MENAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	**MENTAL HEALTH CARE**
Module: 5.5	**ECTS (suggested): 0.25**
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Keywords	Mental health prevention, mental health promotion, Slovenia
Learning objectives	After completing this module, students should have increased knowledge about mental health, and they should be aware of the magnitude of the mental health problem in Europe and understand the major obstacles for mental health service and mental health prevention planning.
Abstract	Mental health conceptualize a state of well-being, perceived self efficacy, competence, autonomy, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. Mental health care are services provided to individuals or communities by agents of the health services or professions to promote, maintain, monitor, or restore mental health. Students will become familiar with extensiveness of the problem, and levels of preventing it. It is illustrated by the case of Slovenia.
Teaching methods	Teaching methods include lectures, exercises, individual work, interactive methods such as small group discussions, seminars etc. Plenary lectures are followed by discussion and project work in exercises. The work is done partly individually and partly in small groups.
Specific recommendations for teachers	• work under teacher supervision/individual students' work proportion: 50%/50%; • facilities: a computer room; • equipment: computers (1 computer on 2-3 students), LCD projection equipment, internet connection, access to the bibliographic data-bases; • training materials: recommended readings or other related readings; • target audience: master degree students according to Bologna scheme.
Assessment of students	Assessment could be based on structured essay, seminar paper, case problem presentations, oral exam and attitude test.

MENTAL HEALTH CARE

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THEORETICAL BACKGROUND

Definitions and explanation of basic terms

Mental health

According to World Health Organization (WHO), mental health is more than the mere lack of mental disorder (1-3). The WHO states that mental health conceptualize a state of well-being, perceived self efficacy, competence, autonomy, intergenerational dependence and recognition of the ability to realize one's intellectual, and emotional potential. It is also a state in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community (4). In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for the community. This core concept of mental health is consistent with its wide and varied interpretation across cultures (4).

Mental disorder

Mental disorder refers to a psychological or physiological pattern that occurs in an individual and is usually associated with distress or disability that is not expected as part of normal development or culture. It is any of various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioural functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma (5).

Mental health care

According to Last et al. (6), health care are services provided to individuals or communities by agents of the health services or professions to promote, maintain, monitor, or restore health. Health care is not limited to medical care, which implies therapeutic action by or under the supervision of a physician. According to this general definition of health care, mental health care are services provided to individuals or communities by agents of the health services or professions to promote, maintain, monitor, or restore mental health.

Mental health services

According to Last et al. (6), health services are services that are performed by health care professionals or by others under their direction, for the purpose of promoting, maintaining, or restoring health. In addition to personal health care, health services include measures for health protection, health promotion, and disease prevention. According to this general definition of health services, we could define mental health services as services that are performed by mental health care professionals or by others under their direction, for the purpose of promoting, maintaining, or restoring mental health of a population.

Community mental health

Community mental health is a decentralized pattern of mental health, mental health care, or other services for people with mental diseases accessible and responsive to local needs

because it is based in a variety of community settings. Community mental health assessment, which has grown into a science called psychiatric epidemiology, is a field of research measuring rates of mental disorder upon which mental health care systems can be developed and evaluated (7).

Mental health prevention

General concept of disease prevention and its levels (primordial, primary, secondary, and tertiary; detailed description of these levels is out of scope of this module) (6), can be applied to all different fields of population health, also to the field of mental health. Mental health prevention could be described as interventions to avert the initial onset of mental disorder, interventions to treat these disorders and prevent comorbidity and interventions used to prevent relapse, and disability.

Mental hygiene

In public health, the concept of "mental hygiene" is more and more important. Felix and Bowers (8) defined mental hygiene as knowledge and skills requisite to reduce mental disorders and maintain mental health.

Levels of mental health prevention

Before discussing levels of mental health prevention according to public health classification, we need to expose one of most important supportive elements not only for primordial level of prevention, where is usually classified, but for all levels of mental health prevention - a healthy mental health policy - a special document, containing the goals for improving the mental health situation of the country at all levels (9).

Like mental health policy, also stigma as negative companion, and one of the most responsible causes for social exclusion of people with mental disorders, and undertreatment, is penetrating all levels of mental health prevention. Combating stigma should be present at all levels of mental health prevention, and public education in this respect should be one of the most important efforts of public health. There already exist programmes for combating stigma, one of the most prominent being World Psychiatric Association "Schizophrenia. Open the doors" that mission is to dispel the myths and misunderstandings surrounding schizophrenia. Stigma creates a vicious cycle of alienation and discrimination which can lead to social isolation, inability to work, alcohol or drug abuse, homelessness, or excessive institutionalization, all of which decrease the chance of recovery (10). On the other hand, those affected need to be encouraged to seek mental health prevention treatment (e.g. psychotherapy, and support groups).

Similarly as in prevention of other disease groups, also in mental disorders we divide prevention in four groups, being primordial, primary, secondary and tertiary.

Primordial prevention

Primordial level of mental health prevention is aiming at keeping mental disorders from ever occurring.

Activities at this level are mainly focused at total population and are acting by using non-specific measures. The most important activities are taken at the field of:

1. Policy

   In this category mental health policy (healthy mental health policy), and social policy targeting reduction of social exclusion, unemployment and stigma, are classified.

Stable and supportive political system, secure environment supporting violence prevention, good housing conditions, good and .accessible educational system, good employment policy, and good care for occupational health are of great importance for well-being of an individual and population, and also determine mental health of a population. Reducing unemployment and enhancing job security, that both proved to be one of the main primary prevention actions in mental health, since unemployment is strongly connected with anxiety, depression and substance abuse.

2. Health promotion

Mental health promotion with providing mental health supportive social environments, especially to endangered and vulnerable population groups (e.g. mothers and young children, workplace mental health promotion, addiction prevention programmes, etc.), as well as promoting healthy environment on general (healthy food supplies, accessible transport, etc.) is the next category.,

Mental health promotion is defined as a process of enabling people to increase control over the determinants of their mental well-being and to improve it (9). It covers a variety of strategies, all aimed at having a positive impact on mental health.

Like all health promotion, mental health promotion involves actions that create living conditions and environments to support mental health and allow people to adopt and maintain healthy lifestyles. This includes a range of actions that increase the chances of more people experiencing better mental health at the community level (4). Examples of mental health promotion interventions include (11):

- improving the social environments in schools,
- designing facilities to encourage meeting and social interaction in communities,
- promotion of healthy lifestyle,
- follow up and support for healthy and good parenting,
- promoting healthy upbringing and education,
- workplace mental health promotion campaigns, etc.

