



**MENTAL HEALTH
IN THE COMMUNITY:
the case of Slovenia**

MENTAL HEALTH IN THE COMMUNITY: THE CASE OF SLOVENIA

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Tone Vrhovnik Straka

Survivor's point of view – The Slovene mental health system

In the first edition of this book, the user's point of view was contributed by dr. Tanja Lamovec the north star of psychiatry's survivors in Slovenia. She is, sadly, no longer with us, so the burden of continuing where she left off falls to me now. Originally, I intended to continue from the point where the respected author has concluded and to summarize her work as well as describe the developments that took place over the previous decade in survivors' and users' movements. Now, I'm forced to conclude that such an approach is meaningless, as it only leads me to question the reason why we so rarely come together. I will, therefore, introduce these points as we go along a different path on which we will investigate each of the areas that directly concern survivors (term is used as defined by WNUSP: World Network of Users and Survivors of Psychiatry and ENUSP) from three disparate viewpoints.

- From the viewpoint of a user that has been negatively affected by the »system« and feels offended. These accounts are intentionally presented in situ, with vulgarity so common to the depressed male culture.
- From the viewpoint of objective and, consequentially, boring reality that is common to outsiders which are sympathetic to the survivor problematic.
- From a wide and optimistic perspective, that emphasizes ideas and plans leading to a bright future for people affected by a psychiatric experience. This »calm hypomanic« perspective is intentionally removed from the objective viewpoint. I find the term »survivor« appealing, as it stresses both the independence and the strains that former users of psychiatric services are subjected to.

Those interested in a better understanding of the survivor's perspective may wish to focus on the last few sentences of individual segments. If you are, on the other hand, interested in the viewpoint of a veteran of mental health treatment, you may wish to focus on the first few sentences of individual segments.

Introduction

Over the past few decades, Slovenia has seen the development of various forms of community treatment for people with severe mental illness. The beginnings of community treatment are found in the social work movement during the era of deinstitutionalization. Regionally, the process was at its most evident in Italy in 1986, where the psychiatric hospital in Trieste was closed and admittance to institutions was banned by law. In Italy, people with severe and chronic mental health disorders were cared for in several regional mental health centers, a move which was not mirrored in Slovenia. The rhetoric justifying the decision not to commence with deinstitutionalization claimed numerous faults in the deinstitutionalization process and possible negative effects, such as an increase in homelessness and the lack of care for psychiatric patients (1). Despite this, several professionals managed to revisit the topic over the years, mostly through a historic consideration of the reasons for rejecting community treatment (2) and pragmatic attempts to implement psychiatric care in the primary level of health care. This was reflected in the institution of a network of psychiatric outpatient clinics (dispensaries) in 1970s. These centers were meant to ensure that everyone in need of treatment would be able to access it in larger settlements across Slovenia. These dispensaries should have been closely connected with existing regional health centers, but they were not formed according to expectations. Funds were rerouted from the primary health care level to the secondary, meaning that these funds were directed to six psychiatric hospitals, which then further directed their expenditure. The majority of the dispensaries were not to last through the 1990s, as psychiatrists were given the option of opening private practices. A number of smaller psychiatric outpatient practices was formed into a network, which suffered from uneven regional placement, which in practice means that they are mostly available in a few of the largest settlements and, of course, the capital(3). Two community networks were developed. The first, non-governmental organizations (NGOs), primarily established rehabilitative services for people with chronic and severe mental health disorders. These services included the development of care planning methods, day-to-day care services, housing groups, vocational rehabilitation and employment and advocacy. NGOs were also heading significant destigmatization campaigns. The second network consisted of social work centers, which had

been offering counseling and practical assistance to people with mental health disorders, even though they did not define their efforts as mental health care at the time. With the signing of the Mental Health Act, social work centers were given the power and the funds to legally plan and execute community treatment programs for discharged patients. It should be noted that community treatment programs were being established alongside other reforms in primary health care, which include the all-important institution of referential health care centers with contemporary team-based models of treating patients suffering from chronic conditions. (4). Other forms of community treatment will be covered later on.

The current call from international organizations to move treatment from institutions to the community (5) makes it essential to define existing models of treatment and compare them, making it possible for us to have a comprehensive overview of evidence based methods and guidelines needed. The reasons for this are professional-the sheer number of available alternatives in the mental health psycho-social care field is staggering, which breeds competitiveness, making it hard to recognize what forms of help are actually available in community treatment and what options a patient seeking recovery has.

This book begins with chapters on ethics, legal framework and user demands. Further chapters provide an overview of research on recovery, stigmatization and rehabilitation, followed by chapters on available forms of community treatment. The chapter on general practice treatment was prepared and written by prof. dr. Janko Kersnik, who has throughout his scientific and practical career been critical, although also supportive of community treatment. He has furthermore been involved in NGO multidisciplinary education we provided in order to facilitate community projects. All proven forms of treatment offered by NGOs are introduced, including psychotherapeutic counseling, self-help groups and psychoeducation. A chapter is devoted to the introduction of teamwork, which is a requisite essential for recovery led services. The final few chapters introduce proven forms of prevention in mental health, specifically focusing on children and young adults. Every group of chapters is prefaced by a »survivor's« take on the subject. A survivor is a person who has undergone treatment for a mental disorder and has personal experience of the system and how it operates. *At the end of each preface, a set of recommendations for those working in the mental health field is laid out in italics.* This appeal is supplemented by Renata Ažman's essay. She is an intellectual, publicist, reporter and a service

user, whose texts touch upon the most serious and sensitive of subjects, such as self-discrimination and stigma and at the same time offer ways of overcoming such setbacks.

Our work needs to consider the goals of working with severe and chronic mental health disorders in the community, which makes the fact that a diagnosis does not equal identity and cannot define a person, our core premise. Consider the example of Vincent van Gogh, who suffered from severe mental issues. Between the periods when his condition worsened, he could be considered healthy, although not precisely in keeping with the definition of mental health (a state of physical, mental and social wellbeing). He said. "It is perfectly true that the attack returned various times in that last year – but then also it was precisely by working that my normal condition returned little by little" (6).

Mental illnesses and conditions can, in fact, offer the possibility to reorganize one's life and find new meaning in it, which has been proven conclusively through testimonials (7). Such a dramatic acceptance and recovery from illness is only possible when people we work with are carefully attended to and all areas of their life are made our concern. Their symptoms do not suffice. It goes without saying that most find their disorder or illness a tragedy, one that needs prevention and treatment, yet this does not absolve us of the responsibility of making it an opportunity to take advantage of it. Our attitude should be one of respect for the subjective experiences of those that went through treatment. The diagnosis requires recognizing that the person experiencing mental illness is usually the victim of their sensitivity to a trigger or cause that can be identified with careful listening and questioning. We psychiatrists still use our intuition as part of the diagnostic process, as a reflection of the human capability for empathy. The method, as a counterpoint to the more quantifiable diagnostic tools, can be explained by acknowledging the existence of "mirror neurons" in our brain. These allow us to experience another's condition intimately (8). Karl Jaspers' claim (9) that schizophrenics are strange, cold and distant, even inexplicably so, is simply wrong in light of this understanding. Rather, it reflects the truth of a pervasive failure to reach our patients on a personal level (6). The quality of our work improves by carefully listening to personal testimonies. These are also the strongest weapon available in overcoming stigma and discrimination (10).

The history of psychiatry is rife with accounts of neglect, abuse, injustice and discrimination (6). The way we approach our work is directed at

preventing recurrences of such acts in the mental health field and helping care providers to reduce the chances of inappropriate and careless treatment of patients in need.

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The state and us

The Slovene Mental Health Act, which was signed into law in 2009, foresaw that the government prepares and the National Assembly accepts a resolution on a national mental health program within the calendar year. I feel nothing but loathing for those who are directly responsible for the lack of progress in this endeavor, as no programs of nondiscriminative aid distribution have been set, the paradigm shift from institutional to community help has not come into being, with similar delays affecting the special care programs aimed at the young and the elderly. The government officials are directly responsible and are legally liable for the failure of the mental health act and its paragraph 111.

Slovene survivors consider the day the Mental Health Act was signed into law a significant one—the act precisely defined in which cases the state is allowed to transfer patients to a closed ward in psychiatric hospitals, time and other limitations have been imposed on “special” treatment methods available, it defined the accepted way to deal with underage patients and, most importantly, introduced the Patient Representative concept. This new institution is meant to be a patient's ally, especially in forced institutionalization cases. Not only has the profession made its displeasure known, particularly in view of the massive increase in required paperwork (including reports on methods and treatments used, the time spent applying them and legal notifications), the patients themselves also feel disappointed. Not only since most patients in closed wards have no idea that they have a right to a representative, but mostly because the state has decided that representatives and »treatment coordinators« should simply be the employees of the nearest available social work center or an NGO. People who do not always have the patient's best interests at heart. The government has displayed its concern with its Patient Rights Act of 2008, yet I can find no data that would show whether the patients are even aware of the options that this gives them or whether they have successfully been applied.

Slovenia is a signatory of the Convention on the Rights of People with Disabilities and is now formally bound to discuss any and all legal and other initiatives that affect the disabled population with them. This is not the case.

The service user's recommendation

The state, through an open dialogue with survivors, taking account of detailed analyses that show the economic damage caused by suicide, poverty, exclusion, disability, sick leave and other parameters that are affected by the state of mental health nationwide, provides resources for a regionally allocated prevention, treatment and diagnostic programs aimed at mental health issues. Focusing on early diagnosing of mental illness in children and young adults, it brings back regional counseling offices and dispensaries. It strengthens the network of psychotherapy workshops and provides funds for them from the health system itself. Community treatment teams focusing on community work are dispatched and strengthened, along with their NGO counterparts. The participation of survivors in all aspects of mental health is legally defined—this results in an increase in the quality of life not only among the mentally ill, but also among the public at large.

Preserving the rights of persons with disabilities: United Nations Convention on the Rights of Persons with Disabilities¹

The United Nations Convention on the Rights of Persons with Disabilities is an international convention that comprehensively regulates and protects the rights of persons with disabilities. The Convention was adopted by the UN General Assembly in 2006, and ratified by Slovenia in 2006 (1). With ratification the Convention became a part of Slovene legal order and is directly applicable. Besides Slovenia, 153 other members of the UN ratified the treaty, including the European Union (2).

The Convention addresses various rights enjoyed by persons with disabilities; with the intention of ensuring respect their human rights, liberties and dignity. (1st paragraph of the Convention).

The Significance of the Convention: From medical to the social model of disability

Physical and mental disabilities are an issue in every society and often have social ramifications (3). The perception of disability has changed in the second half of the 20th century with the advances of modern psychiatry. Traditional medical model of disability was, gradually replaced by models based on individual autonomy. Simply put, the traditional treatment patterns of the early twentieth century, which were mostly based on restrictions placed on persons with disabilities, were replaced by means the modern world no longer deems inhumane or torturous (4).

In the second part of the 20th century in the Anglo-Saxon world, community therapy was born as a response to the growing public awareness of institutionalization and its issues (5). The subsequent changes in policy resulted in the marginalization on institutionalization, which was to be used solely in extreme circumstances. Treatment of persons with disabilities was moved to the community, which allows for better psychosocial

¹ This text is a part extraction of: Cotič Ž. The Road to International Implementation of Supported Decision-making. King's College London. 2014

rehabilitation. This was the result of change in attitude towards mental health, which resulted in the current three-fold perception of reduced capabilities. The first is the traditional medical model, which assumes that disability is always unwanted and must therefore be cured. This, in turn, means that those with reduced capabilities deserve our compassion, not our respect (6). Medical model of disability is based on stigmatization, which can lead to further psycho-social issues (7), and discrimination. In practice it functions in a manner that excludes persons with disabilities from society. It comes as no surprise that this model has been proven ineffective (8).

The second model, the social welfare model, does not apply a medicinal viewpoint to disability, yet it still sees disability as an obstacle. This, again, leads to social exclusion (9).

The Convention represents a paradigm shift, as it is the first international document to move beyond medical model of disability and rather institutes a social model for disability. The latter requires countries to enforce a series of rights of persons with disabilities and aims at social reintegration (9,10). The social model of disability has the advantage of allowing persons with disabilities reduced capabilities to fully realize their potentials, as opposed to the other two. Society at large also benefits from individuals able to effectively contribute to it (10), which is the basis of social inclusion. To clarify, social inclusion implies that social standards allow individuals to form relationships with each other (11).

The Convention introduces this social model in the first paragraph that provides the definition of persons with disability people with reduced capabilities as those »suffering from long-term physical, mental intellectual or sensorial defects, that in combination with various obstacles, limit them from equally and efficiently participating in society. Despite the significant improvement that the Convention represents, full inclusion of people with reduced capabilities still requires de facto protection and enforcement of the afore-mentioned rights.

Some rights of persons with disabilities

The rights listed in the Convention are mostly part of various international legal documents. In Slovenia, they are also present on the constitutional level. These rights include the right to life, legal protection, freedom of

movement, citizenship, and prohibition of torture. All rights that were re-defined in the Convention as inalienable, regardless of diminished physical or mental capabilities.

Slovenia is required to enforce and encourage all human rights of the disabled, without discrimination. These include appropriate measures to eliminate discrimination any individual, organization or private enterprise (Article 4 of the Convention).

In accordance with Article 8 of the Convention, the state must take measures to (i) raise societal awareness regarding persons with disabilities, and encourage respect for the rights and dignity of persons with disabilities; (ii) fight stereotypes, prejudices and other unwanted practices relating to persons with disabilities in all areas of life; and (iii) promote awareness of the persons with disabilities' capabilities and contributions.

In Article 9 paragraph, the Convention requires States Parties to enable independent living and full participation in all aspects of life for persons with disabilities. States Parties to the Convention should take measures to ensure persons with disabilities access to transportation, information and communication technologies and other services in urban and rural areas.

Perhaps one of the most important parts of the Convention, Article 12, recognizes that persons with disabilities have full personhood under the law and legal capacity. This provision goes counter to guardianship systems, which are in force in States Parties (12). Article 12 requires that State Parties shall take measures to ensure the equal right of persons with disabilities to, for example, own or inherit property and control their own financial affairs. Article 19 holds particular significance for Slovenia, as it recognizes the right of persons with disabilities to live in the community. In accordance with Article 19, persons with disabilities should be able to choose where and with whom they will reside. Moreover, when in need of community services, which should be available on an equal basis, they should have access to support services, including personal assistance. All these measures are in line with social model of disability and should prevent social exclusion.

Independence and social inclusion is strongly connected to the concepts of habilitation and rehabilitation, which the Convention addresses in Article 26. States Parties are required to implement measures enabling persons with disabilities independence and participation in all aspects of life. In order to achieve this, appropriate measures such as comprehensive

habilitation and rehabilitation services and programs in the areas of health, employment, education and social services need to be taken. These programs need to be timely and based on multidisciplinary assessments of persons' needs and strengths. Moreover, the programs need to be voluntary and a part of community services in urban and rural areas.

Persons with disabilities and the role of the Committee for the Rights of Persons with Disabilities: the Case of Slovenia

In Slovenia, the aforementioned provisions are of particular importance in the context of psychosocial rehabilitation, community treatment and supported decision-making frameworks. In the annual report for 2013, the Human Rights Ombudsman of Slovenia has found, that Slovenia should »accept more effective and appropriate measures, that will allow the disabled population to achieve and maintain the highest possible level of independence, including professional independence and their full inclusion and cooperation in all areas.« (13) Moreover, the Human rights Ombudsman has argued for full implementation of the Convention, requiring adoption of a number of appropriate statutory instruments. International treaties signed by the state, even ratified Conventions supported by appropriate laws, are to a significant extent unenforceable without the proper legal framework. A clear example of this can be found in the 2010 Equalization of Opportunities for Persons with Disabilities Act (ZIMI), which remains unenforceable due to the lack of statutory instruments.

Other findings that were made by the Human Rights Ombudsman are equally concerning, particularly those about visits of social care institutions, which were made in Ombudsman NPM² capacity and accompanied by members of the selected non-governmental organizations (NGOs). These findings included treating those with dementia in closed wards, lack of understanding in admitting patients to closed wards, forced hospitalizations and other safety measures (13). These failings demand a change to the existing Mental Health Act (ZDZdr).

The actual implementation of the Convention and its provisions is thus not

2 NPM (National preventive mechanism under the Optional Protocol to the UN Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment).

only reliant on the aforementioned legal framework but on a number of other laws and programs. In keeping with the Convention, Slovenia must regularly report on its progress and measures taken to fulfill its obligations. This report is then sent to the Committee for the Rights of Persons with Disabilities, which was established by the Convention and presides in Geneva. Based on the report and its review, which includes a dialogue with the country in question, the Committee then adopts recommendations and proposals regarding implementation of the Convention's provisions. The first such report by Slovenia was sent to the Committee as late as 2014, to be reviewed at an upcoming assembly (15). In accordance with the Optional protocol, the Committee also has the power to treat any individual or group complaints that claim a State Party has breached provisions set forth in the Convention. The proposals made by the Committee are considered morally and professionally binding, and are commonly put into practice.

