



CALMD

A comprehensive kit for social inclusion
of people with mental disabilities

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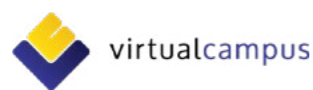
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CHAPTER 1

SUPPORTIVE CARE, INCLUDING COUNSELING AND SELF-HELP

Introduction

Mental illness, also called mental health disorders, refers to a wide range of mental health conditions – disorders that affect your mood, thinking and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors.

Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function.

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices.¹ Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Symptoms

Signs and symptoms of mental illness can vary, depending on the disorder, circumstances, and other factors. Mental illness symptoms can affect emotions, thoughts, and behaviors.

Examples of signs and symptoms include:

Feeling sad or down

- Confused thinking or reduced ability to concentrate
- Excessive fears or worries, or extreme feelings of guilt
- Extreme mood changes of highs and lows
- Withdrawal from friends and activities
- Significant tiredness, low energy or problems sleeping
- Detachment from reality (delusions), paranoia or hallucinations
- Inability to cope with daily problems or stress
- Trouble understanding and relating to situations and to people
- Problems with alcohol or drug use
- Major changes in eating habits
- Sex drive changes
- Excessive anger, hostility, or violence
- Suicidal thinking

Sometimes symptoms of a mental health disorder appear as physical problems, such as stomach pain, back pain, headaches, or other unexplained aches and pains.

For Educators

Educators are often the first to notice mental health problems. Here are some ways you can help students and their families.

What Educators Should Know

You should know:

- The warning signs for mental health problems.
- Whom to turn to, such as the principal, school nurse, school psychiatrist or psychologist, or school social worker, if you have questions or concerns about a student's behavior.
- How to access crisis support and other mental health services.

What Educators Can Do In Classrooms

You can support the mental health of all adult learners in your training sessions not just individual students who may exhibit behavioral issues. Consider the following actions:

- Educate staff, parents, and adult learners on symptoms of and help for mental health problems;
- Promote social and emotional competency and build resilience;
- Help ensure a positive, safe school environment;
- Teach and reinforce positive behaviors and decision-making;
- Encourage helping others;
- Encourage good physical health;

How does a person's mental illness affect their family and friends?

Having a mental illness can affect a person's family and friends in many ways. As their relative, partner or friend, your experience will depend on your relationship with the person and their specific mental health condition.

It's normal to feel a range of emotions when someone you care about is diagnosed with a mental illness, including:

- Fear;
- Confusion;
- Guilt;
- Shame;
- Uncertainty;

Some people also describe feelings of grief and loss for their previous relationship, and for the kind of future they imagined together.

What do I need to know about the person's mental illness?

Every mental health condition is different. Everyone's experience with mental illness will also be different. Recovery may include trying different treatments or medicines, which work differently for everyone. Try to be patient with your loved one (and yourself) throughout this process

How do I talk to a person one about their mental illness?

Talking to your loved one about their mental illness can help them feel less alone and more supported throughout their recovery. Simply being present and available to support them can be invaluable. Here are some tips for talking to your loved one about their mental illness:

- Plan the conversation in advance. Think about the best time and place to start the conversation.
- Be patient and non-judgmental.
- Offer support but be clear about what you can, and can't, do to help.
- Remember that the person is more than their mental illness. Reminding the person about who they are and what they enjoy can help them (and you) separate their identity from their illness.

How do I look after myself while caring for someone with a mental illness?

Caring for someone with a mental illness can be challenging. It can increase the risk of you developing a mental health condition, as well. Looking after your own physical and emotional needs will allow you to keep caring for your loved one throughout their illness and recovery.

It's normal to experience a range of emotions when caring for someone with a mental illness. Don't be afraid to acknowledge your feelings and the effect of your loved one's illness on your own life.

Consider sharing your feelings with a friend or family member, or seeing a counsellor or psychologist. Some people find it helpful to join a support group for carers of people with a mental illness.

It's important to look after your own needs. Try to get enough sleep, follow a balanced diet and maintain your own interests.

If your loved one needs a lot of support, you may need to plan a break. Arranging respite care can help you focus on your own physical and emotional needs while knowing that the person is being well cared for.

General principles

Express empathy - It means accepting and respecting the patient trying to understand her/his thoughts and emotions in a human approach.

Avoid arguing with the patient about particular points in their story

Ask open questions - The ones that cannot be answered simply with a yes or a no. Allow and encourage the patient to explain

Specific guidelines counsellors, psychologists, educator

- Make sure that both of you can sit comfortably and in a position where the interviewee can look you directly in the face and you can respond looking him in the eye.
- If the person is lying down for health reasons, ask if she/he can sit up and help her to do so, making sure she is comfortable.
- Adapt the time of the interview to the health conditions of the interviewee.
- Although it is important to have a certain order in the interview, the plan can be modified according to the circumstances.
- Avoid frequent interruptions.
- Whenever possible, it is preferable to exhaust one topic before moving on to another and go from the simplest to the most complex. Note if there is a specific topic that the interviewee avoids.
- Once the person has spoken freely, begin with the pertinent questions according to the case, both to better clarify what was reported and to find out about aspects that have not been treated spontaneously or have been eluded.
- Try not to start questions with "Why?" since this can be interpreted as an intention of criticism or direct questioning.
- Maintain a logical and coherent order in the questions.
- Do not try to exhaust the entire subject in a single interview, there may be pending aspects or information that can be dealt with in other appointments when there is greater confidence or less emotional disturbance.

Sometimes people are reluctant when asked about background or more intimate aspects or that seem unrelated to what is currently happening to them, especially because of the impact that memories of what happened may have. Although it is useful to comment that the desire is to help him and that it will be easier to do so if the details of his life are better known through what he can tell you, always respect the silence and the decision of the person not to speak if he does not feel comfortable to do it.

Reflective listening

It is one of the fundamental skills in the initial interview. It is about finding out what the patient is trying to say and giving it back through affirmations. These statements can be:

Repetition: of some word that the patient has said and may seem important to us

Rephrasing: The same as repetition, but changing the word to a synonym

Paraphrasing: Reflecting what the patient has said, but with other words

Emotional signaling: Phrases that show feelings or generate emotions ("You seem worried" "It seems that you are excited to talk about this") Summarize highlighting what seems most important to us.

Guidelines for Mental Status Assessment and Identification of Risk Factors

The mental status assessment at the individual level should include at least:

- Carry out an individual open interview.
- Analyze the person's background, emphasizing psychosocial aspects
- Interview family members or friends, and
- Perform a minimal mental exam.

Basic guidelines for the individual interview

In the interview, the subject's personal presentation and attitude should be analyzed in reference to his background and his current situation, and the way he reacts to the interview: how is he dressed? Does his grooming match his background? Is there any explanation for his appearance being inappropriate or strange? Remember to assess the person in their particular context which may determine an appearance that may be mistakenly interpreted as deliberate carelessness.

- Synthesize the fundamental elements of what is told, ordering them and then, in a pause, explain what has been understood. Example: "If I have understood you correctly, you have had..." or "I get the impression that you feel...". Allow the person to correct and complement if the assessment has been wrong or incomplete.

Doing a family interview is always useful to complement and clarify aspects of the information provided and to seek cooperation from the family in management. Always consult with the person about their opinion about talking to their family about their problems and comment that the purpose is only to help them and facilitate their recovery.



Compilation of personal background, especially of a psychosocial nature

Personal history may be useful in identifying risk or protective conditions. Generally, the background is obtained in the interview with the affected person or through family and friends. They understand the basic data of their personal history and their family and social environment.

It is important to highlight the following elements:

- Personal information;
- History of illnesses, including psychiatric and neurological;
- Family functioning; (see family approach component)
- Presence of violent behavior or alcohol abuse in the family environment.
- Significant developmental milestones in childhood, including performance school, to have a global idea of the level of intelligence of the person;
- Social and labor adaptation in the different stages of life;
- Information on personality traits (sociability, conflicts);
- Interpersonal skills, patterns of reaction to conflicts, and stability in relationships and jobs);
- Beliefs and values, for example religious (which can be a protective factor);
- Recreation habits and use of free time;
- Pathological history (physical or mental illnesses), with special mention of chronic or long-term diseases, to assess the previous state of health and the existence of sequelae or disorders;
- History of alcohol or drug use.



Specific advice for the patient and their families

- Ask about a possible risk of suicide (does the patient frequently think about his own death? Has he attempted suicide before? Does he have suicidal ideation?) Close monitoring may be necessary for part of family or friends.
- Plan short-term activities aimed at fun and strengthen self-confidence, but always respecting their decision and determining the expectation of attention without pressuring them in any way.
- Identify problems of daily life and stressful situations. make the person concentrate, step by step, on specific events so that they improve their coping strategies.
- Prevent him from making drastic decisions about her life.
- If there are somatic symptoms, try to find out the relationships between these symptoms and mood.
- After improvement, monitor possible signs of relapse and plan with the patient and family possible formulas to resort to if new symptoms appear.

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CHAPTER 2

HELP WITH ACTIVITIES OF DAILY LIVING AND REINTEGRATION INTO THE COMMUNITY

Introduction

Mental illness is not a personal failure, it happens to most of us at one time or the other in life. Mental, behavioural and social health problems are an increasing part of health problems in the world. The WHO estimates that mental and behavioural disorders constitute 12% of the global burden of disease. Worldwide, nearly 450 million people have mental or behavioural disorder (WHO 2001).

The number of PWMI will increase substantially in the coming decades for the following reasons. Firstly the number of people living in the age groups of risk for certain illness is increasing because of the changes in the demographic features. Thus there has been increase in the number of person with mental illness in the age group of 15- 45 years. Secondly, there has been substantial increase in the geriatric population having mental health problems, as the life expectancy is increasing. Thirdly, there is an overall increase in the rate of depression seen in all age groups as an effect of the changing socio- cultural-economic and political situation of the modern world (Janardhan and Naidu, 2006; Janardhan and Naidu 2007)

Mental illness in certain cases leads to psychosocial disability (Tally and Murali 2001). Advances in behavioural science have proven that mental and behavioural disorders are treatable like any other physical illness (WHO 2001). Unfortunately, in most countries mental health and disorders are low priority, with no services in the community for treatment and well-being. Though the burden resulting from psychiatric, psychosocial, and behavioural disorders are enormous; it is grossly under represented by conventional public health statistics. Nearly 10% of Disability Adjusted Life Years (DALYs) across all age groups are due to depressive disorders, suicides and alcohol related problems. If a person is unable to perform an activity because of disease/illness or due to bodily impairment, the person is considered as disabled.

Though psychiatric disorders do not cause any physical impairment, they can stop a person from doing many activities that are expected of them. The disability in psychiatric illnesses is dynamic being influenced by the nature of illness, phase of the illness, treatment status and social support network available to them.



Community Based Rehabilitation (CBR) and people with mental illness

Development and changes in the concept of CBR over the last two decades has influenced the thought of inclusion of mental health in CBR programmes. The CBR strategy shifts rehabilitation interventions to homes and communities of people with disabilities. Basic services are provided or facilitated by CBR workers who are minimally qualified non professionals but who are highly qualified change agents. The main goal of rehabilitation has become broader and focuses beyond the individual, to the family and communities in which people live. CBR recognizes that breaking down barriers to inclusion in society is as important to the mission of the CBR programme as is the functional rehabilitation of individuals with disabilities.

Thus the universal mission of CBR is:

1. To enhance activities of daily life of disabled persons
2. To create awareness in disabled person's environment to achieve barrier free situations around him and help him in meeting all human rights.
3. To create a situation in which the community of the disabled persons, participates fully and assimilate ownership of their integration in to the society. The ownership lies with the affected persons. Maya Thomas and M.J Thomas 2003, Pritivish 2006).

The above mission is no exception for people with mental illness - PWMI. CBR programmes can link with mental health professionals, users of mental health services, DPOs and SHGs to broaden its scope to include people with psycho social disabilities and to promote community mental health services.

Indicators of readiness

In order to begin a mental health component in the CBR programme, the following readiness indicators should be demonstrated:

1. Organization's willingness to work with mental illness
2. Basic understanding of the mental health concept/problem
3. A match of br between current CBR activities and mental health and development needs
4. Resource stability of the organization (Shoba Raja 2005)

Inclusion of mental health into CBR

There are a number of reasons why mental health should be integrated into community-based rehabilitation programmes:

- Community processes, full participation, equal opportunities, social inclusion, gender, diversity and a focus on rights are some of the key common elements of CBR work. Community mental health work is no different, so the programmes integrate well together.
- The high prevalence of psychosocial disabilities emerging through mental illness and its impact on communities, societies and economies means that CBR workers are confronted with the issues in their work. CBR programmes can have a positive impact on the lives of PWMI, their families and on the situations in which people live by including people with psychosocial disabilities in their programmes (WHO 2010).
- There are a limited number of mental health professionals and mental health services in low-income countries, making a CBR strategy which empowers community level stakeholders to take action an important strategy
- The emerging trend away from vertical health programmes to integrated, multipurpose health programme models favours primary level services and community based strategies
- There is an increasing recognition of the importance of early detection and treatment of mental illness in order to prevent chronic conditions.
- The goal of continuity of care and inclusion of people who are mentally ill into the community is more readily achieved when there is an existing community based strategy
- The prevalence of mental health problems among people with other disabilities means that a mental health component in the CBR programmes brings added value

The care for people with mental illness can be provided by:

- Family members providing care to PWMI starts from baring all the violent behaviour, to accompanying them for treatment, than administering medicines, helping to engage in gainful productive work.
- Community providing support for the well-being of PWMI. This is seen in the form of not labelling them as mad people, giving opportunities and advocating for the ensuring measures to meet the needs of PWMI.
- Rehabilitation workers providing care for the PWMI and their families. This starts with identification, assessment, follow up, home based support and linking them to existing groups and mainstreaming.
- Organization providing support to deal with other associated problems of PWMI and their caregivers. This is seen in the form of conducting camps, integrating them in to their existing programmes.
- Provided with the above support, the role of mental health professionals would be more meaningful.



