

GUIDELINES FOR THE PRIMARY PREVENTION OF MENTAL, NEUROLOGICAL AND PSYCHOSOCIAL DISORDERS

This is a version edited for the general public of WHO Documents WHO/MNH/MND/93.21-24 and 94.21, respectively on:

- [General principles for primary prevention](#)
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Division of Mental Health and Prevention of Substance Abuse

World Health Organization

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PRIMARY PREVENTION

What it is

It is estimated that approximately 500 million people suffer from mental and neurological disorders in the world. It is also estimated that a considerable proportion of those disorders could be avoided by using effective, affordable and simple methods.

The set of measures that help avoiding the appearance of diseases and disorders is called primary prevention.

PRIMARY PREVENTION REFERS TO METHODS DESIGNED TO AVOID THE OCCURRENCE OF A SPECIFIC DISORDER OR GROUPS OF DISORDERS

Primary prevention should be differentiated not only from treatment and rehabilitation, but also from health promotion, which specifically includes nutrition, housing, employment, and well being.

The present work is based on the following set of principles:

- a. Most mental and neurological disorders have multiple and interacting causes, with biological, psychological and socio-cultural components.
- b. Preventive action should have a wide array of targets.
- c. Preventive action should aim at Public Health level rather than individual level.
- d. Whenever a difference in frequency of a problem is found across comparable population groups, there is room for primary prevention.

Who does it

Most of the effective prevention of mental and neurological disorders falls outside the usual field of responsibility of mental health workers (in fact, in many cases outside the health sector altogether). What these workers usually do has

low - if any - preventive power, whereas what does have preventive power is usually beyond their professional mandate.

This, however, should not discourage mental health workers willing to work in primary prevention from doing so. It reminds us that perhaps some role modifications must occur, for instance, the enhancement of mental health workers' capabilities as advocates and advisers to professionals in other sectors, in relation to some interventions and results specific to their domain. What matters is not so much the mode of action of the agent, the venue in which it is applied, or the academic discipline of the practitioner, but the effectiveness of the preventive measure.

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MENTAL RETARDATION

The problem

Mental retardation (MR) is a disorder characterized by a significantly low intellectual functioning, with deficits in social and emotional functioning with its onset before the age of 18 years. The disorder is found in different degrees of severity, from a borderline through to a very severe form.

Its frequency

It affects some 110 million people worldwide; despite the lack of definite information, it seems to be more frequent in developing than in developed countries. Men seem to be twice as much affected as women, and the highest frequencies are usually found among school-age children.

<p>MENTAL RETARDATION AFFECTS MORE THAN 100 MILLION PEOPLE WORLDWIDE</p>
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Its causes

MR is caused by or closely associated with several factors, such as genetic factors (e.g. Down's syndrome or phenylketonuria), prenatal factors (e.g. rubella in, or alcohol abuse by a pregnant woman), nutritional deficits (e.g. iodine deficiency), infections (e.g. meningitis), intoxications (e.g. by lead or mercury), or brain trauma (e.g. traffic accidents).

One solution: prevention

Many cases of MR can be prevented by using simple, affordable methods. Among the most cost-effective interventions for the prevention of MR we can include: prenatal counselling, new-born screening, iodine supplementation, immunization against and prompt treatment of brain infections, and environmental and traffic control.

<p>MENTAL RETARDATION CAN BE PREVENTED BY SIMPLE, AFFORDABLE METHODS</p>
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Who does it

These interventions can be applied by a variety of people with different levels of responsibility working at distinct places. Health workers - at central and local levels - probably can carry out most of these interventions; other people, however can also be very efficient in this respect, particularly women's and other civic associations, traffic authorities, teachers, journalists, officers in charge of environment control, politicians, etc. Some of these activities are planned and implemented at a central level, others are planned at a central level and implemented at local level, while still others can be planned and implemented at local level.

A. IODINE DEFICIENCY

The problem

Deficiency of iodine in the normal diet is a cause of MR in both developed and developing countries. The mental impairment due to iodine deficiency is part of a spectrum of the effects of iodine deficiency on growth and development.

**ONE BILLION PEOPLE WORLDWIDE
ARE AT RISK FOR IODINE DEFICIENCY**

Its frequency

It is estimated that approximately one billion people are at risk for iodine deficiency around the world. In Asia alone there may be more than 700 million, more than 200 million in Africa, some 60 million in Latin America and some 30 million in Europe. At least 6 million people suffer from severe consequences of iodine deficiency, including MR.

