

SOCIAL AND BEHAVIOURAL FACTORS IN HEALTH

MODULE FOUR (4) ASSIGNMENT



24-july-2019

aFRICA INSTITUTE FOR PROJECT MANAGEMENT STUDIES

**NAME:** FRANCISPAULGALERIO

**COURSE:** POST GRADUATE DIPLOMA IN PUBLIC HEALTH

**REG NO: AIPMS/216/002/2019**

**ASSIGNMENT:** FOUR

**Definitions of Mental Illness**

Definitions of mental illnesses have changed over the last half-century. *Mental illness* refers to conditions that affect cognition, emotion, and behavior (eg, schizophrenia, depression, autism). Formal clinical definitions now include more information (ie, we have moved from a partial to a more holistic perspective and transitioned from a focus on disease to a focus on health). The informal response has fostered a parallel transition from a focus on the stigma of mental illnesses to the recognition that mental health is important to overall health.

In the 1960s and 1970s, a person with a mental illness was defined by diagnosis alone, and there were few broad classes of mental disorders. National statistical data were reported by diagnoses (eg, cases of schizophrenia and cases of depression). People with mental illness were commonly stigmatized and institutionalized. At the same time, deinstitutionalization had begun and was accelerating.

A mental illness is a disease of the brain that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life’s ordinary demands and routines.  There are more than 200 classified forms of mental illness. Some of the more common disorders are clinical depression, bipolar disorder, dementia, schizophrenia and anxiety disorders.  Symptoms may include changes in mood, personality, personal habits and/or social withdrawal.

**The Follow Below Are the Major Categories of Mental Illness and Their Treatment**

**Mood Disorders**

**Depression (as a disorder on its own or a part of bipolar disorder)**

Refers to severe and prolonged feelings of discouragement, frustration and even a sense of despair. Multiple causes such as specific, distressing life events, a biochemical imbalance in the brain or persistent psychological factors such as a negative or pessimistic view of life.

Common symptoms of depression:

* Irritability.
* Anxious mood.
* Trouble sleeping or sleeping too much.
* Loss of energy and excessive fatigue.
* Physical aches and pains.
* Diminished ability to think and concentrate.
* Feeling bored and not interested in many aspects of your life.
* Imagining you have an illness such as cancer when there are no physical indications.
* Feelings of worthlessness, hopelessness
* Possibility of suicidal thoughts
* Changes in personal grooming
* Isolation and withdrawal
* Inability to experience joy or pleasure

**Bi-Polar Disorder**

Refers to the “two poles” of the continuum of mood with alternating periods or cycles of mania (highs) and depression (lows) as described previously.

Common symptoms of mania:

* Persistently high or irritable.
* Decreased need for sleep.
* Appetite disturbance.
* Excessive spending.
* Reckless and impulsive behaviour.
* Inflated ideas about what you are capable of doing – grandiose thoughts.
* Delusional and psychotic thinking.
* Hyper sexuality
* Heightened senses to colour, noise, and smell
* Accelerated thoughts and speech.

**Schizoaffective Disorder**

This term is used when a person has both a mood disorder and a psychotic disorder within the same period of illness. This does not mean you have two disorders but a combination of symptoms. The depressive type of schizoaffective disorder is accompanied by symptoms such as loss of energy, concentration impairment, guilt, feelings of hopelessness, and suicidal thoughts. At the same time, the person experiences psychotic symptoms such as delusions, extreme paranoia, or hearing voices.

The manic type of schizoaffective disorder often takes the form of elation, with increased self-confidence and grandiosity. The person may feel energized, but may act inappropriately in social situations, and have trouble concentrating. Symptoms of psychosis are also present, and the person’s behaviour is markedly different from usual.

Psychosis

The word “psychosis” is used to describe conditions that affect the mind, in which there has been some loss of contact with reality. When someone experiences the symptoms of psychosis, their condition is referred to as a psychotic episode. It affects an individual’s thoughts, feelings and behaviours. Some people experience psychosis as a part of their mental illness or as a result of using or withdrawing from drugs and alcohol. It is most likely to occur in young adults. About 3 out of every 100 people experience a psychotic episode in their lifetime. It occurs equally in males and females and across all cultures and levels of socio-economic status.

Most people make a full recovery from the experience. Common signs and symptoms of psychosis:

* Disorganized or confused thinking.
* Reduced concentration, attention
* Reduced drive and motivation, lack of energy
* Sleep disturbance
* Anxiety
* Social withdrawal
* Behavioural changes, irritability
* Hallucinations or delusions
* Disorganized speech

**Anxiety Disorders**

A group of disorders which affect behaviour, thoughts, emotions and physical health. Caused by biological and situational circumstances. Heightened and continuing response to a perceived threat.

Types of anxiety disorders:

**General Anxiety Disorder**

Repeated and excessive worries lasting at least six months pertaining to routine life events and activities like work, relationships, finances and family.