Suggested Activities for inclusion of people with mental illness to be included in the existing CBR programmes:

1. Promote community based mental health services

The community based services should emphasize on community acceptance, family involvement, social integration and livelihood opportunities as a key component of interventions while rehabilitating people with disabilities. Similar approach is required for PWMI for integrating them in to the community. An approach, where in medical inputs are seen as a part of a larger whole including income generation and mainstreaming individuals with mental health problems into the full community.

The community based organization, SACRED, included mental health programme in their existing CBR programme. PWMI had to travel 100 kilometres to attend the mental health camp conducted by the National Institute of Mental Health And Neuro Science because there were no services available in that district. With the support of the federation of people with disabilities, PWMI were successful in sensitising the district authorities and advocating for the availability of mental health services with in the district. Of course the struggle took more than three years for the appointment of Psychiatrist in the District Hospital

Similar experience in Koppal and Raichur districts, PWMI and their caregivers were travelling 10-12 hours to reach Karnataka Institute of Mental Health, Dharwad for assessment, diagnosis and treatment services. Organizations of people with disabilities promoted by CBR programme of Samuha sensitised the authorities and were successful in getting the services with in their district. Awareness building among family members and community complemented the efforts.

2. Promote community mental health services

Community Inclusion (CI) is a community-based service that is designed to help individuals safely and successfully integrate into their local community. While how this happens will look different for each person, all individuals will be provided with the opportunity to access the community in ways that are individualized and personally meaningful to them.

Mental health professionals in several low-income countries are actively promoting Community Mental Health (CMH) and are attempting to influence their governments to initiate measures to bring mental health into the primary health care system. CBR programmes can work with mental health professionals, local health centre staff and users of mental health services to promote community mental health servi-

ces. Many mental health problems can be effectively resolved by working together with people who experience mental illness in their own homes and communities, using resources and support networks that are available to them. Awareness raising campaigns and large-scale dissemination of knowledge and skills would help in reducing the stigma attached to illness. Building knowledge and awareness among families can make the real difference, in ensuring that PWMI are integral members of the family and community, participating in all social and cultural activities.

3. Street theatre

Street theatres play a major role in generating awareness in the community. Some organizations also have formed puppet shows troops. Street plays can provide knowledge on causes, treatments and symptoms of mental illness. The purpose is to demystify the subject and to raise the awareness of the public on mental health issues. Street theatres can also highlight the important roles and responsibilities of families and the community, which could go long way in rehabilitating PWMI. The street theatre performances can be followed by question and answer sessions, where people can ask specific questions.

4. Self-help groups

Self-help groups are a common feature of CBR and development work. A self-help group of women were clearly working hard to be strong in the face of personal tragedy and unrelenting poverty. Comprising twelve members, they came together with the support of CBR worker to promote savings of Rs.100 per month per person so that individuals can accumulate enough to buy a buffalo. This would then be a source of regular income, the milk being sold to a cooperative at a guaranteed rate per litre. One of the women had lost her husband to snakebite the previous week and so the group was rallied around to support her and her three children.

The link comes from the member living with schizophrenia, who has been accepted as treasurer for her literacy skills (despite only having stabilised her schizophrenia during the previous year). And she also derives benefit as any other marginalized member of the group. Together the group advocates for meeting the individual, group and community needs.

This way they play an important role in integrating PWMI in main stream and provide mutual support to people in crisis.

Seek out alliances for training and mutual support

Local community organizations staff like community rehabilitation workers/field staffs, coordinators of self-help/user groups and other programmes, lay volunteers/ animators, nurses, and health workers; who are not professionals in mental health or health care provide a variety of services. Many of these informal community-care providers have little or no formal mental health care training, but in many low income countries they are the main source of community mental health provision. They are usually accessible and generally well accepted in local communities. They can help with the integration of people with mental disorders into community activities and the other developmental activities of their own organizations, and thus play an supportive role in meeting the treatment needs of PWMI.

Caregivers Associations

PWMI and their caregivers are encouraged to form an association of their own. This provides a platform for them to discuss various problems they share and find solutions. For example, Mr B's, family experienced unwelcome reactions of neighbours towards their son. Mr B was wandering in the streets and his parents had to find him and bring him back. The caregivers' association in the village took the responsibility to explain the illness to others. Mr B has now returned to work as a labourer and is maintaining full-time employment.

Another caregivers association took the decision to advocate for their right to treatment. The association members met the district authorities, explained to them the need for treatment to be made available at their block level. PWMI and their families decided to voice their needs rather than depending on the local organizations. This resulted in the deputation of a psychiatrist to conduct mental health camps in the local health care centres on a monthly basis, with medicines being distributed during these camps..

Some of the important roles of the CBR and the community development work force are:

- Awareness creation and dissemination of information;
- Identification of people with mental health problems and referral to health services;
- Crisis support;
- Home based support - supportive care, including basic information and counselling;
- Helping in the activities of daily living skills and community reintegration;
- Formation of caregivers groups/associations;
- Advocating for the rights of PWMI;
- Preventive and promotive services;
- Organising affected people to advocate for meeting their needs.

Mr. M, a young volunteer from a youth group in Jalahalli, took initiative in supporting a woman who is mentally ill and destitute in his village. He witnessed a shop keeper physically abusing (pushing) her for entering his restaurant. Mr M took this abuse seriously. With the help of an NGO he took her to the mental hospital for treatment, following guidelines of mental health act for the involuntary admission. After her discharge, he spoke with the woman's relatives and made arrangements for her stay and for her livelihood. People like Mr M, volunteer to support NGOs in their work. NGOs also experience stabilised people playing the role of volunteers and advocates. Always people inspired by good work voluntarily offer assistance.

Advantages of inclusion of people with mental illness in the existing CBR programmes:

1. Meeting the needs of most disadvantaged group.
2. This promotes faster integration of PWMI into the mainstream societal activities.
3. Promotes good mental health in the community and leads to early identification.
4. Inclusion of PWMI in CBR programme would be cost effective.
5. CBR strategies and approaches very much fit in meeting the needs of PWMI.
6. Encourages innovative use of the resources that already exist (for example street theatre troops, advocacy groups, etc.)
7. Inclusion would ensure coverage of all people with disabilities.
8. Mental health problems of people with disabilities are addressed, which adds value to the existing CBR programme.
9. An environment would be built where in all disadvantaged groups including PWMI fully participate in their own development and the community in which they live in.

CBO

The project head during one of the meeting expressed that because of inclusion of the mental health programme, the credibility of the organization has increased, the organization got more recognition in the community and also in the district administration. The organization leaders were invited to become members of the government constituted boards. District authorities were appreciative and requests were received to extend mental health services to other parts of the district.

Broaden understanding of the issues

Development practitioners need basic understanding of mental disorders. It is essential to consult PWMI and their family members to listen to their experiences, and needs aspirations to understand that particular individual and the family. Training can be provided in basic competencies, such as counselling- listening and communication skills and need to maintain confidentiality, managing conflict of interests while dealing with individuals as well as their families, maintaining a neutral stance and dealing with disturbing emotions.

Outcomes expected from inclusion

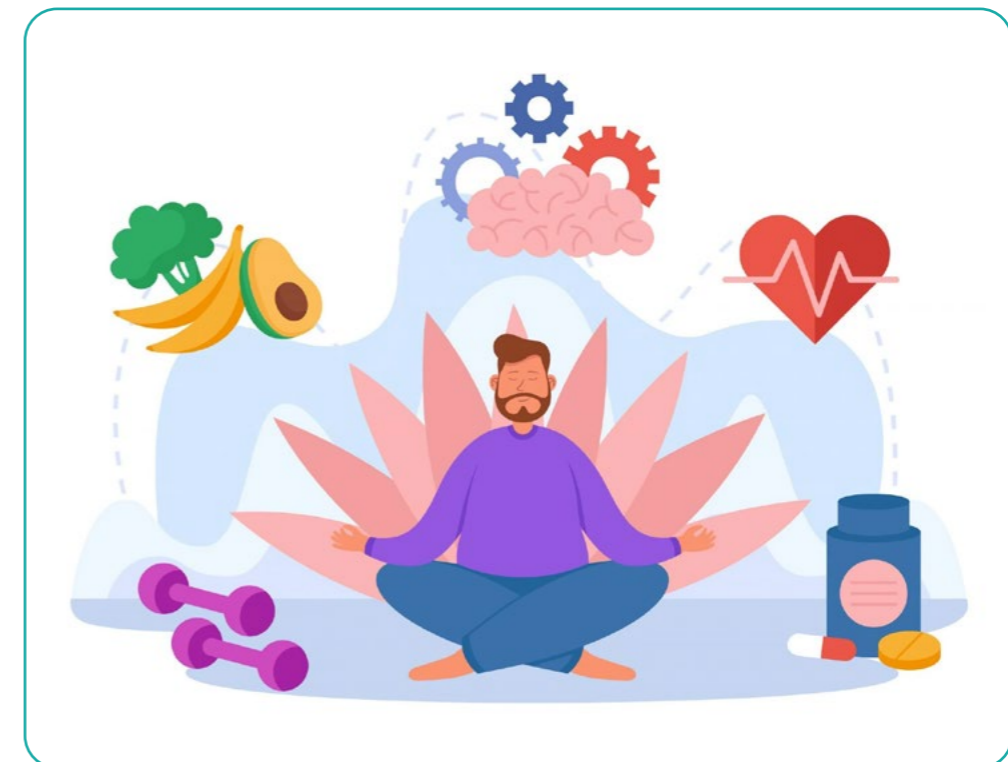
By including PWMI in CBR programmes, the following outcomes can be achieved:

- PWMI advocate for their rights and entitlements as equal and full participants in the disability movement
- PWMI participate in their own development and the development of communities in which they live
- PWMI are listened to and are able to consent to or refuse treatment in circumstances that are not life-threatening.
- PWMI have access to appropriate community-based treatment and support.
- Families of PWMI are provided with the support

- PWMI and their families are able to earn their livelihoods.
- Community health workers include mental health issues as an integral aspect of their work
- PWMI are able to access health care and educational services within and outside of the community
- PWMI participate in the social, cultural and religious life of their communities as they choose.
- PWMI fulfil their roles as community members, family members, parents and citizens

Conclusion

It has been tested and proved that inclusion of mental health issues in CBR programmes is possible, cost effective and help building an environment where in people with all disabilities access their entitlements and enjoy equal opportunities for full participation in their own communities. A different and better world for all people, including PWMI can be created through community based mental health services, where in the communities understand issues related to mental health, resulting in positive response to the issues. In this scenario the families of people who are mentally ill are vitally involved in bringing change in the attitude of the community. Through these an environment of mutual understanding can be built, where in PWMI enjoy their rights.



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CHAPTER 3

SUPPORTIVE CARE, INCLUDING COUNSELING AND SELF-HELP

Introduction

The term 'mental disorders' is used frequently in peoples' everyday lives. Certainly, it is common for people to encounter such disorders. However, sometimes this term is misunderstood. The content attributed to it does not exactly comply with the content that scientific community of experts have described. This might lead to a series of misconceptions regarding mental disorders and the people affected by them. It is therefore necessary to attempt to give a scientific definition. Mental disorders address to behaviors that may seem not so usual and may not be desirable and pleasant. Examples can be behaviors which can prevent people from living normal life and being functional and are accompanied by other physiological symptoms such as sweating, heart palpitation or upset stomach.

Even though experts might still be continuously searching for the factors that generate and let these mental disorders emerge and grow, they agree on some common findings, regarding their causes.

They might be attributed to a combination of environmental, social and genetic factors. These might include heredity, weaknesses of, tolerance in low stress, experiences of childhood, being exposed to frequent stressful situations and lack of ability to cope. they usually develop gradually. there are different types of mental disorders which call for different approaches theoretically and practically.

Finally, intervention is necessary. This intervention can be provided by different groups of people, such as experts, family members, educational and professional institutions (NIOS, 2012).

A significant number of cases of mental disorders can be attributed to the factor of stress. According to Hans Seyle (1985) stress has to do with mostly psychological but also physiological responses of a human to any demands. There are different levels of stress. There is the 'eustress', which is moderate and, in some cases, it can be desirable and creative, since it can motivate people to perform better, as in cases of competitive sports. There is however, the 'distress' which can be excessive, not to let people work and live functionally and normally. There are various factors that can lead to stress or to greaten it. Major life events and changes can be one of them. Examples of such factors are divorce, retirement, which might not be managed effectively and have enduring side-effects. Another example can be uncomfortable daily

hassles, such as frequent rough deadlines, confusions and other conditions that can cause frustration and unpleasant feelings. Chronic role strain can cause stress too. People who live in dysfunctional families, or might have to face challenges such as poverty, war or live with a family member with disability, can be included in that category. A final example can be the experience of a trauma, which can be horrifying, such as surviving a terrorist attack or the loss of a beloved person. These incidents or situations can have a significant impact on the way a person deals with everyday life and can be linked with stress.

Advocating the rights of people with mental disorders - The UN charter

The United Nations, in an effort to support people with mental disabilities have introduced in 1991 a series of 25 principles that every member nation is expected to follow, in order to support these people. Moreover, their implementation is expected to help these people become active members of the community and help others too.

The first set of principles 1-5 addresses fundamental topics and values that all people should understand and share if they are to assist fellow-citizens with mental disabilities.

