



For mental health

in Ljubljana



Ljubljana
Zdravo mesto
Healthy City





Ljubljana 2015

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*Zoran Janković,
Mayor*



Photo: Miha Fras

Greetings!

To me, Ljubljana is the most beautiful city in the world. It is a city in which we live together and respect diversity. We devote special care and attention to the most vulnerable groups as we believe that a city friendly to them is friendly to everyone.

The diversity of its residents gives Ljubljana a special charm and their life stories flow into the history of our city. We strive to give all of them the highest quality of life, while ensuring the sustainable development of our city. We are proud that our common work has been recognised, appreciated and rewarded with the prestigious title of European Green Capital 2016.

This is the new brochure in the series Ljubljana – Healthy City. It focuses on the issue of mental health, to which we at the City of Ljubljana pay particular attention. In addition to expert contributions on the importance of mental health and information on where to go when you need help, this brochure also includes the everyday stories of people that face mental health difficulties, despite which each are included in the social life of the city to the best of their ability.

I am pleased that the City of Ljubljana in partnership with NGOs successfully participates in organising a range of events and activities promoting mental health in Ljubljana and I am sure that we will continue to devote special attention to this issue to further build awareness of the importance of mental health.

*Tilka Klančar,
Head of the Health
and Social Care
Department*



Photo: Miha Fras

In partnership with experts in the mental health field and NGOs, we at the Health and Social Care Department have compiled a new booklet in the Ljubljana – Healthy City series, which this time addresses the area of mental health. Maintaining and creating good mental health is of key importance for a good and healthy life.

Programmes of social care and health protection and other activities carried out by NGOs in the mental health field have been continuously supported by the City for many years. Support in this area is multifaceted.

Thus the City of Ljubljana has its now-traditional co-financing of programmes of public works and of counselling, advocacy, information, day centres and self-help groups, which are available to people free of charge. In line with our capability, we provide premises for implementing programmes, take part in awareness-raising campaigns and promotion and are partners in preparing strategic documents. We provide co-payments of the costs of residential care in residential groups for those that use alternative forms of accommodation and care outside the public service network.

In Ljubljana, in addition to services and programmes carried out by NGOs in the mental health field, assistance or advice is also available as part of the public healthcare network. There are five centres for mental health at primary level as part of Ljubljana Health Centre, which the City of Ljubljana founded. At secondary level, there is Ljubljana University Psychiatric Clinic and those in difficulty can seek help from psychiatrists with a concession or pay themselves for a private psychiatrist or psychotherapist.

The City of Ljubljana is exceptionally active in this field as well as in the search for better systemic solutions at State level. Thus, regarding the issue of co-payments for costs of residential care in residential groups for people with mental health issues, in recent years we have put significant effort into improving legislation in this sector, in which we finally succeeded this year. From now on, we as a local community will have a firm basis for co-financing care in residential groups.

In the future, we in Ljubljana intend to use diverse awareness-raising campaigns to promote equality in society as we believe that only in this way can we prevent the social exclusion of people that face mental health issues.



Dr Mojca Urek

MENTAL HEALTH IN LJUBLJANA: REFLECTIONS ON MENTAL DISTRESS AND RESPONSES

Inequality and mental distress

*Dr Mojca Urek,
Faculty of Social
Work*

Mental health is increasingly frequently accepted as a category in which social, health, cultural, personal (biographical) and other viewpoints of human existence are interwoven in their own ways. Ultimately there is also the political, as our stories and bodies intersect the political current, which in societal relations can designate us as either as a full, participatory citizens or excluded, subordinated and powerless.

European Union data shows that people that experience long-term mental distress are among the poorest and most socially excluded Europeans in terms of long-term unemployment, low incomes, poor working conditions, homelessness, poor states of health, their degree of institutionalisation as well as low levels of education and early exit from the education system. This list is complemented by factors such as lack of legal status, lack of options to start a family, narrow or non-existent social networks, various forms of discrimination, such as by ethnic origin or gender, dual diagnosis as well as recurrent rejection and consequent loss of hope and expectations. Meanwhile, in most EU states there are people who have mental health issues who have so far received only minimal solidarity, mainly due to the discomfort that mental health causes in the non-expert public. The key issues of social justice and inclusion must be addressed via a range of options such as supporting people with mental health issues in education, employment, housing in decent accommodation in the community, inclusion in social and cultural groups, support in exiting isolation and participating in civil society.

In the economic crisis, health inequalities have become a pressing political issue, which raises significant questions regarding public health; first and foremost, how public healthcare can simply be preserved, without raising the principle of social justice in access to healthcare. The impact of inequality and discrimination on health is an extensively researched topic and one of the key research topics in the field.

Numerous studies have shown that experiencing gender, ethnic and other inequalities significantly increase the likelihood of mental distress. Groups that are prone to greater risk of mental distress are poorer, less educated, long-term unemployed, people who have endured several tragic events at the same time or who have lasting physical illness, single parents without support, who are often women, migrants, ethnic groups and people who have experienced violence or abuse, many of whom are women. However, links between occurrence of mental distress and the various forms of deprivation are not automatic. For example, living in poverty is not necessarily and of itself the greatest problem, but the inherent social inequality that is most significant for mental distress (feeling of less value or those who blame themselves for poverty).

The economic crisis (to simplify a complex scene characterised by the loss of the social state) has caused large numbers of middle class people to be plunged into poverty and uncertainty in a short period, and those on the margins of society have been pushed over the edge to the bottom. It has become one of the leading factors in the risk of serious mental distress in the last decade. Evictions of people who cannot pay the rent or bills have become a daily scene on the evening news which these days excites only activists fighting the implications and its normalisation. Long-term unemployment or job insecurity and psychological distress are present with (ever) greater numbers of people and have formed a vicious circle as they foster and preserve each other. The unemployment of a family member impacts the whole family. Experts and teachers often face the reactions of children to severely stressful events, such as when parents lose their jobs.

