Journal for Re Attach Therapy and Developmental Diversities
eISSN: 2589-7799
2023 July; 6 (7s): 441-450

Understanding the Social Determinants of Mental Health in the Elderly: Implications for Institutional Planning

Selvi S[1], Seema Singh Parmar[2], Saleem Ahmad[3]
[1]Associate Professor, Department of Finance, JAIN (Deemed to-be University), Bangalore, India
[2]Professor, Department of Psychitary , Teerthanker Mahaveer University, Moradabad, Uttar Pradesh, India.
[3]Assistant Professor, Department of Management Studies, Vivekananda Global University, Jaipur, India.

Received: 21-May-2023
Revised: 19-June-2023
Accepted:02-July-2023

Abstract

Introduction: The purpose of that investigation was to investigate the previously published socioeconomic factors of mental health amongst elder providers.

Objectives: The impact of certain socioeconomic variables on the mental health of the senior population is the focus of this purpose. For instance, researching the connection between depression and low poverty or the effects of social isolation on cognitive aging.

Methods: The evaluation of data and a methodical technique were both applied. The economic drivers of mental health were investigated using data from a variety of levels provided by the World Health Organization (WHO).

Results: Twelve publications were considered, and the majority of them indicated the various stages in physical health" as a factor related to mental health disparities towards older carers. Research on the gender-related, racial, and socioeconomic differences in carers' mental health.

Conclusions: To address mental health inequities, more study and transmission program on socioeconomic determinant of mental wellness between older carers are required. This study's implications might maintain elder carers' access to mental health fairness.

Keywords: caregivers, older adults, social determinants mental health, mental wellness

1. Introduction

Social determinants Mental health (SDMH) have emerged to the foreground as crucial strategies toward achieving health equality as the focus of health care shifts to place a greater focus on public health results and quality of care [1]. Health care consumption is one of the well-known triggers of suicidal conduct, and social variables are related to health in a variety of complicated ways that are crucial for understanding biological consequences [2]. Over the past forty years, a considerable enhance in the numeral of persons being held in mental facilities has been seen. Legislative variety or disparities in rates of severe mental illness cannot entirely explain these global variances and rises of involuntary stays in hospitals, and these causes remained unresolved [3]. Different social circumstances have a significant impact on how people live their lives and how inequality and shared experiences are created. On the other hand, people have the ability to conduct individual and group activities and make choices that have an impact on their life paths and results [4]. Adults in the community who were at least 18 years old were chosen for participation using a structured multiple proportionate random sample of the Taiwanese populace. Self-rated physical and mental healths were used to gauge general well-being [5]. As healthcare providers and patients deal with the sense of loss, loss of independence, and increased care demands, loneliness hazards may be of particular concern to those who are suffering from severe illnesses [6]. The Independent Living and Economic Responsibility Reconciliation Act give states more latitude in deciding how to treat non-citizens and whether they qualify for public programs [7]. The circumstances that dictate how people are formed, bring up their children, reside, work, and years of age, along with the systems put in place to deliver healthcare to a population [8]. The justification has been that people are free to decide what they eat and how active they want to be. Evidence demonstrates that this reasoning fails to adequately explain the variations in how health-related behaviors are distributed and that solutions based on this assumption are unsuccessful at

eliminating health behavior disparities [9]. A surge of healthcare sector activities focusing on social factors that influence of health has resulted from inadequate housing and food poverty, as well as growing acceptance of risk-based assessments Payment methods [10].

2. Literature Review

The study [11] discuss the convincing evidence demonstrating the wide-ranging effects of these processes, including how disparities in gender and strict gender stereotypes affect health through various treatments, behaviors related to health, to get to care, in addition to the manner in which gender-based health-care systems and develop disparities in gender, with grave implication for wellness. The research [12] goal is to draw attention to the consequence of planning for and defensive the psychological mental wellness of medical organizations, specifically consider the epidemic and the negative effects that difficult working conditions and instances of difficulty have on the mental health. A starting point, they present a general study of the improved risk of anxiety, fatigue, damage, sadness, strain, and between healthcares specialized. The research [13] of individuals between the ages of 12 and 25 who sought out early intervention services discovered a significant and persistent risk of progression to serious anxiety, mood, psychotic, or associated illnesses. Poorer social functioning, manic-like symptoms, psychotic symptoms, and disruption of the circadian were linked to the course of the disease. The author [14] throughout the research that these two associated ideas should be combined. By focusing only on loneliness, for examples, they fail to see the differences between older people who are socially isolated and lonely. Our discussion of older persons is divided into four categories: solitary which is alone; solitary in a group; alone and lonely; and not lonely. The study [15] was conducted to identify the things was obtaining consideration regarding this topic and why, particularly in light of how such beneficial impacts are generated, and to provide the supporting records for systems of organization that increase the mental health and wellbeing of healthcare professionals via workplace-based therapies. Research [16] studying sleep and mental health are becoming more aware of the requirement to modernize instead of just adding it to the overall daily "screen time" of one hour, the study for considerate the different public, exciting, and cognitive aspect of public medium use. They explore current issues in this industry, emphasize some recent improvements, and suggest next procedures. To understanding the social determinants of mental health in the elderly is crucial for effective institutional planning and providing appropriate care and support. Social determinants refer to the social and environmental factors that shape an individual's mental health and well-being.