A look to the future

By ratifying the Convention, Slovenia has made an important step in ensuring the respect for basic human rights of persons with disabilities. The importance of the Convention lies not only in ensuring rights, but also in a paradigm shift in societal perception of persons with disabilities. A shift of this magnitude, one that is based on respect and successful inclusion, could only be considered successful when effective psychosocial rehabilitation programs are in place, ones that do not rely on institutional care, but rather on community acceptance.

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Tone Vrhovnik Straka

Environment and us

I never read the newspaper, but then again, I don't have to. One barely has to turn on a computer on to find out that »one of ours« has shot a policeman, flew a plane into a mountain, strangled a child, stabbed her husband... Calling the media does not work here, seeing as the exciting story of the badly dressed overweight person with no makeup, who won't get out of bed, does not make for an exciting movie..

If you disagree, please try to find a positive example of a survivor in print or any media. Where is the epic saga of the woman who overcame illness, fought through the pitfalls of modern living and now, having won the heart of a loving partner, has settled down to run a sanatorium in South Africa? In reality, such a story would probably run along the lines of: »I have managed to get out of bed yet again! I went for a walk twice this week!«

Recovery

When discussing recovery and rehabilitation, a method of supporting recovery, we often think in terms of improving objective quality of life. By this we mean housing, friendship, a sense of security, employment and achieving goals. We forget that quality of life is far from an objective absence of pain, but is rather a subjective, unique blend of an active life, sense of control, dignity and identity (1). A brief review of the research on the recovery of mental health patients shows that they consider being connected (social inclusion, inclusion in the community), hope and optimism, the development of identity, a sense of strength and meaning (2). The desires of those who have recovered from a mental disorder are in no way different from the desires of other people. They want to achieve or keep roles valued in society—those of employees, partners, family members and free citizens with the power to affect change and make decisions. Grading or measuring the success of recovery is then simply measuring a person's success in achieving social roles and personal goals (3). Consequently, these norms must be measured against accepted social standards, not by way of professional instruments intended to diagnose illness or reduced capability (4). Internalized stigma is the biggest hurdle to overcome in this process, and is often exhibited as low expectations from both patients and staff (5).

It has become clear over the past few decades that we need to change the way we think about recovery, if there is to be a successful and rational overhaul of the system. People who overcome a mental disorder or illness enter a process perhaps best described with the following phrases: »deeply personal unique process of changing one's attitudes, values, feelings, goals, skills and roles«. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life. This identity needs to be created anew, to allow the person in question to live a fulfilling life within the limits imposed on them by their mental disorder (6). This viewpoint is the result of firsthand experience, namely of those who have overcome mental illness. The fact that recovery from mental disorders takes such a complex form led some to believe that it was impossible to rigorously research. Now, an understanding of the process is becoming more and more important to researchers, professionals and those who have experienced

mental disorders. The value of a survivor's perspective has shown itself so important that it is now an integral part of evaluating effectiveness, success rate and financial efficiency (4). Global priorities in the field of mental health are inextricably linked to recovery and are ranked, by importance, on »national mental health program«, the »stigma and discrimination-awareness promotion«, »recovery and employment oriented psychosocial rehabilitation« and the »shift from institutional to community care« (7).

Medication and recovery

The use of numerous successful psychiatric drugs has reduced suffering or even removed it among many of those with mental disorders. Mike Slade, in his chapter on the role of medication in recovery (8), discusses the importance of a patient taking responsibility for his or her own medication. According to Slade, patients should overtake responsibility for medication use and establish control over their effects and side effects. This means that a patient use medication that he is familiar with, and be given the ability to choose. The informed choice requires a person to possess sufficient clear and scientifically accurate information on the subject. Choice is easier when appropriate questions are asked and clear answers presented. We do not want to see ourselves as passive, just observing what happens as our brain does our thinking and deciding for us. We do not want to think, feel and act at the whim of brain chemicals (1). People can take advantage of alternative means of managing their condition. These can include anything from diverting attention to genuine patience offered in a close relationship, from recreation to expressing creativity. Understanding alternatives shows us that medicine is but one means of preventing recurrences of illness. It should be noted however that the effectiveness of medication declines sharply when secondary requirements are not met, such as a safe and stable environment, lack of drug abuse, low stress levels in the workplace and many others. Experience shows us that most patients ultimately find balance by combining medication and other forms of managing their disorder, and that only when they decide to do so and take responsibility for it.

Process of recovery is strongly linked with stigma, discrimination and self-stigma.

Us and us

What can a person do when confronted by a loss of self? While it is true that most users will use the internet and the telephone to say a few words about the medication they are using, their therapists and so on, they very rarely actively seek out the company of similar individuals, despite the insistence of doctors and family members. Few see the reason for it, as they feel they are not being listened to. Even those that are lucky enough to be situated in an area that boasts a day center are forced into groups that discuss topics that are widely considered idiotic. To be forced to recount their day and feelings, unchanged for years, listen to other individuals' treatment methods and medicine, their financial situation, pension checks and other banalities.

Self-organized survivor activities are few in number. The web forum »neboj.se« is a notable exception to an otherwise troubling situation, as it has been operating successfully in the field of self-organization for a number of years. The rest (the Mostovi project, the "bipolarna.si" portal, bipolar users' club and numerous others) have slowly died off over the years. What is left of the structure is almost wholly in the domain of NGO day centers (Altra, Novi paradoks, Ozara, Šent and Vezi) and in the housing framework that a few of these groups have established. The need for self-organization amongst survivors seems to wax and wane as activists fall prey to health issues, the non-profitability of such enterprises, poor relations with the mental health profession and other issues. The relationship that exists between mental health professionals and survivors is a particular point of contention with the late dr. Lamovec, who emphasized the need for a critical view of professionals involved in self-help programs. This, of course, is only a part of her proposed framework-she also advocated for a strong focus on empirical knowledge and overcoming guilt that mental health patients experience. She maintained that individuals with mental health problems should not consider themselves in any way responsible for their condition. Such a viewpoint was to be replaced by a sense of responsibility for future actions and a general atmosphere of »realistic optimism« (Lamovec, 2006, pg. 183).

Stigma

In the past, it was often thought that mental illness makes normal functioning impossible and that it reduces an individual's abilities to an extremely low level (9, 10). Schizophrenia, for instance, is still widely debated along with attempts to prove that it causes a consistent and constant decline in brain function and abilities. The proof is supposed to lie in the results of illness outcome analyses, brain scans and patient sensory evaluations. What the evidence actually shows is that only about 25% of people suffering from schizophrenia show a poor long-term illness outcome, only a few of which experience progressive loss of function (a characteristic of neurodegenerative illnesses); secondly, magnetic resonance imaging studies show only slight alterations in brain structure with the onset of schizophrenia, which can be explained as a side-effect of anti-psychotic medication, psychoactive substances or any number of other factors we are all subject to, such as aging. Finally, even evidence of cognitive deficits (memory, deduction and minor information processing capabilities) does not mean much, as these functions do not decline further over the course of the illness. Most patients diagnosed with schizophrenia can expect a long-term remission and can function effectively in society. The reasons for decline can often be attributed to poor access to treatment, reduced participation or simply the changing financial and social circumstances that the illness triggers. It remains a fact that most people suffering from schizophrenia have little access to relevant services and social aid they need to attempt recovery and have a sufficient quality of life. The outcome of schizophrenia is hard to predict, as stigmatization and its consequences: poverty, unemployment, and institutionalization inevitably impede the progress of every patient (11).

Despite evidence to the contrary, many professionals meant to help those with mental disorders still hold the belief that schizophrenia sentences an individual to an inevitable decline. Families, workplaces and other social structures often try to make patients abandon life goals that are shared amongst the wider society, such as employment, forming a family, friendship or an independent life (12). It seems that one of the parameters of social exclusion amongst the ill is fear, not only of illness, but also of stigma, discrimination and hardship. So far, there has been a distinct lack of research into these fears (13), without doubt caused by the inertia and condescension that are so widely present in the profession.

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Tone Vrhovnik Straka

Doctors, Pharmacists and Us

After a month's worth of preparation, report writing, assessing questions and responses and polite requests, this is usually the extent of conversation I have with my doctor:

»How are you feeling? Do you need a refill?«

»I...«

»Take this prescription to the nurse, please, and have a nice day.«

The underlying characteristic of the Slovene psychiatric system is, as far as the user is concerned, waiting. Waiting for a consultation that never comes, waiting for a reduction in the amount of drugs, waiting for reasonable advice about the situation at home, waiting for a decision on whether or not hospitalization is an option. We petition doctors as if they were kings, except those of us who can afford to pay for a private practice consultation. Perhaps all the extra work the psychiatrists are doing, such as legal consultations, makes them so tired that they forget our names or why we are there.

The fact remains that the psychiatric network has been overburdened for decades. The low number of practitioners forces them to focus on essential care, into a quick-fix routine. They rarely bother to explain the side effects of medicine and how this correlates to weight gain and other problems that the mentally ill face. The arrogance that they display is, of course, not limited to doctors working in psychiatry, yet I believe that they should share more of the blame than their colleagues. I expect them to know much more about the reasons, forms and progression of the various illnesses that we try to discuss with them, all of which is a distant second to my desire for more time spent in consultations. Sadly, because of how we see psychiatrists, there exists a conviction among survivors that doctors are basically an extension of the pharmaceuticals industry, that they are interested in profit and not medical research that could help those suffering from more severe forms of mental illness. We can clearly see that the market for more gentle sedatives and other home-use medicine is continuously expanding as general practitioners prescribe more and more of them.

The inpatient departments of Slovene hospitals remain dark places in which reports of physical and mental violence still circulate, where you

can still hear the terms »atonement«, »obedience« and others. We can see that psychiatrists simply don't put in enough of an effort. People suffering from severe disorders are limited by the careless, lackadaisical approach that they display. There is not enough information on successful treatment and goals are set too low.

Treatment is considered successful when a patient finds a way to live with a life-long supply of medicine, not when he is returned to a state of good mental health. The fact that patients remain polite and do not fight back is no argument for the quality of services on offer.

The service user's recommendation

The reform of the health care system allowed psychiatrist to carve out an accepted place in the system. They work in clinics and offices, work with psychologists and neuroscientists to come up with ideal forms of therapy, demand and achieve teamwork on more complex cases, perform outpatient services, and help rehabilitate patients returning to daily routines and work. Cooperation between the patients and the doctors has never been higher, resulting in a lower rate of suicide. The pharmaceutical industry continuously makes advancements in treating depression, in developing anti-depressants that do not affect weight gain in patients and has banned the production and sale of addictive sedatives. Reorganizing itself into a responsible, social branch of industry it has managed to achieve great leaps in removing the reasons for youth crises and has set its sights on maintaining good mental and physical health in the ever-increasing population of senior citizens.

Vesna Švab

Psychosocial rehabilitation (PSR) and community treatment

The before-mentioned inertia in psychosocial profession is slowly changing. The past few decades saw a number of initiatives to bring the perspective of recovery into the halls of power. Programs that embody this new way of thinking have appeared, in Slovenia, in the form of social, non-governmental and psychiatric services.

Psychosocial rehabilitation (PSR), according to the American PSR Association, is a method that accelerates recovery, community inclusion and improves the quality of life amongst those diagnosed with a severe and recurring mental disorder. A mental disorder is considered severe when it reduces a person's ability to live a fulfilling life (1, 2). The core principles of a rehabilitative approach can be summarized through the following fifteen parameters:

1. Recovery is the ultimate goal of psychosocial rehabilitation. Interventions must facilitate the process of recovery.
2. Psychosocial rehabilitation practices help people re-establish normal roles in the community and their reintegration into community life.
3. Psychosocial rehabilitation practices facilitate the development of personal support networks.
4. Psychosocial rehabilitation practices facilitate an enhanced quality of life for each person receiving services.
5. All people have the capacity to learn and grow.
6. People receiving services have the right to direct their own affairs, including those that are related to their psychiatric disability.
7. All people are to be treated with respect and dignity.
8. Psychosocial rehabilitation practitioners make conscious and consistent efforts to eliminate labeling and discrimination, particularly discrimination based upon a disabling condition.
9. Culture and/or ethnicity play an important role in recovery. They are sources of strength and enrichment for the person and the services.
10. Psychosocial rehabilitation interventions build on the strengths of each person.

11. Psychosocialrehabilitation services are to be coordinated, accessible, and available as long as needed.
12. All services are to be designed to address the unique needs of each individual, consistent with the individual's cultural values and norms.
13. Psychosocialrehabilitation practices actively encourage and support the involvement of persons in normal community activities, such as school and work, throughout the rehabilitation process.
14. The involvement and partnership of persons receiving services and family members is an essential ingredient of the process of rehabilitation and recovery.

Psychosocialrehabilitation practitioners should constantly strive to improve the services they provide.

Proven PSR methods:

- Training in living independently and social skills: Learning theories focusing on basic life skill achievement and maintenance are used.
- Patient and family psychological support: This program includes psychoeducation, to be described later on.
- Housing management: The goal of this program is to provide housing in a normal, regulated environment, which may include support staff if necessary.
- Work rehabilitation and employment: Supported employment programs are extremely successful, contributing to an increase in general health and fulfillment.
- Social inclusion and interpersonal relationship counseling: Meant to improve an individual's ability to handle difficulties, by either diminishing stressful situations or strengthening the individual.

Vesna Švab, Milan Krek

Mental Health Care in the Community

Why community treatment

The treatment of mental disorders can be done in both the community and in an institution. The vast majority of people suffering from mental disorders are treated at home, where their health is overseen by a general physician and nursing staff, along with other professional employed at the primary health care level as Kersnik describes in the one of the following chapters. Even so, most funds allocated to treat mental disorder are spent on institutional forms of care, which can be easily explained by the amount of human resources used by institutions. Studies show that governmental institutions boast ten times the amount of human resources an average NGO does (Ministry of labour, family, work, social affairs and equal opportunities, Slovenia).

Finances aside, there is a further reason for community treatment. Glover (3) tells us that those with mental disorders are not simply strange birds in the garden, but rather equal and, in most senses, similar members of society, that in no way wish to be institutionalized. Institutionalization is proven to harm their mental health, with the proven long-term effects of diminishing their capabilities and confidence. Although community treatment does not mean that treatment needs less time and is often even more time consuming than institutional treatment, it does have the benefit of continuously improving functional skills. It has been reported that those working in communities show more caution around patients, including a measure of respect, although the situation is not always ideal. Community treatment shows better recovery outcomes than institutional treatment, but it does require a carefully balanced set of services that have to include some forms of institutional treatment (4,5). Most countries are now in the process of making the shift from institutional treatment to community treatment of people with mental disorders.

Definitions

Community psychiatry: The use of techniques, methods and theories that reveal needs in the field of mental health and attempt to answer those needs in a functionally or geographically limited area. Community services should therefore answer the needs of individuals, not produce new services.

Community treatment: Treatment meant to ensure versatile and continuous support, preventing institutionalization wherever possible. Other parts of the definition include user participation in creating community treatment services, quality control and other forms. Community treatment is also defined as treatment with evidence based methods (2). As per the definition, the main alternatives to hospitalization in community treatment are at-home treatment and various types of rehabilitative employment and day care. The existing system of mid to large size institutions is to be slowly replaced by a more adaptable network of alternative services, which would include psychiatric treatment.

Needs assessment

The World Health Organization (WHO) warns that people diagnosed with mental disorders are widely discriminated against. Many are exposed to various forms of violence and violations of their basic human rights, including the right to receive emergency treatment and social aid. They receive poorer education and consequently have trouble finding employment. On average, a mental disorder will shorten a person's lifespan by twenty years (6). This is the result of various health issues, stigmatization and lack of social assistance. Such assistance needs to be based on actual needs, not simply be a copy of existing services. To assess existing needs among users and their families, epidemiology, demographic and other databases need to be used. The existing WHO guidelines state that mental health patients should be treated on the primary health care level and in the community, which should result in better accessibility, treatment and financial efficiency (7). When planning new services in the field of mental health, three approaches are usually considered. The first is to analyze data from existent programs. However, individual cases have very little effect on such analyses. The second approach is to analyze national databases. While this approach still suffers from low individual impact, it allows us to assess regional needs. The third approach is a direct dialogue with service users and providers. This approach makes it easy to recognize local needs as perceived by the community and its leaders, but can suffer from being too closely involved with local politics, personal desires and other factors.

The following steps should be followed when attempting to establish a service network:

1. Condition Analysis:
 - a. Identify the target group;
 - b. Overview existing services;
 - c. Establish a dialogue with key personnel;
 - d. Identify those responsible for organizing and financing the network;
 - e. Identify other mental health services.
2. Need assessment study (Percentage and incidents of mental disorders in the community);
3. Set short-term, long-term goals and priorities while taking non-apparent needs into account;
4. Realize goals
(for example in 8).

The development of community treatment in Slovenia

The last five years have seen the development of four separate models of treating those with severe mental illness in Slovenia. These need to be compared and reviewed according to their success rate and financial solvability. The four models use comparable methods, with the first two models developed by the medical and the second two developed by the social sector.

