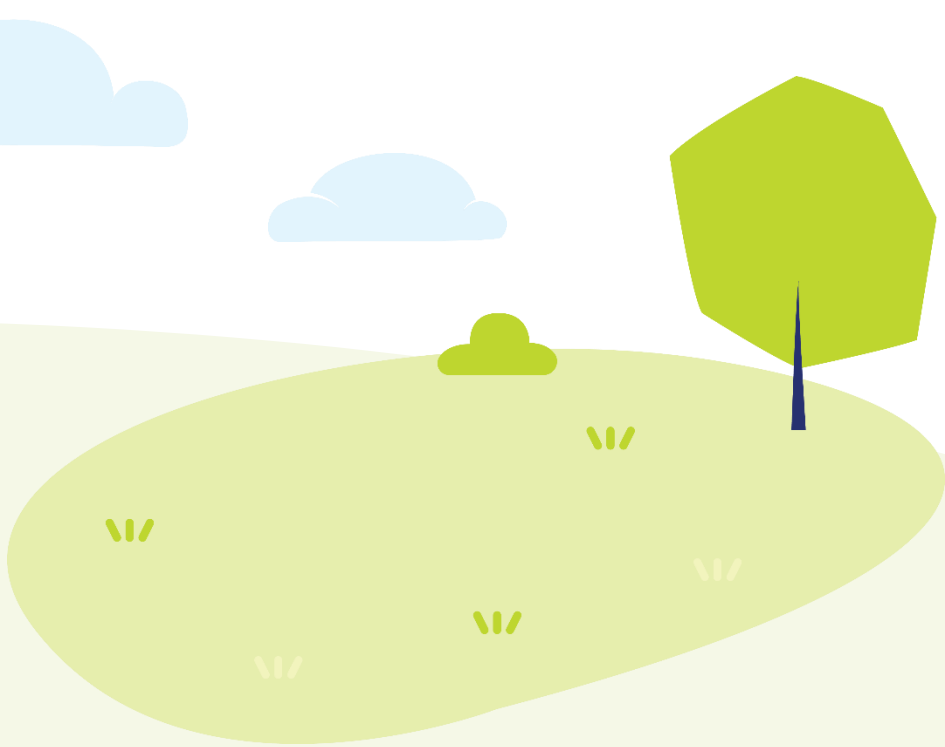
ADVANCED SKILLS FOR ACTIVE LIVING



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How the age variable can affect the mental health

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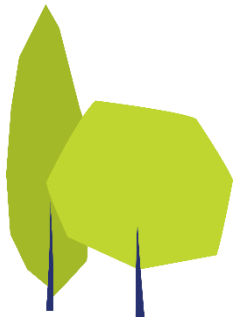

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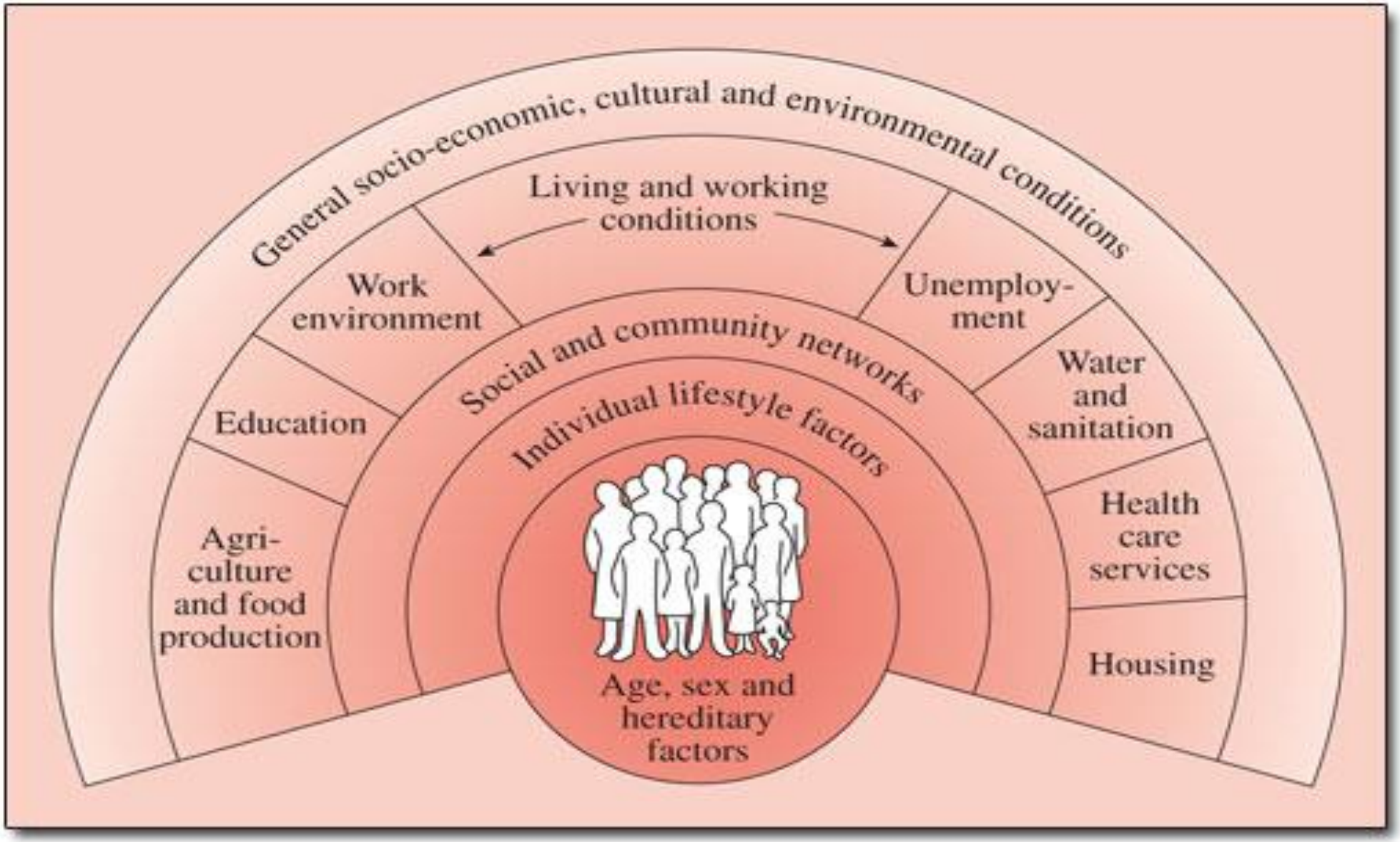
INTRODUCTION



The relevance of age, sex, culture and hereditary factors have been overlooked in the last decade.

Recently their importance has been taken into consideration

Sex, gender and health

It has long been assumed that sex, rather than gender, determines health

In most countries, male life expectancy is lower than that of females and this is projected to continue, but lastly the male disadvantage has decreased

Age and the lifecourse: healthy ageing

Lifecourse perspectives depend on age, sex and hereditary factors

Illness and ageing are often linked

Old age is often portrayed as a period of decrepitude and decline

According to some researchers the 'mask of ageing' is socially constructed, rather than biologically determined

The concept of positive and healthy ageing has been promoted as the way forward for older people (consequence of changes to the age structure of the population)

It is recognised that behavioural, social and environmental factors all have a part to play

Attention has been given to the relationships between ageing, activity and health

Particular emphasis has been given to the role of physical activity throughout the lifecourse and into later life

PROPENSITY TO DEPRESSION

In the most of Eu countries countries the propensity to report depression disorder is high among elderly people over 65 years of age:

- this increase is mostly contained in most European countries,
- in Italy its value roughly doubles compared to the average (11.6%, the increase is 1.7% in the EU),
- higher prevalences are observed only in Portugal (18.9%) and Spain (13.7%)

It is widespread tendency towards unhealthy or health-risk behaviors among young and adult depressed or with chronic anxiety

In Italy, the 28.3% of who those suffer from anxiety or depression habitually smokes, against the 20.6% of the peers who do not have the same pathologies

WHO - suicide:

- nearly 800,000 people die by suicide every year

- in the young people (15 - 29), suicide is the second leading cause of death

- in Italy, in 2015, 3,988 suicide deaths (6/100,000 inhabitants)

- in Europe the rate is 11/100,000 inhabitants

- in Italy the risk of suicide of elderly population increases in relative terms, more than in Ireland, Greece, the United Kingdom, Cyprus and Malta

Passi: depression and quality of life in Italy

- 6% of adults (18-69) report depressive symptoms and perceive their psychological well-being compromised

- depressive symptoms are more frequent with age (almost 8% among 50-69), among women (less than 8%), among the socially disadvantaged classes due to economic difficulties (14%), education, among precarious workers (8%), among those who have a chronic disease (13%) and among those who live alone (8%)

- 70% of the Italian adult population consider their overall health status to be positive

In Italy - over-64s

- 21% report depressive symptoms and perceive their psychological well-being compromised for 18 days in a month,

- depressive symptoms are more frequent with increasing age (25% after the age of 75), among women than men (26% vs 14%), among those reporting many economic difficulties (41%), and among those reporting have multi-chronicity (36% vs. 11% among those who do not report any chronic disease),

- 59% of disabled elderly suffer from symptoms of depression

- 21% of people with depressive symptoms do not ask anyone for help

People with symptoms of depression (n = 7952) (pool Pda 2009-2010)

Features	Modalities	%
Total		21,6
Age cohorts		
	65-74	18,8
	75 and over	25,3
Gender		
	male	22,3
	female	25,1
Education		
	low	24,3
	high	25,7

AGING AND SOCIAL ISOLATION

2/3 of people with symptoms of depression require help to:

- health workers or doctors (almost half)
- trusted people (20%)

- many people do not ask anyone for help

Social isolation:

- associated with many aspects of health status and the use of health resources,

- is a multidimensional concept, to the construction of which contribute both "structural" aspects and aspects of a "functional" nature

- the absence or scarcity of social relationships constitutes one of the major risk factors for health like cigarette smoking, alcohol abuse and obesity

In the elderly social isolation is related to:

- the decline of cognitive abilities
- a worse state of health (psychic and physical)
- an increase in mortality.