**Panic Attacks**

Fear of imminent death leading to heart palpitations, choking, nausea, faintness, dizziness, chest pain and sweating.

**Panic Disorder**

Fear of situations which may cause a panic attack.

**Phobias**

Overwhelming feelings of terror in response to a specific object, situation or activity.

**Obsessive-Compulsive Disorder (OCD)**

Repetitive actions used to cope with recurring or unwanted thoughts.

**Post-traumatic Stress Disorder (PTSD)**

A sense of re-experiencing a traumatic event for months and sometimes years after the incident.

**Schizophrenia**

Refers to an illness in which the changes in behaviour or symptoms have been present for a period of at least six months. Caused by a chemical disturbance of the brain’s functioning. Affects one out of every 100 people.

Common Symptoms:

**Eating Disorders**

Involve distorted body images that make it difficult for people to nourish themselves in a healthy way. Most common in women and men under age 30. Types:

**Anorexia Nervosa**

Dramatic weight loss due to fasting and excessive exercise.

**Bulimia Nervosa**

Binge eating followed by self-induced vomiting or other forms of purging.

**Personality Disorders**

Involve patterns of thinking, mood, social interaction and impulsiveness that cause distress to those experiencing them and others.

Types of personality disorders:

**Borderline Personality Disorder**

Difficulty maintaining positive relationships.

**Paranoid Personality Disorder**

Overwhelming distrust and suspiciousness of others.

**Antisocial Personality Disorder**

Impulsive behaviour, aggression and violations of the rights of others. For more information on mental illnesses and their symptoms log on to [www.cmha.ca/english/info\_centre](http://www.cmha.ca/english/info_centre)

**Treatment & Recovery**

Treatment for any mental illness, whether or not it is complicated by drug and alcohol misuse, should occur as soon as symptoms appear.

Recommended treatment involves a combination of approaches:

**EDUCATION** – To help you and your family/support system understand the illness, its causes and effects and ways of dealing with symptoms.

**MEDICATION** – New ones are now available with fewer unpleasant side effects than older medications.

**PSYCHOLOGICAL THERAPY OR COUNSELLING** - To help you understand what is happening, change your lifestyle to optimize the chances for recovery and learn new skills such as problem solving and relaxation techniques.

**SOCIAL, EMPLOYMENT AND EDUCATION SUPPORT** – You may need support to stay at your job, or in school. This is important so you maintain skill development and continuation of income and do not become cut off from friends and workmates. Research has shown that people who experience mental illness have fewer relapses when their family or other support system is involved in their care and treatment. The same is true when substance misuse is involved. If friends and family are knowledgeable and informed, they are in a better position to support you.

**Medications**

The four main categories of medications used to treat mental health disorders are antidepressants, anti-anxiety medications, antipsychotic medications, and mood-stabilizing medications.

Which type is best for you will depend on the symptoms you experience and other health issues you may face? People may try a few medications at different doses before finding something that’s right for them.

**Psychotherapy**

Talk therapy is an opportunity for you to talk with a mental health provider about your experiences, feelings, thoughts, and ideas. Therapists primarily act as a sounding board and neutral mediator, helping you learn coping techniques and strategies to manage symptoms.

**Hospital and residential treatment**

Some people may need brief periods of intensive treatment at hospitals or residential treatment facilities. These programs allow an overnight stay for in-depth treatment. There are also daytime programs, where people can participate in shorter periods of treatment.

**Lifestyle treatments and home remedies**

Alternative treatments can be used in addition to mainstream treatments as a supplement. These steps won’t eliminate mental health issues alone, but they can be helpful.

**Social Factors Affect the Health Outcomes of Individuals/Communities**

There are many factors that influence our health. These are called determinants of health. One kind of determinant of health is what is in our genes and our biology. Another determinant is our individual behavior. This could include whether we smoke, exercise, or eat a balanced diet. Many people assume that their health is a result of their genes, their behaviors, and how often they get sick or go to the doctor. But it’s not just how you live that determines how healthy you are. Social and physical environments have a big impact on our health, too. These are called social determinants of health.

**Path to improved health**

Social determinants of health are the conditions that we live, learn, work, and play in. These conditions can influence the health and wellbeing of you and your community. They can include things like your education level, your exposure to violence, the way your community is designed, and if you have access to health care. These factors affect your ability to take part in healthy behaviors, and this affects your health.

**Here are some examples of major social factors that can influence your health.**

**Education**

Your education level can have an effect on how healthy you are. Education gives you the tools you need to make good decisions about your health. People with more education are more likely to live longer. They are more likely to participate in healthy activities like exercising and seeing their doctor regularly. They are less likely to participate in unhealthy activities, such as smoking. Education also tends to lead to higher-paying jobs. These often come with benefits, such as health insurance, healthier working conditions, and the opportunity to make connections with other people. All of these things add up to better health.

