

EQUALITY AND INEQUALITY IN HEALTH CARE: THE CASE OF MENTAL HEALTH

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Abstract: *This paper is based on the observation that some certainties in care and rehabilitation of mentally ill people have not been and are not yet sufficiently guaranteed; furthermore discrimination and inequalities are generated by a certain kind of science and politics. So we conducted a study at a Diagnosis and Care Psychiatric Service (DCPS) located in the South of Italy. We have observed and stated that some inequalities in care are redressed when dramatic situations must be coped with, so that the more the situation is dramatic, the more inequalities will be prevented. At the same time we have observed that in relation to some phenomena and etiologies, unlike others, inequalities in treatment do persist. Therefore we have worked out and developed a possible model to redress the imbalance, by drastically redesigning the agreements among public, private, para-private and social private services by means of innovative systems targeted to users and their families, rather than to facilities.*

Key words: *Mental illness, stigma, marginalization, citizen, family, resilience.*

Although the risks and contradictions of life go on being as socially produced as ever, the duty and necessity of coping with them has been delegated to our individual selves.

(Zygmunt Bauman 2007 p. 14)

1. Introduction. Some data: numbers, costs and inequalities in mental diseases

The WHO estimates that the "Depression" is destined to become the most frequent cause of illness in 2020; The European Union, comparing the statistical data provided by the member countries has estimated that 27% of the population suffers from a significant mental disorder at least once during their lives. Therefore, according to the WHO are approximately 400 million people currently suffering from mental disorders, or psychosocial

problems, especially associated with alcoholism or drug addiction. Depression is currently the fifth leading cause of death and disability in the world and, according to the WHO, the disease could reach second place by 2020.

The statistics show that women are more susceptible to depression than men, and on average, it's so for one in five women, compared to one in ten men. Additionally the depression, which affects 340 million people worldwide, can make its appearance several times in the course of a lifetime. As well as the depression are

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many other mental disorders, are considered to be particularly debilitating and covering approximately 1% or 2% of the general population.

The Italian population, compared with European average, shows a worse emotional state, as documented by a study which reveals that in the four weeks prior to the interviews only 33% reported not having felt deeply torn down (compared to 47% of Europeans) and only 16% demoralized and sad (compared to 35% of Europeans) (source: survey Eurobarometer 2010). 6.4% of the Italian population between 18-64 years complained during 2010 depressive symptoms in last two weeks. It's also useful to underline the correlation between mental illness and chronic diseases (it affects the 13% of the depressed people) and the fact that these people don't go to health personnel (only 33.8%) (source: study PASSI 2010). Mental disorders are 13% of the global

burden of disease, and only 4.3% is represented from unipolar depressive disorders. According to current forecasts, the depression will become the leading cause of disease by 2020. Unfortunately, although the data are so alarming, there is a wide gap between the need for care and that for treatment, with a range which varies between 76% and 85% in low-and middle-income countries and 35% - 50% in those with higher income (source: 65th world Health Assembly, 2012)

The socio-economic inequalities are particularly pronounced in cases of physical and mental comorbidities, mainly in evens of depression. All this further confirms a strong vulnerability of the health of population groups most economically disadvantaged, as you can see in the chart below aimed describing the comorbidities in patients with four common chronic diseases.

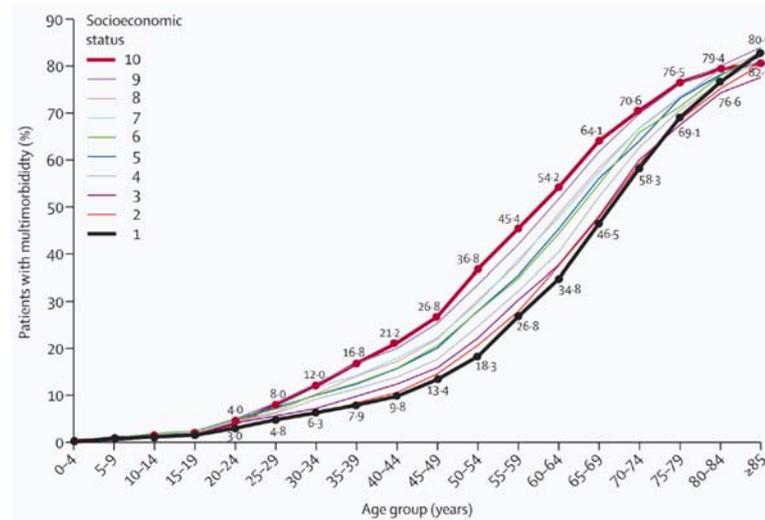


Fig. 1. *Prevalence of multimorbosità in relation to age and socio-economic status (black line: the richest, red line: the poorest).* Source Vick et. al 2012

