COURSE GUIDE

HED 311
MENTAL & SOCIAL HEALTH

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INTRODUCTION

HED 311 Mental & Social Health is a two (2) credit unit course available to all students offering Bachelor of Science (BSc.) in Health Education. Mental health refers to cognitive, behavioral, and emotional well-being. It is all about how people think, feel, and behave. People sometimes use the term "mental health" to mean the absence of a mental disorder. Mental health can affect daily living, relationships, and physical health. However, Looking after mental health can preserve a person's ability to enjoy life. Doing this involves reaching a balance between life activities, responsibilities, and efforts to achieve psychological resilience.

The course is broken into three modules and 9 study units. It introduces the students to the meaning and definition Mental and Social Health. It is also to educate the students on the concept of mental health and mental health condition and risk factors for mental health condition. The course exposes the students to the knowledge of stigma of mental illness, mental health assessment and mental health promotion and mental health condition prevention.

At the end of this course, it is expected that students should be able to understand, explain and be adequately equipped on issues concerning mental and social health.

The course guide, therefore, tells you briefly what the course: HED 317 is all about, the types of course materials to be used, what you are expected to know in each unit, and how to work through the course material. It suggests the general guidelines and also emphasizes the need for self-assessment and tutor-marked assignments (TMAs). There are also tutorial classes that are linked to this course and students are advised to attend.

WHAT YOU WILL LEARN IN THIS COURSE

The overall aim of this course, HED 311, is to introduce students to the variables associated with mental and social health. During this course, you will learn about the issues of Community Organisation in broad perspectives: ranging from historical perspectives of Community Organisation; Community development; Community Organisation Programme; Community Organisation as a problem solving. It will explain the place of principles of Community Organisation.

COURSE AIM

The aim of this course is to provide you with an understanding of basics of Community Organisation for Health Programme. It aims at helping you

to become more equipped on your own Community and Community Organisation strategies.

COURSE OBJECTIVES

Each unit has specific objectives to guide you into the purpose of the study. You should read the objectives before you begin the study and ask yourself whether the objectives have been met after you are through with such unit.

However, below are the overall objectives of this course. On successful completion of this course, you should be able to:

- Describe the concept of mental health
- Describe the role played by each category of health professionals.
- Outline the common mental health conditions
- Explain the features common mental health conditions
- Staten disease burden the common mental conditions
- The stigma and stigmatization in mental illness
- Discuss the historical perspectives of stigma in mental illness
- Describe various stigma terms used in mental health condition
- State the consequences of stigma in life situations
- To discuss the components of mental health screening and assessment
- Explain Behavioral Health Assessment
- Discuss the concept of mental health promotion and mental health condition prevention

WORKING THROUGH THE COURSE

To satisfactorily complete this course, you are expected to read the study units, read recommended textbooks and other materials provided by the National Open University of Nigeria (NOUN). Most of the units contain exercise tagged ―Tutor-Marked Assignment‖. At a point in the course, you are required to submit these assignments for assessment prior to the real examination. Stated below are the components of the course and what you are expected to do.

COURSE MATERIALS

The major components of this course are:

1. Course Guide
2. Study Units
3. Text Books and References Sources (listed at the end of each Unit)
4. Assignment File
5. Presentation Schedule

STUDY UNITS

The study units in this course are as follows:

Module I

Unit 1	Concept of Mental Health
Unit 2	Concept Mental Illness
Unit 3	Theories of Mental Health & Mental Illness
Unit 4	Mental Health Professionals
Unit 5	Description of common mental illnesses

Module 2

Unit 1	Concept of stigma in Mental illness
Unit 2	Types of Stigma
Unit 3	Theories of Mental Illness Stigma Reduction
Unit 4	The Law and Mental Health Stigma
Unit 5	Stigma Terms in Mental Illness

Module 3

Unit 1	Mental Health Screening and Assessment
Unit 2	Mental Health Care Basic Principles
Unit 3	Mental Health Promotion and Mental Disorder Prevention
Unit 4	Mental health laws and public health policies
Unit 5	Mental Health Promotion Interventions

ASSESSMENT

There are two aspects of the assessment of the course. Firstly, the tutor marked assessment and secondly, there will be a written examination (final). In dealing with the assignments, you are expected to apply information, knowledge and strategies gathered during the course. The tutor marked assignments are expected to be submitted online in accordance with the directives of the university.

TUTOR MARKED ASSIGNMENT

Each unit has tutor marked assignment questions at the end of the units.

SUMMARY

HED311: is mental and social health and upon completion of this course, you will be equipped with required knowledge of meeting the needs of your mental and social health. You will be able to answer these questions:

- Describe the concept of mental health
- Describe the role played by each category of health professionals.
- Outline the common mental health conditions
- Explain the features common mental health conditions
- Staten disease burden the common mental conditions
- The stigma and stigmatization in mental illness
- Discuss the historical perspectives of stigma in mental illness
- Describe various stigma terms used in mental health condition
- State the consequences of stigma in life situations
- To discuss the components of mental health screening and assessment
- Explain Behavioral Health Assessment
- Discuss the concept of mental health promotion and mental health condition prevention

Text Books and References Sources (listed at the end of each Unit)

MAIN COURSE

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MODULE 1

UNIT 1 DEFINITION OF MENTAL HEALTH AND MENTAL ILLNESS

CONTENTS

1.0 INTRODUCTION

Mental health refers to cognitive, behavioral, and emotional health. It is about how people think, feel and behave. People sometimes use the term "mental health" to refer to the absence of mental disorders. Mental health affects daily life, interpersonal relationships and physical health. However, taking good care of mental health can maintain a person's ability to enjoy life. Doing so involves striking a balance between life activities, responsibilities, and efforts to achieve psychological resilience. Conditions such as stress, depression, and anxiety can affect mental health and disrupt a person's daily life. Although the term mental health is commonly used, many conditions that doctors consider mental disorders have physical roots. In this module, we explain what people with mental health and mental illness mean. We also describe the most common types of mental disorders, including their early symptoms and how to treat them.

2.0 OBJECTIVES

By the end of this unit, you will be able to

- Describe the concept of mental health
- Discuss the characteristics of people with mental health
- Pose the challenges of mental health

3.0 MAIN CONTENT

3.1 What is mental health?

According to the World Health Organization (WHO), mental health disorders are one of the leading causes of disability in the United States. "Mental health is a state of happiness. In this state, people are aware of their capabilities, can cope with the normal pressures of life, can work efficiently, and can contribute to their own communities." The WHO emphasized that mental health "is not just the absence of mental disorders or disabilities." During the peak period of mental health, it is not only necessary to avoid active conditions, but also to take care of ongoing health and well-being. They also emphasized that Protecting and restoring mental health is essential for individuals and for different communities and societies around the world.

In the United States, the National League for Mental Illness estimates that nearly one in five adults experiences mental health problems each year. In 2017, there were an estimated 11.2 million adults in the United States, representing about 4.5% of adults. They have serious psychological conditions. According to national statistics, the balanced development of personal personality and emotional attitudes allows you to get along with your peers. The ability of individuals to establish harmonious relationships with others and participate or constructively promote / change their social and physical environment. Mental illness a mental or behavioral manifestation of impaired brain function, characterized by inaccurate perception of reality, disordered thinking, social dysfunction, and inability to cope. Severe emotional thought or behavior disorder in a mental emergency that requires immediate attention. Institute of Mental Health (NIMH).

3.2 Characteristics of people with mental health

Mental health does not only refer to emotional health, but also to the way people think and behave. Many different factors have been found to affect mental health.

1. A mentally healthy person has the ability to make adjustments.

2. A mentally healthy person has a sense of personal worth and feels that he is valuable and important.
3. People who are mentally healthy mainly rely on their own efforts to solve problems and make their own decisions.
4. Have a sense of personal security, feel safe in a group, and understand the problems and motives of others.
5. A mentally healthy person has a sense of responsibility
6. Can give and receive love.
7. Live in the real world instead of a fantasy world.
8. Demonstrate emotional maturity in their behavior and develop the ability to tolerate frustration and disappointment in daily activities.
9. People who are mentally healthy have multiple interests and usually lead a balanced life of work, rest, and entertainment.

A healthy person is not only physically healthy, but also mentally healthy. Modern concepts of health go beyond the normal functions of the body. It includes a healthy and efficient mind and controllable emotions. "Health is the state of health, solidity or integrity of the body, mind or soul." This means that the body and mind work efficiently and harmoniously.

The human being is an integral mechanism, a body-mind unit, whose behavior is determined by physical and mental factors. This is a normal state of happiness, in the words of Johns and Webster, "a positive but relative quality of life."

This is a characteristic of ordinary people, they face the needs of life according to their abilities and limitations. The term "relative" refers to the constant changes in the degree of mental health that a person enjoys at a time. It is not just the absence of mental illness that constitutes mental health; on the other hand, it is the positive quality of an individual’s daily life. This quality of life is reflected in a person's behavior, and his body and mind work together in the same direction.

Your thoughts, feelings, and actions work harmoniously toward a common goal: the ability to balance feelings, desires, ambitions, and ideals in daily life. It means the ability to face and accept the reality of life. Other definitions of mental health refer to skills such as making decisions based on the ability to obtain satisfaction and assuming responsibility; achieving success and happiness in completing daily tasks of living effectively with others and exhibiting socially considerate behavior. Mental health or well-adjusted individuals possess or develop in daily life.

These characteristics can be used as the criteria for optimal mental health:

1. Have their own philosophy of life: Mental healthy people formulate their own values in consideration of social needs. He carefully evaluates his behaviour and accepts his mistakes with an open mind:
2. Exercises his wise judgment well as he knows strength and limitations well, he choose those social and individual tasks which are neither too difficult nor too easy. Thus he easily achieves his goal.

3. Emotionally mature: He is emotionally mature and stable and expresses his emotion, nationally and exercises proper control over them.

5. A balanced self-regarding sentiment: Have a proper sense of personal respect. He believes that he is an important member of the social group and can contribute to their progress and happiness.

6. Social adaptability: We are all social people. This reality of social life refers to social giving and taking. A mentally healthy person knows social life and the art of social giving and taking.

7. Realistic approach: Your approach to various problems in life is realistic. They will not be intimidated by imaginary fears or traps that may arise.

8. Intellectual health: Your intelligence is fully developed. These enable you to think independently and make the right decision at the right time.

9. Emotional maturity: Fear, anger, love, vulnerability and other emotions. They usually appear in our social lives. Such people have mature emotional demeanor. He can control them and express them according to accepted social norms.

10. The courage to face failure: Life is a seesaw game. If we aim for success, sometimes we will also encounter failure. A person with perfect psychological balance has enough courage and endurance to face failures in life.

11. Punctuality: Mental healthy people have good social and healthy habits. He never forgets his promises and fulfills his duties regularly and on time.

12. National attitude towards sex: Has a natural and normal attitude towards sex, without sexual abnormalities.

13. Self-judgment: Self-judgment is one of the important characteristics of these people. He used it to solve his problems. You do not trust the judgment of others.

14. Diverse interests: they attract all kinds of interests. These bring you diversity and happiness in life. He performed his daily duties with grace and balance. He likes work, rest and entertainment.

3.3 Challenges to Mental Health

The National Alliance on Mental Illness (NAMI) notes that each year an estimated one in five American adults experiences mental health problems. There are many risk factors that increase the likelihood of a person suffering from poor mental health.

Mental health risks may include:

- Discrimination
- Trauma
- Family history of mental illness
- Low income
- Medical illness
- Unable to access medical services
- Low self-esteem
- Poor social skills
- Social skills inequality
- Substance use

Some factors that help prevent poor mental health include supportive social relationships, strong coping skills, opportunities to participate in the community, and physical and mental safety.

3.4 Maintaining Mental Health

Some ways the US Department of Health and Human Services recommends that you promote and maintain mental health include:

- Regular physical exercise
- Get enough sleep
- Help others
- Learn new stress skills
- Stay in touch with others
- Try to stay positive about life

If you are having difficulties, it is also important to be able to ask for help. If you need help improving your mental health or solving a mental problem, consult your doctor or mental health professional.

SELF-ASSESSMENT EXERCISE

i. Describe a mentally healthy person
ii. Determine the challenges of mental health

4.0 CONCLUSION

The meaning and origin of mental health is very important to understand its place in education and life. Mental health refers to cognitive, behavioral, and emotional health. It is about how people think, feel and behave. This unit explain the definitions of mental health the attributes of people with mental health, how to maintain mental health and the challenges of mental health

5.0 SUMMARY

In this unit, students will study mental health as a concept of cognitive, behavioral, and emotional health. It is about how people think, feel and behave. This unit looks at the attributes of people with mental health, how to maintain mental health and the challenges of mental health

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES/FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

UNIT 2 CONCEPT OF MENTAL ILLNESS

CONTENTS

1.0 INTRODUCTION

This unit analyzes the definition of mental health and mental health conditions based on the previous unit. Students will learn about the factors of mental illness. There is no single known pathogen for mental illness.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- Identify mental illness as one of the most important public health problems.
- Lists common mental illnesses.
- Determine the cause of common mental illness.
- Identify the clinical features of common mental illnesses.
- Describe the role of each type of health professional.
- can start basic management and classification correctly

3.0 MAIN CONTENT

Mental illness, also known as mental health disorder, which refers to a wide range of mental health conditions: disorders that affect your mood, thinking, and behavior. Examples of mental illnesses include depression, anxiety, schizophrenia, eating disorders, and addictive behaviors.

Many people have mental health problems from time to time. However, when persistent signs and symptoms cause frequent stress and affect your ability to work, mental health problems can become mental illnesses.

Mental illness can make you miserable and may cause problems in your daily life, such as school, work, or relationships. In most cases, a combination of medication and psychotherapy (psychotherapy) can be used to control symptoms.

3.1 What is a mental illness?

Mental health is a disorder that reflects problems of mental function in a person's thinking, feeling, or behavior (or a combination of these). They can cause pain or disability in social, work or family activities. Just as the term "physical illness" is used to describe a number of physical health problems, the term "mental illness" covers various mental health conditions.

3.2 Symptoms

Signs and symptoms of mental illness can be stress

- Difficulties in understanding situations and people
- Alcohol or drug problems
- Major changes in eating habits
- Changes in libido
- Excessive anger, hostility, or violence
- Suicidal thoughts
- Sometimes symptoms of mental health disorders manifest as physical problems, for example Stomach pain, back pain, headache, or other unexplained pain.

3.3 Factors of mental illness

- There is no single known cause of mental illness. Mental illness is caused by one or more of the following
- Genetic factors, such as chromosomal abnormalities, can cause mental illness. Children with parents suffering from mental illness are more likely to suffer from mental illness than children with healthy parents.
- Organic factors such as cerebrovascular diseases, nervous system diseases, endocrine diseases, epilepsy and other chronic diseases are related to mental diseases.
- Social and environmental crises, such as poverty, stress, emotional stress, professional and economic difficulties, unhappy marriages, family breakdown, abuse and neglect, population movements, depression, earthquakes, floods and epidemics and other environmental factors caused changes in life It is related to mental illness. In addition to the social and psychological factors that can lead to abnormal human behavior, environmental factors also

include toxic substances, such as carbon disulfide and carbon monoxide, mercury, manganese, tin, lead compounds, etc.

- Psychological factors such as abuse and other psychological trauma in early childhood play an important role in the development of mental illness in adulthood.
- Behavioral factors such as addiction to drugs, alcohol, and substances like Katta are related to mental illness.
- Other factors associated with mental illness include nutritional deficiencies, infections and injuries during delivery before and after delivery, traffic, occupational and other accidents, and radiation accidents. The nervous system is most sensitive to radiation during the neurodevelopmental period.

Misunderstandings about mental illness

- Mental illness is generally believed to be caused by a variety of genetic and environmental factors:
- Genetic characteristics. Mental illness is more common in people whose blood relatives also have mental illness. Certain genes can increase your risk of mental illness, and your living conditions can trigger it.
- Environmental exposure before birth. Exposure to environmental stressors, inflammation, toxins, alcohol, or drugs in the womb can sometimes be related to mental illness.
- Chemistry of the brain. Neurotransmitters are natural brain chemicals that can transmit signals to the brain and other parts of the body. When the neural network involving these chemicals is damaged, the function of nerve receptors and the nervous system changes, which can lead to depression and other mood disorders.
- Complications
- Mental illness is the leading cause of disability. Untreated mental illness can cause serious emotional, behavioral, and physical health problems. Complications sometimes associated with mental illness include:
- Unhappiness and decreased enjoyment of life
- Family conflict
- Difficulties in relationships
- Social isolation
- Problems with tobacco, alcohol and other drugs
- Missing work or school, or other related problems Work or school
- Legal and financial matters
- Poverty and homelessness
- Self-harm and harm to others, including suicide or homicide
- Weakened immune system, so your body cannot fight off infections
- Heart disease and other diseases

3.4 Prevention

- Describes three levels of prevention: primary, secondary and tertiary prevention.
- Primary Prevention: This is the preventable cause of prevention or control: understanding of the cause of mental illness is limited.

However, there are certain known risk factors associated with mental illness. Therefore, the prevention of mental illnesses implies the control of these risk factors, among them:

1. Prevention and control of environmental hazards and other pathogenic factors, such as:
    - Prevention of poisonings and poisonings by drugs, lead and arsenic
    - Prevention of nutritional deficiencies such as: iodine, vitamin B deficiency. Brain injury For example: trauma caused by traffic accidents.
    - Infection control in young children and newborns. For example: Meningitis
    - Laws and social application against drug abuse
    - Control of environmental contamination: For example: Mercury contamination

2. Prevent / control risk factors related to pregnancy, such as:
    - Rh
    - Infection and incompatibility
    - Counseling on known genetic risk factors.
    - Early referral of mothers with abnormal deliveries

3. Human development has a certain relationship with mental illness Prenatal, the first 5 years of life, school age and adolescence are the most important periods of development. Therefore, we must work harder to establish a harmonious family relationship to prevent children from developing mental illness in the future.

4. Health education
    - Environmental risks
    - Prenatal care
    - Misunderstandings of patients with mental illness.

5. Support people with the greatest pressure, such as future parents, floating population, youth and people in disaster areas to improve interpersonal relationships.

2. Secondary prevention:
   - It is the early diagnosis and treatment of patients with mental illness
   - Early referral of patients with mental illness to health institutions for diagnosis and treatment, thus avoiding the progression of the disease or shortening its duration.

3. Tertiary prevention:
   - aims to reduce chronic disability due to mental illness by:
   - Provide social support
   - Create sheltered workshops and supervised residential care outside health institutions.
   - Get regular medical care. Don't neglect to check or skip a visit to your primary care provider, especially if you are not feeling well. You may have a new health problem that needs to be treated, or you may experience side effects from medications.
   - Get help when you need it. If you wait until your symptoms worsen, your mental health condition may be more difficult to treat. Long-term maintenance treatment can also help prevent symptoms from recurring.
   - Take a good hold
   - Psychological evaluation. A doctor or mental health professional will talk with you about your symptoms, thoughts, feelings, and behavior patterns. You may be asked to complete a questionnaire to help answer these questions.
   - Determine what mental illness you have
   - Sometimes it is difficult to know what mental illness may cause your symptoms. But spending time and effort to get an accurate diagnosis will help determine the appropriate treatment. The more information you have, the more willing you are to work with your mental health professional to understand what your symptoms might represent.
   - The Diagnostic and Statistical Manual of Mental Disorders (DSM5) published by the American Psychiatric Association details the defining symptoms of each mental illness. This manual is used by mental health professionals to diagnose mental illness and is used by insurance companies to reimburse the costs of treatment.

3.6 Types of mental illness

- The main types of mental illness are:
- Neurodevelopmental disorders. This course covers a wide range of problems, usually beginning in infancy or childhood, usually before the child enters primary school. Examples include autism

spectrum disorder, attention deficit/hyperactivity disorder (ADHD), and learning disabilities.

- The spectrum of schizophrenia and other mental illnesses. Mental disorders cause disconnection from reality, such as delusions, hallucinations, confusion in thinking and speech. The most obvious example is schizophrenia, although other types of illness may sometimes be related to detachment from reality.

- Bipolar disorder and related disorders. These illnesses include alternating bouts of mania (hyperactivity, energy, and excitement) and depression.

- Depression. These include obstacles that affect your emotional feelings, such as the degree of sadness and happiness, which can undermine your ability to function. Examples include major depression and premenstrual dysphoria.

- Anxiety disorders. Anxiety is an emotion characterized by anticipation of future danger or misfortune and excessive worry. It can include behaviors designed to avoid situations that cause anxiety. This category includes generalized anxiety disorder, panic disorder and phobias.

- Obsessive-compulsive disorder and related disorders. These barriers include worry or obsessions and repetitive thoughts and behaviors. Examples include obsessive-compulsive disorder, hoarding disorder, and trichotillomania (trichotillomania).

- Stress-related traumas and disorders. These are adjustment disorders, in which a person has difficulty coping during or after a stressful life event. Examples include post-traumatic stress disorder (PTSD) and acute stress disorder.

- Separation barriers. These are diseases where your self-awareness is impaired, such as dissociative identity disorder and dissociative amnesia.

- Physical symptoms and related diseases. People suffering from one of these diseases may experience physical symptoms, leading to severe emotional distress and functional problems. There may or may not be other diagnosed medical conditions related to these symptoms, but the response to these symptoms is abnormal. Disorders include physical symptom disorders, illness anxiety disorders and man-made disorders.

- Eating disorder. These disorders include diet-related disorders that affect nutrition and health, such as anorexia nervosa and binge eating disorder.

- Remove obstacles. These diseases are related to the accidental or deliberate improper discharge of urine or feces. Bed-wetting (enuresis) is one example.

- Sleep-wake disorder. These are sleep disorders that are serious enough to require clinical attention, such as insomnia, sleep apnea, and restless legs syndrome.

- Sexual dysfunction. These include sexual response disorders such as premature ejaculation and female orgasm disorders.

- Gender dysphoria. This refers to the pain that accompanies a person's desire to be of another gender.

- Destructivity, impulse control and conduct disorder. These disorders include emotional and behavioral self-control problems, such as theft or intermittent explosive disorder.

- Addictive and Substance-Related Disorders. These include problems related to the excessive use of alcohol, caffeine, tobacco, and drugs. This category also includes gambling disorders.

- Neurocognitive impairment. Neurocognitive impairment can affect your thinking and reasoning skills. These acquired cognitive (rather than developmental) problems include delirium and neurocognitive disorders caused by conditions or diseases such as traumatic brain injury or Alzheimer's disease.

- Personality disorder. Personality disorder involves a long-term emotional instability and unhealthy behavior patterns that can cause problems in your life and relationships. Examples include borderline, antisocial, and narcissistic personality disorders.

- Disorders of libido. These barriers include sexual interests that cause personal suffering or harm or cause potential or actual harm to others. Some examples are sexual abuse disorder, voyeurism disorder and pedophilia disorder.

- Other mental disorders. This category includes mental disorders due to other medical conditions or failing to meet all the criteria for any of the above disorders.

3.7 Treatment

- Your treatment depends on the type and severity of your mental illness and the method that is best for you. In many cases, combination therapy is best.
- If you have a mild mental illness and your symptoms are well controlled, your primary care provider's treatment may be sufficient. However, the team approach is usually applied to ensure that all your mental, medical, and social needs are met. This is especially important for serious mental illnesses such as schizophrenia.
- Treatment team
- Your treatment team may include you:
- Primary care or family doctor
- Practicing nurse
- Physician assistant
- Psychiatrist, a doctor who diagnoses and treats mental illness
- Psychotherapist, such as a psychologist Or licensed consultant
- Pharmacist
- Social worker
- Family member

3.8 Medication

- Although psychotropic drugs cannot cure mental illness, they can usually improve symptoms significantly. Psychiatric drugs can also help other treatments (such as psychotherapy) to be more effective. The best medicine for you depends on your specific situation and how your body responds to the medicine.

- Some of the most commonly used psychiatric prescription drug categories include:

- Antidepressants. Antidepressants are used to treat depression. Rapid anxiolytics help short-term relief, but can also cause dependency, so ideally, they should be used short-term.

- Mood stabilizing drugs. Mood stabilizers are most often used to treat bipolar disorder in which mania and depression occur alternately. Sometimes mood stabilizers are used in conjunction with antidepressants to treat depression.