**Employment Status**

Scientific evidence has shown that employment status affects health status. Unemployed adults have poorer mental and physical health than employed adults. In addition to having poorer health, unemployed adults are more likely to delay or not receive needed medical care and needed prescriptions due to cost than their employed counterparts. Thus, the unemployed adults have both worse health and less access to needed care and treatment than employed adults.

**Social relationships**

People are inherently social, and the quantity and quality of social relationships affect mental health, health behaviour, physical health and mortality risk. Social relationships can impact health in several ways: social ties can influence health-related behaviours and social support can buffer stress. The foundations for the ability to form stable, loving relationships are laid in early childhood. Secure and trusting relationships with adults early in a child’s life shape the development of the ability to form good quality social relationships in later life.

**Social isolation and loneliness**

Social isolation describes the state of having inadequate quantity and quality of social relationships. Loneliness is an emotional perception that can be experienced by people regardless of the extent of their social network. Both have negative consequences for health and wellbeing. A meta-analysis of nine longitudinal studies found that social isolation and loneliness are associated with 50% excess risk of coronary heart disease, which is broadly similar to the excess risk associated with work-related stress. Psychosocial influences on social isolation accumulate throughout life. For example, childhood social withdrawal serves as a risk factor for impairment of adolescent interpersonal interactions, which increases the risk of developing depressive symptoms and diagnoses of depression in young adulthood. Depression in turn increases risk of social isolation.

**Social capital and social cohesion**

Social conditions in adolescent and adult life affect relationships and social networks. The associations between social conditions and relationships and health are examined through the concepts of social capital and social cohesion. These concepts overlap to a certain extent. Social capital, as first described by Bourdieu, refers to the resources available to an individual or group because of their belonging to a social network. In this view, social capital may reproduce inequality in some circumstances, because membership of groups with better access to resources than other groups confers benefits on members of those groups with better access. We might recognise this in the phrase ‘old boys’ network’. Putnam developed the concept of social capital with a focus on the connections between individuals in a society and the levels of trust and mutual support within society. From this perspective, living in a society with high social capital is seen as benefiting everyone, including individuals who are socially isolated.

**Self-efficacy and resilience**

Self-efficacy and resilience are important related concepts used to understand how individuals cope with stressors. Self-efficacy was conceptualised by the psychologist Albert Bandura as the exercise of control: it is a belief in one’s capability to accomplish a specific task, and enables individuals to persevere in the face of setbacks and work actively to overcome difficulties. In this way, self-efficacy enables people to take action to further their own interests (personal agency) and have control over their lives.

**Income**

The amount of money you make has an effect on your health. People with higher incomes tend to be healthier and live longer than people with low incomes. They are more likely to live in safe neighborhoods. They have more access to grocery stores and healthy foods. They usually have more access to safe spaces for exercise or other activities. People with low incomes are more likely to live in a community of poverty. They are more likely to face situations that can lead to poor health. These can include unsafe housing, more challenges in getting healthy food, and less time for exercise or physical activity. Having a lower income also affects your ability to have affordable health insurance. This can affect how often, if ever, you go to the doctor. This can have a direct effect on your health.

**Housing**

Where you live has a significant impact on your health. People who are continually exposed to poor living conditions have a higher risk of developing health problems. Conditions such as pests, mold, structural problems, and toxins in the home can all affect your health. It is important that your home is safe and free from hazards like these. Housing can contribute to your health when it provides you with a safe place to be.

Neighborhood conditions are an important part of housing, and can also affect your health. A neighborhood that is free from violence, crime, and pollution gives children and adults a safe place for physical activity. A home that is close to grocery stores makes it easier for families to buy and eat healthy foods. A thriving neighborhood also offers employment, transportation, and good schools. Being surrounded by all of these things helps you live a healthier life.

**Access to health care**

How easy it is for you to access health care is a big determinant of your health. If you have health insurance, you are more likely to visit your doctor on a regular basis. These trips can include screenings and preventive care that keep you from developing chronic disease. But not everyone has access to health insurance or easy access to care. Some people don’t have transportation to go to the doctor. Some can’t afford it, while others speak a different language. All of these things can prevent them from getting health care they need. Not being able to get health care can have a huge impact on your health.

Above are just a few of the social determinants of health that can affect your health and wellbeing. There are many others. They include:

* Access to nutritious foods.
* Access to clean water and working utilities (electricity, sanitation, heating, and cooling).
* Early childhood social and physical environments, including childcare.
* Ethnicity and culture.
* Family and other social support.
* Gender.
* Language and other communication capabilities.
* Occupation and job security.
* Sexual identification.
* Social status (how integrated or isolated you are from others).
* Social stressors, such as exposure to violence.
* Socioeconomic status.
* Spiritual/religious values.

Any and all of these factors play into your health on a daily basis. It is important to understand how these things affect your health so you can take steps to improve them, and improve your health.