The first model: Community psychiatric care

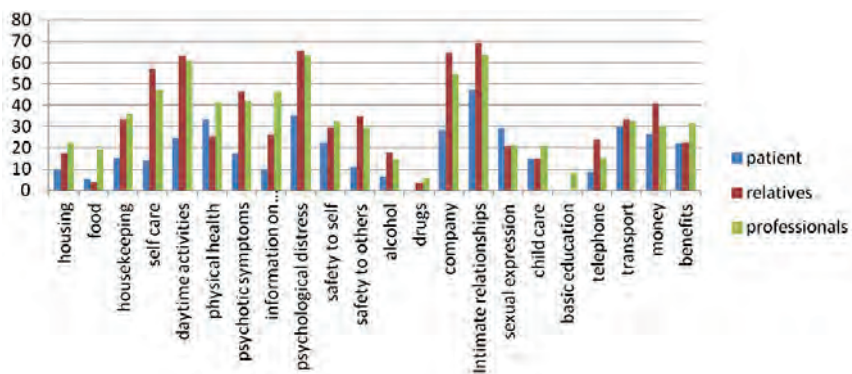
The accessibility and comprehensiveness of psychiatric care for people with mental disorders are much improved by Community Mental Health Teams (CMHTs) (5), consisting of a psychiatrist, a psychologist, a social worker, nursing staff and occupational therapists. These teams are to be distributed evenly, covering a population between 50.000 to 100.000 people, depending on the area. They are meant to be response teams that supply the demand for treatment generated by all those suffering from mental disorders and in need of immediate psychiatric assistance. CMHTs are to spend most of their efforts on treating patients with severe mental disorders, by way of support and treatment at their place of residence while also managing crisis situations and assisting primary health care personnel when treating at-risk patients. The CMHTs are to contact and monitor patients that have not yet received psychiatric care and are termed at-risk

by personnel operating on the primary health care level. CMHTs were established in Slovenia in 2013 as a pilot project in four regions and as an educational program on treatment and prevention of mental disorders. In April 2015, 471 individuals have already been receiving care through the CMHT network, 67 of which live in the Koroška region, 152 in Sevnica region, 164 in Novo Mesto region and 88 in Murska Sobota region.

Four health centers have received funding for CMHTs in their local area, due to high suicide index in these regions and other low mental health indicators. An assessment of local needs has been accomplished and help offered to those with a history of poor cooperation in treatment. This assessment showed that most patients find themselves experiencing hardship in general, with most difficulties existing outside of their psychoses, but rather in day-to-day life. These include loneliness, idleness, poor self-image, poverty and suicidal tendencies (Item 1).

Item 1: The needs of patients as treated by CMHTs in RS. Evaluated by patients, family and professional personnel.

Table 1: The Camberwell Assessment of Needs Results in CMHTs Slovenia. No. of patients (y), unmet needs (x) (122 SMI patients) (9):



Note: Needs are assessed by patients, caregivers and professional workers separately.

Second Model: Assertive Community Treatment

In Slovenia, community therapy is also underway in psychiatric hospitals. Hospital psychiatric teams, working under the Assertive Community Treatment (ACT) model monitor patients with severe and co-morbid mental disorders after discharge and ensure timely treatment and assist in solving any general issues. The monitoring is meant to take place within a limited timeframe following a patient's discharge and, within this time frame, offer unlimited and continuous support. Every ACT team, in every hospital, has achieved a significant reduction in hospitalizations with the patients they have worked with and thus managed to save budgetary resources, since hospitalization is the most expensive form of treatment.

Third and fourth models: Coordinating treatment in the community

Coordinating treatment in the community is a process conducted by social care centers once patients are discharged from psychiatric hospitals. Social workers are educated to perform duties and act within the boundaries of the Mental Health Act. These care coordinators primarily manage social problems that discharged patients experience and also coordinate their work with psychiatrists, for which they are fully licensed. A similar style of treatment is also available in a number of NGOs, which have arrived at their model through experience in these areas, beginning in the early 90s. The program they use is based on the planned treatment model that was under developed by the Faculty for Social work at the University of Ljubljana. The same institution educated care coordinators as well. Data gained from this program can be found in the Slovenian National Mental Health Plan, and can be roughly summed up by the fact that in 2013, 29 coordinators managed 500 instances of care coordination (source: MDSSZ).

Work group protocols

Admittance:

- In CMHTs patients that will eventually be enrolled in a community psychiatric care program are identified by general practice physicians, in social work centers and NGOs and through public program demonstrations performed by the group that runs the program (nursing staff, physical therapist, psychiatrist and psychologist) (2). These

patients can be admitted directly, without a referral. A treatment protocol is prepared for each patient based on needs and goals that have been identified by the initial multidisciplinary team, including the patient, family and external coworkers involved in the treatment process.

- Within the ACT model, a patient is identified in the institution during hospitalization, at which point the diagnostic process is completed and treatment continued.
- Patients are identified when discharged from a hospital. Patients can choose to accept the aid of a treatment coordinator.

Monitoring:

- All three models require that the patient be monitored and treated according to a plan. All measures that take place during treatment must be documented and applied precisely as prescribed in the treatment protocol (CMHT and ACT use treatment protocol notes, CMHTs must use cyphered notes for insurance companies and keep a log of measures and outcomes, while care coordinators use treatment notes and multidisciplinary team logs).

Outcome evaluations:

- are based on the aforementioned data.

Evaluations

CMHT programs have been analyzed based on the demographic data they provided, along with a complete needs evaluation for every enrolled patient with the corresponding clinical assessment taken every 6 months.

In 2010, care coordinators (Centres for Social Work) have performed 642 treatments, 183 of which were performed by multidisciplinary teams. In 2014, 500 care coordinations were administered.

NGOs continue with their work in care planning, maintaining well over a decade worth of psychosocial assistance, housing assistance, day center care and various social enterprises they have established.

All services report that they are focused on recovery and that they provide the best possible treatment, which takes into account patient needs and desires. This network of services occasionally allowed double monitoring that led to first complaints from patients. Excessive control was reported,

along with disrespect for independence and personal space. Staff was accused of being unable to recognize family needs and lack of planned treatment excluding patients, families or any external help. Privacy was also viewed as non-existent as services swapped information on patients with alarming ease or completely ceased to inform anyone. This situation calls for a definition of jurisdiction, a consensus on roles in treatment and of course, appropriate protocols. Patients need to be provided with the services they require and be at the focus of the treatment.

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The role of a family physician in identifying crises and crisis intervention

Introduction

Crises and crisis interventions represent a professional, organizational and humanitarian challenge to all health care workers. Crises cover a broad spectrum of scenarios and causes (1-3). In the eyes of the public health system, when dealing with a crisis, prevention, early diagnosis and treatment (intervention) are extremely important, as well as providing guidance to patient during crisis and after it. Most of the literature available on the subject is psychological or psychiatric in nature, while general practitioners rely only on the process of forced hospitalization as a commencement of a crisis intervention process.

Preventing crises

Many patients consider the fact that they are assigned a general practitioner who is available in case of emergency the first step in managing a crisis, more so when there is an appropriate relationship between the two parties. A general practitioner can contribute to reducing the amount of crises and can achieve early diagnosis. General practitioner's efforts can also support and direct other health care professionals in an emergency situation. Most crisis causes and triggers are beyond the influence of either individual or the health care system, which means that a large part of a general practitioner's responsibility lies in monitoring and directing patients with a known mental disorder, as they are much more likely to experience crisis.

GP and his team contribute to crisis prevention simply by being available and present, as patients can use consultations and the referral system to familiarize themselves with how the system works, which problems can present themselves and other facts. The psycho-social aspect of a physician's work is especially significant, as a whole and holistic treatment, one that incorporates an interest in a patient's physical, mental and social environment is proven to be significantly more effective (3). The more a physician follows these guidelines, the more likely it is for a patient to seek his council early on, allowing them to support a patient and prevent a future crisis.

Early Detection of imminent Crisis

When general practitioners consider their patients' health problems important as warning signs of a future crisis and manage to create a relationship in which a patient is willing to seek their advice in such a state, early diagnosis can be achieved. A prerequisite for such an approach is knowledge of symptoms or signs that show a patient is undergoing a crisis or that a crisis is currently in development. Crises can be expected whenever the patient's social structure undergoes a change (5), making it necessary for us to closely monitor any patients experiencing such a situation. Special attention must be paid to developmental crises, which although a natural and necessary part of development, are accompanied by emotional upheaval. These cycles include adolescence, creating a family, children leaving home and others. Of course, these crises can be anticipated which is not true for traumatic or coincidental crises, which can be triggered by a number of events (1, 2, 5).

Treating crises

Treatment of crises is in the domain of psychiatry, where psychologists and psychiatrists treat patients with the intent of reducing poor outcomes and number of hospitalizations (1, 3, 5). Despite the accessibility of psychiatry, it is the responsibility of the general practitioner to refer all patients experiencing a crisis to a psychiatric service, whether said patient is diagnosed during office hours, on call or in the emergency department (6).

Crisis intervention

Interventions are the responsibility of psychologists and psychiatrists (1-3, 5, 7, 8).

The role of non-psychiatrists and non-psychologists

The role of the general practitioner in forced hospitalization scenarios, an extreme measure used in crisis, is widely discussed in all emergency guidelines (6). The available sources, however, do not provide crisis treatment parameters for other physicians. The role of non-psychiatrists and non-psychologists can, despite this, be described using the guidelines used for crisis intervention teams (3):

- Threat evaluation
- Establish cooperation
- Identify issues
- Consider emotional state
- Consider possible solutions to the situation at hand
- Plan measures
- Monitor (If the patient is not transferred)

As with all other work, the key to any crisis intervention is establishing trust. A high level of trust will make all other tasks easier. When planning treatment measures we must rely on a number of potential coworkers, including social workers, nursing staff, psychologists, psychiatrists and others able to provide appropriate treatment in a crisis situation.

Guiding Patients at increased risk of experiencing a crisis

Even though patients who are about to experience a developmental crisis are part of this group, patients with severe mental disorders who have experienced a crisis due to their illness are more at risk. Patients diagnosed with psychotic disorders are especially at risk and so deserve special consideration. They are to be monitored, encouraged in their treatment, their feelings and condition taken into account as well as the possibility of independence. It is necessary to stay in contact with the family and nursing staff in order to achieve a clearer picture of the patient's condition. Support and a clear statement that we are available to the patient when needed are indispensable.

Conclusion

Despite the fact that crisis interventions are a psychiatric service, general practitioners can significantly contribute to crisis prevention and early recognition. To be able to do so, we must adopt a holistic approach to treatment and acquaint ourselves with causes and triggers that may initiate a crisis. Psychological support and timely and appropriate referrals can significantly contribute to crisis resolution and patient recovery.

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Non-governmental practitioners and us

I believe that the purpose of NGOs is in fact employing people, not actually helping those with mental health disorders. I have yet to hear of anyone getting hired after »vocational rehabilitation«. In day centers, at least those who haven't been replaced by other institutions, we are treated as children. I fail to see the significance of sitting in a circle, discussing the feelings that the color red triggers in me. Why are we forced to leave at the end of the day? Are we not, in fact, the purpose of these centers? Why are the employees constantly whining about how much they could help us if only they had more money? I do not think I should care about how much time they have to spend applying for grants. I just want a place where people would treat me with decency and kindness, where help would be readily available and not given in a patronizing manner. What really makes me mad are the endless ranks of interns whose treatment of us is completely incompetent.

Now, I'm prepared to suffer through a lot, since the girls are young and are basically afraid of us, having virtually no idea what goes on in our heads-but I do not think that excuses their attitude. I know that they need hands-on experience and that a faculty has been established at the university to help us with our problems. I'm also sure that if we didn't exist, there would be a faculty established to help some other endangered species.

Speaking honestly, I do realize that Altra, Novi Paradoks, Ozara, Šent and Vezi along with various incentives are priceless and indispensable to those of us who have had mental health problems. On a practically observable level, hundreds of people (unlike their less lucky counterparts living in areas without day centers) are offered shelter, encouragement, education, counseling and other forms of aid. Through the years, the amount and intensity of aid has changed, which makes sense, as the current economic crisis keeps ravaging Europe. NGOs fight over ever-decreasing funds, as states tighten their belts in areas that will never be extensively covered by the media. NGOs cannot expect support from us, the users and survivors, which is forcing them into a deal with the state, hopefully an honest one. We are, of course, grateful for all the support and help, but we strongly believe that a just order is needed. The funds should be given to us first and only then to those who wish to help us. Whatever their circumstances may

be and however hard it is to maintain this support does not give NGOs the right to solve these issues by sacrificing our interests.

I feel that we survivors have no chance of actually forming a strong community. If we compare ourselves to cancer or diabetes patients, we can immediately see that their desire to survive or manage their illness is not only rational and socially accepted but also praised by the general public. It is taken for granted that friends, infrastructure and support groups consisting of well-informed veterans will be provided. These support groups are often independent of professionals, based on the concept of humanitarianism and the firsthand knowledge of how important it is to have a sympathetic ear available, especially one that is aware of the importance of self-help. Psychiatric patients, on the other hand, usually hail from a poorer socio-economic background, one devoid of physicians, lawyers and economists willing to create a shelter for future sufferers. The efforts of those with mental health issues in the field of self-organization are often compared to the efforts of alcoholics and drug abusers. I consider this to be an apples-and-oranges situation as such organizations are generally viewed as positive by the public-they were established in an effort to stop, free oneself and heal.

A psychiatric survivor does not have the freedom to declare his psychosis over, his depression dead and buried.

The service user's recommendation

We survivors, the subjects of NGOs, participate in them on every level. We are included in the decision-making process and management, we use them as a base for interventions in the field, as a basis for employment. They are used to encourage volunteering, advocacy, the development of sciences and practices in the field of mental health and to coordinate national and international projects. Together with NGOs and by using their professional skills, we stand against evident injustices, demand seats on hospital managerial boards and defend our sphere of influence in the disabled community. With the appropriate funding, of course. We would also like a place in the Paralympics.

Inter-community Psychosocial rehabilitation of individuals with mental health issues

ŠENT – The Slovenian association for mental health has been running community programs for people with mental health problems since 1993. These programs have been established to break the vicious circle of repeated hospitalizations and create new opportunities to develop skills and knowledge required for an independent and self-sufficient life. To facilitate accessibility and reduce financial burdens, these programs are underway in several locations,.

Community psychosocial programs use methods that are meant to empower individuals. Empowerment, in this context, relates to the ability to lead an independent life and make decisions, not depend on family and professionals who offer mental health services (1:16). The second most important goal of such programs is normalization, meaning the ability to lead a normal life—a life that does not reflect any mental health issues that an individual might have, or at least not more so than in the life of a person free of them (2).

Our programs ensure that an individual is treated holistically, meaning that his needs in every area of life are taken into account. This type of treatment requires that a number of professionals that administer treatment and people that the individual considers an integral part of their lives are included in teams. Team members must ensure that the goals they are pursuing coincide with the needs and desires of the individual undergoing treatment and that they offer the minimal amount of support an individual needs to achieve his goals. Such support must be limited to what the individual needs and desires and must empower the individual to take decisions on his own.

Lamovec (1) suggests that the significance of representation lies in enabling an individual to actively confront their problems in a way that they are familiar with. We believe that those experiencing issues must contribute the most to the eventual solution. The task of social workers lies in achieving cooperation (4).

The day center program helps individuals achieve social and other skills and leads to an independent and self-sufficient life. Completing this program allows individuals to apply for employment programs and prevents loneliness and isolation, often the consequences of mental disorders. These programs are underway in 13 locations across Slovenia in 6 regions. As a social care program, it accepts both those with long-term mental disorders and those who are experiencing a temporary crisis.

Long-term users are usually those suffering from chronic disorders and the elderly. Younger individuals after achieving a number of skills and becoming empowered find their way to a full life for the most part.

Day centers provide individuals with the appropriate professional support and assistance. Individuals learn to overcome problems they face on a daily basis, to accept their mental disorder and the diminished capabilities accompanying it, to strengthen their abilities and finally, to learn that a life with a mental disorder can still be full and fulfilling. Besides the aforementioned skills, an individual attending a day center will also strengthen and widen their social circle.

An individual attending the program will undergo both team and individual work. Individual work includes consultations and »venting« sessions. Teamwork includes preparing individual treatment plans (provided they have not been issued by the community treatment coordinator), meant to ensure an individual's independence in fulfilling both simple and complex needs.

Teamwork also focuses on learning social skills, by way of either simple conversation or practical education and testing. Practical skills taught in our day centers include computer skills, foreign languages, cooking classes, nutrition and others. The centers also offer a number of activities meant to expand an individual's social circle, including sports.

The decision to enroll in the program falls to the individual, who must also decide which activities to attend. Those receiving disability pensions and other retired people most often enroll in leisure activities, as they consider their free time and their social circle extremely important.

The programs we offer allow the person to make the transition back to an independent life much faster, yet this does not mean that the journey is short. An individual must accept a new way of life, therapy and its side-effects and then weave all of these new skills and parameters into their personal routine, which requires changing old habits and ways of thinking

while maintaining one's sense of self. Any individual that succeeds in following the program is then ready for employment, which presents its own set of difficulties. Employment under special conditions or protected employment is often not accessible in Slovenia.