- Antipsychotic drugs. Antipsychotic drugs are often used to treat mental disorders, such as schizophrenia. Antipsychotic drugs can also be used to treat bipolar disorder or together with antidepressants to treat depression.

3.9 Psychotherapy

- Psychotherapy, also called talk therapy, involves talking to a mental health professional about your condition and related problems. During psychotherapy, you will learn about your condition and your emotions, feelings, thoughts, and behaviors. With the insights and knowledge you gain, you can learn coping and stress management skills.
- There are many types of psychotherapy, and each has its own way of improving mental health. Psychotherapy can usually be completed successfully in a few months, but in some cases, long-term treatment may be required. It can be done alone, in a group or with family members.
- When choosing a therapist, you should feel comfortable and believe that he or she has the ability to listen and listen to what you have to say. Also, it is important that your therapist understand the journey of life that helps shape who you are and how you live in the world.
- Brain Stimulation Therapy
- Brain Stimulation Therapy is sometimes used to treat depression and other mental illnesses. They are usually used in situations where medication and psychotherapy are ineffective. They include electroconvulsive therapy, repetitive transcranial magnetic stimulation, deep brain stimulation, and vagus nerve stimulation.
- Make sure you understand all the risks and benefits of any recommended treatment.
- Hospitals and inpatient treatment plans
- Sometimes mental illness becomes so severe that it requires treatment in a mental hospital. This is usually recommended when you are unable to take care of yourself properly or are in direct danger of harming yourself or others.
- Options include 24-hour hospitalization, day or partial hospitalization, or hospitalization, providing temporary supportive housing. Another option may be intensive outpatient treatment.
- Substance Abuse Treatment
- The problem of drug abuse usually occurs at the same time as mental illness. It often interferes with treatment and worsens mental illness. If you cannot stop taking drugs or alcohol on your own, you need treatment. Discuss treatment options with your doctor.
- Participate in your own care
- By working together, you and your primary care provider or mental health professional can decide which treatment may be best based on your symptoms and severity, personal preferences, medication side effects, and other factors. In some cases, the mental illness can be so severe that the doctor or loved one may

need to direct your care until you are restored to a level sufficient to participate in decision-making.

- Lifestyle and home remedies
- In most cases, if you try to treat yourself without professional care, your mental illness will not get better. But you can do something for yourself based on your treatment plan:
- Stick to your treatment plan. Do not skip the course of treatment. Even if you feel better, don't skip the medication. If it is stopped, symptoms may return. If you stop taking the medicine too suddenly, you may experience withdrawal symptoms. If you have troublesome drug side effects or other treatment problems, please consult your doctor before making changes.
- Avoid alcohol and drugs. Using alcohol or recreational drugs can make it difficult to treat mental illness. If you are already addicted, quitting smoking can be a real challenge. If you are unable to quit smoking on your own, please see a doctor or find a support group to help you.
- Stay active. Exercise can help you manage symptoms of depression, stress, and anxiety. Physical activity can also offset the effects of some psychotropic drugs that may cause weight gain. Consider walking, swimming, gardening, or any form of physical activity you like. Even light physical activity can make a difference.
- Make healthy choices. Maintaining a regular schedule, which includes adequate sleep, a healthy diet, and regular physical activity, is very important to your mental health.
- Don't make big decisions when symptoms are severe. When you are deep in the symptoms of mental illness, avoid making decisions because you may not be able to think clearly.
- Determine the priority. You can reduce the impact of mental illness by managing time and energy. Reduce obligations and set reasonable goals when necessary. When symptoms get worse, allow yourself to do less. You may find it helpful to list your daily tasks or use a planner to organize your time and stay organized.
- Learn to adopt a positive attitude. Focusing on the positive things in life can improve your life and even improve your health. Try to accept the changes when they occur and look at the problem in perspective. Stress management techniques, including relaxation methods, can be helpful.

3.10 Coping with and supporting

- Coping with mental illness is challenging. Talk to your doctor or therapist about how to improve your coping skills and consider the following tips:

- Know your mental illness. Your doctor or therapist can provide information or recommend courses, books or websites. Also include your family; this can help people who care about you understand what you are going through and how they can help you.
- Join a support group. Connecting with other people facing similar challenges can help you deal with it. Many communities and online have mental illness support groups. A good starting point is the National Mental Illness League.
- Keep in touch with friends and family. Try to participate in social activities and meet with family or friends regularly. Ask for help when you need it and be honest with your loved ones this is also a healthy way to explore and express pain, anger, fear, and other emotions.

1. It is generally considered that patients in psychiatric hospitals spend their time doing useless things and exhibiting strange behaviors.
2. People with mental illness are suspected and considered dangerous.
3. Mental illness is shameful.
4. Mental illness is caused by evil spirits (black magic).
5. Mental illness is incurable and contagious.
6. A mental hospital is a place where only people with dangerous mental illnesses are treated. 7. Marriage can cure mental illness.

SELF-ASSESSMENT EXERCISES

i. Identify the factors that contribute to mental health
ii. Describe strategies for coping with mental problems

4.0 CONCLUSION

Many people have mental health problems from time to time. However, when persistent signs and symptoms cause frequent stress and affect your ability to work, mental health problems can become mental illnesses. Mental illness can make you miserable and cause problems in your daily life, such as school, work, or relationships. In most cases, the symptoms can be controlled by a combination of medication and psychotherapy (psychotherapy).

5.0 SUMMARY

In this unit, students will understand the meaning of mental health, factors of mental illness, misunderstandings of mental illness, coping with and support for mental illness

6.0 TUTOR-MARKED ASSIGNMENT

1 Describe a mentally healthy person
2 Determine the challenges of mental health

7.0 REFERENCE/FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

UNIT 3 MENTAL HEALTH AND PSYCHOLOGY ILLNESS THEORY

CONTENTS

1.0 INTRODUCTION

In order to understand mental health and mental illness in the context of Western science and philosophy, we need to determine which theories have been used to help understand mental health problems and explore how different methods of understanding mental health affect treatment. Options. We must also consider how different perspectives on mental health affect our interaction and response to mental health.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- different theories about mental health and mental illness
- Describe the contributions of theorists to mental health and mental illness

3.0 MAIN CONTENT

3.1 Historical background

Theories: We will consider all Factors that have historical, cultural and religious influence. Socrates (469399 BC) and Aristotle (384322 BC) were the first "thinkers" who wrote articles on the brain and tried to understand the influence of the brain on the "mind" and behavior of people. Aristotle believed that the heart, not the brain, is important for intelligence. Aristotle wrote the first known text in the history of psychology, called Para Psyche, "About the mind", based on the works of the first philosophers and their research on the mind, reasoning and thinking. In this historical book, he explained that the first principle of the investigation of reasoning will determine the direction of the history of psychology; many of his suggestions continue to influence modern psychologists. As written by many early Greek studies, it is considered

the basis of modern mental health thought, however, other ancient civilizations also articulated their thoughts in different ways.

China
Hsün Tzu (ca. 312-230 BC) was a Chinese Confucian philosopher who lived in the Warring States Period and was likened to Aristotle as a naturalist who emphasized natural laws and order. The Chinese describe yin and yang (links to external websites) as opposing and complementary forces. Yang is related to strength, toughness, warmth, dryness and masculinity. Yin is associated with weakness, softness, coldness, moisture, and femininity. The balance of yin and yang is essential for physical and mental health. In this way, the Chinese have opened the door to physiological psychology, since they believe that mental processes are central and related to the body.

Egypt
Egyptian psychology is deeply intertwined with Egyptian polytheistic religion and the emphasis on immortality and life after death. Although the Egyptians seem to be the first to describe the brain, most of the time they regard the heart as the seat of spiritual life.

Other Eastern Philosophies
Indian thinkers, as reflected in the Vedas and Upanishads (links to external websites), have studied knowledge and desire, in addition to many other topics. Hebrew philosophy (links to external websites) and psychology must be understood in terms of radical monotheism: "Human beings have two aspects, one is biological, selfish and the other is capable of enhancing the spiritual aspect of community service. The Hebrews They have a mature view of mental disorders, which are attributed to the wrath of God or human disobedience. According to the teachings of Zarathustra and the Holy Book of Avista, Persia is the birthplace of Zoroastrianism (links to external websites). Zoroastrianism is the first monotheistic religion in history, until the Muslims conquered Persia. Man is a testing ground for good and evil, and physical and mental disorders are considered the work of the devil; demonological diagnosis and treatment are common.

Understanding the main theories of mental health and mental illness

There are many main or important theories related to understanding mental health:

- Development/Analysis Theory: "Development theory provides a framework for thinking about mental health. Human growth, development and learning If you have ever wondered what motivates human thinking and behavior, understanding these

theories can provide useful information about individuals and society."

- (Cherry, 2014) Theorists: Freud, Jung, Eric Sen, Kohlberg.

- Behavior theory: "Behavioral psychology, also known as behaviorism, is a learning theory based on the idea that all behaviors are acquired through conditioned reflex. The famous psychologist John B. According to Watson and B.F. Skinner, behavioral theory dominated psychology in the first half of the 20th century. Today, behavioral technology is still widely used in therapeutic settings to help clients learn new skills and behaviors. "(Cherry, 2014) Theorists: Watson, Skinner, Pavlov

- Cognitive theory:" Cognitive psychology is the branch of psychology that studies mental processes including people's thoughts. "Social psychology focuses on a wide range of social issues, including group behavior, social cognition, leadership, non-verbal behavior, conformity, aggression, and prejudice. It is important to note that social psychology not only deals with social impact. Social recognition Knowing social interaction is also crucial to understanding social behavior."

- (Cherry, 2014) Theorists: Bandura, Lewin, Fesinger

There are many resources on the Internet to explore these theories. One of the best Starting points is http://www.simplypsychology.org/ (links to external sites) before we continue to discuss modern views, we want you to make sure you have a good understanding of these "grand theories."

Modern views

- Does the "big theory" discussed above conform to modern thinking? Can theories from a hundred years ago really tell us what mental health or illness is? The next two videos in the TED series provide completely different perspectives.

- The first lecture is from Johnathan Haidt (Social Psychologist), 2008, "The Moral Roots of Liberals and Conservatives":

- https://learn.canvas.net/courses/510/pages/ the major theories of mental health and mental illness Self advanced.

SELF-ASSESSMENT EXERCISE

i. Identify the main theories for understanding mental health and mental illness
ii. Discuss the contribution of Socrates and Aristotle to the understanding of mental health and mental illness

4.0 CONCLUSION

To understand mental health and mental illness in context of Western Science and Philosophy Mental Illness. In this unit, we identify which theories have been used to help understand mental health problems. It also explores how different methods of understanding mental health affect treatment options.

5.0 SUMMARY

In this unit, students will learn about the contributions of different philosophers and scientists to the understanding of mental health and mental health. It also looks at how these theories affect treatment.

6.0 TUTOR-MARKED ASSIGNMENT

1 Describe a mentally healthy person
2 Determine the challenges of mental health

7.0 REFERENCES /FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

UNIT 4 MENTAL HEALTH PROFESSIONALS

CONTENTS

1.0 INTRODUCTION

It can be difficult to get help with mental, emotional, spiritual or relationship problems. Finding the right mental health professional can help you manage any problems in your life.

2.0 OBJECTIVES

By the end of this unit, you will be able to

- Identify different mental health professionals
- Explain the role of all mental health professionals

3.0 MAIN CONTENT

3.1 Psychologist

The first psychologist of the image in the one that many people think was a person lying on a leather sofa and telling the doctor how he felt. Sometimes this happens, but psychologists do more than ask you how you feel. Psychologists specialize in the science of behavior, emotions, and thinking. They work in private offices, hospitals or schools. Psychologists use counseling to treat all kinds of problems, from interpersonal problems to mental illness. Psychologists usually have a doctorate degree, such as a doctorate degree. In most states, psychologists cannot prescribe drugs.

Psychiatrists
Psychiatrists diagnose, treat and help prevent mental, emotional and behavioral disorders. They use psychiatric drugs, physical exams, and laboratory tests. A psychiatrist is a doctor with a doctor of medicine (MD) degree or a doctor of osteopathy (DO) degree. General practitioners can also prescribe medications to help solve mental and emotional problems. But many people prefer to see a psychiatrist to treat complex diseases.

The expertise of a psychiatrist may include:

- Children and Adolescents
- Forensic Psychiatry
- Learning Disabilities
- Psychoanalyst

Psychoanalysts follow Sigmund Freud's theory and practice to help someone explore their Repressed or unconscious impulses, anxiety, and internal conflicts are accomplished through the following techniques:

- Free association
- Dream interpretation
- Resistance and empathy analysis
- Psychoanalysis has its critics. But many people find that it can help them explore deep psychological and emotional barriers that may produce bad behavior patterns without them realizing it.
- Be careful when choosing a psychoanalyst. Titles and certificates are not protected by federal or state laws, which means that anyone can call themselves a psychoanalyst and promote their services.

Psychiatric Nurses

- Psychiatric nurses are registered nurses who specialize in mental health. They are known for their therapeutic relationships with people seeking help.

- Psychiatric nurses conduct psychotherapy and administer psychiatric drugs. They often face challenging behaviors related to mental health conditions. They performed the operation under the supervision of a doctor.

Psychotherapist

- "Psychotherapist" is the general term for many different types of mental health professionals. This can include psychologists and therapists. All these professionals provide psychotherapy. Psychotherapy is a kind of "talk therapy." Its goal is to improve your mental health and general well-being.

- There are many different schools of psychotherapy. They can involve therapeutic dialogue, group therapy, expressive therapy, etc. The most popular type is cognitive behavioral therapy (CBT). You can use CBT to learn how to change bad behaviors, thought patterns, or emotions.

Mental Health Counselor

- "Mental Health Counselor" is a broad term used to describe the person who provides counseling. Your title may also include terms such as "licensed" or "professional". It is important to ask about the counselor's education, experience, and type of service involved, because the term is vague. Counselors may focus on the following areas:
- Work Stress
- Addiction
- Marriage
- Family
- General Stress

Family and Marriage Counselor

- Family and Marriage Counselor specializes in common problems that may arise in families and married couples, including: Differences in arguments. The duration of treatment is usually very short. Meetings usually focus on specific issues and resolve them quickly.

- This therapy can also be used according to individual circumstances. If a person's problem affects someone close to them, group meetings can sometimes be used. You may see this in counseling about diseases such as eating disorders or addictions.

Addiction Counselor

- Addiction Counselor treats addicts. Although this usually involves substance use or gambling issues, it may also include lesser. They focus primarily on crisis of faith, marriage and family counseling, and emotional and psychological problems. All of this is done in a spiritual environment.

- These counselors are usually local church leaders. They may have received extensive religious and mental health training. They often hold meetings individually or in groups. You can also have conversations in pairs or in a home environment.

Art Therapist

- Art therapists deal with very specific types of treatments. This approach involves using creativity in the form of painting, sculpture, and writing to explore and help treat depression, medical illness, past traumatic events, and addictions.

- People who believe in this therapy think it can help you express potential thoughts and feelings that traditional talk therapy cannot reveal.

Social Workers

- Social workers are committed to helping people solve problems in their lives. These issues may include personal issues and disability. Social workers can be public officials or work in other fields, including hospitals, universities, and appropriately licensed therapists.

- They can also solve social problems, such as material use, housing, and unemployment. Social workers are often involved in family disputes involving domestic violence or child abuse.

- There are many subtypes of social work. These may include:

- Children, families and schools

- Medical and public health

- Mental health and substance use

- Need training

- The training of mental health professionals depends on their specific field and the state of exercise. Psychologists usually need a doctorate, while psychiatrists need a medical degree.

  Almost all states require all types of counselors to have a specially trained university degree.
- Some things to look for in the context of a mental health professional include:

- National License

- Postgraduate Degree: Master or Doctorate

- Clinical Experience

- Published Article

SELF-ASSESSMENT EXERCISE

i. Describe in each category the role of health professionals.
ii. Determine the training needs of all mental health professionals

4.0 CONCLUSION

In this unit, the focus is mainly on people who work in mental health and mental health conditions. This unit explains the responsibilities of all mental health professionals and their training needs

5.0 SUMMARY

In this unit, students will learn about professionals and their role in mental health. Describes the training needs of all mental health professionals.

6.0 TUTOR-MARKED ASSIGNMENT

1 Describe a mentally healthy person
2 Determine the challenges of mental health

7.0 REFERENCES/FURTHER READING

https://www.healthline.com/health/mentalhealthprofessionalstypes#training

https://www.mayoclinic.org/diseasesconditions/mentalillness/diagnosistreatment/drc20374974

UNIT 5 DESCRIPTION OF COMMON MENTAL ILLNESSES

CONTENTS

1.0 INTRODUCTION

Mental disorders are diseases that affect cognitive, emotional, and behavioral control, and seriously affect children's learning ability and adults' ability to play a role in family, work, and society as a whole. Mental disorders often start early in life and are usually chronic and recurrent. They are common in all countries where their prevalence is checked. Due to the combination of high prevalence, early onset, persistence, and exacerbation, mental disorders contribute significantly to the total burden of disease. Although most of the burden caused by mental disorders is related to disability, premature death, especially premature death caused by suicide, is not insignificant.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- Summarize common mental health conditions
- Explain the characteristics of common mental health conditions
- State the burden of disease of common mental conditions

3.0 MAIN CONTENT

Mental illness is still an important obstacle to seeking mental health in the world Help, diagnosis and treatment everywhere. Compared with other diseases, the stigma of mental illness leads to differences in access to care, research, and violations of the human rights of patients with these diseases. This chapter focuses on the four avoidable and attributable burdens of global mental illness: schizophrenia and related non-affective psychosis, bipolar disorder (manic depression), major depression, and panic disorder. The selection of these diseases depends not only on their contribution to the burden of disease, but also on the availability of cost-benefit analysis data.

3.1 Schizophrenia

Schizophrenia is a chronic disease with splendid psychotic symptoms such as hallucinations and delusions. Hallucinations are sensory perceptions that occur in the absence of adequate stimulation. Hallucinations can occur in any form of feeling, but the most common in schizophrenia are auditory hallucinations, for example, hearing sounds or noises. Delusions are fixed false beliefs that cannot be explained by the individual's culture, and the patient persists despite all reasonable evidence to the contrary. Patients also show negative symptoms: defects in normal abilities, such as obvious social deficits, poor thinking and language, slow emotional reactions, and lack of motivation. In addition, patients often present with cognitive symptoms, such as confusion or illogical thinking, and an inability to remember objective information to make decisions or plan actions.

3.1.1 Clinical history and course:

Schizophrenia defined in the current diagnostic manual is almost certainly heterogeneous, but does not yet include all non-affective psychoses (NAP). In addition to schizophrenia, NAPs also include schizophrenia-like disorders, which are characterized by insufficient duration of schizophrenia-like symptoms and do not meet the criteria for schizophrenia. Since they cannot be easily separated in a community epidemiological survey, schizophrenia is considered in conjunction with other NAPs. However, due to the available data, the cost-benefit analysis reported below is limited to schizophrenia. Despite the possible heterogeneity of etiology, schizophrenia exhibits a consistent pattern of symptoms in the countries and cultures studied (Jablensky et al. 1992). Morbidity studies have shown that the onset of schizophrenia and other NAPs generally occurs in mid or late puberty in men and from late puberty to early adulthood in women, although later onset is observed. Cases of onset in children are very rare, but particularly serious (Nicolson and Rapoport 1999). Schizophrenia is usually first diagnosed as an acute onset of striking psychotic symptoms. Usually there are prodromal symptoms before the first episode of psychosis, such as social withdrawal, irritability or irritability, increased academic or work difficulties, and

After the onset of psychosis, complete remission may occur after the first and occasionally other early onsets, but over time, residual symptoms and disability usually persist between relapses (Robinson et al. 1999). Maintenance treatment with antipsychotic drugs significantly prolongs the interval between relapses, usually at a lower dose than that required to treat acute attacks. In the early stages of the disease, cognitive and occupational functions tend to decline, and then stabilize at a level that is usually much lower than one's expectations. However, for reasons that are

not yet clear, residual damage has significant cross-cultural differences. In epidemiological investigations, schizophrenia has been found to be highly comorbid, usually accompanied by anxiety, mood disorders, and substance use disorders (Kendler et al., 1996).

3.1.2 Epidemiology and burden

A large number of APN incidence studies have been conducted in clinical samples. In a review of these studies, Jablensky (2000) found that the incidence of schizophrenia is estimated to be in the range of 0.002% to 0.011% per year, while the overall incidence of NAP is estimated to be 0.016% to 0.042% per year. . These annual estimates can be multiplied by the number of birth cohorts at risk to arrive at an estimate of the lifetime risk in any cohort. Conservatively assuming that the main age risk range is between 15 and 55 years, the researchers estimate that the lifetime risk of schizophrenia is between 0.08% and 0.44%, while the NAP is between 0.64% and 1.68%. Lifetime prevalence estimates from the NAP community epidemiological survey are highly consistent with estimates from clinical studies, ranging from 0.3% to 1.6% (for example, see Hwu, Yeh, and Cheng 1989; Kendler et al. 1996). . Although schizophrenia is a relatively rare disease, the overall estimate of the burden of the disease is high: about 2,000 DALYs are lost per million inhabitants because this disease is associated with early onset, long duration, and severe disability.

3.1.3 Intervention measures

There is a large amount of evidence showing the efficacy of various treatments for schizophrenia and NAP and the effectiveness of various medical care models provided for patients with these diseases. This evidence mainly comes from industrialized countries. Efficacy data conclusively show that antipsychotic drugs can reduce the severity of attacks, accelerate the resolution of irritation symptoms, and shorten hospital stays. Maintenance treatment with antipsychotic drugs will extend the interval between relapses (Joy, Adams, and Lawrie 2001). Second-generation antipsychotic drugs (also called atypical) are replacing old antipsychotic drugs throughout the industrialized world. In some clinical trials, second-generation drugs have shown little advantage in efficacy compared to first-generation drugs, but their widespread adoption is due to significantly improved intolerance. Compared to first-generation drugs, they have relatively fewer side effects, improving quality of life and adherence to treatment. However, second-generation drugs are not without side effects. For example, some are linked to substantial weight gain and an increased risk of diabetes. One drug, clozapine, is more effective than other antipsychotic drugs, but due to the 1% risk of agranulocytosis, its use requires weekly blood counts and is

cumbersome and expensive. Psychosocial interventions also play an important role in the management of schizophrenia (Bustillo et al. 2001). Cognitive behavioral methods for managing specific symptoms and improving adherence to medication, group therapy, and family intervention have been shown to be effective in improving clinical outcomes. In health systems in industrialized countries, community-based mental health care delivery models with trusted case management and outreach programs have proven to be effective methods of managing schizophrenia in the community, for example, by reducing the need for hospitalization. However, due to differences in the characteristics of health systems, it is difficult to estimate the applicability of these models to developing countries, as discussed below. The long-term remission rate of schizophrenia in developing countries appears to be significantly higher than that reported in industrialized countries (Harrison et al. 2001), which may be due to factors such as strong family social support. Although clearly helpful, current treatments do not prevent schizophrenia and there is no clear evidence that they can induce full recovery or prevent premature death. On the contrary, treatment reduces the time of magnificent psychosis and increases the time between attacks; therefore, the effect of treatment can be understood from the perspective of improving disability. The meta-analysis in the literature reports the magnitude of the treatment effect, which translates into an improvement in the average level of disability (Andrews et al. 2003; Sanderson et al. 2004), showing an improvement (compared to no treatment) of 18% to 19% (antipsychotic drugs only) and 30% to 31% (antipsychotic drugs and psychosocial therapy). Placed at a disability level of 0 to 1, where 0 equals no disability, the "average" case of schizophrenia has increased from a disability level of 0.63 (untreated weight from the Global Burden of Disease Study, Murray and Lopez 1996) to 0.43 to 0.54 (treated).