3. Methodology

The approach consists of six stages: leading query, journalism explore, data assortment, and significant investigation of the study produced. To classify the SDMH, gather the pertinent data, and compile the elements, we employed the complex structure developed by the WHO. We used a methodical process and data investigation techniques to increase the precision of integrating several methodologies. The papers' admissibility was assessed using a systematic SPIDER methodology. Due to the qualitative character of this study, an SPIDER approach was determined to be an acceptable systemic approach to searching tool. Despite of the conventional United Nations classifications of "older" carers as those 60 or 65 years or older, we designated all those caregivers elderly 50 "older" caregivers. These pieces beyond the Western world, wherever older persons are occasionally considered as those over 50 years old, may have been overlooked if not for this.

4. Data extraction and synthesis

The research paper's system of assortment and favorite treatment stuff for The Prefer Report Item for Systematics Review and Meta Analyses approach (PRISMA) methodology were reviewed. Based on the inclusion factors, the first and last writers independently verified the paper titles and abstracts. The next step included reading abstracts from the papers the writers had chosen as being eligible. The qualifying papers from this category were chosen for the final step after the qualifying publications had been thoroughly reviewed. Before moving on to the following stages of this integrative study, differences over the articles that were selected were resolved via dialogue and group consensus. The investigators selected 12 publications for evaluation from 1,086 screened articles. Ten research studies (83%) and two meta-analyses (17%) appeared among those papers. As a result, the first author methodically gathered material from a selection of papers. Furthermore, when data was extracted, all research designs were handled identically. The data extraction and synthesis elements are listed in Table 1. In addition, the words "caregiver" and "family caregiver" were used

often in the publications under evaluation to describe carers. We'll refer to this person as a "caregiver" throughout the outcomes. Also included in the papers under consideration were caregivers who were "men," "women," "females," and "males." While the final two phrases allude to sexual orientation, which is socially created, both the initial and subsequent conditions often refer to gender, which is a physically determined element. We shall thus cite the very first source.

Table 1: Retrieving and combining data

stuff	**Data extraction**
Suggestion	author, Publication year
Study location	nation
Study intention	Aim/principle of the study
Study populace	Adulthood of carers as stated compared to the population's average age (50 years)
Results	From the evaluated publications, conclusions were drawn that connected socioeconomic factors affecting mental wellness to prevalent mental illnesses and sub-threshold mental disorders among carers.
Tools	Sociodemographic characteristics as well as data on the instruments used to evaluate medical results were retrieved.
Data synthesis	**Description**
frequent mental disorders	Older carers are dealing with or have lower thresholds mental problems, including feeling anxious and sad. Elderly memory carers were not included.
Caregiver	Someone untrained caregiver who looks after an elder at residence. No restrictions depending on whether you are providing care for others for pay or not.
Older adult	Caregivers above the age of 50. The sample used for the study of carers has a stated mean age that might be as low as 50 years. Most of the carers in the group being studied should be older than 50 if the average ages of the study group is not stated.
The WHO identified factors associated with disparities in older individuals' mental wellness.	Social considerations of mental wellness include financial status, degree of academic achievement, ethnic origin, age, and physical wellness. The initial source did not specify "older adults," thus the factors are thought to be appropriate for evaluating caregiver who are more than fifty years old.

5. Data reduction, display, and comparison

According to the data and the pre-established conceptual categorization, the included papers were split. The categorization included the SDMH, and each sort of determining information was combined into a descriptive matrix style. For data comparison between the compared publications, the primary researcher used structure coding in a matrix. As a result, the data comparisons and visualizations helped to clarify the subject of interest.