Loneliness and social isolation: a greater use and longer duration of hospitalizations, malnutrition, alcohol abuse or the risk of falling.

Social relationships can influence the state of health through:

- information exchange,
- emotional support,
- material help,
- promoting the adoption of healthy behaviors

Risk of social isolation (n=8348) (pool dati Pda 2009-2010)

Features	Modalities	%
Total		
Age cohorts		8,7
Features		
	65-74	6,4
	75 and over	12,1
Gender		
	male	8,6
	female	11,1
Education		
	low	11,5
	high	8,9

YOUTH AND MENTAL HEALTH

Adolescence: crucial phase of the building of identity

Difficulties experienced can be solved in constructive/dialectic way

Transition into adulthood - confusion, isolation

Not an unidirectional mechanism of socialization

Awareness of a possible discordance as they perceive themselves/how they feel perceived by others

This discrepancy push them to evaluate if to conform or to differentiate themselves to the expectations of the others

Acquisition of skills to analyze themselves

In the relationship the adolescents bring into play themselves in order to confer a new sense to the own identity

Biological maturity precedes psychosocial maturity

The changes in adolescence have health consequence not only in adolescence but also over the life-course

Study HBSC (2014) – Italy: students of 11, 13 and 15 years about the perception of the state of health

- the perception (postive or negative) of mental health is associated with scholastic performances and with the relationship of communication with parents
- 90% consider themselves in "good health”

Suicide is among the top five causes of mortality, apart from the African Region and boys in the Eastern Mediterranean Region

5% - 15% of younger adolescents (ages 13–15) reported a suicide attempt in the 12 months before the survey

Fewer than 25% adolescents meet recommended guidelines for physical activity

According to many adolescents mental health issues are among the leading risk factors for death (suicides) and are the most important health problem for them

They would like more access to mental health care

Suicide attempts are not widely monitored

Main causes of suicide among adolescents are:

- feelings of hopelessness and helplessness
- no solutions/no control to change their situations
- trying to escape feelings of pain, rejection, hurt, being unloved, victimization or loss
- feelings are unbearable and without an end
- afraid of disappointing others such as their parents
- bullying/cyberbullying
- abuse
- a detrimental home life
- loss of a loved one or even a breakup

Often, many of these environmental factors occur together to cause suicidal feelings and behaviors

The good support networks (family, peers, extracurricular sport, social, or religious associations) are very important to help adolescents in crisis

Specific circumstances can contribute to an adolescent's consideration of suicide.

The critical situations in which adolescents think to not have control are:

- divorce
- a new family formation (e.g., step-parents and step-siblings)
- moving to a different community
- physical or sexual abuse
- emotional neglect
- exposure to domestic violence
- alcoholism in the home
- substance abuse

Behaviour changes to watch in order to understand suicidal tendencies are:

- withdrawal from family and peers
- loss of interest in previously pleasurable activities
- difficulty concentrating on schoolwork
- neglect of personal appearance
- obvious changes in personality
- sadness and hopelessness
- changes in eating patterns, such as sudden weight loss or gain
- changes in sleep patterns
- general lethargy or lack of energy
- symptoms of clinical depression
- violent actions, rebellion, or running away
- drug and alcohol use
- symptoms that are often related to emotional state (e.g., headaches, fatigue, stomach aches)
- loss of ability to tolerate praise or rewards

Some adolescents with suicidal tendencies hide their problems underneath a disguise of excess energy

Explicit signs are low self-esteem and self-deprecating remarks

Previous suicide attempts are cries for help

Almost half of 14- and 15-year-olds have reported feeling some symptoms of depression

Symptoms of depression in youth are often overlooked or passed off as being typical "adolescent turmoil"

The easy access to firearms, drugs, alcohol, and motor vehicles can lead teens to suicide

The prevalence of suicide attempts ranges widely

Many high income countries report rates of 5–10%

In several low and middle income countries the rates are 15%

In a few countries more than 33% adolescents attempted suicide

In Europe and the Americas, adolescent girls are nearly twice as likely to attempt suicide as boys.

WHO found that many mental disorders usually start during childhood or adolescence

Half of all lifetime mental disorders appear to start by age 14

In high income countries fewer than half of adolescents with mental health problems receive needed care

In low-middle income countries access to treatment is scarce

Being bullied is linked to a wide range of mental, psychosocial, cognitive/educational and health problems

In about half of the countries, more boys than girls report being bullied

Bullying is declining in most high income countries in Europe and the Americas

THE ACTIVITIES OF NATIONAL TWIN REGISTRY

It is possible to estimate gene influences (heritability) and environment on mental health

NTR – relationship: the ability to self-regulate emotions-quality of sleep in adolescence. The preliminary results on a sample of twins aged 14-17 confirm the existence of this relationship

Mental health: as a result of the joint action of the prevention of pathological states-the promotion of states of well-being

It exists a substantial genetic component for self-esteem and satisfaction for life, while for optimism a predominant contribution of environmental experiences emerged

DIFFERENCES OF SELF-PERCEPTIONS AND ATTITUDES TO SEEK HELP

Developmental sport psychology research: young and older adults differ in their self-perceptions, social influences, emotional responses, motivations, and self-regulation with regard to sport and exercise participation

Developmental factors, such as age, could potentially influence mental toughness

Older age is associated with more positive help-seeking attitudes

Women exhibited more favorable intentions to seek help than men

Older adults exhibited more favorable intentions to seek help than younger adults

Negative attitudes related to psychological openness might contribute to men's underutilization of mental health services

Need for education to improve men's help-seeking attitudes and to enhance older adults' willingness to seek specialty mental health services

How the gender variable can affect the mental health

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Introduction

Sex: men/women on the basis of their biological characteristics

Gender: different features socially constructed.

Gender influences the control men and women have over the determinants of their health:

- economic position,
- social status,
- access to resources.

Material and symbolic positions that men and women occupy in the social hierarchy

Gender interacts with other variables: age, family structure, income, education and social support, and with a variety of behavioural factors

Sex and gender affect biological vulnerability, exposure to health risks, experiences of disease and disability, and access to medical care and public health services

Gender-sensitive research is more likely to lead to improved outcomes in treatment and preventative interventions

The role of gender in public health is now widely acknowledged

Gender has profound implications for many other aspects of mental health disorders, on sufferers and their families, the burden of care (which most frequently falls on women), and the stigma associated with mental health problems

Some data to start with

Statistics on mental disorders conceal the considerable differences men/women in the prevalence of specific types of MD and at different stages of the life-cycle

Women are more likely than men to suffer from poor mental health: depression and eating disorders

The rates of substance abuse are more than three times higher in adult men than in adult women

The more severe mental illnesses: schizophrenia and bipolar disorders are equal in men and women

Tipology of disease	Prevalence
Depression	W 41,9%, M 29,3%
Depression, organic brain syndromes and dementias	Older adults
Violent conflicts, civil wars, disasters, and displacement	Women and children.
Rate of violence against women	Ranges 16% - %0%
Rape or attempted rape in their lifetime.	At least one in five women

Depression, anxiety, psychological distress, sexual violence, domestic violence and escalating rates of substance use affect more women than men

Women's poor mental health caused by a combination of:

- their multiple roles,

- gender discrimination,

- factors of poverty (hunger, malnutrition),

- overwork,

-domestic violence and sexual abuse

Sense of loss, inferiority, humiliation or entrapment – depression

Up to 20% of those attending primary health care in developing countries suffer from anxiety and/or depressive disorders. In most centers, these patients are not recognized and therefore not treated

Communication difficulties health workers/women makes a woman's disclosure of psychological and emotional distress difficult, and often stigmatized

3 main factors which are highly protective against the development of mental problems:

- having sufficient autonomy to exercise some control in response to severe events;

- access to some material resources that allow the possibility of making choices in the face of severe events;

- psychological support from family, friends, or health providers is powerfully protective

Gender and Mental Health: why this connection?