It's shown that the condition of poverty is correlated with an increased risk of suffering mental disorders [23]. Epidemiological data resulted from studies in developing countries show that people with a low education level and low income is more vulnerable to common mental disorders (anxiety and depression), regardless to the society in which lives [11]. Additionally, appear to have a greater need for assistance women, youth and people living in a provincial/rural community; these same groups have a lower access to services [19]. Moreover an improper access to care for individuals with socio-economic disadvantage means less effective treatments [2].

Recently in *Social inequalities in mental health: results from the EU contribution to the World Mental Health Surveys Initiative* a group of the research was to provide updated data from ten European countries about the impact of social inequalities in the prevalence of common mental disorders. For this research in Europe, income seems not to be related to the prevalence of mental disorders. Unemployment and disablement are associated with mental disorders. Lower educational level augments the risk for mood disorders. Living in small (rural) areas decreases the risk for mood disorders and living in urban settings increases it. Although despite some contradictions with previous literature, in Europe there are social inequalities in the prevalence of mental disorders. However, income showed not to be associated with inequalities in mental health. Being younger, unemployed or disabled, with no education or incomplete primary studies, living in urban settings, and in Northern Ireland, Portugal or Belgium were associated to an augmented prevalence of mental disorders. Policy makers could

focus on mental health promotion and mental disorders prevention programmes for risk groups such as unemployed/disabled individuals. Support to vulnerable groups (unemployed or those with less education) and mental health literacy can improve European citizens' mental health [18]. Over the past ten years, studies realized in OECD countries for the detection of spending on mental illnesses have shown that the treatment of mental and behavioral disorders absorbs on average 9% of total health expenditure. It is estimated that in the United States overall spending for mental illness and substance abuse has amounted to \$ 121 billion in 2003, corresponding to 7.5% of overall health care cost [13], while in Europe this percentage varies from 2.5% to 14% [15].

In Italy, the average cost of a patient with a mental disorder that has at least one contact with mental health services is about € 2600 per year. The cost has a large variability linked to the diagnosis and stage of disease. In particular, a patient with psychotic disorder costs on average about € 5,400 in a year, while a patient with a non-psychotic mental disorder has an average annual cost of around € 1,700 [3].

The European Commission, gathered in February 2005 in Helsinki, Finland, for the first Ministerial Conference on Mental Health, has produced and disseminated ten years ago, a document on mental health named "Green Paper" [2005], with the intent to promote a debate that, in the various EU countries and among them, involving health professionals and social associations of patients and their family members, namely the so-called civil society. The Green Paper was the European Commission's response to the 2005 Helsinki WHO European Region Ministerial Declaration and Action Plan

for Mental Health. Greater visibility for mental health at an EU level can help challenge the low priority it receives in some European countries. Both the development of national policies and the level of funding for mental health services or initiatives have been disappointing across almost the length and breadth of Europe. Most countries now do have national or regional mental health policies in place. Some have a long pedigree, and are revised quite regularly, but others are rather dated and clearly in need of reform. (Paper Green, 2007, p. 13)

The Green Paper (page 8) proposes four priorities for an EU strategy:

- to promote the mental health of all;
- to address mental ill health through preventive action;
- to improve the quality of life of people with mental ill health or disability through social inclusion and the protection of their rights and dignity; and to develop a mental health information, research and knowledge system for the EU (Green Paper, p. 8).

In Italy the Act May 13, 1978, no. 180, marked the entrance of psychiatry in the National Health Service, removing it from the previous special discipline and restoring the dignity of the healthcare sector, with rehabilitation and therapeutic value. Moreover, this has represented a redefinition of the intervention based on the assumed social dangerousness of the patient with mental health problems and the hospitalization as a repressive measure [6].

This, too, sanctioned the closure of psychiatric hospitals and the establishment of mental health services for diagnosis and treatment (SPDC), as specialized units for the treatment of patients with acute psychiatric disorders within each general hospital, with no more than 15 beds dedicated.