Specifically, the **first principle** clarifies that all people suffering from mental disabilities should be entitled to appropriate medical treatment. In turn, this means that the centers and institutions offering this treatment should be established. Moreover, these institutions should work while taking into account the dignity of the mentally disabled people. There should be no form of discrimination regarding the treatment they receive. Any form of exploitation or abuse against them should not be accepted. Any civil, political, economic, social or cultural rights that these people have should be respected. In case a mentally disabled person needs any type of assistance, for example when he or she is unable to exercise any fundamental rights, there should be opportunity for a representative person to be appointed. This person is expected to act on the interests of both the disabled person as well as the greater community (United Nations, 1991). This principle serves as foundation for the achievement of the desired outcomes of treatment of mental disorders and the appropriate development of patients. (Thoits, 2022).



Principle 2 emphasizes on the age factor and stresses that there should be attention in cases where the people with mental disorders are minors. As it is explained, if it is necessary, another family member can be appointed as a representative of this person to assist in the treatment and other tasks (United Nations, 1991). This is important as childhood is a crucial period for the development of any citizen, including patients of mental disability (Thoits, 2022).

Principle 3 underlines that people suffering from mental disorders should still be entitled to work and participate in any social activities (United Nations, 1991). This can assist in enhancing the patients' self-esteem, which is important and can lead to more successful treatment and life standards-improvement (Witwer et al, 2022).

Parallel to that, **principle 4** provides a fundamental precision. At that initial stage, it is important to understand what a mental illness is and when it is acceptable and accurate to include a person as a patient with mental disability. This precision or definition should be made exclusively on medical or scientific standards and research findings. On no occasion should mental disability diagnosis rely on criteria of cultural, religious, social, economic or political nature (United Nations, 1991). Omission of this principle can cause serious problems (Thoits, 2022).

Additionally, **principle 5** stresses that no person should be forced, in anyway, to undergo any diagnosis of a mental disorder or any kind of examination (United Nations, 1991). This approach can be unethical and misleading (Pawlowski et al, 2022).

The next set of **principles 6-10** emphasize on ethical, moral and other relevant fundamental conditions that any type of treatment for mentally disabled people should abide by. Principle 6 stresses that there should be confidentiality. Any information regarding the patient and his or her condition, past, medication and treatment generally should be kept confidential (United Nations, 1991). The rationale of this principle is that it can reassure trust in treatment provision institutions for anyone (Byrne, 2022).

Principle 7 emphasizes on the role of community and culture. It points out that it is essential for the patient to be treated in a context that is familiar to him or her. This means there should be available place or center to offer treatment near the patients' residence. It also means that the treatment should be compatible to the patients' customs, beliefs or cultural background (United Nations, 1991). This principle, when followed, can enhance even further the trust between patients and the treatment institutions (Thoits, 2022).

Principle 8 clarifies the standards that the treatment of patients should satisfy. Firstly, the treatment should be appropriate for the patient and aiming to improve his or her condition and life. Secondly, there should be no use of inappropriate medical treatment and medication. There should also be no phenomena of abuse or mistreatment of patients, (United Nations, 1991). If this principle is neglected there might be plenty of problems for the patient and the community in general (Witwer et al, 2022).

Principle 9 gives precisions regarding specifically the treatment of mental disorders. At first, it mentions that the restriction factor should be as limited as possible. This means that the patient should ideally not be restricted by anyone or anything during the treatment. Both the environment and the services provided should make the patient and the people accompanying him or her feel the least possible restriction. Certainly, any restriction should be justified before being imposed.

The treatment It should be based on a plan, which should be designed according to scientific findings. This plan should be continuously revised, reviewed and evaluated, by professionals. Ethics should be taken into consideration, to reassure that the treatment aims only to improve the patients and mental disorder therapy, by focusing on targets such as the strengthening of the patient's autonomy (United Nations, 1991). Such principles can lead to more efficient treatment and life-standards improvement (Witwer et al, 2022).

Principle 10 emphasizes on medication. Any medication given should be proved to be exactly what the patient needs, for reasons of diagnosis or therapy. Unnecessary or harmful medication should be avoided. Prior to being distributed, these medications should be checked by legal authorities or mechanisms. Their benefits and needs should be checked. In other words, there should be a law that periodically evaluates these medications and permits their provision and use (United Nations, 1991). This principle aims to achieve sustainable solutions regarding the effectiveness of mental disorder treatment services and the trust of the public towards them (Pawlowski et al, 2022).

The set of principles that follows, 11-15, aims to strengthen even further the democratic and humanistic features of mental disorders treatment. Principle 11 emphasizes on consent, what it should include and how it should be approached. At first, it is mentioned that there should be concern around consent, which should be stated and informed formally. The patient is entitled to obtain, without any kind of threat and improper process, certain details in an understandable language.

These are the basic information around his or her treatment and entail: the process of diagnosis; rationale, method, possible duration, benefits of the specific treatment; alternative treatments, with a special mention to those which are less intrusive; any possible side-effects, risks or discomfort caused by the treatment, as defined in literature. If necessary, the patient might ask for a person to accompany him or her during the treatment, for any reasons such as assistance and psychological support. The patient has every right to refuse treatment and be informed of the outcomes.

There are only specific cases where the patient might be obliged to undergo a mandatory treatment. These are when: a patient is classified as of involuntary status; an official authority judges that this is necessary for the interest of the patient or others; and the personal representative of the patient decides so, if the patient is unable to give consent. All these information should be disclosed to the patients' personal record. Any relevant decision should be made only with the opinion of experts and scientists, mainly of

the medical field (United Nations, 1991). The complex content of this principle guarantees cooperation between patient and care providers (Thoits, 2022).

Principle 12 clarifies that the patient should be informed about his or her rights, regarding the treatment. This information should be provided well in advance, for before the treatment. It should also be provided in understandable language. As with previous principles, if the patient is unable to understand, a representative shall be selected and have all the explanations given (United Nations, 1991). This is another example of principles that strengthen the trust in the medical treatment system (Witwer et al, 2022).

Principle 13 points out rights that the patient should have in the facility where he or she is treated. Privacy, freedom of communication, freedom of religion and any other belief should be respected. It is also essential that the facility should provide environment for recreation, communication, education and other leisure activities. Forced labor should be excluded at any cost (United Nations, 1991). These conditions can help the patient respond better to any kind of treatment (Pawlowski et al, 2022).

Principle 14 emphasizes on the resources that the facilities should have. There should be experts, scientists, doctors, psychologists and generally people with relevant education and expertise. The equipment and services provided should be appropriate (United Nations, 1991). When these conditions are met, the treatment provided can be of high standard (Byrne, 2022).



Principle 15 emphasizes on admission and the legal issues around it. Involuntary admission should be avoided. In cases of voluntary admission, the patient has the right to leave the facility, after providing justified reasons for his or her decision (United Nations, 1991). As with other principles, this recognizes that the relationship between the patient and treatment experts is crucial (Witwer et al, 2022).

Aiming to enhance the democratic character of treating people with mental illness, the next set of **principles, 16-20**, underline basic rights concerning their opinion and how it should be treated.

Principle 16 emphasizes on what involuntary admission is. Any such admission can be done only when a professional expert clarifies that it is the only solution for the interest of the patient and other people. This admission should initially be decided for a limited period and should continuously be revised by groups of experts. Certainly, the patient needs to be informed and the facility needs to be designed for such purposes (United Nations, 1991). Failure to follow this principle might be significant violation of rights (Byrne, 2022).

Principle 17 mentions that the body that supervises the mental peoples' health and makes decisions around the treatment, even for involuntary admission, should be legally official. It should have juridical authority and include people working in the legal field. There should be progressive concern about the decisions, the treatment. The patient shall have the right to appeal at any moment, against a decision of this body (United Nations, 1991). Thanks to a principle such as this, main rights of mentally disabled people are safeguarded (Thoits, 2022).

To further safeguard relevant rights, **principle 18** mentions that any records, around the patient status, treatment, which may also include the decisions about it, should be formally and substantially kept. These should be given to the patient. Of course, in any case where the patient cannot assist or represent himself or herself, a representative can be selected. If the patient is unable to pay, then this representative should be appointed by the state, through legal mechanisms. This representative can be present during decision-making or appeals and should have access to the patient record (United Nations, 1991). This helps prevent unnecessary or damaging treatments (Witwer et al, 2022).

The issue of access to information is stressed in **principle 19**. It is the undeniable right of the patient, or former patient, to obtain information regarding his or her treatment in a facility. The only exception to that rule is when a professional body of experts considers it risky for this person or other groups of people. As always, this decision has to be thoroughly justified and continuously revised and re-examined. If the patient is unable to have the record, at least the appointed representative should have it. At least, the patient should be informed about the decision to be excluded from this information and the reasons for it (United Nations, 1991). The status of mentally disabled people and their role in the community should not be jeopardized. This principle helps in that respect (Pawlowski et al, 2022).

Principle 20 clarifies that these rights should also address people who are criminal offenders. Legal procedures should apply whenever that's needed. However, these previously mentioned principles should be respected whenever this is possible (United Nations, 1991). This principle certainly aims to avoid any misunderstanding that might be caused. Protections of people with mental disabilities should be compatible with general social progress (Thoits, 2022).

The final set of **principles 21-25**, completes the previous ones, by giving clarifications concerning the general context, goals, structure, administration and functions of mental services. Principle 21 mentions that there should be room for complaints. This means that the countries need to establish appropriate legal procedures, through which the patients can express complaints, make appeals, which should be examined (United Nations, 1991). These mechanisms should involve thorough investigation of the complaints and lead to decisions. If these decisions are well-established and followed, there can be positive outcomes for the patients and for the mental care system generally (Witwer et al, 2022).

Principle 22 emphasizes on monitoring medication and remedies distributions. All the mental care facilities and their functions should be subject to continuous evaluation and inspection. Professional behavior should be used in all functions. Juridical procedures should control that everything works appropriately (United Nations, 1991). Thanks to this principle, there are mechanisms that can help the mental care system improve and assure that people with mental disabilities will receive continuously upgrading services (Pawlowski et al, 2022).

Principle 23 aims to set the foundations for the desired improvement, by focusing on implementation. States should take advantage of all relevant sectors, such as health, legislation, administration, public administration or education, to assure the appropriate function of mental health services. Information should also be distributed to everyone (United Nations, 1991). This principle can help establish cooperation between different sectors, which can help the mental facilities benefit and contribute better (Byrne, 2022).

Principle 24 clarifies that all these principles apply to all the people who suffer from mental disabilities and no discriminations or exceptions should be made (United Nations, 1991). This develops room for further research and improvement in different fields and topics (Thoits, 2022).

Lastly, **Principle 25** points out that these principles should on no occasion exclude or cancel any other rights or privileges that people with mental disabilities hold, such as the right to work, vote and participate in social activities (United Nations, 1991). By respecting this principle, it is possible to help more patients along with other groups of people (Pawlowski et al, 2022).

The composition of all these 25 principles of the United Nations covers a holistic approach towards the ideal level of mental health care provision which aims to help not only the people diagnosed with mental disabilities but the community in general too. The first five principles, 1-5, set the foundations for the effective and democratic issues. The next second set of principles 6-10, pays attention mainly to ethical issues regarding how the patients should be treated. The following set, 11-15, stresses more on how the medical services should be designed, applied and evaluated. The next set, principles 16-20, focus more on administration issues and function of mental health care facilities. The last set of principles 21-25, stresses more on the social role of these facilities. The ultimate goal is to assure that no discrimination or abuse against people with mental disabilities should emerge and to ensure that they will be always able to contribute to the society (United Nations, 1991).

Appropriate practices

The principles of the United Nations (1991), regarding the treatment, medical care and rights of mentally disabled people can be used as the main topics and themes that education should emphasize. This means that these principles can be taught in schools in an effort to promote respect towards these groups of people and extinguish any kind of discrimination against them. In order to achieve this goal, teachers need to adopt appropriate practices and become familiar with activities that can help learners understand their principles and use them in their everyday life. Lessons and subjects need to be adopted and include these principles.

The field of study that can investigate what is the best way to teach these principles is inclusive education. Specifically, a study by UNESCO (2009) has concluded that systematic and sustainable inclusive education needs to take into consideration three basic guidelines. The first is that there are different groups of people with different needs. It is unwise to claim that all people that suffer from the same mental disability should have exactly the same treatment, as each one might be a different case. The second is that schools must work towards a non-discriminatory society. The third is that there should be a system that helps, assists, coordinates and supervises schools to work in that direction, by evaluating their work, advising and monitoring how school members behave and respond.

School leaders should be among the first school members to adopt that attitude. Their role and contribution are crucial. Schools can work inclusively if leaders have a relevant vision. This vision needs to be shared with other school members as well. It is important for teachers to understand the importance of inclusive education and agree on its necessity. In this way teachers and the other members will have the motivation to deliver the relevant knowledge and apply it (Fullan, 2015; Hargreaves & Fullan, 2020).



According to Ketikidou & Saiti (2022), inclusive education is a complex concept, encompassing many elements and issues regarding the role of all community members and their responsibilities. Achieving it is possible, but it requires preparation and attention. The greater social context is very important. If there are ideas and beliefs that inclusive education is important, then there are the appropriate conditions for schools to achieve it. That's because teachers will have support when trying to work appropriately.

Moreover, there will be many groups of people and institutions that can help the schools in different ways. Inclusive education requires sensitivity on behalf of school and community members. It also requires cooperation. Even though there may be agreement that inclusive education is mandatory, it may not be easy to clarify what parts of inclusive education should be taught at different levels and subjects. Of course, the fundamental idea that everyone should have in mind is that all individuals have the right to good life standards and contribute to society. This in turn, relates to education for democracy, building knowledge and social activities, establishing an atmosphere of fidelity, respect and empathy. It also relies on creating values that exist inside and outside of the school community.

