MENTAL HEALTH PROMOTION IN NURSING CONTEXT

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Abstract: *The chapter focuses on mental health promotion and the nurses´ roles in primary, secondary and tertiary prevention of mental illnesses. We also present the results of the research on the opinions and attitudes of lay people on the issues of mental health promotion. Our objective was to find out if lay people consider mental health promotion and mental illnesses prevention to be important, and how their personal experiences with the mentally ill influence their attitudes to the issues and integration of the mentally ill into society. The analyses of the results indicate that the closer the interpersonal relationship between the subject and the mentally ill person is, the bigger interest in the information related to mental health promotion and mental illnesses is. The close contact also influences selection of the relevant information sources. Lay people more and more agree with the need of early integration of the mentally ill into society and their return back to home environment. Most of the subjects were interested in the psychiatric nurse roles in community.*

Key words: *mental health, mental illness, prevention, nurse, approach, lay people*

Health and mental health

Health is of an immeasurable value for individuals and their families. Every health improvement as well as deterioration is of a social significance. As Rovný et al (1995) present, health can be seen as a specific immediate status but also as a process with its dynamics. Very often there are differences in understanding health that can change by the influence of the previous experiences, self-expectations, perceptions of self-identity, self-reflexions and social status. Křivohlavý (2001) organises the theories of health in accordance with the fact if health is understood as a means to a specific goal or as a goal itself. Health is a source for everyday life, not a goal of life. It is a positive concept emphasising social and personal resources as well as physical capability. Keller (1997) defines a person as a social being whose nature is formed as a result of interactions with people in their presence.

Health is a basic, continually changing and developing issue; it includes complexly all physical, mental, social, spiritual, intellectual and environmental elements. Understanding health depends on the society and the level of its development. Farkašová et al (2005) quote the best-known definition of health proposed by the World Health Organisation (WHO) of 1974 that defines health as *"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"*.

Kozier et al (1995) quote Pender who, related to the presented WHO definition of health, speaks about three basic characteristics of the positive health conception:

- It reflects concern for the individual as a whole person, not as a simple summary of various parts,
- It places health in the context of environment,
- It equates health with productive and creative living.

The majority of definitions of health also suggest the need of mental health, mental well-being, and the ability of a person to cope with stress, to live in mutual social interaction with environment and communicate effectively. Many of them mention psychosocial scope of health.

Alons White, the American psychiatrist, in the period between the world wars emphasised the connection between the physiologic and psychological factors affecting health and the onset of the disease. His works led to realisation that mental and physiologic disorders can present the response to stresses, their understanding must be in connection with social factors (Janosik, Davies, 1996).

The definitions of mental health have extensive cultural, social and political consequences. There are historical evidences of the fact that the prevailing norms and approaches influenced the definitions of mental health already in the past.

The WHO characterises mental health "*a state of <u>well-being</u> in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*".

Mental health allows accomplishing the mental, emotional powers, finding and fulfilling the roles in social, school and work life. Good mental health supports prosperity, solidarity and social justice in the society.

Mental health promotion

Lehtinen (2004) describes several basic but very relevant reasons why it is inevitable to pay attention to mental health:

1. **Mental illnesses are common.** It is estimated that in the present approximately 20% of the adult population in the EU have problems with mental health. This number includes all the problems, not only the specifically diagnosed mental illnesses. In the adolescents, this percentage is estimated approximately at the same level. The incidence of mental problems in children aged 8-9 years is alarming in many European studies.
2. **Impaired mental health causes large economic burden.** It is related to high prevalence and initial onset in young age, combined with frequent chronic course of mental illness. These diseases were estimated to cost the EU approximately 3–4% GDP. Specifically as a result of productivity loss. Mental illnesses are the principal reason for invalidity retirement in many EU Member States.
3. **Mental illnesses are connected with increased mortality.** The risk of mortality in the patients with mental illness is several times higher than in population in general. The main reasons are suicides or violent death. Suicidal attempts exceed the deaths rates in car accidents. Apart from suicides, mortality is increased also

by the presence of somatic diseases intercurrent to mental illnesses. Impaired mental health affects physical health and vice versa.

4. **Mental illnesses are the source of enormous human suffering.** Anxiety, fear, desperation, depression and the feelings of guilt and shame can be subjectively experienced more intensively than any more serious physical pain.

5. **Mental illnesses easily lead to social marginalisation.** Mental illnesses often evoke the feelings of otherness in people, which cause consecutive stigmatisation and other negative attitudes leading to frequent discrimination. In many EU Member States, the services focused on mental health are of a second rate, especially in the area of financial resources. People suffering from mental illnesses are often socially marginalised. The resulting problems such as poverty, homelessness, criminality, alcoholism and drug addiction often lead to a very low standard of living and consequently to low quality of life.

6. **Mental illnesses negatively affect future generations.** Impaired mental health is not only the question of responsibility of the individuals but of the whole society. Special attention should be paid to children of parents suffering from mental illnesses. In their lives, they are exposed to the risk of the onset of mental illness much more frequently. Special attention should be also paid to children of parents who are addicted to drugs and alcohol because one of the frequent side effects of functioning of those families is child neglect or child abuse.

Role of nursing in mental health promotion

One of the specifics of nursing is the fact that it accompanies the individuals from their birth to death. Nursing should help the sick and the healthy to carry out activities for the benefit of health, recovery or peaceful death, which would be carried out by the individuals without assistance if they had sufficient strength and knowledge (Farkašová et al, 2005).

The World Health Organisation, the European Union, the International Council of Nurses and also the Slovak state, educational and professional organisations intensively address the position of nursing and nurses in care for health of the citizens. The determining principle of policy formation that is based on the new thought streams, is following the complex vision on facilitation of better health and quality of life of the European citizens and on contribution of nurses to its implementation (Farkašová, 2006).

The way of life, lifestyle of the individuals has a key position among the determinants of health. Alimentation, appetite, movement activities, smoking, alcohol drinking, sex life, stress, home and work environment are considered to be the critical elements of lifestyle. These attributes can positively but also negatively affect mental health. As Ondriášová (2005) suggests, the individuals are affected by psychological factors such as stress, conflict, frustration, various losses and life events for all their lives.

In mental health promotion, the role of nursing is to act as a role model by correct approach and action; to encourage and challenge people to spontaneously join their own mental health promotion; to advise them on how they can cope with stressful situations and to enhance the common social relationships; how to solve their emotional problems effectively; to teach them how to use health care in the scope of mental health effectively.

The changes in the society, the social issues, the risks resulting from specific lifestyles and the use of modern technologies in nursing process considerably influence the requirements for nurses in mental health promotion. Their role is extensive. It intervenes in every human development stage of life. However, the priority interventions are the early identification of the risk factors that can cause violation of mental health in any social environment, at home, work, school, and in community, and educational activities on how to eliminate these factors or reduce their effects. Five million nurses working in the European Region play the important role in improving health of the individuals, families and communities. They are the largest unified group of healthcare professionals, and often they provide the first contact with healthcare and social system, focused on the continual care and support of vulnerable and marginal groups in the population (Farkašová, 2006).

The role of nursing is also to become responsible and helpful in promotion and protection of mental health for the clients if those are not able, cannot or do not want to be responsible themselves. *The psychiatric nurses working in communities* should play the important role in mental health promotion. In the Slovak Republic, in the present, the nurses with specialisation in psychiatry work mainly in inpatient institutions. For the patients and their families, counselling rendered by the psychiatric nurses is the irreplaceable element of nursing interventions.