The key areas of mental health promotion in the community to be addressed are therefore directed to:

- reducing work-related stress, including unemployment, and underemployment, but main focus is in reducing stressful working conditions. Educational programmes for employers and employees about mental distress and mental disorders and prevention are recommended. The Scottish programme Health on the Workplace, for example rewards employers for their interest in healthy and motivating environment and for preventing sick leaves. Similar initiatives are emerging also in Slovenia in last years,
- campaigning for access to education and fighting against poverty and social exclusion are cornerstones of social policy directed towards better mental health of the population (12). Programmes for reducing poverty and social exclusion, this is programmes for reducing homelessness, racism, discrimination and stigmatization are one of the main weapons for reducing the rising mental health morbidity in Europe, as well as in Slovenia (13),

- social support with friendship, good social relations and strong supportive networks improve mental health. Good social relationship reduce the physiological response to stress,
- stress prevention programmes with campaigning for leisure and recreational activities are further preventive measures. Access to relief and rest and recreation in leisure time are included. Body-mind techniques for relaxation could prevent a great deal of distress, and consecutively outbreak of mental disorders in some individuals, as well as other diseases.

3. Self-care
   At the individual level taking measures of self-care by practicing healthy lifestyles and learning of skills for coping with stress (mental hygiene) is very important part of good mental health (8,11).

Primary prevention

Primary level of mental health prevention is, like primordial level, also aiming at keeping mental diseases from ever occurring, but it is dealing with endangered and vulnerable population groups (e.g. adolescents, pregnant women, people in employment, disabled, old people etc.) and is acting by using more specific measures like health education. Examples of primary mental disease prevention interventions include:

1. prenatal care and education about parenting,
2. support after childbirth with counselling and practical help in breastfeeding and reducing tension and fatigue,
3. financial and social support to families at social risk,
4. child-abuse awareness and preventive programmes,
5. drug and alcohol free parenting programmes in endangered groups,
6. counselling for crime victims, and
7. somatic disease prevention, since chronic somatic illness increases likelihood for ill mental health.

Secondary prevention

Secondary level of mental diseases prevention involves the early detection of mental disorders and early intervention to reduce the risk of chronicity, disability and suicide. Early detection and treatment in all mental disorders improves their outcome and prognosis.

1. Screening.
   Especially important is this kind of prevention in the field of depression, and alcohol disorders:
   - early detection of depression as most common mental disorder proved to improve outcomes and reduce suicidal rates as confirmed by many studies. US Preventive Services Task Force (USPSTF) recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up, but the evidence is insufficient to recommend for or against routine screening of children or adolescents for depression (14).

     Screening for depression and educating general practitioners (GPs) for recognising signs and symptoms of depression has become one of the most widely used preventive tools all over the world. This kind of education of

GPs proved reduction in suicide rates because of such educational campaigns are strongly embedded also in the Slovenian education of family physicians and proved similar results;

- screening and behavioural counselling interventions to reduce alcohol misuse by adults, including pregnant women is recommended as well (14). It is used in many primary practices, as well as in some NGOs, and social settings through self help and counselling. Early recognition is of course to be followed by proper and evidence based treatment being mostly parallel psychopharmacological, psychotherapeutic and educational.

On the other side, USPSTF concludes that the evidence is insufficient to recommend for or against routine screening by primary care clinicians to detect suicide risk in the general population (14).

2. Other types of secondary prevention.
   But not only screening programmes are secondary prevention. Other types of secondary prevention are case finding, and health risk assessment (15).

   In some cases, also an individual can help to try to find signs of disease him/herself. Self examinations and self help are routine techniques to be transferred and encouraged with individuals with mental disorders, especially when reoccurring. The educational courses and individual counselling on recognising warning signs of disorder and coping strategies, as well as self help groups, are valuable tool in the hands of the individuals at risk and their close ones. This is similar to the case in self-examination of breasts in women to find early signs of breast cancer.

Tertiary prevention

Tertiary level of prevention of mental diseases is: dealing with treatment and care for people with clinically expressed mental disorders. We distinguish between acute, primary, or early phase, and chronically, late or rehabilitation phase:

1. Psychiatric or primary care treatment
   Psychiatric or primary care treatment is aiming at reducing the signs and symptoms of mental disorder, improving coping abilities of patients and families and in improving adherence to treatment process. The ultimate goal is also to improve functioning and the quality of life of patients.
2. Psychiatric rehabilitation
   Psychiatric rehabilitation aims to reduce disability because of mental disorder in the patients' natural surroundings, which is most often his/her home environment. Psychiatric rehabilitation targets patients' assessed and clearly defined personal needs, needs of his/her carers and relatives and uses methods of empowerment and participation to achieve as high level of personal satisfaction as possible.

   Multidisciplinary team work is used to define clear rehabilitation goals and steps to achieve them with careful monitoring and follow up. Coping strategies are taught and discussed with patients and family member, distress is managed and medication is maintained almost inevitably. These methods are combined with counselling, motivation, self help, sheltered accommodation, sheltered employment and education if needed.

   Majority of rehabilitation takes place in the community, even though this process is started already in the phase of psychiatric treatment. The needed level of rehabilitation support varies enormously and depends on the patients' perceived

needs an current functioning more importantly than on the signs and symptoms of his/hers disorder.

Epidemiology of mental disorders in Europe

General considerations

Mental disorders contribute 12.3% to the total burden of disease; the expected burden will rise to 15% in 2020, this is. 450 million people worldwide. Mental disorders contribute from 31% (Europe) to 43% (USA) to the total disability adjusted life years (16).

The prevalence of mental disorders in Europe is increasing, 12-months prevalence is estimated to 27% in 16 European countries. Every second European will develop mental disorder once in his/her life, women more often than men (33%: 22%) (17). Almost half of the people with mental disorders have more than one diagnosis. Co-morbidity with somatic illness and with psychoactive substances abuse and dependence are most common. Co-morbidity of depressive disorder with coronary heart disease is 45% (18). 48% of somatic symptoms are connected with depression (19), which present difficulties in early recognition and treatment and consequently highly burdens medical services, produces over prescription of different medication and increases the cost of treatments. Overall costs of depression involving direct cost of treatment and indirect cost of sick-leaves, absenteeism and underproduction are rising in developed countries (20). Most common mental disorders are anxiety, depression and substance abuse disorders (21). One fifth of women and one tenth of men will develop depressive disorder at least once in their lifetime (22).