Only with the National Project Objective 1998-2000 the protection of mental health was then initiated through a systematic reorganization of mental health services, with the establishment and implementation of the Department of Mental Health (DSM). It as represented a coordinating entity for ensuring the unity and integration of mental health services in the same area (CSM, the SPDC, day hospitals, daily shelter and residential facilities), and links with other services such as primary care, first-aid station, family counseling, social services and the services for children neuropsychiatry and addictions.

Nevertheless, it should be noted that the implementation of various attending articulations of every DSM a has given rise to a considerable heterogeneity in the care provision in Italian regions [16]. As a result, all answers to care needs are related to the organizational arrangements of the DSM. This explains, for example, the great variability in the rates of hospitalization for psychiatric disorders among the different Italian regions, with regard to both youth and adult patients.

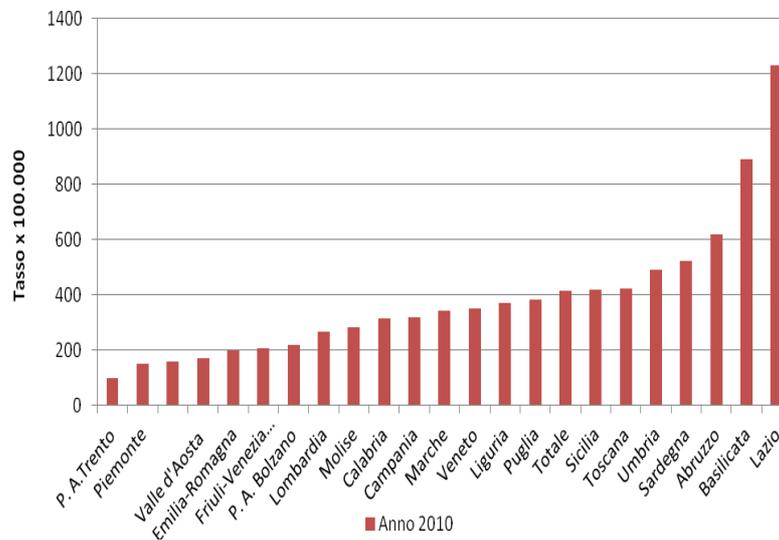


Fig. 2. Rate of hospitalizations for psychiatric disorders per 100,000 residents (> 17 years), Year 2010 - Source Istat

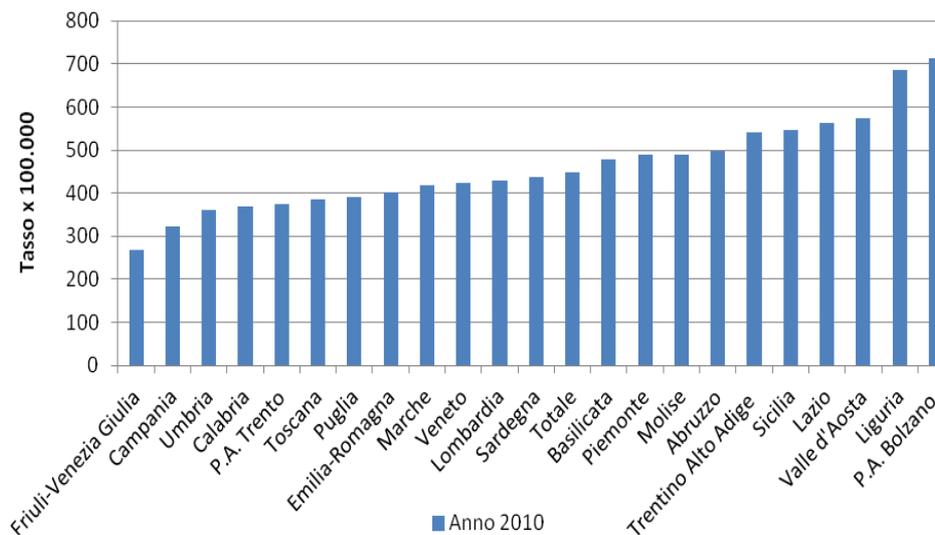


Fig. 3. Rate of hospitalizations for psychiatric disorders per 100,000 residents, Year 2010 - Source Istat

However, the rules and the reorganization of services for mental health involve, today as yesterday, same problems relating to: practice for hospitalization are too long and not suitable for an emergency or too shorts (7 days) to obtain improvements. From these

premises, we started to consider how to identify and remove the causes of mental illness not only strengthening prevention, diagnosis, treatment and rehabilitation, but also focusing on the concepts of accountability, agency, civil society, social capital, networks of relationships to

building a convenient social empowerment. In other words, the goal was and is to develop an operational plan to review the status of mental illness, to promote access to care, to identify barriers that prevent the integration of the sick, to suggest solutions in the field of sustainable policies and involve all possible stakeholders, from doctors to the associations of family members.