Nurses´ roles in mental health promotion in children and youth

As Pasquali et al (1989) present, the Joint Commission on Mental Health of Children already in 1969 defined several problems and factors that seem to act as the sources or precipitants for the development of emotional problems in children and youth:
1. Faulty life experiences and training.
2. Surface conflicts between children and their parents, problematic relationships between siblings, and adjustment difficulties in the areas of school, social relations, and sexuality.
3. Internalised conflicts of a deeper nature leading to neurotic responses.
4. Adjustment difficulties related to somatic diseases or handicaps.
5. Adjustment difficulties related to severe mental disorders such as psychotic behaviours and mental retardation.

Pasquali et al (1989) present that the first or the second of the above mentioned categories were the triggers in 80% children who need help. Diagnosis and acceptance of mental illness in children and youth is difficult. In the past, society ignored the fact that children could have problems related to mental health. Pasquali et al (1989) quotes Long (1980) who presents that the statistics show the rapid increase in the number of children who need immediate care related to the problems of mental health. Significantly low number of them receives necessary treatment.

Primary prevention in children and youth

In mental health of children and youth, the primary prevention focuses on identifying the possible risk factors. Pasquali et al (1989) quote Bumbal and Siemon

(1981) who define three risk areas the nurse should assess within the measurements of primary prevention:

a) Environmental factors,
b) Influence of parents,
c) Characteristic indicators of vulnerability.

Even in the adequate environment, children live with their internal world of uncertainty and worries which can be increased by sudden developmental tasks. The needs of children are met by their parents therefore parents education on child development can act as primary prevention. *"Many altered maturational patterns are created or worsened by unrealistic parental expectations. When parents do not recognize the time frame of development and growth in children, they either hasten or impede processes that may already be within normal range"* (Janosik, Davies, 1996). The nurse must focus on parent education on normal growth and development of children. She must try to minimise the factors leading to the outset of impairment of mental health, or mental illnesses in children and youth. It is important to identify the groups which represent a big risk from the perspective of parental and family system. There is a close relation between the psychological environment of a child and the child´s psyche because the child's psyche is a product of strength in and out of the child (Hanzlíková et al, 2004). It is important to assess the reactions and responses of the child to the environmental stimuli, adequacy of parents´ expectations, the way of parenting, and the children-parent relationship. As Gabert and Kniebe (1993) say, the parents´ behaviour educates children. Dosick (1998) emphasises that education to values starts in early childhood, and includes everyday simple and seemingly automatic ways of behaviour.

The significant phenomena which affect modern children and adolescents include boredom. It is based on a lack of emotions, inability to sense the stimuli, and a lack of resilience. Bagio (1996), and Janosik and Davies (1996) present several ways of strengthening self-esteem and resilience in children:

1. Encourage positive benefits of interaction out of family and classroom regardless of its size.
2. Encourage decision making by offering appropriate options rather than ultimatums.
3. Give feedback in positive, not negative, term; never intimidate or humiliate when giving feedback.
4. Re-examine rules that children challenge or consider unfair. Even when rules are unchanged, re-examination confers feelings of dignity and self worth.
5. Remember that self-esteem and resilience in children are easily impaired, but are restored by consistent intervention that counteracts damage.

It is inevitable to estimate the effects of various factors of social environment. Hanzlíková et al (2004) quote Stanhope and Lancaster who describe the influence of family culture on child´s mental health. Pasquali et al (1989) are of the opinion that the nurses in schools and communities should have the key positions in observing children in social environment and family relationships. The children do not have to manifest only the obvious symptoms but they can be functioning in violated environment which is dangerous. The socioeconomic status of a family and interest in children are precedence. The inadequate diet, neglected appearance of the child, bad school results

and also aggression and bullying classmates often signal the problems of impaired stability in the family.

Low standard of living of the family is usually connected with alcoholism of one or, often, both of the parents. Children grow up with the feeling that nobody loves them. Quite often they are battered and consequently they become emotionally numb.

On the other hand, excessively commanding or hyperactive parents cause that children doubt of their own value. Commanding by parents causes that children start to perceive themselves and their own bodies incorrectly. In the period of adolescence, losing weight and self-control of eating are an attractive way how to enhance self-confidence. Strict diets, excessive exercising, or vomiting can lead to the impression that the person can control oneself and come closer to the dreamed-of ideal. For the short period of time, the adolescents enhance their self-confidence and create the illusion of success but it can lead to the serious illness – mental anorexia. Krch et al (1999) suggest that aversion to food is a manifestation of implacable and impaired attitude to body weight, proportions and obesity.

The big problem in children is abuse of alcohol and drugs along with the use of medicaments. Hanzlíková et al (2004) mention the fact that 5% of older school-aged children drink alcohol. This addiction is accompanied by gambling and criminality as well. Preventive measures are more effective if more institutions, including school, family, free-time activities organisations, healthcare services as well as media, influence children. As Vácha (2005) presents, a very frequent mistake of primary prevention is that it does not perceive drugs as a multidisciplinary problem. The nurses´ role should include organisation and coordination of preventive programmes in young school-aged children. They are only slightly effective if the target group belongs to endangered people with already present symptoms of risk behaviours (Okruhlica et al, 1998).

In mental health promotion, the nurses should focus on detection of suspect symptoms which signal the presented changes in child´s behaviours; they should suggest measurements and seek solutions for mutual cooperation with the families of problematic children; and try to eliminate inadequate behaviours.

In many countries, adolescents perceive the nurses as a reputable source of information and adequate advice. The nurses educated in the field of mental health can provide sufficient information on physical and mental changes which are normal in the period of adolescence.

Secondary prevention in children and youth

According to Pasquali et al (1989), the nurses´ role in secondary prevention in the scope of mental health includes the following:
1. Early identification of mental disorders in children and youth.
2. Seeking prompt and effective treatment to restore individuals and their families to optimum levels of functioning.
3. Assessment of negative community resources.
4. Expansion of appropriate community resources.

Stress in parents´ life can considerably limit providing permanent love to children. Small children can respond in various ways. In the scope of mental health very often they are anxiety, anger, fear, or problems with sleep, eating and elimination. The nurses´ role in secondary prevention in the scope of mental health is to provide the parents with the information on natural sleeping and eating patterns and on individual differences in their children. *"Shame tactics should be strictly avoided"* (Janosik, Davies, 1996). In secondary prevention, shaming and humiliating are unlikely to be effective; on the contrary, they can intensify the identified emotional problems. It is important for the nurses to show the parents the achievements of positive approach in improving the changes in child´s habits and behaviours. For many parents it is much more difficult to praise children than to lecture them. The nurses must be sure that the praise will not jeopardise parental authority or child discipline. Höschl et al (2004) consider solving the relationships and social problems within the families to be of great importance.

When solving the problems, for the adolescents it is important to meet the peers who have the same or similar problems. *"Programs for adolescents that are available include alcohol education in schools, counselling of youths in legal difficulties, and attention to adolescent drunk drivers"* (Janosik, Davies, 1996).

Tertiary prevention in children and youth

In tertiary prevention in children, Hanzlíková et al (2004) present three aspects:
1. Prevention from recurring incidence of health problems.
2. Prevention from health status deterioration.
3. Assistance and promotion in the adaptation process, in chronic illnesses.

Tertiary prevention should include the stimuli for continuing the interventions for children and youth that did not result in complete recovery within secondary prevention. The illnesses related to the behavioural disorders require special follow-up actions after hospital discharge. Within tertiary prevention, children with self-mutilation, eating disorders and drug or alcohol abuse need support in day-care centres. The adolescents should have the possibility to use assistance of the centres if their behaviour disrupts family life. The role of the assistance centres should be to prevent the recurring problems, possible return to drug abuse and committing minor offences or crimes.

