Section 19. Resilience and Health Care

Trauma & Resilience-Informed Solutions Institute of Southern Africa

This is one of 24 sections that make up the proposal to form TRISI. The other sections can be found at:
http://www.ptgrr.com/contents/get-involved/trisi-content

Reference: *Brian Rogers.* **Trauma & Resilience-Informed Solutions Institute of Southern Africa** – Proposal of a Trauma-Activist**;** *PTG-RR; Sep 2015/19*

This proposal is a living discussion platform. The answers do not lie in one person's mind. Its objective is to attract enabling-capital which includes intellectual contribution and financial support. Should you wish to participate, please visit the TRISI web page. Furthermore, it is not in any way intended to presume scientific validity. The style, or method, is argumentative and documentary. It lacks academic skills which include the traditional representation of sources. Full acknowledgement is given at the point of disclosure so that the reader can identify the source and seek its original in order to explore further.

Resilience and Health Care

1. **Human Rights**
2. **Health Care**
3. **Mental Health**
4. **Behavioral Health**
5. **Stigma**
6. **Trauma-Informed Care**
7. **Innovation in Health Care**

"The goal of promoting mental health and preventing mental illness is straightforward: to increase the number of people who enjoy good mental health and reduce, to the greatest extent possible, the number of people whose mental health is poor, who experience the symptoms of mental health problems or illnesses, or who die by suicide. Achieving these objectives is not easy, but there is much that can be done"

Mental Health Commission of Canada. (2012).
Changing directions, changing lives: The mental health strategy for Canada. Calgary, AB: Author.

"One of Jason (Tylianakis)'s research areas concerns pollination, and he warns that we have become very dependent on introduced honeybees to pollinate monocultures of commercial crops. In his opinion our production landscape would be much more resilient to change if we had greater diversity in the kinds of crops we use, the wider landscape and the suite of pollinators that we rely on."

Alison Balance; **Complexity, resilience and bees;**
http://www.radionz.co.nz/national/programmes/ourchangingworld/audio/201769423/complexity-resilience-and-bees

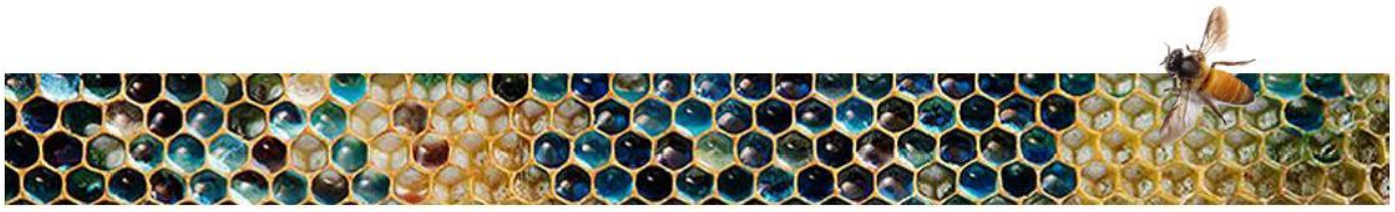
Not knowing in advance exactly how the call will be answered, shouldn't halt the journey.
The fact that we start out not sure of where we're going is what makes the quest so noble.
There's a little Don Quixote in all original ideas.
It's just those windmills in our minds and we should never be scared of them.
John Hunt and Sam Nhlengethwa; **the art of an idea – and how it can change your life**; Zebra Press; 2009

Note: This section, like all the others is prepared in such a way that the experts in their fields primarily tell the story. The sources are clearly displayed and the reader can seek them out for further interrogation of the subject matter.

Regrettably there is not much in the available Resilience literature that supports Solution thinking in Human Rights and Mental Health. Much of what is available is rather euphemistic. Far from detracting from the reason for forming TRISI it enhances it. There is much raw material to work from.

Sarah Skeen, Crick Lund, Sharon Kleintjes and Alan Flisher, University of Cape Town; **The Mental Health and Poverty Project;** Submission to: South African Human Rights Commission

'There is growing recognition that mental health is a crucial public health and development issue in South Africa. Latest reviews of disease burden in this country rank neuropsychiatric conditions 3rd in their contribution to the burden of disease, after HIV/AIDS and other infectious diseases. For the first time a major representative epidemiological study has revealed that some 16.5% of South Africans reported having suffered from common mental disorders in the last year(2). This figure does not include schizophrenia and bipolar mood disorder, which according to expert consensus, would affect 0.5-2.0% of the population during an average year.'



Human Rights

Karen da Costa; **Can the observance of human rights of individuals enhance their resilience to cope with natural disasters?** Centre for Disaster Resilience, School of the Built Environment, University of Salford.

'Human rights are largely understood as rights of human beings arising from their very human nature and inherent dignity. It is generally accepted that members of society in a position of vulnerability are more likely to face serious human rights violations… The conclusion is that human rights can enhance individuals' resilience to face natural disasters, hence the article argues that human rights shall inform disaster-related programs and studies.'

'International monitoring bodies of human rights treaties suggest that states have three levels of human rights obligations, namely the obligation to *respect*, *protect* and *fulfill* human rights. The obligation to *respect* suggests that states themselves should not violate human rights of individuals. Thus, state agents should for example refrain from discriminating against women in post-disaster aid schemes. The obligation to *protect* requires states to take action so as to avoid that third parties encroach upon the rights of individuals… The obligation to *fulfill* requires further action by states to make sure to set the conditions for individuals to at least realize the minimum level of their human rights.'

'It seems that a general climate of respect for human rights by states enhances the resilience of communities to cope with natural disasters. Conversely, the lack of human rights protection may lead to governmental negligence in providing minimum standards of relief and recovery assistance to disaster-affected people.'

Hans Christie Bjønness; **Bhopal2011 and beyond – building resilience through human rights and 'critical discourse analysis'** – facing 'continuous disaster'

'Dealing with 'places of pain and shame' and with difficult heritage is possibly more relevant for our daily professional practice than what we think. First of all, it brings forward the misuse of power, serious violations of human rights and sometimes neglect of the civil society. It also embodies complex issues of national pride, nation building and identity. Nietzsche in his 'On the uses and Disadvantages of History for life' was early in highlighting the contested role of history in this respect. It also concerns, in Foucault's perspective, our daily practice with the 'real history' and in building constitution and civil society according to Habermas in respect of universal human and cultural rights.'

‘The human rights issues of the past are not only about compensation, recognition of severe health effects and rehabilitation, but also about the victims’ rights to get their stories of suffering and neglect heard. It is about the need to recognise and address the ‘continuing disaster’ of groundwater contamination and unsafe upbringing environments along with rights to land and property securing their tenure ship, basic shelter needs and safe drinking water.

Irene Khan makes a convincing case that ‘putting human rights at the centre of the eff ort to end poverty will help us achieve this goal’. Poverty is the denial of human rights through discrimination, state repression, corruption, insecurity and violence.12 In her pledge for a new human rights plan to address the poverty alleviation challenge, Irene Khan stresses on the necessary commitment to achieve results on the ground and states that the generally stated Millennium Development Goals (MDG) are unable to do that.’

‘Relationships between Human Rights and Cultural Rights are mainly discussed in terms of ‘Heritage and Identity’ and in relation to cultural diversity. In this context, I want to bring forward the recent and relevant work of Farida Shaheed to the challenges of working with multiple heritages and with ‘heritage community’. Shaheed recommends in a report on cultural rights to UN Human Rights Council, that a community level dimension should be introduced when it comes to Cultural Rights and the right to access cultural heritage. She writes: “…from a human rights perspective, cultural heritage is also to be understood as resources that enable the cultural identification and development processes of individuals and communities”.

‘In the context of human rights, cultural heritage entails taking into consideration the *multiple heritages* through which individuals and communities express their humanity, give meaning to their existence, and build their world views’ (my italics). And she provides ‘signifi cance for *particular* individuals and communities, thereby emphasizing the human dimension of cultural heritage’.’

‘The use of discourse analysis in critical education and research and development (R&D) eff orts is essential in post disaster inquiries. But we have to be careful to focus on the fascination of making our inquiry into only narratives of representations of social and cultural realities. Our concern must be that discourse matters in bringing forward different stakeholders’ understanding, based on their experiences and class and thereby articulates the understanding of different positions, as suggested by Foucault, of both ‘insiders’ and us as ‘outsiders’.’

Walter Kälin; **A Human Rights-Based Approach to Building Resilience to Natural Disasters**

‘Much of the present debate about disaster risk reduction and strengthening resilience seems to be rooted in a modern version of Rousseau, namely that it is simply reasonable to take such measures. I would like to suggest that in line with the Budayeva judgment the time has come to move on and accept that a human rights based approach to dealing with the risks of disasters in and outside the context of climate change, has much to offer.’

‘If we understand resilience as “the ability of a system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner,” i.e. the ability to “spring back from” a shock, [4] human rights can help in several regards.’

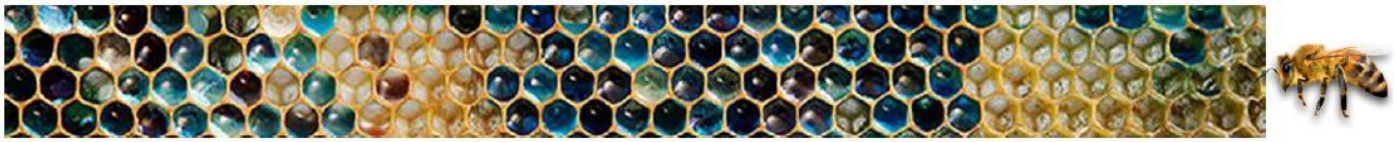
***‘First**, human rights help to determine relevant areas of resilience building in a comprehensive manner.* Human rights can be understood as legal instruments to address comprehensively those needs of human beings that have been identified in the course of history as being particularly worthy of protection.’