The approach to the psychological distress and mental illness, aware of social determinants and social implications of the problems, enhances sociability (display of aggregation, participation, solidarity, individual belonging to the local community) all elements which give rise changing hold from technical skills of social, educational and health services operating in the area.

Such an approach then joins the different actions whose objective is promotion of mental health, prevention and contrast of psychological and psychosocial distress as also all treatments of mental disease and enterprises against stigma and exclusion.

2. The context of the research

The object of study is at a Diagnosis and Care Psychiatric Service (DCPS) located in the South of Italy on the border between two provinces (look Picture, 4). We have observed and stated that some inequalities in care are redressed when dramatic situations must be coped with, so that the more the situation is dramatic, the more inequalities will be prevented. At the same time we have observed that in relation to some phenomena and etiologies, unlike others, inequalities in *treatment* do persist. Therefore we have worked out and developed a possible model to redress the imbalance, by drastically redesigning the agreements among public, private, para-private and social private services, making use of innovative systems targeted to users and their families, rather than to facilities.

In 2012, the search began at above which is presented in its utility and performance indicators primarily considering in the table below its of education and employment level.

Table 1

Diagnostic Groupings Cut-off: VGF e VSFL= 31 - 50/100*	Indicator: Level of Education		
	High school / graduation	Media Lower	Primary school
Psychosis (flare) (42%; N = 140)	(3%; N = 10)	(15%; N=50)	(24%; N = 80)
Personality Disorders (27%; N = 87)	(8%; N = 26)	(9%; N = 30)	(9.4%; N = 31)
Neurosis (25%; N = 83)	(10%; N = 33)	(12%; N = 40)	(3%; N = 10)
Organic disorders (6%; N = 20)	(0,9%; N = 3)	(2.3%; N = 7)	(3.4%; N = 10)
number of users = 330 (nr accesses = 507)			

Source our processing of SDO 2012

Table 2

Diagnostic Groupings. Cut-off: VGF e VSFL ² = 31 - 50/100*	Indicator: Level of Employment		
	permanently occupied	Belbelow busbusy	unemployed
Psychosis (flare) (42%; N = 140)	(5.6%; N = 20)	(18.2%; N = 60)	(18.2%; N = 60)
Personality Disorders (27%; N = 87)	(11.4%; N = 37)	(12.4%; N = 40)	(3.2%; N = 10)
Neurosis (25%; N = 83)	(7%; N = 23)	(13.5%; N = 45)	(4.5%; N = 15)
Organic disorders (6%; N = 20)	(1.8%; N = 6)	(1.2%; N = 4)	(3%; N = 10)
number of users = 330 (nr accesses = 507)			

Source our processing of SDO 2012

It may be noted that in the sample of 330 patients, 72 had a diploma as diploma and degree; 127 middle school and 131 primary school.

In the same sample only 86 patients have a stable employment, 149 have casual seasonal, concealed labour, and other 95 patients are unemployed.

There is a substantial diffusion of "personality disorders", emerging, both for the increase universally recognized, as for the choice of a service to pursue the reduction of the stigma. This aim "lightens" the diagnosis code but the evaluation is unequivocally ascribed to the axis of the categorical "psychosis" paintings.

This implies that case-mix complexity pertains needs a diagnostic caution: before classifying the "psychosis" (with all what that pre-intended the term implies) it's

necessary requires a monitoring, an ongoing control and a more reliable nosodromic confirmations

The users of the Service are mainly individuals whose average age is from 15 to 44 years for 73%, and sex is 56% for sample was female and 44% male.

This figures highlights the SPDC as a privileged observatory of diagnosis and treatment for both diseases at their beginning, as for diachronic exacerbations which, at this stage of life "matureational-productive" produce a greater incidence of symptoms production deficit, or generally susceptible to the behavioral response "hospitalization".