Therefore, there are various nurses´ roles in tertiary prevention. According to Pasquali et al (1989), the nurses should continue in the individual, group and family therapy in the clients who suffer from the chronic behavioural disorder or mental illness. The nurses also have to identify the children, youths and families who demonstrate chronically impaired family relationships.

The objectives of tertiary prevention in mental health care for children and youth are to reduce the remains of long-term negative influence of inadequate family upbringing and the surroundings, and to prevent their recurring influence. In mental health promotion in children and youth, the activities of the nurses should focus on recovery of optimal functioning of families and their individual members.

Nurses´ roles in mental health promotion in adults

Kozier et al (1995) present that a family includes emotionally involved people. Emotional relationship is expressed also by mutual efforts in everyday activities. In many cases, the value system is influenced by family culture. The family value system determines also the perception of health promotion, especially mental health promotion.

A family can be an agent of health hazards. Many diseases are based on impaired family relationships.

In mental health promotion, the nurses´ roles should include promotion and improvement of healthy models of family relationships, and identifying what the individual family members think, what they say, and how they respond in various life situations. Pasquali et al (1989) quote Jones and Dimond who say that the nurses should focus on:

1. Potential sources of family stress.
2. Effective coping patterns for dealing with stress.
3. Lifestyle changes that can positively affect family vulnerability to stressors.
4. Changes in family roles. The roles need to be adjusted to the inevitable lifestyle changes.
5. Family strengths which may support family functioning.
6. Family weaknesses which may jeopardise functioning of the individual family members.

The most frequent sources of stress include: divorce, family violence, alcoholism, unemployment, homelessness, and genetic predispositions to disease, loss of a family member, excessive work requirements, and also workaholism. Lenczová (2005) states that the entrepreneurs spend up to 85% of their time at work. Their families suffer from bigger stress and orientation to consumptive way of life. Mental health can be negatively influenced also by bad eating habits, physical activities, or sexual life. To focus the activities of mental health promotion accurately, the nurses should see the family and its individual members holistically and in the context of all the levels. They also must know the potential factors endangering mental health and family functions in the individual periods of life.

Education, as one of the most important aspects of nursing, is a significant way of improvement of mental health and quality of life of the families and their individual members. The significance of educational activities of nurses can be emphasised by the fact that the present status of population in our country is not satisfactory (Závodná, 2005). The number of people addicted to drugs and alcohol is constantly increasing.

Primary prevention in adults

The age in which the person is considered to be adult is individual and it depends on evaluation of personality maturity. In general, the mature individuals are able to think realistically about their possibilities, tolerate opinions of the others, and adapt to the changes. They are responsible for all their decisions.

Especially in the young adults, the individuals tend to ignore the need of mental health promotion. They completely focus on the family and work.

As Pasquali et al (1989) present, the nurses´ roles in mental health promotion are to:

- Minimise the factors which may be predispositions for mental illness.
- Identify the risk individuals.
- Encourage young people to talk about their work-related problems and stress.
- Help identify the work plans and specify the strategies for their implementation.
- Help define the value of time for mental health of the individuals and their families.

Divorce is a strong emotional stressor and a rather common phenomenon in our modern society. The involved individuals usually become emotionally hurt, angry, anxious and depressive. As Křivohlavý (2002) presents, people can get to difficult situations if their self-esteem is threatened, if they fail to do something that they considered to be important.

The problems with physical battering and mental abuse, especially in women, are reported in all the social classes. As this problem is presented in the media, the battered persons, especially women seek protection and help from the professionals more and more often. The nurses´ roles are, through mutual open communication, to encourage the battered individuals to be able to talk about their problems, and to assist them in enhancing their self-esteem to be able to leave the stressful environment and to start new meaningful life.

The serious result of impaired mental health and emotional crisis is a suicide. *"In general, suicide results from the young adult´s inability to cope with the pressures, responsibilities, and expectations of adulthood"* (Kozier et al, 1995).

Ivanová et al (2005) quote the WHO that presents that about 1 per mille of population die every year as a result of suicide. The more serious is the estimation of suicidal attempts which is 15 times higher than the number of successful suicides. In suicide prevention, the nurses´ role includes detection of the problems which may lead to depressions, social isolation and decreased interest in social activities.

In middle-aged adults, altruism becomes more and more common. Kozier et al (1995) quote Robert Peck who believes that social and mental capacities tend to increase with age. People become interested in new hobbies and activities. Kozier et al (1995) present the opinion of Sheehy who says that middle life is as critical as adolescence. She describes the "midlife crisis" as the crises of "authenticity" in which the person realises the differences between the ambitions of young age and the real achievements. To promote mental health during midlife, the nurse should perform the following activities in the middle-aged adults:

1. Encourage them to do some of the activities they never had time to do previously.
2. Support them in accepting the changes of the period and adjusting to them.
3. Encourage them to pay attention to their appearance and to feel attractive.
4. Discuss their changing roles as parents. Many problems occur when their children leave home.
5. Emphasise the positive outcomes of maintaining old friendships and seeking new ones.
6. Discuss their role in the care of aging parents. Allow them to discuss the frustrations and concerns inherent in this role reversal.

7. Discuss their plans for retirement, and the need to have new hobbies and to spend their leisure time actively (Kozier et al, 1995).

The role of these activities is to assist in achieving realistic and achievable goals which affect mental health positively.

The period over 65 years of age is called late adulthood. The lifestyle and mental health of the elderly are to a large degree formulated in youth. *"Those who learned early in life to live well-balanced and fulfilling lives are generally more successful in retirement"* (Kozier et al, 1995). In many aspects, retirement is the change which can negatively affect mental health. These aspects include a loss of identity, a loss of power and privileges, and very often a loss of income. *"Another loss associated with retirement is the disruption or severing of friendships or associations with colleagues and fellow workers"* (Janosik, Davies, 1996). The changes can cause the feelings of anxiety, loneliness, refusal, anger, uselessness and sadness, or depression.

One of the most serious diseases affecting the elderly is the Alzheimer´s disease. Nowadays, the estimated 17–25 million people in the world are affected. In the European Union, the prevalence is 5.6–7.2% in adults aged 65 years and over, i.e. 3–4 million affected (Höschl et al, 1999). In mental health promotion, the nurses´ responsibility is to encourage the elderly to maintain their self-care and independence as long as possible while maintaining the maximal safety. The nurses´ role is to educate the caregivers of the elderly on the need of accepting their own values and beliefs.

In primary prevention, the nurse can explain the individual critical adaptation tasks related to aging to the elderly. Janosik and Davies (1996) describe five tasks:
1. Recognition of aging and its consequent limitations.
2. Redefinition of their physical and social life space.
3. Substitution of alternative sources of satisfaction.
4. Readjustment of criteria for self-evaluation.
5. Registration of life goals and values.

Reintegration of life expectations and goals necessitates revision of the aspirations and values of the elderly so that they can find meaning and purpose in their present life.

Addiction to alcohol or drugs is the serious problem which seriously impairs mental health in all the periods. It seriously influences morbidity, accident rates, disability rates, preterm mortality, suicidality and transmission of sexually transmitted diseases (Hanzlíková et al, 2004). Lenczová (2005) states that the number of the drug addicted patients up to the age of 24 years increased by 36% in men and by 28.8% in women between 1994 and 2003. The priority nurses´ roles in primary prevention of addictions are healthy lifestyle promotion, and educational activities with the goal of protection from substance abuse and complications resulting from the addictions.