Gender:

- determinant of mental health and mental illness
- has significant power regarding differential susceptibility and exposure to mental health risks and differences in mental health outcomes
- gender differences in rates of overall MD (schizophrenia and bipolar disorders), are negligible

It is predicted that depression will be the second leading cause of global burden of disease by 2020

- Depression is twice as common in women compared with men
- With identical symptoms, women are more likely to be diagnosed as depressed than men
- Men predominate in diagnoses of alcohol dependence
- Depression and anxiety: common comorbid diagnoses - need for gender awareness training to overcome gender stereotypes
- Comorbidity is associated with mental illness of increased severity, higher levels of disability and higher utilization of services
- Women have higher prevalence rates than men of both lifetime in three or more disorders
- Depression and anxiety are the most common comorbid disorders

- Other disorders that predominate in women: agoraphobia, panic disorder, somatoform disorders and post traumatic stress disorder
- To reduce the overrepresentation of women depressed it needs a multi-level, intersectoral approach, gendered mental health policy
- Main gender risks are exposure to poverty, discrimination and socioeconomic disadvantage
- Low rank is a powerful predictor of depression
- Globalization has overseen a dramatic widening of inequality
- For poor women in DC undergoing restructuring, rates of depression and anxiety have increased significantly

- Increased sexual trafficking of girls and women
- The mental health costs of economic reforms need to be carefully monitored
- Severity and the duration of exposure to violence are highly predictive of the severity of mental health outcomes: rates of depression in adult life are 3 to 4 fold higher in women exposed to childhood sexual abuse or physical partner violence in adult life; following rape, nearly 1 in 3 women will develop PTSD compared with 1 in 20 non victims
- Women are at significantly increased risk of violence from an intimate and are over represented amongst the population of highly comorbid people who carry the major burden of psychiatric disorder

Gender, human rights and the global burden of disease

- It is fundamental to consider gender-based discrimination and gender-based violence
- A human rights framework is needed
- It has to be considered the serious violations of their rights as human beings including sexual and reproductive rights suffered by women

Gender and patterns of mental disorder

Depression and anxiety, often associated with somatic complaints, affect around 1 in 5 people in the general community

General population studies indicate that lifetime prevalence rates are a range from 0.1% to 3% for schizophrenia and from 0.2% to 1.6% for bipolar disorders

Gender is related to differences in risk and susceptibility, the timing of onset and course of disorders, diagnosis, treatment and adjustment to MD

Schizophrenia:

- men typically have an earlier onset of symptoms than women and poorer premorbid psychosocial development and functioning;

- women experience a higher frequency of hallucinations or more positive psychotic symptoms than men

Bipolar disorder:

-- gender differences are just in the course of the illness

- women are more likely to develop the rapid cycling form of the illness, exhibit more comorbidity and have a greater likelihood of being hospitalized during the manic phase of the disorder

Women with schizophrenia have higher quality social relationships than men, but..

a cross national survey drawn from Canada, Cuba and the USA found that this was only true for Canadian women; Cuban men reported higher quality of life than Cuban women

a Finnish study on gender differences in living skills (self care, shopping, cooking) found that half the men but only a third of the women lacked these skills that are so important for independent living

Skills inculcated through gender socialization can affect long term adjustment to and outcome of a severe mental disorder

Gender specific exposure to risk also complicates the type and range of adverse outcomes associated with severe mental disorder

When schizophrenia coexists with homelessness, women experience higher rates of sexual and physical victimization, and more comorbid anxiety, depression and medical illness than men

Gender and Depression

It is most significantly to the global burden of disease

It is the most frequently encountered women's mental health problem

Unipolar or major depression occurs twice as often in women as in men

A significant reduction of women depressed should reduce the global burden of disease and disability

It is predicted to be the second leading cause of global disease burden by 2020

Comorbidity contributes significantly to the burden of disability caused by psychological disorders

Studies conducted in Usa, Puerto Rico, Canada, France, Iceland, Taiwan, Korea, Germany and Hong Kong: women predominated over men in lifetime prevalence rates of major depression

Female gender is a significant predictor of relapse

National Comorbidity Survey: Prevalence rates of selected disorders

Mental Disorders	Lifetime Prevalence Female	Lifetime Prevalence Male	12 Month Prevalence Female	12 Month Prevalence Male
Major depressive episode	21.3%	12.7%	12.9%	7.7%
Alcohol dependence	8.2%	20.1%	3.7%	10.7%
Antisocial personality disorder	1.2%	5.8%	NA	NA

Suicidal behaviour

Key risk factors for suicidal behaviour are

- mental disorder
- cultural factors
- social and economic factors

Male:female differences are likely to account for at least some of the observed differences in suicide rates between men and women

In many cases these risk factors interact with one another in complex ways

Completed suicide rates are higher in men

Suicide attempts rates are higher in women

Gender-based violence is a significant predictor of suicidality in women

Women have twofold higher rates of PTSD than men

The male excess for completed suicide has been partly attributed to the use of more lethal methods like guns (cultural differences about using of weapons)

Women tend to opt for "softer", less lethal means, such as pills and cutting

Increased rates of suicide, particularly among men during periods of economic recession and high unemployment

Economic reforms and increase in unemployment have been linked a rise in all-cause mortality in men (East Europe and some of the former members of the USSR)

In East Europe male suicide rates are over three times as high as those of men in most West Europe

It is likely that the differential impact on men and women of the rapid economic transition in eastern Europe (increasing poverty and unemployment), is linked to gendered differences in social roles and expectations

Men who are faced with unemployment and economic crises in societies where their primary role is that of breadwinner are probably at greater risk for suicidal behavior

It is important the role of smoking and drinking, used by men to cope with difficult life events

Gender and Comorbidity

Depression and anxiety are common comorbid diagnoses and women have higher prevalence than men

Almost 50% of patients with at least one psychiatric disorder have a disorder from at least one other cluster of psychiatric disorders

Women predominate in: depressive episode, agoraphobia, panic disorder, anxiety, somatization, hypochondriasis, somatoform pain

Psychiatric comorbidity with depression is a common factor in women's mental health

Comorbidity is associated with increased severity, higher levels of disability and higher utilization of services

It is concentrated in a small group of people

Highly comorbid people have been found to carry the major burden of psychiatric disorder

Women had significantly higher lifetime and 12 month comorbidity of three or more disorders than men

The multi-country WHO study on Psychological Problems in General Health Care:

- panic attacks and a diagnosis of panic disorder were frequently associated with the presence of a depressive disorder

- women predominate in all three disorders- panic attacks, panic disorder and depressive disorder

- combination of these disorders resulted in a long lasting and severe disorder that was linked to a higher rate of suicidality

Comorbidity and compounding over time

Clinicians, policy makers and researchers want to understand why psychological disorders compound and proliferate over the life course of women in particular, in order to devise effective interventions

The risk of onset of physical disability, even after controlling for the severity of the physical disease, increased 1.5 fold three months after the onset of a depressive illness and 1.8 fold at 12 months

The risk of onset of social disability increases from a 2.2 fold risk at 3 months to a 23 fold risk at 12 months

It is very important to identify women who have a history of and/or are currently experiencing violent victimization

Higher rates of depression and PTSD increase when victimization goes undetected, so there is a more costly utilization of the health and mental health care system

GENDER BIAS

Research

The relationship of women's reproductive functioning to their mental health has received protracted and intense scrutiny over many years

The impact of biological and reproductive factors on women's mental health is strongly mediated or disappears when psychosocial factors are taken into account

The contribution of men's reproductive functioning to their mental health has been virtually ignored

Some studies have revealed that men are emotionally responsive to many of the same events as women, such as experience depression following the birth of a child, moreover there is a high level of correlation between parents regarding depressive symptoms

Treatment

Female gender: significant predictor of being prescribed psychotropic drugs

Women are 48% more likely than men to use psychotropic medication after statistically controlling for demographics, health status, economic status and diagnosis

Women are more likely to seek help from and disclose mental health problems to their primary health care physician

Men are more likely to seek specialist mental health care and are the principal users of inpatient care

Men are also more likely than women to disclose problems with alcohol use to their health care provider

Despite these gender differences, many people with psychological disorders do not go to their doctors

If help is not sought in the year of onset of a disorder, delays in help seeking of more than 10 years are common in many countries

Funding, organization and insurance

The organization and financing of mental health care are:

- an important contribution to social capital

- an indicator of access and equity in mental health care

Women's overrepresentation amongst poor means that cost will be a significant barrier to mental health care

A 'user pays' system will further disadvantage poor women, over represented amongst people with depression, anxiety, panic disorder, somatization disorder and PTSD

If access to care is not blocked by cost considerations, those in greatest need are likely to seek treatment

Single motherhood status is the strongest independent predictor of mental health morbidity and utilization of mental health services

Low income is highly related to single motherhood status

Gender sensitive services

To reduce gender disparities in mental health treatment, gender sensitive services are essential

Services must be tailored to meet their needs

To ensure that the assistance available is also meaningful the full range of patients' psychosocial and mental health needs must be addressed

Services should adopt a life course approach

With regard to the doctor patient relationship, preferred health care providers are those who show a sense of concern and respect and are willing to talk and spend time with patients

Services need to be aware of the impact of parents' role on women with mental illness or substance use disorders

Violence and severe mental illness

Violence-related mental health problems are poorly identified

Women are reluctant to disclose a history of violent victimization unless physicians ask about it directly

Violent victimization in childhood predicts admission to a psychiatric facility during adulthood

A New Zealand study: women whose childhood sexual abuse involved penetrative sex, were sixteen times more likely to report psychiatric admissions than those who had been subjected to lesser forms of abuse

Gender and risk

Impact of gender in mental health is compounded by its interrelationships with education, income, employment, social roles and rank

There are strong, albeit varying, links between gender inequality, human poverty and socioeconomic differentials in all countries

Gender differences in material well being and human development are widely acknowledged

Women's health is inextricably linked to their status in society

It benefits from equality, and suffers from discrimination

The status and well being of countless millions of women world-wide remain low

Gender and work

The weakening of worker protection laws as well as their overrepresentation amongst sex workers, represent significant threats to mental and physical health and violations of women's human rights

The workplace is another area where rank is predictive of depression and linked to gender

Work characteristics are closely allied to employment grade and make the largest contribution to explaining differences in well being and depression

Women are more likely to occupy lower status jobs with little decision-making discretion

Relationship between various objective measures of rank and the increased likelihood of poor health, depression and anxiety

Low educational status, unemployment, low employment status and pay, insecure, 'casual' employment, single parent status, homelessness and insecure housing tenure and inadequate income, poor social support and diminished social capital

Gender roles

Women of reproductive age may carry the triple burden of productive, reproductive and caring work

