WFMH
World Federation for Mental Health

MENTAL HEALTH AND CHRONIC PHYSICAL ILLNESSES

THE NEED FOR CONTINUED AND INTEGRATED CARE

WORLD MENTAL HEALTH DAY

October 10, 2010

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World Federation for Mental Health Agenda
The Great Push for Mental Health

The World Federation for Mental Health (WFMH) continues to push its vision of a world in which mental health is a priority for all people. Even though mental health services are increasingly being recognized as critical, they still get short shrift. They do not get the resources and support they deserve.

WFMH continues to sponsor international conferences on mental health innovations and on mental health promotion and prevention, to conduct projects of specific topical or regional interest such as those on HIV/AIDS and depression, and diabetes and depression, and to coordinate and support World Mental Health Day. (World Mental Health Day was created by WFMH!).

More recently, WFMH has redoubled efforts to achieve its vision through an initiative that we are calling the Great Push for Mental Health. WFMH has formed a strategic alliance with the Movement for Global Mental Health (MGMH). The Movement is best reflected in a series of articles in The Lancet. Essentially, these articles make the case that mental illnesses constitute a significant proportion of the global burden of disease and that prioritization and attention on mental health intervention will contribute significantly to both economic and social development. The major themes of the Great Push are Unity, Visibility, Rights, Recovery, and planning of this program is now in progress.

Some major activities that WFMH is embarking on include: the development of a grass-roots campaign so that mental health can have more visibility and priority in the public mind internationally; work with the Commonwealth Secretariat n anticipation of the UN Special Session on Non-Communicable Diseases scheduled for September, 2011; participation in the United Nations process to reformulate the Millennium Development Goals; and promotion of the Great Push through both traditional and social media.

The World Health Organization has recently (September, 2010) released a report titled Mental Health and Development which makes the case for the integration of mental health in development efforts. Mental health is intimately tied with key areas of development such as education and human productivity. Our World Mental Health Day theme this year underlines the relationship of mental health with chronic physical illnesses. As we identify non-communicable diseases like heart disease, diabetes, cancer and respiratory diseases as the new scourge, the relationship to mental health is both intimate and unavoidable. The bottom line is that there is no health without mental health and that there is no development without health AND mental health.

Please join us in the Great Push.

Vijay Ganju, Secretary General/CEO
World Federation for Mental Health

Introduction

Quite often, physical and mental health disorders go hand in hand. Research shows that persons with severe or chronic physical illnesses often have a co-existing mental health problem. At the same time, persons with severe mental illnesses or substance abuse disorders have physical health problems that remain undetected or untreated. This situation, combined with the reality that there is still stigma associated with mental illness and that most persons first seek help through their GP, has resulted in an emphasis on the need for better integration between mental health and physical care, especially for better mental health and substance abuse screening and treatment in a primary care setting.

The World Federation for Mental Health, a 62-year-old international advocacy organization with consultative status to the United Nations, has developed and promoted the idea and celebration of World Mental Health Day. Last year - in 2009 - the focus was on integration of mental health treatment and services with primary care. The major theme was how to improve the capabilities of the primary care system to detect and treat mental illnesses.

This year we extend and elaborate the notion of "integration of care" by focusing on the connection and relationship of mental health disorders and chronic illnesses. As the World Health Organization has noted: Four chronic illnesses - cardiovascular, diabetes, cancer and respiratory illnesses - are responsible for 60 percent of the world's deaths.

Our understanding of the relationship between these chronic illnesses and mental illness has increased dramatically in the last two decades. We now know that persons with these chronic illnesses have much higher rates of depression and anxiety than the general population. Major depression among persons experiencing chronic medical conditions increases the burden of their physical illness and somatic symptoms, causes an increase in functional impairment, and increases medical costs. The presence of mental illness with long-term illnesses impairs self-care and adherence to treatment regimens and causes increased mortality.

The bottom line is that mental illnesses occur with chronic mental conditions in many patients, causing significant role impairment, work loss and work cutback. They also worsen prognosis for heart disease, stroke, diabetes, HIV/AIDS, cancer and other chronic illnesses. Many factors point to reasons that mental illnesses are not adequately addressed in this context. Consumer, provider and system factors all contribute to poor quality of care. Consumers and family members may not recognize or correctly identify symptoms or may be reluctant to seek care. The providers may not have the right training, equipment or support to provide appropriate interventions. Systems may have constraints and limitations related to financing and the availability of and access to mental health treatment.

Yet, effective treatments for mental illnesses exist. We have appropriate interventions to address these problems, reducing the burden on people's lives and the economic and social burden on society. The tragedy is that they are not being implemented. Much needs to be done. Consumers and family members need to have a better understanding of symptoms and possible treatment. Providers and physicians need to have better training and support. Medical schools need to incorporate integrated treatment of mental illnesses more explicitly. Health care financing systems need to recognize that the treatment of mental health illnesses can reduce costs. And, clearly, more research is needed.

The agenda is obvious. Our hope is that these materials developed by the World Federation for Mental Health will boost these efforts.

Vijay Ganju, Secretary General/CEO
World Federation for Mental Health

SECTION ONE

CHRONIC PHYSICAL ILLNESSES AND MENTAL DISORDERS: FACT SHEETS, OVERVIEWS AND ACTION STEPS

This year the WFMH is highlighting the global concern of undiagnosed mental and emotional disorders in people coping with chronic illnesses and the need for our health professionals to provide more integrated or collaborative systems of care. The World Health Organization's World Health Surveys indicated that depression has the largest effect on worsening health compared with the other listed chronic illnesses. Depression, accompanied by one or more chronic diseases, reflected the worst country-wide levels of health – and these scores did not vary much from country to country around the globe.

Non-communicable/chronic/long-term diseases are now the leading cause of deaths world-wide. Dr. Gauden Galea, UN/WHO Coordinator of Health Promotion, has noted that four chronic diseases – cardiovascular, diabetes, cancer and respiratory illness – are responsible for 60 percent of the world's deaths, "and 80 percent of these deaths are happening in the poorest populations of the world." If nothing is done, experts estimate that we could witness another 388 million people die prematurely within the next 10 years. The prevention or management of these chronic illnesses has attracted more attention over the years because of its apparent impact on mortality, health resources, quality of life and its economic burden to governments, health care and families.

One of the many risk factors associated with chronic illnesses is the emotional impact on people who are ill and their families. Many chronic illnesses can have a strong effect on an individual's mental and emotional status; and, in turn, undiagnosed mental disorders can affect a person's ability to cope with an illness and participate in the treatment and recovery process. A. Kathryn Powers, M.Ed., Director of the Center for Mental Health Services, U.S. Substance Abuse Mental Health Services Administration (SAMHSA), states "*we know that many individuals with chronic medical conditions have untreated, co-morbid mental illnesses or substance use disorders, and this can complicate their recovery from both conditions.*"

Learning to cope and live with any long term condition is stressful for most people. Persistent, unrelenting stress often leads to anxiety and unhealthy behaviors. It is not uncommon for patients and family members to have prolonged periods of anxiety about the effect the illness will have on their lives. Indicators of anxiety include physical symptoms, such as difficulty breathing, chest tightness, shakiness, headache, and dizziness. Psychological symptoms of anxiety, such as fear of what will happen, include worrying about who will care for you, and how the illness will progress. What you feel and think and how you deal with those emotions can affect your ability to cope with a long term condition in many ways.

Depression has often been referred to as a normal reaction to an abnormal situation. Therefore, it is not a surprise that depression is the most common complication of almost all chronic or serious medical conditions. "*The risk of getting depression is generally 10-25% for women and 5-12% in men. However, those with chronic illnesses face a much higher risk – between 25-33%*.*" Research has shown that depression often causes changes that can worsen a medical condition and reduce the needed energy necessary to cope with changes and treatment schedules, creating a vicious cycle of worsening physical and emotional symptoms.

References:
*Web MD, Coping with Chronic Illnesses and Depression http://www.webmd.com/depression/guide/chronic-illnesses-depression

HEART DISEASE AND DEPRESSION

FACT SHEET

- Depression is present in 1 of 5 outpatients with coronary heart disease and in 1 of 3 outpatients with congestive heart failure, yet the majority of such cases are not recognized or appropriately treated.

- Major depressive disorder is a risk factor in the development of incident coronary heart disease events in healthy patients and for adverse cardiovascular outcomes in patients with established heart disease. For people with heart disease, depression can increase the risk of an adverse cardiac event such as a heart attack or blood clots. For people who do not have heart disease, depression can also increase the risk of a heart attack and development of coronary artery disease.

- Up to 15 percent of patients with cardiovascular disease and up to 20 percent of patients who have undergone coronary bypass graft surgery experience major depression.

- In one landmark study, the continued presence of depression after recovery increased the risk of death (mortality) to 17 percent within 6 months after a heart attack (versus 3 percent mortality in heart attack patients who didn't have depression).

- Negative lifestyle habits associated with depression – such as smoking, excessive alcohol consumption, lack of exercise, poor diet and lack of social support – interfere with the treatment for heart disease.

- Depression has been proven to be such a risk factor in cardiac disease that the American Heart Association (AHA) has recommended that all cardiac patients be screened for depression.

- Patients with depression after myocardial infarction, especially those with prior episodes, should be both carefully watched and aggressively treated because they are at an elevated cardiac risk and less likely to improve spontaneously.

Cardiovascular Disease and Mental Illnesses

About one in five people will have an episode of major depression in their lifetime. That number climbs to about one in two for people with heart disease. Also the risk of heart disease is double in people with a history of depression. "After adjusting for other risk factors, depression remains a significant predictor of heart disease," says Jeffrey F. Scherrer, PhD, research professor of psychiatry at Washington University School of Medicine and the St Louis Veterans Affairs Medical Center.

Depression observed in acute coronary syndrome (ACS) is common and associated with an increased risk of mortality. Medically healthy individuals who suffer from depression are at significantly increased risk of developing heart attacks and strokes later in life. (Glassman et al., Arch Gen Psychiatry, 2007)

Acute coronary syndrome is both psychologically and physiologically stressful, and it is common to attribute depression observed following ACS to that stress. (Glassman et al., Arch Gen Psychiatry, 2007)

Mental stress and depression can have a profound effect on cardiovascular disease and have implications in recovery. Dean Ornish, M.D. wrote in his book Love and Survival: The Scientific Basis for the Healing Power of Intimacy: "*Among heart patients, depression is as good a predictor of imminent death as smoking, obesity, or a previous heart attack. Study after study shows that people who are lonely, depressed, and isolated are three to five times more likely to die prematurely than people who feel connection in their life.*"

Research has documented a high correlation between depression and increased risk of dying or impairment in patients with coronary heart disease:

- In coronary heart disease, for patients with a history of myocardial infarction (heart attack), the prevalence of depression is estimated from 40 to 65 percent.
- Among coronary heart patients without a history of heart attack, 18-20% may experience depression.
- Major depression puts heart attack victims at greater risk and appears to add to the patients' disability from heart disease. Depression can contribute to a worsening of symptoms as well as poor adherence to cardiac treatment regimens.
- People who survive heart attacks but suffer from major depression have a 3-4 times greater risk of dying within six months than those who do not suffer from depression.

ACTION STEPS

CARDIOVASCULAR DISEASE AND MENTAL HEALTH

Archives of General Psychiatry

A new Dutch Study, led by Elisabeth J. Martens of Tilburg University in the Netherlands, found that anxiety disorders may increase the risk of heart attack, stroke, heart failure and death in people with heart disease. The research included over 1,000 people with stable coronary heart disease who were assessed for anxiety disorder at the start of the study and then followed for an average of 5.6 years.

During that time, there were a total of 371 cardiovascular events (heart attacks or other incidents that may cause damage to the heart). The yearly rate of cardiovascular events was 9.6% among the 106 patients with generalized anxiety disorder and 6.6% among the other 909 patients. After adjusting for a number of factors -- such as other health problems, heart disease severity and medication use -- the researchers concluded that generalized anxiety disorder was associated with a 74% increased risk of cardiovascular events.

According to Dr. Martens and colleagues, many factors may account for the increase in risk:

- Anxiety may be linked with surges in "fight or flight" hormones called catecholamines that may be related to heart risks;
- Anxious patients with coronary heart disease (CHD) may be less likely to seek preventive medical care due to an "avoidant coping strategy";
- People with anxiety may be more likely to seek medical care when they have symptoms of a cardiovascular event (although researchers noted this wouldn't explain the higher rates of death);
- It's also possible that a common underlying factor may increase the risk of both anxiety and heart events.

Patients with stable coronary heart disease (CHD) plus generalized anxiety disorder (GAD) have a higher risk of experiencing cardiovascular events — such as stroke, myocardial infarction, and death — than patients with CHD only. In fact, after adjusting for a variety of potentially confounding variables, GAD was associated with a 74% increased risk for adverse cardiovascular outcomes.

According to Dr. Martens, "*A robust association...was found that could not be explained by disease severity, health behaviors, or biological mediators. These findings have implications for clinical practice and research. GAD is common and treatable and could be, therefore, an important modifiable risk factor in patients with CHD.*"

Common Combination

"*Although 24% to 31% of patients with CHD also have symptoms of anxiety, relatively few studies have looked at the role that anxiety may play — especially compared with the 'extensive literature on depression in patients with CHD,'* the investigators wrote. *"Studies examining anxiety as a risk factor for future CHD events have yielded conflicting results."* Archives of General Psychiatry, 2010.

"*We previously found that the association between depressive symptoms and cardiovascular events was largely explained by poor health behaviors, especially physical inactivity, in depressed patients with CHD,"* explained Dr. Martens. *"For me, [this] was a great opportunity to be involved in a study that could shed more light onto the relationship between body and mind."*

The investigators assessed 1015 San Francisco area outpatients with stable CHD from the Heart and Soul Study, which focused on the association between various psychological disorders and cardiovascular events. All patients underwent interviews, blood and urine sample testing, exercise treadmill testing, and electrocardiography at their first baseline visit between September 2000 and December 2002. Follow-ups were then conducted until March 18, 2009.

The presence of GAD during the past year and of major depressive disorder (MDD) during the past month was determined with the computerized version of the Diagnostic Interview Schedule. A total of 106 patients (10.4%) were found to have GAD.

GAD Associated With Higher Cardiovascular Risks

Results showed that 371 cardiovascular events occurred in the patients after an average follow-up time of 5.6 years. After adjusting for age, the yearly rate of cardiovascular events was 9.6% for the CHD patients with GAD compared with 6.6% for those without the disorder (hazard ratio [HR], 1.43; 95% confidence interval [CI], 1.03 – 2.00; *P* = .03).

"*After adjustment for demographic characteristics, co-morbid conditions [including MDD], cardiac disease severity, and medication use, GAD remained associated with a 62% higher rate of cardiovascular events (HR, 1.62; 95% CI, 1.11 – 2.37; P = .01),*" reported the study authors.