5.1 Conclusion drawing and verification

The integration evaluation's last analysis of data phases were conclusion and verification. After that, independent of the analytical quality of the papers contained, data were pooled based on the guidelines to evaluate the issue in question and develop conclusion. Finally, the initial contributor combined the important aspects of the articles that had been incorporated into a comprehensive summary.

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6. Result

Twelve papers from the 1,088 eligible publications were selected to address the investigation's issue. The PRISMA flowchart and article selection are shown in Figure 1. Two of the pieces were published internationally and were distributed across eight different nations. The indicated range for the mean age of carers was 50.2 to 73.2 years. Due to the fact that two articles did not include the generally signify age but were not omitted, the research participants were mostly above 50 years of age old.

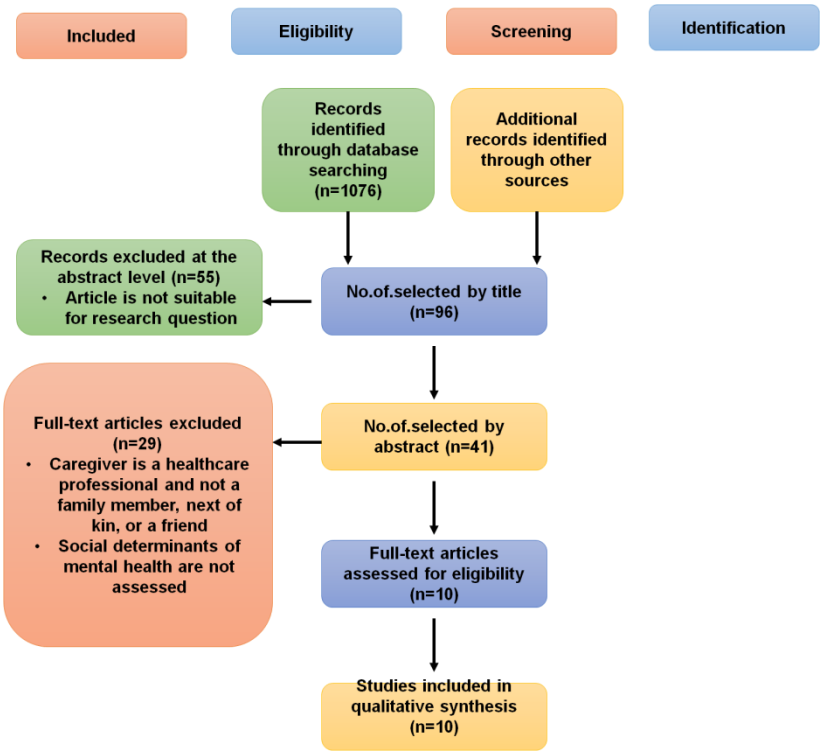

Figure 1: Flowchart to determine investigations using PRISMA

6.1 Methodological quality

The papers were thought to be of average quality overall. 60% to 100% of the MMAT criteria were satisfied by the articles that were included. The quality of the organized examination and meta-analysis was average. The acceptance rate for study respondents varied between 27% and 50%. However, only a small number of researches included rates of reply. Regardless of the methodological caliber, all papers that were qualified were included.

6.2 Sociological factors that affect mental wellness

The "levels of physical health" of older carers were the key variable connected to mental health disparities. The results therefore indicated that mental weariness, load, sadness, and anxiety were associated with elder carers' negative perceptions of their condition. Disease and poor health-related standards of life were also linked with carers' subjective burdens (p .02 and p .001, respectively). Additionally, correlation values range from -0.28 (substantial implementation) to -0.38 (overall health) showed a connection between carers' feelings of depression and all health-related aspects of life indicators. Additionally, caregivers with high levels of sadness reported feeling less energized and having lower overall health. Accordingly, one study discovered a connection between sadness and chronic illness between carers of individuals with cancer. Furthermore, between up to eight months after baseline, across those who were caring to individuals with heart failure, depressed symptoms predicted negative emotionally health-associated quality of life (p .001). Similar to this, carers who had lower family earnings and who felt more threatened and stressed out by their caring responsibilities had higher levels of sadness. According to the study, factors including lower levels of depression and overall family wealth were favorably correlated with caregiver results. In contrast, no variations in perceived care giving load or disparities

in mental health status were found among carers depending on their level of education, while findings related income were mixed.