Perhaps new data from the National Institute of Public Health (NIJZ) showing that antidepressant use is rising in Slovenia and other OECD countries alongside a decline in prescription of tranquilisers must be read in the context of the worsening economic situation and restriction of social security rights. NIJZ also demonstrate that women are given about twice as many antidepressant prescriptions as men. It's true that women go to the doctor more often than men for mental health reasons. For this reason they are off sick more often, and while men are off sick less often, when they are, it is for longer periods. This

picture has not changed significantly in recent decades. The reasons for this are similar and lie in the particular gender-specific life contexts. For example, due to economic inequalities between the sexes (this may occur due to unequal distribution of income in the household or its being a single-parent household) and frequently devalued taken-for-granted roles as carers for dependent family members, women are more prone to both poverty and to excessive overburdening. At the same time they are protected by other factors such as having better developed social networks than men and women find it easier to seek help and begin to resolve distress quickly. Women are still more in danger of repeated experiences of violence and abuse. Violence against women perpetrated by their partners or strangers is certainly the most characteristic gender-defined source of depression, anxiety, panic attacks, social phobias, self harm, substance abuse and revictimisation among women as seen in a 2011 national survey on the incidence of violence and response to violence against women in Slovenia. On the other hand, men's social role is defined with the expectation that they will be strong and able to cope with their emotions, due to which they rarely register abuse or seek help. Frequent gender-blindness in health and social services leads to systematic devaluation and neglect of specific fields of men's and women's mental health.

Discrimination and stressful life contexts are also a cause of mental distress in other groups, such as migrants or members of the LGBT community. Migration can include difficult conditions on route, illegally crossing borders and other risks, which regardless of the mode of arrival often bring people isolation, changes in valued social roles, experience of discrimination, poverty or a sense of difference; these may all be reasons for serious mental distress among refugees and migrants. Like all forms of discrimination, homophobia can, already in milder cases of rejection, lead to feelings of anxiety and concealment of identity. The consequences of attacks and other forms of violence (threats, physical attacks, harassment) can result in feelings of fear, loss, rejection, humiliation and depression. If, on the political dimensions of their lives and distress, people on average know less about the kinds and effects of antidepressants, this is because we have successfully internalised the ideology of individualisation of problems

and self-attribution of personal responsibility for them. The prevalence of mental distress, attributable to the economic crisis and the crisis in the social state, has nevertheless helped to raise awareness that everything can slide “to the other side”, which is, we hope, at least something to bring about destigmatisation. Although this is not yet reflected in surveys of Slovenian public opinion; where there are “emotionally unstable” neighbours remains high on the list of undesirability. Further, greater understanding is still not detectable among employers. People with long-term mental health difficulties find it hard to obtain and retain employment, regardless of somewhat positive measures in employment policy (quotas for employing people with disabilities). Effective initiatives (early intervention against loss of employment, plans for return to work after absence due to mental problems, support at work) are still far too few for people with mental health difficulties. After hospitalisation (or multiple periods in hospital) firms retain only a small proportion of people who generally end up in less demanding and less well paid jobs, although experts warn that the right (paid) work has proven to be the most effective factor in a return to normal life and people's recovery. Intercultural studies show that people can recover – frequently in societies in which social expectations of people are more inclusive. The lower the threshold at which you can be included in regular life in a society, the stronger is the belief that people will recover if they are soon able to return to work and normal life. The trap into which the concept of recovery and strengthening can fall is that it slips to the level of a psychological concept in the hands of experts. The slogan 'the personal is political' is still very topical here.

MENTAL HEALTH

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Health is defined as a state of physical, mental and social wellbeing. Thus there is no health without mental health. The term 'mental health' is a socially constructed and defined concept. This means that various societies, groups, religions, cultures, institutions and professions have very diverse methods of conceptualising mental health, how it forms and how interventions preserve or strengthen it.

Historically, mental disorders have had numerous appellations, from madness, eccentricity and the attribution of magical powers to the expressions illness and finally disorder. These are as old as humanity itself. The changed outlooks on mental health and mental disorders are a consequence of human progress in many fields such as medicine, chemistry, biology, technology, philosophy and anthropology. New scientific evidence is changing the attitudes of individuals and society to mental health and disorders as the latter cannot exist without the former.

William Sweetzer first clearly defined the concept of 'mental hygiene' in the middle of the 19th century; this can be seen as a forerunner of modern approaches to the development and promotion of mental health and preventing mental disorders. At this time, Isaac Ray, one of the founders of the American Psychiatric Association, supplemented and defined the concept of mental hygiene as the art of preserving the mind against incidents and influences which hinder and destroy its energy, quality and development. At the start of the 20th century, Clifford Beers founded the first National Committee for Mental Hygiene and opened the first outpatient mental health clinic in the US (people were not hospitalised, but left home to visit the doctor for a consultation).

Today, the World Health Organisation defines mental health as a state of well-being in which every individual develops independently and realises his or her own potential, can cope with the normal stresses of life, can work productively and is able to make a contribution to the community in which they live.

Mental health is crucial to our ability to adequately perceive, understand and interpret the environment that surrounds us, but also for thinking, speaking and mutual verbal and non-verbal communication. It is indispensable to our ability to form and maintain social contacts and to how satisfying is daily life in the different societies and cultures we live in. It develops on many levels: in the family in which we grew up, and in those in which we live as adults, in educational institutions, in peer and other social contacts, at work and in our relationships with others and the attitude of those around us to the individual. At the same time, mental health impacts on lifestyle, physical health, employment and interpersonal relations.