3.2 Mood disorders

The main characteristics of mood disorders are general abnormalities in a person's main emotional state, such as depression, euphoria, or irritability. In mood disorders, these core mood symptoms are accompanied by physical abnormalities, such as changes in sleep, appetite, and energy patterns, as well as changes in cognition and behavior. In developing countries, concurrent physical symptoms are also frequently reported and may be the main symptoms. A generally accepted sub-category of mood disorders distinguishes unipolar depressive disorder from bipolar disorder (defined as the onset of mania). This distinction is based on symptoms, course of disease, household transmission patterns, and response to treatment. Bipolar disorder is characterized by manic and depressive episodes, followed by a period of relatively healthy mood (emotional pleasure), usually. At the same time, a mixed state of manic and depressive symptoms. The typical characteristics of mania are euphoria

or irritability, a significant increase in energy, and a decrease in sleep requirements. People with mania usually exhibit invasive, impulsive, and unrestrained behaviors. They may be overly involved in goal-oriented behavior characterized by poor judgment; for example, a person can spend all the funds they have the right to use, and Self-esteem is often exaggerated, often reaching the level of deception. Talking is usually very fast and difficult to interrupt. People with mania can also have cognitive symptoms; patients cannot stick to one topic and can quickly jump between ideas, making their thoughts difficult to understand. During a manic episode, psychotic symptoms are common. Depressive episodes in patients with bipolar disorder are symptomatically indistinguishable from those in patients with unipolar depression. Unlike anxiety and unipolar mood disorders, which are more common in women, bipolar disorder has the same sex ratio in lifetime prevalence, even though bipolar women have a higher proportion of depression episodes than men.

3.2.1 Medical history and course

Retrospective reports from community epidemiological surveys consistently show that the age of onset of bipolar disorder is earlier (teens to twenties). Although there are still controversies, there is increasing awareness of childhood illnesses. Late onset is rare. Most people with bipolar disorder have recurrent illnesses, including mania and depression. The classic description of bipolar disorder suggests a return to initial function between episodes, but many patients have residual symptoms that can cause significant harm (Angst and Sellaro 2000). These states of mania, depression, and mild (or no) symptoms are used in the following intervention analysis. The speed of the cycle between mania and depression varies from person to person. A common disease pattern is that the initial interval between episodes is relatively long, perhaps a year, and then becomes more frequent with age. A small number of patients with four or more cycles per year, known as rapid cyclers, tend to be more likely to become disabled and respond worse to existing treatments. Once the cycle is established, most acute attacks start without an identifiable cause; the most documented exception is that manic episodes can be triggered by lack of sleep, which makes regular daily sleep schedules and avoiding shift work important for management (Frank, Swartz and Kupfer 2000). In epidemiological investigations, it has been found that bipolar disorder coexists highly with other mental disorders, especially anxiety and substance use disorders (10 Have et al. 2002). The degree of comorbidity is much higher than unipolar depression or anxiety. Some people with typical symptoms of bipolar disorder also have chronic psychotic symptoms superimposed on their mood syndrome. These people are said to suffer from schizoaffective disorder. Their prognosis is often not as good as that of bipolar patients, although they are worse than those with schizophrenia. Schizoaffective disorder can also be diagnosed

when chronic psychotic symptoms overlap with unipolar depression. Individuals with this combination of symptoms have similar outcomes to schizophrenia patients (Tsuang and Coryell 1993).

3.2.2 Epidemiology and burden

Many community psychiatric epidemiological surveys report estimates of the prevalence of bipolar disorder throughout life and at 12 months. Lifetime prevalence estimates are in the range of 0.1% to 2.0% (Vega et al. 1998; Vicente et al. 2002), and the weighted average of the survey is 0.7%. The incidence estimates in the last year have a similar wide range (0.1% to 1.3%) (Vega et al. 1998), with a weighted average of 0.5%. It is important to note that there is good evidence that bipolar disorder has a wide range of subthresholds, including those that are often severely affected, even if they do not meet the full DSM or ICD criteria for the disease (Perugi and Akiskal 2002). This range can include up to 5% of the general population. The relationship between the short-term prevalence and the lifetime prevalence of bipolar disorder in the community survey is quite high (0.71), indicating that bipolar disorder is persistent. Epidemiological data indicate that bipolar disorder is associated with severe damage to social production and roles (Das Gupta and Guest 2002). Epidemiological evidence suggests that patient's initially seeking professional treatment have been procrastinating (Olfson et al. 1998), especially in early-onset cases and in severe under-treatment of current cases. Each of these characteristics (chronic and recurrent disease course; severely impaired function; moderate treatment rate) helps to estimate the total burden of disease close to schizophrenia (1,200 to 1,800 DALYs lost per 1 million population, representing more 5% of the burden of neuropsychiatric diseases

3.2.3 Intervention

The analysis of the main treatments for bipolar disorder is based on the three health states that characterize the disorder mania, depression and emotional pleasure. There is strong evidence from controlled trials that antipsychotic drugs and some benzodiazepines can reduce mania symptoms relatively quickly. Mood stabilizing drugs are slower, but can reduce the severity and duration of acute manic episodes. Maintenance therapy with two mood stabilizing drugs, lithium and valproic acid (administered as sodium valproate), has been shown to have significant (though partial) effects in reducing the rate of recurrence of mania and the Depression. The disadvantage of lithium is that the toxicity level is not much higher than the therapeutic level; therefore, it is necessary to monitor the serum level. For the cost-benefit analysis, lithium and valproic acid were considered, and their empirical data support their efficacy in the treatment and prevention of manic and depressive

episodes. As there is evidence that psychosocial methods can improve drug adherence (Huxley, Parikh and Baldessarini 2000), adjunctive strategies have also been evaluated. The main effect of treatment is the change in the level of disability in the population related to bipolar disorder (the weighted average of the time spent in mania, depression, or normal mood). The acute treatment effect, calculated as the product of the initial response and the reduced duration of the attack, and the preventive treatment effect are all attributed to lithium and valproic acid, resulting in an estimated improvement of about 50%. The untreated comprehensive disability weight is 0.445 (Chisholm et al. forthcoming). This estimate is then adjusted based on the expected non-compliance in the actual clinical environment, and lithium is slightly lower than valproic acid (Bowden et al. 2000). The side effects of treatment (two-thirds reduction in mortality) are also attributed to lithium, but due to the current lack of evidence, not valproic acid (Goodwin and others 2003). This reduction stems from the normalized mortality rate from 2.5 to 1.5, which is estimated based on natural history studies reported in the lithium era (e.g., Astrup, Fossum, and Holmboe 1959; Helgason 1964) to the post-lithium era. (e.g Goode Wen et al. 2003).

3.3.1 Major depression

The central symptom of major depression is a change in mood; sadness is more typical, but anger, irritability, and loss of interest in normal activities may be dominant. Affected people are usually unable to experience pleasure (heditation) and may feel hopeless. In many countries in developing countries, patients do not complain of such emotional symptoms, but complain of physical symptoms, such as fatigue or various pains. Typical physical symptoms that occur in all cultures include sleep disorders (the most common is insomnia waking up in the morning, but occasionally excessive sleepiness); changes in appetite (usually loss of appetite and weight loss, but occasional overeating); and reduction energy of. Behaviorally, some people with depression show slow movement (psychomotor retardation), while others may become agitated. Cognitive symptoms may include worthless and guilty thoughts, suicidal thoughts, inattention, slow thinking, and poor memory. In a few cases, symptoms of psychosis may occur.

3.2.2 Medical history and course

Major depression is a paroxysmal disease that usually starts early in life (the average age of onset in community epidemiological surveys is in the 20s), although it may be observed throughout life New episode. Although not all early childhood signs of adult depression appear in the form of obvious depression, there is an increasing awareness of the beginning of childhood. Most people with depression will relapse (Mueller et al. 1999),

and patients with early-onset illness are at increased risk of relapse. Many people cannot fully recover from their acute episodes and suffer from mild chronic depression with acute exacerbations (Judd et al. 1998). The current term for mild chronic depression lasting more than two years is dysthymia. Although, by definition, the symptoms of mild depression are not as severe as episodes of major depression, chronicity ultimately makes this milder illness highly disabling in many cases (Judd, Schettler, & Akiskal, 2002). Epidemiological research has always found that depression and other mental disorders largely coexist. About half of people with a history of depression also have lifelong anxiety. Comorbidities of depression and anxiety are usually related to generalized anxiety disorder and panic disorder (Kessler et al. 1996).

3.2.3 Epidemiology and burden

The prevalence of non-bipolar depression has been estimated in several large-scale community epidemiological surveys. In these surveys, the lifetime prevalence of major depression or dysthymia was estimated to be 4.2% to 17.0% (Andrade et al. 2003; Bijl et al. 1998), with a weighted average of 12.1%. Prevalence estimates from 6 to 12 months are equally broad (1.9% to 10.9%) (Andrade et al. 2003; Robins and Regier 1991), with a weighted average of 5.8%. These large differences in prevalence may represent the inherent difficulties of self-reporting conditions, which are always stigmatized in different cultures. The estimated prevalence is always the highest in North America and the lowest in Asia (prevalence estimates for major depression are usually much higher than for dysthymia). Epidemiological data document the continued delays of patients initially seeking professional treatment for depression, especially in early-onset cases (Olfson et al. 1998), and severe under treatment. For example, a global mental health survey conducted in six Western European countries found that in the 12 months prior to the survey, only 36.6% of patients with active non-bipolar depression received professional treatment for the disease during the year. Mental disorders | 611 (ESEMeD / MEDEA 2000 2004 researcher). The situation in developing countries is even worse. The vast majority of depression patients who seek help seek help in general medical institutions and complain about non-specific physical symptoms. These people are correctly diagnosed in less than a quarter of cases and are usually treated with drugs of questionable efficacy (Linden et al. 1999). In community surveys, depression has always been related to severe defects in production and social roles (Wang, Simon, and Kessler, 2003). Like bipolar depression, but due to its high incidence, the recurrence and disabling consequences of depression (unipolar) mean that all regions of the world have high estimates of the overall disease burden. In fact, depression is ranked as the fourth leading cause of the global disease

burden and the largest contributor to the non-fatal burden (Ustun et al. 2004).

3.2.4 Intervention

The efficacy of several types of antidepressants and two psychosocial therapies on depression has been confirmed (Paykel and Priest 1992). Older tricyclic antidepressants (TCA) and newer drugs, including selective serotonin reuptake inhibitors (SSRI), have similar effects.

Newer drugs have milder side effects and are therefore more likely to be tolerated at therapeutic doses (Pereira and Patel 1999). Due to the high cost, SSRI has not been widely used in developing countries, although this situation may change with the expiration of patent protection (Patel 1996). Among the proven effective psychosocial treatments, the most widely accepted method is cognitive behavioral methods. The use of psychosocial and drug therapy alone or in combination can accelerate the recovery from an acute attack. Maintenance medication therapy can reduce the risk of recurrence (Geddes et al. 2003). Some evidence suggests that a course of psychotherapy can also delay relapse. Although most clinical trials are conducted in industrialized countries, at least three high-quality trials have demonstrated the efficacy of antidepressants, group therapy, or both in developing countries (Araya et al. 2003; Bolton et al. 2003; Patel et al. 2003). For the cost-benefit analysis, depression is modeled as a paroxysmal disorder with a high remission rate and subsequent recurrence rate, as well as a high suicide mortality rate (Chisholm et al., 2004). However, due to the lack of strong clinical evidence that antidepressants or psychotherapy itself change the relative risk of suicide death, none of the selected depression interventions has reduced the mortality rate (Storosum et al., 2001). The main simulated effect of the intervention of intermittent treatment for new depressive episodes is a reduction in the duration of depression, which is equivalent to an increase in the remission rate (a 25% to 40% increase over no treatment; Malt et al. 1999; Solomon et al. 1997). In addition, all interventions are attributed to unresolved depressive episodes (10% to 15%) leading to a moderate improvement in the level of disability, which is due to a higher proportion of cases transitioning from a more severe health state to a less severe health state . For an estimated 56% of epidemic cases (at least two lifetime episodes) eligible for maintenance therapy, the additional effect of effective maintenance therapy reduces the incidence of recurrent episodes by 50% (Geddes et al. 2003). The estimate of the effectiveness of the intervention includes naturally occurring positive changes, as well as any placebo effects, which cannot be ignored in the treatment of depression (Andrews 2001).

3.3 Anxiety disorders

Anxiety disorders are a group of diseases characterized by the inability to regulate fear or worry. Although anxiety itself may be a feature of the clinical manifestations of most patients, physical symptoms such as chest pain, palpitations, dyspnea, and headaches are also common, and these symptoms may be more common in countries in developing. There are many different types of anxiety disorders, some of them are briefly described below. The main feature of panic disorder is an unexpected panic attack, which is a discontinuous period of intense fear accompanied by physical symptoms such as rapid heartbeat, shortness of breath, sweating, or dizziness. This person may be very afraid of losing control or dying. Panic disorder is diagnosed when panic attacks repeat and cause anxiety about the anticipation of additional attacks. People with panic disorder may gradually limit their lives to avoid situations where a panic attack occurs or situations that may be difficult to escape when a panic attack occurs. They usually avoid crowds, travel, bridges and elevators, and eventually some people may stop leaving the house altogether. The widespread fear avoidance is described as agoraphobia. Generalized anxiety disorder is characterized by chronic excessive and unrealistic worry. These symptoms are accompanied by specific anxiety-related symptoms, such as arousal of the sympathetic nervous system, hypervigilance, and exercise stress. Post-traumatic stress disorder occurs after severe trauma. It is characterized by emotional numbness, interrupted by an invasive review of traumatic events, usually triggered by environmental cues that serve as reminders of the trauma; restless sleep; and excessive excitement, such as exaggerated startle reactions. Social anxiety disorder (social phobia) is characterized by a constant fear of social situations or performance situations, exposing a person to possible scrutiny by others. The affected person is very afraid of acting in a humiliating way. It is difficult to distinguish social anxiety disorder from extreme normal temperaments (such as shyness). However, social anxiety disorder can cause serious disability. Simple phobias are extreme fears in the presence of unobtrusive cues or stimuli, such as the fear of heights. The core features of obsessive-compulsive disorder are obsessive-compulsive disorder (intrusive and unwanted thoughts) and obsessive-compulsive disorder (displaying highly ritualized behaviors aimed at neutralizing the negative thoughts and emotions caused by obsessive-compulsive disorder). A symptom pattern may be repeated hand washing outside the point of skin damage to eliminate the fear of contamination.

3.3.1 Medical history and course of illness

The age of onset, course of illness, and symptom triggers of anxiety disorders are different. One of these disorders, post-traumatic stress

disorder, depends on the cause of one or more strong negative life events. Although anxiety disorders were analyzed as a group, panic disorder was chosen for the purpose of cost-benefit analysis because of the available data. According to community epidemiological surveys, estimates of the prevalence of anxiety disorders vary greatly, ranging from a low of 2.2% (Andrade et al. 2003) to a high of 28.5% (Kessler et al. 1994). The weighted average of the survey is 15.6%.

Estimates of the prevalence of anxiety disorders in the past 6 to 12 months are equally broad (1.2% to 19.3%) (Andrade et al. 2003; Kessler et al. 1994), with a weighted average of 9.4%. Although the overall prevalence varies widely, several clear patterns of relative prevalence can be observed in all surveys. Specific phobias are usually the most common lifelong anxiety disorder, and social phobias are usually the second most common lifelong anxiety disorder. Panic disorder and obsessive-compulsive disorder are usually the least common. These surveys also provide evidence of the persistence of anxiety disorders, which are indirectly defined as the relationship between the 6 or 12-month prevalence and lifetime prevalence. For general anxiety disorders, this proportion averages about 60%, indicating a high rate of lifetime persistence. Social phobia has the highest persistence and agoraphobia has the least persistence. These estimates of high durability are consistent with the results obtained from a longitudinal study of patients (Yonkers et al. 2003). In epidemiological investigations, anxiety disorders have always been found to coexist largely between anxiety disorders and mood disorders (e.g., de Graaf et al. 2003). The vast majority of people with a history of one type of anxiety also suffer from the second type of anxiety, and more than half of people with a history of anxiety or mood disorders tend to have both types of anxiety at the same time. Retrospective reports from community surveys consistently show that the average age of onset of anxiety disorders is earlier. An impressive cross-country consistency can be seen in these patterns, and the average age of onset of anxiety is estimated to be approximately.

The epidemiological survey also studied the treatment of anxiety disorders. As with depression, consistent evidence from these surveys suggests that initial delay in seeking professional treatment is common after the first onset of anxiety (Olfson et al. 1998). This finding is especially true in early-onset cases. Epidemiological data also show that in Western countries, only a few cases currently receive any formal treatment, while in many developing countries, treatment for anxiety disorders is almost non-existent. A recently published survey, the World Mental Health Survey conducted in six Western European countries, found that in the 12 months prior to the survey, only 26.3% of people with active anxiety disorder had received any professional treatment (ESEMeD / MEDEA 2000 Investigators 2004).

Anxiety disorders have been found to be associated with severe damage to production roles (for example, absenteeism, job performance, unemployment and underemployment) and social roles (social isolation, interpersonal tension, marriage breakdown, etc.) (For example, see Kessler and Frank 1997). As mentioned earlier, for the purposes of this chapter, a type of anxiety disorder, panic disorder, is selected to describe the intervention and to perform a cost-benefit analysis. Panic disorder is just as disabling as obsessive-compulsive disorder. Post-traumatic stress disorder accounts for about one-third of all seriously harmful anxiety disorders. It is one of the most common anxiety disorders that requires treatment. It is estimated that every million inhabitants bears a load of 600 to 800 DALY. There is ample evidence that drugs and psychosocial therapy are effective in controlling anxiety. Antidepressants (former ACTs and SSRIs) have been shown to be effective in treating a variety of anxiety disorders, including panic disorder, and reduce the duration and intensity of the illness. Although highly potent benzodiazepines are effective for panic disorder, these drugs have a risk of dependence and are not considered first-line treatments. Psychosocial therapy, especially cognitive behavioral therapy, is also very effective in reducing panic attacks and avoidance of phobias. Interventions for panic disorder Although evidence-based interventions for panic disorder have not been evaluated or widely used in developing countries, many interventions (including more new and old antidepressants, anti-anxiety drugs (benzodiazepines)) And psychosocial treatment, declined. Review.

Interventions can reduce the severity of panic attacks and increase the likelihood of complete recovery. The effect of symptom improvement is obtained from a meta-analysis of the long-term effects of panic disorder interventions (Bakker et al. 1998), and translated into an equivalent change in the weight of disability (Sanderson et al. 2004). Regarding remission, several controlled and naturalistic studies (such as Faravelli, Pateriti, and Scarpato 1995; Yonkers et al., 2003) have shown that the remission rate of drugs and combination treatment strategies is 12% to 13%, but the use of benzodiazepines With the exception of drugs, there is evidence that long-term recovery is actually worse than placebo (Katschnig et al. 1995), which is a 62% improvement in efficacy compared to the untreated response rate (7.4%).

SELF-ASSESSMENT EXERCISE

i. Describe common mental health conditions
ii. Briefly describe the characteristics of common mental health conditions
iii. State the disease burden of common mental conditions

4.0 CONCLUSION

Mental disorders are diseases that affect cognitive, emotional, and behavioral control, and seriously interfere both the learning ability of children and the ability of adults to play a role in the family, work and society as a whole. In this unit, the discussion focuses on the history, causes, epidemiology, and intervention strategies of some common mental health conditions. This unit also discusses the burden of schizophrenia, anxiety, mood disorders, and depression

5.0 SUMMARY

In this unit, students learn the history, causes, epidemiology, and intervention strategies of some common mental health problems. The unit also teaches the burden of schizophrenia, anxiety, mood disorders and depression

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES/FURTHER READING

2001 World Health Organization estimates of the global burden of disease recalculated by the World Bank region (http://www.fic .nih.gov/dcpp/gbd.html).

https://www.dcp3.org/sites/default/files/dcp2/DCP31.pdf

MODULE 2

UNIT 1 THE CONCEPT OF STIGMA IN MENTAL ILLNESS

CONTENTS

1.0 INTRODUCTION

Mental illness related stigma may be as old as human civilization itself. However, as stigma affects the care of people with mental illness and their human rights, it has recently become increasingly important. Stigma is generally believed to be the key to seeking care for people with mental illness, but it is often one of the hidden obstacles. In the most famous work on the concept of stigma, Goffman referred to it as an "altered identity" (Goffman, 1986). This identity can be private, involving internalized feelings about oneself, or it can be public, involving negative views or behaviors of others. Avoiding negatively labeling yourself or hiding your problems from others is believed to lead to avoidance of treatment, increase abstinence from treatment, and reduce adherence to treatment (see Corrigan, 2004 review).

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- Stigma and stigma in mental illness
- Discuss the historical perspective of stigma in mental illness

3.0 MAIN CONTENT

Construct: stereotype, prejudice and discrimination (Corrigan, 2004). Stereotypes are a set of beliefs about the members of a certain group, which generally represent the common beliefs of society about the group. Stereotypes are generally not controlled by the individual; a person may inadvertently apply negative stereotypes, even if they express a relatively positive and unbiased feeling about a group (Devine and 3 Sharp, 2009).

Stereotypes can include, for example, beliefs that people with mental illness are violent and dangerous, and beliefs related to the causes of mental health problems (Corrigan et al., 2002). For example, stereotypes may include beliefs that mental illness is caused by a person's actions or inactions or due to defects in moral character (Pescosolido et al., 2010). Another stereotype often seen as part of the stigma of mental illness is the belief that people cannot recover from mental disorders. Prejudice is a negative attitude towards individuals or groups (eg, "I don't like / don't want to contact people with mental health problems") (Allport, 1979).

Prejudice can be expressed as the degree of disposition (for example, disposition to be friends, jobs and neighbors) that a person expresses in different interpersonal interactions with people with mental illnesses (Pescosolido et al., 2010). Discrimination is the behavioral aspect of stigma and is believed to be caused by prejudice or stereotypes. It includes the aforementioned social exclusion and negative social interactions, as well as laws, policies and practices that unfairly treat people with mental illness (for example, restricting their right to hold public office or vote or restrict their parental rights (Hemmens et al. al., 2002). Year))).

Stigmatization of mental illness can also reduce the well-being of people with mental illness. The internalization of negative opinions is related to low self-esteem, self-blame, and negative emotional states (Link et al., 1987). The pressure to hide one's mental illness can also hurt those who choose to do so. Goffman discussed the phenomenon of "handover" in which individuals with characteristics of social stigmatization try to hide it from others (Goffman, 1986). In Goffman's view, the psychological cost of living a life of concealment is considerable. There is no direct evidence in this regard, especially among people with mental health problems, but this effect is consistent with some theories from social psychology on the impact of concealment on stress (Pachankis, 2007; Smart and Wegner, 1999, 2000).

Mental illness stigma: a demographic profile Mental illness stigma is common in the United States. The 1996 and 2006 General Social Surveys (GSS) were surveys of a representative group of adults in the United States, which included questions about public knowledge and responses

to mental illness. In 2006, nearly one-third of U.S. adults supported schizophrenia and depression as a result of "grumpy", although a larger group (mostly) attributed both schizophrenia and depression to neurobiology reason. From 1996 to 2006, the percentage of respondents supporting each neurobiological attribution of schizophrenia and depression increased significantly, while the personality attribution remained stable (Pescosolido et al., 2010). This shows that the two investigating agencies have a better understanding of the causes of mental illness, but the blame persists. Guilt can cause or become a symptom of the stigma of mental illness.

Most of those interviewed in 2006 stated that they were unwilling to work closely or socialize with people with schizophrenia, and were unwilling to allow such people to marry their families. Acceptance of people with depression is much better, but about one in two adults reject the idea of a family or work marriage to people with depression. Most people are willing to be friends with anyone in any situation. Comparing the results from 1996 and 2006, only one area for improvement was found: Respondents in 2006 were more willing to be neighbors with people with mental illness. These beliefs have important implications for the social integration of people with mental health problems.

Many adults have also described that people with these diseases can act violently towards each other and towards themselves. In 2006, 60% and 84% of people agreed with these views on schizophrenia, and 32% and 70% agreed with depression (the results are similar to the survey of 1996) (Pescosolido et al., 2010). These views can be increased. Although the 1996 GSS results were similar to the 2006 results, in response to a previous public attitude survey (1989), 24% of respondents agreed that people with chronic mental illness are at higher risk than the general population (Borinstein, 1992).). A 1990 survey found that the majority of respondents believed that "although some people who have been patients in psychiatric hospitals look fine, it is important to remember that they can be dangerous." 59% said that "this is natural to be afraid of the mentally ill" (Phelan and Link, 2004). Comparison of responses from the 1950 survey that asked respondents to describe open-ended items from patients with mental illness and responses to the same item on the 1996 GSS showed that the percentage of people who described people with mental illness as violent it increased from 7% to 12% (Phelan, Link, Stueve and Pescosolido, 2000). This trend may reflect real changes in negative attitudes towards mentally ill patients, but the different results may also be due to differences in the survey items used.