***‘Second**, human rights provide guidance for appropriate action in certain areas of resilience building that pose particularly complex dilemmas for governments and other relevant stakeholders.* Human rights law provides criteria to determine the content as well as the limits of what people can demand, but also of what can be demanded from them in terms of obligations, thus allowing determining the permissibility of governmental orders which are contested by those affected.’

***‘Third,** human rights provide strong arguments for looking at affected persons as rights holders* and not just objects of humanitarian action and disaster management activities. As such affected persons have, in particular, a right to be consulted and to participate in decisions relevant to their fate as a consequence of their freedom of expression and their political rights.’

***‘Fourth**, human rights allow identifying not only right holders but also duty bearers, thus allowing establishing accountability when relevant rights are violated.* Human rights guarantees determine who is entitled to what vis-à-

vis whom. This is particularly important because such identification enables in many cases those whose human rights have been violated to hold duty bearers accountable and get reparation.'



Health Care

Mental Health Commission of Canada. (2012). **Changing directions, changing lives: The mental health strategy for Canada.** Calgary, AB: Author.

'Since our mental and physical health are connected, they should be addressed together. Not only are people with chronic physical conditions at higher risk of developing mental health problems, but people with mental health problems and illnesses are also less likely to receive the care they need to maintain their physical health. Studies have found that adults with severe mental health problems and illnesses die up to 25 years earlier than adults in the general population, with cardiovascular disease being the most common cause of death.

Canada has been a pioneer in finding effective ways to expand the role of primary health care in meeting mental health needs. Collaborative mental health care, defined as primary health care delivered by "providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support," has been embraced by most provinces and territories. It is improving access and results, as well as producing greater satisfaction with care, all while using resources more efficiently.'

'A more integrated mental health system must also be linked to, rather than isolated from, all parts of the community and other service systems. Family doctors, teachers, police personnel, and long-term care workers are among those who should work with each other and with mental health service providers to address people's mental health needs. A more coordinated and integrated system will make available multiple resources to help facilitate recovery: timely access to medications and to adequate and affordable housing; professional counselling, as well as readily available peer support; and help in setting and meeting educational and employment goals.'

'The opportunity to further expand the role of primary health care in meeting mental health needs has never been better. People are more likely to consult their family physician about a mental health problem or illness than any other health care provider, and the on-going transformation of primary health care across the country has meant that 40 per cent of the population now has access to primary health care teams made up of a range of health care providers.'

'As the role of primary health care in mental health expands, it will be important for all family physicians and other primary health care providers to work in new interdisciplinary ways and to possess core mental health competencies that are oriented to recovery and well-being. Providers will need guidelines for screening and for providing services, treatments and supports for mental health and substance use, as well as for addressing the risk of suicide. Particular attention should be paid to the evolution of needs across the lifespan. People living with mental health problems and illnesses and their families must be involved in the design and evaluation of these services.'

Anna Maresso, Matthias Wismar, Scott Greer and Willy Palm; Eurohealth 2013; 19(3). **WHAT MAKES HEALTH SYSTEMS RESILIENT AND INNOVATIVE?** VOICES FROM EUROPE;

'Generally, the term resilience describes the ability to cope with internal and external shocks. In physics, resilience is the ability of a material or structure to absorb the energy of a shock by deformation and release it again by springing back to its original form. In biology it refers to an ecosystem's capacity to absorb and resist any damage from internal or external mechanisms and recover quickly. In psychology resilience is the individual's ability to cope with excess levels of stress and adversity, resuming one's previous life after the crisis. Organisations that are resilient manage to adapt to a change of environment. Often, concepts of resilience hold the promise not only of coping but also of strengthening the individual or organisation recovering from the shock. The experience of successfully coping with stress, trauma or change and the effective use of coping mechanisms provides the grounds for even stronger responses in the future.'

'Investing in prevention and health promotion measures can have a positive impact by potentially relieving the demands made on the health system by those in ill-health, as well as contributing economically to society through healthy and productive citizens. **Vytenis Povilas Andruikaitis** sums up many of the panel's views: *"I could not imagine a resilient health care system without an emphasis on public health. The everyday lives of EU citizens should face as few threats as possible: less exposure to smoke, tobacco, alcohol and bad food, less medicalisation. EU Member States are stressing the importance of prevention but there are still many opportunities to ensure that we can help a healthy person not to get ill rather than simply concentrating on curing people who are already ill".'*

Steven M. Southwick, George A. Bonanno, Ann S. Masten, Catherine Panter-Brick and Rachel Yehuda; **RESILIENCE AND TRAUMA**; Resilience definitions, theory, and challenges: interdisciplinary perspectives; European Journal of Psychotraumatology

'The more we can learn about resilience, the more potential there is for integrating salient concepts of resilience into relevant fields of medicine, mental health and science. This integration is beginning to foster an important and much needed paradigm shift. Rather than spending the vast majority of their time and energy examining the negative consequences of trauma, clinicians and researchers can learn to simultaneously evaluate and teach methods to enhance resilience. Such an approach moves the field away from a purely deficit based model of mental health, toward the inclusion of strength and competence-based models that focus on prevention and building strengths in addition to addressing psychopathology.'

Christopher Nemeth, PhD; Robert Wears, MD; David Woods, PhD; Erik Hollnagel, PhD; Richard Cook, MD; **Minding the Gaps: Creating Resilience in Health Care**

'Resilience is the intrinsic ability of a system to adjust its functioning prior to, during, or following changes and disturbances so that it can sustain required operations, even after a major mishap or in the presence of continuous stress. As an emergent property of systems that is not tied to tallies of adverse events or estimates of their probability, resilience provides the means for organizations to target resource investments by integrating safety and productivity concerns. Resilience engineering (RE) can enable an organization to cope with and recover from unexpected developments, such as maintaining the ability to adapt when demands go beyond an organization's customary operating boundary. Understanding resilience makes the difference between organizations that inadvertently create complexity and miss signals that risks are increasing, and those that can manage high-hazard processes well.'

'Current research on resilience seeks to clarify how resilience works, where it comes from, and what factors facilitate or impede it. These and other active steps can improve the ability of health care systems to respond adequately to increasing demands and to avoid an accumulation of discrete, well-intentioned adjustments that can detract from organizational efficiency and reliability. This makes the difference between organizations that inadvertently create complexity and miss signals that risks are increasing and those that can successfully manage high-hazard processes.'

'Efforts to improve health care without a basis in science do more damage than good by making systems unable to change in response to circumstances—what Sarter, et al., term "brittle." For example, Ash, et al., found that health care information technology systems that are intended to reduce errors can also foster them. In another instance, Perry, et al., found that the introduction of tighter procedures that were intended to improve glycemic (blood sugar) monitoring ironically had the opposite result. In a further example, efforts to standardize between-shift handoffs[6] clashed with the initiatives that clinicians had developed to cope with the complexity, variety, and uncertainty in their work domain. Such interventions are not benign; instead, they induce unforeseen outcomes. They waste time, attention, and resources that could be spent more productively. They also delay progress toward genuine improvement.'

'Resilience provides the means for organizations to target resource investments by integrating safety and productivity concerns. Woods and Wreathall have proposed an approach to model resilience based on an analogy from the world of materials engineering: stress-strain. In a manner that is similar to traditional materials performance models, the approach uses the relationship between stress (the varying loads placed on a mechanical structure) and the resulting strain (how the structure stretches in response) in order to understand organizational response to strains.'

'Resilience engineering is a new approach to this problem that strives to identify and correctly value behaviors and resources that contribute to a system's ability to respond to the unexpected. Put another way, efforts to lean down organizations risk suffering from what an economist would term "cost externalization."'

'Resilience engineering (RE) is a recent development in risk assessment and system safety.

RE accounts for the manner in which people at all levels of an organization can try to anticipate paths that might lead to failure, create and sustain strategies that are resistant to failure, and adjust tasks and activities to maintain margins in the face of pressure to do more and to do it faster.31 A resilient organization can anticipate, cope with, recover, and learn from unexpected activities and resources at the same time as they struggle to handle patient load. Making the deliberate decision to forego care for all but life-threatening illness is an example of what some practitioners have described as a "free fall."'

Anderson, J.E., Ross, A. , and Jaye, P. **Resilience engineering in healthcare: Moving from epistemology to theory and practice**

'Resilience engineering represents a philosophical shift in safety science towards a proactive systems approach that addresses the need for organizations to adapt to changes in the environment in which they operate and to support workers to adapt safely when needed. Safety and harm are viewed as emergent properties of the system, (Flach, 1999; Rauterberg, 1996), both of which are caused by exogenous and endogenous variability. The focus is therefore on how to manage this variability safely and this is proposed to be achieved by four abilities; responding to threats and disturbances, monitoring organisational performance as it unfolds in real time, learning from past experience (both successes and failures), and anticipating changes in the future (Hollnagel, 2009).

Resilience engineering is at an early stage of development and although the epistemological basis is well developed the practical application of these ideas to building resilient organisations is not. Engineering resilience, rather than simply proposing how resilient organisations behave, poses difficult practical questions about how interventions, methods and measurements might be developed and tested in a complex system in the real world, with the requirement to demonstrate outcomes in line with specified safety objectives.'

'Improving safety in complex non engineered systems such as healthcare organisations requires a different approach. We need a change in emphasis from control of error and adverse events via arbitrary targets to a focus on proactive and adaptive processes and how they can be introduced, nurtured and sustained. In this study, we propose an approach that involves developing and testing interventions in four areas;
1. Knowing what to do
2. Learning from past experience
3. Monitoring the work environment for changes and
4. Anticipating demands in the future.'

Anna Maresso, Matthias Wismar, Scott Greer and Willy Palm; **WHAT MAKES HEALTH SYSTEMS RESILIENT AND INNOVATIVE?** EUROHEALTH; Volume 19 | Number 3 | 2013; Building resilient and innovative health systems

'Amid the financial and economic crisis, it is no wonder that resilience is a very attractive metaphor for health system development in Europe. And it has relevance beyond the current crisis because health systems are constantly confronted with stress, shocks, crises and change of environment: demographic change, rising health care costs, the obesity epidemic and pandemic outbreaks provide just a few examples.'

