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Community-Based Mental Health Care

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COMMUNITY-BASED MENTAL HEALTH CARE

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Community-Based Mental Health Care

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1. SOCIAL, PSYCHOLOGICAL AND BIOLOGICAL DETERMINANTS OF MENTAL HEALTH AND THE EFFECTS OF STRESS

Dolores Britvić

1.1. Social, psychological and biological determinants of mental health

According to the World Health Organization (WHO), mental health is "a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to his or her community".

According to Kaplan's definition, mental health is a state of emotional well-being in which a person can function satisfactorily in his or her social environment, and in which his/her achievements and characteristics are satisfactory.

Although it is clear that the concept of mental health goes well beyond the absence of mental illness, two important components of "feeling good" or "positive mental health" have been described. Feeling good is associated with hedonic concept of well-being, which encompasses positive feelings or positive affect (subjective well-being, life satisfaction, happiness) and eudaimonic concept of well-being (Eudaimonia was the Greek goddess of happiness and opulence), which in turn encompasses positive functioning (engagement, fulfilment, sense of purpose, "feeling good" in social settings).

Many scales have been developed to measure not only the absence of mental illness, but also the presence of "well-being", or "positive mental health". For example, a 14-item scale has been developed in Scotland. The Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS) are often used with the 12-item General Health Questionnaire (GHQ-12).

To develop solid mental health as defined above, it is essential to combine social, psych•ological and biological factors that jointly help build and maintain one's mental health.

Every day we get to witness different external and internal factors that may impair the person's emotional balance and contribute to the onset of mental disorder and illness. Maintaining and improving mental health in the community, as well as preventing mental illness and disorders requires a thorough knowledge of the above factors and the ability to apply appropriate interventions to minimize the adverse effects of different kinds of difficult situations and conditions.

1.1.1. Social determinants of mental health

Mental health and the onset of mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live. Hence, social inequalities are associated with increased risk of many common mental disorders. Risk and protective factors operate at many different levels, including the individual, family, community, structural and population levels. Therefore, the social determinants of the approach to healthcare require action across multiple sectors and levels.

Adverse social, economic and physical environment factors may have a strong impact on the mental health of the population at any stage of life. Social organizations and institutions in the education, social care, and labour market sectors have a huge impact on the opportunities that empower people to choose the course of their lives. Both these institutions and daily living conditions are, to a greater or lesser extent, influenced by national and transnational policies.

To reduce inequality as well as the overall prevalence of mental disorders, daily living conditions need to be urgently improved, starting before birth and progressing into early childhood, middle childhood and adolescence, through the stages of starting a family, working age to old age. Action throughout these life stages would provide opportunities for both improving population mental health, and for reducing risk of those mental disorders that are associated with social inequalities.

Taking the life course perspective into account, we can tell that the influences that operate at each every stage of life can affect mental health.

As early as in the prenatal period, poor socioeconomic conditions, inequality and poverty may have a significant impact on physical, mental, and cognitive outcomes during the early years and later in life. A mother's poor health

and nutrition, smoking, alcohol and drug abuse, stress, and a physically demanding job can all harm the development of the foetus and their later life outcomes. Children with poor mothers are more likely to be disadvantaged even before they are born. A systematic review and meta-analysis of 17 studies on maternal depression or depressive symptoms in developing countries showed that children of mothers with depression were at greater risk of underweight and stunting, or low birth weight, which is itself an increased risk factor for developing depression later in life. Risk factors for common perinatal disorders include socioeconomic disadvantage, unintended pregnancy, young age, single status, unsupportive partner who lacks empathy, hostile in-laws, intimate partner violence, lack of emotional and practical support, and, in some settings, a history of mental health problems. Protective factors include higher levels of education, a permanent job, being part of the ethnic majority and having a reliable intimate partner. A large body of research has emphasized the importance of maternal education, given that lower maternal education is associated with increased infant mortality, stunting and malnutrition, childhood overweight, lower scores on vocabulary tests, conduct problems, emotional problems, lower cognitive test scores, mental health problems and infections in children. Factors that may affect mental and physical health in early childhood include adverse family conditions, poor quality parenting, lack of secure attachment, neglect, lack of quality stimulation, and frequent conflicts in the family. Children's exposure to neglect, direct physical and psychological abuse and growing up in homes where there is domestic violence is particularly damaging.

Parental mental health plays an important role in shaping the children's health later in life. For example, children of mothers with mental health problems are five times more likely to develop mental disorders. Poverty can have a significant impact on maternal stress. Exposure to multiple risks is particularly detrimental, as effects tend to accumulate. Children with lower socioeconomic status are less likely to experience conditions needed to promote optimal development. The adverse impact of poor socioeconomic conditions can be offset by protective parenting activities, such as strong social and emotional interactions, support from the extended family and community.

Prevention of mental health problems in children of mothers suffering from mental disorders is done by providing parenting support to the mother.

At school age and during adolescence, social conditions in which a child grows up and receives education continue to play an important role in the prevention of mental disorders. Education plays a protective role by boosting emotional resilience and contributing to better living conditions, better employment and higher income opportunities later in life. At this age, poverty is also a risk factor that may lead to greater exposure to marginal social groups and stressful family situations. Children living in poor conditions are more likely to have poor nutrition, poor housing conditions and poor learning environment. Parental unemployment sets a bad example for children, but it is also a significant source of stress for the whole family. Adolescence may be a particularly sensitive period, as poor socioeconomic conditions increase the risk of different kinds of negative behaviours, so it is important to stimulate protective factors in adolescents, including social and emotional support and building positive interactions with peers, family and the wider community, and to teach them to make informed decisions.

Among the working-age adult population, unemployment and poor quality employment pose a significant risk for the onset of mental disorders. Hence, the increased risk of depression and anxiety is related to long-term unemployment; which means that strategies for improving mental health should also focus on reducing long-term unemployment. Risks that can harm one's mental health include poor quality employment, as well as working without an employment contract or on a short-term contract basis, and jobs with low levels of workplace safety, job insecurity, poor working conditions, and low income.

The quality of family functioning plays an important role in the health of both children and adults. The factors leading to successful parenting and lower prevalence of mental health disorders are related to parental support, better job prospects, higher income and better housing conditions. Parental counselling, parental support in the early days of parenthood, but also during other stages of the child's development (especially during adolescence), in a child-friendly way, until the time they are ready to leave the nest will also help the parents and be useful in overcoming intergenerational inequality.

Old age brings some specific situations, depending on the life a person has been leading before, their physical health and living conditions. The evidence suggests that many factors within this age group affect mental health and can trigger depression, such as poor physical health, poor socioeconomic status, social isolation, loss of contact with their family and friends, single life and

lack of exercise. Higher education, especially in women, is considered a protective factor for the onset of mental disorders in the elderly. The European countries reports indicate the lowest incidence of mental disorders among elderly people in Scandinavia, followed by Western Europe, while the highest incidence of mental disorders in elderly people is found in Greece, Italy and Spain. Incidence proportion for mental disorders is related to the quality of the state social care services and assistance for the elderly. More accessible services will lead to better mental health in the elderly population. A study from England indicates an increased risk and incidence of depression in men over 75 and women over 65.

1.1.2. Psychological determinants of mental health

Various psychological determinants can represent risk factors for the onset of mental disorders. Psychological traits may be genetic and congenital, but they may also be related to specific patterns of psychosocial development or traumatic experiences that had an impact on personality development, patterns of feelings, thoughts, and behaviour.

It is difficult to change the course of congenital conditions, but the adverse effect of the negative personality traits developed later in life on the person's mental health can be minimized. They can trigger the onset of illness, but also cause a relapse. Cloninger's psychobiological model identifies seven fundamental dimensions of personality, based on four dimensions of temperament (novelty seeking, harm avoidance, reward dependence and persistence) and three dimensions of character (self-directedness, cooperativeness and self-transcendence). Temperament is defined as a heritable aspect of personality, related to automatic emotional predispositions such as fear, anger and attachment. Character is a developmental construct that consists of personal attitudes and ideas about life values and goals; being a conscious repertoire of behaviour, it can modulate the influence of temperament dimensions.

In the assessment of psychological factors, it is important to assess a wide range of aspects of a person. According to Cabaniss, five major domains of function are assessed: adapting, relationships, cognition, work and play.

Adapting is assessed through observation of defence mechanisms, impulse control and regulation, managing emotions and sensory regulation.

Adapting means adjusting to internal and external stimuli on a daily basis. Internal stimuli includes thoughts and feelings, fantasies, fears, pain and other sensations. External stimuli includes relationships with others, economic and work-related daily pressures, psychotrauma and other events. Each of us can tolerate different levels of stimuli, pressure and stress. Most often we deal with stress without even realizing it, thanks to the unconscious **defence mechanisms**. In the assessment of defence mechanisms, it is useful to observe them according to how adaptive, flexible, connected to thoughts and feelings they are. Defence mechanisms that allow us to preserve or enhance function are **more adaptive** defence mechanisms, while **less adaptive** defences hinder functioning. Less adaptive defences decrease the awareness of emotional pain, but also impair functioning. In psychoanalytic literature, **less adaptive or immature defence mechanisms** are often described, such as splitting, projection and projective identification, pathological idealization and devaluation, denial, acting out, dissociation and deep regression. More adaptive defence mechanisms include repression, intellectualization, rationalization, isolation of affect, reaction formation, somatization and displacement. Most adaptive defence mechanisms include sublimation, altruism, humour, the ability to consciously focus. Defensive flexibility is an important aspect of defence mechanisms. For example, in some situations, the used defence mechanism may seem immature, while in others, the very same defence mechanism may be very useful and adaptable (dissociation when exposed to a traumatic experience). The conditions in which a specific defence mechanism is used, as well as the person's age, should be taken into account.

The assessment of **relationships with others** includes security, sense of self and others, trust and intimacy and reciprocity. The ability and capacity to maintain a relationship with others is one of the most important functions of personality. Therefore, assessing how a person builds and maintains relationships with others is crucial in assessing a person's level of maturity. For the sake of a clear assessment of the quality of relationships, it is useful to describe the relationships with others observed through a prism of trust, sense of self and others, security, intimacy and reciprocity.

Relationships with our loved ones usually provide us with all these emotions. However, relationships with family, friends and partners can also be a source of pain, suffering, frustration, resentment and confusion due to lack or loss of trust, security, and intimacy.

In assessing **cognitive function**, the following aspects are important: general cognitive function, decision making and problem-solving, relationship with the outside world, judgment and mentalization.

General cognitive function includes intelligence, thinking, attention, speech, language and memory.

Lazarus developed the whole theory by describing the coping skills (in problem-solving situations). He distinguishes between those who respond to problem situations with planning and problem-solving skills, calling this approach a problem-focused coping, those who choose a predominantly emotional response in overwhelming situations, which is called emotion-focused coping, and those who avoid coping with problems in the first place, which is called avoidance-coping strategies. By refusing to deal with a problem, they often respond impulsively and resort to different kinds of addiction, alcohol, gambling, etc.

Relationship with the outside world can be observed through the prism of **sense of reality, reality testing and reality adaptation**.

Judgement has an important impact on our decisions in different spheres of life; it is important in making professional decisions, in making decisions related to our social life, but also in our close relationships. The function of judgment is indirectly reflected in rational decision-making, maturity and functionality of our decisions, or in the ability to make a decision consistent with what we really want to do; the ability to make a decision that will not cause internal or external conflict, and will lead to personal comfort and convenience, as well as positive self-evaluation.

Mentalization is a relatively new concept that has evolved from an attempt to define a disorder that falls into a group of personality disorders and serves as an attempt to find a connection between biological identity, attachment theory and their impact on children's psychological development. It is a form of mental activity that involves imagination about self and others, it represents the naming, observation and interpretation of human behaviour in terms of mental states and intentions (needs, desires, feelings, beliefs, goals, purpose and reason). Therefore, this process is largely unconscious, automatic, intuitive, and implicit. Normal mentalization in mothers is associated with secure attachment with their children, which means that children of mothers who have low levels of mentalization remain at increased risk for developing

disorganized attachment. Insecure disorganized/disoriented attachment increases the level of arousal in children. The increased arousal hinders the orderly development of mentalization in children. Such children are more likely to have poor social cognition abilities, especially in terms of affect regulation and attention control. A mother with a secure attachment to her child and high levels of mentalization expressed through mirroring will be able to recognize the child's emotional signals, which will then return slightly modified to the child, allowing the child to re-internalize them as his/her own. When mirroring is altogether absent, the child introjects the parts of the parent as his/her representation of self, which will later become the alienated self. In response to the traumatic situation in childhood, the attachment system is strongly activated. Arousal occurs, leading to suppression of mentalization in children, which has been explained through neurophysiological models. In most psychiatric disorders, we observe different levels of mentalization disorders, such as a disruption of mentalization, along with the state of mind that we have called a pretend mode, a model related to magical thinking, a teleological model (in which the only thing that matters is the physical reality in the present moment). The best researched mentalization disorders are those in people with personality disorders, especially a borderline personality organization.

An important aspect of assessing the maturity of a person is their ability to work and play. A similar definition of mental health dates back to Freud who defines mental health as the ability to work and love. Work is a physical or mental effort exerted to do a purposeful activity. Work activity can take different forms and types. Work can be paid or unpaid. For some people, the most important aspect of work is making money, while for others, such as writers or artists, work is more than making a living. One can work out of their home or from home, or work by taking care of the household and children. A job can be intermittent or steady, one that can be done with very little education and experience, while other jobs may require an extensive repertoire of skills and responsibilities.

Ability to play should be an important part of our lives. Playing is a way of spending our free time to relax and to enjoy life. Everyone has fun in their own different ways: reading, cooking, playing sports, watching TV, surfing the Internet, socializing, travelling, relaxing on a beach. How much time a person will spend playing and to what extent this will be varies from one person to another. One person may enjoy painting very much, which will then

become an important activity for him/her, somebody else may enjoy sailing or hiking regularly, while another person will just go for a walk a few times a year. Sex also plays an important part, reflecting the way we relax and enjoy intimacy with another person.

When assessing these functions, it is important to consider whether a person's job or his/her way to spend their free time is appropriate for his/her developmental level, age, talents and limitations. We follow similar steps when we assess a person's work capacity. The fact that someone has never stayed at the same job for more than a year, or that he/she has been changing job frequently points to difficulties in adjusting to the workplace and reduced work capacity. In other words, this is a sign of low perseverance and low levels of functioning. Furthermore, the fact that a person has been doing a job that does not match his/her education can also be a source of strong frustration and may mean that they are unable to perform complex tasks.

The assessment of work and play needs to show whether the activities bring us satisfaction and pleasure. Some people will choose to earn far less to do the job they enjoy, others are happy with their job, but do not enjoy it.

1.1.3. Biological determinants of mental health

Each person is represented by his/her unique and unrepeatable physical and mental identity, called a phenotype, which is determined by the impact of environmental factors on the genotype. Not only are our physical traits determined by the genes, but some psychological traits are biologically conditioned too. We can define temperament as the heritable, biologically-based behavioural patterns, present from the early childhood, consistent across situations and relatively stable over time. For example, people can develop several temperament types: inhibited temperament, anxiety, sensation seeking, and impulsivity.

The importance of adverse events during pregnancy and childbirth (ill mother, congenital and/or hereditary foetal abnormalities) for mental health of children later in life has already been discussed. Physical conditions, medications, lifestyle choices, or abuse of psychoactive substances may affect one's mental health too.

Information on one's physical illnesses and the impact of physical health on mental health, a differential diagnosis, or understanding that there is a physical condition manifesting itself as a psychological problem is very important, as it may reveal that this is not a mental illness, but rather a physical condition appearing as a mental health problem. Some somatic conditions cause symptoms that mimic mental illness (e.g. hypothyroidism).

There is, however, a two-way link between physical illness and mental health. Physical illness can affect mental health, but poor mental health can also have a huge impact on our physical health. Cardiovascular disease is less common in people with good mental health and more common in people with major depressive episodes, mild depression, or moderate mental health problems. This is consistent with literature review, according to which the risk of coronary heart disease is associated with the severity of depression. It is important to emphasize that the onset of physical illness is affected by the person's mental health, which can range from mental illness to "feelings of flourishing and happiness".

When considering the biological determinants of mental health, the impact of specific medications (psychopharmaceuticals and other medications) and their side effects should be taken into consideration, as well as the side effects that patients could experience if they stop taking their medications abruptly, which can lead to serious mental health problems. Psychoactive substance abuse, such as alcohol and drugs, either through acute disorders associated with intoxication and substance abuse, or through the development of alcohol or psychoactive substance dependence can significantly affect mental health. Therefore, when assessing the impact of these factors on mental health, information regarding current use, previous use, or discontinued use that may lead to withdrawal (abstinence) symptoms should be taken into account.

Also, some psychological symptoms may occur in connection with biological cycles. For example, it is known that PMS symptoms can worsen depression or anxiety symptoms and that the patients may even experience a premenstrual dysphoric disorder.

In assessing the biological factors of mental health, the person's lifestyle - including diet, physical activity and the presence of other physical conditions - needs to be assessed.

To assess the impact of biological determinants on mental health, we need to know whether psychiatric disorders are running in the family, which suggests that there might be a genetic predisposition to specific mental illness.

To improve one's mental health, the existing psychiatric disorders and illnesses need to be kept under control. Therefore, we want to learn if there were previous episodes of mental disorders, even if it still does not mean that every condition that prompts the patient to seek help for mental health problems is necessarily related to the previous diagnosis. For example, a person who has been previously treated for depression, and who is currently suffering from panic attacks, without the symptoms of depression, will be diagnosed with panic disorder, rather than depression. Therefore, adequate treatment for psychiatric disorders needs to be provided based on a personalised treatment plan that will include biological, psychological and psychosocial treatment methods.

This will be further discussed in the chapter on treatment and rehabilitation.

A patient's clinical condition is often dictated by the selection and amount of information collected and recorded in their medical records. In acute conditions, more focus will be put on the current episode of illness, and less on the history of previous psychiatric treatment.

A family medical history is linked to the information regarding a family history of mental illness. Physicians need to check with patients if someone in their family has been treated for the same, similar or any other disorder, such as psychosis or alcohol addiction, and ask further questions about the history of suicide and previous suicide attempts in the patient's family. If a member of their family was previously treated for the same illness, we need to try to find out about the pharmacological treatment they received, as family members may have a similar response to medication, which is important in choosing the right treatment. In addition to the questions on mental illness, it is necessary to ask about physical illnesses running in the family.

CONCLUSION

Mental health is a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to his or her community. To have solid mental health as defined above, it is essential to combine the

social, psychological and biological factors that jointly help build and maintain one's mental health. Adverse social, economic and physical environment factors may have a strong impact on the mental health of the population at each stage of life. Psychological characteristics can be genetic and congenital, but they may also be related to specific psychosocial development or traumatic experiences that have influenced personality formation, patterns of feelings, thoughts, and behaviour. In the assessment of psychological factors, it is important to assess several aspects defining a person. Five major domains of function are assessed for each person: adapting, relationships, cognition, work and play. Adapting is assessed through observation of defence mechanisms, impulse control and regulation, managing emotions and sensory regulation. The assessment of relationships with others looks at security, sense of self and others, trust and intimacy and reciprocity. In the assessment of cognitive functioning, general cognitive abilities, decision making and problem-solving, relationship with the outside world, judgment and mentalization are important. Biological factors, defined by our genetic identity, intertwined with the environment create a phenotypic expression that determines both the peculiarities of our temperament, as well as other psychological traits. For example, people can develop several types of temperament: inhibited temperament, anxiety, sensation seeking, and impulsivity. **A**dverse events during pregnancy and childbirth, physical illness at some point in life, taking different types of medication, lifestyle, or use of psychoactive substances also play an important role in one's mental health.

1.2. Stress, crisis and psychotrauma

Stress is a physiological and psychological response to different stressors. A number of factors can be a source of stress. They can be divided into psychological and social factors. Besides being a stressor, physical illness can also contribute to the onset of mental disorders.

Some psychosocial factors may represent stressors of varying intensities. Daily stressors are defined as a series of events that the average person can normally deal with without major problems. If they get more intense and require the mobilization of additional adaptation capacities, daily stressors turn into a crisis or distress. The most severe types of stressful events are traumatic events that affect one's physical or mental integrity and can lead to mental

health disorders, such as acute stress reaction, post-traumatic stress disorder or adjustment disorder.

Resilience and vulnerability define how a person will adapt to stressors.

In recent years, stress has been one of the most frequently used terms in everyday life. Unfortunately, most people use it without being aware of its underlying meaning, health implications, aetiology and pathophysiological effects (the body's response to stress). All of us can experience stress, and by that we understand the situations in which we are constantly exposed to some kind of pressure, work-related pressure, chores, or we are going through a financial crisis, get paid late, or we could be about to lose our jobs, and we still need five more years to pay off the loan. Good things cause stress, too. We tend to stress out about getting married, starting a family, first day of school, living with our parents, and the list goes on. We also get stressed out when we find ourselves in extremely uncomfortable situations, such as seriously ill family member, losing a loved one, or losing a job. We are also exposed to stress when we get involved in a car accident, or when our life is in danger (floods, armed robberies, attacks, etc.). Because of the phenomenological confusion over the meaning of stress, it is important to have at least basic knowledge of the definition and physical signs of stress, as well as the factors of resilience and vulnerability in adapting to stressful events.

1.2.1. Stress

Stress or eustress is a response of the body to situations that either make us feel uncomfortable or that may be creating harm in our lives. The concept of eustress is a ubiquitous phenomenon and can occur as a reaction to both negative and positive events, known as stressors. Examples of stressors include negative events such as taking an exam, sitting the final high school exams, being stuck in a traffic jam, a child's illness, and positive events such as getting married, leaving for a long trip, etc. The stressor may persist for a short or long time, but generally speaking, the person will adapt to it without much difficulty. Research has shown that mild and moderate stress has a positive and stimulating effect, however, chronic and long-term stress can lead to negative effects. McEwen et al. demonstrated that repeated exposure to stress causes dendritic atrophy of CA3 pyramidal neurons in the hippocampus, owing to raised cortisol levels. As symptoms of stress fade, the observed

hippocampal atrophy is reversed. Stress can have different **emotional, cognitive and physical** symptoms.

The most common **emotional symptom** of stress is anxiety that feels like a premonition of impending doom, fearful anticipation, and fear of an unknown cause. Fear may be accompanied by anxiety and resentment. **Physical symptoms** of stress are caused by the activation of the sympathetic nervous system, which manifests itself as tachycardia, high blood pressure, rapid breathing, increased muscle tension, dry mouth, sweaty palms, and, if stress persists, headache and muscle pain. As a result, a person with anxiety may experience **cognitive impairments** in the form of constant negativity, worrying, fear of the future and low productivity at work. Feeling this overwhelming stress for a long period of time can get even more complicated by different psychosomatic disorders or psychiatric illnesses, such as depression or anxiety disorders.

1.2.2. Crisis

A crisis is a temporary emotional state triggered by a difficult life event, and the usual problem-solving strategies do not seem to not help. The concept of crisis denotes the effects produced by unpleasant, negative or positive events that significantly affect an individual's life when they experience a disruption in their usual functioning. They usually require the mobilization of additional psychological mechanisms, because the way of handling the situation did not prove to be effective. As a rule, the causes of crisis are events of intolerable difficulty that are so sudden and intense that they may take a heavy emotional toll. They can last for weeks or even months. Examples of negative life events that can trigger a crisis include losing a loved one, losing a job, a serious illness in the family, while examples of positive life events include moving to a new location, changing jobs, or getting married. Not all people who go through any of this will actually think of it as a crisis, the onset of crisis will rather depend on their character traits, the type of event and how he/she experienced the event. Sudden and intense events, which take an emotional toll, are usually harder to deal with. Highly sensitive people who have previously been exposed to other stressful events will be more vulnerable to stress and crisis. The importance of the cumulative effect such events may have has long been recognised, as evidenced by the Holmes-Rahe Stress Inventory compiled over 40 years ago, with death of spouse, divorce, marital

separation, and the death of a close family member at the top of the list, while minor offences, holidays and summer vacation are at the very bottom.

Sometimes, a crisis manifests itself physically, by eating, sleep and temperature regulation disorders, muscle pain, and headache. The affected person is often preoccupied with cyclical thoughts and the incident itself, overwhelmed by fear that they will never be able to overcome the crisis, they do not see a way out, and feel helpless and hopeless. In doing so, the person often struggles to function, he/she finds it difficult to focus on work or to follow what others are saying and needs to deal with disturbed sleep and appetite problems. One of the typical signs of the crisis is isolation and cutting off all of his/her social life. The affected person often feels alone or thinks that nobody can understand the problems he/she is going through, and that nothing can help them. Restoring social relationships is considered to be one of the first signs of recovery. The ever deepening, unresolved crisis can be accompanied by depression or anxiety disorders, or other mental or physical conditions.

1.2.3. Trauma

There are many different ways to define a traumatic event. In most definitions, a traumatic event is a threat or serious harm to a person's psychological or physical integrity. The traumatic event can also involve witnessing a threat to the psychological or physical integrity of another person. In general, it is unpredictable, beyond our control, it compromises people's sense of safety, making them feel vulnerable and anxious.

Examples of traumatic events include exposure to violence, kidnapping, war, terrorist attacks, torture, imprisonment in concentration camps, and natural or other disasters. Each type of traumatic events is specific, which needs to be taken into account. For example, war can confront an individual with helplessness, family separation, physical exhaustion, insomnia, noise, fear of death, loss of normal living conditions and death of his/her comrades, while natural disasters can confront an individual with helplessness and loss of daily routine, as well as a great deal of destruction and human suffering.

Fear is the first commonly reported reaction to trauma. Fear is a basic psychological reaction pattern when faced with a dangerous situation. Even if it may cause discomfort, there is a positive side of fear because it serves as a

warning and sets off a chain reaction of adaptive mechanisms that will protect the person from toxic effects of traumatic experiences. This chain reaction involves physical and psychological reactions. A set of bodily reactions is described as a "stress response of the body" divided into the alarm reaction stage and resistance stage that comes along with the sympathetic nervous system activation, and exhaustion stage that comes when the parasympathetic nervous system is activated. Its purpose is to prepare the body for the fight-or-flight response. The amygdala is the brain region where the process of activating the neurochemical and neuroanatomical response to a potentially life-threatening situation starts. Therefore, reactions to a traumatic event can be described as immobilization, changing movement patterns, or goal-directed behaviour. Fortunately, people generally resort to the latter. Likewise, most people manage to work through a traumatic event, but some of them develop complex post-traumatic reactions. In most cases, the symptoms subside after two weeks to two or three months, but in the most severe cases, post-traumatic stress disorder (PTSD) will develop.

It is very challenging to set a clear boundary between a pathological response to a traumatic event and the response we would consider "normal". Usually, the severity of the reaction, its duration and effect on the person's ability to get back to their normal daily activities will be crucial in our assessment of whether the reaction to the traumatic event is "normal" or "pathological".

1.2.4. Theories about the effects of stress and trauma

Psychological theories

Several theories attempt to describe how the mental apparatus adapts to trauma. Theories that are now widely considered obsolete, but also more recent ones point to the significant impact of trauma-related emotions on adapting to trauma. A person who manages to adequately process the emotions triggered by traumatic events and store them in the "repository" of emotional memory in the amygdala will normally have less pronounced psychological consequences after a traumatic event.

Freud's work and theories helped shape the **psychodynamic theory**, as he became aware of the importance of traumatic events for the onset of psychiatric disorders. This is further supported by the impact of the so-called "primal

scene" (witnessing by a child of a sex act between the parents) on the onset of later symptoms of anxiety disorders. Nonetheless, Freud coined important concepts that have persisted in dynamic theories to present day. These are the concepts of the "signal anxiety" and "repetition compulsion". Signal anxiety arises when events from the outside world evoke deeply suppressed memories of emotionally overwhelming events from early childhood. This fundamentally neuropsychological concept of recollecting events that once caused anxiety is called **repetition compulsion**. Severe long-term anxiety exceeds and depletes the resources of the common defence mechanisms, and they often occur along with other symptoms of anxiety disorders.

Some later authors argued that the responsibility for a traumatic reaction, almost exclusively, lies with the nature of the traumatic event, while others put an emphasis on the individual's personality, pointing to the impact of trauma on the reliving of childhood conflict and fixation or regression to the early conflict, activation of defence mechanisms and emotions typical for specific stages of development.

The coping theory suggests that it is important to store traumatic memories. Due to its strong emotional charge, the traumatic event may not be immediately stored, so it keeps coming back, and a person relives the event over and over again. This is called "intrusion" and helps the person work through the trauma-related emotions, and trauma is consequently cast aside. Denial, which is another control mechanism, can suppress and control traumatic memories. Interconnected control mechanisms help store traumatic memories. To explain this phenomenon, we will provide an example of a specific traumatic experience. By talking about traumatic experience with friends and family, one may feel anxious, afraid and worried, but trauma-related emotions will eventually begin to fade away and the situation will no longer seem so difficult and hopeless. The affected person will soon realize that thinking about a traumatic experience has become less frequent, and as time goes by, they will barely remember to think about it.

Unfortunately, fear is not the underlying emotion that is first provoked in all cases of a traumatic event. A significant contribution to understanding the impact of trauma was made by working with Holocaust survivors and observing their inability to identify and verbalize their emotions. A traumatic event may lead to feeling overwhelmed, along with the helplessness and inability to express feelings and emotions that will often be felt in the body, or one may

try to control them by using psychoactive substances (medications, drugs, alcohol).

Along these lines, the complex post-traumatic reactions have been explained through the concept of **dissociation** that occurs when a person is unable to integrate and store traumatic memories, but keeps them separate from other memories. More recent findings show that consciousness appears to be fragmented into different areas that manage to connect in normal states of mind. But psychological trauma causes problems in the ability to make a connection between dissociated fragments of consciousness. There are three types of dissociation: primary, secondary, and tertiary dissociation.

Primary dissociation happens when the sensory and emotional aspects of the traumatic event cannot be integrated into memory, so this part of memory "remains" outside of conscious awareness. Examples include intrusive memories, nightmares and flashbacks, all of which are clinically associated with PTSD.

Secondary dissociation is a phenomenon in which a person is psychologically "separated" from the body during a traumatic event and acts as an observing party who witnessed the trauma. This helps protect the person against full awareness of the traumatic event and results in diminished awareness of the trauma.

Tertiary dissociation is the most severe and drastic example of dissociation that leads to the creation of separate personalities as a defence against traumatic experience. Each of these alters personalities to create a different identity with their own cognitive, affective and behavioural characteristics. They are often described as a consequence of sexual abuse in childhood and exemplified by multiple personalities in dissociative identity disorder.

An important contribution to understanding the pathological adaptation to trauma was made by contemporary psychodynamically oriented analyst Lindy, after years of experience working with psychotrauma. He describes what happens to the individual after an extensive dissociation of traumatic memories. The psychic apparatus uses several defence mechanisms (splitting, denial, regression, and magical thinking) that can seriously deplete the body's energy stores. Thus a new level of adaptation gets developed, along with a state of numbing, emotional alienation, and avoidance of thoughts and actions reminiscent of the trauma. New external stress imposes a tremendous burden on defence mechanisms, which in turn leads to disruptions in the functioning

of the psychic apparatus and many body systems. Disorder of the psychic apparatus is reflected in a distorted judgement and inaccurate perception of everyday life events, impaired regulation of emotions and personality changes. For such persons, the world is unpredictable and malicious, their belief system reflects cynicism, their expectations and the other people's expectations are permanently changed, and the future looks gloomy and threatening. Due to impaired regulation of emotions, PTSD patients are often overwhelmed with feelings of anger, anxiety, helplessness and guilt at the cost of denying these feelings, or struggling with emotional numbness. Such changes in personality are often drastic, and patients and their families report that they have changed, lost the sense of personality consistency, and feel as if the traumatic event turned them into a completely different person.

As for contemporary theories, **behavioural and cognitive theories** must be taken into consideration.

Recent insights about the types of memory have been incorporated into the behavioural theory. According to behavioural theory, the traumatic event itself is a crucial factor in responding to trauma. During the first phase, the person exposed to a traumatic event (the unconditioned stimulus) develops feelings of intense anxiety and fear. Distressed by a traumatic event, the person remembers different stimuli (thoughts, smells, images, sounds) from a traumatic event (conditioned learning). Even after a traumatic event, these stimuli, occurring through the classical conditioning, may cause intense fear and anxiety. In the second phase, instrumented learning leads to the avoidance of unconditioned and conditioned stimuli. Unpleasant feelings of fear and anxiety can be avoided altogether by simply refusing to engage with the stimulus.

According to cognitive theory, a person exposed to a stressful situation will very quickly start interpreting it in terms of relevance and significance to his/her life, which is called an "appraisal of the situation". A stressful situation can either be perceived as harmful and threatening or can be seen as a challenge, in which case it becomes an opportunity for growth and development. When the situation is perceived as stressful, a secondary appraisal then kicks in. How a person will respond to a situation perceived as a threat depends on how they interpret their ability to cope with stress, which is best described by the term "tertiary reappraisal". According to cognitive theory, there are two basic categories of **coping with stress**: 1. Problem-focused coping (directing one's internal forces towards solving stress-induced problems) and 2.

Emotion-focused coping (reducing tension through intrapsychic efforts such as negation or behaviour change). Problem-focused coping seems to be more appropriate, as evidenced by the lower incidence of PTSD in people who resort to this kind of coping effort. The effectiveness of the coping effort depends on the type of stress in specific situation.

According to cognitive theories, three important symptoms in the clinical features, including intrusive memories, difficulty in distinguishing relevant from irrelevant information, as well as the massive use of dissociation after the trauma are considered to fall into a category of impaired information processing.

Biological theories

Exposure to stress and trauma results in the stress response that triggers a complex biological response to assess the degree of danger and adjust one's behaviour accordingly. The amygdala is the brain region where the process of activating the neurochemical and neuroanatomical response to a potentially life-threatening situation starts. Being aware of the existing danger triggers the activation of the sympathetic nervous system responsible for the "fight or flight response", followed by the activation of the parasympathetic nervous system, which is responsible for the suppression of the sympathetic nervous system. The hypothalamic-pituitary-adrenal axis (HPA) activated by the neuropeptides stimulates the hypothalamus to secrete a corticotropin releasing-factor (CRH), which in turn stimulates the release of the adrenocorticotropic hormone (ACTH) from the pituitary gland, while ACTH stimulates the release of cortisol from the adrenal gland. On one hand, the role of cortisol in stress is to keep the sympathetic nervous system activated. On the other hand, cortisol exerts negative feedback effect on the amygdala, hippocampus, hypothalamus and pituitary gland to reduce its further secretion.

1.2.5. Adaptation to stressful and traumatic events

How a person will adapt to a stressful and traumatic event depends on several factors. For didactic purposes, they are usually divided into *personality, traumatic event and environment factors*.

People who were exposed to early childhood trauma, or those who have specific personality traits (obsessive behaviour, anxiety, and depression) or a

personality disorder, are thought to be at higher risk of developing pathological reactions.

The importance of the meaning that a person has attributed to a traumatic event is very important. This meaning is closely related to the context in which the event took place, the individual's personality, culture or civilization. For example, in primitive tribes, the girls are artificially deflowered by a phallus as a part of the rite of passage, while the same event would be considered sexual trauma in our culture.

Traumatic events can occur at different stages of life. As a rule, their impact is stronger and more devastating if the traumatic event occurred early in a person's life.

The nature and duration of the traumatic event may also play a role in how one will respond to the traumatic event. Traumatic events marked by interpersonal violence have a stronger impact than natural disasters.

Community-based social support plays an important role in how an individual will cope with a potentially traumatic experience. Stories, legends, myths and rituals that are part of the specific culture are important mechanisms, along with religion, by which an individual may transform his/her catastrophic reaction to a loss. Culture, through ritual, plays an important part in coping with grief and loss. Mourning rituals allow the bereaved person to control his/her emotions and behaviour, closely associate them with the social group to which they belong and serve as a symbol of continuity. Family and workplace support are often critical factors in building adaptive capacities in response to trauma.

Unfortunately, the times of social or cultural upheaval also see drastic changes in the system of social values, personal expectations and value systems. Mass disasters, wars, community revolutions are causing the breakdown of the traditional system, leading to the loss of community's cultural identity, whose place is mostly taken by negative identity models and different ways of creating social groups. When the protection and safety of one community's culture fall short, paranoia becomes a substitute for trust, aggression takes the place of care and support, identity confusion or negative identity becomes a substitute for the positive identity.

Unless the group is allowed to work through humiliation and mourn for their loss, the sense of victimization will be tied to the group identity and

passed on to the future generations, which is then called the transgenerational transmission of trauma.

Stigma and discrimination associated with mental illness are strong psychosocial determinants of one's mental health. The vicious circle of the effects of stigma, discrimination and self-stigma that hinder recovery is notorious.

CONCLUSION

Stress or eustress is a response of the body to situations that either make us feel uncomfortable or that may be creating harm in our lives. The concept of eustress is a ubiquitous phenomenon and can occur as a reaction to both negative and positive events, known as stressors. A crisis is a temporary emotional state triggered by events in life that are difficult to deal with, and the usual problem-solving methods did not seem to help. This concept describes the effects of unpleasant, negative or positive events that significantly affect an individual's life when they experience a disruption in their usual functioning. A traumatic event is a threat or serious harm to one's psychological or physical integrity, which can also include witnessing an event that involves a threat to the psychological or physical integrity of another person. In general, it is unpredictable, beyond our control, it destroys our sense of safety, and makes people vulnerable and anxious. A number of psychological and biological theories have been presented to explain the body's response to stress and traumatic events.

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2. THE ROLE OF STRESS IN THE ONSET OF MENTAL DISORDERS AND THE PSYCHOBIOSOCIAL MODEL OF ILLNESS

Slađana Štrkalj Ivezić

2.1. Introduction

Mental disorders reflect the complexity of interactions between biological, psychological, and social factors related to the incidence, onset, course, and outcome of an illness. The incidence of psychiatric disorders and the impact on the condition after the disorder had already developed is evaluated in interaction with the assessment of psychological (psychological personality traits influenced by early childhood events, including specific ways of experiencing, interpreting and responding to life events, including defence mechanisms), biological (genetic predispositions, assumed biological brain changes) and social factors (housing conditions, work, communication with the environment, interaction with other people, support network, traumatic events, interpersonal relationships, family relationships). Psychological and social factors are often intertwined, so they are sometimes jointly referred to as psychosocial factors. According to the biopsychosocial model, illness is determined by an interaction between biological, psychological, and social factors. Today we know that the brain responds to biological, psychological and social factors and that any kind of division into biological, psychological and social factors, or neglecting the impact of any of the three groups of factors is unjustified and has adverse effects on the treatment of patients. It is well known that changes in a person's patterns of thinking and behaviour can lead to positive changes in the brain and thus reduce psychobiological vulnerability, which means that psychosocial factors can influence the biological basis. Stress vulnerability theory helps us understand the interaction between biological and psychosocial factors.

2.2. Stress vulnerability theory

Stress vulnerability theory explains the relationship between biological predisposition (vulnerability) for psychiatric disorders and environmental stressors. Adverse interaction may result in the onset of illness or worsening of symptoms. Minor daily stressors may accumulate and result in a person's struggle to deal with a mental disorder, which will only worsen the symptoms. The model takes into consideration the protective and risk factors. Social skills, for example, can be protective factors in preventing the stress-induced exacerbation of disease by helping a person create a social support network, which is also considered a protective factor. The model of personality vulnerability and the relationship between coping with stress and capacities explains the onset, course and outcome of symptoms and social functioning as a complex interaction between biological, environmental, and psychological factors. The psychobiological vulnerability may result in the onset of symptoms of a psychiatric disorder when stressful events in the family or at work exceed the person's coping capacity. Therefore, social skills training that reduces personal vulnerabilities by increasing skills and capacities can help promote stable remission. Not taking prescribed medications that would stabilize the condition or drug abuse may impair the biological basis of the disorder, impose a risk factor and lead to an exacerbation. Low self-esteem, anxiety management problems, combined with external stressors such as family tension and drug abuse also pose a risk of worsening the condition by affecting the symptoms of the disease, while cognitive, emotional and social deficits may lead to difficulties in social and work functioning. Protective factors can increase a person's ability to better cope with stress. They include psychopharmaceuticals, psychotherapy, and psychosocial interventions. Protective factors increase a person's ability to cope with external stressors and help reduce morbidity and disability, so they must be included in the patient's treatment plan. Coping with stress and increasing one's ability to cope with stress are important protective factors. According to this theory, biological factors, such as substance use and stressful events combined with poor coping skills in dealing with a new situation can worsen the symptoms. For example, discharge after a long hospitalization of a patient who has not been prepared for living in the community outweighs the protective factors of medication, while lack of the patient's capacities to cope with a specific situation, lack of social skills, and lack of social support can even worsen the symptoms. Even if there is no

major external stressor, the patients who have not been provided with sufficient protection mechanisms in terms of medication, stress management skills, social skills and support may also be vulnerable to the usual demands of everyday life, which they may find stressful, given the lacking ability to cope.

Through skills development and strategies for coping with stress, psychosocial interventions help mitigate the negative effects of stress and serve as protective factors as they increase the person's ability to cope better with life problems and protect him/her from the negative effects of stressful events. Inadequate coping with stress may significantly reduce social and work functioning and self-care. Deterioration of health by the onset of disease symptoms accompanied by impaired function can occur when psychobiological vulnerability factors become the trigger, which often happens when the following factors are lacking: 1. optimal antipsychotic therapy; 2. stressful events that prevent the person from developing satisfactory coping/ problem-solving strategies and skills in social and other roles; 3. not using the necessary skills in case that a person has developed good coping and other skills, either for lack of motivation and hope, or because he/she has accepted the role of the patient as predominant role in life.

One of the goals of the treatment plan is to prevent disease recurrence. Therefore, it is important to increase protective factors and reduce risk factors. In the treatment plan, it is important to identify the protective factors that can contribute to maintaining the optimal state of health and help prevent disease recurrence and risk factors that may, in turn, provoke the risk of recurrence and deterioration of health. Protective and risk factors should be identified individually for each patient. Research has identified the following protective factors in people with psychosis: antipsychotic therapy, good social functioning and different psychosocial interventions, good relationship with the therapist; self-esteem and coping with stress, case management, especially community-based assertive treatment. Understanding the importance of protective and risk factors for the outcome of a disease is key to planning the treatment of patients with psychotic disorders.

The stress - coping mechanisms - social support model is a leading model in training of different professionals working in mental health services, including training of those working in crisis intervention centres, mental health centres, community-based services, and user and family associations. It involves a range of psychosocial interventions through which patients are taught

about daily living skills, families are instructed on how to better tolerate the illness of their family member and how to help him/her, and it has also proved to be a useful approach for the whole team, including professionals from different sectors, who agreed to share a common operational model. A biopsychosocial approach is universally relevant for treatment planning in patients seeking help for mental illness.

CONCLUSION

Stress means a physiological and psychological response to different stressors. According to the intensity of events and adapting mechanisms, it can show as eustress or stress of daily life, distress or crisis, and traumatic event or reaction to trauma and PTSD. Biological, psychological, and social theories explaining the response to stress and traumatic events have been discussed. Stress plays an important role in the onset and course of mental disorders; therefore, the factors of resilience, vulnerability and protection need to be defined.

Protective and risk factors should be identified individually for each patient. Research has identified the following factors as protective in people with psychosis: antipsychotic therapy, good social functioning, and different psychosocial interventions, working with families, and good relationship with the therapist, self-esteem, coping with stress and case management. Understanding the importance of protective and risk factors for the outcome of a disease is key to planning the treatment of patients with psychotic disorders. The stress - coping mechanisms - social support model is a leading model used in training different professionals working in mental health services, community-based services, and user and family associations. A biopsychosocial approach is universally relevant for treatment planning in patients seeking help for mental illness.

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3. NEUROPLASTICITY

Dolores Britvić

3.1. Introduction

Our brain is shaped by many environmental factors throughout our lives, affecting the inherited genetic material. Environmental factors affect the continuous formation of brain structures, brain circuits, the formation of neurons and synapses. The environment alters gene activity and the epigenetic state.

A distinction should, however, be made between neurogenesis and neuroplasticity. Neurogenesis refers to the growth of new neurons, which may happen in the learning process, while neuroplasticity refers to the brain's ability to change, the ability of the brain to take on new functions or to create new synapses and brain circuits. It also refers to the capacity of the nervous system to develop structural and functional adaptations to stimuli. Neurogenesis and neuroplasticity occur after the birth and they may continue throughout life. Furthermore, it is known that increased levels of corticosterone suppress neurogenesis, while increased levels of estrogen, serotonin, glutamate antagonists and some antipsychotic drugs promote neurogenesis. Impaired neurogenesis may provoke depressive disorder.

3.2. Early development

In the early years, very early experiences play an important role in brain development, leaving an important trace in a child's memory, the child's early relationship with their mother, and her ability to recognize and respond to the child's needs in an optimal way. For the child to develop properly, the conditions of the appropriate physical environment (food, warm clothes, and appropriate care), but also continuous interaction with people in their environment, especially their mother, must be met. At the beginning of life, a healthy baby is born with all the brain structures, the brain stem, responsible for a

regulation of different bodily functions (temperature, alertness, sleep, breathing, heart rate and reflexes), the limbic system (emotional brain), and the cortex (sensory processing, motor and higher brain functions, experience, learned relationships, and interaction with the environment). Shortly after birth, a baby follows her instinct, according to "genetically determined knowledge", phylogenetically "belonging to a species". This stage of child development is described as primary autism, and the id dominance, as well as primary process thinking. Damasio uses the term "primordial feeling" to denote an affective state in which the mind and the self are grounded, along with the states of pleasure and pain.

During development and maturation, daily stimulation of neural circuits and an increase in the number of synapses among neurons happens under the influence of external factors (relationship with the mother or child carer, environment, learning) and biological factors (genes and hormones). The early mother-child relationship is one of the most important factors in the development of the child's brain. According to attachment theory, normal development of a child's experience requires mirroring of the child's emotional signals onto the mother in a way to reflect the mother's part too.

At birth, the central nervous system enables instinctive responses controlled by the brain stem (temperature, heart rate regulation, basic reflexes), the striatum, i.e. the basal ganglia (responsible for routine motor behaviour) and the limbic system (emotions, learning, memory, approach-avoidance behaviour modulation and caring for the young). The limbic brain is also referred to as emotional brain consisting of the hippocampus that has a central role, along with the amygdala, hypothalamus and thalamus. The hippocampus is responsible for encoding declarative memory, which is a type of memory that involves facts, experiences, and events. Sleep has an important role in the consolidation of memory. Changes in the hippocampus have been reported in patients with schizophrenia who showed a decreased hippocampal volume, especially the medial temporal lobe, which is believed to be a result of neuropsychological impairment in schizophrenia, rather than a result of the symptoms per se. Hippocampal volume reduction is also reported in other mental health disorders (depression, PTSD, bipolar disorder, and alcohol dependence).

The **cortex** develops through gradual biological maturation and learning, and it is responsible for sensory and motor experience, conscious experience

and learned relationships and social interactions. The neocortex is the most advanced part of the human brain, also referred to as **logical brain** or **executive brain** and is responsible for planning the future, problem-solving and controlling one's emotions. It may be associated with the analytical concept of the **secondary process thinking**, which respects logic and causality.