Community group programs offer housing, social skills education, self-sufficiency training and support. Community group programs are underway in 11 units and are meant exclusively for those of age, who because of mental disorders occasionally or consistently need assistance in living independently. This is usually the case because they lack appropriate living arrangements or social networks. These programs are designed to allow the individual to make decisions about their housing, employment and treatment to the highest possible extent. The staff offers assistance when needed, whether in an organizational capacity or otherwise.

A group resides in a house or a number of apartments. 4 to 6 people are housed together, two people per room, for security purposes. Single bedrooms are also available, if an individual needs one. An on-site kitchen, bathroom and living room are considered communal spaces. Program coordinators ensure an equal distribution of chores and other tasks needed to maintain the property.

All properties currently being used in the Community housing programs are located in area with a developed infrastructure, which gives the residents access to a number of leisure activities.

The main condition that needs to be satisfied before an individual is enrolled in a community housing project is partial independence, or at least, the ability to master such skills. In practice, these skills include basic hygiene and nutrition, the ability to take medicine unsupervised and consistent follow-up visits with their doctor. Rules and conditions must be followed at all times, and the program must be actively participated in.

The following documents need to be submitted before an individual can join a community housing project:

- A motivational letter, which includes a personal statement, future goals and a CV
- A doctor's opinion,
- A social work center's report.

Every individual must accept certain rules and guidelines before being admitted. These hold true for everyone admitted at all times, ensuring quality and tolerance.

Upon admittance, a new resident creates an individual plan for independent living, with the help of a professional. This plan incorporates goals that are significant to the resident and is then put into motion. Success in following the plan and achieving personal goals is monitored and evaluated on a yearly basis. The evaluation takes the residents opinion and experience into account, as per our empowerment doctrine.

This form of consistent support, besides following the two methods established at the beginning of the chapter, also ensures a decrease in hospitalizations. Patients that consistently take their medication and are monitored by those able to recognize symptoms and signs of crisis are at a significantly lower risk than others. We also try to involve family and other people important to the resident, who help improve their relationships and aid destigmatization.

The last step in the program for some of the residents is returning to their homes and continuing to live independently, with appropriate support from the community.

To ensure that, community treatment coordinators are involved before an individual leaves the program. A plan is made that ensures a smooth transition and minimizes the risk of a decline in mental health or social circumstances. Day centers also remain an important part of an individual's life, as they provide a link to professional aid that may still be requested at any time. Due to the poorly implemented housing policy in Slovenia, finding a place to live remains only a distant possibility for most of the individuals enrolled in the program. The main cause for the current state of affairs lies in the scarcity of non-profit apartments. Most individuals suffering from a mental disorder receive only social aid or a pension, rendering them unable to buy or rent on their own. Even those that have the financial capacity to buy or rent often refuse to do so, as they are afraid that society will be unable to accept their disorder and that their contract will be terminated as soon as others find out about their mental state. Most former users therefore stay with their families, which is why our program includes intensive work on a user's relationship with his family.

We are trying to improve and expand our community housing program, as it answers a real need. Smaller, marginalized groups in particular have shown tremendous interest in the project, which will enable them to

remain a part of society in the future. In this effort, we are limited by the system itself, both by the aforementioned housing policy and the existing employment mechanisms. In practice, it often happens that a person has graduated from the program and is more than capable of taking care of themselves, yet they cannot start an independent life as they are simply too poor. Slovenia particularly lacks the advanced mechanisms in place abroad, infrastructure, subsidized rent and financial aid. .

ŠENT's programs are therefore limited and include 11 housing groups, 5 in central Slovenia, 3 in the Savinjska region, 2 on the coast and 1 in the North-West of the country. There are several people in the program that have received individual housing and are thus not part of housing groups. They enjoy flexible support that does not rely on scheduled interventions.

Regardless of their status, participation in a ŠENT housing program guarantees equal legal rights to an individual joining a housing group. A contract binding the resident, financier and the contractor is drawn up in every case, ensuring a full measure of responsibility and rights.

What separates a ŠENT program from other services underway in various institutions? Admission to a ŠENT program is very informal, which reduces the anxiety felt by users (5). Although collecting data and documentation is a requirement and a prerequisite for any serious enterprise, we try to maintain a humane approach, characterized by our focus on practical skills and knowledge. As participants master our programs they also achieve independence and all the necessary social skills they require to lead a life free of assistance from either us or other institutions.

Because ŠENT is not limited by norms, we offer a much larger degree of flexibility required to make sure that our participants are treated as individuals. We offer aid that is individually tailored to our users and their goals. The treatment of an individual while taking into account his circumstances offers a host of options not available elsewhere.

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Tone Vrhovnik Straka

Family and us

Even though my family wishes me to move beyond my illness, I have no idea how to do so when the world knows what I'm like. The situation at home does not help, as I'm dependent on my family who make sure that I take my medicine, lest I burn down an orphanage, while simultaneously making sure that I do not forget how out of touch and fat I am due to it. Money is also an issue, as it cannot deposit my pension or my social aid in the bank, seeing as how the social aid will dry up as soon as some bureaucrat decides that I can live off my savings. This leads to bad blood between my parents and me, who worry about my future and my physical wellbeing. A gym membership costs money-money that they do not return when you feel bad and cannot go.

This bleak picture of my life shows how unprepared most families that are forced to deal with mental health issues are. Even in the information age, with information freely available, numerous support systems and other benefits, the realization that life has to change takes a long time. These families come from all social and educational classes, yet they are never truly prepared to help in such a situation.

The prognosis for mental health patients is, obviously, not good. Most of those, who like me, have developed mental health problems during their school years, will not be able to finish their primary education, much less an university course. They will not have a family of their own and will stay with their parents living off social aid. Some will be lucky enough to find work and will live off their retirement money. I believe that having a mentally ill person in the family will drag everyone down by a step, as most people will see us as a slightly round, sluggish people who are often annoyed and lethargic, maybe even spoiled. Even within the family, most have no means of distinguishing between a simple bad mood and a serious change in our condition. This places a great deal of stress on a family member, especially when they want to campaign on our behalf. How are they to know whether a person is sick or simply spoiled from all the care you've been giving them?

The service user's recommendation

Families are wholly included in the rehabilitation team. They are first educated and prepared, and then the situation is evaluated by a number of professionals. In more difficult cases, additional help is given to the more sensitive members of the family. We try to evaluate whether the family is already benefiting from the appropriate social aid systems and then inform the family of any possible benefits or other issues at hand (such as a transition to a family of a disabled individual statues, ownership and inheritance issues, employment options etc.). In case the affected individual does not have any next of kin, he is gradually introduced into a housing community and, later on, into a fully independent life. Through this process, we try to enable families to receive all rights and benefits that will allow them to lead a full life.

Working with families

The most important step in introducing a family to life with a severe mental disorder is the development of appropriate relationships. This can only be done when those in the family feel no guilt or shame stemming from the mistaken belief that their actions are the cause of illness. Many parents believe that a permissive upbringing or an overly strict one is to blame. They sometimes do not realize that there is not one person alive that does not wish to change something about the relationship they have with their family, yet only a handful of people ever suffer from mental disorders. Severe mental disorders, such as schizophrenia or bipolar disorder are primarily illnesses, and are not caused by families. They are caused by a complex series of factors, including a person's genetic and physical makeup. However, we must remain aware that feelings of shame and guilt are so common that family and other important people in a patient's life need to be asked about them, even if they do not approach the topic. As long as these feelings are mitigated, a proper relationship can be formed between the patient and his family. A relationship is considered appropriate when those involved (1): possess proper perspective, accept the illness, are in balance with their family and have realistic expectations.

We will summarize several manuals intended for families who include a person with a mental disorder. One of them is the Australian SANE Guide for Families, a manual that uses the family perspective to provide an appropriate approach. SANE is a national charity helping all Australians affected by mental illness lead a better life through support, training, and education.

The first thing any family member or a professional should learn is that a high level of emotional concern does not benefit the patient or positively influence the treatment. Neither hostile behavior nor an overprotective attitude will help, but neither will a lack of information or support.

As stated above, families need to be freed from feelings of guilt or shame. There are many approaches to this end, including psychoeducation and other approaches that increase feelings of security and trust within the family. Family based interventions are proven to be effective in improving prognosis and reducing the number of relapses. Psychosocial support programs, on the other hand, are very effective in reducing high emotional

concern (2), which is important in all forms of treatment and support, including those outside the nuclear family.

Mental illness may completely change the life of everyone in the affected family. This always leads to a number of concerns and questions about the treatment and recovery process. The most frequent ones are about (3):

- Mental disorders, medical interventions and treatment;
- Family dynamics, relationships and feelings in families where a member has a mental disorder;
- Protecting ill family members;
- Sharing experiences and concerns;
- Outside help;
- Acceptance;
- Ways to manage the disorder and factors causing stress;
- Communication;
- Stigmatization;
- Suicide;
- Financial difficulties.

In October 1998, ŠENT organized a round table focusing on family members and caregivers of those with mental disorders. The most significant conclusions that we made then are listed below:

- families of those with mental disorders do not need therapeutic treatment, but rather concrete daily assistance in addressing practical problems. Professionals mental health service should in part redirect their efforts from psychotherapy and group work to continuous support at a patient's home;
- families expect financial assistance and aid from the state, as they are taking on a formerly institutional responsibility. Social aid, tax exemptions, security bonuses and other forms of aid could be accepted;
- professionals are expected to maintain a professional and respectful attitude, provide support and offer trust, especially in when a forced hospitalization is in place;
- families require organizations to represent their needs and the needs of patients;
- families require a network of support services to be established and maintained. These services are meant to improve the patients' quality of life and reduce the pressure on the caregivers.

Basic recommendations offered by most manuals are that following goals should be achieved:

Confrontation – confronting the fact that a family member is mentally ill is hard. It means that all the family members will be affected. It usually leads to feelings of anger, confusion, loss and mourning. These emotions need to be accepted and discussed.

Developing a balance between:

- admitting the illness and its effect and maintaining hope for a recovery;
- the desire to help and accepting a patient's independence;
- showing concern and stop being overbearing or over-engaged;
- spending time with the patient and having time for oneself and other members of the family;
- encouraging the patient and maintaining realistic expectations.

The most important recommendation among these is definitely achieving the fine balance between support and concern. A patient must be encouraged to achieve independence and take responsibility, which can be hard to do. It is therefore highly recommended that a family remain in close contact with a team of professionals that can provide advice in specific situations.

Discussing emotions

Mental illness usually represents a significant emotional burden on the family. Therefore, it is essential that these emotions and feelings have an available outlet. Despite the fact that discussing our emotions can be healthy, an overbearing or overly concerned attitude may negatively influence the illness' development. It is best for everyone involved that a team of professionals be consulted before any such discussion. Support groups and other self-help options are also available to family members in need.

When the condition of a family member takes a turn for the worse, the following guidelines may help with dealing with stress of relapse or the first psychotic episode:

- all communication should be clear, honest and understanding. The patients should not be forced or unnecessarily touched or in any way made anxious;
- a calm and secure environment should be provided and all objects that the patient can use to harm himself or others removed from it;

- family and professional staff should behave in a calm, decisive and friendly fashion. Threats are to be avoided at any cost;
- in the event that a patient had had suicidal thoughts, a history of self-injury or aggression a psychiatrist must be contacted immediately. The family, including the patient, should have a contingency plan designed for such an event. Professional staff should rely on treatment protocols.

Various approaches to helping families

One of the more successful approaches to helping families incorporates several components:

- An evaluation of issues faced by the family and family inclusion.
- Education and symptom monitoring. If family members cannot recognize symptoms and effects specific to the illness at hand, if they do not know how the illness is treated and what the chances for recovery are, they have little chance of helping the patient. Sometimes family members mistakenly attribute symptoms to the patient character instead to the illness or misread their significance. The answer lies in psychoeducation and other forms of education.
- Communication training: Family members should master asking for assistance when it is needed. Stigma can be increased by unwarranted feelings of guilt and stop family members from seeking aid. Families can also benefit from support groups that offer communication skills training and confidentiality. Such groups often include members that can make the family's experience seem normal or average and offer advice and assistance when needed. Communication training is further composed of courses in calm response, patience and understanding.
- Goals definition: Realistic expectations need to be established. By removing unrealistic expectations, family members will find it much harder to negatively influence the patient. Consider the example of a patient who has been hospitalized for several weeks. Upon his return home, his family will expect a full recovery. He himself might want to immediately resume his education or employment. He then adds several additional activities to his daily schedule to make up for time lost while in the hospital. All this severely increases his stress levels, leading to a relapse. A slower pace of recovery might be more appropriate.

- **Problem resolution:** This is an integral part of any approach and is related to emotional control and day-to-day problems resolution. It consists of identifying and defining the problem and then forming response strategies. A strategy can be formed by organizing existing knowledge, identifying possible sources of assistance, and identifying relevant skills. Over the course of applying a strategy, progress must be monitored and the resolution evaluated. It goes without saying that such strategies are best tested in simple scenarios and a restricted environment. After successful testing, such a strategy can be employed as desired.
- **Behavioral methods of self-control and symptom control:** The latter is important in preventing relapses. Every patient has a unique pattern of symptoms that are mostly consistent before every relapse. Excessive sleeping, anxiety and fear, irritation, difficulties accomplishing mundane tasks, tiredness, confusion, low attention span and sadness are all typical symptoms and should be noted.
- **Controlling stress:** To control stress levels, a patient and his family must learn what triggers anxiety. The patient may be responsible for documenting such experiences in order to recognize them in the future. A log of sensations and emotions and corresponding behavior should be kept. Such a tool allows the patient to find alternative solutions and ways to avoid stressful situations. Dealing with stress requires strategies that can be developed by the patient and the family, who must also provide the patient with a safe space to retreat to.
- **Maintaining improvements:** A program that reduces critical comments and intrusive behavior from the family must be instituted. This program should, at the same time, also provide the patient with the support needed to monitor his medication and take it regularly, along with symptom control assistance and developing behavioral skills (3, 5).

A few other general recommendations (6):

- **Cooperation between the patient's family and the psychiatric team:** When a patient actively cooperates this significantly increases the possibility of a successful outcome. The family should encourage the patient to cooperate and honestly report his condition, feelings and doubts.

- **Creating a relationship:** This includes creating an equal relationship, allowing the patient to take responsibility and set boundaries. People with mental disorders often feel that they have lost control and are stigmatized. This is accompanied by a poor self-image that requires that they be treated with respect, no matter how pronounced their symptoms are. Ultimatums on banal subjects are best avoided, while as much responsibility as they can bear should be given to them in regard to important issues such as medication. While a patient may occasionally attempt something that the family believes is beyond his capabilities, they should still allow him to do so. Such situations often turn out surprisingly well. A well-defined daily routine with corresponding boundaries should be created. These boundaries are especially important when dealing with aggressive patients. It goes without saying that all members of the family should respect these boundaries.
- **Recognizing a patient's courage and maintaining and expressing hope:** Anyone suffering from a severe mental disorder who has gathered the courage to return to life in his own way. We must remember that many manage to recover from their disorder and lead a fairly normal life, which is not possible if they are not given enough time.
- **Self-help:** Family members should not forget that they have limits of their own and that they require rest, leisure and socializing outside the family. This must be noted and planned for in advance, as many families forget about themselves until they are completely exhausted. Without replenishing one's strength there can be no help to give.

The influence of illness on siblings, children and partners

In general, the influence of illness on patient's parents is noticeable and well documented, while it is often forgotten that other members of the family might be influenced. The latter often experience strong feelings of shame and embarrassment that force them to distance themselves from the patient and their home. Patients with severe mental disorders often require much more attention than their siblings, which can lead to feelings of jealousy and resentment. On the other hand, feelings of sadness and guilt may prevail. Many feel that the illness has taken away the person they once knew and shared their life with. An illness almost always causes changes in

family roles. A daughter might become a replacement parent, a wife, who was previously at home, might become the family's breadwinner. Another negative influence that an illness might have is the increased stress siblings experience when trying to compensate for the family's loss (1).

The following is a selection of observations made by patients' families:

The most common violations of family rights

In practice, many families cannot participate in the treatment process. While family members understand that a patient must first consent to the inclusion of family in the treatment process, they still believe that we are the strongest allies a patient can have on his path to recovery. As such it is both useful and right for families to be included in every phase of treatment and rehabilitation. They also believe that they should have the right to accept or refuse the role of caregiver. They believe this is necessary as they too have finite amounts of energy and a right to a peaceful retirement. Families might become financially or socially threatened, especially when the cost of treatment and rehabilitation places vast amounts of stress on breadwinners. This leads to a fear of the future, uncertainty, and anxiety and ultimately increases the possibility of mental disorders among those who have none. We believe that we have the right to live decently. This is in response to the fact that a person with a mental disorder often requires family members to give up their own, private space. We have the right to community mental health care and to access an integrated support and assistance network present in the community.

How to help oneself?

My own (Edo Belak) experience shows me that family members must fight for and protect their rights primarily on their own and that the strongest support we can count on comes from NGO's and their own family member organizations.

