rather than just within particular systems (such as the healthcare system) (Pauly 1995; McIntosh et al. 2010). Cost–benefit analysis (CBA) is a method that allows such broader comparisons. It translates health consequences into monetary values and therefore it offers the broadest possible scope for comparison. Comparing the costs associated with an intervention with the monetary value of its effects immediately reveals whether the intervention adds net value and how much. This cost–benefit estimate for one intervention can consequently be compared to other public policy interventions for which the benefits can also be expressed in monetary terms. If reliable monetary figures for health effects were available, CBA would be of indispensable value for allocating public budgets in a way that maximizes welfare for the whole community. However, translating the widely rippling consequences associated with health outcomes into money terms (i.e. into benefits as defined by economic evaluation) is extremely complex. The literature suggests different approaches: the 'human capital approach' (assessing the value of health gains based upon extra income or productivity that could be generated), revealed preferences (based upon observing the actual choices people make where health risks are traded-off against money, e.g. higher salaries for riskier jobs, or buying safer but more expensive cars) or stated preferences. The latter is done by asking people how much they would be willing to pay to receive particular health gains, or how much money they would need to receive to be willing to accept a particular health problem (e.g. a flu episode). Each of these techniques has substantial methodological limitations and practical drawbacks (O'Brien and Viramontes 1994; Hausman 2015) and therefore CBA is rarely used in healthcare studies. Interestingly, one of the very first ever economic evaluations in the mental health field—a randomized controlled trial of the Training in Community Living model in Wisconsin (an assertive outreach service) was a CBA. However, the authors focused exclusively on patient earnings as the monetised benefits of care (Weisbrod et al. 1980).

18.6 Conclusions & Take Away Messages

- All over the world, public funding for health is increasingly constrained and policy-makers face difficult decisions about how to set priorities in the context of the ever-increasing supply of healthcare.
- Whereas a multitude of ethical principles is at stake, an essential value to consider in priority-setting is efficiency.
- Economic evaluation is a systematic way to identify, measure, compare and trade-off the costs and consequences of interventions and it can provide an objective, evidence-based platform to discuss the merits of strategies to promote mental health or to prevent mental illness.
- Mental health problems often generate a complex mix of economic impacts, which makes assessments of costs and consequences more complicated. Often an atypical cost pattern occurs and consequences can extend beyond their pure health impact.
- Several economic evaluation techniques are available, of which the most important are cost–effectiveness analysis, cost–utility analysis and cost–benefit analysis.
- An estimate of an intervention's cost-per-effect, cost-per-QALY or cost-per-monetary-benefit can greatly assist decisions on whether an intervention is ultimately 'worth it' or not.
- Nonetheless, economic evaluation does not and should not 'make' decisions. Correct interpretation of study results can be complex and other values next to efficiency (e.g. equity) play a role in prescribing healthcare resource allocation.
- Mental illness represents a significant and growing challenge to societies and there are good efficiency and equity arguments for increasing investments in mental health care. Investments might not only improve health, functioning and quality of life, but also be attractive from a pure cost-containment perspective.

References

Brazier, J.E., Ratcliffe, J., Salomon, J. (2007). *Measuring and valuing health benefits for economic evaluation*. Oxford: Oxford University Press.

Cerri, K. H., Knapp, M., & Fernandez, J. L. (2014). Decision making by NICE: examining the influences of evidence, process and context. *Health Economics, Policy & Law, 9,* 119–141. doi:10.1017/S1744133113000030.

Chisholm, D., Healey, A., & Knapp, M. (1997). QALYs and mental health care. *Social Psychiatry and Psychiatric Epidemiology, 32,* 68–75.

Clement, F.M., Harris, A., Li, J.J. (2009). Using effectiveness and cost-effectiveness to make drug coverage decisions: a comparison of Britain, Australia, and Canada. *Journal of the American Medical Association, 302*, 1437–43. doi:10.1001/jama.2009.1409.

Cohen, J., Neumann, P., & Weinstein, M. (2008). Does preventive care save money? Health economics and the presidential candidates. *New England Journal of Medicine, 358,* 661–663. doi:10.1056/NEJMp0708558.

Dakin, H., Devlin, N., & Feng, Y. (2014). The influence of cost-effectiveness and other factors on nice decisions. *Health Economics, 24,* 1256–1271.

Dolan, P. (2000). The measurement of health related quality of life for use in resource allocation decisions in health care. In: A. Culyer, J. Newhouse, (Eds.) *Handbook of health economics* (pp. 1724–48). New York: Elsevier.

Dolan, P., & Olsen, J. (2002). *Distributing health care: economic and ethical issues*. Oxford: Oxford University Press.

Drummond, M., & McGuire, A. (2001). *Economic evaluation in health care: merging theory with practice*. Oxford: Oxford University Press.

Drummond, M., Sculpher, M.J., Torrance, G.W., O’Brien, B., & Stoddard, G. (2005). *Methods for the economic evaluation of health care programmes* (Vol. 3). Oxford: Oxford University Press.

Gold, M. R., Siegel, J. E., & Russell, L. B. (1996). *Cost-effectiveness in health and medicine*. New York: Oxford University Press.

Hausman, D. (2015). *Valuing health: wellbeing, freedom and suffering*. Oxford: Oxford University.

Kaplan, R. (1995). Utility assessment for estimating quality-adjusted life years. In: F. Sloan (Ed.) *Valuing health care: costs, benefits, and effectiveness of pharmaceuticals and other medical technologies* (pp. 31–6). New York: Cambridge University Press.

Knapp, M., & Iemmi, V. (2016). Chapter 2: mental health. In R. Scheffler (Ed.), *World scientific handbook of global health economics and public policy*. New York: World Scientific.

Knapp, M., Mcdaid, D., & Parsonage, M. (2011). *Mental health promotion and prevention: the economic case* (p. 2011). London: LSE.

Luyten, J., & Beutels, P. (2009). Costing infectious disease outbreaks for economic evaluation: a review for hepatitis A. *Pharmacoeconomics, 27*(5), 379–389.

Luyten, J., & Henderson, C. (2017). Cost-effectiveness analysis. In D. Razzouk & M. Kayo (Eds.), *Mental health economics: The costs and benefits of psychiatric care*. New York: Springer.