Gender differences in rates of depression are strongly age related

The largest differences occur in adult life

Multi country WHO study on Psychological Problems in Primary Care: when social role variables were matched between women and men the female excess in depression was reduced by 50% across all centres in the study

Gender roles intersect with critical structural determinants of health (social position, income, education and occupational and health insurance status)

Role patterns of women are not evenly distributed across income levels

Low income mothers - higher levels of depression

Poor women are exposed to more frequent, more threatening and more uncontrollable life events: illness and death of children and the imprisonment or death of husbands

They face:

- more dangerous neighbourhoods
- hazardous workplaces
- greater job insecurity
- violence and discrimination

Abortions, experiencing sexual abuse, other forms of violence and adversity in childhood or adult life contribute to poorer mental health

These factors work to reduce the degree of autonomy, control and decision making latitude possible for women on low incomes

Economic policies

Connection among rising income inequality - increasing rates of common mental disorders - increased rates of mortality from physical conditions - increased mental health related mortality associated with substance use disorders and suicide

In Russia:

- significant falls in life expectancy include fast economic change
- high turnover of the labour force
- increased levels of crime
- alcoholism
- inequality
- decreasing social cohesion

Impact of globalization and structural adjustment programmes is especially severe in the poorest nations

It occurs in gender distinct ways because of the separate roles men and women play

Cutbacks in public sector employment and social welfare spending can cause the costs of health care, education and basic foodstuffs to become unaffordable, especially to poor women

Evidence on the gender specific effect of restructuring on mental health show significant associations between high rates of depression, anxiety and somatic symptoms and female gender, low education and poverty

Gender inequality accompanies but is also worsened by economic inequality and rising income disparity

The result of this interaction is a steep rise in the very mental disorders in which women already predominate.

Economic policies that cause sudden pose overwhelming threats to mental health

An increase in the number of disruptive, negative life events is paralleled by an increase in the numbers of women becoming depressed

Research carried out in GB:

- 85% of women who developed 'caseness' for depression in a 2 year study period experienced a severe event in the 6 months before onset

- depression was accompanied by low self-esteem and inadequate support

- the matching of a current severe event with a pronounced ongoing difficulty was also critical to the onset of depression

- most important of all was the experience of humiliation, defeat and a sense of entrapment, often in relation to a core relationship

Research based studies of women in Zimbabwe, London, Spain:

- women meeting the criteria for depression varied from a low of 2.4% in the Basque Country to a high of 30% in Zimbabwe

- negative, irregular, disruptive life events were found to trigger depression in all Countries

- a strong linear relationship exists between the number and severity of events and the prevalence of depression

Impact of gender-based violence on mental health

Gender differentiated levels of susceptibility and exposure to the risk of violence place stringent limitations on women's ability to exercise control over the determinants of their mental health

Social research indicates that depression in women is triggered by situations that are characterized by humiliation and entrapment and that this occurs in relation to 'atypical events'

Violence in the home tends to be repetitive and escalate in severity over time and encapsulates all three features identified in social research on depression in women:

- humiliation
- enforced inferior ranking and subordination
- blocked escape or entrapment

Violence-physical, sexual and psychological - high rates of depression and comorbid psychopathology

Psychological disorders are accompanied by multi somatisation, altered health behaviours, changed patterns of health care utilization and health problems affecting many body systems

Being subjected to the exercise of coercive control leads to diminished self esteem and coping ability

Violent victimization increases women's risk for unemployment, reduced income and divorce

Gender based violence is a particularly important cause of poor mental health because it further weakens women's social position

Female victims of sexual violence make up the single largest group of those suffering from PTSD

The likely causal role of violence in depression, anxiety and other disorders such as posttraumatic stress disorder is suggested by:

- three to four fold increases in rates of depression and anxiety in large community samples amongst those exposed to violence compared with those not exposed
- severity and duration of violence predicts severity and number of adverse psychological outcomes (impact of domestic violence and childhood sexual abuse)
- marked reductions in the level of depression and anxiety once women stop experiencing violence and feel safe compared with increases in depression and anxiety when violence continues

The female excess in depression and other disorders reflects women's greater exposure to a range of stressors and risks to their mental health, rather than an increased, biologically based vulnerability to psychological disorder

How cultural variable can affect the mental health

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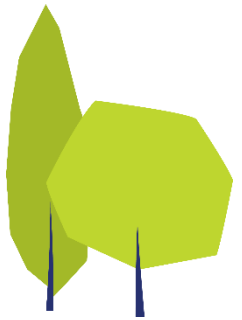

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Introduction

The concept of culture:

- intellectual and material heritage,
- heterogeneous/integrated,
- sometimes internally antagonistic,
- durable but subject to continuous transformations

Consisting of:

- values,
- norms,
- definitions,
- languages,
- symbols,

- signs,
- behavior patterns,
- mental and bodily techniques,
- a cognitive, affective, evaluative, expressive, regulatory, manipulative function;
- objects,
- supports,
- material or physical vehicles;
- material means for the production and social reproduction of man produced and developed entirely through work and social interaction

Prevalence rates of common mental disorders vary considerably between countries

It is fundamental to find meaningful empirical instruments for capturing the latent construct of 'culture' of mental disorders

It bears upon what all people bring to the clinical setting

Variations in how people communicate their symptoms

Some aspects of culture may also underlie culture-bound syndromes

It is important to consider if people seek help, what types of help they seek, what types of coping styles and social supports they have, and how much stigma they attach to mental illness

It influences the meanings that people impart to their illness

Users of MH services carry diversity inside the service

The cultures of the clinician and the service systems affect the clinical approach and shape the interaction with the MH user

Culture and social contexts shape the MH of minorities and alter the types of MH services they use

Cultural misunderstandings patient

Culture of patient

The culture of the patient influences: MH, mental illness, and way to use of health care

Cultural characteristics of a group may invite stereotyping of individuals based on their appearance or affiliation

Culture affects the way in which people describe their symptoms

Cultures differ in the meaning and level of significance and concern they give to mental illness

Every culture has its own way of making sense of the subjective experience (MH)

Each has its opinion on whether mental illness is real or imagined: who is at risk for it, what might cause it, and its level of stigma

Mental illness can be more prevalent in certain cultures/communities:

- the prevalence of schizophrenia is consistent throughout the world
- depression, PTSD, and suicide rates are more attributed to cultural and social factors

In US some Asian groups prefer avoidance of upsetting thoughts about personal problems rather than outwardly expressing that distress

Cultural factors often determine how much support people have from their families and communities in seeking help

It has a significantly impacts a person's quality of life and can cause severe distress and secondary health effects

The symptoms of mental disorders are found worldwide

Cultural and social context weigh more heavily in causation of depression

Social and cultural factors play a greater role in the onset of major depression

Factors often linked to ethnicity can increase the likelihood of exposure to types of stressors

Cultural and social factors have the most direct role in the causation of PTSD

Traumatic experiences are particularly common for certain populations: combat veterans, inner-city residents, immigrants from countries in turmoil

There are high rates of PTSD in communities with a high degree of pre-immigration exposure to trauma

Family factor

Family life influences MH

Family factors protect against, or contribute to, the risk of developing a mental illness

Family risk and protective factors for mental illness vary across ethnic groups

Researches on family factors and mental illness deals with relapse in schizophrenia

Studies in GB: people with schizophrenia who returned from hospitalizations to live with family members who expressed criticism/hostility, or emotional involvement were more likely to relapse than were those who returned to family members who expressed lower levels of negative emotion

Other studies reconceptualized the role of family

A study comparing Mexican American/white families found that different types of interactions predicted relapse:

- in Mexican American families, interactions featuring distance or lack of warmth predicted relapse for schizophrenics

- in white families, the converse was true

So, culturally based family differences may be related to the course of mental illness

Coping Styles

How people cope with everyday problems and more extreme types of adversity

Some Asian American groups tend not to dwell on upsetting thoughts, thinking that reticence or avoidance is better than outward expression - suppression of affect

African Americans tend to have an active approach in facing personal problems, rather than avoiding them

A better understanding of coping styles has implications for the promotion of MH

Treatment Seeking

Ethnic minorities in US seek less help in MH services than whites, so they are underrepresented in MH services

Treatment seeking denotes:

- the pathways taken to reach treatment and the types of treatments sought;
- the final outcome of contacts after that the MH disorder has been recognizes

Some minority ethnic groups are more likely than whites to delay seeking treatment until symptoms are more severe

In some cases they turn to informal sources of care: clergy, traditional healers, and family and friends

Some African Americans prefer therapists of the same ethnicity (development of ethnic-specific programs that match patients to therapists of the same culture)

Many African Americans also prefer counseling to drug therapy

Many ethnic minorities are less inclined than whites to seek MH treatment because of:

- cost
- fragmentation of services
- societal stigma on mental illness
- mistrust
- limited English proficiency

Mistrust

Mistrust is a major barrier to the receipt of MH treatment by ethnic minorities

Mistrust of clinicians by minorities arises from:

- historical persecution,
- present-day struggles with racism and discrimination,
- documented abuses and perceived mistreatment

In US a survey found that 12% of African Americans and 15% of Latinos, in comparison with 1% of whites, felt an unfairly or disrespect treatment by MH operators

Immigrants and refugees feel extreme mistrust of government, based on atrocities suffered in their country of origin

Stigma

Gradualness in the intolerance towards the stranger

Prejudice - cognitive mechanism: distinction of the 'objects' in pre-established categories (the reality and the strangers are ranked in mental categories)

Prejudice - ground for the origin of stereotypes: rigid and standardized representations of social groups (negative and stigmatized evaluations)