A worthy example of this is the Slovenian Family Members Forum (SFMF), which works as a counseling body to the Slovenian Mental Health Association (ŠENT). SMFM has through its work attracted the attention and the cooperation of numerous other NGOs, culminating in the establishment of the Committee for the Family Members of Those Suffering from Mental

Disorders. In cooperation with the Council of users we have managed to get the Mental Health Law passed in 2008, thus at least in part protecting and ensuring users' and family members' rights. The battle was won, but the war still rages. We continue to do work on the behalf of both users and family members and are determined to help all of us achieve a better, higher quality life. The power us family members have, lies, for the most part, in cooperation between our organizations both within and outside our borders and the users that keep reminding those responsible of all the unsolved issues in the field of mental health.

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Counseling

The goal of psychotherapy is to reduce pain and obstacles to a fulfilling life. It aims to improve self-understanding and self-fulfillment (1).

While preparing this chapter on counseling in the field of severe and chronic mental health disorders we found that most workbooks on rehabilitation avoid this topic. There are mentions of behavioral and behavioral-cognitive approaches to symptom management in severe mental disorders such as schizophrenia, yet the word psychotherapy remains neglected in favor of »psychosocial intervention«.

The theory of psychotherapy is based on the theory of objective relationships. This theory explains a psychotic state as a regressive state. A regressive state is one characterized by destroyed logical sequences, vague thought patterns and object fragmentation. The division between self and other is malleable in this state. People suffering from psychosis therefore feel estranged from themselves, different and, consequently, utterly alone (2).

Principles

The first principle of psychotherapeutic counseling in people who have experienced a nervous breakdown so severe that their sense of reality has been compromised is creating a safe and trusting environment. Psychologically speaking, a psychosis is a regressive process connected with early phases of development. As a child, a person is both in feeling and fact, completely dependent on others. His sense of self is, correspondingly, brittle and vague, as are his conceptions of others. The need for stable and secure relationships is consequently extremely pronounced in those suffering from psychosis.

Counseling should be done in a place free of stress and little emotional tension. There are parallels to the most important piece of advice given to family members of those suffering from mental disorders: »Low levels of emotional concern, non-intensive displays of those emotions and a calming environment are crucial to the recovery. «

We can imagine that a person experiencing symptoms of psychosis is experiencing an immense and overwhelming number of stimulations coming from within. We should attempt to reduce those coming from outside. Even those people not suffering from psychosis can occasionally be overwhelmed by information, which can lead to crisis, excitement or inappropriate behavior. A person suffering from an overabundance of ideas and stress of the nervous system is far more susceptible to outside stimulation. This is the reason why working with such individuals in group settings is extremely difficult. A group setting overwhelms such an individual with both verbal and non-verbal information, causing the individual to have difficulties with focusing his attention. Most people do not find it strange if a person chooses to avoid crowds in malls or at parties, which makes it strange that a patient's right to restricted access is often ignored.

The foundation of any psychotherapeutic work is an honest, focused and nonjudgmental listening. It should also include empathy, accompanied by support and acceptance to the highest possible level.

Many methods can be used in psychosis psychotherapy, provided that the person administering them is qualified to do so. An acceptable qualification is no less than a diploma issued by an internationally recognized psychotherapy educational institution, which should in turn be recognized by a relevant national body. These methods include cognitive-behavioral psychotherapy, systemic (family) psychotherapy and analytical psychotherapy. Psychotherapists working with those suffering from psychotic disorders should be especially familiar with psychopathology, a branch concerning itself with the study of symptoms, as recovery can be negatively affected by intensive psychotherapeutic procedures. Regardless of technique, psychotherapy should always be based on an equal, caring relationship, characterized by low levels of stress in treatment and high levels of support.

Psychotherapeutic continuum

Psychotherapeutic methods vary in intensity, from high in analytical treatment to lower in cognitive-behavioral treatment. A patient undergoing analytic treatment is required to form free associations, expose subconscious impulses and conflicts. This can be extremely painful, demanding and can be seen in individual analysis, group analysis psychotherapy, transactional analysis, psychodynamic therapies and Gestalt analytic approaches.

Cognitive-behavioral therapy is less stressful and can assist in solving mental issues by changing thought patterns and, particularly in psychoses, use rational recognition and control of issues and symptoms. Psychoeducation and controls skills are further down on the intensity scale, as are revealing one's own past, empathic communication and containing of what is received. We will not describe each of the methods, as they must be studied intensively. Suffice it to say that low-intensity treatments and methods are generally better suited to those with severe and chronic mental disorders (3). Regardless of approach, our methods should include support, an umbrella term for genuine assistance when needed, and expressing care for an individual, and effective communication. Support is given by individuals, hence the difficulty in describing it. While our personal traits might influence the type of support we offer, it always includes commitment, a demonstration of a caring attitude, acceptance, a message of equality and cooperation, a communicated belief in the possibility of recovery, respect for one's personal defenses and focusing on capabilities (4, 5).

Empathic communication that takes individuals into account, as well as their emotions and control is thus the basis of any psychotherapeutic process in psychotic disorders.

Cognitive therapy of psychotic symptoms

In recent years, the focus of psychosocial treatment of psychotic disorders has shifted from behavioral to cognitive methods. The main subject was residual symptoms, hallucinations and delusions in particular. The first pilot tests showed that such treatment is effective in reducing belief in delusions, which led to an expansion in research. Behavioral-cognitive approach is now employed in the wider field of psychosis. Kuipers and associates (6) have found that approximately 50% of those treated showed significant improvements. CBT (cognitive-behavioral therapy) as a mode of psychosocial treatment is exceptional in the fact that it has no known side effects, and that clients undergoing it seem to enjoy participating in it. The positive effects reported by patients engaged in Kuipers' research showed not only stability but also improvement over 18 months of treatment. Conclusive clinical improvement was shown by 68% of those undergoing CBT treatment. The number of delusions and their effects were reduced. The frequency of hallucinatory experiences was also reduced.

Several comparisons with other treatment methods were made. Intensive CBT treatment showed that it was significantly superior to routine treatment. A nine-month therapy was proven comparable to unspecific supportive relationship with the therapist, yet only the group that received CBT treatment retained the progress they made. (7).

Therapists using CBT treatment in treating those suffering from psychosis agree that professional help and methods require a complementary relationship between the patient and the therapist. Psychotic symptoms cause severe stress that is, in general, not understood by others. This leads to concealment and loneliness, which makes it necessary for the therapist to establish an accepting and trusting relationship.

Cognitive remediation

The term cognitive remediation has seen a lot of use recently. It describes learning, practical individual exercise and group discussions, all aimed at improving cognitive function (8). Put simply, it is memory training that improves learning and concentration capabilities. Wykes and Reeder, authors of the workbook on cognitive remediation begin the description of the technique by stressing the importance of the environment therapy takes place in and the importance of the therapeutic relationship. They direct our attention to the first rule in the technique, which is reducing outside stimuli- thus making learning processes easier. The second rule states that the therapist and the patient should, at least initially, meet alone (9). This directly contradicts the existing doctrine of group work, which is designed to reduce demand on hospitals, day centers, institutions and housing group staff.

Working with families

The basis of working with families is the Expressed Emotionality Index (EE). In families with a high EE index, i.e. those exhibiting frequent critical remarks, hostility and overly high levels of concern for the patient, patients show a higher number of relapses than families with a low EE index. One of the most important therapeutic methods in severe and chronic mental disorders is therefore psychoeducation, which can reduce the EE index (10). Psychoeducation informs families on symptoms, causes and effect of the

disorder, which most often reduces guilt. The lack of guilt increases stability, reduces stress and, consequently, the EE index. Families with a high EE index find dealing with an illness much harder and can actually increase risk of relapse by creating an unpredictable environment (9). The same principle can be applied to members of the profession seeking to help. The main methods of working with families should therefore be supportive and informative in nature. Promoting mutual assistance is essential.

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Self-help organizations in the field of mental health

Introduction

Mental health issues profoundly affect all areas of our lives, including education, employment, social status and social circle to name but a few. All of these changes increase the stress that an affected individual is under and in turn present new problems and questions. To ensure that an individual has the highest quality of life possible, it is important that they acquire strategies that allow them to take control over these changes. These strategies are not only meant to help individuals manage their mental health issues, but also manage their effects to the point where they are capable of reclaiming their life.

Regardless of the individual's commitment to these strategies, he or she still needs the help of both family and society. Society can provide an individual with a number of extremely effective exchanges and meetings with those who are undergoing similar problems or have already successfully overcome them. Options available to such individual are support groups (SG) and self-help groups (SHG). These provide a safe environment for an individual to seek help and support, while assisting others by sharing their experiences and cooperating with the group.

The development of self-help group

Self-help groups (SHG) flowered during the 1970's and the 1980's. The first SHG's, Alcoholics Anonymous groups (AA) (1, 2, 4), were established in the US in the 1930's. The first SHG in Slovenia³ (AA) were established in the 1980's, yet they did not expand into other areas of life until the change in our socio-political system in the 1990's (5). Among the more prominent examples of these are SHG dedicated to the elderly (6), followed closely by SHG dedicated to mental health issues. Users formed many of these, while members of the profession initiated others (7). The field was soon expanded by dedicated mental health professionals, who established the first support groups (SG).

3 See also: Klemenčič Rozman MM. Sami po moč: skupine za samopomoč in podporne skupine kot vir moči. [SG and SHG as source of Power]. Ljubljana 2015. Pedagoška fakulteta.

SHGs operating within certain fields or organizations often combine into clearinghouses, which offer technical, informational and executive assistance to individual groups (8, 9). Clearinghouses can combine to form national bodies (e.g.: American Self-Help Group Clearinghouse (10) that oversees and collects data from all existing groups within the country. These organizations represent both an information center dedicated to SHG and a source of support to individual groups.

While Slovenia still lacks a nation-wide organization, there are several groups that are connected through various organizations, societies and associations. The situation is the same for support groups operating in the mental health field, including those that provide support to affected families or individuals. Despite the delay in establishing these organizations, they have increased in number over the past few years, along with professional interest in their operations.

Self-Help Groups and Support Groups in the field of mental health

Self-help does not mean that people should rely solely on themselves (i.e.: individual self-help), but rather the opposite of help from other sources, such as the church, state, nation and other entities. Self-help means that the impulse to help originates within a person. Any entity that organizes itself with the intention to help can thus be engaged in self-help (4).

We consider a group an SHG when people organize themselves into groups that offer mutual support and assistance. These are mostly small groups that meet voluntarily to solve a specific issue and are, at least not initially, a part of a bigger organization (1, 11). In these groups, members often share the same issue and the same goal (recovery), past experiences and stigmatizations. This leads to a high level of understanding and support.

They are personally committed to and responsible for their work. The members are equals-which includes the leader of the group, as he is usually merely responsible for coordination⁴ (12, 13, 2, 14).

4 More on mental health SHG, their characteristics, organizational methodology and founding practices: Lamovec T. Psihosocialna pomoč v duševni stiski. [Psychosocial help in mental crisis]. Ljubljana 1998: Visoka šola za socialno delo ter v Campbell P. Kako začeti. [How to start]. Maribor 1996. Ozara.

SHGs in the field of mental health can be divided into:

- Groups that intend to alter the existing mental health system,
- Groups focusing on personal improvement,
- Combined groups that mean to affect both social and personal changes (15).

Support groups (SG) are the other form of mutual assistance groups (16). Based on SHG, they overlap in function and organization to some extent (i.e.: people are similarly encouraged to share experiences). SGs offer therapeutic group support involving mental health professionals in addition to SHG services (17).

The differences between SHG and SG are described in Table 1 below. Such descriptions are usually the result of comparing ideal organizations that are very rare in practice (13). Actual groups in operation most often possess a combination of characteristics of both types. An overview of the available literature shows that both SHG and SG operate within the field of mental health, with SHG being more common amongst users, and SG amongst family members. The reason for this is that organization amongst users are mostly led by users themselves, while organization amongst family members are usually established by professionals employed in the field of mental health. The situation is very similar in Slovenia.

Table 1: The differences between SG and SHG according to: Farris Kurtz (13); Schopler and Galinsky (17)

Criteria	SHG	SG
Definition	A group dedicated to support, education and personal improvement. All members share an issue or condition.	A group in which members offer mutual emotional support and share information on a common issue.
Intention	Personal/Social change or both.	Emotional support, education. Behavioral and societal changes are not considered as important.

Criteria	SHG	SG
Ideology	Present and intended to aid in confronting the issue.	None or only in exceptional cases.
Leadership	Mainly shared amongst members	Often by a professional or a volunteer. Members lead only in exceptional cases.
Participation	Voluntary	Voluntary
Contributions	Voluntary, no contributions or membership fees	Voluntary, no contributions or membership fees
Professional presence	Rarely active (except in case of membership).	Group often established by a professional. (Equality among members. Competence and education translates into legitimacy, rarely shares the issues experienced by members)
Membership	All facing the same issue.	Limited to members of the organization managing or sponsoring the group)
Meetings	Structured, focused on the task at hand, the use of specific methods of help.	Unstructured
Autonomy	Local groups, mainly independent from national organizations.	običajno organizirane znotraj nacionalnih organizacij ali lokalnih strokovnih delavcev
	Normally organized within national organizations or by local professionals	

The processes that take place in SHGs and SGs are: Support, information exchange, offering a feeling of acceptance and belonging, exchanging experience, exchanging practical and learning new coping mechanisms. The processes exclusive to SHGs are: reforming identity, strength recovery, achieving comprehension, changing the perspective a member has of the issue at hand and creating a new community (13). Later on, two of the processes that are rarely mentioned in Slovene literature are more closely examined.

In certain circumstances SHGs and SGs can be destructive to their members.. This is usually an effect of over-revealing intensive and negative emotions (18), pressuring group members to conform, stress connected with obligations to the group, a feeling of being overwhelmed, learning inappropriate and non-effective responses, crisis and overconfidence (17).

SHGs and professional assistance in the field of mental health

Most people that we meet in SHGs in the field of mental health already have some experience with professional help. It seems plausible that people join SHGs when they are confronted by the limits of effective professional treatment. This means that both people who see SHGs as a parallel form of treatment as well as those who were directed to one by a professional are present. SHGs are often also composed of members seeking alternative treatment methods and those who use it as a base to seek professional help (19).

SHGs were initially almost completely independent of professional assistance and presented an alternative to such treatment. Connections between the two forms of help (20) started to develop. Today, SHGs and SGs are common companions to the more formal methods of treatment offered by the health industry. They are accessed by those seeking help due to a health or psychosocial crisis and are established in both prevention and treatment (1). The situation in Slovenia is the same.

An evaluation of how both approaches work together in the field of mental health shows that patient membership in a SHGs significantly decreases the number of days spent in a hospital and increases satisfaction with work and education (21). In cases of addiction, patients attending an SHG have sought professional help less frequently, a decrease in hospitalizations and an increase in abstinence were recorded (22). Younger patients also benefit from SHGs as a safety measure, particularly those in risky environments

(23). SGs for families significantly contribute to reducing stress and increasing feelings of competence in one's own role and positive personal changes. Family members also feel that they received more emotional support and they perceive improvement in the diseased family member clinical condition (18, 24, 25).

It often happens that mental health professionals recommend self-help, while not completely trusting it (26). A Slovene study showed that leaders (N = 146) of those SHGs and SGs that are removed from professional assistance estimate that both knowledge and inclinations that professionals have of and towards these groups could be improved, while 634 members of these groups expressed a high level of satisfaction with their membership (M= 8,44, SD = 1,74, scale 0-10) (27).

Experiential knowledge

Many SHGs and SGs occasionally invite professionals to the group in order to inform and educate their members. While they are aware of the meaning of professional knowledge, they are also aware of the fact that professional knowledge is not the only pool of knowledge available. Personal experience is an invaluable resource, especially experience gained in overcoming or surviving a problem. This type of knowledge is different from professional or layman knowledge (13, 11). Every person who is a member of a SHGs or an SGs has a wealth of experience to draw on.

Some SHGs and SGs members choose to complement their experiential knowledge with professional knowledge, whether through books, articles or additional education. Such members may become professionals who share the weight of such an experience and possess vast reserves of experiential knowledge. Caron-Flinterman (28) explains experiential professionalism as a combination of a holistic experiential knowledge and knowledge that goes beyond the boundaries of an individual's experience.

The recognition of experiential knowledge of patients began as late as the 1980s, and quickly developed into a movement. Those supporting this movement are convinced that knowledge of medicine, treatment and health in general is no longer being developed solely in clinical settings, but also by groups of patients using various forms of self-treatment (29).

Today, many counties take care to educate those with experiential knowledge in order to provide others with professional help. They are invited to

be lecturers in various forms of patient education. Slovenia has not come far in this particular area, even though ŠENT has been running and developing programs in which the lecturers have all had firsthand experience since 1996. Both “Help and self help in mental crisis” and the “Community mental health” programs were spread over several regions; the first ran continuously up until 2006, while the second ran throughout 2014.

Most professionals in the field of mental health approach both users and families from a position of authority and strength, not being aware that professional knowledge is only a part of what people require. When treatment begins, people like to hear from those who have shared their experience. They are given hope, confidence and willingness to cooperate. In the recovery period, they should talk with an experienced veteran, one that can help them overcome issues and find coping mechanisms. Later on, this form of help can be only occasionally employed to help a patient deal with specific issues.