Bearing in mind the above findings, theorists and researchers suggest that the best practices for teaching the rights of people with mental disabilities rely on hands-on activities. The nature and scope of these activities can be broad. It depends on several factors. First, it has to do with the exact knowledge, skills or attitudes that are expected to be taught, each time. Certainly, the principles of the United Nations (1991) and all other points regarding how to include and respect people with these disabilities cannot be taught all in one single session. It requires time, revision and approach from different subjects, if not all.

The teachers need to take into consideration several other factors. An example of those is the legislation. Teaching topics that are not approved of by the law can hinder any effort on behalf of them. A factor relevant to the legislation is the curriculum and the syllabi that teacher has, which also have to be used as required. The teacher can be helped significantly when he or she knows what the curriculum and the legislation consider appropriate knowledge, because then it is possible to combine them with the principles around mentally disabled people. Another factor is the school infrastructure and financial resources. It is helpful for the teacher to know what equipment, means and classroom arrangements exist in the school, so that any planned activities and sessions can be easily implemented. Lastly, it is important to see what happens with time available. This way, they can set a feasible timetable for their sessions and activities. In short, the teachers must understand the context, the climate and the school culture within which they work. Any innovation requires that (Fullan, 2015). This will help them decide better how they can work, so that they can effectively teach the main points regarding how mentally disabled people should be approached (Hargreaves & Fullan, 2020; Ketikidou & Saiti, 2022).

The hands-on activities implemented may include role play and role allocation. For example, learners may adopt roles of people responsible for deciding about a case concerning patients with mental disabilities, their treatment and rights. A learner might step in the shoes of an expert, a legal juror involved in such a case or a representative of a patient. By examining the case, the learners can engage in discourse. This way, they can understand better the points around these peoples' lives, responsibilities, abilities, values and decisions. This method is appropriate to deepen their knowledge, develop skills and adopt attitudes regarding what the community needs to do. In doing so, the teachers and the schools might cooperate with organizations that work with people with mental disabilities. These can provide accurate resources and information about that subject and help learners understand even better. For that scope, it is important that the general social context emphasizes on the appropriate care of mental disabilities. Otherwise, the schools, the leaders and the teachers will probably have limited resources, information, knowledge and support in delivering relevant knowledge or values (Ketikidou & Saiti, 2022).

Several points of consideration have been disseminated with regard to the education for the mentally disabled. Ilkim et al (2018) as well as Purnomo et al (2020) emphasize on the importance of socialization. Socialization can have benefits at different levels. It is a basic biological and psychological need. At a personal level, it can help the mentally disabled people develop the necessary social skills. They can learn how to communicate, approach people, interact and establish self-confidence and healthy relationships. At a social level, it can help these people demonstrate their abilities and qualities. This way, others can understand what these people can contribute and what needs they have. Misconceptions about mentally disabled people, their condition and capacities, can be rejected. Discrimination against them can be fought.

Kaya and Yidliz (2019), mention that it is important to implement different education approaches, such as Montessori model, which emphasizes on a variety of social and cognitive skills. Particularly for the mentally disabled people, this model can assist significantly on skills related to movement, visual and perception, which are crucial for all people, including mentally disabled. For example, these people can be helped develop skills such as mental or physical balance or flexibility. Thanks to such an approach, it is possible for them to understand the value of being autonomous and self-reliant as well as how to achieve that. This approach differs from mainstream and classical education for the mentally disabled in many ways. Family members can have an active role, contribute and teach. Education takes place more in real contexts and challenges, rather than theoretical, hypothetical situations. Evaluation and importance can be based on actual outcomes, which can be observed in the performance and behavior of the learners. Therefore, the benefits or achieved goals are more accurate and trustworthy.

As Suleiman et al (2021) point out, the role of ICT is important. ICT is recognized as helpful means for all learners, as it can assist in writing and editing text, gathering resources, creating visual representations, facilitating research and exchanging ideas, information or documents. The mentally disabled people might be helped with assistive and specially designed tools, which address to them and help them overcome any disability. There is a wide range of such technologies, developed, distributed and used over the last decades: Braille Duplicators and Writers; Group Hearing Aid for classrooms; Tactile mathematical devices; Tactile geography devices; tactile science devices; Screen readers & magnifiers; Assessment & evaluation tool Models; Multimedia Content; Content Development Software; Word Bank & Prediction Systems; Text-to-Speech Engines & Speech Recognition; Spe-

cial Access Switches & Mechanism; and Sign Language & Braille Learning Software. Generally, there are plenty of applications that can help in visual impairment, hearing impairment, locomotor impairment, speech impairment and mental retardation. Their use should be planned appropriately and consider factors of social, physical and financial nature. If this careful planning happens, the use of such technology can have benefits for mentally disabled people, non-disabled people teachers and other social groups.

Indicative activities

Having in mind the following principles and practices, several researchers have suggested interventions which turned out to be effective enough to assist people with special needs and enhance their living conditions or environment. All these interventions have included several kinds of activities oriented towards a specific goal (Hargreaves & Fullan, 2020; Ketikidou & Saiti, 2022). These activities can be extracted from the theories around development of social skills.

A type of activity that can be used is role play. Thanks to role play, learners can understand better how other people and other groups of people live. They can learn and appreciate the challenges that they may face in their lives, along with the potential, or strong points that they may have and the cases where they can contribute to. Role play can help the development of empathy, through communication, interaction and cooperation. Thanks to these, role play can lead to the adoption of new behaviors that are friendlier towards people with disabilities. Of course, role play is generally considered an enjoyable activity for the learners (Pekdoğan, 2016; Mpella & Evaggelinou, 2018; Diaz-Garolera et al, 2022).

Another type of activity can be brainstorming. Thanks to that, all learners can express ideas, experience and knowledge around a topic, including assistance to people with mental disabilities and the qualities they need. By initiating with such task, it is possible to help the learners to express misconceptions that they may hold and examine ways to reject and reconstruct them. Aside that, learners can develop skills for efficient dialogue and discourse too. The brainstorming can expand to the design of appropriate material. This material can be conventional or digital, audiovisual and can help understanding appropriate behaviors and attitudes. The outline or implementation can be carried out in different stages, depending on the topic of discussion or the goals that the educators or instructors set (Kaya & Yidliz, 2019; Diaz-Garolera et al, 2022; Ketikidou & Saiti, 2022).



Project-based activities can help too. These projects can address different topics, such as the role of foundations and institutes, the policies that aim to support the patients with mental disabilities, or even the biography of people who have been recognized to help those groups of people. Such activities can help learners understand better what they can do. They can focus on actual real-life cases or situations about people with mental disabilities. This way they can understand what these cases are like or how they should be dealt with (Ilkim et al, 2018; Purnomo et al, 2020; Ketikidou & Saiti, 2022).

In short, any interventions, sessions or seminars that emphasize on treating people with mental disabilities, can benefit from activities such as role play, brainstorming or projects. Certainly, these activities have to be well planned. These activities can be more efficient if they include applications of ICT (Suleiman et al, 2021). In any case, the ultimate goal should be to create a culture that is friendly towards these groups of people and to help everyone share and realize the vision towards this goal (Hargreaves & Fullan, 2020; Ketikidou & Saiti, 2022).

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CHAPTER 4

PREVENTIVE AND PROMOTIVE SERVICES

Key facts

- Affordable, effective and feasible strategies exist to promote, protect and restore mental health.
- The need for action on mental health is indisputable and urgent.
- Mental health has intrinsic and instrumental value and is integral to our well-being.
- Mental health is determined by a complex interplay of individual, social and structural stresses and vulnerabilities.

Concepts in Mental Health

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.

Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.

Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm. People with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always or necessarily the case.

Determinants of Mental Health

Throughout our lives, multiple individual, social and structural determinants may combine to protect or undermine our mental health and shift our position on the mental health continuum.

Individual psychological and biological factors such as emotional skills, substance use and genetics can make people more vulnerable to mental health problems.

Exposure to unfavorable social, economic, geopolitical and environmental circumstances – including poverty, violence, inequality and environmental deprivation – also increases people’s risk of experiencing mental health conditions.

Risks can manifest themselves at all stages of life, but those that occur during developmentally sensitive periods, especially early childhood, are particularly detrimental. For example, harsh parenting and physical punishment is known to undermine child health and bullying is a leading risk factor for mental health conditions.

Protective factors similarly occur throughout our lives and serve to strengthen resilience. They include our individual social and emotional skills and attributes as well as positive social interactions, quality education, decent work, safe neighbourhoods and community cohesion, among others.

Mental health risks and protective factors can be found in society at different scales. Local threats heighten risk for individuals, families and communities. Global threats heighten risk for whole populations and include economic downturns, disease outbreaks, humanitarian emergencies and forced displacement and the growing climate crisis.

Each single risk and protective factor has only limited predictive strength. Most people do not develop a mental health condition despite exposure to a risk factor and many people with no known risk factor still develop a mental health condition. Nonetheless, the interacting determinants of mental health serve to enhance or undermine mental health.

Mental Health Promotion and Prevention

The terms mental health promotion and prevention have often been confused. Promotion is defined as intervening to optimize positive mental health by addressing determinants of positive mental health before a specific mental health problem has been identified, with the ultimate goal of improving the positive mental health of the population. Mental health prevention is defined as intervening to minimize mental health problems by addressing determinants of mental health problems before a specific mental health problem has been identified in the individual, group, or population of focus with the ultimate goal of reducing the number of future mental health problems in the population (Miles et al., 2010). Mental health promotion and prevention are at the core of a public health approach to children and youth mental health which addresses the mental health of all children, focusing on the balance of optimizing positive mental health as well as preventing and treating mental health problems.

Promotion

Mental health promotion attempts to encourage and increase protective factors and healthy behaviors that can help prevent the onset of a diagnosable mental disorder and reduce risk factors that can lead to the development of a mental disorder. It also involves creating living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles or a “a climate that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health.”

Specifically, mental health can be promoted through

- Early childhood interventions (e.g., home visits for pregnant women, pre-school psychosocial activities);
 - Providing support for children (e.g., skills building programs, child and youth development programs);
 - Programs targeted at vulnerable groups, including minorities, indigenous people, migrants, and people affected by conflicts and disasters (e.g., psychosocial interventions after disasters);
 - Incorporating mental health promotional activities in schools (e.g., programs supporting ecological changes in schools and child-friendly schools);
 - Violence prevention programs; and, among others,
 - Community development programs.
- Positive youth development is defined by the Interagency Working Group on Youth Programs as an intentional, pro-social approach that
- Engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive;
 - Recognizes, utilizes, and enhances youths’ strengths; and
 - Promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths.

It provides a lens for promoting young people’s mental health, focusing on the protective factors in a young person’s environment and how these factors might influence a person’s ability to overcome adversity.



Prevention

Prevention efforts may differ depending on the target audience, the level of intensity they provide and the development phase they are aimed at. Figure 1 depicts the different types of prevention, as defined by the Institute of Medicine. As prevention efforts move from universal prevention interventions to treatment, they increase in intensity and become more individualized.

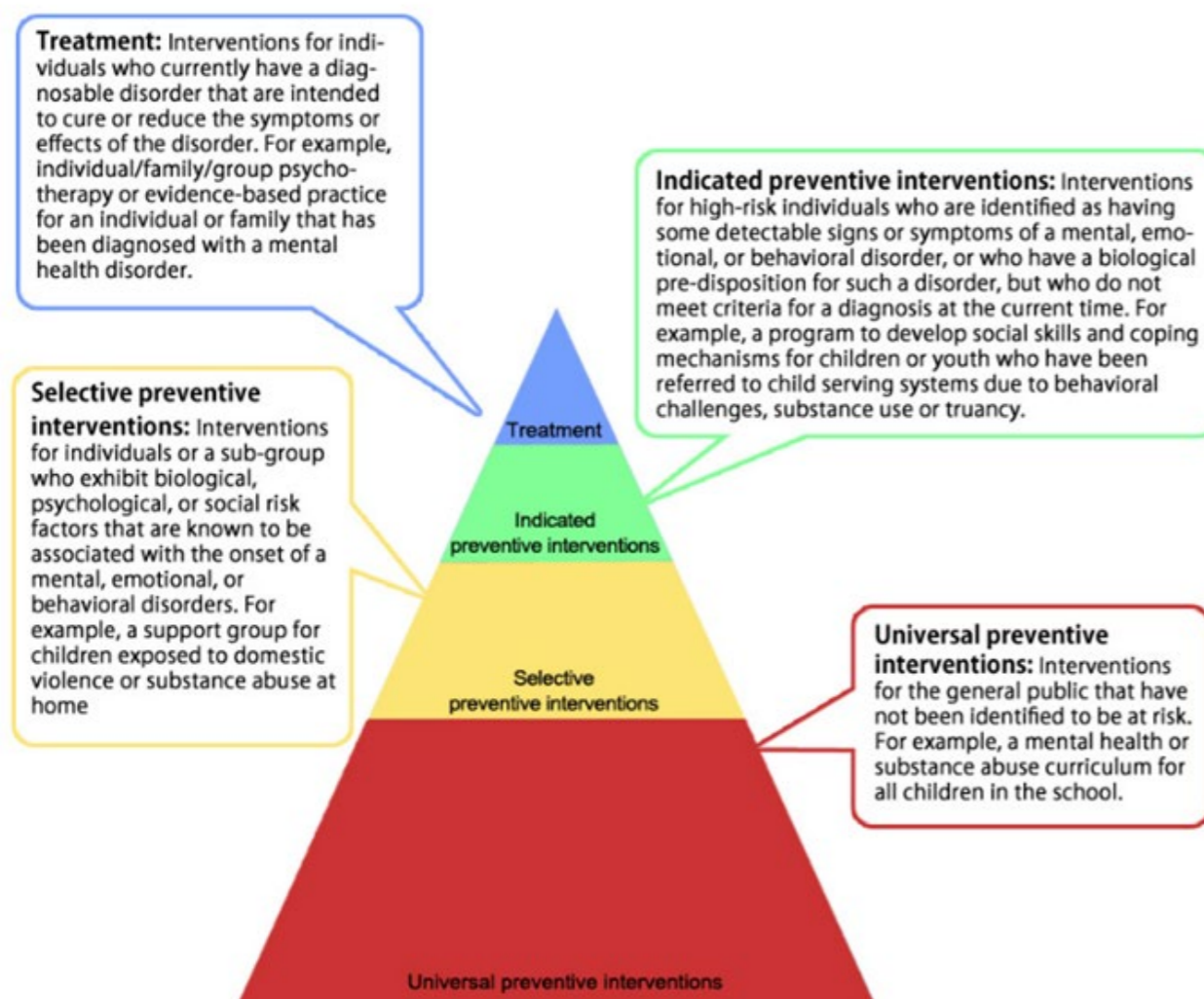
In the context of national efforts to strengthen mental health, it is vital to not only protect and promote the mental well-being of all, but also to address the needs of people with mental health conditions. This should be done through community-based mental health care, which is more accessible and acceptable than institutional care, helps prevent human rights violations and delivers better recovery outcomes for people with mental health conditions.