Mental disorders have thousands of faces. There can be various combinations of illness-modified thinking, feeling, perception, changes in behaviour and impairment of cognition and memory. Due to these signs (symptoms), the person encounters difficulties in the performance of their daily activities in the family, at school, work and in their wider social surroundings. The World Health Organisation notes that more than a third of the global population report mental health problems that meet the criteria for a diagnosis of one or more mental disorders at some point in each individual's life. Particular mental disorders can be mild, moderate or severe; the course can be acute or chronic, can occur just once in a lifetime or repeat more or less frequently throughout whole lives.

An overview of research and other accessible indicators of mental health from medical records and other databases show that Slovenia has one of the highest suicide rates in the European Union, while the most common mental disorders in the general population are depression and anxiety. The most common reason for hospitalisation is schizophrenia, due to which patients with various mental disorders are hospitalised the longest. The data show significant disparities in mental health in terms of age, gender and region. Women often recognise mental health problems and seek professional help for them, while men undergo more hospital care and death by suicide. Children, young people and the elderly are especially vulnerable groups who require special attention and for which there is a need for additional programmes.

The conventional approach, conceived mainly in the treatment of mental disorders, in part already existed but it is necessary to further broaden it to a comprehensive and multidimensional approach that will not be oriented solely at illness, but also to mental health and its promotion and prevention. The involvement of every level is crucial in this, from legislative and public health institutions and NGOs to the individual.

It will certainly be much easier and more motivating for us all to follow encouraging and stimulating advice than threats and sanctions as it is human nature to try to evade prohibitions and pointing fingers but to listen to well intentioned wisdom and experience.



Simon Novak

I appreciate all the little things in life as I wasn't born into a wealthy family. My father took his own life, so I lived with my mother. Since mother did not know how to manage the money she got, we were dependent on the goodwill of relatives, especially my grandfather.

I had trouble learning at school, as I found it hard to learn or didn't know how. Later, with the help of a friend with whom I could learn, I finished secondary technical school. I enrolled at university, passed three exams then had to give up due to financial troubles. I did a lot of work through the Students' Service to be able to pay my mum's debts, cared for the household and paid the bills.

I didn't have much luck in my choice of friends, as they often took advantage of me. Because of this I felt left out, which really hurt me. By nature I am a very emotional person, with great social sensitivity as I like stepping in to help. People have often taken advantage of my good nature, as I have problems with self esteem.

With the help of the Pelikan programme, I got to know new residents with whom I had friendly contact and learned to live independently. Above all I got used to speaking about myself and my emotions, as previously I had no idea how to do this.

When I finished their programme, after talking to the therapist I decided that I would join Šent, the Slovenian Association for Mental Health, to carry on working on myself, to help towards an independent life. I feel safe at Šent and I am active, learning a lot of practical things that I need to live. Sometimes I make contacts on social networks. I've been using a computer to get in touch with schoolmates and friends from childhood. I'd like to meet a girl, have a relationship and start a family.

I like being with people and talking about various topics. My passion is reading history books; I'd like to take this opportunity to thank Ljubljana City Library for free membership.

STRESS AND EVERYDAY LIFE

Stress is a chemical balance, a hormonal event in the body which serves to prepare us for fight or flight. The triggers can be any situation that demands urgent adaptation; this is a change in behaviour. It can thus be triggered by unpleasant or unusually pleasant events. If people find themselves out of money they get stressed and they get just as stressed if they win the lottery. Stress enables us to cope with changes and progress, unless, of course, there is a brain impulse which can also, in certain circumstances, be quite appropriate. People are variously sensitive to stress and what's more, we are variously sensitive to different kinds of stress, which makes a general discussion about the "stress under which we live" quite absurd. Some people survive stress in concentration camps and grow personally from this, while others completely collapse as soon as they are burdened with a brief separation from a partner or some other step to greater independence. If we endure great stress, we are resilient, if less, we are more sensitive. Stress damages mental health especially when it is continuous and uninterrupted. The biggest and most common example of chronic stress is caused by poverty and deprivation, which lasts and cannot be resolved with no end in sight. In our cultural environment, which does not absolve or mitigate, but finds those affected guilty and subjects them to various forms of humiliation, such as standing in line for aid parcels or begging in the media, it is not possible to maintain mental health in situations where people cannot be themselves and cannot provide life's basic essentials to those around them. Mental or physical breakdown very frequently arise if poverty is accompanied by stressful humiliating situations. Chronic stress severely undermines physical health and causes numerous chronic illnesses such as high blood pressure.

Stress cannot be escaped entirely, but it is possible to make it manageable. The chances of recovery are better if in a particular case the effects are treated in a way that enables the person to maintain their personal dignity. The burden of stress is thus also dependent on the extent to which other people are ready and willing to alleviate it. To a great extent, it is easier to accept or even develop other capabilities if we are respectful of the distress, which always carries a chance of improvement, of

people suffering from a serious illness which has reduced their capacity. The crisis is therefore always an 'opportunity'. People can also be stressed due to overwork or an excess of life's options, but in these cases it is usually possible to hope that people know how to protect themselves. Their status and position in society usually demonstrate that their defences are strong enough, but not always. Anyone can break down and even the most successful may encounter insurmountable obstacles and break down due to continuous exposure. Psychotherapeutic support and help in difficult circumstances are needed mainly by those for whom life has not offered the opportunity to strengthen, mostly because for this they are too weak, sensitive, friendly, more subtle in their feelings and therefore often less financially successful and more marginalised, because these features are not socially appealing. To cope with stress, it is necessary to learn indifference to defeat. It is possible to preserve self-esteem despite sensitivity and avoid excessive stress if a person treads his or her path vigorously and has faith in his mission and goals (even though they do not contribute to status) and these are recognised by those close to them.