**SIX MILLION PEOPLE SUFFER FROM
SEVERE CONSEQUENCES OF IODINE DEFICIENCY**

Its causes

Iodine deficiency first decreases the functioning of the thyroid gland. During fetal life brain development is particularly vulnerable to hypothyroidism, which can result in severe MR.

**ALL CASES OF MENTAL RETARDATION DUE TO
IODINE DEFICIENCY COULD BE PREVENTED**

One solution: prevention

In iodine-deficient areas iodine must be supplemented. To this end the most used measure is the iodization of common cooking salt. When a prompt correction of iodine deficiency is needed, it is possible to administer iodine individually to subjects at risk, orally or by injection. With such prophylactic measures all cases of MR due to iodine deficiency could be prevented.

Who does it

Salt iodization will usually be the major preventive intervention. This requires the full participation of many groups concerned with salt production, marketing and consumption, both in the governmental and private sectors. An active role of national and regional sectors however, is needed to achieve this aim. When iodine has to be administered individually the active involvement of the health sector is required. Finally an effective educational preventive programme is important to make all interested parties aware of the risks of iodine deficiency and its correction.

B. DOWN'S SYNDROME

The problem

Down's syndrome is a genetic, non-inherited condition in which MR is accompanied by a number of physical abnormalities. The face is characteristic: usually round, the eyes slant laterally upwards with a fold in the inner corner, the external ears are rather low and slightly simplified; in general, Down's syndrome people are shorter than the average with a tendency to obesity in later childhood and later life.

Its frequency

Down's syndrome is the most frequent of genetic abnormalities associated with MR. Between 10% and 32% of all cases of severe MR in developed countries, and a slightly smaller proportion in developing countries, are cases of Down's syndrome. Approximately one in every 2,000 live births is affected by Down's syndrome.

**ONE IN EVERY 2,000 LIVE BIRTHS
IS AFFECTED BY DOWN'S SYNDROME**

Its causes

PRIMARY PREVENTION

In human beings' cells there are 23 pairs of chromosomes, which are microscopic structures responsible for the transmission of genetic and sexual characteristics. Down's syndrome is found in people in which in pair 21 there are 3 chromosomes instead of the normal 2 (hence its other name: chromosome 21 trisomy). There is a well-established relationship between the occurrence of Down's syndrome and maternal age. The estimated risk of giving birth to a Down's syndrome baby for women aged 20-25 years is about 1 in 2000, whereas in women aged 45 years the risk is 1 in 30; for older women it is even higher.

In addition, it has been shown that there is a higher than normal risk of such a birth if the mother is very young (below 16 years of age) or if the father is aged 50 years or over.

Its prevention

The relation between the age of the mother and the risk of Down's syndrome indicates the clear benefits to be obtained by reducing the number of pregnancies in older women. This simple method of primary prevention could reduce the number of children affected with this condition by up to 50%. Therefore, careful birth planning represents the best preventive strategy in the case of Down's syndrome.

**BIRTH PLANNING IS THE
BEST PREVENTIVE STRATEGY
FOR DOWN'S SYNDROME**

In some countries, another possibility is the identification of cases of Down's syndrome during pregnancy by some sophisticated examinations of the liquid carefully taken from the pregnant womb. The identification of an affected fetus can allow, depending on national legislation, selective therapeutic abortion to prevent the birth of an affected child.

Who does it

Those working in family planning programmes are in the ideal setting for the prevention of Down's syndrome by discouraging pregnancies in women above 35 years of age.

Those working in the health sector, especially in maternal services, have the responsibility to provide educational information to women and couples about ways of decreasing the risk of giving birth to a baby affected by Down's syndrome. In developed countries, maternal health services have the responsibility of providing the special examinations to all pregnant women older than 35 years in order to allow the identification of affected fetuses.

C. FETAL ALCOHOL SYNDROME

The problem

Fetal alcohol syndrome (FAS) designates a situation in which a child with mental retardation, and characteristic abnormalities in the face, in the central nervous system and in the heart is born to a mother who abused alcohol during the pregnancy.

**ALCOHOL ABUSE DURING PREGNANCY
CAN CAUSE FETAL ALCOHOL SYNDROME IN
ONE IN EVERY 500 CHILDREN**

Its frequency

FAS affects approximately one in every 500 children born in Australia, Europe and North America, regions for which data are available. When we consider only mothers who abuse alcohol during pregnancy, then we find one child with FAS in every 30 live births, on average. Although no hard evidence yet exists, it seems that FAS is more frequent in some developing countries and among poor women.