Stereotype and prejudice are complementary to ethnocentrism

Ethnic prejudice and ethnocentrism determine racism and xenophobia

Mental illness stigma: devaluing, disgracing, disfavoring

Discrimination

Inequitable treatment

Denial of citizenship rights

Consequences of stigmatization:
- denying resources
- disadvantages at the economic, social, legal, and institutional levels
- difficulties to seek treatment
- difficulties to adhere to treatment regimens
- difficulties to find a job
- difficulties to live successfully in community settings

Attitudes toward mental illness vary

Cultural and religious teachings can influence beliefs about mental illness

Beliefs about mental illness can affect patients' readiness and willingness to seek and adhere to treatment

Understanding individual and cultural beliefs about mental illness is useful to deliver effective approaches to MH care

Each individual's experience with mental illness is unique

Different attitudes of stigmatization of American Indian tribes towards mental ill: totally or partially

In Asia mental illnesses are often stigmatized and seen as a source of shame

Perception of causes of mental illness can influence the stigmatization

Study in which Chinese Americans and European Americans were involved: genetic attribution of mental illness significantly reduced unwillingness to marry and reproduce among Chinese Americans, but it increased the same measures among European Americans

World Mental Health Surveys: stigma was closely associated with anxiety and mood disorders among adults reporting significant disability

Stigma leads to diminished self-esteem and greater isolation and hopelessness

Stigma can also be against family members

Experience of symptoms, a cross-cultural studies about Asian Americans living in Los Angeles:

- 12% would mention their MH problems to a friend or relative (versus 25% of whites),

- 4% would seek help from a psychiatrist or specialist (versus 26% of whites)

- 3% would seek help from a physician (versus 13% of whites)

Public attitudes toward mental illness, in a study of stigma in the US emerged:

- people with mental illness were perceived as dangerous and less competent to handle their own affairs

- ethnicity doesn't influence the degree of stigma

In US minorities hold similar or stronger, stigmatizing attitudes toward mental illness than do whites

Societal stigma keeps minorities from seeking needed mental health care

Stigma affects the self-esteem both of patients, and of family members

Stigma is very powerful in the deterring people from seeking help

A majority of all people with diagnosable mental disorders do not get treatment

Presenting MH care services in culturally-sensitive ways could increase access to and usage of MH care services

Conceptualizations and treatments for depression should take into account diverse perspectives on mental illness in order to maximize the effectiveness of MH care delivery programs

Immigration

Migration, a stressful life event, can influence MH

Acculturative stress occurs in the process of adapting to a new culture

Refugees experience more trauma

The psychological stress-immigration tends is often concentrated in the first three years

According to studies of Southeast Asian refugees:

- first year - initial

- second year - strong disenchantment and demoralization reaction

- third year - gradual return to well-being and satisfaction

Immigration per se does not result in higher rates of mental disorders

Traumas experienced by adults and children from war-torn countries - PTSD

Overall Health Status

The burden of illness is higher in ethnic minorities

Higher rates of physical disorders among ethnic minorities hold significant implications for MH

Chronic physical illness is a risk factor for mental disorders

Ethnic minority groups who already have both a mental and a physical disorder are more likely to have their mental disorder misdiagnosed

People with comorbid disorders are:

- treated with more drug interactions and side effects

- more likely to be unemployed and disabled, than who have a single disability

Interrelationships mind/body

Culture of the Clinician

Professionals have a "culture":

- a shared set of beliefs, norms, and values

- jargon, orientation and emphasis in their their way of looking at the world

Western medicine: the primacy of the human body in disease

MH professionals trace their roots to Western medicine

- the first forms of biological psychiatry in the mid-19th century (advances in pharmacological therapy)

- the advent of psychotherapy (psychoanalysis)

Today many forms of psychotherapy - verbal communication patient/therapist

Best today's treatments for specific mental disorders combine pharmacological therapy and psychotherapy

Most clinicians: interrelationship body-mind-environment

Possible different visions clinicians/patients about symptoms, diagnoses, treatments

When clinician and patient do not share the same ethnic or cultural background, cultural differences emerge

Clinicians should understand how their relationship with the patient is affected by cultural differences

Communication

The emphasis on verbal communication

The diagnosis and treatment mostly depend on verbal communication patient/clinician about symptoms, their nature, intensity, and impact on functioning

Overt and subtle forms of miscommunication and misunderstanding can lead to misdiagnosis, conflicts over treatment, and poor adherence to a treatment plan

Clinician Bias and Stereotyping

Misdiagnosis can be due to clinician bias and stereotyping of minorities

Clinicians reflect attitudes and discriminatory practices of their society

Racism and discrimination have diminished, but there are traces which are manifest in less overt medical practices:

- diagnosis
- treatment
- prescribing medications
- referrals

In US African American patients are subject to over diagnosis of schizophrenia and under diagnosed for bipolar disorder, depression, anxiety

Minority patients are less likely than whites to receive the best available treatments for depression and anxiety

Possibility that institutional factors and attitudes that were common to black and white physicians contributed to lower rates of utilization by black patients

Service Settings and Sectors

MH services are provided by numerous types of practitioners in different settings:

- home,
- community,
- institutions,

and sectors:

- public or private primary care,
- specialty care

The current availability of services is in sharp contrast to the institutional orientation of the past

Today's best mental health services extend beyond diagnosis and treatment to cover prevention and the fulfillment of broader needs

Services are:

- formal (professionals)
- informal (volunteers)

There are four major sectors for receiving MH care:

1. services - mental hospitals, residential treatment facilities, community MH centers, day treatment programs, rehabilitation programs with specialized MH professionals

2. general medical and primary care sector (primary care physicians, nurse practitioners, internists, and pediatricians) in clinics, offices, community health centers, and hospitals;

3. human services sector - social welfare (housing, transportation, and employment), criminal justice, educational, religious, and charitable services;

4. voluntary support network - self-help groups and organizations devoted to education, communication, and support

Users can exercise choice in treatment between psychotherapy, counseling, pharmacotherapy (medications), or rehabilitation

Culturally Competent Services

Tremendous changes in MH service delivery were in the last four decades

Social factors:

- civil rights movement,

- the expansion of MH services into the community,

- the demographic shift toward greater population diversity

Huge variations in utilization minorities/mainstream

It has discovered the influence of culture on MH

Major differences were found in some mental disorders, idioms for communicating distress, and patterns of help-seeking

Self-examination by the MH field and the advent of user and family advocacy

Key elements of therapeutic success depend on:

- rapport and the clinicians' understanding of patients' cultural identity,
- social supports,
- self-esteem,
- reticence about treatment due to societal stigma

Insistence by stakeholders to deliver services responsive to the cultural concerns of ethnic minority groups

Humanistic values and intuitive sensibility

Tailoring services to the specific needs of these groups improves utilization and outcomes

Cultural competence underscores the recognition of patients' cultures

Services tailored to culture would encourage minorities to get treatment

Cultural competence represents a fundamental shift in ethnic relations

Participation of users, families and communities helping service systems design and carry out culturally appropriate services is also essential

Racism, Discrimination, and Mental Health

Racism and discrimination: beliefs, attitudes, and practices that denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation

Discrimination in housing rentals and sales and in hiring practices

Racism and discrimination also in the administration of medical care

Racism and discrimination: from demeaning daily insults to hate crimes

Racism and discrimination can be perpetrated by institutions or individuals, acting intentionally or unintentionally

General Social Survey (in US): significant percentage of whites held disparaging stereotypes of African Americans, Hispanics, and Asians

Minority groups commonly report experiences with racism and discrimination to be stressful

African Americans and Hispanic Americans reported higher overall levels of global stress than did whites

Some studies link the experience of racism to poorer mental and physical health

Racism linked with hypertension among African Americans

Discrimination is associated with psychological distress, lower well-being, self-reported ill health, and number of depression

Racism and discrimination are clearly stressful events

US researchers asked how racism may jeopardize MH of minorities. Three general ways are proposed:

1. Racial stereotypes and negative images can be internalized, denigrating individuals' self-worth;

2. Racism and discrimination by societal institutions have resulted in minorities' lower SES in which poverty, crime, and violence are persistent stressors that can affect MH;

3. Racism and discrimination are stressful events that can directly lead to psychological distress

Poverty and Mental Health

People living in poverty have the poorest overall health (also MH)

People in the lowest SES are about 2-3 times more likely than those in the highest strata to have a mental disorder

An environment is conducived to violence when has:

- disadvantaged community marked by economic and social flux,

- high turnover of residents,

- low levels of supervision of teenagers and young adults

Young ethnic minority men from such environments perceived as prone to violent behavior – higher rates of arrested for violent crimes

Exposure to community violence leaves immediate/long-term effects on MH

Poverty related to poorer MH:

1. people poor are more likely to be exposed to stressful social environments

2. having a mental disorder can lead to poverty

So poverty is a consequence of mental illness

Poverty and SES don't play an exclusive role

A lower SES by itself does not explain ethnic disparities:

- Mexican American immigrants in US even if impoverished, enjoy excellent mental health

- immigrants' culture is a protection against the impact of poverty

Organization of public and private services for mental health

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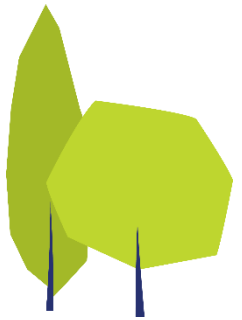

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European level

The promotion of mental health and the prevention and treatment of mental disorders are objectives were adopted by: EU-MS, European Commission and Council of Europe

WHO Regional Office for Europe has developed this Action Plan in partnership with the leading actors in MH

The Action Plan is fully aligned with the values and priorities of the new European policy framework for health and well-being, Health 2020