Some of these studies have found that different sociodemographic groups have different attitudes and beliefs of stigma. For example, in the 1990 survey, there was a non-linear relationship between age and perceived

risk: as age increased, it first decreased and then increased. Respondents were ethnic minorities, less formal education, and lower family income levels. 10 20 30 40 50 60 70 80 90 100 Percentage of people who have married, make friends, socialize and have close cooperation with neighbors) Schizophrenia, depression6 People with mental illness are considered more dangerous than the general population. Gender has nothing to do with the perception of danger (Phelan and Link, 2004).

A 1997 study also found that ethnic minority people believe that people with mental illness are more dangerous than white respondents (Whaley, 1997). However, a 1996 GSS analysis found that there were no differences between ethnic minorities and white respondents in terms of stigmatizing beliefs. When checking social distance (people are willing to interact with people with mental illness and want to avoid interacting with people with mental illness), only two of the seven demographic factors examined can predict stigma: higher income levels High respondents and those who live in more urban areas are more likely to avoid people with mental illness. Age, gender, and race / ethnicity have nothing to do with social distancing attitudes (Martin, Pescosolido & Tuch, 2000). In 2006, a survey of a representative sample of adults living in Canada found that more men than women support stigmatizing beliefs. Compared to people with lower levels of education, people with higher levels of education have more mental illnesses and are less stigmatized (Cook and Wang, 2010).

SELF-ASSESSMENT EXERCISES

i. Determine people's opinions about the stigmatization of mental illness
ii. Factors that lead to stigma

4.0 CONCLUSION

A stereotype is a set of beliefs about the members of a certain group, which generally represents common beliefs of the company over the group. Stereotypes are generally not controlled by the individual; a person may inadvertently apply negative stereotypes, even if they express a relatively positive and unbiased feeling about a certain group. This unit reports the results of scientific research to explain the basis of stigma and stigma in mental health.

5.0 SUMMARY

In this unit, students learn about people's opinions about mental health. Explain many people's perceptions of mental health stigma through scientific research.

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES/FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

UNIT 2 TYPES OF STIGMA

CONTENTS

1.0 INTRODUCTION

Social stigma is extreme opposition to individuals based on social characteristics that are believed to distinguish individuals from other members of society. Social stigma runs so deep that positive social feedback about the ways in which the same person complies with other social norms overwhelms.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- Identify forms of stigma
- Briefly describe the different types of stigma

3.0 MAIN CONTENT

Stigma plays an important role in sociological theory. One of the founders of the social sciences, Émile Durkheim, began studying the social signs of deviance in the late 19th century. The American sociologist Erving Goffman (Erving Goffman) is responsible for bringing stigmatized terms and theories into the main field of social theory. In his works, Goffman uses stigma as a basic tenet of social theory, including his interpretation of "stigma" as a means of undermining identity. In this way, he mentioned that stigmatized nature "undermines" the individual's ability to recognize social norms in other aspects of the self. Goffman identified three main types of stigma:

(1) Stigma related to mental illness;
(2) Stigma related to physical deformation; and
(3) Stigma related to a specific race, ethnicity, and religion.

Although Goffman is responsible for the fundamental text of stigma theory, stigma remains a popular topic in contemporary sociological

research. In Conceptualizing Stigma (2001), sociologists Jo Phelan and Bruce Link explained stigma as a fusion of four different factors:

(1) The differentiation and labeling of various classes of society
(2) Will be different Socio-demographic labels associate individuals with prejudice against these factors;
(3) The development of co-use ethics; and
(4) Disadvantaged people who are marked and placed in the category of "them".

In the final analysis, stigma is related to social control. Inferring from this, stigma must be a social phenomenon. Without society, there can be no stigma. To have a stigma, a person must have a stigmatized person and a stigmatized person. Therefore, this is a dynamic social relationship. Since stigma originates in social relationships, this theory emphasizes not the existence of abnormal characteristics, but the perception and marking of certain characteristics by the second party. For example, stigma theorists are rarely concerned with whether Emily has a psychiatric diagnosis, but rather with how Sally views Emily's psychiatric diagnosis and then treats Emily in a different way. Stigma depends on another person's perception and understanding of the characteristics of stigma. Since stigma must be a social relationship, it must be full of power relationships. Stigma is committed to controlling abnormal members of the population and encouraging conformity.

Harmful effects of stigmatization

Some of the effects of stigma include:

- Feelings of shame, despair, and isolation
- Reluctance to seek help or treatment
- Lack of understanding from family, friends, or others
- Reduced employment opportunities or Social interaction
- Bullying, physical violence or harassment
- Doubt: Believe that you will never be able to overcome the disease or achieve the life you want.

Dealing with stigma

Here are some ways to deal with stigma:

- Get the mental health treatment you need. Try not to let the fear of being labeled a mental illness stop you from seeking help.

- Don't believe it. Sometimes if you hear or experience something frequently, you will start to believe in yourself. Try not to let the ignorance of others affect your perception of yourself. Mental illness is not a sign of weakness and you can rarely solve it yourself. Discussing your mental health problems with a

healthcare professional will help you on the road to recovery or management.

- Don't hide. Many people with mental illness want to isolate themselves from the world. Reach out to someone you trust - family, friends, coach, or religious leader - which means you can get the support you need.

- Connect with others. Joining a mental health support group, either online or in person, can help you deal with feelings of isolation and make you realize that your feelings and experiences are not alone.

- You are not your disease. Don't use illness to define yourself the way other people do. Instead of saying "I have schizophrenia", it is better to say "I have schizophrenia". Language has power.

- This is not personal. Remember, other people's judgments often come from a lack of understanding, not for any other reason. These judgments were made before they met you, so don't think their opinions have anything to do with you personally.

Discrimination against you

Australia At the international level, the United Nations General Assembly has formulated the principles of "protecting patients with mental illness and improving mental health care." The World Health Organization also has information on mental health and human rights.

Challenging the stigma associated with mental illness

Everyone can play a role in creating a mentally healthy community, a community that tolerates, rejects discrimination and supports recovery. Ways to help include:

- Learn the facts about mental illness and share them with family, friends, colleagues, and classmates

- Meet people with personal experiences of mental illness so you can learn to treat them in the way they prefer more than their sick ones.

- When you meet someone with a mental illness, don't judge, mark, or discriminate. Treat everyone with respect and dignity.

- Avoid using language that puts disease first and people second. Say "a person with bipolar disorder" instead of "that person is a person with bipolar disorder".

- When you hear people around you making stereotyped or inaccurate comments about mental illness, please say something.

- Share your own mental illness experience (if you have ever experienced it). This will help dispel the myth and encourage others to do the same. Mental illness is not shameful and must be hidden.

Mental Health: Overcoming the Stigma of Mental Illness, Mayo Clinic Sane Australia; Reducing Stigma

SELF-ASSESSMENT EXERCISES

i. Brief analysis of the types of mental health stigma
ii. Determining the harmful effects of stigma

4.0 CONCLUSION

Stigma commits to controlling anomalous members of the population and promoting compliance. This unit explains the types of stigma, the harmful effects of stigma, and the defiant stigma associated with mental illness

5.0 SUMMARY

In summary, this unit has taught you about the types of stigma, the harmful effects of stigma, and related challenges. Stigma People with Mental Illness

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES/FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

UNIT 3 THEORIES TO REDUCE THE STIGMA OF MENTAL ILLNESS

CONTENTS

1.0 INTRODUCTION

Stigma refers to someone who is due to a particular characteristic or attribute (for example, skin color, cultural background, disability or illness). When someone treats you negatively because of your mental illness, this is discrimination. Stigma arises when a person defines someone by their disease rather than by them as an individual. For example, they can be labeled as "mentally ill" instead of being a mentally ill person. For people with mental health problems, the social stigma and discrimination they experience can make their problems worse and make recovery more difficult. It may cause the person to avoid getting the help they need for fear of being stigmatized.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- Discuss theories to reduce the stigma of mental illness
- State the plan to reduce the stigma of mental illness

3.0 MAIN CONTENT

Some theorists believe that it produces changes in ingrained attitudes and attitude behaviors need to produce mutually reinforcing changes on multiple levels, usually using a multi-component approach (Hornik, 2002). Stigma can exist at the institutional, social and personal level and describe these levels as mutual influence. Successful interventions take advantage of these interdependencies. It is believed that the reduction in smoking in the United States may be based on this process. Effective media campaigns, such as the Truth About Smoking campaign, reduce the smoking rate by a small amount (12%) each year. At the same time, these movements changed social norms and stopped accepting smoking. This rule change encouraged policy changes that made smoking less

convenient (for example, smoke-free buildings) and strengthened anti-smoking rules. In turn, personal smoking rates have further declined (Hornik, 2002). This pattern of change shows that with the integration of social norms, personal behaviors and beliefs, and institutional policies and practices, support for accepting people with mental health problems and the degree of intervention, the stigma of mental illness may be reduced. .

Several specific theoretical models of mental illness stigma describe the components that should be part of this type of intervention. Contact, education, and protest are the core elements of influential stigma reduction theory (Corrigan and Penn, 1999). Contacts include videos of people with mental illness or 8 direct face-to-face contacts. Educational methods to reduce mental health stigma aim to provide objective information about mental illness and rehabilitation, replace inaccurate stereotypes and beliefs, and enhance positive attitudes (eg about rehabilitation, empowerment, social inclusion). There is some evidence to support education, and research on the impact of direct contact strategies on stigma reduction has produced promising results (Couture and Penn, 2003; Yamaguchi, Mino, and Uddin, 2011). But protests, including identifying cases of prejudice or discrimination, promoting and opposing them, can be ineffective and can even lead to further discrimination or fear of discrimination, because more attention is paid to the cases in which it occurs (Corrigan et al., 2001). In other words, when a person with negative beliefs about mental illness is trying to avoid these thoughts attentively, they need to regularly monitor their mind for inappropriate thoughts. The irony is that he or she pays more attention to these beliefs and is more likely to play a role in their interactions (Macrae et al., 1994). This counterintuitive influence of thought suppression is a universal, nonspecific phenomenon of prejudice: the more we try not to think about something, the more our thoughts annoy us (Wegner, 1994). Perhaps, for this reason, there seems to be an increasing focus on establishing support networks or empowering people with mental illness through intervention efforts, rather than emphasizing opposition to stigma.

The importance of exposure in reducing the stigma of mental illness is consistent with the broader theory in social psychology of reducing prejudice and discrimination. However, the "contact hypothesis", as commonly mentioned in this paper, suggests. Equal status, common goals, conditions that support access to people in positions of power or authority, and the absence of competition should be part of the interaction between two groups or group members (Pettigrew and Tropp, 2006).

This larger document also proposes other ways to reduce prejudice, which are not directly addressed in the literature on mental illness stigma. A recent report by the American Psychological Association (APA) (2012)

described several evidence-based strategies. In addition to contact, the report points out that interaction, cooperative learning or cooperative interaction can be effective ways to reduce prejudice. "Reclassification intervention" attempts to decompose or reorganize social categories. Some plans emphasize that "anyone can suffer from mental illness." Mental illness will affect the majority of the population, or people with mental illness will recover. These ideas are only indirectly related to stigma, but can be based on an intuitive understanding of reclassification. Changing these beliefs is likely to break the perception of "us" and "them". Interventions that focus on the personality and diverse experiences of people with or without mental health problems will also involve these processes, presumably reducing the possibility of classifying people based on their mental health history. Report APA (2012) also noted that, compared to static, people who believe that human nature is changeable tend to be less prejudiced and support opinions that emphasize affirmative attitudes, such as the possibility of recovery of patients mental health. Mental health Challenges can help reduce the stigma of mental illness. Other effective strategies that may be applicable to reduce the stigma of mental illness include making people feel guilty about prejudiced beliefs, inducing sympathy and enhancing the skills of prejudiced objects (mental patients), and empowering people to get rid of them stereotypes by repeatedly confronting them. Prejudge and allow them to practice suppressing their stereotypes.

3.1 Projects to reduce the stigma of mental illnesses

Parallel to these theories, although they are not always based on them, a large number of plans and initiatives try to reduce the stigma of mental illnesses. They can be roughly divided into two categories: training interventions involving face-to-face communication between educators / speakers and small and medium-sized groups, and broad and multi-faceted media campaigns and interventions. Some initiatives include these two components.

Training interventions

Training interventions generally involve educational content, providing information on the causes of mental illness, mental health treatment and the experiences of patients with mental health problems to eliminate stereotypes and prejudices and promote attitudes positive towards mentally ill patients. Disease (Corrigan and Penn, 1999). Some training interventions include only educational strategies, while other training interventions combine educational strategies with 10 contact strategies. There are a variety of training interventions for different audiences, including students, healthcare professionals, and the general public. Strategic training for “key power groups” such as employers, landlords, criminal justice, healthcare providers, policy makers, and the media is

considered a potentially effective way to reduce stigma (Corrigan, 2004, 2011). Quite a few of these programs have been evaluated. For detailed information on the evaluation of a selected set of key examples, please refer to the appendix.

Educational strategies

Training interventions based on educational principles can be relatively low-cost SDR methods that can be widely disseminated (Lincoln et al., 2008; Mino et al., 2001; Schmetzer, Lafuze, and Jack, 2008). The short-term effects of educational interventions on mental illness attitudes have received some empirical support (Corrigan and Penn, 1999; Penn et al., 1994, 1999); there is relatively little evidence on the effects of long-term outcomes or behavior changes (Corrigan & Gelb, 2006). Interestingly, the definition of the etiology of mental illness as an educational method that mainly has a biological or genetic component (Brown and Bradley, 2002; Mann and Himelein, 2008) has been shown to counteract certain forms of stigma (for example, Compensation for blame), while strengthening other aspects (for example, the belief that mental illness is incurable) (Corrigan & Shapiro, 2010). In addition, the improvement of mental health literacy is related to more negative attitudes, such as the desire to maintain social distancing from people with mental illness (Angermeyer, Holzinger, and Matschinger, 2009; Schomerus et al., 2012).

Education programs are usually strategically positioned for different audiences. Efforts have been made to provide educational programs to professional groups such as health care providers who, due to the nature of their positions, may come into contact with people with mental illness. Several studies have tested the effectiveness of educational programs for health care providers still undergoing training (such as pharmacy students, medicine, occupational therapy) (Beltran et al., 2007; Mino et al., 2001; O`Reilly et al. , 2007). , 2011). The results show that trained health care providers can show positive attitude changes within a few weeks after receiving educational interventions (Beltran et al., 2007; Altindag et al., 2006). The extensive 40-hour crisis intervention training provided to police officers enables police officers to feel a higher sense of self-efficacy when working with people in crisis (Bahora et al., 2008), higher awareness, and greater awareness of patients with mental illness. Positive attitude (Compton et al., 2008)., 2006).) And reduce the stigma of people in crisis (Bahora et al., 2008; Compton et al., 2006). Such training may also reduce the use of force and unnecessary arrests, and increase referrals to mental hospitals (Bower and Pettit, 2001; Steadman et al., 2000). In short, the less extensive training of police has also increased awareness of mental illness, although the reduction in stigma has not been proven (Pinfold et al., 2003).

Since a large proportion of young people have mental illness for the first time during adolescence (Costello, Foley, and Angold, 2006), adolescents have been the target of many RDS educational interventions. Among the high school population, educational interventions have produced positive results in terms of attitude and knowledge (Essler, Arthur, & Stickley, 2006; Rahman et al., 1998; Morrison, Becker, & Bourgeois, 1979). 11 similar benefits for undergraduates. Reducing self-stigma and promoting feelings of empowerment and self-determination among people with mental illness have also been the focus of educational interventions. Educational interventions aimed at reducing self-stigmatization have limited support (MacInnes and Lewis, 2008; Alvidrez et al., 2009); however, no impact on behavioral outcomes was found. Mental Health First Aid (MHFA) (Kitchener & Jorm, 2002) is an educational program that trains people to recognize when a person has a mental health problem and how to provide support. MHFA has been shown to produce positive changes in the knowledge, attitudes and behaviors of the general population (Kitchener & Jorm, 2002, 2006; Jorm et al., 2010).

Contact Strategies

There is evidence that encouraging interaction with people with mental illness may have a greater impact on attitude changes than education or protest strategies (Corrigan et al., 2001). In addition, interpersonal communication strategies are related to the results of behavioral changes and long-term attitude changes (Corrigan et al., 2003a, 2003b). Therefore, in the review of SDR interventions for the young population (Yamaguchi, Mino, and Uddin, 2011), direct contact with people with mental illness appears to be a key component of reducing stigma, while education is a single and video-based contact strategy Its role is still questionable. A recent meta-analysis reported consistent findings, which found that direct contact strategies were more effective than video-based contacts (Corrigan et al., 2012). In addition, compared with education strategies, contact strategies are more effective for adults, but the opposite is true for young people.

A widely publicized SDR intervention that emphasizes interpersonal communication is the In Our Own Voice (IOOV) program of the National League for Mental Illness (PintoFoltz, Logsdon, and Myers, 2011; Pitman, Noh, and Coleman, 2010; Wood and Wahl), year 2006). IOOV involves a 90-minute group interaction, led by two group counselors with serious mental illness, and he's on the mend. The presenter showed a video with five main parts, covering the first experience of mental illness, acceptance of the illness, treatment, coping mechanism, overcoming the mental illness and progress towards the goal. After each section, the coordinators share their corresponding personal experiences and lead group discussions and interactions. Compared with the control group, the individuals who participated in IOOV showed less stigmatizing and social

avoidance attitudes (Rusch et al., 2008; Wood and Wahl, 2006). Furthermore, compared to the educational intervention alone, participants who participated in the shortened 30-minute version of IOOV recalled more positive than negative stereotypes about mental illness (Corrigan et al., 2010).

Extensive and multifaceted media campaigns and interventions

Extensive media campaigns usually convey educational messages, just like the messages contained in SDR training. It usually provides information about the causes, symptoms, prevalence, and treatability of mental illness. Sometimes this information is sent by a mental health professional, usually a celebrity. Usually, when the person in the media promotion is someone who has experienced mental health problems, it can also be said that contact is involved.

According to the conceptual model, large-scale initiatives usually include a multi-faceted special drawing rights strategy that combines media information with community and organization mobilization activities. These large-scale initiatives focus very broadly on the stigma of mental illness, or mostly schizophrenia or depression.

Although there are many large-scale interventions aimed at reducing the stigma of mental illness, some of which are global, only a few have been evaluated and not in the United States (Corrigan, 2012). The most frequently cited assessments are the two efforts of the United Kingdom, "Overcoming Depression" (Paykel, Hart, and Priest, 1998) and "Changing Mind" (Crisp et al., 2005), as well as comments on Like Minds, Like Mine. Long-term continuous evaluation, in New Zealand (Vaughan and Hansen, 2004). All of these involve repeated cross-sectional population studies. Fighting depression seems to reduce stigmatized beliefs about depression and the suicide rate. The second initiative followed closely behind, aimed at addressing a wider range of mental health issues. Changing thoughts is related to positive changes in attitudes and beliefs, although they are moderate. However, for each of these initiatives, the evidence of effectiveness is weakened due to the lack of comparison groups. Over time, the changes may reflect changes caused by factors unrelated to the anti-stigma initiative.

Other key initiatives have produced stronger evidence and fairly consistently demonstrate that large-scale SDR methods are effective. A recent work aimed at assessing the intensive movement to see me in Scotland used the Survey of Attitudes in English as a comparison and used it as a benchmark to see my effect. The results showed that the impact of changing your mind was short-lived, as the stigma of mental health increased shortly after the campaign ended; however, during the same period, Scottish attitudes were mostly stable. During this period,

media reports on mental health problems in both countries were negative. Therefore, in the absence of other factors, it may make people's negative attitudes towards mental illness more negative, but the "See Me" movement may be in Scotland. Minimize this impact.

An evaluation of the Australian and German initiatives suggests that the SDR movement can go beyond reducing negative attitudes, increasing awareness of symptoms of self and others, and providing more help for depression. Beyond Blue (Hickie, 2004) is an Australian government funded depression initiative that includes protest strategies (e.g. educational journalists, advertising campaigns), direct contact and interaction (e.g. celebrities talking about depression) and provision of educational materials (eg Printed Materials, information posted on the Internet). Using states with less activity as a control group, states that were more active in implementing the Beyond Blue component showed a more open attitude towards depression and a more positive belief in the usefulness of treatment (Jorm, Christensen, and Griffiths, 2005, 2006 Years). Compass Strategy is an Australian initiative aimed at addressing mental illnesses other than emotional disorders and has produced similar effects. Germany's assessment of Open the Doors, a global initiative aimed at addressing the stigma of schizophrenia, shows promising improvements in attitudes and beliefs.

However, the most impressive results to date come from the evaluation of the Nuremberg Alliance Against Depression (Hegerl and Wittenburg, 2009), a community campaign conducted from 2001 to 2002. It involved interventions with community providers (e.g., police, clergy, and teachers), consumers and their relatives, and a public information campaign. Compared to Wurzburg, a nearby city that served as a control (Dietrich et al., 2010), residents of Nuremberg exhibited more positive attitudes toward antidepressants, increased awareness of depression, and diminished beliefs that depression was due to a lack of self-discipline (Hegerl and Wittenburg, 2009). These shifts toward depression awareness and perceived treatability may have resulted in greater treatment-seeking among those in distress. Of significant note, Nuremberg demonstrated a greater reduction in suicidal acts compared to Wurzburg, the effects of which persisted a year after the intervention had ended (Hegerl and Wittenburg, 2009).

Together, these studies indicate strong potential for using SDR methods combining media campaigns with trainings and other direct intervention to improve attitudes toward a variety of mental health problems. They suggest that behavioral outcomes such as treatment-seeking may be influenced as well. There is some evidence that the effect of campaigns wears off shortly after initiatives are concluded, but few studies conducted

any follow-up to determine this. It will be important for future evaluations to test for enduring effects whenever possible.

SELF-ASSESSMENT EXERCISES

State and briefly explain the mental illness stigma reduction programs

4.0 CONCLUSION

Theorists argue that producing shifts in deeply ingrained attitudes and behaviors requires producing mutually reinforcing changes at multiple levels, typically with a multicomponent approach (Hornik, 2002). Stigma can exist at the level of the institution, society, and individuals and depicts these levels as influencing one another. This unit discusses the perceptions of the theorists of stigma reduction. It also identify and explains stigma reduction programs.

5.0 SUMMARY

In this unit students will learn the perceptions of the theorists of stigma reduction. It also identify and explains stigma reduction programs.

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES/FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

UNIT 4 THE LAW AND MENTAL HEALTH STIGMA

CONTENTS

1.0 INTRODUCTION

The law does not help to reduce stigma, and it can even be argued that it is exacerbated by the failure to recognize stigma and its adverse effects on mental health and the rights of people with mental illness. In fact, the mention of mental health in our legislation generally does not provide human rights protection, and is generally excluded on the grounds of "mental disorder."

2.0 OBJECTIVES

By the end of this unit, you will be able to explain

- The role of the law in reducing stigma in mental health
- Identify reform proposals to reduce stigma in mental health laws

3.0 MAIN CONTENT

Some human rights violations have been victimized. The deepest is the right to equal rights and non-discrimination. Currently, the law does not specifically address the issue of discrimination because there is currently no legislation on mental health. However, the 1999 Constitution of the Federal Republic of Nigeria prohibits discrimination.

1. However, it did not clearly indicate that health status is one of the reasons for prohibiting discrimination. Perhaps recognizing this, the law specifically addresses the issue of discrimination against people living with HIV/AIDS and persons with disabilities. Therefore, the 2014 HIV/AIDS Anti-Discrimination Law and various anti-discrimination laws of Enugu, Ekiti and other states, as well as the 2011 Lagos State Special People's Law and other legislation. However, there are no laws specifically addressing discrimination based on mental health status.