**Psychosocial Factors That Affect Health Behavior**

**Demographic factors**

Including race, gender, and marital status are consistently found to influence health behavior. Statistics show that most ethnic minorities in the United States and the world at large have significantly higher mortality rates from most diseases than whites. Males have higher mortality rates than females at all ages, although females tend to suffer more from chronic illness. Married people are in general healthier than people who are not married, whether single, separated, widowed, or divorced. The reasons for these differences are believed to be primarily social.

**Exposure to Community Violence and Discrimination**

Research on the psychosocial impact of young people’s exposure to community violence has been prompted by concern that in some communities exposure may be frequent, and that such exposure to violence (including witnessing) may be a stressful experience that requires psychological adaptation and that adverse psychological sequelae may result into change of health behavior of that person or individual in the community.

**Health Inequalities**

Studies reporting differential outcomes by gender and socio-economic group can potentially shed light on how psychosocial factors contribute to health inequalities, and help inform how interventions might be tailored and targeted to reduce such inequalities. Of the more robust reviews we identified (including higher scoring reviews, and recent reviews presenting numerical outcomes and/or outcomes that prioritise more robust evidence), nine provide some evidence of differential effects. The fact that this number is relatively small may reflect the poor quality of some of the reviews we identified, but it may also reflect a tendency sometimes visible in epidemiological studies and meta-analyses to seek a single overall outcome for all participants that controls for differences in gender, age, ethnicity etc, rather than to explore heterogeneity of outcomes amongst different sub-groups.

**Socioeconomic Status (SES)**

The most important predictor of health is socioeconomic status (SES), a concept that includes income, education, and occupational status, factors that tend to be strongly associated with each other. SES accounts in part, though not entirely, for the health differences by race, sex, and marital status. For example, blacks tend to be less healthy than whites, and they generally have lower SES than whites. However, even wealthy, educated blacks have higher mortality rates than whites of comparable SES. Groups with the lowest SES have the highest mortality rates, a fact that is true in many different countries and has been true for centuries, for reasons known and unknown. In London in 1665, the poor were more likely to die in the plague epidemic because of poor nutrition and sanitation and because they could not flee the city to escape infection as the wealthy did. In the United States today, the health of the poor is threatened by the adverse environmental conditions of the inner cities, such as lead paint and air pollution, crime, and violence. Poor people also have poorer nutrition, less access to medical care, and more psychological stress It is not only the effects of poverty that account for socioeconomic variations in health, however. The association is seen at all levels of the socioeconomic scale, the very rich being healthier than the rich, who are healthier than the middle class, and so on. In a study of British civil servants called the Whitehall Study, mortality rates over a 10-year period were compared across four employment grades. Top administrators were compared with executives and professionals, the clerical staff, and unskilled laborers.

**Health of Minority Populations**

Race and ethnicity have been seen to profoundly affect health in the United States. Most data on health status of different population groups show that the health of black Americans, the largest racial minority, constituting about 17 percent of the population, is poorer than that of white Americans. Hispanics are a heterogeneous group, and their health status varies among different subgroups. American Indians generally have poorer health indicators than whites, while Asian Americans have better health status.

**Stress and Social Support**

A number of psychological factors have been found to influence health, some of which may have a role in the health effects of SES. One of these factors is stress, which is due to the adverse physical and social conditions associated with lower SES, which may act both directly, by affecting physiological processes, and indirectly, by influencing individual behavior. Early evidence of the health effects of stress came from observations that widows and widowers seemed to have an unusually high risk of dying soon after the death of their spouses. Several studies in the 1960s and 1970s found that mortality rates of survivors are 40 percent to 50 percent higher during the six months after the death of a spouse compared to the mortality of married people of the same age. These studies were expanded to include the effects of other stressful life events such as death of other family members, divorce, and loss of a job, all of which were found to increase the risk of illness or death.

Stress is well established as a contributor to heart disease, a relationship that has been demonstrated in a variety of epidemiologic studies. A particularly convincing example is a study of the male employees of two banks. At first, the two groups were similar, but one bank changed its management policies to become commercial. The employees of the commercial bank had to deal with considerable competition, risk, and responsibility for investing funds; employees of the other bank, a semipublic savings bank, had less competition and fewer responsibilities. Over a 10-year period, the employees of the commercial bank were found to have 50 percent higher rates of heart attacks and sudden death.

**Physical activity Regular**

physical activity benefits health and wellbeing by contributing to the prevention of several physical diseases, including cardiovascular diseases, diabetes, hypertension and osteoporosis, and by reducing stress, anxiety and depression. Physical activity is also socially patterned. Men in the most deprived income quintile are less likely to take part in recommended levels of physical activity than men in other income groups, and women in the four lowest income quintiles are less likely to take part in recommended levels of physical activity than those in the highest income group.

