

3.10. Workshop: The impact of stressful life events on mental health

Chairs: Jutta Lindert, Germany and Lena Andersson, Sweden

Organizer: EUPHA section on Public Mental Health

Although significant associations of life events and violence along the life course with adult mental disorders have been documented consistently in epidemiological surveys, these studies generally have examined only stressful life event per study.

Objective

To examine the associations' life events with the first onset and course of mental ill health. The life events and determinants in our studies were highly prevalent and correlated. The stressful life events cluster (e.g. socio-economic situation, family violence, physical abuse, sexual abuse and neglect) were the strongest correlates of disorder onset. Associations over the life-course stage will be investigated.

Determinants of mental health in different age groups: results of a national representative survey

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Introduction

The distribution of determinants of mental health can vary with age. It was the aim of this study to analyse the association of different variables of mental health in different age groups.

Methods

The analysis is based on the data of the Austrian Health Interview Survey (AT-HIS) 2006–07 ($N=15\,474$ aged ≥ 15 years). The interviews were conducted face-to-face using CAPI (computer-assisted personal interviewing). The questionnaire was designed based on the European Core Health Interview Survey (EC-HIS) and was adapted to the Austrian setting by a national expert panel. As independent variable an indicator termed 'mental health' was built. This indicator consisted of 10 questions. In linear regression analyses the association of different socio-demographic and socio-economic variables external health resources and detriments and personal health resources and detriments and health behaviour and the mental health status were analysed in three different age strata (15–29, 30–59, ≥ 60 years).

Results

In subjects aged 15–29 years a significant association between mental health status and the co-variables was found to be psychological health resources with a standardized β of 0.60 ($P < 0.001$). In subjects aged 30–59 years there were significant associations found between mental health and income (standardized β 0.07, $P=0.11$), education (standardized β 0.09, $P < 0.001$), familial situation (standardized β 0.09, $P=0.002$), the social network (standardized β 0.09, $P=0.004$), physical exercise (standardized β 0.08, $P=0.001$) and with psychological health resources (standardized β 0.42, $P < 0.001$). In subjects aged ≥ 60 years, there was no significant association of any of the analysed covariates with the mental health status.

Conclusions

This analysis shows that in different age groups the mental health status is dependent on different health resources. While in younger psychological health resources have the highest impact on mental health, in middle-aged subjects influencing factors on mental health include socio-economic status, social relationships, familial resources and physical activity.

The contribution of psychosocial work stressors and non-work stressors to common mental disorders in the adult psychiatric morbidity survey (2007)

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Background

While associations have been established between psychosocial work stressors and common mental disorders (CMD), other non-work factors such as recent life events and low social support also show robust associations, indicating that CMD have multifactorial causation. To date, few studies have examined the combined influence of work and non-work stressors on CMD, and those which have tend to examine only one type of non-work stressor. The aim of this article is to establish the contribution of work-stressors to CMD, compared with non-work stressors using multiple measures of work and non-work stressors.

Methods

The Adult Psychiatric Morbidity Survey (APMS) 2007 is a stratified probability sample survey conducted among adults aged ≥ 16 years living in private households in England. CMD in the past 7 days were assessed. Work stressors were assessed using Karasek's Job Demand-Control and Siegrist's Effort Reward Imbalance models. Non-work stressors included recent life events, social support, discrimination, domestic violence, caring responsibilities, and financial strain. Preliminary logistic regressions adjusted for gender, examined the associations of the work and non-work stressors with CMD. Analyses were weighted to take account of non-response and survey design: working age participants were selected for the analysis.

Results

Non-work stressors including any life event, domestic violence, caring responsibilities, low social support and financial strain were all associated with CMD [odds ratio (OR) ranged 1.66–3.79]. Work stressors including high demands/high control, high demands/low control, and low demands/low control were associated with CMD (OR ranged 1.41–3.09); similarly, low rewards/high effort, high rewards/high effort, and low rewards/low effort were associated with CMD (OR ranged 1.82–4.78). Further multivariable models will be presented that examine the combined influence of work and non-work stressors on CMD.

Conclusions

The findings will further contribute to understanding and policy relating to the impact of the psychosocial work environment on psychological health.

Violence and life events in childhood and mental health as adults

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Background

Exposure to stressful life events violence and neglect are widespread among children. Stressful life events and especially neglect and violence are recognized to be important risk factors for common mental disorders (CMD) and for post-traumatic stress symptoms. Their prominence may vary across age groups and across men and women.