Secondary prevention in adults

Secondary prevention includes early identification of the problems related to impaired mental health and possible mental illness.

During the interventions of secondary prevention, the nurse has to be aware of inadequate reactions of the relatives to mental illnesses. The family members seem not

to want to see the behaviours of their relative. Often they react only after warning from the co-workers, neighbours or friends. The closer relationship to the affected person is, the smaller readiness to interpretation of the person´s behaviour related to mental illness is. The most likely explanation is the depth of familiarity with the close person (Chromý, 1994). The family is often worried because of the shame that can occur after disclosing the mental illness of its member. They try to "cope with" the developed illness at home. This kind of reaction of the family is not adequate and it is dangerous for the mentally ill person and his or her environment. To prevent such negative reactions of the family members, it is inevitable for the nurse to obtain the necessary information on how the families perceive mental illnesses of their members.

The nurses´ role is to use the activities to promote effective functioning of the individual family members. In cases of occurrence of mental illness, the nurse should use the professional interventions to allow the fastest possible integration of the mentally ill back in the society. The practical and very effective approach to achieve this goal includes empowerment which can be used especially by the nurses working with the mentally ill in the in-patient facilities, but also in the surgeries or communities.

The mentally ill are not only the passive objects of the diagnostic, therapeutic and nursing efforts, but they are the partners of the nurse. However, the quality of nursing care cannot be based only on the good will, good temper or likes of the nurse. The patients must have adequate and reasonable information so that they can participate in decision-making. This new understanding of the patient-caregiver interaction is called empowerment; it can be characterised as a mutually beneficial process (Janosik, Davies, 1996).

Communicative interaction between the patient and the nurse must be open and it should serve the needs of the patient. In the past in nursing care for the sick, the attention was paid to subordination to the medical profession and to the control over many aspects of care. The rule was that the professional knew always best about everything. Empowerment destroys this traditional way of thinking. It requires equality and reciprocity in dealing with the patients and their families. The basis of the relationship is not in control and subordination, but in interactivity and mutual cooperation. The effective use of such a relationship can result in the bio-psycho-social change which enhances self-esteem and reduces negative reactions to stress. Empowerment develops if understanding is seen in the same way, and if the patient is offered the interventions which reduce his or her labelling and stigma resulting from the fact that it is a psychiatric disorder. Almost in every individual, the empowerment in social relationships is critical (Janosik, Davies, 1996).

Tertiary prevention in adults

Tertiary prevention should be focused on minimising the consequences of mental disorders and possible disablement. It provides adequate inclusion of the individuals, their families, friends, social groups, and communities in all the fields of health care, and thus promotes self-esteem and self-care (Salvageová, 1995). The nurse should use the educational programmes helping reduce the effects of chronic stressors on the family and its individual members and on the stability of the family system. The nurses should pay attention to the effective use of the potential of the risk groups of

patients, their family members and significant others; they should provide support in solving the problems which can occur after return from the in-patient facilities. Patient education must include promotion of the whole personality. According to Škrla and Škrlová (2003) it means that the nurse should be interested in the patient´s concerns, thoughts and feelings, i.e. not only in the physical dimension but also the mental, social and spiritual ones. The nurse supports the patients by assisting them to accept their new image, to find new meaning of life, and the right way.

Assistance and mental health promotion for caregivers who look after people affected by dementia are of great importance. They are focused on providing the information on how to facilitate care in home environment so that the process of progression is slowed, and the self-care and sufficient quality of life of their relative are maintained as long as possible. Adamczyk (2002) suggests that hope and trust provide mental energy to caregivers so that they are able and willing to persist in providing care. The nurse should prepare the caregivers for possible loss of their relative. The natural emotional response to the loss is sorrow which is inevitable for mental health. However, it can affect health negatively therefore the nurse should pay attention to the accompanying difficulties: anxiety, depression, dizziness, tiredness, headache, excessive sweating, sleep disorder; these can result in impaired mental health.

Providing information thoroughly is an inevitable part of tertiary prevention. It allows and helps identify the pathological and specific personal needs correctly. In education of the family members of the mentally ill, it is very important to emphasise that any mental illness is not the manifestation of weakness or a lack of will, but that it is a disease. Education plays the important role in improvement and promotion of mental health in the families, and it helps provide optimal functioning of the family members within the limits of the disease. As Janosik and Davies (1996) present, many professionals mention the fact that little emphasis is put on psychoeducation. It may be based on the opinion that the mentally ill cannot understand psychoeducational conception, and that they are not willing or capable to become responsible for themselves. *"However, some investigators using psychoeducation report greater compliance, reduced defensiveness, and greater self-esteem among clients who received formal instruction about the nature of their disability"* (Janosik, Davies, 1996). Španiel (2005) presents the fact that only the informed individual can make decisions completely and cooperate fully. The role of psychoeducation is to inform the ill on the nature of the disease, treatment, relapse and its prevention (Heretik, 2005).

Motlová et al (2002) present that the goal of psychoeducation is to provide the patients with the extensive and relevant information, to teach them the skills and to provide them with support. Praško et al (2005) emphasise the detailed information on inevitable medication use. Psychoeducation has been used in approximately a thousand patients and the hundreds of family members in Slovakia since 1997. The main objective is to help the families become responsible for their own health (Korcsog, 2005). The global strategy leads to improvement of mental health and well-being of the individuals, families and the whole society. The nurse should be aware of the fact that a family is always the first and significant place of the activities related to the mental disorder or impaired mental health. To function well, the family needs to have adequate information on the disease and adequate skills on how to manage the disease (Motlová et al, 2005).

The mentally ill patients are often neglected by their closest relatives. It is not only about external isolation, but also the internal one. They are denied the human approach especially in the mental level because it is seen, even before any attempt of deeper understanding, as ill and impaired, thus with distance and caution. Usually, everyone around imposes the condition: ´when you are normal as we are´. This approach forces the ill to stay the patient for the rest of life. On the contrary, to help the ill, it is to understand that the ill will be ´normal´, if they are understood and get really human attitude (Černoušek, 1994).

In tertiary prevention, the obtained data are the basis for planning and providing nursing care to the family as the whole. The main objective is reintegration of the patient into society or maintenance of self-care. This activity depends on the existence of rehabilitation workshops, day care centres, night care centres, sheltered housing, and community housing (Hašto et al, 1999). As Eikelmann (1999) states, occupational therapy plays a special role in the system of psychiatric rehabilitation. The community nurses should be significantly involved in the care in those facilities and they would spend most of time with the patients.

Mental health and community care

In the present, the community psychiatric care is the modern trend in the field of care for mental health and the mentally ill. Höschl (2006), and Breier (2005) present the community psychiatric care is the balanced, mutually linked hospital and non-hospital care which includes all the biological and psychosocial approaches. It is provided in the patients´ natural communities, as close to their homes as possible, without disturbing the original social ties, with the possibility of integration into the original community with the handicap resulting from the mental illness. As Hanzlíková et al (2004) present, the definitions of communities vary, but they also have the common elements: people, relationships, area, and basic ties. Křička (2006) defines the community care as the focus on all the basic needs of the client, not only the symptoms of the disorder; the support provided in the community care focuses on development of the patient´s capabilities. Based on this, the role of the community care is to positively affect the quality of life of the patients and their families. Janosik and Davies (1996) characterise the community as any group of people who live close to each other, have special interests regardless of the distance, work on the special common goal, or maintain the special values.