**Alcohol**

Drinking alcohol is socially acceptable in England. Alcoholic drinks are cheaper relative to average household disposable income than they were in the 1980s, although following the 2008 financial crisis alcohol prices rose above wages for several years. Within the environment of social acceptability, some people misuse alcohol and drink to excess. The causes of misuse of alcohol are complex and involve interaction between genetic and psychosocial influences. Having a parent who is an alcoholic is a risk for misuse of alcohol in their children as they grow up. There is a genetic component to this intergenerational transmission, but also psychosocial influences. Unravelling these psychosocial influences is challenging for researchers because parental alcohol and substance abuse co-occurs with a range of interrelated psychosocial and socioeconomic factors that can independently impact early child development.

**Smoking**

Psychosocial processes are at play in the decision to start smoking, continuing to smoke and in quitting. People use tobacco smoking as a way of coping with life stressors, but the relationship between stress and smoking is complex. Reasons for starting to smoke differ from the reasons why people continue to smoke. People who smoke usually start in adolescence, a phase of life when young people seek new sensations and are highly susceptible to peer pressure. A study of survey data over the period 1994–2008 of children aged 11–15 found that children from more disadvantaged backgrounds were more likely to start smoking earlier and to escalate to daily smoking than children from families of higher socioeconomic status. Therefore, although tobacco control measures are associated with reduced uptake and more quitting in childhood, socioeconomic inequalities in childhood smoking remain. Nicotine is highly addictive, and evidence shows that nicotine ingested from smoking stimulates the production of dopamine, which temporarily reduces feelings of stress, but these negative feelings rise again once the effect has worn off.

**The Following below are the Three Public Health Threats in the 21st Century,**

**Epidemic-prone diseases**

Cholera, yellow fever and epidemic meningococcal diseases made a comeback in the last quarter of the 20th century and call for renewed efforts in surveillance, prevention and control. Severe Acute Respiratory Syndrome (SARS) and avian influenza in humans have triggered major international concern, raised new scientific challenges, caused major human suffering and imposed enormous economic damage. Other emerging viral diseases such as Ebola, Marburg haemorrhagic fever and Nipah virus pose threats to global public health security and also require containment at their source due to their acute nature and resulting illness and mortality. During outbreaks of these diseases, rapid assessment and response, often needing international assistance, has been required to limit local spread. Strengthening of capacity is imperative in the future to assess such new threats.

Gains in many areas of infectious disease control are seriously jeopardized by the spread of antimicrobial resistance, with extensively drug-resistant tuberculosis (XDR-TB) now a cause of great concern. Drug resistance is also evident in diarrhoeal diseases, hospital-acquired infections, malaria, meningitis, respiratory tract infections, and sexually transmitted infections, and is emerging in HIV.

**Foodborne diseases**

The food chain has undergone considerable and rapid changes over the last 50 years, becoming highly sophisticated and international. Although the safety of food has dramatically improved overall, progress is uneven and foodborne outbreaks from microbial contamination, chemicals and toxins are common in many countries. The trading of contaminated food between countries increases the potential that outbreaks will spread. In addition, the emergence of new foodborne diseases creates considerable concern, such as the recognition of the new variant of Creutzfeldt-Jakob disease (vCJD) associated with bovine spongiform encephalopathy (BSE).

**Accidental and deliberate outbreaks**

As activities related to infectious disease surveillance and laboratory research have increased in recent years, so too has the potential for outbreaks associated with the accidental release of infectious agents. Breaches in biosafety measures are often responsible for these accidents. At the same time, opportunities for malicious releases of dangerous pathogens, once unthinkable, have become a reality, as shown by the anthrax letters in the United States of America in 2001.

In addition, the recent past has been marked by disturbing new health events that resulted from chemical or nuclear accidents and sudden environmental changes, causing major concerns in many parts of the world.

Toxic chemical accidents

West Africa, 2006: the dumping of approximately 500 tons of petrochemical waste in at least 15 sites around the city of Abidjan, Côte d’Ivoire, led to the deaths of eight people being attributed to exposure to the waste and to nearly 90 000 more people seeking medical help. Other countries were concerned that they could also have been put at risk as a result of dumping elsewhere or as a result of chemical contamination of transboundary rivers.

Southern Europe, 1981: 203 people died after consuming poisoned cooking oil that was adulterated with industrial rapeseed oil. A total of 15 000 people were affected by the tainted oil and no cure to reverse the adverse effects of toxic oil syndrome was ever found.

Radionuclear accidents

Eastern Europe, 1986: the Chernobyl disaster is regarded as the worst accident in the history of nuclear power. The explosion at the plant resulted in the radioactive contamination of the surrounding geographical area, and a cloud of radioactive fallout drifted over western parts of the former Soviet Union, eastern and western Europe, some Nordic countries and eastern North America. Large areas of Ukraine, the Republic of Belarus and the Russian Federation were badly contaminated, resulting in the evacuation and resettlement of over 336 000 people.

Environmental disasters

Europe, 2003: the heatwave in Europe that claimed the lives of 35 000 persons was linked to unprecedented extremes in weather in other parts of the world during the same period.