Luyten, J., Naci, H., & Knapp, M. (2016). Economic evaluation of mental health interventions: an introduction to cost-utility analysis. *Evidence-Based Mental Health*. doi:10.1136/eb-2016-102354.

McIntosh, E., Clarke, P., Frew, E., & Louviere, J. (2010). *Applied methods of cost-benefit analysis in health care*. Oxford: Oxford Unversity Press.

Mulhern, B., Mukuria, C., & Barkham, M. (2014). Using generic preference-based measures in mental health: psychometric validity of the EQ-5D and SF-6D. *British Journal of Psychiatry, 205*(3), 236–243.

O’Brien, B., & Viramontes, J. L. (1994). Willingness to pay: a valid and reliable measure of health state preference? *Medical Decision Making, 14,* 289–297.

Pauly, M. V. (1995). Valuing health care benefits in money terms. In F. Sloan (Ed.), *Valuing health care: costs, benefits, and effectiveness of pharmaceuticals and other medical technologies*. New York: Cambridge University Press.

Thomas, C. M., & Morris, S. (2003). Cost of depression among adults in England in 2000. *British Journal of Psychiatry, 183,* 514–519.

Weinstein, M.C., Torrance G., McGuire, A. (2009). QALYs: the basics. *Value in Health,* 12(Suppl 1):S5–9. doi:10.1111/j.1524-4733.2009.00515.x.

Weisbrod, B., Test, M. A., & Stein, L. (1980). An alternative to mental hospital treatment. 2: Economic cost-benefit analysis. *Archives of General Psychiatry, 37,* 400–405.

WHO. (2013). *Investing in mental health: evidence for action*. Geneva: World Health Organization.

Chapter 19
Mental Health and Journalism—Chances and Risks

Angelica Hüsser and Michael Schanne

19.1 Introduction

In modern societies, problems increasingly tend to be solved by means of communication. Communication serves to label a problem, to raise public awareness, to make it known to a broader audience, to provide differentiated information, to grow informed understanding, to sensitize members of society, even to change behaviour, and to foster public acceptance of the affected persons (Bonfadelli and Friemel 2014; Valkenburg et al. 2016). Journalists employ a broad media mix and use different communication tools, such as events, campaigns etc. Within this "communication mix" journalistic reporting in news media is—still—the core.

19.2 Journalistic Reporting on Mental Health

Philipps (1974) set the tone for a number of intra-media-data versus extra-media-data studies. In this approach intra-media-data, e.g., media reporting, is compared to any kind of extra-media-data, e.g., administrative data of mental illness or suicide statistics.

Following this line of investigation, it becomes clear that it is a challenge in journalistic reporting to illustrate a comprehensive representation of the real numbers of mental illness cases and/or events, nor the real mental disorders or the real people affected.

A. Hüsser (✉) · M. Schanne
Former School of Applied Linguistics, IAM Institute of Applied Media Studies,
ZHAW Zurich University of Applied Sciences, 8401, Winterthur, Switzerland
e-mail: angelica.huesser@zhaw.ch

M. Schanne
e-mail: michael.schanne@bluewin.ch

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_19

For this reason, psychologists and psychiatrists require that media reporting should be improved. However, from a journalist's point of view these results emphasize that media reporting follows its own selection and presentation criteria. Reviewing the literature at the beginning of the 1990s, Wahl (1992) showed a lack of consistency within all studies from study to study. "Although [...] research supports concerns about the high frequency, unfavourable nature, and harmful effects of mass media images of mental illness, a more careful look reveals numerous limitations that prevent definitive generalizations about the current state of media depictions of mental illness" (Wahl 1992: 348). Since then the question whether or not media reporting has improved persists (Wahl et al. 2002; Thornicroft et al. 2013).

The Werther-effect vs. the Papageno-effect is one of the most discussed topics. Especially Reinemann and Scherr (2011), but also Pirkis and Blood (2010), point out the heterogeneity and inconsistency of all these studies and results. Scherr (2013) describes three groups of studies: the first group shows a Werther-effect (suicide rates may increase after media reporting of suicides), the second group shows a Papageno-effect (suicide rates may decrease after media reporting of suicides), and the third group doesn't show any effect at all. Additionally all these studies are unrelated without common understanding. Reinemann and Scherr (2011) first show that the chance for a potential suicidal person to come across a piece of suicide reporting is low. They criticize that the studies do not respect the self-determination of individuals and the public—they can choose for themselves if to follow media coverage or not and whether to act accordingly. They criticize the simplistic stimulus-response logic of most studies and the aggregate-data-only approach. Reinemann and Scherr (2011) conclude that theoretical models and methodologies need a much more complex, sophisticated elaboration. (For a different systematic review see Sisak & Värnik 2012). Looking back on their own research experiences, Whitley and Berry (2013) show that conceptualizations of central terms and operationalizations for media reporting need a much more thorough consideration. Stout et al. (2004) argued that an appropriate definition of mental illness for use in media research is not given.

19.3 Current Status of Research on Journalistic Reporting of Mental Health

Analyses using a broader and above all systematic communication studies approach conclude that newsrooms rely on information provided by external sources. Journalists cover events and the person affected by it. Newsrooms have no specialized resources at their disposal and thus have to rely on external expertise. Without expertise and resources they develop amateurish ideas and dangerous half-truths to cope with situations. They do neither provide links to evidence-based knowledge nor to professionals and institutions that can provide help. Reporting does not enable individuals (Corrigan et al. 2005; Corrigan et al. 2013).

To conclude: (1) Journalistic coverage of mental health follows the routines of conventional everyday news journalism. The selection of news items on mental health is driven by chance, as events happen; coverage does not take place in a continuous way. (2) The easiest accessible sources of information for journalists are on the one hand police reports and on the other hand courtroom proceedings. Individuals are caught, arrested, taken to court, sentenced and the suspected reason for their crime is caused by psychological problems, mental illness. Nevertheless: (3) Journalistic coverage refers to the facts as they are presented in the police- or courtroom-reports. In the majority of cases, journalistic reporting is not overstating, not dramatizing and does (certainly) not give a reason for stigmatization on its own (Hüsser and Schanne 2010; Schanne and Hüsser 2011).