Looking at the tables n. 1 and n. 2 first remarks is that mental disorders are prevalent in more deprived social class; considering the most deprived social

² Rating scales of global functioning and social-work (VGF, Global Assessment of Functioning and Assessment of Functioning VSFL Social and Business): 31-40 = alteration of reality testing or communication or severe impairment in several areas of functioning socio- business; 50-41: severe symptoms or significant impairment in social and work behavior. Based on the severity of the clinical picture (cut-off) the inequality (Indicators: Education and Employment) is attenuated in diagnostic classes: Personality Disorders and Neurosis.

classes there is a reduction in the prevalence of neurosis and an increased prevalence of psychosis. Moreover privileged social classes will receive more psychotherapy, whilst unprivileged classes will receive only custody or pharmacological treatments. So persists what had been already detected by Hollingshead and Redlich in 1958.

This figure confirms the persistence of inequalities in events of mental diseases because high levels of social control will produce a greater use of services while social deprivation in areas with a reduced mobility will produce a lower utilization of services [4, 5]. Such a behavior will further undermine the status of social marginalization of individuals with behavioral disorders.

3. In what the drama of mental illness makes people equal?

Our survey, although focused on a reality not comparable with others as to size, geographical features, structural poverty and so on. In our opinion if inequality and unfairness persist during the treatment and care in accessing services, these same patients will turn again equal in their everyday life after a hospital admission for treatment of psychiatric, psychological, psycho-relational etc. Similarly the administration of semi-structured questions to some patients who assented our project pointed out some prejudices still active, beet-rooted and difficult hard to remove inside friends, family, colleagues in front of mental illness.

The survey was realized during 2012, and was administered a questionnaire to patients hospitalized in the SPDC. After that a first selection was made from the medical staff (psychiatrists, neuropsychologists) resulted 330 persons as verifiable from tables 1 and 2. Have

been indicated 210 patients, but only 103 have assented to our proposal of participation. This group of 103 patients was consisting of: 54 patients with medium-high level of education: 36 males and 18 females. Only 28 are employed at full time: 21 men and 7 women; 16 have irregular work: 15 males and one female; and the remaining 7 workers, all females are unemployed. 38 patients with middle school: 11 are males and 27 females. Out of these 38 patients, 36 are employed at full time and 2, both women, unemployed. They are mainly workers, and also saleswoman and concierge. Finally, only 11 patients with a primary school, all females, 6 employed as caregivers, family helpers.

As evident, people with higher levels of education was more willing to participate to research, and inside people with a lower level of education women were more present and available, evidence that the socio-cultural factors have a weight in the choices.

We received a confirmation of our hypothesis during some meetings with numerous relatives of patients and some talks with the doctors who continue with their therapies after hospital discharge.

The laws, practices and social norms in many nations give extensive powers to guardians of people with mental disorders; who can decide where their patients can live their movements, their personal and financial affairs, and their care including their commitment to mental hospitals [17].

As we shall see, however, the research has highlighted that clinicians and others, including family members, inaccurately judge what patients value resulting in unnecessary restrictions in their rights to work, education, marriage and participation in community or family functions.

The questions asked answer related to the following areas:

- a. relations: family, friends, feelings, neighborhood institutions (school, municipality, municipal police, church, local associations etc.);
- b. work;
- c. feelings: self perception, before and after hospitalization in SPDC (self-confidence, loss of confidence, fear of judgment, etc.).

Coherently with overall size of our paper, we will present briefly only some results. The most significant data that break down every idea of inequality inside ill in this disease is the fact that others, after a knowledge of their health status look patients apart from their educational qualifications, professional occupation, cultural capital, sex or gender.

97% or 100 out of 103 patients reports that the neighbors as well as friends started to avoid them and do not ask them any more information. Always of these 100, 41 reported that sometimes the neighbors refrain from taking the elevator with them.

40 reported that their neighbors avoid also a short walk with them in front of a common street in the municipality; 20 of these 40 are graduates, 15 have completed middle school and 5 elementary school

Among the 103 respondents only 48 have a stable love affair, as married or as common law couple. Of these, 34 reported that their partners don't more retain them sure from risks; 5 reported that their partners hide them some things, while 9 are deciding whether to part with.

In this case looking at 48, 21 have a degree average high and inside five 5 who reported that the partners don't more trust them, there is only one person who left school, while inside the others four 4 have a degree 3 and one a graduation.

Of the 70 respondents who work stably, 52 of them, 27 with diploma and degree, 19 with middle and 6 with upper middle school colleagues, but also employers are less sociable. The others 18 have noticed some

changes, without identifying an exact definition.