The research also showed a favorable relationship between depressed symptoms and the female sex of carers. Male carers had less severe sadness than female caregivers did (p =.024). However, it seemed more probable that female carers' increased risks of going through unpleasant feelings were related to their more intense caring. Finally, in terms of gender differences, 24% of male carers and 39% of female caregivers reported feeling melancholy, respectively (p.001). Although several of the publications included in this integrative review were undertaken in nations with a variety of ethnic groups, there was a dearth of data addressing nationality. One research did find those White (non-Hispanic) caregivers who provided more activities of daily living (ADL) care and more hours of care per month than their low-intensity peers did felt greater negative feelings. However, during the extremely intense care, Black (non-Hispanic) caregivers were more likely to feel pleasant emotions connected to caring. Additionally, there was a correlation between a caregiver's ethnic minority identity and greater mental health. However, while providing very intense care, Black (non-Hispanic) caregivers were more likely to feel happy or content. A caregiver's membership in a minority ethnic group was also associated with improved mental health. Additionally, there was a correlation amongst caregivers' ethnic minority identity and greater mental health. However, because the research was comparing "White non-Hispanics" against "others," the "minority status" in this situation is questionable described in Table 2.

Table 2: The synthesized data on social determinants of mental health from included studies

No	Reference	Aim	Instrument	Function	Social determinants I
1.	[18]	Cross-sectional	Self-reporting of symptoms of depression and anxiety. The Government Statistical Council of Spain performed the DIDSS 2008. Factors related to sociodemography include the following: gender, age, relationship status, place of residency, maximum educational institution reached, occupational position, and socioeconomic class	To explore relationships between socioeconomic factors, carer network encouragement, the financial cost of care, and carer wellness and standard of living.	Gender Education Socioeconomic status
2.	[19]	Cross-sectional	A depressive disorder and nervousness: Three main caregiver QOL results were evaluated: socially strain, unfavorable feeling responsibility, and favorable feelings benefits. Each of these results were earlier confirmed by component analysis. Social characteristics include a person's gender, age, race, and yearly income of the family.	To investigate the relationship connecting the amount of caring and three separate domains that comprises the standard of life consequences.	Age Ethnicity
3.	[20]	Systematic review +meta-analysis	Depressive and anxiety disorders: The work of Beck Depression Inventory; Centre for epidemiological research. Depressed scale; Hospital Depression and anxiousness Scale Profile of Mood States; Depression Anxiety Stress Scales DSM-IV structured clinical interview and State-Trait Depression Questionnaire. The European Organization for Research and Treatment of Cancer's 15-item Core Questionnaire examined caretaker satisfaction with life. Compact Form, Excellence of Living The questionnaire Caregiver's Excellence of Life Index Cancer, and WHO The quality of Life Greatest Accessible Methodologies.	To determine what causes anxiety and what variables impact caretakers' personal life, as well as the high incidence of depression among those who care for cancer patients.	Age Education Physical health

4.	[21]	Cross-sectional comparative study	Despair and apprehension The general EQ−5D score measured caregiver medical quality of lifestyle. CSI assessed caregiver strain. Demographics: ages, genders, schooling, revenue, and profession.	To evaluate perceived stress by caregiving demographics and quantitative impact	Physical health
5.	[22]	Cross-sectional	Despair and stress: PHQ−9. The SWLS. ZBI—Zarit Burden Interview. 36-item SHQ. Sexuality, class in society, occupation, revenue from families, and training.	To evaluate illnesses occur quality-of-life and mental aspects.	Physical health
6.	[23]	Meta-analysis	Distress and anxiety disorders: The Caregiver Suffering Interviewing, Caregiving Endurance Index, Perceived Stress Scale, and other tools measured caregiver burden. The Center for Epidemiological Studies Depression Scale, Geriatric Anxiety Scale, and additional assessments were most typically used to evaluate caregivers anxiety.	To explore how demographic factors affect psychological suffering in caring partners, children of adults, and offspring-in-law.	Age Education Physical health
7.	[24]	Cross-sectional	Anxious and sadness: Bakas Being a caregiver Effectiveness Measure The Oberst Caregiver Burden Scale Anxiety Subscale of the Brief Symptom Inventory. Workers' indicators of depression were assessed using the Physician's Epidemiological Questionnaire-8 (PHQ-8). Mind and Body SF−12 summary of the Medical Outcomes Study. Age, sex, race, income, and educational institutions: demographic characteristics	To discover determinants of family healthcare performance for cardiac failure caregiver and those who have the most challenging and unfavorable chores.	Physical health
8.	[25]	Cross-sectional	Depression/anxiety: Seniors GDS: Depressed Demographics: income by family, gender, age group, training, marriage status, and work involvement.	The responsibility of caring time and signs of depression by income level	Socioeconomic status
9.	[26]	Cross-sectional	Distress and the condition: WHO Impacts of Providing care Scale. Sexual orientation, age, location of where they live, training, relationship status, spirituality, and job status: demographic details.	Evaluate caregivers characteristics and parenting demand factors	Education
10.	[27]	Cross-sectional	Depressed and disorder: Doppler depressive and anxiety Inventories, Zarit Burden Interview, and Maslach Burnout Inventory. Social demographics: Population Survey	To study providers' sociodemographic and clinical information, psychological health, and rapports with patients	Physical health