Methods

Prevalence and psychological impact of specific violent events in a German community sample of $n=486$ men and women aged 60–85 years. Socio-demographic, stressful life events and CMD and post-traumatic stress symptoms were disorder were ascertained through standardized questionnaires. Data collection was done from January 2009–July 2009 by face to face interviews. Bi- and multivariate regression analyses were done to describe the overall rates of violent life events in childhood and the prevalence rates of CMD and post-traumatic stress symptoms in late life while controlling for the effects of age and gender.

Results

Among the $N=648$ respondents were 52% female ($n=343$) and 48% male ($n=305$). A history of life events pertaining neglect and interpersonal violence in childhood was established (21.9%; $N=142$). Lifetime prevalence rates of CMD symptoms and post-traumatic stress symptoms. The prevalence rates were highest for neglect, humiliation and physical violence; lowest for sexual violence. The strength of association between life events increased the risk for CMD and for post-traumatic stress symptoms later in life even 40 years after the events. A dose response relation was found between the number of types of violence reported by the elderly and mental health scores for CMD and post-traumatic stress symptoms.

Conclusions

Neglect and violence are strongly associated with CMD and post-traumatic stress symptoms in late life; future research examining the effects of exposure to violence should include a wide range of violence experiences over the life course.

Associations between general self efficacy, barriers to care and self-reported mental illness—a population-based study

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Background

Mental illness is an increasing health problem globally. However, many individuals do not seek health care although evidence-based care is available. Research has shown that self efficacy is associated with various health outcomes and it is of importance to investigate if it also is associated mental illness. Early detection promotes recovery and decreases suicide risk.

Aim

The aim of this study is to investigate whether low levels of self efficacy is associated with a higher degree of mental illness and whether level of self-efficacy influence health seeking behaviour.

Methods

This is a cross-sectional study based on data from the Health Assets study, with data collected in 2008 in West Sweden. The study population is a randomly selected population sample of 4027 individuals, aged 18–65 years. Data collection was done by a postal questionnaire and the response rate was 50.4%. Bi- and multivariate analyses were employed to investigate associations and results were stratified on sex, age, civil status, education and social support.

Results

A total number of 1361 (36%) out of 3811 individuals answered 'Yes' on the question 'Have you ever felt so mentally ill that you had (felt a need) to seek care'. A total of 33% of the women answering yes were found in the lowest quartile of the general self efficacy scale, 20% in the highest quartile. Corresponding figures for men were 30 and 23% respectively. The most common reason stated for not seeking health care was a belief that the mental health problem would disappear by itself. Others reasons mentioned were beliefs that health care would not help, they did not know were to go or they felt ashamed for showing others they suffered from mental illness.

Conclusion

Mental illness is a serious health problem and access to care needs to be improved. Health promotion should also include individual traits/characteristics such as self efficacy and health-seeking behaviour.

3.11. Workshop: Migration and health in the European Union

Chairs: Bernd Rechel, UK and Walter Deville, Netherlands

Organizer: European Observatory on Health Systems and Policies and EUPHA Section on Migrant and Ethnic Minority Health

Migrants comprise a growing share of European populations. However, all too often their situation is compounded by immigration and citizenship regulations, socio-economic deprivation, cultural differences, language barriers and problems in realizing their human rights and in accessing health and other basic services. There is a need for tailored health policies, but robust data on the health needs of migrants and how best to meet them are scarce, partly because routine data on migrant health are only available in few European countries and understandings of who constitutes a migrant differ widely. Furthermore, the number of countries in Europe with well developed policies on the health of migrants is still small.

This workshop will start bridging this information gap by presenting preliminary findings of a European research project undertaken in 2010–11 by the European Observatory on Health Systems and Policies, the EUPHA Section on Migrant and Ethnic Minority Health, and the International Organization for Migration. The project brings together available evidence on the health needs of migrants in the European Union and how these can be met most effectively.

Particular attention is being paid to the health needs of the most vulnerable groups of migrants who also face the highest barriers to accessing services, such as asylum seekers, refugees, undocumented migrants and victims of trafficking.

The workshop will explore four key topics of migration and health in the European Union. It will start with a review of the legal rights of migrants to health care and their implementation. This will be followed by an analysis of migrants' access to health care. The last two presentations explore current migrant health policies in the European Union and examples of best practice of health care for migrants. The presentations will be short enough to allow for plenary participation and debate.

The right to health of migrants in Europe

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Background

Migrant health is receiving increasing attention worldwide. This is particularly the case in Europe, as demonstrated by legal, policy and practice developments that have occurred in