Some authors interestingly suggest that the brain is an organ that translates life experiences into neurochemistry. Kagan points out that different neuroimaging techniques can only unravel the consequences of experience in all its subjective splendour, which is not possible for emotions, thoughts or beliefs. Unlike renal function, brain function cannot be measured. Indeed, a distinct state of fear or anxiety is not naturally created. There is no such thing as a distinct set of neural conditions or functions that can predict a potential psychological condition, which in turn means that identical or similar conditions may be triggered by activation of different brain regions.

3.3. Neuroplasticity

The brain is the most complex organ in the human body. Gerald Edelman, a Nobel Prize-winning scientist, says that out of 100 billion neurons, the cerebral cortex contains 30 billion neurons and 1 million billion synapses. If we were to count one synapse per second, we would finish counting them 32 million years after we began. He believes that each neuron has between 10,000 to 100,000 synapses and that, with each second of our life, a million of new connections are created. A process known as pruning happens to reduce the number of synapses, which are then replaced by new ones.

The importance of the connections between brain structures is emphasized by the "connectomics", i.e. the study of the brain's structural connections. Mental health disorders are believed to be caused by abnormal brain connectivity, also known as "connectopathy".

The idea that the human brain is made up of a strictly defined set of anatomical connections defined by the genome must be abandoned. The adult brain is a dynamic biological system in which new connections are constantly created, partly in response to constant sensory stimuli from the outside world, and partly as a result of the principle of self-organization.

Gene transcription is an important molecular foundation for neuroplasticity. Kandel reminds us of two gene functions: one is the ability of successful

replication, and the other is gene transcription. It means that genes encode the synthesis of specific proteins in each cell, therefore the cell may respond to the environmental factors. Given that the regulation of gene expression is influenced by external and social factors, different bodily functions, including brain functions, are susceptible to social influences. By changing the gene expression, the environment can change the anatomical structures of the brain.

3.4. Role of genetics in the onset of mental health disorders

The human genome research has identified 22,000 genes distributed across the 23 chromosomes. About half of the genes are active in the brain, but there is no clear connection with the development of schizophrenia, depression, or anxiety. Based on genome studies, there is a link between the observed duplications or depletions in specific copy number variations (CNV) or copy number polymorphism (CNP) and the onset of schizophrenia. Copy number polymorphisms (CNP) are 3 to 4 times more common in patients with schizophrenia than in respondents in good health. Nevertheless, genes may be a risk factor, rather than a cause of illness. High-risk environmental factors such as social isolation, migration, poor living conditions, neurodisorganising and unhealthy relationships, and negative meaning that a person has attached to specific experience may lead to their manifestation. Positive and supportive interpersonal relationships, the influence of the environment and the person's ability to put the experience in context and to attach a true meaning to it serve as protective factors for the onset of mental illness. Research has shown that stress may have a potentially damaging impact on the chromosomes and molecules.

Studies seeking to address the contribution of individual genes to the aetiology of schizophrenia have shown that their impact is comparable to some environmental risk factors, while others, such as birth complications (placental abruption, emergency caesarean section, or hypoxia-related complications) have higher risk potential compared to some candidate genes. Researchers also point to the harmful effects of maternal prenatal stress and substance abuse during pregnancy.

Genotype-environment interaction can be defined as genetic control of sensitivity to the environment, or environmental regulation of gene expression.

In addition to their DNA, parents also pass a chromatin state, cellular environment and cellular mechanisms important for gene expression on to their children. Regional chromatin modifications affect the gene expression levels through the process of methylation or histone acetylation. Chromatin modification may be induced by a specific diet or environmental factors. The cellular environment provides cells with the capacity to transform information from the nucleic acid sequence to the levels of active agents in biological development and functioning.

Despite the significant potential impact of the hormones, minor and early developmental changes may be compensated in brain development, showing remarkable plasticity and regenerative potential.

A recent study has shown epigenetic changes in patients with schizophrenia. In addition to the above mentioned DNA methylation and chromatin modification, RNA interference, changes in RNA (editing) and DNA (rearrangement) have also been observed.

3.5. Neuropathological studies

Contemporary neuropathological studies have also identified schizophrenia as a disruption of synaptic transmission and multiple interconnected brain circuits. Although the total number of neurones in schizophrenic patients has remained unchanged, some neuronal subpopulations appear to be reduced, just as in the mediodorsal thalamus, which may affect corticothalamic connectivity. Deficits in the GABAergic system in the dorsolateral prefrontal cortex (DPFC) and the anterior cingulate cortex (ACC) were observed.

The deficit in glial cell density and number was observed in major depressive disorder, bipolar disorder, and schizophrenia, suggesting potentially common neuropathology in all three disorders. Glial cells have different roles; providing support for neurons, they contribute to neurotrophic support, glucose metabolism, and glutamatergic transmission. Cotter pointed to the toxic effect of glucocorticoids on the reduction of glial cell activation in the hippocampus and a deficit in glial cell proliferation in major depressive disorder, bipolar disorder and schizophrenia.

Looking at the differences between patients with good and those with poor response to therapy, researchers observed that, during a psychotic episode, patients with good response exhibit functional disconnection syndrome

associated with high levels of inflammatory cytokines, disrupted white matter integrity and poor information processing. Psychotic episode remission was associated with a partial recovery of white matter integrity.

3.6. Role of the neuroendocrine system and stress

The two-way nature of the relationship between the immune and neuroendocrine systems should be emphasized. Stress leads to the activation of the HPA axis and the secretion of glucocorticoids, and their strong anti-inflammatory properties affect the immune system. Inflammatory cytokines (IL-6, IL-1, TNF factor) stimulate the HPA axis, contributing to the secretion of stress hormones. Cytokines synthesized in immune cells, neuroendocrine tissues and neural centres (such as the hippocampus) are key regulators of the inflammatory response and contribute to local inflammation. Cytokine production in stressful situations may be a causal factor in the disruption of white matter integrity in persons with schizophrenia.

When considering the impact of social stressors on gene expression, the importance of factors that modulate the response to stressful events should be borne in mind. It is known that persons with one or two copies of the short allele for the promoter 5-HTT (serotonin transporter gene) will be more likely to develop depressive symptoms and suicidality in the event of exposure to stressful events when compared to the long allele homozygotes. However, due to inconsistent results, additional research is needed.

The effects of stress are also evident in the decreased synthesis of neurotrophic factors such as brain-derived neurotrophic factor (BDNF), whose deficiency causes neurodegeneration and neuronal decay. Exposure to stress can cause genotoxic damage that occurs in leukocytes, at the molecular and chromosomal levels.

The experience of early abuse leads to a range of physiological and neurohumoral changes; which in turn activate the stress response system by altering its molecular organization, modifying its sensitivity and future responses to stress; exposure of the brain to the development of stress hormones leads to changes in gene expression, myelination, neurogenesis and synaptogenesis; it affects the sensitivity of different brain regions, which depends on the duration of stress exposure, the developmental stage and glucocorticoid receptor density; it leads to functional impairments such as the impaired development

of the left hemisphere, decreased integration of the left and right hemispheres, and increased electrical excitability in neural circuits of the limbic lobe; it increases vulnerability and the risk of developing neuropsychiatric consequences; it may lead to the development of posttraumatic stress disorder (PTSD), depression, borderline personality disorder, dissociative identity disorder and psychoactive substance abuse. Therefore, stress alters the neurodevelopmental trajectory of adaptation to the environment that has been perceived as dangerous and threatening.

CONCLUSION

Our brain is shaped by many environmental factors throughout our lives affecting the inherited genetic material. Environmental factors affect the continuous formation of brain structures, brain circuits, the formation of neurons and synapses. The environment alters gene activity and the epigenetic state. In the early years, very early experiences play an important role in brain development, leaving an important trace in child's memory, the child's early relationship with their mother, and her ability to recognize and respond to the child's needs in an optimal way. The importance of the connections between brain structures is emphasized by "connectomics", which is the study of the brain's structural connections. Mental health disorders are believed to be caused by abnormal brain connectivity or "connectopathy". Genes may be a risk factor, rather than a cause of illness. High-risk environmental factors such as social isolation, migration, poor living conditions, neurodisorganising and unhealthy relationships, and negative meaning that a person has attached to experience may lead to their manifestation. Positive and supportive interpersonal relationships, the influence of the environment and the person's ability to put the experience in context and to attach a true meaning to it serve as protective factors for the onset of mental illness. Research has shown a potentially damaging effects of stress on chromosomes and molecules.

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4. ASSESSMENT OF FUNCTIONING IN PEOPLE WITH MENTAL HEALTH PROBLEMS

Slađana Štrkalj Ivezić

4.1. Introduction

Why is a functional assessment so important?

The International Classification of Functioning, Disability and Health (ICF) developed by the World Health Organization (WHO) defines functioning as the ability to perform and participate in various activities of daily living, from daily routine to complex interpersonal communication and the ability to take on different roles that are normally expected to be taken by an average, healthy individual. The functional assessment looks at the capabilities and limitations and discusses their causes.

In mental health disorders, symptoms and functional difficulties are intertwined. The assessment of functioning is just as important as symptom assessment. We should always be interested in how the symptoms of the disease affect the patient's daily life in terms of his or her ability to work, study, communicate with other people, live a satisfying life, participate in society, and what can be done to improve his or her functioning by learning new skills and/or organizing appropriate support. From a clinical point of view, greater functional impairment in patients with different mental disorders will be reflected in a more serious medical disease or condition. Improvements in functioning may help reduce symptoms, and vice versa. According to the recommendations of the World Health Organization (WHO), in the assessment of health, including mental health, symptoms and functioning need to be assessed separately. Observing the symptoms separately from the functioning is important in creating a treatment or rehabilitation plan, as well as in the disability assessment that a person needs to attend if they have applied to claim specific rights. However, if the functional assessment fails to be conducted, it means that a person with mental health problems may not be able to receive

adequate medical attention, and may therefore not be allowed to exercise some of his/her rights, such as the right to a pension, disability allowance, attendance allowance, driving ability test etc.

The Commission for the Review of Disability Rating will rely on a person's medical history as they do not perform any kind of examination, so if the levels of functioning have not been specified in the medical records, the patient may not be properly assessed.

Areas of functioning observed in the assessment

The assessment of functioning and participation in activities under the ICF refers to the assessment of functioning and participation in daily living activities, from daily routine to more complex activities, such as social communication skills, functioning in social roles in different contexts, including family, relationship with a partner, workplace, education and the wider community. Capacities and limitations, as well as reasons for limitations (symptoms of illness, lack of motivation, stigma, hopelessness, etc.), are assessed. The assessment of functioning looks to identify personal factors such as a lack of assertiveness skills and environmental restrictions.

To gain insight into the functioning of an individual with any medical condition, including people with mental health problems, it is important to evaluate functioning in the following areas, including the attitudes and barriers in the person's environment:

1. **Learning and applying knowledge** – which means the assessment of cognitive functioning
2. **Carrying out daily routine** – it includes taking care of one's hygiene, self-care, personal safety, taking care for the household, nutrition, budgeting, etc.
3. **Mobility** – including the ability to move independently
4. **Communication, interaction and relationships** – they include communication difficulties and the quality of relationships with other people and social skills in communicating with others.
5. **Role functioning** – family, workplace, education, community, recreation and leisure
6. **Social isolation**
7. **Handling stress and other psychological demands** in different activities – it includes resilience to stress and managing stressful situations

8. **Support –** it includes assistance by people in their immediate environment and asking for and getting help in challenging activities, as well as reaching out to different institutions providing support.
9. **Attitudes –** it involve identifying the environmental factor that may be a facilitator or barrier to different activities. On one hand, this is particularly the case for stigma and discrimination, and, on the other hand, community-based professional support systems.

Purpose of the assessment of functioning

The purpose of an assessment of functioning is to identify fields of functional capacities and limitations, as well as the available community-based resources to improve one's functioning, including different services, from treatment services to support services that will help patients to exercise their disability rights. In addition to treatment needs, an assessment of functioning needs to be done for the different assessment of disability rating authorities in the labour, social welfare, and other relevant sectors.

Identifying functional difficulties, causes of functional difficulties, and creating a treatment/recovery plan

Once functional difficulties have been identified, a treatment/recovery plan is needed to list the methods for eliminating the impairments and/or organizing support.

Furthermore, once disability or limitations have been established based on the assessment, it is important to find the cause of functional difficulties. We seek to learn whether the cause of functional difficulties is the illness, stigma, a lack of community resources, restrictions imposed by others, a lack of rehabilitation programmes, a lack of organized support, etc.

It is important to know that functional impairment is a major source of stress; as such it poses a risk for the onset of illness. Therefore, once functional difficulties have been identified, a treatment/rehabilitation/recovery plan should be created and people suited to implementing the treatment plan need to be listed. A treatment plan, including the plan for improving one's skills, organizing help or both, contributes significantly to stabilization of symptoms and recovery.

Who conducts an assessment of functioning?

In his or her report, the psychiatrist will document any difficulties in all areas of functioning, regardless of whether they gathered such information during the interview or they relied on other assessments, conducted by, for example, a psychologist for the area of cognitive functioning, an occupational therapist for the area of self-care (hygiene, nutrition, budgeting, etc.), a social pedagogue for the area of communication skills, and other professionals, family members, colleagues, home visits, etc. A comprehensive assessment of functioning will require the collaboration of different professionals. The work capability assessment will require collaboration between different professionals, and well as getting relevant information from a person's employer.

Due to the lack of insight into the disease in some people, like those with schizophrenia and bipolar disorder, conducting a functional assessment may be challenging, so we will need to use heteroanamestic data and observation, as well as the information from other sources and assessments conducted in the person's immediate living environment. We need to be aware that any functional assessment that has not been made in the person's natural environment may be incomplete, for example, it will be difficult to assess capability for work in people who have never worked.

What is assessed in a functional assessment?

Capabilities, levels of disability, independence and stress levels in performing activities in a specific area of functioning are assessed and compared against the results for an average healthy person. Performance barriers are also assessed to learn why somebody fails to perform an activity for which they have the capacity. Persons with mental illness can move around, but their movement may be impaired, for example, due to symptoms of illness such as agoraphobia, PTSD, or social isolation and avoiding to leave the house due to stigma. In the functional assessment, equal attention is paid to capacities and incapacities (limitations). Assessing what patients can do independently and what they need help with is important for creating a treatment plan, especially in terms of rehabilitation, but also in producing medical reports that will be used by the commission for the review of disability rating in the pension or social welfare system, driving assessment centres, etc.

Assessment instruments

As for the assessment instruments, it is recommended to follow the criteria outlined in the International Classification of Functioning, Disability and Health (ICF). In line with the ICF domains, recommendations for the assessment of functioning of persons with mental health disorders, as well as the assessment of functioning scale designed to assess functioning have been prepared.

4.2. Areas of assessment

This section contains a detailed description of specific domains of functioning, support, facilitators and barriers with recommendations of interventions that can be used in treatment/recovery plan to increase the capacity to function in different activities/roles and/or organization of support for the activities that a person is unable to do independently. The cause of difficulties (e.g. a lack of skills, a lack of motivation, medication side effects, stigma, and demoralization) and patient preferences need to be taken into consideration when creating a treatment/recovery plan. Proposed treatment methods should also include a list of other professionals who will help implement the treatment plan that is expected to improve the patient's functioning. When it is unlikely that the person will be able to perform the activities independently and the psychosocial interventions did not produce the expected results, a treatment plan needs to be updated with appropriate support by defining the type of support that is necessary, as well as the persons who will help provide support. Examples of assessment reports that describe capabilities and limitations have been provided in the section discussing specific domains of functioning.

4.3. Cognitive functioning

Assessment of cognitive functioning means the assessment of learning and application of knowledge, the process of thinking, problem solving and decision making. Concentration and memory problems, difficulty staying focused, ability to put knowledge into practice and transform knowledge into a practical skill, ability to read, write and calculate are also assessed. Problem-solving and decision-making skills can only be assessed against specific examples.

Assessment data: For a more detailed assessment of cognitive functions, a medical and collateral history alone may not suffice, which means that a psychological assessment is required.

We want to know the extent to which cognitive impairments affect the person's life. What difficulties does he/she experience in their everyday life (daily routine, work, learning, etc.) due to cognitive impairments? What kind of help does he/she need? Can we expect that the situation will change? What causes cognitive impairment? Furthermore, we also want to see what is possible in terms of the cognitive enhancement plan**.**

The assessment of cognitive function involves the assessment of **focus and concentration** distractibility by external stimuli, maintaining goal-oriented behaviour, including making plans and putting a plan into action, **memory** (short-term and long-term memory, recalling information); **executive functions** - ability of **organization and planning** pertaining to mental functions of **coordinating of separate parts into a unified whole** and systemizing skills; **time management** refers to ordering events in chronological sequence, allocating a specific amount of time to specific events and activities; **cognitive flexibility** refers to changing strategies, or shifting mental sets, especially in problem solving; **perception of emotional and social cues, abstract thinking; decision-making capacity** to make a decision, such as choosing a treatment.

The decision-making capacity assessment is important for assessing a patient's capacity to give informed consent and the need for appointing a guardian. The assessment includes the following elements: 1. the person can understand the information that is relevant to the decision, which has been provided in an appropriate way, including the possible consequences of both positive and negative decision. A person needs to have a general understanding of the decision and why he/she needs to make this decision; 2. the person is capable of retaining such information, even for a short while; 3. the person is able to consider the advantages and disadvantages in order to to make a decision; 4. the person may express his or her decision in spoken language and sign language alike, or by using other means of communication understandable to others.

Assessing decision-making capacity is important in deciding on taking away or restoring one's legal capacity.

Other domains are also assessed: **knowledge and intelligence, motivation and insight into the illness.** In assessing one's knowledge, a person's education should be taken into account**.** When assessing motivation, it is important to find out about the person's motivation. **Insight into the illness** means the level of awareness and understanding of illness and treatment information.

Assessment. The patient finds it difficult to concentrate, he/she reports difficulty watching TV, he/she can't stay focused on the task, he/she can't remember what they have just read, he/she has problems with short-term memory, e.g. he/she often forgets what to do next, he/she finds it difficult to organize time around different activities, he/she needs to be reminded to take medication, he/she finds it difficult to decide on their treatment, or where to live, etc. Difficulties with short-term memory and concentration affect the person's capacity.

Causes. For example, some common causes of difficulties include medication side effects, mild cognitive impairment, depression, preoccupation with psychopathology, for example, constantly hearing voices impedes the person from doing other tasks, he/she jumps to conclusions without having enough information, etc., or **capacities**, including the ability to concentrate, the ability to coordinate multiple activities etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. The treatment/recovery plan may include cognitive remediation to increase cognitive ability, concentration exercises, dose reduction/medication change if cognitive problems are caused by medication side effects, metacognitive training to help change the thinking patterns and foster decision-making processes. The interventions will be carried out individually or in a group by trained professionals by following recommended interventions, including recommendations for deprivation/restoration of legal capacity, and/or recommendations for supported decision-making.

4.4. Self-care: daily routine

Capacities, disability, levels of independence and stress in performing and organizing a daily routine for people with mental disorders are assessed against those of the average healthy person.

Sources of information. The patient, family members, occupational therapist assessment, observation etc.

Self-care assessment. Areas of assessment from 1 to 5 are usually assessed by occupational therapists, who conduct life skills training, but case managers and other professionals may be involved in the assessment too. Areas 6 and 7 are usually assessed by doctors, nurses and case managers.

4.4.1. Personal hygiene and appearance

A list of questions to ask. Are you having difficulties in maintaining personal hygiene? How often do you bathe, or shower? Do you shave regularly? Do you wear clean clothes? Do you take care of your nails? Do you maintain personal hygiene after using the toilet? How often do you brush your teeth? How often do you wash your hair? Do you use a hairdryer? How often do you get a haircut? How often do you maintain your intimate area hygiene? How often do you change your underwear? Do you use cosmetics? Are the clothes you wear usually clean and ironed? Do you dress appropriately for the weather and the occasion? Do you look presentable? Do other people find your outfit weird, or do you dress differently than most people? Are you independent when maintaining personal hygiene, dressing, or choosing your clothes? Do you do laundry or wash your clothes? Does it take longer for you to dress when compared to other people? If not, who lends you a hand? Has your illness affected your hygiene, neatness and appearance? Did you take care of your hygiene and appearance differently before you got ill? Has anything else changed in terms of your hygiene and appearance behaviour?

Assessment. The client does not maintain personal hygiene if he/she is not encouraged, he/she looks unkempt, he/she does not change his or her clothes if not encouraged to do so, or he/she has no difficulty in maintaining personal hygiene, a person is neat and tidy, he/she takes care of their appearance etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Life skills training is planned to improve self-care, including improved personal hygiene and taking care of one's appearance. The occupational therapist will help develop a skills training plan.

4.4.2. Diet

A list of questions to ask. Do you eat regularly? How many meals do you eat? Are you eating enough food? Do you eat a balanced diet? Do you eat the usual meals (breakfast, lunch, snack, dinner)? Do you avoid eating? Are you

overeating? Do you vomit after eating? Do you drink water and other drinks? What is your daily fluid intake? Are you dieting? Do you tend to gain or lose weight? Do you consume food in a culturally acceptable way (e.g. by using cutlery)? Do you have swallowing problems? Was your attitude towards food and meal preferences different before you started treatment? How has your relationship with food changed when compared to your pre-treatment habits? Has something else changed your relationship with food (e.g. budgeting for food on a low income)? Do you need other people's help to eat and prepare food regularly?

Assessment. According to the information collected from home visit or heterodata, the client doesn't have any food in the fridge, so they need help getting food, he/she has only one meal a day, or he/she tends to eat too much, or a lots of dry food, their diet isn't balanced, he/she doesn't use eating utensils, he/she is fed at the soup kitchen on a regular basis, etc.

Causes. Causes include lack of motivation, skills and support.

Individual treatment/recovery plan and persons responsible for putting the plan into action. The case manager can help with grocery shopping or food delivery from a nearby care home and teach the client about a balanced diet, etc. Family, friends and other trusted persons may be asked to make sure that the client has enough food. The case manager will monitor the plan implementation.

1. Independent meal planning and preparation

A list of questions to ask. What are your eating habits? Do you cook on your own? Do you cook for other people? Do you have difficulties with food preparation? Do you have problems with things such as peeling potatoes, vegetable cutting and chopping, using a blender, etc.? What dishes do you prepare? What is your favourite recipe? Can you think of a healthy eating plan? Do you use household appliances? If a client cannot cook, the case manager needs to find out where they normally eat (with their family, food delivery, etc.). What do you usually have in your fridge? If you do not cook your own meals, can you reheat the food? Why don't you prepare your meals? Do you need other people's help to get food, prepare a meal or organize your diet? How did preparing meals and organizing your diet go before your illness?

Assessment. The client knows how to cook but lacks interest**,** the client doesn't know how to cook, he/she makes sure that there is enough food in the fridge, the client has a hard time deciding on what to cook, he/she needs help

with some tasks, he/she buys food himself or herself, the client can reheat the food, the client is able to safely use household appliances, the client knows how to prepare simple meals, food delivery is arranged through a neighbouring care home, etc.

Causes. Causes include lack of skills, lack of motivation, lack of support, logistics – the client lives in a remote area etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. The client wants to learn how to prepare simple meals, so they will enrol to a cooking class run by an occupational therapist; the client needs help with organizing food from a neighbouring care home, they need shopping assistance, so the assistance needs to be planned with a family member, case manager in the mobile team, etc.

4.4.3. Budgeting and shopping

A list of questions to ask. Do you budget your money on your own? Do you buy your housewares, clothes, etc.? Are you familiar with grocery prices? Do you know how to use an ATM? Do you use banking services, such as a personal loan? Do you have a current account? Do you manage money well enough to cover your expenses such as food, utilities, and other needs? Do you often run out of money? Do you spend money on trifles you don't need and end up running out of money for utilities and food? Do you manage to save some money? Does anyone help you manage your money, shopping and other money-related activities? How did you manage your money before treatment? Has your way of managing your money changed after you got ill/started treatment? Do you need help with managing your money?

Assessment. The client has good money management skills**,** the client needs help with managing their money, the client tends to spend money on trifles they don't really need, the client fails to pay their utility bills and runs out of money very quickly, the client has accepted help with managing their money, the client understands the value of money, the client has good money management skills, the client is able to do the shopping, the client is able to use an ATM, the client regularly pays the utility bills, the client tends to spend very little, the client has accepted help with money management, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. The client needs help with managing their money

to pay the bills regularly, so the occupational therapist will develop an assistance plan that includes support from a family member, friend, occupational therapist, etc.

4.4.4. Keeping the house clean, maintenance of personal space and home safety

A list of questions to ask. What are your household chores? If you don't live alone, what chores do you help with at home? How do you keep your living area tidy? Do you find it difficult to do the chores properly (cleaning, washing dishes, doing the laundry, storing clothes, making your bed, etc.)? Do you do the chores on your own? What chores do you do? Do you regularly sweep, vacuum, mop the floors, and dust your home? Do you regularly hang your clothes in a closet, and make your bed? Do you clean your clothes? Do you iron out your clothes? Do you organise your clothes in a closet? How often do you change your bed sheets? Do you clean the windows? How often do you do that? Do you take care of dirty dishes? Do you use a stove, vacuum cleaner, washing machine, and other household appliances? Do you store food properly? Do you keep an eye on the shelf life of the food? Do you take out the trash regularly? Do you keep an eye on the home repairs that may be needed? If you have pets, do you take care of them? Do you water your plants? Do you do home repairs? Do you organize professional home repair service as and when necessary? Can you drive a car? Do you take good care of your car?

Home safety matters. Can you stay at home on your own and take care of yourself? What's the longest time you can spend home alone? If you are home alone, do you have trouble taking care of your hygiene, nutrition, housekeeping, and especially safety (turning off the electricity, gas, and water)? Do you need help with chores? If yes, which ones? What was it like for you to do household chores before you got ill? What changed after you got ill and started treatment?

Assessment. The client is unable to keep the house tidy on their own, the client wants and needs help, the client has problems with mopping a floor, vacuuming, washing dishes, the client can stay home alone with assistance available, the client can independently keep the house clean, there are no safety problems, the client is able to independently do all household chores, the client knows how to use household appliances, the client is able to water their

plants, the client does not need help, the client is able to call home repair services, the client takes care of a pet, the client can stay home alone.

Individual treatment/recovery plan and persons responsible for putting the plan into action. The client needs help with housekeeping, the client wants to keep the house clean and tidy on their own, the client wants to learn, the client will receive life skills training by an occupational therapist during a home visit, or during a life skills training programme at a day hospital, and a housekeeper or a family member will be asked to help.

4.4.5. Self-care, treatment adherence

A list of questions to ask. How satisfied are you with your health? Do you want to improve your mental health? Do you take care of your physical health? What is the last time you made laboratory tests for complete blood count, blood glucose test, liver function tests, ECG, etc.? Do you usually make an appointment with your doctor on your own? Do you take care of getting and taking your medication? Does anyone help you with taking your medication? Do you take care of yourself when you get sick (e.g. you catch a cold)? Do you take your medication as prescribed by your doctor? Do you think medication helps you? When you notice that something is wrong with your physical or mental health (e.g. you have a fever, you're in pain, or you're depressed), do you call or go to the doctor on your own or does someone accompany you? Do you see your psychiatrist regularly, as recommended? Do you take medication for mental health problems and other medications as recommended? Can you recognize the signs of deteriorating mental health and do you make an appointment earlier than planned when necessary? Do you eat according to the healthy eating guidelines, do you eat a balanced diet? Do you get active (exercise, walking, sports)? Do you sleep well? Do you make sure that you feel comfortable (not too cold or too hot)? Do you take any dietary supplements, such as vitamins? Do you keep yourself physically fit? How do you keep fit? Do you follow your doctor's advice when you're ill? Do you try to prevent illness through your behaviour (e.g. by washing your hands, by taking care not to hurt yourself, or practising safe sex)? Do you take prescribed medication for mental health problems at the recommended dosage? If you think your current medication isn't helping, or may even harm you - do you speak to your psychiatrist? Do you feel you need psychiatric treatment? Did

you change any of your physical self-care practices after you became ill with a mental illness?

Assessment. The client must be encouraged to take care of their health, including dental care, the client must be encouraged to go see the doctor, to get medications, the client refuses to take medication, he/she cannot recognize worsening symptoms, the client is not physically active, the client is able to go see the doctor on their own, take and get medication, the client can recognize signs of deterioration, the client goes to the psychiatrist on their own, the client exercises regularly, etc.

Causes. Causes include lack of insight, lack of interest, lack of support, refusal of treatment, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. The client is invited to join a group Healthy Lifestyles Programme (HeLP) delivered by a registered nurse/medical technician, schedule regular health check-ups, improve his/her treatment adherence, as part of mental health education provided by the psychiatrist, identifying early signs of deterioration of health, with a deterioration prevention programme that can be provided individually or in a group, the client may be assisted by a case manager in the mobile team, a family member, a legal guardian, if one has been appointed, etc.

4.4.6. Mobility, slowness, passivity

The client's capacities, limitations and obstacles to moving outside the home, and moving slowly are assessed in this section.

Assessment. The client doesn't leave the house/the room/home (due to a lack interest, physical restriction, lack of friends, stigma), he/she doesn't move independently because he/she finds it difficult to get by, he/she needs to be accompanied, the client doesn't know how to use public transport, he/she suffers from fear of public transport because he/she doesn't like other people to be around, the client is afraid of being followed… The client dresses and speaks slowly, making decisions 'on the go' (medication side effect?), the client takes longer to finish the task, or **the client has no moving difficulties**, he/she can move independently, the client can go to town on his own, or travel, the client knows how to use public transport, but he/she doesn't apply this knowledge because he/she lives in a care home where he/she isn't allowed to

do so, the person believes that other people would isolate him or her if they knew about his/her mental health problem.

Causes. Causes include symptoms of the disease e.g. believing that someone is following them, passivity, stigma, lack of skills and support, sedation from drugs, extrapyramidal side effects, etc.

Individual treatment/recovery plan. Depending on specific circumstances, the plan may involve volunteers to help the client with social inclusion, organize CBT therapy for PTSD and agoraphobia, help the client improve their skills for moving around the town, organize anti-stigma and anti-discrimination interventions, a psychiatrist might need to adjust the dosage or change the medication, a case manager may be involved, etc.

4.5. Communication/interpersonal interaction and relations

In this section, verbal communication skills are assessed, including the ability of written communication, sending and receiving messages, establishing relationships and showing emotions in a way appropriate for the context and in a socially acceptable manner. A client's ability to show attention, respect, and control his/her emotions in communication while interacting with other people is also assessed. The assessment also includes the use of different communication channels/techniques, including telephone and the internet. Furthermore, it involves understanding verbal and non-verbal messages, the ability to make a conversation, to engage in a discussion, and create and maintain various interpersonal interactions and relationships in formal and informal contexts, as well as with family.

1. ABILITY TO SEND AND RECEIVE MESSAGES, TELEPHONE AND INTERNET COMMUNICATION

Assessment. The client finds it difficult to express their thoughts and desires, the client finds it difficult to ask questions and make requests because they are afraid that people will reject them or won't understand them, other people have a hard time understanding what they want to say, the client finds it difficult to understand what others are saying, he/she struggles with understanding the meaning of non-verbal messages, the client tends to misinterpret other people's messages, he/she often thinks that there is a hidden message in what other people say, such as people turning against him/her, he/she doesn't ask questions, even if something wasn't clear, the client needs to be explained

several times what is being said to him, the client finds it difficult to make a conversation, the client finds it difficult to use their phone, send messages, he/she doesn't use the Internet. **Capabilities** may include: he/she communicates well, he/she trusts people, he/she understands the message correctly, he/she makes a conversation, he/she makes an argument, he/she asks when he/she wants to know more about something, he/she uses the phone and the internet without any problems.

Causes. Causes include symptoms of illness, lack of skills.

Individual treatment/recovery plan and persons responsible for putting the plan into action: assertiveness training, verbal and non-verbal signals communication training, metacognitive training, etc. conducted by professionals with training in social skills, and metacognitive training.

2. CONVERSATION SKILLS, MAKING A CONVERSATION

Assessment. The client finds it difficult to present himself or herself, he/she finds it difficult to start a conversation, he/she finds it hard to converse, he/she struggles to find topics for conversation, he/she tends to lead a monologue, he/she doesn't ask questions, he/she needs to be encouraged to talk, he/she is suspicious when making a conversation, he/she doesn't know how to end a conversation, he/she doesn't know how to use the phone/mobile phone/the internet, he/she tends to inappropriately touch people during a conversation, he/she struggles to keep a distance, he/she finds it difficult to accept criticism, he/she sees other people as provocative, he/she is unable to express dissatisfaction or satisfaction adequately. **Capabilities** may include the following: the client makes good contact and participates in conversations on topics of interest, the client finds it easy to present himself or herself, the client behaves in a socially acceptable manner, the client tolerates criticism, the client listens to others, the client is able to follow a conversation, the client asks appropriate questions, and ends the conversation appropriately. The client can use a phone, the internet, or communicate in writing. He/she shows respect for the interlocutor and expresses emotions appropriately.

Causes. Causes include symptoms, lack of skills, consequences of impaired emotional development, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Skills training covering the following aspects: how to make a conversation, how to appropriately express criticism and

dissatisfaction, how to introduce yourself, how to express emotions as part of skills training, metacognitive training etc. conducted by a trained professional.

3. ENGAGEMENT WITH STRANGERS OUTSIDE THE HOUSEHOLD

The assessment looks at the way a client communicates with other people outside of home and his/her flexibility in a group of people through informal situations, or their reactions when they accidentally run into somebody they know, relationships with their neighbours, the situation at work, contacts with neighbours and other people, friends, acquaintances. Assessment includes observing how the person responds to the questions and requests of other people, the person's readiness for coexistence on an impersonal level (e.g. with colleagues, other people on the bus or other shoppers in a store, in a care home, etc.).

Assessment. The person finds it difficult to engage with strangers, acquaintances, neighbours, authorities, they keep avoiding contacts, other people's company, they find it difficult to control anger, they find it difficult to express satisfaction, to give compliments, or to maintain a friendship, and they tend to terminate relationships with other people in an inappropriate way. They find it hard to ask for information from strangers. The person does not offer a proper response when asked a question. **Capabilities** may include the following: the person easily makes friends, the person can maintain friendly, professional and intimate relations, the person is able to end a relationship with other people in an appropriate way, the person feels comfortable in other people's company, the person is happy to socialize, and the person is sociable and able to express his/her feelings in an appropriate way. The person doesn't find it difficult to ask a stranger for information. The person responds appropriately to strangers when asked for some information, he/she knows how to give directions, etc.

Causes. Causes include symptoms of illness, lack of skills, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Social skills training in the field of communication, teaching a person on how to start a conversation, how to make friends, how to ask a question, how to express feelings, how to ask for information, etc. that will be conducted by trained professionals.

4. CONTACTS WITH FRIENDS AND FAMILY

Assessment. The person doesn't have any friends, he/she finds it difficult to make friends, he/she ends a friendship easily, he/she doesn't show respect and warmth to friends, he/she doesn't socialize with friends, he/she isn't close with his/her family and finds it difficult to maintain family relationships, he/she doesn't show warmth and respect for them, he/she reacts violently to criticism**. Capabilities** may include the following: the person has friends, the person enjoys spending time with his or her friends, he/she finds it easy to maintain a friendship, he/she shows care for his or her friends, he/she is close with his or her family, and he/she shows warmth to them.

Causes. Causes include self-stigma that makes the client avoid other people, lack of skills, lack of support in social inclusion, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Social skills training, eliminating self-stigma, organizing volunteer support, etc.

5. CREATING RELATIONSHIPS IN FORMAL SETTINGS

Relationships in formal settings (relating with persons in authority, at work) are assessed, they relate to the creation and maintenance of specific relationships in formal settings, such as those with employers, professionals or service providers. It includes relating with persons in authority (formal relations with people in positions of power or of a higher rank or prestige relative to one's own social position, such as an employer, persons in authority), relating with subordinates (relations with people in positions of lower rank), relating with equals (creating and maintaining formal relations with people in the same position of authority).

The assessment also includes the ability to show attention, respect, appreciation, tolerance (accepting diversity) towards other people, responding to criticism (differences of opinion), using physical contact (including initiating and responding to physical contact with others) in communicating in a socially acceptable manner, respecting the context in which the interaction occurs.

Assessment. The person has difficulties when in a relationship with another person who has authority, the person feels anxious, full of fear and distrust, he/she feels unaccepted, he/she has a hard time expressing his/her opinion because he/she is afraid of rejection. **Capabilities** may include the following**:** the person behaves appropriately in interaction with persons in authority,

with equals and subordinates, he/she tends to cooperate with people, he/she respects other people's opinions, he/she is tolerant of others, he/she uses appropriate physical contact, he/she shows warmth in his/her relationships.

Causes. Causes include dysfunctional behaviour patterns associated with a personality disorder, lack of skills, symptoms of illness etc.

Individual treatment/recovery plan. Skills training, individual or group psychotherapy, conducted by trained professionals.

6. CONTROLLING EMOTIONS AND IMPULSES

Here we seek to assess whether a person can control the expression of feelings and behaviour while communicating with other people. Precisely, we assess the person's ability to control anger and verbal and physical aggression. We assess whether the person can control his/her emotions and behaviour described above while communicating with other people, following social rules and conventions. Creating relationships and showing emotions in a contextually and socially appropriate manner is also assessed. A person's ability to show attention, respect, and control one's emotions in communication while interacting with other people is also assessed.

Assessment. The person finds it difficult to identify and express emotions (anger, helplessness, fear); the person finds it difficult to control anger, the person gets angry very easily, he/she is impulsive, reckless, he/she gets himself/herself involved in incidents of aggression, anger, scaring other people, he/she is prone to self-harm, he/she finds it difficult to express emotions, he/she harbours anger, and is often suicidal. **Capabilities** may include the following**:** the person identifies emotions, he/she can talk about them, he/she is not aggressive, he/she is not suicidal, and he/she is thoughtful and assertive.

Causes. Causes include symptoms of illness, dysfunctional behaviour patterns, emotional development impairment, not being surrounded by empathetic people in their childhood, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Anger management classes, assertiveness training, individual and group psychotherapy provided by trained professionals.

7. SOCIAL ISOLATION

Here we seek to assess the person's avoiding other people, lack of communication skills, and narrow social contact. Furthermore, we seek to assess his/her verbal contact with family, friends and acquaintances, avoiding other

people's presence, initiating and maintaining communication skills by asking questions, showing interest in others.

Assessment. The person is socially withdrawn, passive, he/she spends most of his/her time in the room, he/she is not involved in any activity, he/she needs to be encouraged to socialize with people, the person is anthropophobic, he/she avoids social situations, he/she is afraid of being mocked by other people, he/she avoids going out for fear that they may embarrass themselves etc., he/she tends to avoid the place where they suffered from a PTSD-inducing trauma, he/she is not involved in the social life of the community.

Capabilities may include the following: the person is actively involved in communication with other people and life in their household/community, he/she enjoys the other people's company, he/she is not socially withdrawn, and he/she is sociable.

Causes. Causes include symptoms, social phobia, PTSD, stigma, lack of skills, lack of social inclusion programmes, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. CBT**,** plan for reducing self-stigma and treatment of stigma and discrimination, social inclusion with the help of a family member, volunteers, case managers, getting help to find hobbies or interests. The plan involves professionals who will run a self-stigma reduction programme, case manager, volunteers, etc., interventions will be delivered by trained professionals.

4.6. Role functioning

4.6.1. Functioning in the family, with a partner, including sexual functioning

Here we seek to assess the ability to function in family roles, which involves the creation and maintenance of family relationships with members of the nuclear and extended family, caregivers, and adoptive families. The emotional atmosphere in the family is assessed for the high expressed emotion-EE factors in the family, reflected in excessive criticism and overprotection.

Parent-child relationship (parenting capacity): Here we seek to assess the person's ability to provide physical, emotional and intellectual nurture to their biological or adopted child, the person's actual performance in

childcare-related tasks, role in the household, the person's involvement in the lives of his/her children, and childcare patterns in the family. The following should be considered: 1. the basic tasks and activities undertaken by the person to ensure the health and safety of the children, 2. child abuse or the possibility of expressing negative emotions to children, 3. the partner's emotions or reactions regarding their parenting.

Assessment. The person finds it difficult to take care of his/her children, the person is unable to take care of their meals, health, leisure activities, he/she is unable to attend parents' evenings, he/she cannot provide necessary clothing and food, he/she is unable to play with children, or guide them through leisure activities, he/she is unable to discipline them appropriately, he/she may care for their children with support, his/her behaviour causes distress in children, he/she is violent towards children, he/she finds it difficult to achieve closeness in parent-child relationship, he/she has no interest in childcare. He/she can take care of their children with the help of their partner or family. **Capabilities** may include the following**:** the person is capable of taking care of their children, except in a crisis when he/she may need the support of other family members.

Causes. Causes include symptoms of illness, diminished parenting capacities in times of crisis, reduced energy levels and a lack of skills, exposure to expressed emotions in the family (high EE factor), etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Parent support programmes, organizing other people's support, family interventions for improving communication with children provided by trained professionals.

Relationships with parents, siblings and extended family

The assessment includes a child-parent relationship, the way in which a client is taking care of his/her elderly parents, creating and maintaining a relationship with siblings, creating and maintaining a relationship with one's extended family. Assessment also looks at emotional atmosphere when the person still lives with his/her parents, who take care of him/her.

Assessment. The client has difficulties in the relationship with their parents, siblings, there is no warmth between them, frequent conflicts, family tensions, he/she cannot take care of his/her parents, he/she needs help from his/her parents due to his/her mental health problems, he/she lives with parents in a tense home environment, there is no contact with the extended

family. **Capabilities may include the following:** the person keeps in touch with his/her family and regularly visits them, their relationship is close and full of warmth, and he/she lives with his/her family in harmony and mutual understanding.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Communication training to improve family relationships conducted by trained professionals, family counselling, planning family support through a mobile team, etc.

Intimate relationships/romantic relationships, marital and partner roles, sexual relationships

Assessment includes communication with one's significant other, spouse/partner (area of the person's life that he/she discusses with the spouse), and ability to show emotions and caring for the spouse/partner, the amount of support to the spouse/partner, intimate relationships (emotional and sexual intimate relationships). The assessment also involves creating and maintaining a sexual relationship with a spouse or partner. The definition of sexual activity includes sexual act, kissing and other intimate activities. It also includes the interest the patient has in sexual activity with a spouse/partner. It includes information about how much he/she enjoys it and how willing he/she is to satisfy his/her partner.

Assessment. The person doesn't have a partner, he/she has no interest in having a partner, he/she doesn't use social media to meet other people, he/she finds it difficult to find and communicate with a potential partner, he/she thinks he/she is not attractive to anyone, he/she is shy, she/he has never had a boyfriend/girlfriend, he/she has no skills necessary to ask a potential partner out on a date, his/her relationship with a spouse isn't good, there is no intimacy, there is no contact between the partners, they don't spend free time together, he/she has difficulty in trusting, showing emotions, attention and interest in a partner, the couple is not interested in solving problems together, he/she is physically aggressive towards his/her partner, the person has no interest in sexual activities, the person has problems with sexual desire, erection, he/she shows aggression and impulsiveness in sexual behaviour, he/she can become a victim of another person's sexual behaviour, he/she expresses dissatisfaction with his/her sex life, etc. **Capabilities may include the following:** he/she wants to have a partner, he/she can be in a relationship in an appropriate way, he/she has a satisfactory relationship in marriage, in which he/she gets

understanding and support, he/she fosters positive emotional relationships and spending free time, he/she has an interest in his/her partner, he/she is satisfied with his sex life (whether he/she engages in sexual activity or not).

Causes. Causes include lack of interest, stigma, lack of skills, communication difficulties, unpleasant experiences of abuse, sexual side effects due to medication, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Skills training, partner therapy, partner counselling, changing medication to reduce the sexual side effects, sexuality and contraception education (visit the Croatian Society of Sexology website to get a booklet), sex therapy provided by trained professionals etc.

The presence of an emotional climate of tension in the family which results from communication problems and poses a risk of deteriorating mental health is then assessed. Assessment involves identifying whether the family members tend to over-criticize the person with a mental disorder living with them, or whether they are overprotective towards the client, in which case he/she is treated like a helpless child and/or as a dependent person who is not expected to make any progress. Once the described behaviour in the family has been identified, a plan of family intervention needs to be made to help improve family communication.

4.6.2. Work and education/employee role - any work performed by the client is assessed (employment, volunteering)

In this section, the activities and participation levels needed to function in education, work, and employment settings are assessed. It includes engaging in all forms of work, such as paid, unpaid work, part-time work, volunteer work, working from home, etc. It also includes vocational training, apprenticeship programmes - preparation for work, job search, getting and keeping a job and termination of employment. If a person is unemployed, but still engaged in some kind of regular work activity, such as volunteering, his/her activities should still be assessed, indicating the tasks he/she performs, as well as his/her working hours.

What is assessed?

The assessment involves the patient's independent and assisted performance, showing up for work on time, keeping up with the work pace,

supervising other employees. In work performance, the following should be considered: work discipline (respecting working hours), quality and quantity of performance (meeting the standards), decline in work performance, ability to keep up with the work pace, negative social consequences for the patient. Performance assessment is done in a real work environment.

Incapacity/disability is the consequence of a complex interaction between an individual's medical condition, and personal and external factors (circumstances in which a person lives and works). Different settings, including the work environment, may have a different impact on the person with mental illness. Therefore, all three elements should be included in the performance assessment.

Hindering environments may increase disability, while supporting environments may have the opposite effect. The person may have some sort of disability, and still have the legal capacity (e.g. they may have auditory hallucinations that do not interfere with their performance at work). Performance problems may still happen even if the person is not disabled, or if they do not have reduced capacity (stigma). Not using one's capacity may lead to problems, for example, placing a person in residential care where the patient will not get necessary stimulation may lead to social isolation and loss of communication skills.

The work capacity of people with mental disorders depends on the interaction between several factors:

- the patient's state of mind related to illness: temporary/chronic symptoms of illness
- functioning in a daily routine, social functioning, work functioning
- the possibility of reversing disease with treatment
- the work environment
- attitudes in the workplace about mental illness
- opportunities for the company to offer workplace adjustment programmes for people with disabilities

Assessment. The person has no motivation to work, he/she has no work experience, he/she is unable, or only partially able to work, he/she is retired, he/she is able to work several hours a day/week, he/she has difficulty reaching the set work standards and/or quality of performance, or work discipline, he/she hardly tolerates stress at work, he/she can't keep up with the work pace, he/she stopped working due to stress, he/she was made redundant due to a

violation of discipline, incapacity, etc. **Capabilities** may include the following: the person has full or partial work capacity, he/she is motivated to work, he/she is involved in a job assistance programme, he/she works part-time, or volunteers, he/she can work part-time, he/she can work with the help of a job coach/support at work, he/she tolerates stress at work with or without support, he/she communicates well with persons in authority, with subordinates and with equals.

Causes. Causes include symptoms of illness, lack of motivation, lack of support for finding a job, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. The client is motivated to work, he/she made a plan to get in touch with the employment services that would encourage him/her to try to find a job on their own, or refer him/her to a work capability assessment, or help him/her in finding a volunteer opportunity, or a part-time position, or advise them to get a vocational retraining, etc.