'Generally, the term resilience describes the ability to cope with internal and external shocks. In physics, resilience is the ability of a material or structure to absorb the energy of a shock by deformation and release it again by springing back to its original form. In biology it refers to an ecosystem's capacity to absorb and resist any damage from internal or external mechanisms and recover quickly. In psychology resilience is the individual's ability to cope with excess levels of stress and adversity, resuming one's previous life after the crisis. Organisations that are resilient manage to adapt to a change of environment. Often, concepts of resilience hold the promise not only of coping but also of strengthening the individual or organisation recovering from the shock. The experience of successfully coping with stress, trauma or change and the effective use of coping mechanisms provides the grounds for even stronger responses in the future.'

'Tonio Borg, EU Commissioner for Health underlines the importance of transparency as part of health reform processes: *"Some health systems managed to successfully increase value-for-money and mitigate effects on patients.*

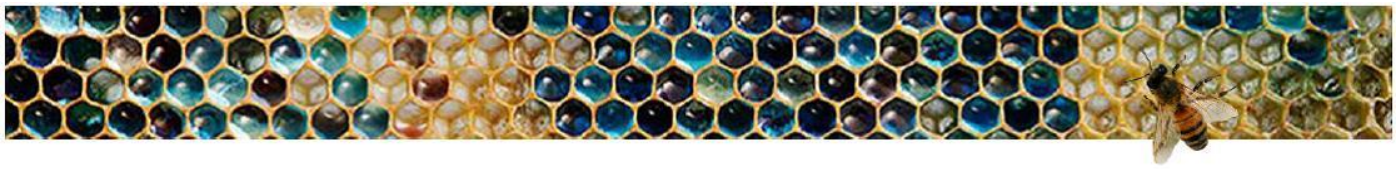
These 'resilient' systems maintain an adequate and stable flow of health funds; apply transparency regarding the prices, volume and cost-effectiveness of publicly covered health care; apply sound risk pooling methods to ensure patient equity; explore information systems to pursue a needs-based supply of health care and have a solid health workforce and integrated care practices".'

'Tonio Borg outlines some of the European Commission's work in this area: *"health is an investment that can boost economic growth by enabling people to remain active longer. Structural reforms and sound innovation can bring efficiency gains and improve health. The Commission works with Member States to identify effective ways of investing in health through studies and expert advice. It encourages a more cost-effective provision and use of health services and medicines, a balanced mix of staff skills, a stronger focus on primary health care and disease prevention and better data collection through integrated eHealth tools.'*

'Vytenis Povilas Andruikaitis sums up many of the panel's views: *"I could not imagine a resilient health care system without an emphasis on public health. The everyday lives of EU citizens should face as few threats as possible: less exposure to smoke, tobacco, alcohol and bad food, less medicalisation. EU Member States are stressing the importance of prevention but there are still many opportunities to ensure that we can help a healthy person not to get ill rather than simply concentrating on curing people who are already ill".'*

'Monika Kosinska, Secretary General of the European Health Alliance (EPHA) concisely summarises this objective when she explains that *"we know that from a public health perspective, the adoption of a broad view of health alone is not enough if this occurs in isolation or in opposition with other policies that may have an even greater impact on health. Moreover, austerity measures continue to emphasise the need for policy-makers to design new care delivery models that [among other things] facilitate the transition from treatment to prevention …".'*

'**Zszsuanna Jakab** also stresses the economic considerations that come with innovation: *"[there is] the need to look for innovations in the health sector to serve not just patients' interests, but so too towards keeping costs affordable and helping to insulate budgets against future shocks".'*



Mental Health

HMG/DH; **No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages;** 02 Feb 2011

'Reducing inequalities requires a multi-stranded approach that tackles the economic, social and environmental determinants and consequences of mental health problems. such an approach needs to take into account the fact that people have more than one protected characteristic. Approaches must also take into account people's living environments and social circumstances, which are critical to the onset and course of their mental health problems.'

Andrew Zolli & Ann Marie Healy; **Why Things Bounce Back**; Simon and Schuster; 2012

'As Ann Masten, () described: The great surprise of resilience research is the ordinariness of the phenomena. Resilience appears to be a common phenomenon that results in most cases from the operation of basic human additional systems.'

'So why don't psychologists have a more widespread appreciation for our innate characteristics of resilience? The answer, it turns out, is rooted in the history of psychology and in our own cultural responses to adversity and trauma….Throughout most of the twentieth century, the grieving process was filtered through the lens of Freudian psychoanalysis….As with much of Freud's work, it I important to remember the context within which his ideas developed. His theories were rooted in intimate, individual observation, not statistical analyses of populations, and though they obviously reflected his own thinking, they also reflected a cultural backdrop of mas trauma and loss during the First World War.'

'In sum, by the last decade of the twentieth century, the bulk of Western cultural assumptions about the grieving process were based on almost no quantitative research at all. There was essentially one conceptual model for processing grief, and any framework for human experience deviating from it was viewed as apostasy.

(Clinical psychologist George) Bonanno was able to break responses down into five main patterns: (1) Chronic depression, (2) Chronic Grief, (3) depressed-improved (4) recovery from grief, and (5) resilient. Over and over again () Bonanno's longitudinal studies on loss and trauma revealed the exact same pattern at the population level. No matter how bad the trauma, rates of PTSD never exceeded one-third, and rates of resilience were always found in at least one-third and never more than two-thirds of the population.'

'It bears repeating that Bonanno was not defining resilience as a lack of feeling or absence of sadness. He used the term "resilient" to identify people capable of functioning with a sense of core purpose, meaning and forward momentum in the face of trauma (echoing our own definition: the capacity of a system, enterprise, or a person to maintain its core purpose and integrity in the face of dramatically challenging circumstances.")

The standard toolkit for treating trauma includes pharmacological intervention and intensive therapy. These are important tools, often essential to the healing process, and we heartily endorse their appropriate use. But they may not be accessible – financially or logistically- to everyone. They also might not be the right intervention for every circumstance, () it would be better I other interventions could obviate their need in the frits place.'

'Current research in neuroscience is revealing the effectiveness of one tool in particular that can complement other forms of intervention: This tool is portable, teachable, free, and it's been on the market for more than two thousand years. It's called mindfulness meditation.'

Regional Research Institute for Human Services, Portland State University; **RESILIENCE AND RECOVERY: FINDINGS FROM THE KAUAI LONGITUDINAL STUDY FOCAL POINT** *Research, Policy, and Practice in Children's Mental Health* Summer 2005, Vol. 19 No. 1, pages 11-14

'For many years mental health professionals tended to focus almost exclusively on the negative effects of biological and psychosocial risk factors by reconstructing the life histories of individuals with persistent behavior disorders or serious emotional problems. This retrospective approach created the impression that a poor developmental outcome is inevitable if a child is exposed to trauma, parental mental illness, alcoholism, or chronic family discord, since it examined only the lives of the "casualties," not the lives of the successful "survivors."'

Jayasree Kalathil; Beth Collier, Renuka Bhakta, Odete Daniel, Doreen Joseph, Premila Trivedi; **Recovery and resilience: African, African-Caribbean and South Asian women's narratives of recovering from mental distress; Survivor Research. User-led perspectives in Mental Health**

'Despite its centrality in developmental psychology, the term 'resilience' is not one that is commonly used in mental health contexts. It has a much more extensive history in critical thinking around women's experiences in the context of violence, rape, abuse and adversity, in understanding health contexts like cancer and HIV/AIDS, and in individual and community contexts of poverty, racism, disadvantage, disaster and so on.

In the mental health context, the term gained credibility following the work of Norman Garmezy (1973) who studied adults living with schizophrenia and children at risk of developing the condition. The development psychologist Emmy Werner's work moved on from a focus on risk to a focus on positive factors that enabled resilience – "self-righting" capacities (Werner and Smith 1982).'

Steven M. Southwick, George A. Bonanno, Ann S. Masten, Catherine Panter-Brick and Rachel Yehuda; **RESILIENCE AND TRAUMA; Resilience definitions, theory, and challenges: interdisciplinary perspectives;** European Journal of Psychotraumatology

'Dr. Rachel Yehuda: Biological underpinnings I don't really know what makes some people more resilient than others. If we think about resilience as a stable trajectory or predictive trait, then we can think about biological underpinnings or even one's genes as important determinants (Simeon et al., 2007; Yehuda, Flory, Southwick & Charney, 2006; Yehuda et al., 2013). However, when we think about resilience as a process, then we are talking about an organism that is actively interacting with an environment.'

'Dr. Yehuda: Biology and the study of resilience It is not yet clear exactly if or how the science or biology of resilience is going to impact the way we deal with trauma in the context of systems. I think there is a real opportunity for science to inform us about the more narrow question of recovery from certain kinds of consequences that are maladaptive. If we understand the kind of biological underpinning of symptoms, then we may be able to have

effective interventions for those who we know are going into harm's way, or we may be able to identify those people more rapidly and then build resilience programs on an individual level.'

Sarah Skeen, Crick Lund, Sharon Kleintjes and Alan Flisher, University of Cape Town; **The Mental Health and Poverty Project;** Submission to: South African Human Rights Commission

'A recent study looking at psychological distress found that it was significantly more common among South Africans with low socio-economic status lending further weight to a developing theme in recent research: that mental ill-health and poverty are locked in a vicious cycle.'