People with the serious mental illnesses require the continual and long-term care. The legislation changes in providing health care in the Slovak Republic aim to move the core of help for the patients affected by the mental illnesses to non-hospital care. Thus, the non-institutionalised care complements the pharmacologic care. It can help create the conditions for occupational and social rehabilitation, and decrease the negative effects of the disease. It is helpful in recovery of the social competences, facilitates the return of the patients to society, reduces the risk of relapse of the disease, and generally helps decrease the costs of treatment. The concept of the community which links the institutional with non-institutional care has its historical roots in the 1930s in the Netherlands. It was developed significantly in the 1960s in the USA and Great Britain (Dušek, Večeřová-Procházková, 2005). There is the developed network of

the community centres in Great Britain. The nurses are involved in independent work, provide nursing services and counselling, and receive the social reputation and prestige (Höschl, 2006).

The traditional elements of the psychiatric care which include the psychiatric clinics and inpatient departments are complemented by the new services in the community care.

- **Crisis services** are for the clients who require the acute psychiatric or psychosocial assistance. Marková et al (2006) define three groups of the clients who need it:
  - The patients with the acute mental disorder,
  - The clients without the mental disorder in the acute psychosocial crises,
  - The long-term mentally ill with the decompensation of mental condition.

These centres are able to perform the tasks of the psychiatric first aid and the initial intensive psychiatric care (Dušek, Večeřová-Procházková, 2005).

- **Mobile crisis centres** – the helpers act in the home environment of the patients who suffer from serious behavioural anomalies. As Marková et al (2006) present, the clients do not perceive their own mental condition and are not willing to seek help spontaneously. During home visits by the mobile centre workers there is hope that the situation is not as dramatic as it can be during the interventions with police assistance.
- **Partial hospitalisation programme** – the day and night care centres provide the therapeutic and rehabilitation services. They try to be the alternation of the psychiatric hospitalisation. They support active inclusion of the clients in the whole-day activities, and they are used as the rehabilitation programmes for the patients for easier and fluent transition back to ordinary life. The night care centres provide the services in the afternoons and evenings (Marková et al, 2006; Kafka et al, 1998).
- **Housing support** focuses on establishment and improvement of self-care activities, assistance with budgeting and paying bills, communication with the flatmates and neighbours, setting goals and their support, and support of the independence and the ability to manage the difficult situations. It focuses on the long-term interaction with the clients. The most common ways of housing support include: half-way homes, care at home, sheltered housing, and social housing (Marková et al, 2006).
- **Helplines** – the Slovak League for Mental Health has been active in the Slovak Republic for several years; it provides free telephone counselling about mental health, and help for people in the difficult life situations.

The non-traditional forms of care include the non-governmental organisations focusing on assistance for the mentally ill and their families. Their goal is to help the ill to cope with their disease, to provide the emotional and social support, and to improve their social status.

There are often differences in perceiving mental health, which can be changed by the influence of the previous experiences, self-expectancy, and perceiving the self-identity, self-reflexion and social status. The ability of the individual to join the society and to adapt to its requirements depends significantly on mental health. The interest

in the issues of mental health and mental illnesses is absent in many people. This fact is determined by a lack of the relevant information as well as the prejudices and stigmatisation of the mentally ill which still last in our society. As Höschl (2006) and Kafka (2004) suggest, the mental health care becomes the political priority in most of the developed Member States.

Attitudes of lay people to mental health promotion

We were interested in the opinions and attitudes of lay people towards the issues of mental health promotion. We surveyed the situation if lay people consider mental health promotion and mental illness prevention to be important. We monitored if the personal experiences with the mentally ill affect their attitudes to the issues and the integration of the mentally ill into society.

Material and Methods

We developed the *Questionnaire for Lay People* which included 20 items. Four of the attributes representing the questions were identification. The *gender* and *residence* attributes were alternative, and the *age* and *education* attributes were ordinally measured on the 4 and 5-point nominal scales. From the other 16 attributes corresponding with the base questions of the questionnaire, three attributes were measured on the nominal scale and 13 attributes were measured on the ordinal scale.

The cohort included the citizens of the Slovak towns.
The inclusion criteria: age over 18; gender: male, female; willingness to cooperate.
The exclusion criterion: healthcare education.
We distributed 1050 questionnaires; 95.9% questionnaires returned; $n_1 = 1007$ subjects participated in the research.

We evaluated the obtained data quantitatively and qualitatively with the use of the statistical methods. The psychometric analysis of the data was performed by the statistical methods with the use of the application programmes. The statistical processing was carried out by the algorithms used in STATISTICA Cz. v. 6, STATGRAPHICS centurion v. XV, and with the use of the statistical functions from MS Excel.
The dependence of the selected attributes was tested with the use of χ^2-*test*, and the *coefficients of association* – the Cramer´s coefficient of association (strength – relative intensity between the qualitative attributes; min = 0, max = 1) were calculated.

Results

We present the selected findings on the issues of mental health promotion and mental illness prevention related to the personal experiences with the mentally ill.
Gender: The cohort included n = 558 (55.41%) males and n = 449 (44.59%) females.

Age: The age group 18–29 years included n = 231 (22.94%) subjects, the age group 30–39 years included n = 188 (18.67%) subjects, the age group 40–49 years included n = 344 (34.16%) subjects, the age group 50–59 years included n = 205 (20.36%) subjects, and the age group 60 years and over included n = 39 (3.87%) subjects.

Education: The highest education obtained in the subjects was as follows: n = 22 (2.18%) basic, n = 300 (29.79%) apprenticeship, n = 313 (31.08%) secondary education finished by the school-leaving examination, and n = 372 (36.94%) university education.

Residence: The cohort included n = 654 (64.95%) subjects from towns, and n = 353 (35.05%) subjects from villages.

Descriptive characteristics	Attribute			
	Age	Education	Gender	Residence
Minimum value	1	1	1	1
Maximum value	5	4	2	2
Modus	3	4	1	1
Empirical entropy	1.436	1.175	0.687	0.648
Maximum entropy	1.609	1.386	0.693	0.693

Table 1: Descriptive characteristics for identification attributes

Descriptive characteristics	Questions – ordinal scale								
	Q1	Q2	Q3	Q5	Q6	Q7	Q8	Q9	Q10
Minimum value	1	1	1	1	1	1	1	1	1
Maximum value	5	5	5	5	5	5	5	5	5
Modus	5	5	1	4	4	5	4	1	5
Median	5	4	3	4	4	4	4	2	5
Lower quartile	4.00	1.50	1.00	3.00	2.00	2.00	2.00	1.00	4.00
Upper quartile	5.00	5.00	4.00	5.00	5.00	5.00	5.00	3.00	5.00
Distance	1.27	1.73	1.61	1.39	1.57	1.45	1.49	1.29	1.27
Herfindhal index	0.35	0.22	0.25	0.27	0.25	0.26	0.24	0.29	0.35
Redundancy	5.65	5.36	5.42	5.47	5.44	5.48	5.39	5.54	5.65
Minimum and maximum values	**Minimum**				**Maximum**				
Distance	0				1.998				
Herfindhal index	0				1				
Redundancy [nit]	0.000				6.915				

Table 2: Descriptive characteristics – the ordinal scale

Descriptive characteristics	Question Q4 – nominal scale
Minimum value	1
Maximum value	5
Modus	2
Empirical entropy [nit]	1.473
Maximum empirical entropy	1.609