Dr. Martens noted that "*despite an exhaustive search for potential mediators*, the investigators did not identify the exact reason for the increased risk of adverse cardiovascular outcomes associated with GAD."

"*The results of this study indicate the need for future research to identify the underlying processes by which GAD contributes to adverse events in patients with CHD and to test interventions to alleviate the risk,*" they write.

"*These findings have implications for clinical practice and research*," Martens and colleagues concluded in a news release, since the evaluation and treatment of anxiety might now "*be considered as part of the comprehensive management of patients with coronary heart disease*." They added that scientists need research programs to help understand the impact of anxiety disorders on medical prognosis, including that of heart disease, and to develop evidence-based approaches to patient care.

The study appears in the July 2010 issue of the journal *Archives of General Psychiatry,* 2010;67:750-758.
http://www.medicinenet.com/script/main/art.asp?articlekey=117818

DIABETES AND DEPRESSION

FACT SHEET

- Estimates indicate that one in four persons with diabetes suffers from depressive symptoms. The odds of developing depression and the rate of depression are doubled for people who have diabetes.

- Depression increases the risk of mortality in people with diabetes by 30 percent.

- Based on global prevalence estimates of diabetes done in 2000, 43 million people with diabetes have symptoms of depression.

- The economic burden of diabetes alone is significant. When depression is present with diabetes, there is an additional increase in health care costs by 50-75 percent.

- People who have both diabetes and depression have more severe symptoms of both diseases, higher rates of work disability and use more medical services than those who have diabetes alone.

- Studies suggest that depression increases the risk of developing type-2 diabetes by more than 20 percent in young adults.

- Depression can lead to poor lifestyle decisions such as unhealthy eating, less exercise, smoking, alcohol abuse, and weight gain. All these are risk factors for diabetes and make it more difficult to control sugar levels.

- The interaction between diabetes and depression is not well understood. However, whether a cause or an effect, the combination of diabetes and depression can be deadly. Interactions between diabetes and depression make each illness more difficult to control.

- If you suffer from diabetes, ask your doctor for a depression screening. While we may not know if depression actually triggers diabetes, we do know that depression makes diabetes a lot worse.

Diabetes and Mental Illnesses

According to the International Diabetes Federation, "*the number of people around the world suffering from diabetes has skyrocketed in the last two decades, from 30 million to 230 million, claiming millions of lives and severely taxing the ability of health care systems to deal with the epidemic.*" Diabetes is considered one of the most psychologically demanding of the chronic illnesses because it requires such a strict daily routine. Individuals with diabetes commonly must undergo extensive lifestyle changes in order to properly manage their disease, and often experience substantial stress and negative affect – which significantly impacts quality of life and the ability to adhere to the new lifestyle changes. This increases their risk for developing complications such as heart disease, blindness, stroke, kidney disease, nerve damage and reduced blood flow necessitating amputation.

Studies confirm that people with diabetes frequently experience emotional disorders: diabetics are reported to have almost three times the rate of anxiety and at least three to four times the rate of depression found in the general population. Those with both conditions find it more difficult to control their diabetes. Patients typically turn to eating more food, usually less healthy food, which increases blood sugar and exacerbates the consequences of the disease. They may smoke, drink alcohol or abandon exercise – all the things that make diabetes worse.

A report of the World Health Organization and International Diabetes Federation has drawn attention to the importance of encouraging psychological well being in people with diabetes. The establishment and maintenance of psychological well being is recognized as a valuable goal of diabetes management, which is expected to reduce the occurrence of metabolic problems and complications. Education in emotional self-regulation may have particular clinical relevance in diabetes, as emotional disturbances and ineffective coping styles have been associated with significantly poorer glycemic control, the increased report of clinical symptoms, decreased compliance and increased risk for complications. Emotional stress can contribute to the exacerbation of diabetes by direct physiological effects on glucose regulation, as well as by reducing adherence to self-care behaviors. Conversely, studies have shown that significant relationships exist between self-efficacy, self-care and measures of glycemic control. Thus, multiple lines of evidence clearly support the integration of an effective stress reduction and emotional management intervention program as a fundamental component of any diabetes management regimen.

The best treatment is often a multidisciplinary team effort where many professionals are involved with the individual and the family: a physician to manage the diabetes, a mental health therapist to help define and deal with emotional issues, a family therapist to help the family, and a dietitian to provide nutritional counseling and education.

ACTION STEPS

DEPRESSION AND DIABETES

American Diabetes Association

- People with diabetes are at greater risk for depression.
- Poor diabetes control can cause symptoms that look like depression.
- If physical causes are ruled out, referral to a specialist for mental health treatment, including psychotherapy and antidepressant medication, is recommended.

Feeling down once in a while is normal. But some people feel a sadness that just won't go away. Life seems hopeless. Feeling this way most of the day for two weeks or more is a sign of serious depression.

Does diabetes cause depression?
At any given time, most people with diabetes do not have depression. But studies show that people with diabetes have a greater risk of depression than people without diabetes. There are no easy answers about why this is true.

The stress of daily diabetes management can build. You may feel alone or set apart from your friends and family because of all this extra work.

If you face diabetes complications such as nerve damage, or if you are having trouble keeping your blood sugar levels where you'd like, you may feel like you're losing control of your diabetes. Even tension between you and your doctor may make you feel frustrated and sad.

Just like denial, depression can get you into a vicious cycle. It can block good diabetes self-care. If you are depressed and have no energy, chances are you will find such tasks as regular blood sugar testing too much. If you feel so anxious that you can't think straight, it will be hard to keep up with a good diet. You may not feel like eating at all. Of course, this will affect your blood sugar levels.

Spotting Depression

Spotting depression is the first step. Getting help is the second. If you have been feeling really sad, blue, or down in the dumps, check for these symptoms:

- Loss of pleasure; You no longer take interest in doing things you used to enjoy.
- Change in sleep patterns; You have trouble falling asleep, you wake often during the night, or you want to sleep more than usual, including during the day.
- Early to rise; You wake up earlier than usual and cannot to get back to sleep.
- Change in appetite; You eat more or less than you used to, resulting in a quick weight gain or weight loss.
- Trouble concentrating; You can't watch a TV program or read an article because other thoughts or feelings get in the way.
- Loss of energy; You feel tired all the time.
- Nervousness; You always feel so anxious you can't sit still.
- Guilt; You feel you "never do anything right" and worry that you are a burden to others.
- Morning sadness; You feel worse in the morning than you do the rest of the day.
- Suicidal thoughts; Or thinking about ways to hurt yourself.

If you have three or more of these symptoms, or if you have just one or two but have been feeling bad for two weeks or more, it's time to get help.

Getting Help

If you are feeling symptoms of depression, don't keep them to yourself. First, talk them over with your doctor. There may a physical cause for your depression.

Poor control of diabetes can cause symptoms that look like depression. During the day, high or low blood sugar may make you feel tired or anxious. Low blood sugar levels can also lead to hunger and eating too much. If you have low blood sugar at night, it could disturb your sleep. If you have high blood sugar at night, you may get up often to urinate and then feel tired during the day.

Other physical causes of depression can include the following:

- Alcohol or drug abuse
- Thyroid problems
- Side effects from some medications

Do not stop taking a medication without telling your doctor. Your doctor will be able to help you discover if a physical problem is at the root of your sad feelings.

Mental Health Treatment
If you and your doctor rule out physical causes, your doctor will most likely refer you to a specialist. You might talk with a psychiatrist, psychologist, psychiatric nurse, licensed clinical social worker, or professional counselor. In fact, your doctor may already work with mental health professionals on a diabetes treatment team.

All of these mental health professionals can guide you through the rough waters of depression. In general, there are two types of treatment:

- Psychotherapy, or counseling
- Antidepressant medication

Psychotherapy

Psychotherapy with a well-trained therapist can help you look at the problems that bring on depression. It can also help you find ways to relieve the problems. Therapy can be short term or long term. You should be sure you feel at ease with the therapist you choose.

Medication

If medication is advised, you will need to consult with a psychiatrist (a medical doctor with special training in diagnosing and treating mental or emotional disorders). If you opt for trying an antidepressant drug, talk to the psychiatrist and your primary care provider about side effects, including how it might affect your blood sugar levels. Make sure that these doctors will consult about your care when needed. Many people do well with a combination of medication and psychotherapy.

If you have symptoms of depression, don't wait too long to get help. If your health care provider cannot refer you to a mental health professional, contact your local psychiatric society or psychiatry department of a medical school, or the local branch of organizations for psychiatric social workers, psychologists, or mental health counselors. Your local American Diabetes Association may also be a good resource for counselors who have worked with people with diabetes.

American Diabetes Association **www.diabetes.org** Copyright 1995-2010, ADA. All rights reserved

CANCER AND MENTAL ILLNESSES

FACT SHEET

- Approximately half of all patients with terminal or advanced cancer suffer with poor mental health. Specifically, depression, anxiety, and adjustment disorders plague people with advanced or terminal cancer. While half of terminally ill or advanced cancer patients suffer from depression, anxiety, and/or an adjustment disorder, less than half of cancer patients receive treatment for their mental health.

- Death rates are as much as 25% higher in cancer patients who felt depressed and 39% higher in cancer patients who received a diagnosis of depression.

- Depression is a disabling illness that affects about 15% to 25% of cancer patients. It affects men and women with cancer equally.

- The relationship between cancer and depression is complex. Depression may be triggered by the diagnosis of cancer, other issues related to the cancer and its treatment, or the impact of the cancer on a person's life. However, depression may occur by chance or be related to other difficult events, either in the past or in the present, which have nothing to do with cancer, such as the loss of a loved one.

- Cancers, especially breast cancer and lung cancer, are the second most common cause of death in people with schizophrenia, whose risk for cancer death is 50% higher than that of the general population. Possible explanations for these findings include a delay in diagnosis due to patients paying less attention to symptoms; the difficulty for schizophrenic patients to benefit from optimum treatment; and less compliance with treatment, the authors speculate.

- Adequate recognition and treatment of depression in patients with cancer can enhance quality of life and help patients and families make the best use of their remaining time together. Since patients are often reluctant to describe their depressive symptoms, caregivers need to know how depression can be recognized.

CANCER AND MENTAL ILLNESSES

About 1 in 4 people with cancer, including adults, children and teens, will experience depression at some point after diagnosis. Symptoms can include: lack of sleep; loss of interest in life; anxiety; irritation; loss of concentration; and, in severe cases, thoughts of suicide – all of these leading to an overall poor quality of life. Unfortunately, many people with cancer and their family members believe that it is quite normal to be depressed or sad if diagnosed with cancer; depression is sometimes viewed as being "appropriate" in these patients. However, it should never be appropriate for cancer patients to suffer with serious depression. Dr Michelle Riba, Director of the Psycho-oncology Program at University of Michigan Cancer Center says, *"Often, patients tell me that dealing with the emotions of cancer is actually harder than coping with the other medical problems."* Recent studies demonstrate that untreated mental illnesses can prolong the length and increase the number of hospitalizations, hamper effective treatment, and ultimately reduce the chances of survival.

It is critically important to establish tools for evaluating distress in cancer patients and helping them seek treatment for the emotional aspects of coping with the illness. Dr Riba states that *"Patients and families should make it a point of talking to their doctors about their emotional feelings. If you feel depressed, anxious, or confused and generally not like yourself, you or your family should ask about the cause and treatment of these symptoms. It is also important for doctors and nurses to initiate asking patients about their levels of distress and patients should feel that they can answer these questions without prejudice."*

Assessing depression in people with cancer should include:

- A careful evaluation of the person's thoughts about the diagnosis;
- Medical history;
- Personal or family history of depression or suicide;
- Current mental status;
- Physical status;
- Side effects of treatment and the disease;
- Other stresses in the person's life; and,
- Support available to the patient.

"One of the most debilitating side effects of cancer is the depression that comes with it. Depression is unfortunately one of the most under-recognized conditions in patients fighting cancer."

Cancer Treatment Center of America,
http://www.cancercenter.com

According to researchers, a person with cancer and depression can get treatment for the mind that ends up being a huge help for the body. A Stanford University study led by David Spiegel, M.D., showed that women with advanced breast cancer who attended a weekly support group lived approximately twice as long as a similar group who didn't have a support group. Dr. Spiegel says that treating depression in people with cancer not only eases symptoms of pain, nausea, and fatigue but it may also help them live longer and maintain a better quality of life.

In order to produce the most positive outcome, it seems clear that cancer, no matter of what type, should not be treated in isolation. Mental health concerns should be reviewed carefully by the treating physician, the patient, and close family and friends who provide primary support for the individual.

ACTION STEPS

CANCER AND EMOTIONS: IS IT NORMAL TO BE DEPRESSED?

The emotions of cancer are often more difficult to cope with than other medical problems. It is not surprising that approximately 50% of patients with cancer have some form of diagnosable psychiatric disorder at some point during their course of care. The Dana-Farber Cancer Institute and Brigham and Women's Hospital in Boston found that at least 50 percent of patients with advanced or terminal cancer are suffering from anxiety, depression or an adjustment disorder. Unfortunately, less than half receive the help they need.

The researchers highlight the need to incorporate mental health care into the treatment plans for patients, as depression and anxiety can compromise one's quality of life, perhaps more so than physical pain. They also point out that oncologists and physicians can screen cancer patients for mental illness and refer patients for treatment and support groups.

Categories of psychological distress for cancer patients:

- adjustment problems
- depression
- anxiety
- delirium
- substance abuse

Distress may also occur from such problems as:

- pain management
- difficulties with family
- work related problems
- financial issues
- worries about children

Challenges in diagnosis and treatment:

- the perceived stigma of psychiatric care
- difficulty in adding yet another problem to a complex medical diagnosis
- patients are sometimes embarrassed or ashamed that they are feeling sad or anxious
- fear of the physician seeing the patient in a negative light
- physicians may find it difficult to raise sensitive issues related to mental health

Special Risk Factors for psychiatric problems among cancer patients:

- The type and stage of cancer - pancreatic cancer and certain types of lung cancer and advanced stages of cancer at time of diagnosis - portend more of an incidence of psychiatric problems.
- Very young or very old patients

- Those who are not married or have little support
- Those who have few friends and are not affiliated with community or religious groups
- Patients with a history of psychiatric problems
- Patients with co-occurring medical problems

Symptoms of Major Depression:

- change in appetite
- problems with falling asleep or staying asleep
- depressed mood
- feelings of hopelessness or helplessness
- suicidal feelings
- decrease in energy
- decrease in the capacity to enjoy things
- problems with concentration
- psychomotor agitation or retardation

When patients have a number of symptoms for at least two weeks, it is time to get evaluated by a professional.

Recommendations:

- Screening for psychiatric problems should be part of routine care in all visits for cancer patients. The National Comprehensive Cancer Network (NCCN) has developed guidelines for evaluating distress to help patients and the practitioners who provide such screenings. http://www.nccn.org/professionals/physician_gls/about.asp
- There are a number of treatment options for these types of emotional issues. After a good psychiatric evaluation and diagnosis, the options for care will follow. Treatment options may include:
    - Psychotherapy (supportive; cognitive behavioral; psychodynamic; interpersonal; dialectic behavioral; etc), including couples and family therapy.
    - Antidepressant medications and anxiolytic agents that can help with mood and sleep problems.
    - Group therapy can be quite helpful, either supportive or supportive/expressive types of group therapy.