Community-based mental health care should be provided through a network of interrelated services that comprise:

- Mental health services that are integrated in general health care, typically in general hospitals and through task-sharing with non-specialist care providers in primary health care;
- Community mental health services that may involve community mental health centers and teams, psychosocial rehabilitation, peer support services and supported living services; and
- Services that deliver mental health care in social services and non-health settings, such as child protection, school health services, and prisons.

The vast care gap for common mental health conditions such as depression and anxiety means countries must also find innovative ways to diversify and scale up care for these conditions, for example through non-specialist psychological counselling or digital self-help (WHO, 2022).

Figure 1. Levels of Intervention. (O'Connell, Boat, & Warner, 2009, p. 66)



Best Practices

Joint Experiences and Local Mental Health Systems, third edition 2014-2017

Location: Italy

More information: <http://aisme.info/en/2015/06>

The Joint Experiences and Local Mental Health Systems program was started in 2014 and was initiated by the cultural sector, the social sector, and the health and social sector. Joint Experiences focuses on action and research. The Joint Experiences and Mental Health Systems project (JE&LMHS) is based on the assumption that mental health is not only a matter of special services, but has also to do with the whole local community.

The objectives of Joint Experiences and Local Mental Health Systems include:

- to develop local knowledge in mental health by activating social and cultural elements in order to better balance the current predominance of the therapeutic approach of services based on global and mainly bio-medical knowledge;
- to develop different initiatives at local level through peer to peer collaboration among users, carers, local governments, and services (Joint Experiences);
- to permanently monitor both the state of each Joint Experience and the relationships among users, carers, local governments and services; and
- to establish an intermediate area between the service and the community as support to the Joint Experiences, which is led democratically by user organizations, relative organizations, services, and local governments.

Activities of Joint Experiences and Local Mental Health Systems focus on a questionnaire for mapping the Joint Experiences in Tuscany, data collection, data processing and discussion with the core group, and production of a web profile for each Joint Experience. Furthermore, meetings are held with all stakeholders for revision of the questionnaire and the project; a conference is held to launch a permanent online mechanism to update the Joint Experiences regarding both their internal functioning and the relationship with their local mental health system. Concrete results (outputs and outcomes) of the practice include the direct involvement of user and carer organizations in the field of action-research and the development of local knowledge beyond the biomedical knowledge.

The Shared Experiences and Local Mental Health Systems Project (SE&LMHS)

Recovery Conference. November 4, 2021

A fundamental belief of the SE&LMHS project is that mental health is not just a matter for mental health services. It should include the whole community.

Therefore, a central aim of the project is to facilitate peer to peer relationships in the community between mental health professionals, service users, carers, voluntary sector organisations and representatives of the local community. The relationships built up can help to address the power imbalance inherent in mental health services and facilitate a move away from the 'them' and 'us' culture. Rather than focus on illness and symptoms, the conversations can focus on sharing experiences, learning from each other, encouraging collaboration and community activities.

The roots of the project are based on two previous experiences in Italy (Florence and Prato) when psychiatric hospitals were being closed and the local community was becoming one of the main players in mental health. In this context all stakeholders met weekly, outside of mental health services, where everyone had an equal say and equal power.

Service professionals used to dedicate part of their working time outside the service venues and settings. A new extra-clinical common language was needed by considering the importance of the local and individual languages. The research and evaluation of the many groups set up in these two locations highlighted that there was not only a benefit at the individual level to all participants, but also at a collective level. The pilot project that mirrors the Italian experience started officially in Watford in May 2018 with the development of a monthly Steering Group at Watford Town Hall. It was during these meetings that it was acknowledged that the mental health situation in the Watford area had several issues including the fragmentation of services; the revolving door phenomena and dominance of the therapeutic model and symptoms containment which led to clinical interventions and forced treatments.

The development of a 'Common Sense' Group, within the community, for a maximum of 15 people, was suggested as a way to partially address these issues. This group started in October 2019 at the Watford Central library, with referrals coming in from the CMHT (Colne House). Referrals were only accepted if the mental health professional had discussed the group in full with the service user and if they initially attended the group. Before COVID19 there had been 20 referrals to the group and 10 service users had begun to attend regularly.

As with so many other projects, the COVID-19 pandemic had many implications for the development of both groups. Unable to meet face to face, there was no major problem for the Steering Group to continue online, but there were some problems for the Common Sense Group due to technology and confidentiality issues, so it was halted a few months in.

With the lifting of restrictions, the Common Sense Group resumed again using a hybrid model of Zoom for those who preferred to connect through video and face-to-face at Colne House. Colne House professionals continued to make referrals to the group and it is clear that there is a need to help people to find appropriate solutions also outside the service in the community.

Recently, a most important development in the project was a successful application to the HPFT Innovation Fund. This Fund was established by the Trust to encourage and fund projects, both large and small, with innovative and original ideas. The fact that the Steering Group's bid was successful is a promising recognition of the value of our project. Of equal importance, was the support the members showed each other by continuing the peer relationships and sharing of experiences so fundamental to the project.

Up till now, all participants have given their time for free, fitting it in around other commitments. Whilst this arrangement was perhaps the only way in which we could have progressed to this point, it was obvious a long time ago that it could not be a permanent solution.

The successful bid formally supports a pilot of the Common Sense Group, of nine months duration, with clear objectives and outcome measures, which will provide the data necessary to establish if the idea produces the tangible benefits we all hope. The funding enables the Steering Group to recruit a paid project manager, an administrator and a clinical lead to run the pilot. It also enables us to train facilitators for the Common Sense Group, hire premises for face-to-face meetings, and collect, collate and analyze the data from the pilot.

In 2022 the project is expected to:

- Formally implement the project as funded by the Innovation Fund
- Appoint the paid staff
- Train facilitators
- Make contacts with community groups, third-sector organizations and Colne House staff to generate referrals into the Common Sense Group

- Place the Common Sense Group on a more regular and formal footing
- Produce the data to inspire more Common Sense Groups in Watford and perhaps in other areas of Hertfordshire.

Suicide Prevention Austria (SUPRA)

Location: Austria

More information: <https://www.suizidforschung.at/supra/>

Suicide Prevention Austria began January 2017. The practice focuses on action programmes and policy. SUPRA is a multilevel national suicide prevention programme with the main objectives to ensure support for risk groups, to restrict access to means of suicide, to raise awareness and develop media support for suicide prevention, to integrate suicide prevention programmes into other health promotion activities, and to support research on suicide.

- In 2012, the Austrian suicide prevention program SUPRA was published and the Austrian Ministry of Health established a „coordination centre“ at the GÖG (Austrian Public Health institute) to support the process of implementation.
- Goals and measures that were already ongoing (i.e. media guidelines) or easy to achieve were conducted immediately (i.e. annual national suicide reports and conferences, webpages, several regional initiatives and projects).
- Meanwhile, a structured concept for implementation, with 6 strategic, 18 operative goals and 70 measures (including target sizes, indicators and responsibilities), was developed with a panel of leading national experts.
- Finally, a suicide prevention starter package was defined with prioritisation of measures on regional and national levels that will be implemented within the next two years.

In 2012, the Austrian suicide prevention program SUPRA was published and the Gesundheit Österreich GmbH was assigned to support its implementation by the ministry of health. The program is a 70 page paper that was written by Austria's leading experts. It describes a broad range of possible measures. However, the paper does not go into details on prioritization of measures, responsibility for implementation, recommended target goals or outcome indicators. In order to convince decision makers to foster suicide prevention in a federally structured country like Austria, all of this information is crucial, especially in times of limited resources. A double strategy was chosen for the implementation of SUPRA. In close collaboration with a panel of leading experts, 6 strategic and

18 operative goals were identified and more than 70 measures, target sizes, indicators, and responsibilities were described.

Suicide Prevention Austria has been evaluated or assessed. The measures associated with Suicide Prevention Austria are based on scientific evidence; implementation of SUPRA in the region of Styria has partly been evaluated during the last two years but has not been published at this time.

Methodology

Prevention is better than cure, and many of the risk and protective factors for mental ill-health are well characterized. However, there is evidence of an increase in the incidence and prevalence of mental illness in young people and an increase in the number of suicides, particularly among young women. (Twenge, et al., 2019; Stefanac, 2019). The role of social media and new technologies, climate change and a range of socio-economic forces in undermining young people's mental health and well-being is significant (Berry, 2021; Twenge, 2020).

Specific programmes target some of these risk factors, for example,

- anti-bullying programmes (Fraguas, et al. 2021),
- the #chatsafe guidelines developed in partnership with young people to provide support to those who might be responding to suicide-related content posted by others or for those who might want to share their own feelings and experiences with suicidal thoughts, feelings or behaviours. The #chatsafe guidelines may also provide practical assistance to parents, educators, and those who provide support to young people engaging in online activities (Robinson, et al. 2018), and
- resilience programmes in schools (Dray, et al., 2017; Fenwick-Smith, et al., 2018),

And have value. However, other risk factors are not particularly malleable and have a broader social and economic character and scope (e.g., climate change and social media).

In response to these risks and challenges, the CALMD project proposes an integrated methodology for prevention and promotion services for providers of adult education for adults with mental disabilities.

Innovations Training of Adult Educators

Through CALMD's training programme, educators of adults with mental disabilities will be able to offer them a new psycho-pedagogical framework of support. The methodological basis is the concept of "cycles", in which the adult with mental disability is placed at the center of the many levels of support required.

Cycles of care and education include parents, family, friends, caregivers, educators, health care workers, and others, such as neighbors, business owners, and community members, and others, and each individually plays a valuable role in supporting the adult with mental disabilities to find their way into society and thrive.

The CALMD Framework for Life (MOOC and Toolbox)

The integration of digital technologies to enhance the principle of independent living for adults with intellectual disabilities, taking into account factors such as language, culture, level of education, access to technology, digital literacy and available infrastructure.

Gaming

Games, when used positively, can be a really useful way of caring for mental health. This is because it can give the learner an opportunity to relax, to escape the pressures of everyday life - just as reading or sport can do, in line with Self-Determination Theory.



Activities

Activity 1

Create a list of prevention and promotion services in your country, starting with those available locally and moving on to those available nationally.

Describe how these services can support the work of your educational organization. List how these services can support your organization's adult learners with mental disabilities.

Exemplary Table:

Preventive and Promotion Services	Contact Information	Description of Services
Community Level		
Special Recreational Centre for the Creative Employment of People with Disabilities	Address: 8 Gr. Xenopoulou & Trapezountos, Thessaloniki, 54645 Phone numbers: (+30) 2310 819515, 2310 509013	It is addressed to people over 18 years old with mental disabilities. Services provided: music, singing, dance, visual arts, theatre education, etc.
The Psychiatric Hospital of Thessaloniki Website: https://www.psychoth.es.gr/	Email: polithspsychothes.gr Address: 196 Lagada Municipality of Pavlou Mela, 56430, Greece Phone numbers: (+30) 2313 324100	The Psychiatric Hospital of Thessaloniki is a Special Hospital with extensive activity in the provision of services in the specific field of mental health, both through its Network of Community Services operating in the prefecture of Thessaloniki and through its operation as an educational institution.
National Level		
KLIMAKA Website: https://www.klimaka.org.gr/	Address: 50 Dekeleon, Keramikos, Athens, 11854, Greece Phone numbers: (+30) 210 3417162-3 and 1018	KLIMAKA is a social organisation, a non-profit - non-governmental organisation (NGO), founded in 2000 and active in the operation of units and the implementation of programmes and interventions for the promotion of mental health and the promotion of social integration of excluded groups in Greece and abroad.

Activity 2

Organize an information and awareness-raising workshop with representatives of the services mentioned in activity 1. For services operating at regional and/or national level, which are located in another city, you can provide online remote participation. Ask the representatives of the invited services to explain to adult learners with mental disability how they can support them.

You can present the CALMD project and its results in supporting and enhancing the quality of life of adults with mental disabilities as a resource and example of good practice.

Create a support network and systematically monitor its impact on the prevention and promotion of services for adults with mental disabilities.



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CHAPTER 5

CRISIS INTERVENTION

Crisis:

- Definition
- Purpose of a crisis intervention
- Diagnosis and attitude towards crisis
- Duration
- Response
- Escalation of a crisis
- De-escalation techniques

Definition

Crisis intervention refers to the different methods used to provide immediate, short-term and long-term help in a crisis in order to help people facing an event that causes strong distress. The distress can include emotional, mental, physical, and behavioral distress.

Crisis is an event that can be very difficult to cope with and it can refer to any situation in which the individual perceives a sudden loss of their ability to use effective problem-solving and coping skills, usually a situation that seems to exceed an individual's ability to cope. As a result of a crisis people can suffer psychological, emotional, physical and behavioural imbalance. All of this causes confusion in the individual, disorganisation and panic.