**ALL CASES OF
FETAL ALCOHOL SYNDROME
COULD BE PREVENTED**

Its causes

FAS is clearly caused by alcohol abuse during pregnancy, particularly during the first three months of pregnancy.

One solution: prevention

At least in theory all cases of FAS could be prevented if women stopped abusing alcohol - or drinking it altogether - as soon as they become pregnant. At any rate, some well-conducted programmes have obtained a reduction of approximately half of the cases of FAS. The only efficient methods for the prevention of FAS involve public education, counselling and, in the extreme cases, detoxification.

Who does it

These interventions can be applied by a variety of people with different levels of responsibility working at distinct places. Since public education is probably the most efficient method for the prevention of FAS, community leaders - particularly those working with women's groups - teachers and journalists are in the best position to disseminate the information that can be provided by scientists and health workers. These workers can also be effective in individual counselling and in other interventions with more severe cases. Most of these activities can be planned and implemented at local level, although central coordination can be effort-saving.

D. PHENYLKETONURIA

The problem

Phenylketonuria (PKU) is a genetic disease characterized by the harmful accumulation of certain substances in the brain of the newborn due to an inability to adequately process a substance existing in the usual diet (a protein called phenylalanine). This accumulation inhibits normal brain development and results in mental retardation, in addition to other medical problems.

Its frequency

PKU affects approximately one in every 12,000-15,000 live births worldwide, on average. However, those figures can vary from one in 4,500 to one in 300,000.

Its causes

PKU is determined by genetic factors and as such cannot be adequately prevented. However, it can be identified before the accumulation of the harmful substances takes place, hence preventing the mental retardation associated with PKU.

**PHENYLKETONURIA CAN BE IDENTIFIED
AND ITS CONSEQUENCES PREVENTED**

One solution: prevention

The identification of children with PKU can be done with a drop of blood taken from the child's heel, during the first three weeks of life. If positive, the child must be put on a special diet that avoids foodstuff containing phenylalanine, the dangerous substance. This dietary management, when initiated before 4 weeks of age, is highly effective in reducing mental impairment in people with PKU.

Who does it

The prevention of mental retardation caused by PKU is done mainly by health workers. Paediatricians and other workers involved in birth attendance and child care play a major role, but health planners at central level carry responsibilities for establishing policies and conditions for newborn screening and for training the relevant personnel. In many countries neonatal screening for PKU is regulated by specific legislation.

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EPILEPSY

The problem

Epilepsy is a disease that presents a heavy burden on patients, their families and their country's economy. It is characterized by fits (seizures) during which there are loss of consciousness and convulsions, or brief movements or sensations that start suddenly and stop abruptly with or without loss of consciousness; some of the movements may look like bizarre behaviour. Although each fit lasts for only a few minutes, fits occur repeatedly, sometimes more than once a day.

Its frequency

It is estimated that there are approximately 50 million people with epilepsy world-wide, of which at least half are not properly treated or not treated at all. Given the lack of adequate treatment and support, the consequences of epilepsy are felt more severely in developing than in developed countries.

**EPILEPSY AFFECTS ONE IN EVERY 100 PEOPLE
IN BOTH DEVELOPED AND DEVELOPING COUNTRIES**

Its causes

Among the several causes of epilepsy the most important are genetic factors, birth asphyxia, infectious and parasitic diseases, and brain damage caused by alcohol, trauma and pesticides. Epilepsy itself is not infectious or contagious.

**INFECTIONS AND BRAIN INJURY
ARE COMMON CAUSES OF EPILEPSY**

The incorrect idea that spirits, or sins and wrongdoings by ancestors can cause epilepsy represents a serious obstacle to the prevention, treatment and rehabilitation of people with epilepsy and contributes to their stigmatization.

One solution: prevention

Most of the cases of epilepsy could be prevented. Activities that are part of routine primary health care are effective in reducing epilepsy. The following six steps are basic for the prevention of epilepsy:

SIX BASIC STEPS FOR THE PREVENTION OF EPILEPSY

**PRENATAL CARE
SAFE DELIVERY
CONTROL OF FEVER IN CHILDREN
REDUCTION OF BRAIN INJURY
CONTROL OF INFECTIOUS AND PARASITIC DISEASES
GENETIC COUNSELLING**

Who does it

Primary health care workers have a main role for the prevention of epilepsy. People in other sectors such as education and the media can also be very helpful.