Besides 101 out of 103 reported that their birth family of, as well as their friends treat them in a less tolerant way than in the first days of their illness. Only two people, with diploma and family of humble origins, reported to have received a greater solidarity, help and comprehension.

As well as the relations with the other institutions are based on formality. 59 of the 103 respondents said that only before admission, and acquaintance of their disease were treated as persons with own rights.

Inside these 59, 36 have a high mean title, 28 a full-time employment while 3 have a work and occasional work, 5 are unemployed. Moreover 18 were middle school while all work. Finally, the five 5 with middle school are all unemployed.

Discrimination, therefore, towards people with mental illness persists and is a deep and ubiquitous phenomenon, which does not seem stratified, despite the closure of mental hospitals and the progressive development of a mental health service that takes care of the psychiatric patients in the community and aids in lowering the stigma against the mentally ill

The weight of discriminations due to mental illness, experienced in social areas "public" is still very present as compared to traditional gender discriminations related to mental illness. Psychiatric patient is denied identity as "relational subject" in sexual, friendships, family relationships. From this data we need to reflect on the specificity of the stigma against the mentally ill, with loss of status for which the discrimination, making the impersonal relationship centered on the dichotomy inclusion/exclusion override the value of individual differences and incite behaviors that increase the social distance [12].

The stigma towards mental illness is based on stereotypes as dangerousness, unpredictability, de-socialization attributed in part to its inability to comply with the rules and social stimuli but also to an apathy/abulia whose patients are considered at least partly responsible [14]. But the category of stigma is not sufficient to explain the social distance that occurs mainly in the most intimate and personal relationships (family, friends, neighbors). It is also determined by emotions in the unconscious interpersonal relationship, is what Scheff (1974) determines as the residual sum of squares of the unwritten rules of social relationships. However not everything coincides with discrimination or is reducible to sociological descriptions of manifest social interactions: it is necessary to consider the complexity of the experiences, the unknowability of most of the psychic dynamics.

Certainly we must consider that equality among people different for backgrounds and socio-economic status is also determined by perception of these respondents. More and less recent researches show that at every latitude and longitude people, with distant levels of socio-economic relationship perceived and perceive processes of stigmatization and marginalization.

The criticality of the subjective aspects related to low self-esteem of patients, an internal stigma described in terms of "self-discrimination", affects all classes and strata.

This process involves mutual expectations (negative and/disappointed) in interpersonal relationships rather than on the level of the bias, causing a downward spiral leading to a progressive de-socialization and featuring all the processes of stigmatization [21].

Therefore the fight against the stigma makes people with different socio-economic backgrounds equal in social relationships. This means that the socio-

economic status ruins cumulative knowledge (as levels of education, different cultural capitals, etc.).

Discrimination assimilates power, and social norms of the dominant culture, growing into dominion in front of asymmetry of interpersonal relationships.

Therefore, this idea of self-stigma is a process, that if on a level equalizes, on the other reinforces the stereotype of the mentally ill and the real difficulty of integrating this into everyday life. The perception of being mentally ill induces patient to social action adhering to the same stereotype. It's growing a sensitivity, and recognition and a culture of ex and in psychiatric patients witch produced a methodology of analysis of psychic facts (pathological or not) centered on narration and on the enhancement of subjective experience. This methodology imposed also to official perspective a qualitative analysis by which now it's necessary compare the data of the research evidence based medicine.

Recovery [8] concept is centrally in this perspective. It means that yesterday maybe again to day, forward of tomorrow. This process is enriched from awareness of own disease, utilities of care, significance of relationship with caregivers. This means too that together with what is still impossible to finish, there are others with functions, so are possible wishes satisfactions comparable opinions and an they life looking at future.

These perspective questions of medical concepts of diagnosis and healing, favoring construction of the concept of multifactorial psychic complex pathology, result of a crisis in which biological, psychological, and social relationships are intertwined and inseparable.

Awareness of mental illness in medical and patients enlarged the field, moving from observation by clinical to social rehabilitation. In this perspective is central

a process of accountability, agency and social empowerment, offering so authority and diffusion to new concepts and deriving from those new organization (associations, mutual help, etc.).