A WHO study, performed by Murray at al. (23), identified depression to be heading the list of disorders responsible for the global burden of disease in industrial countries, following by abuse of alcohol. (Figure 1)

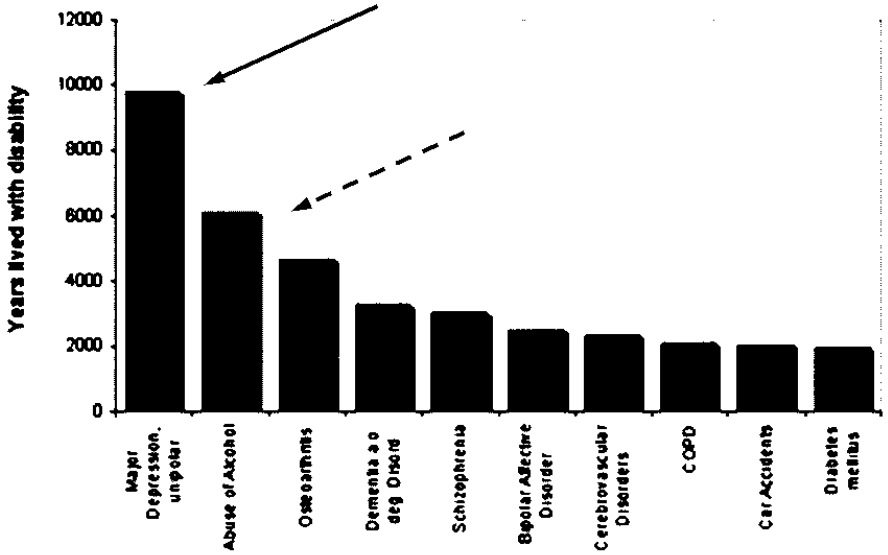

Figure 1. Results of the WHO study "Global Burden of Disease". Source: European Alliance Against Depression (EAAD) (24).

The research proves that the prevalence of common mental disorders connects itself with the lower socio-economic status or social inequality (21). Unequal distribution of wealth is more strongly connected with worse mental and physical health and with early mortality than the GDP (25). The cost of mental disorders in Europe amounts to 295 billion Euro.

Mental disorders remain under-recognised and under-treated. In European Union (EU) only 26% of people with mental disorder get proper treatment. Among reasons for under-treatment are poor accessibility of services for mental health, under-recognition and stigma associated with mental disorders (17).

The most severe consequence of mental disorders is suicidality**.**

Suicidality

More than 90% of suicides occur in the context of a psychiatric disorder, depression being by far the most important one. Annually, more than 58,000 persons in the countries of the European Union commit suicide. Suicide rates (number of people died of suicide per 100.000 population) per country range from 5.92 per 100,000 in Italy up to 25 per 100,000 in Slovenia (WHO-data, 2001-2003) (Figure 2).

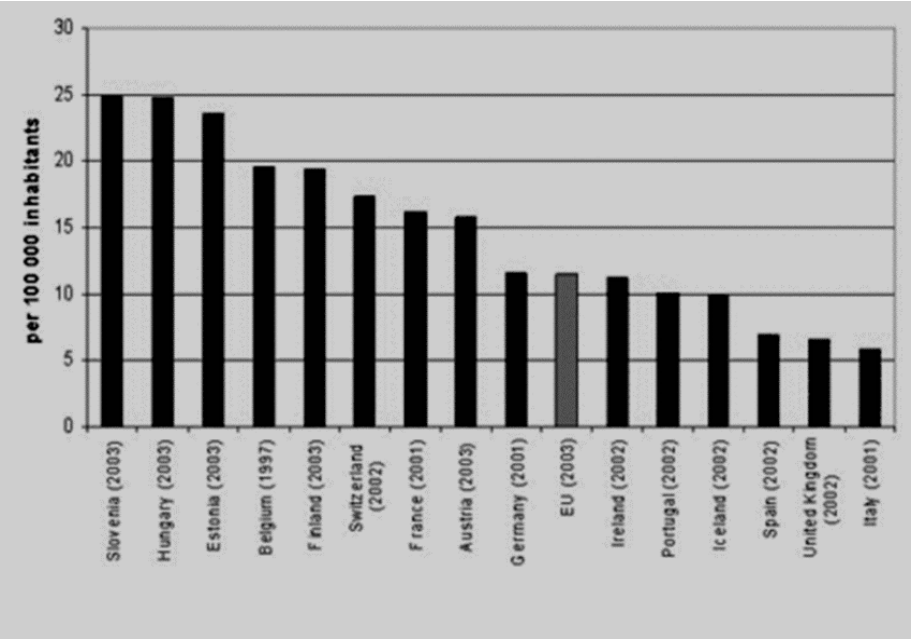

Figure 2. Suicide rates in EAAD partner countries. Source: European Alliance Against Depression (EAAD) (24).

Europe-wide, dying from suicide accounts for the second highest risk of death for young men and the third highest risk for young women. About 14% of all suicides occur in the age range of 15–24 (Report on the state of young people's health in the EU, EC Working Paper). Compared to the number of suicide deaths, the number of suicide attempts is assumed to be much higher. Estimates for the younger aged, range from 20 to 30 suicide attempts on every suicide. Given this situation, interventions aiming at the prevention of suicidality and, thereby, especially focusing on children, adolescents and young people are urgently needed.

Mental disorders are also connected to harmful alcohol consumption. In addition to having a direct impact on drinkers it also poses a threat to others. Drink-driving and working under the influence of alcohol; drinking during pregnancy; and violence related

to alcohol consumption too often cause early death of mostly young people, invalidity, and social deprivation. Harmful and hazardous alcohol consumption causes more than 7 per cent of early morbidity and mortality in EU, which represents an enormous economic burden to society. At her speech at the 3rd European conference on alcohol policies - Building Capacity for Action, 2008, the Minister of Health of the Republic of Slovenia, Zofija Mazej Kukovič, pointed out that the Estimated annual costs at the EU level resulting from harmful use of alcohol have been estimated to EUR 125 billion, or 1.3 percent of the gross national product.

Child and adolescent mental health in EU

In Europe one adolescent out of five has cognitive, emotional and behavioural difficulties and one adolescent out of eight suffers from a diagnosable mental disorder. The prevalence of these disorders is increasing decade by decade. Suicide associated with depression, substance abuse, eating disorders, conduct disorders, attention deficit hyperactivity disorders (ADHD) and post traumatic stress disorder (PTSD) in children deserve concerted action. Developmental psychiatric disorders rarely have a spontaneous remission and may cause difficult social adaptation or mental disorder in adult life, if not early diagnosed and treated (26).

Mental health on the WHO and EU agenda

Mental health is the WHO's agenda of priority as well as the European Commission regarding EU population's health.