Table 3: Descriptive characteristics – the nominal scale
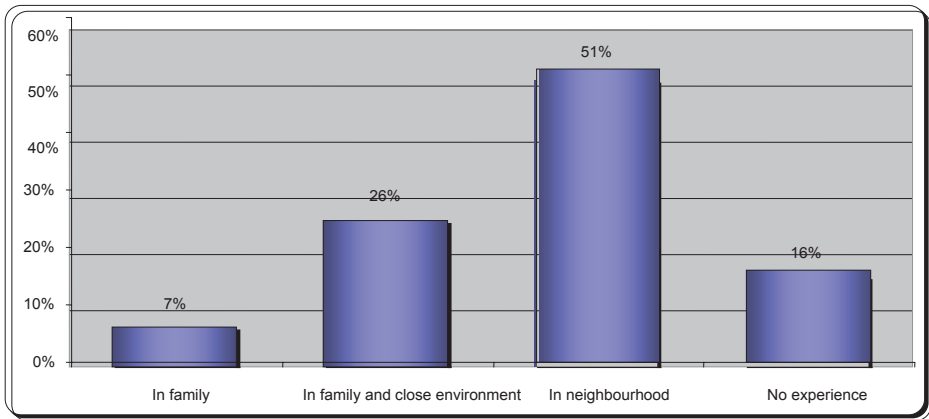
Graph 1: Personal experience with the mentally ill

The personal experience with the mentally ill was reported as follows: in family: n = 67 (7%) subjects; in family and close environment: n = 261 (26%) subjects; and in neighbourhood n = 516 (51%) subjects. No experience with the mentally ill was reported by n = 163 (16%) subjects.
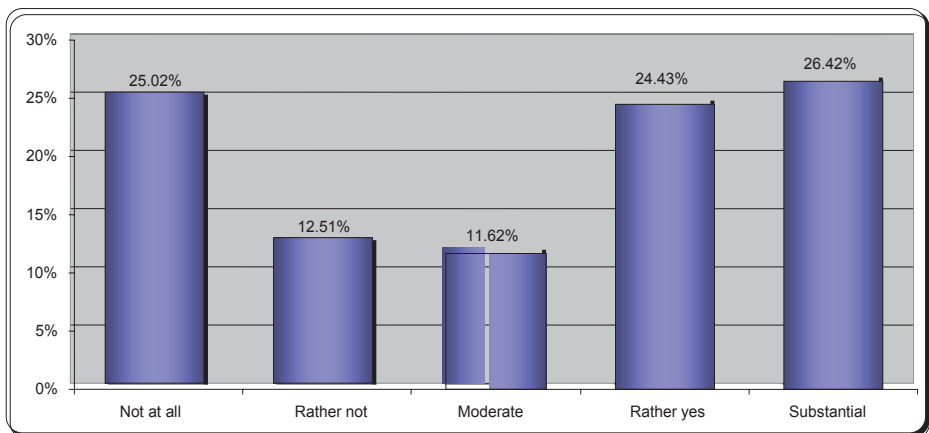
Graph 2: Interest in the issues of mental health

The interest in the issues of mental health was reported as follows: not at all n = 252 (25.02%) subjects; rather not n = 126 (12.51%) subjects; moderate n = 117 (11.62%) subjects; rather yes n = 246 (24.43%) subjects; and substantial interest was reported by n = 266 (26.42%) subjects.
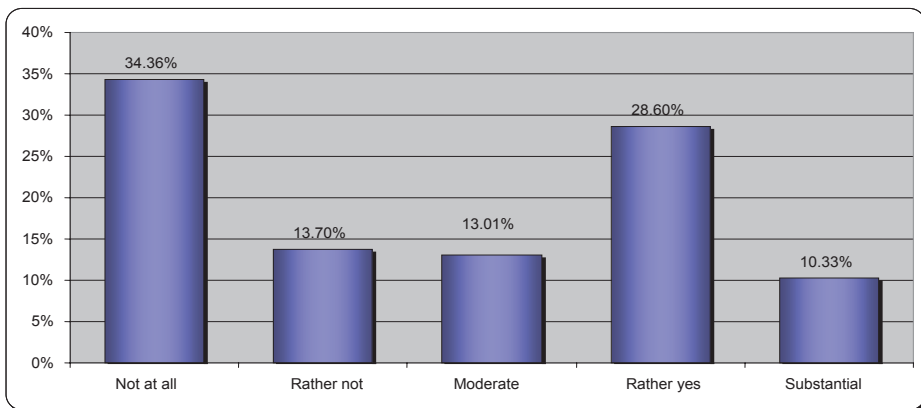
Graph 3: Interest in the issues of mental illnesses

The interest in the issues of mental illnesses was reported as follows: not at all n = 346 (34.36%) subjects; rather not n = 138 (13.70%) subjects; moderate n = 131 (13.01%) subjects; rather yes n = 288 (28.60%) subjects; and substantial interest was reported by n = 104 (10.33%) subjects.
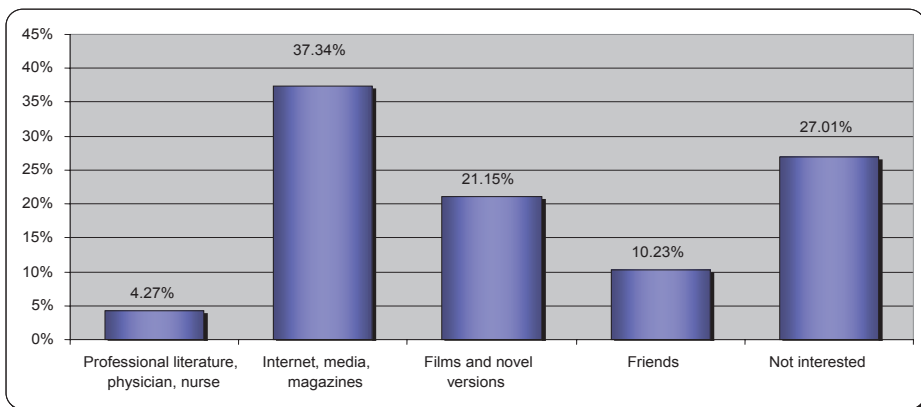
Graph 4: Sources of the information on the issues of mental health and mental illnesses

The sources of the information on the issues of mental health and mental illnesses included: professional literature, a physician and a nurse in n = 43 (4.27%) subjects; the Internet, media and magazines in n = 376 (37.34%) subjects; the films and novel versions in n = 213 (21.15%) subjects; and friends in n = 103 (10.23%) subjects. n = 272 (27.01%) subjects were not interested in the issues.
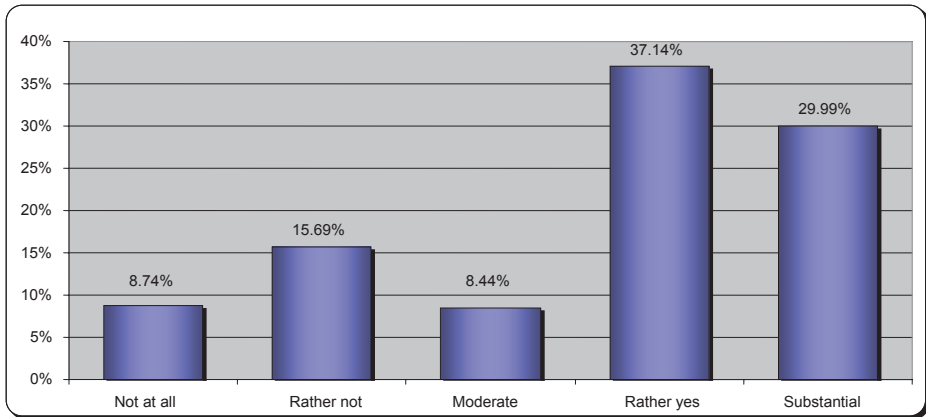
Graph 5: Importance of care for mental health