In addition, mental illness is not well recognized in law as a disability problem. In addition, legislation across the country has not effectively addressed disability issues; Lagos State remains a notable exception. For example, the Lagos State Special People's Law of 2011 addresses many aspects of disability, and has established a special agency to manage disability-related issues and provide a voice for all types of disabled people. However, it does not mention mental health or provide any intervention in this regard. In my opinion, most of the problem of abuse of power to imprison a person involuntarily in a facility also comes from stigma, which is a form of dehumanization and heterosexuality, allowing people who do not necessarily conform to this idea to make promise the "normal "Under what circumstances can a mentally ill person be fixed or legally detained in Nigeria? Who makes this call when? Previous research in this field has shown that involuntary detention or detention in Nigeria has a long history, first of all by the British colonial ruler before Nigeria's independence.

2. Of course, under certain circumstances, people with mental illness may be detained involuntarily against their will: when people pose a danger to themselves or others. However, human rights principles require certain steps to be taken to ensure any unintentional restrictions on mental health within certain prescribed parameters. In 1991, the UN Principles for the Protection of Patients with Mental Illness and the Improvement of Mental Health Care and the guidelines formulated below provide clear guidance on mental health, as do some documents of the World Health Organization. The Nigerian Constitution also provides for certain rights that apply to mental patients and other citizens of the country. Generally speaking, involuntary detention should only occur when the person may harm himself or others. It is not clear whether many psychiatrists and other medical professionals in Nigeria really understand or apply it appropriately. The result is a careful realization that psychiatrists and other medical staff make certain judgments about the treatment of patients with mental illnesses that are ethical and in the best interests of patients and society. Therefore, stigma is a key challenge that must be addressed from multiple perspectives. More and more awareness is increasing, especially in social media circles such as Facebook and Twitter, but also in the field of online health.

3 People are sharing personal experiences of mental illness, humanizing them and potentially changing existing narratives. These types of stigma reduction methods are worth studying.

However, in this article, I defend the legal perspective: a method of legal reform. `

Proposals for Reform of Law No.

The following are some reform proposals to address the challenge of stigmatization from the legal perspective analyzed in this document. The key to the proposal is to enact a law to replace the "Insanity Act." They are certainly not exhaustive, as they are mainly based on the perspective of legislative reforms.

Mental health legislation Nigeria's current mental health legislation is the Mental Illness Act of 1958, which dates back to the 20th century. Starting from the title now regarded as derogatory, it belongs to the law of another era, when there was less understanding of mental illness and the human rights of people with mental illness were not taken seriously. There are currently no clear regulations on mental health care, no direct legal protections, no financial or wellness regulations for people with mental illness. In 2003, the National Assembly introduced new legislation on mental health. More than a decade later, the bill has not passed. The enactment of a well-thought-out law to address key issues relating to the rights of the mentally ill and safeguards from involuntary commitments has been a vital and long-standing need. Current mental health policy notes the importance of legal reform and its impact on the rise of humanity, stating that "the protection of human rights is also addressed in separate legislation submitted to the federal government."

Many developments in the new mental health law are popping up to expand the rights of people with mental disorders and allow them to be treated in the least restrictive way. The WHO has done extensive work in the field of mental health legislation and provides guidance on how to formulate effective mental health legislation.

WHO has identified certain steps that need to be taken

1) Identify the main mental disorders and obstacles in the implementation of policies and plans in the relevant countries;

(2) Identify (or map) existing mental health laws or general laws to solve mental health problems, and look for missing legal aspects

(3) Investigate international conventions and standards related to human rights and mental health, and determine the internationally recognized obligations and standards under the international human rights instruments that the country has ratified;

(4) Research in other countries, especially those with similar societies and cultures Background part of national mental health legislation;

(5) Consultation and negotiation of changes.
To address the key challenge of stigma that often leads to involuntary commitments, the mental health bill must include certain key provisions, including provisions on rights and capabilities / capabilities. As mentioned above, Nigerians with mental illness often face degradation and stigma. People with mental illness can be incarcerated in institutions against their will and deprived of their freedom, dignity and basic human rights. Sick people generally face discrimination in society, especially when it comes to finding housing or employment. Therefore, especially for people with mental illness, it is particularly meaningful to clearly state the protection of human rights in the law, and may even be more meaningful than for other people with disabilities. Therefore, even if there are other human rights laws that incorporate the general rights of the people, it is important to specifically include a part about protecting and emphasizing the basic rights of people with mental illness, that is, human rights. The inclusion of this right is very important to ensure the equality of people with mental illness and their full participation in society.

Therefore, the purpose of including rights in the Nigeria Mental Health Act is to cover topics that may not be covered by other rights clauses (such as the Constitution). Also for emphasis. In this regard, inclusion emphasizes the importance of the government's willingness to recognize the basic rights of mental patients and provide protection for mental patients in Nigeria. This is especially important in light of the current context in which discrimination against mental health challengers and many human rights violations persist. The most relevant rights include the right to life, the right not to be subjected to inhuman, cruel or degrading treatment, the right to equal protection in accordance with the law, the right to human dignity, the right to health services and appropriate, the right to privacy and the right to be free from unjustified detention.

The last right, the right to be free from unprovoked detention, is particularly relevant to the second challenge discussed in this article: involuntary commitments. Safeguards must be in place to ensure that non-psychiatric patients are not detained for mental illness. Therefore, it is important to establish standards for determining capabilities or capabilities in legislation. Ability refers to the degree of mental soundness required to make decisions on specific issues or perform specific behaviors legally. Generally speaking, unless the court decides otherwise, all adults are assumed to be capable. Therefore, lack of ability is defined as a functional defect caused by mental illness or mental retardation. The

discovery of incompetence means that a person is judged to be unable to meet the requirements of a particular decision-making situation, taking into account the possible consequences of making such a decision. Only the court can determine disability. In accordance with international standards for the development of mental health legislation and rights-based methods, it is appropriate to include a section in the bill that clearly states that people are capable unless otherwise specified. Criteria for determining ability also need to be clearly established, which refers to an individual's ability to make informed decisions. Unlike skill, skill discovery can be done by a doctor. Individuals who are unable to make an informed decision or consent may need to be referred to an eligibility hearing or appointed a guardian. According to international standards, mental health law now attaches great importance to people's right to make free and informed decisions, unless mental illness prevents them from doing so. Therefore, provisions indicating the need for informed consent and the ability to provide such consent are crucial in Nigeria's proposed mental health legislation.

a) Participation of people with mental illness and their families in policy making and decision-making

It is vital that people with mental illness have the opportunity to contribute to the proposed law. Obviously, people in this situation know best about the challenges they face and the support they need. Therefore, they should be given the opportunity to participate in the development process as much as possible. In addition to those whose laws may affect them directly, family members in Nigeria also provide most of the care that mental patients need. Since family members are the primary caregivers of people with mental illness, it is important to seek their opinions as we move through the legislative process. Involving the public, especially family members and users of mental health services or people with mental illness, is not only a desirable policy, but it is also important to provide a vision that can provide adequate support to women, people with mental illness and the profession itself. At present, this view is very flawed, partly due to the stigmatization of mental illness in Nigeria. Therefore, efforts should be made to ensure that the government, including the legislature, creates an environment conducive to such participation. Such participation can ensure the active participation of people who actually use mental health services and are affected by policies. Public participation can also include other non-professionals who are not normally involved in the provision of mental health services.

b) Establishment of Commission for Human Rights of the Mentally
In view of the large number of human rights violations, including involuntary commitments, it is necessary to establish a project and an institution where people with mental illness and those caring for them can obtain remedies. The task of the National Human Rights Commission is to resolve human rights violations. However, specific expertise is required in this area to be effective. Without sufficient experience, the National Human Rights Commission cannot provide effective assistance to those who request it. An office must be established within the committee. One of its tasks is to investigate allegations of infringement and provide psychiatrists, other health professionals and experts with training on human rights in mental health from time to time. Legal professionals involved in mental health care and mental health advocacy in the country.

To establish such an institution, in addition to other important requirements, we also need comprehensive mental health legislation. Legislation should authorize the investigation of violations of the rights of mental patients. The existence of such an institution will help prevent stigma and discrimination.

Research to solve more problems in the areas of law, policy and practice
It is important to do more research to address the two key challenges discussed here and other challenges. Such research should collect and update existing information on the following questions: How do Nigerians view mental illness? To what extent does stigma hinder necessary care and treatment? To what extent does the stigma surrounding mental illness and mental health challenges affect not only the acceptance of treatment, but also our humanity and our understanding of what it means to care for others and maintain their dignity while undergoing treatment? ? Some of these questions require in-depth research and are not currently available. In Nigeria, funding from governmental and non-governmental organizations for such research is crucial

SELF-ASSESSMENT EXERCISE

i. Explain the role of laws in reducing mental health stigma
ii. Discuss proposals for reform of mental health laws to reduce stigma
iii. Determine the need to take action on mental health legislation.

4.0 CONCLUSION

The most serious violation of the rights suffered by the mentally ill is the right to equality and non-discrimination. Since there is currently no

mental health legislation, the law does not specifically address discrimination. However, the 1999 Constitution of the Federal Republic of Nigeria prohibits discrimination. This module explains the role of the law in reducing the stigma of mental health, recommends reforms to reduce the stigma of mental health laws, and identifies the steps that need to be taken to develop good mental health legislation.

5.0 SUMMARY

This module will understand the role of the law in reducing mental health stigma, recommend reforms to reduce mental health laws, and steps to take to develop good mental health legislation.

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES / FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

UNIT 5 TERMS OF STIGMA IN MENTAL ILLNESS

CONTENTS

1.0 INTRODUCTION

Stigma continues to be the most fundamental, cultural and moral barrier to alleviating mental health problems. As a result, human rights violations deeply rooted in the stigma associated with mental illness continue to run rampant uncontrollably to a large extent, and have a negative impact on the dignity of people with mental disabilities as human beings. In this unit, students will learn various terms used in mental health

2.0 OBJECTIVES

By the end of this unit, you will be able to

- Describe various stigma terms used in mental health
- State stigma in life Consequences

3.0 MAIN CONTENT

"Citizen" means tattoo or marking in Greek. This is a typical physical sign of ancient Greece, burned or cut into the flesh of slaves or criminals so that others can see them as less respected members of society. Through Latin, the word has evolved into a modern language as a shame.

Research on stigma has made significant progress in the past three to four years, and social psychologists have tried to define it in various ways. Owen Goffman is one of the most outstanding social scientists and anthropologists of the 20th century. He eloquently described the stigma in his paper, which is a classic today. According to Goffman, stigma is "a very credible attribute that reduces the wearer to a person who is contaminated and discarded" (Goffman, 1963). The dishonest people can be divided into three different groups: people with physical defects, people belonging to a certain race, ethnicity or religious group, and finally those with defects recognized and documented, such as mental illness, drug addiction, and many more. Alcoholism or extreme political

behavior, etc. Therefore, persons with disabilities, blind persons, persons with a history of mental illness, or members of ethnic minorities or religious groups are considered social "deviants" and risk being excluded or considered inferior to others.

Since Goffman's key contributions helped demystify stigma, many definitions of stigma have emerged. In his description, Goffman believes that stigma is closely related to stereotypes. Both are mutually agreed norms or concepts that occur in daily social interactions and may play a role unconsciously.

However, social psychologists separate stereotypes from prejudice and discrimination. The following table gives some definitions related to stigma:

3.2.1 Commonly used terms in the field of stigma and discrimination in patients with mental illness

Stereotypes:
They are the beliefs or socially accepted concepts of a group of people that are mutually agreed upon (e.g. "Most people with mental illness are violent").

Prejudice
People who agree with stereotypes and react to them with strong emotions show prejudice (for example, "Yes, all mental patients are violent, and I am afraid of them"). Bias tends to generalize to all members of the group.

Discrimination:
People whose behaviors and actions are based on prejudice show discrimination. This may be due to the conventional practice of institutions and structural mechanisms that discriminate against patients. For example, the poor quality of mental health services is the main form of structural discrimination perceived by patients with schizophrenia (Schulze and Angermeyer, 2003), or involuntary discrimination by hospital staff when providing routine clinical care (Lee et al., 2006).

Perceived stigma:
Most people with mental illness live in a society that degrades and stigmatizes them, and they obviously feel low self-esteem, self-efficacy and confidence. If these people have internal cultural stereotypes before illness, they tend to apply these stereotypes to themselves after illness begins, resulting in low self-esteem (Watson & River, 2005).

Self-stigma:
The patient first accepts the stereotype. (For example, "I have a mental illness, I think I should not be able to do the job"). This can lead to strong emotional reactions and a decrease in self-esteem and self-efficacy. It continues to be self-discriminatory without applying for a successful job (Watson & River, 2005). The public's response to patients with mental illness is a public shame.

Label:
Identifies a person based on outstanding characteristics and puts a label on them. For example, "amputee" or "drunkard". Link and Ferran (2001). Active stigma, an interesting concept about how stigmatized individuals overcome the difficulties of being stigmatized, researched by Margaret Shih (2004). Shih said that people who are stigmatized use various measures or strategies. For example, individuals who are stigmatized may work harder and insist on (compensation), or they may compare themselves with members of their own group rather than their favorites (strategic interpretation of the social environment), or use their own race, Gender, religion, occupation, etc. to protect your mental health (multiple identities). Finally, the stigmatized person tries to overcome adversity (empowerment) instead of passively preventing negative results (coping), Shih believes that the latter can be exhausting and an exhausting process. However, these concepts have not been carefully studied in successful psychiatric subjects and require detailed evaluation.

3.3 Consequences of stigma

Stigma affects all aspects of personal life. In our review, we will consider the consequences related to key groups or individuals that may affect the lives of people with mental illness.

Family members
Stigma affects not only people with mental illness, but also people who have close relationships with family, friends and relatives. Goffman (1963) called it "Courtesy Stigma". Family members and direct caregivers experience shame, shame, uncertainty about the disease, stigma, (Brady and McCain, 2004) psychological distress, poor quality of life and difficulties in life (Kadri et al., 2004) strong personalization and stigma public (Muhlbauer, 2002), “what to do in times of crisis” lacks clarity (Lukens, 2002), and when the emotions expressed are also high (Phillips et al., 2002), people experience higher levels of stigma. Research in India reported similar experiences of stigma and discrimination in the families of patients with schizophrenia (Thara et al., 2003a, 2003b; Srinivasa Murthy, 2005).

Services and service providers

In a recent editorial, Thornicroft (2008a) noted that 70% of people worldwide with some type of mental disorder are not receiving treatment. If low- and middle-income countries (LAMIC) are considered, this number is much higher (Wang et al., 2007). For example, in a survey in Nigeria, only 1.6% of respondents actually received mental health care. Lack of awareness, ignorance of where to seek treatment, prejudice against people with mental illness, and anticipation of discrimination are the main reasons for terrible statistics. The general medical treatment of these people has a similar fate. Compared with people without mental illness, those who are labeled as mentally ill receive much less medical care (Druss et al., 1998; Desai et al., 2002). The above-mentioned structural discrimination (Link and Phelan, 2001) may lead to low quality of mental health care services and even insufficient funding for mental health services and research (Link and Phelan, 2001; Hinshaw, 2007). Service providers can actually bring stigma to patients or they can expose themselves to stigma. The first is called iatrogenic stigma (Sartorius, 2002). For example, in people receiving antipsychotics for schizophrenia or bipolar disorder, extrapyramidal side effects such as tremor or tardive dyskinesia can be a sign of illness and lead to prejudice and discrimination. Regarding the stigmatization experience of service providers, despite the lack of empirical evidence, it is believed that among providers of mental health and related disciplines, residents, trainees and professionals experience low morale (Gabbard and Gabbard, 1992; Persaud, 2000)). With other health care professions, mental health itself receives less funding.

Sartorius & Schulze (2005) summarized these events that can affect individuals, family members, or service providers. These events created a vicious cycle of stigmatization or cycle of inferiority (Figure 6), which led to the widespread existence of stigma. In one of our studies (Loganathan & Srinivasa Murthy, 2010), we mentioned this vicious circle model earlier to explain the gender stigma of Indian men and women from a sociocultural perspective.

The law and the justice system

The most common stereotype associated with people with mental illnesses, especially schizophrenia, is that they are violent (Arboleda Florez, 1998). This has to do with how the criminal justice system, the media and the public view them. The police are often the first point of contact for people with serious mental illness. Subsequently, officials decide whether the person receives appropriate psychiatric treatment or continues to fight under the control of the criminal justice system. Criminalization of mental illness will lead to an increase in the proportion of mentally ill patients in prisons. A person with a mental illness may be a victim of a crime or a witness to the crime. It has been found that police

officers do not take the initiative to help crime victims and, as crime witnesses, are often

Landlords and Employers

Housing options for mentally ill patients have always been a problem. In the United States, there are often reports of inability to obtain a good standard of living, living in an unsanitary environment, or being homeless (Wills et al., 1998). In India, the homelessness of patients with chronic mental illness has also been a problem, and there has recently been controversy about people's efforts to solve their problems in a similar way to the results achieved in the past with leprosy (Deccan Herald, 2009). Compared with people without mental illness, the unemployment rate of people with mental illness is higher. Marwaha and Johnson (2004) concluded that the employment rate of patients with schizophrenia in European countries is 10% to 20% of the general population. Barriers to finding a job include stigma, discrimination, fear of losing benefits, and lack of adequate professional help. Difficulties in finding jobs, job-related discrimination among people with schizophrenia, and negative effects on their self-esteem have also been reported in the Indian population, further perpetuating the stigma (Shankar et al., 1995; Loganathan and Srinivasa Murthy, 2008, 2010

SELF-ASSESSMENT EXERCISE

i. Identify various terms used in mental health stigma
ii. Discuss the impact of stigma on mental health

4.0 CONCLUSION

Mental illness-related stigma is deeply rooted in human rights violations His behavior continues to be largely unconstrained and has a negative impact on the dignity of people with mental disabilities as human beings. In this unit, students will learn various terms used in mental health conditions and the consequences of stigmatization in mental health conditions

5.0 SUMMARY

In this unit, students will learn about various terms used in mental health conditions and the consequences of stigma. The impact of naming on mental health.

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES/FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

MODULE 3

UNIT 1 MENTAL HEALTH SCREENING AND SCREENING

CONTENTS

1.0 INTRODUCTION

Mental and Behavioral Health Screening Includes a combination of tests, exams, and assessments, which provide information about how to provide information a patient is operating. These assessments help identify mental health issues, distinguish between mental and physical health issues, and provide information about patients who are referred for work, school, or family issues.

Understanding the methods and practices related to mental health assessment can help you adopt practical diagnosis and treatment methods for each client.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- Discuss the components of mental health assessments and exams
- Explain behavioral health assessments

3.0 MAIN CONTENT

Mental health assessments and assessments exams are usually grouped together but they are independent processes. Screening is a formal

interview and/or testing process used to identify areas in the client's life that may require further examination. It assesses possible problems, but does not diagnose or determine the severity of the disease. For example, assessing a person's drug abuse may involve asking him some interview questions about drug use and related issues, and using a brief drug abuse and/or drug dependence screening scale. When a positive indicator is found, arrange for someone to conduct an assessment. The assessment is a more in-depth assessment used to confirm the existence of a problem, determine its severity, and specify a solution to the problem. He also investigates the client's strengths and resources for solving life problems. The evaluation usually checks not only the possible diagnosis, but also the history of the disease. For example, drug abuse assessment assesses the severity and nature of drug use disorders and may also explore the possibility of disorders occurring simultaneously; the client's family, marriage, interpersonal relationship, physical and spiritual life; financial and legal conditions; and any other possible impact on treatment and rehabilitation issues. Evaluation usually involves in-depth interviews and the use of various evaluation tools, such as psychological tests.

Although there are few studies on the differences in the response of men and women to screening and evaluation, some literature (such as Cochran 2005) shows that men have unique difficulties. The socialization of male gender roles will cause some men to minimize difficulties or underreporting problems, while some problems, such as depression, may show different manifestations in men, covering up this obstacle and leading to missed or misdiagnosed problems. In addition, different screening or evaluation environments (e.g. prisons, outpatient programs, primary care clinics) can affect whether and how men show their struggle. Culture also played a role. Men from certain non-mainstream cultures may be reluctant to share information about difficulties or diseases. Counselors need to be sensitive to these nuances and create an environment where men are willing to share their perceived weaknesses or shortcomings.

Each mental health assessment you perform will be different based on your patient and their symptoms.

A typical mental health assessment may include the following elements.

- Interview: A general interview allows you to observe the patient's mood and performance. Asking questions about the patient's symptoms and worries, as well as their living conditions and thinking patterns, can help reveal areas that need attention in the first place.

- Physical exam: To help distinguish between symptoms caused by mental disorders and symptoms related to a physical illness, you may need to complete a physical exam. Ask about the patient's personal and family medical history and the medications they are taking.

- Laboratory test: Certain symptoms may indicate the need for a laboratory test or examination. When evaluating patients, blood or urine samples and MRIs, EEGs, or CT scans can be helpful.

- Written or Oral Test: You may want to take a test to help identify specific problems, test certain functions, or further evaluate the patient's health psychological and behavioral assessment tools can help and guide your assessment by identifying symptoms and providing valuable data.

3.1 Psychological and Behavioral Assessment Tools

Assessment tools are specific methods for collecting information to help understand patients, their symptoms, their living conditions, etc. These tools can be Assessing the overall mental health of each patient is the key to providing effective and high-quality treatment.

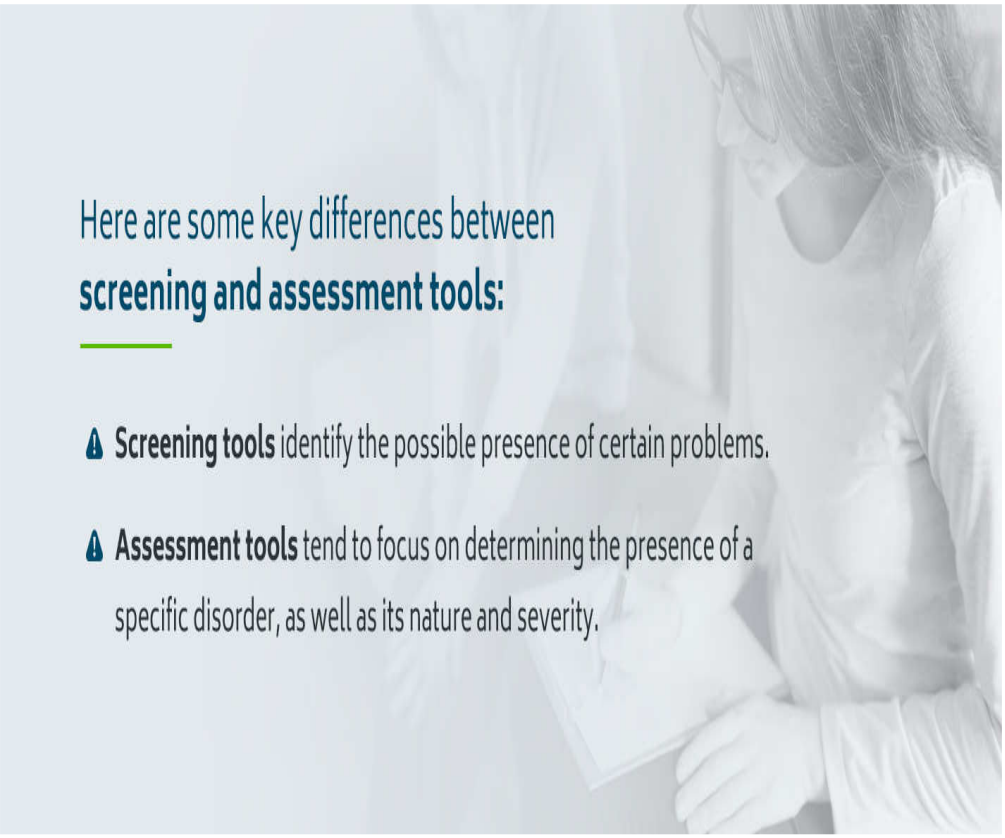
How to assess mental health status?
Determining how you assess the patient's mental health will depend on the type of screening and assessment tools you use. Consider the following factors when choosing a tool:

- Reliability: Does the test have the reliability to produce consistent results?
- Effectiveness: Does the test have the effectiveness of distinguishing problematic patients from non-problem patients?
- Sensitivity: Does the test have the sensitivity to accurately identify problems?
- Specificity: Does the test have the specificity to identify people without problems?