4.6.3. Leisure, recreation and social life, engaging in community, social and civic life

Assessed factors include the **activities and participation in community life outside the family,** in social and civic life, leisure activities, engaging in all kinds of social life in the community such as charities, clubs or professional associations, participating in ceremonial events such as commemorations and anniversaries, weddings etc., attending social events.

Free time means engaging in any form of games, recreation or activity such as organized play or sports, exercise programs, relaxation, entertainment or leisure, going to galleries, cinema, museum, theatre, and skills or hobbies such as reading, playing a musical instrument, sightseeing, tourism, leisure travel. **Games** (spontaneous recreation, such as playing chess, playing cards, or traditional children's games…), **sports** (organised games or sports competitions, individually or in a group, such as bowling, gymnastics, football,...), **arts and culture** (cultural events, such as going to the cinema, theatre, museum, gallery), skills (pottery, knitting...), **hobbies** (activities such as collecting antiques, stamps, old money…). **Social life** (meeting with others, visiting relatives, meeting in public), **religion and spirituality** (engaging in religious or spiritual activities such as going to church, temple, mosque or synagogue, religious praying or chanting, and spiritual contemplation). Furthermore, their

knowledge **on** widely known **society developments** is also assessed. This includes taking an **interest in social events** (politics, culture, sport) according to his/her level of education and customs of their immediate environment. For example, the person likes to read newspapers, surf the web, watch TV shows, etc.

Assessment. The person is not involved in any sports activities (e.g. playing sports or going to sports events), physical activity, art (creative activities and/or attending events), culture (cinema, theatre, etc.), hobbies, reading (books, newspapers, magazines), watching TV, listening to music, surfing the web, not participating in leisure activities, religious activities-going to church, participating in leisure activities if encouraged by others, the person is not involved in community activities, he/she does not meet his/her family, he/she does not attend weddings, funerals, and similar occasions, he/she is not aware of what is going on in politics, culture, sports. **Capabilities** may include the following: capacities include everything the patient actually does from the above list.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Tailor-made leisure activity plan, planning social inclusion support.

4.7. Coping with stress

Stress is a set of emotional and behavioural responses to situations perceived as overwhelming and difficult. Coping with the usual stressors is necessary to function properly in everyday life. Responses, reactions, the ability to cope with mental health requirements needed to perform activities and take part in all areas of life (daily routine, family, work, social activities) that are perceived as stressful are assessed. Furthermore, the stress levels caused by the activities need to be assessed. The assessment includes 1. **the ability to cope with daily stress** (disturbances) while performing or participating in activities of daily living, including simple activities such as housekeeping, and complex activities such as communication with other people and 2. **the ability to cope with a crisis** - dealing with decisive moments in a crisis or time of acute danger or difficulty, reaction to a sudden event, such as a pipe burst in the apartment, conflict situations at work, etc.

The assessment also includes a response to stressful situations: the situations in which the patient is agitated, or he/she tends to withdraw, or become aggressive, etc.

Assessment. Daily routine activities and tasks are stressful for the client, he/she finds it difficult to adapt to small steps in changing their daily activities and routine, etc., he/she struggles to solve problems with other people, he/she struggles to keep up with the work pace, he/she has poor relationships with colleagues, family communication is stressful for the client, he/she does not know his/her neighbours, shopping is stressful for the client, he/she gets involved in stealing things, not having cigarettes or coffee at hand causes him/her a great deal of stress**,** he/she needs to get other people's help to overcome the agitation. It is important to make a list of stressful situations and typical reactions. The patient may be asked to take the survey on coping with stress. **Capabilities** may include the following: the person successfully copes with stressful situations in everyday life, he/she copes well with crises.

Causes. Causes include problems controlling their emotions, problem-solving difficulties, lack of skills, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Anxiety management techniques, stress management, seeking help from professionals that would be able to recommend the right interventions, self-help books, etc.

4.8. Support and relationships

This part of the assessment was developed to assess the practical physical or emotional support, nurturing, protection and assistance. The assessment includes the following categories: family (nuclear and extended); friends (trust and mutual support); colleagues (acquaintances, neighbours, community members with whom the patient shares a common interest); employers (individuals who make decisions on behalf of others and those who have social influence); health professionals (all healthcare providers within the healthcare system); persons in authority, personal assistants; and pets.

Assessment. The patient feels like he/she isn't getting any support**;** he/she feels that he/she is getting support from the family, but not from the employer; he/she does not believe he/she would get any support from public institutions**;** public institutions, such as social care centres, do not provide any information

on where to get help. **Capabilities** may include the following: colleagues at work, other residents in residential accommodation, and health professionals have been supportive. The client views his/her pets as sources of support.

Causes. Causes include poor family relationships, social isolation, loneliness, lack of community-based support programmes, and lack of information on where to get support.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Improvement of support-seeking skills, providing support for needs that the patient cannot meet independently, skills training, counselling, finding the information on their rights, initiating procedures for exercising their rights, such as the right to an assistant, personal disability benefits, employment assistance, the right to choose housing etc., getting a dog or other pets, etc.

4.9. Stigma

The assessed factors include **the person's attitudes towards illness** (acceptance, rejection, agreement with diagnosis, self-stigma); **the attitude of people around the client** which can be a barrier, for example, if it reflects stigma and discrimination that might affect his/her functioning.

Assessment. The person feels incompetent, less worthy, rejected and discriminated against because of his/her illness, because he/she is placed in residential care, or because he/she doesn't have a job, he/she doesn't have friends, he/she cannot accept his/her diagnosis, he/she avoids meeting people because he/she believes that he/she will be rejected, hurt and discriminated against, he/she has experienced stigmatization and discrimination that he/she cannot deal with. The person's fellow citizens, family, health professionals, other people express stigmatizing attitudes. He/she thinks his/her life is ruined because he/she has a mental illness, or has been placed in residential care, so he/she avoids people to avoid the stigma. **Capabilities** may include the absence of self-stigma, successful coping mechanism to deal with social stigma and discrimination.

Causes. Causes include low self-esteem, pessimism, losing his/her faith in recovery, poor treatment that does not leave much room for hope, stigma and discrimination the person is facing in different situations: in their family, at work, in healthcare, among neighbours, etc.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Self-stigma reduction programme and interventions for dealing with social stigma, getting the information about his/her rights and the fact that discrimination is against the law**.**

4.10. Barriers and facilitators

The WHO believes that impairment/disability is a problem of the society that indeed needs to create conditions for equal inclusion of people with disabilities in community life and remove the barriers. When it comes to mental illness, this means the availability of different outpatient treatment options, rehabilitation programmes and fighting the negative effects of stigma and discrimination because of ill health. Assessment of barriers and facilitators includes the availability of different community-based services that provide assistance, organized programmes, and activities in different areas that may be helpful for recovery from mental illness. These include treatment programmes that increase social inclusion and employment; control authorities that monitor the institutional compliance, such as the People's Ombudsman and make recommendations for improvements in the protection of human rights, and choosing the optimal treatment. Legal, health, social care services, systems and policies are important for people with mental health problems, including the availability of rehabilitation services, community treatment services, mobile teams, recovery-oriented mental health policies, employment services, social inclusion services, non-governmental user organizations that run different programmes and provide different types of support and protection services. The existence of barriers means that the above services are not made available to those in need, which is why some patients cannot access the services that may help them recover.

Assessment. The client is not informed about different recovery-oriented services for people with mental disorders, he/she has no interest in programmes offering rehabilitation services that could help him/her, such as psychosocial assistance, employment, social inclusion programmes run by associations, he/she is not informed about his/her rights, etc. **Capabilities** may include the following: the patient is informed about the available services and associations, he/she is capable of using and finding the right programmes, he/she needs professional help to get in touch with a relevant service, he/she is

informed about the housing, employment, and social inclusion programmes, he/she is familiar with available social benefits and uses the appropriate disability benefits, he/she is familiar with the rights related to deprivation of legal capacity, he/she knows how to make a complaint if unhappy with the accommodation, medical treatment, the way other people treat them, in case of abuse or exposure to humiliation, he/she knows which service to address, and knows that he/she will not be punished for raising any of these issues. The patient is informed that he/she is entitled to make a notarial deed allowing him/her to decide about their treatment if he/she is unable to consent to hospitalization in the future.

Individual treatment/recovery plan and persons responsible for putting the plan into action. Providing information about support services and assistance in contacting them.

Conclusion

Functional assessment is an integral part of a comprehensive clinical assessment of a person with mental health problems, regardless of the diagnosis. It helps us gain a comprehensive understanding of mental illness, its consequences, and identify interventions that will lead to improved functioning and recovery from mental illness. Functional assessment helps us to make precise assessment of a person's health related to the treatment plan and goals, as well as the person's rights on the basis of disability.

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Appendix: The assessment of social functioning, ICF-based

SOCIAL FUNCTIONING SCALE

Name and surname:

Age:

Date and year:

Diagnosis:

Profession (occupation):

Circle:

I. assessment II. assessment

INSTRUCTIONS:

The Assessment of Functioning Scale is used to rate normal functioning in everyday life to help identify areas of good and difficult functioning. The results can be used to rate the condition and make a plan to improve functioning as part of the treatment. The fields marked **with an asterisk (*)** are explained at the end of the scale.

Below you will find **a list of different situations important for functioning in daily life.** Please read each statement carefully and decide how you feel about each statement. Please answer every question by **circling the appropriate number** on each line. Please put an **X** in the box that best describes your answer if you want to **work** on a specific area, or **improve** your functioning in that area. If any statement remains **unclear,** please **speak to a member of staff** to help you complete the question.

This survey can also be completed during an interview with a mental health professional and behaviour-based observation in your natural environment or during treatment.

	1. COMMUNICATION SKILLS	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	**Clinician rating**
1.	I often use please, thank you, and you're welcome	0	1	2	3	4	5		
2.	I show respect for others (e.g. standing up and offering a seat to an elderly person on a tram)	0	1	2	3	4	5		
3.	I accept compliments without devaluing them	0	1	2	3	4	5		
4.	I give compliments to others	0	1	2	3	4	5		
5.	I apologize when appropriate/necessary	0	1	2	3	4	5		
6.	I accept apologies	0	1	2	3	4	5		
7.	I represent others in society	0	1	2	3	4	5		
8.	I introduce myself to other people	0	1	2	3	4	5		
9.	I usually use appropriate greetings	0	1	2	3	4	5		
10.	I usually start a conversation in an appropriate way	0	1	2	3	4	5		
11.	I am usually engaged in the conversation in an appropriate way	0	1	2	3	4	5		
12.	I usually end the conversation in an appropriate way	0	1	2	3	4	5		
12.	I talk on the phone in an appropriate way	0	1	2	3	4	5		
13.	I have good table manners	0	1	2	3	4	5		

14.	I'm a good host, people feel comfortable in my home	0	1	2	3	4	5		
15.	I offer my help to other people	0	1	2	3	4	5		
16.	I engage in a conversation without interrupting others as they speak	0	1	2	3	4	5		
17.	I check things twice by asking if I heard well what was being said	0	1	2	3	4	5		
18.	I identify and understand the content of the conversation	0	1	2	3	4	5		
19.	I identify and understand the feelings of others, I recognize the meaning of non-verbal messages	0	1	2	3	4	5		
20.	I use encouragement to let others know that I am following the conversation	0	1	2	3	4	5		
21.	I use *open-ended questions** and I support the conversation	0	1	2	3	4	5		
22.	I usually ask for help when I need it	0	1	2	3	4	5		
23.	I can start, maintain and end the conversation	0	1	2	3	4	5		
24.	I can engage in a discussion	0	1	2	3	4	5		
25.	I listen to others as they speak	0	1	2	3	4	5		
26.	I'm tolerant	0	1	2	3	4	5		
27.	I can take criticism without any problems	0	1	2	3	4	5		
28.	Usually, I control my behaviour during communication	0	1	2	3	4	5		

29.	I act by the existing social rules	0	1	2	3	4	5		
30.	I can freely say what I mean	0	1	2	3	4	5		
31.	I use open body posture (arms and legs not crossed in any way)	0	1	2	3	4	5		
32.	I understand *non-verbal messages**	0	1	2	3	4	5		
33.	I turn my face towards my interlocutor	0	1	2	3	4	5		
34.	I lean towards the interlocutor	0	1	2	3	4	5		
35.	I maintain appropriate eye contact	0	1	2	3	4	5		
36.	Usually, I am relaxed while communicating with others	0	1	2	3	4	5		
37.	Usually, I follow the content of the conversation well	0	1	2	3	4	5		
38.	I speak in a normal voice (my voice is not too loud and not too quiet)	0	1	2	3	4	5		
39.	I speak at a normal pace (not too quickly and not too slowly)	0	1	2	3	4	5		
40.	I do not interrupt others in a conversation	0	1	2	3	4	5		
41.	I engage in a conversation according to circumstances	0	1	2	3	4	5		
42.	I do not impose my opinion on others	0	1	2	3	4	5		
43.	I criticize, but at the same time I respect other people's opinions	0	1	2	3	4	5		
44.	I am considerate of others and I do not offend them	0	1	2	3	4	5		

45.	I have a sense of humour	0	1	2	3	4	5		
	2. PERCEPTION OF SELF AND EXPRESSION OF ONE'S FEELINGS	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	***Clinician rating***
46.	I see myself and my abilities positively	0	1	2	3	4	5		
47.	I am positive about the world and my future	0	1	2	3	4	5		
48.	I feel accepted by society	0	1	2	3	4	5		
49.	I usually think people do not accept me	0	1	2	3	4	5		
50.	I am confident in myself	0	1	2	3	4	5		
51.	I usually handle tense situations well	0	1	2	3	4	5		
52	I have trouble expressing my feelings	0	1	2	3	4	5		
53	I am hypersensitive	0	1	2	3	4	5		
54.	I feel bad in a group of people I know	0	1	2	3	4	5		
55.	I feel bad in a group of strangers	0	1	2	3	4	5		
56	I show warmth to other people	0	1	2	3	4	5		
57.	I have no problem accepting other people's feelings	0	1	2	3	4	5		
58.	I trust other people	0	1	2	3	4	5		

	3. ORGANIZATIONAL SKILLS	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	***Clinician rating***
59.	I get tasks completed on time	0	1	2	3	4	5		
60.	I show up for all my meetings on time	0	1	2	3	4	5		
61.	I keep track of special dates (e.g. birthdays)	0	1	2	3	4	5		
62.	I am flexible	0	1	2	3	4	5		
63.	I have good money management skills	0	1	2	3	4	5		
64.	Usually, I plan things well	0	1	2	3	4	5		
65.	I am responsible	0	1	2	3	4	5		
66.	I finish what I start	0	1	2	3	4	5		
67.	I complete planned tasks	0	1	2	3	4	5		
68.	I usually handle stress well	0	1	2	3	4	5		
69.	I manage the crisis successfully	0	1	2	3	4	5		
70.	I am a creative person	0	1	2	3	4	5		
	4. BEHAVIOUR CONTROL	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	**Clinician rating**
71.	I am patient	0	1	2	3	4	5		
72.	I can cope in different Situations	0	1	2	3	4	5		
73.	Usually, I handle conflicts effectively, I tend to negotiate and compromise	0	1	2	3	4	5		

74.	Usually, I deal with anger effectively	0	1	2	3	4	5		
75.	I refrain from aggressive behaviour	0	1	2	3	4	5		
76.	I often react violently	0	1	2	3	4	5		
77.	*I am assertive**	0	1	2	3	4	5		
78.	Usually, I spend money sensibly	0	1	2	3	4	5		
79.	I don't usually make *impulsive* decisions	0	1	2	3	4	5		
80.	I take great care not to say things that could hurt other people	0	1	2	3	4	5		
81.	I use touch to communicate with other people in an appropriate way	0	1	2	3	4	5		
82.	I can express disagreement without yelling and insulting another person	0	1	2	3	4	5		
83.	I find it easy to relax	0	1	2	3	4	5		
84.	Usually, I'm not nervous	0	1	2	3	4	5		
85.	I think twice before I react	0	1	2	3	4	5		
	5. RELATIONSHIPS WITH OTHER PEOPLE	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	***Clinician rating***
86.	I am sensitive to the needs of others	0	1	2	3	4	5		
87.	I have at least two or three close friends	0	1	2	3	4	5		
88.	I am adaptable	0	1	2	3	4	5		
89.	I respect other people's boundaries	0	1	2	3	4	5		

90.	I treat others with respect	0	1	2	3	4	5		
91.	Usually, I have a good relationship with my parents	0	1	2	3	4	5		
92.	Usually, I have a good relationship with my children	0	1	2	3	4	5		
93.	Usually, I have a good relationship with my siblings	0	1	2	3	4	5		
94.	I have a good partner or marital relationship	0	1	2	3	4	5		
95.	I have no sexual problems	0	1	2	3	4	5		
96.	I am tolerant of other people's differences	0	1	2	3	4	5		
97.	Usually, I start a conversation easily	0	1	2	3	4	5		
98.	Usually, I have no difficulty forming close relationships	0	1	2	3	4	5		
99.	I can maintain good relationships with others	0	1	2	3	4	5		
100.	I'm able to end a relationship with others if I'm not feeling good about it	0	1	2	3	4	5		
101.	Usually, I have a good relationship with my friends	0	1	2	3	4	5		
102.	Usually, I have a good relationship with my neighbours	0	1	2	3	4	5		
103.	Usually, I avoid social contacts with other people	0	1	2	3	4	5		
104.	I respect others in their relationships	0	1	2	3	4	5		

	7. SELF-CARE	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Extreme difficulty	Not Applicable	I want to improve my skills in the field X	*Clinician rating*
105.	I can take care of my hygiene routine on my own	0	1	2	3	4	5		
106.	I have a neat appearance	0	1	2	3	4	5		
107.	I dress properly for the occasion	0	1	2	3	4	5		
108.	I can prepare food on my own, and eat in an acceptable way	0	1	2	3	4	5		
109.	Usually, managing my money is not a problem (and I manage my money well)	0	1	2	3	4	5		
110.	I keep my living space clean and tidy	0	1	2	3	4	5		
111.	I make sure that my home is safe (e.g. I don't leave the oven on)	0	1	2	3	4	5		
112.	I take care of my health (I take recommended medications, go to see the doctor regularly)	0	1	2	3	4	5		
113.	I help around the house	0	1	2	3	4	5		
114.	I do my shopping	0	1	2	3	4	5		
115.	I sleep well and long enough	0	1	2	3	4	5		
116.	I make sure to eat properly, I don't eat too much or too little	0	1	2	3	4	5		
117.	I have no problems using public transport and moving around on my own	0	1	2	3	4	5		
118.	My movements and/or thoughts are slowed	0	1	2	3	4	5		

	8. COGNITIVE FUNCTIONING	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	***Clinician rating***
119.	I have difficulty making decisions	0	1	2	3	4	5		
120.	Usually, I can concentrate	0	1	2	3	4	5		
121.	I have difficulties remembering things	0	1	2	3	4	5		
122.	I have difficulties in problem-solving	0	1	2	3	4	5		
123.	I have problems with reading	0	1	2	3	4	5		
124.	I have problems with writing	0	1	2	3	4	5		
125.	I have problems with calculus	0	1	2	3	4	5		
126.	I have problems with learning new things	0	1	2	3	4	5		
	9. WORK (only for employed persons or job seekers)	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	***Clinician rating***
127.	I find it difficult to find a job	0	1	2	3	4	5		
128.	I find it difficult to keep my job	0	1	2	3	4	5		
129.	I find it difficult to terminate my employment	0	1	2	3	4	5		
130.	I'm motivated to work	0	1	2	3	4	5		
131.	I find it difficult to keep up with work pace (workflow pace)	0	1	2	3	4	5		

132.	I find it difficult to keep up with work discipline	0	1	2	3	4	5		
133.	I have problems with production requirements	0	1	2	3	4	5		
134.	I have problems with the quality of work performance	0	1	2	3	4	5		
135.	I have problems with stress in the workplace	0	1	2	3	4	5		
	10. FREE TIME	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	***Clinician rating***
136.	I find it difficult to organize leisure activities (reading, TV, music, going for a walk, ...)	0	1	2	3	4	5		
137.	I attend social events (e.g. get-togethers, parties)	0	1	2	3	4	5		
138.	Usually, I have no problem finding a hobby	0	1	2	3	4	5		
139.	I'm motivated for different leisure activities	0	1	2	3	4	5		
140.	Usually, I enjoy recreation/free time	0	1	2	3	4	5		
	11. SUPPORT	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	***Clinician rating***
141.	I have the support of my nuclear family	0	1	2	3	4	5		
142.	I have the support of my extended family	0	1	2	3	4	5		
143.	I have supportive friends	0	1	2	3	4	5		

144.	I am actively involved in support/self-help groups	0	1	2	3	4	5		
145.	I have other types of support	0	1	2	3	4	5		
	12. ATTITUDES	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	**Not Applicable**	**I want to improve my skills in the field X**	***Clinician rating***
146.	People treat me differently because I have a mental illness	0	1	2	3	4	5		
147.	I think I'm less worthy because of my mental illness	0	1	2	3	4	5		
148.	I have problems with *discrimination* * due to mental illness	0	1	2	3	4	5		

Please put an **X** in the box that best describes your answer if you want to work on a specific area, or **improve** your functioning in that area.

Areas on which you want to **work** or areas in which you want to **improve** your functioning	X
SELF-CARE	
COMMUNICATION SKILLS	
PERCEPTION OF SELF AND EXPRESSION OF ONE'S FEELINGS	
ORGANIZATIONAL SKILLS	
BEHAVIOUR CONTROL	
RELATIONSHIPS WITH OTHERS	
COGNITIVE FUNCTIONING (decision making, concentration, memory, reading, ...)	
WORK (finding a job, keeping a job, work performance)	
FREE TIME ORGANIZATION	
OTHER PEOPLE'S SUPPORT	
ATTITUDES	

Glossary of terms

***Open questions** - Open questions start with how? when? what? who? where? how much? and require longer answers, opening the conversation and making communication longer and more successful.

***Non-verbal messages** -Besides speaking, we communicate and send a message in other ways: by using gestures, mimics, gestures, tone of voice, etc. Sometimes we only use non-verbal communication, such as clapping hands, shaking our heads, or slamming the doors, to convey our thoughts and feelings in a given situation.

***Assertiveness -** Assertiveness means expressing thoughts and feelings to achieve our desires and goals in such a way as to ensure that our opinions and feelings are heard without denying the rights of others (as opposed to aggression). Furthermore, it means stating clearly which *behaviour* bothers us, giving the reason why this behaviour bothers us (expressing our own opinions, feelings and/or the consequences of that behaviour) and clearly saying what we want.

***Impulsiveness** - Impulsiveness is defined as behaving without thinking about the risk involved in the behaviour.

***Discrimination** -Discrimination is any different and unequal treatment/ disadvantageous treatment of a person or group of people. It can be based on sex, gender, nationality, religion, physical characteristics (disability), mental illness, etc.

NB: To use the scale more efficiently, see the manual "**Procjena funkcioniranja u psihijatriji**" **(Functional Assessment in Psychiatry)**, **Slađana** Štrkalj Ivezić**.**

5. PSYCHOBIOSOCIAL FORMULATION AND INDIVIDUAL TREATMENT PLAN

Slađana Štrkalj Ivezić

5.1. Introduction

The psychobiosocial approach to treating people with mental health problems includes assessing the psychological, biological and social determinants on the development of mental disorders, course of illness and recovery as well as planning of various psychological, psychosocial and psychotherapeutic interventions according to individual treatment plan. An individual treatment plan with recovery goals is considered a standard of practice and should be made available to every patient. Recovery is stated as a goal in all of the world's guidelines for treating different mental disorders. Recovery involves a feeling of empowerment, whereby a person lives his or her life in a way that allows achieving the desired goals, living a meaningful life, and having a sense of positive belonging to the community.

Recovery is a deeply personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life.

The modern treatment of mental disorders encouraged by the World Health Organization in the QualityRights Tool Kit model for recovery and human rights has undergone a major shift. Unlike the goals set under disease-centered model – centered around eliminating symptoms and remission - return to premorbid level of functioning, there is a significant shift towards recovery, so that the person can regain control of his or her life, take on different roles in society; better understand his or her emotional difficulties, become more independent, live with persistent symptoms, but still live a fulfilling life. A person may still have emotional difficulties, but they are no longer the primary focus of his or her life. The recovery goals should be listed in the individual

treatment plan that is made based on seeing the patient as an individual and understanding his or her mental disorder in the context of his or her life.

Recovery-oriented mental health practice requires the professionals working with people with mental disorders to reconsider their attitudes, to drop the attitude that mental disorders are chronic disorders one can rarely recover from, given that such attitudes oppose scientific evidence and personal testimony of recovery in persons who have long been treated in a mental health facility, which was found to be detrimental to the process of recovery from mental illness.

According to the WHO QualityRights Tool Kit, the treatment standards should include the following:

The recovery goals must be integrated into the user's individual treatment plan. Treatment should be organized in such a way that the therapeutic environment, including the therapeutic relationships between service users and staff, fosters hope, optimism, empowerment, the right to choice, conditions that help people recover, use their full potential and participate fully in the community. Achieving personal goals such as having friends, getting a job, community belonging and having a useful role in the community is important in recovery, which is different from clinical goals that are often focused on eliminating symptoms by taking medication.

In recovery-oriented treatment, the patient is observed primarily as a person with his or her own personal values who has the right to choose his or her goals. The diagnosis is observed as just one of a person's characteristics. Furthermore, the client is observed as a person who has the right to professional help and other forms of support that help the person reach his or her goals. Treatment must be comprehensive and include biological, psychotherapy and rehabilitation interventions, provide support network, anti-stigma activities, and other services needed for recovery and social inclusion in the individual's own environment, based on informed consent. We should bear in mind that both inpatient and outpatient treatment interventions are part of a comprehensive system with a common goal of independent living in the community, with support provided whenever necessary. Therefore, the treatment goals need to be observed from a holistic perspective of continuity of care, including the connection between hospital and outpatient care to maximise the prospects of recovery.

To achieve their recovery goals and satisfactory life in the community, each patient in the system of care needs a comprehensive, individual treatment/recovery plan with biological, psychological and social goals including education, employment, social support network, housing and other goals that the patient has identified. Therefore, a multidisciplinary team is needed to help prepare a personal treatment plan and its implementation, as well as cooperation between different services, including healthcare services, but also social care, employment, education services, NGOs and other community-based services that can help provide the necessary support.

All the steps that need to be taken in order for the patient to recover, as well as the stakeholders involved must be considered. A multidisciplinary team must share a common vision of goals agreed with the patient that will be achieved individually by members of the team through professional interventions and/or through joint efforts with other community-based services.

All professionals involved in the treatment must be familiar with the treatment plan and contribute to the quality of its preparation and implementation. The treatment plan is a result of joint efforts between professionals and patients, and patients are expected to be active participants in its implementation.

In case of a hospital treatment, a continued outpatient care should be included in the individual treatment plan and mentioned in the discharge letter that should include other outpatient services and healthcare providers that the patient needs to contact/has contacted during the treatment, as well as professionals involved in outpatient care; therefore, both medical history and discharge letter should reflect recovery-oriented practice.

Recovery can be observed as an outcome in relation to the symptoms, functioning and personal psychological recovery process. All three recovery goals must be covered in the treatment plan. The focus is no longer put on recovering from symptoms when it is not possible, but rather on functional and personal recovery so that a person can live a satisfying life, despite the symptoms and functional impairments. People with mental health problems who have difficulty in functioning, achievement of goals and social inclusion have the right to rehabilitation in order to increase their capabilities and support, which would allow them to participate in everyday activities they have chosen. Identified need for outpatient rehabilitation and support must be mentioned in the individual treatment plan.

Treatment plan is an agreement between the therapist/medical team and the patient on the goals of treatment/recovery in which patient's preferences are given priority, containing the list of treatment interventions that need to be taken to reach the identified goals, as well as the list of professionals and other people who will help the patient achieve their goals. The individual treatment plan is made on the basis of a free informed consent. The patient is provided with information regarding their diagnosis and recommendations for treatment (choice of therapeutic environment, hospital ward, recommended medications, psychotherapy and psychosocial interventions), professionals involved, recommended services to be included in the treatment plan, patient rights regarding voluntary and involuntary hospital admission/treatment, rights that he/she is entitled to across different sectors, and information about community-based services that can help them live a satisfying life in the community, so that he or she is able to make a decision about their treatment plan.

To develop a treatment plan, psychiatrists need to evaluate the impact of biopsychosocial factors on mental health problems for the patient, establish a trusting therapeutic alliance, and be aware of different therapeutic interventions, such as medication, psychosocial interventions, rehabilitation and psychotherapy that can contribute to the positive treatment/recovery outcomes.

An individual treatment plan must be documented in medical records, and both patients and staff involved in its implementation must be informed thereof. Creation of a treatment plan with the patient who accepted it on the basis of informed consent must be duly documented. A treatment/recovery plan must be assessed on a regular basis.

5.2. Psychobiosocial formulation

Mental disorders are the result of complex interaction between biological, psychological and social factors. The circumstances in which a person lives, early and later life trauma, professional circumstances, stigma and discrimination as psychological and social determinants of mental health may impact the risk of developing a mental disorder.

Psychobiosocial formulation is a hypothesis about the causes of a current episode of mental health disorder, or earlier episodes, based on an assessment of the interaction between psychological, biological and social factors. During the treatment process, psychobiosocial formulation needs to be updated and

evaluated based on new information. Based on medical history and information from other sources, (e.g. family, other professionals, other services, etc.), the impact of biological, psychological and social factors on the onset of a mental disorder is checked against the symptoms, functioning and their impact on recovery difficulties in order to be able to choose the right recovery-oriented interventions. For example, in case of a tense atmosphere in the family, with high EE factor (expressed emotion factor) associated with frequent psychosis relapses, family intervention should be applied, given that changing a medicine will not be efficient in such cases.

Learning about the circumstances in which a person lives, stressful events prior to treatment, previous stressful events, the individual's capacity to cope with stressful situations, patient's emotional development that has affected the way in which a person feels, thinks and behaves, and previous levels of functioning and patient's family medical history help us understand the patient in a comprehensive way, which makes it possible to develop a psychobiosocial formulation that will serve as a basis for treatment.

A psychobiosocial formulation is patient-specific, because it is based on the unique life experience of each person.

A psychobiosocial formulation refers to a hypothesis that tries to explain the development of a problem and why the problem still persists, it serves as a basis for planning the treatment. The hypothesis can also help anticipate difficulties during the treatment process. A psychobiosocial formulation is a dynamic hypothesis based on available information at the time of assessment, whose scope can be extended or changed during the treatment, based on the information collected.

A psychological and/or psychodynamic formulation is a part of a psychobiosocial formulation related to the assessed contribution of psychological factors, using the psychological theory of the therapist's choice (psychodynamic, cognitive, systemic theory). Knowing the basic principles of psychodynamic psychiatry is essential for a better understanding of individual patient experience. Psychodynamic theory helps us understand the impact of the unconscious on symptom development; it also helps us understand transference and countertransference that are always present when working with patients, so the psychiatrist must have the skills to recognize transference, and to work with transference and countertransference so as to be able to better assess the patient's clinical condition, to establish a strong therapeutic relationship, to be

in control of the countertransference emotions and to create a treatment plan (for more details about psychodynamic formulation, please see the chapter on the psychodynamic formulation).

+Constructing a psychobiosocial formulation is a compulsory part of the standardized treatment of patients with mental disorders on the basis of which the individual treatment/recovery plan is developed. When constructing a psychobiosocial formulation, a detailed history of all psychosocial factors must be taken into account (see the table of psychobiosocial factors and the psychobiosocial assessment in the medical history) as they may affect the onset of mental health disorder, functioning and recovery. A psychobiosocial formulation is a note entered into the patient's medical records.

A psychobiosocial formulation helps us gain a comprehensive understanding of the factors related to the development, maintenance of symptoms of illness and difficulties related to functioning and recovery, and everything that can help eliminate or alleviate symptoms of illness, functional impairment, and foster social inclusion and recovery of a person who got in contact with us because of their mental health problem. Therefore, it helps us understand why the symptoms of mental illness and functional and mental health problems have developed in the first place, specifically for the patient whose treatment plan is being developed, by observing the circumstances and the overall context of his/her life from early symptoms to the current situation. A comprehensive understanding of all the psychobiosocial factors that have an impact on mental health and interventions that can help eliminate the symptoms and challenges faced in recovery are crucial in developing an individual treatment plan and help the patient work on their individual recovery plan. The initiative of creating a personal recovery plan started by patients through user associations has proven to be a good practice, so they need to be encouraged to create their own recovery plans either independently, or with the help of peer workers, people they trust and professionals.

To create a psychobiosocial formulation that serves as a basis for the treatment plan, we need a detailed medical history, including information on symptoms, previous episodes and treatment, functioning, developmental psychosocial history, family medical history, risk assessment, as well as the assessed impact of biological, psychological and social factors on a specific mental health condition.

Modern mental healthcare services are oriented towards individual treatment plan, which puts the person with all of his or her capacities and limitations at the centre, rather than focusing on his or her diagnosis. In this context, a psychobiosocial formulation must be the result of the patient's psychobiosocial medical history, in which we do not only observe the symptoms, but also the overall psychosocial context in which a mental disorder has occurred. The patient's medical history as the data collection process necessary to establish the diagnosis is just a part of the necessary information, hence it is not enough for developing a successful treatment plan. To develop an individual treatment plan, we must actively listen to the patient's story, to understand how their experiences affect their condition, and understand him or her as a person, rather than just a patient. If we fail to see the client as a person and if we do not make the effort to hear about the circumstances in which they developed a mental disorder, it will be difficult to develop a personalized treatment plan for that person.

The psychobiosocial formulation suggests that there is a link between the symptoms of a psychiatric disorder, the person's functioning and different psychobiosocial factors affecting the incidence of illness, persistent symptoms, as well as difficulties in functioning and recovery. For example, if we fail to assess the impact of self-stigma on the recovery of a psychotic patient, and choose to treat depression with medication, we may be able to mitigate the symptoms to some extent, but the patient will not make substantial progress if we do not help him/her tackle self-stigma through psychosocial treatment for stigma.

Different questionnaires and scales can be helpful in evaluating the psychobiosocial factors and they can help the healthcare professionals develop a good treatment plan.

For the evaluation of social functioning, it is recommended to use the guidelines for the assessment of functioning according to the World Health Organization's International Classification of Functioning. To assess the needs of a patient diagnosed with a serious mental illness and to prepare a treatment plan, it is recommended to use the Camberwell Assessment of Need.

In psychobiosocial formulation, we acknowledge the established diagnosis and symptoms and try to zfind a connection between the symptoms and the circumstances in which a person lives, his or her recent traumas and development history.

5.3. How to develop a treatment plan

Based on the psychiatric assessment, overall health status assessment and psychobiosocial formulations, the goals of treatment are agreed with the patient, and an individual treatment plan is prepared. The individual treatment plan consists of different biological, psychological and social interventions, connected with the goals of treatment set by the patient, in agreement with their medical team.

It is important to bear in mind that a synergy between all proposed interventions will contribute to the goals of treatment, including recovery from mental illness and independent life in the community with adequate support, available at any time and as long as necessary. It is important to look at the goals of treatment beyond the narrow limits of recovery from symptoms and expected remission in which anything less than a remission feels like a failure, interweaving with a sense of chronicity, without hope for a satisfying life. People can live a satisfying life with the limitations that come with the illness, even if they may need to rely on our help, and we can refer them to other community resources, people and organizations that will help them with social inclusion.

Therefore, the treatment plan for those who need support should also include making the support plan. In case of a hospital treatment, the treatment plan always has to include the continuity of care and outpatient care.

The treatment plan always involves working on all aspects that contribute to recovery: symptoms, functioning, change of attitudes, stigma, social inclusion, etc., always bearing in mind that recovery and quality of life in the community is the final outcome of therapeutic intervention, including the patient's involvement in community life, such as finding a job, employment counselling and keeping their job, organizing their free time, making new friends and achieving any other personal goal that are important to them.

While preparing an individual treatment plan, it is important to rely on a detailed assessment of the impact of psychological, social and biological factors on the patient's mental health and recovery in order to plan psychosocial interventions and support to make recovery happen. Assessing and taking into account the impact of psychological, social and biological determinants will make it easier to understand the complexity of a particular condition, and explain to the patient why he/she needs medication, psychotherapy and

psychosocial interventions or a combination thereof, which is the most common situation.

In planning the treatment, it is important to identify protective factors that can contribute to maintaining good health and help the patient prevent recurrent episodes, foster and maintain recovery and ward off the risk factors that could lead to the deterioration. The process of creating a psychobiosocial formulation will help us identify protective factors that help ward off deterioration, and risk factors for mental health disorders that we need to present to the patient and explain that encouraging protective factors and avoiding risk factors contributes to empowerment, reduces the feeling of helplessness and fosters recovery. In order for the patient to understand the treatment plan, the psychobiosocial model of illness needs to be explained in an empathetic way, taking into account the context of his or her illness, life experience, and the prospects for recovery. Hope and optimism and recovery-oriented attitudes should always be communicated to the patient, starting from the small steps to big goals, bearing in mind that recovery is a process and that it is down to us as the therapists to walk down the road of recovery with the client as long as they need it, and help them achieve their goals.

5.4. How to present the psychobiosocial formulation, treatment goals, and individual treatment plan to the client

NB: To select the suitable evidence-based intervention that will be proposed in the treatment plan, you may want to use the guide to the diagnosis and treatment of mental disorders available on the website of the Croatian Psychiatric Association and the Croatian Association for Clinical Psychiatry of the Croatian Medical Association.

After collecting information that helped us create a psychobiosocial formulation and understand the patient's current condition through the assessment of biological, psychological and social factors, we should inform the patient about the mental health disorder (symptoms, diagnosis), causes and treatment in a simple way, reflecting optimism, hope and recovery-oriented vision. Based on a psychobiosocial formulation, we can better understand the biological, social, and psychological factors that affect the incidence/deterioration of mental disorders, protective and risk factors, barriers to recovery and how to foster recovery. After we briefly present our position on their condition and

suggested interventions to the patient, the next step is to agree on the treatment goals, interventions, and intervention providers with the patient. The individual treatment plan and any other mental health intervention are provided on the basis of the patient's free, timely and informed consent.

As they explain the condition and treatment recommendations to the client, professionals need to show empathy for the client's condition and check if everything was clear, encourage the client to ask questions, set the treatment goals together, suggest a treatment plan and ask the client to cooperate. It is important to bear in mind that any information shared on illness and treatment must be recovery-oriented.

The health professional needs to discuss the symptoms that the client has described in a clear and empathetic way, make a connection between the symptoms and the established diagnosis (you can either describe or name the illness, depending on your clinical judgment), explain the previously mentioned biological**,** social and psychological factors that may have an impact on the onset of symptoms and functional limitations, and suggest the interventions (medication, psychotherapy, psychosocial interventions, rehabilitation) that would foster recovery, putting it in layman terms. Furthermore, the health professional needs to summarize the functional limitations that the client has previously described and summarize the way he or she sees the situation and causes of illness, as well as the patient's attitude towards his or her illness. The patient should be given the opportunity to express his/her feelings about the illness, he/she should be allowed to react on what they have just heard, and work through their emotions, which needs to be included in the treatment plan to prevent the risk of self-stigma in the first place. Therefore, the psychobiosocial formulation should be presented in a simple language, so that the patient can easily understand it, and make a connection between the psychobiosocial formulation and a planned recovery-oriented intervention.

5.5. How to discuss the treatment plan with clients

The mental health professional's motivation to discuss the client's problems is not just to collect information, but also to develop a therapeutic relationship, as an efficient treatment would not otherwise be possible. Therefore, at the very beginning of treatment, mental health professionals should acknowledge the client's feelings with an empathic statement. For example, as

a mental health professional you may want to tell them you understand that they feel depressed and anxious in a situation they have just described (when they are sad about their beloved son moving abroad, when they have just lost their job, when they are going through financial difficulties, or when they are exposed to workplace humiliation, etc).

To make a connection between the symptoms and a specific situation, you may want to say: "You said you had trouble sleeping, that it was hard for you to fall asleep, that you had no interests and that your energy levels were low, you feel anxious, you feel tense, the back of your throat has been burning on and off, you believe that other people turned against you, you hear voices that other people don't… Such symptoms occur in what is called depression/ anxiety disorder/ psychosis. You started experiencing the symptoms in difficult circumstances, as you say you were overwhelmed at work, you feel like nobody understands you, etc." Alternatively, we could say: "This situation came about after a stressful event (fighting with a family member, losing a job, the family doesn't understand you, you feel frustrated because you don't have a job, you lost your sense of purpose, you can't see the light at the end of the tunnel, you have a long-term unhappy relationship with your partner or you don't get along with your family, you're dealing with a lot of stress at work, or you're the victim of domestic violence, you're coping with physical illness, a member of your family is ill, etc.).

5.5.1. Finding the connection between the symptoms and developmental circumstances

"You're also saying that you grew up in a family where you felt misunderstood, that you weren't allowed to express your feelings, you were often criticized, you were abused, your parents were very strict. You say that you were mocked at school, which made you feel insecure, left you with low self-esteem, overly sensitive to rejection and criticism, etc." Alternatively, we could say: "You describe yourself as an insecure person who trusts people too much and who is afraid to express his or her opinion."

5.5.2. Finding the link between the symptoms and functioning

"You say that you have difficulties with personal hygiene, home maintenance, managing your money, you feel uncomfortable around people you don't know well, you struggle expressing your thoughts and feelings,

organizing your free time, socializing with other people, in relationships with your family, your family and friends don't support you, and you'd like to change it in order to get more support from your family, better negotiate for your needs, communicate better, so you need to do something to improve your functioning, such as joining our social skills training. Feel free to discuss this option with our social pedagogue."

5.5.3. Work functioning

"You say you don't feel capable of doing your job, so we need to discuss the causes, we need to discuss whether you want to improve your work functioning, we should talk about what can be done to help you, so we can arrange a meeting with a social worker or contact the employment service. You also say you're afraid to get a job because you think people might reject you if they find out about your mental illness, so we can arrange an intervention to better cope with such situations and fight stigma."

"You say you'd like to get a job, but you can't concentrate, you lack communication skills, your response to stress is poor, so we could plan a communication skills training and improve your stress response by using different ways of responding to stress."

5.5.4. Workplace mobbing

"You say you are exposed to workplace mobbing, so we should talk about ways to protect you, we can help you get in touch with an association for legal counselling related to workplace mobbing, and our social worker will contact them on your behalf to make an appointment."

5.5.5. Safety plan to reduce suicide risk

"You say that you're having suicidal thoughts sometimes, so it would be good to discuss how to stop suicidal thoughts and prevent any risk of harming yourself."

5.5.6. Planning the intervention to prevent self-stigma

"You say you feel uneasy because you were diagnosed with a mental illness, you feel ashamed, you avoid talking about it. It would be good to talk about how to overcome this feeling, the goal is to eliminate self-stigma because it may adversely affect your condition."

5.5.7. Motivation for treatment

Example:

"You say you don't agree that you have a mental illness, but you're also telling me that you hear disturbing voices and believe that someone is following you. We can plan how to calm your distress and discuss whether there is some other explanation for the situation you have described."

5.5.8. Recommended therapeutic interventions

"For your condition to change, I'd recommend you to take your medication, e.g. antidepressants for depression. To calm your distress when you feel you're being watched on a camera, I'd recommend antipsychotics, while anxiolytics will help you feel less tense and sleep better. We expect you to gradually be able to improve your mood, energy levels, reduce your vulnerability to feeling threatened, eliminate or alleviate auditory hallucinations, hearing threatening voices etc. Medications work at the biological level and help balance the brain, thereby contributing to the alleviation or elimination of the symptoms."

When suggesting medications, we need to explain how they will affect the symptoms, and warn the client of potential side effects. The client should also have the opportunity to discuss the effects and side effects of the medication with a mental health professional; furthermore, the patient needs to know how long it takes for the medication to work.

5.5.9. Recommended psychosocial interventions

"You say that you feel like you're losing control, you feel overwhelmed in stressful situations. Or you're pulling away from other people. To better deal with stressful situations, I'd advise you to take a stress and anxiety

management course to learn how to better control your reaction. The course is delivered by the psychologist to whom you can talk. You will discuss how you can help yourself reduce anxiety in stressful situations and whenever you feel anxious, how to deal with problems, etc."

"You say you have low self-esteem, you find it hard to disagree with others even if you think they're wrong, which in turn affects your mental health. To improve your self-esteem and help you become more skilled in expressing your views, wishes and feelings, we'd recommend you to join our assertiveness training and communication skills course. The course is taught once a week and is delivered by a social pedagogue, a psychologist etc."

To emphasize the importance of support, you may say: "You're saying that nobody can really understand you, you feel lonely, you don't have any friends, but you'd like to have friends, so you may wish to join a local association or our social worker can help you get in touch with local associations active in the activities you are interested in, together we can also plan volunteer and peer worker support if this is alright for you."

5.5.10. Interventions to improve functioning

"You're also saying that you have difficulties with personal hygiene, home maintenance, paying utility bills, organizing your free time, socializing with people, family relationships, your family and friends don't support you, etc. You say that you'd like to change: you'd like to be able to keep your place tidy, get more support from your family, express your needs, and communicate better. Therefore, we can arrange that you start working with an occupational therapist who will help you establish a good personal hygiene routine, maintain your home, make a plan to improve your family relationships, etc."

5.5.11. Recommended assertive training and psychotherapy

"You also say you grew up in a family where you felt they didn't understand you, you didn't feel accepted, you felt as if you couldn't express your wishes, opinions, feelings, you say you were abused, your parents were strict ... All this made you feel insecure, left you with low self-esteem, highly sensitive to rejection and criticism, you say you feel guilty of things that happened etc. Also, you have described yourself as an insecure person who trusts others too much, and who is afraid to express his or her opinion. You say that they

always criticized you when you were young, and they never bothered to say something positive. Therefore, an assertive training and cognitive psychotherapy could be the right choice for you."

5.5.12. How to recommend psychotherapy

"You say that the home you grew up in affected you in a way that you've become an insecure introvert with low self-esteem, who finds it difficult to express or control emotions, or to discuss your feelings or past experiences. Individual/group psychotherapy could help you with that. It could help you understand and stabilize your feelings, and synchronize them with your thoughts and behaviour. If you agree, we can make an appointment with a therapist."

"You say you are sensitive to failure, sensitive to criticism, it's hard for you to find love. Discussing the connection between past experiences and your current situation could be helpful, so I'd recommend psychotherapy to help you see yourself in a different light and react differently."

"You also say that you often feel like a failure, incompetent, helpless, you think that things will never change, that people don't like you, etc. Such thoughts could be affecting your feelings and behaviour, triggering depression and anxiety. Cognitive-behavioural therapy (CBT) could help you relieve the negative impacts."

"You're telling me about frequent conflicts with your spouse or family member, so we'd recommend family counselling and family psychotherapy because it seems that the way you communicate with your family could be the reason why your illness tends to get worse so often."

5.5.13. Money and housing issues

"You're saying that you are in financial distress and that your living conditions are inadequate, and it is quite disturbing. We will make an appointment with a social worker so that he/she can inform you about your rights and how you can exercise the rights for which you are eligible."