19.4 Discussion

Overall there is an ongoing lively—sometimes heated—debate if journalistic reporting can meet the demands (needs) of civil society. The least common denominator of all criticism within the professional journalistic and the media scientific communities is, that journalistic reporting does not or only partially provide vital information necessary for evidence-based, effective, understanding and behaviour. There are a multitude of potential reasons for this: the precarious economic status of the traditional journalism industry; structural deficiencies of traditional news reporting; limited knowledge of newly developed journalistic research techniques and concepts; limited access to meta-analytic sources; self-sufficiency with the conventional ways to do the job (Altmeppen 2015; Pew Research Center 2016).

Journalistic reporting on mental health, mental illness and suicide will continue. There will always be a certain amount of traditional reporting. There will be cases of thoughtless, offending and unscrupulous reporting, meanwhile ignoring every known journalistic deontology. Whether done intentionally or not, there will be other extraordinary events—like the “Germanwings” fiasco—where journalists will again just copy the mainstream opinion and generate sheer speculations (von Heydendorff and Dreβing 2016; Newman and Drevo 2015). The important question is: why are journalists unaware of the numerous online resources (see Chap. 5 “Take Away Messages”) available to help them improve their reporting on mental illness? Moreover, if journalists maintain a continuous relationship with experts (see Campbell et al. 2009), the impact is twofold: there is a social monitoring effect plus it leads to a self-reflection of their journalistic code of practice.

Hence, lamentation about journalistic reporting can go on endlessly. If reporting should change, psychologists, psychiatrists and their institutions will have to assume their responsibility: to provide accurate and easy to understand information continually, to serve as sources, to open access to institutions, to explain the complexities of the psyche. There may be reasonable doubt that psychologists, psychiatrists and their institutions can face this challenge, given the resources needed to respond just in time and be prepared for every circumstance.

This prompts the "Mental Health and Suicide Prevention Sector" to review the previous, very cautious method of public information. Interfaces—comparable to "mediendoktor.de" (c.f. 5.2 "Online resources for reporting in German language")—could be established. In any case, it will increase the chances of opportunity reporting.

Empirical research of journalistic reporting about mental health, mental illness and suicide—in whatever scientific discipline—needs a new beginning (Scherr 2013). The core subject should be journalistic reporting in news media. A clear line should be drawn at the event and campaign research as well as at the entertainment and fiction research. A consensus should be reached with which terms entities are selected, and with which operationalization the news coverage of concepts such as discrimination, stigmatization and other should be assessed. The effect of the news coverage should no longer be argued with aggregate-data only. Likewise, the theoretical foundation—for example, in the context of the cultivation theory (Gerbner 2000) or the theory of social learning (Bandura 2000)—should be complex and based on the state-of-the art scientific error.

If further intra-media-data resp. extra-media data studies should be carried out, the methodological implications of the extra-media-data must be considered. Extra-media data are also subject to interests. No further studies are necessary addressing the issue that journalistic reporting follows its own logic regarding selection, discussion and presentation. It is not a new finding that media coverage could be thoughtless which might result in serious consequences for peoples affected by a mental illness.

Take Away Messages

A plethora of online resources are at disposal for every journalist looking for information about mental health. Resources are provided by various institutions: organizations from the field of journalism, media and media research, from the field of psychiatry, psychology, medical sciences, from the field of public health and public health policy, from the field of self help and from the field of civil society.

Online resources include guidelines for reporting, story ideas, examples of good or bad reporting, comments from journalistic or scientific peers on reporting, they provide the "dos" and the "don'ts" of reporting, they show "myths" in reporting, they provide facts and statistics, they offer appropriate terminologies, they give good advice for interviewing disabled persons and they act as an intermediary to other expertise, institutions and organizations in the field.

Codes of Ethics and Guidelines for Reporting

Guidelines and codes are provided by professional organizations, e.g. Schweizer Presserat, Deutscher Presserat, Österreichischer Presserat and others. The general message is that reporting should not be discriminating.

Maloney et al. (2014) put together a comprehensive list of 31 recommendations specifically for suicide reporting.

Online Resources for Reporting in German Language

In German language, the *"Leitfaden zur Berichterstattung über Suizid"* by Kriseninterventionszentrums Wien (Tomandl et al. 2014) offers practical advice for reporting. The site provides different scientific and medical-clinical know-how. A chapter is about terminologies and appropriate wording. Journalists should not simplify complex, multi-faceted suicidal situations. Examples for "good" reporting are provided.

"www.leidmedien.de" is an online-resource for reporting on disabilities and disabled persons. The site provides a comprehensive terminology from "A" to "Z". "Leichte Sprache" expresses what disabled people would like to say to journalists. Examples of reporting about "heroes", "villains" and "victims" are shown. Additionally, there are examples of "good" and "bad" reporting. Current statistics and laws—related to Germany only—complement the site.

"www.medien-doktor.de" is about medical reporting and reporting from medical sciences. Furthermore, the site features reporting about mental health and mental illness. The most decisive feature of this online resource is that it has been developed within media science, journalism science and applied journalism practical perspective (see also Waddell 2005). Authors produced a set of journalistic quality criteria. These criteria are elaborated at length. Articles and corresponding media releases are analyzed and evaluated accordingly. Evaluations—one to five stars—are published on the website. "medien-doktor.de" screens television and radio programs, daily newspapers, news magazines, news agencies and online media in Germany. "medien-doktor.de" provides a lot of tips for journalistic investigations (Serong et al. 2015).

"www.anorexie-heute.de" shows what good online science journalism could look like. The author started her internet project with the intention to write about anorexia from a scientific perspective, following all rules and thus not subject the illness to stigmatization or to sensational aspects.

Online Resources for Journalists in German and English

Aktionsbündnis für Seelische Gesundheit. Fair Media
Stiftung Deutsche Depressionshilfe. Medienguide
Mindframe. National Media Initiative (Australien)
The Carter Center. (Mental Health Program)
Dart Center for Journalism and Trauma. A Project of Columbia Journalism School
Poynter. News University. Reporting on Mental Health Conditions and Suicide (with "self-directed course")
American Psychiatric Association. Words Matter: Reporting on Mental Health Conditions.

Online Resources for Media Relations of Psychologists, Psychiatrists and Their Institutions

Hunter Institute (Hunter Institute of Mental Health 2011): Suicide and Mental Illness in the Media. A Mindframe Ressource for the Mental Health and Suicide Prevention Sectors. This site provides a "crash course" for psychologists and psychiatrists and their institutions on media relations.