Central Africa, 1986: more than 1700 people died of carbon dioxide poisoning following a massive release of gas from Lake Nyos, a volcanic crater lake. Such an event requires rapid assessment to determine if it is an international threat.

**Here are Some of The Psychosocial Interventions for Mental Health and Substance Use Disorders**

**Strengthen the Evidence Base**

The framework’s cycle begins with strengthening the evidence base for identifying effective psychosocial interventions and their key elements. The data on these interventions are compelling. A number of meta-analyses have established the effects of psychosocial interventions on mental health and substance use disorders. Psychotherapies in particular have been subject to numerous meta-analyses. Few meta-analyses exist for other types of psychosocial interventions, such as suicide prevention programs, vocational rehabilitation, and clinical case management. However, these interventions have been subjected to randomized clinical trials and have been shown to have positive effects on the intended intervention target. Although metaanalyses support the use of psychosocial interventions in the treatment of mental health and substance use problems, additional studies are needed to further determine the utility of these interventions in different populations and settings, as well as to determine who is most capable of delivering the interventions, what the interventions’ limitations are, and how best to implement them. Finally, there is a need to develop and test new interventions that are more effective and address currently unmet needs.

**Identify Key Elements of Interventions**

Once the evidence base for psychosocial interventions has been expanded, the next step is to identify the key elements that drive the effects of the interventions. Most evidence-based psychosocial interventions are standardized, and these standards are detailed in treatment manuals. Most if not all evidence-based, manualized psychosocial interventions are packages of multiple elements. An element is a therapeutic activity, technique, or strategy that is categorized as either “nonspecific”—fundamental, and occurring in most if not all psychosocial interventions (e.g., a trusting relationship with a therapist)—or “specific”—unique to a particular theoretical orientation and approach (e.g., systematic exposure to feared objects, a specific element of cognitive-behavioral therapy for anxiety). The application of effective interventions involves assembling combinations of elements that, based on evidence, are targeted to particular disorders and other patient characteristics The elements that make up evidence-based psychosocial interventions are clearly specified in measures of fidelity, which are used to ascertain whether a given intervention is implemented as intended in research studies, and to ensure that practitioners in training and practice are demonstrating competency in an intervention.

**Conduct Independent Systematic Reviews to Inform Clinical Guidelines**

No national, standardized, and coordinated process exists in South Sudan for compiling, conducting, and disseminating systematic reviews, guidelines, and implementation materials for use by providers and by those formulating guidance for implementation and for insurance coverage. Since as far back as 2011 of South Sudan Independence, some in the field of mental health have suggested that a regulatory body be formed to conduct high-quality systematic reviews for psychosocial interventions, much as the South Sudan Food and Drug Administration regulates all medications and most medical devices. It is this approval process that informs decisions on which medications and devices can be included for coverage by health plans and should be used by providers as effective interventions. While the concept of having a single entity oversee and approve the use of psychosocial interventions has practical appeal, it has not gained traction in the field and has not been supported by Congress. In an attempt to address this gap, professional organizations, health care organizations, federal entities, nonfederal organizations, and various researchers have independently reviewed the literature on psychosocial interventions. However, the result has been sets of guidelines that often are at odds with one another, and clinicians, consumers, providers, educators, and health care organizations seeking information are given little direction as to which reviews are accurate and which guidelines should be employed.

**Develop Quality Measures**

New care delivery systems and payment reforms being instituted under the ACA require measures for tracking the performance of the health care system. Quality measures are among the critical tools for health care providers and organizations during the process of transformation and improvement. To date, quality measures are lacking for key areas of mentalhealth and substance use treatment. Of the 31 nationally endorsed measures related to these disorders, only 2 address a psychosocial intervention (screening and brief intervention for unhealthy alcohol use). This lack of measures reflects both limitations in the evidence base for determining what treatments are effective at achieving improvements in patient outcomes and challenges faced in obtaining from existing clinical data the detailed information necessary to support quality measurement. To guide the consideration of opportunities to develop quality measures for psychosocial interventions, the committee built on prior work to offer an approach for the development of quality measures—structure, process, and outcome measures—for psychosocial interventions. Structure measures are necessary to ensure that key elements of care can actually be implemented in a way that conforms to the evidence base linking those elements to key outcomes. Structure measures can be used to assess providers’ training and capacity to offer evidence-based psychosocial interventions. They provide guidance on infrastructure development and best practices. They support credentialing and payment, thereby allowing purchasers and health plans both to select clinics or provider organizations that are equipped to furnish evidence-based psychosocial interventions and to provide incentives for the delivery of high-quality psychosocial care.