'There are a number of rights in the Bill of Rights that relate to the fight against poverty including sufficient food and water; health; social security; and education. Mental ill-health and poverty have been linked at all stages of economic development. People living in poverty are at increased risk of developing mental health problems due to societal factors such as increased levels of stress, exclusion, and reduced access to social capital, as well as physical factors such as malnutrition, obstetric risks, and exposure to violence. Those with mental illnesses are more likely to slide into poverty due to stigma and exclusion from social and economic opportunities, the high cost of accessing treatment, or the loss of employment due to diminished productivity. This relationship has been corroborated in several studies (in South Africa and other low and middle income countries) looking at mental health and a variety of poverty indicators including employment , income, social welfare, housing, education, food security, financial stress, and higher exposure to life events. The implications of this are clear: in much the same way that social determinants of physical health are being increasing acknowledged so too should it be recognised that mental ill-health forms a part of the lived experience of poverty for a considerable portion of the population.'

Mental Health Commission of Canada. (2012). **Changing directions, changing lives: The mental health strategy for Canada.** Calgary, AB: Author.

'Positive mental health—feeling well, functioning well and being resilient in the face of life's challenges—has always been something for which people strive. It improves the quality of their lives and is integral to their overall health and well-being. Currently, around the world, there is growing recognition that improving the state of mental well-being for the whole population brings social and economic benefits to society. Even when there are on-going limitations caused by mental health problems and illnesses, people can nevertheless experience positive mental health, and this can contribute to their journey of recovery.'

'There is growing evidence about what kinds of programs can be effective. The best results for mental health promotion, mental illness prevention, and suicide prevention have been achieved by initiatives that target specific groups (defined by age or other criteria) and settings (school, workplace, home). They address a combination of known risk and protective factors, set clear goals, support communities to take action, and are sustained over a long period of time.16, 17 Better mental health promotion and mental illness prevention will improve well-being, reduce suffering and ease demand for more specialized services so that they are more readily available to those who need them most.'

'An orientation toward recovery is helping to bring about important changes in the mental health systems of many countries. Here in Canada, recovery has strong roots in the advocacy efforts of people with lived experience and in the psychosocial rehabilitation field. It has been over five years since *Out of the Shadows at Last*, the final report of the Senate Committee, called for recovery to be "placed at the centre of mental health reform." Recovery and well-being form the base of this *Strategy* and are now embraced by most provincial and territorial mental health policies. There are significant pockets of practice oriented toward recovery and well-being across the country.

Despite the evidence to support it, there are many challenges and misconceptions to overcome in explaining recovery and putting it into practice. Some people have understood recovery to be a synonym for 'cure' for all mental health problems and illnesses, and see it as promoting false hope. On the contrary, recovery is about supporting each individual's journey toward a meaningful life even with symptoms of mental illness. It does not mean expecting that everyone will be 'cured.' Others have feared that recovery is about replacing medical treatment and medication with social services and peer support. Rather, recovery seeks to promote people's ability to choose and to ensure that options are available to meet the full range of people's needs.'

'Still others are concerned that recovery is only relevant for adults, or for people living with severe mental illnesses, or just for people living with more moderate mental illnesses. In fact, recovery is for everyone. Investing in recovery and well-being has the potential to provide hope and opportunities to thousands of people living with mental health problems and illnesses, and will also benefit families, communities and the country as a whole. Drawing on the

recovery principles of hope, informed choice, dignity and responsibility will contribute as much to the well-being of children and seniors as to that of adults who are living with mental health problems and illnesses.

A recovery-oriented system strives to encourage partnerships with service providers, families, and friends to support people on their journey toward recovery and well-being. It encourages mental health professionals, health professionals and other service providers to build on people's strengths and to create genuine partnerships with people living with mental health problems and illnesses (and their families).

The expertise gained from lived experience should be complemented by professional expertise, not overwhelmed by it. All stand to benefit from ensuring that there are as few imbalances as possible in the distribution of power throughout the mental health system. This will not only enable people who use services to be actively engaged in all aspects of the mental health system, but will also allow the people who provide services to have a more positive context in which to offer their skills, experience, and knowledge.

Consistently upholding the rights of people living with mental health problems and illnesses is an integral part of fostering recovery and well-being. Barriers that can contribute to discrimination against people living with mental health problems and illnesses and hinder their full and effective participation in society must be eliminated. These barriers can be rooted in people's attitudes and behaviour, in the ways in which programs and institutions are organized, or in the ways in which our schools, workplaces and other everyday environments are structured.'

David McDaid; *Eurohealth* 2013; 19(3). **MENTAL HEALTH:** A KEY CHALLENGE FOR EUROPE IN THE 21ST CENTURY

'Despite all the evidence on risks to mental health and psychological wellbeing, services for mental health can be an easy target for cost cutting measures during times of austerity. Cuts to mental health budgets may be seen as a lesser evil compared to cuts in budgets for physical health problems where illness and premature death are very visible. Mental health may be emerging from the shadows but it is still not as visible in the public consciousness; yet mental health impacts are felt early during a time of economic shock and can be long lasting. They also increase risks to physical health.

Budgets are inevitably tight and tough choices have to be made. This makes it even more important that innovative actions to promote and protect mental health go beyond health care systems. They need to harness the resources, goodwill and mutual interests of other sectors. One key area for greater collaboration is in the workplace. Europe's workforce will need protection to help it retain its competitive advantage in terms of knowledge and skills. It will need to respond to changing dynamics in the global economy. Good mental health will be vital if it is to compete effectively with the rest of the world. This means tackling issues such as stress, depression and alcohol harm in the workplace.'

Alexandra McEwan, Dr Jennifer Bowers and Tim Saal; **A human rights based approach to mental health promotion in the context of climate change in rural and remote Australia;** Centre for Rural and Remote Mental Health Queensland;

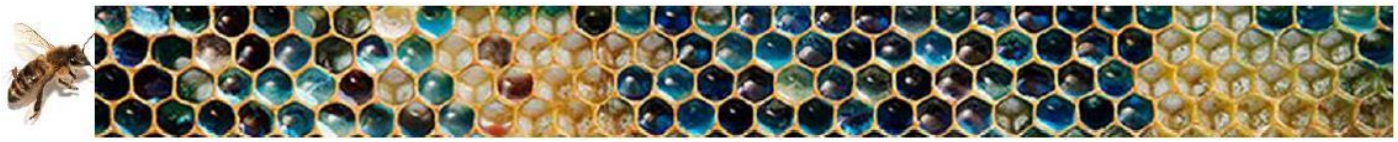
'As we are currently witnessing in the domestic climate change debate, conflict between interest groups who have different stories about how climate change will impact on their rights and livelihoods is unavoidable and is likely to intensify as adaptation strategies are developed and implemented. In thinking through how to negotiate these claims from a rights perspective, major considerations include:

1. Protecting and encouraging basic standards of health for groups which evidence indicates are most vulnerable to the effects of climate change;
2. Respecting and responding appropriately to claims for collective rights made specifically within the context of climate change.
3. Integrating the link between mental health and human rights into community-based climate change adaptation initiatives for those experiencing, or at risk of, mental illness. This applies to the mentally ill as a group that is likely to be more vulnerable to the effects of climate change (for example, post extreme weather events: Fritze, Blashki, Burke and Wiseman, 2008; Blashki, Berry and Kidd, 2009) and as individuals who already encounter barriers in asserting their right to health; *and*
4. Respecting and responding appropriately to human rights claims of those who may not fall into one of the above groups but who may, for a variety of reasons, require support.'

'An important element of the effectiveness and value of empowerment and resilience strengthening strategies is their capacity to create opportunities for participation. Participation in decision-making processes is an essential aspect of mental health promotion (Drew et al, 2005: 83). Improving access to reliable, up-to-date information on

the effects of climate change, policy and regulation, and related issues is an important aspect of supporting a sense of self-determination and control for individuals and communities. How such information is communicated will also be an important determinant of community emotional and behavioural responses (NCCARF, 2008:31). Information needs to be conveyed in ways that are culturally appropriate, relevant, and provided by credible organisations and individuals.

While these strategies will obviously include media campaigns utilising a range of information technologies, it is also true that face-to-face community interaction can generate social support and inclusion (Fraser et al, 2005:16; Berry, 2009; Berry, et al, 2008). This is one reason that it is important to bring people together to talk through issues and to develop strategies in a variety of settings: the workplace, the family home, community groups or through arts, sport and recreational activities. As mental health relies on the exercise of civil and other rights, by encouraging constructive participation we simultaneously support human rights and positively influence mental health and wellbeing.'



Behavioral Health

Steven M. Southwick ; **The Science of Resilience;** Huff Post Science; August 28, 2015

"…resilience is the complex product of genetic, psychological, biological, social and spiritual factors…"

"As scientists learn more about the complex interplay of genetics, development, cognition, environment, and neurobiology, it will be possible to develop behavioral, social and pharmacological interventions and training programs to enhance resilience to stress."

SAMHSA; **Substance Abuse and Mental Health Service Administration** http://www.samhsa.gov/

'Building individual resilience is an on-going process related to many factors, including: individual health and well-being, individual aspects, life experiences, and social support. Interactions with responsive parents and other caregivers, rich sensory stimulation, and routines that shape a child's day can actually build a child's brain in healthy ways. Further, responsive communities can provide critical support for vulnerable children and families. Family organization, belief systems, and communication all contribute to resilience as do strong community bonds, resources, and capacity.'

Mental Health Commission of Canada. (2012). **Changing directions, changing lives: The mental health strategy for Canada.** Calgary, AB: Author.

'This *Strategy* recognizes that we will never be able to adequately reduce the impact of mental health problems and illnesses through treatment alone. As a country, we must pay greater attention to the promotion of mental health for the entire population and to the prevention of mental illness wherever possible. Compelling evidence for the effectiveness of promotion and prevention programs has been accumulating in Canada and internationally for many years, and we cannot afford to wait any longer to implement these programs as widely as possible.

Mental health is also not the concern of the health sector alone. The policies and practices of multiple government departments (including education, justice, corrections, social services and finance) have a major impact on people's mental health and well-being. Beyond government, it is clear that workplaces, non-government organizations, the media, and many others all have a role to play.'