The Center for Excellence in Health Care Journalism defines highest standards of reporting, writing, editing and broadcasting in health care journalism for the general public and trade publications (Association of Health Care Journalism n.d.).

Additional Suggested Readings

Since the field of research is rather widespread, a tremendous amount of studies and publications by various research disciplines have been published, making it almost impossible to follow all developments and progress. This comprehensive list may help giving an overview of the state-of-the-art. Included are only units published (issued) after 2000—with one exception: Frey et al. 1997.

Angermeyer, M.C., & Schulze, B. (2001). Reinforcing stereotypes: How the focus on forensic cases in news reporting may influence public attitudes towards the mentally Ill. *International Journal of Law and Psychiatry*, *24*, 469–486.

Aragonès, E., Lopez-Muntaner, J., Ceruelo, S., Basora, J. (2014). Reinforcing Stigmatization: Coverage of Mental Illness in Spanish Newspapers. *Journal of Health Communication*, *19*(11), 1248–1258. doi: 10.1080/10810730.2013.872726.

Bohanna, I., & Wang, X. (2012). Media guidelines for the responsible reporting of suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *33*(4), 190–198. doi: 10.1027/0227-5910/a00137.

Bowen, M.L. (2016). Stigma: Content analysis of the representation of people with personality disorder in the UK popular press, 2001–2012. *International Journal of Mental Health Nursing* (online first). doi: 10.1111/inm.12213.

Buila, S.M.D. (2009). Using the media to enhance well-being and mental health. *Rural Society*, *19*(4), 363–367.

Collings, S.C., & Kemp, C.G. (2010). Death knocks, Professional practice, and public good: The media experience of suicide reporting in New Zealand. *Social Science & Medicine*, *71*, 244–248. doi: 10.1016/j.socscimed.2010.03.017.

Clement, S., & Foster, N. (2008). Newspaper reporting on Schizophrenia: A content analysis of five national newspapers at two time points. *Schizophrenia Research*, *98*, 178–183.

Dietrich, S., Heider, D., Matschinger, H., Angermeyer, M. C. (2006). Influence of newspaper reporting on adolescents' attitudes toward people with mental illness. *Social Psychiatry and Psychiatric Epidemiology*, *41*(4), 318–322.

Domenig, D. & Schäfer, U. (Hrsg.) (2015). *Mediale Welt inklusive! Sichtbarkeit und Teilhabe von Menschen mit Behinderungen in den Medien*. Zürich: Seismo.

Englund, L., Forsberg, R., Saverman, B. (2014). Survivors' Experiences of Media Coverage after Traumatic Injury Events. *International Emergency Nursing*, *22*(1), 25–30. doi: 10.1016/j.ienj.2013.03.010.

Edney, D.R. (2004). Mass media and mental illness: A literature review. Retrieved August 25, 2016, from Ontario.cmha.ca/files/2012/07/mass_media.pdf.

Finzen, A., Benz, D., Hoffmann-Richter, U. (2001). Die Schizophrenie im "Spiegel"—oder ist der Krankheitsbegriff der Schizophrenie noch zu halten? *Psychiatrische Praxis* (28), 365–367.

Frey, C., Michel, K., Valach, L. (1997). Suicide reporting in Swiss print media. responsible or irresponsible? *European Journal of Public Health*, *7*(1), 15-19.

Gandy, J., & Lennox Terrion, J. (2015). Journalism and suicide reporting guidelines in Canada: Perspectives, partnerships and processes. *International Journal of Mental Health Promotion*, *17*(5), 249–260. http://dx.doi.org/10.1080/14623730.2015.1077613.

Gould, M.S., Kleinman, M.H., Lake, M., Forman, J., Bassett Midle, J. (2014). Newspaper coverage of suicide and imitation of suicide clusters in teenagers in the USA, 1988–96: A retrospective, population-based, case-control-study. *The Lancet Psychiatry*, *1*(1), 34–43.

Goulden, R., Corker, E., Evans-Lacko, S., Rose, D., Thornicroft, G., Henderson, C. (2011). Newspaper coverage of mental illness in the UK. *BMC Public Health*, *11*, 796.

Hoffmann-Richter, U. (2000). *Psychiatrie in der Zeitung. Urteile und Vorurteile*. Bonn: Edition das Narrenschiff im Psychiatrie-Verlag.

Knifton, L., Quinn, N. (2008). Media, mental health and discrimination: A frame of reference for understanding reporting trends. *International Journal of Mental Health Promotion*, *10*(1), 23–31.

Machlin, A., Skehan, J., Sweet, M., Wake, A., Fletcher, J., Spittal, M., Pirkis, J. (2012). Reporting suicide: Interpreting media guidelines. *Australian Journalism Review*, *34*(2), 45–56.

Meurk, C., Whiteford, H., Head, B., Hall, W., Carah, N. (2015). Media and evidence-informed policy development: The case of mental health in Australia. *Contemporary Social Science*, *10*(2), 160-170.

Michel, K., Frey, C., Wyss, K., Valach, L. (2000). An exercise in improving suicide reporting in print media. *Crisis*, *21*(2), 71–79.

Niederkrotenthaler, T., Sonneck, G. (2007). Assessing the impact of media guidelines for reporting on suicide in Austria: Interrupted time series analysis. *Australian and New Zealand Journal of Psychiatry*, *41*(5), 419-428.

Niederkrotenthaler, T., Till, B., Herberth, A., Voracek, M., Kapusta, N.D., Etzensdorfer, E., Strauss, M., Sonneck, G. (2009). The gap between suicide characteristics in the print media and in the population. *European Journal of Public Health*, *19*(4), 361–364.

Niederkrotenthaler, T., Voracek, M., Herberth,A., Till, B., Strauss, M., Etzensdorfer, E., Eisenworth, B., Sonneck, G. (2010): The role of media reports in completed and prevented suicide–Werther versus papageno effects. *British Journal of Psychiatry*, *197*(3), 234-243.

Niederkrotenthaler, T., Reidenberg, D., Till, B., Gould, M.S. (2014): Increasing help-seeking and referrals for individuals at risk for suicide by decreasing stigma: The role of mass media. *American Journal of Preventive Medicine*, *47*(3), 235–S243. doi:10.1016/j.amepre.2014.06.010.