1. In »Health 21«, adopted in 1999, the Target 6 is dealing with improvement of mental health (27). According to this target, by the year 2020, people's psychosocial wellbeing should be improved and better comprehensive services should be available to and accessible by people with mental health problems. Preventive, clinical and rehabilitative services were supposed to be of a good quality.
2. In 2001 WHO report (28), the following recommendations were accepted:
    - provide treatment in primary care - the management and treatment of mental disorders in primary care is a fundamental step which enables the largest number of people to get easier and faster access to services it needs to be recognized that many are already seeking help at this level. This not only gives better care. It cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments. For this to happen, however, general health personnel need to be trained in the essential skills of mental health care. Such training ensures the best use of available knowledge for the largest number of people and makes possible the immediate application of interventions. Mental health should therefore be included in training curricula, with refresher courses to improve the effectiveness of the management of mental disorders in general health services;
    - make psychotropic drugs available - essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in every country's essential drugs list, and the best drugs to treat conditions should be made available whenever possible. In some countries, this may require enabling legislation changes. These drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse. They often provide the first-line treatment,

especially in situations where psychosocial interventions and highly skilled professionals are unavailable;

- give care in the community - community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community, with the use of all available resources. Community-based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support, which meet all the needs of the ill that were the responsibility of those hospitals. This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment;
- educate the public - public education and awareness campaigns on mental health should be launched in all countries. The main goal is to reduce barriers to treatment and care by increasing awareness of the frequency of mental disorders, their treatability, the recovery process and the human rights of people with mental disorders. The care choices available and their benefits should be widely disseminated so that responses from the general population, professionals, media, policy-makers and politicians reflect the best available knowledge. This is already a priority for a number of countries, and national and international organizations. Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closer to each other;
- involve communities, families and consumers - communities, families and consumers should be included in the development and decision-making of policies, programmes and services. This should lead to services being better tailored to people's needs and better used. In addition, interventions should take account of age, sex, culture and social conditions, so as to meet the needs of people with mental disorders and their families;
- establish national policies, programmes and legislation - mental health policy, programmes and legislation are necessary steps for significant and sustained action. These should be based on current knowledge and human rights considerations. Most countries need to increase their budgets for mental health programmes from existing low levels. Some countries that have recently developed or revised their policy and legislation have made progress in implementing their mental health care programmes. Mental health reforms should be part of the larger health system reforms. Health insurance schemes should not discriminate against persons with mental disorders, in order to give wider access to treatment and to reduce burdens of care;
- develop human resources - most developing countries need to increase and improve training of mental health professionals, who will provide specialized care as well as support the primary health care programmes. Most developing countries lack an adequate number of such specialists to staff mental health services. Once trained, these professionals should be encouraged to remain in their country in positions that make the best use of their skills. This human resource development is especially necessary for countries with few resources

at present. Though primary care provides the most useful setting for initial care, specialists are needed to provide a wider range of services. Specialist mental health care teams ideally should include medical and non-medical professionals, such as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers and occupational therapists, who can work together towards the total care and integration of patients in the community;

- link with other sectors - Sectors other than health, such as education, labour, welfare, and law, and nongovernmental organizations should be involved in improving the mental health of communities. Nongovernmental organizations should be much more proactive, with better-defined roles, and should be encouraged to give greater support to local initiatives;
- monitor community mental health - The mental health of communities should be monitored by including mental health indicators in health information and reporting systems. The indices should include both the numbers of individuals with mental disorders and the quality of their care, as well as some more general measures of the mental health of communities. Such monitoring helps to determine trends and to detect mental health changes resulting from external events, such as disasters. Monitoring is necessary to assess the effectiveness of mental health prevention and treatment programmes, and it also strengthens arguments for the provision of more resources. New indicators for the mental health of communities are necessary;
- support more research - more research into biological and psychosocial aspects of mental health is needed in order to increase the understanding of mental disorders and to develop more effective interventions. Such research should be carried out on a wide international basis to understand variations across communities and to learn more about factors that influence the cause, course and outcome of mental disorders. Building research capacity in developing countries is an urgent need (28).

3. In 2005, a Mental Health Declaration for Europe was adopted in Helsinki (29). The Ministers of Health of Member States in the European Region of the WHO, in the presence of the European Commissioner for Health and Consumer Protection, together with the WHO Regional Director for Europe, recognized that the promotion of mental health and the prevention, treatment, care and rehabilitation of mental health problems are a priority for WHO and its Member States, the European Union (EU) and the Council of Europe (29). According to this declaration, it is a priority of every country to design and implement comprehensive, integrated and efficient mental health system that covers promotion, prevention, treatment and rehabilitation, care and recovery;
4. This Declaration was followed by the Mental Health Action Plan for Europe (30). This action plan sets out 12 priority areas of action being:
    - promoting mental well-being for all,
    - demonstrating the centrality of mental health,
    - tackling stigma and discrimination,
    - promoting activities sensitive to vulnerable life stages,
    - preventing mental health problems and suicide,
    - ensuring access to good primary care for mental health problems,
    - offering effective care in community-based services for people with severe mental health problems,
    - establishing partnerships across sectors,

- creating a sufficient and competent workforce,
- establishing good mental health information,
- providing fair and adequate funding, and
- evaluating effectiveness and generate new evidence.

It stresses the need for mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems (31).

CASE STUDY: MENTAL HEALTH CARE IN SLOVENIA

Epidemiological data on mental disorders in Slovenia

In Slovenia, the burden of mental disorders in is measured only indirectly, and only some proxy variables allow us to infer about extensiveness of the problem. On one hand, we have the data on health care resources and health care utilization, which tell one story about the problem (by observing the number of outpatient visits on the primary and secondary level, hospital admissions, retirements and absenteeism due to mental disorders). On the other hand there are data on determinants. The third part of the story tells us morality data, precisely the data on suicide. Thus, the problem of epidemiological data in mental disorders in Slovenia is, that we do not have morbidity data (incidence and prevalence of mental disorders) since we do not have corresponding registries. But this is not only the case in Slovenia. Measuring mental health is very difficult, since the data on mental disorders are tightly connected to personal data protection. On the other hand, measuring the burden of mental disorders isn't a financial priority nor in Slovenia, nor elsewhere.

Mindful project leaded by Slovenian authors (32), tried to make the methodology of supervising of mental health prevention equal in several EU states, but did not find common indicators for measuring positive mental health in EU.