The Helper Principle

Helping another has a therapeutic effect both for the helper and the helped. SHGs provide a framework in which such help is accessible to all members, with all the corresponding advantages. People who provide help reject the passive role of the »patient« with an active, socially valued role of an individual representing an example to those who are still in recovery. Accepting help is destigmatized in such situations (30).

The person offering help receives several personal benefits from effectively helping others. A successful intervention or act of help increases feelings of competency and value, educates and improves confidence (31).

Borkmanova (11) expands on the influence of the helper principle by noting that not only does the principle combine the helper and client in a single person. A new community is built around a client, where stigma is normalized and an individual has the capability to identify as complete personality, restricted capabilities and limits included. Lamovec (12) similarly states that self-help and professional help are not to be judged by the same criteria. She concludes that the two forms are complementary.

Obsessive compulsive disorder (OCD): A personal experience

»When things were at their worst and I didn't dare tell my psychiatrist what I was thinking and how bad it actually was, she suggested that I should talk with someone who has gone through the same thing. How? Nobody I know went through this. The psychiatrist gave me someone's phone number and explained that she and the person on the other hand have an arrangement-she was supposed to give the number to those that want to talk about dealing with OCD.

I hesitated for several days before making the call. Neja answered, and in a minute we were chatting like old acquaintances. Similar problems, similar fears... Over the next few weeks I started to feel better, the medicine helped, as did Neja. She could offer encouragement like no one else, having completely overcome her obsession and compulsions. When I came back to see my psychiatrist for a check-up I told her that I wanted to do the same thing as Neja. I gave her my number and told her my time was at her disposal. A month later I got my first call. Although OCD caused me no end of trouble, I managed to make some great friends along the way. We see each other every week. There are 8 of us, and we Skype together all the time. We have all already seen one another, but there's problem. We all live far apart, so I cannot see how we're going to establish a self-help group.«

This is only one amongst many stories that prove how effective the helper principle can be and how underused and underappreciated it can be in the mental health treatment process. Experts and professionals should offer help where it cannot be replaced and it is absolutely necessary. When people have the option of mutually supporting each other, such processes should be encouraged, as they can create new communities that can add immense value to an individual's life.

Conclusion

SHGs can be the first form of assistance that an individual turns to, or an excellent aid to existing treatment and rehabilitation. If an SHG is the first form of assistance an individual turns to, this gives him the information necessary to find other forms of assistance. An individual will adjust his expectations and find things in general easier to manage. This benefits both the society and the individual. An individual might become a member of an

SHG as a complementary form of treatment or rehabilitation, or as a means of receiving additional support and assistance in order to shorten the treatment and make it easier. If the profession and SHGs/SGs manage to establish open and cooperative relationships, both forms can become even more effective and capable of offering individuals exactly what they need.

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Maja Valič, Pika Bensa

Psychoeducation

Successful treatment of mental disorders and other mental problems is only possible with a wide support network, provided by the health services and the local environment. Faster and more effective treatment can be achieved when individuals choose to learn more about their disorders. Psychoeducation is often described as one amongst many therapeutic approaches to treating those suffering from mental disorders and their families. It is often used in treating schizophrenia, psychotic disorders, bipolar disorders, depression, anxiety, eating disorders and personality disorders.

The term “psychoeducation” can be interpreted in several ways, mainly relating to the area of personal and interpersonal relationship and skills, used by individuals to resolve present and future psychological issues, increasing their general satisfaction (1). The understanding of the term changed with time and adjusted according to therapeutic needs. The modern definition incorporates all aspects of psychoeducation, including systematic, didactic-psychotherapeutic interventions for the aim of familiarising the patients and their families with the illness and treatment processes. Psychoeducation further helps them understand and manage the illness responsibly. The origins of psychoeducation can be traced back to behavioral therapy. The current understanding of psychotherapy includes elements of client-focused therapy as well. In the field of psychotherapy, psychoeducation stands for those components of treatment that emphasize communication between those afflicted and informing others about the treatment of different illnesses (2).

Psychoeducation represents a part of the treatment for those with mental disorders. Family members and others who live or interact with patients are often included (3).

There are many different programs of psychoeducation and ways of implementing them. They all share certain goals. Programs for psychoeducation are meant to (4):

- Increase knowledge about mental disorders and treatment options.
- Improve insight into mental disorders.
- Improve understanding of how medications work.
- Explain the importance of taking medication.

- Improve patient persistence in the treatment process.
- Improve physical health and mood.
- Improve stress and problem management.
- Reduce the possibility of relapse and hospitalization.
- Quickly diagnose relapses.
- Create plans to prevent crises and relapses.
- Influence the speed of recovery and the level of inclusion in the community.
- Enable those with mental disorders to make informed decisions.
- Improve cooperation and communication between patients, family members and specialists.
- Reduce the family members' psychological burden.

Psychoeducation programs can be implemented either individually or in groups. Lectures and workshops are usually performed in sets of 4-16, once or twice per week. Meetings typically last an hour to an hour and a half and are mostly run by doctors and psychologists who can be assisted by members of other professions (5, 6). Many experts include patients in their programs. These "veteran" patients are encouraged to share their experiences and can improve the level of trust in the treatment process.

A sample of Slovene psychoeducation programs

Psychoeducation for patients with severe and chronic mental disorders (7, 8)

The program in question is aimed at patients and families affected by schizophrenia, schizoaffective disorders, bipolar disorders and delusional disorders. Even though the same materials are used, patients and family members attend separate meetings. The psychoeducational program was designed by prof. dr. Vesna Švab, through the Slovenian Mental Health Association. Patients were involved with the program as equal partners. The program is still underway in various institutions throughout Slovenia.

The psychoeducational meetings are weekly and last for 90 minutes. The literature used in these meetings is the "Priročnik o shizofreniji" written

by dr. Švab. Other printed materials are available and those attending usually take notes.

The programme is led by members of a multidisciplinary team.

First Meeting

Purpose: Establishing a partnership

Goals:

- Empathic assessment of psychopathology and functioning;
- An introduction to problems and obstacles faced by patients and family members in daily life
- Establishing an authentic, caring and empathetic relationship
- Evaluating the needs of the patients and family members
- Discussing possible obstacles preventing participants from attending meetings;
- Enabling open communication
- Establishing reciprocity between the therapist and the patient
- Displaying the willingness and the ability of responding to the patients' and family members' needs (service access, house calls, patient-doctor communication)
- "The patient is always right."

Second Meeting

Purpose: To recognize and restructure the existing knowledge about and perception of mental disorders, strengthen recognition and communication among patients, family members and professionals.

Goals:

- Acquire information and record symptoms that patients and family members already recognize
- To structure their knowledge within the framework of accompanying materials
- To standardize the terminology.
- To encourage communication with treatment providers

- To adjust information delivery (flexibility)
- To specify duration of acute symptoms (from-to)
- To encourage questions
- To achieve cooperation

Third Meeting

Purpose: To identify and structure pre-existing conceptions and knowledge relating to causes of mental illness in order to overcome prejudice.

Goals:

- Gather pre-existing conceptions and about mental illness, its causes and triggers.
- Organize pre-existing knowledge by classifying factors as biological, psychological or social
- Present the vulnerability – stress model to the participants
- Emphasize the significance and dominance of biological factors
- Explain the dopamine hypothesis and expand on it by explaining the influence of other neurotransmitters
- Stress the importance of social and psychological factors on the course of the illness
- Explain the significance of self-control
- Achieve cooperation
- Reduce feelings of guilt

Fourth Meeting: Treatment

Purpose: To identify and structure all pre-existing knowledge relating to psychiatric medication, its side-effects and how and when it is prescribed. To motivate patients to take an active part in the treatment and hold informed discussions with specialists.

Goals:

- Learn about medication and other therapeutic methods
- To structure said knowledge into segments: psychopharmacotherapy, psychotherapy, rehabilitation.

- Explain the various types of antipsychotics, antidepressants, stabilizers and sedatives and their side-effects.
- Learn about medication side-effects
- Structure pre-existing knowledge on medication types
- Describe the limits of psychiatric prescriptions
- Motivate patients for long-term treatment

Fifth Meeting: Rehabilitation, Psychotherapy

Purpose: Assist patients and family members in finding and using evidence-based forms of treatment. Help motivate them to undergo psychiatric rehabilitation and strengthen cooperation. e.

Goals:

- Learn about which therapeutic methods, beside psychopharmacotherapy, are considered effective
- Structure pre-existing knowledge and introduce proven methods.
- Get opinions on methods to be used in the community and methods to be used in hospitals
- Find out about the treatment and support services patients are already familiar with
- Structure and introduce existing services in the local area
- Introduce the community treatment work group
- Introduce the principles and method of psychiatric rehabilitation
- Improve cooperation and achieve better accessibility

Sixth Meeting: Warning Signs

Purpose: To recognize and learn more about warning signs in individual patients. Prepare a list of such signs and make a plan of individually tailored measures in case of crisis (i.e.: A crisis plan).

Goals:

- Enumerate the warning signs
- Elaborate on differences between warning signs and ways in which they appear

- Every individual prepares a list of warning signs
- Comparison
- Define possible intervention methods
- Prepare a crisis plan for every individual in the group

Seventh Meeting: Family members' role

Purpose: Reduce prejudice and feelings of guilt. Manage the level of emotional concern.

Goals:

- Explain that family members are not responsible for the illness (Research overview)
- Explain that family members can affect the course of the illness
- Acquire information on how family members can assist patients
- Define the term »Expressed Emotion Index« and why people respond differently
- Explain cultural differences
- Reduce expectations
- Explain that there is a real chance of recovery
- Define recovery
- Allow family members to form self-help groups
- Inform the participants about all forms of assistance and provide a list of options that are available

Psychoeducational workshops for bipolar affective disorder

The workshops at hand were designed for individuals affected by bipolar affective disorder (BD) and their family members. Knowledge of this particular disorder can help reduce symptoms and raise the general quality of a person's life. It's important for participants to learn about self-observation and symptom management, as these measures can significantly reduce the possibility of relapse.

The program takes the form of 6 separate workshops, lasting 2 hours each. All workshops are held at the Furlan Health Centre in Ljubljana.

Workshop content:

First Workshop

- Program introduction.
- Meet & Greet.
- Recognizing symptoms of BD

Second Workshop

- Typical traits of BD
- Causes of BD

Third Workshop

- Medication used in the treatment of BD

Fourth and Fifth Workshop

- Relapse: Early recognition
- Early prevention of relapse
- Relapse diminishment techniques.

Sixth Workshop

- Importance of a healthy lifestyle and good relationships in preventing relapses in the long term

Psychoeducational workshops for depressive mood disorder

In 2014, the National Institute of Public Health began introducing workshops entitled "Support in Dealing with Depression" as part of the national programme "Together for a healthy society". The workshops in question are now being held at a number of institutions across Slovenia.

The psychoeducational workshops on depressive mood disorder are thus being implemented in every region, contributing to preventive programmes in the primary healthcare network. All workshops are led by qualified nurses.

The basic aim of the workshops is informing individuals and family members of those affected by depression about depression, its characteristics, its course and treatment. They invite participants to share, exchange

experiences and support each other, crucial components of any successful treatment. Workshops help individuals

suffering from depression and their family members to identify the main issues, support coping strategies and support active participation in treatments.

Workshop content:

1. Recognizing the causes and symptoms of depression.
2. Getting familiar with the various treatments available.
3. The influence of negative thought processes on the mind, the body and behavior.
4. Preventing relapse.

<http://cindi-slovenija.net/> hosts the manual »Prepoznajmo in premagajmo depresijo«. A newer edition is currently being prepared (10).

Psychoeducation for neurotic, stress-related and somatoform disorders

Psychoeducational programme for neurotic, stress-related and somatoform disorders has been conducted in Psychiatric Hospital Begunje, specifically in ward B1, where individuals affected by depression and anxious disorders are being treated.

The programme takes three weeks to complete and takes place from Monday to Thursday, with daily meetings of 10-12 participants lasting about 90 minutes a day.

Meetings begin with an overview of the participants' current mood, an overview of their therapeutic tasks and a short review of previous workshops.

First meeting:

- Patient introductions,
- Discussion of anxiety and its signs,
- An exchange of opinions and experiences,
- An introduction to various relaxation techniques,
- Task: Review relaxation techniques at home.

Second meeting:

- An introduction and review of instant relaxation techniques,
- An explanation of the cognitive-behavioral model of anxiety/depression,
- An introduction to cognitive-behavioral therapy,
- Task: Monitoring anxiety triggers, noting automatic thoughts and behavioral processes.

Third meeting:

- Recognizing situations that might be dangerous to the patient and first signs of anxiety,
- Discussion on experiences and interpretation of the physical symptoms of anxiety,
- Discussing strategies for managing anxiety,
- Sharing opinions and experiences,
- Task: Noting dangerous situations, automatic thought patterns, physical symptoms and behavior.

Fourth meeting:

- Seeking alternative means of relaxation,
- Encouraging activities that bring contentment and pleasure,
- Identifying thought patterns and convictions that prevent a patient from enjoying such activities,
- Task: Patients identify and plan for activities they enjoy, as well as those they stopped engaging in due to their illness.

Fifth meeting:

- Continuing the discussion of hobbies and various other beneficial activities,
- An introduction and review of the STOP technique,
- Task: Review the STOP technique,
- Bibliotherapy: The therapist provides a list of recommended literature.

Sixth meeting:

- Identifying emotions,
- Discussing the adaptive function of emotions,
- Differentiating between normal and pathological emotional responses,
- Task: Identifying emotional and behavioral responses in threatening situations.

Seventh meeting:

- Discussing anger, accepting and giving criticism,
- Task: A review of relaxation techniques.

Eighth meeting:

- Discussing praise and self-praise and their influence on mood and behavior,
- An exchange of opinions and experiences between patients. Identifying prejudice in praise,
- Task: Focusing on the good in oneself and others, rewarding and praising oneself and one's family members.

Ninth meeting:

- Patients exchange experiences of successful use of the techniques they learned,
- Patient praise each other and discuss their mood and emotions,
- Task: Reinforcing anxiety management relaxation techniques.

Tenth meeting:

- A discussion of ruminations,
- Learning the cognitive deflection technique,
- Task: Reinforcing the cognitive deflection technique, focusing on observation without judgment.

Eleventh meeting:

- Patients share opinions and experiences,
- Teaching creative visualisation,
- Task: Reviewing creative visualisation before sleep.

Twelfth meeting:

- Patients share opinions and experiences,
- The therapist encourages patients to enroll in a self-help group (7).

Psychoeducational programmes described above are by no means the only way of educating and gathering information relating to an illness or a disorder. The term psychoeducation covers a variety of means of providing information, including flyers, workbooks, manuals and, of course, the World Wide Web. We would recommend resorting to Internet for anyone interested in the use of psychoeducational material. A wide variety of materials is available in both Slovenian and English.

A list of books, manuals and other materials available in the Slovene language:

ANXIOUS DISORDERS	Online materials	Obvladajmo anksioznost [Let's Cope with Anxiety]. A Manual for Workshop Leaders ; www.nebojse.si
		Anxiety – assistance in dealing with anxiety; www.nebojse.si
		The Anxiety disorder toolbox; www.nebojse.si
		How to help children suffering from anxiety disorders ; www.nebojse.si
		“Jaz in moja OKM” [Me and my OCD-Children] – Pfizer; www.karakter.si
		Obsessive Compulsive Disorder (OKM) – Mylan; www.karakter.si
		General anxiety - Mylan; www.karakter.si
		Panic disorder [Panic Disorder]- Mylan; www.karakter.si

ANXIOUS DISORDERS	Printed	C. Elliott. Premagovanje anksioznosti za telebane; Pasadena (Coping with Anxiety for Dummies)
		K. Rebolj. Panična motnja: tris; Ravnesje [Panic disorder, Tris, Balance]
		C. Elliott, L. Smith. Obsesivno kompulzivna motnja za telebane [Obsesive Compulsive Disorder for Dummies]; Pasadena
DEPRE-SSION	Online materials	Prepoznavmo in premagajmo depresijo [Facing and Recognizing Depression] – IVZ; www.cindi-slovenija.net
		Obvladovanje depresije za najstnike [Coping with Depression for Teenagers]; www.nebojse.si
		Orodje za depresijo [Manual for Depression]; www.nebojse.si
		Soočanje z diagnozo depresije [Facing A Depression Diagnosis]; www.nebojse.si
		Preprečevanje ponovitve depresije [Relapse Prevention in Depression];
		Sodelovanje z zdravnikom pri zdravljenju depresije [Participation in Treatment of Depression]; www.nebojse.si
		Zima v srcu: Ko se materinstvu pridružita depresija in tesnoba, radost pa odide starejšimi [Frozen Heart] – IVZ; www.ivz.si
		Depresija med starejšimi [Depression in Elderly]– IVZ; www.ivz.si
		Spregovorimo o depresiji in samomoru med starejšimi [Let's TalkAbout Depression in the Elderly]–IVZ; www.ivz.si

DEPRE-SSION	Printed	L. Smith. Depresija za telebane [Depression for Dummies]; Pasadena
		D. Burns. Kako smo lahko srečni in zadovoljni. [How to be Happy and Content]. Ljubljana, Mladinska knjiga
		B. Cobain. Ko nič več ni važno: priročnik za mladostnike z depresijo. [When Nothing Matters Anymore: Manual for Adolescents with Depression]. Didakta
BIPOLAR MOOD DISORDER	Printed	Fink C., Kraynak J.. Bipolar motnja za telebane; [Bipolar Disorder for Dummies]. Pasadena
		ŠENT. Od znotraj navzven - vodič do samoobvladovanja bipolarnе motnje razpoloženja. [From the Inside Out – Coping with Bipolar Disorder]
SCHIZO PHRENIA	Printed	Švab V. Shizofrenija - Informacija za družine [Schizophrenia: Information for Families]. Šent
		Švab V.. Priročnik o shizofreniji [Schizophrenia Manual]; Šent
		J. Levine, I. Levine. Shizofrenija za telebane (Schizophrenia for Dummies); Pasadena
OTHER	Online materials	Kratek program KVT v 7 korakih [A Short Seven-Step CBT course]; www.nebojse.si
		Ko te stresse stres [When you are Shattered by Stress] – IVZ; www.ivz.si
	Printed	Švab V. Duševna bolezen in stigma [Mental Illness and Stigma]. Šent
		Branch R. Kognitivno-vedenjska terapija za telebane [Cognitive Behavioural Therapy for Dummies]. Pasadena

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Majda Pahor

Alliance for health: collaboration in healthcare teams⁵

Modern healthcare and social care have embraced the term of inter-professionalism that has joined the previously established term of professionalism; D'Amour and Oandasan (2) define inter-professionalism as a process characterised by constant interaction and exchange of information and knowledge among team members to form a comprehensive and interconnected response to the needs of users, specific groups and the entire population and increasing their level of inclusion. The basic reason for inter-professionalism is the fact that health problems are usually complex and multilayered and call for coordinated actions by different experts (1).