The subjects stated the importance of care for mental health as follows: not at all n = 88 (8.74%) subjects; rather not n = 158 (15.69%) subjects; moderate n = 85 (8.44%) subjects; rather yes n = 374 (37.14%) subjects; and substantial n = 302 (29.99%) subjects.
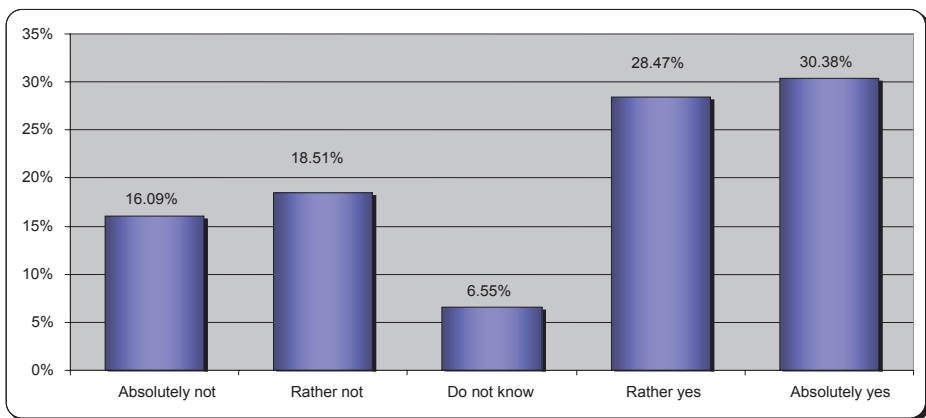

Graph 6: Seeking help of psychiatrist in case of mental problems

In case of mental problems, the subjects reported seeking help as follows: absolutely not n = 162 (16.09%); rather not n = 186 (18.51%) subjects; do not know n = 66 (6.55%) subjects; rather yes n = 287 (28.47%) subjects; and absolutely yes n = 306 (30.38%) subjects.
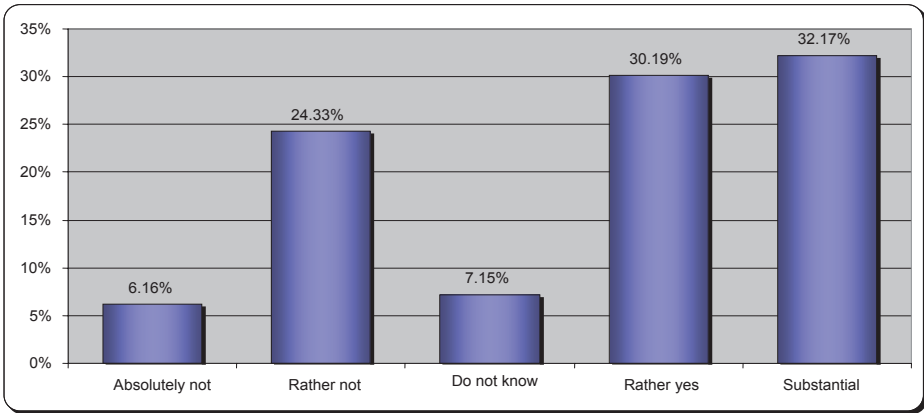
Graph 7: Effects of impaired mental health on incidence of physical symptoms

The subjects stated the possibility of the effects of impaired mental health on incidence of physical symptoms as follows: absolutely not n = 62 (6.16%) subjects; rather not n = 245 (24.33%) subjects; do not know n = 72 (7.15%) subjects; rather yes n = 304 (30.19%) subjects; and substantial n = 324 (32.17%) subjects.
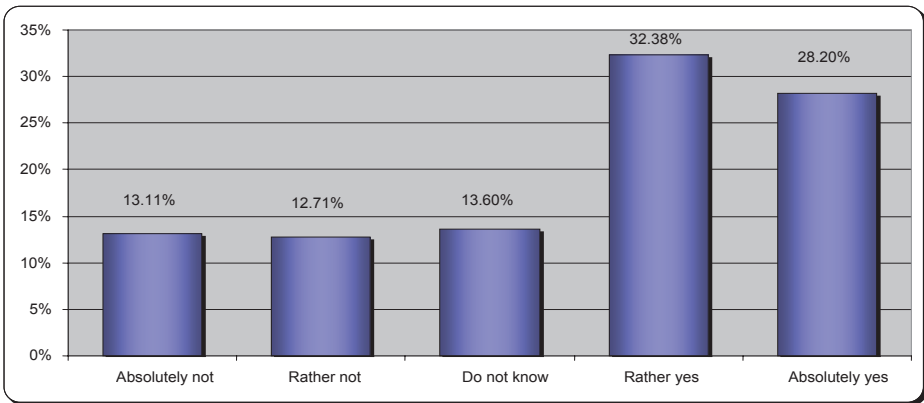

Graph 8: Integration of the mentally ill into social life

The subjects agreed with integration of the mentally ill into social life as follows: absolutely not n = 132 (13.11%) subjects; rather not n = 128 (12.71%) subjects; do not know n = 137 (13.60%) subjects; rather yes n = 326 (32.38%) subjects; and absolutely yes n = 284 (28.20%) subjects.
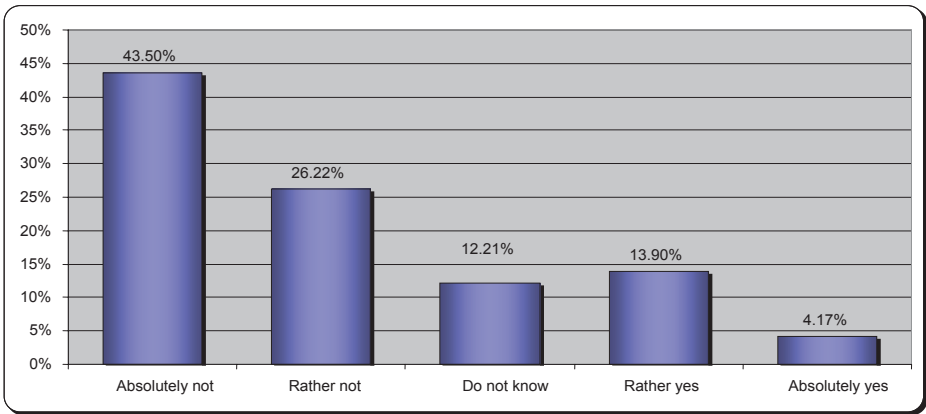
Graph 9: Long-term care placements of the mentally ill in psychiatric clinics

The opinions of the subjects on long-term care placements of the mentally ill in psychiatric clinics are as follows: absolutely not n = 438 (43.50%) subjects; rather not n = 264 (26.22%) subjects; do not know n = 123 (12.21%) subjects; rather yes n = 140 (13.90%) subjects; and absolutely yes n = 42 (4.17%) subjects.
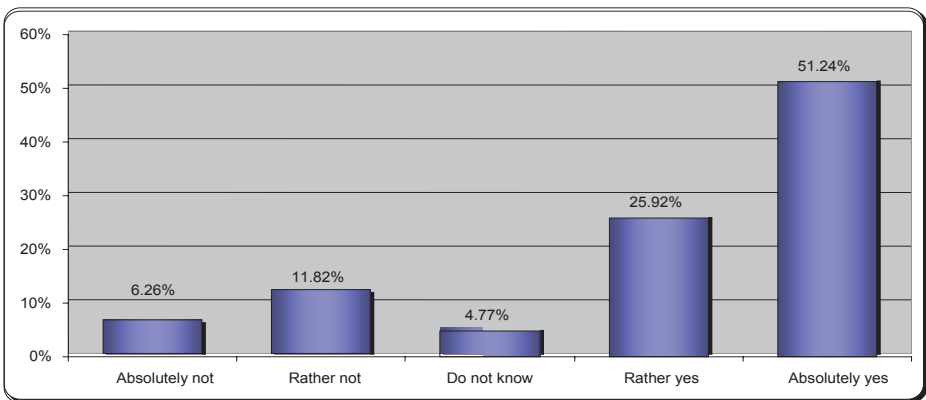
Graph 10: Interest in community psychiatric nurses´ role