Adult mental health data

1. Data on determinants of mental disorders
   Results of CINDI Health Monitor Survey for 2001 showed that (33):
   - 8.4% participants reported depression (males 6.3%, females 10.1%),
   - 19.1% participants reported insomnia (males 16.1%, females 21.6%) during the last month prior the survey:
   - 7.7% participants (males 5.4%, females 9.5%) took sedatives or sleeping pills during the last week prior the survey,
   - 24.3% participants (males 21.0%, females 27.0%) perceived tension, stress, or heavy pressure every day or frequently, and had at least minor difficulties in coping with these feelings (34),
   - global prevalence of heavy alcohol drinking for Slovenia was 13.4% (males 22.6%, females 5.5%) (35, 36).
2. Suicide
   Every thirtieth death in Slovenia is due to suicide, which is approximately 600 persons committing suicide per year and represent one of the nine highest suicidal rates in the world, with standardized death rate of about 22-24 per 100.000 population in total population (males 37-42; females 9-12) (37). The most

affected parts are Štajerska, Prekmurje Koroška and Dolenjska, which are placed on the east and east-north of the country. The gender difference is 3.6 (in males) versus 1 (in females), which is in line with other high risk countries. Suicide is connected with metal disorders (depression, alcohol dependence and schizophrenia), with old age, unemployment and poverty (38).

In conclusion, we could say that in adults two major mental health problems in Slovenia at the moment are prominent, being alcohol addiction and suicide, while depression and stress are still under study.

Child and adolescent mental health data

In children and especially in adolescents the major problem is alcohol use and abuse, and possible addiction later, and illicit drugs abuse. Several kind of evidence proves increase in alcohol and other addiction in young people and adolescent group.

1. Alcohol consumption and other addiction

   Data from the European School Survey Project on Alcohol and Other Drugs (ESPAD) for the year 2003 showed that the percentage of Slovenian students who had been drinking any alcohol during the last 12 months was 83%, while the proportion of students who have used marijuana or hashish was 28%. The use of other illicit drugs was about 5%, the use of inhalants was 15%, and the use of tranquillisers or sedatives without a doctor's prescription as well as alcohol in combination with pills was 5 and 6% respectively (39). Other results could be found in earlier reports (40, 41).

   Other data show that smoking behaviour in adolescence was connected with truancy, substance abuse, suicide attempts and infrequent engagement in sports, thus being a part of problematic behaviour in this life period and indicating that smoking is a life style of more vulnerable part of the population (42).

3. Depression and self esteem

   The study on Risk factors in Slovene secondary school students, performed on representative sample in 1998 showed clinically important level of depression in 20.5% of boys, and in 41.5% of girls (evaluated by Zung self-rating depression scale). The average value of results on the depression scale was 45.6, indicating that depression is rather prominent characteristic of secondary school students. Along to these results, average value of self-esteem on the 0-10 self-rating scale was in boys 6.9, while in girls it was 6.3. On general, girls expressed higher level of depression and lower level of self-esteem than boys (43).

2. Suicide

   Suicide in adolescent population is among the first three causes of death in all countries that have reliable health monitoring data. In Slovenia 20 adolescent die because of suicide each year, the number of boys being four times greater than the number of girls. The research proved that suicidal adolescents (13,6% of girls and 6,8% of boys) were experiencing family dysfunction and confrontation with unresolved problems prior to suicidal attempts and that they used dysfunctional strategies for their resolution (44), which provided grounds for several preventive actions on the field. Sport and physical activity were defined as protective factors relating to adolescent suicide attempts, being a coping style in distress, even though they had not proven to have a direct effect on non-suicidal behaviour (45).

Needs assessment

The need for research in mental health in Slovenia is in spite of all described initiatives still enormous. We actually do not have randomized clinical trials on various programmes on prevention It is also true, that recommendations for evaluation of prevention are still not developed on EU level, but should be prepared by EU Taskforce on evidence in mental health shortly.

Primordial and primary level of prevention

Mental health policy

For the time being, a national programme of mental health has not yet been adopted in Slovenia. Mental health it is the responsibility of the Council for Health, a Government advisory body which includes experts from the fields of both health and social security.

In Slovenia the former National Programme for Public Health prevention which was operative until 2004 did not include mental health priorities and prevention. The new is in preparation and is should be adopted this year. In its draft, mental health is mentioned several times as important field of public health action.

However, national programmes have been suggested for preventing suicide and dependence on alcohol and drugs. The guidelines for alcohol addiction prevention were developed by the Ministerial task group and finished lately. Actual implementation of preventive programmes still lacks continuity.

The Mental Health Act which regulates system of health and social care on the field of mental health, holders of activities, and rights of persons under treatment including voluntary and involuntary admission to treatment, advocacy and care planning was recently adopted (46), what can be regarded as very big step forward.

Mental health promotion and mental health education efforts

In Slovenia there are several health promoting activities which include also mental health component.

Among actions that increase the chances of more people experiencing better mental health, the “Wind in the hair” programme could be classified. This programme is a very successful national prevention programme implemented in local communities with support of National Sports Association (47). Sport activities with concerts, befriending and rewarding healthy lifestyle activities was successful enough to get a European certificate and to be implemented in several EU countries.

There are also many activities which could be classified on one hand among mental health promotion activities, and on the other among primary prevention:

1. Programmes for infants and toddlers

   Programmes for infants and toddlers influence above all parents’ behaviour and upbringing, but they should also target social injustice, prevention of physical abuse, violent behaviour and provide psychological counselling at crisis, for example in divorce. In the neighbouring Austria the literacy of parents regarding developmental phases, conflict solving, parenting styles and their access to relevant information about needed help are targeted.

   In Slovenia these programmes are strongly connected to primary health care teams and community nurses. Nationally all kinds of prevention programmes are also developed through obstetric dispensaries, those providing counselling and help in prenatal and immediate postnatal periods. The social and psychological interventions are still often lacking.

2. School children and adolescents mental health prevention
   The concern about ill mental health of children and adolescents is one of the main areas of interest of Slovene psychiatry from 1950s (48). Until now Slovenia developed a network of mental health services for children and adolescents which were until a decade ago affiliated with the national health care service. The majority of prevention and treatment was developed within the framework of educational and social care provision. School counselling services with psychologists and pedagogues are today part of each school workforce. These experts are strongly connected with child and adolescent psychiatric services, which are in last years more often part of private psychiatric outpatient clinics than the public ones. The development nevertheless follows the principles of holistic and community care with involvement of educational, social and medical institutions in care planning in line with the child or adolescent mental health needs. The role of parents in this process is strongly supported, even stronger when the mental health problems are difficult to manage.
3. "That is me" project
   In Celje region "That is me" (in Slovene To sem jaz) project was lunched for health promotion among youth in 2000 (49, 50). It showed that greatest adolescents' problems are lack of self-confidence and optimism, lack of self-respect and fear of failure. The website was launched to provide information about health and well being and to influence adolescent views and values about their health and well- being and to prevent risky behaviour.
4. "Taking brain to the party" programme
   The programme called "Taking brain to the party" (in Slovene Z glavo na zabavo) had much success in last years in illicit drug prevention (51). It is strongly supported by media and targets places where young people gather, have parties and exercise risky behaviours.
5. Healthy schools
   Schoolchildren mental health prevention is targeted also to the teachers, who should develop sensitivity to emotional needs of children. Schools should develop programmes preventing violence, abuse and bullying. Adequate counselling is part of the psychological support to victims and perpetuators (if children). These programmes are being developed also in Slovenian network of Healthy Schools. This programme makes an important improvement at early recognition and treatment of eating disorders, anxiety and depression. Substance abuse prevention is included in many local school programmes and developed on the national level as a set of educational interventions in schools.