THE EVERYDAY LIFE OF AN INDIVIDUAL WITH A MENTAL DISORDER

*Špela Zgonc,
Šent – Slovenian
Association for
mental health*

When a person first encounters a mental disorder, a lot of information is needed about the disorder, about treatment and the possibilities, where and what kind of support are available.

Later, they are faced with accepting or not their new situation, with the stigma that mental disorders (sadly) still arouse, and consequently also withdrawal from the environment.

Only when an individual accepts their new situation can they set out on the path of psychosocial rehabilitation. This means accepting the fact that the mental disorder is (at least currently) part of their life and that they must learn once again the social and everyday skills and competences that enable control over their lives.

However, the journey is not usually as simple or as easy as it sounds, especially when talking about long-term troubles. It is easier for those who have only a single occurrence or a milder disorder, as troubles are much easier to overcome and affect their lives much less.

People encounter problems in multiple areas of life with long-term problems and severe forms of disorder – psychological and physical health, reduced social contacts, reduced social and everyday skills and competences, inability to obtain paid employment, as well as (a temporary) inability to live independently.

The problems faced include those caused by the side effects of drugs, non-acceptance of the illness and thus not taking the medication prescribed, exclusion from society due to stigma or as a consequence of the disorder, reduced capacity to function each day and reduced motivation to take on roles and responsibilities in everyday life.

Everyday, social and working skills and competences are acquired in psychosocial and vocational rehabilitation programmes that help people to be able to assume a more active and equal role in the family and community. An individual who has already achieved a certain level of

psychosocial and working rehabilitation must often confront the fact that there is no accommodation that would enable independent living, (at a price that they, normally on low incomes, can afford), that there are few adapted jobs for those who cannot hold down a regular job and that in some quarters they are still stigmatised due to mental disorders.

HOW TO RECOGNISE AND ACCEPT MENTAL HEALTH ISSUES

Anamarija
Zavasnik,
clinical
psychologist

Most people want to be healthy, both physically and mentally. The idea of health is related to many values: a healthy person is strong, capable, confident, respected, happy and much more. Illness is linked to other feelings: helplessness, pain, suffering, fear, reduced competence, loneliness and marginalisation. In the case of mental disorders, these feelings are joined by shame, guilt and fear of loss of control over one's behaviour. That is why it is difficult to cope with illness, emotional distress and mental disorders. We can only hope that the difficulties go away by themselves or we choose various ways to get around them. It is possible to build a belief system which prevents insight into the severity of the problem, or reinforces the previously held standpoint that we cannot influence what is happening to us or that somehow we are a "bad person" who deserves nothing better in life. Sometimes we deny a difficulty or illness or transfer blame and responsibility for them to someone else. All this just deepens the trouble and gradually leads to more serious mental disorders. Let's look at some examples that show how feelings and prejudices reduce our ability to recognise mental health problems and willingness to seek help.

A young woman had been going to the doctor's for more than a year because of continuous headaches. The doctor had done a series of medical tests that revealed no physical cause of the headaches. During an in-depth conversation with the doctor, she herself realised the connection between the headaches and difficulties in her relationship with her partner.

A man with a university degree, aged about 30, employed, living with his parents with whom he gets on well, feels deeply lonely, as he has neither friends nor a partner. He spends his free time at home and doesn't dare to go to the city centre because of the numerous beggars who he finds hard to reject and take a large part of his earnings. He is desperate, cannot see a way out, such a life seems pointless and does not seek help from a psychotherapist as he fears his parents will think he is weak.

A middle-aged woman loses her husband in a road accident. Sadness has so overwhelmed her that she has not worked for months, she leaves home only to go to the cemetery, has no appetite and has trouble sleeping. She rejects relatives and medical help as she is certain that nobody can help her.

Parents have already been waiting some years for their adult daughter to graduate, yet she sleeps all day and spends her evenings and nights partying and often doing drugs. They talk about her a lot, but are sure she is not an addict yet and that this is just youthful experimenting with drugs.

A single mother notices that her 25-year-old son has changed his behaviour, is always scared and keeps looking for listening devices around their flat. She's worried that a psychiatric exam would 'stigmatised' him and have a negative impact on his future.

It is therefore very important that in facing the minor difficulties that we encounter in life we observe our feelings, try to link them to the events around us and try to talk to people that we trust about them. Discussions cannot change our situation, but can enable us to look at the problem more broadly and from different angles. That way we get to know ourselves, recognise situations that disturb and affect us and acquire experience to resolve problems effectively.

If among those around us we cannot find anyone to talk to about distress, then it is important to seek professional help (a doctor, psychologist, psychotherapist, social worker or psychiatrist). A visit to one of these experts is essential when mental health problems hamper our daily functioning at school or work, in the family or the wider social environment.

LIVING WITH A PERSON WHO HAS MENTAL HEALTH ISSUES

*Edo Pavao Belak
MSc.*

As a rule, people with mental health problems, and I have in mind repeated and serious mental disorders, live at home with their parents or other relatives if they have no parents. There are many reasons why:

- the stigma that is still ever present in our society; the consequence is isolation which prevents people creating social networks;
- the social and material position of the family with a member with mental health problems – such a family is usually poor and the material conditions are catastrophic;
- the characteristics of the mental disorder, which cause them to be bound to the known, domestic environment, with fear restricting a person from functioning in the wider world;
- restricted employment options for such people; I can say that the labour market is minimal, even though most are young people who would like to live independently, something employment would enable them to do;
- independent living – an apartment, which would enable them to live with dignity.