**Implement Interventions and Improve Outcomes**

A comprehensive quality framework needs to consider properties beyond interventions themselves—in particular, the context in which interventions are delivered. This context includes characteristics of the consumer, the qualifications of the provider, the clinic or specific setting in which care is rendered, characteristics of the health system or organization in which the setting is embedded, and the regulatory and financial conditions under which the system or organization operates. Stakeholders in each of these areas can manipulate various levers that can shape the quality of the psychosocial interventions delivered to patients. Stakeholders and examples of levers as their disposal include

• consumers—meaningful participation in governance, in organizational leadership positions, and as board members;

• providers—quality measurement and reporting, such as tracking outcomes for practices and for populations served;

• provider organizations—electronic data systems with which to share medical records across disciplines and sites of service;

• health plans and purchasers—benefit design, such as pay-forperformance systems; and

• regulators—accreditation and licensure to help ensure the implementation of evidence-based practices.

**INDIVIDUAL THERAPIES**

A variety of individual therapies are commonly used with dual diagnosis clients. These include interventions that target mental health, substance abuse, or post-traumatic symptoms. Most build on cognitive behavioral, motivational enhancement, or 12-step models. Standardized therapies for mental health problems, such as social skills training and supportive psychotherapy, have not been studied specifically with dually diagnosed clients. Several substance abuse interventions have been tailored specifically for dual diagnosis clients, including psychoeducational counseling, 12-step counseling, motivational counseling, cognitive behavioral counseling, and skills training. In many studies the substance abuse counseling intervention is instead part of a larger case management intervention that includes individual counseling, group treatment, and other interventions. In other studies, the substance abuse counseling intervention is well specified but combined with other interventions, such as family therapy.

**GROUP THERAPIES**

Group intervention has a major appeal in the treatment of substance use disorders for at least two reasons. First, as substance use is often a social behavior, the use of group processes to develop social support and establish different social norms offers the opportunity to capitalize on these processes. Second, group interventions may be a more efficient treatment modality than individual-based treatment, although cost-effectiveness analyses remain to be done. A variety of different models of group intervention have been studied and empirically validated in the substance abuse treatment field, with less research on persons with co-occurring disorders

**FAMILY THERAPIES**

Family interventions are among the most powerful psychosocial treatments for both substance use disorders and psychiatric disorders. Research on persons with co-occurring disorders participating in integrated dual diagnosis treatment shows that the number of people using substances in clients’ social networks predicts a worse substance abuse outcome. However, despite the strong evidence documenting the effects of family work for substance abuse and (separately) for mental illness, very little research has examined its effects in persons with dual disorders. Although the reasons for this are unclear, it is possible that the challenges of working with families of persons with dual diagnoses are compounded by the fact that substance abuse in this population often results in the loss of family support and housing stability, and by the high rates of substance abuse in those family members.

**STRUCTURAL INTERVENTIONS**

Structural interventions involve changes to the health care system by which mental health and substance abuse services are delivered, such as case management models or day treatment compared to less intensive outpatient treatment. Several studies have examined different approaches to case management for clients with dual disorders, although the nature of the comparison groups is markedly different across the studies.

**PROCEDURAL INTERVENTIONS**

Contingency management procedures involve the systematic provision of incentives and/or disincentives for specific behaviors of an individual for the purposes of modifying those behaviors and improving functional adaptation. There are several reasons why contingency management may be potentially beneficial for persons with a dual diagnosis. First, existing naturalistic contingencies impinging on persons with a dual disorder may inadvertently reinforce substance use behavior. Use of substances is often motivated by the pleasurable effects of substances, efforts to escape anxious or depressed mood states, in response to boredom, or to facilitate social contacts with others. Furthermore, financial entitlements may be used to support substance use habits, with evidence showing that substance abuse is greatest immediately following receipt of such funds.

**HOUSING INTERVENTIONS**

Substance abuse adversely impacts stable housing for persons with dual disorders and is strongly associated with homelessness. Clients who live in independent housing are particularly prone to relapses, and they appear to lose their housing due to several factors, not only relapses but also financial problems, disruptive behaviors, and absences due to hospitalizations or incarcerations. Furthermore, the provision of stable housing alone does not appear to reduce substance abuse severity. Therefore, integrated dual disorder and housing programs, or residential programs specifically tailored to address both mental health and substance abuse treatment needs, are increasingly common around the U.S.

**REHABILITATION INTERVENTIONS**

Many studies as well as self-reports suggest that dual diagnosis clients have difficulty attaining and sustaining substance abuse remissions without changing their lives considerably in terms of developing new relationships and activities that do not involve substance use. Rehabilitation interventions to address social and vocational functioning are therefore often incorporated into dual diagnosis programs, but there have been no studies of stand-alone rehabilitation interventions. The most relevant research in this area might be studies of supported employment, which often include many clients with co-occurring substance abuse. These studies show that dually diagnosed clients benefit from supported employment programs more than from other vocational approaches, and that they often, but not always, do as well as non-substance abusing clients. Moreover, a majority of clients in a long-term follow-up of supported employment reported that having a job helped them to reduce substance abuse. However, there is as yet no experimental evidence that supported employment or getting a job improves substance abuse outcomes.