   Mental health prevention for children and adolescents in Slovenia is providing counselling workshops and seminars for teachers, school counsellors and parents about psychopathology, suicidality, social skills training and healthy lifestyle. The programme includes also drug prevention mainly through education. It is performed in primary schools with the guidance of National Institute for Health Prevention and some Regional Public Health Institutes, and with prominent Slovenian child psychiatrists.

   The central psychiatric hospital and Child Guidance Clinic are organizing professional crisis interventions in need, for example on occasions of suicidal attempts, suicide or unpredictable violent behaviours in schools.
6. The "European Alliance Against Depression (EAAD)" network
   EAAD is an international network of experts with the aim to promote the care of depressed patients by initiating community-based intervention programmes in 17

European countries including Slovenia. It aimed to prevent depression and suicide (52). Results of the Nuremberg pilot study have already shown that the community-based intervention following the 4-level-approach was clearly effective in reducing suicidal acts (about 20 %). When evaluating the efficacy of the EAAD intervention programme, the primary outcome criterion is, in general, again changes of numbers of completed and attempted suicides in EAAD intervention regions.

In Slovene regions Celje and Koroška, which have the highest social exclusion rates and highest suicidal rates, the project included an educational programme about treatment of depression and suicide prevention with general practitioners and medical nurses. The prevention programme has also been implemented with police officers, social workers and priests. The project was evaluated and showed important suicide reduction. The regional programme for suicide prevention in region of Celje conducted by Zavod za zdravstveno varstvo Celje a serial of preventive, mainly educational activities for suicide reduction from 2001 (53).

Problems in mental health promotion and primary prevention

The main implementation problem of evidence based prevention is lack of human resources and the educational gap among their acquired and needed knowledge and skills. Mental health promotion and prevention workforce is the people who already work in primary or secondary medical services, or the people who work as teachers, psychologist or pedagogues in their school working environments. In last years some initiatives are emerging in educational institutions, for example in the Faculty of Health Sciences of Ljubljana University (study programme Nursing) and in the Faculty for Education of Ljubljana University (study programme Social pedagogy) for developing mental health prevention and promotion educational programmes at undergraduate and at postgraduate level.

Programmes and projects already described, are not a part of regular curriculum and therefore not accessible to all children and adolescents.

Similarly to other EU countries and US, we witness in Slovenia lack of resources for training and lack of working posts for prevention and promotion. Educational curricula do not follow quickly developing mental health promotion and prevention science and evidence. This level of prevention is underdeveloped, since Slovenia's health care system is still mainly oriented in treatment of diseases and we could hardly say that it is in its way to reorienting health care services towards more comprehensive (54).

Secondary level of prevention

Secondary level of prevention is to be performed by special units of Community Health Centres. Majority of primary care physicians underwent additional educational programmes on recognizing depression and suiciudality and improved their diagnosis. Lack of human resources impedes the development and implementation of early recognition and treatment of mental disorders that proves to be most important preventive mental health tool as described in many documents and papers (55).

There are around six so-called Counselling centres for children, adolescent and their parents in Slovenia, which offer different activities in the filed of mental health, especially early diagnostic of mental health and learning problems, individual and group therapy. In these centres interdisciplinarity and muldisectoriality is a method of work with a child,

adolescent and their patent. Some of these centres are active also in the field of research, education and prevention also.

There exist other activities which could be to the certain extent classified as secondary prevention - crisis telephone lines as for example “Call in mental crisis” (in Slovene: Klic v duševni stiski) could be seen as special form of secondary prevention. This service seems to becoming more and more used also in Slovenia and it is also increasingly reachable through information technology communication.

Tertiary level of prevention

Psychiatric services

Before presenting the current situation of psychiatric services in Slovenia, we would like to present some historical points of view.

History of psychiatric services in Slovenia

The historical context of Slovene psychiatry and psychiatric rehabilitation is important for understanding the development of mental health prevention in our country. The beginnings of psychiatry in Slovenian lands reach as far back as the year 1786, when the first ward for mentally ill monks was established in the general hospital of Ljubljana. In 1827, the first specialized ward for the treatment of the mentally ill was founded within the general hospital of Ljubljana. In 1881, a large psychiatric hospital was built in the manner that was at the time regarded to be the right one: outside the town, in unspoiled nature and tranquilizing greenery. Before the 1940 Slovenia had 1.1 bed per 1000 population. The German and post-war psychocide reduced the capacities by one half. After the war (and nowadays), we made do with 6 psychiatric hospitals - including the University Psychiatric Hospital - and 0.8 beds per 1000 population and the average hospital treatment period of 48 days. During the Second World War, Slovenia was occupied by Nazi-Germany who in 1942 enforced the so-called euthanasia programme with about 450 patients from one of the Slovene psychiatric hospitals.

During the war the University Psychiatric Hospital in Ljubljana helped the anti-nazi resistance in every possible way. It also contributed by diagnosing antifascists who were in danger, as mentally ill and hiding them among the “'real” patients. It offered medical help to wounded fighters of the resistance and helped antifascists escape the Nazi controlled areas and join the resistance. Psychiatrists also tried to use “psychiatric diagnosis” to help a Jewish family that tried to escape from Croatian fascist Ustasha across Slovenia to Italy. Two leading psychiatrists were liquidated by the occupator for their cooperation with the resistance, the principal was sentenced to lifetime imprisonment, many of the staff members were interned, and some died in the liberation war.

It is a historical paradox that after the end of the war, in Slovenia, psychocide went on for another ten years. Patients were treated so badly that the mortality was almost as high as it had been towards the end of the war, i.e. about 40% - due to famine and tuberculosis. For Hitler, patients had been “lives unworthy of lives”, for communists they were an obstacle on the way to better socialist future. But in general, the communist regime of ex-Yugoslavia was much “'softer” than those in other East European countries.