A crisis can be experienced as a stressful event that can occur because of other conditions being present (an acute illness, work overload, changes in routine or environment, changes in life, stages of life etc.). Sometimes an ill person can experience a crisis just because of the body's inability to deal with too much stress, but in a different state of health the same person would or could react differently. Sometimes it is sufficient for an individual to witness certain events that people experience, events which will trigger a crisis or even a traumatic past experience. Even witnessing an event of less intensity can provoke a crisis in some people.

Several events or circumstances are considered to be crises for any type of person with or without disability: life-threatening situations such as natural disasters (such as an earthquake or tornado), sexual and physical assault or other types of criminal victimization; life threatening medical illness; mental illness; thoughts of suicide or homicide; and loss or drastic changes in relationships (death of a loved one or divorce, for example), etc.

In this guide we will also discuss crises resulting from self-injury, aggression towards others including the caregivers, property destruction and other challenging behaviours some adults with intellectual disability might display.

Crisis intervention and trauma counselling is a fluid process in which help must be given and delivered immediately. You do not have the luxury of creating a therapeutic relationship or letting the therapeutic relationship run its course.

You must be prepared to work faster and sometimes be direct with clients giving advice and directives. In order to understand what happened you need to begin with a rapid assessment. Assessment must be moving and continued throughout the intervention to meet the ever-changing, fluid needs of clients during the crisis.

If you are afraid and feel unprepared to work with this type of beneficiary and if you have the luxury, you might need to make an urgent referral to other specialists that are more experienced. Sometimes you even have to be prepared to allow clients to be dependent on you until they reactivate their coping mechanisms and can access the resources needed for recovery.

Purpose of crisis intervention

Crisis intervention has several purposes. It aims to reduce the intensity of emotional, mental, physical and behavioural reactions to a crisis. It also helps individuals return to their pre-crisis level of functioning if it is possible.

Sometimes functioning can be improved beyond this by developing new coping skills and by eliminating ineffective ways of coping, such as withdrawal, isolation and abuse of substances. In this way, the individual is better equipped to cope with future difficulties. By discussing what has happened and the feelings about what has happened and by developing new coping skills and new problem-solving skills, crisis intervention aims to help the individual recover from the crisis, to prevent serious long-term problems from arising plus to avoid similar crises to occur in the future when possible. Research documents positive outcomes of crisis intervention, such as reducing stress and improving problem solving.

Diagnosis and attitude towards crisis

Try to refrain from categorising and diagnosing a person during a crisis (e.g. attachment disorder, attention seeking, autistic outburst, maniacal episode etc.). When you are suddenly confronted with a stressed, indignant and potentially suicidal or violent person, you will not care and you will not be tasked with finding out what the person's diagnosis is. Conducting a psychiatric assessment and understanding of the correct diagnosis in such a situation is often difficult or even impossible even if you have a team of three psychologists plus three psychiatrists - you will probably get five different diagnoses.

Knowing a little in advance about their diagnoses that correlate with an angry or aggressive presentation can be helpful in guiding your intervention when behavioural problems/crises arise. This knowledge will help you see the recipient, or potential offender, not as an evil person but as a person in distress, unable to meet their needs, or confused. More than that, this attitude will help you avoid escalating the situation.

In a crisis you may need to set clear boundaries, but if you see an agitated person as an aggressor trying to take advantage of you, your reaction is likely to be harsher than necessary and it will escalate the conflict. It is helpful to keep in mind that most often people are more open to receiving help during crises. Crisis intervention must be carried out in a supportive manner.

Duration

A person may have experienced the crisis in the last 24 hours or in the last few weeks before asking for help. The duration of crisis intervention can vary from one event/session to several weeks, with an average of four weeks.

Crisis intervention is very important but not sufficient for individuals with long-standing problems- long-term problems like people with ID. The duration of the session can vary from 20 minutes to two or more hours.

Where

A crisis can take place anywhere but more often takes place in a range of settings such as institutions working with people in crisis like emergency rooms, hospitals, crisis centres, counselling centres, mental health settings and clinics, schools, correctional institutions and other social service agencies dealing with PWD like day programs, supportive housing etc.



Crisis responses

A typical crisis response goes through several phases.

1. Assessment

It begins with a rapid and ongoing assessment of what happened during the crisis and the individual's responses. The following should be assessed:

- Mental reactions (difficulty concentrating, confusion, nightmares)
- Emotional reaction (saddens, uncontrollable crying, numbness, suicidal/homicidal thoughts, anger, desperation)
- Physical reactions (headaches, dizziness, fatigue, stomach problems)
- Behavioral reactions (sleep and appetite problems, isolation, restlessness).

An assessment of the individual's potential for suicide and/or homicide is very important also should be carried out.

Other important information to be obtained is about the individual's strengths, already used coping skills in the past and availability of a social support network.

1.1. Preliminary assessment

Many clinicians use the bio-psycho-social model as an assessment framework.

The bio-psycho-social approach can be a useful framework for thinking about what is going on with the client and for guiding your subsequent intervention.

Here we return to the importance of knowing the person before the crisis and the assessment tools that can guide intervention methods although sometimes, we don't have this advantage in a crisis situation.

Bio-psycho-social model in mental health

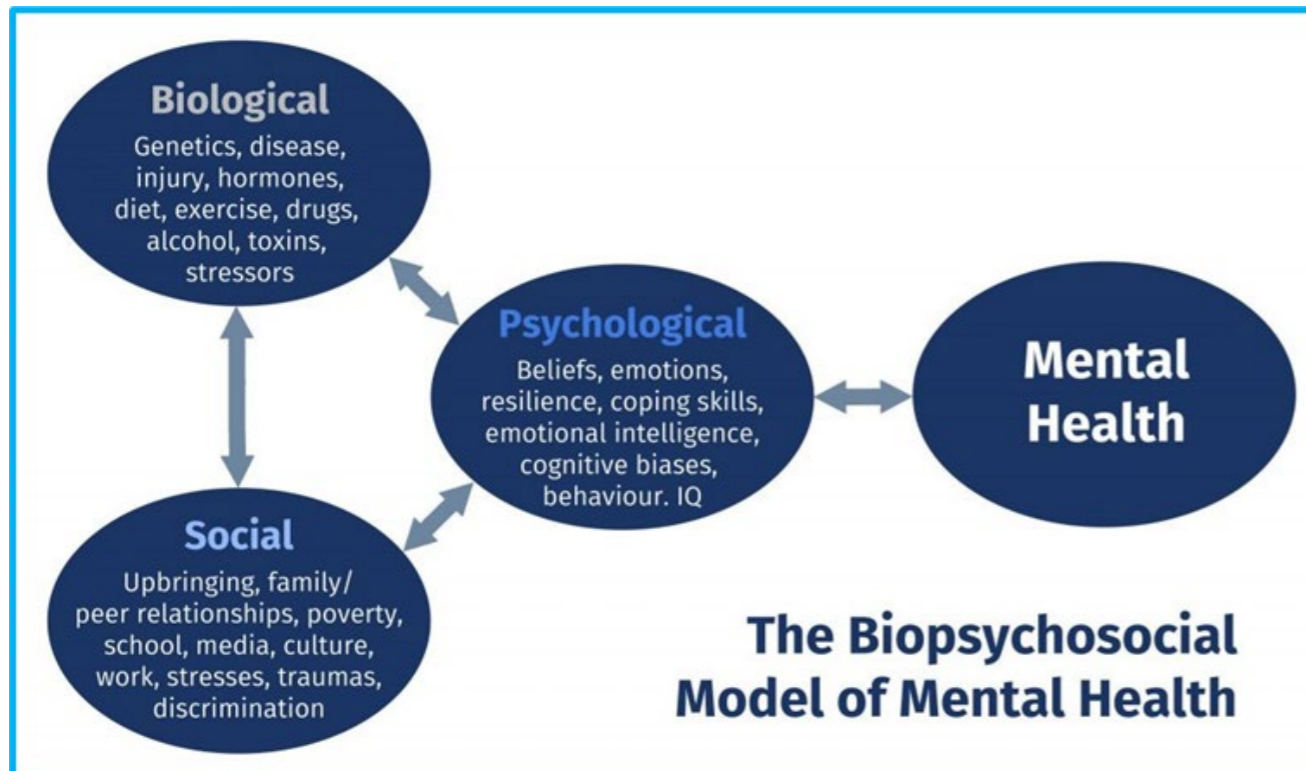
According to the biopsychosocial model, the health of a person, including his mental health, is the result of many different forces, circumstances, factors and events which have a cumulative effect on the individual.

These cumulative effects can produce positive or negative results in people's lives.

If the negatives out way the positives, then a person could develop a mental illness or can be born with an intellectual or physical disability.

The model below is helpful when you begin to do the assessment. It's unlikely to be one specific thing that causes a crisis, but rather a mixture of negative circumstances that have built up. Usually there is one thing that pushes a person too far, but it's unlikely to be this alone that caused a crisis.

When negative factors add up and they are overlooked by the people around them, the result might very well be a full-blown crisis.



Example 1

Imagine you're having a bad day at school or work. You already had a stressful morning at home, woke up too late, forgot your coffee in the coffee maker and left with your car thinking about how much you need that coffee, you get stuck in traffic, you've dealt with many more problems than normal at work, and you have just got out of an exhausting meeting you had half forgotten about. You sit back down at your desk and promptly knock your coffee over. All of this might send you into a rage, tears or make you feel that you hate your job, all red in your face or trembling.

An outsider watching this scene might be justified in thinking that you are so emotional, clumsy, and weak because you knocked your drink over or you were not able to state two intelligible phrases in that important meeting. But that wasn't the real issue. It was all the other cumulative effects that happened before that created a situation where, when you did knock your drink over, it was too much. This is just a simple example. We all had those days, days when nothing seems to go right come along now and then and it's infuriating.

We can all recognize how events can add up to the point where something small can tip us over the edge. In a similar way, biological, psychological, and social factors can add up across a person's life to lead to times of mental ill-health.

In reality there are a myriad of conditions that can cause irritability or contribute to aggression. Add to this the number of medications that can cause irritability and you have an idea why, even if you were a skilled emergency doctor, diagnosis is a real challenge.

Telling someone- take your meds- when they're in the middle of a tantrum is just as effective as saying "calm down". How many people really "calm down" when given this command in the middle of an argument?

Example 2

Is not very well known that a widespread disease that can lead to aggression is diabetes. Unfortunately, many go undiagnosed with diabetes nor do they know how they feel or why. Agitation/aggression can be one of the many symptoms of the disease. Brad Bushman, a professor at Ohio State University, explained that "avoiding aggressive impulses requires self-control, and self-control requires a lot of energy". Glucose provides that energy in the brain. In Bushman's experiments, subjects handled aggression better after drinking sweetened lemonade.

"Diabetes may not just be bad for yourself - it's bad for society"

"Healthy glucose metabolism can contribute to a more peaceful society by giving people a higher level of energy for self-control; "

It can be so simple in the case of people with diabetes - more sugar, more calmness for some people.

Bushman and others have done several studies that have shown that people who have problems in metabolizing glucose in their bodies show more evidence of aggression and less desire to forgive others.

1.2. Further assessment of the person in crisis

Apart from knowing diagnosis and medication taken where is possible, what is very important to consider are the following:

- Direct exposure to events or as a witness.
- Anticipated or sudden crisis (e.g. death of a loved one after a long illness or a sudden death)
- Level of impairment of the person before the crisis
- Level of impairment resulted from the crisis (e.g., accidents)
- How close the individual is to another person who is in crisis or traumatized.
- The nature of the crisis: aggression/death/destruction/large or small losses etc.
- Solitary or shared crisis or trauma

Reactions in crisis/trauma vary from person to person, some may react with a strong emotional display to a crisis resulting from minor disruptions in their life (like routine disruption in the case of a person with autism) while others may endure major crises without many noticeable reactions. Both this type of crisis should be addressed in spite of our opinion of the magnitude of the problem that can constitute a crisis or in spite of the absence of the signs of a crisis when we can assess that it is a crisis situation but we get no reaction from the person with ID.

When the crisis or trauma occurs, the person can experience:

- Shock
- Psychological/emotional numbness/ frozen stress reaction
- Denial/refusal to accept reality
- Strong emotional reactions (aggression, anger, crying, withdrawal, loss of hope)
- Physical reactions (rapid breathing, palpitations, trembling etc.)
- Inability to process information at a normal pace, slowed thinking, etc.
- Confusion, inability to concentrate.

2. Crisis intervention

2.1. Crisis intervention has an educational component.

It is essential for the individual to be informed about the different reactions to the crisis and to be made aware that they have normal reactions to an abnormal situation. The individual will also be told that these reactions are temporary.

Activities:

Consider developing good communication skills. Be aware of the person's level of alertness and his or her communication capabilities. Attempt to identify the cause of the crisis with questions or statements, such as:

- “What has happened to make you so upset?”
- “Can you tell me the reason you're so upset?”
- “I would like to hear what you have to say”
- “I'd like to hear what happened.”

Consider how you will respond in case you will hear the answer to your above questions? How will you interact with the person with ID once you know what happened?

2.2. Coping and problem solving in crisis situations

2.2.1. Coping strategies

A major goal of crisis intervention is to explore coping strategies. Other elements of crisis intervention include helping the person understand what happened that led to the crisis and the response to it. More help can be provided as well if necessary, with awareness and expression of feelings such as anger and guilt and despair.

Very helpful are the strategies that the individual has previously used to cope with the crisis that can be used in the current crisis and can be improved or encouraged. New coping skills can also be developed in the moment of crisis.