Women's associations and other consumer associations - such as those involving people with epilepsy - have the important role of advocating for the promotion of preventive measures.

At any rate, once fits (seizures) occurs repeatedly treatment should be started as soon as possible and should be maintained at least for a period of five years without seizures.

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SUICIDE

The problem

Suicide is an act with a fatal outcome that is deliberately initiated and performed by the person himself or herself in the knowledge, or expectation, of its fatal outcome.

SUICIDE IS AMONG THE
TEN LEADING CAUSES OF DEATH

Its frequency

Suicide is among the 10 leading causes of death for all ages in most of the countries for which information is available throughout the world; in some countries it is indeed among the top three causes of death for people aged 15-34 years. On average it can be reasonably estimated that during one year approximately some 400,000 people commit suicide around the world.

400,000 PEOPLE COMMIT SUICIDE
EVERY YEAR AROUND THE WORLD

Its causes

There are several theories to explain why people commit suicide. Doctors link it to mental and physical diseases, whereas sociologists rather see it as being associated with socio-economic factors, such as political unrest and unemployment.

DEPRESSION AND ALCOHOLISM ARE
IMPORTANT RISK FACTORS FOR SUICIDE

People with some psychiatric disorders are the most vulnerable to the risk of suicide, and two disorders, depression and alcoholism, are associated with almost half of all suicides. Other vulnerable people are men, the elderly, those living alone, and those with some chronic, incurable physical illness. Previous suicide attempts are also associated with an increased risk of suicide in psychiatric patients.

MALE SEX, OLDER AGE, LIVING ALONE
AND THE PRESENCE OF PHYSICAL ILLNESS
ARE ALSO RISK FACTORS FOR SUICIDE

Who does it

Several people working in many different sectors, such as legislators and parliamentarians, police officers, car makers and gas supply officers, officers in the agricultural and environmental sectors, and journalists can all be effective in the reduction of suicide rates.

SIX BASIC STEPS FOR THE PREVENTION OF SUICIDE

TREATMENT OF PSYCHIATRIC PATIENTS
GUNS POSSESSION CONTROL
DETOXIFICATION OF DOMESTIC GAS
DETOXIFICATION OF CAR EMISSION
CONTROL OF TOXIC SUBSTANCES AVAILABILITY
TONING DOWN REPORTS IN THE PRESS

In addition to the above,, health workers have a major role in identifying vulnerable groups and providing them with appropriate treatment and help.

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STAFF BURNOUT

The problem

The expression Staff Burnout Syndrome was coined to describe a condition characterized by exhaustion, disillusionment and withdrawal in voluntary mental health workers. This concept has aroused considerable interest in all the helping professions, with the publication of a large number of papers and books. This suggests that burnout is a major problem in health services today.

**BURNOUT IS A MAJOR PROBLEM
IN HEALTH SERVICES TODAY**

There is no single accepted definition of burnout; however, there is agreement among experts that this syndrome includes three main dimensions, to be found among various caregivers, particularly health workers and family members:

1. emotional exhaustion;
2. depersonalization; and
3. a reduced feeling of personal accomplishment.

There are other dimensions which are commonly described:

- i. the phenomenon may occur at an individual or institutional level;
- ii. it is an internal psychological experience that involves feelings, attitudes, motives and expectations; and
- iii. it is a negative experience which highlights problems, distress, discomfort, dysfunction, negative consequences, or all of these.

BURNOUT = EMOTIONAL EXHAUSTION + DISILLUSIONMENT + WITHDRAWAL

Burnout involves physical, emotional and mental signs and symptoms. Physical exhaustion is evidenced by low energy, chronic fatigue, weakness, weariness, increased susceptibility to illness, frequent headaches, nausea, muscle tension, back pains, various somatic complaints, and sleep disturbances. Emotional exhaustion may involve feelings of depression, helplessness, hopelessness, increases in tension and conflicts at home, increases in negative affective states (e.g., anger, impatience and irritability) and decreases in positive states (e.g., friendliness, considerateness, courteousness). Mental exhaustion may involve dissatisfaction and negative attitudes towards oneself, towards work and towards life in general. Finally, an increase in work-withdrawing behaviours has also been noted (e.g., absenteeism and turnover).