So far, NGOs have done their utmost in the prevailing circumstances, but the restrictions are growing ever larger and the space to operate is shrinking quickly.

As one of the largest organisations in this field, Šent offers accommodation in residential groups, employment in social businesses and employment centres plus social inclusion. Our care for this population is also seen in all Šent's other activities: the advocacy programme – Users' Council, Relatives' Forum, day centres for people addicted to psychoactive substances, programmes of awareness-raising and education for users and their relatives.

The main burden of care for people with mental health problems lies with their relatives, both psychologically as well as materially. Most of the time you are with them 24 hours a day.

Materially, they are almost 100% reliant on their relatives.

The entire burden falls onto the relatives as most of our treatment of mental disorders is institutional. What's missing is community treatment, the transfer of care for mental health to the community. There should be a network of assistance and support available, with services that are accessible and free of charge.

Due to the heavy burden upon them, relatives themselves often fall ill, and there is a lot of depression among them, mainly due to the constant stress in this coexistence. The concern increases over the years as their relatives and those around them grow old, as does the question of what happens after the death of their relatives, which is ever more pressing.

The answer to this is completely unknown at present. Currently, the only answer is an institute or institution.

And this leads to a less social society and greater social and spiritual misery.

Does our society not violate the human rights of users and their relatives, I won't specify which, as it is evident from the content what is at stake?

My, our story can be a case study.

My wife and I live with our son aged over 35 who has been diagnosed with paranoid schizophrenia.

There have been quite a few problems that piled up and sometimes drove us to despair and we had to solve most of them ourselves. I can say that we have found appropriate support and help only when we recognised that we as relatives must first take care of our own spiritual development and help ourselves, so that now I can say that we function quite well.

At Šent we got the appropriate responses and quality support when we needed it.

So I'm sure that the answer to the question "What will happen to our relatives after we've died?" can only be offered by NGOs.

In partnership with Ozara, Šent is preparing the PHOENIX programme, which will be a quality response to this question. Of course, without adequate financial support to the association, mainly from local authorities, it will be impossible to run the programme. I hope we get partnership and support.

In any event, it is necessary to immediately begin the process of deinstitutionalisation, to continue the community psychiatric treatment programme, transfer mental health care to the community and give NGOs the situation they deserve in an advanced and civilised society, in particular, by providing them with regular financial resources to implement programmes in mental health.

Aljoša Černe

I have troubles with personal thoughts that characterise a different outlook on my world. The impact of this is a long-term personal lack of my own operating role. I noticed changes and understanding among my relatives. This in turn had an impact on my activities, motivation and acceptance of my illness.

I struggled for years and years without any activities with the intention that I would manage to find an environment that would encourage me in certain areas. Those that I missed most in my period of immobility. When I was in hospital, it motivated me that I could become a service user with an association. For me, it is extremely important to make progress in the social field, alongside which I also strove for as many activities as possible.

I was made welcome by Altra. I soon realised that they have the same attitude to each service user. They also respect personal beliefs. In addition, they listen to my troubles. What's more important for Altra is themed groups rather than therapeutic workshops. Most such groups are based on the topic of how to help at a personal level.

I found the group on emotional intelligence on Wednesdays most responsive. I got to know very many approaches to how to put myself on the right track, and to be able to put my situation into words. The group image is a group for personal growth, which was also really helpful to me, I really got the feeling that my personality was progressing and this had an impact on my emotional balance. There was the impression that I could be pleased with myself. I also really wanted to go to the group on music and emotions. While listening to the music, we were recommended to pay attention to our feelings and to the feelings generated by the music; I experienced this group as a kind of healing of my complexes in dealing with the forms of emotion.

It's also very important that I joined the outside world, that I was active at that time and the fresh air and even sunshine help me and affect my mood. Altra's programmes include morning exercise and a walk. So, beside the other things, the more I come into contact with the outside world, get exercise and strengthen my body, the more pleased I am with myself. I also like the culinary workshops. We cook three times a week, I help on Wednesdays and Fridays and I am learning the preparation and cooking. Above all it means a lot to me to make food for the other programme users. What are most important are my mood and interest. I think I know how to assess my own abilities, including what I can and cannot do. I ask for an interview with a professional worker when it happens that I need help. At Altra there is such an atmosphere – friendly, accepting and homely, so I'm becoming happier and happier, and becoming ever more of a believer in myself and ever more independent. I like going to the groups and would like to stay with Altra for a long time. I'm pleased I've made progress and that others praise me.



MENTAL HEALTH ACT

The Mental Health Act, passed in 2008, identifies the main care providers in the fields of health and social care and defines their competences, responsibilities and duties. In addition, it outlines and assures the protection of the rights of people with mental health problems and the processes in which people are deprived of their liberty on account of the right to treatment. The criteria for involuntary hospitalisation are also set out in the Act. The Act also introduced new professional profiles; these are: agent, co-ordinator of community treatment and co-ordinator of supervised treatment. In the mental health field, NGOs are considered to be among the providers of community treatment.