Coping skills can include techniques for relaxation, breathing and physical exercises to reduce tension and stress on the body, as well as writing down the thoughts and feelings by writing in a journal, sending a letter instead of keeping the emotions inside. Rapid connection with a social network and other options for social support or spending time with people who offer a sense of comfort and care must be encouraged.

2.2.2. Problem solving

This process involves thoroughly understanding the problem and desired changes, considering alternatives for solving the problem, discussing the pros and cons of alternative solutions, selecting a solution and developing a plan to try it and evaluating the outcome together with the person with ID.

2.2.3 Assessment of the results

In the final phase of crisis intervention, the person who did the crisis intervention will analyse the changes they have made with the person with ID and will emphasize that it is possible to cope with difficult life events and also explain that all of us will have to go through some difficult events in life.

The use of already effective coping strategies that have reduced their stress, will be further encouraged. Ideally, assistance will also be provided to make realistic plans for the future, particularly in terms of dealing with potential future crises.

Is important to observe signs that the individual's condition is worsening, or other warning signs that a person can display, for example acting calm and joyful but speaking about suicide thoughts with a clear plan. Information will be provided about more resources or additional help if needed.

It might be recommended to arrange a telephone or face-to-face follow-up at an agreed date in the future with the person with ID and their caregivers.

3. Aggression episode as a crisis

3.1. What are the causes of aggression?

Aaron Beck, a pioneer of cognitive behavioral therapy (CBT), describes as a main reason for agitated people the feeling of being diminished. “People in conflict perceive and react to the threat emanating from image rather than to a realistic assessment of the opponent. They confuse the image with the person”

The most negative images a person can have about another person is an image that contains qualities of the opponent as dangerous, malicious and cruel or sadistic.

“ Even if you have the best of intentions and no malice - whether due to psychosis, trauma, or just fleeting physical resemblance - the person in front of you may hold a grudge. The individual may have thoughts of inferiority and victimization, hurt feelings, triggering beliefs that the aggressor has wronged him, that the injury was deliberate and undeserved, and the abuser should be punished”. - Karen Horney, a psychotherapist, has written about the “tyranny of should”.

Is the case of people “who have a fixed/rigid idea of how someone should behave. -You should give me that object... or ...; you should serve me - not fulfilling the wishes of these types of people can contribute to anger, aggression and inappropriate behavior.”

Example: Clients who have mental health and addiction problems often also have traumatic brain injury history, many of these clients are the type who engage in risky sports and were hit in the head by team members or were involved in fights, had accidents in which they bumped their heads against car windshields, have fallen while under the influence of drugs, and generally lead a lifestyle.

Most of the deinstitutionalized and mentally disabled people are likely to have a traumatic history of being physically, sexually and emotionally abused, beaten and assaulted on a regular basis.

Traumatic brain injury or other organic brain injuries may be accompanied by speech disorders or other motor impairments. Symptoms vary widely, depending on which part of the brain is affected.



3.2. Simple de-escalation techniques

1. Keep communication simple, speak in a non-condescending way - a high priority.
2. Decrease stimulation of any kind, such as any background noise might also be helpful.
3. Do not engage in an argument or yell back at the person who is agitated.
4. Do not pronounce the word NO to his requests.
5. Avoid people and environments that created the crisis or the escalation of the crisis. A person who already got in an argument with the person with ID should, if possible, leave the scene and other people have to de-escalate the situation.
6. Do not ask for a different activity engagement during or right away after a crisis. Provide space and time for relaxation. Brain damage for example can make it difficult to concentrate, which can add to agitation and blurred thinking.

3.3. Important steps in de-escalation of an aggressive episode

Keep your distance- for the mathematically inclined, the safety formula is:

Space + Time = probability of not being injured
OR a chance of injury

What constitutes a safe distance?

A safe distance is a distance that can make the beneficiary and the responder feel safe, but at least 4- 5 meters around the person in crisis. It is recommended to leave the room if it is a safe action for everyone.

Sometimes responders tend to approach the person in crisis and to offer a soothing gesture, is not a good idea until the person gets calmer and invites you into her space.

How much time is enough?

The answer is - as much as they need, it can be minutes or hours. As a responder to a crisis, if a beneficiary/client/patient is agitated and verbally aggressive it is important to offer space and time for people to calm down, and keep in mind that everyone is different, the brain is wired differently, and the coping skills can be insufficient or nonexistent. When the responder intervenes, he/she should avoid making the situation worse, or will produce a worse situation with a worse outcome. What is recommended in a case of a crisis is to work with people with ID and help them de-escalate, do not take things personally.

4. Suicide attempts

Suicide attempts are urgent crisis situation and many people who already had a history of a few suicide attempts can succeed and commit suicide in the future. The best thing we can do is to prevent and observe the signs that show such profound distress in a person.

Warning signs that a person may be in immediate danger of attempting suicide include:

- Talking about wanting to die or wanting to commit suicide
- Talks about feeling empty or hopeless or that they have no reason to live
- Talks about feeling trapped or that there are no solutions
- Feeling unbearable emotional or physical pain
- Talks about feeling like a burden to others
- Withdrawal from family and friends
- Giving up important possessions
- Saying goodbye to friends and family
- Takes big risks that could lead to death
- Talk or think about death often, asking questions about death

Other serious warning signs that someone might be in danger of attempting suicide include:

- Displaying extreme mood swings, suddenly going from very sad to very calm or happy
- Planning or looking for ways to commit suicide, such as looking for lethal methods online, or stockpiling
- Talking about feeling guilty or ashamed
- Using alcohol or drugs more often
- Acting anxious or agitated
- Changing eating or sleeping habits
- Expresses anger or talks about seeking revenge.

It is important to remember that suicide is not a normal response to stress. Suicidal thoughts or actions are a sign of extreme distress and should not be ignored. Never let a suicidal person alone, call the ambulance immediately. People in crisis feel hopeless, it's important to foster hope and positive expectations.

Don't give them false promises, but encourage them to solve their problem with the help provided by you or a support system that is built around him already. Speak about new unimagined yet possibilities.

What if you were to . . .?;

What might happen if you would . . .?;

What do you think someone else might try at this time?

Be sure to help the person anticipate any obstacles to implementing the plan. We cannot assume that the person will follow through without first considering the obstacles.

5. Last step in crisis intervention - instill self-reliance

Our hope in crisis intervention is to work all through the final stages and to finalize by trying to instill self-reliance. A person in crisis is at the end of their rope, they don't have the skills and abilities to get over an event without clashing. Is our hope that outside of the intervention that focuses on action plans and coping skills we will help a person to avoid crises in the future or to survive them with less damage.

We don't have all the answers, there is always unknown, and we need to be responsible when we discuss solutions and plans. We also don't want to do everything in place of the person, making them dependent on us, is not empowering and is not respectful. To keep a person from becoming too reliant on you, you need to make it very clear that you do not have all the answers. You expect some effort from the person. Make sure the person is beginning to do things and is doing them successfully. Connect with their caregivers. Assure them that small steps should be undertaken to the final goal or otherwise the person will become overwhelmed.

This is especially true for anyone with ID and depression, for any failure sends him or her two steps back down the ladder. Self-reliance comes from the involvement of the person with ID in the planning. If you are working with someone who is, for the most part, a dependent person, it will be more difficult to get him or her to take responsibility.

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CHAPTER 6

IDENTIFICATION OF MENTAL HEALTH PROBLEMS AND REFERRAL TO HEALTH SERVICES

Contents

1. Introduction
2. Mental health is an inherent element of health and well-being
3. Social inclusion and participation in community life in the construction of care pathways
4. Mental Health assessment: an introduction
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6. The referral to health services: a care pathway to build to increase the access to mental health care

1. Introduction

When informal service providers are able to identify people with mental health problems but lack the competencies to address those problems, a key function is to refer those individuals to the relevant health services equipped to deal with such problems. This guidance note has been developed for all professionals who carry out or support formal and non-formal educational activities for young people with mental health problems and focuses specifically on the needs of support workers and educators, as well as psychologists and educational coordination teams. In addition, it is useful for public entities: community groups, peers, families.

One of the factors considered really important in the CALMD project (www.calmdproject.eu) is the competence of the adult educators to adapt their work to the needs of the beneficiaries and to focus on the concept of autonomous life and also the principle of social inclusion, for that this note can provide tools for planning, programming, and developing new thinking and strategy. This content is therefore also useful for those working in sectors such as public health protection and mental health.

Another purpose of these documents is to provide information and guidance to all stakeholders who wish to develop or transform their mental health system and services.

2. Mental health is an inherent element of health and well-being

Mental health' is a field characterised by the complexity of the causes of suffering, by the need for a multidisciplinary approach, and by recognising and remembering in the practice of care that treatment cannot be reduced to the pattern/structure of traditional Western medical therapy. Perspectives that reduce the complexity of human experience and discomfort, increase the risk of work that does not take into account the complexity and specificity of a distress in the life of a person embedded in a specific culture, in a specific time.

Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Mental health, like other aspects of health, can be affected by a range of socioeconomic factors that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach¹.

Clinical practice, social research and the literature indicate that the determinants of mental health and illness include individual, social and societal factors and their mutual interaction. Therefore, mental health can only be understood by considering biological, psychological and socio-cultural perspectives together. In order to prevent mental illness and promote mental health, it is therefore necessary to intervene simultaneously on several multi-layered factors.

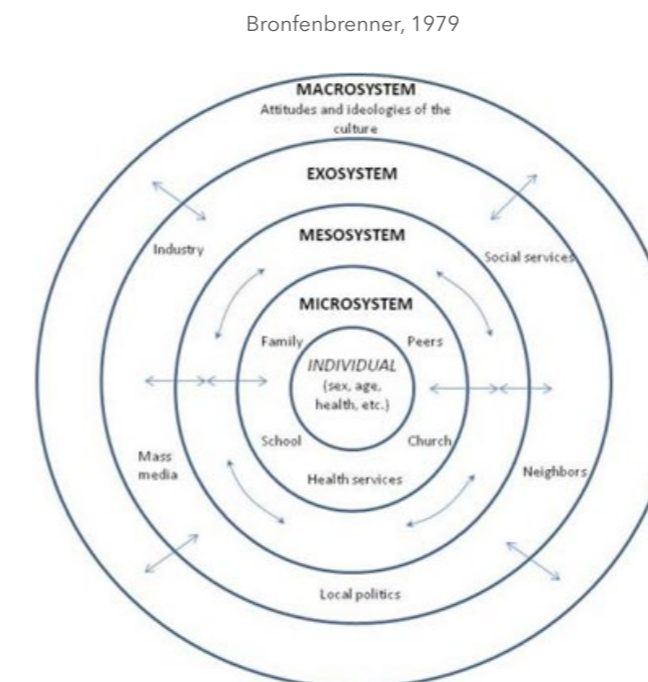
Bronfenbrenner (1979) argues that a person's development must be understood within a complex environmental system, ranging from the microsystem to the macrosystem. It must be understood that each system is conceived as a unit communicating with a larger, organised system. These different socio-ecological levels are placed within a transactional perspective that supports a strong individual/environment reciprocity.

¹ WHO. Mental health action plan 2013-2020

These systems are characterised as follows:

- The microsystem: is the immediate environment of the individual
- The mesosystem: is an environment composed of specific places in which the individual invests a significant amount of time. These places generally come from the microsystem (family - school)
- The exosystem: takes into account the external factors that influence the individual more or less directly. It is the set of social and/or organisational structures that govern the other systems already mentioned.
- The macrosystem: includes the meso- and exosystem and focuses on the social and cultural values that influence behaviour and attitudes.
- The chronosystem: this is a reference to the temporal dimension of any human environment, but also a temporal environment linked to social and cultural variables. The chronosystem thus encompasses normative transition links (transition from one period of existence to another partially influenced by other systems).

These different systems would then be able to promote a better understanding of the behaviour and attitudes of individuals, but also to understand what might promote or inhibit their well-being.



The influence of all contexts, systems, and environments on an individual and family must be recognised in order to fully understand and support healthy development among individuals, families, and the context in which they live. The socio-ecological model proposed by Bronfenbrenner in 1979 and then updated in successive years, was created and is re-proposed here to help shift the narrative of mental health and illness from a purely individual problem to a broader social and environmental responsibility, in order to identify and offer the most relevant care services to the individual's need.

Around the world, mental health services are striving to provide quality care and support for people with mental health conditions or psychosocial disabilities. But in many countries, people still lack access to quality services that respond to their needs and respect their rights and dignity. Even today, people are subject to wide-ranging violations and discrimination in mental health care settings, including the use of coercive practices, poor and inhuman living conditions, neglect, and in some cases, abuse. The Convention on the Rights of Persons with Disabilities (CRPD), signed in 2006, recognizes the imperative to undertake major reforms to protect and promote human rights in mental health. Significant changes in the social sector are required to support access to education, employment, housing and social benefits for people with mental health conditions and psychosocial disabilities².

Mental health promotion, prevention, care and protection is an essential element of universal health coverage. This refers not only to improved service access through better integration of mental health care into primary care services, but also greater financial protection. However, mental disorders pose several service and financial access challenges (stigma, low awareness, chronicity). Integration of mental health care in primary care services is important in ensuring accessible, affordable and acceptable services to people with mental health problems and their families³.

Integrated mental health care within primary care has the potential to enhance access to mental health services that are provided in a way that is coordinated around people's needs, respects their preferences, and is safe, effective, timely, affordable, and of acceptable quality.

² WHO. Guidance on community mental health

³ https://www.who.int/docs/default-source/primary-health-care-conference/mental-health.pdf?sfvrsn=8c4621d2_2_services_2021

Core principles for integration of mental health into primary health care⁴:

- Equity: Persons with disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.
- Human rights: Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments, ensuring that the independence and dignity of persons with disorders and psychosocial disabilities is not infringed.
- Evidence-based practice: Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural and contextual considerations into account.
- Life course approach: Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.
- Multisectoral approach: A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector to advance a whole of society response, as appropriate to the country situation.
- Empowerment of persons with disorders and psychosocial disabilities: Persons with disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation⁵.