5.5.14. How to let the client know about their rights

"You say you were worried that you would need to stay in hospital forever and that you wouldn't have your say in it, but the law is very clear. We'll give you a brochure where you can learn more about your rights, and I'll also tell you about your rights."

5.6. How to agree on the treatment goals

After the first step in which the health professional presented the diagnosis and treatment options, he/she needs to agree on the goals of treatment with the patient.

The goals of treatment are agreed with the client, he/she should therefore say them out loud and agree with them, so you will ask the client the following questions:

"Based on everything we have discussed and my recommendations, what are your treatment goals and do you agree with what I said? What would you like to change, improve or eliminate in terms of the symptoms/difficulties you were telling me about? What would you like to improve in your functioning? What would you like to improve in your reactions, your perception of yourself and the world around you, in the way you think, feel and behave?"

Once the client has presented his or her personal goals, it is important to summarize them and agree on the planned interventions. Always ask the clients whether they agree and check if they have any questions.

Do you agree? Is that alright for you? What are your priorities? Did we leave something out?

It is important to bear in mind that the way you talk to a patient needs to be empathetic and you have to convey the idea that recovery is possible. The information should be given in a way that the patient does not feel discouraged, but empowered.

All mental health disorders can be observed as an interaction between biological, psychological and social factors that we will identify if we listen carefully to the client, asking them "What happened to you?", rather than "What's wrong with you?".

Health professionals must not let any judgmental biases stand in the way. For example, if we believe that psychosis is a biological disorder and that it can only be treated with medications, we are missing the big picture of what has happened to the patient who now displays psychotic symptoms, which might, for example, lead us to "refuse" to help a patient who refuses medication.

5.7. Developing a treatment plan

In order to make an individual treatment plan and recommend the interventions to be applied throughout the treatment/rehabilitation, health professionals need to answer the following questions: What is the underlying cause of the client's problems (symptoms and functioning)? How does it affect the patient's condition? What stands in his/her way to recovery? We need to understand biological, psychological and social reasons that contribute to their symptoms, current behaviour, and difficulties in functioning; therefore, we need a psychobiosocial formulation.

5.8. Treatment goals

Individual treatment and recovery plan is designed according to the client's individual goals and this is why the goals need to be identified. The client's individual goals are usually linked with the desirable life roles - for example, they need to say where they see themselves in the future. What do they want to change? What would they like to achieve? To achieve their goals, the clients need to know why a series of therapeutic interventions such as medications, psychosocial interventions, or psychotherapy are needed. Let us say that a client with severe functional difficulties (who spends most of his time in bed, completely inactive, with poor personal hygiene, and does not spend any time with other people) and occasional auditory hallucinations says that his goal is to have a girlfriend. You will then agree that this is a great goal and that life and social skills training in the rehabilitation centre could be helpful because it would motivate him to go to places where he would have the opportunity to meet a girlfriend. The client will be motivated for therapy once he has become aware of the link between the therapeutic intervention and their own goals. When a client says that his goal is to find a job, you will discuss

the possible obstacles and offer him interventions that will help him improve his job search capabilities, or offer your help in finding a job.

5.9. The treatment goals related to the symptoms, functioning, biological, psychological and social factors that contribute to the onset of the disorder, the persistence of symptoms and the risk of recurrence

Symptoms of illness. After identifying the symptoms of illness and understanding the onset of illness through the psychobiosocial formulation, the treatment plan will allow for planning different interventions, pharmacotherapy, psychotherapy, and psychosocial interventions. However, the client needs to know why an intervention is planned and who will carry it out. In the planning process, the client should be told why medication for anxiety, depression, sleep problems, auditory hallucinations, and psychotic symptoms have been included. Other interventions may include: breathing exercises for anxiety, relaxation techniques, changing dysfunctional thinking patterns, individual and group psychotherapy, CBT, metacognitive training, and physical activity. If we suggest psychotherapy, we should explain how psychotherapy might help them better understand their thoughts, feelings and behaviours, get more realistic idea of one's self, set realistic goals, understand the influence of early experiences or trauma on current behaviour etc. If we suggest that the client may need to improve his/her communication skills, we need to explain how this would help them in the future. For example, we need to explain to the client that we have understood that he/she finds it difficult to express his/her attitudes and feelings because he/she fears rejection, or that he/she struggles with anger management, so he/she could benefit from the assertiveness training that would help him/her better express his thoughts, feelings and interests, and better control his/her anger.

For example, we have learned that in the client's family there is a lot of criticism or excessive protective behaviour, so improving family communication could help reduce the risk of a new episode of illness (a psychiatrist, psychologist, social pedagogue could be in charge for the intervention). If the client struggles with poor leisure time management, we can suggest helping him/her with better organization of leisure time (occupational therapist), or better problem-solving skills (psychologist).

As healthcare professionals and clients create an individual treatment plan together, the client needs to understand the link between their personal goals and treatment**.** If personal goals are not identified, the client may not be able to see the benefits of treatment and may consequently not be sufficiently involved in the treatment. For example, if a client wants to have a friend, or feel less lonely, communication skills training and leisure activities planning intervention could be helpful, and the link between the goal and treatment needs to be explained.

If we learn that a client has not previously worked with the mental health professional in a truly collaborative manner, we need to let him or her know that collaboration is important, that this is a two-way process, that clients and professionals work together as a team to encourage collaboration; the client should be encouraged to ask questions. It is important to foster a trusting relationship in which the client knows that he or she is in charge of making decisions about his/her treatment and that he or she is responsible for treatment adherence, that he or she has a right to learn from his or her mistakes, bad decisions, just like any other person (for more on the therapeutic relationship, see the guidelines for psychosocial interventions).

If the client exhibits the attitudes such as denial, self-stigma, chronicity, and believing that his/her condition is incurable, psychoeducation and stigma-reduction programmes should be suggested, along with programmes that would help the client improve their skills in dealing with stigma and discrimination.

Improvement in functioning. Functioning and psychopathology must be assessed independently. It is important to assess the patient's capabilities (what he or she can do) and limitations (what he or she cannot do), what he or she wants to change alone or with somebody else's help and in which areas of life they need support. Depending on the functional assessment, we define the goals, interventions and people that need to be involved to help the clients achieve their goals, such as improving the everyday functioning: engaging in daily routine such as personal hygiene, home maintenance, cooking, paying the bills, better functioning in family relationships, at work, in the society, leisure time management, socializing with friends, efficient response to stressful situations, better control of expressing their emotions, better response to protect their rights (e.g. to protect themselves from mobbing), ability to express their attitudes, emotions, make better decisions, improved job skills,

better communication with their spouses and families, better communication with others at work or in community, improved problem-solving skills, getting more support from their families, etc.

Causes of functional impairment. Symptoms of illness (anxiety, depression, delusions), the side effects of medication, lack of skills, lack of motivation, hopelessness, demoralization, stigma, lack of stimulation. The answer to this question will define the course of action in further treatment.

Goals related to addressing biological factors. The goals are to prescribe **e**fficient psychopharmacological treatment and other biological treatment methods, reducing or eliminating side effects, improving physical health, body weight, getting the person to stop smoking and quit an addiction. Regarding physical health, goals may include having a check-up, and adopting healthy lifestyles.

How to increase medication adherence. After assessing medication adherence, conclusions can be: no problems have been observed, the client is capable of taking medications independently, the client needs assistance in taking medications, the client refuses to take medications, the client has reported side effects, the client takes more medication than prescribed, and the client takes medications other than those prescribed. Therefore, the client needs to agree to take the medication exactly as prescribed.

Social factors contributing to the symptoms and functional impairments include different stressful events, cumulative stress, stress in daily life, difficulties in interpersonal relationships, living conditions, work conditions, lack of support in the immediate environment, family relations, loneliness, having no friends, losing a job, losing a loved one, relocation to a care home perceived as a stressful event, negative environment, poor relationships with other users, discrimination etc.

Individual recovery goals could include better ways to cope with stress, trying to build a support network, improving family relationships, finding a job, progressing to independent housing, enjoying a leisure activity etc.

What prevents the client from achieving their goals?

We should talk to the clients to find out what prevents them from achieving their goals, so that the right interventions can be planned. The patient can say that it is all about fear, anxiety, panic, poor communication, fatigue, low mood, suicidal thoughts, poor anger management, difficulty concentrating,

nightmares, pessimistic thinking, withdrawal from social life, overthinking the past, feeling ashamed of their illness, believing that nothing can help them, overwhelmed by the feeling of being different, the lack of motivation etc.

To determine the goals of treatment, we can also use the information gathered from the scale we decided to use, such as the Camberwell scale, Recovery Star, occupational therapy functional assessment, etc.

Motivational interviewing may be suitable for those who refuse medication, even if it would be beneficial for them. Clients should be told that they decide whether or not they will accept the medication. After explaining the reasons, recommendations, benefits, risks and consequences of taking and refusing to take a medication, the patient needs to decide whether they will take a medication or not. If they persist in their decision to refuse the medication, the patient should be advised of the risks. It is important to bear in mind that people have different experiences in terms of medication efficiency. The patient who decides not to take a medication and later experiences an acute episode can learn from their experience. Health deterioration due to psychosocial reasons cannot be solved by medication, and psychosocial interventions need to be planned instead.

Psychological factors contributing to the symptoms and functional impairments include low self-esteem, helplessness, demoralization, shame, excessive guilt, self-stigma, low anxiety tolerance, difficulty in recognizing and expressing emotions, low assertiveness, immature defence mechanisms, the impact of early emotional experiences/traumatic events, distrusting other people, loss of hope, lack of insight.

Psychological functioning goals include a boosted self-esteem, a better understanding of one's behaviour, a more realistic assessment of themselves without underestimating and overestimating their capabilities, understanding the impact that past experiences have on the current behaviour, reducing the impact of the past on their lives (traumatic experiences), finding the meaning of life etc. Psychotherapy and skills training could be helpful in achieving the above mentioned goals. Individual goals related to psychological factors could include regaining trust in other people, new hope and optimism, improving the ways for coping with stress - fostering better coping mechanisms, working on better insight, and positive attitudes towards the treatment, reducing or eliminating self-stigma and demoralization, increasing medication adherence in case of psychological barriers, etc. **In the treatment plan, health**

professionals will recommend psychosocial interventions that can help clients achieve their goals, such as learning about their illness and recognizing the early signs of illness, family intervention, supported employment, social care services intervention to help the client exercise their rights, working with volunteers, social skills training with specific focus on the skills that the client wants to achieve. For example, a person who finds it hard to express their wishes and feelings, or expresses them in an aggressive way could be offered assertiveness training and anger management training, a person who finds it difficult to start and keep communicating can be offered communication skills training which includes understanding verbal and non-verbal messages, active listening, asking questions; a person who finds it hard to solve problems could be offered a problem-solving training. In case of specific difficulties, a person can be offered interventions that would address anger, stress, establishing contact and maintaining a healthy intimate relationships, organizing leisure time, case management, stigma, health education, sex education, occupational therapy including gardening, creative workshops etc.

In choosing appropriate psychosocial and psychotherapeutic interventions, we should be guided by "evidence-based" criteria, according to the indications and treatment goals. The following psychosocial procedures may be helpful:

1. Life and Social Skills Training: specify the skills to work with in terms of life and social skills
2. Case management, with defined intensity and frequency of support
3. Occupational rehabilitation and supported employment for clients who want to get a job
4. Patient education on the illness with a relapse prevention plan - as an individual or group intervention
5. Interventions for reducing stigma and self-stigma, for all those who may be affected by this problem
6. Working with the whole family for people who show an elevated or reduced EE factor, with psychoeducation for the whole family
7. Healthy lifestyles for all those who are interested in this topic and people at risk of poor physical health
8. Cognitive remediation for individuals with cognitive impairment

9. Metacognitive training: for individuals displaying dysfunctional thinking patterns
10. Housing Care Programme - for individuals whose housing-related problems may lead to further deterioration risks
11. Psychotherapy - detecting a specific technique that will be useful for the client.

5.10. Examples of psychobiosocial formulations and treatment plans

Katja, 35 - a qualified teacher, unemployed, living with her father.

Psychobiosocial formulation. The client was referred to treatment by a mobile mental health team due to a long-standing problem associated with the persistent symptoms of depression and serious difficulties in taking care of herself, relationships with other people, inability to work and social isolation. As she was growing up, she was unable to separate from her mother, she only felt fulfilled with her, she was unable to have a strong sense of "self", which still depends on getting the recognition from other people, which doesn't happen because she feels that they put her down and treat her as less worthy of respect. She wasn't able to build trust in her relationships with other people. Her father was partly a substitute for a mother figure, so she continued to function in a symbiotic relationship with him. Their relationship was damaged as her father got ill, so she stopped merging with him as the symbiotic object. The environment in which she lives after her mother died is not supportive, she is unable to find her social network that would make her feel safe, accepted and understood, or make her feel good. The symptoms of depression persist partly due to the unprocessed grief following her mother's death, and this separation never really happened. In stressful situations, she responds with anger, she loses control and becomes aggressive, or she simply pulls away. Losing her mother felt like losing the only support she has ever had. Her intellectual skills are well developed, but she cannot use them properly due to psychological problems. Knee pain also has a psychological side to it, as other people feel sorry for her because of poor physical health. She feels stigmatized by her own family. The biological vulnerability to depression has been identified in this client.

"You say that you have problems with low energy levels, concentration, sleep, loss of interest, maintaining your home, walking difficulties, feeling

lonely, feeling that your family doesn't support you, that you don't have any friends, that you find it difficult to cope with stressful situations and that you find it difficult to communicate with your father and agree on the simplest things, it is difficult for you to accept the difficulties your father is currently experiencing, due to which he has changed his attitude towards you. We understand that you feel upset and sad, now that you feel you have lost your father's support. We also understand that in a current situation, when you have difficulty moving around and you're facing low energy levels and lack of motivation, it's difficult for you to do chores, which is why we'd like to get someone to help you with your housekeeping needs. You also say that you'd need somebody to help you become more involved in social life and to better cope with stressful situations."

Individual treatment plan. As the client said that she wanted to try with some other antidepressant, the health professional can see what the client had been taking and how she reacted to therapy. To tackle her sleeping problems, the health professional can suggest her to practise proper sleep hygiene and take a sleep aid to help her fall asleep. As the client said she would like to boost her self-esteem and learn to deal with stressful situations, especially better manage her anger, assertiveness and anger management course could help the client express her unhappiness in a more appropriate way and achieve her goals. The client complained she had been struggling with doing her duties, so we believe that a case manager (registered nurse) could help her get better at dealing with her obligations and become more involved in social life, discover her abilities and live an independent life to the maximum extent possible. Case managers can also help the client develop their personal recovery plan. The client also said that her father and sister criticized her all the time and that she felt sad and angry because she believed they didn't understand her. Mental health professionals can plan to talk to the client's family to reduce the reactions that make her upset. If the client agrees, health professionals will make an appointment to meet the family. The client said she needed help with grocery shopping because she barely left her house, so health professionals could help her with signing up for online shopping for groceries and home delivery. We believe that a peer worker could help the client as she had faced similar challenges and recovered, so sharing her recovery experience could be helpful; she could also help the client feel less lonely and plan some daily routine. The client said she was having doubts about finding a job, so health professionals could also discuss her work ability. The client also said she was

worried about her father's health, but health professionals can help her with arranging support and treatment for her father, and the case manager will contact their family doctor.

The health professional needs to check if the client agrees with the plan and if she has any questions.

"We're glad you agree. We'll start tomorrow; your case manager Ivan, whom you met earlier today, will introduce you to Mira, a peer worker, so you'll decide for yourself and let us know if you feel comfortable working with her. The case manager will once again go through the whole plan with you and support you in achieving the goals you have set, and help you develop your personal recovery plan."

Marko, 30 – Marko is a young man with a Bachelor in Public Administration degree, he requires repeated admissions to the hospital as he was diagnosed with schizoaffective disorder. He showed up accompanied by his parents, and he agreed to do so upon his parents' request, as he displayed irritability, lack of social contacts, poor hygiene, he stopped enjoying leisure activities that he used to love, convinced that his neighbours were watching his every move.

Psychobiosocial formulation. The patient was admitted to the day hospital programme for social isolation, losing interest, low mood with serious functional impairments in all areas: daily routine, social skills and interactions, leisure time, poor job performance, poor family and relationships functioning. Symptoms got worse when the patient performed poorly at work and when his relationship fell apart, associated with cumulative stress in a person who struggles to use adequate stress-coping mechanisms. Circumstances surrounding his emotional development resulted in a development of an unstable self-image and low self-esteem. He is biologically vulnerable to psychosis. Growing up with a schizophrenic aunt who had been stigmatized and passed on her irrational fears to him was a traumatic experience for the client, he didn't want to become like his aunt, which in part leads him to refuse the diagnosis and treatment. He made it clear that he wanted to avoid further admissions to hospital.

Psychodynamic formulation. From a psychodynamical perspective, the patient failed to establish a good enough relationship with his mother, which most likely resulted in early interpersonal difficulties in the child-mother

relationship. The patient's mother is described as anxious, often giving "double bind messages". The patient's father was cold and distant, and during his early and late childhood, he was rather absent, and the client seems to have an insecure attachment with his father. Consequently, the son's self was overwhelmed with anxiety because his early needs were not fulfilled, so a coherent self that would see himself as good enough did not have a chance to develop. These feelings were later dissociated and suppressed, but resulted in low self-esteem. As he moved through later stages and into adulthood, his environment made him feel insecure and anxious, conflict situations contributed to psychotic disorganization, or regression to the paranoid-schizoid position. If we observe the patient's personality in the stages of recovery, we can see that he tends to use immature defence mechanisms such as projection, projective identification, negation and denial. Occasionally, in acute stages of the disease, he still uses manic defences (delusions of grandeur) in order to protect a fragile, non-cohesive self from narcissistic injury.

Individual treatment plan. The health professional needs to tell the patient that he/she understand how depressed he must feel thinking that he's not capable of working, when he's afraid he will lose his job and when he's afraid that he'll have to go through the same ordeal as his aunt, who also spent some time in a psychiatric hospital. He needs to be told that hospitalization occurs in situations when his distrust of other people prevails, and it tends to happen in stressful situations, when he feels he may be rejected. He needs to hear that health professionals believe he can recover and that it is possible to avoid hospitalization, because this is what he wants. He seems to respond really well to the medications, but he tends to refuse them after getting an impression that the medications slow him down, so it should be suggested that he tries some other medication that he may tolerate better. We could also learn that he tended to give up on his goals in stressful situations, so it would be good to work on his stress response and improved self-esteem. The mental health professional must explain the psychobiosocial model of illness to the patient, where medications and improved stress response are protective factors, low self-esteem and stopping his medication are risk factors, and conclude that a lot can be done to increase the protective factors. The client complained that he felt inferior and feared that he might be stigmatized once the other people learn about his treatment, so we'd suggest him to join a psychoeducational group to solve this problem. Metacognitive training could also help him understand that there are different interpretations of events. Mental health professionals

need to explain who would be running the programme, ask the patient if he has any further questions and ask for his informed consent.

Ivan, 30 – Ivan is a young man with a Bachelor of Economics degree, has joined a rehabilitation programme treatment as his problems greatly interfere with his daily functioning, which is a result of continuous psychotic symptoms. He feels anxious about situations that happen to him, for example, he keeps hearing voices swearing at him, asking him to swear out loud, he also hears voices telling him to kill or rape somebody, and he also believes that people he has never seen before keep following him.

Psychobiosocial formulation and treatment plan. A client, who is not biologically vulnerable to psychosis, has been referred to the rehabilitation programme, feeling pressured to find a job, which led to an increased fear and irritability and more intense, persistent psychotic symptoms and difficulties in everyday functioning related to communication with other people. The precipitating factor for the onset of psychosis was a child abuse trauma that the patient has never been able to work through, because of which he never got to trust other people, expecting that other people will only hurt him. As for his development, his mother was overprotective, so due to prolonged association and being overprotected all his life by his family, the patient couldn't develop his independence and confidence in his own abilities. Throughout his life, he wasn't able to learn how to trust other people, or develop a stable self and identity. Psychotic symptoms and projective identification serve him as protective mechanisms.

Treatment plan. The mental health professional needs to summarize the psychobiosocial formulation to the client in an empathetic way. He needs to hear that he may be having difficulties in making friends and avoiding people due to his negative, understandably painful peer experiences that he had previously described. The health professionals might reflect back to the client about his wish to find a job, even if he keeps wondering whether he is really capable of it, so the health professional may want to refer him to work capability assessment centre. The client made it clear that he would like to boost his self-esteem and be more independent in taking care of yourself. The rehabilitation programme could help him because it includes different therapeutic interventions, such as life and social skills programme that can help him boost his self-esteem, improve his life skills, help him establish relationships with

other people and help him better take care of himself. In occupational therapy, the client can learn about his strengths, which can encourage him to find a job, and social worker will be happy to help. It is also possible to consider changing the medications to reduce the symptoms that the client had previously described. The client is then asked to give informed consent.

Mirjana, 59 – The client was admitted to a day hospital after an acute manic episode (hyperactivity, agitation, and disorganization) of bipolar disorder. As her mental functioning became more stable, she got a treatment in a day hospital. Day hospital treatment was recommended so that the client could receive psychosocial intervention to reduce the risk of recurrence.

Psychobiosocial formulation: Mirjana, who is not biologically vulnerable to mental disorder, showed up in a partially stable condition after a hypomanic episode for treatment at a day hospital, still displaying hypomanic symptoms. Recurrent episode has occurred as she was exposed to stressful life events (her daughter's divorce, putting her mother in a care home, difficult communication with her siblings), high level of TSH may also have an impact on her health. She grew up in a family where she did not feel accepted by her mother, she developed low self-esteem and low assertiveness, which is a risk factor for further deterioration. She fails to recognise the way in which low self-esteem affects the inflated self-esteem during a hypomanic episode**.** The feeling of being rejected, low assertiveness, the excessive feelings of guilt and responsibility contribute to the episodic hypomania. During the current episode of illness, she feels responsible for her daughter's divorce. The client lacks insight, and she is unable to recognize the early signs of deterioration and links between deterioration and stressful events. She is getting some support from her family. Out of the potential biological factors, there is no family vulnerability to psychotic disorder, thyroid problems happen occasionally, which is why she is taking hormone replacement therapy.

Individual treatment plan. The mental health professional needs to present the psychobiosocial formulation to the client in an empathetic way. The health professional will then reflect back to the client by saying that the current episode, which led to the hospital admission, occurred as she was worried about her daughter's divorce and putting her mother in a care home. Her family is obviously aware that her behaviour has changed, but she is still having doubts. So far, she has experienced several episodes in which she can easily

recognize depression, but she is struggling to recognize severe episode of illness. The client will then be advised to change her medicine and switch to one that could help her reduce mood swings and switching between phases. The mental health professional needs to explain the client about the use of mood stabilizers. Given the frequent switching between phases, the client needs to be advised to follow the plan that can help prevent the recurrence, along with the plan of recognizing early symptoms. Furthermore, the whole family will be invited to attend family therapy to reduce the disturbing excessive criticism towards the client. Given the negative childhood experiences, this period can be discussed with the client, which is expected to help her gain confidence and learn to trust people again. We also believe that assertiveness training will help her express herself and meet her own needs.

Mental health professionals will then present the treatment plan to the client, along with an explanation of its purpose, present the alternatives and risks if she chooses not to follow the plan and let her know which professionals will be involved in her care. The client is then asked to give informed consent.

Ina, 50 – The client is a sales assistant with 30 years of experience, she was referred to a day hospital due to the deteriorating mental health with a chronic course of PTSD. Her health had begun to deteriorate several months earlier, as a result of a traumatic event (a man entered the convenience store, wearing a hoodie). She was referred to a day hospital to receive psychosocial and psychotherapeutic treatment to improve her mental health.

Psychobiosocial formulation. The client with biological vulnerability to depression was admitted to a day hospital after the symptoms of PTSD become worse due to the recurrence of work-related trauma, long-term exposure to traumatic event at work and distress in the workplace. Her working environment was constantly reminding her of the traumatic event. Her lack of protective mechanisms is also associated with traumatic events in her childhood that she could not escape, and nobody from her immediate environment was able to protect her. Vulnerability of the self is associated with low self-esteem and helplessness, while reluctance to seek help is associated with the expectation that everyone will reject her. She has a positive attitude towards medication, she feels that her therapy helps stabilize her condition. In part, she has a problem with self-stigma. Until the traumatic experience of a store

robbery, work served her as a defence mechanism that helped her maintain self-respect and self-confidence.

Individual treatment plan. The mental health professional needs to present a psychobiosocial formulation to the client in an empathetic way and explain her the link between current trauma, traumatic childhood and her current symptoms and functioning, and show empathy to the client. A change in pharmacotherapy is recommended to calm the symptoms of disturbance, low mood and PTSD, while CBT is recommended to reduce the symptoms. Coping skills training is recommended to help the client deal with stress, whereas assertiveness training could help her learn how to stand up for herself. Psychoeducation is recommended to help her understand her illness, as well as protective and risk factors. Mental health professionals need to explain why CBT is recommended. CBT will help identify and work on the client's dysfunctional thoughts of constant danger and expected attack contributing to agitation. A sociotherapy programme is proposed to improve her anxiety and stress coping mechanisms, and assertiveness training is recommended to the client as she is struggling to express her opinion and has occasional anger management difficulties. A neurological examination also needs to be planned to assess the reported episodes of confusion. To gain a better insight in the client's difficulties at work, the occupational history will be examined, and her abilities to work at a current job will be assessed. Helping the patient abandon the mental health illness stereotypes and find better strategies for coping with stigma is planned to prevent self-stigma. The psychiatrist (pharmacotherapy and supportive psychodynamic approach and group psychotherapy), psychologist (cognitive psychotherapy), social pedagogue (assertiveness training), social worker (occupational history) will be involved in the creation of a treatment plan.

This plan was developed with the patient, and she gladly accepted it.

Ana, 54 – The client was referred to a day hospital due to a new depressive episode that resulted in poor work performance. She specifically asked to be treated in a day hospital, because her previous treatment experience was positive.

Psychobiosocial formulation. The client, who is not biologically vulnerable to depression, was admitted due to a new depressive episode caused by external stressful events – she was exposed to mobbing, putting her father in

a care home – which resulted in a disrupted self-image, low self-esteem in the client, who has high expectations from herself and who needs other people's recognition to maintain a positive self-image.

Individual treatment plan. The mental health professional needs to present the psychobiosocial formulation to the patient in an empathetic way. The client has identified getting back to work and returning to the same job as her treatment goal. Therefore, supportive psychodynamic approach in the form of a brief psychotherapy is recommended so that she can work through a traumatic experience in the workplace, improve self-esteem and ego functioning through assertive behaviour and standing up for her rights. As the client was already involved in a day hospital programme, the mental health professional will suggest her to attend any of a day hospital programme that could help her achieve her goals. The client is familiar with the programme, so there is no need for further explanations.

CONCLUSION

The psychobiosocial formulation is a hypothesis that helps us understand all biological, social and psychological factors that contribute to the onset of mental health problems in people who come to us to seek help. It helps us see the client primarily as a person with his or her current and past experiences. Based on that knowledge, we can decide with the patient on recovery-oriented treatment goals and interventions.

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Appendix 2

Table 1. Psychobiosocial factors that have an impact on the onset of illness, symptom persistence, poor functioning and difficult recovery

Social factors:
Housing and living conditions: inadequate housing, low income, poor public transport access, poor transportation network to community-based services, lack of support in doing everyday activities, being placed in residential care where a person does not want to stay, lack of incentives for community participation, boredom, bad relationships in residential care
Reaction to physical illness: one's own health problems, ill family member or spouse/partner
Family: family relationships, emotional tension in the family, lack of support
Work: unemployment, work environment, work relationships, job satisfaction, job performance, mobbing, burnout, stress in the workplace
Disability: having difficulty accepting their disability, lack of support for lacking skills
Education: poor school performance, learning difficulties
Stressful events: losing a job, losing a significant other, divorce, etc.
Cumulative stress
Trauma and abuse
Getting into trouble with the law
Being part of a national minority group, having a different sexual orientation
Benefits : a lack of financial benefits
Social support: family, friends, community, health facilities, loneliness, lack of friends
Stigma, self-stigma and discrimination

Biological factors

Mental illnesses in the family

Pregnancy and childbirth: adverse events during pregnancy and childbirth

Temperament: **inhibition, seeking excitement, uninhibited, impulsive temperament**

Physical illness

Medication impact and side effects (e.g. extrapyramidal, metabolic, cognitive side effects)

Stopping one's medication abruptly

Taking psychoactive substances: drugs, alcohol

Psychoactive substances are stopped abruptly

Menstrual cycle and menopause

Nutrition and physical activity

NB: Please note that the list is not exhaustive and only includes some of the most common psychobiosocial factors.

Psychological factors

Self-esteem, trusting other people, attachment style

Defence mechanisms (immature denial, projection, splitting, mature mechanisms)

Stress-coping mechanisms

Influence of early development on the stability of self and ego, impulse control

Passive, assertive and aggressive behaviour

Psychosocial developmental history - psychodynamic formulation

6. THERAPEUTIC RELATIONSHIP AND THERAPEUTIC ALLIANCE

Slađana Štrkalj Ivezić

6.1. Introduction and definition

The patient-therapist relationship represents the interaction between the patient and the therapist, aiming to achieve positive change in the patient. It is a professional relationship that must be safe for the patient, respecting professional, legal and ethical boundaries. Given that the relationship between the therapist and the patient involves a certain level of intimacy, the therapist must be very careful not to cross professional boundaries, which can happen in the case of physical contact, inappropriate disclosure of one's feelings, or exchange of private content on social media, etc. The therapist must instead find the best balance between excessive interactions, such as insisting that the patient discloses information that he/she is not ready to share, and complete lack of interest for the patient, reflected in ignoring his/her feelings or considering him/her a hopeless case. The therapist must understand that being "friendly" with the patient does not involve a personal friendship, but rather an empathetic relationship in which the therapist seeks to understand and help the patient in line with the professional standards. The therapist must introduce himself/herself to the patient and explain his/her role in treatment, appropriately address the patient, by respecting the patient's preferences, refrain from making any comments that may be inappropriate for the therapeutic situation or cause discomfort to the patient. Psychologically, the patient-therapist relationship is a therapeutic tool that contributes to change, and the therapist must know how to use it and how to manage it.

The therapist-patient relationship is an important therapeutic environment and an important therapeutic tool that stimulates the process of change, leads to improvement of the medical condition and promotes personal psychological growth and recovery. The therapeutic relationship is an important therapeutic agent regardless of the type of therapy: medication therapy,

psychotherapy, sociotherapy, rehabilitation or a combination thereof. In a therapeutic relationship, the patient needs to see the professional as a person who is there to support him/her every step of the way. Support means showing interest in people who need help and wanting to help. A supportive relationship offers empathy for what patients are going through, it radiates comfort, hope and confidence that a person can solve their problem. Establishing an empathetic relationship of trust, optimism, hope and therapeutic alliance is crucial to healing. The ability to establish a therapeutic relationship is a skill that can be learned and that compares to learning how to apply different therapeutic interventions, such as medication therapy, family therapy, group psychotherapy, and other therapeutic interventions. Professionals can learn the skill of establishing a therapeutic relationship by knowing the basic elements that contribute to building a therapeutic relationship and applying them in daily patient care, as well as by learning from identification with a mentor who can demonstrate good practice in building a therapeutic relationship and therapeutic alliance. Most professionals can learn how to show warmth, spontaneity, interest, a balanced approach to power, optimism and hope, and other elements of the therapeutic relationship through mentor observation and role-play. The therapeutic relationship is associated with a favourable treatment outcome for patients diagnosed with a mental disorder. Therefore, establishing a therapeutic relationship between the therapist and the patient should be part of the treatment standard, a process that needs to be followed to achieve optimal treatment goals. Research has shown a number of beneficial effects of therapeutic relationship, such as a reduction in symptoms and severity of symptoms, improved social functioning, improved quality of life, better medication adherence and adherence to treatment, and reduced medication doses needed to stabilize the condition, and more successful rehabilitation outcomes. A good therapeutic relationship with the case manager is associated with fewer days spent in the hospital.

Greenson suggested that there are three components to a therapeutic relationship: transference, the therapeutic alliance, and the real relationship. Greenson considered the therapeutic alliance as a reality-based collaboration between client and practitioner.

Bordin (1979) conceptualized the therapeutic alliance as consisting of three components: 1. the therapist's and client's agreement on the goals of therapy, in which goals represent the results the client hopes to achieve in

counselling, based on his or her presenting concerns (this includes consensus about the definition of problem and goals of therapy, and consensus regarding the methods employed in therapy; 2. the therapist's and client's agreement on the tasks of therapy (tasks are what the therapist and client agree to do in order to reach the client's goals); 3. the positive bond that exists between the therapist and the client. The bond forms from trust and confidence that the tasks will bring the client closer to his or her goals. Bordin noted that optimal therapeutic alliance is achieved when patient and therapist share beliefs about the goals of the treatment and view the methods used to achieve these as efficacious, and when both actors accept to undertake and follow through their specific tasks. The first two components of the therapeutic alliance can only develop if the client and the therapist have built trust in their relationship, since any agreement on goals and tasks requires the patient to believe in the therapist's ability to help him/her and the therapist, in turn, must be confident in the patient's abilities to achieve the agreed goals. Bordin suggests that the therapeutic alliance will influence the outcome as an ingredient which empowers the client to accept and follow his/her treatment plan, and believe a treatment will work.

The therapeutic relationship is the means by which the client and the practitioner engage with each other, encouraging beneficial change in the client. The therapeutic relationship is associated with trust, respect, and hope in recovery, agreeing on common goals of treatment and establishing a therapeutic alliance. The therapeutic alliance is a component of the therapeutic relationship that guarantees a professional attitude of the practitioner, and shared responsibility between the client and practitioner to work together on the agreed goals of treatment.

The therapeutic alliance is a joint decision - an agreement between a therapist and a client on the goals of treatment and therapeutic methods that help them achieve these goals.

The therapeutic alliance is a joint agreement between the therapist and the client in which they define the client's problem and work together to solve it.

The therapeutic relationship means a way in which the therapist and the client work together to achieve the desired changes in the client's life. It includes mutual trust, respect, hope in recovery and common agreement on the goals of treatment. The therapeutic relationship is often the only factor that motivates the client diagnosed with psychosis for treatment, which is

particularly important at an early stage when clients tend to refuse treatment due to a lack of insight, and that is exactly when the therapeutic relationship may become a driving force that helps the client adhere to the treatment. It is important to know that many clients treated for psychotic disorders such as schizophrenia or closely related conditions may take longer to develop a trusting relationship with the therapist, agree on treatment goals and establish a therapeutic alliance. Building a therapeutic alliance in the acute phase of illness requires the practitioner to be flexible and patient, and to work towards maintaining a positive therapeutic relationship throughout the long-term treatment.

Without establishing a therapeutic relationship in psychiatric clinical practice, it will be difficult to make a good mental health assessment, evaluate the factors contributing to the client's mental health problems, and propose a treatment plan. Psychiatrists and other mental health professionals must have the capacity to build a therapeutic relationship and therapeutic alliance.

6.2. The therapist's capacity to develop the therapeutic alliance

The therapist's capacity to build a good therapeutic alliance include an ability to listen to the client's concerns in a manner which is emphatic, supportive, non-judgmental, and sensitive, and which conveys a comfortable attitude when the client describes their experience, an ability to ensure that the client is clear about the rationale for the intervention being offered, an ability to gauge whether the client understands the rationale for the intervention, and to respond to these concerns openly and non-defensively in order to resolve any ambiguities; an ability to check that the client is clear about the rationale for treatment and to review this with them and/or clarify any misunderstandings; an ability to help the client express any concerns or doubts they have about the therapy and/or the therapist, especially where this relates to mistrust or scepticism; an ability to help the client articulate their goals for the therapy, an ability to hold the client's world view in mind throughout the course of therapy and to convey this understanding through interactions with the client, in a manner that allows the client to correct any misapprehensions; an ability to respect the client's value system, and to help the patient create their value system, without imposing the therapist's values, and an ability to be clear about what can, and what cannot be done.

6.3. Therapist factors that reduce the probability of forming a positive alliance

Therapist factors that reduce the probability of forming a positive alliance are: being rigid, being critical, patronizing, making inappropriate self-disclosure, being distant, being aloof, being distracted, and making inappropriate use of silence.

6.4. Qualities of effective therapists

Qualities of effective therapists include the therapist's ability to answer the client's questions, regardless of his/her ambivalence and mistrust regarding the diagnosis and treatment, non-defensively and without inappropriate emotional responses, and use the approach that would help the client resolve any ambiguities. It also includes the therapist's ability to help the client articulate their goals for the therapy and reach an agreement with the therapist about the goals for the therapy, an ability to apprehend the ways in which the client understands themselves and the world around them and help them change false beliefs, an ability to clear up potential misunderstandings regarding the therapy goals, and allow the client to express his or her negative feelings about the therapeutic relationship and assume responsibility for the creation, maintaining and ending the therapeutic alliance. Some of the qualities of therapists effective in establishing a therapeutic relationship include their ability to allow the transference, to receive the client's projective identification, to recognize countertransference, and to analyse whether they can be attributed to the client's transference, projective identification, the therapist's transference, or empathy (the client's feelings), and use them appropriately in a therapeutic relationship by showing empathy, interpreting the patient's emotions, and controlling the inappropriate expression of emotion. Using motivational interviewing techniques can be very helpful in establishing a therapeutic relationship and therapeutic alliance.

6.5. Essential skills for building a therapeutic relationship

A therapeutic relationship is an effective therapeutic tool that leads to better treatment results. The therapeutic relationship is a skill that can be learned, so the therapist should first focus on building the following 12 elements of the therapeutic relationship to learn how to use it as a powerful therapeutic tool:

1. **The therapist uses active listening, shows empathy and interest for the client.** The therapist needs to actively listen to what the patient is saying in order to hear the client's personal "story", the therapist also needs to take into account incoherent dissociative fragments of thought and show genuine respect for what the client is saying, no matter what he or she is saying. The therapist must be able to show empathy. The therapist must show that he/she understands how the client feels, thinks and behaves in the circumstances that he/she has described, and needs to show a genuine interest in helping the client. The empathetic message conveying an understanding of how the client feels in the situation he/she has described and offering reassurance that the therapist wants to help is one of the first messages we need to convey to the patient, it must be sincere, genuine, verbal and non-verbal. An empathetic statement will strongly encourage the creation of a therapeutic relationship and therapeutic alliance. For example, the psychiatrist/therapist can say that he or she understands that a client must be feeling depressed, anxious, and helpless as they are going through hardships such as losing their job, or coping with a loss of a loved one. In his/her attitude towards the client, the therapist must show acceptance and understanding without prejudice, criticism and blame, regardless of the client's demonstrated behaviour resulting from the illness. This does not mean that the therapist necessarily agrees with the client's behaviour, but he/she rather shows he/she understands that this is the only possible way the client can act in a specific situation, offering their point of view and giving the client a fresh perspective on more efficient behaviour patterns. The therapist always needs to make it clear that he/she wants to help the client.
2. **The therapist offers individual approach to the client and sees him/her primarily as a person, rather than treating them as just another diagnosed case.** Although the diagnosis is important for treatment, we must never forget that each person with a diagnosis has their past, present and future, that their personal life story is linked to the onset of illness, and that we are there to treat the person, not just the disease. Therefore, the therapist will always strive to take a holistic approach and develop an understanding of the client as a person with symptoms, conflicts, difficulties, emotional reactions, attitudes and value systems, and let the client know that the therapist understands them.

3. **The therapist increases the sense of hope and optimism, empowers the patient, encourages recovery and prevents self-stigma.** One of the therapist's first tasks is to convey optimism and hope, empower the patient, reduce helplessness, and prevent demoralization and self-stigma. The therapist's attitudes have a significant impact on the outcome of treatment, so it is important for the therapist to bring a genuine sense of hope and optimism into the therapy process, to believe that recovery is possible, and to support the patient in creating a recovery plan. The therapist must break free from attitudes of chronicity, incurability and lowered expectations. Positive treatment expectations are associated with better prognosis. Transmitting a sense of hope and optimism should be authentic, so members of the team working with the client need to make sure the optimism they are feeling is realistic, based on their own experience. The therapist must be able to recognize feelings of hopelessness, helplessness, withdrawal, accepting stigmatizing attitudes, and create a plan to help the patient get out of the bad expectations trap that hinders recovery and leads to demoralization. Demoralization is a persistent inability to cope with a situation, the client feels trapped and believes that things can no longer change, so he/she needs the encouragement, optimism and hope that the therapist will demonstrate through his/her actions**.** Many clients entering the rehabilitation system have lost hope after a string of failed treatment attempts, so the first task of the therapist and the team working with the patient is often to restore hope that recovery is possible. The therapist always needs to open up the prospect of recovery, even if sometimes this may mean taking small steps towards recovery.
4. **The therapist demonstrates authentic behaviour, congruent in verbal and non-verbal communication, and fosters honesty in their relationship.** The therapist's authentic behaviour is important in conveying messages related to treatment and therapy and showing empathy, care and interest. It is important to know that patients can learn through identification with the therapist, so the way in which the therapist addresses problems and emotions is an important roadmap for creating positive changes in the client. The client will respond to empathetic messages only if the therapist is authentic. The therapist has to be honest about what can and what cannot be done for the client**.**

5. **The therapist shows respect for the client's difficulties and accepts his/her value system.** No matter what the client says, the therapist needs to show respect for his/her way of thinking, which does not mean that the therapist agrees with his/her point of view, but listens carefully to the client, understanding that this is the only possible perspective for the patient, and paves the way for new opportunities through different interventions to help the client. The therapist always needs to respect the client's resistance because he/she knows they use it as a defence mechanism to protect themselves against painful emotions and helps him/her overcome the resistance in a non-aggressive manner. The therapist needs to be flexible and encourage the client to discuss issues that are important to him/her. The therapist accepts different views, different value systems, and cultural differences, and does not impose his/her opinions and values on the client in matters such as money management, leisure activities, choosing a partner, etc. Anything that goes against the client's value system is considered crossing professional boundaries.
6. **The therapist explains the understanding of the situation from the viewpoint of a professional.** The therapist offers the patient the opportunity to think differently, to look at his/her situation and problem from a different angle and from a different perspective, to consider an alternative explanation of the situation, and the possibility to learn how other people would react in a similar situation.
7. **The therapist helps the client to repeatedly engage in reality testing**. By offering non-aggressive and considerate confrontation and clarification, the therapist will help the client improve his/her reality testing. The therapist helps the client consider all aspects of their dysfunctional behaviour.
8. **The therapist believes that the client can change.** The therapist's belief that the client can change and the client's belief that change is possible is key to successful treatment.
9. Therapists who believe that clients can change and clients who believe that they can change together contribute to change, and vice versa, change cannot happen in a relationship where nobody believes in the power of change. It is important to help the client get rid of the patient identity with low expectations of change. The therapist's belief in the power of change can lead a demoralized, self-stigmatized patient to believe that a change can happen.

10. **The therapist takes a balanced approach to power - encouraging the patient to actively participate in his/her treatment.** The therapist encourages therapeutic alliance, joint decision making, partnership, a relationship free from the paternalistic approach in which decisions are made by the therapist who knows best what is in the best interests of the client. Collaboration and responsibility are shared between the client and the therapist, so the therapist must understand and respect the reasons for which the client refuses medication or psychosocial treatment, and work on a common vision of treatment. The client should feel like a partner who shares equal power in his/her interactions with the therapist. The therapist provides information on services he/she can offer, explains available treatment interventions and how they can help, he/she uses motivational interviewing to help the client decide on their treatment in order to motivate him/her to change. It is important to develop a cooperative relationship as opposed to coercion and overprotection.
11. **The therapist fosters a professional relationship with clear boundaries - a relationship that is comfortable for the client and the therapist.** The relationship between the therapist and the client involves a certain degree of intimacy, so it is very important to set clear boundaries. The only goal of a therapeutic relationship is to improve the client's condition. T**he therapist may be friendly with the patient, but he/she is not the patient's friend in the proper sense of the word, so it is important to keep professional boundaries in the therapeutic alliance and the agreed effort to achieve the goals. Difficulties in dealing with emotions that occur during treatment can pose a challenge for professional boundaries, so the therapist must have the appropriate skills to handle his or her emotions, and the supervisor must be available for case review.**
12. **The therapist needs to be available and accessible and give enough time for the client to discuss his/her problem during a session.** The client must have enough time to talk about their difficulties. The therapist should provide enough time and clearly explain to the client about the session duration and when they can make a new appointment, and let the client know how he/she can get in contact with the therapist to discuss his/her problems. The therapist must make sure that he/she will be available at the given time slots, the client must be duly informed about the session duration, and a therapy office should offer a safe counselling environment.

13. **The therapist is able to recognize the client's transference and has an insight into countertransference. The therapist-client relationship will surely involve emotions. Therefore, the therapist must be able to recognize transference and counter-transference to use them in their work with the patient, which will result in beneficial changes in the client's condition. The sole purpose of discussing one's emotions is to improve the client's condition. The therapist's inappropriate reaction can lead to violation of professional, ethical and legal boundaries.** In the therapist-client relationship, the therapist needs to develop the skills of monitoring and understanding the patient's emotions, but also their own feelings. Transference and countertransference seem to lie at the root of it. Therefore, mental health professionals involved in treatment of a patient with mental illness must develop the ability to recognize and control their feelings and behaviours in the therapeutic relationship. Therapists need to understand and recognize what feelings come from the patient that may be related to his/her previous experience with significant persons in his/her life (this is called transference), including the feelings conveyed by projective identification, and what feelings of the therapist come from his/her personal experience in the past or present with others, which is called the therapist's transference or countertransference. Transference is defined as the experiencing of feelings, drives, fantasies, attitudes, and defences towards a person in the present, originating in regard to significant persons of early childhood. Freud defined transference as repeating events in therapist-patient relationship. The repetition of feelings, attitudes and behaviours once attributed to parental figures occurs in most emotionally significant relationships people may have. The tendency to repeat past experiences is a universal phenomenon in human experience. The person who experiences transference does not perceive those feelings as part of the past, but rather as the present. When the client's reaction is related to transference, his/her response is inappropriate to the present and transferred from significant past experiences. The more closely the present situation resembles the situation from the past, the more intense the patient's reaction can be.

Consider the following example: *after waiting for a long time in a queue to get his documents at the counter which had been closed for quite a while, a client started to shout, bang and tear his documents into pieces. He eventually showed up in a doctor's office for the appointment, full of anger. Talking about his reaction led him to understand that his low tolerance for waiting*

and injustice was related to the events of his early childhood when he got grounded by his parents and had to wait for hours locked up in his room.

As not all reactions to him or her are transferential, it is important for the therapist to distinguish between transferential and non-transferential reactions.

Countertransference means the therapist's response to the client's behaviour, which may also be based on the transference of the therapist who makes a wrong judgment and unconsciously relates it to their personal experience. According to the classic view of countertransference, countertransference is the response that is elicited in the therapist by the client's transference. According to the totalistic view, countertransference is the total response of the therapist to the client, not just the one elicited by the client's transference. Therefore, the countertransference response is not just indicative of the therapist's own unresolved intrapsychic problems, but also a response to the client's pathology. It is therefore very important to analyse both transference and countertransference response in working with psychiatric patients. The therapist should be able to discuss any concerns with a supervisor focusing on their feelings as part of the rehabilitation programme.