**Two Psychological Models of Health Behavior**

**The Health Belief Model**

The health belief model (HBM; Becker 1974) was developed in the 1950s by a group of social psychologists working in the field of public health who were seeking to explain why some people do not use health services such as immunization and screening. The model is still in common use. There are four core constructs: the first two refer to a particular disease whereas the second two refer to a possible course of action that may reduce the risk or severity of that disease. Perceived susceptibility (or perceived vulnerability) is the individual's perceived risk of contracting the disease if he or she were to continue with the current course of action. Perceived severity refers to the seriousness of the disease and its consequences as perceived by the individual. Perceived benefits refer to the perceived advantages of the alternative course of action including the extent to which it reduces the risk of the disease or the severity of its consequences. Perceived barriers (or perceived costs) refers to the perceived disadvantages of adopting the recommended action as well as perceived obstacles that may prevent or hinder its successful performance. These factors are commonly assumed to combine additively to influence the likelihood of performing the behavior. Thus, high susceptibility, high severity, high benefits and low barriers are assumed to lead to a high probability of adopting the recommended action. Another factor that is frequently mentioned in connection with the HBM is cues to action (events that trigger behavior), but little empirical work has been conducted on this construct.

**Stages of Change (Transtheoretical Model)**

The Stages of Change (SoC) model (also referred to as the Transtheoretical Model) (Prochaska 1979; Prochaska and DiClemente 1983; Prochaska et al 1992) is a widely applied cognitive model which sub-divides individuals between five categories that represent different milestones, or ‘levels of motivational readiness’ (Heimlich and Ardoin 2008: 279), along a continuum of behaviour change. These stages are (i) precontemplation, (ii) contemplation, (iii) preparation, (iv) action, and (v) maintenance (see Table 3 for a summary). First developed in relation to smoking, and now commonly applied to other addictive behaviours, the rationale behind a staged model is that individuals at the same stage should face similar problems and barriers, and thus can be helped by the same type of intervention (Nisbet and Gick 2008).

**References**

Rogers, R W, (1983). Cognitive and physiological processes in fear appeals and attitude change: a revised theory of protection motivation. In J T Cacioppo, R E Petty and D Shapiro (Eds), (1983). Social Psychophysiology: A Sourcebook (pp. 153–176). New York,: Guilford Press.

Marmot M, Siegrist J, Theorell T: Health and the psychosocial environment at work. Social Determinants of Health. Edited by: Marmot M, Wilkinson R. 2006, Oxford: Oxford University Press, 97-130. Second

Schwarzer, R and Fuchs, R, (1996). Self-efficacy and health behaviours. In M Conner and P Norman (Eds), (1996). Predicting Health Behaviour: Research and Practice with Social Cognition Models (pp. 163–196). Buckingham, UK,: Open University Press. AbstractPsycINFO | $Order Document

M. G. Marmot et al., “Health Inequalities Among British Civil Servants: The Whitehall II Study,” Lancet 337 (1991): 1387–1393.

J. M. Snowden et al., “Prevalence, Correlates and Trends in Seroadaptive Behaviors Among Men Who Have Sex with Men from Serial Cross-Sectional Surveillance in San Francisco, 2004–2011,” Sexually Transmitted Infections 90 (2014): 498–504.

N. K. Janz, V. L. Champion, and V. J. Strecher, “The Health Belief Model,” in K. Glanz, B. K. Rimer, and F. M. Lewis, eds., Health Behavior and Health Education: Theory, Research, and Practice, 3rd ed. (San Francisco, CA: Jossey-Bass, 2002), 45–66.

R. R. Lau, “Beliefs about Control and Health Behavior,” in D. S. Gochman, ed., Health Behavior: Emerging Research Perspectives (New York, NY: Plenum Press, 1983), 43–63.

MacLeod J, Davey Smith G: Psychosocial factors and public health: a suitable case for treatment?. J Epidemiol Community Health. 2003, 57 (8): 565-570. 10.1136/jech.57.8.565.

Martikainen P, Bartley M, Lahelma E: Psychosocial determinants of health. Int J Epidemiol. 2002, 31: 1091-1093. 10.1093/ije/31.6.1091.

Alloway R, Bebbington P: The buffer theory of social support: a review of the literatue. Psychol Med. 1987, 17: 91-108.

Wilson WC, Rosenthal BS: The relationship between exposure to community violence and psychological distress among adolescents: a meta analysis. Violence Vict. 2003, 18 (3): 335-353. 10.1891/vivi.2003.18.3.335.

acleod J, Davey Smith G: Psychosocial factors and public health: authors' reply. J Epidemiol Community Health. 2003, 57: 553-556. 10.1136/jech.57.8.565.

[U.S. Office of Disease Prevention and Health Promotion, Social Determinants of Health](https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health)

[Centers for Disease Control and Prevention, Social Determinants of Health](https://www.cdc.gov/socialdeterminants/)