It is closely interrelated with other WHO programmes and it covers mental health and mental disorders across the life-course

MH in Europe: status and challenges

EU is facing diverse challenges affecting the (mental) well-being

Challenges common to MS:

- maintaining the well-being of the population,

- making a commitment to the rights and empowerment of service users and their families,

- guaranteeing access and quality of care

Policies across government can increase mental well-being and reduce exposure to risk factors

MH problems are the main cause of disability and early retirement in many countries and a major burden to economies

Commitment to deinstitutionalization, but different outcomes

Care and treatment should be provided in local settings

Large mental hospitals often lead to neglect and institutionalization

Focus on multidisciplinary MH staff in community-based facilities

A large proportion of people with mental disorders has difficulties to access to treatments

Reforms need to achieve higher confidence in the safety and effectiveness of care

The life expectancy of people with MH problems is many years shorter than other population

Lack of awareness and stigma play an important part

All sectors of society have a responsibility for MH

It can still be difficult to identify who is in charge of coordinating action

The importance of choice and partnership emphasizes the need for transparent information and accountability to inform all stakeholders about quality of care and interventions, and to demonstrate the need for improvement and the potential for innovation and change

European values and vision for mental health

3 complementary values and accompanying visions inspiring this Action Plan:

a) Fairness: everyone is enabled to reach the highest possible level of mental well-being and is offered support proportional to their needs

b) Empowerment: all people with MH problems have the right, to be autonomous, having the opportunity to take responsibility for and to share in all decisions affecting their lives, MH and well-being.

c) Safety and effectiveness: people can trust that all activities and interventions are safe and effective, able to show benefits to population MH or the well-being of people with MH problems

European MH Action Plan: scope

Scope of the Action Plan proposes a three-pronged, interdependent, indivisible and mutually-enforcing approach

a) Improve the mental well-being of the population and reduce the burden of mental disorders (special focus on vulnerable groups)

b) Respect the rights of people with MH problems and offer equitable opportunities to attain the highest quality of life

c) Establish accessible, safe and effective services that meet people's mental, physical and social needs and the expectations of people with MH problems and their families

European MH Action Plan: objectives

Actions should be prioritized according to needs and resources at national, regional and local levels

The 4 core objectives are:

a) everyone has an equal opportunity to realize mental well-being;

b) people with MH problems are citizens whose human rights are fully valued, protected and promoted;

c) MH services are accessible and affordable, available in the community according to need; and

d) people are entitled to respectful, safe and effective treatment

The 3 cross-cutting objectives are:

e) health systems provide good physical and mental health care for all;

f) MH systems work in well-coordinated partnerships with other sectors; and

g) MH governance and delivery are driven by good information and knowledge

MH services are accessible and affordable, available in the community according to need

Centrality of psychological, biomedical socioeconomic and cultural matters

In all UE countries: shift from institutional psychiatry to community based MH care

Large asylums have been closed in some countries, while closure plans are in place in others - reduced number of psychiatric beds in most countries

Primary care is the first point of access

The stigma of accessing primary care is low

Settings are accessible and brief interventions can be delivered efficiently

MH services that are local and community-based, organized around the needs of a population catchment area, that provide and integrate:

- information and means to help oneself or support family members,

- primary care linked services for treatment of common MH problems,

- community MH services for prevention, treatment and psychosocial rehabilitation,

- beds available as a last resort in settings such as health centres or district general hospitals for people requiring intensive care,

- support in residential homes for people with long term MH problems and some regional or national services for special conditions including forensic services.

Community services often rely on the commitment of families, that should benefit from the necessary support, education and the provision of resources

Necessity of competent staff

Changes in service structure and ways of working require - changes in workforce numbers and skill mix in all parts of the MH services

MH care in Europe is usually, but not always, free of user charges at the point of entry

Payment or co-payment may be required for specialized services in some countries

Health systems provide good physical and mental health care for all

The high burden of disease posed by MH problems is exacerbated by many co-morbidities and interactions between mental and physical (ill) health

Disparities in health care access, provision and utilization have a role in determining the morbidity and mortality gap between people with mental disorders and the rest of the population (this gap is increasing)

Mental disorders are risk factors for a range of physical diseases

Poor mental health adversely affects the course and outcome of many physical diseases

MH systems work in well coordinated partnership with other sectors

It is essential a combination of services working in partnership

Agencies need to determine their roles and responsibilities and organize appropriate coordination systems

In many countries, funding streams for mental health, public health and social care services originate from different sources and budgets, resulting in payment or reimbursement rules that can hinder good practice

In some circumstances, service users and their families know best how to allocate resources effectively and efficiently, and this also empowers them

Italian level - The organization of MH services

Implementation of 180 Law:

-78-98: experimentation of the reform

-First project aimed at protecting MH 1994 - historic step

-Second project to safeguard MH 1999-2000:

-it confirms the contents of the law 180,

-the Department of Mental Health (DMH) becomes the organizational and coordination structure

The objective project to protect mental health

Useful for qualitative and quantitative development of psychiatric assistance for 5 fundamental reasons:

1) final overcoming of the asylum

2) It identifies the DMH as the most suitable organizational model for therapeutic continuity and unitarity of interventions

3) It defines the DMH as an integrated set of structures and services with unique management and coordination

4) PDSC, even if located in a general hospital, is an integral part of the DMH

5) It requires verification of the quality of services and interventions

Tasks of the DMH

therapeutic

rehabilitation

social reintegration

Therapeutic task:

ambulatory and home psychiatric activities, emergency and crisis response interventions

Rehabilitation task:

act to develop the person's skills (few or many), to improve his or her autonomy and relationships

Social reintegration task:

create the conditions necessary to include the person in the collective life (therapeutic and rehabilitative programs, economic and relational resources, work and housing opportunities)

The operational units of the DMH (objective project)

- Mental Health Center (MHC)
- Psychiatric Service of Diagnosis and Care (PSDC)
- Residential and semi-residential structures (RS)

The DHM of Trieste

4 MHC 24 h

1 University Psychiatric Clinic / MHC (8 beds of which 4 territorial)

1 Qualification and Residency Service (QRS) (coordinates social cooperatives, training and job placement)

1 PDSC (6 beds at the general hospital)

The Mental Center Health

Place of acceptance and exchange, opportunity for relationship, possibility of staying at least temporarily out of a difficult family situation

The MCH to work well should:

- manage a population between 50,000 and 80,000 inhabitants,
- being accessible without difficulty even with public transport

Functions, activities, programs of the MHC

Recognition and crisis management in the 24-hour

Individualized rehabilitative treatment programs

Protagonism, participation and user involvement

Information and training for family members

Promotion of self-help activities

Facilitation of associations

Recreational and recreational activities

Basic, professional and social enterprise training activities, job placement

Consulting service in prison

Integration with health districts

Family doctor involvement (Health Tutor)

Prevention of discomfort related to the loneliness of the elderly

Suicide prevention

Gender differences and MH

Relations with the cultural agencies of the city

Services of Mental Health Center

- Night hospitality:

For variable periods of time (from one night to several weeks)

Acceptance for the purposes of Mandatory Healthcare is also normally carried out in the MHC

- Day hospitality:

For a few hours, or for the whole day, it is proposed to offer a condition of temporary protection or protection during the crisis, to alleviate the family

- Outpatient visit:

During the outpatient visit, news and opinions are exchanged with the person and / or family members, or action is taken in crisis situations

- Home visit:

Programmed or urgent, it allows the knowledge of the living conditions of the person and his family

- Individual therapeutic work:

Meetings with family members to verify and discuss the dynamics and conflicts, in order to promote greater knowledge and participation in problems

- Goup activity:

Meetings in which the exchange of information on common problems strengthens the ability to know each other. Main purpose: to activate the social network

- Habilitation and prevention interventions:

Initiatives to initiate paths to access information and culture, training and job placement

- Support for access to social rights and opportunities

- Housing support:

Programs carried out at home to support daily life skills and preserve or re-learn social and interpersonal skills of group life. Support for residential activities

- Consulting activity

Interventions in: health services or hospital wards, prison, district offices, public and private retirement homes

- Telephone:

Active at least 12h a day for reports, suggestions, appointments, checks even in case of emergencies

Psychiatric Service of Diagnosis and Care (PSDC)
The interface between hospital and territory

- Structure for emergencies / emergencies
- placed inside a general hospital
- open 24 hours a day, 7 days a week
- place of transition (improper use in many realities)
- implements Compulsory Healthcare (CH) and Voluntary Health Treatment in admission conditions
- psychiatric counseling to other hospital divisions and to the emergency room
- connected to the MHD (administratively, functionally, operationally)

- a bed every 10,000 inhabitants
- max 16 beds
- adequate spaces to guarantee respect for privacy and rights also for people in CH
- spaces for common activities
- open doors
- no containment
- reduce the duration of hospitalization, in line with the principle of territoriality of care
- hospitalization never replacing the taking charge of the MHC but only an exception motivated by very particular needs
- possibility of maintaining contacts with one's environment for easier overcoming of crisis situations
- guarantee the continuation and territoriality of the care by the MHC

Residential Structures
Respond to people's housing needs

- Extra-hospital facilities where part of the therapeutic, rehabilitation and social integration program takes place
- Providing a network of relationships and emancipatory opportunities is not just a housing solution
- Location in urbanized and easily accessible areas
- Managed by DMH or private social and / or business (DMH project owner)
- Access and discharge based on personalized therapeutic program agreed with MHC operators, RS operators, person, family members and / or other reference persons
- 2 places / 10,000 inhabitants

Therapeutic community:

- structure with high therapeutic rehabilitation intensity
- operators 24 hours a day
- particularly active individual and empowering individual programs