An example of the development of a therapeutic relationship that has led to recovery is shown below.

"Before the treatment in the Centre for Rehabilitation, I thought that I was a ruined and destroyed man. I believed my life was over because I was treated in a psychiatric hospital, having just been diagnosed as schizophrenic who had to take medications. I let my family and social worker make decisions about my life. Simply, I thought that was the only way because I was ill and couldn't make decisions. I felt they knew better. They acted the same way, too. I was desperate because of my illness; I was avoiding people so that they don't ask me about my illness, I thought others would make fun of me. I thought my life was over and that I would never find a girlfriend.

Here I have learned that my attitude towards mental illness is important. I have learned that I matter as a person and that it had nothing to do with illness. I started to think that disease helped me become a better person and understand other people better. I decided to take control over my life and do things I've always wanted to do. My attitudes towards medications have also changed – now I see the medication as something that helps my brain work better. I'm more comfortable with the idea of living with schizophrenia. I understand that it is just a disease that can be treated. I can work, I found a job,

I have a girlfriend. I'm happy with my life, and it has changed dramatically since I changed my attitude towards my illness. At the Centre, I learned how to recognize my abilities. I'm so proud of them. I've also learned some new skills - how to communicate better with others, how not to be afraid of problems and how to ask for help. I make my own decisions, even if I often discuss things with family, friends and my medical team. My life finally makes sense. I still have times when my symptoms get worse, I get scared and sometimes people seem to give me an ugly look. Now I can deal with it, especially when I don't let fear hold me back. When I ask for support, things get back to normal. It happens to other people too, that's how life goes."

CONCLUSION

The therapeutic relationship between the client and the therapist is essential to effective psychiatric treatment. It enables the establishment of a safe and comfortable therapeutic environment and is a therapeutic tool that encourages change and recovery from mental illness. Active listening, hope and optimism, empathy, appreciation of what the patient says no matter what he/she says, genuinely honest attitude, balance of power, giving the client enough time to talk about their problem, setting the goals of treatment with the client, creating a therapeutic alliance, and understanding how transference and countertransference work are skills that psychiatrists and other mental health professionals need to have to help their clients recover from mental illness. Establishing a therapeutic relationship is a skill that can be learned, so the therapist must work to improve their skills in building a therapeutic relationship and therapeutic alliance. Building a therapeutic relationship and alliance takes *different amounts of time*, depending on the severity of illness, degree of regression as well as the therapist's ability to initiate a therapeutic relationship. Unconscious factors in the therapeutic relationship will often influence the therapeutic alliance. Therefore, the therapist needs to have the necessary skills to identify these factors and minimize their negative impact on the treatment and recovery process.

Table: Therapist skills for building the therapeutic relationship

1. The therapist uses active listening, shows empathy and interest for the client
2. The therapist offers individual approach to the client and sees him/her primarily as a person, rather than treating them as just another diagnosed case

3. The therapist increases the sense of hope and optimism, empowers the patient, encourages recovery and prevents self-stigma
4. The therapist demonstrates authentic behaviour, congruent in verbal and non-verbal communication, and fosters honesty in their relationship
5. The therapist shows respect for the client's difficulties and accepts his/her value system
6. The therapist explains the understanding of the situation from the viewpoint of a professional
7. The therapist believes that the client can change
8. The therapist helps the client to repeatedly engage in reality testing
9. The therapist takes a balanced approach to power - encouraging the patient to actively participate in his/her treatment
10. The therapist fosters a professional relationship with clear boundaries - a relationship that is comfortable for the client and the therapist
11. The therapist needs to be available and accessible and give enough time for the client to discuss his/her problem during a session
12. The therapist is able to recognize the client's transference and has an insight into countertransference

NB: It is recommended that you print this list and put it in a visible place to remind you that the therapeutic relationship is a skill that you need to work on every day.

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7. INFORMED CONSENT AND DECISION- MAKING CAPACITY

Slađana Štrkalj Ivezić

7.1. Introduction

Free informed consent to treatment is a legal obligation in treating any medical condition, including mental illness. Informed consent should also be considered as a therapeutic tool for building a strong and trusting therapeutic relationship that will contribute to a positive treatment outcome. Informed consent including the obligation to inform the patient about their condition and recommend available treatment options so that they can make a decision about their treatment is the first interview with the patient that paves the way for building trust, ensuring the cooperative relationship and starting a treatment process. The time we dedicate to review the information contained in the informed consent is not a mere formality, but rather the process that helps build and use a therapeutic relationship as a vehicle to change.

Free informed consent to treatment is the right of a person to decide independently on their own medical treatment and act in accordance with their own decisions.

Regarding the field of treatment, patient autonomy is the right of patients to have their own opinion about their medical condition, the proposed treatment, and the right to make decisions on accepting or refusing medical care in accordance with their opinions and attitudes. However, in order for a patient to make a decision, they will need reliable information. A patient must be an informed participant in making decisions about his or her health.

Informed consent involves informing the patient about all the important facts they may need to make a decision about treatment, or give consent to treatment.

Informed consent means that a person must voluntarily give permission for treatment. Yet, the consent given after the patient had been pressured into signing the informed consent, or after they were told that otherwise they

might be subject to an involuntary treatment, is not considered informed consent. Involuntary treatment in which the patient is admitted to hospital without their consent is regulated by law and relies on specific criteria setting out the rules about an intervention in the absence of consent is authorised. However, this does not mean that patients should not be duly informed that they will be admitted to hospital without their consent and given appropriate explanation for this.

7.2. Validity of informed consent

For an individual to give valid informed consent, three components must be present: patient competency, disclosure and voluntariness.

Competency (decision-making capacity) pertains to the ability of a person to understand the information relevant for a decision-making process, to understand the relevance of the information in a specific situation, to form a judgment using the information, to choose between possibilities and to communicate a reasoned decision. If a patient cannot make prudent decisions, the court will assign a guardian to make decisions on the patient's behalf.

Disclosure means that the doctor or health care provider must give to the patient clear information about the purpose of treatment, expected results, a description of what needs to be done during the treatment, possible benefits and risks, alternative therapies, and potential risks if the patient refuses a recommended treatment.

The medical interview is used to inform patients in a way that is understandable to them about their health condition and treatment recommendations.

Medical paternalism of physicians and other professionals in treatment refers to a set of attitudes according to which patients cannot properly understand medical information and are unable to understand their medical condition. Therefore, they should not be given any information, as it was perfectly normal that professionals, at that time believed to know better, make decisions on behalf of their patients. Such attitudes are no longer acceptable, both from a legal and professional point of view.

Today, it is believed that the medical interview is the central and critical part of the informed consent that needs to be done according to the patient's

condition; however, the doctor must make sure that the patient has understood all the relevant information to make a decision. The patient should be given enough information to make a decision, so that neither too much nor too little information is provided. If a patient wishes to appoint a trusted person who would be present throughout the process, their wishes must be respected.

7.2.1. How much information patients need to receive to make informed decisions

The purpose of informed consent is to increase the patient's understanding of his/her own health, the nature and risk of the proposed medical intervention, as well as the knowledge of possible alternatives and their risks, in order to make it possible for him/her to make an informed decision and accept or refuse treatment. How much information about a proposed intervention is appropriate to disclose depends on the patient's needs; this information should be provided in lay language to make sure the patient has received the information necessary to make an informed decision. Many patients will make a decision based on the trust in their physician, so the professional should provide accurate and honest information, free of any duress that would place the patient at a disadvantage or that would compel them to make a decision out of fear of negative consequences, such as involuntary admission to hospital, restrained access to outpatient care, etc.

This information standard, set according to the patient's needs, puts the patient's autonomy and right to self-determination at the centre, implying the amount and quality of information that a "reasonable patient" (i.e. an average, competent patient) would find enough to make an informed decision.

The next step of the informed consent is the assessment of the patient's understanding of the information provided. The physician must pay attention to factors that may affect the patient's understanding (education, socio-cultural influences, current state of mind, language) and autonomy, i.e. voluntary decision-making (e.g. family involvement in the decision making process, etc.).

The quantity and quality of information must be tailored according to the patient's individual needs, their intellectual capacities, as well as their social and cultural background. This approach requires a great deal of physician engagement and medical effort. The medical interview session may take some time as the physician has to get to know the patient, earn their trust and find the best way to share information about their health and illness, the nature

of the diagnostic and therapeutic procedure, the potential risks and alternatives in a way that the patient understands, and to make sure that the patient has understood all of the information provided. Information provided must be short and informative, without unnecessary details. The informed consent is important because it is incompatible with deception or coercion of the patient. Patients must be informed that they can change their mind at any time, withdraw their consent and refuse recommended treatment. The right to refuse treatment is the most important measure of protection against deception and coercion.

Voluntariness implies that patients have the freedom to make a decision on their own, without any other influence, coercion, deception, and manipulation, and that their consent may be withdrawn at any time.

Given the specific patient–physician relationship, patients may feel compelled to participate, for example, in a study out of fear that if they refuse to do so, the physician will not take good care of them. In this situation, patients must get a guarantee that their refusal to take part in the study will not affect the treatment.

7.3. Legal capacity

In accordance with the UN Convention, the WHO has reiterated that the right to legal capacity is a fundamental human right.

Legal capacity means the right to make decisions, while decision-making capacity is the ability of a person to make a decision in specific situations. However, this ability may vary, so a person with reduced decision-making capacity needs support, which means other people can help him or her to make a decision to reflect his or her wishes, rather than having someone else make a decision on his or her behalf.

A person who has difficulty making decisions, or has mental capacity impairment have the right to be given support to make their own decisions. Some people need support for complex decisions, others for simple ones. The person decides whether he or she wants support to make his or her own decisions.

In supported decision-making, one shall not simply assume the best interest of the person, but support a person to make a decision based on his or her

wishes and preferences. People with conflicting interests about a decision that a person needs to make are not allowed to be formally appointed to help with making a decision. NGOs providing legal assistance and other forms of support may be contacted to get access to supported decision-making provided by persons authorised under specific orders, including peer workers.

CONCLUSION

Informed consent is a legal obligation, however, it also has therapeutic elements, as it involves building a trusting relationship and is often the first step in creating a therapeutic alliance. Owing to its potential for creating a strong therapeutic relationship, informed consent shall be considered an important therapeutic tool.

Informed consent to treatment means that a person has received enough relevant information regarding the recommended treatment in a way they could understand, discussed in lay terms, and that they could use it to make an informed decision. Relevant information must include the potential benefits and burdens of the treatment on the person's health, the risks, the alternatives to the recommended treatment, and the likely consequences of refusing recommended treatment. Informed consent also means that a person has the right to refuse treatment.

NB: Any medical procedure performed pursuant to the Protection of Persons with Mental Disorders Act in the Republic of Croatia must be duly documented in medical records, indicating if the procedure was done with or without the patient's informed consent (Art. 23).

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8. PSYCHOSOCIAL INTERVENTIONS AND REHABILITATION

Slađana Štrkalj Ivezić

8.1. Introduction

Rehabilitation is a set of different psychosocial interventions designed to enhance skills in different areas of functioning that include self-care, communication skills, functioning in roles such as partnership, family, work, educational and social roles, including the development of coping skills for stress, stigma and discrimination and problem solving techniques. Those skills are important because they enable people to be the directors of their own lives, be independent and live in the community. In addition to interventions that teach patients and improve patient skills, rehabilitation also includes support interventions for activities for which a person is less equipped and which he/she cannot do independently. Generally speaking, the more skills a person has to live and work independently, the less support they will need. Rehabilitation is best suited for individuals with serious functional impairments and diagnosis due to which they cannot live independently and work and it is designed to help persons with mental illness to function as independently as possible and to help them get the support they need for independent living in the community. The goals of rehabilitation are to increase a person's independence in daily activities, reduce dependency, foster social inclusion, improve functioning in different roles to make the person feel useful, needed, productive and satisfied, and help them find a sense of belonging in the society that they live in.

Rehabilitation is provided based on an individual assessment of functioning and an individual rehabilitation plan. The rehabilitation plan assesses the patient's abilities and disabilities associated with functioning in different areas of life, connecting them with personal goals and methods that will help them achieve their goals. Rehabilitation focuses both on the abilities it seeks to build, and the disability it seeks to overcome. Psychiatric rehabilitation focuses on comprehensive, continuous and coordinated, often long-term, and

sometimes even lifelong treatment, and strives to keep symptoms under control, prevent relapse and foster optimal psychosocial functioning.

Rehabilitation is a whole-system approach to recovery from mental illness that maximizes an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy to give them hope for the future. A psychobiosocial model of understanding mental health problems is used in rehabilitation planning. The implemented methods are aimed at empowering the individual and promoting recovery from mental illness. Recovery is associated with relief of symptoms, improved functioning, and personal recovery, which is given a lot of attention today, as recovery is viewed as complete only when it is personal. Recovery is a 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 as one grows beyond the catastrophic effects of mental illness. Recovery means regaining of what we lost, such as rights, roles, responsibilities, decision-making capacity, potentials and support. Recovery means developing one's own experience of being able to decide on important life goals in order to create the psychological and material resources necessary to achieve the goals, and progress towards personal goals. Rehabilitation methods should lead to empowerment. Empowerment includes embracing a healthy view of self-efficacy or self-confidence to achieve desired goals, increased levels of self-acceptance and self-worth, the sense of purpose and active self-advocacy, and hope and motivation. Empowerment is the self-esteem that comes from participation in activities, success and sense of achievement. Empowerment is the process of enhancing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. Empowerment involves a person's determination to take control of their lives and their participation in the community and society that they live in. Rehabilitation is commonly available at disability day care centres, which can be organized by various mental health services including mental health services, social services and NGOs. However, it can also be provided in a hospital for people who have difficulties in using day treatment programmes or have severe difficulties in daytime functioning or cannot use those services for other reasons, such as poor service availability, or services based far away from their home. The programmes offered by the rehabilitation centres may vary, depending on the treatment goals and needs of

different patient groups that often vary in terms of diagnosis and functional impairment, as well as the goals that need to be achieved. Rehabilitation programmes combine different psychosocial methods. The methods used often include social skills training, working with family, patient education, employment programmes and other methods according to an individual rehabilitation plan.

8.2. Patient education

Patient education is an individual or group intervention that involves the exchange of information about the illness and treatment in interaction between the therapist and the patient or their family member. This is not a series of lectures on symptoms of mental illness and treatments, but a process that takes place in a positive therapeutic environment, and involves an open discussion about the symptoms, the psychological and social consequences, treatment and recovery. It is a process in which a patient gets to learn more about mental illness in terms of symptoms, treatment and prevention of relapse, including recognizing the symptoms, understanding the onset of symptoms, as well as treatment and self-help interventions that can help him/her maintain his/her health. The goal of patient education is empowerment - intended for the patient to experience that he or she is in a position to influence their situation and manage their lives. Patient education needs to address the following topics: symptoms of illness, including recognition of early signs, possible causes, stress vulnerability, theory of disease, medication treatment, psychotherapy and psychosocial interventions, side effects of medication, recovery, treatment expectations, impact of illness on the patient's life, strategies for prevention of relapse, risk and protective factors and understanding the disease from one's own experience. During patient education, it is also important to work through the emotional aspects of going through a medical condition that include stigma, depression, guilt, shame, self-esteem, self-confidence, and hopelessness, the experience of loss accompanied by different emotions such as anxiety, depression, anger and sudden loss of sensation. Psychoeducation should also include working on stigma and discrimination, including effective strategies to eliminate self-stigma, stigma and discrimination.

Psychoeducation provides a framework for understanding illness in a psychobiosocial context and understanding the impact of protective and

risk factors that are important in preventing recurrent episodes of illness. Psychoeducation aims to teach patients and their family that there are a lot of opportunities and time for recovery. In psychoeducation, patients learn that medications, recognizing early signs of deterioration, establishing a supportive network, improving family communication, enhancing the skills needed for daily life and work, stress and anxiety reduction intervention and psychotherapy are important for recovery and that this is why they need to adhere to treatment. Information should be provided in an appropriate way that will increase understanding and encourage cooperation. For example, if a patient believes that his/her delusions are true and does not accept his/her illness, he/she should be encouraged to discuss his/her interpretation of the situation with a therapist, who needs to offer a possible alternative solution. It is inappropriate from the therapist to insist that their understanding is the only correct one, because it may not encourage the patient to change, but rather increase the patient's resistance and possibly lead to emotional arousal which may pose a risk for further deterioration and/or treatment interruption.

An essential part of informing about the disease is to convey a key message that recovery is possible and that it takes time. As part of patient education, each patient should be allowed to discuss the meaning he/she attaches to his/her diagnosis to help the patient reject the personal stereotype of mental illness. An effective psychoeducation is expected to help the patient: overcome the idea of illness as a catastrophic event, gain insight into illness, which will make them feel empowered, prevent self-stigma, embrace their identity as a person, as opposed to their identity as a patient, prevent relapse, reduce hospital admission in the future, and improve treatment adherence. In an integrated model of psychoeducation, the patient is given the opportunity to understand the symptoms of illness in the context of his/her life, to understand the symptoms at the psychological level, to be empowered through awareness that his/her actions can influence the outcome and change the negative self-image caused by identity transformation after the experience of receiving a diagnosis. When used properly, psychoeducation is a powerful tool that can change the illness trajectory, enabling the patient to stay on track on the road to recovery.

The healthy lifestyles education programme can also be part of the patient education or part of the special education as it can help improve physical and mental well-being, reduce the risk of metabolic syndrome and the related

diseases, such as diabetes and cardiovascular disease, and reduce the side effects of medicine-related weight gain. The programme includes providing recommendations on a healthy diet and physical activity and support in sticking to a treatment plan.

8.3. Working with family

Family communication has an impact on increasing or decreasing the risk of new episodes of illness, so it is important to learn about efficient ways in which the family would need to communicate, identify dysfunctional communication patterns that contribute to the risk of the onset of illness, help modify such patterns, and help the family members by giving them effective support. Different studies involving patients with different psychiatric disorders have shown that living in a tense atmosphere with the overcritical family that does not show empathy and warmth, and living in an overprotective environment given that patients are often considered unable to care for himself/herself is related to a risk of deterioration of the patient's mental and physical health. It is important to note, however, that these communication patterns have a negative impact on overall health and may be observed in patients and families affected by all kinds of diseases, including physical illness. The relationship between relapse risk and the therapeutic environments in which these emotions are prevalent has also been found. Therefore, professionals need to be trained on how to prevent this communication pattern and change the way in which families communicate. The described family communication pattern is known as high expressed emotion factor - EE factor.

One of the goals of working with families with high EE factor is to identify dysfunctional communication patterns, make the families understand such patterns so that they can try to change them through learning from a therapist's demonstration model, which is expected to reduce family stress, facilitate conflict resolution and consequently reduce the risk of the patient's mental health deterioration, and improve the mental health of other family members.

Dysfunctional communication in the family is associated with high stress levels, which in turn poses a risk for recurrent episodes of illness and prevents recovery, so working with the family needs to be included in the patient's individual treatment plan. Medications can help reduce stress response,

however, it may not be enough because it cannot affect dysfunctional family communication patterns, which is a constant source of stress.

The goal of family communication skills training is to break negative patterns of communication, introduce active listening and empathy, and learn how to balance criticism and praise. The goal is make the family members understand their communication patterns and to acknowledge them for what they do well. Adopting those skills will help the family communicate better, which will reduce the risk of deteriorating mental health and reduce the family's emotional burden of having an ill family member. Working with family involves patient and family education, working on communication skills, conflict resolution, and dealing with stigma. The goal of working with families is to optimize the capacity of family members to support the patient, as well as to get help for themselves when they need it.

Working with families can be done individually, at home and in groups, with patients, or without them.

8.4. Social skills training

Social skills are learned forms of behaviour, that is to say, mastered skills. Social skills are groups of skills that people need to better interact and communicate with other people. Social skills training (SST) uses behavioural learning techniques in teaching of skills in the areas of self-care, interpersonal relationships, and societal expectations. Goals include improving social performance, reducing stress and difficulties in social situations, and improving functioning in different social roles (for example, family, work, community). Social skills training is specifically structured to address the needs of people with mental disorders and those who are socially dysfunctional and face many barriers in leading an independent life, from basic self-care to more complex interactions with people and fulfilling other roles in life. Social skills training is an active-directive therapy that helps patients achieve their physical, emotional, social, work, family and intellectual skills necessary to live, learn and work in the community, to increase their independence and quality of life. Social skills training can be delivered individually, in groups and with family members. This training aims to train people with mental disorders to better cope with and function in everyday situations. Social skills training involves filling skill gaps. Specific situations require specific skills, so social skills

can be easily explained by describing a situation, such as showing positive or negative emotions in a situation where they do not need to fear losing social support. Social skills include the ability to analyse the situation and a set of appropriate responses. When planning an interpersonal interaction, a socially skilled person will analyse the situation and know when, where and how to structure their response. This combination of attention, analytical skills and knowledge is what we call social perception.

Social skills training helps develop social skills and self-confidence, improve coping skills in social situations, reduce social stress and improve quality of life. Lack of social skills in patients with mental disorders, especially when accompanied by serious functioning impairment, is associated with functioning impairment in different interpersonal communication situations, including communication with the family. These difficulties affect all areas of life such as self-care, work, family, and leisure and community participation.

Social skills are associated with maintaining one's health - a socially skilled person will be able to communicate with others by fulfilling his or her needs, rights and wishes and contribute to building stronger relationships and achieving personal satisfaction and self-actualization at a personal level.

Some of the most common social skills taught in group social skills training are self-presentation, active listening, empathy, assertive training, friendship, problem-solving, self-control, expressing feelings, expressing gratitude, receiving and giving compliments, making decisions, setting goals, making a request, and understanding the conversation. A person may have problems with social skills regardless of a diagnosis, for example, people treated for depression often have problems with assertiveness or organising satisfactory leisure activities. People with schizophrenia have a poor social perception. Good social perception requires quick identification of non-verbal and verbal changes in communication. A person with schizophrenia may have difficulties with interpreting the situation as they need to process and memorize different types of information, integrate it with previous experience, and make a decision about when to interact with others. Daily living skills include the ability to perform daily routines such as taking care of one's hygiene, safety and housing, paying utility bills, shopping, eating, etc.

Life skills training is usually recommended to persons with low self-care skills, who have difficulties in carrying out their daily activities, and those who are dependent on other people's help. Considering the degree of

functional impairment in self-care, life skills training covers the following areas: self-care - appearance, taking one's medications as prescribed, essential skills - understanding written instructions, using the phone book, taking care of home security, learning how to call emergency medical services, how to use public transport, cooking and shopping, taking care of one's finances, budgeting according to the income, adequate use of leisure time.

The goal of social skills training is to increase social competence, which is enhanced by identifying relevant social cues that guide a person towards choosing the appropriate response or behaviour in a social situation, such as determining which person will most likely react positively if they choose to approach him/her. The goal of social skills training is to improve the level of functioning in social situations by knowing how to behave in a socially acceptable/appropriate way and by recognizing the context in which our response is expected, which falls into a category of social competence. Social skills training will be recommended to persons diagnosed with mental disorders who have problems with communication, functioning in different roles, social isolation, which makes it difficult for them to achieve personal goals that would contribute to recovery and satisfactory levels of social inclusion in the community where they live and where they belong. To join social skills training, the person must be able to follow directions and have enough concentration to focus on the training process. Social skills training starts with the assessment and analysis of individual social skills in different areas of functioning that are important in everyday functioning and living in the community. Training is conducted through the systematic rehearsal of specific behaviours, necessary to succeed in social interactions. For example, learning a skill can focus on identifying non-verbal social cues by improving specific behaviours, such as speaking louder or, for example, the ability to start a conversation when being introduced to someone.

The goal is to teach the patient to integrate new skills into their normal behaviour, making the skill automatic and spontaneous. Skills are learned through a combination of therapist demonstrations that serve as a model for interactions, videos, role-play, positive reinforcement and corrective feedback, and homework assignments practised between the sessions to be done at home or temporary place of residence (such as a hospital). Using video in teaching social skills can be very helpful for corrective feedback as the patient can directly observe their behaviour and monitor changes in behaviour.

Behavioural rehearsal is practised individually, most commonly in a group, in the role-playing format. Skills important for each patient in different social situations are practised, such as starting a conversation with a neighbour, or making positive requests. Besides the therapist and the patient who work together on a specific skill, a co-therapist, who may also be a patient who is good at the skill that is being taught, will also take part in a role-play. Social skills training can be delivered individually, but is usually conducted in small groups of 6 to 8 patients. Groups larger than that are not recommended because patients will not have enough chance to actively participate.

8.5. Case management

Case management is a treatment approach for persons who have long-term functioning difficulties that may be a major barrier to recovery. Most commonly, case management programmes are offered to patients affected by disorders such as schizophrenia, bipolar disorder, and other disorders that fit into the definition of a serious mental illness. When remission is not achieved, a person has impairments in different areas of functioning. To get started on their road to recovery, he/she needs assistance from other services besides mental health services, such as social care and employment services. Assistance includes home visits, comprehensive assessment of care and social needs, coordination of different services within the mental health services system and other necessary services. The patient gets help to achieve his or her personal goals and to start his or her journey to recovery. The key person in the case management system is a care coordinator - known as case manager who takes on responsibility for long-term supportive therapeutic relationship, regardless of the patient's location and other services involved in patient's care. Case manager's function is to help the patient identify and ensure inner and outer resources required for independent living in the community. The case manager is involved in all aspects of the patient's physical and social environment, including housing, psychiatric treatment, health care, benefits, transportation, family and social environment (Kanter, 1989).

The case management model was first established in the United States between 1960 and 1970, parallel with the closure of large psychiatric facilities, when it was found that discharged patients had self-care difficulties, that they hesitated to seek psychiatric help, they had poor treatment adherence and

experienced difficulties maintaining continuity of care, and that community services required for treatment did not exist.

Assertive Community Treatment **(ACT**) was developed to treat poorly cooperative patients with frequent hospitalizations. It stands for intensive treatment in the patient's home. It involves a multidisciplinary team, most commonly including a nurse, occupational therapist, social worker, psychologist and psychiatrist, providing treatment outside mental health facilities, in patient's natural environment, at home or in community, instead of the doctor's office or hospital. The usual number of patients per case manager is 10, per team member. This model offers training in activities of daily living, symptom control, medication, therapeutic support, family education, 24/7 care and the possibility of unlimited treatment duration. The team has full responsibility for patients' treatment. In practice, there are big differences in the actual implementation of this model due to financial restrictions, practitioners' reluctance to work in a community-based settings, and other factors. Assertive case management is used in different forms, so one of its variations is a Dutch model of flexible mobile teams.

Efficiency of case management has been confirmed in various studies. Best researched is the effectiveness of the assertive model. Case management significantly reduces the number of days spent in the hospital and increases the quality of life. Success of the assertive model is associated with a case manager - patient relationship, continuity of care, treatment adherence, good multidisciplinary team and psychiatrists having to work as part of a wider team, applying psychobiosocial model approach to illness and treatment.

Case managers can come from a variety of fields and professions given that none has been shown to be superior to another. Case management is not a profession, but a specialized practice in a specific field. Therefore, case managers come from different backgrounds within health professions, including nurses, social workers, psychologists or occupational therapists.

The number of patients served per case manager depends on care needs and the organization of the mental health service. For example, in the *Assertive Outreach Team* model in the UK, in serving uncooperative patients who mostly receive assertive outreach, the number of patients served per case manager should be no more than fifteen. If the number of patients served per case manager exceeds those recommended, research has shown negative reactions among case managers, which in turn negatively affects the patients.

8.6. Supported employment

Supported employment (SE) is an evidence-based practice designed to promote employment for people with serious mental illness (SMI). Supported employment is a psychosocial method adapted for people with serious mental illness. It emphasizes collaboration between employment and mental health services, rapid job search, individualized access, and available support at work. In this approach, supportive employment professionals are part of the patient's treatment team. The goal of supported employment is to help the person with SMI get a competitive job in the community. Unlike more traditional approaches to occupational rehabilitation (e.g. the Clubhouse model, transitional employment), the employment in this model is arranged in specific work environments.

Fundamental principles of Individual Placement and Support (IPS) include rapid job search, integration with mental health services, and time-unlimited support.

8.7. Stress management

Stress management includes a range of techniques for dealing with stress, particularly chronic stress, to improve daily functioning. Stress management procedures include better planning, such as better organization, time planning, conflict resolution, problem solving, self-assertive behaviour, etc. It also includes breathing exercises, progressive muscle relaxation, autogenic training, meditation and physical activity, or healthy lifestyles that include active rest in addition to physical activity and a healthy diet.

8.8. Cognitive remediation for schizophrenia

Cognitive functions such as executive functions, learning and memory, data processing speed, and attention maintenance are often impaired and cause functional impairments in schizophrenic patients, and adversely affect functioning in different roles, such as the role of an employee. Cognitive remediation (CR) or cognitive rehabilitation procedures are designed to enhance cognitive function through repetitive practice of cognitive tasks. CR interventions are typically time-limited. They can be conducted individually or in

groups. Some involve the use of computers while others focus on paper-and-pencil tasks. Research has shown the efficiency of CR, but whether these improvements are sustained or whether they translate into improved functioning remains unclear.

8.9. The therapeutic community

The therapeutic community is a group method and milieu of therapy that uses socio-therapeutic and group psychotherapy techniques in the treatment of patients with different psychiatric disorders. The therapeutic communities are small cohesive communities in which all members have significant involvement in decision-making and the practicalities of running the unit. It can be used in hospital wards, in day care centres, day hospitals, residential care facilities, or in other settings where patients and staff interact formally and informally. Key principles include collective responsibility, a shared sense of belonging to a group and empowerment, structured in a way that deliberately encourages personal responsibility and discourages unhelpful dependency on professionals. The belief in the flattening of hierarchies and delegated decision-making should not be confused with anarchy. However, staff in therapeutic communities are deeply aware of the need for strong leadership and their responsibility to provide a safe 'frame' for therapeutic work. Although the voice of all members of the community is taken into account in decision-making, the reality and clarity on boundaries must be kept in mind as regards democratic decision-making and staff accountability to provide a safe 'frame' for therapeutic work.

Maxwell Jones is considered the "founding father of the therapeutic community" who developed a method of group therapy that can be used to treat people with different psychiatric disorders, primarily using social learning principles. One of the fundamental principles of the therapeutic community is the culture of enquiry, which means that all members are encouraged to ask questions and to be curious about themselves, each other, the staff, the management structure, psychological processes, the group process, and relationships within the community. This principle involves an open questioning attitude, so that everyone, not just the staff, is involved in the process of psychological understanding. Symptoms of illness or behavioural disorders in therapeutic communities are considered problems of an individual in his/

her relationship with other people. Therapy is a learning process, learning new skills on how to connect with others, better understanding self and others, and better coping with stress.

Rapoport outlined four defining and interconnected therapeutic community principles:

1. Democratization: every member of the community and staff has equal opportunities to participate in organizing a therapeutic community.
2. Permissiveness: members are free to express their thoughts and feelings without negative consequences (in terms of punishment or censorship).
3. Communalism: direct communication and free interaction in creating a sense of sharing and belonging.
4. Reality confrontation: members can and must be constantly confronted with their image (and its consequential effect), as perceived by other members of the community and staff.

Permissiveness is usually limited to verbal expression of feelings, but it needs to be ensured that other members of the community are not emotionally hurt and that their feelings are not neglected.

For many patients, the process of "primary emotional development" has gone seriously wrong in the therapeutic communities, with abuse, trauma, neglect, deprivation and loss disturbing the network of interpersonal relationships. Therapeutic communities, by recreating these conditions, can facilitate "secondary emotional development", where things that went wrong can be re-experienced and worked on, leaving members stronger and more insightful.

Attachment theory helps understand patients lacking 'basic trust', due to which they find it difficult to express their frustration constructively. A safe frame and structure of the therapeutic community both help the patients get to know themselves better and find more constructive ways of dealing with emotional problems. The specificity of the therapeutic community is to enable therapeutic change through "learning by living": everything that happens between members of the community during time they spend together, especially at a time of crisis, is used as an opportunity to learn, as well as a culture of enquiry: through conscious identification and questioning dogma or universally accepted opinions. A central part of a therapeutic community is a special meeting that aims to share as much information as possible in a large group so that it is available to everyone. Special meetings are important in establishing

open communication in which individuals can resort to reality testing of certain situations and events, to reduce suspicion and encourage emotional expression. In the event of a crisis, meetings can be held at any time. Open communication and reflection on feelings, instead of impulsive action, help empower the super-ego and improve impulse control. Therefore, the therapeutic community provides a range of situations that are similar to real-life situations in which the difficulties experienced by the community members in their earlier relationships are re-experienced, and such problems can be worked on in small groups and special meetings to learn from them and adopt new behavioural models. For the therapeutic community to work as a therapeutic method, all of its components must work well together. The therapeutic community as a therapeutic environment that includes therapy sessions, psychotherapy and support groups, a structured daily schedule, member interactions, clear rules and boundaries allows for strong attachment that helps overcome high levels of aggression and change dysfunctional behavioural patterns while maintaining at least some level of independence. Given that, without adequate psychosocial therapy, patients often become frequent users of health care services, therapeutic communities play an important part in organizing the therapeutic environment of different mental health services.

CONCLUSION

Rehabilitation means the therapeutic process of encouraging and building skills for everyday life and work. It works with persons who have functional impairments based on an individual rehabilitation plan that includes a selection of different psychosocial methods.

Psychosocial treatment methods include a range of psychosocial interventions to improve the patient's daily living and working skills, empower them and encourage recovery from mental illness, as well as provide support for activities they cannot do independently.

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9. SUPPORTIVE PSYCHOTHERAPY

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Supportive psychotherapy was neglected and regarded as the "Cinderella" of psychotherapies for decades, but in recent years, there has been increasing talk of supportive psychotherapy and it may be about to make a comeback. The reason for this lies in the fact that it has a broader scope of application, it is often short and incurs lower costs. Supportive psychotherapy can be very beneficial for a wide range of psychiatric disorders, it is used as the treatment of choice for people with severe and serious psychiatric disorders (psychotic disorders), mood disorders, anxiety disorders, transient disorders, crises, and mental health problems in patients with physical illnesses. Psychoanalytic psychotherapies take a lot of time, offer relative recovery, and require a serious effort on the part of both psychotherapists and patients, which often make them inaccessible to many users.

Due to its broad applicability, supportive psychotherapy training is nowadays part of the training programme for psychiatrists, as well as other mental health professionals.

9.1. Definition

There are many definitions of this therapeutic technique. According to Knight, supportive psychotherapy is a superficial therapeutic technique that uses techniques of persuasion, suggestion, counselling, and education for patients with a fragile self. According to the dictionary definition of supportive psychotherapy, it is a type of psychotherapy that seeks to reduce psychological conflict and strengthen a patient's defences through the use of various techniques, such as reassurance, suggestion, counselling, and reeducation. According to Pinkser and Rosenthal, this is a technique in which the dyadic relationship aims to reduce symptoms, improve and maintain self-esteem,

adaptive skills and psychological functions. It is a therapy in which the therapist generally plays a more active and direct role in helping the patient improve his or her social functioning and coping skills. The goal is to enhance behaviour and subjective feelings which is then followed by gaining insight and understanding.

Difference between supportive psychotherapy and other forms of psychotherapy

What sets it apart from hundreds of other psychotherapy techniques is that it does not have a unique underlying theoretical concept, but it rather uses different empirically validated techniques.

Supportive therapy is practical and "down to earth", aimed at solving daily, but important problems and difficulties in our patients' lives. The therapist is far more active, he or she asks questions, makes suggestions and remarks, he or she praises and guides the patient, etc. A good supportive therapist believes in and demonstrates common sense and mutual respect.

Described in this way, it may seem superficial and less demanding than analytical therapies, while in fact, supportive psychotherapy requires a sound knowledge of the theoretical and practical framework. It requires a well-developed psychodynamic formulation about the patient as well as a very good knowledge of the various techniques and their use. This is why some authors argue that supportive therapy is probably more difficult to perform.

The key differences between supportive and insight-oriented psychotherapy techniques are not tied into their theoretical background and theoretical understanding, but rather in their goals, therapeutic strategies, and tactics. Good implementation of supportive therapy must be based on sound knowledge and understanding of psychodynamic and psychoanalytic theories and therapies. We should not lose sight of the fact that in every analytically oriented therapy there are elements of supportive therapy, and any supportive therapy has some elements of insight-oriented techniques. Each psychotherapy contains a mix of supportive and exploratory interventions; the ultimately prevailing technique will depend on the level of organization of the patient's psychic apparatus, his or her motivation, and capacity for insight, ego strengths and weaknesses, levels of anxiety, regression and disorganization.

Supportive psychotherapy is eclectic psychotherapy whose theoretical foundation does not have strong ties to any school of thought. In supportive psychotherapy, the clinician uses the technique that best suits a patient's needs at the right time. The clinician uses different techniques derived from

psychodynamic, cognitive, behavioural, interpersonal and/or experiential psychotherapy.

The negative attitudes towards supportive therapy stem from the belief that it is used for patients who cannot benefit from therapy, or those who cannot afford demanding long-term therapy, and that it is used in patients with severe mental illness. Such beliefs stem from ignorance of the basic principles of supportive psychotherapy that can be applied to highly functional persons who are experiencing some kind of crisis or find it difficult to cope with physical illness, etc.

9.1.1. Types of supportive psychotherapy

By the ratio of incorporated specific techniques, supportive therapies may include therapies ranging from the supportive relationship, counselling, supportive psychotherapy, supportive-expressive psychotherapy, and expressive-supportive to psychoanalytic psychotherapy. A supportive relationship is a relationship of support and optimism that we create with family members, colleagues, and friends. It is by no means considered to be therapy. Supportive psychotherapy is a therapy aimed at reducing symptoms, rebuilding, boosting and improving self-esteem, ego functions and ego adaptive mechanisms.

A historical overview

Elements and techniques of supportive psychotherapy were first described in ancient times by ancient Greek philosophers, who described counselling and support in a crisis, as well as other techniques used in people with mental illness. From a historical perspective, Pinel, a French psychiatrist who pioneered in the humane treatment of the mentally ill in the 18th century, played a major role in developing a supportive attitude towards patients. This development continued in the work of Benjamin Rush, the founder of modern American psychiatry, who emphasized the importance of patient counselling and education in addition to biological treatment. In the late 19th and early 20th centuries, suggestion and hypnosis were introduced into therapy, while Alexander and French emphasized the importance of corrective emotional experience, which paved the way for the development of behavioural therapies and solution-focused (brief) therapy. In his work during the 1950s, Gill pointed to the fact that, in some patients, interpretation of defences would cause unwanted regression and anxiety. Therefore, behavioural support for adaptive

defences is recommended to these patients. A similar approach was advocated by Hartman, the founder of ego psychology.

Goals

Essentially, the primary goals of supportive psychotherapy are to promote a supportive relationship between the therapist and the patient; enhance the patient's inner strength, coping skills and ability to use environmental support; reduce subjective stress and dysfunctional behaviours; to achieve the highest degree of patient independence, reduce the impact of the disease on his or her functioning and allow him or her to make decisions with a maximum of autonomy during treatment. Less common goals are to gain insight and self-awareness, to explore interpersonal experiences, to explore and understand inner psychological experiences, to resolve internal intrapsychic conflicts, to restructure the personality.

The most important goal of a supportive psychotherapist is to strengthen and maintain a positive therapeutic alliance with the patient throughout the treatment. This kind of relationship is like the relationship between a good parent and a child, which does not mean that the therapist should love the patient, agree with him or approve all his thoughts, feelings, beliefs and behaviours.

The goals are adjusted according to the type of problems the patient is facing and the stage of treatment. Examples of these goals are: resolving acute stressful or crisis situations (grieving, suicide attempts, crises related to physical illness), treatment adherence in pharmacotherapy and other types of treatment, reducing inappropriate behaviours, improving social skills, improving conflict management skills, hospital admission and relapse prevention, improved reality testing, maximizing family and social support, etc. Another important goal is to instil a sense of authenticity and uniqueness in the patient.

Whom is supportive psychotherapy intended for?

Supportive psychotherapy is intended for a very wide range of patients. People with psychotic disorders (schizophrenia, schizoid personality disorder, persistent delusional disorder), mood disorders (depression, bipolar affective disorder), personality disorders, anxiety disorders, and disorders related to stress and crises can benefit most from appropriately used supportive psychotherapy.

9.1.2. Conducting supportive psychotherapy

When conducting supportive psychotherapy, the therapist needs to shed light on the psychodynamic organization of the patient's personality, ego function and strengths, defence mechanisms, superego, level of conflict, quality of object relations, and only then set specific goals.

In doing so, the goals of supportive therapy for each individual should be borne in mind, as well as the techniques necessary to achieve those goals. During the course of therapy, the therapist must be aware of the characteristics of transference and countertransference to understand the patient's specific characteristics, but use them only if necessary.

As mentioned earlier, a positive therapeutic alliance in which the therapist plays the role of a good parent is of great importance. This type of relationship reveals the regressive characteristics of psychiatric patients, and they, at least in some spheres of function, often think, feel, or behave like children, rather than as adults. Therefore, supportive therapy has proven effective in improving reality testing, problem solving, affect modulation, impulse control, or interpersonal relations. The supportive therapist therefore assumes a parental role with respect to the patient.

According to Mish, the basic strategies of supportive psychotherapy are:

1. Formulate the case
2. Be a good parent - The relationship that has been previously discussed plays an important role in supportive psychotherapy. The therapist is friendly, parental, flexible, creative, and, above all, human. The therapist must respect the patient as a person—a person who, at least at some level, is struggling with the same life issues as is everyone else, mentally healthy and unhealthy alike. The supportive therapist must couple this respect with compassion, empathy, and commitment.
3. Supportive therapists do not interpret the transference, they manage it. Positive transference is used to foster the therapeutic alliance and to instil more adaptive behavioural patterns in the patient. Negative transference is not interpreted or connected to the past, it should be minimized and neutralized to the highest extent possible. Supportive therapist need to help patients make the association between negative transference and a situation in the real world that triggered transference. For example, if the patient

gets upset about the therapist's running late for the session, the therapist needs to apologize and give the reason for being late.

4. Fostering and protecting the therapeutic alliance is very important in supportive psychotherapy. The therapist's task is to locate and identify the healthy parts of the patient and ally with them or enlist them in the service of the patient's goals. The therapist needs to try to use the patient's observing ego as an ally. The term observing ego refers to an individual's ability to step back, get some distance or perspective, and observe himself as he would a friend or family member.
5. The therapist needs to allow the patient to openly express their feelings, fears, symptoms and hold and contain them by providing empathy and understanding. Holding and containing may also include working to channel the patient's impulsivity and improve affect modulation. Sometimes, containment may also mean the need to protect the patient from his or her suicidal or homicidal ideation, by introducing interventions such as medications. Similarly, a therapist may need to call a family member, co-worker, social service agencies and health facilities. Sometimes, the patient may even require hospitalization. However, it is important to protect his or her autonomy as much as possible. As soon as the patient is able to regain control, the therapist should relinquish control in those domains.
6. Sometimes the patient will need to "borrow a psychic structure" from the therapist. In effect, the patient is encouraged to think like the therapist, who presumably represents a good role model for mental health. This is especially the case when the patient has difficulties with reality testing, impulse control and affect modulation. Other important ego functions that may be lent include problem analysis and solving and the functions subsumed under the term of "emotional intelligence", which include empathy and social skills.
7. Encourage and maximize coping strategies and adaptive defence mechanisms. These mechanisms include intellectualization, rationalization, humour, anticipation, altruism, and sublimation. In contrast, maladaptive defence mechanisms include projection and projective identification, denial, splitting and acting out. Examples of useful strategies include hanging out with friends, going for a walk, applying relaxation techniques, speaking with a therapist. The supportive therapist can enhance a patient's coping skills through education about specific mechanisms for dealing with

stressful situations, such as mindfulness, interpersonal effectiveness, and distress tolerance skills.

8. The therapist needs to provide a role model for identification, which does not mean that the patient needs to learn personal details about the therapist, but is offered the opportunity to adopt more adaptive behavioural patterns, especially with respect to reality testing, impulse control, affect modulation, interpersonal interactions, and problem solving. The idea is not to present the therapist as a perfect human being, but to set an example of how the therapist handles anger, confusion, failure, disappointment, etc.
9. Decreasing alexithymia means to allow the patient to experience emotions, to help the patient verbally label and recognize what he or she is feeling. The inability to verbally label what he or she is feeling (alexithymia) is a big problem because such patients cannot make connections between feelings to events in their environment, or their own and other people's behaviour. The inability to verbally label what he or she is feeling is connected with the inability to experience emotions and share them with others. Some patients benefit from a written list of feelings, others begin to recognize and label their feelings by concentrating on somatic sensations associated with particular affects, while some patients find it helpful to describe their emotions in terms of metaphors relevant to their state of mind.
10. Making connections between one's thoughts and feelings is also an important basic principle of supportive psychotherapy. Making connections between feelings and thoughts and events is a common problem for patients with mental health problems. There are many patients, more severely impaired, who are unable to make the association between an event or situation in the real world and their thoughts and feelings. For these individuals, feelings often seem to come out of nowhere, and they feel affectively helpless and out of control. Teaching patients how to make a connection between feelings and events through everyday life examples helps the patient to recognize the source of affects and to specifically target areas for helpful intervention. (For example, we can help the patient understand that he or she is sad because they won't be hanging out with friends as they expected, or because he or she has just learned that their friend is seriously ill). This principle, enshrined in cognitive therapy, can help the patient learn how to identify the underlying automatic thoughts and core beliefs that lead to unpleasant affects by using the basic cognitive

therapy techniques. This often helps patients gain a greater sense of control. A fundamental connection that is often deficient in personality-disordered and other severely psychologically impaired individuals is that between their behaviour and the way in which others respond to them. In such cases the therapist might say, for instance, "Perhaps so many people are angry with you because you provoke them in some way." Such confrontations must be done sensitively, empathically, and tactfully. The ultimate result is a change in locus of control from external to internal, a heightened sense of personal responsibility, and relief on the part of the patient at actually having some control over the way in which the world responds to him or her.

11. Raising the patient's self-esteem by encouraging employment and helping him/her normalize his/her thoughts, feelings and behaviour.
12. Ameliorate hopelessness that often occurs in people with mental illness can be achieved by using cognitive behavioural therapy techniques. With these, the patient can remove the blinders, learn that there are more options available, and increase their hope for the future. Discussing negative cognitive distortions and reinforcing a new way of thinking can be very useful in this situation. Reframing is an important technique, which gives the patient a new framework and helps set new behavioural goals. The patient's bitter struggle with her parents will then be reframed as an attempt to obtain the entirely legitimate goal of adult autonomy and taking responsibility and control over her own live. The therapist may also take further steps through direct environmental manipulation by helping a patient obtain disability status, get retired or find a job. All this contributes to the patient's increased optimism about the future.
13. Focus on the here and now. The primary focus should be on the following questions regarding the patient's current condition. How is the patient feeling? How is the patient getting along with family, with friends? How is the patient getting along with co-workers? Does a patient have any problems (financial or health problems)? How does the patient tolerate pharmacotherapy? Have there been any side effects? Using these questions will help shed some light on how the patient is doing and what should be the focus of therapy. It is often helpful for the therapist to detect a "hierarchy of primary targets" or a "hierarchy of thematic priority". At the top of such lists are threats to physical safety of the patient or others, such as suicidal or homicidal thoughts or behaviours. Therefore, it is important to detect

all behaviours that present an obstacle to successful therapy, such as treatment noncompliance, terminating the therapy and/or negative transference. Focusing on the here and now can help improve the patient's relationships with others, improve reality testing, change some negative attitudes, etc.