It is critically important to consider the emotional aspects of cancer care. Screening and detection are the first steps. Patients and families should make a point of talking to their doctors about their emotional feelings. It is important not to assume that it is normal to feel anxious, depressed, overwhelmed, etc. If you do feel depressed, anxious, or confused and generally not like yourself, you or your family should ask about the cause and treatment of these symptoms.

It is also important for doctors and nurses to initiate asking patients about levels of distress; and for patients to feel that they can answer these questions without prejudice. If you do have symptoms, you should be seen by a mental health professional trained to evaluate psychiatric problems (psychiatrist; psychologist; social worker, etc) and an appropriate treatment plan developed. Family members should be encouraged to participate in the development and implementation of the treatment plan. Insurance and managed care companies will hopefully support the treatment plan to ensure the optimal health of the patient. Patients with cancer will do better medically if emotional and psychological needs are addressed.

RESPIRATORY DISEASES AND MENTAL ILLNESSES

FACT SHEET

- Chronic obstructive pulmonary disease (COPD) is a leading cause of disability and death, affecting approximately 11.4 million people in the United States and millions more across the world.

- Twenty percent of patients with asthma and COPD suffer from major depression and/or anxiety (generalized anxiety, panic and phobia), a prevalence rate that is substantively greater than that in the general population.

- Depression and anxiety are associated with worsening of consumer/patient-reported respiratory symptoms and decreased lung function.

- Panic disorder, panic attacks, general anxiety disorders (GAD) and phobias appear to be the anxiety disorders most strongly associated with asthma.

- Depression makes it more difficult to adhere to treatment regimens for patients with respiratory disease.

- Research studies report increased cigarette smoking among individuals with COPD who also have anxiety disorders. Smoking is particularly problematic in youth with asthma, leading to higher symptom burden and treatment resistance.

- Depression has been found to hinder life-style adaptations that are necessary for increasing survival rates and optimizing the quality of life for individuals suffering with respiratory disease.

- Studies suggest that psychopharmacological and/or psychosocial interventions might improve asthma control.

Respiratory Diseases and Mental Illnesses

After cardiovascular disease, respiratory diseases, such as asthma and COPD, are the biggest global killers. There are more than 40 different respiratory conditions and many continue to progress and make it more difficult to adjust to the new challenges each disease stage presents. The gradual and persistent change in lung function can make daily activities more and more difficult to perform or more frightening to attempt. It can also affect a person's social, physical and personal activities. All of these changes can have a profound impact on a person's mental and emotional outlook.

The Australian Lung Foundation states that "*it's important to empower patients with better coping skills to deal with both physical and psycho-social stressors. If care for respiratory diseases is not integrated with concern about psychological and emotional responses to these chronic diseases- negative feelings such as anxiety, anger, tension, frustration, hopelessness and depression are likely to occur and to contribute to worsened health outcomes for patients. The prevalence of depression and anxiety in COPD patients can range between 40-90%, compared to 8-20% in the normal population.*"

Although many experts have noted a link between lung diseases, such as chronic obstructive pulmonary disease (COPD), and depression and anxiety, there is emerging research that suggests the mental disorders may actually worsen COPD and cause increased hospitalizations.

"This is an important and revealing finding, indicating that for COPD patients, depression and anxiety must be treated as potential clinically important risk factors, rather than simple co-morbidities that are caused by COPD," said principal investigator of the paper, Jean Bourbeau, M.D., Director, Respiratory Epidemiology & Clinical Research Unit of McGill University Montreal.

The influence of emotional states on pulmonary functioning in asthma has been studied extensively. Recent findings indicate that airways are reactive to psychological states and this is corroborated by personal retrospective accounts that suggest that changes in emotional states result in asthma exacerbations.

In many patients, treatment for a mental disorder can create an improvement in their overall medical condition, contributing to a better quality of life and allow the person to adhere to treatment plans, life-style changes and physical limitations.

In recent years, there has been increasing interest in the relationship between respiratory disease and anxiety and depressive disorders among youth. Studies suggest that early respiratory symptoms are associated with increased rates of mental disorders among youth and that these linkages have been established using both clinical and community-based samples. Children and youth with respiratory symptoms and disease have odds of later mental disorders 2 to 4 times higher than those without. The relationship between respiratory disease and mental disorders among youth holds even after adjustments are made for hypochondria, functional impairment, and cigarette smoking.

Self-management of asthma can be challenging, and depression has been identified as one factor which may decrease the effectiveness of asthma self-management and compliance: patients with chronic disease and depression are three times more likely to be noncompliant with medical treatment than non-depressed patients.

Studies suggest a possible "feedback loop" between asthma and depression. Depression experienced by people with asthma may be as much as the result of having asthma, as it is the cause of it, and this bi-directional association may lead to a continual cycle resulting in ever-worsening physical and mental health.

It is hoped that by treating depression in asthma, the negative effects of the co-existence can be minimized. While treating depression may increase adherence to medical treatment and more effective asthma self-management, and even decrease asthma-related mortality, treating depression is likely to dramatically improve quality of life.

OBESITY AND MENTAL ILLNESSES

FACT SHEET

- There is no simple association between obesity and depression and/or anxiety.

- Depression and anxiety are associated with unhealthy behaviors, such as poor diet, physical inactivity and sedentary lifestyle, tobacco use, and heavy alcohol consumption. Many of these unhealthy behaviors are linked to an increased potential for obesity.

- Obesity and depression share similar symptoms such as sleep problems, sedentary behavior and poorly controlled food intake; but for the most part are treated as separate health problems, often leading to poor treatment outcomes. Individuals with current depression or chronic depression are 60% more likely to be obese than those with no history of depression.

- Individuals with a chronic history of anxiety are 30% more likely to be obese than those who have not had a diagnosis of anxiety. The Centers for Disease Control and Prevention (CDC) reports that obesity is associated with serious chronic illnesses such as coronary heart disease, stroke and osteoarthritis, making effective treatment for obesity all the more important.

- Obesity has been associated with an increased lifetime risk for major depression and panic disorder, particularly among females.

- Some research studies indicate that obesity in adolescence may lead to depression in adulthood, while other studies indicate that depression in adolescence leads to obesity in adulthood.

Obesity and Mental Illnesses

The World Health Organization (WHO) believes that we are in the grip of a global epidemic, and it is estimated by the year 2020 obesity will be the single biggest killer on the planet.

Psychological disorders which obesity may trigger include depression, eating disorders, distorted body image, and low self-esteem. Understanding the connection between obesity and mental disorders, such as depression, is an important public health issue because both of these conditions will individually have significant implication on health care systems across the globe and account for a significant proportion of the global burden of disease.

Evidence from the Swedish Obese Subjects (SOS) study indicates that clinically significant depression is three to four times higher in severely obese individuals than in similar non-obese individuals. "Depression on a level indicating psychiatric morbidity was more often seen in the obese," the authors, Professor Marianne Sullivan and her team from Sahlgrenska University Hospital, Sweden wrote in a journal article. They reported that the depression scores for obese people were as bad as, or worse than, those for patients with chronic pain.

Untreated depression can be both the cause and effect of obesity. "*As a practicing child psychiatrist, I see a clear association between obesity and depression and anxiety disorders among children and teens,*" notes David Fassler, M.D., an American Psychiatric Association (APA) Trustee and child and adolescent psychiatrist from Burlington, Vermont.

A recent University of Minnesota study reveals that children who were teased about being overweight were more likely to have poor body image, low self-esteem, and symptoms of depression. The study found that 26 percent of teens who were teased at school and home reported they had considered suicide, and 9 percent had attempted it. Suicide is the third leading cause of death among adolescents. (Archives of Pediatrics and Adolescent Medicine, "Associations of Weight-Based Teasing and Emotional Well-being among Adolescents," August 2003)

Both depression and obesity are widely spread with major public health implications, especially increased risk for cardiovascular disease, and now recent studies have confirmed the link between depression and obesity. Depression is associated with an 18% increased risk of being obese.

Studies suggest that depression and obesity interact reciprocally. The longitudinal, bi-directional association between depression and obesity is an important consideration for clinical practice. Since weight gain can be a consequence of depression, care providers should monitor the weight of depressive patients. Similarly, in overweight or obese patients, mood should be monitored. This awareness could lead to prevention, early detection, and co-treatment for people at risk, ultimately reducing the burden of both conditions.

SECTION TWO

Chronic Physical Illnesses and Mental Illness: The Need for Integrated Care

Introduction

Dr Michelle Riba

Summary: *Primary care services need to improve ways of screening for depression associated with particular chronic illnesses like heart conditions or diabetes. There are a number of ways that services by mental health professionals could be incorporated into primary care. Providing this linkage is a huge need, and should be a public health mandate.*

There is No Health Without Mental Health

Evidence continues to mount for the need to improve the recognition and treatment of mental health issues in primary and specialty clinical practice. Depression is a chronic, disabling condition that is associated with poor quality of life, functional limitations, less favorable self-care behaviors, and higher health care costs among patients with chronic co-morbid medication conditions, such as diabetes and cardiovascular diseases.

While primary care clinicians are now better able to recognize depression and anxiety when patients provide psychosocial, rather than physical complaints (Kirmayer et al, 1993), physical symptoms are often the chief or only complaint described by depressed and anxious patients (Simon et al, 1999). When present with physical illness, psychotropic medications, sedentary life styles, modern diets, and mental illnesses themselves can all contribute to morbidity and early mortality. It is, therefore, an imperative for a call to action to recognize such conditions and risk factors, and develop collaborative models and educational processes to regularly manage these complex clinical situations with evidence-based treatment.

Two major chronic medical conditions—diabetes and cardiovascular disease—and co-morbid depression, serve to emphasize the impact of these important linkages. In spite of the high rates of co-morbid major depression in patients with diabetes mellitus, depression is frequently unrecognized and untreated in approximately two thirds of patients with both conditions (Katon 2008). Up to 80% of patients with diabetes and depression will experience a relapse of depressive symptoms over a 5-year period. Depression impacts negatively on diabetes with non-adherence to diabetes self care, including not following dietary restrictions, medication adherence and blood glucose monitoring, and worse overall clinical outcomes (Katon 2008).

> ***"Primary care services need to improve ways of screening for depression."***

It has been shown that as many as 30-40% of cardiac patients experience clinically important depressive symptoms (Thombs et al, 2008). Major depressive disorder is present in as many as 20% of patients with cardiovascular disease and is associated with adverse cardiovascular outcomes, even after controlling for other risk factors. **Depression is related to the onset of cardiac disease, and is associated with higher medical costs, reduction in patients' quality of life and triple the risk of non-adherence with medical treatment regimens.** In fact, cardiovascular prognosis is linked to the severity of depressive symptoms. Risk increases along with symptom severity whether or not the patient meets diagnostic criteria for a depressive disorder. Depression reduces the chances of successful modification of cardiac risk factors and participation in cardiac rehabilitation, and is associated with higher health care utilization and costs and greatly reduced quality of life.

While there is still debate on which types of screening tools might be best for a particular group of patients, the medical community seems poised and receptive to incorporate some level of mental health questioning into clinical care (Lichtman et al, 2008). The task, then, is to develop ways to encourage, support and provide incentives for clinicians and patients to incorporate standard and routine screening for psychiatric symptoms, such as depression, anxiety, substance abuse, and suicide for patients at regular intervals of care. Paradigms and methods of referring patients to mental health providers must be established. Some successful models include co-location of mental health professionals who are embedded in medical practice. Other models include using the telephone, email or web (Skype) to have primary care clinicians have ready access to mental health professionals or well-positioned psychiatric clinics within the medical setting.

Communication, collaboration, and evidence based care are key factors. We know the problem is huge; unquestionably, it should be a public health mandate. But we must develop new ways to understand the scale of mental health problems, and optimal ways to evaluate, manage and treat these psychiatric conditions in patients with other co-morbid medical conditions.

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The Role of Primary Care in Improving Access to Care for Persons with Mental Health Problems and Chronic Physical Illnesses

Dr Gabriel Ivbijaro

Summary: *Many people experience co-occurring mental and physical illnesses. Often treatment is provided in separate facilities, if it is available. In many low and middle income countries, there is very limited provision for mental health care. With appropriate training, it is possible to provide care for both mental and physical health in a primary care setting to improve services for patients.*

Mental illnesses and physical health conditions are interwoven. Many patients who suffer from mental illness also suffer from physical health conditions, either as a consequence of the treatment they receive, or as part of the complexity of the illness itself. Many health care systems do not adequately provide an integrated approach for physical and mental health care. Often an individual receives mental health care from one organization and physical health care from a different system. In some cases, one condition may be looked after while the other is not.

The consequence of fragmented or incomplete care is that the individual does not receive appropriate holistic care and, thus, may have a lower life expectancy and a poorer quality of life. Many people who live with serious mental illness also have other long term physical health problems or co-occurring mental health conditions and the additive effects of each health condition often produce worse overall health outcomes.

This year, World Mental Health Day focuses on the relationship between chronic physical illnesses and

mental health conditions. This provides us with an opportunity to reflect on our current situation and to think about the way forward.

Understanding the need to focus on the link between mind and body is not new. In the correspondence section of the British Medical Journal of June 10, 1933, Dr. C.M. Billington, commenting on an article in the Journal, wrote: "There has been a tendency for many years past to regard the human organism as a rat or a guinea pig as regarded in the laboratory. Surely it is time that we all recognized in our work and hypotheses of disease that our patients have minds, and that this highly civilized part of them has a very strong influence indeed over their bodies." Dr Billington noted that all general practitioners were faced with this indisputable fact in their daily work, and suggested that the medical profession as a whole should take the inextricable link between mind and body into account. Other medical conditions— for example, the Chinese, Tibetan and Indian—have recognized the mind-body connection for centuries.

Unfortunately, those who advocate for the separation of mind and body, either through emphasizing the need to design health systems with an emphasis on single condition specialization, or through designing health facilities where physical and mental health facilities are geographically distant, appear to have succeeded in breaking the mind body connection.

The *2008 World Health Report: Primary Care - Now More Than Ever* noted the urgent need to re-focus health systems on primary care. All too often, investment is targeted at specialization and runs the risk of further eroding the mind body connection. This report stated that the core values of primary care articulated in the Alma-Ata Declaration of 1978 remain valid, and are still necessary to deliver health to all. The Declaration also emphasized the need for strong policies and leadership to enable us to develop health care systems that will be able to deliver primary health care goals and advantages.