Apartment groups:

- operators 12 h per day
- people with a reasonable level of skill and autonomy
- individual programs aimed above all at social integration and to guarantee a useful and dignified housing possibility

Housing houses or cohabitation centers:

- more people encouraged to live together and share the apartment and the management costs

- operators only a few hours a day or by necessity

guarantee integration with the surrounding social structure, ensuring them a decent living

Residential Structures: what shouldn't be

Substitute places of the asylum

Places of passive and chronic abandonment

Places of management of the psychiatric crisis

The semi-residential centers

- They host people by day

- They provide individual and group rehabilitation therapeutic programs

- They can be located in the same structure that hosts the CSM

- Day Hospital: Particular attention is given to intensive therapeutic programs even in crisis conditions

Day center: Special attention is paid to training and socialization paths

The Italian mental health-care reform: outcames

Decreased of patients in psychiatric hospitals/wards (78 538 in 1978 - 7704 in 1998)

Currently there are 10 beds/100.000 in psychiatric wards and 46 beds/100.000 in community residential facilities

Wide differences between geographical areas

Decreasing the number of psychiatric beds is not linked to increased suicide rates

OECD: suicide rates have remained stable in Italy

After Law180 number of compulsory admissions progressively declined: more than 20 000 in 1978 - less than 9000 in 2015

Proportion of compulsory psychiatric admissions progressively declined between 1978 and 2005 and remained stable thereafter, in 2015 they were less than 5% (8815) of all 187205 psychiatric admissions

Decreasing the total number of psychiatric beds does not lead to increased use of psychiatric forensic facilities

In 2016, after the phasing out of forensic psychiatric hospitals, there were 541 individuals placed in new residential facilities and 201 individuals with mental disorders placed in psychiatric units in prison

Italy has invested in psychiatric beds placed in community residential facilities

How to approach patients with MH problems on the basis of three variables

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Before proposing physical activity the reference psychiatrist must be consulted in order to obtain information about:

- the possible cardiovascular and metabolic diseases.

- the side effects of the drugs,

so the instructor is able to assess how far he can go with the patient in proposing physical exercise

Sketching a project, in which the patients themselves should also be involved in order to establish:

- the intervention,
- the amount of physical activity time,
- the observation time of how the patient reacts to the proposed exercise,
- the assessment of the limits and physical possibilities of patients and changes,
- the attention to the patient's diet and changes

EAP: physical activity (aerobic), is useful and should be practiced regularly to:

-improve well-being and health on various fronts,

-it is a real adjunctive therapy effective in treatment of psychiatric illnesses

Benefits - reduction of the risk of developing:

- hypertension,
- acute and chronic cardiovascular diseases,
- diabetes/overweight,
- impoverishment of bone mass and osteoporosis,
- attenuation of psychiatric symptoms,
- improvement of physical, mental and intellectual functionality (possible slowing down of the cognitive decline)
- beneficial effects of the movement on sleep at night

To get the maximum benefits, people with depression should do aerobic physical activity or a mix of aerobic training and endurance at least 2-3 times a week, for about 45-60 minutes per session

One can choose the discipline that one prefers, in relation to age and individual physical potential, in every case they have to be performed under the supervision of a competent instructor

In the case of schizophrenia, the EAP recommends at least 150 minutes of moderate-to-vigorous physical activity per week

One should not expect miracles from physical activity, but the additional benefit it can bring is demonstrated

Working with young

Broader population health interventions are required to :

- prevent disengagement from physical activity,

- reduce sedentary behaviors in young people generally, particularly those at risk of developing mental health problems

Studies indicate the potential for exercise interventions in improving depression symptoms in young people

The age range of 12–25 years is a critical time to intervene to:

- promote early recovery,
- limit negative consequences to social and vocational functioning
- maximize the opportunity to establish positive long-term health-related behaviors

These kind of interventions are highly acceptable and non stigmatizing

Interventions for young people should:

- promote exercise as a pleasant and enjoyable activity to maximize adherence and sustained engagement,

- track the long-term health and MH outcomes as essential to demonstrate the longer-term effects of exercise in young people's lives

Exercise is:

- efficacious in reducing key clinical symptoms,

- can be delivered alongside usual treatment for early psychosis

Individualized exercise training - improving symptomatic, neuro cognitive and metabolic outcomes in first-episode psychosis/early stages of illness

Carter T, Morres ID, Meade O, Callaghan (2016) reported some recommendations:

- Group-based and supervised light- or moderate-intensity exercise activities three times a week for a period of between 6 to 12 weeks could bring about an improvement in depression

- Exercise seems to be equally effective for both moderate and severe depression in both inpatient and outpatient settings

Age group 5–17, appropriate levels of physical activity contribute to the development of:

- healthy musculoskeletal tissues,
- healthy cardiovascular system,
- neuromuscular awareness,
- facilitates maintenance of a healthy body weight

Physical activity has been associated with psychological benefits in young people

Working with adults

Report WHO (2010) - recommendations for level of physical activity needed for prevention of non-communicable diseases:

- age 18 - 65, to take at least 150 min of moderate-intensity aerobic activity throughout the week

- performed on 2 or more days per week

The recommendations are (Paterson, Murias, 2014):

- perform moderate- to vigorous-intensity aerobic activities to enhance cardio respiratory fitness,

- perform a minimum of 150 min/wk of moderate-intensity activity that amounts to an energy expenditure of approximately 1000 kcal/wk (or ~90 min/wk of vigorous exercise)

- gain additional benefits from adding 2 sessions/wk of muscle-strengthening activities

- balance and mobility are limitations, include balance-related activities

- structured exercise-training programmes, usually consisting of 30 min/ session of moderate- and vigorous-intensity exercise, have been shown to be effective and safe

Improvements observed in psychosocial functioning and verbal short-term memory

Increases in cardiovascular fitness and processing speed associated with the amounts of exercise

High-intensity exercise and low-intensity exercise - decreasing overall anxiety sensitivity

High-intensity exercise had several distinct advantages over low-intensity exercise

High-intensity exercise group reported significantly less fear of anxiety-related bodily sensations at post-intervention compared to comparison group

There are limitations to using high-intensity aerobic exercise as an intervention for anxiety sensitivity

Aerobic exercise may prove to be an invaluable treatment alternative for individuals with high anxiety sensitivity who cannot or will not consider more traditional means of intervention

Working with elderly

Physical activity and exercise influence MH

Impairments in physical capacity and dependence in ADL are common among older people in residential care facilities

Increased physical capacity and independence in ADL may be important for MH:

- improved self-esteem and ability to participate in social activities

- enhancing the possibilities of increasing the level of daily physical activity

People with dementia often have difficulties to initiate physical activities

Epidemiological studies have provided evidence of the effectiveness of PA in increasing active life expectancy and in preventing:

- functional losses leading to loss of independence and well-being and some aspects of cognitive losses and depression

- disease and all-cause mortality

Regular physical activity is generally associated with psychological well-being, although there are relatively few prospective studies in older adults

Pasco et al.:

- higher levels of habitual PA are protective against the subsequent risk of development of de novo depressive and anxiety disorders

- therapeutic effects of exercise in the treatment of depression are established

- exercise is a viable lifestyle candidate for the primary prevention of high prevalence MH disorders

Erickson & Kramer (2008): 6 months of moderate levels of aerobic activity are sufficient to produce significant improvements in cognitive function

Improvements accompanied by altered brain activity measures and increases in prefrontal and temporal grey matter volume

Moderate levels of exercise can serve as:

- a preventive measure against age-related cognitive and brain deterioration

- a treatment to reverse decay and cognitive deficits already present in older adults

According to one meta-analysis, the combination of aerobic and non-aerobic regimens produces greater benefits to cognitive function than either type of exercise by itself

There is mounting evidence that exercise has beneficial cognitive and neural effects on a number of populations besides those with dementia, including children, multiple sclerosis patients, and Parkinson’s patients

Differences in reaction to physical activity based on gender

Zhang et al (2015) analyzed the relation between depressive symptoms and PA among mildly and moderately depressed individuals: a regular physical activity reduces depressive symptoms

PA is an effective tool to combat depression

To reduce depressive symptoms for individuals with a record of bad PH, the amelioration of depression would have to be accomplished along with PA and other means

A moderate to vigorous intensity exercise program is a promising strategy for reducing anxiety sensitivity (AS)

Medina et al. (2014): the effects of exercise on MH outcomes may vary as a function of gender, with men benefitting more than women

These interventions should be different in women than men at least as it relates to anxiety reduction

Studies that compare types of exercise modalities and doses can help refine the knowledge needed to develop individually tailored exercise interventions

From the psychosocial perspective, it is thought that women's biological tendencies for increased worrying are often strongly reinforced by gender-related norms

The predominance of women suffering from anxious or affective disorders is most likely due to a combination of these fundamental differences at the biological and psychosocial levels

Differences in reaction to physical activity based on culture

A social gradient exists in PA behaviour

This gradient is established to a large extent in childhood and prevails across the life course

Physical inactivity in the socially deprived might accentuate the effects of psychosocial stress and partly account for the established social disparities in health and well-being

Adverse socioeconomic position is linked with lower PA and greater sedentary behaviour (poorer education)

Brodersen et al. (2006) assessed the developmental trends in PA and sedentary behaviour in British students (11–12 years). Results:

- Asian students were less active than whites, also true of black girls but not boys
- Black students were more sedentary than white students
- Levels of sedentary behaviour were greater in respondents from lower SES
- Most differences between ethnic and SES groups were present at age 11 years, and did not evolve over the teenage years