Sarah Skeen, Crick Lund, Sharon Kleintjes and Alan Flisher, University of Cape Town; **The Mental Health and Poverty Project;** Submission to: South African Human Rights Commission

'The mechanisms of interaction between mental health and poverty and potential strategies to address the link should be brought to the attention of policy developers to promote the integration of this focus area into policies and programmes of all sectors involved in poverty alleviation and community upliftment. This requires evidence-based support to promote recovery and inclusion of people with mental disability in community life, such as access to education and skills development, income generation opportunities for users, reasonable accommodation provisions for employees and where income generating work is not possible social support, housing and transport.

Finally, decreasing human rights violations experienced by those with mental health disorders can be achieved through the development of a mental health user lobby, ensuring participation of people with mental disability on the broader disability, development and public health agendas.'

'While moving forward to 2015 and beyond, it will be crucial for South Africa to keep vulnerable and hard-to-reach populations in mind if they are to reach their goals. Unless mental health is mainstreamed into social and economic programmes, people with mental health problems risk slipping through the „development net". It is becoming apparent that development efforts in our country will require the participation of local communities and resources to assist with the implementation of policies at a local level. Improving population mental health could mean that we, as citizens, will be in a better position to contribute to development processes, through increasing our participation in communities, providing for our children, and achieving improved levels of education.'

Mental Health Strategic Partnership (UK); **Building resilient communities;** Making every contact count for public mental health August 2013

'There is clear evidence and a convincing economic case for investment in public mental health. We know what makes a difference, and we now know what a successful public mental health strategy looks like. Every local area should be supporting its community to take part in activities that promote wellbeing, build social connections and improve psychological coping skills – building community resilience and 'futureproofing' wellbeing. In particular, a targeted approach is needed to support people living in the most difficult life circumstances.'

'Mental health should be a key part of every public health strategy. There is a strong moral and economic case for tackling the rising challenge of mental health problems for communities and the people who experience them. There are also clear, evidence-based and cost-effective steps that can be taken to build resilience, promote wellbeing and help to prevent mental health problems.'

'Resilience should be central to any public mental health strategy but is only one element; it is essential that structural inequalities, like income or access to affordable housing, are also tackled. As well as providing the right services, facilities and resources that help to build resilience, local communities must have the capacity and infrastructure to support people to access them.

'To be successful, public mental health strategies must touch a whole community and involve the whole community in both their development and delivery. If we are going to build community resilience in such challenging times, it is essential that we make every contact count for wellbeing.'

Department of Social Development. **INTEGRATED CRIME PREVENTION STRATEGY-ISCPS** Building a Caring Society. Together. ISBN: 978-0-621-40570-5 2011

'Due to (the various aforementioned) stress factors and challenges, vulnerable families and families at risk require government departments intervention. The strategy makes provision of services to families. Not only the risk factors, but also the strengths of the family should be taken into consideration to ensure that families are placed on a path that fosters self-reliance, which is indispensable in building strong and resilient families, especially among those families that are in need of intensive intervention.'

Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy; **Respect, Recovery, Resilience:** Recommendations for Ontario's Mental Health and Addictions Strategy; December 2010

'The needs of people with mental health or addiction problems are not new – neither are the problems they face getting the services they need when they need them. Ontario has had programs and services in place for many years. We already spend billions on mental health, but our past mental health and addiction strategies have not had the intended impact.

What will be different this time? What is the best way forward?

During our consultation, Ontarians told us they want a comprehensive approach to mental health and addictions – one that meets the needs of individuals, their families and their communities. We listened carefully to what Ontarians told us, and propose the following direction forward. We will take a more holistic approach – one that looks at the whole population, the whole person, the whole lifespan, the whole family, the whole health system, the whole human services system, the whole of government, and the whole of society.'

'In the past, we have treated the problem not the person. Mental health and addiction services have focused mainly on the mental health diagnosis or the addiction, and have not always been able to take into account the person's other health and social needs or their strengths. We will change the approach to care, making it person-directed. People with mental illnesses and/or addictions will shift from being patients to being active partners in their care. They will have real choice in the services they use, and a variety of options close to where they live. They will receive the least intrusive services possible in the least intrusive setting, as well as flexible, individualized supports that involve their families, significant others, and communities. The system will continue to provide effective, evidence-informed clinical treatments, such as psychiatry, psychotherapy and drug treatment – but it will do so within a recovery approach to care, which looks at the whole person and defines individuals positively, focusing on their strengths and goals rather than their illness.'

'Severe mental illnesses and addictions have traditionally been treated as episodic illnesses. People are treated for a short period of time in acute care or other institutional settings and then released – often without ongoing support. In the transformed system, we will recognize that mental illnesses and addictions are often long-term, chronic conditions that people must manage over time. We will provide more services and supports in the community. People with lived experience will have access to ongoing education and services to support their self-care and help them cope with relapses.'

'Healthy child development, including a focus on the effects of early experiences on brain development and school readiness, is a preventive approach to ensuring positive child and youth health, that can extend into later life. Early child development is a powerful determinant of health. Many other determinants of health affect the physical, social, mental, emotional and spiritual development of children and youth.'

'Youth development is *"...the ongoing growth process in which all youth are engaged in attempting to (1) meet their basic personal and social needs to be safe, feel cared for, be valued, be useful, and be spiritually grounded, and (2) to build skills and competencies that allow them to function and contribute in their daily lives." (Pittman, 1993, p. 8)'*

'A youth development approach helps young people develop a sense of safety and structure, high self-worth and self-esteem, a feeling of mastery and future, a sense of belonging, a sense of responsibility and autonomy, and self-awareness and spirituality. (Centre for Youth Development and Policy Research)'

Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy; **Respect, Recovery, Resilience:** Recommendations for Ontario's Mental Health and Addictions Strategy; December 2010

'Changing discriminatory attitudes and behaviours is not enough. We must also create healthy, resilient, inclusive communities that promote mental health and ensure people with a mental illness and/or an addiction have the same opportunities as other Ontarians to succeed in life. The social determinants of health – education, employment, income and housing – are strongly correlated with mental health because they affect people's sense of competence and control – of being connected to the community – as well as their socioeconomic status. They influence people's ability to cope with their environment, satisfy needs, and identify and achieve their goals. (Raphael, 2004) People with lived experience of a mental illness and/or an addiction often describe the most important determinants as "a home, a job and a friend."'

'Creating healthy, inclusive communities is no small task. It requires the commitment of all segments of society: governments, employers, municipalities, schools, colleges and universities, community organizations and faith-based organizations. All ministries must work closely together, share a common understanding of the importance of the social determinants of health, and align their policies and programs. At the current time, government policies often work against each other and prevent people from achieving their mental health goals.'

'The early stages of a mental illness or addiction can create enormous stress for the person and family. Acting early – at the first signs of mental illness or problematic substance use and gambling – can have a profound effect on the person's long-term mental health and well-being. Providing services and supports early and quickly can stop an addiction problem – before it does too much harm to the person, his or her family and friends, or society. Acting early can also prevent future episodes of mental illness, and reduce the health, social and economic costs of mental illness and addictions.'

'For many people their first point of contact will be with a family doctor, and the primary care sector will provide most of the care for people with mild to moderate mental health and addiction problems. For some people, their

addiction may begin with pain medication prescribed to treat another health problem. Primary care providers must be able to identify people at risk (e.g., people with chronic diseases, people who have recently experienced a loss, people being treated for pain), screen people, help people manage their own care, find ways to engage and support their families, and monitor their health over time. To fulfill this role, primary care providers need the support of collaborative, multidisciplinary models of care and referral networks. They must be able to access specialized advice quickly and easily – wherever they are in the province.'

'Specialized mental health and addiction services should be provided by teams with the right mix of skills based on the person's and family's needs and aspirations. These comprehensive, coordinated health services should be integrated with the other human services that people with mental health and addiction problems need, such as housing, income support and employment programs.

The system must look at how services are currently organized and delivered, and find ways to make better use of all resources. Good system design can lead to better integration of services and better health. The key to improving mental health and well-being is to strengthen community mental health and addiction services, and integrate those services with other health services and other human services. More effective services and better service integration means more timely care and smoother transitions between services. It also means more effective use of all health system resources and shorter wait times.'

'Regardless of where people with a mental illness and/or addiction receive care – in a primary care setting, at school, in the community or in hospitals – they should receive high quality, personalized, culturally competent care based on the recovery/wellness model of care. This focus includes a range/mix of person-directed approaches, including psychosocial rehabilitation services, harm reduction services, trauma-informed services and clinical treatment, such as psychiatric assessment, psychotherapy and drug treatments. It is important that providers in the system have the core competencies to work using the principles and values of a recovery-focused system. We need a valued workforce made up of many different workers and disciplines, regulated and non-regulated, with the competencies to work in the transformed system.'

'Ontario's ability to implement the proposed 10-year plan depends on effective leadership and accountability including:

- clear accountabilities within government, across mental health and addiction services and across other health and human services
- effective leadership and structures that support the integration of services across systems and sectors
- accessible and relevant information and quality improvement systems
- development and use of system, program and service level performance targets and monitoring change.'

National Social Inclusion Programme (UK); **Vision and Progress - Social Inclusion and Mental Health**

'People need to engage with the wide range of communities that they rely on for their incomes, social support, self-expression and sense of continuity; these include communities of place (neighbourhoods), common interest, and the major life domains such as employment, education and housing. For this to be successful, services and opportunities need to be accessible, well organised, stable and secure.

Our vision is that:

- Everyone is supported to access the opportunities available within the many communities to which they belong.
- Everyone understands and appreciates the mutual benefits of contributions made by people with mental health problems towards creating and sustaining a positive community.
- Mental health services will work with individuals and communities to promote active civic participation and effective social support.
- There will be equal opportunities for active citizenship, increased social capital and less unwanted service dependency.'