14. Encourage patient activity. Even if changing the attitude is encouraged during therapy, adopting new ways of thinking is a crucial step in encouraging the patient to become active. It is important to set achievable and operationalized goals whose achievement significantly contributes to a sense of the patient's importance and improved their self-confidence and self-esteem. The supportive therapist can assist the patient in every step of the way in getting a job; finding the right job, choosing their clothes, writing a CV, etc. The seemingly overwhelming task is thus broken down into smaller, achievable goals. The supportive therapist, like a good parent, should assess the patient's current psychological state and capacities, pondering when the patient should venture forth into a new or difficult experience. Behavioural approaches — behavioural rehearsal, role playing, relaxation, graded exposure, visualization and imagery, and so forth — are often the most useful in helping the patient to reach his or her goals. In terms of encouraging the patient to be active and experiment with new ways of thinking, feeling, or behaving, it is helpful to emphasize patience ("Everything in its time and place" or "Rome wasn't built in a day"), persistence ("Winners never quit and quitters never win"), and practice ("Practice makes perfect"). In doing so, the patient will need constant support and assistance.

15. Educate the patient and family. Every psychotherapy includes some educational elements, and education is a large and important part of the supportive therapist's work. Education takes place on several levels, on different topics. It is very beneficial to educate the patient and his family about the illness and disorder, its nature, duration, early symptoms, and treatment. Special attention should be directed towards precipitants of exacerbations, such as psychological stress, alcohol and substance use, as well as premonitory symptoms that presage impending decompensation. If the patient is prescribed medications, he or she should be educated with respect to indications for the pharmacologic intervention, side effects, importance of taking medications and risks related to premature termination of therapy. The therapist may also educate the patient with respect to impulse control

and modulating affect, which has been previously discussed. It is helpful to involve family, friends, or co-workers in helping and supporting the patient. At the same time, the patient's autonomy and confidentiality must be respected. Except in cases of emergency, the therapist should ask the patient's explicit permission to speak with others about his or her case.

16. Manipulating the environment is a fundamental principle applied in supportive therapy as opposed to analytically oriented psychotherapy. The supportive therapist may intervene in the environment around the patient to help him/her. For example, the therapist may speak to the patient's family to explain the patient's condition, and to foster better understanding and relationship. The therapist may also speak with the patient's employer or co-workers, perhaps even communicate with the court system or social security office to provide the help that is needed.

CONCLUSION

Supportive psychotherapy was neglected and regarded as the "Cinderella" of psychotherapies for decades, but in recent years, there has been increasing talk of supportive psychotherapy and it may be about to make a comeback. The goals of supportive psychotherapy are to reduce symptoms, improve subjective feelings and self-esteem, reduce stress, and improve adaptive mechanisms. It is a therapy in which the therapist generally plays a more active and direct role in helping the patient improve his or her social functioning and coping skills. What sets it apart from hundreds of other psychotherapy techniques is that it does not have a unique underlying theoretical concept, but it rather uses different empirically validated techniques. Supportive psychotherapy is eclectic psychotherapy whose techniques stem from psychodynamic, cognitive, behavioural, interpersonal, and/or experiential psychotherapy. It is intended for a very wide range of patients. People with psychotic disorders (schizophrenia, schizoid personality disorder, persistent delusional disorder), mood disorders (depression, bipolar affective disorder), personality disorders, anxiety disorders, and disorders related to stress and crisis benefit most from supportive psychotherapy interventions, when used appropriately.

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10. THE ORGANIZATION OF CARE FOR PERSONS WITH MENTAL ILLNESS: COMMUNITY MENTAL HEALTH

Rene Keet

10.1. The organization of care for persons with severe mental illness

PREFACE

Psychotic disorders are the most prevalent disorder in people with a severe mental illness. Going through one or more psychoses goes hand in hand with serious limitations in social and/or social functioning. Research has shown that 86% of people with a psychotic disorder are unable to recover socially. They keep dealing with problems in the area of living and self-care, work, training or meaningful daytime activities and social contacts. This is a social problem that requires a broad social approach. Mental Health Care can be expected to make a contribution to recovery in a broad context.

Coordinated care provided by professional care providers in care networks can prevent and help restore limitations in social and social functioning. That is why the focus in the organization of care is not only on treating psychotic and comorbid disorders, but also on preventing and limiting deterioration in social and social functioning. A good healthcare organization helps contribute to this.

10.1.1. Network psychiatry

For the organization of care, the Flexible Assertive Community Treatment model (F-ACT) is an appropriate model for (ambulatory) teams. These are multidisciplinary teams that meet on a daily basis to discuss those patients for which the entire team is responsible, they can upscale care at all times, set out to see patients in their own environment (assertive outreach) and integrate medical and social interventions. F-ACT teams form a network with relevant organizations and individuals in society. The ambulatory F-ACT teams work

closely together in a Mental Health Care network with hospitals. In this network, an admission to a psychiatric hospital is an intermezzo in the ambulatory treatment. There are no fundamental differences in the organization of care for people with psychosis in different stages of illness. There are, however, differences in focus in the care of people in different phases. We distinguish three groups: ultra-high risk (UHR), early psychosis treatment and care for people with long-term and recurring psychoses.

Ultra-high risk

Ultra-high risk refers to a group of young people who have not been diagnosed yet, but who have subclinical symptoms or a genetic burden. This cannot be reliably determined in the general adolescent population. This results in too many false-positive identifications. Screening within the Mental Health Care is a good strategy and therefore belongs to the care organization of every organization.

Early psychosis

The focus of the care organization for early psychosis is put on treating and promoting good development of social functioning. This way, the development of a serious mental illness with a limitation of social and social functioning can be prevented.

Mental Health Care cannot do this alone and requires good cooperation with the client and his informal network, the municipality, the general practitioner and other relevant stakeholders.

This requires doing the right thing together at the right time (right at once), less iatrogenic damage caused by long waiting lists or unnecessary internal referrals, prevention and early detection, doing the right interventions in childhood, adequate cooperation in the network (within the organization and beyond).

Some organizations have separate teams for the treatment of people with early psychosis (so-called Early Intervention Services). The other organizations integrate this within the community mental health teams. In both cases, care organizations must provide an attractive group offer aimed at adolescents and young adults. Young peer experts who have experienced psychosis can serve as a role model and offer hope that recovery is possible. Social functioning support is both about support in getting and keeping a job, and about completing or starting a training.

Recurring and long-lasting psychosis

With long-term and recurring psychotic episodes, the focus is put on treatment and improving social functioning. This requires a strong multidisciplinary approach, with knowledge of the treatment guidelines. The organization must make it possible for the biological, psychological and social interventions as described in the treatment guidelines to actually be carried out. It also requires a good network organization within Mental Health Care. Recurring psychotic episodes are rarely isolated. Disorders that can greatly contribute to a chronic course are autism, personality disorder, addiction, intellectual disabilities and trauma. The expertise in these domains often lies with other components than the team that treats people with psychosis. In that case, a network organization that easily discloses this expertise is decisive.

If FACT care for this target group is insufficient or if recovery is stagnating, it may be considered to add residential care to FACT. This can be done in different intensities: assisted independent living, protected living or clinical living. In this way, more attention can be paid to daily life and the basic needs of the client. The ART care model that has recently been developed for this (Active Recovery Triad) helps develop that seamlessly and connects with the FACT model.

The aim here is also to provide as ambulatory treatment as possible, in which the client is constantly sought for as much control as possible.

10.2. Community mental health

Community mental health is the integrated approach to mental health that uses social resources to ensure that people with mental health problems have the right to accessible care and is supported in their own environment to work on their recovery. Community mental health as we know it today was a response to the closure of psychiatric hospitals and the transfer of care to outpatient settings. Two phases can be distinguished here. The first, from 1950-1980, was a silent revolution, characterized by the setting up of multidisciplinary teams. The second phase began in 1980 with the publication of the study into assertive community treatment. More attention was paid to human rights, participation in social life and a multidisciplinary and multisectoral approach. The recovery vision subsequently triggered a

paradigm shift in the vision of health and the role of the professional. The patient became a partner in the organization of care.

In Europe there has been a network of European Community Mental Health Service providers since 2015 (EuCoMS, www.eucoms.net). In a consensus document, this network describes community mental health from 6 perspectives (EUCOMS, 2017). In this chapter we will describe these perspectives and discuss the implications for healthcare organizations in the Dutch context.

The perspectives are:

- Ethics
- Public Health
- Recovery
- Effective treatment
- Community network of care
- Experience Expertise

10.2.1. Ethics

The ethical perspective has been on the agenda for decades. A visible start of this was the publication of the book “Asylums” by Goffman in 1961, which discussed whether psychiatric institutions offered protection, or they rather became the organizations that have placed people who are already struggling in an even more debilitating environment. The process of de-institutionalization and socialization is thus underpinned by the ethical perspective that mental health organizations are there to protect human rights and not to violate them.

The use of coercion in Mental Health Care is common and controversial. It is applied without substantiation of effectiveness. The ethical perspective is about more than relinquishing coercion and imprisonment of people. In 2006, the United Nations formulated the Convention of the Rights of Persons with Disabilities (CRPD; UN General Assembly, 2007). This convention describes the right of people with mental health problems to participate in the full social life, and in this context names among others the right to education, health, work, housing and social protection. However, access to work is limited and life expectancy is 10-25 years shorter, with no prospect of improvement.

Table 1. Ethics: Implications for health care organization

Theme	Organization of care
Coercion	
1. Coercive treatment	• Approach coercion as iatrogenic damage and therefore always weigh up the damage done with and without coercion • Evaluating the use of coercion as a failure to timely identify a hazard • Evaluate and monitor the deployment of coercion at organization and team level
2. Seclusion	• Making seclusion cells disappear, focusing on human alternatives in collaboration with peer experts
3. Ethical dilemmas	• Reflect on ethical dilemmas around (experienced) coercion using the Moral Case Deliberation (Weidema, Molewijk, Kamsteeg, & Widdershoven, 2013)providing group-wise, structured reflection on dilemmas from practice. Although moral case deliberation is well described in literature, aims and results of moral case deliberation sessions are unknown. This research shows (a
CRPD	
1 Work and training	• Actively deploying Individual placement and support aimed at paid work and with young people starting and completing a course (Fioritti et al., 2014)generating widespread interest about its implementation in Europe. Purpose: This article describes and compares details about achievements and challenges of IPS in 4 European countries: the United Kingdom, Italy, The Netherlands, and Spain. Sources Used: This description draws from published and nonpublished material about policy, development of services, and services evaluation. Results: In the United Kingdom and in The Netherlands, empirical studies exploring the consistency of results over time and the effectiveness of IPS adaptations to local needs and special population are in course. In the United Kingdom, IPS has become national policy, as well as in some regions of Italy and Spain. Training is quite extensive in the United Kingdom and in The Netherlands, developing well in Italy and Spain. Implementation seems to be less straightforward, mostly because of deeply rooted cultural values regarding both work and mental health care. Strong local leadership is still required. In all countries contingencies related to the current economic crisis seems to have increased interest in IPS. Conclusions and Implications for Practice: With the converging forces of strong local leadership, rapid economic changes, and slow cultural shifts, IPS may soon become a priority intervention in Europe for ensuring that people living with serious mental illnesses are able to obtain competitive employment. (PsycINFO Database Record (c
2. Life expectancy	• Actively promoting a smoke-free MENTAL HEALTH CARE and offering stop programs (Hopman, 2017) • Organize metabolic screening as an integral part of care for people with psychotic disorders (Hert et al., 2011)

10.2.2. Public Health

Public Health is the art and science of protecting and improving health of the population at population level. This level can be a local neighborhood, the region of a central municipality or one or more provinces. For mental health care organizations, this means that they are there for all citizens in the geographical area (catchment area) in which they operate, regardless of the number of citizens who are in their care. This makes the task wider than the treatment. The promotion of mental health of the entire region is a task for mental health care. This requires a network approach.

A team can translate this principle into practice by writing a team document (www.ccaf.nl). In it, a team explores the demography and resources of the region in which it operates to contribute to an integrated approach to promoting mental health in the region. The size of the region is determined by the composition of the population and the available resources.

An important public health measure is the active reduction of stigma. However, many deployed campaigns proved to be ineffective in practice. Corrigan describes the 'TLC3 formula': 5 characteristics that a campaign must meet if it is to be successful in reducing stigma:

Targeted: focused on specific group, for example employers

Local: Local programs are most effective

Contact: Organizing contact between people with and without a mental illness is the key to success

Credibility: Contacts must be credible, with the clients in the lead

Continuous: Contacts must be recurring

Table 2. Public health: Implication for healthcare organization

Theme	Consequences for organization of care
Mental Health Care organization work area	Structural contact with social stakeholders Concluding agreements with stakeholders such as general practitioner organizations, housing associations, educational institutions, police and the justice department
Mental Health CareTeam region	Writing team document, which describes the team and the region in which the team operates. Direct exchange with general practitioners: Mental Health Care professionals and general practitioners have each other's mobile phone number.
De-stigmatization	Contribute to local de-stigma campaigns. This can, for example, take the form of festivals, theater and forum meetings.

10.2.3. Recovery

The recovery movement is an emancipation and civil rights movement, which originated in the 90s, in which citizens with mental health problems wrote stories about how their recovery went. Mental Health Care was one of the stories often considered to be only a little recovery-promoting or even downright undermining recovery. Recovery is often described as a journey, which revolves around the strengths, talents and goals of the patient.

The recovery vision places the strengths, goals, wishes and talents of the patient at the center of the organization of care. A recovery-promoting mental healthcare requires that the recovery vision is made accessible to the practice of professionals in mental healthcare. This requires the development of an organizational vision with dialogue meetings and training. Training modules are available and these can be combined with online training (http://www.Mental Health Careecademy.nl). In the EUCOMS consensus document, 10 points have been identified for mental health professionals to contribute to recovery.

10 Ways to be A Good Guide in the Recovery of a Client

1. Support recovery of health, functioning and identity

These can be regarded as the three domains of recovery. They are related, yet can be distinguished. There is no hierarchy. A recovery oriented treatment involves these three domains and is working with the clients on the domains where the client wants to succeed.

2. Offer hope for recovery

Offering hope is the key intervention. Without hope, a client will not start the recovery journey.

3. Ask ourselves in everything we do: do we help or do we hinder

Any intervention we do can potentially be counterproductive, as it may not match with the stage of recovery a person is in.

4. Focus on what's strong, not on what's wrong

It is important to explore the strengths, talents, ambitions and resources.

5. Decide *with* not *about* the service user

The professional and client make the decisions together. This process starts with the diagnosis that can be described as understanding together what is going on.

6. Acknowledge that the expertise of the service user is as important as our own expertise

A dialogue with a client is a meeting of two experts. The expertise of the professional consists of knowledge, experience and ability to have a dialogue. The expertise of the client is the experience, the goals and knowing what helped in the past and who or what are the resources.

7. Collaborate with our stakeholders

The larger part of recovery occurs outside of mental health services: at work, at school, with family, in the community. Therefore, community mental health services collaborate with social stakeholders.

8. Acknowledge the service user's right to take risks

Denying the right to take risks undermines the possibility of recovery. The client advocacy movement emphasises 'the dignity of risk'.

9. Collaborate with the family and network as a resource and partner

It is in most cases better to make the recovery journey together with others, family, partner, friends etc. This is the foundation for several approaches like the Resource group in Sweden. and Open Dialogue in Finland and the UK.

10. Share and integrate knowledge

A recovery oriented treatment requires the integration of objective, subjective and normative knowledge.

Table 3 Recovery: Implications for health care organization

Theme	
Organization: vision for recovery as a basic attitude for all healthcare	- Training and dialogue meetings for all employees. Experience experts should play a role in this. - Acting from a recovery vision from first contact: personal diagnostics at intake with questions about strengths, talents and goals
Team: monitor recovery support work	Decrease Recovery Oriented Practices Index (ROPI), a tool to monitor the extent of recovery-oriented work

10.2.4. Effective treatment

Community mental health requires a combination of complementary pharmacological, psychological, somatic and social interventions. This involves an approach within one's own context, and this requires the willingness to use successful interventions in a flexible manner to do justice to a specific situation and the availability of resources.

Together with the client, where possible with their support group, a treatment plan is written from their own context. Evidence-based working can go well with the recovery vision. This requires an integration of two principles.

Effective care is determined by the following nine factors:

Be well defined

View the patient's goals

Supporting social goals

Being supported by scientific evidence

Lasting results

Minimal unwanted effects

Reasonable costs

Be adaptable within different contexts and subgroups

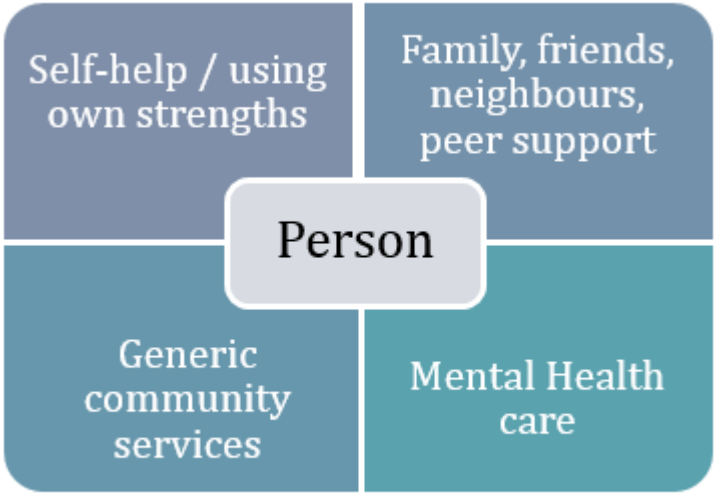
Easy to implement

Table 4: Effective treatment: Implication for healthcare organization

Theme	
Deploy effective interventions	Permanent blended training for all employees Assemble the treatment team around the care needs of the client Unlocking the expertise in the organization for all patients, regardless of the group they are treating Unlocking the expertise in the network in the region, for example by offering training to GPs and other network partners

10.2.5. Community Network

Community mental health is about the combination of one's own strengths and talents, that of the informal network, that of generic social provisions. The place of Mental Health Care, from general practitioner to specialist Mental Health Care, is always one within this network. In some episodes with mental health problems, some citizens need professional help of Mental Health Care and/ or social services. However, the strengths of their own informal network are often sufficient. E-health offers an easily accessible option to strengthen these networks, also for people with serious mental illnesses. It is a core task of MENTAL HEALTH CARE to deploy these own forces and those of the informal network and, where necessary, to strengthen or organize them. This was already described by Trainor in 1984 in the framework of support model:



Framework of support (Trainor & Church, 1984)

Flexible Assertive Community Treatment (F-ACT) is a well-developed mental health care organization model that is suited to this network approach. The model has been described and there is a model fidelity scale (www.ccaf.nl).

In the practice of community mental health, a multidisciplinary and multisectoral network that organizes and coordinates care with a broad spectrum of

flexible interventions a help citizens in their own environment to recover with support from their own social network.

Different domains can be distinguished within the network. Within the Dutch context, these are seen as both separate teams and functions of teams. Separate teams have the power of specialization and the risk of resource fragmentation. With integrated teams that is exactly the opposite. In practice, a balance must always be found between integration and specialization.

The table in which implications for the care organization are shown, also contains different domains in which a network approach can help secure an integrated approach. They can be organized as distinct domains of an integrated team or as domains for separate teams.

Table 5: Community network: Implications for health care organization

Domain	Description
(Ultra) high risk	Specialized early intervention services to maximize the chance of positive outcomes in psychosis.
Early psychosis care	Early Intervention Service team Integration within Flexible ACT team
General practitioner	Family doctor is part of the network for people with severe mental illness
Social interventions	Organize individual placement and support (IPS) in conjunction with employers and UWV Housing First organize housing associations in conjunction with protected housing providers Apply interventions in the social domain
Outreach acute	Organizing public mental with integrated multidisciplinary intensive home treatment
Outreach as a recurring phenomenon	Flexible ACT teams can deliver customized care while maintaining continuity through flexible up and down scaling. Care for the hard to engage is a core task of specialist mental healthcare
Collaboration with informal network	The Resource Group is a well-structured method to work closely with the informal network (Norden et al., 2012)
Integration with addiction	Dual diagnosis: addiction problems and other psychiatric disorders integrated treatment by a multidisciplinary care team (Boyle & Kroon, 2006)
Acute admission	The psychiatric hospital communicates structurally with the ambulatory teams.
Residential care and protected living	The organization focuses on the triad of client-family caregiver and is intended for people whose recovery process has stagnated.

10.2.6. Peer expertise

Peer expertise plays an important role in the recovery journey of a client. Peer experts are the living proof that recovery is possible and can help other professionals to use their own experience in a professional manner. Peer expertise is therefore a distinct domain and strength of all professionals in Mental Health Care, in addition to knowledge and experience in practicing the profession. From this vision, the organization of care becomes a process of co-creation with the people who are in care. This co-creation takes place on three levels. Co-creation of Mental Health Care means that clients, experiential experts and other professionals work together as equal partners to design, deliver and evaluate healthcare. It is the recognition of the importance of experiential expertise as a foundation for restorative care.

Individual level

Co-creation at the individual level means that the patient is a partner in making all decisions regarding treatment, treatment goals and determining a treatment plan. Making choices together is leading and the patient has the last word, so that people can speak better about making supported choices.

Team level

The experience expert as a colleague in the team has two functions: supporting the patient in working on recovery and supporting colleagues in learning how to deal with their own experience professionally. This requires investing in this experiential expertise through education, training and peer review. For the other professionals, it may be an invitation to use their own experience as a means to support recovery processes. The self-disclosure is therefore an extension of the palette of possibilities of all professionals.

Policy level

At the policy level, patients and their informal network are an important source of knowledge and experience to improve our healthcare organization. In the position of manager or management and management consultant, experience experts help shape healthcare. A logical continuation is that the position of director or director is also filled by an experienced expert.

Table 6. Peer expertise: Implication of healthcare organization

Level	Form
Individual	- Writing a treatment plan together according to the principles of making choices together. The patient has 24/7 access to his own file and can read and write in it
Team	Peer expert as a team member - Deployment peer expert as a professional in the team - Use life experience of other professionals.
Policy	Client panels as an audit tool Peer expert as manager or director Experience expert as an advisor

Mental Health Care collaboration partners: network of psychiatry

Recovery from a serious mental illness does not automatically require the commitment of the client and his personal network. As the client movement puts it: Recovery is hard work (http://recoveryinnovations.com/). Where the strength of a citizen and that of the network fall short, other services such as Mental Health Care are needed. The focus of Mental Health Care is the treatment of mental disorders. However, recovery is not the exclusive domain of Mental Health Care. Various other services and providers in the social network play a sometimes decisive role. These are summarized in the table below (Anthony, Cohen, Farkas, & Gagne, 2002). The interplay of Mental Health Care with these services and providers requires a flexible care system where Mental Health Care works closely with several partners: network psychiatry.

Table 7 Network psychiatry: the various services and providers in the social network that contribute to the recovery of citizens with serious mental disorders

Service categories	Description	Consumer outcome	Partners of Mental Health Care, client and informal network
Therapy	Reduce symptoms and suffering	Symptom reduction	General Practioner
Crisis intervention	Checking and solving critical and dangerous problems	Personal safety	Law enforcement

Rehabilitation / recovery	Developing skills and support for the life goals of the patient	Role functioning as partner, employee, student, club member, etc.	Personal network Municipal home care Subsidized programs focused on work
Fulfilment	Engaging in fulfilling and satisfying activities	Self-development	Social and municipal services. NGO's
Case management	Obtain the services that the patient needs and wants	Services obtained	Social work of the municipality in collaboration with Housing associations
Legal protection	Stand up for your own civil rights	Equal opportunities	Municipality Legal profession Law enforcement
Basic support	Places and things needed to live and survive	Personal survival guaranteed	Housing associations UWV Home care from the municipal district teams Social service Meals on Wheels
Self help	Voice and choice in your own life	Empowerment	Patients advocacy groups
Wellbeing	Promote a healthy lifestyle	Better health status	General practitioner Medical specialist Physiotherapist Sports clubs Smoking cessation training

Research

One of the most critical issues in researching the organization of the Mental Health Care is a treatment gap between expertise on effective treatment and patient experience in practice (Torres-González, 2009). Evidence of effectiveness is often based on research in academic settings, without knowing whether these interventions can successfully be implemented in mental health.

New organizational models such as F-ACT are often asked whether they are evidence-based, while in the past this test never took place for existing organizational models. Assertive Community Treatment is one of the few models that has been subjected to an RCT. However, this successful organization model requires adaptation to the regional context and changing circumstances and insights.

The scientific evaluation of Mental Health Care is a new branch of science, the so-called implementation science. The implication for organizing care is that this is accompanied by a permanent plan do study act (PDSA) cycle. This gives the opportunity to learn from positive and negative results.

It appeared in England that Assertive Community Treatment teams have no obvious advantages over regular community mental health teams, while they have proved to be much more expensive. This motivated Mike Firn to integrate Dutch F-ACT model with the existing community mental health teams. The surprising finding of this study was that the F-ACT model was not only cost – effective, but also more effective than ACT, also in the longer run.

Research should not only focus on symptom reduction, but also on the extent of recovery. It is important to closely follow people with serious psychiatric disorders in multiple areas of life and not just focus on improving the symptoms. This is in line with Huber's definition of health, which, in addition to bodily functions and mental well-being, has also defined 4 domains that are relevant to health: sense of purpose, quality of life, social participation and daily functioning.

A summary of the evidence in the field of community mental health can be found in the scientific report in 2018, written at the request of the European Union. The biggest barrier to the implementation of community-based health care are the low political priority, and insufficient funding. This is often experienced by professionals, as the area of clashes between the wish to provide humane care and the focus on cost-effective care that has to be as inexpensive as possible.

CONCLUSION:

This chapter describes that the care organization for people with severe mental illness requires a broad social approach that prevents mental disorders from leading to serious limitations in social functioning. This is a task that the Mental Health Care cannot perform alone. It does, however, require that Mental Health Care is organized as a network organization. Internally, this means close collaboration between the ambulatory and hospital teams, sharing of expertise and the deployment of peer experts. Externally, this means good cooperation with social partners based on shared values centered around

human rights, public health, recovery, effective treatments, a network approach and peer expertise.

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11. STIGMA

Vesna Švab

11.1. Stigma and discrimination

11.1.1. Introduction and definition

Stigma is a term that applies to labeling certain people as different and inferior. It is a mark of shame, a sign of worthlessness applied to the stigmatized. Its consequence is avoidance, and even expulsion from society. It can be described as a form of social monitoring or exclusion of minorities from certain competitive areas, working as a form of intangible control over groups of people with mental disorders.

The ultimate behavioral expression of stigma is discrimination. Affected people are discriminated against by being marginalized, avoided and being victims of violence. Many patients report feeling lonely, losing friends, not being in contact with their families, losing their jobs and being transferred to a job in a lower salary grade. Discrimination is not authoritarian and directly aggressive anymore, it is most likely due to anti-stigma movements, which managed to change the way discrimination is exhibited, but what discrimination is all about has stayed the same. Social distance raises the levels of disability amongst the persons with mental illness and significantly worsens their position. Stereotyping, prejudice and discrimination can thus stop people from realizing their ambitions and life goals.

Behavioural reactions are where the rubber meets the road with regard to stigma, low expectations for consumers.

The research shows that all mental disorders are stigmatised, regardless their diagnosis, but most severely people with drug addiction disorders, followed by people with alcohol dependence and schizophrenia. The least stigmatized disorders are anxiety and depression disorders. The

public perceives people with mental disorders as dangerous, incapable for independent living, decision making and production, as weak individuals, responsible for their own troubles; lazy ones, and incurable. One of the most powerful stereotypes is about unpredictability and people unable of discussion, which is followed by social distancing, being the most common representation of discrimination. Social discrimination is increasing with the degree of intimacy in relationships. The most common prejudice is today about people with mental disorders being responsible and in professional groups about being powerless victims of the biological illness.

11.1.2. Self-stigma

The psychological cause for self-loathing is internalization of prejudice. Some people accept disdain as something justified and legitimate. They start to act passively, dependently and helplessly as they are expected to do. A social quarantine, devoid of encouragement and responsibility, is formed around the individual. Their expectations are reduced. One withdraws and gives up hope and wishes, making himself/herself less emotionally dependent and less likely to speak out – which are all recognized as "negative" symptoms of mental illness. It was proven that people who identified themselves as being stigmatized tended to compare poorly to other people who do not feel stigmatized on the grounds of their intellectual capacity. This means that a stigmatized social group actually functions well below their intellectual potential, stigma being the reason for their impairment, rather than only their illness. They feel incapable of functioning as rational, competent and functional individuals, have lower self-esteem and are often depressed, anxious and hostile. Being a part of a stigmatized group is a barrier to one's success and often means that a person will lose his/her life opportunities. They also actually start to avoid opportunities because of anticipated discrimination - i.e. fear to be rejected in different life areas, from employment to partnerships (INDIGO and ASPEN research EU). People with mental disorders are often isolated, unemployed, poor, single and alone. Recognizing their situation, many in turn disdain and even hate their fellow patients - a group of people with mental illness. They may exhibit the same or even more stigmatizing behavior as those outside of the group towards their fellow, more stigmatized patients. The individual does not want to be a part of the disadvantaged group. The anger and outrage directed towards the barriers keeping them out of social life is turned

on themselves. Self-stigma is exhibited in feelings of shame, exclusion and loss of importance. Still, the consequences of self-loathing do not stop there. Patients in its grasp do not argue their rights or interests, thus maintaining the vicious circle of stigma and legitimizing the fact that non-stigmatized people avoid and exclude them. Mental illness does not necessarily mean a loss in effectiveness and self-esteem. People react differently to disease and possible disability. Some fight discrimination and abuse, and some are indifferent, depending on an individual's personality and the situation. People who refuse to accept the stereotype feel angry and strong, and justifiably so. The only way to resist self-loathing is to stand up to discrimination and resist abuse.

Structural discrimination. Structural discrimination happens at a systematic level, in a way that automatically stops any attempt to acquire a different social status. The mentally ill are pushed to the margins of society, drastically reducing their life options. Being pushed to the margins of society means that any group can be forced into humility, anonymity and silence. Any discussion of equal rights, respecting diversity and understanding is futile if discrimination is built by the general society and the state itself, as the ultimate defense against intrusion of marginalized groups, and the unadjusted into any decision making system. The most generally present effect of structural stigma is poor quality of mental health services and their inaccessibility, basically denying patients their right to treatment and care in an apparently accidental way. The reasons for this can be found in social service management, political decisions and poor legislation. In a cultural environment with strong values on work and income, a patient is stigmatized and cornered. He is unemployed because of not being able to reach the required production norms. As unemployed individual, he is labeled twice: as being mentally ill and for being unproductive or even lazy, unable to achieve the socially requirements to be considered a productive member of the community. The only possible way out of this situation is belonging to a wider community of people who also feel wronged by the prejudice directed towards the mentally ill. Patients who are able to find a way to belong to such a group and identify with it have more self-esteem and are significantly stronger. Stronger individuals report better recovery. Those with political connections influence the quality of mental health services. Poor care for the patients' physical health is one of the most serious problems that mental health care has to face. People with mental disorders have the same somatic diseases as other people do, yet the standard for hospital care drops severely whenever a mental health problem comes into play. The risk

for physical problems such as diabetes, high blood pressure and cardiovascular disease is far greater amongst people with mental disorders than in other groups. Cardiovascular disease is the main cause of death in this group. The paradox here is that severe physical illness is incompatible with good mental health. Any physical illness is strongly connected with depression, anxiety and other mental health problems. A logical conclusion is that every physician should be trained in identifying and treating mental health problems, yet psychiatry is mostly treated as unimportant at most medical schools, by the teaching staff and students alike. The average medical student is likely to have the same opinion of mental health problems as the general public. They mostly feel that psychiatry as a branch of medical science is ineffective and unscientific. Improving the education at all levels of the educational system, including lessons on needs, rights and the reality of life in fringe groups lies at the basis for improving the life and treatment quality of patients with mental disorders.

11.1.3. Areas of discrimination

Friendship

Compared to others, people with mental disorders have scarce social networks and are more strongly linked to their families and more dependent on them. A small social network can be a consequence of stigmatization and the mental disorder itself. Loneliness is a risk factor for poor recovery. Most patients try to hide their illness from their friends, as they believe hiding is essential for their social survival.

Divorce is one of the most stressful events in an average person's life. Most people need to be helped when faced with divorce, the mentally ill even more so. Several cases of patient's being used and manipulated during the separation process have been reported.

Parenting, nurturing and caring

Parenting, nurturing and caring for a child after giving birth is one of the hardest physical and mental tests for mothers. Sleeplessness, hormonal imbalance, physical stress, financial difficulties, breastfeeding and relationship difficulties can shake even the strongest of women. Those who are vulnerable to psychiatric disorders often experience a relapse in the year following birth. Admitting this, there is little evidence to suggest that schizophrenic mothers

are unable to take care of their children. Women with mental disorders often lose their children, despite all the facts. This can be attributed to not receiving any assistance when it is most needed. Mothers don't have access to counseling, education or family therapy. Most parents who have some form of mental disorder provide excellent care to their children and are considered good parents, if sufficient support is provided for possible overloads.

Sexuality

People with mental health disorders often exhibit radical sexual behavior, the outstanding group being those with mania. Women with mental health disorders are far more likely to be sexually abused. Research has shown that there are many cases when a patient should be treated both for sexual abuse and illness. Several drugs used in psychiatric treatment have a negative effect on libido, erection and ejaculation, which is one of the leading reasons for avoiding use.

Sexual relations, because of the above mentioned, are less likely to happen in a psychiatric institution as opposed to other institutions, perhaps not regularly, but not rarely either. Prohibiting sexual activity is discrimination, yet it must be implemented sometimes in order to prevent people from acting in a way clouded by their reduced reasoning because of the illness. People with low self-esteem who consent to intercourse they would otherwise refuse also need to be protected. Consequences of these dilemmas became evident in hospital management decisions conflicting over gender separation. In the name of normalization, England implemented mixed wards for a couple of decades, which are now being separated again. This happened owing to numerous reports of abuse and dissatisfaction of women due to a lack of privacy. Closed wards fared badly in this experiment of gender mixing, as the patients there have a problem controlling their behavior. Women who experienced abuse before hospital admission are often very vocal in demanding their right for privacy. A number of women in treatment because of traumatic sexual experiences in psychiatric hospitals is not low. A patient's right to sexual expression needs to be balanced with the reasonable demand for protection. In clinical practice, this means that in closed wards sexual intercourse is usually prohibited, even though it is a breach of their basic human rights.

Employment

Employment discrimination is one of the most common forms of stigma. Work is known to improve mental health; it help an individual find a sense of

direction in life and makes a person feel appreciated. Unemployment deprives people of social interaction, reduces their self-esteem, intensifies feelings of incompetence and pushes people into poverty. Research has shown that most people with mental disorders possess the capabilities to work and want to find a job. The low employment rate of people with mental disorders can be blamed on discrimination.

Employers expect mentally ill workers to be unproductive and frequently absent. They fear unpredictability and damage to the workplace or the company. Physically disabled people are twice as likely to be employed compared to people with mental illness. Even if people with mental disorders get employed, they can expect a lower and less paid position, and their experience and education are not taken into account.

Given the time it takes for things to change, a lot of people with mental illness give up on finding a job and accept their social status. Half of the available and appropriate positions are scrapped or changed to the mentally ill worker's disadvantage because of poor workplace relations. When discussing possible employment with a patient, the most commonly asked question is whether the individual should reveal their condition to the employer. There is no simple answer to that question. It depends on the employer's prejudice and the levels of job stress. Hiding the diagnosis might lead to difficulties. If the individual cannot perform set tasks or cannot handle the stress, he will probably be called "inefficient".

The most common solution seems to be denying the illness and covering up problems. Professionals who try to lower their patients' or clients' expectations and try to get them to accept welfare benefits or pensions are also part of the problem. Adjusting the work that needs to be done to the needs of people with mental health disorders improves their job performance. This means that their work environment will be more serene, that people will be able to work from home, adjust their work hours, or it may mean just making sure that individuals work in a tolerant environment where they will get support when needed. There are clear guidelines on how to organize work for people with mental health disabilities. People with mental disorders need adjusted work hours and support at the workplace. An organizational culture that respects mental health, diversity and offers support is therefore necessary, as job performance can be significantly improved, even in people with the most severe mental disorders. In the times of economic crisis, hiring people with

mental disorders generally declines if governments do not have a clear policy on reducing exclusion of people with disabilities. Legislation can help speed up the process of employing people with mental disorders, but only slightly as employers still see them as a threat, despite financial incentives the government offers to encourage their employment. Productivity is the cornerstone in many cultural environments. Getting and keeping a job is the best path to recovery that has also been taken by many people with severe mental illness. There are many examples of people who received enough support to be able to recover in this way.

Education

A student with a mental disorder can experience significant difficulties. Their reduced capabilities manifest themselves as problems with studying, communicating, memory, thinking and sleep, which significantly affects their studies. Such students are hard to recognize, as most student difficulties are attributed to a lack of motivation and poor working habits. Research of their special needs is very scarce. The astounding diversity of mental disorders and their varied symptoms further complicate the problem. A student may be suffering from depression, anxiety, addiction, psychotic disorders or personality disorders. Each and every of these problems requires a different treatment and different types of support. However, the diagnosis alone should not be the reason for reasonable adjustments, it should rather be the reduced capabilities caused by the illness and its other effects - including stigmatization. Obstacles that prevent the student from reaching optimal results need to be removed. Specific social skills, for example, in obtaining information can be improved by an appropriate mentor. Additional rights can be provided for a student who has just recovered from a mental illness, such as additional timelines, additional flexibility, adjustment of class attendance requirements, providing additional mentors and tutors, additional lectures arranged for specific problem areas and making necessary arrangements for studying at home. Counselling, stress control classes, study planning classes and social skill classes should also be considered. Adjusting the study process should not jeopardize its quality, only change its difficulty. It is not expensive to adjust educational programs, the difficulty lies in combating discrimination against the mentally ill in all stages of the educational system. Rights and needs awareness need to be raised among the staff working in the education sector. Students who received

sufficient support are a living proof that education can help control a mental disorder.

Accommodation, communities

Different social and cultural environments mean different types of care for people with mental disorders. The Slovenian social environment, for instance, sees most patients living in their nuclear families, similar to the Mediterranean countries. In northern and western countries, most patients live on their own. Nowadays, patients live in sheltered living arrangements. This form of accommodation offers different levels of care and is an alternative to living with relatives. Patients/users mostly choose to live in such a community when their domestic situation offers no advantage to recovery, when they feel they have no chance of living on their own and when they require help with everyday tasks. The alternative living choices can only work with competent staff at hand, which means that they can recognize and answer the different needs that people in such a community may have. In Slovenia, social institutions are still one of the most common types of long-term accommodation, and no matter how well-developed they are, they still seem to be facing the same problems – a high risk of neglect and inadequate treatment that has been frequently reported. Having a mental health condition can make finding a home challenging. “When I was trying to find a place to live, I never told anyone I was ill. People don’t like people who are... different. It’s best to keep a low profile”. “My landlord knows that I’m ill, she’s a bit more careful now. I think it’s because I didn’t tell her much, but she still tries to talk about it and she appears to actually understand me. I know it’s a bit awkward for the both of us, but I guess it’s okay, it’s her house”. “My parents think I’m not mature enough to live in my own flat, even if I have one. I can cook for myself. I’m still having a hard time ironing and washing up, but I’ll get help from a therapist so I can look after myself after I’m discharged”. According to Housing First model, one is able to exercise other human rights only after they had a safe and secure roof over their head. Housing cannot be separated from rehabilitation and care. It is about free choice and strengthening capabilities. Housing should offer rapid dignity and hope, with offering housing first instead of treatment adherence and complete sobriety (www.housing-project.eu).

Social relations, finances, civil rights

A person’s social life outside the family and the workplace depend on his social skills, opportunities, rights, resources and a person’s own perception of

their value in society. The mentally ill can be discriminated against by having no means for day to day recreation, quality time and simple pleasures. The most common reason for this is financial deprivation, usually caused by unemployment and poor pension or social aid, sufficient only for the bare necessities. Most patients need a job that would help them improve their financial status. Even if they do manage to find a job, they have to deal with management that is not always tolerant. Furthermore, they are often not sufficiently informed about their rights and consequently, they do not seek to exercise them. Others do not want to exercise their rights because they want to enter all of their relationships on equal grounds. Some simply accept their inferior status because they have low expectations.

Income

People with severe mental disorders are poorer than the general population and suffer from disrespectful behavior, sometimes they are exposed to physical violence and underestimation. However, it should be noted that there are many positive cases of reported tolerance, cooperation and equal treatment.

Neighbors

According to reports from Great Britain and the US, people with severe mental disorders are avoided and excluded by their communities. When the NGO "ŠENT" in Slovenia first started organizing group homes, we believed that people living in the neighborhood should not be given prior information concerning the possible (absence of) danger to help them accept the newcomers. We have firmly stated, however, that any event out of the ordinary, even if it was just an unscheduled visit by an ambulance, needs to be explained to everyone affected. The recommendation that residents should be notified at the earliest stages of creating the community carries weight, which might be relativized by the right to confidentiality and the fact that half of the world's adult population will be affected by a mental disorder at some point in their life, and that three quarters of this population know somebody who suffers from one. Reports given by the interviewed people with schizophrenia in INIGO vary significantly. The neighbors are often the first ones to notice that somebody needs help. The individual affected may perceive this as an intrusion into his autonomy that damages his self-respect.

Professionals

Professionals have the most stigmatizing views about mental disorders. Stigma in professional services is one of the main causes of treatment

discontinuation among patients. Common stereotypes in mental health settings are that people with mental health problems are weak, boring, insensitive, shy, unsociable, cruel, awkward, unintelligent, and needy. Professionals stigmatize the mentally ill for the following reasons. They are pessimistic about their recovery, despite all scientific evidence to the contrary. The prognosis for most mental disorders is far better than for most recurring physical illnesses. Professionals rarely meet recovered patients, they see only those in grave need of assistance. Another reason is the need for distance and superiority, in short, power, which can be easily satisfied in any type of institution. Most professionals claim that they do not stigmatize, that problems arise from patients' oversensitivity to what they say. The anticipated discrimination only contributes to patient stress. Stigma directed against the professionals themselves is also very much a reality- people often perceive professionals as arrogant and uncomprehending and therefore do not trust them. This leads to procrastination in seeking help. Research has shown that most people never seek help for mental disorders. The most stigmatized diagnoses are alcohol addiction, eating disorders, personality disorders, self-harm and schizophrenia. The most stigmatized patient groups are men with financial problems and the homeless. Discriminatory behavior of staff increases in case it is decided that the mental problem is the patient's own fault, if the patient gets frequently admitted to the hospital, if the patient engages in violent or criminal behavior, if the patient is believed to have little chance of recovery or, finally, if the patient is believed to be dishonest. Besides patronizing, double standards are a common type of stigmatization – everything they do is judged by their diagnosis, even when there is no objective reason to do so. For example, a patient who is upset about the quality of his treatment could be labelled as agitated because of the illness, even if his complaints are legitimate. People with mental disorders face the same kind of discrimination in all institutions, not just in the hospital. The attitudes of the professionals toward the mentally ill has a large influence on other people's behavior. Psychiatrists and nurses who see their profession as stressful, hard and unsatisfying lead the public to see apathy, ignorance and poor patient care as the way to behave toward people with mental disorders. On the other hand, committed professionals who are happy with their career decisions set an example of respect, hope and the need to cooperate.

11.1.4. Coping with stigma

Protest

Protest is the most used strategy to fight injustice, as unsuccessful as it may be. People who discriminate against others are prone to responding with more discrimination when subject to outrage and opposition. They are less likely to stop when other opinions are forced on them. Protest can only positively affect media coverage, particularly the reporters who have failed to form a clear opinion on the matter in question. Protest is a reactive strategy; it attempts to diminish negative attitudes about mental illness, but fails to promote positive attitudes supported by facts.

Education

The belief that prejudice is irrational inevitably leads to the logical conclusion that reason can prevail. If we were able to understand the whole truth about mental disorders, the affected people and ourselves, we would be able to overcome prejudice and easily detach it from our emotions. This thesis is the basis on which all anti-stigma educational programs are developed, including those that promote a contact between the non-discriminated and the discriminated. Promoting mental health awareness is by far the most accepted method of combating stigma and discrimination. The same method was used in intercultural dialogue campaigns, aimed at reducing racism and homophobia. The prevailing assumption was that people could rationally "delete" prejudice from their system. Even if short educational programs were successful in improving relationships and awareness, they only had short-term effects. Their effect on discriminatory behavior has not been proved and there is still some doubt as to whether they influence the behavior itself, or merely change the understanding of a problem. The fact that people understand mental disorders better, however, does not mean much to stigmatized individuals. The main problem of educational programs seems to be that discussion is always focused on the stigmatized group, rather than the group that stigmatizes. Instead of paying attention to prejudiced individuals, objects of their prejudice are being focused on, as Henriques noted in 1984 in his book "Changing the subject". The following years showed that more than convictions, actual discriminatory behavior needed to be stopped, which required good knowledge of history, institutions, legislation and the cultural traits of the affected environment.

Contact

Establishing direct contact with those who recovered from mental illness is another way to educate. Stories and reports by empowered individuals are a strong weapon against

stigmatization. They were proven more successful than educational campaigns, especially in combating fear, yet even these programs only managed to fight stereotyping, not social distance. Relating to an individual with mental disorder experience does not affect the social nature of stigma. But, even the effects of direct contact can be relativized, as it may happen that individuals consider the one they are talking to an exception. An informed and competent individual will not affect the reputation of the whole group, except for when he/she is a recognized representative. People with mental health problems know where to expect stigma in everyday life. Professional representatives of the mentally ill that give speeches at conventions and seminars are not typical representatives of the group. Just like professionals, they need frequent public appearances to maintain their status. Their posture is consequently militant, disdainful and they are constantly trying to find mistakes in the way in which their healthy colleagues communicate. They demand "appropriate" behavior in keeping with the marginalized group's code. Their expectations differ significantly from the rest of the population, trying to be polite and careful in order not to jeopardize their position. Most individuals with mental disorders try to demonstrate that they are well-adjusted, behaving similar to others. At the same time, they try to convey that they are not the same; that they are at a disadvantage that needs to be accepted as a fact. Most of the discriminated have developed careful and artful forms of communication, which enables them to be at least partially accepted and prevents severe problems.

11.1.5. What works?

The evidence about success of anti-stigma campaigns is undeniable. It is proved that anti-stigma programmes need comply with international conventions (the UN Convention on the Rights of People with Disabilities) to improve economic position and reduce political and social obstacles to social inclusion and political participation of people with disabilities, and that we need to implement multilevel and multifaceted anti-stigma campaigns targeting behavioural change. Besides, wider public structures should be challenged with legislation and advocacy.