Just as in the years before the Alma Ata Declaration, there still remains a disproportionate focus on

Patients with chronic mental health conditions often present in primary care, which for the majority of patients is the first place to seek help.

secondary and tertiary services which leads to fragmentation of local health services. This over-reliance on hospitals to deliver health care has failed to deliver optimal health outcomes for the majority, as these institutions are often unable to focus on the person in a holistic way, especially in the area of mental health where most patients have not single but co-occurring conditions. Mental health conditions are often associated with long term physical health care illnesses and long term physical health care conditions are often associated with mental health problems.

Patients with chronic mental health conditions often present in primary care, which for the majority of patients is the first place to seek help. Primary care services are usually delivered close to home, which can lead to a reduction in stigma (WHO/Wonca 2008). In well organized community care settings, continuity of care is enhanced.

Despite these findings, the World Health Organization noted in the mhGAP Report (2008) that many who suffer from mental health conditions do not get the physical or mental health services they need or deserve. In high income countries, the ratio of psychiatrists to the general population is 10.5 per 100 000, in middle income countries it is 2.7 per 100 000, and in lower income countries it is only 00.05 – 1.05 per 100 000. The ratio of psychologists to the general population is 14 per 100 000 in high income countries, 1.8 per 100 000 in middle income countries and 0.04 – 0.6 per 100 000 in lower income countries. The ratio of psychiatric nurses to the general population is 32.95 per 100 000 for high income countries, 5.35 per 100 000 for middle income countries and 0.16 – 1.05 for lower income countries. The ratio of social workers to the general population is 15.7 per 100 000 in high income countries, 1.5 per 100,000 for middle income countries and 0.04 – 0.28 per 100 000 for lower income countries.

These data show that globally, resources available for mental health through both hospital and secondary

care services are inadequate. We need an easily available, cost-effective work force that is trained in dealing with both mental health and physical health conditions. That workforce is more readily available through primary care. Starfield et al (2003) noted the high percentage of co-morbidity in the community and suggested that single-disease management is not capable of dealing with it. Primary care physicians provide general care to a large proportion of the population and are therefore better prepared to cope with co-morbidity.

Good primary care provides continuity of care because the patients and the team know each other. This results in a reduction of total health care costs. Evidence shows that patients are satisfied with primary care services and that primary care outcomes at a public health level are better than single specialization health outcomes because primary care is better equipped to deal with patients in a holistic way.

Many studies have noted excess mortality among patients with mental illness. Up to 50% of people with serious mental illness have recognizable co-morbid physical health conditions. Approximately 35% may have undiagnosed medical disorders and about 20% have medical problems that may explain or cause exacerbation of their psychiatric conditions (Lawrence et al 2000, WHO/Wonca 2008). The conditions associated with long term mental illness include asthma, chronic obstructive airways disease (COPD), diabetes, coronary heart disease (CHD), arthritis, some specific tumors and cancers, skin conditions including psoriasis and some smoking related diseases. The cost of care increases by 70% when individuals with mental health problems develop physical health problems.

A recent European review noted that mental health and physical health problems have both a human cost and an associated financial cost, and estimated that approximately 436 billion Euros per year is spent because of poor mental health. This equates to about 2,000 Euros per household. The occurrence of physical health problems in people with mental health problems increases the cost of care by another 70%. This report also noted the positive interaction between mental health and physical health and advocated the need for the European Union to improve its access to mental health services through primary care and improve training in primary care teams.

Many people question primary care's ability to deliver good mental and physical health care management. In 2008 the World Organization of Family Doctors (Wonca) and the World Health Organization produced evidence from around the globe showing that primary care teams from high, middle and low income countries can deliver a holistic mental health service with a good, cost effective outcome and satisfied patients. However, these standards of effectiveness cannot be guaranteed universally.

Good training of the primary care work force can deliver benefits but General Practitioners (GPs) need to be trained in understanding the mind body connection. In 2007 the World Organization of Family Doctors and the World Federation for Mental Health joined the *Breaking through Barriers Campaign* and jointly carried out an online survey in France, Germany, Mexico, Brazil and Australia. This survey was designed to gain an insight into the shared understanding between GPs and their patients about the mind body connection. A total of 252 adults who received at least one prescription for the treatment of depression from their doctors were surveyed. A total of 501 practicing GPs were also surveyed.

Some of the findings showed that:

- 78% of GPs agreed that a mind body connection existed.
- 85% of GPs agreed that understanding the connection between mind and body helped them in their diagnosis.
- 93% of GPs agreed that this understanding helped them in their management.
- 84% of GPs agreed that there was a need for GPs to be educated on the mind and body connection.
- 62% of people who received at least one prescription for the treatment of depression agreed that they had discussed the possible mind body connection with their GP.

Those people who had received at least one prescription for the treatment of depression, and agreed that there was a mind body connection, on average presented 68 weeks earlier to their GP than those people who had received at least one prescription for the treatment of depression and did not believe that there was a mind body connection. This survey underlines the need for the general public and family doctors and their teams to be educated about the existence of the mind body connection.

The traditional approach of dependence on secondary care will not be enough to deal with the volume of co-morbid physical and mental health conditions in the population. We already know that primary care is effective in improving general health outcomes in both physical and mental health. We need to continue the integration of mental and physical health care globally, to better address the mental health gap that exists across all societies of the world. This gap cannot be addressed through primary care alone. There is a need for primary care to collaborate effectively with secondary care, service users and their families, and to enable people to harness the informal health care supports that are available within each community.

Good mental health can only occur if there is access to physical health care. Equally, good physical health requires access to mental health care. For too long there has been a separation of mind and body health care to the detriment of our patients. World Mental Health Day 2010 allows us to re-focus on this important element of health care, so that health for all becomes a reality.

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Mental Health as an Investment: Cost Savings and Improved Quality of Care

Dr. David McDaid

Summary: *Economic arguments can strengthen the case for integrated mental and physical health care. Evidence from high-income countries shows significant cost savings from treating co-morbid disorders. These include lower medical costs, lower absenteeism from work, a reduction in early retirements, lower family obligations for care, and lower welfare costs. More evidence is needed from low and middle income countries on economic costs and benefits.*

The importance of the links between long term physical and mental health problems have been highlighted, but what do we know about the consequences of such co-morbidities? Do they exacerbate health and non-health system costs in different country contexts? What impact do they have on participation in employment or education? Do they hinder progress in reaching different Millennium Development Goals? To what extent might the provision of better integrated and coordinated services help to avoid and/or alleviate some of these costs? How might barriers to the provision of effective interventions be overcome?

Providing ever more comprehensive answers to these questions can help policy makers and planners in making decisions on how best to use their resources, both within and external to the health care system. At a time when many countries are experiencing an economic downturn, information demonstrating that investment in tackling co-morbidity represents good value for money is of particular importance.

Multiple Impacts

We now have an abundance of evidence on the profound personal, social and economic consequences of poor mental health. In the European Union, for example, the annual total costs of living with an enduring mental health problem, let alone having an additional physical health condition, have been estimated to be in excess of Euro 2,000 for every European household [1]. Only about a third of these costs fall on the health system; major costs include work absenteeism, premature retirement and withdrawal from the labor force, while family members, including children, may lose the opportunity to work or study because of care obligations.

> *The economic impact of living with co-existing mental and physical conditions can be significant for the person with the conditions as well as his/her family.*

Other key personal impacts include the risk that individuals may be ostracized by their families and become homeless or come into contact with criminal justice systems. Many effects can be long lasting: poor child mental health can have profound long-term consequences limiting opportunities in adulthood. All of these human, social and economic impacts may be even starker in low and middle income countries where social protection safety nets are minimal at best, and very high levels of stigma persist.

A growing body of evidence indicates that these costs are exacerbated by co-morbid physical health problems. Co-morbid depression and physical illness have been estimated to increase individual costs of health care alone by as much as 50% in high income countries [2]. Costs can be higher for some conditions – for instance diabetics with depression can have health care costs alone that are 4.5 times greater than those with uncomplicated diabetes [3]. The additional costs of co-morbid cardiovascular disease and poor mental health may be 15% to 40% higher [4]. Poor mental health and musculoskeletal disorders are the principal contributors to absenteeism from the labor force; co-morbidity increases these costs [5]. Maternal depression has been associated with an increased risk of child physical health problems and incomplete immunizations [6]. In low and middle income countries, poor mental health may also reduce the effectiveness of measures to contain the spread of communicable disease such as HIV/AIDS [7] and tuberculosis [8].

Many factors may contribute to these additional costs. Poor mental health may reduce the likelihood that individuals will follow any advice/treatment regimen for the management of any physical health problem. Individuals with mental health problems may also be reluctant to come into contact with primary or other health care services for fear of being labeled. Both primary health and specialist care professionals treating chronic physical health problems may fail to detect mental health problems and vice versa. Within health care systems, there may also be organization barriers between mental health and general health care services that impede the development of a more holistic, integrated approach to care [8].

Using economics to strengthen the case for action

Encouraging investment in effective actions to tackle both mental health problems and associated co-morbidities remains a key challenge. It is essential to provide information not only on the effectiveness of potential options for action, but also on the costs of implementation, as well as potential costs that would then be averted through better health. A range of interventions have already been shown to be cost-effective

in helping to prevent and/or treat mental health problems, even in low and middle income countries where resources are very limited [9]. Highlighting the cost of potential physical health problems that can be averted will make the case for investment in such interventions even stronger in all settings.

Increased investment in the health care system can also have positive economic payoffs in other sectors, for instance through improved employment participation, which raises both national productivity and income tax related revenues. It is therefore important to engage with policy makers, employers and others beyond the health system.

It is also critical to look at what we know about the cost effectiveness of actions to tackle and/or prevent co-morbidity mental health problems in those who already have a chronic physical illness. Strengthening the evidence base in low and middle income countries, in particular, may also help provide a powerful argument to international donors and aid organizations that tackling mental health can be an effective additional tool to help achieve goals for reducing the impact of communicable diseases. In high income countries, cost effective measures can be identified. Some focus around better recognition and management of depression in those with chronic physical illness, as in the case of collaborative and stepped care for co-morbid diabetes and depression in the US [10]. A challenge is to assess whether such approaches are cost effective in other settings.

Regular monitoring of the physical health status of people with mental health problems, coupled with health promotion measures, may also merit greater investment. Key to the value for money of such an approach is a better understanding of factors that affect the uptake of interventions. Research could, for instance, look at the role that different financial and non-financial incentives can play, e.g. in encouraging regular physical health monitoring in primary care settings, as well as in helping encourage individuals to sustain healthy behavior changes.

In summary, the economic case for action is promising; the challenge now is to further strengthen the evidence base on what works and at what cost in different settings, so as to provide additional powerful arguments for tackling mental and physical co-morbidity.

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SECTION THREE

STRATEGIES FOR CONSUMER AND FAMILY CAREGIVERS

Part 1: Building Resilience

With any life changes or difficult events, people go through a period of adjustment, learning about their illness and how to adapt to a new way of living. Some people bounce back quickly and move right into treatment and back into life, while others have a more difficult journey. Building resilience can be an important factor in one's quality of life and isn't something that is always automatic; some people will have to learn how to become more resilient. The American Psychological Association states, "*Resilience is not a trait that people either have or don't have. It involves behaviors, thoughts, and actions that can be learned and developed….*"

In his document, Gaining Psychological Control of Your Chronic Illness, Dr Vijai P. Sharma, PhD, gives some important advice: "*If a disease becomes for you a life-long companion, the more determined you feel to manage it, the more you can improve on the quality of life you live. Whether you have arthritis, diabetes, heart disease, cancer, emphysema, or any other chronic illness, you can make a difference in what happens to you. You can learn to play a more active role, cope better, and exercise greater control over the outcome of your illness and your capability to function in life.*

When you become an expert in your disease, you manage it better. Learn everything you can find about your condition. That will give you ideas as to what actions to take to minimize your disability and complications. Become an active partner in your treatment and rehabilitation and help your doctor to help you.

Ask yourself the following questions, and if possible, write down your answers:

1. *What makes my condition worse or better?*
2. *What should I and my family do when my symptoms flare up?*
3. *What are the warning signs to watch out for professional help/emergency care?*
4. *What can I expect from my medical team and what will I need to do myself?"*

(**http://www.mindpub.com/topic16.htm**)

Resilience is, more often, a combination of internal traits and learned behaviors but also it can be developed from outside factors such as social support systems and good relationships with your medical team. Angela L. Carter, in her article, Resilience: Do you have what it takes to bounce back after illness?, states that social support is when you have friends, family or a network of other people who provide you with a variety of different kinds of support.

Coping with the mental and emotional challenges of a chronic illness requires an approach that is realistic, but also positive. Adapting to your condition or feeling good about the future may seem impossible at first, but it can be done. A recent study of kidney patients undergoing multiple dialysis treatments each week found that their perceived mood and life satisfaction was no different from a control group of healthy people.

A qualified psychologist can help you build the emotional resilience necessary to navigate the difficulties of chronic illness. Working with your physician and other specialists, the psychologist can help develop appropriate coping strategies that will not only reinforce your treatment program, but also help you find fulfillment in life regardless of any physical limitations.

Here are some other suggestions for coping with chronic illness:

- Stay connected. Establish and maintain quality relationships with friends and family. Many health organizations also sponsor support groups composed of other people experiencing similar challenges. These groups will not only aid your own well-being, but also provide rewarding opportunities to help others.
- Take care of yourself. Don't allow worries about your illness to get in the way of eating properly, getting rest and exercise, and having fun.
- Maintain a daily routine of work, errands, household chores, and hobbies as much as possible. This will provide you with a feeling of stability amid the chaos and uncertainty of your illness.

Promoting Resilience in Youth

While the life expectancy for youth with chronic conditions has improved dramatically, less attention has been paid to enhancing the psychosocial development of youth and families. All too often, intervention focuses on the disability alone and adolescent health care issues and normal developmental needs are overlooked. However, health care professionals are in key positions to influence both physical and mental health outcomes, particularly because of their ongoing contact with youth with chronic conditions.

Research on resilient youth and families suggests specific strategies providers can use to promote healthy functioning. The fact that youth with chronic and disabling conditions and their family members face a two-fold risk of mental health problems (Gortmaker, Walker, Weitzman, & Sobol, 1990; Lavigne & Faier-Routman, 1992) underscores the importance of integrating strategies that promote positive mental health into existing health care services for these populations. In addition, health care for adolescents with special health care needs must be delivered with conscious attention to the family context since the family plays such an integral role in the adolescent's development and day-to-day care. Clinicians need to provide care that supports healthy family functioning and avoid strategies that undermine family functioning (e.g., planning rigid treatment protocols and making decisions for, rather than with, families).

The following three recommendations for treatment plans promote resilience in youth with chronic conditions and their families.

1. Include the Adolescent and Family in Treatment Plans

Youth and families obviously play a major role in the day-to-day management of the chronic condition. Therefore, providers need to understand the impact that the chronic condition has on everyday life so realistic treatment plans can be designed. Problems arise when treatment plans do not consider the social context within which the adolescent lives. Treatment plans should minimally disrupt family life and enhance the healthy development of the adolescent. Providers can include families even when they are not physically present during office visits. For example, information about the family can be gathered from the teen. The goal is to gain an understanding of the adolescent within the family context.