An analysis of inequalities, aware of social, political and economic organization and of power distribution, can foresee and share to promotion of a individual and institutional conflict against in inequalities. The binomial "accountability/agency" recognizes the indissolubility of information and its use, both at institutional and individual level, and at macro, meso and micro level. The accountability however, is not a sufficient element for institutions. Must show not only a responsibility of transparency in their actions and interventions, but must also stimulate health promotion and conflict stigma and prejudice. If the responsibility of the disease involves all levels, it's necessary a collective involvement which will render subjects of institutional action also protagonists of "accountability" and "agency".

This process must include as straight active subjects: patients, citizens and their social networks; become actors of the promotion of their care and rehabilitation.

Such a perspective of participation involves the concept of social ecology fractal, which voices intertwines social and biological characteristics [10], introduction to the knowledge of self-organizing systems and unbalanced of the globalized world.

4. Conclusion

The more we shall clarify the contradictions of our life, of existential pathways, of personal identity construction, of the sense of one's own life, by reviving relations that have been reduced to mere individuality by crisis, the more awareness of the mental illness and

the mentally ill as "relational subject" will be fostered by new dynamic juridical tools.

Narrating and referring to the lives of mental ill, giving voice to their feelings means an awareness of the absolute need to listen to the silent voices of their daily life in its relationship with related social dynamics, premise for recalling a new inclusive socio-sanitary model for mental ill.

Therefore, see Figure 4, we have worked out and developed a possible model to redress the imbalance, by drastically redesigning the agreements among public, private, para-private and social private services by means of innovative systems targeted to users and their families, rather than to facilities

A work has been realized in improving the abilities of social and health services to respond to changing social, labor and economic population structures and to an early recognition of mental health problems.

For this has been first of all shifted the focus on primary care to increase accessibility, prevention and early detection of mental sphere and socio-relational disorders. The general practitioner has so become the Primary Care form of medical care: he privileges a direct knowledge of the patient and a continuous responsibility of prevention and care outside hospitals. This medical strategy is an interface between SPDC, DSM, specialists of the mind and the local authorities. Similarly has been tried to enhance social capital produced by the resources offered to individuals from social relations and networks in their area.

Social networks, such as worker's sand mutual aid's associations, religious and sports groups, etc., constitute a safety net against every negative consequences of economic change [22]. Has been also sought to strengthen the participation of

every citizen patient to the activities of these groups / associations, because it has been showed that the perceptions of a

possible external help are associated with a better level of mental health.

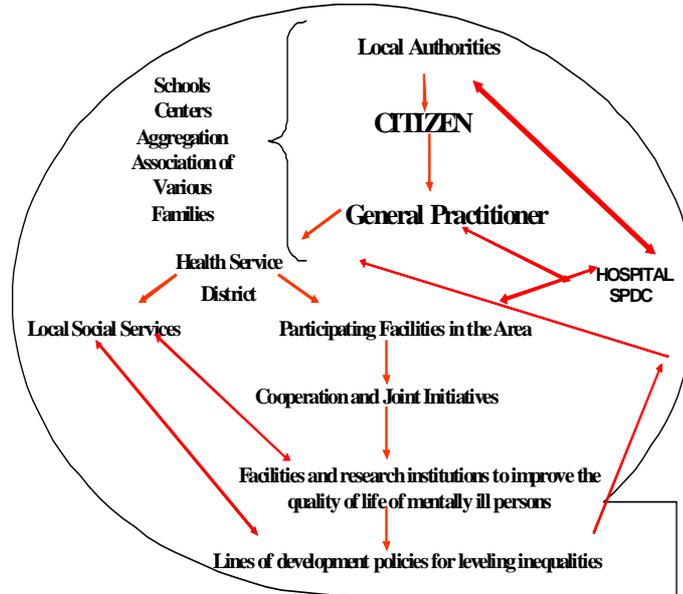


Fig. 4. Reorganization for a just equality of access and equality of opportunity to all citizens with psychiatric problems

In other words everything is expressed today with as in the literature on resilience explored below, the importance of the emotional and social dimensions of the lives and histories of individuals, families, organizations and communities emerges clearly. This suggests that mental health is a core element of health assets and that the skills and attributes associated with positive mental health confer protection. This might operate at the following different levels environmental capital: structural factors and features of the natural and built environment that enhance community capacity for wellbeing; social capital: norms, networks and distribution of resources that enhance community trust, cohesion, influence and co operation for mutual benefit; emotional and cognitive capital as resources that buffer stress

and/or determine outcomes and contribute to individual resilience and capability. [7].

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