7. Depressive disorder in elderly individuals and related variables

The average incidence of depressive disorder between older individuals living in the Bahir Dar city was 57.9% (95% CI: 53.2, 62.6). Bi-variable evaluation revealed an important correlation (P 0.25) between elements like marriage status, informative attainment, and employment status, each month income, present living situation, psychological impairment, heritage of permanent medical conditions, currently taken medications, family the

past of thoughts illness, and quality of life. Amongst them, a multivariate study found a strong correlation between depressed and factors such socioeconomic status, funds, cognitive decline, relatives with a history of mental disorders, and low quality of life. In comparison to elderly people with a grade point average of college and above, those with educational levels of grades 5-8 were almost six times (AOR: 5.72, 95% CI: 2.87-11.34) and 9–12 were 3.44 times (AOR: 3.44, 95% CI: 1.59–7.41) more likely to experience depression. In Figure 2 comparison to individuals with a source of income of 2004 ETB, older persons with that kind of money were almost twice as likely to have despair (AOR = 1.89, 95% CI: 1.16-3.07).

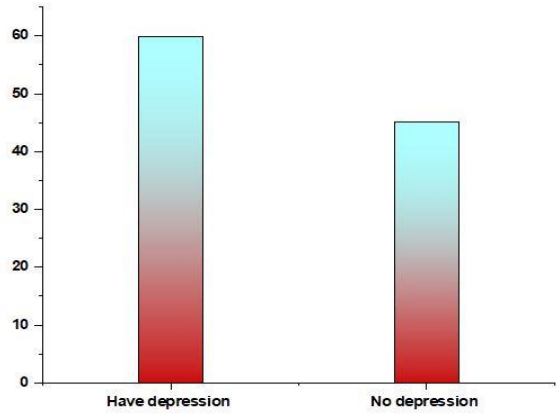

Figure 2: Anxiety in elderly individuals and related variables

8. Older people mental wellness self-perception

The findings from the poll on the self-perceived mental wellness state of the whole individuals elderly seventy and over in 2017 are shown as a number below. According to the data shown in figure 3, twenty- two quarters of the older population rated their current level of psychological well-being as being very excellent. No one who responded said that the condition of their mental wellness was really poor.

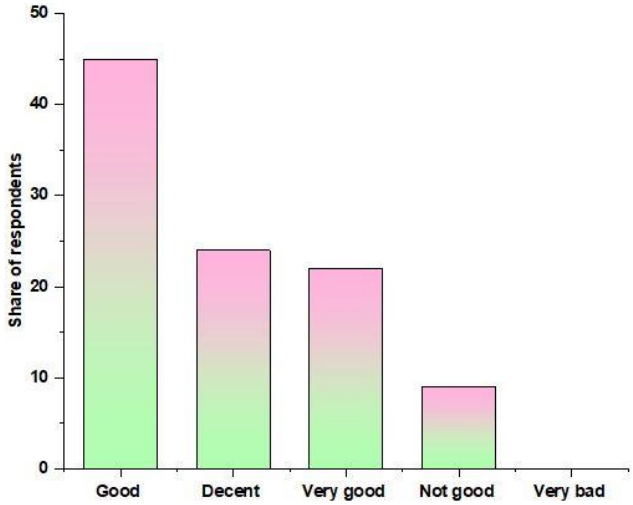

Figure 3: Overall self-reported mental wellness among older adults

9. Discussion

According to this comprehensive analysis, the disparities in mental wellness are correlated with older carers' worse physical health. As a result, the poor health of elder carers and the connection between those difficulties and mental wellness problems might indicate that physical issues with caregivers contribute to emotional health