Political intervention

A case of intervention from the part of the communist authorities after the war was the following: an internationally renowned author and politician fell from grace and became a kind of dissident. He then fell ill with Alzheimer's disease and was hospitalized at the clinic for distinctively disturbed behaviour at the wish of his wife and children. The authorities

often inquired whether detention was still necessary and whether he could not have been taken care of outside the psychiatric clinic. They were truly afraid of the reaction of the international public and the possible reproach that they used psychiatry to do away with political opponents (personal communication with Jože Darovec, former director of Ljubljana Psychiatric Hospital, 2008).

The practice of detention of "dangerous people" during foreign statesmen visits was abolished only in 1968 by prof. Miloš Kobal, He was educated in Great Britain and used his experience from there - as well as his own ideas - for an extremely early reform of the Slovenian psychiatry, as early as 1968/70 - much earlier, in fact, than many other more developed European countries: he diminished the number of beds by sending patients to other suitable institutions (not to the streets like President J. F. Kennedy and F. Basaglia in Italy), opened the majority of the up-to-then closed wards, founded the centre for mental health, the day and night ward, the family care within a family other than a patient's own, established specialized wards for the treatment of addictions in all psychiatric hospitals, designed the dispensary psychiatric care, introduced psychiatric counselling service in most old people's homes and asylums, introduced the long-term therapy by fluphenazine depot in 1969 and the lithium therapy already in 1970 (personal communication with Jože Darovec, 2008).

Current state of psychiatric services

Psychiatric service is in Slovenia given in all levels of health care system:

1. Primary mental health care.
   Acute treatment of all mental disorders is available at the primary health care level, but in a limited way as described previously. Primary health care is delivered by Community Health Care Centres and private practitioners. At the moment there is about 75 Community Health Centres in Slovenia.

   Some of Community Health Care Centres, but not all unfortunately, has specialized units called dispensaries – psychiatric dispensary for adults and mental hygiene dispensaries for children and adolescent. The reorientation towards more comprehensive primary health service is questionable since it is under rapid transformation towards privatization;
2. Secondary and tertiary level of mental health care.
   At the secondary and tertiary level of mental health care, there are altogether six regional psychiatric hospitals including the University psychiatric hospital. All have wards for general psychiatry, psycho-geriatrics and the treatment of alcohol dependency. The University Psychiatric Hospital also has wards for adolescent psychiatry, drug dependency and psychotherapy. There is also the Child Psychiatry Ward in the Paediatric Clinic.

   In 2002, the number of all psychiatric hospital beds was 1569 (56). About 30 beds have been allocated for child and adolescent psychiatry. In the period 1998/99, beds actually in use per 100.000 population (all psychiatric in-patient institution) decreased from 84 in 1965/95 period to 71 (56).

   There are 24 child and adolescent psychiatrists in the country. Hospital treatments are becoming shorter and more intensive, with complementary services providing day hospitals and participation in selected activities for time limited follow up.

   In Table 1, psychiatric secondary and tertiary services resources are presented, in comparison to some other EU members (9).

Table 1. Psychiatric secondary and tertiary services resources in Slovenia in comparison to some other EU countries (9).

	per 10,000 population				
Indicator	**Great Britain**	**Austria**	**Netherlands**	**Italy**	**Slovenia**
No. of psychiatric beds	5.80	6.50	18.70	4.63	8.46
No. of beds in psychiatric hospitals		4.50	15.40	0	7.20
No. of beds in general hospitals		2.00	1.00	0.92	1.26
No. of psychiatric beds in other institutions			2.30	3.70	0
No. of psychiatrists	1.10	1.18	0.90	0.98	0.53
No. of neurosurgeons	0.10	0.17	0.10		0
No. of psychiatric nurses	10.40	3.78	9.90	3.29	0.58
No. of neurologists	0.10	0.82	0.37		0.08
No. of psychologists	0.90	4.90	2.80	0.32	0.16
No. of social workers	5.80	10.34	17.60	0.64	0.04

Rehabilitation

Psychiatric rehabilitation methods are developed in institutions and in the community and these systems are connecting themselves with the method of care planning. This is achieved by communication among inpatient and community services as far as possible. Since there is no community psychiatric treatment available in Slovenia yet, except from an attempt of the psychiatric team in the central hospital to perform community psychiatric treatment, these endeavours are sporadic and not available to everybody in need, but rather exceptional and due to personal engagement of mental health workers. The legislation and financing are however anyway being prepared and close to adoption right now in 2008.

In Ljubljana (the capital), a rehabilitation unit of the psychiatric hospital was therefore established to follow up the patients with severe mental illness with high risk for relapse and dual diagnosis. This service is well connected with non-governmental (NGOs) and social services as well as primary health care services. These connections are widely used also by other hospital departments, but nevertheless can not reply to the needs of patients and their families. Crisis interventions are organized by the central primary health care service providing urgent interventions. This service need better collaboration with psychiatrists in the cases of involuntary referrals, but this is not achieved because of lack of psychiatrists and other psychiatric personnel. Professional and user organizations and associations of interested experts have been founded for the group of patients with severe mental illness. The largest are ŠENT, ALTRA, OZARA and PARADOKS which are, together with the psychiatric profession, involved in preventive, mainly anti-stigma programmes. Among the psychosocial services offered are housing facilities with support, day centres, vocational rehabilitation development, sheltered employment and education for professionals, patients and carers. NGOs providing support for people with anxiety, depression, substance abuse and dependence, and for carers, and families of people with dementia are emerging as well in last ten years with

increasing influence to health and social policy. The carers (families) organization has developed a network of interest for mental health prevention and promotion in Slovenia at the level of republic and connected itself with international organizations of carers (57).

Here we will shortly introduce only two of NGOs, being ŠENT, and Trading centres since detailed description of all of them is beyond the scope of this module.

1. Slovenian association for mental health ŠENT.
   ŠENT is the largest non-profit NGO in Slovenia providing from 1992 coordinated social care for patients with severe mental illness. The difference to other NGOs was at first acknowledging the need for coordination among psychiatric and social care services to improve quality and comprehensiveness of care for people in need. The context of mutual respect provided grounds for quick and stable development of vocational rehabilitation, education of patients, families and professionals, day centres and group homes. All these services are intended for the group of patients (users) with disability due to mental illness and stigma, and supported by carers and patients. ŠENT is today taking lead in anti stigmatization of mental illness, education of professionals for newly emerging community psychiatry and community social work. It provides also advocacy and self help groups mostly in day centres and among families of patients with severe mental illness. The variety of needs, opportunities and demands regarding mental health service development, consumers' movement, legal and organizational issues provide a turbulent environment for continuous development of this organization. The programmes are comparable to other NGOs listed above.
2. Trading centres for people with disabilities.
   One of the rehabilitation initiatives is "Trading centres for people with disabilities".