'Many services, which have historically provided both segregated activities and a safe social environment, are now focused much more on supporting people to engage with their local community and the resources and activities within it. This means that the term 'day services' has become somewhat misleading as activities may take place in the evenings as well as during the day, and are often very different in nature from those that people expect a day

service to offer. Indeed many day services have re-named themselves as 'community support' or 'community resource' services in recognition of their changed role.'

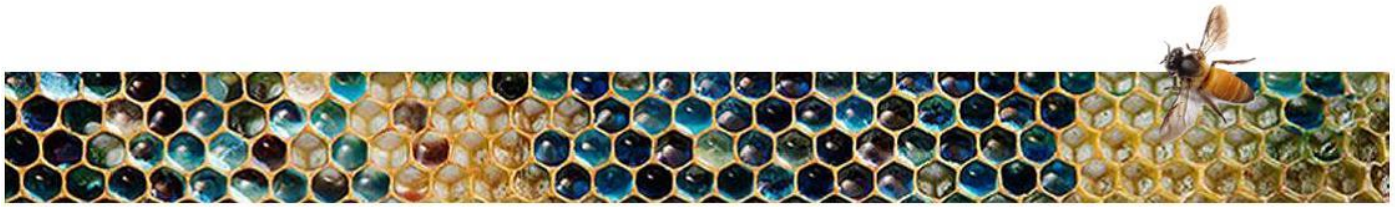
Mental Health Commission of Canada. (2012). **Changing directions, changing lives: The mental health strategy for Canada.** Calgary, AB: Author.

'A transformed mental health system should *primarily* be based in the community, because obtaining services, treatments and support in communities improves quality of life and leads to spending less time in hospital. De-institutionalization—when Canada, along with many other countries, moved away from a long tradition of warehousing people with mental illness in institutions (or 'asylums')—was the right policy. Our failure was in not replacing institutional care with sufficient services and supports in the community.

This failure has contributed significantly to the proportion of people living with mental illness among the homeless population and in our jails and prisons, turning them into the 'asylums' of the 21st century. Lack of access in the community to crisis support, mental health and primary care services also drives people to emergency rooms for help, increasing waits and stretching resources. Many community services do not even keep waiting lists, because it might give false hope to people in need that eventually their turn will come.'

Lloyd Vogelman; **Psychology, Mental Health Care and the Future; Is appropriate transformation in a future South Africa possible?** *Social Science and Medicine*, Vol. 31, No. 4, pp. 501-505, 1990.

'Community psychologists have placed much emphasis on primary prevention. The latter of course may mean different things to different community practitioners. For example, some may see primary prevention as ridding South Africa of its political injustices, migrant labour, racism, etc. On the other hand, some primary preventative programmes only focus on a particular community rather than the society as a whole. Some practitioners attempt to straddle the link between community-specific deficiencies and the broader social context. It would appear that, whatever approach people adopt, most community practitioners emphasise that where possible primary prevention be given more priority than treatment. But in South Africa treatment facilities are often absent or inadequate. The potential for massive state financing of primary preventative mental health programmes, for example, education, is limited, considering people's need for relief of their psychological difficulties. This potential is further heightened because the absence of preventative care is less noticeable, has fewer political repercussions and its benefits are only manifest in the long term.'



Stigma

Steven Southwick and Dennis Charney: **Resilience – The Science of mastering Life's greatest Challenges**; Cambridge University Pres, New York. 2012

'There is a bridge between victimhood and returning to the world.'

"Underlying many of psychiatry's nearly 400 diagnoses is the experience of helplessness, hopelessness, passivity, boredom, fear, isolation, and dehumanization — culminating in a loss of autonomy and community-connectedness. Do our societal institutions promote:

- Enthusiasm — or passivity?
- Respectful personal relationships — or manipulative impersonal ones?
- Community, trust, and confidence — or isolation, fear and paranoia?
- Empowerment — or helplessness?
- Autonomy (self-direction) — or heteronomy (institutional-direction)?
- Participatory democracy — or authoritarian hierarchies?
- Diversity and stimulation — or homogeneity and boredom?"

Patrick Corrigan; **How Stigma Interferes With Mental Health Car**e; University of Chicago

'Framing stigma as a prominent public health concern has led to defining the problem vis-a`-vis the medical model…

Although improving treatments may yield secondary effects including diminished prejudice and discrimination, framing mental illness stigma as a medical concern may also exacerbate the problem. Antistigma programs solely reflecting the medical perspective may have unintended consequences (Corrigan, Watson, Byrne, & Davis, 2004).'
The public may view mental illness as a genetic condition from which the person does not recover (Phelan, Cruz-Rojas, & Reiff, 2002). It might suggest the harm caused by stigma has greater impact on the mental health system rather than the person with mental illness. It might foster pity rather than parity. It places responsibility for the stigma on the person with mental illness rather than where it belongs—on the public.'

'When viewed in terms of the prejudice and discrimination experienced by other out-groups, such as ethnicity and gender, stigma is better understood as an issue of social injustice. On the basis of sociological research, a social injustice perspective argues that many of the lost opportunities experienced by people with mental illness result from the difference and defects suggested by stigma.'

'Framing stigma as social injustice expands understanding of the phenomena as well as broadens the approach to erasing stigma. Ultimately, it may be the integration of public health and social injustice models that leads to the greatest challenges to stigma. Psychologists and other social scientists need to partner with advocates to identify the best strategies to bring about these goals.'

Peter Kinderman & Sara Taiet et al **; Psychological health and well-being: A new ethos for mental health -** *A report of the Working Group on Psychological Health and Well-Being;* The British Psychological Society; 2009; ISBN 978-1-85433-498-5

'Public 'anti-stigma' campaigns often attempt to address the media presentations of mental health issues which emphasise dangerousness and risk with more appropriate messages…. Simple educational approaches appear largely ineffective in changing behaviour. For example, campaigns that stress biomedical explanations of mental health problems are undeniably well-meaning, but too much emphasis on the concept of a biologically-based (even genetic) illness may reinforce notions of dangerousness and stigma, and actually increase social distance (Read & Harre, 2001; Read, Haslam, Sayce & Davies, 2006).'

Key points: Equality and inclusion: Stigma, discrimination and human rights
(a) The term 'discrimination' should be preferred to the term 'stigma'.
(b) Issues of discrimination in mental health care, including 'multiple discrimination' require particular attention...
(c) A social or 'well-being' ethos is most likely to reduce prejudicial attitudes.'

Anti-Stigma Project; **Stigma: Language Matters**; http://www.onourownmd.org/projects/the-anti-stigma-project

'Consider This... DON'T focus on a disability. Focus instead on issues that affect the quality of life for everyone, e.g., accessible transportation, housing, affordable health care, etc. DON'T portray successful persons with disabilities as superhumans. This carries expectations for others and is patronizing to those who make various achievements. DON'T sensationalize a disability. This means not using terms such as "afflicted with," "suffers from," "victim of," and so on. DON'T use generic labels such as "the retarded," "our mentally ill," etc. DON'T use psychiatric diagnoses as metaphors for other situations, e.g. a "schizophrenic situation." This is not only stigmatizing, but inaccurate. DO put people first, not their disabilities. Say, for example, "person with schizophrenia" rather than "schizophrenic." DO emphasize abilities, not limitations. Terms that are condescending must be avoided.'

Mental Health Commission of Canada. (2012). **Changing directions, changing lives: The mental health strategy for Canada.** Calgary, AB: Author.

'Stigma and the fear of being labeled prevent many people from looking for help. Finding the right service can be a serious challenge. Some people do not recognize that they have a problem, whether from lack of knowledge or because the illness itself can prevent people from understanding what is happening to them and that help would make a difference. The mental health system should be there for everyone who needs it.'

'Changing attitudes and fighting stigma require more than just improving understanding of the signs and symptoms of mental health problems and illnesses. The best way to break down stigma is through 'contact-based education'—meeting and talking with people who can share their experiences of mental illness and recovery.25

Reducing stigma is important for changing how people think, but addressing discrimination, upholding rights and eliminating structural barriers are critical for changing how people act.'

'MHCC Opening Minds. This 10-year anti-stigma/anti-discrimination initiative is the largest systematic effort to reduce the stigma of mental illness in Canadian history. Instead of creating one program to reach the entire Canadian population, Opening Minds is taking a targeted approach. Its initial target groups are youth, health care providers, the workforce, and news media, with other groups to be added in future years.

Whenever possible, Opening Minds is building on the strengths of existing programs in Canada, by evaluating their effectiveness at reducing stigma and discrimination. The goal is to replicate successful programs, sharing toolkits and resources with other organizations across the country.

Opening Minds promotes *contact-based education,* which the international literature has identified as one of the most promising practices for reducing stigma. It involves individuals with lived experience of mental illness sharing their personal stories of illness, stigma and recovery.

Opening Minds is focused on *changing behaviours:* reducing stigma is important for changing how people think, but addressing discrimination, upholding rights, and eliminating structural barriers are critical for changing how people act.'

The Mental Health Council of Australia (MHCA); **Submission to the Disability and Mental Health Policy Branch on Improving the Employment Participation of people with a disability in Australia. February 2013.**

'Until the issue of community stigma around mental illness is addressed, specifically amongst employers, significant challenges to the employment of people with mental illness will remain.[10,11] The MHCA proposes that there is a strong business case for the implementation of an antistigma campaign, with significant international evidence of their effectiveness.'

'Using the disclosure of mental illness to indicate prevalence in the employed workforce is not a workable option. Because of the current community stigma around mental illness there are very few incentives and many more potential negative consequences for people disclosing their illness status, particularly in employment situations.'

Emily Hutcheon, Gregor Wolbring; **Deconstructing the Resilience Concept Using an Ableism Lens: Implications for People with Diverse Abilities;** Faculty of Medicine, University of Calgary, Alberta Canada

'One might expand a constructionist understanding of resilience to apply to those with presumed impairments. A constructionist understanding of resilience might include perspectives of individuals and groups who possess plurality of ability-sets and preferences, body types, and levels of functioning. Additionally, scholars might appropriately expand the definition of resilience proposed by Ungar (2004) to include multiple understandings of normalcy, ability, and wellness, in order to avoid a further conflation of resilience with 'health'. This renewed understanding of resilience has potential, in turn, to critically deconstruct understandings of 'ableness' and 'normalcy.'