2. Build Treatment Plans Based on the Adolescent's Strengths and Abilities

Identifying strengths and capabilities helps providers design interventions that build competencies in adolescents with chronic conditions. In addition, youth need specific information about their particular strengths and limitations so they can make realistic plans for future career, educational and living arrangements. By contrast, services and programs that are solely based on deficits can limit the adolescent's potential, particularly when funding for services is dependent on demonstration of certain degrees of continued impairment.

3. Address the Normal Developmental Needs of Youth and Families

The medical condition typically becomes the focus of attention in encounters with service providers and mental health concerns often are ignored. Since adolescents with chronic conditions are more like their healthy peers than unlike them, health care concerns common to adolescents must be addressed. Youth with chronic conditions deserve comprehensive care that addresses adolescent health and disability-related issues. Furthermore, parents and other family caregivers need to find new ways for managing the chronic condition as the adolescent moves into adulthood. Providers can ease transitions by incorporating developmentally appropriate information and instruction into office visits over time, beginning at an early age. Treatment plans need to be evaluated periodically to ensure that they fit the developmental stage and capabilities of the young person. Developmental issues must be integrated into treatment plans to foster the healthy functioning of youth and families.

Reference:

Garwick, A., & Millar, H. (1995). Promoting Resilience in Youth with Chronic Conditions & Their Families.

Maternal & Child Health Bureau. Health Resources & Services Administration. U.S. Public Health Service.

Resource Material

10 Ways to Build Resilience

American Psychological Association
http://www.apa.org/helpcenter/road-resilience.aspx

Make connections. Good relationships with close family members, friends, or others are important. Accepting help and support from those who care about you and will listen to you strengthens resilience. Some people find that being active in civic groups, faith-based organizations, or other local groups provides social support and can help with reclaiming hope. Assisting others in their time of need also can benefit the helper.

Avoid seeing crises as insurmountable problems. You can't change the fact that highly stressful events happen, but you can change how you interpret and respond to these events. Try looking beyond the present to how future circumstances may be a little better. Note any subtle ways in which you might already feel somewhat better as you deal with difficult situations.

Accept that change is a part of living. Certain goals may no longer be attainable as a result of adverse situations. Accepting circumstances that can't be changed can help you focus on circumstances that you can alter.

Move toward your goals. Develop some realistic goals. Do something regularly -- even if it seems like a small accomplishment -- that enables you to move toward your goals. Instead of focusing on tasks that seem unachievable, ask yourself, "*What's one thing I know I can accomplish today that helps me move in the direction I want to go?*"

Take decisive actions. Act on adverse situations as much as you can. Take decisive actions, rather than detaching completely from problems and stresses and wishing they would just go away.

Look for opportunities for self-discovery. People often learn something about themselves and may find that they have grown in some respect as a result of their struggle with loss. Many people who have experienced tragedies and hardship have reported better relationships, greater sense of strength even while feeling vulnerable, increased sense of self-worth, a more developed spirituality, and heightened appreciation for life.

Nurture a positive view of yourself. Developing confidence in your ability to solve problems and trusting your instincts helps build resilience.

Keep things in perspective. Even when facing very painful events, try to consider the stressful situation in a broader context and keep a long-term perspective. Avoid blowing the event out of proportion.

Maintain a hopeful outlook. An optimistic outlook enables you to expect that good things will happen in your life. Try visualizing what you want, rather than worrying about what you fear.

Take care of yourself. Pay attention to your own needs and feelings. Engage in activities that you enjoy and find relaxing. Exercise regularly. Taking care of yourself helps to keep your mind and body primed to deal with situations that require resilience.

Additional ways of strengthening resilience may be helpful. For example, some people write about their deepest thoughts and feelings related to trauma or other stressful events in their lives. Meditation and spiritual practices help some people build connections and restore hope.

The key is to identify ways that are likely to work well for you as part of your own personal strategy for fostering resilience.

Strategies for Consumers and Family Caregivers

Part 2: Building Support Systems

Some of the first steps to consider after diagnosis of a chronic illness are finding support and learning to manage your illness. While those around you can give you the basic emotional and physical support you need, it is you who should become your biggest advocate and supporter. Taking an active role in your illness and building a support system around you will create a strong plan for your journey ahead. In order to assist patients with this, we need to consider making changes in health care systems and the community to support patients having a more active role in their illness management.

One new program that is receiving a good deal of attention is the building of *Self-Management Support Systems*. The Institute for Patient and Family Centered Care (**http://www.ipfcc.org/advance/topics/pc-selfmgmt.html**) describes self-management support as "*the education and resources that are offered to individuals with chronic conditions to support them in building their confidence and competence to manage their conditions. Health care providers work collaboratively with patients and their families to make decisions about their care. For people with chronic conditions, this means making lifestyle changes as well as following through with treatment and medication regimens. For providers, it means partnering with the patient and family to create a plan of care.*

Collaborative self-management support shifts care delivery from the traditional provider- or system-centered model to a patient- and family-centered approach. Patients, their families, and providers build a mutually respectful relationship where all respect each others' expertise, share information candidly, and build a shared understanding of the patients' and family members' goals, priorities, values, and needs as well as evidence-based clinical options. Together they create a plan that guides care in the clinical setting and at home."

Another important area to consider is the need to build a circle of resources, social supports, willing family caregivers, support groups, and other key people around you. Studies show that without a strong support system, many will not manage their illness effectively, thereby leading to poorer outcomes and increased hospitalizations costing the individual and the system more money. One cost effective means of support is developing peer support groups. These groups empower patients; give them contact with others with the same illness, and a place to feel comfortable talking about any part of their journey. This is also very helpful for family members as well.

In 2006, the California Healthcare Foundation published a document describing 7 models for success to build peer support programs for people with chronic illness – you can find the complete document at: **http://www.familydocs.org/files/Building%20Peer%20Support%20Programs%20CHCF.pdf**.

It's important for each individual to find a path, and the people they wish to help them, that fit their needs, illness and personality. Some use just family, while others rely on support systems that include peer groups, individual therapy, friends, social groups, blogs and websites. It is important to seek out what will help support you personally while you learn to live with your illness.

RESOURCE MATERIAL

BUILDING SOCIAL SUPPORT

US Center for Mental Health Services

Explore your community resources. Is there a support group for your problem? Most local newspapers, radio and TV stations issue a calendar of events for community resources. Do you know what your local hospitals, social service agencies, or health department offer that may be beneficial to you? Perhaps the local library has books on your medical condition; request the librarian to help you find the information.

The U.S. Center for Mental Health Services has created an "Illness Management and Recovery Workbook" which includes a handout on "Building Social Support" which is excerpted below. The handout focuses on ways to increase social support in one's life. Please visit the website listed for the entire handout and workbook.

"Social support" refers to having relationships that are rewarding, enriching and helpful. Relationships can be considered "supportive" when they are positively focused and have a minimum of conflict and strife. Differences in opinions are natural in any relationship, and a supportive relationship can involve disagreements from time to time. Disagreements in a supportive relationship, however, can usually be resolved in a peaceful and effective manner.

Social support can come from relationships with a variety of different people, including family members, friends, peers, spouses, boyfriends/girlfriends, co-workers, members of religious or other spiritual groups, classmates, mental health practitioners, and members of peer support groups. Social support systems vary widely from culture to culture.

People have their own individual opinions about what makes a relationship supportive. They also have their own perspectives about what they want from their relationships and whether they are satisfied with the number and quality of their relationships. The following questions may help you evaluate what social support means to you.

- Who are the people your life that support you?
- What kinds of things do people do that you find supportive?
- Which aspects of your relationships are you satisfied with?
- Which aspects of your relationships would you like to change?
- In what ways are you supportive of other people?
- Are you satisfied with the way that you are supportive of other people?
- Would you like to have more social support in your life?

Increasing social support

People are often interested in increasing their social support and improving their relationships with others. Two general strategies can be used:

- You can increase the number of people with whom you have contact.
- You can improve the quality of your relationships with people with whom you have regular contact.

For many people a combination of both strategies is most helpful.

Good places to meet people

You can meet people in all kinds of places. It is helpful to always be on the alert for the possibility of meeting someone, no matter where you are. While it is possible to meet people in many different places, there are some places to go where meeting people may be easier. These tend to be public places where people naturally gather for recreation, to pursue an interest or to take care of business. Some examples include:

- Community organizations such as libraries or civic associations
- School or class
- Support groups
- Workplace
- Places where people gather for religious or spiritual activities (churches, synagogues, temples, mosques, etc)
- Peer drop-in centers
- Health or exercise clubs such as the YMCA or YWCA
- Parks
- Museums
- Concerts
- Special interest groups such as those related to politics, hobbies, sports, conservation or recreation
- Bookstores, coffee shops
- Volunteer programs

Tips for starting conversations

In order to get to know someone or to get to know someone better, it is helpful to be able to start conversations. Starting and maintaining enjoyable conversations involves a combination of skills. These skills include choosing someone who might be receptive to a conversation, having something interesting to say, and showing interest in the other person.

Some specific tips for conversation are provided below:

- **Find someone who isn't occupied.**
  Choose someone who isn't obviously occupied. If the person is in the middle of doing something, they may not want to stop what they are doing in order to talk to you.
- **Choose an interesting topic.**
  The topic you choose could be related to something that you are doing when you are starting the conversation. For example, if you are in an art gallery, you could start a conversation about the paintings you are looking at. You could also choose another topic, such as the weather, recent events, or sports. If you don't know the person, you can start by introducing yourself. But as you do so, you should also be thinking of a topic to follow the introduction.
- **Look at the person.**
  Eye contact is important when you are talking to people because it shows them that you are interested

in what they have to say. If you feel uncomfortable looking into someone's eyes, you can look somewhere close to their eyes, such as their forehead or nose.

- **Smile and nod your head to show you are listening.**
  It can be helpful to let the person know that you are listening and are interested in what he or she has to say. Showing an interest in the other person indicates that you don't want to dominate the conversation by doing all the talking and that you are receptive to their ideas and point-of-view.
- **Tune in to what the other person is saying.**
  Asking questions about what the other person says and responding to their comments lets them know that you are interested in their perspective. If the person seems uninterested, consider changing topics or politely ending the conversation.
- **Avoid telling very personal things about yourself.**
  When you are just getting to know someone, avoid telling the person very private information about yourself. Such information too early in a conversation sometimes makes the person feel uncomfortable and can make it harder to make a connection with him or her. When you get to know the person better, he or she will feel more comfortable with conversations about more personal topics.

Strategies for getting closer to people

Getting closer to people, including developing friendships and intimate relationships, is an important goal for many people. The most rewarding close relationships are ones in which each person cares about the other person's perspective and well being. In order to be close to other people, it is important to be able to share more personal things about yourself and to be open to them sharing more personal things about themselves with you. It is also important to be willing to do things to help the other person.

Summary of the main points about building social support

- Social support means having relationships that are positive, rewarding and helpful.
- Relationships are an important part of people's lives.
- Supportive relationships can help people reduce stress and reduce relapses.
- Social support can be increased by connecting with more people and improving the quality of existing relationships.
- There are many different places to meet new people.
- To start a conversation: find someone who isn't occupied, choose an interesting topic, and show an interest in what the other person has to say.
- Showing the other person that you care about him or her is part of being in a close relationship.
- To develop closer relationships, it helps to express positive feelings, ask people questions about themselves, and gradually tell them more about yourself.
- To develop closer relationships with people, it helps to try to understand their point of view, to do things together, to compromise, and to be there for them when they need you.
- Close relationships involve gradually increasing the levels of disclosure between people.
- It is important to develop a support system that works for you as an individual

Reference:
Center for Mental Health Services.
http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/workbook/handout4.asp

Strategies for Consumers and Family Caregivers

Part 3: Self Management

With most chronic conditions, day-to-day management of the illness will fall most heavily on patients and their families. The vast number of people currently suffering with a chronic illness and the shortage of physicians available to all of these people makes the idea of learning self management tools a possible life saving option for many patients. Self-management is a phrase used more frequently now to describe the decisions and actions taken by the patient or family members to cope with or improve the patient's overall wellbeing. It can include managing more personal facets of their condition, such as pain, fatigue and medication, and incorporating healthy lifestyle changes with diet, exercise and stress reduction.

Self-management support goes beyond traditional patient education, though, by including practices that develop stronger problem-solving skills, improved self-worth, and increasing the patient's ability to handle real-life situations that can ease stress and strain for all people involved. This new approach can also include system changes within the primary care environment. General Practitioners can support patient self-management by forming better patient-physician communication to identify problems from the patient's perspective and providing this information on an individualized basis or through available community resources. Patient education is usually handled by a health care professional; self-management can be taught and supported by health care professionals, office support staff, peer leaders, and other social support systems.

As a patient, the benefit of increasing your knowledge about your illness has been shown to give people a better sense of control, ownership or power over the illness, and their coping skills and emotional stability increase for the better. Knowledge leads to personal empowerment.

Four of the most important lessons patients with chronic diseases need to understand are:

1. Their illness is serious. There are still patients out there who believe they have the "not-so-serious kind of diabetes." If they don't believe it is a problem, they will never make changes to improve their health.

2. Their condition is essentially self-managed. Every decision patients make throughout the day, from what they eat to whether they walk or ride the bus, has an influence on their health. Communicate to patients that *they* are the most important individuals in managing their illnesses.

3. They have options. There is rarely one perfect way to treat a condition. In the case of diabetes, for example, patients can be treated through diet and exercise, oral medication, insulin and so on. Patients need to understand the different treatment options available and should be encouraged to look at the personal costs and benefits of each. Only the patient can decide if the benefits are greater than the costs.

4. They *can* change their behavior. Rarely do patients leave the doctor's office and immediately enact whatever change was recommended. The reality is that it often has to be spread out into a series of steps. Teach patients that significant behavioral changes can be made by setting goals, taking that first step and figuring out what you learn about yourself along the way.

American Academy of Family Physicians **http://www.aafp.org/fpm/20000300/47help.html**

RESOURCE MATERIAL

THE TEN ESSENTIALS FOR MANAGING CHRONIC ILLNESS

Cynthia Perkins, M.Ed

Managing one's illness means to take responsibility for the actions that are necessary to cope and live life as optimally as possible within the realistic limits one is facing. It empowers the individual to improve the quality of life, reduces helplessness and hopelessness and promotes self-confidence and self-esteem.

There are many steps one can take to manage the illness, and these steps may vary greatly from week to week or from individual to individual. But, there are several essentials that are fundamental to any health care path regardless of the diagnosis.

These essentials are:

1. Proper Nutrition

You are what you eat. What you eat has a profound impact on your mental and physical health. Eating a healthy diet is essential for optimal functioning and healing. Depending on your particular illness, this may include incorporating new foods into your diet or eliminating some favorites.