The subjects reported the interest in community psychiatric nurses´ roles as follows: absolutely not n = 63 (6.26%) subjects; rather not n = 119 (11.82 %) subjects; do not know n = 48 (4.77%) subjects; rather yes n = 261 (25.92%) subjects; and absolutely yes n = 516 (51.24%) subjects.

Question	Cramer´s association coefficient	χ^2	P
2	0.2673	287.83	< .001
3	0.3089	384.32	< .001
4	0.3233	420.93	< .001
5	0.3619	395.57	< .001
6	0.3297	328.45	< .001
7	0.3046	280.28	< .001
8	0.2751	304.75	< .001
9	0.3290	436.01	< .001
10	0.1912	147.32	< .001

Table 4: Cramer´s association coefficients and results of χ^2 test

We analysed the data obtained by the questionnaire for lay people using the attributes 2, 3, 4, 5, 6, 7, 8, 9 and 10 as the tested attributes; and the attribute 1 – *personal experience with the mentally ill* was used as a categorisation criterion.

Dependence of the tested attributes is highly significant at $\alpha = 0.05$ level of significance. The values of the Cramer´s association coefficient indicate a medium dependence between the tested variables. There is a weak dependence between the variables in the question 10.

The presented results suggest: the closer the interpersonal relationship between the subject and the mentally ill person, the bigger interest in the information related to mental health promotion and mental illnesses. The close contact also influences selection of the relevant information sources. The subjects who had not been confronted with the mentally ill reported only the minimal interest despite the fact that the care for mental health may act as the factor of prevention.

As Höschl et al (2004), and Marková et al (2006) present, lay people usually classify mental illnesses as "nervous breakdown" or "complete madness", and feel they have enough information about mental disorders. However, when they face a mental illness in their families or close environment, they usually become interested in the information. Motlová et al (2005), Korcsog (2005), Španiel (2005), and Preiss et al (2007), who focus their works on the issues of influence of the interest and knowledge of the families on quality of life of patients, present unambiguous benefits of the information for improvement of quality of life of both the patients and their families. The families need to have adequate information and sufficient abilities to manage the disease to function well (Motlová et al, 2005; Praško et al, 2008). The subjects reported the programmes in media and the articles in the magazines as the sources of the information. We assume that this information is a popular science; it provides the information of preventive character, and it is focused on mental health, healthy sleep, relaxation, and stress prevention. The subjects also reported the films and novel versions about the issues as the sources of the information. Nowadays, in our opinion, media deepen the stereotypes and the stigma of the mentally ill. Fiction most often depicts the mentally ill as dangerous and violent persons. The subjects only minimally reported the

physicians and nurses as the sources of the information despite the fact that education is included in the list of the activities in the statement of work. The information by the physicians and nurses was common in the subjects who had the mentally ill person in their families; therefore we assume it was targeted education.

Höschl et al (2004), Pečeňák (2005), Marková et al (2006), and Fričová (2008) present that mental illnesses are stigmatised in the society. Admitting mental problem can cause the feelings of shame and the risk of rejection by people. Most people keep mental problems to themselves. Fear of being labelled by mental illness, being excluded from the society, or losing the job prevent many of the affected from seeing the psychiatrists or psychologists. We assume that the answers of the subjects were affected by these facts. However, we noticed significant differences in opinions of the subjects who had personal experiences with the mentally ill in their families or close environment who would seek help of the psychiatrist in case of mental problems. On the other hand, only 30% of the subjects without the personal experience with the mentally ill admitted the possibility they would actively seek help of the psychiatrist. Acceptance of the relation between the impaired mental health and the onset of the physical symptoms of diseases was significantly higher in the subjects with personal contacts with the mentally ill. The opinions on inclusion of the mentally ill in social life were also determined by personal experiences. The stereotypes of stigmatization persist significantly in the subjects with no experience with the mentally ill. More than 47% of them do not consider inclusion of the mentally ill in social life to be suitable, even though they had never had negative experiences with the mentally ill. More than 64% of the subjects with the personal experiences in their families considered inclusion of the mentally ill in social life to be suitable.

More and more, the society prefers the need of early reintegration of the mentally ill in society and their return to home environment. Even the subjects without personal experiences with the mentally ill consider the long-term placement of the mentally ill in the psychiatric facilities to be unsuitable.

In spite of the fact that the subjects obtained the information on the issues of mental health and mental diseases from the physicians and nurses only minimally, up to 75% of all the subjects expressed their interest in community psychiatric nurse activities. We consider the community psychiatric nurse activities to be important in mental health promotion and in prevention of mental illness. In our opinion, the community psychiatric nurses can significantly positively influence the opinions of lay people on the need of mental health promotion by their educational activities. Transferring the part of care for the mentally ill to the natural social environment would allow lay people to experience personal confrontation with the mentally ill in the community. As the findings in the study show, the personal experiences with the mentally ill change the attitudes, eliminate stigmatisation of the mentally ill, and increase the interest of lay people in mental health.

Conclusion

The National Programme for Mental Health (2002) creates and improves the system of care which allows effective enhancement of mental health, prevention of mental problems and freeing people with mental problems from isolation in the form

of social exclusion from community or deepening the dependence on the institutions, and thus creates the conditions for dignified life of people with mental problems as it is in the rest of population in community. The educated psychiatric nurses play the irreplaceable role in such the system of care.

PODPORA DUŠEVNÉHO ZDRAVIA V KONTEXTE OŠETROVATEĽSTVA

Abstrakt: Kapitola sa zaoberá problematikou podpory duševného zdravia, úlohami sestry v rámci primárnej, sekundárnej a terciárnej prevencie duševných ochorení. Prezentujeme tiež výsledky výskumu, cieľom ktorého bolo zmapovať názory a postoje laickej verejnosti na problematiku podpory duševného zdravia. Zisťovali sme, či považuje laická verejnosť podporu duševného zdravia a prevenciu duševných ochorení za dôležitú a ako ovplyvňuje ich postoje k danej problematike a k integrácii duševne chorých do spoločnosti osobná skúsenosť s duševne chorým. Analýzy výsledkov svedčia o tom, že čím je užší interpersonálny vzťah medzi respondentom a duševne chorým, tým je väčší záujem o informácie týkajúce sa problematiky podpory duševného zdravia a duševných ochorení. Tento úzky kontakt má vplyv aj na výber relevantných informačných zdrojov. Laická verejnosť sa stále častejšie prikláňa k potrebe skorej reintegrácie duševne chorých do spoločnosti a návratu do domáceho prostredia. Väčšina respondentov prejavila záujem o pôsobenie psychiatrických sestier v komunite.

Kľúčové slová: duševné zdravie, duševné ochorenie, prevencia, sestra, postoje, laická verejnosť