At the time we thought that the Act would stimulate the adoption of a National Mental Health Programme, which includes various forms of help and support to people with mental health issues and their relatives in the community. Unfortunately, to date it has still not seen the light of day. As NGOs, we work well and have long-term experience implementing social care programmes that enable people with mental health issues various forms of assistance which influence a raised quality of life and rehabilitation in the community. We have been active in mental health care in the community in Slovenia for over 20 years. We have pioneered innovative and community models of assistance for people with mental health issues and their relatives. We were the first to introduce advocacy, residential groups, day centres, services for information, counselling and planning, co-ordination and implementing support, services including crisis teams and mobile help at home. These are all proven and verified forms of assistance that are carried out in modern, democratic societies. Sadly we have too few of them. We have a chronic lack of staff, contractors who could implement care in the community smoothly and qualitatively. In fact, the Act also forgot about the relatives. These are still overburdened with unwell family members and left to fend for themselves. We still believe that we need a Care in the Community Act to introduce methods and forms of work that will enable people with mental health issues and their relatives practical help and support near their homes, in the local environment where they live.

Therefore, seven years after introduction of the Mental Health Act, which for NGOs brought no changes, we find that in

Slovenia mental health in the community is still developing very well conceptually, but much less so practically or legislatively, which is already a tragedy. Modern mental health legislation must define and promote:

1. the participation of users of psychiatric and other services in mental health: the user has the right to be informed and to participate in treatment as an equal partner;
 2. the effectiveness of healing and treatment in the community – the individual is entitled to healing and treatment that is effective for them personally and is in line with professional guidelines;
 3. a wide selection of healing and treatments that enable and ease informed decision-making for the most appropriate treatment;
 4. equality, above all the absence of discrimination against people with mental disorders compared to healthy people and also regarding people with physical disorders;
 5. localised activity:
 - mobile and multidisciplinary teams, who offer help in the individual's local area,
 - uniform distribution of smaller hospitals,
 - establishment of crisis teams and the option to see out the crisis at home,
 - community models of assistance;
 6. the safety of the user, relatives and medical and other staff in mental health; simultaneously rejecting linkage of mental disorders with a priori risks;
 7. make users autonomous and empowered; for this the user must be properly informed;
 8. the participation of the family, which is particularly important for cultures oriented to the family;
 9. respect for the user, which means a reduced patronage role, especially by psychiatrists;
 10. search for the least restrictive methods of treatment;
 11. support the development of advocacy and
 12. timely checking of capacity for informed decision making.
- Thus recorded and regularly audited concern for our national mental health should follow World Health Organisation guidelines. This would ensure that appropriate treatment is offered to people that need it in the right place and at the right time. An innovative solution that protects and does not stigmatise could be proof to others around the world that this is possible. Something to be proud of ourselves about.



I was born in Bosnia in 1969. As a family we soon moved to Croatia where I finished primary school. When the war started, I went to Austria and tried to survive with temporary jobs and lived illegally. I came to Slovenia in 2001 and lived with my sister for a while. I worked in construction, where I began to have problems with the bosses. I wasn't getting paid regularly, so I found a new job, but it was the same story there. Life was hard, I had a flat as a subtenant, the pay was low and erratic and my mental disorder started (bipolar disorder). I was in hospital in Begunje where there were presentations of different NGOs, so I found out about Ozara and Bogdan Dobnik. He helped me a lot. When I was in hospital, I didn't have a flat or a job (they didn't extend my contract). Bogdan drove me to Ljubljana, helped me find a flat, we went together to look at them. We found a flat in Bizovik, where I lived for a year, and then I moved to the barracks in Šiška for a longer period. I was living off my savings and help from relatives. I was constantly looking for work, and found a temporary job again, and this happened several times. In the end I found an employer who would get me a work permit if I paid €20. My health got worse and I found myself out of work again, looking for a new job and living on sickness benefits for the next two years. My doctor suggested that I could retire on a disability pension.

Throughout that time I was going to Ozara in Ljubljana, where they helped me to arrange my official documents and stood by me. What was especially important was their help in arranging my disability status, obtaining a permanent residence permit and accompanying me on official matters. I've managed to sort all this out so that I am on a disability pension, but still living as a subtenant as I don't have the right to a not-for-profit flat or residential unit.

I like living in Ljubljana, because I can always go somewhere. Such as going to Ozara, to social meetings, Slovene lessons, IT classes, on trips and so on, sometimes I also go to other societies. There's always something going on in Ljubljana, there are many free events, which is great for those of us on low incomes. I also have to mention material support from the Red Cross and Caritas, sometimes I go to supper at the Society of St Vincent de Paul, and for lunch I go to Pod strehico, where a meal for the underprivileged costs 50 cents. I am very grateful that all of us on disability pensions in Ljubljana have the right to free public transport.

Ljubljana is a beautiful city, I like living here and I would be very grateful for the right to a not-for-profit flat.

CARE IN THE COMMUNITY IN LJUBLJANA

Section 91 of the Mental Health Act (2008) defines care in the community as the provision of assistance to people who no longer need treatment in a psychiatric hospital or supervised treatment, but need assistance in psychosocial rehabilitation, everyday tasks, managing the necessities of life and inclusion in daily life on the basis of planned care in the community.

The goal of co-ordinating care in the community is to enable people to have support in their lives in the community. It is comprehensive care (monitoring, support and assistance in various areas of life), based on the strength perspective of the person and assuring an impact on their life. It is designed for people with mental health issues. The person is voluntarily included in care in the community and they can end their involvement at any time.

The treatment is implemented by care in the community co-ordinators, employed regionally in individual centres for social work.