At the very least, you should be eliminating things such as sugar, caffeine, refined foods and unhealthy fats and replacing these with whole foods such as vegetables, whole grains, nuts and seeds, fruits and fresh or frozen meat and poultry. Preferably your diet should be free of chemicals and toxins found in the average diet such as pesticides, herbicides, additives, dyes and preservatives.

Healing can't take place in a body fed with unhealthy foods and neither can maximum functioning.

2. Exercise

Incorporating exercise into your life is crucial for the mind, body and soul. The body's natural release of endorphins, which occurs with exercise, provides wonderful improvements in mood and is also a fantastic pain reliever.

In addition to reducing heart disease, building healthy bones and muscles and managing weight, exercise is an excellent outlet for relieving depression, anger, stress and anxiety and also boosts self-esteem and self-confidence.

Regular exercise improves energy levels, helps you sleep better and more deeply, promotes healthy bowels and boosts the immune system.

3. Spiritual Nourishing

Feeding yourself with spiritual food is just as important as feeding your stomach. Find ways to nourish and replenish yourself spiritually. Participate in activities that make you feel whole, alive and at one with the Universe. Neglect of your spirituality results in a loss of joy and life fulfillment.

Yoga, meditation, prayer, communing with nature, music, art, writing, walking or deep meaningful relationships are some great sources of spiritual food.

4. Take an Active Role in Your Health Care

You should play a central role in your health care treatment. Instead of passive compliance with doctor's orders, this requires a partnership with your health care provider.

You're with your body 24 hours a day, so no one knows how your illness or treatment approaches impact you and your life better than you do.

Be an active participant in treatment approaches. Pursue all possible avenues and present your physician with options.

5. Communication

Honest, direct communication with health care providers, friends, family, etc., is vital to your mental and physical health as well as the quality of your relationships. You'll get the best possible care if your physician is clear about your symptoms and how the illness and treatment impacts you.

Everyone gets their needs met more effectively when there is understanding of one another and this can only occur with communication. Communication prevents misunderstandings and promotes intimacy.

6. Educate Yourself

Learn everything you possibly can about your illness and your options. Consult with physicians, nutritionists, alternative health providers, other individuals with your condition, etc.

Go to the library or bookstore and read everything you can get your hands on; do research on the Internet. Saturate your mind with knowledge about all aspects of your condition so that you can make informed choices.

Self-knowledge restores a sense of personal power.

7. Pace Yourself

Set priorities with your time and your energy. Break down your tasks and activities into hard and easy categories and list them according to priority.

Do the things that are urgent or most important first and then the others when you are capable. Break long-term goals down into several short-term goals. Permit yourself to achieve a goal in small steps instead of all at once.

Always allow yourself to rest when needed and give yourself permission to leave the list unfinished.

Be flexible and accept your limits. Allow yourself time to recuperate when you have participated in a draining activity.

8. Humor and Inspiration

Humor and inspiration are good for the spirit and the immune system and necessary to help us keep things in perspective and out of negativity. They improve mood and make life a little lighter and more manageable. Feed yourself with humor and inspiration daily.

Keep quotes, nature pictures or jokes in your daily space for frequent viewing; if you have Internet access, you can receive quotes of the day or jokes of the day delivered to your email box. You can also watch funny films, read cartoons or read inspirational magazines or books.

9. Nurture Primary Relationships

Everyone needs love and support and it is especially important for those with chronic illness. It assists in the acceptance and adjustment process and helps you cope; relationships are what make life worth living. There is nothing more fulfilling than loving and being loved.

Chronic illness will undoubtedly be a strain and stress on relationships and has the potential to erode or destroy them if left unchecked. It will be necessary to make a conscious effort to nourish them. Make those most important to you a priority and reserve quality time for them. Encourage open communication of feelings.

Deal directly and honestly with the impact the illness has on your relationships. People have a tendency to try and spare one another's feelings by avoiding these types of discussions; although you may avoid the discomfort of the moment, in the long run, this is destructive to the relationship. Seek friends who are supportive and understanding.

10. Reduce Stress

Life is stressful and there is no way to eliminate it, but keeping stress to a minimum and finding ways to deal effectively with your stress on a daily basis is essential to preventing it from overburdening your already limited physical and emotional capacities.

If possible, delegate responsibilities and chores to others in your life. Shorten duration of visits and activities when necessary. Participate in soothing, relaxing activities like massage, meditation, prayer and exercise.

Don't allow yourself to get caught up in the vicious rat race of life by trying to live up to the expectations of others. Most of society lives a very unhealthy pace of life.

Keep life simple; enjoy the simple things of life.

Cynthia Perkins, M.Ed. is a holistic health counselor helping individuals living with chronic illness or chronic pain to live life more fully. She is also author of "Living Life to the Fullest: Creative Coping Strategies for Managing Chronic Illness," land earn more by visiting her at: ***http://www.holistichelp.net/***.

Strategies for Consumers and Family Caregivers

Part 4: Caregivers and Support Persons

If someone you love is diagnosed with cancer, diabetes or a life-threatening disease, you may feel desperate and completely helpless. But it doesn't have to be that way.

Research has shown us that family and friends can play a huge role in helping patients deal with a chronic illness. When a person is suffering from a chronic illness, it's important that they feel truly cared about. What matters most is how people interact with the sick person.

Here are some ways that patients and their families can get the kind of support they want and need from others:

- Put an end to family secrets. In other words, honesty is still the best policy. We often try to protect our families and loved ones from bad news, but hiding a person's serious illness from the rest of the family can backfire. Communicate directly and be open with family members.
- Include your children. Although their understanding of the situation may be limited, children still appreciate being told what's going on around them. Children can sometimes view themselves as the cause of problems or major events that happen around them. They may view a parent's illness as being caused by something they did. Be open, honest, and let children know its okay to ask questions. This will help relieve some of their anxiety. Remember, a child can be a great source of laughter and warmth for a sick individual.
- Be selective. Everybody under the sun doesn't need to know about your illness or your loved one's illness. Choose who you care to share your news with carefully. Some relationships will prosper and some will become strained. What's important is that you feel that sharing the information with an individual will provide a stronger sense of support and strength.
- Be clear about how family and friends can help. People want to feel useful. Don't be ashamed to ask for help or favors, such as cooking a meal or helping with the school carpool.

At the same time, though, in many situations the caregiver or support persons are more than just an emotional support or a ride to the doctors; they are often responsible for the day-to-day physical, emotional and monetary aspects of a family member who is unable to take care of themselves due to an illness. As would be expected, most of the attention is usually given to the person diagnosed with the chronic illness and very often the family members and/or support persons are left to cope with the new responsibilities and changes on their own.

There are several ways that chronic illness can influence family life:

- Daily routines may change because the limitations of the ill member and the demands of treatment may require that others be more available.
- Families may need to share care giving responsibilities; this helps all members feel they are contributing to a loved one's welfare and it also protects any single member from caregiver fatigue.
- Family members may experience strong emotions, such as guilt, anger, sadness, fear, anxiety and depressed mood. These are normal reactions to stress. It is useful to talk about these emotions within the family.

- The ill member may need to find ways to be as independent as possible, given the limitations that the illness causes.
- Despite the demands of the illness, families may need to work hard to maintain a sense of "normal" life. This can benefit the ill member, as well; it may help him or her integrate into family life more and may reduce the ill member's sense of guilt regarding the demands the illness places on the family as a whole.

(American Association of Marriage & Family Therapy - http://www.therapistlocator.net/families/Consumer_Updates/ChronicIllness.asp)

It's clear that caregivers are sometimes dealing with the same amount of emotional turmoil as the person diagnosed with the chronic illness. It is, therefore, very important that caregivers or support persons help develop a larger support system that will give the caregiver space to take care of themselves, enabling them to be physically and emotionally available for as long as needed. The demands of caregiving can be overwhelming and can often lead to "burn-out" when the caregiver can no longer function. The role can be very stressful and it is important for caregivers to get the help that they need in order to continue being a good support for the person dealing with the illness.

WFMH Board President and family carer, Tony Fowke, agrees with this and adds, "Stress is recognized worldwide as something that can lead to the development of a mental illness and a person caring or supporting in some way for a person with a chronic physical illness is often placed in a stressful situation. If this continues then it ideally needs to be dealt with before a mental illness develops, to enable the caregiver to continue in the role. One way to ensure this happens is by the provision of appropriate respite or "time out." It can often be achieved by sharing the role with someone else who is closely connected to the ill person; but if this is not possible, then short term care of the ill person in a purpose provided facility may be an alternative possibility. Unfortunately, caregivers can find themselves in a situation where respite in any form is not a possibility and then they should seek help in ways to manage the stress."

RESOURCE MATERIAL

FAMILY CAREGIVERS
WHAT YOU SHOULD KNOW ABOUT BURNOUT

Providing care for a family member in need is a centuries-old act of kindness, love, and loyalty. And as life expectancies increase and medical treatments advance, more and more of us will participate in the caregiving process, either as the caregiver, the recipient of care, or possibly both.

Unfortunately, care giving can take a heavy toll if you don't get adequate support. Caregiving involves many stressors: changes in the family dynamic, household disruption, financial pressure, and the sheer amount of work involved. The rewards of care giving – if they come at all – are intangible and far off, and often there is no hope for a happy outcome.

Common warning signs of caregiver burnout:

- You have much less energy than you used to
- It seems like you catch every cold or flu that's going around
- You're constantly exhausted, even after sleeping or taking a break
- You neglect your own needs, either because you're too busy or you don't care anymore
- Your life revolves around caregiving, but it gives you little satisfaction
- You have trouble relaxing, even when help is available
- You're increasingly impatient and irritable with the person you're caring for
- You feel overwhelmed, helpless, and hopeless

When you are a caregiver, finding time to nurture yourself might seem impossible, but you owe it to yourself to find the time. Without it, you may not have the mental or physical strength to deal with all of the stress you experience as a caregiver. Give yourself permission to rest and to do things that you enjoy on a daily basis. You will be a better caregiver for it.

Tips for taking care of yourself:

- Incorporate activities that give you pleasure even when you don't really feel like it. Listen to music, work in the garden, engage in a hobby…whatever it is that you enjoy.
- Pamper yourself. Take a warm bath and light candles. Find some time for a manicure or a massage.
- Eat balanced meals to nurture your body. Find time to exercise even if it's a short walk every day. Do the best you can to sleep at least 7 hours a night.
- Laughter really is the best medicine. Buy a light-hearted book or rent a comedy. Whenever you can, try to find some humor in everyday situations.
- Keep a journal. Write down your thoughts and feelings. This helps provide perspective on your situation and serves as an important release for your emotions.
- Arrange a telephone contact with a family member, a friend, or a volunteer from a church or senior center so that someone calls each day to be sure everything is all right. This person can help by contacting other family members with status updates or to let them know if you need anything.

Try to set a time for afternoons or evenings out. Seek out friends and family to help you so that you can have some time away from the home. If it is difficult to leave, invite friends and family over to visit with you. Share some tea or coffee. It is important that you interact with others.

To view the full fact sheet please go to http://www.helpguide.org/elder/caring_for_caregivers.htm

RESOURCE MATERIAL

CHRONIC PHYSICAL ILLNESS - THE EFFECTS ON MENTAL HEALTH: INFORMATION FOR PARENTS, CARERS AND ANYONE WHO WORKS WITH YOUNG PEOPLE

Royal College of Psychiatrists, UK

Introduction

Children with a long-lasting physical illness are twice as likely to suffer from emotional problems or disturbed behavior. This is especially true of physical illnesses that involve the brain, such as epilepsy and cerebral palsy.

Why are mental health problems so common?
Serious illness or disability can cause a lot of work and stress for everyone in the family, especially the parents. Children who are ill have many more stressful experiences than children without an illness. Most children will, at some time, get upset by this. Sometimes, the upset feelings and behavior can go on and on. If they do, this can add to the child's health problems by making their life even more difficult.

How does this affect the child and family?
Following the diagnosis of a potentially serious or long-term illness, most parents and children go through a process of coming to terms with it.

Long-term effects

The affected child might have fewer opportunities to learn everyday skills, and to develop their interests and hobbies. Educational problems are also common:

- Your child might have to miss a lot of school and have particular difficulties with learning.
- Be sure to be in touch with your child's teacher on a regular basis. Your child might need extra help at school.
- Your child might see themselves as different from other children, and they hate this.
- Some children may become depressed
- Some children may be vulnerable to bullying.

It is easy for you as parents to be overprotective of your child. You may find it harder to say 'no' than you normally would, making it difficult to control your child. It is harder to allow them to manage the 'rough and tumble' of childhood. Sometimes it can be difficult and confusing to cope with all the different doctors, and other professionals involved with your child's illness. This can be very stressful for everyone.

Brothers and sisters sometimes feel that they are being neglected. They may feel embarrassed by their brother or sister. They may feel responsible for them. They can miss out on school or their social life, get bullied or lose friendships.

How to help

It's very important to remember that although long-lasting illness does make things very difficult, most children and their families cope well. It is only a minority who experience problems.

- Live as normal a life as possible.
- Be open with your child about their difficulties.
- Restrict them as little as possible.

- Meet other families with similar experiences.
- Seek help if you feel that you're not managing.

A lot can be done to prevent further problems developing. Parents who appreciate the emotional impact of the illness on the child, and on the rest of the family, are much better placed to spot problems early and do something about them.

Where can I get help?

Making sure that there is enough help and support is very important. In addition to support from family and friends, try:

- Contact a Family Website (www.cafamily.org.uk)
- your general practitioner
- voluntary support groups
- social services
- school
- health visitor
- school nurse

If there are signs that your child is developing emotional or behavioral problems, your general practitioner can refer you to the local child and adolescent mental health service for specialist advice. They may suggest that some family work could be helpful. Also, it often helps to link up with the other professionals involved in the ill child's care. This can help sort out any problems related to the treatment, and make sure that everyone is working together effectively.

About this leaflet

This is one in a series of leaflets for parents, teachers and young people entitled *Mental Health and Growing Up*. The aims of these leaflets are to provide practical, up-to-date information about mental health problems (emotional, behavioral and psychiatric disorders) that can affect children and young people. This leaflet looks at the effects that a long physical illness can have on a young person's mental health and offers advice about how to recognize and deal with these problems.

References

- Carr, A. (ed.) (2000) *'What Works with Children and Adolescents?' - A Critical Review of Psychological Interventions with Children, Adolescents and their Families.* London: Brunner-Routledge.
- Rutter, M. & Taylor, E. (eds) (2002) *'Child and Adolescent Psychiatry'* (4th edn). London: Blackwell.
- Scott, A., Shaw, M. & Joughin, C. (eds) (2001) *'Finding the Evidence' - A Gateway to the Literature in Child and Adolescent Mental Health* (2nd edn). London: Gaskell.