Long-term effects of burnout

There are suggestions that early career burnout does not seem to lead to any significant, negative, long-term consequences. However, burnout occurring later in the career might have more serious long-term effects. In other words, health service workers can recover from early career burnout. Interestingly, some of the factors which help individuals to recover from burnout are the same ones which help prevent burnout: new work situations which provide more autonomy, organizational support, and interesting work.

Its frequency

It is difficult to make a precise estimate of the magnitude of the burnout phenomenon, because, as has been seen above, it depends on the interplay of a variety of organizational, environmental and individual factors. However, it has been stated that it may affect up to 30-40% of doctors, at a level sufficient to affect their personal or professional performance. Health workers with other qualifications and from different settings may also suffer from high rates of burnout.

**ALL TYPES OF HEALTH WORKERS
EXPERIENCE HIGH LEVELS OF BURNOUT**

Its causes

Most authors see stress, in one way or another, as the key factor in the development of burnout. It is, however, useful to

analyze causes of staff burnout according to the areas where preventive action can take place, i.e., job features, the organization environment and the individual.

Features of jobs in the health services

As seen above burnout is a phenomenon very common amongst the helping professions, although it is not restricted to them. There are specific factors related to these professions which may be responsible for the occurrence of the phenomenon. Other important factors are (i) inability to help an acutely distressed client and (ii) lack of observable progress with patients.

The very characteristics of the work with chronic, incurable and dying patients is particularly conducive to burnout. This is the case in working with people with chronic mental disorders and with AIDS patients.

RISK FACTORS FOR BURNOUT INCLUDE:
 CHARACTERISTICS OF HEALTH SERVICES
 ORGANIZATIONAL ENVIRONMENT
 INDIVIDUAL TRAITS

The organizational environment

Although no factor taken in isolation can be considered as a source of burnout, their interplay and the simultaneous presence of several of them (which is very often the case) can significantly contribute to causing burnout among health professionals. The following environmental and organizational factors in health services may cause stress:

1. role or case overload with few structured time-outs;
2. institutional disregard for the needs of patients in favour of administrative, financial, and bureaucratic needs;
3. inadequate leadership, supervision, or both;
4. lack of training and orientation specific to the job;
5. lack of a sense of impact on and control over one's work situation;
6. lack of social interaction and support among staff;
7. caseloads consisting predominantly of extremely difficult patients; and
8. majority of time spent on administration and paperwork tasks.

Perceived lack of control seems a particularly important risk factor for burnout. In fact, research has shown that therapists in institutional settings more frequently admitted feelings of disillusionment than did therapists in noninstitutional settings, including private practice.

Lack of social support has also been indicated as a contributing factor to the development of burnout. In addition, organizational climate, supervisor behaviour, and work group relations exert a direct influence on job satisfaction. In particular, an environment which allows the expression of views is favourable and leads to more open and supportive relations among nurses, which in turn reduces role ambiguity.

The individual

It has been suggested that some health workers possess personality characteristics that make them more prone to burnout. In particular, burnout has been associated with neurotic anxiety, unrealistic goals and expectations, and low self-esteem. Another important characteristic which affects stress reaction is flexibility. Flexible people tend to experience more stress associated with role conflict than do more rigid people, because the more flexible find it difficult to set limits and say "no" to extra demands. Also, research findings suggest that subjective perceptions of work may be more important than objective work conditions in influencing burnout.

One solution: prevention

It is possible to identify a few interventions which carry a great potential for prevention. These are based on careful observation of the daily routine of caregivers, on the one hand, and on results of techniques employed for treating or attenuating already existing burnout, on the other hand, which have relied heavily on techniques derived within the stress management field. Experience indicates that they are probably effective for the prevention of burnout, as well.

FOCI FOR THE PREVENTION OF BURNOUT ARE:

THE INDIVIDUAL EMPLOYEE
THE WORK GROUP
THE ORGANIZATION

Setting strategies, actions and interventions proposed for the prevention of burnout them depends greatly on a favourable organizational decision and their implementation is a task for whomever in the organization is in charge of personnel. Obviously the collaboration of other parties - such as staff counsellor, career development officer, staff's medical service, supervisors at different levels in the administration, staff association leaders, union leaders, as well as workers in general - is fundamental for an effective implementation of these interventions. *Individual and group interventions*

The availability and viability of organizational methods of coping with burnout are often matters of personal control. Employees in settings which offer few opportunities to exercise personal control over their environments are restricted to individual coping methods in the first instance. If they cannot control the balance of demands and resources inherent in the job, coping can only be a matter of developing a greater capacity to endure. Thus, time management serves as a means of gaining some control when interacting with demands from patients or co-workers. Relaxation and cognitive therapy methods increase a person's capacity to tolerate the impact of demands.