PA declines and sedentary behaviour becomes more common during adolescence

Ethnic and SES differences are observed in PA and sedentary behaviour in youth, that anticipate adult variations in health risks

Adolescents of lower SES engage in more sedentary behaviour, but physical activity differs by SES only in girls

Earlier intervention

PA is an important factor in determining health outcomes among ethnic minority groups, who reside in more socially deprived areas

PA interventions need to be targeted to socially deprived groups, but it is important to understand the environmental barriers to PA in deprived areas

PA programmes should be tailored to the individual and contain multiple components:

- goal setting,
- problem solving,
- self-monitoring,
- supervised exercise

Changing health behaviour in low-income groups can be challenging and complex and requires a collaborative approach among different actors

Interventions should be applied during both childhood and adult life

TO SPREAD PA TO ENHANCE MH

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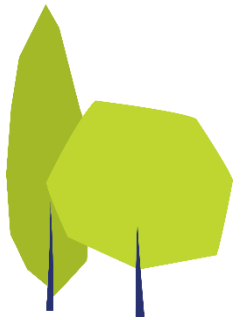
Sociologist - Educator

Coo.S.S. Marche



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Towards a new public health

Public health has a broad scope:

- control of communicable diseases
- the original impetus for public health work
- to the leadership of intersectoral efforts to promote health

Public health: a social and political concept, aimed at improving health, prolonging life and improving the quality of life among whole populations

Health promotion, disease prevention and other forms of health intervention

Health promotion strategies are based on the question of how health is created, and it aims to offer people more control over the determinants of their health

It needs to shift the debate about MH away from a singular focus on the health sector to a focus on areas such as:

- employment,
- education,
- transport,
- housing,
- criminal justice,
- welfare,
- built environment

Success in promoting MH: involvement and support of the whole community and the development of collaborative partnerships with a range of agencies throughout the public, private and nongovernment sectors

MH promotion needs to occur within the health sector and in all other sectors that influence the way in which people live, love, are educated and work

The onset of mental illness

Half of all chronic mental illnesses begin by age 14

When students learn about MH are able to effectively recognize signs and symptoms related to MH issues and know where to turn for help

In turn, the stigma that surrounds mental health will decrease

Depression in adolescents has doubled between the mid 1980s and 2000s:

- the prevalence of MDD is now ranging from 4% to 8%,
- 12% of children/adolescents may have sub threshold symptoms of depression,
- 20% of young people experience at least one episode of major depression before they reach 18 years of age

Mental health education

There are four key MH literacy components important to everyone's well-being and success:

1. Understanding how to obtain and maintain good MH;

2. Decreasing stigma related to MH;

3. Enhancing help-seeking efficacy (know when, where, and how to obtain good health with skills to promote self-care); and

4. Understanding mental disorders and treatments

PA helps to improve cognitive performance and academic achievement

Negative associations MH-sedentary behaviour

MH: important throughout the life cycle, affecting thinking and learning, feelings and actions

In childhood and adolescence, MH: attaining developmental and emotional milestones, while learning healthy social skills and how to cope with challenging situations

Mentally healthy children/youth have a positive quality of life and can function well at home, in school, and in their communities

When young people are educated about MH, the likelihood of health and well-being will lead to effective signs and symptoms

CDC: Focusing on healthy behavior during childhood is more effective than trying to change unhealthy behavior during adulthood

Health education that respects the importance of MH helps young people and their families and communities feel more comfortable seeking help, improve academic performance and save lives

In USA: a satisfactory program in health education developed in accordance with the needs of pupils in all grades must include instruction in the several dimensions of health, and must:

- Encompass MH and the relation of physical and mental health; and

- Enhance student understanding, attitudes and behaviors that promote health, well-being and human dignity

ACEs:

- stressful or traumatic events that can lead to social, emotional and cognitive impairment,

- adoption of high-risk behaviors, disease, and early death

Children who experience these traumatic events often struggle in school

The cumulative effect of trauma and toxic stress can be significant and result:

- unhealthy behaviors,

- inability to focus and process information

- challenging responses to classroom and social situations

Recommendations to promote MH in the educational setting:

- Support children and youth in the development of: o Positive routines and practices; o PA, exercise and play; o Good nutrition; o Regular sleep habits; o Stress management skills; and o Caring relationships

- Institute efforts to reduce stigma around mental health.

- Foster warm and caring relationships

- Promote positive school climate and culture

- Support development of social-emotional skills and help-seeking behaviors

- Provide support to students with concerns about the MH of self, friends and family

- Adopt use of an interdisciplinary partnership approach with community resources

- Develop support for school staff for their own mental health and wellness

A child's brain and other systems develop most rapidly through the first three years of life

Adolescence is a second critical developmental stage

Potentialities acquired in childhood can blossom into skills, behaviours and opportunities - well-being in adolescence and later to a more productive adulthood

The right investments and opportunities may offer a second chance to young people who missed out during childhood

Mental toughness (MT):

- control (emotional and life)

- commitment

- challenge

- confidence (interpersonal and in abilities)

Health interventions are required to prevent disengagement from PA and reduce sedentary behaviors in young people, but particularly those at risk of developing MH problems

Physical exercise appears to improve depressive symptoms in adolescents (antidepressant effect)

Exercise may be a useful treatment strategy for depression

Multiple Dimensions of Addressing Mental Health Well-being

Education on the importance of the mind-body connection enhances student understanding, attitudes and positive behaviors

MH as something more than an illness

CDC: MH in childhood/adolescence is to attain developmental and emotional milestones, learning healthy social skills and coping with challenging situations

Mentally healthy children/youth have a positive quality of life and function well at home, in school, and in their communities

A comprehensive MH wellness approach includes a focus on physical education, health education, and nutrition

Physical Education and MH

PE is directly connected to MH, emotional health and overall well-being

PE teaches students how to achieve lifelong commitment to PA, MH

Forming positive habits and routines (PA) contributes to one’s wellness account

Moderate amounts of PE can increase mood and self-esteem

A quality PE program focuses on the following:

- Decreases in obesity and chronic illnesses;

- Reduction of stress and anxiety;

- Instills self-confidence and self-esteem;

- Promotion of assertiveness, independence, and self-control; and

- Encourages healthier eating habits through proper nutrition

Physical Activity and Classroom Functioning and Learning

PA - significant improvements in MH and cognitive functioning

Late adolescence is characterized by increased stress and an increase in MH problems, which likely persist and reach a peak in early adulthood

PA is especially important during late adolescence

Considerable public attention has been given to emphasizing the relationship of physical activity and school learning and behavior

Tomporowski et al.: exercise fosters the emergence of children's mental functions, particularly executive functioning

Others report that:

- providing short physical activity breaks during the school improved on-task behavior

- after exercise, students were sharper, more attentive, less impulsive and fidgety, and sustained their attention longer

- PA increased concentration on the academic material in the classroom

- participation in a PA program improves muscular capacities, motor skills, behavior, and level of information processing of children with ADHD

- promote PA through comprehensive school PA programs, including recess, classroom-based physical activity, intramural physical activity clubs, interscholastic sports, and physical education

- ensure that PE is provided to all students in all grades and is taught by qualified teachers

- work with community organizations to provide out-of-school-time physical activity programs and share PA facilities

Prominently mentioned strategies for increasing PA during school hours include:

- providing enhanced PE that increases lesson time, is given by trained specialists (instructional practice at a moderate to vigorous PA level)
- taking classroom activity breaks
- creating activity sessions before and after school while providing adequate space and equipment
- participating in active transportation (walking and biking to and from school)
- encouraging physical activity during recess, lunch and other breaks, with organized activities and game equipment available

The Relationship Between School Climate and Well-being

School climate affects an individual's sense of safety, acceptance, safety, wellness and connected with others

A school climate that supports healthy emotional functioning involves structures that offer preventive and responsive supports

Elements of support include:

- fostering safety
- promoting a supportive academic
- disciplinary, and physical environment
- encouraging and maintaining respectful, trusting, and caring relationships throughout the school community

Creating an environment where the mental well-being of all is valued and fostered, free from stigma, is essential to helping students feel safe and accepted

Schools should support social-emotional learning and MH for all students as essential components of health and wellness

Everyone within the school environment succeeds when everyone feels accepted, valued, and respected

Health Education

Health education teaches about physical, mental, emotional and social health

Health education develops positive health attitudes

Comprehensive health education curricula are important to motivate students to improve and maintain their health, prevent disease, and reduce risky behaviors (drugs, alcohol and tobacco; sexuality; injury; nutrition, and disease)

The Role of Motivation

Some students are highly motivated to pursue physical activity/some are not

Efforts to enhance student PA must:

- address differences in motivational readiness,

- develop processes that promote engagement during school and beyond

In establishing opportunities for participation in PA schools should provide a wide range of options

Mental Health Resources Fostering School and Community Agency Partnerships

Facilitating the relationship schools-community agencies is:

- critical to positively impact school climate to support all students (especially those who have MH needs)

- can facilitate access to existing services in new ways

So student wellness can be enhanced, fostering a healthier overall school climate

Quality of the school climate may be the single most predictive factor to promote student achievement

Assessments:

- can be formal or informal, and brief or more complex
- should be conducted at regular intervals

Following an assessment, districts should focus their attention on building and strengthening school and community partnerships that are most needed

Schools are places where a considerable amount of PA takes place

The degree to which the PA is fully integrated into school varies with the amount of public concern about health matters and advocacy for PE and sports

The trend continues to be one of ad hoc and piecemeal initiatives

For the future, the question remains: How should schools embed a regular, well integrated, and equitable focus on physical activity into its other concerns for promoting healthy development and addressing student's problems?

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