@ [2004] Royal College of Psychiatrists **http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthandgrowingup/27chronicphysicalillness.aspx**

SECTION FOUR

INTEGRATED CARE: IT TAKES A VILLAGE

Recent advances in biological sciences and clinical research are uncovering how the body and mind interact directly in health and disease. It's clear that there isn't only a co-existence or co-morbidity of medical and physical conditions; there is also a primary inter-connectedness of the body and mind in the development of disease states. But for clinicians, health care systems, and patients, this new knowledge and understanding also brings new challenges. We need to implement this knowledge into the daily lives of patients and the clinical care they receive. As we know more, there is more to do. The task at hand is to inform caregivers, patients, and the public of the crucial, far reaching interrelationships between physical and mental illness.

One direct approach is to offer World Mental Health Day programs addressing this year's theme. Educational and informational programs are an opportunity to reach out to those affected by mental illness and those providing clinical and supportive care. Just as we need to integrate conceptual views of illness and impairment, these programs will, in like fashion, help to bring together concerned individuals, disciplines, and systems of care.

> **"It is critical to recognize that 99% of disease management is in the hands of individuals and their families; managing at home, at work, at school. Our health systems, however, still behave as if it is the professionals, clinics, and hospitals that are disease managers."**
> Noreen Clark, PhD, Center for Managing Chronic Disease

The Role of Consumers, Families and the Public

Robert M. Levin, MD, MPH

Summary: *It is important to provide public education about physical and mental disorders, and there are many options for developing suitable programs. World Mental Health Day provides an opportunity for outreach in local communities, and also for educating the staff of health care providers.*

The issue of the relationship between medical and psychiatric disorders needs to reach the general public. It is important to raise awareness in the public about, for example, how depression and anxiety influence general quality of life parameters, and about more "silent" risk factors, including the relationship between anxiety disorders and hypertension. Even for "healthy" people without acute or chronic medical illnesses, there are preventive measures of screening, and education can be provided about the subtle but significant effects of common psychiatric disorders on their physical well being and longevity.

Ideas for Programs and Interventions

In considering specific programs for World Mental Health Day, there are numerous options for raising awareness of the relationship between mental and physical illness and bringing together concerned individuals. Given the far-reaching breadth of the issue, choices for a specific focus and audience would depend on the relevance to one's locale and community.

One opportunity, given our Mental Health Day theme, is educating people with mental illness and their families, and the public in general, about the increased risk of medical illness. This could include a program addressing lifestyle issues, how to use the local medical system and clinicians, and the medical side effects of psychiatric medications.

A program for patients, family members, and mental health advocacy associations could have talks and discussions by both mental health and medical clinicians, and include nurses and nutritionists. Relevant topics include the following: proper diet and nutrition; the medical effects of lithium, antidepressants, anti-psychotics, and mood stabilizers; medical risks of alcohol, tobacco, and sexually transmitted diseases; the importance of regular medical check-ups; how to obtain medical care within the local health system; and basic discussions of medical illnesses common in psychiatric patients, such as diabetes, hypertension, and pulmonary disease, and how to recognize them.

The Internet is another rich venue for disseminating information. Where available, Internet and web-based programs offer access to those who cannot obtain information in their communities or are concerned about the stigma of attending programs on mental disorders. Also, such programs can be useful to older people. For example, web sites for the elderly in China have become popular. Given the growth in the numbers of older people in many countries, large numbers of whom are homebound or with limited community resources, the Internet can be an effective way of reaching them.

The Role of Mental Health Clinicians and Providers

Providers of mental health services could organize a program for their clinical staff about the significance of medical conditions in their patients. Programs for staff without a medical background, such as social workers and case managers, would be especially helpful as they are often the patient's sole contact with clinical services and play a crucial role in coordinating non-psychiatric care for their patients.

These talks could be given by physicians, nurses, nutritionists and pharmacists, with an emphasis on relevant medical conditions, what to look for in patients, and when and how to refer within the local medical community.

Topics could include common medical illnesses associated with psychiatric disorders; physical and neurologic symptoms secondary to psychiatric medications such as sweating, dry mouth, akathisia, tremor, etc; issues about diet, substance abuse, unprotected sex; and risks of medications while pregnant or breastfeeding.

Dr Robert Levin is at Harvard Medical School.

The Role of Primary and Specialty Care Physicians

Professor Michael Kidd and Dr Patrick Coker

Primary and specialty care physicians appreciate the link between the physical health and well being of our patients and their mental health and well being.

We are aware of the consequences of physical ill health on the mental health of many of our patients. Depression, in particular, is a common co-morbidity for many people with chronic health conditions, such as cancer, heart disease, diabetes, HIV and tuberculosis. We are also aware of how mental ill health can impact

on the physical well being of our patients.
This especially affects our patients with intellectual disability and chronic mental health conditions.

A 2008 joint publication of the World Health Organization (WHO) and the World Organization of Family Doctors (Wonca) reinforced the importance of integrating mental health into primary care and demonstrated that this is the most viable way of ensuring that all people receive the mental health care they need. Indeed integration of mental health is important in the work of all physicians, whether they are working in primary care or specialty care.

This call to action needs to create awareness and change the public perception of mental health. It should sensitize the public on the issues of mental health.

The call to action needs to include a commitment to education and training, with emphasis on the importance of addressing the mental health concerns of our patients with chronic health conditions. This includes education and training of our medical students and junior doctors, and also needs to be included as part of the continuing life-long professional development of all medical practitioners.

The call to action needs to highlight the role of clinical leaders and champions among primary and specialty care physicians in each nation who will advocate for the need to manage both the physical and mental health care needs of each of our patients with chronic health concerns.

The call to action must reinforce the need for active national and local government and corporate support, including funding reform, to ensure that the care of mental health concerns is integrated with the care of physical health concerns for people attending to both primary and specialty medical care.

The call to action needs to see funding increase for further research to expand the evidence base of ways in which mental health care can be effectively integrated into the daily management of chronic physical conditions. Research should also address the impact of mental health on physical health and well being.

Michael Kidd is Wonca Executive at Large; Flinders University, Australia. His email address is: **Michael.kidd@flinders.edu.au**.
Patrick Coker is President, West African College of Physicians, Nigeria. His email address is: **patcoker@hotmail.com**.

Reference:

WHO/Wonca. Integrating mental health into primary care: a global perspective. World Health Organization and World Organization of Family Doctors (Wonca). 2008.

The Role of Governments and NGOs

Dr John Bowis, OBE, and Dr David McDaid

Summary: *Governments should adopt policies to address a major health care need of their citizens—mental health care that is integrated with care for physical illnesses. NGOs in different health specialties should join together to press for coordinated care.*

Many powerful arguments about poor mental health can be made to support action by both governments and non-governmental organizations (NGOs). Approximately 450 million people in our world are living with

neurological or mental disorders; 121 million of us live with depression alone – three in every 100 of us every year. There are one million suicides and ten million attempts each year. While one in three of us visiting a primary care provider may have mental health problems, only one in six may be diagnosed as such. Isn't it time that policy makers gave mental illness and mental good health the priority they deserve?

We can also point to the risks of being labeled, patronized, despised, feared, and, to a greater or lesser extent, segregated – in society, within our own families, at work, at play and even within our health and social services. Surely it is time that we gave people with mental health problems the respect, sympathy and care we would not hesitate to give if their problem were physical?

If these arguments were not compelling enough, little progress has been made in tackling the greatly increased risk of avoidable physical health problems in people with mental disorders. For too long these risks have been neglected in policy and practice, even though the impact on life expectancy of co-morbid physical and mental disorders can sometimes be stark, with many years of life unnecessarily lost. Equally more can be done to support the mental health needs of people with chronic conditions such as cancer, diabetes, cardiovascular and respiratory disease. Isn't it time to take action to reduce the risks of co-morbid physical and mental health problems?

Both governments and NGOs need to consider not only how to help the public understand mental disorders, as well as the value of help and support for independent community living, but also how to increase awareness of the risks to physical health in those with mental health problems. The public should also have a better understanding that people with chronic physical health problems are at risk of poor mental health.

What of services? Primary care practitioners are ideally placed to deal with both physical and mental health. But developing approaches to this issue requires more collaboration and trust between service users, health and social care professionals, families and service providers, NGOs, industry and scientists. Isn't it time that unique experience and skills that comes from those living with both mental and physical disorders are recognized as being indispensible contributions to the personal treatment plan and the planning of services?

Is there not a compelling economic case for governments to take action? The state of the world's economies means two irreconcilable truths. More people are going to be at risk of mental health problems – particularly depression. At the same time, the burden of personal or national economic challenges may put additional pressures on health care budgets: mental health budgets may well be vulnerable. Potentially in the EU alone as much as Euro 50 million per annum in economic costs might be avoided, through greater better continued and integrated care for individuals at risk of co-morbid physical and mental health problems.

Governments have begun taking action to counter stigma, to reduce suicide levels, to enhance and support mental health reforms and to promote mental wellbeing. The European Union's launch of its European Pact for Mental Health and Wellbeing is an example of an approach that has given a focus and defined priorities for action across the life span. It is important for all of us to build on these initiatives and commit to actions that can help prevent or alleviate the adverse consequences of co-morbid physical and mental health problems.

At national and regional levels governments might consider the economic and health benefits of preventing such co-morbidities; they might explore ways in which they can work to help increase awareness of this issue in primary care, whether this be the provision of training and guidance on the topic, or perhaps providing incentives within the system to encourage better holistic monitoring of patients' needs. They might also consider what incentives might be used to help encourage liaison between physical and mental health professionals. NGOs representing people with mental health problems or chronic health problems can look

at ways of working more collaboratively to make a case for action, as well as help bring professionals from across the health spectrum together to help agree a common approach to this issue.

We know the challenges we face. The human, social and economic consequences of poor mental health alone are substantial; they are magnified by poor physical health. It is time for policy makers not only to deliver on existing pledges for mental health reform, but also to look at the case for investment to prevent/ alleviate mental disorders in those with chronic health problems. If individuals develop mental health problems they can become some of the most vulnerable people in society. They rely on governments and NGOs to act to protect both their mental and physical health. They have no-one else to trust. Isn't it time we stopped letting them down?

John Bowis is Former ME, MEP, UK Health Minister/Mental Health. His email address is: **johnbowis@aol.com**.

David McDaid is at the London School of Economics & Political Science in the UK. His email address is: **d.mcdaid@lse.ac.uk**.

Conclusion:

Optimal care of patients requires integration of divergent concepts about health and disease, as well as the involvement of people and providers across numerous disciplines. For both the treatment and prevention of illness, we need to overcome the understandable tendency to see medical and psychiatric conditions as separate and unrelated, World Mental Health Day gives us an opportunity to reach out to and bring together patients, medical clinicians, health care systems, and the general public. We can help by providing concrete information to individuals and clinicians about the interplay of mental illness and physical illness, and attempting to coordinate and integrate the existing systems that provide care.

SECTION FIVE

The following section contains:

- **A World of Thanks**
- **Resources**
- **2010 Report Form**

We cannot do this program each year without thanking those involved – it takes a team effort and some very generous groups and people to make this happen. We send out our World of Thanks to everyone who helps create, produce and publicize the 2010 World Mental Health Day Campaign.

We have provided you with many resources and articles to help you find more detailed information on all the topics covered in this year's theme.

Lastly we also provide you with a Report Form so you can let us know about the highlights of your WMHD Event. Please send us reports on your events – no matter how big or small – so we can show everyone how WMHD is covering the world. We would appreciate copies of videos, printed materials, articles and photographs of what you produced and did for World Mental Health Day 2010. **This Report Form is very important to us because it is the basis of the funding we get to develop materials and supports for World Mental Health Day.**

WORLD OF THANKS

2010 has continued our focus on the integration of health and health care with attention focusing on chronic illness or non-communicable diseases and the impact of developing mental or emotional disorders. We hope that in the last few years you have been able to see the great need and overwhelming desire for more understanding of co-existing illnesses, more collaboration between patients and their entire medical team, and more health care systems focusing on patient centered care. As mentioned earlier, we have appropriate interventions to address these problems, reducing the burden on people's lives and the economic and social burden on society.

This is, again, our opportunity to show the benefits of focusing on total body health. We must remember that working together is the only way forward. Each health movement would benefit from reaching out and working with others. Together we can create a stronger message and actually see our advocacy turn into reality. The WFMH will continue to use our World Mental Health Day campaigns to bring much needed global attention to mental illness and how our mental health is critical to our ability to obtain the best quality of life possible. The World Mental Health Day campaign is a great example of what can happen when groups and people work together for a common goal. This year's campaign was made possible by a number of dedicated health professionals from around the world whom we would like to bring to your attention.

We would like to recognize the WFMH staff and special partners for their efforts this year. A special thanks to Patt Franciosi and Deborah Maguire for their continued effort and leadership in keeping the WMHDAY program alive. Our new CEO/Secretary General, Dr Vijay Ganju, has focused much of his first few months on making this material the best it can be for all levels of people and professions. Our appreciation goes out to Ellen Mercer who volunteered her time to assist with the writing and editing of this year's material. Also, Dr Gabriel Ivbijaro, Wonca Working Party on Mental Health, deserves special thanks for his significant involvement in helping lead the campaign this year. The continued support of Wonca and Dr Ivbijaro has given WMHDAY more visibility and the opportunity to reach new audiences.

We would also like to thank our guest writers for their dedication to global mental health and their support of WMHDAY. Professor Michelle Riba, MD; Professor Michael Kidd, Dr Patrick Coker, Dr David McDaid, and Dr. John Bowis, OBE.