inequities and in turn [18]. The analyzed data, despite this, did not pay particular attention to the state of a person's physical wellness or the relevant societal, cultural, and financial aspects. Additionally, female carers were more likely than male caregivers to have experienced distress [19]. The conclusion is supported by earlier data. According to the social scale, women endure the majority of negative health effects. Therefore, social systems, Discrimination based and gender norms should be taken into account in caregiver research when examining mental health disparities. As a result, women were more likely to be responsible for household duties, such as providing care [20]. These obligations have an impact on their professional paths, potentially lowering their earning potential and raising their chance of being impoverished later in life. The prevalence of omission of older persons with varied SOGI from studies makes it impossible to evaluate the variables linked to mental wellness difficulties and disparities in mental wellness. Consequently, further research on mental wellness issues that caregiver of different SOGI face is crucial [21]. However, results were conflicting. It was also probable that elder carers' lower income and level of education were related to mental wellness disparities. Additionally, less attention was paid to SES in the included publications, and the two variables were evaluated individually.

Evidence for the transmission from generation to generation of inequality among elder caretakers is, however, scant. In accumulation, it is required to receive into account whether the financial condition of elder carers in various nations is stable enough to provide a respectable and healthy existence [22]. For elder carers who are already at risk for economic as well as social vulnerability, a lack of resources and financial backing may make mental wellness inequities much more likely. In fact, the lowest-income group in Europe accounts for almost 40% of non-working caretakers, which may be detrimental to their mental well-being. In order to solve carers' low financial status and differences in mental wellness, society may have a significant say in the matter.

Finally, the results of this research suggest that earlier caregiving literature among older carers may not have specifically addressed issues associated to older people's mental health inequalities as identified by the WHO. As a result, throughout our scientific search, we found several studies that discussed issues related to carers' mental wellness or inequalities in mental well-being; despite this, elderly carers received less attention or the age of the providers was not evident. It is concerning that these aspects are not taken into account in studies since socioeconomic inequality is a major contributor to the risk factors for many prevalent mental diseases [23]. In addition, the absence of evidence results in a dearth of information that prevents the development of effective instruments and processes for evaluating the emotional wellness of elder carers. The findings are also crucial for people who are organizing healthcare and nursing education. Including a broad group of older carers and the people they provide care for in research and disclosing their heterogeneous causes leading to mental wellness inequalities is one of the first steps to improving older providers' mentally mental health. Adopting a life-course approach to health and social service provision is the second idea to think about. This strategy is strongly advised by the WHO's multidimensional structure because many mental wellness difficulties that develop subsequently in life are really the result of earlier occurrences. Consequently, a life-course approach emphasizes a person's social and historical viewpoint or the daily activities of a cohort, such as elder caretakers [24]. These events are connected to the socioeconomic, cultural, and social variables that define present behaviors regarding well-being and sickness. The life-course approach takes into account social constructs and institutions like social welfare and schooling that have a big effect on how people choose their life's path. Additionally, this strategy successfully tackles the generational transmission of inequality [25]. Additionally, SDMH may be treated with the help of certified mental nurses, family doctors, and psychologists. These activities, for example, include individually responses, such as counseling as well as instruction. However, the prior research demonstrates that some nursing professionals have insufficient abilities to address socioeconomic factors. In reality, dealing with socioeconomic factors in daily practice may be challenging for health practitioners. A greater social will is necessary to solve SDMH since policy changes are the third act to examine [26]. Additionally, given lower SES may be a significant factor in carers' mental wellness disparities, legislative strategies should stress the need of enhancing social safety programs for elder caregivers in hardship or at risk of deprivation. To combat SDMH, despite this, attention should be given to the socioeconomic differential in mental wellness as well as the most at-risk caregivers. As a result, concentrating just on the most disadvantaged

does not result in the necessary decrease of mental health inequities [27]. Furthermore, universal laws must be adopted to assist mental wellness fairness, but they must also be harmonized with regard to drawbacks.

10. Conclusion

According to this research, there were differences in the physical and mental health of elder carers. In addition, women and those with less education were more likely to have mental health issues. The research on SDMH in elder carers, particularly in light of gender, ethnicity, and socioeconomic inequalities, seems to be lacking. Therefore, future studies on caring might concentrate on identifying the factors that influence a varied set of senior carers and developing screening initiatives to address mental wellness disparities. Additionally, connection with mental health services that include the mental disorders biologically and social views of nursing as well as more thorough learning on SDMH amongst nurses from all specialties should be taken into consideration. Finally, policies should unify their methods in terms of susceptibility and concentrate on the broader socioeconomic a transition of mental wellness.

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