TREATMENT PROCESS:

1. At the **FIRST MEETING**, the individual briefly outlines their life situation, and then the co-ordinator offers the first information and the option to take part in care in the community. In cases where the person opts to take part in treatment, both sign a **statement of consent**.
2. Then the co-ordinator and individual begin to prepare a **CARE IN THE COMMUNITY PLAN**. The plan consists of the content and implementation of work. Regarding content work, the co-ordinator and individual write out the person's life situation and draw up goals in the following areas: management of residential conditions, social care, employment and work, support in carrying out basic tasks and managing support in providing social contacts and socialisation, plus goals set in other areas which are significant for the individual's integration in the community. In the implementation part, these goals are operationalised in such a way that both write out specific tasks, steps or actions to be implemented to achieve each objective, specify who is to do what, the funds necessary

and the anticipated start and end of the implementation of each specific objective.

3. After writing out the plan, the co-ordinator convenes a **MULTIDISCIPLINARY TEAM**, with invitations to a psychiatrist, a professional from the locally competent centre for social work and others who can make significant contributions to realising the individual's specific goals. The individual and their legal representative, if any, are also invited to the team. Team members consider the plan and offer their opinions and suggestions, and then the plan is adopted by the locally competent centre for social work.
4. There then follow six months of **PLAN IMPLEMENTATION**, in which the co-ordinator and individual follow the plan's objectives. In cases where implementing the objectives is urgent, they begin to implement them even while still planning. In the plan implementation process, the co-ordinator constantly co-ordinates and oversees the plan implementation, offers the individual support and helps them towards realising their objectives. In this, they obtain data and work with diverse contractors, organise and co-ordinate the work of the contractors and simultaneously offer them professional support in carrying out their tasks.
5. After six months, there is an **EVALUATION** of the care in the community plan. The co-ordinator and individual assess together which goals have been achieved and which not, how they have been implemented and why some have not. The individual also offers an assessment of implementation and their satisfaction with the implementation of the community treatment, the implementation of the plan and the contractors. After reviewing the realisation of the goals and giving assessments of implementation, they define new objectives for the next six-month period or whether to conclude the treatment if it is no longer necessary.

Treatment in the community ceases if the co-ordinator and individual conclude that the treatment is no longer necessary, if the person does not participate in writing and implementing the plan or if the person states in writing that they no longer wish to be included in treatment.



Dominik Baligač

My name is Dominik Baligač and I'm from near Murska Sobota. After finishing middle school I decided to continue my education in Ljubljana at the Vocational College for Catering and Tourism. I got a staff scholarship from a company called Vivo, d.o.o., but at the start of my course I fell ill with paranoid schizophrenia. At that time I had no idea what caused the illness or what the symptoms were. At first I was treated at the psychiatric hospital in Ljubljana. The treatment lasted two months, but after being discharged I quickly went back to hospital, because I wasn't disciplined and forgot to take my medication. I went back to hospital and managed better this time, and I succeeded in taking my medication. Then I was only going to the outpatients', where they offered me accommodation in a Šent residential group. I didn't know what this was, I had a bad feeling about it, and I imagined that everything would be smoky and messy, but it wasn't like that. Just the opposite; the flat was clean, well-aired and there were good people living in it.

As I had no future at home in Prekmurje, I decided to try living in the residential group. I opened a new chapter in my life and joined a Šent residential group. I was positively surprised, I have everything I need, friends, expert staff, volunteers and so on. The staff always help me with advice and suggestions; they offer comfort and support. I've learnt a lot from them.

I came to Ljubljana to study, but I didn't finish my studies due to my illness. But I didn't give up and I have kept trying. I have managed to finish my first year at the Vocational College for Catering and Tourism and I am continuing my studies with the help of Šent and the school's support. I feel at home in Ljubljana. My future is here, I wouldn't have such opportunities at home in Prekmurje as I have in Ljubljana.

WHERE AND TO WHOM A PERSON IN MENTAL DISTRESS CAN TURN BEFORE BEING REFERRED TO A PSYCHIATRIST

*Dr Tadeja Čerin,
MD, Ljubljana Moste-
Polje Health Centre*

Ljubljana Health Centre provides primary health care for the territory of the City of Ljubljana and for certain activities also for the broader area around Ljubljana. Within this range of activities there are a good number organised for patients that find themselves in mental distress.

There is a development clinic available for children with developmental disorders. Children are accompanied and help is offered to their families. The team includes a developmental paediatrician, neurophysiotherapist, occupational therapist, speech therapist, psychologist, special educator and a social worker. There are links with kindergartens, schools and other institutions. There is also a specialist clinic for children's psychiatry.

Care for the mental health of children, young people and their families is offered by Centres for Mental Health. These are located in the units of Center, Vič-Rudnik, Šiška, Bežigrad and Moste-Polje. They treat difficulties in various fields of physical development, psychosomatic difficulties, adjustment disorders and educational problems, as well as emotional and behavioural disorders, various hardships due to breakdowns in parental relations and distress as a result of serious life events (death, divorce, relocation etc). The centres have a team of specialists, selected individually according to the patient, who attempt to clarify the problem from different angles and then advise. There is a brochure available with a presentation of the centres.

At the level of Ljubljana Health Centre there is a Centre for the Prevention and Treatment of Drug Addiction, which is the largest centre for the treatment of drug addicts in South East Europe. The treatment programme includes 600-800 patients. In addition to substitution therapies, addicts have the options of psychotherapeutic treatment with a psychologist.

As part of the Centre for Occupational Health, Traffic and Sports, psychologists advise and offer short forms of therapy for

distress at work, after accidents at work etc. They also organise workshops on coping with stress at work. The latter two services are self-paid and paid for by the employer respectively.

Adults have health-educational centres, with senior and graduate nurses and professors of health education. They work in all Ljubljana Health Centre units offering health education for health preservation. They run workshops on the theme of depression to which patients are referred by their family doctor. They can also come to a reference clinic for a consultation with the graduate sister who then, with the doctor, tries to help the patient and if necessary refer them to a psychiatrist. Patients can always turn to their family doctor, who will discuss the problem with them, offer advice, treatment and if necessary a referral to a psychiatrist.