Choosing a test that meets the above factors will help make your results as accurate and useful as possible. When working with patients, disease-specific assessment is a valuable tool, but how do you know which areas to test? Detection tools can be used as a starting point to clarify these risk areas.

3.2 The difference between screening tools and assessment tools

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM5) contains nearly 1,000 pages and contains hundreds of potential diseases, which you can view at your center. A detailed assessment of all potential problems is illogical and time-consuming, which is why clinicians use screening tools.



The following are some important differences between the screening and assessment tools.

- Screening tools identify specific problems that may exist: usually in the form of checklists or questionnaires, the scope of the screening test can be broader than the scope of the assessment. Doctors often use screening tools as early as possible when working with patients to help focus on underlying conditions.

- Assessment tools provide the complete picture: Assessment tools often focus on determining the existence, nature, and severity of specific diseases. Clinicians often use screening tools to drill down into screening test results. The assessment tool can be used on a variety of topics and has multiple formats.

Mental health screening and screening tools are beneficial because they can help clinicians quickly and accurately diagnose and treat patients. Understanding the different types of screening and evaluation tools available allows you to make an informed decision for each patient.

3.3 Types of behavioral health screening tools

Appropriate screening tools depend on the patient's level of self-awareness and obvious symptoms. If your patient's family history has mental illnesses, you may also want to be screened for these illnesses.

Here are seven common types of screening tools to consider.

1. General
   In some cases, your patients may not be able to recognize the symptoms and disorders they are experiencing. General mental health screenings, such as the Kessler Mental Distress Scale, Patient Stress Questionnaire, or my Emotional Monitoring Checklist, can detect early signs of mental health symptoms. Primary care physicians can also use these exams during regular check-ups to refer at-risk patients to behavioral and mental health professionals.

2. Depression
   If your patient shows signs of depression or has a family history of depression, screening tests such as the Patient Health Questionnaire (PHQ) can help provide a clearer answer.

3. Drug and alcohol abuse
   Drug and alcohol screening tests can help identify patients' disruptive habits or addictive behaviors. For example, the World Health Organization's Alcohol Use Disorder Identification Test verifies the use of dangerous or harmful alcohol. Other common drug and alcohol screening tests include drug abuse screening and testing for the use of tobacco, alcohol, prescription drugs, and other substances.

4. Bipolar Disorder
   To help identify the symptoms of bipolar disorder, clinicians can use the mood disorder questionnaire. Since bipolar disorder exists in a range, it is also helpful to use the biphasic spectrum diagnostic scale to determine where or whether your patient is registered.

5. Suicide Risk
   You can use the Five-Step Assessment and Suicide Assessment Rating, the Columbia Suicide Severity Rating Scale, or ask suicide screening questions to help determine if your patient is at risk for

suicide. To improve patient safety and reduce risk, suicide risk detection is an essential preventive measure.

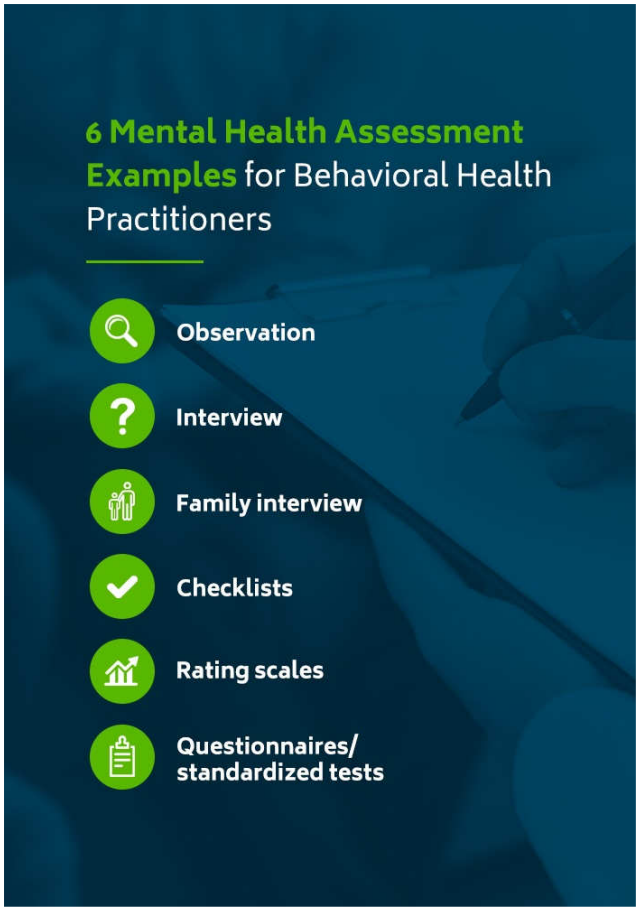
6. Anxiety Disorders
   Anxiety Disorder Screening can help you determine if your patient shows symptoms of generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder (PTSD), or social phobia. Some related anxiety assessments include the Generalized Anxiety Disorder Scale Seven (GAD7), the DSM5 Post-Traumatic Stress Disorder Checklist, and the Hamilton Anxiety Scale.

7. Trauma
   To detect possible traumatic events in a patient's life, you can use the DSM5 life event list. This tool can search for common sources of PTSD or extreme distress.

Talk to your patient to determine what tests may be needed. After highlighting the areas of interest, you can use the assessment tools to understand the depth and scope of individual problems.

3.3 Mental Health Assessments for Behavioral Health Professionals

Mental and Behavioral Health Assessments have multiple uses when working with patients. Assessments can help you complete the diagnostic and treatment planning process, provide information for your decision making, and allow you to track patient progress. Unlike screening tests, there are many forms of free mental health screening tools. Regardless of which method you choose, behavioral assessment can help you understand, diagnose, and treat your patients.



Common behavior assessment methods

1. Observation
   Observation can help you find clues about the patient's condition. Consider your patient's attitudes, expressions, words, and behaviors in various environments to understand situations other than those expressed by her. To use this tool well, please pay close attention to your patient and observe him in a professional and neutral manner.

2. Interviews
   Psychiatric interviews can help you build relationships with patients and gather information about their symptoms and experiences. Let your patients speak freely and use open-ended questions to guide their answers. When asking questions, remember to diagnose the reasoning. If you want to build trust with patients, make sure they feel recognized and understood. Allowing your patients to express their feelings and experiences can reveal the factors causing their symptoms.

3. Family interviews
   In some cases, especially when working with young children, you can choose to interview family members of the patient. Family interviews can provide more information about the patient's condition and help family members better understand what the patient is going through. Before involving family members, you may need to review the Health Insurance Portability and Accountability Act.

4. Checklist
   Like many screening tools, the assessment tools also have checklists for obtaining information about the patient's mental health. Targeted lists can be a quick and effective way to supplement knowledge. DSM5 contains lists to identify and categorize the patient's symptoms, but you should use these lists with caution. The checklist does not consider all the biological, psychological, sociological and cultural variables that may exist in the life of the patient. However, when combined with other assessment methods, the checklist can be a suitable tool.

5. Rating Scale The
   Rating Scale provides numerical data and helps patients classify confusing feelings and emotions into simple responses. They can be valuable when working with patients who have difficulty communicating their illness or as a general assessment tool to determine the severity of symptoms at any given time.

6. Questionnaires The functions of the
   Screening questionnaires are similar to the screening questionnaires, but generally describe specific diseases and their severity in more detail. If the results of the screening test show the likelihood of a specific disease, evaluating the specific disease can help you collect more data. A typical standardized assessment includes the Comprehensive Mental Health Assessment Tool, which can detect and assess various mental health problems.

SELF-ASSESSMENT EXERCISE

i. Describe the factors that assess mental health status
ii. Briefly explain the difference between mental health assessment tools and screening tools

4.0 CONCLUSION

Understand methods and practices related to mental health assessment Mental Health can help you perform a practical diagnosis and treatment

method for each client. In this unit, students will learn about mental health screenings and assessments, psychological and behavioral assessment tools, types of behavioral health screening tools, the difference between test tools and assessment tools, and common health assessment methods.

Discussion of this unit Mental health screening and assessment, psychological and behavioral assessment tools, types of behavioral health screening tools, differences between screening tools and assessment tools, and common methods Behavioral Assessment

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES / FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

UNIT 2 FUNDAMENTAL PRINCIPLES OF MENTAL HEALTH CARE

CONTENTS

1.0 INTRODUCTION

The principles of mental health guide the provision of mental health services. Mental health service providers must consider mental health principles when providing mental health services. A person must consider these principles when performing any duty or function or exercising any power under the Mental Health Act of 2014.

2.0 OBJECTIVES

By the end of the unit, you will be able to:

- Fundamental Principles of Mental Health Care
- Describe the components of the Fundamental Principles of Mental Health Care
- Explain the implementation process of the Fundamental Principles of Mental Health Care

3.0 MAIN CONTENT

3.1 Exercising the Basic Principles of Mental Health Care

Rights may be restricted only by law and necessary to protect the health or safety of persons or others, or otherwise protect public safety, order, health or morals or the basic rights and freedoms of others.

Principle 1
Fundamental freedoms and rights

1. Everyone has the right to the best mental health care, which will become part of the health and social health care system.

2. All people suffering from mental illness, or who are being treated as such, must be treated humanely and respect the inherent dignity of human beings.

3. All persons suffering from a mental illness, or those treated as such, have the right to be protected against economic, sexual and other exploitation, physical or other abuse and degrading treatment.

4. There will be no discrimination for mental illness. "Discrimination" refers to any distinction, exclusion or preference that has the effect of canceling or damaging equal enjoyment of rights. Special measures designed to protect the rights of people with mental illness or to ensure their progress are not considered discrimination. Discrimination does not include any distinction, exclusion, or preference based on the provisions of these principles, and is necessary to protect the human rights of the mentally ill or other people.

5. Every person with mental illness has the right to exercise all civil, political, economic, social and cultural rights recognized by the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant. Civil and political rights, as well as other related instruments, such as the Declaration on the Rights of Persons with Disabilities and a Set of Principles for the Protection of All Persons Subject to Any Form of Detention or Imprisonment.

6. Any decision that someone lacks due to mental illness
People with capacity have the right to appoint lawyers to represent them. If the person with capacity does not obtain it on his own or does not obtain the agency, he may provide it free of charge if he does not have sufficient ability to pay. Unless the court is satisfied that there is no conflict of interest, the committee will not represent the mental health facility or its staff in the same litigation, nor will it represent the family members of people with abilities. Decisions on the capabilities and needs of individual representatives will be reviewed at reasonable intervals as prescribed by national laws. Persons with capacity problems, their personal representatives (if any) and any other interested parties have the right to appeal the above decision to a higher court.

7. When the court or other competent court determines that a mentally ill person cannot manage his own affairs, it will take necessary measures appropriate to the person's situation to ensure protection. Your interest.

Principle 2
Protection of minors

Within the purpose of these principles and in the context of national legislation related to the protection of minors, special attention should be paid to protecting the rights of minors, including the appointment of an individual if necessary Representatives except for family members.

Principle 3
Community Life

Every person with a mental illness should have the right to live and work in the community to the extent possible.

Principle 4
Determination of mental illness

1. Whether a person suffers from a mental illness will be determined according to internationally recognized medical standards.

2. Mental illness will never be determined based on political, economic or social status, or membership in cultural, ethnic or religious groups, or any other reason not directly related to mental health...

3. Family or professional conflicts, or disagreements on the prevailing moral, social, cultural or political values or religious beliefs in a person's community will never be a decisive factor in the diagnosis of mental illness.

4. The patient's past treatment or hospitalization history alone does not guarantee the determination of mental illness now or in the future.

5. No person or authority may classify a person as suffering from or otherwise indicate that a person has a mental illness, except for purposes directly related to mental illness or the consequences of mental illness.

Principle 5
Medical Examination

No one is obliged to undergo a medical examination to determine whether he has a mental illness, except in accordance with procedures authorized by national legislation.

Principles 6
Confidentiality

The right to confidentiality of information related to all persons to whom these principles apply must be respected.

Principle 7
The role of community and culture

1. Every patient shall have the right to be treated and cared for to the greatest extent possible in the community in which he lives.

2. If treatment is carried out in a mental health facility, patients should have the right to receive treatment close to family or friends whenever possible, and to return to the community as soon as possible.

3. Every patient has the right to receive treatment appropriate to his cultural background.

Principle 8
Standards of Nursing

1. Every patient has the right to receive health and social care that suits his health needs, and to receive care and treatment in accordance with the same standards as other patients...
2. Every patient must be protected from harm, including unreasonable drug use, abuse by other patients, staff, or others, or other behaviors that cause mental distress or physical discomfort.

Principle 9
Treatment

1. Every patient shall have the right to receive treatment in the least restrictive environment and to the least restrictive or invasive treatment that is adapted to the health needs of the patient and the needs to protect the personal safety of others.

2. The treatment and care of each patient should be based on the plan prescribed by the person, discussed with the patient, periodically reviewed, revised if necessary, and provided by qualified professionals.

3. Mental health care should always be provided in accordance with the ethical standards applicable to mental health professionals, including internationally recognized standards, such as the

"Principles of Medical Ethics" adopted by the United Nations General Assembly. Mental health knowledge and skills will never be abused.

4. The treatment of all patients is aimed at protecting and enhancing personal autonomy.

Principles 10
Medications

1. Medications should meet the patient's best health needs, used only for treatment or diagnostic purposes, and should not be administered as punishment or for the convenience of others. According to paragraph 15 of Principle 11, mental health professionals will only use drugs that are known or proven to be effective.

2. All drugs will be prescribed by a mental health professional authorized by law and recorded in the patient's medical record.

Principle 11
Consent for treatment

1. The patient will not be treated without the informed consent of the patient, except in the cases specified in paragraphs 6, 7, 8, 13 and 15 below.

2. Informed consent is consent that is freely obtained without threats or undue incentives. After adequate and understandable information is appropriately disclosed to the patient in a form and language that the patient can understand:
(a) Diagnostic evaluation;

3. In the consent procedure, the patient may request the presence of one or more persons chosen by the patient.

4. Except as specified in paragraphs 6, 7, 8, 13 and 15 below, the patient has the right to refuse or interrupt treatment. The consequences of refusing or stopping treatment should be explained to the patient.

5. Patients shall not be invited or induced to give up their right to informed consent. If the patient attempts to do this, it will be interpreted as being unable to treat without informed consent.

6. In addition to the provisions of paragraphs 7, 8, 12, 13, 14 and 15 below, if the following conditions are met, a recommended treatment plan can be provided to the patient without the patient's informed consent:
   (a) The patient is detained as an involuntary patient at the relevant time;
   (b) An independent authority with all relevant information (including the information specified in paragraph 2 above) is convinced that at the relevant time, the patient has not given or refused consent to the proposed treatment plan Ability. Treatment, or, if national legislation so requires, the patient unreasonably refuses to consent for the safety of the patient or others; and
   (c) The independent authority is convinced that the proposed treatment plan is in the best interest of the patient's health needs.

7. The above paragraph 6 does not apply to patients whose legally authorized personal representative agrees to the patient's treatment; however, except in the circumstances specified in paragraphs 12, 13, 14 and 15 below, if the personal representative After the information mentioned in the paragraph is agreed in the name of the patient, the patient can be treated without the patient's informed consent.

8. In addition to the provisions of paragraphs 12, 13, 14 and 15 below, if a qualified mental health professional authorized by law determines that there is an urgent need to avoid the patient's informed consent, the treatment of any patient can also cause immediate or imminent consequences for the patient or others s damage. The treatment will not exceed the time absolutely necessary for this purpose.

9. If treatment is authorized without the patient's informed consent, every effort will be made to inform the patient of the nature of the treatment and any possible alternatives, and as far as possible to involve the patient in the treatment development plan.

10. All treatments will be immediately recorded in the patient's medical record, indicating whether it is involuntary or voluntary.

11. No physical restraint or involuntary imprisonment will be used on patients unless in accordance with officially approved mental health facility procedures and only if this is the only available means to prevent direct or imminent harm to the patient or others. It will not exceed the period absolutely necessary for this purpose.

All cases of physical restraint or involuntary imprisonment, their reasons, nature and scope will be recorded in the patient's medical record. Patients who are confined or isolated should be kept under humane conditions and under the close and regular care and supervision of qualified staff. If there are any relevant personal representatives, they will immediately receive notice of any physical restraint or involuntary isolation of the patient.

12. Sterilization should not be used as a treatment for mental illness.

13. Major medical or surgical operations may be performed on mentally ill patients only when permitted by national legislation, and deemed to best meet the health needs of the patient and the informed consent of the patient. Unless, if the patient cannot give informed consent, the procedure is only authorized after independent review.

14. Psychosurgical operations and other invasive and irreversible mental illness treatments must not be performed on involuntary patients in mental health institutions, and within the scope permitted by national legislation, can only be performed on any other patient if the patient has been treated Informed consent and independent external agencies ensure true informed consent, and the treatment better meets the health needs of patients.

15. Without informed consent, clinical trials and experimental treatments are not allowed on any patient, but patients who cannot give informed consent can enter clinical trials or receive experimental treatments, but they must be competent and specially established for this purpose. Independent review agency.

16. In the cases described in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his personal representative or any interested person shall have the right to appeal to judicial or other independent authorities. Regarding any treatment you receive.

Principle 12
Notice of Rights

1. After admission, patients in the mental health facility will be informed of all their rights under these principles in a form and language that the patient understands as soon as possible, and in accordance with the national legislation. This information should include the interpretation of these rights and how to exercise them.

2. If and while the patient cannot understand such information, the patient's rights must be communicated to the personal representative (if any) and the person who best represents the patient. Interested and willing to do it.

3. Patients with the necessary capacities have the right to designate the people who should be informed on their behalf, as well as the people who represent their interests before the institutional authorities.

Principle 13
Rights and conditions in mental health institutions

1. Every patient of a mental health institution shall have, in particular, the right to fully respect him:
   (a) to be recognized everywhere as a person before the law;
   (b) Privacy;
   (c) Freedom of communication, including the freedom to communicate with others in the facility; freely send and receive uncensored private communications; receive private interviews from the consultants' personal representatives and accept information from other visitors at all reasonable times Freedom of access and freedom of access to postal and telephone services, newspapers, radio and television;
   (d) Freedom of religion or belief.

2. The environment and living conditions of mental health institutions should be as close as possible to the normal living conditions of their peers, especially including:
   (a) Recreational and leisure facilities;
   (b) Educational facilities;
   (c) Purchase or receive daily life, entertainment, and facilities for the exchange of goods;
   (d) Facilities and encourage the use of these facilities so that patients can participate in active occupations appropriate to their social and cultural origin, and take appropriate professional rehabilitation measures to promote reintegration into the community. These measures should include vocational counseling, vocational training, and placement services to enable patients to obtain or retain employment in the community.

3. Under no circumstances should the patient be forced to work. The patient must be able to choose the type of work to be performed

within the limits of meeting the needs of the patient and the management requirements of the institution.

4. The work of patients in psychiatric hospitals should not be exploited. Each of these patients is entitled to receive the same remuneration for any work performed by him as to pay non-patients for such work in accordance with national laws or customs. In any case, all such patients should be entitled to a fair share of any remuneration paid to a mental health facility for work.

Principle 14
Mental Health Facility Resources

1. Mental health institutions should be given the same level of resources as any other health institution, in particular:
   (a) A sufficient number of qualified medical personnel and other appropriate professionals with sufficient space to provide privacy for each patient and plan a treatment active and appropriate;
   (b) Patient diagnostic and treatment equipment;
   (c) Adequate professional care; and
   (d) Adequate, regular and comprehensive treatment, including the supply of medications.

2. The competent authority shall inspect each mental health facility frequently enough to ensure that the conditions, treatment and care of patients comply with these principles.

Principle 15
Principle of admission

1. If a person needs to be treated in a mental health facility, every effort should be made to avoid involuntary admission.

2. Entry to a mental health facility should be managed in the same way as entry to any other facility due to any other illness.

3. Unless the involuntary patient retention criteria specified in Principle 16 are applied, any patient who has not been involuntarily admitted should have the right to leave the mental health facility at any time, and should be notified of that right.

Principle 16
Involuntary admission

1. A person may (a) be admitted to a mental hospital involuntarily as a patient; (b) have been admitted voluntarily as a patient and detained as an involuntary patient in a mental health institution if and only as a qualified mental health professional authorized by law Determine that the person has a mental illness according to Principle 4 and believe that:
   (a) Due to the mental illness, it is very likely that the person or others will be injured immediately or about to be injured; or
   (b) For persons with severe mental illness and impaired judgment, Failure to accept or retain the person may cause a serious deterioration of the person's condition or prevent the provision of adequate alternatives based on the least restrictive principle, and treatment can only be carried out by entering a mental health facility.

   In the circumstances mentioned in (b), a second mental health professional should be consulted as far as possible, independent of the first. If such consultations are conducted, no involuntary admission or reservation shall be made unless the second mental health professional agrees.

2. Involuntary admission or detention will initially be subject to short-term observation and preliminary treatment in accordance with the provisions of the national legislation, waiting for the review agency to review the admission or detention. The reason for admission must be reported to the patient immediately, and the facts of admission and the reason for admission must also be reported in detail and in a timely manner to the review agency, the patient's personal representative (if any), and , unless the patient objected, to the patient's family.

3. The psychiatric hospital can only accept the involuntary admission of patients to the psychiatric hospital designated by the competent authority under national law.

Principle 17
Review agency

1. The review agency must be a judicial or other independent and impartial agency, established by national law and operating in accordance with procedures prescribed by national law. You should have the assistance of one or more qualified and

independent mental health professionals to make decisions and consider your suggestions.

2. In accordance with the requirements of paragraph 2 of principle 16, the preliminary review of the review agency's decision to admit or retain a person as an involuntary patient shall be carried out as soon as possible after the decision, and will be conducted in accordance with the simple and rapid procedures stipulated by national legislation.

3. The review agency will review involuntary patient cases on a regular basis at reasonable intervals as provided by national law.

4. Involuntary patients may apply to the review agency for release or voluntary status at reasonable intervals as prescribed by national law.

5. In each review, the review agency will consider whether the involuntary admission criteria specified in paragraph 1 of Principle 16 are still met. If not, the patient will be discharged as an involuntary patient.

6. If the mental health doctor in charge of the case at any time is convinced that the conditions for keeping someone as an involuntary patient are no longer met, he will order the person to be discharged as such a patient.

7. The patient or his personal representative or any interested person shall have the right to appeal to a higher court against the decision of the patient to be admitted or detained in a psychiatric hospital.

Principle 18
Procedural safeguards

1. The patient has the right to choose and appoint an attorney to represent him, including representation in any complaint or appeal procedure. If the patient is unable to obtain such services, an attorney must be provided without payment from the patient if the patient does not have sufficient ability to pay.

2. If necessary, the patient should also have the right to receive help with interpretation services. When such services are necessary and patients cannot obtain them, they must be available without the patient's payment when the patient does not have sufficient ability to pay.

3. The patient and the patient's lawyer may request and provide an independent mental health report and any other relevant and acceptable oral, written and other reports and evidence at any hearing.

4. Copies of patient records and all reports and documents submitted will be provided to the patient and the patient's lawyer, unless it is determined in special circumstances that the disclosure of specific information to the patient will cause serious consequences. Endanger the health of patients or endanger the safety of others. As national legislation may provide, any documents that are not delivered to the patient should be delivered to the patient's personal representative and lawyer as long as it can be kept confidential. When any part of the document is detained by the patient, the patient or the patient's lawyer (if any) will receive a notice of detention and the reasons for it, and undergo judicial review.

5. Patients and their personal representatives and lawyers shall have the right to attend, participate in any hearings and hear their opinions in person.

6. If the patient or the patient's personal representative or lawyer requires a specific person to attend the hearing, that person will be admitted unless it is determined that the person's attendance may cause serious damage to the patient's health or put the patient at risk. Risk the safety of others.

7. Any decision about whether the hearing or any part of it is public or private, and can be reported publicly, must fully consider the patient's own wishes, respect the patient's privacy and the needs of others. There is a need to prevent serious harm to the patient's health or to avoid putting the safety of others at risk.