And as always we are indebted to the people and organizations that are willing to translate the material. If you are reading this material in any language other than English, you should thank:

Arabic – Eli Lilly and Company, Middle East and North Africa

Chinese - Diversity Health Institute, Australia

French – Diversity Health Institute, Australia

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Russian – AstraZeneca, Russia

And Finally, the WFMH would like to thank our sponsors for giving us the ability to continue producing and distributing these materials:

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TAKEDA PHARMACEUTICALS

2010 WMHDAY RESOURCES

International Council of Nurses
3, Place Jean Marteau
1201 - Geneva
SWITZERLAND
Phone: +41-22-908-01-00
Email: **icn@icn.ch**
Web: **www.icn.ch**

Family Health International Headquarters
2224 E NC Hwy 54
Durham, NC 27713 USA
T 1.919.544.7040
F 1.919.544.7261
Web: **www.fhi.org**

Center for Managing Chronic Disease
University of Michigan
1415 Washington Heights
Ann Arbor, MI 48109-2029 USA
Phone: 734.763.1457
Fax: 734.763.7379
Web: **http://cmcd.sph.umich.edu/**

The Global Alliance for Chronic Diseases
1st Floor, 28 Margaret Street
London W1W 8RZ
UNITED KINGDOM
Tel: +44 (0) 20 7637 4333
Fax: +44 (0) 20 7637 4336
Email: **info@ga-cd.org**
Web: **www.ga-cd.org/**

American Assn of Marriage and Family Therapy
112 South Alfred Street
Alexandria, VA 22314 USA
Phone: (703) 838-9808
Fax: (703) 838-9805
Web: **www.aamft.org**

Royal College of Psychiatrists
17 Belgrave Square
London SW1X 8PG
UNITED KINGDOM
Tel: 020 7235 2351
Fax: 020 7245 1231
Web: **http://rcpsych.ac.uk**

If you would like to find more information on DIABETES:

List of National Diabetes Organizations in 142 countries:
http://www.medicalwatches.com/organizations.html

WorldWIDE
PO Box 3709
New York, NY 10163-3709
USA
Fax: + 1 212-915-9130
Email: **worldwide@worldwidediabetes.org**

National Diabetes Education Program (NDEP)
1 Diabetes Way
Bethesda, MD 20814–9692
Phone: 1–800–438–5383
Fax: 703–738–4929
Email: **ndep@mail.nih.gov**
Web: **www.ndep.nih.gov**

National Diabetes Information Clearinghouse
1 Information Way
Bethesda, MD 20892–3560
Phone: 1–800–860–8747
TTY: 1–866–569–1162
Fax: 703–738–4929
Email: **ndic@info.niddk.nih.gov**
Web: **www.diabetes.niddk.nih.gov**

International Diabetes Federation (IDF)
Chaussée de la Hulpe 166
B-1170 Brussels, Belgium
Tel: +32-2-5385511*
Fax: +32-2-5385114
Email: **info@idf.org**

International Society for Pediatric and Adolescent Diabetes
c/o KIT, Kurfürstendamm 71
10709 Berlin
Germany
Phone: +49 30 24603210
Fax: +49 30 24603200
Email: **secretariat@ispad.org**

"The Psychologist in Diabetes Care"
Clinical Diabetes Vol. 16 No. 2 1998
http://journal.diabetes.org/clinicaldiabetes/v16n21998/PG91.htm

Diabetes, Depression, and Quality of Life: A population study, Diabetes Care May 2004 vol. 27 no. 5 1066-1070
http://care.diabetesjournals.org/content/27/5/1066.full

If you would like to find more information on CANCER:

List of National and International Cancer Organizations:
www.cancerindex.org/clinks7.htm

Association of Oncology Social Workers
100 North 20th St., 4th Floor
Philadelphia, PA 19103
Phone: (215) 599-6093
Fax : (215) 564-2175
Email: **info@aosw.org**
Web: **www.aosw.org**

Cancer Support Association Inc
80 Railway Street, PO Box 325,
Cottesloe, WA, 6911
AUSTRALIA
Phone (08) 9384 3544,
Fax (08) 9384 6196
Email: **csa@cancersupportwa.org.au**
Web: **www.cancersupportwa.org.au**

The International Confederation of Childhood Cancer Parent Organizations
c/o VOKK
Schouwstede 2B.
3431 JB Nieuwegein, NETHERLANDS
Phone: +31-30-242-2944
Fax: +31-30-242-2945
Email: **icccpo-secretariat@vokk.nl**
Web: **www.icccpo.org**

"Cancer Survivors at Higher Risk Of Mental Distress"
Archives of Internal Medicine, July 27, 2009
http://www.reuters.com/article/idUSTRE56Q57S20090727

"Mental Illness Affecting Half of Cancer Patients"
http://www.associatedcontent.com/article/376550/mental_illness_affecting_half_of_cancer.html?singlepage=true&cat=70

"Psychiatric Disorders and Mental Health Service Use among Caregivers of Advanced Cancer Patients"
Journal of Clinical Oncology, Vol 23, No 28 (October 1), 2005: pp. 6899-6907
http://jco.ascopubs.org/cgi/reprint/23/28/6899

If you would like to find more information on CARDIOVASCULAR DISEASES:

List of National and International Cardiac Organizations:
www.cardiologyonline.com/organizations.htm

Cardiology Online, Inc
PO Box 17659,
Beverly Hills, CA 90209, USA
Tel: +1 310 657 8777
Fax: +1 310 659 4781
Email: **klimedco@ucla.edu**
Web: **www.cardiologyonline.com**

Heart Research UK
Suite 12D, Joseph's Well
Leeds, LS3 1AB
UNITED KINGDOM
Phone: 0113 234 7474
Fax : 0113 297 6208
Email : **info@heartresearch.org.uk**
Web: **www.heartresearch.org.uk/index.htm**

Heart and Stroke Foundation of Canada
222 Queen Street, Suite 1402
Ottawa, ON K1P 5V9
Telephone (613)569-4361
Fax (613)569-3278
Web: **www.heartandstroke.com**

"Psychiatry and Cardiovascular Disease"
Focus, Spring 2005; 3: 208 - 224.
http://focus.psychiatryonline.org/cgi/reprint/3/2/208

Heart Disease and Depression: Don't Ignore the Relationship"
Cleveland Clinic Journal of Medicine September 2003 vol. 70 9 745-746
http://www.ccjm.org/content/70/9/745.full.pdf+html

If you would like to find more information on RESPIRATORY DISEASES:

List of International Respiratory Organizations: **http://www.irccouncil.org/newsite/links/index.cfm**

Further resources in US and Canada: **http://www.aarc.org/links/**

Global Alliance against Chronic Respiratory Diseases (GARD)
Dept of Chronic Diseases and Health Promotion
World Health Organization
20, Avenue Appia
CH-1211 Geneva 27
SWITZERLAND
Tel: +41 22 791 3960/2578
Fax: +41 22 791 4769
Email: **gard@who.int/**
Web: **www.who.int/gard/en/**

"New opportunities for respiratory research in Europe: FP7"
ERJ February 1, 2007 vol. 29 no. 2 223-225
http://erj.ersjournals.com/content/29/2/223.full

"Examining the Relationships between COPD and Anxiety and Depression"
Putman-Casdorph H, McCrone S *Heart Lung*. 2009;38:34-47
http://www.medscape.com/viewarticle/589345

"Study Links Asthma and Mental Illness"
By Julie Robotham, Medical Reporter
December 2, 2003
http://www.smh.com.au/articles/2003/12/01/1070127350267.html

If you would like to find more information on CARER/CAREGIVER Resources:

Carers UK
20 Great Dover Street
London SE1 4LX
UNITED KINGDOM
T: 020 7378 4999
F: 020 7378 9781
Email: **info@carersuk.org**
Web: **www.carersuk.org**

Family Caregiver Alliance
180 Montgomery St, Ste 1100,
San Francisco, CA 94104 USA
phone: (415) 434.3388 (800) 445.8106
fax: (415) 434.3508
Web: **www.caregiver.org**

National Family Caregivers Association
10400 Connecticut Avenue, Suite 500
Kensington, MD 20895-3944
Toll Free: 1-800-896-3650
Phone: 301-942-6430
Fax: 301-942-2302
E-mail: **info@thefamilycaregiver.org**
Web: **www.nfcacares.org**

Family Caregiving 101
Web: **www.familycaregiving101.org**

**This list is intended to supplement the resources listed in the preceding text. It is by no means a complete list of good resources on this theme. Do not hesitate to do your own searches and further educate yourself on the subject!

2010 WORLD MENTAL HEALTH DAY REPORT FORM

How Did You Celebrate The Day?

Here is your chance to let us know about your World Mental Health Day events and help us improve future education packets. The strength of this project lies in the effect it has in the field - therefore we urge you to send in a report of your 2010 activities. We hope everyone will join in, not only by doing something to 'spread the word' but also by letting the rest of the world know what you are doing by writing back to us! Every event - no matter how large or small - is important to us. Your pictures, news articles, and promotional materials are welcome. Most of the prominent activities will be posted on the WFMH Website, as time allows. Please be sure to send us your full reports by March 5, 2011.
We look forward to hearing from all of you!

(PLEASE PRINT ALL INFORMATION)

NAME:

ORGANIZATION:

ADDRESS:

PHONE: FAX:

EMAIL:

1. How has this educational packet improved your ability to educate people in your community?

2. What impact has the WMHDAY program had on…

- Reducing stigma in your community?

- Improving treatment or access to means of treatment?

- Bringing more attention to your organization and work in the community?

3. Where and how did you use the material in this packet?

4. How many people did you reach with your event? What kinds of people did you reach?

5. If you were to choose the one outcome that you are most proud of accomplishing through your World Mental Health Day Event, this year, what would it be? (Use additional pages, if needed)

6. How will you follow up on what you did for WMHDay this year?

7. What is your recommendation for the theme of World Mental Health Day 2011? (Please send your suggestions by November 1, 2010)

Please return this form to:
World Federation for Mental Health
12940 Harbor Drive, Suite 101
Woodbridge, VA 22192 USA
wmhday@wfmh.com

SECTION SIX

COMMUNICATION AND PUBLICITY

The following section contains:

- **A WMHDAY Proclamation**
- **A sample Media Release**
- **A sample newspaper op-ed article or letter to the editor**

In order to create more publicity around your WMHDAY events, the World Federation for Mental Health has put together sample press releases, media releases, the official 2010 Proclamation and information on Marching for Mental Health.

The best way to reach a larger audience with powerful advocacy tools is to use your media outlets, create a group presence, and work together with others to show solidarity.

WORLD MENTAL HEALTH DAY 2010 PROCLAMATION

WHEREAS, the major chronic illnesses - such as cardiovascular, diabetes, cancer and chronic respiratory illness - are responsible for 60% of the world's deaths and 80% of those occur in the poorest populations of the world;

WHEREAS, chronic illness can complicate anyone's life and a person's emotional wellbeing and resilience are among the most important factors in helping to find quality of life while coping with the challenges of ongoing illness;

WHEREAS, addressing depression, anxiety, and other mental disorders associated with chronic conditions can contribute to a better quality of life, improve medical outcomes, reduce mortality, and reduce medical costs;

WHEREAS, we envision an integrated health system where all doctors and specialists work together to give the best in patient-centered care;

AND WHEREAS, the World Federation for Mental Health has designated the theme for World Mental Health Day 2010 as *"Mental Health and Chronic Physical Illnesses: The Need for Continued and Integrated Care,"* and urges increased availability of appropriate and equitable treatment through primary healthcare services and facilities for those experiencing mental health problems and chronic illness;

THEREFORE, I, ______________________________, __________(TITLE)_____________ OF THE _______________ (AGENCY, ORGANIZATION, MINISTRY) DO HEREBY PROCLAIM 10 OCTOBER 2010 AS WORLD MENTAL HEALTH DAY IN _______TOWN/CITY/COUNTRY_________ and urge all governmental and non-governmental organizations and agencies to work in concert with elected and appointed public officials to increase public awareness about, and acceptance of, mental illnesses and the people living with these disorders; to promote improved public policies to enhance diagnosis, treatment, and support services for those who need them through the primary healthcare system; and to reduce the persistent stigma and discrimination that too often serve as barriers for people seeking services and other assistance.

I FURTHER URGE ALL CITIZENS to join and support the local, state/provincial, and national non-governmental organizations that are working to make mental health a priority in communities throughout our nation.

Together, we will all make a difference and promote mentally healthy communities and citizens!

Signed ____

Title ____

Ministry/Office/Agency ___________________________________

Date ____

(SEAL)

2010 WMHDAY MEDIA RELEASE

General Media Release for World Mental Health Day 2010

For Immediate Release

(Date)

18th Annual World Mental Health Day on 10 October Focuses Attention on Mental Health and Chronic Illnesses

The World Federation for Mental Health has selected integrated care for those people with coexisting chronic physical and mental illness as the theme for this year's World Mental Health Day. This year the annual event, observed worldwide on 10 October, targets the close association of depression with chronic physical illnesses.

Chronic illness, lasting more than four months, affects multitudes. These medical conditions may require careful lifelong management or periods of intensive treatment. Four of them – cardiovascular disease, diabetes, cancer and respiratory illnesses – are leading causes of disability and account for 60% of deaths around the world.

Other conditions often coexist with chronic illness, complicating care and further diminishing quality of life. One, frequently found, is major depression, a disabling illness that seriously impacts overall health. Research shows that depression carries an increased risk for physical illness, while conversely a number of chronic illnesses carry an increased risk for depression.

Physical and mental illness do not always coincide, but do so often enough that medical professionals should give it special consideration. It affects substantial numbers of those with cardiovascular disease, diabetes, cancer and respiratory illnesses.

Mental illness is treatable. Integrated care can help people with coexisting mental and physical illness to manage both. The World Health Organization recommends incorporating mental health into primary care as a cost-effective and convenient way of providing services and reducing stigma and discrimination. Referrals from primary care to specialized services should be available as needed.

The World Federation for Mental Health was founded in London in 1948. It established World Mental Health Day in 1992 to provide an annual opportunity for public education about current issues and improving wellbeing. It is the only annual global awareness campaign to focus attention on specific aspects of mental health and mental disorders.

The World Federation for Mental Health encourages local, national and regional authorities and organizations to observe World Mental Health Day on 10 October with events and programs that focus on "Mental Health and Chronic Illness: The Need for Continued and Integrated Care." Campaign materials prepared by the World Federation are available for download on its website (www.wfmh.org).

2010 WORLD MENTAL HEALTH DAY
SAMPLE NEWSPAPER OP-ED ARTICLE OR LETTER TO THE EDITOR

Chronic Care Management Should Include Mental Health

The failure to provide mental health care for people with chronic illnesses is a major gap in health services. People with long term physical illnesses require comprehensive health services that address complex medical issues. Mental health disorders are often associated with chronic illness, and should be addressed as part of general care. Patients often have mental health problems that are connected with their illness, or have mental illnesses that increase their vulnerability to chronic physical conditions.

Each year the World Federation for Mental Health selects a topic of current concern for its annual public education campaign which centers on World Mental Health Day (10 October). This year the chosen theme is "Mental Health and Chronic Illness: The Need for Continued and Integrated Care."

There are established links between depression and chronic conditions like heart disease, diabetes, cancer and respiratory illnesses. While it is not inevitable for people to have physical and mental illnesses together, it happens often enough that physicians should routinely consider the possibility. Research shows that people with serious physical illnesses are at higher risk of experiencing depression, while those with depressive symptoms are at higher risk of cardiovascular disease, diabetes, cancer and respiratory illness. In addition, untreated depression can contribute to adverse outcomes when patients are unable to follow directions for care. In diabetes, for example, untreated depression can cause a higher risk for serious complications.

People with chronic long term physical illnesses face demanding programs of treatment and ongoing disease management. The debilitating nature of depression can further diminish their quality of life. Failure to view physical and mental health as an integrated area of care is a common treatment gap, even although mental illnesses can be successfully treated.

The World Health Organization and the World Association of Family Doctors have pointed out that with training and appropriate planning, primary care providers can address physical and mental problems together as now happens in the health systems of several countries. Patients can be referred to specialty mental health services when needed. The World Federation for Mental Health is using its annual public education campaign this year to encourage health professionals, patients and their families to advocate for integrated care of physical and mental health. Government health departments and local health authorities should pay close attention to the importance of this issue in planning for services.

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WORLD MENTAL HEALTH DAY IS A REGISTERED SERVICE MARK OF THE WORLD FEDERATION FOR MENTAL HEALTH