Therefore, help exists. We have many years of experience and provide continuous education. So do not hesitate. There are leaflets and all necessary information can be found on the website of our health centre www.zd-lj.si.

City of Ljubljana programmes offering help to people with mental health issues

Day centres (in Ljubljana the programmes are operated by the Altra and Šent associations)

The day centre programme is intended for people with mental health issues, their relatives and those close to them and other people in distress and difficulty. The programme aims to socialise users, help them spend their time actively, structure their days and reintegrate them into their social environment and establish or strengthen social networks, thus a comprehensive approach to psychosocial rehabilitation for people with mental health issues, improving the quality of their lives and reducing or eliminating social or material exclusion and deprivation as well as eliminating stigmas as a consequence of societal prejudice to mental distress.

Counselling centre (in Ljubljana the programme is operated by the Altra association)

The programme is intended for people with mental health issues and their relatives. Through psychosocial assistance and its working methods the programme works to positively impact the individual's health and behavioural orientation, reduce hospital admissions and placement in social welfare institutes as well as offering users greater autonomy and choice to enable them to develop and preserve the skills that they need for life in the community. Their working approaches contribute to the integration, co-ordination and greater transparency of services intended to offer help to people with mental health issues

Advocacy for people with mental health issues (in Ljubljana the programme is operated by Altra)

The programme is based on the broader concept of advocacy and is oriented to protect the rights, interests and integrity of people with mental health issues, who often find themselves in life situations in which they cannot or do not know how to assert their interests or rights. They are often victims of violence and often have troubles of a legal nature which they cannot resolve successfully due to their financial circumstances

or poor co-operation with their lawyer. The programme offers advocacy to their advantage.

Office for information and counselling (in Ljubljana the programme is operated by the Ozara association)

Users are offered help in their domestic environment, via which they are enabled a durable and more easily accessed support system. The programme provides users with information and counselling, advocacy, work with families and couples, direct help and assistance, organised accompaniment and socialising in everyday activities, co-ordination of service provision, co-ordination and implementation of social care, education programmes, supplementary programmes and public awareness-raising and informing.

Residential groups (in Ljubljana the programmes are operated by Altra and Šent)

The programme is aimed at adults with long-term mental health difficulties, who need appropriate help, support and guidance in their daily lives with their illness. The programme includes the organisation of appropriate accommodation for residents, appropriate professional support and other methods of work that enable users to obtain social skills and competences and resume active social roles, co-creation of space for discussions and work, discovery and establishment of objectives in line with the user's needs and individual plan.

Contacts:

Altra Association – Committee for Innovations in Mental Health

Zaloška cesta 40, 1000 Ljubljana

T: 01 544 47 61

E: info@altra.si

Šent – Slovenian Association for Mental Health

Belokranjska ulica 2, 1000 Ljubljana

T: 01 230 78 30

E: info@sent.si

Ozara Slovenia – National Association for Quality of Life Ljubljana Office for Information and Counselling

Gregorčičeva ulica 5, 1000 Ljubljana

T: 01 244 51 20

E: info@ozara.org

DAM – Society to help people with depression and anxiety disorders

Topniška ulica 43, 1000 Ljubljana

website: www.nebojse.si

Slovenian Association for Suicide Prevention, Unit: Centre for psychological counselling – Consultation

Novi trg 2

T: 031 704 707

E: info@posvet.org

Ljubljana University Psychiatric Clinic

Studenec 48, 1260 Ljubljana

T: 01 587 21 00

E: info@psih-klinika.si

Call in Mental Distress hotline

T: 01 520 99 00

Open for calls every night between 7pm and 7am

Urgent psychiatric assistance Ljubljana University Medical Centre – Polyclinic Njegoševa ulica 4, 1000 Ljubljana

Centre for Mental Health

Grablovičeva cesta 44a, 1000 Ljubljana

Urgent psychiatric assistance is available all day at the Polyclinic on 01 434 4517, at night and all weekend at the **Centre for Mental Health** on 01 587 4900.

Centres for Mental Health in units of Ljubljana Health Centre:

CMH Moste-Polje

Prvomajska ulica 5, 1000 Ljubljana

T: 01 584 42 44

E: narocanje.CMH.mos@zd-lj.si

CMH Bežigrad (PE Črnuče)

Primožičeva ulica 2, 1000 Ljubljana

T: 01 300 33 34

E: narocanje.CMH.bez@zd-lj.si

CMH Center

Metelkova ulica 9, 1000 Ljubljana

T: 01 472 38 26

E: narocanje.CMH.cen@zd-lj.si

CMH Šiška

Derčeva cesta 5, 1000 Ljubljana

T: 01 581 52 20

E: narocanje.irena.logonder@zd-lj.si

CMH Vič

Šestova ulica 10, 1000 Ljubljana

T: 01 200 45 96

E: narocanje.CMH.vic@zd-lj.si

Contact details for care in the community co-ordinators – Ljubljana region

Four care in the community co-ordinators cover Ljubljana region with their head office at **Ljubljana Moste-Polje Centre for Social Work (CSW)**, who manage work for CSW Ljubljana Bežigrad, CSW Ljubljana Center, CSW Ljubljana Šiška, CSW Ljubljana Moste-Polje and CSW Ljubljana Vič-Rudnik:

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As journalist and writer Renata Ažman puts it “Mental health issues can affect any of us, so concern for mental health is something for all of us”.



City of
Ljubljana