8. The decision of the hearing and its reasons shall be stated in writing. Copies will be provided to patients and their personal representatives and consultants. When deciding whether to announce the decision in whole or in part, the patient's own wishes, the need to respect their and others' privacy, and the public interest of public management will be fully considered. Justice and the need to prevent serious damage to the patient's health or to avoid putting the safety of others at risk.

Principle 19
Access to information

1. The patient (the term in this principle includes former patients) shall have the right to obtain information about the patient, including information about their health and personal records kept by the mental health center. This right may be Be restricted to avoid serious harm to the patient's health and to avoid putting the safety of others at risk. As national law may stipulate, any such information that is not provided to the patient should be provided to the patient's personal representative and attorney, if it can be kept confidential. When withholding any information from the patient, the patient or the patient's attorney (if any) should be notified of the concealment and its reasons, and should be subject to judicial review.

2. Any comments written by the patient or their personal representative or attorney will be inserted into the patient's record when requested.

Principle 20
Delinquent

1. This principle applies to persons serving sentences for criminal offenses or persons otherwise detained during criminal proceedings or investigations.

2. All of these people should receive the best mental health care specified in Principle 1. These principles should apply to them as completely as possible, with only limited modifications and exceptions as necessary depending on the situation. Such modifications and exceptions shall not affect principle 1.

3. The rights of the person under the instrument mentioned in paragraph 5. National legislation may authorize the courts or other competent authorities to act on competent and independent medical advice and order the admission of such persons to psychiatric hospitals.

4. Treatment of persons determined to be mentally ill must comply with Principle 11 in all circumstances.

Principle 21
Complaints

Every patient and former patient has the right to file a complaint through the procedures prescribed by national legislation.

Principle 22
Oversight and redress

States must ensure that appropriate mechanisms are effective to promote compliance with these principles to inspect mental health facilities, present, investigate and resolve complaints, and establish appropriate disciplinary actions or prosecutions for misconduct professional or violations of patients' rights.

Legal proceedings.

Principles 23
Implementation

1. States must adopt appropriate legislative, judicial, administrative, educational and other measures to implement these principles, and they must be reviewed regularly.

2. States should make these principles widely known in a positive and appropriate manner.

Principles 24
Scope of principles related to mental health institutions

These principles apply to all people admitted to mental health institutions.

Principle 25
Existing rights reserved

Non-recognition or recognition of any existing rights of the patient shall not be used as an excuse to limit or derogate any existing rights of the patient, including rights recognized by applicable international or national laws to a lesser extent higher.

SELF-ASSESSMENT EXERCISE

Discuss the basic principles of mental health care

4.0 CONCLUSION

Mental health service providers should consider the principles of mental health when providing mental health services. In this unit, students will learn the basic principles of mental health care, the components of the basic principles of mental health care, and the process of implementing the basic principles of mental health care.

5.0 SUMMARY

This unit teaches the basic principles of mental health care, the components of the basic principles of mental health care, and the process of implementing the basic principles of mental health care.

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES / FURTHER READING

https://www.psychologydiscussion.net/healthpsychology/characteristics of a mentally healthy person/2072

UNIT 3 PROMOTION OF MENTAL HEALTH AND PREVENTION OF MENTAL DISORDERS

CONTENTS

1.0 INTRODUCTION

The terms promotion and prevention of mental health are often confused. Advocacy is defined as the optimization of positive mental health by addressing the determinants of positive mental health (i.e., protective factors) before identifying specific mental health problems, and its ultimate goal is to improve the positive mental health of the population. Mental health prevention is defined as an intervention that addresses the determinants of mental health problems before specific mental health problems are found in key individuals, groups or populations to minimize mental health problems (i.e. risk factors), and the ultimate goal is to reduce mental problems. Health problems (that is, risk factors). The number of future mental health problems in the population.

2.0 OBJECTIVES

- By the end of this unit, students should be able to
- Discuss the concepts of mental health promotion and mental health prevention

3.0 MAIN CONTENT

In order to improve their capacity for mental and emotional health, the root cause of the problem must be addressed. “Prevention emphasizes the avoidance of risk factors; promotion aimed at improving the individual's ability to achieve positive self-esteem, mastery, well-being and social tolerance. “Risk factors that can lead to the development of mental disorders. It is very important to improve your emotional and mental

health by establishing positive interpersonal relationships. As human beings, we need friendship and interaction with others. Another way to improve your mental and emotional health is to participate in activities that relax you and take time for yourself. Yoga is a great example of activities that calm the entire body and nerves. According to Richards, Campania, and Moose bock's research on happiness, "Mindfulness is considered a state of purpose. Those who practice it may believe in its importance and value of the emphasis on self-care activities can affect intentional components of mindfulness."

3.1 Promotion of mental health and prevention of mental disorders

Description: Everyone should benefit from the best measures to promote their mental health and prevent mental disorders

Components: This principle includes the following components:

1 Promotion of mental health;
2. Mental disorder prevention work.

Implementation: Suggested actions to promote this principle include:

1. Promote behaviors that help improve and maintain mental health.
2. Determine and take appropriate actions to eliminate the causes of mental disorders.
3. Access to basic mental health services
   Description: All those in need should receive basic mental health services.

Components: This principle includes the following components:

1. Mental health care must be of sufficient quality, namely:
   Maintain the dignity of the patient; Pens Consider and enable technology to help patients cope with mental health disorders, disability, and barriers on their own; degrees Celsius provides recognized clinical and relevant non-clinical care, aimed at reducing the impact of disease and improving the quality of life of patients; days. Maintain an adequate quality mental health care system (including primary health care, outpatient, hospital and hospital facilities);

2. Access to mental health care must be affordable and fair;
   Implementation: The recommended actions to promote this principle are:

1. There are specific provisions in the law that guarantee high-quality medical care, and it is better to extend the general provisions applicable to mental health care;

2. Have a Quality Guarantee Guidelines (such as those developed by the World Health Organization) for medical practices;

3. National quality assurance guidelines and tools developed and / or adapted for all qualified professionals or government agencies;

4. Provide culturally appropriate mental health care;

5. Require and consider the patient's assessment of the quality of care;

6. Treat, decide and act on a person receiving mental health care, and record them in the person's medical record;

7. Introduce a mental health component into primary health care;

8. Promote medical insurance plans (public or private) to provide insurance for as many people as possible, and not exclude but specifically include mental health;

9. Incorporate voluntary admission procedures into the mental health legal system and be respected in practice;

10. In accordance with WHO's instructions, mental health care is geographically "accessible", namely:

a. Provide basic mental health services within one hour of walking or traveling; and birds. Provide essential drugs determined by WHO (or drugs of the same family with similar characteristics: amitriptyline, biperiden, carbamazepine, chlorpromazine, clomipramine, diazepam, phenobarbital, fluoro Perphenazine decanoate, haloperidol, imipramine, lithium carbonate and temazepam).

3.2 Mental health evaluation in accordance with internationally recognized principles

Description

Mental health evaluation must be in accordance with internationally recognized medical principles and tools (for example, WHO ICD10 Classification of Mental and Behavioral Disorders Clinical Description and Diagnostic Guidelines, Tenth Revised Edition, 1992).

Components: This principle includes the following components:

1. The mental health assessment includes a. Diagnosis; B. Treatment options; C. Determination of capacity; d. Determine that someone may cause harm to themselves or others due to a mental disorder;

2. The mental health assessment should only be used for purposes directly related to mental illness or the consequences of mental illness.

Implementation: The recommended actions to promote this principle are:

1. Promote clinical training using internationally recognized principles;

2. Avoid referring to non-clinical standards, such as politics, when evaluating the possibility of harm to yourself or others, Economic, social, ethnic and religious reasons;

3. A full reassessment is required every time a new assessment is made;

4. Avoid assessments based solely on the previous history of mental disorders.

5. Provide the least restrictive mental health services

Description: Patients with mental health disorders should receive the least restrictive health services.

Components: This principle includes the following components:

1. Items to consider when choosing the least restrictive alternatives include:
   a. The diseases involved;
   b. treatment pens available;
   c. degrees Celsius degree of personal autonomy;
   d. days. My acceptance and cooperation and
   e. The possibility of causing harm to oneself or others;

2. Community-based treatment must be provided to eligible patients;

3. Institutional treatment must be provided in the least restrictive environment and, when necessary, involving the use of (eg, isolation room, camisole) and chemical containment treatment must depend on the situation:

a. Continue trying to discuss alternatives with patients;
b. inspections and prescriptions from approved healthcare providers;
    a. degrees Celsius The need to avoid direct harm to yourself or others;
    b. days. Regular observation;
    c. Regularly reassess restraint needs (eg, physical restraint every half hour);
    d. Strictly restricted duration (for example, 4 hours of physical restraint);
    e. grams. Documents in the patient's medical record.

Implementation: Recommended actions to promote this principle are:

1. Maintain legal instruments and infrastructure (human resources, venues, etc.) to support community-based mental health care, including providing patients with varying degrees autonomy

2. Take measures to eliminate isolation rooms and prohibit new isolation rooms;

3. Amend relevant legal documents to remove regulations that are inconsistent with community mental health care;

4. Train mental health care providers to use traditional restraint alternatives Ways of dealing with crisis situations.

5. Self-determination

Description: Before any kind of interference with a person, consent must be obtained.
Components: This principle includes the following components:

1. Interference includes:
   Physical and mental health (such as diagnostic procedures, medications, electroconvulsive therapy, and irreversible surgery); birds Freedom (for example, mandatory hospitalization).

2. The consent must be:
   After obtaining advice from any traditional decision-making unit (for example, family, relatives, work unit), it will be provided by the relevant personnel according to the cultural discretion; feathers (not improperly affected);
   degrees Celsius Informed (information must be accurate, easy to understand, and sufficient to make decisions, such as advantages, disadvantages, risks, alternatives, expected results, side effects);

days. Recorded in the patient's medical record, except for minor disturbances.

3. If a person with a mental disorder is found to be unable to give consent (this often happens occasionally, but not always), an alternative decision maker (relative, friend, or authority) must be authorized to decide on the patient. It is in the name of the patient and in the best interests of the patient.

The parent or guardian (if any) must agree to the minor.
Implementation: The recommended actions to promote this principle are:

1. Assume that patients are capable of making their own decisions, unless otherwise proven;

2. Ensure that mental health care providers do not systematically assume that people with mental disorders cannot make your own decision;

3. Failure to systematically consider that the patient cannot exercise the right to self-determination over all components (eg integrity, freedom) because the patient is found

4. Regardless of whether the patient is capable of expressing consent, the patient's opinions should be sought and carefully considered before taking actions that affect their integrity or freedom; those who believe that they cannot make decisions for their own interests are required to explain certain opinions The reasons may show reasonable considerations and thus promote the exercise of the right to self-determination;

5. To satisfy any wishes expressed by the patient before the consent cannot be expressed.

6. The right to assistance in exercising the right to self-determination.

Description: If the patient has difficulty understanding the impact of the decision, even if he is unable to make the decision, he will benefit from the choice of a third party to notify you.

Component: There are many reasons for difficulties, including the following:
1. Common sense;
2. Language ability;
3. Disability caused by health disorders.

Implementation: Some actions recommended for further compliance with this principle include:

1. Inform patients of this right when they need help;
2. Recommend potential assistants (for example, lawyers, and social workers);
3. Promote participation of participants, including providing free help where possible;
4. Promote Establish a structure to provide assistance to mental patients (e.g. monitors, patient committees (users)).
7. Review Procedures Availability

Description: There should be a review process for any decision made by officials (judges) or agents (representatives, such as guardians), decision makers, and healthcare providers.
Components: This principle includes the following components:

1. The procedure must be provided upon request by all parties (including relevant personnel);

2. The procedure must be provided in a timely manner (eg, within 3 days of the decision); 3. The patient's health status should not be prevented from visiting and checking; Four. Patients must have the opportunity to hear opinions in person.

   Implementation: The selected actions recommended to promote this principle are:

   1. Have a review process and/or a standing review committee established and operating by legislation;

   2. Establish a state-run mental illness that provides legal and advocacy services Patient representative office.

8. Automatic periodic review mechanism
   Description: If the decision affects completeness (treatment) and/or freedom (hospitalization) and has a lasting impact, there must be an automatic periodic review mechanism.
   Components: This principle includes the following components:

   1. The review should be automated;
   2. The review must be conducted at reasonable intervals (for example, once every six months);
   3. The review must be performed by an official qualified decision-makers.

Implementation: The recommended actions to promote this principle are:

1. Designate a review agency for review;
2. Request review agency members to meet with patients and review cases at prescribed time intervals;
3. Give patients and the right to meet the review agency (this should be facilitated by the health authority);
4. The review process is required to be completed every time (ideally, the review agency should not be composed of the same person, if more than one occurs in a given case) Automatic review, and should not be unduly influenced by your previous decision);
5. Sanctions against members of institutions that violate the contract (for example, those who do not fulfill the assigned tasks).

9. Qualified Decision Makers

Description: Decision-makers acting in an official capacity (such as a judge) or in a power of attorney (consent) (such as family, friends and guardians) must be qualified to do so. Component

To become a qualified decision maker, the decision maker must:

1. Proficient;
2. Expert;
3. Independence (if acting in an official capacity);
4. Impartiality (if acting in an official capacity). Ideally, a decision-making body acting in an official capacity should consist of multiple people (for example, three) from different related disciplines.

Implementation: The recommended action to promote this principle is:

1. Provide decision makers and / or their assistants acting in an official capacity with initial and ongoing training in relevant disciplines, including (as required) psychiatry, psychology, law, social services, and other disciplines;

2. Cancellation is decision-related Qualifications for decision makers with direct vested interests 3. Provide adequate remuneration to decision makers acting in official capacities to ensure that they perform their duties independently.

10. Respect for the rule of law
    Description: The decision must be made in accordance with the laws in force of the jurisdiction in question, not on a different or arbitrary basis
    Components: This principle includes the following components:

    1. Depending on the country's legal system, the legal system may exist in different types of legal documents (such as the constitution, international agreements, laws, decrees, regulations, orders) and / or past judicial decisions (precedents);

    2. Applicable

    3. Laws must be public, accessible and easy to understand.

Implementation: Recommended actions to promote this principle are:

1. Inform patients of their rights;

2. Ensure that relevant legal documents are disseminated (for example, published and explained in easy-to-understand language in the guide, if necessary) to interested members of the general public, especially decision makers;

3. Provide decision makers on the meaning and impact of the rule of law Training;

4. Interpret the current laws of the jurisdiction in question from relevant internationally recognized human rights documents (such as United Nations principles, the current ten basic principles);

5. The practical application of the mental health law system is independent of the health authorities and Control agency supervision of health care providers.

3.3 Promote and improve mental health

Medication: Medication is a therapy that uses drugs.

Physical exercise: For some people, physical exercise can improve physical and mental health. Exercise, walking, biking, or any form of physical activity can trigger the production of various hormones, sometimes including endorphins, which can elevate a person's mood.

Studies have shown that, in some cases, physical activity has the same effect as antidepressants in treating depression and anxiety.

In addition, stopping physical exercise can adversely affect certain mental health conditions, such as depression and anxiety. This can lead to many different negative results, such as obesity, distorted body image, reduced levels of certain hormones, and more health risks associated with mental illness.

Activity therapy: Activity therapy, also known as leisure therapy and occupational therapy, promotes recovery through active participation. An example of occupational therapy is to promote activities that improve daily life, such as self-care or hobby improvement. Similarly, recreational therapy focuses on sports, such as walking, yoga, or cycling.

Each of these treatments has been proven to improve mental health and make people healthier and happier. For example, in recent years, in many studies, coloring has been considered an activity that significantly reduces depression symptoms and anxiety levels.

Expression therapy: Expression therapy or creative art therapy is a psychotherapy that involves art or artistic creation. These therapies include art therapy, music therapy, drama therapy, dance therapy, and poetry therapy. Facts have shown that music therapy is an effective way to help people with mental illness. Theater therapy has been approved by NICE for the treatment of mental illness.

Psychotherapy

Psychotherapy is a general term for the scientific treatment of mental health problems based on modern medicine. It includes multiple schools such as Gestalt therapy, psychoanalysis, cognitive behavioral therapy, psychedelic therapy, transpersonal psychology / psychotherapy, and dialectical behavior therapy. Group therapy involves any type of therapy performed in a multi-person setting. It can include psychodynamic groups, expression therapy groups, support groups (including twelve-step plans), problem-solving groups, and psychoeducation.

Self-compassion

According to Neff, self-compassion includes three main positive components and its negative components: self-kindness and self-judgment, common humanity and isolation, and mindfulness and over identification. Additionally, a study by Shin & Lin has evidence that specific components of self-compassion can predict specific dimensions of positive mental health (emotional, social, and mental health).

Social Emotional Learning

The Collaborative Academic, Social and Emotional Learning (CASEL) comprises five broad and interrelated areas of competence, highlighting examples in each area: self-awareness, self-management, social awareness, interpersonal skills, and responsible decision-making. Alexendru Boncu, Iuliana Costeau, and Mihaela Minulescu (2017) conducted a meta-analysis of the research on socio-emotional learning (SEL) and its impact on emotional and behavioral outcomes. They found that the impact of outsourcing problems and socio-emotional skills was small but important (across all studies).

Meditation

The practice of mindfulness meditation has many mental health benefits, such as reducing depression, anxiety, and stress. Mindfulness meditation can also be effective in treating substance use disorders. Additionally, mindfulness meditation appears to bring beneficial structural changes to the brain. The health meditation program has been shown to significantly improve the mental state of healthcare professionals. A study published in the National Library of Medicine showed that these professionals with different stress levels can improve their condition after implementing this meditation program. They benefit from exhaustion and emotional health. 4,444 people with anxiety disorders participated in a stress reduction program conducted by researchers from the mental health service hotline of the W.G. Veterans Affairs Medical Center. Hefner is in Salisbury, North Carolina. Participants practice mindfulness meditation. After the study was completed, it was concluded that "mindfulness meditation training programs can effectively reduce anxiety and panic symptoms, and help maintain these reductions in patients with generalized anxiety disorder, panic disorder, or panic disorder accompanied by agoraphobia.".

Mental Fitness

Mental Fitness is a mental health exercise that encourages people to regulate and consciously maintain their emotional health through friendship, regular interpersonal communication, and activities such as meditation, calming exercises, aerobic exercise, and mindfulness. Enough live sleep. Mental health aims to build resilience to face daily mental health challenges to prevent the escalation of anxiety, depression, and suicidal ideation, and to help them cope with these emotional escalations (if they do occur).

Spiritual Counseling

Spiritual counselors meet with people in need, provide comfort and support, help them better understand their problems, and establish a problem-solving relationship with the spirit. These types of counselors provide care based on spiritual, psychological, and theological principles.

Develop an action plan for the promotion of mental health and the prevention of mental disorders. Although it provides opportunities for social and economic benefits and social health, the resources for the prevention of mental disorders and the promotion of mental health are very limited. To solve the problem of mental illness, it is essential to adopt public health action methods that include and prioritize promotion and prevention, as well as care and rehabilitation, especially in developing countries such as Nigeria, where the prevalence of mental disorders is high. All countries should develop comprehensive action plans for the prevention and promotion of mental health. Resources allocated to mental health should be commensurate with the burden of mental health problems and distributed between prevention and advocacy to support implementation, research, infrastructure, and professional development.

SELF-ASSESSMENT EXERCISES

i. Discuss the concepts of mental health promotion and mental health prevention
ii. Determine strategies to prevent and improve mental health

4.0 CONCLUSION

The purpose of promotion is to enhance the individual's positive sense of self-worth, control, and happiness, the ability to feel, and social tolerance. In this unit, students understand the concepts of mental health promotion and mental health prevention and determine strategies.

5.0 SUMMARY

In this unit, students understand the concepts of mental health promotion and prevention of mental health conditions, and determine strategies to prevent and improve mental health

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCE/FURTHER READING

https://www.ohchr.org/EN/Professional Interest/ page Number/ PersonsWithMentalIllness.aspx

https://www.who.int/mental_health/media/en/75.pdf Module

UNIT 4 MENTAL HEALTH LAW AND PUBLIC HEALTH POLICY

CONTENTS

1.0 INTRODUCTION

There are many factors that affect mental health. Including illness, disability, and suicide are ultimately the result of a combination of the acquisition and use of biological, environmental, and mental health treatments. Public health policies can affect access and use, which in turn can improve mental health and help improve the negative consequences of depression and related disabilities.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- Define mental health law
- Define public health policy

3.0 MAIN CONTENT

Emotional mental illness should receive special attention in the United States, because among 14 developing and developed countries, the United States has the highest annual prevalence of mental illness (26%). In the United States, about 80% of people with mental disorders will eventually receive some form of treatment, but on average, people cannot get care until nearly ten years after the disease has progressed, and less than one-third of those who seek help Receive the minimum appropriate care. The government provides programs and services to everyone, but veterans get the most help and must meet certain eligibility criteria.

Policy

The mental health policy of the United States has undergone four major reforms: the American asylum movement led by Dorothea Dix in 1843; the "mental health" movement inspired by Clifford Beers in 1908; and 1961 the deinstitutionalization of the mental health initiative and the community support movement called for by the 1975 amendment to the CMCH Act.

In 1843, Dorothea Dix filed a complaint with the Massachusetts legislature describing the abuses and dire conditions suffered by mentally ill patients in prisons, cages, and shelters. She was in her Eulogy revealed: "Gentlemen, I continue to draw your attention briefly to the current situation of the mentally ill confined in this federation. They are locked up in cages, closets, cellars, stalls and fences! Nudity, beatings and whipping with sticks, many shelters were built during that period, patients were separated from other member communities by fences or high walls, and there were strict regulations on entrances and exits A disease, but a restoration The method of human homeostasis, as well as other elements basics like healthy eating, fresh air, middle-class culture, and visits from neighboring residents. [Citation needed] In 1866, a proposal came to the New York State Legislature to establish a system for people with chronic mental illness. Some hospitals place chronically ill patients in different wings or wards, or in different buildings.

In A Mind That Found Self (1908), Clifford Whittingham Beers (Clifford Whittingham Beers) described the insulting treatment and sad conditions he received in a psychiatric hospital. A year later, the National Council on Mental Health (NCMH) was established by a small group of intellectual reform academics and scientists, including Bills himself, and this ushered in the "mental health" movement. The campaign emphasized the importance of child prevention. World War I promoted this idea and further emphasized the effects of maladaptation, leading hygienists to believe that prevention is the only practical way to treat mental health problems. However, prevention has not been successful, especially for chronic diseases; condensable conditions are more common in hospitals, especially under pressure from increasing numbers of chronically ill patients and the influence of depression.

In 1961, the Joint Mental Health Committee issued a report called "Mental Health Action", with the aim of allowing community clinics to bear the burden of mental illness prevention and early intervention, thus providing severe and chronic patients in hospitals. The court began issuing a ruling in favor of the patient's wishes on whether the patient should be compelled to receive treatment. By 1977, 650 community mental health centers had been built, covering 43% of the population, serving 1.9 million people each year, and treatment time had been reduced

from 6 months to just 23 days. However, the problem persists. Due to inflation, especially in the 1970s, community nursing homes received less funding to support care and treatment. Less than half of the planned centers were built, and the new method did not completely replace the old method to achieve its full energy processing capacity. In addition, a community support system has not been fully established to support patients' housing, career opportunities, income support, and other benefits. Many patients return to social care and criminal justice institutions, and many more are homeless. The deinstitutionalization movement faces huge challenges.

After realizing that simply changing the location of mental health care from a state hospital to a nursing home was not enough to implement the idea of deinstitutionalization, the National Institute of Mental Health created the Community Support Program (CSP) in 1975 to provide funding for the community to establish Comprehensive mental health services and support help people with mental illness integrate smoothly into society. The plan emphasizes the importance of other support besides medical care, including housing, living expenses, employment, transportation, and education; and sets new national priorities for people with severe mental disorders. In addition, Congress enacted the Mental Health System Act in 1980 to prioritize the provision of services to patients with mental illness and emphasize the expansion of services beyond clinical care. In the late 1980s, under the influence of Congress and the Supreme Court, many programs were initiated to help patients regain benefits. A new Medicaid service has also been established to provide services to people diagnosed with "chronic mental illness." People who are temporarily hospitalized are also helped and cared for, and a pre-release plan has been developed so that people can apply for reinstatement. It was not until 1990, about 35 years after deinstitutionalization, that the first state hospital began to close. The number of hospitals has been reduced from more than 300 in the 1990s to more than 40. In the end, the "Mental Health Report" showed the efficacy of mental health treatment and provided a variety of treatment methods for patients to choose from.