Work can generally be coordinated in two ways:

- a hierarchical way that presupposes vertical levels of decision-making and implementation with professionals in subordinate and superordinate positions, and
- a collaborative way, where the structure is more horizontal and there is no significant difference in the power between subjects, or is established in individual situations based on the knowledge and experience.

Collaborative relationships are a result of conscious decisions and purposeful actions. Healthcare was and to a certain extent still is characterised by a predominately hierarchic work organization. The latter works as long as everyone involved accepts such organisation of work and as long as the social context, culture and socialisation support it as well. Another characterisation of modern times is a **growing need for collaboration** since the leaders can no longer be familiar with and control all aspects of work performed by other professionals.

The most common actual health problems are long-term conditions that call for a different and more complex treatment than acute states. At the same time, the needs and demands of patients are higher and increase the pressure encountered by healthcare and social care.

⁵ This work is extracted from the chapter: Pahor M. Alliance for Health : collaboration in healthcare teams. Faculty of Health Sciences. Ljubljana 2014. 215 pp. ISBN 978-961-6808-56-9. ilustr.

What is collaboration?

A group of researchers (3) identified the following elements of collaboration:

- bonding or sharing commonalities

The commonalities shared by all participating members are responsibility, philosophy behind the activities, values, data, planning the activities and performing the actions

- partnership

Collaboration happens when at least two actors are engaged in a common activity with shared goals. Relationships between the participants are characterized by fellowship and a constructive relationship, open and honest communication, mutual trust and respect. Partnership also entails the recognition of individual contribution and views of each and every member.

- co-dependence

Co-dependence needs to be clearly stated and brought to awareness. It is only this awareness that enables a synergy of individual effects.

- distribution of power

In collaborative relationships, power distribution is based on knowledge and experience more than on functions or status in the organization. A typical trait of collaboration is empowering of all of the participants.

- process

Collaboration is a transformative process bringing change to all of the participants both on a personal and a professional level. It is characterized by negotiations and compromises in the process of decision-making, planning as a team and intervention.

Team as a form of cooperative work

A team is a group of individuals with different levels of education, different perspectives, skills and qualifications that work together in order to achieve common goals. Members are familiar with and appreciate contributions of all members.

There are various types of teams that differ according to their organization (for example, teams can be formed with members belonging to a single profession or several professions, differences between members can be small or big, and there are also several possible levels of formalisation of the relationships), teams can have different levels of interaction (working simultaneously to solve a problem together or for example engaging in daily or weekly meetings in real or virtual space etc.) and teams also differ according to the role of the patient / client / service user. There are different types of teams, depending on their duration or location: work teams (e.g. members of the same ward) or task-focused teams (usually temporary).

Team leadership can be authoritative (the leaders having an exposed position and good reputation with their leadership focused on the achievement of goals, while the tasks of members have a clear structure) or self-directed (autonomous, democratic and teams formed on a voluntary basis with team members having an equal role and the leader acting as coordinator). Another style of leadership is a mixed or combined style.

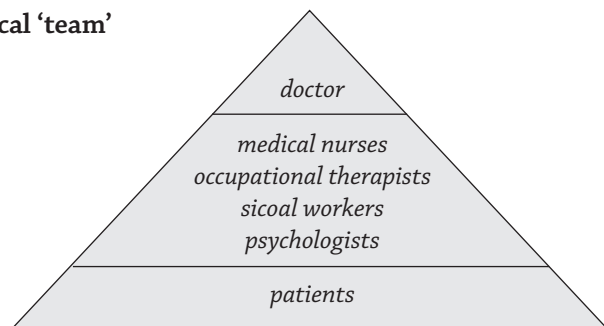
There are three general types of teams, based on how connected the activities of different team members are:

- Multidisciplinary team (members with a different professional background have different roles and do not take decisions together, work independently of each-other)
- Interdisciplinary team (more unity between members with a different professional background, members know each-other better, discuss actions and take decisions together)
- Transdisciplinary team (a high level of connection in a team, the ability to approach the task in a comprehensive manner by every member)

Healthcare teams can consist of different healthcare professionals of regulated and un-regulated professions as well as psychologists, social workers, economists, IT professionals, managers, vets, urban planners etc., depending on the healthcare problems at hand as well as the tasks (4).

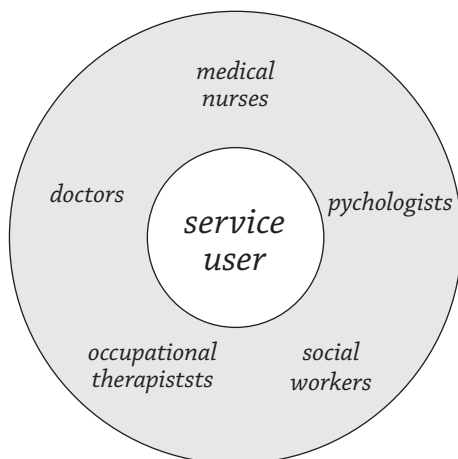
Types of teams based on the relationship between members and the role of the patient

Hierarchical 'team'



The expression 'team' is in quotes due to the hierarchy in the sense of predominance of relationships of subordination and superordination based on the members' position rather than competence or the problem at hand as opposed to the basic idea of an organisation characterised by collaboration.

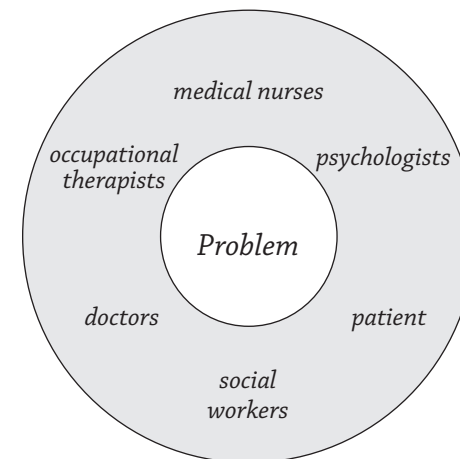
Patient-focused team



Increased knowledge base of those professions in healthcare that had a subordinate role in the past has led to more egalitarian relationships within a team.

Health problem-focused team

The patient becomes a member of the team that is based on the health problem. This type of a team is not appropriate for all health problems, but is becoming more and more frequent because of the growing prevalence of chronic disease where an active role of the patient is of key importance for outcomes.



Stages in team development

Studies (5) have shown decades ago that teams typically develop through stages that can be identified and expected, which makes them easier to understand and control.

Stage 1: Formation

Due to the individuals' need to be accepted by others and avoid confrontation and conflicts, the formation stage is usually a time when serious problems are avoided and members deal with routine questions, such as organisation of work, definition of roles, place and time of meetings etc. Individuals are still gathering their impressions at this stage. The team does not yet perform its function at this stage, instead still testing its abilities and challenges, forming goals and embarking on tasks. Members still act in an independent manner, while their level of inclusion and connection is not yet high. They are polite with each-other, but focused mainly on themselves. More experienced members act as role-models while other members model them. It is very useful for a team at this stage to familiarise itself

with the stages of team development in order to avoid surprises in the future. It is important for members to get to know each other and exchange some personal information and build friendships. The stage reveals more about how members act as individuals and how they respond to tasks.

Stage 2: Confrontation

At this stage, members discuss what the problem is, how to address it, what tasks they are supposed to perform independently and which decisions will need to be discussed and coordinated. Members become more open towards each other and compare different ideas and aspects. This stage can conclude rather fast in some cases and form decisions that are acceptable for all members, depending on the level of the maturity of members. The stage of confrontation is a necessary stage in team development. It can be time-consuming, unpleasant or even painful for the members who do not like conflicts. It is necessary to highlight the importance of tolerance and patience between colleagues at this point, otherwise the team may fail. That is precisely what happens in some cases since an environment that is full of conflicts is counter-productive in terms of maintaining motivation.

Stage 3: Accepting the rules

The team forms a clear goal at this stage as well as the plan how to achieve it. Some team members give up their ideas and support ideas of others and solutions are formed, either based on individual suggestions or combined to form a new solution. The feeling of belonging to a team is increased at this stage, all members accept responsibility for their outcomes and start working towards attaining a common goal.

Stage 4: Action

The stage of action is not achieved by all teams. At this stage, team members act in a coordinated way and perform their tasks in a smooth and effective manner. There are no more unnecessary conflicts, nor the need for control or seeking support outside of the team. All team members are motivated and familiar with the work and the roles of other members. They are competent, autonomous and able to make decisions without control. Disagreements are allowed and resolved in a manner agreed upon beforehand, e.g. at team meetings. Team supervisors are practically not needed since it is the team that takes all the necessary decisions. The team can,

however, sometimes fall back to one of the lower stages, such as for example when new members join the team or work tasks change. Consequently, teams usually go through all of the stages of team building several times.

Values and ethics of collaboration between professions

The focus is on the patient and includes working with the community or population, based on the decision to support the common good in health-care. Values reflect a shared commitment towards creating a safer, more effective and successful help system. Values stem from specific competences and value system of individual professions, including the patients and their families as equal members of teams. Their understanding of professionalism emphasizes the meaning of collaboration between professions based on 'common values' of different professionals (6), including altruism, excellence, care, ethics, respect, communication and responsibility. They come from the assumption that health is a human right. Mutual respect and trust form the basis for work relationships between healthcare professions with each profession making its unique contribution.

Knowing other team members

Each team member needs to be clear on their professional role. They should be able to present it to other members of the team in a clear way and at the same time understand the roles of others as well as how they complement each other. Being familiar with other members' professional roles is a precondition for successful collaboration (7, 4, 8, 9, 10). Diversity of team members can be an advantage as well as a problem hindering cooperation (11) as the number of perspectives a team includes thus grows. A problem that may be encountered are stereotypes, both positive and negative, that members hold about the characteristics of others (12). Collaboration calls for constant training and familiarisation with others. Generally speaking, those teams that have worked together for longer, function better.

Collaboration within a team

Team work includes coordinated collaboration without any overlapping actions, cessations or mistakes, problem-solving within a team and taking decisions together, especially in situations of uncertainty. A team is a small and complex system with every member influencing the outcomes. Consequently, it is crucial to be aware of team processes.

Conflicts may arise due to differences in professional areas and leadership styles, especially when status or power are more important than professional qualifications. Conflicts should be resolved with the patient's best interest in mind while the condition guaranteeing success should be an open and constructive communication and team problem solving.

Good team leaders stay focused on the needs of the patients and value contributions of all members. They communicate with team members in a way that improves their contributions and support team work by understanding team dynamics (15). Mutual responsibility as well as solving problems and taking decisions as a team are the preconditions typical for team work characterised by collaboration. Team processes can be improved by using tools that improve the quality of work. There are many sources available addressing team work and discussing the ways it can be improved (for example 16).

Conclusion

Healthcare still stands for an area where individuals help other individuals – and not only individuals, but also different groups and the whole of society. According to the assessment provided by World Healthcare Organisation, relationships as health factors are still 'solid facts' (17). Hence, the relationships among healthcare professionals are similarly a condition for their effective work.

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Urška Weber, Nataša Potočnik Dajčman

Preventing mental health disorders in children and young adults

Preventing mental health disorders in children and young adults is extremely important for a variety of reasons. Mental disorders represent a significant burden on society, as their effects bear a significant influence on the health, social, educational, employment and legal areas. (1). Most chronic mental disorders appear at a young age – 50% until age 14 and 75% until age 25 (2). Studies show the treatment of the disorders in question to be relatively ineffective; making preventive measures even more important (3-5). Some studies show that a 25-50% of mental disorders could be prevented with the appropriate, professional measures (6). The burden on both children and society is further increased by stigma, which makes destigmatization a significant aspect of this promotion and, more widely, a preventive measure in the populations of children and young adults (7).

1. Mental disorders are frequent among children and young adults

The prevalence of mental disorders among children and young adults is considered to be around 20% in Europe (3). In Slovenia, most children and young adults seek professional help because of mental development disorders, reactions to severe stress, adaptive disorders, eating disorders, ADHD (Attention Deficit Hyperactive Disorder) and other behavioral and emotional disorders that usually appear in childhood. The reasons for seeking professional help in individuals over 15 years of age are similar to the reasons in the adult population – behavioral and mental disorders, depression, anxiety, severe reactions to stress, adaptive disorders and eating disorders. Individuals in this age bracket also experience a significant increase in behavioral and mental disorders due to alcohol abuse, the use of cannabinoids, solvents and various combinations of illegal substances. In recent years, an increase in the number of mental and behavioral disorders among children and young adults has been noted. A significant number of them already exhibit symptoms and will, in their adulthood, develop a personality disorder. The lower age limit continues to descend into childhood in some mental disorders (First episodes of depression or schizophrenia) (8).

2. Risk and protective factors in the development of mental disorders among children and young adults

The probability of mental disorders among children and young adults is higher due to various **risk factors**, both biological and psychosocial. Individuals who are often and chronically ill, individuals with a central nervous system disorder, individuals growing up in an unfavorable environment, individuals subject to constant stress, individuals with a lower socio-economic standard, individuals with fewer friends, individuals with educational issues as well as those attending a less demanding high school are considered *especially at risk* and *demand a higher level of care*. Among prospective parents, those that are in an unfavorable socio-economic situation and victims of violence are especially at risk (3, 8, 9).

The effects of risk factors on the mental health of children and young adults can be significantly reduced by several **protective factors**. Protective factors can be divided into biological and psychosocial factors. An appropriate level of care for the mother's health before and after birth, appropriate parental care (including upbringing, attachment patterns and other familial relationships), an appropriate social circle and social support (including the development of necessary social skills and a favorable educational and wider social environment), a reasonable socio-economic status (within a family enjoying such a status or one taking advantage of financial, employment and other forms of aid meant for families lower on the socio-economic scale) and a favorable genetic makeup and personality structure of the child are considered the most important protective factors (3, 9).

3. Mental health preventive programmes among children and young adults

In Slovenia, prevention of mental disorders among children and young adults is organized in stages (8):

1. Informal community assistance (community counseling offices, preventive drives and programmes, web-based, professional and lay support)
2. Primary prevention within:

- *Primary health care* (education for prospective parents, pregnancy-specific health care, counseling offices, periodical systematic health checks of children and young adults, developmental out-patient clinics, health education),
- *Educational institutions* (school counseling services, kindergarten and school programmes),
- *Social care institutions* (children, young adult and family programs within social work centers, NGOs and family centres).

3. Multi-level, secondary and tertiary prevention within:

- *Specialist out-patient clinic health services*,
- *Specialist hospital health services*,
- *Counseling centres for children, young adults and parents*,
- *Institutional care* (youth welfare and youth educational institutions, training centres, work and protection centres, youth centres, community housing groups and recovery centre).

There is a large variety of available preventive services at all afore-mentioned levels of care. It must be noted, however, that they are not standardized on a national level and only a few are evidence-based and available at all times (8).

Assessment studies revealed that the key characteristics of proven-successful primary prevention programmes are (14-16):

- Limiting risk factors and strengthening protective factors in mental disorder development
- Learning cognitive-behavioral skills and social skills,
- Employing age appropriate and exciting approaches,
- Implementation in the immediate environment – family, school, social work centers, youth centres...
- A sufficiently long and continuous implementation of the programme,
- The inclusion of a number of significant individuals in the child's immediate environment – family, teachers, health care, social workers, police, youth institutions and others.