Successful anti-stigma programs follow the underlying tenets:

1. Service users and their carers must be included in the whole process: from planning, through implementation to evaluation and control;
2. Campaigns should be evaluated.
3. Campaigns should be implemented at the national level and consider grassroots initiatives (i.e. teachers should run anti-stigma programs in schools)
4. Campaigns should target behavioural change;
5. Messages must be clear;
6. Campaigns need to be continuous and publicly funded;
7. Action is needed at different levels;
8. The government support is needed;
9. Successful campaigns lasted for several years and often decades;
10. Successful campaigns targeted different needs;
11. Coordination was made at local, regional and national levels

Good practice examples:

Opening Minds Canada is a contact-based education involving people with lived experience, sharing their personal recovery stories, which is one of the most promising strategies for stigma reduction with 4 optimal contact conditions (equal status, work toward common goal, support from authorities, co-operation). Educational anti-stigma intervention in youth changed stereotypes, in health care providers, it helped improve patronizing attitudes and they were replaced by learning about client-educator life experience at a personal level, the educational component was about myth busting in an unthreatening and interactive format, comparison among mental and physical illness and applying this experience to individual workplace levels, as well as planning actions and taking commitments to improve behaviours. When a person with lived experience of mental illness shares their personal story, it disconfirms the stereotypes of health care providers. Lived experience brings better results than video-based social contact. Workshops allowing health care workers to find the answers to questions such as “what to say” and “what to do to help”, i.e. practical skills for communication, work as well.

Like Minds Like Mine is a successful anti-stigma programme in New Zealand to increase social inclusion and reduce discrimination is a public anti-stigma campaign taking place from 1996, led by the Ministry of Health (National Plan). The national meetings were organized to bring together people with experience and other stakeholders "to create a nation that values and includes people with mental illness". A part of this project is dedicated to empowering consumers, increasing public awareness through media with personal testimonies. The continuous program based on media cooperation with human rights and social model and disability resulted a national mission mentioned above, extensive improvement in policies and practices for fighting discrimination in all organizations. People with lived experience were central to this development. The program lasted for 12 years. Effective contact was defined as targeted, continuous, local and credible. A general increase in positive attitudes and acceptance and a decrease in negative attitudes and increased acceptance were proved. The economic evaluation shows that for 5 million dollars spent there was 720 million dollars accrued through better employment - through reduced employment discrimination.

The national campaign for anti-stigma in Denmark One of US developed at national, regional and local level using social contact, videos, images, challenging myths, public events, festivals, happenings, workshops and conferences, very similar to Slovenian anti-stigma campaign that never got to reach public funding and national level, using the testimonies of ambassadors and celebrities, social media had economic impact as well and strongly changed discriminatory attitudes, also in psychiatric staff. There were posters and flyers made to stir up attention among staff, such as "See the person behind the diagnosis" or "Have you asked your patient for his/her opinion?".

The most famous and large-scale anti-stigma campaign of all time is English **Time to Change - TTC**, which has been going on since 2007 and is led by independent non-government organizations Mind and Rethink Mental Illness. This campaign was thoroughly evaluated by the Institute of Psychiatry at King's College, London. Before the campaign, they found that 49 percent of people with mental disorders experienced harassment or attack, and that they had the experience of getting fired, as well as anticipated discrimination that manifested itself in a way that they did not dare to apply for a job.

It includes 35 projects: community local initiatives, national high-level programs, mass participation in the physical activity week, it also includes

legal activities and education for students. However, the core element is advertising, social media campaign, informing and community activities. The target of the campaign is changing behaviour, which is considered more important than changing stereotypes and prejudice.

In one year, they achieved:

- Four percent reduction in discrimination, as reported from people with experience of mental health problem;
- Six percent reduction of people reporting being made redundant because of mental health problems and
- More than 117 organizations that took part in TTC's activities.

The campaign is a part of the national strategy and is predominantly funded by the Department of Health. Social marketing is the core action, and personal contact with people with mental disorders is made possible.

The TTC decision-making structure consists of 12 people with experience of mental health disorder. They are part of advisory board and prepare recommendations about the way the program will include and engage people with mental health disorder experience in TCC. This is the group that keeps track of progress; the members are ambassadors and key speakers of the organization.

There is a lot of evidence about the first years of TCC campaign showing that public stigma was reduced and that help seeking was improved. The first improvement was in the field of employment: there were reports about adapting working conditions, and at least at first, lower discrimination at workplace was reported. Media reported about mental disorders more positively.

TCC is evaluated in public opinion evaluation each year regarding stereotypes, service user opinion and anticipated discrimination, with analysis of media reports and economic analysis that showed clear economic benefit.

TTC has made the following recommendations:

- Evaluation of anti-stigma programs is needed;
- The main tool of anti-discrimination is contact with service users;
- Empowerment of people with mental disorders is important, so that they can answer to stigma and discrimination.
- National and local plans work, if they are performed long enough and continuously

- In later phases of evaluation, the results are encouraging. A 10-year trend between 2003 and 2013 has shown some step-by-step improvements, in spite of economic recession that worsens stigma and discrimination.

CONCLUSION

People with mental disorders should be brought up in every conversation about marginalized groups, given their suffering because of stigma and discrimination. People with mental disorders are entitled to accessible and timely quality services and they need to have possibility to participate in all areas of life. Services must be adapted to patient needs, not to the needs of service providers and policy makers. Protection from abuse and violence is a must. Families need respectful help in their mission to provide help and support. Children should be taught about respecting differences and reconciliation. In conclusion, anti-stigma lies at the very heart of promotion and prevention in mental health.

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12. SELF-STIGMA PREVENTION PROGRAMME

Slađana Štrkalj Ivezić

The stigma of mental illness, or anything regarding mental illness - patients, their families, mental health facilities and psychopharmacology - is one of the main barriers to better mental health care and improved quality of life for the patients. People with mental health disorders feel that stigma has a negative impact on their lives, that it diminishes their credibility, renders them helpless and leads them down the path of social distance.

Once an individual is labelled and given the diagnosis of a mental health disorder, two types of difficulties occur, including secrecy, lowered self-esteem and shame at the personal level and social isolation, prejudice and discrimination at the level of society. Being aware of stigma does not necessarily imply agreeing with stigma; however, people with mental illness who agree with the stereotype also tend to believe that they are less worthy and incompetent, and turn the prejudice against themselves. Higher levels of self-stigma, in turn, are associated with low self-esteem. Self-confidence is an overall evaluation of feeling worthy of love, competent, moral and capable of being the director of one's own life, and is associated with the experience of empowerment. People who have low self-esteem feel like worthless, damaged goods who have nothing to be proud of.

People with mental illness often develop a range of negative beliefs about anticipated discrimination and devaluation by society, even when they have not personally experienced stigma and discrimination. Research has found that anticipation of discrimination in job search and job retention was more prevalent in persons who had no personal experience of discrimination than those who had experienced discrimination. A number of people who anticipated discrimination stopped looking for a job because they did not expect they would get a job anyway, and the same goes for intimate relationships. We can, therefore, expect a number of people resorting to social withdrawal and giving up on their goals, think they will fail because of the stigma

and discrimination. Consequently, this is a vicious cycle of stigma, a chain of consequences for the person, his/her family, treatment services and society at large. However, changing one part of a vicious cycle chain can lead to changes in other parts too. Empowerment programmes that help people persist in reaching their goals, increase their self-esteem, reject stigma, and increase their skills in dealing with stigma and discrimination help break the vicious cycle of negative effects of stigma.

12.1. Self-stigma or internalized stigma

Recognizing stigma and discrimination against persons with mental illness does not necessarily need to have a negative impact on all patients. Therefore, a number of stigmatising events do not have any impact, and may even be empowering, depending on the person's environment and personality.

Unfortunately, many people will still respond to stigma by developing self-stigmatization, in line with stereotypical beliefs about people with mental illness. Findings from research involving 14 European countries on respondents with schizophrenia found that 41.7% of respondents experienced moderate to high levels of self-stigma, while 69.4% of them anticipated discrimination.

People with mental illness sometimes believe that other people will belittle or reject them because of their mental illness. Such beliefs may result in a number of consequences, such as demoralization, low self-esteem, poor social adjustment, unemployment, financial loss, low drug adherence, and poor patient compliance. Low self-esteem, poor self-image and self-discrimination significantly interfere with life goals, quality of life and opportunity for recovery, and feeling safe and secure about one's future. Stigma and self-stigma create a sense of low self-esteem, demoralization and the fear of patients being rejected, which is why patients often avoid communication with others.

Research results suggest that self-stigma has many negative consequences. Internalized stigma has been linked to a difficult subjective and objective recovery, diminished self-esteem, low self-confidence, poor quality of life, poor social relationships, increased risk for depression, lack of hope, suicidal risk, poor rehabilitation adherence, reduced work capacity and negative health-related outcomes and decreased empowerment, increasing psychopathology, which then contributes to having poor insight.

Internalized stigma promotes the attribution of one's responsibility for the onset of illness and increases stigma coping strategies in terms of withdrawal/social isolation and secrecy regarding the mental health condition. Self-stigma adversely affects patient compliance, care-seeking; it may affect rehabilitation goals such as job search; it may reduce one's capacity for independent living and active social participation. Self-stigmatization leads to an increase in hospital admissions. Due to self-stigmatization, many people with internalized stigma believe that nothing can help them, so they refuse treatment and other forms of social rehabilitation.

Self-stigma or internalized stigma means the process of accepting attitudes related to mental illness, which then becomes a source of low self-esteem and self-efficacy. A person with internalized stigma agrees with other people's stigmatizing attitudes, unlike those who are aware of other people's negative attitudes, but strongly disagree with them. Internalized stigma means that the person not only accepts stigmatizing attitudes, but also agrees that he/she does not fit the social environment.

Self-stigma is self-devaluation, shame, secrecy and withdrawal driven by the person's stereotypes about themselves. Shame associated with self-stigma causes the person to doubt whether he or she is capable of living independently, keeping their job, earning a living, or finding an intimate partner.

Although people with mental illness manage to overcome the symptoms and their incapacity, they still need to overcome self-stigma – believing that they are not worthy members of the community, in which they need the help of professionals and society, because, for many of them, self-stigma is a barrier to achieving valuable goals.

To experience self-stigma, being aware of the existent stereotype describing a stigmatized group is not enough. The person would also need to agree with the stereotype and turn it against themselves. For example, being aware of the stereotype that people with mental illness are weak should be accompanied by agreeing with the stereotype and applying it to the specific situation, such as in the following statement: "I'm weak because I have a mental illness, so I'm the one who must be responsible for that".

A person who self-stigmatizes will feel inadequate or weak if they need to seek professional help, therefore they should change their perception to reflect that seeking help means that they are strong, rather than weak.

Self-stigma or internalized stigma means the process in which a person with mental illness accepts societal stigma (e.g. persons with mental illness are dangerous and incompetent), which then results in narrowing the expectations that a person previously had (e.g. expectations on becoming a student, employee, parent etc.). Therefore, self-stigma is also defined as a conscious or unconscious process in which a person accepts limited expectations.

Self-stigma is associated with a loss of self-esteem, dignity, fear, shame, and guilt, and therefore patients should get help to release difficult emotions and work to increase self-esteem and start their recovery.

Self-stigmatization can lead to identity transformation in which a person loses his or her previous or desired identity, such as their previous roles or desire to achieve such roles (e.g., to become a student, employee, parent, etc.) and adopt stigmatizing attitudes, such as seeing himself/herself as incompetent, while at the same time, they struggle with losing their identity as a person after they've become a patient. Patient identity significantly affects the recovery from mental illness, so it needs to be addressed and prevented in a timely fashion. Patient identity refers to the roles and attitudes that a person has developed in relation to his or her personal understanding of what it means to have a mental disorder; which comes along with the acceptance of definition of mental illness, implying inadequacy and incompetence, which in turn has a strong impact on the person's hope and self-esteem. All of this further impacts suicide risk, social interaction, work functioning, and symptom severity.

Patient identity refers to a situation where mental illness becomes the main characteristic of a patient's personality. This happens when a person with mental illness talks about illness as their defining characteristic, neglecting all other personality traits such as "I'm a good friend/ a good employee/ the one who helps others; I'm a kind person, or I have a hobby". The person who did not accept their illness as part of their identity will primarily see himself or herself as a person who has different characteristics and who is treated for schizophrenia, so he/she will say "I'm a person who's treated for schizophrenia", whereas the person who accepted their illness as part of their identity will say "I'm schizophrenic", neglecting most of the other characteristics that make them unique.

The impact of social stigma on a person's experience of *self* will most often lead to diminished self-esteem and self-confidence (Chamberlin, 1998;

Degan, 1998) and social withdrawal. Therefore, many are likely to use communication avoidance as a defence against the anticipated rejection and discrimination, just to avoid rejection, which leads to negative consequences and difficulties in social adjustment, and significantly hinders their recovery.

Social withdrawal as a strategy of coping with illness leads to higher levels of anxiety and increases the experience of stigmatization and reduces empowerment, which in turn does not let break a vicious cycle of stigma.

The impact of expected negative social reactions towards people with mental illness, including anxiety, anger, ridicule, resentment leads to an increased sense of inferiority and produces anxiety and depression, which in turn reduces interactions with other people.

The way in which a person handles their illness may become a constant source of stress and anxiety, even when there is no discrimination.

In the therapeutic approach, to achieve a favourable outcome of treatment, the negative expectations in a person with mental illness need to be reversed and a recovery-oriented therapeutic environment needs to be created. Therefore, the first step that needs to be done after the diagnosis is to reconsider the meaning that the person has attributed to illness. Once he/she is diagnosed, it is important to help the person work through their response to illness in a way that will prevent self-stigma and help start the recovery process. It is important to prevent the development of illness identity, which means not letting a person remain "trapped" in the illness identity associated with poor prognosis. The acceptance of illness identity will result in poor treatment adherence and social exclusion. Qualitative research has shown that the construction of a new self is important for the recovery process and that a progression from the identity of "patient" towards the identity of a "person" is important for recovery. Qualitative research has also shown that engaging with mental health service user associations can help build a new empowered identity that keeps internalized stigma away.

12.2. Impact of attitudes of mental health professionals on the process of self-stigma

The therapist-patient relationship is crucial in preventing self-stigmatization and the development of illness identity. Therefore, one of the first strategies in preventing self-stigma is to review the attitudes of therapists who may

create adverse effects on the stigmatization process. The therapist should not be burdened with expected poor prognosis, but should rather embrace recovery-oriented hope and optimism and take an empowering approach.

Attitudes of mental health professionals about the chronicity of mental disorders in terms of incurability and limited recovery opportunities can significantly affect the patient's acceptance and development of stigmatizing attitudes. Some medical conditions have a chronic course of illness, which means that the disease recurs or leaves some limitations in functioning; however, it will still be possible to live a satisfying life even with limitations caused by the illness. Many psychiatric patients labelled "chronically ill" believe that it means that their illness cannot be cured, that they are incompetent, without a future; unfortunately, some professionals share this view, which may have adverse psychological effects reflected in demoralization and withdrawal from active participation in the treatment and achieving life goals. In this context, chronicity produces stigmatizing effects, and patients need help not to perceive chronicity as something that would prevent them from living a satisfying life. To keep a person safe from the stigmatizing effect of chronicity, the professionals need to use this term carefully and give realistic hope that a person can live a good and successful life, even if they suffer from a chronic condition. When chronicity is believed to be synonymous with incurability, and when the patient accepts this definition, the realization of a self-fulfilling prophecy about a poor prognosis is more likely to happen because people have low expectations tend to give up on their plans, and ask themselves "why try?", reflecting the lack of hope and optimism that are necessary for successful treatment and recovery. The vicious cycle of chronicity, created by the interaction of the professional's perception of the negative outcome of illness therefore needs to be broken. It is based on chronicity rather than recovery, the negative self-fulfilling prophecy among patients who take on illness identity, and structural discrimination reflected in the gaps in community-based mental health services and recovery- promoting programs. Patients must, therefore, get help to break the vicious cycles in all its forms, in the therapist-patient relationship, in the patient's attitude towards himself or herself, and by improving the treatment plan, which will contribute to better treatment outcomes for patients with mental illness and prevention of self-stigmatization.

Clinical vignette

Marko is 32 years old and he completed a vocational secondary school programme. He had a job before the onset of illness at the age of 20, but was made redundant due to stigma when the word about his treatment for mental health problems got around. He has been hospitalized a few times after joining the rehabilitation programme. He was diagnosed with schizophrenia. During 12 years of treatment and before the admission to a rehabilitation programme, he would often stop taking medication and he would often drink alcohol. Before the admission to a rehabilitation programme, his medical records read: „deficit symptoms prevail, chronic condition". He lives with his mother and brother, and he is often at odds with them over their insistence that he should be taking medication regularly. After losing his job, he did not even try to find a job anymore because he was afraid that he would be made redundant again if the employer found out about his mental health problems. Therefore, he accepted the social worker's proposal to apply for a disability allowance, and was granted the allowance. He considered himself disabled, so he felt that he did not have to, and was not able to work in the first place. He believed that other people would do things for him, so he let his family take care of everything. Because he feared rejection, he did not socialize with people; he resorted to social exclusion, fearing that someone would ask him about mental health treatment that made him feel ashamed.

During the assessment at the rehabilitation centre, he made it clear wanted to avoid further admissions to hospital. He also wanted to learn more about his illness, improve a relationship with his family, connect with friends and get a job. Difficulties preventing him from doing what he wanted to do have also been identified: lack of insight, poor relationship with his mother and brother, social isolation, shame, stigma, and lack of work experience. The treatment plan included psychoeducation, including working on self-stigma and coping techniques, prevention of recurrence, social skills training, improved capacities for work, and family therapy. The medical team assessed that treatment plan needed to include helping the patient find renewed hope that he could achieve his goals, which required professional support. During the rehabilitation process, as we were working on a recovery plan, we were able to analyse the contributing factors to chronicity. We analysed the factors that may have contributed to the chronicity in the health care system in which Marko received treatment before joining the rehabilitation programme, and

identified the following factors: lack of insight, without offering continuous psychoeducation to help the patient better understand why he needed treatment in the first place, he was told that he was affected by a chronic disease that can be managed, and he understood that the disease was incurable, with no hope of recovery; he was told that he was too unwell to work, so he felt that there was nothing that can be done, he felt that his family should take the blame for his hospitalizations, which would often ignite heated arguments with the rest of his family. Most of what he could hear before he joined the rehabilitation programme boiled down to poor prospects of recovery, which affected his attitudes towards himself: "Before I joined a programme at the Rehabilitation Centre, I felt like a failure, I felt as if my life stopped because of my diagnosis, I believed that life was over, and that I'd never have a girlfriend and a normal life."

Given that many patients, just like Marko, feel that their diagnosis comes with a poor prognosis and that the diagnosis is associated with a poor outcome, that they are deprived of any hope of recovering or leading a satisfactory life, it is necessary to talk about the meaning attached to the diagnosis as early as possible in a treatment. Adopting an illness identity, stigma and social exclusion all contributed to chronicity in terms of disability. "I was feeling insecure, I let my family and my social worker decide for myself because I thought that was just how things were done around here. I believed that I was ill and unable to make a decision, I thought they knew better. This was how they acted too." The identity of a psychiatric patient is an interpersonal and social process, not an indispensable part of the illness; therefore patients need professional help to prevent such a development, as well as to prevent self-stigma and social isolation. Marko was ashamed, avoiding people, he feared that others would ask him about his illness and that he would be ridiculed and humiliated. In this case, social isolation, and social withdrawal serve as a defence mechanism against the pain due to the anticipated social rejection.

The rehabilitation process he was involved in led to empowerment and helped start a process of recovery. "At the centre, I learned that the way I handle my illness was very important and that it can make such a difference. I learned that I was worthy as a person and that my worth had nothing to do with my illness. I even realized that illness helped me become a better man, now I understand other people better." Marko was empowered through the rehabilitation process. Empowerment fosters a sense of self-esteem and

self-efficacy, it helps the person take responsibility for their life, as well as for their treatment and making important decisions. The recovery process helps encourage the client to improve a damaged concept of himself after learning about mental illness.

"Here I learned to distinguish between illness and reality. My attitude towards medication has changed; I look at them as something that helps my brain work better." Psychoeducation helps identify the symptoms of illness, boost one's confidence in the ability to manage their illness, and understand the experience of illness as a life experience. "I no longer feel discomfort associated with schizophrenia, and now I understand that mental illness is like any other illness that can be treated and that I had nothing to be ashamed of, even if I'm a little embarrassed when I remember everything that crossed my mind throughout my illness". Marko has defeated self-stigma. Therefore, the intervention aimed at prevention of self-stigma should be part of a comprehensive treatment plan.

"I've also learned skills that helped me communicate better with other people, I'm no longer afraid of the future. I'm confident I'll be able to solve any problems, and that I'll know how to seek help."

"I got the opportunity to work. I was encouraged to try to find a job."

Skills are important for living in the community. the more skills a person has, the less support they need, and they feel more empowered. "Now I can make my own decisions and take responsibility for my actions, even if I discuss things with my family, friends and medical team quite often. I see my relationship with my mother and brother in a different light, they understand me and I can count on them, we even stopped arguing." His family was motivated to get involved in the rehabilitation programme. Group discussions with the family proved to be really helpful, his mother no longer criticizes him in a way that makes him feel irritated. "At the Centre, I learned to recognize my abilities and started appreciating them, so I take a great deal of pride in that." Empowerment means the power to recognize and develop strengths (skills, capacities) that a person already has or can develop, develop self-efficacy and confidence that he/she can achieve the desired goals, live a life full of purpose, be active in standing up for himself/herself, and foster hope and motivation. "My life finally makes sense. I still have an occasional crisis, I get scared and sometimes people seem to give me an ugly look, but I can deal with it when I stop being afraid. When I ask for support, things get back to normal.

It happens to other people too, this is how it goes in life." In rehabilitation, it is important to help the patient overcome the feeling that illness is a disaster – or irreparable damage. "In my experience, the condition does not have to worsen as they kept telling me. I recovered, I haven't been hospitalised for three years, I have a job, I have friends, I'm not ashamed of my illness and I don't even think about the illness anymore, except when I need to attend the regular follow-up appointment. Had I been given this opportunity earlier, I probably could have avoided many admissions to the hospital. I decided to take my life into my own hands, and do the things I've always wanted to do." Marko has recovered, and that can be defined as taking his life into his own hands. His mental health assessment report after the rehabilitation reads: there are no symptoms of schizophrenia, the patient functions well in his daily routine and family and friend relationships, he has had occasional jobs, there is no self-stigma, and he has recovered from illness.

This example shows that the negative perception of chronicity needs to be changed in favour of the possibility of recovery in people with schizophrenia; mental health services that offer modern rehabilitation programmes, as well as building a therapeutic culture of recovery is what we really need. This example pinpoints the importance of fighting illness identity from the first episode of illness, given that, after the first psychotic episode, young people often feel that illness defines them, pushing all other aspects of their lives aside. This phenomenon is known as a focus on the disease, with the illness and illness-related stigma completely defining one's concept of *self*. Individuals with mental health problems readily apply the negative labels and stereotypes to themselves, subsequently feeling that they are 'just schizophrenic'. Therefore, from the very beginning of treatment after the first episode of psychosis, patients should get professional help to be able to cope with self-stigma, low self-esteem, hopelessness, depression, lack of self-efficacy, but also decreased social adjustment over time.

12.3. Theoretical models for understanding mechanisms of stigma and self-stigmatization processes

Despite the significant progress in the treatment of patients with mental disorders, the possibility of recovery, raising awareness of stigma as an obstacle to the treatment of mental disorders and a number of anti-stigma

programmes in different countries worldwide, stigma remains persistent in all cultures. Therefore our efforts need to be streamlined on the prevention of the negative impact of stigma on the patients' lives. To counter stigma and its effect on the lives of people with mental illness, it is necessary to understand why stigma develops in the first place and why it has been so persistent in all cultures and all walks of life. There are various psychological and social reasons for this. Patients, their families and professionals involved in treatment should, therefore, be aware of those reasons so that persons with mental illness can reject the stigma of mental illness and prevent self-stigma, discrimination and other negative effects of stigma.

Cultural perception of mental illness, causing patients to be depicted as dangerous or unpredictable, may lead to associating mental illness with a threat to physical integrity or fear of contamination, which would cause another person also lose their sanity. It is safe to assume that the stereotype of danger associated with mental illness has a defensive role. It is thought to stem from the projection of the fear of losing control and the fear of insanity on the mental health patients and treatment facility. Therefore, our fears of "insanity" are shifted to our conception of mental illness, which is in turn based on the prejudiced beliefs.

According to the theory of stigma, people develop a stance on mental illness very early in life as they grow up in their family, as they gain their personal experience, or under the influence of media reporting on mental health problems.

Based on the stereotype of mental illness - social stigma, people expect that most people will reject a person with mental illness as a friend, neighbour, employee, intimate partner and that most people will think that people with mental disorders cannot be trusted, or that they are less intelligent and incompetent. A person who has never been affected by mental illness and has not been admitted to a mental health facility will not attribute personal meaning to such beliefs, but in case that the person or his or her family becomes affected, these beliefs become emotionally relevant to them. At this point, it is very important to reject the stigma of mental illness as something real, because otherwise the person may experience self-stigma that will adversely affect their recovery.

The stereotypes underlying stigmatization, such as the belief that mental illness is synonymous with a weak personality, are believed to serve a purpose

of maintaining the image of a strong personality in the psychological sense, while in a social sense they serve to categorize information, to make it easier to cope with the world we live in. The prevalence of stereotypes in different societies has shown that the stereotype of mental illness has a psychological and social function. Possible interpretations of the development of stigma include sociocultural model: stigma develops to justify social injustices, e.g. the belief that the African Americans are inferior justifies slavery; motivational model: stigma develops to maintain a positive self-concept as a strong person, e.g. "I feel good when compared to a group of bad people" and cognitive model, in which stigma serves the purpose of categorizing the information and restoring order by categorizing the information with which a person is constantly bombarded.

To examine the stigma of mental illness, we need to look at psychological motivation behind the development and persistence of stigma, both to understand social stigma and self-stigma that tends to develop in many people with mental illness.

It can be assumed that, as we grow up and form the perception of ourselves and the world around us, the conception of the absence of mental illness associated with a weakness of character plays a role in affirming a positive concept of self-worth, which is important for building one's self-esteem and self-confidence. Before they are affected by illness or stigma, people with mental illness share the same stereotypes as the society in which they live.

Mental illness is a metaphor for the weakness of character – inferiority complex, so it is possible for a person suffering from mental illness to consider themselves weak and inferior and expect other people to reject them. For patients with mental illness, this association is harmful.

The person with the learned stereotype that is usually common in society and that tends to define persons with mental illness as weak, incapable of living a normal life and unable to make their own decisions, by activating the internalized stereotype of society at the moment of becoming affected by mental health issues, will start to see himself or herself as weak if they accept such stereotypes as personally relevant, which in turn leads to self-stigmatization and feeling inferior, which generates a number of further consequences related to the severity of illness and the outcome of treatment. This process is largely unconscious, and many people may not be aware of it - to protect the positive self-image, they project unpleasant feelings in the outside world, for which

they believe to be stigmatizing without exception, anticipating discrimination even if they had not been stigmatized. However, this may lead to social withdrawal, which is detrimental to their mental health. Persons with mental illness should, therefore, be encouraged to learn about successful strategies to overcome self-stigma, better cope with stigma, and integrate into society that belongs to all of us, fighting against social exclusion.

As for self-stigmatization, is important to know that most people, before they are affected by mental health problems, tend to share the predominant societal views about mental illness; so it may happen that mental illness could pose a threat to one's concept of self, as a person believes that the stereotype of weakness is true, which affects his or her self-esteem and poses a risk to recovery. Therefore, it is important to restore his or her positive self-image in a way to encourage the person to accept treatment and play an active part in their recovery, rather than to reject treatment and deny a diagnosis to protect themselves from stigma-related shame, fear and guilt. By accepting the diagnosis and treatment, the person demonstrates his or her strength and ability to deal with the problems of illness and stigma in such a way that stigma does not adversely affect their recovery from mental illness.

In order to preserve a good self-image after the diagnosis of mental illness, different defence mechanisms against the illness may occur: denial of mental illness, which in turn will not make the illness disappear, while the lack of treatment may lead to poor results; agreeing with stereotypes and self-stigma, disempowerment and taking on an illness identity, and preferably, challenging the stereotype, acknowledging it, but disagreeing with it, rejecting the stigma and focusing on recovery.

Therapeutic strategies should be based on this model, which points to the need to redefine the self that will result in the rejection of internalized stereotype and help make room for building a positive self-concept, and eliminating the stereotype. The following procedures can successfully contribute to rejecting the stereotype of stigma and restoring a positive self: learning about the stereotype, injustice and stereotype inaccuracy, insight into the connection between the stereotype as a contributing factor to maintaining a positive self-concept and different activities demonstrating their own efficiency and support to a positive self-concept, all of which will eventually lead to empowerment.

12.4. Methods of prevention and dealing with self-stigma

The way in which mental health services handle stigma can significantly impact the processes of empowerment and reduction of self-stigma. Ignoring self-stigma and empowerment may have far-reaching negative implications on the recovery from mental illness. Therefore, it is necessary to educate all professionals involved in the treatment of people with mental illness to make their interventions empowerment-oriented, which will in turn lead to the prevention of self-stigma. Effective intervention for the prevention of self-stigma has sparked immense professional and scientific interest, making it a focus of research in this field. The development of self-stigma reduction interventions appears to be a relatively new area. Self-stigma is associated with empowerment and self-esteem, so empowered patients are expected to better cope with social stigma and to be less prone to self-stigma. Procedures that boost self-confidence and improve self-efficacy may lead to reducing self-stigma, even when they are not directly focused on self-stigma reduction. In most cases, self-stigma is an unconscious process, so specific prevention procedures need to be planned.

Turning to the bibliography for the period 2000-2012, using the keywords: self-stigma, internalized stigma, perceived stigma and stigmatizing actions revealed only a limited number of programmes designed to reduce self-stigma. The authors included programmes that involved patients diagnosed with schizophrenia and depression. They identified 14 programmes addressing self-stigma and found that eight were effective in reducing self-stigma. Disease education or disease education combined with a cognitive approach was the most commonly used method, and interventions were conducted in a group setting. The content of these interventions varied across groups, as did the number of sessions conducted, while their efficiency in reducing self-stigma varied too. The literature review confirmed that an intervention based on a purely educational approach designed to increase knowledge about the disease did not affect reducing self-stigma, such as the three sessions programme focused on providing stigma coping skills. This time-span did not allow significant increases in participant knowledge, but also proved to be a limiting factor concerning inter-group processes, and the potential for normalization, so that good outcome indicator could not be expected. Likewise, the study conducted in an educational format to educate the participants about consequences of stigma and encourage them to share their personal experience in

a 16-session intervention did not change the perception of stigma, improve coping strategies, nor did it improve the group's self-esteem; nonetheless, the study provided impetus for further exploration of approaches combining the benefits of education and group experience, within a structured, therapist-led format. Some educational programmes have shown good results in overcoming self-stigma, such as the programme for people with schizophrenia and schizoaffective psychosis. In ten group sessions, the authors educated the participants on definitions of illness, medication side effects, stigma, relapse prevention, communication, stress management skills, self-help, and community resources. They concluded that a better understanding of mental illness leads to stigma reduction. There was also a programme that indirectly targeted self-stigma through improving self-esteem in a group. The intervention included education about schizophrenia and its symptoms, epidemiology, and course of the illness as well as stress and medication effects. The psychoeducational approach was based on the stress vulnerability model. The aim was to empower patients with information, to emphasize hope, and to encourage them to participate in group discussions. The study was conducted in 8 sessions held once a week, lasting from 40 to 60 minutes with 3 to 8 patients in a group. The staff responsible for the group received a two-week protocol-based training. The results demonstrated an increase in participants' knowledge of their illness, illness insight, treatment adherence, improved attitude towards medication and higher self-esteem.

The programme for patients after the first episode of illness, designed to improve their self-esteem and prevent illness identity, finally resulted in decreased illness identity, improved quality of life, and increased hope in the part of research held in 2006. The intervention aimed to develop an acceptable interpretation of the disease experience, diminish self-stigmatizing attitudes, take the focus away from illness, create hope for the future, and develop individual life goals. The programme was conducted in a 12-session group, structured, manual-based intervention, but there was enough room for open discussion. The groups are led by experienced therapists supervised by project researcher. In another study conducted in 2007, there was no improvement in self-stigma outcomes and the concept of *self*.

Knight et al. (2006) used a cognitive behavioural approach. Assertiveness techniques and role-play were applied. It was expected that participants would demonstrate an increase in levels of self-esteem, empowerment, and

a reduction in levels of psychopathology. Each group met weekly, over a 6-week period, for 90 minutes in an interactive format, allowing exchange between the group and the group leader to find efficient stigma coping strategies. Themes of social stigma, internalized stigma, discrimination, myths about schizophrenia, and evaluation of self were discussed, and selective disclosure of group leader experiences of stigma was encouraged. The intervention presented information regarding patient advocacy associations. The results demonstrated a significant change in self-esteem, and significant positive effects were found for psychopathology (decreased levels of depression, positive symptoms, negative symptoms and general psychopathology). Contrary to the research hypothesis, no significant effects were observed in empowerment and coping mechanisms. Regarding the lack of empowerment, the authors comment that empowerment is a group-driven process and that it may have subsequent effects. As they had predicted, stigma perceptions did not change significantly as it was hypothesized that stigma really existed.

MacInnes and Lewis (2008) encouraged programme users to share their experience of illness. They investigated the impact of a 6-week group programme designed to reduce the stigma of persons with serious mental illness. The theoretical foundation of the programme was the cognitive approach and unconditional acceptance. The programme content included the following: learning about mental health problems; discussion about experiences related to diagnosis and symptoms; the consequences of mental health problems; stress - vulnerability model; description and definition of stigma; experience and consequences of stigma; principles of self-acceptance, assessing specific stigma-related beliefs and encouraging active involvement of service users in their treatment. The results demonstrated a statistically significant reduction in self-stigma; there were no statistically significant changes in the increase in self-esteem.

Fung et al. (2011) created an intervention that combined five intervention strategies, including psychoeducation, CBT, motivational interviewing, social skills training, and goal attainment. This programme consisted of 12 groups and four individual sessions for persons diagnosed with schizophrenia, who were included in a three-month psychosocial programme before joining this programme. The programme was evaluated after group session 7, group session 12 and in the 6-month follow-up period. The findings suggested that the programme had positive outcomes on self-esteem, it helped enhance

treatment adherence and promote readiness to change problematic behaviours. However, there was a lack of therapeutic maintenance effects during the 6-month follow-up period, which helped identify a major need for continuous work with stigma.

Lucksted et al. (2011) developed Ending Self-Stigma (ESS) to help people reduce self-stigma.

Inclusion criteria included a diagnosis of schizophrenia, schizoaffective disorder, and depression. Ending Self-Stigma consisted of nine 90-minute group sessions. The focus was put on stigma. The sessions combined lecture, discussion, sharing of personal experiences, teaching and practice of skills, group support, and problem-solving. Participants are asked to complete individualized practice assignments between sessions. Each session includes: welcome, review of home practice and previous session, the introduction of new skill or strategy, discussion and in-session practice. Each meeting offers a different strategy for dealing with stigma. Strategies include telling myth from fact (Session 1), using cognitive-behavioural principles to change one's dysfunctional thinking (Session 2 & 3), strengthening positive aspects of one's self and self-esteem (Session 4), increasing belongingness in the community (Session 5) and with family/friends (Session 6), and responding to stigma and discrimination (Session 7). Session 8 reviews all strategies and Session 9 guides participants to plan the next steps beyond the course. The results suggest that ESS significantly reduces self-stigma, improves recovery and perceived social support. Changes in empowerment were statistically insignificant.

Based on a critical review of the literature, Mittal et al. (2012) found that there were two significant approaches to reducing stigma, one attempting to change one's self-stigmatizing beliefs and the other focused on improving one's skills to cope with stigma through self-esteem, empowerment, and help-seeking behaviour. Both approaches are important for tackling self-stigma and should be combined in these interventions.

Identification with a large group of people having the identity of those who are stigmatized - is a key variable, affecting how they will respond to stigma. Some studies suggest that developing an empowered group identity for persons with schizophrenia could lead to reducing stigma, which is also supported by research on self-stigma as part of a programme for self-help groups in user associations, where their members have proved to have low levels of

self-stigma. Therefore, a programme that promotes an empowered group identity for persons with schizophrenia could be effective, so this should be considered in future planning of self-stigma reduction programmes.

Many patients believe that the diagnosis of a mental disorder implies poor prognosis and that there is no hope for recovery. Dysfunctional beliefs are associated with poor prognosis. Believing that people with mental disorders cannot recover promotes self-stigma and hinders recovery, so the main goal of education is to talk about the meaning that the patien has attached to his/her illness, and to list dysfunctional beliefs about poor prognosis against recovery prospects to prevent or eliminate self-stigma. Research has shown that people with the right insight and low levels of self-stigma have the best prognosis, which in turn fosters interventions that combine psychoeducation and self-stigma reduction and prevention programmes. Therefore, information about mental disorders based on the psychobiosocial concept of illness given in an environment that fosters therapeutic optimism, hope, recovery and empowerment should be accepted as a fundamental principle in any type of information presented to patients and their families, regardless of when the illness began.

Treatment, especially illness education, should include working on stigma and discrimination, including effective strategies to combat self-stigma, stigma and discrimination. Professionals must recognize the early signs of self-stigma, detect the effects of stigma and self-stigma on the symptoms, functioning and personal recovery to define procedures that will counter the effects of stigma, or prevent the development of self-stigma and its negative consequences.

12.5. Programme for self-stigma prevention and empowerment in dealing with social stigma

The self-stigma prevention programme is conducted as a group psychosocial intervention of at least 4 sessions focusing on stigma-related topics. The programme can operate as part of an illness education programme, or as a separate programme. The Programme Guidelines can also be used in individual sessions.

Diagnosis of mental disorder is almost always associated with negative attitudes towards mental illness. The patients believe that mental illness is a sign of personal weakness and that other people will reject them when they

find out about their mental illness, they anticipate discrimination, low expectations regarding the potential for a successful private and social life, self-stigma, and emotional reactions to stigma and discrimination can occur at any stage of the treatment of people suffering from mental disorders. So, in order to tackle the problem, a programme for prevention and dealing with self-stigma has been developed at the University Psychiatric Hospital Vrapče, the Referral Centre for Psychosocial Rehabilitation of the Ministry of Health of the Republic of Croatia.

The goals of the programme are to help people diagnosed with mental disorder to reject the stereotype of mental illness as personally relevant, to help them build or rebuild the positive self-concept which has been shattered when diagnosed with mental disorder, to encourage them to build their identity as a person, rather than one of a patient, to prevent social isolation and to help them develop and apply the skills needed to tackle social stigma. Discussing the meaning of diagnosis, working through the emotional response to the diagnosis, and learning about the illness from the recovery-oriented perspective are an important part of the programme.

The therapeutic relationship based on the culture of recovery and recovery-oriented mental health services both facilitate the process of rejecting stereotypes. Because of the nature of stigma that drives the patient to feel inferior and ashamed, some of them rarely talk about the experience of stigma and discrimination, so therapists have to ask about it. Professionals need to have the skills to recognize the signs of self-stigma and defence mechanisms such as social isolation and giving up on their life goals so as not to mistake them for the negative, or any other symptoms of illness without tackling self-stigma as the underlying cause of these symptoms. Depressive symptoms are common in patients diagnosed with a mental illness, or those with the first psychotic episode. Psychiatrists must recognize that the development of this type of depression may be related to the *reaction* to the diagnosis, which should in no way be neglected in the individual treatment plan, in which a self-stigma prevention intervention needs to be planned.

Methods: The programme integrates the elements of illness education, cognitive techniques for dealing with dysfunctional thoughts, working through stigma and illness-related emotions and assertive skills training to learn how to cope with stigma and discrimination.

An open discussion on general knowledge, attitudes and emotional reactions focused on different stigma-related topics is encouraged. Sharing personal experience, including success stories of coping with stigma, and learning about stigma and discrimination coping skills is widely encouraged.

Topics include: stereotype awareness, agreement/disagreement with stereotype; reactions to diagnosis and meaning attached to it; self-reflection on self-stigma; experience with stigma and discrimination; anticipated discrimination through the anticipated rejection that did not really happen, taking a decision on whether to reveal or not to reveal information about mental illness, whom to tell and what is the best time to tell others about a diagnosis of mental illness.

Four-session self-stigma prevention programme

The self-stigma prevention programme may be conducted as a separate programme, independent from the psychoeducational programme, aimed at working through the stigma-related, specific topics. Just like psychoeducation, this programme involves integrated educational, psychotherapeutic and sociotherapeutic goals. **Educational goals** include learning the facts about stigma, discrimination, and self-stigma, the negative impact of stigma, self-stigma and discrimination on the patient's life and recovery from mental illness based on the bibliographic resources. **Psychotherapeutic goals** include working through the stigma-related emotions and protecting positive self-concept from stigma, while **sociotherapeutic goals** include working on efficient strategies to deal with stigma.

The goal of the intervention is to set the patient free from false beliefs about the illness, stigma-related feelings of shame, guilt and anger and self-stigma that hinder recovery. The patients will learn about the mental disorder and illness-related attitudes, and will be given the opportunity to express and work through their personal attitudes, expectations and emotional reactions on their diagnosis and/or admission to hospital. The professionals need to help them learn and use efficient strategies to fight against the negative effects of stigma on their lives. An open debate on the topic empowers the individuals and makes them more resilient to the negative effects of stigma. Encouraging the individuals to share their personal experience with stigma, including success stories, contributes to rejecting stigma-related stereotypes and fosters self-stigma prevention.

The goal of the first session on stigma is to discuss the attitude of the general public towards mental illness, to encourage debate in order to learn about the usual stereotypes of mental illness, the reasons why people have stereotypes, and to find out whether diagnosis/treatment has affected the person's life, including their perception of self-worth and other people's attitudes towards them. Negative attitudes will then be further discussed. The goal is to raise awareness about the universality of attitudes among patients, as well as to make them understand that most patients share a similar pattern of attitudes before they start treatment. The debate tends to confirm the presence of stereotypical beliefs in different groups of people, including the patients, family members, mental health professionals, employers and staff involved in treatment, thus confirming the universal nature of stereotypes in people from all walks of life.

The purpose of further discussion is to encourage the group to disagree with the stereotype of mental illness and to spark a debate to see whether the group will feel that the stereotype is true. For example, they will be asked whether they agree that all persons with mental illness are incompetent, unreliable, weak, inferior, dangerous, etc. The facts debunking the stereotypes will then be presented, such as the fact that the persons with mental illness are more often victims than perpetrators of violent crimes, and other facts debunking the stereotypes. In this session, it is important to contrast the myths (prejudice) on mental health illness with scientifically proven facts, and the results of different studies can serve as a basis for that.

After discussing myths and facts, a discussion on feelings potentially caused by stigma will be started, including their feelings and experiences with stigma and discrimination. We need to try to find out whether stigma makes them feel ashamed, angry, guilty, inferior, and full of fear of rejection if people learn about their diagnosis and treatment, keeping the information on their illness secret, social withdrawal etc. In other words, we need to find out how they cope with stigma and whether they are prone to self-stigma. The group is then led to conclude that knowing more about stereotypes and their universal nature does not mean that they are true and that affected individuals do not need to agree with them.

Key messages of the first session. Key messages of the first session on stigma include the following: one needs to be aware that there are many people with negative attitudes towards mental illness, including false beliefs that

mental health patients are incapable, weak and dangerous. It is important to suggest that mental health patients should dismantle and get rid of stereotypes, and dismiss any stereotype-related problem (such as difficult functioning and low self-esteem) as a medical problem that can be solved, rather than a confirmation of stigmatizing attitudes.

The goal of the second session is to educate on discrimination and identify discriminatory behaviour, to talk about situations in which it may happen (workplace, family, neighbours, doctor, friends, society, etc.). The group is invited to discuss the personal experience with stigma and discrimination, as well as the coping strategies they used. The group is encouraged to describe the situations that they have already experienced or that they could experience in the workplace/neighbourhood/family environments, which could be uncomfortable for patients with mental illness. They are then asked to describe their behaviour and reactions in that situation. The group is invited to discuss the efficiency of coping strategies, as well as any new efficient coping strategies that spring to their minds.

The educational session covers the topic of discrimination, including legal consequences, discrimination associated with mental illness and ways to protect yourself against discrimination. A **psychotherapy** session includes dealing with feelings and behaviour of a person facing discrimination, including discomfort, anger, rage, shame, embarrassment, feeling inferior, and withdrawal from social life. A **sociotherapy** session includes topics such as learning about efficient coping strategies, practising efficient strategies and encouraging the group to use such strategies in everyday life. The group will then be invited to present examples of dealing with stigma and discrimination, by encouraging them to find alternative behaviours and practise assertive behaviour through role-play. The suggestions of the group serve as an important contribution to the pool of efficient strategies and they are used in assertiveness training for dealing with social stigma and discrimination. The members of the group become aware that they can choose from different coping strategies, which is usually an empowering experience. They are encouraged to engage in assertive ways of dealing with stigma, and discouraged from using the strategy of social exclusion. The goal is to find efficient coping strategies for stigma and discrimination, which become an empowering experience for the group, newly empowered to fight against the harmful effects of stigma and

discrimination. The members of the group usually realize they are not helpless and that there are different ways of reacting to stigma and discrimination.

Key messages of the second session. Usually we can't control the way in which other people behave and think, but we are in control of our behaviour. It is normal to feel discomfort and anger when exposed to stigma and discrimination, but the most important thing one should bear in mind is that those who discriminate against other people are wrong, and their attitudes/prejudices about mental illness are incorrect, which is supported by scientific evidence. It is important to tell yourself the following: even if I feel embarrassed, or feel bad about the discrimination I've been exposed to, I have nothing to be ashamed of and I'm OK. I can choose how to respond in specific situation, it's up to me to decide whether I'm going to talk to these people and tell them that it's not alright to act like that, or rather choose not to discuss it with them. Maybe I can even lodge an official complaint with the relevant authority. Most importantly, I choose how to respond, I choose to be OK, I choose not to be ashamed, I choose not to withdraw from social life and I choose to stick to my personal values. It is important to make sure that I behave properly, that I'm aware that I'm the one who's responsible for my behaviour and treatment, and that I don't behave in a way that would let others know that I don't feel okay (e.g. violent behaviour), and that I know when I need to get professional help.

The third session covers the dilemma of whether to disclose, or not to disclose information about illness and treatment and discusses the advantages and disadvantages of each option. At the beginning of this session, the group is invited to discuss their experience regarding disclosing the information about mental illness and treatment, including both positive and negative experiences and attitudes towards disclosure or non-disclosure of such information. The group usually shares both positive and negative examples. Such examples are then analysed in terms of advantages and disadvantages of disclosing/not disclosing their mental illness.