Klin, A., & Lemish, D. (2008). Mental disorders stigma in the media: Review of studies on production, content, and influences. *Journal of Health Communication*, *13*(5), 443–449. http://dx.doi.org/10.1080/10810730802198813.

Roloff, E.K. (2010). Das schwierige Forschen nach dem Werther-Effekt. *Publizistik*, *55*(4), 427–430.

Ruddigkeit, A. (2010). Der umgekehrte Werther-Effekt. Eine quasi-experimentelle Untersuchung von Suizidberichterstattung und deutscher Suizidrate. *Publizistik*, *55* (3), 253–275.

Ruddigkeit, A. (2010). Forschung zum Werther-Effekt. Anmerkung zu Klaus Eckart Roloffs Beitrag„ Das schwierige Forschen nach dem Werther-Effekt“. Publizistik, 55. Jg. 2010, S. 427–430). Replik. *Publizistik*, *56*(1), 85–87.

Schäfer, M., & Quiring, O. (2013). Gibt es Hinweise auf einen „Enke-Effekt“? Die Presseberichterstattung über den Suizid von Robert Enke und die Entwicklung der Suizidraten in Deutschland. *Publizistik*, *58*(2), 141–160.

Schäfer, M., & Quiring, O. (2015). The press coverage of celebrity suicide and the development of suicide frequencies in Germany. *Journal of Health Communication*, *30*(11), 1149–1158. doi:10.1080/10410236.2014.92373.Epub2014Nov3.

Shekan, J., Greenhalgh, S., Hazell, T., Pirkis, J. (2006). Research, awareness and uptake of media guidelines for reporting suicide and mental illness: an Australian perspective. *The International Journal of Mental Health Promotion*, *8*(4), 29–35.

Sieff, E. (2009). Media frames of mental illnesses: The potential impact of negative frames. *Journal of Mental Health*, *12*(3), 259–269. http://dx.doi.org/10.1080/0963823031000118249.

Stuart, H. (2003). Stigma and the daily news. Evaluation of a newspaper intervention. *Canadian Journal of Psychiatry*, *48*, 651–656.

Tatum, Ph.T., Canetto, S.S., Slater, M.D. (2010). Suicide coverage in U.S. Newspapers following the publication of the media guidelines. *Suicide and Life-Threatening Behavior*, *40*(5), 524-534. doi:10.1521/suli.2010.40.5.524.

Trepte, S., Reinecke, L., Bruns, C. (2008). Psychologie in den medien. In: B. Batinic & M. Appel (Eds.), *Medienpsychologie* (pp. 555–581). Heidelberg: Springer.

Van Atteveldt, N.M., van Aalderen-Smeets, S.I., Jacobi, C., Ruigrok, N. (2014). Media reporting on neuroscience depends on timing, topic and newspaper type. *PLoSONE*, *9*(8), 1–12. e104780. doi:10.1371/journal.pone.0104780.

References

Altmeppen, K.-D. (2015). Algorithmen und Roboter. Automaten kennen keine Moral. Metamorphosen des Journalismus und die Folgen für die Verantwortung. *Communicatio Socialis*, *48*(1), 16–33.

Bandura, A. (2000). Die Sozial-Kognitive Theorie der Massenkommunikation. In A. Schorr (Ed.), *Publikums- und Wirkungsforschung. Ein Reader* (pp. 153–180). Wiesbaden: VS Verlag für Sozialwissenschaften.

Bonfadelli, H., & Friemel, T.N. (2014). *Medienwirkungsforschung (5., überarbeitete Auflage).* Konstanz: UVK Verlagsgesellschaft mbH.

Campbell, N.N., Heath, J., Bouknight, J., Rudd, K., & Pender, J. (2009). Speaking out216 for mental health: Collaboration of future journalists and psychiatrists. *Academic217 Psychiatry, 33*(2), 166–168. doi:10.1176/appi.ap.33.2.166.

Corrigan, P. W., Watson, A. C., Gracia, G., Slopan, N., Rasinski, K., & Hall, L. L. (2005). Newspaper stories as measures of mental stigma. *Psychiatric Services, 56*(5), 551–556. doi:10.1176/appi.ps.56.5.551.

Corrigan, P. W., Powell, K. J., & Michaels, P. J. (2013). The effects of news stories on the stigma of mental illness. *The Journal of Nervous and Mental Disease, 201*(3), 179–182. doi:10.1097/NMD.ob013e3182848c24.

Gerbner, G. (2000). Die Kultivierungsperspektive: Medienwirkung im Zeitalter von Monopolisierung und Globalisierung. In A. Schorr (Ed.*), Publikums- und Wirkungsforschung. Ein Reader* (pp. 101–121). Wiesbaden: VS Verlag für Sozialwissenschaften.

Hüsser, A., & Schanne, M. (2010). *Journalistic reporting on mental disorders: examples from Swiss newspapers*. Paper presented at the International Association of Mass Communication Research IAMCR Conference, University of Braga, Portugal, 18–23 July 2010.

Maloney, J., Pfuhlmann, B., Arensman, E., Coffey, C., Gusmão, R., Postuvan, V., et al. (2014). How to adjust media recommendations on reporting suicidal behavior to new media developments. *Archives of Suicide Research, 18,* 156–169. doi:10.1080/13811118.2013.824833.

Newman, E., & Drevo, S. (2015). Journalists as partners in early response to trauma: Agreements, tensions, and future directions to aid collaboration. *European Journal of Psychotraumatology, 6,* 28544. doi:10.3402/ejpt.v6.28544.

Pew Research Center. (2016). State of the News Media. Retrieved August 25, 2016, from www.journalism.org/2016/06/15/state-of-the-news-media-2016.

Phillips, D. P. (1974). The influence of suggestion on suicide: substantive and theoretical implications of the Werther effect. *American Sociological Review, 39*(3), 340–354.

Pirkis, J., & Blood, W. (2010). Suicide and the news and information media. A critical review. Retrieved August 25, 2016, from www.mindframe-media.info.

Reinemann, C., & Scherr, S. (2011). Der Werther-Defekt. Plädoyer für einen neuen Blick auf den Zusammenhang von suizidalem Verhalten und Medien. Replik. *Publizistik, 56*(1), 89–94.

Schanne, M., & Hüsser, A. (2011). *Kurzbericht: Psychische Krankheiten in journalistischen Darstellungen*. Bern: Zuhanden des Schweizerischen Nationalsfonds.