Team building also represents a useful way to avert or ameliorate burnout. Social support networks at work comprise co-workers from within the organization and employees of similar occupational groups employed by other organizations. Social networks are a medium for exchanging innovative ideas on managing tasks, coping with stress, and developing in a career.

The key principles for conducting successful mutual aid groups are:

- Ensuring that potential participants understand the reasons for forming such a group and agree with them;
- Ensuring that group members will participate actively in its development;
- Ensuring that group members select a leader whom they are willing to support in maintaining a productive focus;
- Limiting the size of the group to between 8 and 12 members;
- Promoting a structured group, rather than a process group, format.

Educational interventions include a variety of techniques which are designed to increase the coping skills of individual employees. Training approaches for addressing stress and burnout often include progressive muscle relaxation. The general purpose of these interventions is to increase the employees' capacity to tolerate the strains arising from the job. Not only will they then experience the job as more pleasant, they will cope more effectively in a relaxed state. Relaxation has particular relevance to burnout in that it ameliorates the experience of exhaustion and increases the capacity to interact effectively with service recipients.

RELAXATION
COGNITIVE THERAPY
TEAM BUILDING

ARE USEFUL WAYS TO PREVENT BURNOUT

Organizational techniques

Many proponents of organizational strategies view individual-based techniques as blaming the victim by concentrating on problems within individuals, overlooking stress factors beyond individual control. Alternatively, three organizational strategies can help in overcoming job stress and burnout among human service professionals: modifying the job, reducing stress through supervision, and organizational problem-solving.

The development environment comprises organizational systems for enhancing the skills and the career development of employees, including both learning intrinsic to the job and formal training opportunities. A strong development environment enhances feelings of professional efficacy and personal accomplishment; a weak environment engenders hopelessness and lethargy.

a) Modifying the job: Modifying the job provides one of the simplest and most powerful ways of reducing stress by lessening role overload, underload, ambiguity or conflict. It also allows flexibility to permit compatibility between

employees and their jobs (implies the value of effective human resource divisions in job placement) since a job considered as being stressful to one person might not be to another. These are ways to restructure jobs in order to reduce individual employee stress:

1. spread out the unpleasant work so that no one person or group of people have to shoulder all the burden;
2. arrange the day in order to alternate pleasant and unpleasant activities so as not to become overwhelmed by unpleasant tasks;
3. set aside time during the day for rejuvenative activities related to work e.g., reading;
4. encourage part-time employment - this has the potential of increasing the number of available human resources while providing flexibility in individual schedules; and
5. give staff members the opportunity to develop new programmes (fosters job spontaneity and creativity and overcomes boredom of routine).

MODIFYING THE JOB
SUPERVISOR DEVELOPMENT
SOLVING ORGANIZATIONAL PROBLEMS

ALSO PREVENT BURNOUT

b) Supervisor development: This strategy may help to modify supervisory behaviour while providing a sense of empowerment to rank-and-file workers. They help supervisors to become more open to suggestions and employees to feel that their opinions and suggestions are valuable. Feedback should be collected from subordinates through regular anonymous surveys at regular intervals (e.g. every six months). It combines meaningful structure and direction whilst providing support and confirming autonomy with a consultative supervisory style.

c) Organizational problem solving: One of the objectives of a quality improvement program is the recognition of the need to institute permanent, formal mechanisms to monitor internal work climate and deal with problems when they first arise. Holding regular meetings with employees focusing on problem-solving contributes to reducing the sense of powerlessness, role ambiguity and conflict while encouraging improved communication patterns within the organization.

CONCLUSIONS

Burnout syndrome has become a major problem faced by caregivers of people affected by chronic disorders, both staff and family members. As such, it compounds and aggravates the several difficulties health services meet in their daily functions.

Whereas the hardships created by some disorders cannot be completely eliminated, the burden they place on those who have to deal with them can indeed be alleviated by using a few simple and affordable measures. This is true both in the workplace and at home, where more and more care is expected to take place, with the shift from hospitals to community-based health care. Therefore, the implications of what has been discussed here should not be overlooked by health managers, particularly, for example, those involved in programmes of deinstitutionalization of mental patients.

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