   One of the biggest trading companies in Slovenia recently planned to implement a programme that would allow people with disabilities better access to their various facilities. This programme, labelled "Kindly to disabled" focuses on all groups of people with disabilities, including the physically disabled, those with learning disabilities and people with disabilities caused by mental disorders. The programme was developed in cooperation with Slovenian Association for mental health ŠENT, which provided counselling on the matter and education for employees about the needs of the disabled. Since the needs of different disabled groups are very different, a series of adaptations including employees' attitudes and communication skills was proposed beside technical adaptation of the shops' environments. This action seems to be becoming important preventive step for including the disabled in the society on equal terms. The project should succeed because the disabled strongly participated in the assessment of the needed adaptations and in the education of the employees and employers.

Results of some studies on mental health in Slovenia

There exist some different kinds of research on different aspects of mental disorders and their consequences. The majority of programmes are evaluated regarding their efficiency in experimental circumstances. Among studies are following:

1. Delphi study on alcohol prevention in Slovenia (58)
   Alcohol abuse is an avoidable behaviour that can threaten health. In Slovenia, only a few public campaigns against drinking alcohol are under way. It is important to establish which community measures are acceptable to society in Slovenia in order to reduce alcohol-related risks.

   This study was a Delphi study with 45 professionals from different disciplines was conducted. Participants offered many suggestions to improve the current

situation. After three rounds of questionnaires, 86 participant statements were accepted as a consensus.

Results showed that actions such as: state monopolies, alcohol taxation, legislative restrictions on availability and purchase of alcohol, age-related restriction on sales, drink-driving laws, school-based alcohol education and media information campaigns are most likely to be achieved by consensus. The main target populations for implementation of alcohol-related educational programmes are children, young people and employees.

The conclusions of this study were that as a result of the study, a number of community actions against drinking alcohol that could be acceptable for society can now be suggested. They vary across different target populations, change agents (individuals, organizations and institutions) and methods of implementation.

2. Outcome assessment (59)

Majority of long-term hospitalized patients with severe mental disorders considered resistant to standard hospital psychiatric treatment have been discharged during last decade from Slovene psychiatric hospitals mainly due to economic pressure without any assessment of outcomes or patients' needs. Rehabilitation unit has been established within University Psychiatric Hospital in Ljubljana for inpatients with severe mental disorders. The research was aimed at to find out characteristics and needs of patients with schizophrenia in order to develop hospital service in accordance with patients' needs.

In the study, forty-one long-term hospitalized and frequently admitted patients with diagnosis of schizophrenia were followed through 12 months period by a public psychiatric hospital team due to discharge planning. The patients were assessed regarding their needs, clinical status, global functioning, and quality of life and thoroughly informed about their illness, treatment and rehabilitation plan.

Follow up assessments showed improvement in negative syndrome of schizophrenia, better satisfaction in some areas of patients' lives and a decrease in their needs in spite of considered resistance to standard hospital psychiatric treatment.

The study results prove rehabilitation programme to be successful for patients with severe mental disorders and present some information for further development of services for patients with severe mental disorders in Slovenia.

3. Evaluation of stigma

In Slovenia there were several evaluations of attitudes of different groups toward people with mental disorders. One of them is a study entitled "Does psychiatric education reduce stigma? "(60).

Evaluation of discriminative attitudes of medical students towards people with mental disorders was evaluated by a questionnaire before and after the mental health curricula in several faculties that have mental health curricula. The attitudes towards psychiatric patients didn't change much after education, except from lowering the level of fear perceived by students (Table 2).

Table 2: Differences between students in discriminative attitudes towards people with mental disorders before the study of psychiatry and after the completion of the cycle of lectures and exercises in the year 2004.

Variable	N	Mean	SD	Difference	P
They are dangerous	83	3.169 3.602	1.177 1.287	0.434	0.024*
They are incompetent	83	3.686 3.181	1.164 1.211	0.458	0.021*
I feel fear to meet them	72	3.375 4.153	1.204 1.206	0.778	0.000*
I feel reluctant to them	72	4.069 4.153	0.983 0.977	0.375	0.013*
I feel alienated to them	73	3.219 3.644	1.133 1.159	0.425	0.034*

LEGEND: SD – standard deviation

The attitudes of patients towards patients were also researched and showed higher discrimination scores among patients', than in students' group. This was interpreted as self stigma, but it might be better defined as an expressed reluctance to participate in the patients' group which is characterised by extreme exclusion, poverty and low life opportunities

Another study was undertaken by a medical student that organized a serial of films presentations of stories of people with different mental disorders. The attitudes of student after these shows were somewhat better in certain areas of discrimination.

Future steps for strengthening mental care in Slovenia

There are several challenges posed in front of public health and clinical sphere in the field of mental care in Slovenia, two of most important being

- one challenge is, of course, adoption of mental health policy and national plan for mental health. According to WHO (61), national mental health policies should not be solely concerned with mental health disorders, but also recognize promotes mental health. These would include the socio-economic and environmental factors, described above, as well as behaviour. Policies for reduction of suicide, anxiety and depression should develop evidence based approach towards improvement of early recognition of mental disorders with increasing sensibility of employers, professional mental health workers and public about early recognition of warning signs of mental disorders, suicidal behaviour, recognizing triggers and circumstances connected with suicide, dangerous behaviour and mental illness. Denmark for example achieved 60% reduction of suicide rate with combination of policies and preventive programmes in last 20 years: among these are reduces access to suicidal means (weapons), with better treatment of somatic and mental disorders after suicide attempts, with improved access to telephone counselling and emergency psychiatry and with increase in social and cultural stability (62);
- another challenge is to reorient mental care towards more comprehensive one, with more emphasis on mental health promotion and mental disorders prevention. Mental health promotion should be mainstreamed into policies and programmes

in government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as the health sector. Particularly important are the decision-makers in governments at local and national levels, whose actions affect mental health in ways that they may not realize (61). One of the biggest challenges facing Slovenia at the moment in the area of health promotion is increasing concern among both, the general public and among experts and professionals about mental health, (62). Slovenia should build a strong network of experts, institutions and consumers organizations that are responsible in the field of mental health promotion and prevention. To intensify effects, there is a need to harmonize programmes with a long term vision, making them concrete through actions across different settings, at different levels, pointed to different target groups (62).

EXERCISE

Task 1

Make a Medline search on medical students-stigma-mental illness, choose several most cited articles and try to propose a model for reducing discrimination in this group for your country.

Task 2

Search for available needs assessment (mental health) questionnaire and list it. Use the most cited one and exercise its implementation with a close person (without diagnosis)

Task 3

Make a list of needed mental health services in your local area and try to explain your decisions.

Task 4

Design a substance abuse prevention programme for your local community.

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