Scherr, S. (2013). Medien und Suizide: Überblick über die kommunikationswissenschaftliche Forschung zum Werther-Effekt. *Suizidprophylaxe, 40*(3), 96–107.

Serong, J., Anhäuser, M., & Wormer, H. (2015). Ein methodischer Ansatz zur Bewertung der Informationsqualität medizinisch-wissenschaftlichen Wissens auf dem Transferweg zwischen Fachpublikation und Massenmedien. *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen, 109*(2), 166–170. doi:10.1016/j.zefq.2015.04.016.

Sisask, M., & Värnik, A. (2012). Media roles in suicide prevention: A systematic review. *International Journal of Environmental Research and Public Health, 9*(1), 123–138. doi:10.3390/jierph9010123.

Stout, P. A., Villegas, J., & Jennings, N. A. (2004). Images of mental illness in the media: Identifying gaps in the research. *Schizophrenia Bulletin, 30*(3), 543–561.

Thornicroft, A., Goulden, R., Shefer, G., Rhydderch, D., Rose, D., Williams, P., et al. (2013). Newspaper coverage of mental illness in England 2008-2011. *The British Journal of Psychiatry, 202,* 64–69. doi:10.1192/bjp.bp.112.112920.

Valkenburg, P.M., Peter, J., Walther, J:B. (2016): Media effects: Theory and research. *Annual Review of Psychology, 67*, 315–338. doi:10.1146/annurev-psych-122414-033608.

Von Heydendorff, S. C., & Dreßing, H. (2016). Mediale Stigmatisierung psychisch Kranker im Zuge der „Germanwings“-Katastrophe. *Psychiatrische Praxis, 43*(3), 134–140. doi:10.1055/s-0042-101009.

Waddell, C., Lomas, J., Lavis, J. N., Abelson, J., Shepherd, C. A., & Bird-Gayson, T. (2005). Joining the conversation: Newspaper journalists' views on working with researchers. *Healthcare Policy, 1*(1), 123–139.

Wahl, O. F. (1992). Mass media images of mental illness: A review of the literature. *Journal of Community Psychology, 20*(4), 343–352.

Wahl, O. F., Wood, A., & Richards, R. (2002). Newspaper coverage of mental illness: Is it changing? *Psychiatric Rehabilitation Skills, 6*(1), 9–31.

Whitley, R., & Berry, S. (2013). Analyzing media representations of mental illness: Lessons learnt from a national project. *Journal of Mental Health, 22*(3), 246–253. doi:10.3109/09638237.2012.745188.

Links

Aktionsbündnis Seelische Gesundheit (n.d.). Fair Media. Retrieved August 4, 2016, from http://fairmedia.seelischegesundheit.net/.

American Psychiatric Association (n.d.). Words matter: Reporting on mental health conditions. Retrieved August 4, 2016, from https://www.psychiatry.org/newsroom/reporting-on-mental-health-conditions.

Burgard-Arp, N. (2015). Anorexie–heute sind doch alle magersüchtig. Retrieved August 4, 2016, from http://www.anorexie-heute.de.

Association of Health Care Journalists (n.d.). Center for Excellence in Health Care Journalism. Retrieved October 10, from http://healthjournalism.org/about-news.php.

Columbia Journalism School (n.d.). Dart Center for Journalism & Trauma. Retrieved August 4, 2016, from http://dartcenter.org/.

Hunter Institute of Mental Health (2011). Suicide and Mental Illness in the Media. A Mindframe Ressource for the Mental Health and Suicide Prevention Sectors. Retrieved May 30, 2016, from www.mindframe-media.info.

International Labour Organization ILO. (2015, 2nd edition) (Sanchez, Jeanette). Reporting on Disability. Guidelines for the Media. Geneva. Retrieved August 4, 2016, from www.ilo.org/skills/pubs/WCMS_127002/lang–en/index.htm.

Sozialhelden e.V. (n.d.). Leidmedien.de. Über Menschen mit Behinderung berichten. Retrieved August 4, 2016, from http://leidmedien.de.

Stiftung Deutsche Depressionshilfe (n.d.): Depression erforschen. Betroffenen helfen, Wissen weitergeben. Retrieved August 4, 2016, from http://www.deutsche-depressionshilfe.de/stiftung/media/Medienguide.pdf.

Technische Universität Dortmund (n.d.). Mediendoktor-de. Retrieved August 4, 2016, from http://www.medien-doktor.de.

The Carter Center (n.d.). Mental Health Program. Retrieved August 4, 2016, from https://www.cartercenter.org/health/mental_health/index.html.

The Poynter Institute (n.d.). Reporting on Mental Health Conditions and Suicide. Retrieved August 4, 2016, from https://www.newsu.org/reporting-mental-health-suicide.

Tomandl, G., Sonneck, G., Stein, C., & Niederkrotenthaler, T. (2014). Leitfaden zur Berichterstattung über Suizid. Kriseninterventionszentrum Wien. Retrieved August 4, 2016, from www.kriseninterventionszentrum.at.

World Health Organization WHO, International Association for Suicide Prevention. (2008). Preventing Suicide. A Ressource for Media Professionals. Geneva. Retrieved August 4, 2016, from www.who.int/mental_health/prevention/suicide/ressource_media.pdf.

Chapter 20
Conclusions

Sabine Bährer-Kohler and Francisco Javier Carod-Artal

Mental and substance use disorders are the leading cause of disability worldwide (WHO 2014a) and mental diseases will increase (Kessler et al. 2009), but global mental issues have until today not reached the positions, which are requested and necessary to bring these topics out of the shadow (Worldbank 2016; Saraceno and Dua 2009).

In the last couple of decades, research on genetic and functional neuroimaging correlates of mental disease was performed. This public perception about the progressive neurobiological understanding of mental illness has not yet been translated into a decrease of stigma (Pescosolido et al. 2010; Angermeyer et al. 2013).

Stigma and discrimination against people with mental disease can have negative consequences in their lives. Although some steps have been done to reduce stigma, even the development of community mental health services have limitations to integrate people with mental illness (Angermeyer et al. 2006).