'An integrative approach here retains many of the advantages of the view that post-traumatic stress disorder is both a medical disorder and a political label. Thus, the disorder can be approached in terms of the underlying psychobiological mechanisms that result in its symptoms. At the same time, the integrative approach is able to acknowledge that trauma is experienced and expressed in different ways in space and time….Such an approach attempts to address a fundamental debate in consideration of individual and social response to severe traumas—we need to achieve a balance between emphasis on heroism and resilience for the majority of people, and at the same time being compassionate to the few who need additional sympathy because they are not coping. This is a difficult balance; we need to promote and reward bravery and resilience, as well as look after and compensate victims. We need to respect courage, but not stigmatise breakdown.'

'Under Ontario's *Human Rights Code*, people with a mental illness or addiction are protected from discrimination – such as being fired or denied a job or promotion – or harassment on the job. Employers also have a duty to accommodate people with a mental illness or addiction, and organizations are required to design their services, policies and processes so people with a mental health problem can be fully integrated into all aspects of society. These rights are reinforced in the *Accessibility for Ontarians with Disabilities Act*. The Accessibility Directorate of Ontario is developing accessibility standards in five key areas – customer service, transportation, information and communications, employment and the built environment – that will help prevent and remove barriers for persons with disabilities, including mental health/addiction illnesses. Under these standards, organizations will be required to be proactive in their efforts to accommodate persons with disabilities.'

'When people feel welcome, accepted and respected – when they receive stigma-free services – their health and well-being improves. To improve mental health, reduce addictions and make services more effective, Ontario must change attitudes towards mental illnesses and addictions.'

To stop stigma and discrimination:

2.1 Educate all Ontarians about mental illnesses and addiction. Dispel the myths and misperceptions and reinforce the human rights of people with a mental illness or addiction.

2.2 Engage people with lived experience and their families in programs and initiatives to educate the public about mental illness and addiction. They are powerful spokespeople against discrimination.

2.3 Collaborate with the Mental Health Commission of Canada to develop an ongoing anti-stigma campaign that targets children, youth and health care providers.

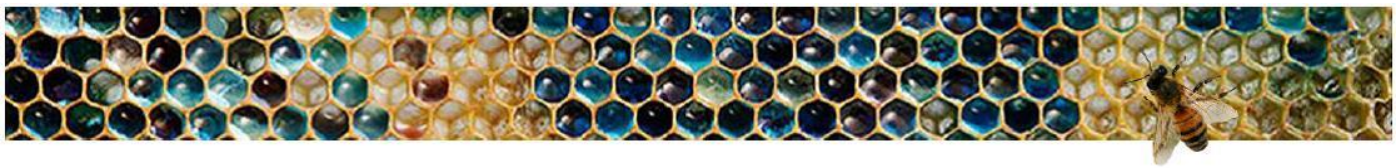
2.4 Provide anti-stigma training for first responders, health providers in emergency departments, social workers, youth workers, educators, justice workers, and other key front-line service providers. These individuals are often the first contact that people with mental health and/or addiction problems have with the system and the gateway to other services. The experience that people with lived experience have with these service providers will shape their perception of the service system.

2.5 Develop anti-stigma training programs that target employers and landlords. Reinforce their responsibilities under the *Ontario Human Rights Code* and *Accessibility for Ontarians with Disabilities Act* to recruit, retain and accommodate people with mental health and addiction issues.

2.6 Develop policies, mechanisms and training to enforce anti-discrimination legislation.

2.7 Lead by example. Ensure all publicly funded programs and services are free of stigma and discrimination, and culturally safe and competent. Provide opportunities for employment for people with lived experience within public services.

2.8 Recruit and develop a more culturally diverse health and human services workforce, which can provide more culturally competent services.'



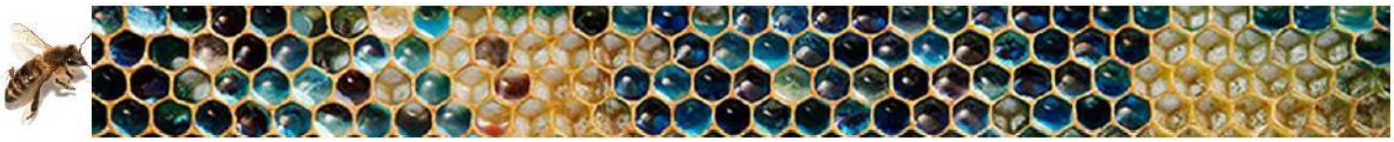
Trauma-Informed Care

SAMHSA; **Substance Abuse and Mental Health Service Administration** http://www.samhsa.gov/

'Trauma -informed care recognizes symptoms as originating from adaptations to the traumatic event(s) or context. Validating resilience is important even when past coping behaviours are now causing problems. Understanding a symptom as an adaptation reduces a survivor's guilt and shame, increases their self -esteem and provides a guideline for developing new skills and resources to allow new and better adaptation to the current situation." (Elliot et al., 2005, p. 467)'

SAMHSA; ***Leading Change: A Plan for SAMHSA's Roles and Actions*** *2011–2014* SAMHSA Technical Assistance Package or Access to Recovery (ATR) grantees

'At its best, **Trauma-Informed Care (TIC)** is resilience-informed care. It is an overall approach, at the *individual, organizational, and systemic levels,* that uses respect and consideration of trauma histories to create safety and hope for clients. Truly effective TIC recognizes human vulnerability, but still insists on finding and mobilizing survivors' strengths, resources, and capacity for healing and recovery.'



Innovation in Health Care

Rowe and Moodley ; **Patients as consumers of health care in South Africa: the ethical and legal implications**; BMC Medical Ethics 2013, 14:15 http://www.biomedcentral.com/1472-6939/14/15

'Patients who view themselves as informed 'consumers' in the medical market may demand medical services that the doctor views as inappropriate. The twenty-first century being the era of information and technology also has a role to play. The Internet has resulted in certain patients, particularly in the private sector in South Africa, having easy access to information regarding health conditions. The reliability of such information is questionable as patients are not necessarily trained in the principles of critical appraisal and choosing peer-reviewed journals as sources for information. Nevertheless, patients today are definitely more likely to come armed with knowledge than patients in the past.'

Anna Maresso, Matthias Wismar, Scott Greer and Willy Palm; Eurohealth 2013; 19(3). **WHAT MAKES HEALTH SYSTEMS RESILIENT AND INNOVATIVE?** VOICES FROM EUROPE;

'What is true innovation in the health sector and how can innovation help to strengthen health systems' resilience? **Helmut Brand** reminds us that *"true innovation in [this] sector can be social or technological. It influences processes in the health sector in a way that we can deliver better health and health care in an effective and efficient manner and reduce existing inequalities".* In a similar vein, **Tonio Borg** defines technical innovation in the health sector as being *"all about learning to deliver high quality care to more people in a more efficient and cost-effective manner"*. This view is shared by **Vytenis Povilas Andruikaitis** who states that *"I deeply believe that innovation is an investment and EU Member States have to do their best to ensure that their health care systems are technologically advanced; (…) there are still challenges in making health care systems more efficient, to consume as little resources as possible".*

All panel members point to new technologies such as telemedicine, e-health and m-health solutions as having huge potential that can be explored further as aids to delivering better health care. They can help to empower citizens to not only lead potentially healthier lives but also to take a more active role in framing the health care services they utilise. **Tonio Borg** explains that *"by being more involved in their own health and health care – for example through tele monitoring – patients can complement professional care. Using e-health solutions can offer patients more freedom in their daily routine and control, enabling them to remain active and in better health longer".*

However, **Zszsuanna Jakab** also stresses the economic considerations that come with innovation: *"[there is] the need to look for innovations in the health sector to serve not just patients' interests, but so too towards keeping costs affordable and helping to insulate budgets against future shocks".'*

Taking up the theme of balancing the need for technological innovation with social innovation, **Monika Kosinska**, advocates that *"innovation in the health sector must include social innovation, experimentation of methods, ideas and challenge preconceptions. We need to be brave enough to consider the unthinkable collaborations – bringing together health service delivery, community care, community engagement, even urban farming, art, regeneration, child services and active ageing. We need to foster and support the innovators. Innovation does not happen in large, rigid institutions (whether governmental or industry). Innovation is the craft of the small, the risk-takers, the young, and often is borne of need".*

She also echoes the need for concrete strategies to incentivise and help potential innovators: *"despite the fact that often the risk is shared by the public sector through government funding of research and often public-private partnerships, our outcomes of research are too often unaffordable, unavailable or simply unsuitable. We have the means to tackle some of these challenges by promoting collaborative research, new innovation models for biomedical research, inducement prizes, patent pools, open source research and public development partnerships".*

Daniela Negri, Louise Boyle and Edwin Maarseveen; **THE FUTURE OF HEALTH** EUROHEALTH; Volume 19 | Number 3 | 2013; Building resilient and innovative health systems

'Investing in innovation and research can radically alter the course of medical service provision. Within this context, the European Union has announced a series of initiatives that aim to promote medical advances and improve the quality of health care delivery in Europe.'

'In January 2013, the European Union announced that the Human Brain Project would receive €1 billion of funding in order to advance medicine and shed light on how the brain works. The ultimate objective is to develop personalised treatment of neurological and related diseases.'

'"The Human Brain Project is developing a combination of several IT platforms, to aggregate neuroscience knowledge and medical data from brain diseases, to develop models at and across the various functioning levels of the brain and to run these models on high performance mega computers or specialised hardware mimicking the neurons circuitry for faster evolution analysis".'