Key messages of the third session. Information about one's health is confidential (the right to privacy) and the person has the right to choose whether or not to share their condition with others. He/she will decide based on an assessment of the situation, which would show whether it is in the person's best interest to tell about their mental health condition or not. The group is encouraged to discuss the advantages and disadvantages of telling others about their

condition, and provide specific examples. If the group cannot find an example, the professionals will then share real-life examples to spark a debate. The principles of motivational interviewing and problem-solving skills are used to teach the group how to decide on whether to tell or not to tell about their condition in a specific situation.

Fourth session. The goal of the fourth, wrap-up session is to sum up all strategies covered in the previous three sessions, and to create a personal action plan that would help the group use the acquired knowledge and skills in everyday life.

CONCLUSION

Self-stigma has many negative impacts on recovery from mental illness. Therefore, self-stigma needs to be prevented, its symptoms need to be recognized early and the interventions for reducing self-stigma need to be applied, either as a separate intervention, or as a part of illness education programme. The self-stigma prevention programme run at the University Psychiatric Hospital Vrapče as a part of the psychoeducation programme in a study conducted on 40 patients has been proven effective in reducing self-stigma, compared with a control group that did not participate in the programme.

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13. HOUSING

Vesna Švab

13.1. History

The history of housing for people with mental disorders is that of a pendulum swing. Nevertheless, it can be summed up by saying that predominantly hospital or asylum based-care is slowly transforming to community-based care, at least for people with severe mental disorders. Deinstitutionalization of mental health care should protect patient human rights, as defined in the UN Convention of the Rights of People with Disabilities (CRPD). In the area of deinstitutionalization some decades ago, number of hospital based patients was significantly reduced. The support that patients received upon discharge in the early days of deinstitutionalization, which in many cases remained this way to this day, usually consisted solely of medication, which has serious consequences. The evolution of housing approaches shows that they slowly changed from custodial (staff control – patient position) to supportive housing (still little resident control in rehabilitation service) to finally supported housing with residents' control and staff working as facilitators. The idea of supported housing was launched in 1995 in a project Housing First. The essence of this approach is that mental health consumers "choose, get, and keep" the housing that they like the most. Support staff is there to assist the clients in finding permanent "homes", rather than specialized housing programs.

The WHO produced a WHO Quality Rights Toolkit in order to assess and improve quality and to observe human rights in both outpatient and inpatient facilities in order to change and improve living conditions of people with mental disorders. A comprehensive assessment of facilities can help to identify problems in the existing health care practices and to plan effective means to ensure that the services are of good quality, respectful of human rights, responsive to the users' requirements and promote the users' autonomy, dignity and right to self-determination. Assessment is important not only for

reforming past neglect and abuse, but also for ensuring effective and efficient services.

13.2. Definition of housing

Everyone has the right to a home. Only after making sure they have a roof over their head, people can exercise other human rights. It is all about free choice and strengthening capabilities. Housing is high on the patient agenda of needs, especially when the danger of homelessness comes into play. Housing cannot be separated from rehabilitation and care.

There are different aspects of looking at the problem of accommodation for people with mental disorders. For psychotic patients, unstable housing can be stressful and exacerbate relapse. On the other hand, patients with severe mental health problems often drift into housing deprivation and poor housing. Poor housing means social isolation. Community-based housing requires cooperation with the social welfare system.

13.3. Housing support

Assertive housing support should give service users better chance to stay in their own homes, longer than would otherwise be the case. Generally supported accommodation is arranged in group homes that already have hostel or social work staff looking after arrangements for every specific person and his/her accommodation needs. People in supported housing may also legitimately ask for more specific support, such as support of a nurse and other mental health staff for behavioural interventions and crisis management. They are usually gathered in community mental health teams. If they work with people in independent accommodation, their goal is to enable people to stay at home. In our environment, independent accommodation is one of the social norms. Group homes are mostly established for more chronically disabled patients that typically cannot recover to the extent that everyday function is severely impaired, and those whose problematic behaviour poses a challenge to social inclusion. For such patients, connection among social staff providing housing services and medical staff providing treatment is a crucial challenge, especially because they need to consent to treatment is often a precondition for being admitted to this type of housing.

Community-based treatment and short hospital admissions raise the issue of available housing options. A growing number of people with severe mental illness (SMI) choose to live as independently as possible in their own flat, as shared housing with other mentally ill people feels like being in an institution (according to the APA 2010).

13.4. Types of accommodation in the community

The most common types of housing that are currently used include:

- Transitional halfway houses is defined as a residential facility that provides room and board and promotes socialization, until more suitable housing is found. It is used as a transitional option between spending time in hospital and community for patients in recovery.
- Long-term group residences These residences have on-site staff available, and they are available to people with severe mental illness. The stay at such residences is permanent, as opposed to staying in transitional housing, which is usually for 6-8 months.
- Cooperative apartments . The staff is not always present, but employees regularly visit, supervise tenants and provide guidance to them.
- Accommodation for intensive care or community-based crisis centre: Such housing options can be used to prevent hospitalization or shorten the duration of hospitalization. Usually, staff is always present to provide care and counselling.
- Foster or family care: Some patients are placed in a foster or family care in private homes. There is a concern that in some cases, adult-sitting is the only service actually provided. Foster families should be closely controlled to make sure that the patients live in a therapeutic environment.
- Board-and-care homes: In general, such homes are privately-owned. Just like in foster care, such homes should be directly monitored and controlled, because some of them provide substandard environment for the patients.
- Nursing homes: Nursing homes are suitable for some geriatric patients or patients with chronic disabilities, but they are inappropriate for patients in a long-term treatment to facilitate their discharge from big

psychiatric institutions. A number of researchers have suggested that a programme of activities and psychiatric supervision is developed in order to prevent a decline in social functioning in nursing homes residents.

HERO project has a different view of housing and accommodation options.

According to HERO, the types of housing are:

1. Custodial ones in which psychiatric staff are available all the time. Research has shown that residents became more dependent over time in custodial housing.
2. Supportive housing in which staff is working on rehabilitation, and is not all the time there but decides about "where and with whom". Research has shown significant improvements over time in terms of reduced hospitalization and increased competitive work.
3. Supported housing in independent homes where residents make choices. Research has shown that resident choices and control are related to independent functioning, housing satisfaction, residential stability, and psychological stability, mastery and reduced psychiatric symptoms, even if we neglect preferences, which tend to be strong in individual housing settings.

Some of the principles of supported housing (e.g., permanency of housing, individualized support) have infiltrated supportive housing programs and we get to witness a congregation practice.

In supported housing, the person with a mental health disorder is perceived as a resident at his or her home, a person with rights and the potential to contribute to society, rather than as a patient or client who needs to be supervised or managed. A focus is also put on strengths and the potential for recovery, not on the person's weaknesses or illness. Moreover, in a transformed mental health system, clients become active participants in planning, services, and research, with real power, voice, choice, and control. A major barrier to implementing this value is that professionals who have the power to diagnose and treat mental illness are sanctioned in the existing schemes. Another important assumption for a new paradigm in mental health is that of social inclusion. People with mental health struggles should not only be in the community, they should be valued members of the community. Finally, there is a need for social justice and a more equitable allocation of resources. Policies and support

options need to be put in place to overcome poverty that has affected many mental health service users (Nelson, 2010: 136-7).

The service approach in group homes in Slovenia is striving to offer rapid dignity and hope along with offering housing first. The key workers offer practical help with grocery shopping, repairs, cooking, cleaning and money arrangements. They also provide every day and social skills training for residents. The model is closer to supportive model, while individual placement is still rare. In 2016, the European Core Learning Outcomes for the Integration of Support and Housing (ELOSH) project was conducted in the Slovenian capital. It was all about service research and teaching about cooperation and human rights, followed by a fruitful discussion about service user involvement in care planning and service delivery, which was performed in a group setting in 2016. Service users with different disabilities were involved, together with housing staff in equal numbers. Service users presented their wishes, complaints and goals, while housing staff discussed the obstacles, concerns and wishes for improvement in the spirit of equality. Shifting of regular roles made a major change in communication among the two groups, even if we did not evaluate whether they made change stick.

13.5. Skills training

Social inclusion depends on the person's ability to engage in regular household activities and in social activities, hobbies and similar activities that bring fulfilment to his/her life. Patients with severe mental illness in housing accommodation often lack motivation, they have difficulties in cognitive processing and planning their activities. Skills training means that staff resists from doing things for them, but at the same time acknowledge that many among them will need long term support. Neurocognitive deficits in working memory, concentration, processing information, poor cognitive flexibility etc. need continuous re-learning and support. Cognitive remediation (brain training techniques) have shown some improvement in this functions.

The first step in skills training is assessment, best done in the realistic environment, to see the person's strengths and weaknesses of daily living. Goals should be defined and documented in the care plan and supported by patients' wishes for their role functioning. This assessment is generally done

by semi-structured interviewing and with some scales as for example Social Functioning Scale.

There are many specific interventions, among them social skills training aimed at coping and functioning in social situations, with training and rehearsal of skills (ŠENT, Social skills manual 2019: in press). This training often works for avoiding exploitation experienced by many patients. Others want to improve eye contact and other non-verbal reactions, as well as be more careful when other people talk. Skills training include homework tasks that are individually adapted to specific patient's capabilities.

13.6. Evaluation

The Housing project developed evaluation schemes for housing. They gathered the available information and, in consultation with service users, they developed an evaluation scheme on ten key areas:

- evaluation of users skills;
- local context and resources;
- organizational structure and network of mental health services/case manager skills;
- evaluation of perceptions, representations, motivations and satisfaction of users;
- flexibility, clinical governance, communication and cooperation;
- responsibility and decision making of users;
- volunteering system and civil society inclusion;
- lifelong learning;
- resources for housing and
- impact evaluation.

Four HERO target groups were defined: users and their families, local health services, workers from non-health agencies and residents. 249 people in different countries were involved. A clear recommendation was produced.

The main question arising from evaluation of the existing housing schemes is how to proceed from supportive to supported housing, preferred by most service users.

The best practice examples from Slovenia point to the importance of connecting different sectors and service providers in establishing needs led service provision. People with repeated hospital admissions and low community and family support achieved major improvement in recovery, when they, either at once or one after another, got support necessary to resolve their housing and employment situation, apart from skills training and support from rehabilitation services. A network that connected NGOs providing day care and housing, the employment agency and supported employment schemes in line with the users' wishes and needs proved to be key to success. The experience says that housing and skills training only provide safety, but also prolongs institutionalisation outcomes, or the so called negative symptoms and low functioning. Productive work and financial stimulation is the core rehabilitation method, as proved by many randomised control trials all over the world. The evidence suggests that supported employment is effective in improving vocational outcomes relevant to people with severe mental illness. Individual placement and support (IPS) model is the most popular implementation of supported employment. Meta-analytic analyses of the randomized controlled trials of IPS showed that IPS, compared to usual treatment conditions, had better vocational, clinical and quality of life outcomes.

CONCLUSION

Housing, in essence, represents a basis for the rehabilitation and recovery. Our understanding of housing for people with mental health disorders has changed dramatically. In contemporary housing trends, there is definitely a trend towards caring for the user in a way that emphasises users being in control over the household and other aspects of the habilitation process.

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14. WORK REINTEGRATION IN RECOVERY OF PSYCHIATRIC PATIENTS

Marijana Cvitan

14.1. Introduction

Working in outreaching treatment services for patients with severe mental illness in the Netherlands during the period that a new method of helping patients to work or school was introduced, provided me and a lot of my colleagues a whole new perspective on the potentials and prognosis of our patients. It made me wonder to what extent functional outcome in people with serious mental illness is determined by their illness and their social circumstances and to what extent it is determined by recovery-oriented care that implements models of active supported employment.

14.2. Background

Major psychiatric disorders disproportionally affect young and working age population. Because of their peak of onset in adolescence and its probability of a chronic course, any severe mental illness (SMI) carries tremendous consequences for development and functioning of these affected young people. For the society as whole, it seems that the biggest loss of productive years is due to mental illness. The burden of mental disease is great, both for the person, as the family and society. Mental illnesses can be roughly divided in Severe and Common Mental Disorders. One aspect of this division lays in the level of occupational and psychosocial (dys)functioning of the affected person. Psychosocial functioning is defined as the capacity of a person to interact and cope in the context of school, work, family and social settings.

Schizophrenia and other disorders in the psychosis spectrum belong to the severe mental disorders and have a detrimental impact on long-term level of functioning of affected people. It is clear that the biological treatment of schizophrenia has a large influence on remission or at least the amelioration of

symptoms of the illness. Unfortunately, the level of every day functioning often remains impaired even if remission of symptoms can be reached. Both the illness as well as the side effects of the necessary medication is often blamed to be the source for these problems in functioning, since they both can cause fatigue, being slow or having motivational problems and problems with taking initiatives. Often we notice that patients, despite good treatment on different levels and even when side effects are minor, still are not being able to improve their psychosocial functioning. Herein, we must always be aware of the personal process patient is going through with such a devastating disorder on multiple levels. Psychological treatments, developed for or adjusted to psychotic illness, have shown good results and are proven effective in the process of healing of traumas, dysfunctional ways of thinking and controlling commanding voices, aggression and fear. Still, despite the developments in biological, therapeutic and psychosocial interventions, schizophrenia remains a recurrent and severe illness with heterogeneous response to treatment strategies.

It is therefore not surprising that the expectation associated with psychiatric population is a low quality of life. The large unemployment levels have generally become an accepted outcome bringing along financial, housing, social and health problems. People affected with any mental illness are employed at significant lower rates than people with other conditions. This has led mental illness to be the major cause of social security disability benefits and working disability in Europe and the United States.

So, should getting back to work or school really be a priority for people with serious mental illness and their care workers considering these facts? As it happens, most of these patients really do want to work. According to the NAMI report in 2014 about 60% of 7.1 million users of unemployment benefits in United States due to mental health illness are willing to work. And for those care for people with severe mental illness, what importance is work for us employed? As Oscar Wilde has stated in the past: “The best way to appreciate your job is to imagine yourself without one”. People who are unemployed typically have worse health, more negative outcomes and more suicides than those employed. Mental illness not only can result in impairments leading to long-term unemployment, but the stigma associated with mental illness itself often forms a barrier of itself in regaining employment.

People derive a great sense of meaning from their work, along with the structure, social role, contacts and sense of independence. The benefits of work in regard to mental health are subject of many publications. In psychiatric illness, there is strong evidence that early functional recovery and restoring the quality of life is associated with better long-term outcomes in schizophrenia. An example is a large Australian study that followed 209 of young people affected with the first episode psychosis during 7.5 years. They examined the relationships between 'full functional recovery' and symptom remission in FEP over 7.5 years. Amongst other important findings in this population, the study showed that functional recovery in the first year of treatment predicted a better outcome of these young people on the long term. The improvement was clear not only on the level of future daily functioning, but also in days of future hospital admissions and even in the rate of 'negative symptoms'. The follow up of 7.5 years indicates this is a stable effect on the long run.

Using the growing knowledge about recovery in Severe Mental Illness (SMI), many professional, family and patient organizations are supporting a change in treatment goals in modern psychiatry. For example, the definition of "outcome" in psychiatric treatment in severe mental illness is broadening. Targeting symptomatic remission only in treatment seems to give limited guarantees on regaining a "normal' life. Adding overall quality of life as the measure of success of treatment is enriching modern treatment plans with new strategies to improve daily functioning. This focus, alongside with assessment of symptoms, medication and health status has several consequences. When quality of life is an additional goal in treatment, professionals tend to ask more about experienced well-being of patients and their wishes for the future. The positive effects of this development are situated in setting personalized goals that are valued by patients and regularly evaluated as part of the social-psychiatric treatment. This also renders a greater compliance of patients to their medical treatment, which is important as treatment non-compliance often leads to recurrence of psychiatric symptoms.

For professionals, a big question in clinical practice is how to construct and deliver a rational treatment plan integrating these diverse goals. What are the common factors and distinctive factors for rehabilitation? Research is suggesting three factors that can improve the variable functional outcomes in schizophrenia: stable relationships, stable employment and using second-generation antipsychotics.

A clinician might say ‘easier said than done’ in this regard, certainly when it comes to increasing employment levels for people with psychiatric illnesses and they are right. The aim of this chapter is to provide the latest developments and highlight the current best practice method, that increases the chances of successful work-reintegration of patients with psychiatric disorders and consequently increase the quality of life of patients and their families.

There is enough evidence in favor of an appropriate and systematic approach, effective and efficient, in helping patients back to work or education. Occupation is a vital part of our lives and it helps a great deal of patients to restore their daily life with structure, meaning and perspective.

Still, the road to restore ‘a normal life’ is burdened with many obstacles including societal stigmatization, self-stigmatization and loss of hope, which often accompanies those with a psychiatric illness. These are hard issues to address on your own. Intensive individual coaching towards regular work or education can help passing these obstacles.

Taken together, in practice it is difficult to say what the future is going to look like for a young person with psychotic disorder. We do know what challenges this future can hold and that with comprehensive support, we can make a significant positive difference in their life.

14.3. A short history of supported employment

Although employment is defined as the key social determinant of health, a methodical approach to assisting patients to employment in psychiatry has a relatively short history.

The view that psychiatric patient needs a form of occupational therapy, being it sheltered work or job-training arose in the seventies and led to the development of a variety of different rehabilitation programs around the world. Mostly, patients with psychiatric illnesses were deemed to be unable to regain a regular job and that they had to be protected of the stresses regular work would give. Led by a general idea that supporting daily structure is important for treatment, but without strong methodical plans behind these good intentions, the implementation mostly took place according to the possibilities, interests and ideas of professionals, institutions and local communities.

Although the approaches were quite different, depending on individual efforts and funding, they often shared a common idea: the rehabilitation takes place after the medical treatment has brought patients in (partial) remission. The success rates varied, but were generally low, whereby methods were difficult to disseminate and study, probably due to the weak descriptions of models.

The other reality of 'work rehabilitation centers' or 'translational work' was that patient often got offered existing programs of work or training that could not take into account many personal needs and ambitions. Therefore, the risk was considerable that the offered sheltered working conditions were not intrinsically motivating, even demoralizing. In practice, it became clear that for most of our patients the 'one-size-fits-all' approach was not optimal in fulfilling the individual needs and interests. Especially for young people it felt as a great loss of time, because of the limited window of time where they have to make fundamental choices in their lives and how to develop further. This would often negatively influence the motivation to attend the programs by young patients, fuelling the impression of caregivers that patients don't want to work or are too impaired to participate in regular jobs. Common complaints of patients were: "I don't like it, there is nothing interesting for me in this program, I am not growing or prospering by occupational therapy, it keeps me busy but I am not going forward", whereas caregivers would complain that patients had missed their appointment again: "Ah, probably he/she didn't get out of bed on time again!"

With the rates of success staying low, and the 'experience of success in normal life' sparse, patients and health workers are at risk of building a mutual idea of low expected prognosis regarding the level of functioning in life. It is hard to get out of these long held beliefs and change to a different ideology, whereby health care workers themselves have to start believing in the recovery potential of their patients who had, for the largest part, always been impaired.

Modern supportive employment services have put aside some general assumptions used in the first approach, such as: "people with SMI need an extended period of time in sheltered vocational places preparing them before potentially achieving competitive job", secondly that "rehabilitation services should be provided separately from mental health services" and finally that "programs should use some transitional employment programs in order

to train the patients". These assumptions are ubiquitous and in many places are still held up to this day as guiding principles before the patient is considered ready for a competitive job. The aim of supported employment has not changed (achieving a regular job), but the method has. By trying to immediately pursue competitive employment, in 1997 group in US changed supported employment radically compared with the previous step-wise approach. Supported employment workers try to provide patients regular schooling or a paid job from the very beginning of personalized coaching. New approach proved to be much more successful and should no longer be an exception for a minority of patients.

A recent review of the literature regarding Supported Employment identified five key features of successful interventions: (1) a multidisciplinary team that communicates regularly and collaborates, (2) a comprehensive package of services, (3) one-on-one and tailored components, (4) a holistic view of health and social needs, and (5) prospective engagement with employers.

14.4. IPS - State of the art of Supported Employment

The leading method nowadays in implementation of this new concept of supported employment is Individual Placement and Support (IPS).

IPS can be considered the current state of the art in vocational intervention showing by far the best empirical and scientific evidence in the field of vocational rehabilitation. It is the most tested intervention in psychiatric rehabilitation with 24 Randomised Controlled Trials (RCTs) up to 2017 (Met cafe & Bond 2017). In the past years more trials have been published regarding IPS, looking for ways to further improve the intervention (see later in Effects of IPS). A RCT is the most strict research method where a new approach is tested by randomly assigning patients in too groups: one with the new method and the other using the 'Treatment as Usual' (TAU) as control. The difference between the test and control group is subjected to a rigorous statistical testing and corrections. The next step in scientifically testing whether a new intervention really outperforms the old intervention is a systematic review comparing results and analyzing the quality of different RCTs. If possible such a procedure is summarized by an overall analysis of the effect by a meta-analysis of the selected studies. Systematic Review of the literature showed that taken

together patients with IPS job-coaching are three times more likely to find a job compared to other rehabilitation methods.

IPS not only shows higher rates of getting a competitive job, but it also positively influences job-tenure (amount of days worked in a competitive job) and likelihood of building a working carrier. Some studies investigated the long term outcomes of IPS and, although the sample sizes in these studies were modest, they found that most of the participants who received IPS in the past held their job longer during follow-up then the ones allocated to TAU. One study found that a half of the participants ten years after the program still had a regular job.

14.4.1. Principles of Supported Employment

As mentioned earlier the novelty in Individual Placement and Support (IPS) is a change in basic ideas behind psychiatric rehabilitation. The central aim is reaching a regular job on competitive job market or start/proceed with standard education, as described later.

The motto is ‘first place than train’ with the person providing IPS (the job-coach) trying to help the patient find a regular job and then providing support during employment (either directly on the work floor or behind the scenes). The work reintegration process occurs simultaneously with other aspects of psychiatric treatment. The IPS job-coach can start immediately as a part of the treatment team around the patient. The other big paradigm shift is ‘zero exclusion’. IPS intervention can start immediately if patient expresses the wish to get back to school or work no matter the severity of the underlying psychiatric condition.

This partly prevents health care workers of developing a paternalistic attitude in this regard. The teams feel this change in the general attitude towards healthy goals. IPS is designed to follow individual wishes of patients and systematically develop the working carrier by offering continuous personalised support. The integration of IPS coaching in the psychiatric treatment team is making this intensive and daring approach possible.

How does it work in daily practice? Job-coaching following IPS principles is an interesting vocation integrating team-work with different disciplines and expertise, working with patients, and acquisition of jobs by networking with potential employers. The IPS job coach focuses primarily on helping patients

making choices, supporting their ideas and helps intensively in search and applying for jobs or education. The practical support is given in the finances and administration if needed. The IPS job coach keeps contact with the patient during this whole process as well as with mental health team and the employers.

Besides coaching of the patient, the IPS job-coach has to invest at least a quarter of their time for acquisition of jobs. Maybe this is the biggest strength and specialty of the IPS method. He or she creates their own network of employers and is continuously searching for new connections to meet individual aspirations of patients. A good job-coach is a great networker. This is important since a large obstacle for many employers is the fear of lacking the support and expertise to employ a 'psychiatric patient'. A job coach knows his/her market, adjusts to it with attitudes such as dressing code and is very well informed about legislation and benefits around employment of this special target group. It seems that the main source of network contacts in IPS comes from so called 'warm acquisition', i.e. through recommendations. 'Cold acquisition', for example by folders or telephone calling, has less impact. Personal acquaintance with the IPS job-coach and intensive help in job-reintegration to the patients provides employers with the guarantee that giving somebody a chance won't result in additional problems in running the business. Good experience with IPS coaching is needed for a sustainable network. In practice it appears time and time again that most of the people basically want to help each other.

Another crucial aspect of IPS lies in its potential for dissemination and implementation. IPS is the best developed model of vocational rehabilitation in severe mental illness, with training programs and a well-tested 'Model Fidelity Scale' that can be used to monitor and guide implementation after training. This provides opportunities to identify factors contributing to success and to apply the model as close as possible to the 'best practice' standard. It has been shown that a higher fidelity to IPS model is associated with better effect of the vocational intervention. This is important since it confirms that a significant part of the effect is attributable to IPS model itself, apart from the non-specific factors associated with a supportive therapeutic contact.

We as mental health care workers can keep focusing on 'functional recovery' in treatments better if we have the availability of a methodical approach and

measure. Work or school constitutes a big part of functional recovery, whereby a good vocational intervention gives us the opportunity to influence the process of recovery in our patients. The IPS method accentuates a well-being oriented view within treatments and helps keeping the focus of treatment-plans on concrete 'functional-recovery oriented' goals.

14.4.2. Effects of Individual Placement and Support

When supporting patients intensively in search for school or a job they actually desire, in practice we witness a positive change in motivation within different aspects of life. People have more social contacts, they have something new to discuss and hope for, families and other persons supporting the patients automatically get directed in helping them in a more healthy way. The motivation shifts from a generalised wish to feel good again to more concrete set of goals, which IPS-coaching actively helps to achieve. With positive experiences, patients tend to be more compliant to psychiatric treatment in order to maintain a good level of functioning. They have more concrete goals to achieve and so the motivation to follow the treatment for symptoms hindering patients in their reintegration efforts. Consider post-traumatic stress symptoms, social anxiety or addiction problems that often accompany severe mental illness. The change in future perspectives and creation of hope seems to be an important driving force in the process of rehabilitation and recovery.

Taken together, the good results of the IPS method and great satisfaction of patients and families with this type of provided healthcare, make IPS job-coaches an valued profession positively adding to the teams they participate in. The rendered increased success in functional recovery witnessed by other disciplines in the team can shift the collective beliefs in better outcomes of patients with severe mental illness.

1. EFFECTS ON EMPLOYMENT

Individual Placement and Support clearly shows superior employment rates of patients with severe mental illness around the world. For example nine RCT's in the US were IPS showed 65% vs. 25% employment rate. Other vocational outcomes consistently favor IPS over comparison programs in: 1. achieving first job several months faster 2. working duration twice as many weeks and three times as many hours per year 3. higher average income.

The IPS model kept its success rates in different countries, various populations, levels of social benefits and national GDPs. For instance, the systematic review and meta-analysis of 21 RCTs in 12 countries confirmed the positive effects on employment by IPS. Studies from U.S. suggests that IPS is equally effective for men and women and for different ethnic groups: African Americans, Latino Americans, and Euro Americans.

Research also shows that the differences in social and healthcare systems do have an effect on success rates when providing supported employment. The studies indicate that weaker the social benefit, healthcare and support system, the greater the impact of IPS will be. So the question is what is the real added value of IPS method without economic, labor and regulatory moderators specific for the country self?

In Norway a research group tested the value of IPS in the context of high income country, with comprehensive social welfare system and high quality of reintegration programs. They set up one of the largest trials to date regarding evaluating IPS, with a multi-center RCT including 410 patients with 18 months follow up. Even here distinctive results of IPS on vocational outcomes were found. In this study they looked at 'secondary outcomes' such as the quality of life as well and have drawn positive conclusions (for more details, see the Effects of IPS). This finding is further supporting the intrinsic value of IPS as a method to improve health care results in general.

Research has also evaluated the longer-term effects of IPS model compared with traditional vocational rehabilitation. The research field on long term effects of IPS is in its infant stage. The available data on small sample sizes so far show that most of the participants who received IPS in the past held their job longer during follow-up then the ones receiving the treatment as usual. One study found that even ten years after the program half of the successful participants still had a regular job. Hofmann and colleagues in 2014 randomized 100 unemployed persons with severe mental illness and followed them for 5 years. Good effects on work in IPS condition translated in obtaining job (65% compared with 33%), participants worked more hours and weeks, earned more wages, and had longer job tenure at two years and sustained it over the five year follow-up period. The literature is clear, IPS is currently the most successful vocational rehabilitation method at the moment in achieving and maintaining of employment for patients with severe mental

illness in the regular labour market. Evidence also indicates that its effects are held across the cultures, socio-economic systems and levels of healthcare.

2. EFFECTS ON PSYCHIATRIC DISORDER

This method is broadly tested by population with Severe Mental Disorders, mostly psychotic disorders, where high level of multidisciplinary care is needed because of the difficulties in functioning and controlling symptoms. Most current research on IPS presented considers this population. There is a larger group of people with Common Mental Illness, like depression, trauma, anxiety, also suffering severe symptoms and problems with sick-leaves, difficulties performing at work, home and in the society. Especially this group takes great part within social service and benefit systems, as discussed before. More about the current state of evidence targeting this new group is discussed in the last part of this chapter, IPS and common mental disorders.

Is it wise to pursue a regular job if one is burdened with severe mental illness (SMI)?

This is common question of healthcare workers, who are concerned that stresses of regular work will lead to an increased likelihood of exacerbation or recurrence of psychiatric symptoms.

However studies so far indicate there are no increase rates of adverse events found including: program dropouts, suicide attempts, hospitalizations, incarcerations, homelessness, or symptomatic relapses.

There is mixed evidence on non-vocational outcomes attributable to IPS itself, like symptoms, health and quality of life. It seems that positive outcomes mostly relate to employment and IPS leads to it. As shows the systematic review of the literature until 2014, employment was consistently associated with reductions in outpatient psychiatric treatment as well as with improved self-esteem by patients. Employment in this research was weakly associated with positive outcomes of symptom severity, psychiatric hospitalization, life satisfaction and global wellbeing. Around the same time the data analyses from EQUOLISE study showed on a sample of 312 patients that the IPS intervention has positive effects not only on vocational but also on clinical outcomes in patients with schizophrenia in Europe. An earlier mentioned prospective randomized research of Hoffman emerged in the same year with some new findings. In this study 100 unemployed SMI patients were followed for five years. Along with previously discussed

superior effects on competitive employment, they also measured hospitalization rates. The participants in this study were significantly less likely to be hospitalized, had fewer psychiatric hospital admissions and spent fewer days in the hospital. They even produced a higher social return on investment.

Nevertheless, what happens to those patients where IPS did not lead to successful reintegration? So far, regarding the potential negative effects the evidence is conclusive - there is a little to fear from putting efforts in the reintegration of people with severe mental illness. A review of the literature in 2014 showed that employment was consistently unrelated to worsening outcomes.

In practice, we see that IPS job-coaching as a method (practical, active, outreaching and following clients wishes) helps early recognition and intervention in relatively early stages of symptom exacerbation, compared to standard, or previous, psychiatric treatments. This can be caused by several things. Firstly, a change in intrinsic motivation of the patient is often observed, possibly making him or her also more willing to report worsening of symptoms in order to prevent getting ill and risk losing their job. Secondly, the treatment team gain more trust by mutually pursuing the goals the patient has themselves, potentially leading to earlier disclosure of worsening of symptoms. Lastly, by helping the patient regaining a place in society, he or she is less socially isolated, which could increase the likelihood of a person connected to the patient identifying a worsening of functioning.

3. EFFECTS ON QUALITY OF LIFE

In the recent years quality of life (QoL) in patients with severe mental illness rightfully became an important measurement of outcome of treatments. With that measure it is increasingly recognized that in severe psychiatric illness symptomatic remission does not yet mean recovery. By recognizing the societal and personal impact of the sickness and redefining treatment by focusing on other goals, an overall better quality of life can be achieved.

How supported employment influences the QoL and vice versa, is a more recent subject of research. The difficulty in studying this is usually the limited follow-up time of studies, while the effects on this complex domain are expected to emerge on the longer run than within the first year or two, as the financing of research projects generally permit. Nevertheless, results so far are promising.

The biggest program done to return unemployed people with SMI to work, and to measure effect in the quality of life of the IPS intervention, included and randomized 2059 patients in 23 cities for two years. The intervention group experienced more paid employment (60.3% compared with 40.2%) but also reported better general mental health and increased quality of life compared to control.

A recent European multi-centre randomized controlled trial from 2018 followed 116 patients over three years, especially focusing on the dimensions of physical health, psychological health, social relationships and environment. They found a strong association between getting competitive employment and increases in physical and psychological quality of life. Around the same time another RCT followed 85 patients for five years, focusing on effects of sustained competitive employment on days of hospitalizations and on the quality of life. They reached the same conclusion that by getting and keeping a job was the core factor of success in reducing the number of hospital admission days and increasing the quality of life of the patients. An earlier mentioned Norwegian multi-centre RCT was also interested in 'secondary effects' of IPS. They focused not only on the rates of achieved competitive employment but also on symptoms of the psychological distress, depression, general health complaints, level of functioning, quality of life and well-being. The study found positive effects on all mentioned domains.

A better chance of getting the job for this population, if adequately supported and its beneficial influence on later quality of life, constitute a strong argument against the isolation that occurs within the traditional sheltered services. They justify the costs and efforts needed for the integration of persons with severe mental illness into society.

14.4.3. IPS and additional interventions

There are several interventions developed to 'boast' the psychiatric rehabilitation treatments for the more 'treatment resistant' group of people. In the IPS research, the best results so far are seen by interventions aiming at improving cognitive performance by enhancing concentration and attention as done within cognitive remediation programs (McGurk 2007, McGurk 2015). They achieved the improvement on measures of cognitive functioning and had

better competitive employment outcomes during two years of follow-up period. More specifically: in jobs obtained (60% compared with 36%), weeks worked (23.9 compared with 9.2), and wages earned ($3.421 compared with $1.728). Several other studies confirm that adding a cognitive training strategy clearly helps those who are less responding to IPS intervention. The research further suggests that adding Social Skills Training to cognitive remediation training gives even better results.

Current technical innovations are bringing new possibilities to support the treatments, also IPS. Virtual Reality (VR) technology is providing possibilities to train the social skills or simulate situations that render social anxiety to train them for the real situation.

Simulation training has several advantages over traditional learning methods in an educational setting. These include a) repetitive practice on simulated interactions, b) exercises that allow trainees to practice new skills, c) unique and individualized training experience with each simulated interaction, d) consistent feedback in the moment, e) a stress-free environment to make and learn from errors, f) accurate representation of real-life interactions, g) application of different skills and strategies as the level of difficulty increases (e.g., hierarchical learning), as well as

h) Access to Web-based didactic material to enhance learning.

In a small randomized study in 2014 the Virtual Reality Job Interview Training (VR-JIT) proved to enhance job interview performances and self-confidence in job interviewing for individuals with psychiatric disabilities. Recently another study showed that VR-JIT addition to IPS seems to help trainees to improve their job interview skills and receive more job offers within six months of completing VR-JIT.

14.4.4. IPS and education

Severe mental illness (SMI) begins in 3/4 of all cases before 25 years of age. Therefore, the first episode of illness often affects young people at their school age of during their study in the middle of transitioning from child to an adult and independent person. For a lot of young people with first episodes of SMI at this age looking for a job not an option yet. Their wish is to finish the school first. In the western world a completed high-school education is a

necessary minimum to participate on the labor-market. Therefore, there is an obvious necessity to help the reintegration at school in an appropriate way for this vulnerable group in order to thrive again. Given the positive effects of IPS on attaining and keeping a regular job, the adjustment of this method to serve educational goals in young people with SMI is a natural development and is called supported education.

Young people with first episode psychosis are certainly a target group of special interest and the group where most research on IPS is done so far. The prognosis of first psychotic disorder is negatively affected by longer duration of untreated disease and the course in the first years of disease largely determine long term course. An early intervention in this stage has proven to double the chance of recovery and improve prognosis. The implementation of an comprehensive early intervention program with supported education rendered positive results. Furthermore, a randomized trial with a big sample of young people with first episode psychosis showed that an early functional recovery in the beginning of their treatments makes a clear positive difference for their functional outcome. The effect of IPS showed to be the vehicle of functional recovery in this young population. The biggest study on the effect of supported education based on IPS principles and within a multidisciplinary team for early psychosis, followed 404 young people for two years and found distinctive improvement in work and school participation and positive outcomes attributable to supported education.

In recent years, experts have proposed an integration of supported employment and supported education to promote career development for people with psychiatric disabilities, particularly for young people who may have decades of work participation ahead of them. Many IPS programs in the U.S. have adopted this integrated model. Despite differences in population and treatment settings, common components of successful Supported Education emerged: ‘specialized and dedicated staffing, one-on-one and group skill-building activities, assistance with navigating the academic setting and coordinating different services and linkages with mental health counselling’.

Not surprisingly, IPS-Education aims for the certificate or diploma within the formal education system of choice. Much effort is directed in prevention of staying at home. Loosing pace at school and contacts with friends often leads to social isolation in crucial stages of development of young people and can become quite difficult to turn around. Also here, it is all about

an integrated approach and “zero exclusion”. Working together on recovery in an ordinary learning environment demands vision and attention of different parties involved, like family, school, mental health workers. IPS-Education gives special attention to the ‘system’ around the student making sure that the same age-appropriate and recovery-oriented-goals are followed. The IPS coach has knowledge of schools and rules concerning education. He/she can provide help with choice, administration, application, contacts with school, helping structuring and practicing social and learning skills. The IPS Education is supporting the basic attitude towards the person as a student and not as a patient through the process of education. A fidelity scale is a tool to measure the level of implementation of an evidence-based practice or method. The IPS Supported Employment Fidelity Scale defines the critical ingredients of IPS in order to differentiate between programs that have fully implemented the model and those that have not. The importance lays in the fact that high-fidelity programs are proved to have greater effectiveness than low-fidelity programs. Recently, a fidelity scale has been proposed for IPS work and education with young people from 15-26 years is a 35-item scale assembled of two components: IPS-EMP (25 employment items) and IPS-ED (9 education items and 1 new family contact item) (2). The difficulty in researching IPS supported education is that the method has not crystallized yet into one model. So, different intervention models, outcome measurements, lack of sufficient randomized controlled trials, and small samples still limit the knowledge regarding the effectiveness of supported education. Further research is needed to study and optimize the model for supported education. Despite these imperfections, generally research shows that IPS services are well received, effective in young adults and are currently being broadly accepted as best practice.

14.4.5. IPS and Common Mental Disorders

It is interesting to see what the IPS method could mean for a far bigger group of people suffering from Common Mental Disorders. Depression, trauma and anxiety often lead to stagnation, problems related to work or unemployment, financial difficulties, debts and other psychosocial problems. As

discussed before, a great deal of social benefits is spent on this group. The research on the application of IPS for this broader group is yet in its infancy.

Acknowledging a lack of evidence regarding effectively of IPS in people with affective disorders, in Sweden researchers set up a small RCT including 61 participants with affective disorders and followed them for one year. They aimed to study the effectiveness of a newly developed Individual Enabling and Support (IES) model adapted for the target group and compared it to traditional vocational rehabilitation (TVR). IES was more effective for employment compared to TVR (42.4% vs. 4%). Also, significant group differences were seen in favor of IES concerning secondary vocational outcomes such as hours and weeks worked, time to employment, and depression severity. The IES-group had significantly lower in depression scores and increased quality of life after the intervention period.

Recently, a systematic review looked at the literature concerning the application of IPS in people with psychiatric disorders other than SMI, which were mostly anxiety, depression and PTSD. They also included studies that aimed at people with substance use disorders, with musculoskeletal or neurological disorders. The results on competitive employment rates in all these different conditions significantly favored IPS approach versus usual rehabilitation. The findings on symptom reduction and quality of life were inconsistent, except for the group of war veterans with PTSD. In the last mentioned study, IPS was given to war veterans with PTSD compared to traditional vocational rehabilitation. In addition to superior employment outcomes, IPS has a positive impact on occupational and psychosocial outcomes and functioning. Other work confirmed these findings. In a multi-centre RCT of IPS in the U.S. among 541 unemployed veterans with PTSD were followed for 18 months. IPS improved functioning on different domains like work, education, relationships and lifestyle. The researchers' hypothesis that intensive IPS coaching breaks through avoidance, a hallmark of PTSD, which adds to the process of fear extinction. Through experience of IPS, people who tend to avoid stress and socially isolate themselves because of PTSS symptoms can experience safety in a new working environment, consequently attenuating hyper vigilance, fear and stress symptoms. As long known, positive circumstances can modify negative beliefs.

Norway went a step further in exploring the possibilities of IPS in employment of a population of special interest: this time young adults. Norwegians

were first to randomize 98 young people 'at risk of' or being unemployed, due to various social and health-related problems, with or without mental illness involved. In their study IPS was superior to traditional vocational rehabilitation in increasing competitive employment in 48 versus a mere 8%. It promoted improvements in some non-vocational outcomes well: physical and mental health, well-being, coping, alcohol consumption and drug use. This research recommends IPS services for improving the labor market participation among young adults at risk of early work disability.

14.4.6. Costs and financing of IPS

The evidence is encouraging that supported employment services decrease mental health costs. There are also some researchers who remain cautious about over-stating estimated savings. In studies of looking at the costs and outcomes of IPS and other vocational services models, costs tend to be comparable, but IPS vocational outcomes are two to three times greater than alternative programs. Interestingly, the studies comparing the sheltered work services with IPS showed that IPS both reduces costs and improves vocational outcomes (Clark, Xie, Becker, & Drake, 1998; Knapp et al., 2013). International longitudinal studies suggest that young adults experiencing first episodes of psychosis are at great risk of employment/education delay and of early entrance into the social welfare system. There is emerging evidence that including IPS services in early intervention programs for young adults may result in substantial savings to the social security costs on the long run.

IPS seems to generate two main cost compensations:

reduced costs for mental health treatment

reduced participation in financial disability/ benefit systems.

Since IPS is combining and connecting mental health and vocational rehabilitation, so is the financing of IPS often an interplay of different domains as well: the healthcare and social domain. Working together between the organisations involved in co-financing IPS creates the optimal situation.

The burning questions for financing of IPS are 1. does the health insurance policy covers IPS as a part of multidisciplinary treatment and 2. who are the social partners addressing work and income in the country and the region?

In the Netherlands, as decided by the government in 2016, the start of IPS trajectories fall under basic health insurance of the patient. Other partners are municipalities, which from 2015 are also responsible for work reintegration, and UWV, an independent government instance issuing social benefits and addressing work reintegration. Since 2014 UWV is helping mental health institutions in financing three years of IPS. Recent research of Erasmus University Rotterdam (Schuring 2016) made an economical evaluation of IPS where they collected data on social benefit costs, IPS costs, income from work and healthcare costs. They calculated that the earnings outperform the extra costs associated with executing IPS for health insurance within 2.5 to 5 years and for social domain, mostly divided between municipality and UWV, within 4 to 7 years. Also, the city of Nijmegen was interested in the value of IPS. They looked at 734 persons with SMI. In their study estimated costs of IPS were 8.5 million euro and benefits were 10.6 million euro.

In England, researchers at King's College London made a comprehensive economic evaluation of costs associated with schizophrenia as well as costs and benefits of current evidence-based interventions aimed to cut its burden of disease on the long run (Andrew 2012). Individual Placement and Support was one of these interventions. This economic evaluation of IPS in this work was largely based on a randomized controlled trial carried out in six European cities, the EQOLISE trial. The calculation of costs and benefits for IPS showed initial higher costs, rapidly declining during the mid- and long term of the intervention and later associated with decreases in costs due to decreased use of social benefits and in hospital admittance days. It accounted for an positive financial difference per user of the IPS service during 1,5 year:
- estimation of savings of the National Health Service £5.193 per user
- estimation of savings of the public sector as a whole £5.501per user

benefit for complete societal costs are estimated to be £6906 per user, which includes the increase in total production, not just the tax revenue by the government.

Bear in mind that the same study came up with the estimation direct annual costs for public sector associated with schizophrenia of £36.000 per year and indirect societal costs of £65.000 per year.

This illustrates potential benefits and provides numbers to concern the policy makers.

One of the greater barriers on granting financial support to implementation of IPS in Europe is

its theoretically unlimited duration advocated by the model itself. Recent research indicated that a more limited duration of IPS didn't differ much in job acquisition compared with unlimited IPS as prescribed by the model (Jackel 2017). More research is needed to investigate the effective duration of IPS.

Considering these costs and benefits, policy-makers in many countries are increasingly choosing for implementation of the IPS model on a bigger scale. For example, in the past several years in the Netherlands IPS is implemented within many multidisciplinary outreaching community teams specialized in severe mental illness. Kenniscentrum Phrenos is the leading organization in research, knowledge dissemination and implementation of IPS in Netherlands. Because of gained positive experience, IPS is nowadays widely supported by professionals, patients and family organisations.

A small qualitative study in Amsterdam identified several factors as important for the stakeholders, 8 practitioners and 7 decision makers in mental health care and vocational rehabilitation, collaborating on IPS: - as facilitating: the key principles of the IPS model, regular meetings, experienced ownership of IPS and collaboration between the stakeholders

the barriers included the experienced rigidity of the IPS model fidelity scale, lack of independent fidelity reviewers, the temporary character of the funding, lack of communication between decision makers and practitioners and negative attitudes and beliefs among mental health clinicians.

IPS seems to be on a good way of implementation in The Netherlands context with twice as much clients in IPS from 2016 to 2017 (n 2100). Additionally from 2019 the Ministry of Health has started to subsidize IPS research with 200 places available for IPS trajectories for patients with milder forms of psychiatric illness.

In addition to practitioners, policy makers play a large role in determining the extent of IPS implementation and availability. Without the policy and structural support of IPS, financing and continuity remains a problem. Political leaders need to implement accessible funding mechanisms that will help agencies providing positive, client centered and measurable outcomes, like employment.

CONCLUSION

Research and practice indicate that clinicians should be hopeful about the possibility of employment for people with mental disorders.

Individual placement and support (IPS) is most successful standardized method of reintegration in competitive employment for people with severe mental illness. The IPS method of vocational intervention is effective regardless of clients' mental health diagnosis, symptom severity, substance use behavior, or ethnic background and local unemployment rate. Its effect on getting and keeping a job is considerable and stable across the world. The evidence on positive effects on quality of life and its sustained effect on long-term employment is growing. Researchers have developed implementation strategies, validated fidelity assessments and documented long-term sustainability of IPS. Importantly, no evidence has supported the hypothesis that work is too stressful for people living with serious mental illness and would lead to adverse mental health effects.

In the current western social and economic system there is a necessity and expectance to maintain independency mostly through paid employment. Part of the population, especially those affected with severe mental illness, suffers a great deal of social exclusion, stigma and psychosocial problems related to unemployment. Although the majority of patients with severe mental illness does want to work and could benefit from it, the gap in employment of psychiatric patients compared to the general population is large. Here we have to bear in mind the early age of onset of severe psychiatric disorders affecting the people in a fragile period and often before finishing their formal education. There is urgency of support in early functional recovery especially by adolescents and young adults with first episodes of severe mental illness where IPS has an important place in adapting the services to meet the individual needs of these people. Fortunately, modern psychiatry is building treatment plans not only based on amelioration of symptoms but also on improvement of functional recovery and Quality of Life. Successful vocational intervention has shown to be an essential and accessible tool to enhance the prospects of our patients. Because of this, supported employment is increasingly concerned to be an essential part of treatment programs in severe mental illness, equal to medical, psychological and social treatments.

This new experience in reintegration these patients in society is changing perspectives, expectations and believes of many healthcare workers, patients, families, friends, colleagues and employers. From an expectation of 'life-long impairment' associated with schizophrenia and related disorders to seeking new perspectives. Maybe the biggest 'day-to-day' gain of working with the IPS approach is in actively focusing the treatments on the process of recovery by setting the goals beyond the temporary barriers of illness.

"If you think work is bad for people with mental illness, try poverty, unemployment and social isolation" (Marone, Golowka, 2000)

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