Besides stigma and discrimination many indicators influence de facto mental health of humans in a non-sufficient way, e.g., not existing adequate treatment possibilities, not existing adequate and quantitative enough mental health services, not existing adequate access to mental health services, which are reachable, financed, supported and tailored. To summarize it, a gap exists between adequate treatment and the prevalence of mental disorders (WHO 2008). In addition, human

---

S. Bährer-Kohler (✉)
Dr. Bährer-Kohler & Partners, Birsstrasse 58, 4052 Basel, Switzerland
e-mail: sabine.baehrer@datacomm.ch

F.J. Carod-Artal
International University of Catalonia (UIC), Barcelona, Spain
e-mail: fjcarod-artal@hotmail.com

F.J. Carod-Artal
Neurology Department, Raigmore Hospital, Old Perth Road, IV2 3UJ Inverness, UK
e-mail: javier.carodartal@nhs.net

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_20

rights violations of people suffering mental and psychosocial disability are routinely reported in most countries (WHO 2014a).

To reflect the complexity of a mental health disease it has to put within a complex correlation. For example, around 70% of 115 analyzed studies found a relationship between common mental disorders and poverty (Lund et al. 2010), well aware that structured actions on social determinants can be supportive to prevent mental disorders (WHO 2014b).

The life span approach about social determinants of mental health showed that there may be many vulnerable groups in the societies from both developing and developed countries. They include children and adolescents exposed to neglect and substance abuse, elderly people and community groups suffering any type of discrimination including ethnic minorities (WHO 2013b).

In general mental health issues around the world need more promotion and better financial investments, sustainable funded, to create the possibility to fulfill the fundamental rights of health over the lifespan (WHO/Alma Ata Declaration 1978) of all people, especially within difficult life span situations, e.g., under pressure, violence and torture (Fazel et al. 2005; Knipscheer et al. 2015). This should be a public mental health priority.

Mental health legislation and plans for its promotion and care are still missing for 70% of people living in low-income countries (Lund et al. 2011). As a consequence, a substantial gap exists between the need of mental healthcare and its provision and quality of care.

Around the world the number of migrants and refugees has reached an expansion which never happened before in this huge magnitude (MPI 2016; UN 2016). The number of international migrants worldwide has continued to grow rapidly over the past 15 years reaching around 250 million in 2015, up from 222 million in 2010 and 173 million in 2000. Many of these humans have mental health problems. Although most of them live in Europe (76 million) or Asia (75 million), migration is a global phenomenon.

Worldwide, there is huge inequity in the distribution of skilled human resources for mental health (WHO 2014a). But mental health professionals are needed (Saxena et al. 2006), in rural and urban areas, and they should be well trained with qualified national and international standards, and with continuing education choices (American Mental Health Counselors Association—AMHCA 2016).

The growing and ageing of human population has as a consequence an increase in mental illness prevalence. Approximately 8 billion people will be alive in 2025, and 2 billion elderly people are expected in 2050, and many of them will be women. These facts may add further strain for understaffed mental health teams if no proper training and recruitment plans of mental health professionals are done in advance (Charlson et al. 2014).

Interdisciplinary approach in the field is significant (Vinokur-Kaplan 1995). Sharing and synthesizing professional knowledge and experiences for a sustainable development is necessary.

The inclusion of gender aspects (Kastrup 2006), cultural aspects, and ethics should be standards, not an exception.

The perspective in this field has to be wide open, at the beginning has to be the possibilities to prevent mental health diseases and the promotion of mental health in general, but as well the implementation of, e.g., self-management conceptions, empowerment, and recovery (Slade et al. 2014). Therefore, education programmes, trainings, information, and psychoeducation will be requested, tailored, and culturally and cross-culturally adapted.

Strengthening and empowering the civil society and a central place of the community-based mental health care in mental health care settings are also needed.

Responsibilities around the world, but as well professionals in the field have to be engaged for people with mental health diseases and have to focus on stigmatization (Goffmann 1963) around the globe.

There are institutions, organizations and networks, which are the addressees to bring up, to push global mental health concerns, to push mental health issues and to incorporate it into health policy and legislative frameworks with ongoing governance (WHO 2008, 2017).

In 2013, the World Health Assembly approved the Comprehensive Mental Health Action Plan for 2013-2020 (WHO 2013a), which focused on 4 key objectives: strengthening an effective leadership for mental health; providing a comprehensive and integrated mental healthcare service based on community settings; implementation of mental health promotion strategies; and strengthening of evidence and research for mental health.

But the production in form of national and international binding contracts and exchanges need implementation with, e.g., indicators for measuring progress toward defined targets, e.g., of the comprehensive mental health action plan 2013–2020 (WHO 2013a, p. 20 ff). Permanent evaluation- internal and external- is requested on our way with long-term- and short-term visions for a better Global Mental Health.

References

American Mental Health Counselors Association (AMHCA). (2016). Continuing Education. Retrieved October 24, 2016, from https://amhca.site-ym.com/page/About.

Angermeyer, M., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatrica Scandinavica, 113,* 163–179.

Angermeyer, M. C., Matschinger, H., & Schomerus, G. (2013). Attitudes toward psychiatric treatment and people with mental illness: Changes over two decades. *British Journal of Psychiatry, 203,* 146–151.

Charlson, F.J., Diminic, S., Lund, C., Degenhardt, L., Whiteford, H.A. (2014). Mental and substance use disorders in Sub-Saharan Africa: predictions of epidemiological changes and mental health workforce requirements for the next 40 years. *Public Library of Science (PLoS) One*, *13*, *9*(10): e110208.

Fazel, M., Jeremy, W., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet, 365,* 130914.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Engelwood Cliffs, NJ: Prentice-Hall.

Kastrup., M.C. (2006). Mental health consequences of war: gender specific issues. *World Psychiatry, 5*(1), 33–34.

Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., Ormel, J., et al. (2009). The global burden of mental disorders: An update from the WHO World Mental Health (WMH) Surveys. *Epidemiologia e Psichiatria Sociale, 18*(1), 23–33.

Knipscheer, J. W., Sleijpen, M., & Mooren, T. (2015). Trauma exposure and refugee status as predictors of mental health outcomes in treatment-seeking refugees. *British Journal Psychiatric Bulletin, 39*(4), 178–182.

Lund, C., Breen, A., Flisher, A., Kakuma, R., Corrigall, J., Joska, J., et al. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Social Science and Medicine, 71,* 517–528.