'"Massive aggregation of data will allow the identification of unique brain disease signatures and probably a better classification of these neurological or mental disorders. First targets are the neurodegenerative diseases like Alzheimers. The simulation will allow the identification of potential new drug targets against such diseases, opening better development opportunities for the pharmaceutical industry. It will also offer carers the possibility to personalise treatment to the patient´s exact condition.'

'"In terms of non-health related impacts, it is expected that simplified versions of the cognitive models of the brain will permit the realisation of better robotic control and possibly new algorithms for complex problem solving, while neuron-like electronics will be much less power-consuming and more resilient to faults.'

Terje Peetso; **HEALTH AT YOUR FINGERTIPS;**EUROHEALTH; Volume 19 | Number 3 | 2013; Building resilient and innovative health systems

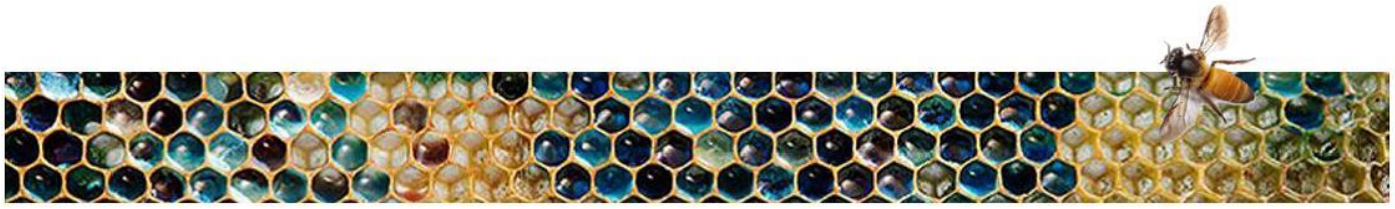
'Mobile health (mHealth) is considered to be a subset of eHealth and can be defined as *"medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices"*. mHealth offers the promise of giving patients easier access to their health information, increasing efficiencies across the continuum of care, and enabling more accurate diagnosis and treatment. Furthermore, it allows the collection of a great deal of medical and also physiological, lifestyle and daily activity data.'

Currently, there are more than 97,000 mobile apps available related to health and fitness, mostly helping users track specific health parameters as well as providing basic information and guidance. The mobile health app marketplace is expected to grow significantly over the next few years. According to a recent market research report… consumers are increasingly using health and wellbeing apps, with the top ten mobile health apps generating up to four million free and 300,000 paid downloads per day. **1** By 2017, it is expected that 50% of mobile users will have downloaded

mobile health apps. Experts believe that mobile health apps could change the way health care is practised and also could influence people's behaviour. Potentially, the emphasis could shift from people having to manage multiple chronic diseases in their later stages to receiving their doctor's advice on healthy lifestyles, performing regular medical check-ups and treating diseases discovered in the early stages of their development.'

Mental Health Commission of Canada. (2012). **Changing directions, changing lives: The mental health strategy for Canada.** Calgary, AB: Author.

'There are tremendous possibilities for new technology in promoting mental health and preventing mental health problems. Technology makes collaboration easier and can be a remarkable tool for supporting self-management, especially for younger people, who use the Internet in every aspect of their lives. The emerging world of e-health offers new opportunities for interaction and engagement between people who need services and providers. Electronic health records, telemedicine, Internet-based screening and treatment, videoconferencing, and on-line training are all tools that can enhance collaboration, access and skills. While telephone help lines have been a mainstay of community crisis services for decades, new forms of phone-based services are helping people to deal with moderate depression and anxiety, and to prevent and identify mental health problems and illnesses in childhood.'



Research

Johan Hansen, Natasha Azzopardi Muscat, Ilmo Keskimäki, Anne Karin Lindahl, Holger Pfaff, Matthias Wismar, Kieran Walshe and Peter Groenewegen; MEASURING AND IMPROVING THE **SOCIETAL IMPACT OF HEALTH CARE RESEARCH;** EUROHEALTH; Volume 19 | Number 3 | 2013; Building resilient and innovative health systems

'In light of the many health care challenges that countries face, there is growing recognition that high quality health care research can help decision-makers by providing scientific evidence to inform policies and practices. With governments and health care systems becoming more and more focused on effectiveness and efficiency, it is a logical development that the same also applies to research production. Health care research needs to be accountable and show that investments produce value for money.'

'How to determine this value and for whom, is a topic of debate. There is growing awareness that the impact of research should not only be determined in scientific terms. Especially when funded through public sources it is also important that research findings are actually used by end users, such as policy makers, managers, patient organisations or the public at large.'

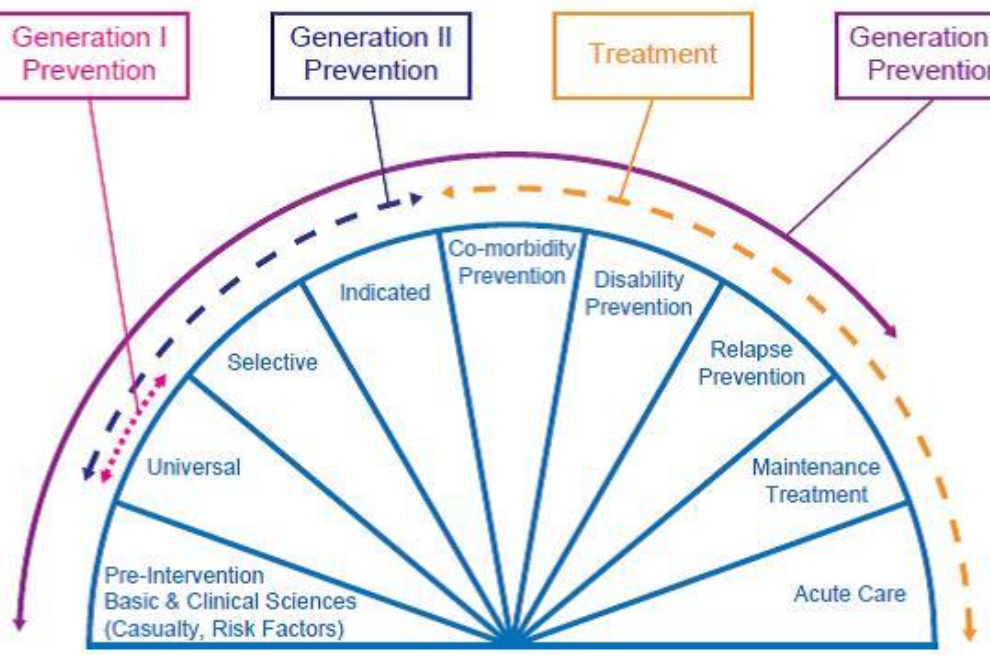
'There is growing awareness among health care researchers and funders that assessing societal impact is a key priority for all those involved in producing or funding health care research, especially in times of scarcity. Which impact assessment tool to use is highly dependent on the exact purposes: is the assessment intended for monitoring research performance of health care research or for biomedical research?'

SAMHSA; Submitted by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration' & Center for Mental Health Services; **Promotion and Prevention in Mental Health: Strengthening Parenting and Enhancing Child Resilience**; Requested in Senate Report 109-103 and Conference Report 109-337

The term "resilience" has its origins in physics and architecture. To be "resilient" means that a building material, such as tempered steel, has the ability to withstand stress. This same term has been adapted to describe a person's ability to face the challenges of life. Resilience often is defined as "the ability of a person to spring back from and successfully adapt to adversity." Just like tempered steel, it means that an individual can withstand stress (i.e., adversity) and continue to function well.

A misleading perception regarding resilience is that it is a static trait of an individual. Instead, resilience in a person is dynamic and varies across time and life domains (e.g., relationships, academic and professional life, and health). Individuals do not develop resilience by "pulling themselves up by the bootstraps" when faced with life's challenges. Resilient adaptation to adversity comes about as a result of characteristics of an individual *interacting* with resources in the environment, such as caring adults, good schools, safe neighbors, good friends, and other "protective factors".

Figure 4. The mental health intervention spectrum.



Source: National Institute of Mental Health (1998). *Priorities for Prevention Research at NIMH: A Report by the National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research* (NIH Publication No. 98-4321). Rockville, MD: Author.

'Evidence-based programs implemented with fidelity can teach many of the skills that correlate with resilience. These skills are collectively known as social-emotional skills and include how to recognize and manage emotions, develop caring and concern for others, make responsible decisions, establish positive relationships, and handle adversity effectively. Most developers of prevention programs do not describe their programs as "programs to foster resilience." One who does, however, is Dr. Karol Kumpfer, the developer of the *Family Strengthening Program*. Kumpfer clarifies the resilience and prevention issue as follows:

> Luckily, although not specifically designed to increase resilience, most prevention programs *logically or intuitively focus on increasing protective mechanisms*. Many of these protective mechanisms are synonymous with resilience mechanisms.

Hence, increasing research findings about resilience-building processes should better inform prevention program design and increase program effectiveness.'

Emily Hutcheon, Gregor Wolbring; **Deconstructing the Resilience Concept Using an Ableism Lens: Implications for People with Diverse Abilities;** Faculty of Medicine, University of Calgary, Alberta Canada

"Research has since shifted away from risk-assessment to the assessment of both risk factors and protective factors (Carlson, 2001). This shift aimed to challenge persistent assumptions about an individual's outcomes in certain contexts (Hartley, 2009), and to provide foundational strategies for supportive intervention measures (Glantz & Johnson, 1999). From this perspective, resilience involves the presence of internal and external protective factors in contexts of risk (Glantz & Johnson, 1999). As Ungar (2004) further observes, the resilience construct "has come to mean both a set of behaviors and internalized capacities... it may refer to either the state of well-being achieved by

an at-risk individual (as in 'he or she *is resilient*') or to the characteristics and mechanisms by which that well-being is achieved (as in 'he or she *shows resilience to* a particular risk')" (Ungar, 2004, 346). Further, resilience as a set of behaviours or capacities is strongly tied to, and founded upon, cultural and social preferences for particular abilities."