However, some critics believe that from a mental health perspective, deinstitutionalization is a complete failure. People with severe mental illness are homeless or in prison; in any case (especially the latter), they receive little or no mental health care. This failure can be attributed to a certain degree of controversy for multiple reasons, although it is generally believed that community support programs are at best ineffective due to lack of funds.

The 2011 National Prevention Strategy includes mental and emotional health, and the recommendations include better early intervention and

parenting programs, increasing the possibility that prevention programs will be included in future mental health policies The NIMH only studies suicide and HIV / AIDS prevention, but your national prevention strategy may allow you to focus more on longitudinal prevention research.

3.1 Nigeria's Mental Health Act, the "Mental Illness Act"

The current Nigerian mental health legislation is the same as that which entered into force before the independence of the United Kingdom in 1960. The Mental Health Atlas of the World Health Organization it was originally called the "Mental Illness Act". A good place to start a review of mental health legislation is to define the conditions that the law seeks to address. Under the Lunatic Act, lunatics include idiots and anyone else with sick minds. Crazy Act (1958). In addition to using terms that are not currently standard terms, the definition also has the potential for wide and fluent interpretation. This discretionary interpretation gives physicians and magistrate's great powers to decide which citizens are protected by the Mental Illness Act (1958). In relation to involuntary detention, the flexibility of the definition can lead to excessive application of the law, leading to the wrongful imprisonment of mentally healthy people.

Although it creates a range of potentially highly affected people, the bill seeks to protect the people who may be included in its definition. Although the detention procedure has certain discretionary powers of the interrogated person, it requires both the doctor and the magistrate to find that a person is a lunatic. If the doctor believes it is necessary to detain someone for observation, the person can only be detained for 7 days without the authorization of the magistrate. 6 However, some procedural elements leave room for possible abuse. For example, when a local judge decides to investigate a person's emotions, if the magistrate is worried that the person will not appear in court, they may issue an arrest warrant. Crazy Act (1958). Detention under such arrests can be as long as one month. The Lunatic Asylum Act (1958) the district governor lays down the rules for the conditions in the shelter, and he can issue regulations on the "management of the shelter and the guardianship of the mentally ill".

In addition, the bill stipulates that certain people are "visitors, who can inspect the nursing home and investigate any complaints. To ensure a formal and regular review of asylum conditions, the governor must designate at least three "visitors" for each asylum. These visitors will then inspect the refuge and report their findings to the governor at least once a year.

The last noteworthy aspect of the bill is not in the text, but in what is missing in the text. The bill does not mention treatment; nor does it use words synonymous with treatment. The variety of reasons for detaining a

person under the law is that a person is "a lunatic and a proper subject of prison." In fact, the full name of the law is "a [law] that regulates the detention and expulsion of lunatics. The absence of any treatment provision may be one of the most important factors affecting the country's mental health law reform movement.

3.2 Nigeria's Mental Health Law

"Reform movement" may not be the best term to describe the largely ignored call for change in Nigeria's mental health law. Although the calls for reform were high, no movement in the direction of reform has been realized. A bill to repeal the Mental Disorder Act was originally introduced in 2003, but after years of little activity, the bill was withdrawn from the Senate in 2009. Nonetheless, on the positive side, at least one senator thought the issue was important enough, and therefore raised the bill.

An analysis of the provisions of the bill shows that its enactment into law will mark Nigeria's mental health law moving towards modern international standards. First, the bill will delete the broad definition of "lunatic" and replace it with "mental disorder", thereby reducing the scope of the current law. The latter term is more easily accepted by the medical community than the term "lunatic", and the definition clearly excludes "social deviation or conflict" from the scope of coverage. The bill also defines additional provisions, which will provide more enforcement guidance than the "Madness Act". In addition to restricting the scope of the law, the bill will also provide additional procedural protection for people subject to it by creating three compulsory admission methods: temporary admission for observation, admission based on emergency requests, and admission for treatment. Magistrates will no longer play a role in admission decisions, which will be based solely on medical classification. For each type of admission, the applicant (that is, the person requesting the admission of another person) must make a request based on two reasons:

(1) Subject-suffering from a certain nature of mental and behavioral disorders or a degree that guarantees their compulsory admission ", and

(2) Subjects "must be detained in this way for their own safety or to protect the safety and interests of others." Temporary admission requires the recommendation of a doctor who believes that the person meets the required qualifications. Urgent requests do not require a doctor's recommendation, but they can only be submitted under "urgent needs" and temporary admission requests "will cause undesirable delays". According to an urgent request, a

person can only be detained for a maximum of three days. Similarly, if in order to protect the interests of detainees or others, police or social workers can move people suspected of mental and behavioral disabilities to a safe place. According to the provisions of this article, the police or social workers may detain the person for no more than 72 hours. The procedural requirements for prolonged detention are higher than the other two types of admission requirements, and are much higher than the involuntary commitments under the Mental Disorder Act. A medical staff or a close relative of a person can start the acceptance process by submitting an application. If a health worker submits an application, their close relatives must at least agree to submit it. Then, the two doctors will have to recommend admission to the hospital after the exam within 7 days of each other. Once the application has been successfully completed, the applicant or any person authorized by the applicant has 14 days from the date of the last medical examination (on which the application is based) to take the detainee to a mental health facility. In the case of following the full procedures, the Law does not limit the period of detention. The main difference with the Psychiatry Law is that the Law only allows detention for up to 365 days without the need to renew the application. Detainees can challenge the mental health review court within six months of their incarceration, which is the only legal party involved in forced admission cases. Since one of the main problems with the Mental Disorders Act is the lack of provisions for the treatment of persons detained for mental health problems, the Act clearly defines treatment as the purpose of detention. The bill will also limit the types of treatment that are provided and the circumstances under which treatment can be provided. For example, any treatment generally requires consent and the patient can withdraw consent at any time. Additionally, the bill will protect detainees by requiring that facilities meet the minimum standards set by the Minister of Health. Finally, although Bill a comparison of the outdated mental health legislation mentioned above in Nigeria with recent proposals shows that at least the Nigerian Mental Health Law protects in detail your citizens from potential mental health problems. The main difference between the Mental Disorders Act and previous bills is the duration of involuntary detention of potentially mentally ill patients and the compulsory admission procedure. However, in addition to improvements to the Mental Illness Law, any updated Nigerian Mental Health Law should seek to promote the human rights of those covered by it. Furthermore, human rights should not be judged on the basis of subjective and improvement standards; the objective standards stipulated by the national constitution and international law should determine the measurement standards. A.

> International conventions and constitutional obligations. The bill itself will not violate the constitutional rights of Nigerians with mental disorders. Although everyone has the right to personal liberty, the Nigerian Constitution excludes "mentally ill" persons when they are detained "for the purpose of caring for, treating or protecting the community." In addition to its own constitution, Nigeria has also signed two binding international legal agreements that govern human rights and provide general principles for judging any Nigerian mental health law. First, the International Covenant on Economic, Social and Cultural Rights (ICESCR)- recognizes that everyone has the right to enjoy the highest possible level of physical and mental health. The general language of the convention does not provide much guidance to states on how to protect this right of their citizens, but the principles of the new law should at least conform to the broad rights guaranteed by the convention. To this end, the proposed Mental Health Law recognizes the need to address mental health issues related to the health of the affected and public safety.

According to the agreement, the most important change that may be frustrated by the withdrawal of the bill is the inclusion of legislative provisions for the treatment of patients, which are not in the current legislation. The bill also passed orders for the Minister of Health to set minimum standards for such facilities to ensure high-quality health for patients who were once confined to treatment facilities. The purpose seems to be well-intentioned and a legitimate attempt to ensure "the highest level of physical and mental health." Secondly, Nigeria is also committed to the recognition and realization of the rights proclaimed in the African Charter of Human and People's Rights. In addition to including the same language as the aforementioned "International Covenant on Economic, Social, and Cultural Rights," the charter also establishes the general right to enjoy an environment conducive to further development, and specifically requires "special protection measures" for persons with disabilities. The bill should comply with the charter, requiring treatment facilities to meet minimum standards, separate mental health departments in hospitals and primary care centers, and stricter mandatory admission procedures. The background of the recommended international standards advocated by the World Health Organization (WHO) can further illustrate whether the provisions of the bill comply with Nigeria's international obligations. B. The World Health Organization's Mental Health Legislation List. As part of its role of "proposing recommendations on international health issues" and "promoting activities in the field of mental health", WHO has compiled a resource book to "assistance countries in drafting, adopting and implementing "Mental health legislation. This book describes the different provisions that countries should include in their mental health

legislation to protect the rights of people with mental disorders. It is not recommended that countries fully follow the regulations discussed in this book, because each legal system is different and each country has its own special needs. The resource manual is accompanied by a WHO mental health legislation checklist ("checklist"), which provides countries with a way to evaluate their mental health legislation by answering the questions posed in the document.

This section will use the checklist to assess whether the proposed Mental Health Law will improve Nigeria's mental health legislation. The definition will start to analyze again. The previous bill basically conforms to the World Health Organization's recommendations on the definition of specific terms. The bill has a clear definition of "mental disorder" and defines other important terms. The definition of "mental disorder" has some ambiguities in the coverage of diseases such as drug abuse. The WHO warned against this, but it clearly excluded pure social deviations to curb misunderstandings. The procedural elements of compulsory entry in the bill largely conform to the recommendations in the list, which will represent a huge improvement to the current law. First, the bill proposes to reduce the requirement for mandatory detention only because of mental disorders in accordance with the recommendations of the World Health Organization. It also reflects recommendations on the number of doctors who must prove that patients are eligible for involuntary detention, the qualifications of these doctors, and the patient's right to appeal.

The WHO further recommends that independent agencies review all or at least some types of involuntary admissions, but the bill lacks similar provisions. When dealing with emergencies, the bill follows the general principles implied in the list, but lacks details on when the emergency provisions will apply. On the other hand, the provisions in the draft regulations that allow the use of police forces under certain circumstances are closely related to the recommendations of the WHO. The WHO also made a series of recommendations to protect the rights of people entering mental health facilities, and the bill complies with many of these recommendations. However, the bill left some loopholes in the provisions and could have benefited from more details in some parts. For example, both the checklist and the bill start with the assumption that treatment must require patient consent, and the bill requires similar standards to the checklist to allow involuntary treatment. However, the list recommends more protective measures for involuntary treatment not included in the bill. In addition to treatment recommendations, the checklist recommends that any institution accepting and / or treating mental health patients must be certified before accepting patients. The bill requires facilities to meet the minimum required standards, but gives the Minister of Health full authority to determine these standards.

Finally, the list calls for the establishment of a monitoring and review mechanism to protect the rights of involuntary detainees. Although the bill will establish a mental health review court and give the Minister of Health the power to determine the court's number, composition, and rules of procedure, it does not provide enough specific provisions to satisfy WHO recommendations. Regarding the protection of human rights, the bill will establish a framework to establish a system that can protect these rights. Creating a detailed structure based on the recommendations will depend on the Minister of Health.

As mentioned above, by following the recommendations of the World Health Organization in its mental health checklist, many parts of the bill will provide human rights protection. The bill does not meet the recommendations and there are still loopholes, but overall, the legislation will be a huge improvement over the current Nigerian law. C. Comparison with best practices in the region In addition to comparisons with Nigeria's international obligations and international recommendations, considering the development of similar national mental health legislation can help assess the quality of previous bills. South Africa is one such country that has only taken action in the past ten years to correct the shortcomings of its old mental health law and is also facing challenges related to resource constraints.

South Africa passed new mental health legislation in 2002, repealing its outdated apartheid law. The previous law, like current Nigerian law, "highlighted the guardianship method for mental disorders, which not only frustrated failed to protect the array of human rights to which people with mental disorders are entitled, but also dealt with certain abuses of mental disorders Responsible behavior Human rights Nigerian bill includes procedural protections for involuntary commitments similar to South Africa's Mental Health Care Act Unfortunately, the similarity between the provisions does not affect the decisions of the Nigerian legislature Legislation that can lead to different outcomes An important difference in the process is that Nigerian legislators did not publicly solicit the views of different stakeholders. Although Nigeria has made some positive progress in dealing with mental illness, further steps must be taken to achieve protection against abuse due to mental illness AND the result of stigmatized Nigerians.

The most important step that Nigeria can take to improve its involuntary commitment system is to reform its mental health legislation. You have the opportunity to do this through the Mental Health Act, and the National Assembly must seize the opportunity to create positive change. While the bill does not provide a perfect solution to the country's problems, its quality far exceeds current law. In a perfect world, senators would propose a bill to fill the void left by the Mental Health Act described in

the previous section. The members of the National Assembly will listen to their voters supporting the reform and will approve such a bill. The Minister of Health will seek internationally recognized standards when formulating regulations such as facility standards. Unfortunately, this is not a perfect world. Ignorance and stigma about mental health are common all over the world, including Nigeria.

Therefore, all stakeholders in Lagos, from politicians to psychiatrists, families and drivers, must work together to strengthen support for reforms and encourage lawmakers to take action. It may be that the bill proposed by Senator Manzo is irreconcilable with certain groups in the country. In this regard, supporters of the new bill should seek the views of a wide range of affected groups and individuals, such as in South Africa, to develop a new draft. Assistance from WHO or other entities can help guide this process, but in the end, change must come from Nigerians. Only inner strength can overcome the current negative mindset. The country has shown great capacity in the progressive treatment of mental health in the past; Now is the time for the new leaders to step up and bring Nigeria and its mental health laws into the modern era.

4.0 CONCLUSION

Public health policies can affect access and use and can subsequently improve mental health and help ameliorate the negative consequences of depression and related disabilities. In this unit, students learn about mental health policy, Nigerian mental health policy, and lunatic law. Nigeria Mental Health Law

5.0 SUMMARY

This unit expresses the Mental Health Policy, the Mental Health Policy of Nigeria and the Lunatic Law.

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

7.0 REFERENCES / FURTHER READING

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Compare S.B. page 183 3 (Nigeria 2008), and the Crazy Act (1958) Ch. (112), §§ 11-13 (Nigeria).

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UNIT 5 MENTAL HEALTH PROMOTION INTERVENTIONS

CONTENTS

1.0 INTRODUCTION

This module outlines the available evidence for specific mental health promotion interventions for school-age children and adolescents Although there are various school-based mental health promotion interventions, for the purposes of this unit, the Socio-Emotional Learning (SEL) program has been selected as a priority area. As described in the literature, the social, emotional, and behavioral results of generic SEL interventions, as well as the components of effective programming, are introduced. The evidence provided can be used to inform policy and actual decision-making to help promote the mental health of school children and youth in the province and to support the second phase of Ontario's mental health and addiction strategy.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- Define Social and Emotional Learning (SEL)

3.0 MAIN CONTENT

Social and Emotional Learning (SEL) is the acquisition and effective application of necessary knowledge, attitudes and attitudes for children and young people Skills to understand and manage emotions, set and achieve positive goals, feel and express compassion for others, build and maintain positive relationships, and make responsible decisions. 1 Although everyone develops social and emotional abilities in their lives, SEL programming in childhood can help reduce future behavior problems in children and adolescents Aber, J.L., J.I. Brown, and S. Jones. (2003). SEL programming can also help children better prepare for learning when

they are in school by supporting children's learning methods: academic self-concept, goal setting, and perseverance.

SEL is important to saving children

SEL is important because children are prepared to learn and have the necessary knowledge, attitudes, and social and emotional skills wherever they are in order to realize their potential and adapt to any changes in the environment. By prioritizing SEL in the plan and specifically including it in the 2016 and 2018 emergency education strategies, it is Save the Children's broader risk reduction and . In the meantime, the goal is to invest in and test SEL's programming and assessment tools to ensure that our method produces positive results for children.

The Importance of SEL for Learning

When children are given educational opportunities that include social-emotional learning strategies, they generally show greater readiness for learning and achievement in school. Crises, such as forced immigration or community violence, can have a negative impact on the social and mental health and learning capacity of children or adolescents. By strengthening protective factors, SEL programming can not only help children cope with the adverse effects of negative life events, but it can also increase their concentration, improve behaviors, and help develop a more learning attitude.

When is SEL appropriate?

SEL and Mental Health and Psychosocial Support (MHPSS) are complementary methods and there is considerable overlap in their implementation. SEL programming can be used for the full range, even in humanitarian emergencies, and MHPSS can also be used. MHPSS is used primarily in acute humanitarian emergencies and is a targeted intervention method. It is designed to help those most in need of emergency psychosocial support (to reduce the negative effects of crisis situations) due to severe adversity or chronic trauma. 5 On the other hand, SEL is a universal intervention method that can develop knowledge, attitudes and personal social and emotional skills in different settings, and can be used at any stage, be it emergency, early recovery or developmental stage. In non-crisis situations, SEL can be included in the entire planning cycle to address the long-term development of children and adolescents. In the context of a severe crisis, the potential continuity of the SEL program may be interrupted by the crisis. In this case, a dedicated MHPSS may be the most appropriate option right after the crisis, and gradually shift to regular SEL programming over time. After all children and adolescents have received the basic mental health and screening services they need, there may be a gradual transition between MHPSS and SEL. The timing of this gradual change will be different in each case, and a decision about the change needs to be made after

considering the consequences of a serious crisis. In a protracted context, the underlying continuity of SEL programming may be interrupted multiple times. In this case, we recommend combining MHPSS and SEL programming components to use the principles of general and specific intervention to determine what services different communities need.

Incorporates SEL into EiE programming there are three main entry points for SEL programming.

1. Education Department: SEL can be included in the curriculum of formal school curriculum (classroom) or informal learning environment (such as community center, integrated child center space/child-friendly space or temporary learning space).
2. MHPSS related plans (such as HEART or SC Denmark's resilience plan): SEL can be included in the plan as a general plan method to provide specific MHPSS interventions for children who need specific psychosocial support.
3. Disaster Risk Reduction: SC's comprehensive school safety framework should be planned around “education for resilience”. SEL courses / content (such as emergency wellness and learning programs) can be used as an integral part of this flexible education, especially when it comes to flexibility at the individual level.

Learning and Wellness in Emergencies (Resource Kit) is a programmatic approach that can be used to address SEL of children. It combines the school / classroom learning environment and the home / community environment to provide support and opportunities to practice SEL, which has been found to improve positive student outcomes 4 and extend the duration of effect. 6 In relation to SEL and resilience, DRR and emergency messages are also included in the program. Learning and benefits in emergencies include the following parts:

Teacher training - In addition to training on literacy content and teaching methods, teachers also receive guidance on the different components of SEL, how to develop skills SEL status of children and how to prioritize self-assessment watch out. Teachers receive approximately 40-50 hours of professional development training (and ongoing support) in 8 core courses (+2 additional courses) depending on context. Ideally, all courses should be completed and the SEL key course is required at the beginning, but there is some flexibility at the time of the course launch. Community Action: Complementing the school / classroom learning environment, there is a strong community component. Through the 21-hour course, counselors work with community members (caregivers, youth, etc.) to increase their awareness of their own personal care and children's SEL and general health. Some of these awareness courses also focus on literacy and numeracy exercises that families can use to support children's

learning. In addition, there are many community-based activity options to choose from, including community library, book festival, book club, and book partners.

Assessment - A set of tools used to measure SEL skills, children's learning methods, literacy development, and the classroom / family environment, which can be used to measure program impact or as a tracking component.

Some Best Practices in SEL Programming

Harmless Similar to MHPSS, SEL programming for children who have experienced severe stress can cause harm because it involves sensitive topics (IASC MHPSS Guidelines, 2007). In order to minimize the risk of injury, it is essential to:

- Use all available information to design a situation-related plan
- Coordinate with other internal and external partners to provide necessary child support
- Understand local stakeholder relationships
- The power of Participatory monitoring and evaluation methods are used for formative and summative learning, and the structured way of thinking about harm reduction is through the “choice challenge” approach.

In the process of training and course implementation, participants should be encouraged but not forced to participate. Because SEL activities can bring stressful memories or emotions, it is important that participants can choose not to participate in an activity or modify the activity so that they can participate.

Plan

The development of a person does not occur in isolation, but through various relationships between the individual in different settings (Bronfenbrenner, 1977). SEL programming should include classroom and school settings, as well as home and community settings. When the SEL is integrated into the teaching and learning process, as well as the classroom and school setting, this can provide important daily non-clinical psychosocial support for children affected by crisis. More serious or more specialized MHPSS cases can be determined through SEL work in the classroom, and then appropriate referrals can be made. MHPSS and SEL should also allow for effective support from caregivers, families, and communities.

A structured way of looking at comprehensive planning in emergencies is to incorporate SEL into the conflict-sensitive education framework (Dean, 2014). Unless proper protective measures are taken to ensure a safe learning environment, the SEL program will not be effective. The

broader education system must be inclusive, fair, and provide safe and high-quality educational opportunities. At the school and classroom level, it is also important to promote a positive and caring atmosphere by improving teacher-student interaction and useful teaching and methods.

Cultural and contextual understanding and adaptation
The development of children and their social and emotional abilities are intertwined with culture (Rogoff, 2013). This means ensuring that our interventions and materials are context-specific and relevant so that we can handle different capabilities in a culturally sensitive way. Incorporating SEL into the plan requires a deliberate adaptation process that enables communities to provide feedback on what capabilities make sense in their environment and how. Although it is not a complete list, here are some examples of past experiences implementing SEL programs in different cultures:

- Some parents may think that SEL activities that involve physical movement and dance are inappropriate, especially if their children are mixed. Stress management / care activities include asking participants to close their eyes, which is not always appropriate or comfortable.
- Cultural norms and beliefs affect people's methods of social interaction and socially acceptable content, as well as how people express their emotions and whether people seek help from unfamiliar people.
- When talking about stress management, people of different cultures respond to and handle stress differently. For example, some people may trust their beliefs and prayers, or they may take a more spiritual approach.
- Language proficiency affects assessment and socio-emotional assessment. For example, children who are not taught in LOI and do not have a high level of proficiency in LOI may show delayed socio-emotional development (Chang et al., 2007; Tabors, 2008). We need to ensure that children with different language skills will not be unfairly judged.

Precautions to ensure SEL learning
Because SC SEL programming is at an early stage, our investment and testing are very important. This means finding effective ways for Save the Children’s country offices to capture the learning of SEL programming to better understand how culture affects our SEL work and the impact of our SEL work on children. Field experience to date has revealed some common practices worth considering when incorporating SEL into your programming.

- Adaptation: Whenever possible, we recommend that the national team adjust all assessment plans and materials with the help of local children, parents and/or community members. This can take the form of a two-day seminar where stakeholders express their opinions on the most appropriate way to carry out different activities.

- Translation: In previous evaluations of the SEL program, we have seen that the local dialect can have a large impact on the way children respond to the evaluator. The same is true for the actual program material. Whenever possible, hire local staff or translators to use local jargon and jargon to translate all materials into the local language.

- Knowledge Management: As we develop our SEL program in South Carolina, it is important that we ensure that we keep track of what we learn in different settings so that we can better tailor the program materials and assessments in the future. As part of project / SEL scheduling, we recommend appointing a contact person to be responsible for recording the content learned from the project.

SELF-ASSESSMENT EXERCISE

i. Describe mental health promotion policies for school-age children and adolescents
ii. Identify school-based mental health promotion interventions in your school

4.0 CONCLUSION

This module provides an overview of specific mental health promotion interventions for school-age children and adolescents existing evidence. It is a series of school-based mental health promotion interventions, Social Emotional Learning (SEL) programs, which have been selected as priority areas for this unit. The social, emotional, and behavioral results of general SEL interventions and the components of effective planning are introduced. The evidence provided can be used to inform policy and actual decision-making

5.0 SUMMARY

This teaches students the existing evidence on specific mental health promotion interventions for school-age children and adolescents promote the mental health of school-age children and adolescents in the province.

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe a mentally healthy person
2. Determine the challenges of mental health

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