MPI. (2016). Frequently Requested Statistics on Immigrants and Immigration in the United States. Migration Policy Institute (MPI) tabulation of data from the U.S. Census Bureau's 2010 and 2014 American Community Surveys (ACS), and 1970–2000 decennial Census. Retrieved October 22, 2016, from http://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states.

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). A disease like any other? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry, 167,* 1321–1330.

Saraceno, B., & Dua, T. (2009). Global mental health: the role of psychiatry. *European Archives of Psychiatry and Clinical Neuroscience, 259*(Suppl 2), 109–117.

Saxena, S., Jané-llopis, E., & Hosman, C. (2006). Prevention of mental and behavioural disorders: implications for policy and practice. *World Psychiatry, 5*(1), 5–14.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., et al. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12–20.

United Nations, Department of Economic and Social Affairs, Population Division. (2016). International Migration Report 2015: Highlights (ST/ESA/SER.A/375).

Vinokur-Kaplan, D. (1995). Enhancing the effectiveness of interdisciplinary mental health treatment teams. *Administration and policy in mental health*, *22*(5), 521–530.

Worldbank. (2016). Out of the shadows: making Mental Health a global priority. Retrieved October 24, 2016, from http://www.worldbank.org/en/events/2016/03/09/out-of-the-shadows-making-mental-health-a-global-priority.

World Health Organization. (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 1978. Retrieved October 22, 2016, from http://www.who.int/publications/almaata_declaration_en.pdf?ua=1.

World Health Organization and World Organization of Family Doctors-Wonca. (2008). Integrating mental health into primary care: a global perspective. Retrieved October 24, 2016, fromhttp://www.who.int/mental_health/policy/Mental%20health%20+%20primary%20care-%20final%20low-res%20120109.pdf.

World Health Organization. (2013a). Mental health action plan 2013–2020. Retrieved October 24, 2016, from http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf.

World Health Organization. (2013b). *Review of social determinants and the health divide in the WHO European Region: final report*. Copenhagen: World Health Organization. Retrieved October 25, 2016.

World Health Organization. (2014a). *Mental health: a state of well-being*. Geneva: WHO. Retrieved October 24, 2016, from http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/index1.html.

World Health Organization. (2014b). Social determinants of mental health. Retrieved October 24, 2016, from http://apps.who.int/iris/bitstream/10665/112828/1/9789241506809_eng.pdf.

WHO (2017). Mental health included in the UN Sustainable Development Goals. http://www.who.int/mental_health/SDGs/en/.

Chapter 21
Epilog

Margret Föppl-Georg

It has been certain since the times of antiquity for people to live a truly free life, develop their soul, and acquire the resilience, and strength they need to cope with the highly diverse tasks confronting them in their daily life and their society they should be healthy and stable both mentally and physically (Flashar 2016). Yet it is apparent that the importance of building, caring for, and preserving mental health is not nearly known well enough in countries that are increasingly individualized, performance-oriented, urbanized, and secularized (cf. NIH 2007; cf. Hell 2013, p. 18). Even in the traditional rural communities and cities of less-developed countries, where the chief concern of the people is to ensure their daily survival, it is the top priority of those in positions of responsibility to provide physical primary health care, if anything (cf. van der Ham et al. 2011; cf. Mascayano et al. 2015; Worldbank 2016).

According to the United Nations' universal declaration of human rights of 1948 (UN 1948), the right to health and access to medical care constitutes one of the fundamental human rights to which every human being anywhere on the globe is entitled—independently of their ethnic origin, religion, age, gender, or other characteristics.

Given the importance of mental health, and considering the ethical precept that all humans are equal in value and entitlements, the right to mental health must always be included among these rights. This includes raising the general awareness of its rank and affording access to facilities for preventing and treating mental illness as well as, for example, the therapy of traumas.

There are cases worldwide that show how people, groups, and institutions as well as others who have succeeded in ordering their inner life may change their outward behavior correspondingly, assume responsibility in their social environ-

Margret Föppl-Georg (✉)
The Association Global Mental Health, Basel, Switzerland;
a member of the World Federation for Mental Health, Occoquan, USA
e-mail: mfoeppl@gmx.ch

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0_21

ment, and behave more tolerantly towards others who are different (Bährer-Kohler 2016; Polli 2015, p. 48 and p. 63–65).

The author is convinced that this publication, Global Mental Health—Prevention and Promotion, represents an important contribution to raising public awareness and to prevention as well as to the promotion of mental health on the national as well as the global plane.

References

Bährer-Kohler, S. (2016). Engagement for and investment in global mental health. *Mathews Journal of Psychiatry and Mental Health*, *1*(2), 7. Retrieved December 11, 2016, from http://www.mathewsopenaccess.com/PDF/Psychiatry/M_J_Psyc_1_2_007.pdf.

Flashar, H. (2016). *Hippokrates: Meister der Heilkunst*. München: Beck Verlag.

Hell, D. (2013). Die Sprache der Seele verstehen. In: J. Armbruster, K. Ratzke, & J.P. Petersen, J. P. (Eds.), *Spiritualität und seelische gesundheit* (pp. 16–26). Köln: Psychiatrie Verlag.

Mascayano, F., Armijo, J. E., & Hsin Yang, L. (2015). Addressing stigma relating to mental illness in low- and middle-income countries. *Frontiers in Psychiatry, 6,* 38. doi:10.3389/fpsyt.2015.00038.

National Institutes of Health. (2007). NIH Curriculum Supplement Series. Biological Sciences Curriculum Study. Retrieved December 11, 2016, from https://www.ncbi.nlm.nih.gov/books/NBK20369/.

Polli, T. (2015). Ursula Hauser. Die Rebellin: Ein Leben für Frieden und Gerechtigkeit. Wörterseh. Gockhausen.

United Nations. (1948). The Universal Declaration of Human Rights. Retrieved December 11, 2016, from http://www.un.org/en/universal-declaration-human-rights/.

Van der Ham, L., Wright, P., Van, T. V., Doan, V. D., & Broerse, J. E. (2011). Perceptions of mental health and help-seeking behavior in an urban community in Vietnam: An explorative study. *Community Mental Health Journal, 47*(5), 574–582.

Worldbank. (2016). Health expenditure, total (% of GDP). Retrieved December 11, 2016, from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS.

Index

S. Bährer-Kohler and F.J. Carod-Artal (eds.), *Global Mental Health*,
DOI 10.1007/978-3-319-59123-0