Within the universal primary prevention field, the most successful programmes are directed towards expectant mothers and the parents of very young children, along with violence prevention programmes and tolerance programmes in educational institutions (7, 10-13). Selective or indicated primary prevention programmes are even more effective. They are aimed specifically at children and young adults with known mental disorder risk factors or those suffering from developed less severe forms of disorders (14).

Within secondary and tertiary prevention, comprehensive programmes are proven extremely successful due to(14):

- Appropriate drug treatments when indicated,
- Appropriate forms of psychotherapy,
- Limiting risk factors and strengthening protective factors in mental disorder development,
- Involvement and cooperation of the child's family and other important members of his social circle,
- Inter-sector cooperation (health, educational and social sectors) in the form of community preventative and inclusion activities
- Ensuring formal community mental health services, i.e. "case management", where each child and his/her family are assigned a coordinator. The coordinator then ensures that the appropriate institutions perform diagnostics and other measures, including community rehabilitative and inclusion activities.

Below, two programmes that exhibit all previously enumerated characteristics of preventative programmes are listed (17-23).

Krog varnosti (Circle of security) (11) is an early intervention programme, aimed at children below 5 years of age. It is based on attachment theory. The purpose of the programme is to teach both parents and children to establish a mutually supportive emotional relationship. The programme also exists in several modified versions aimed at older children and young adults. These modified versions are intended for parents who have children at high risk of developing a mental disorder (e.g.: parents who are not yet of age, parents with a poor socio-economic status, parents serving a prison sentence, adoptive parents and foster parents, parents suffering from personality or mental disorders...) and for parents of children who were already diagnosed with a mental disorder.

Neverjetna leta (*Incredible Years*) (13) is an early treatment and prevention programme aimed at children below 12 years of age. It is a primary prevention programme that includes subprogrammes for parents, teachers and children. It is based on a developmental theory that focuses on explaining significant risk and protective factors in behavioral disorder development among children. The purpose of the programme is to strengthen parents' and teachers' skills and their roles in a child's education. This improves their ability to deal with a child's educational, social and emotional issues and consequently, benefits prevention and early treatment of any behavioral issues. In a modified form, the program has been implemented for parents of children with developed behavioral disorders, attention deficit hyperactivity disorder, disorders on the autistic spectrum or speech development disorders.

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Promotion and prevention in mental health

Mental health promotion and mental disorder prevention are becoming more and more important to countries and societies. Data shows that a large number of people suffer from mental disorders, that mental disorder can have severe effects in the form of reduced capabilities along with corresponding economic consequences, which can be immense (1). Most mental disorders appear in childhood or adolescence and persist through adulthood (albeit in a different form), affecting quality of life. They reduce a person's capabilities and increase the stress on social aid systems, the judicial system and others (2). Concrete proof exists that mental disorders can be prevented before they form. In the event that they do, they can be both treated extensively or controlled (3).

The purpose of this chapter is to introduce groups of proven preventative and promotional services in the mental health area. An overview of professional literature shows that many methods of improving one's mental condition exist, along with educational materials intended to assist parents in raising their children and educating them. Other methods include programs aimed at strengthening employers, professionals working in the field of mental health, the educational field and the social services. There is also a strong and continuous trend in the media intended to improve the mental health of the general public. The European Psychiatric Association's guidelines summarize all this by pointing out that 70% of the burden mental illness places on our society cannot be reduced by treatment. This vast percentage can, however, be influenced by prevention and promotion (4, 5).

Mental health and its status in the world are tightly interwoven with human rights. Stigma, discrimination and disrespecting basic human rights are a big burden on those suffering from mental illness, additionally, severely damaging their mental health. Besides this, societies around the world still consider mental disorders to be untreatable. This false assumption occasionally surfaces even among professionals and future professionals-sometimes even in educational materials. Effective prevention is aimed at stopping prejudice and is formed in accordance with the principles of social equality, equal opportunity and accessibility to the most marginalized societal groups. Injustice does happen, however, which makes

strengthening user cooperation in mental health services also more important. In effect this means that users should evaluate the services they use by being involved in decisions, planning and implementation. Prevention is, in essence, the message that people's dignity needs to be preserved and that the quality and accessibility of services need to be improved. Assistance and treatment needs to be organized in close vicinity of home, in the community also because of organization of preventive and promotion activities is much easier and achievable at the primary level of care. Moreover, community organization shows significantly fewer violations of human rights than community one (6).

Prevention and promotion programs can be divided according to where they are implemented, who implements them and what groups of people they are aimed at.

The first group of measures consists of political and economic measures aimed at improving nutrition, housing, education, reducing financial uncertainty and enable employment and adapted employment to vulnerable groups. This preventative measure can only be used by the state, which is obligated to contribute to the mental health of the general population. Recommendations on reducing exclusion are written down in the European Mental Health Plan and were emphasized years ago, when the economic crisis was about to descend on Europe, in the well-known Helsinki Declaration (7).

Since a person's personality undergoes the fastest and the most dynamic development during his childhood, mental health prevention and promotion programs aimed at children and young adults are a priority. Resistance to mental disorders among children and young adults can be achieved by promoting appropriate parenting techniques and implementing early interventions where children that are considered at risk for mental disorders are concerned. An overview of existing research in this area shows that programs aimed at mothers-to-be and mothers with very young children are extremely effective because they allow for early recognition of mental issues in mothers after birth. All mothers are involved in the program which makes the program non-discriminatory. The program also uses a holistic approach to evaluating the health of mothers and children, meaning that the mental health aspect is evaluated alongside the mother and child's physical health. The high value of prenatal house calls is further confirmed by research done abroad (4, 5). Identifying developmental

issues in the early childhood period through periodical examinations performed by highly qualified professionals in mental health centers (community nurses) are the other part of the prevention program, though not a well evaluated one, in my opinion.

Research further shows that school aid and support programs that include teachers and parents are very effective as well. Proven bullying prevention programs and tolerance education programs, as well as supportive environment programs are being implemented to great effect. The Australian Mind Matters program (8) includes the whole school environment and is a good example of such a program. In Slovenia, the Incredible Years program is to be initiated (9).

The third group of measures that has achieved success in prevention and promotion are workplace mental health programs, aimed either at mental health protection or support programs for those already suffering from mental disorders and so need additional support or aid in their work. Most promotional programs focus on stress control and a holistic healthy lifestyle promotion. It seems that such programs are economically successful, while also reducing the amount of sickleaves and increasing employee productivity. Protection programs for those already suffering from mental disorders are also very successful, especially in social enterprises. It turns out that employment is one of the best means of rehabilitation from mental disorders (4,5,9).

In the senior age group, understanding the connection between physical and mental health is extremely important. This can be proven by observing the correlation between mortality and good mental health, as well as the good physical health of those seniors who are emotionally balanced. 25% of seniors in the community (e.g.: Great Britain) exhibit symptoms of depression severe enough to require assistance. Dementia affects 5% of seniors over 65 years of age. Those that are physically ill are even more re at risk.

Successful prevention of mental disorders in old ager are psychosocial interventions, a high level of social support when enduring illness, social isolation prevention, physical activity, learning, appropriate housing, psychoeducation and reducing poverty. Mental health promotion and prevention in seniors is mostly implemented through house calls, physical exercise, psychosocial groups and work therapy.

The worst consequence of mental disorders is suicide. Preventing suicide is one the basic preventative and promotional activities in the European

Union. In Slovenia, suicide prevention programs have been underway for decades, mostly in the professional education field, public education and, in some areas, aid accessibility. Prevention and promotion activities are mostly headed by the National Public Health Institute. Other institutions are also actively involved to a lesser extent, including NGOs, the Slovenian Research Centre in Koper, individual out-patient clinics, media, hospitals and clinics through research.

We now know what the most important suicide risk factors are, yet it is still extremely hard to identify individuals who are especially at risk. Consequently, prevention is focused on high-risk individuals, specifically those who were recently discharged from various institutions. These individuals are to be carefully followed and educated about their disorders. Among other forms of assistance, behavioral-cognitive methods are proven successful (10).

Protective factors ensuring good mental health in every population are beneficial parenting, favorable childhood environment, significant social support networks, low levels of inequality, employment, goal-oriented and meaningful work, social capital, confidence, autonomy, altruism, emotional and social knowledge and, of course, physical health.

Wellbeing has therefore been one of the most important areas of political interest and research over the previous decade. Wellbeing is a subjective term, defined as how content with various areas of life a person is or, alternatively, how good a person judges their life to be. The current emotional state of a person making such a judgment, needs to be taken into account (11). The importance of this area of study is reflected in the fact that the World Health Organization has organized a number of events with wellbeing as the main theme. During the ROAMER (Roadmap for Mental Health in Europe) project, data was collected on the already implemented wellbeing projects in Europe. The number of publications in this area has doubled since 2007, with most publications coming from Scandinavian countries, the Netherlands and Ireland (12,13).

Mental disorder prevention among children and young adults with reduced capabilities

The most fundamental children's right is the right to the removal of obstacles preventing inclusion in society. Children's fundamental rights include the right to identity, the right to live with parents, the right to education, right to be free from abuse and torture, right to live in the community and the right to health. Children from the lowest socio-economic classes are three times as likely to develop a mental disorder. Children that do not live with their families are five times more likely to develop a mental disorder, children with learning disorders six and a half times, while male children from 15 to 17 years of age who live in institutions are 18 times more likely to commit suicide than others of the same age.

Committing children to institutions is a violation of their basic human rights and the consequence of severe ignorance of a child's needs, especially where children with reduced capabilities are concerned. What children need, first and foremost, is growing up in a family. All families cannot ensure that all conditions for a healthy upbringing are met. These families obviously need assistance in caring for their children. This assistance is vastly preferable to children being institutionalized, as being in an institution has been proven to cause regression in a child's development and a significant increase in likelihood of illness, injury and suicide. This is due to the lack of quality care, lack of interpersonal communication and lack of stimulation. Children in institutions also have a generally lower lifespan. A variety of evidence exists that proves institutional care is the cause of psychological and physical damage and that children in institutions are exposed to violence much more than their non-institutionalized counterparts.

The most common institutionalization prevention strategy is developing community services. Programs that can accelerate a child's inclusion into the community include early interventions, community mental health services, educational and other high quality upbringing and care programs aimed at parents, informal support for children and families, inclusive education, financial aid for families that need it to survive, ensuring free time for parents, developing fostering programs, developing work groups and monitoring child and young adult services.

The most common reasons for institutionalizing children are poverty, stigma, discrimination and the lack of community services. In institutions,

children are often exposed to neglect and abuse, humiliation and carelessness. The consequences of such upbringing can appear in the social, behavioral and mental areas (14). Comfort, equipment, colorfulness and even the staff's commitment in such institutions has comparatively little effect. Children and young adults develop best at home, next to their families, especially when they and their families are offered assistance sufficient to ensure a comparatively comfortable life for the child.

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Recovery from a user's perspective

Introduction

One of the main characteristics of recovering from a mental illness is the fight for survival. While this sounds dramatic, it can be summed up as an attempt to achieve health both spiritually and physically by ways of proper nutrition, exercise, therapy, psychotherapy, reading and writing. One should also make regular visits to the psychiatrist, go for walk and always take one's medicine.

The above paragraph describes how world sees our recovery sometimes, yet the elements at hand are but the first step on the path to recovery which winds ever onwards – through pain, relief, burden and acceptance and finally ends at our own feet.

My story

It all began with my first experience of depression in the fall of 1992 followed by severe mania in the following spring. In March of 1993, I was hospitalized for the first time and stayed at the Polje Psychiatric Hospital. Upon discharge, I continued to visit a private practice managed by Dr. Borislava Lovšin. I rejected the treatment because I thought I could overcome symptoms without the use of medication.

It took me a decade and two hospitalizations before I finally took the responsibility for my own life. I was able to overcome my illness and live with my symptoms eventually by taking the prescribed medications, finding my own spirituality and expressing myself in writing is. I realized that the things that helped me, definitely worked for me – regardless of how they may have beenseen. I found my answers in nature, healing crystals and people around me, which definitely shows that the path to recovery is an individual one.

What all those suffering from mental disorders share is the fact that our path to recovery is a matter of survival. We fight to survive the system, to get through our treatment, survive our illness and ourselves. I believe it was my decision to embrace my own wishes that led me to recovery and I am truly grateful for it.

Following my heart, I managed to take stock of my past and write four books (Japajade, 2005, Depra, 2007, Itaq, 2011 in Yoyo, 2014), lead more than ten workshops on therapeutic writing and was also one of the people behind the anthology "Izpišimo bolečino" (Celjska Mohorjeva družba, 2014). I am proud of what I have become and have a feeling that the best is yet to come. Accepting myself lead me to appreciate how blue the sky is and that I deserve my own place underneath it. Depression is still a part of me, yet now a part that is understood and accepted.

Stories

Every mental health disorder hides a story that needs to be heard, analyzed and accepted. These stories are hard to imagine and even harder to relate. Some parts of them are hidden deep beneath what we can perceive and need the help of others to release them. In my opinion, this is a part of what a psychiatrist or a psychotherapist does and is, a person that can unlock our memories. A person who is interested and trusted, who knows how to listen and hear. Writing is a part of this process of unlocking and acceptance.

Employing the basic journalists' tools – asking who, when, what, where and why – I tried my hand at therapeutic writing. This eventually resulted in the publication of my books and my attempting to write stories that would not be constrained by the therapeutic writing model. I learned that the true therapeutic writing takes place on three levels of communication, first on the level of communicating with myself, secondly, communicating with others and on the third level, engaging in communication with the public. I am fully aware of the fact that therapeutic writing holds greater importance for the writer and less so for the public. Authors can thus articulate their thoughts and transform themselves through writing, which makes writing letters, diaries and even stories a very popular mode of treatment.

Communication with others may employ letters (sent and unsent) and other forms of writing that we give to others to read. The use of the latter allows us to communicate with people important to us at a slow pace, one that is characterized by measured responses. These responses will be positive for the most part, which can significantly help transform our own self-image. Any secrets revealed through writing lose their hold over us, while the risk of shock, disgrace and shame is tempered by the measured response inherent to writing. There can be no doubt that this form of

treatment is effective, bringing relief with few exceptions – and even those can be used to trim our social circle.

The final step in communication occurs when we communicate with the public. In the moment when anyone is able to read what we wrote, our secrets cease to be secrets. They become stories bringing with them the power that stories possess. It can inform and show the causes and consequences of mental illness, adding significantly to the process of destigmatization.

Social circle

I believe that recovery depends, to an extent, on our relationship with those in our social circle. Our relatives, friends, co-workers and acquaintances form a network capable of helping us through our recovery. The people we surround ourselves with are what we know ourselves by and are thus extremely valuable. The social circle that we establish needs to be tended with sincerity and respect to ensure stability and mutual benefit to everyone in it.

The profession

The relationship patients establish with their psychiatrist or psychotherapist is extremely specific and would bear a significant effect on the way the treatment proceeds. Trust is of course a keyword in all therapeutic relationships. When we begin to trust a psychiatrist to know what will help us and how it will do so, the treatment becomes much easier. Establishing a relationship that is honest and empathetic, we give ourselves the chance to recover. Patients need to be encouraged and directed to activities that both interest and benefit them, which can be hard as we don't often get to see our doctors. Therefore, our survival rests in our hands for the most part and with the exception of times of hospitalization, we are the ones responsible for what we do and how we feel. We can do a lot to redirect our thoughts when they stray into shadows and we can always adapt to our symptoms. The fact remains that we might not be able to control them. Psychiatrists and other professionals step forward in those cases and enforce rules that let us stay a part of society. I believe the shortest path to freedom is following those rules.

Stigma and destigmatization

When I woke up in the hospital for the first time and realized that I am now a mental health patient, I was shocked. I realized that I will always be a patient, a person with a mental disorder, carrying that mark. An experience of that kind would hurt anyone.

I consequently tried to hide my illness and became ashamed of myself, starting to hide from my loved ones. I faced isolation and lost most of my social circle, however, when I released my first book *Japajade* (2005), it put an end to all secrets as well as all bad and good advice. In the book, I disclosed everything in relation to my experience and the publication resulted in meeting some wonderful people. While it was not as big of a success as my second book *Depra* (Celjska Mohorjeva družba, 2007; Chipmunk publishing, 2007), which saw three separate editions, it helped me to accept myself. People wrote to me and thanked me for writing the book. Stigma lost its hold on me. Other books followed – *Itaq* (Miš, 2011) and *Yoyom* (ALUO, 2014).

Mental Ecology

I believe that patients who genuinely wish to be resocialized need to relinquish what is left of their former lives. Attempting to heal old wounds requires clearing the foundations. This is, as I can attest, a long and a painful process that demolishes what we used to believe ourselves to be. I can also attest that it is worth the pain to remove what we must change to be happy again. Body, mind and soul all need to be cleansed and taken care of. Food, hygiene, nature, clothing and the company of kind people is needed. Our mind should be cleansed of questions and doubts, of dark thoughts and destructive impulses. Reading about what affects us, thinking and writing is the best way to do so, I have found. We need to cleanse our soul as well, which can be done with music, art and spirituality. A belief in good overcoming evil and a universal order are balms to a tortured soul.

Conclusion

No path to recovery can be treaded twice, yet the decision to walk it is the same every time. Always remember that fortune favors the brave.