In the broader context, there are some critical social determinants that impact people's mental health such as violence, discrimination, poverty, exclusion, isolation, job insecurity or unemployment, and lack of access to housing, social safety nets, and health services, are factors often overlooked or excluded from mental health discourse and practice. In reality, people living with mental health conditions and psychosocial disabilities often face disproportionate barriers to accessing education, employment, housing and social benefits – fundamental human rights – on the basis of their disability. As a result, significant numbers are living in poverty. For this reason, it is important to develop mental health services that engage with these important life issues and ensure that the services available to the general population are also accessible to people with mental health conditions and psychosocial disabilities⁶.

Integration of mental health in primary care will and an attitude of cooperation between different local actors and service not only enhance service coverage for mental disorders but also facilitate promotion of mental health and wellbeing, prevent mental disorders and reduce risky behaviours including self-harm. It is estimated that more than half of adult mental health problems begin during childhood and adolescence⁷. Poor mental health and inadequate life and emotional regulation skills in adolescence are associated with risk behaviours and self-harm, health and social problems such as school failure, delinquency and substance misuse, and increase the risk of poverty and other adverse outcomes in adulthood. WHO and UNICEF have recently initiated development of an evidence-based adolescent health package – Helping Adolescent Thrive (HAT) – for promotion of mental health, prevention of mental disorders, and reduction of risk behaviours and self-harm.

The rates of mental health disease conditions increase significantly during and after humanitarian emergencies. While many people recover naturally without treatment, the long-term prevalence rates for a wide range of conditions remain elevated. Psychological distress is also common amongst refugees, who are often exposed to various interrelated stressors including the loss of resources and belongings, death of, or separation from, loved ones as well as direct exposure to armed conflict and violence. To realize the goal of universal health coverage, it is essential to maximize efforts to scale up care for people with mental disorders and for countries to provide sufficient financial and human resources for mental health care and improve access to care for people with mental disorders and their families. It is to recognize the cross-cutting nature of mental health issues and the need to integrate mental health services into the primary care.⁸

⁴ https://www.who.int/docs/default-source/primary-health-care-conference/mental-health.pdf?sfvrsn=8c4621d2_2

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⁸ World Health Organization. Mental Health Action Plan (2013-2020); 2013.

3. Social inclusion and participation in community life in the construction of care pathways

The construction of identity and the meaning of communities and role of culture shows the importance of social inclusion and participation in community life in the construction of care pathways. Support in accessing employment and training opportunities, education, social and leisure activities are important features. Therefore, this document intends to emphasise the important role of coordination and collaboration between territorial services in order to refer people to different services and supports in the community.

The construction of identity

Personal identity is in part heterodetermined, therefore built through encounters and stories, and is the flexible result of overlaps, of additions linked to the story of each individual. The identity is multifaceted. The human being is both one and multiple: each individual carries within himself functional characteristics essentially common to the others and at the same time possesses peculiar and distinctive mental, cerebral, psychological, affective and intellectual characteristics. Thus, the individual is complex in itself, just as other individuals are complex and so is society, which is made up of individual complexes. The self is composed of different parts (more precisely representation) of itself in continuous evolution and changing in based on their own experiences, encounters, education and transformations. These changes are organic.

Human beings enter this world in particular contexts and environments, which vary in time and space, and which build them as specific human beings, and have in common the ability to embrace what determines them, but also to reject it and try to replace it. On a generically human basis, constituted by the extensive potential and great plasticity of the species, specific, cultural, ethnic humans are constituted and capable - interacting first and foremost with others in their own group - of evolving in the environment to which they have come and of contributing to the progress of the specific history in which, whether they want to or not, they participate.

Since what builds humans are relationships, and, first and foremost, the encounter (of materials, intentions, influences) from which the unprecedented combination that we are is born into the world, there can be no solitary humanisation: there is continuity between individual and collective identity; there is no one without the other.

The person would represent the point of intersection of three straight lines: the vertical one of lineage, the horizontal one of continuity with the environment, human and non-human, that is here and now, and that of our specific existential vicissitude.

The meaning of community

“Community” refers to a group whose members share certain commonalities – such as geographical location or location of perceived origin, language, interests, beliefs, values, tasks, political affiliation, ethnic or cultural identity, sense of belonging and other – and whose size varies from very small, such as a nuclear family, to extremely large, such as inhabitants of an entire continent. More precisely, communities are human systems characterized by interrelationships and interactions among their members in a given context.

As such, a community is a composite of clusters of:

- Individuals;
- Nuclear and/or extended families;
- Tribes and/or clans
- Confessional groups;
- Political parties;
- Congregations;
- Men's, women's, disability and youth associations;
- Professional associations ;
- Amateur artistic groups ;
- Sports teams;
- Interest groups, such as people who like a certain kind of music, or a football club, or a star;
- Many others

Hierarchical and non-hierarchical interrelationships among individuals, groups and systems of meaning characterize each community. Communities are dynamic and changing, not only in terms of their actual membership, but also in terms of their characteristics and preoccupations. Communities, like all systems, need both a degree of stability and a degree of change in order to survive and thrive. If there is too much stability, the system stagnates; and if there is too much change, the system is put into chaos. Communities always need to keep a viable contact with their roots and traditions, while they also need to adapt to the new circumstances and challenges they face along the time continuum, especially when encountering adversity.

4. Mental Health assessment: an introduction

As an introduction we would like to describe a brief outline of topics tackled during a first mental health care patient assessment. Those guidelines and the interviews to conduct the assessment is, of course, responsibility of professionals authorized to do it (psychologist, psychotherapist and psychiatrist). To know the topic and the main fields of investigation is useful to understand what domain we could explore to use the map of common sign and symptoms you find below.

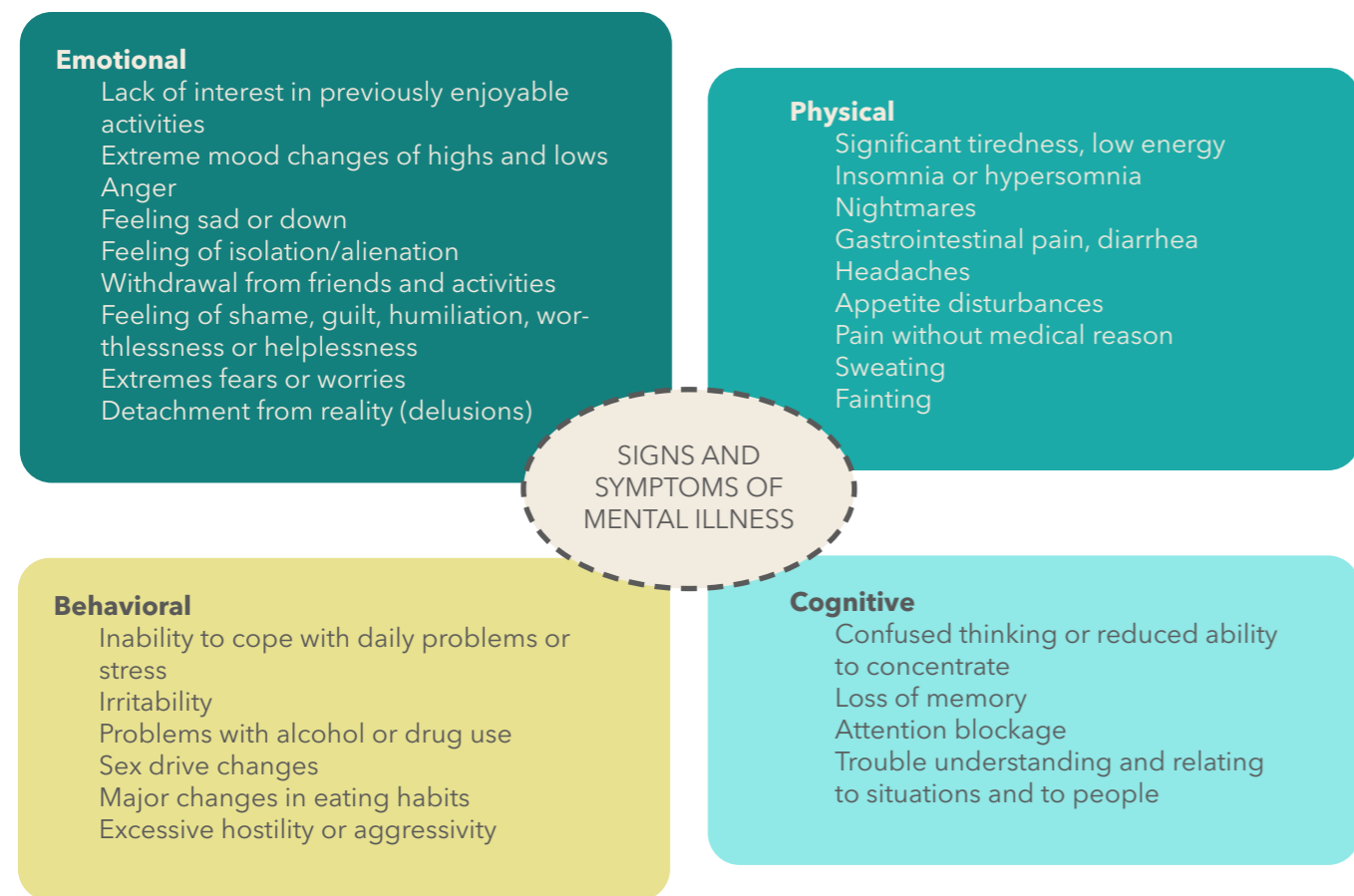
Main topic of first assessment:

- Complained symptoms
- Personal history (important life events the person has gone through, e.g. level of education, history of relationships: bereavements, separations)
- Precipitating factors (loss of loved ones, separation, traumatic events) which may have aggravated the state of mental suffering and the presence of the complained of symptoms
- Medical and mental history (e.g. has he/she had similar symptoms in the past, is it the first time he/she has had them, previous and present medications)
- Internal strengths and other external resources

- General family history (relationships with family members) and family history of mental disorders (presence of other members in a situation of mental distress)
- Social situation and social support (living conditions, work/employment, financial stability/security, access to care)
- Mental state. Observation of form and content of thought and speech, observation of mood, behaviour, appearance/hygiene

Map of Common signs and symptoms of mental illness

Signs and symptoms of mental illness can vary, depending on the disorder, circumstances and other factors. Mental illness symptoms can affect emotions, thoughts and behaviours. The presence of just one of those sign is not a proof of a mental illness. Is the co-occurrence of more of those sign and symptoms that can help you in taking the decision to start a care pathway to referral the person/user you are in charge of, to the mental health care. So, you can start the networking path in order to foster a multiservice equipe work.



Complications

If an unsupportive social-family-community environment can hinder mental well-being by fostering the development of symptoms of distress, similarly symptoms of mental distress can include complications and can cause serious emotional, behavioural, physical and social health problems.

Complications sometimes related to mental illness may include:

- Family conflicts
- Lack of work or school, or other problems related to work or school
- Legal and financial problems
- Poverty and homelessness
- Self-harm and harm to others, including suicide and homicide
- Weakened immune system - heart disease and other medical conditions

The great number of variable that should play a role in the detection of those sign and symptoms and the understanding of the personal situation of the individual we are in charge of, need an effort more. The best practice to follow **is to discuss the case with a supervisor or a group of supervision with professionals** that should helping and orienting yourself in the write understanding of your observation. This is a compulsory step to insert in work process to start with a concrete awareness about what we observed and the need of the pathway to refer the person to the mental health care services.

5. Assessment and mapping of specialized services for those with mental disorders

When a professional working with an adult with mental disabilities detect that should be a mental disorder, is time to plan the possible intervention in multi-services equip approach. Before to design and deliver interventions targeting those with mental disorders, we could do a mapping activity focusing on:

- Existing "informal" sources of care available for people with severe mental disorders at the community level;
- Knowledge around the different sources of available care in the community/territory;
- Attitudes towards the different sources of care;
- Health-seeking behaviour of people with severe mental disorders;
- Existing coping mechanisms, including social, cultural and spiritual outlets, which could be usefully strengthened;
- Any current or previous community plans to address the needs of people with severe mental disorders, including capacities, gaps and requests for additional support;

- Resource persons from different community subgroups (for example, women's groups, youth organizations, cultural and religious associations) who could potentially be recruited and trained to support individuals with severe mental disorders. This information should facilitate to identify:
 - Services for immediate referral of those in need;
 - Partner with those services, with the objective to gradually build their capacity to receive referrals;
 - Possible obstacles created by perceptions and health-seeking behaviour of affected individuals, families and communities.

IASC pyramid of MHPSS - Mental Health and Psycho-social Support (IASC, 2007)

The Inter-Agency Standing Committee (IASC)¹⁰ structures MHPSS activities in a pyramid, which has become extremely popular in MHPSS interventions in emergencies around the world. However, we can take this model to express the intervention and dispatch system also in countries with non-emergency conditions.

The pyramid provides a layered system of complementary supports that respond to the needs of the target population and the needs of the intervention. These include basic and safety services, community and family support, targeted services and specialised services. These layers are not hierarchical and should ideally be implemented simultaneously.



¹⁰ The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007).

The **first layer** of the pyramid refers to protecting the well-being of all people, ensuring that psychosocial and/or social considerations are taken into account when (re)creating basic services and safety. Security, adequate governance and services that meet basic needs, such as 'food, shelter, water, primary health care and communicable disease control', should be provided in 'participatory, safe and socially appropriate ways that protect the dignity of the individual and the local community, strengthen local social supports and mobilise community networks'. MHPSS responses at this level could include promoting these services "with responsible actors; documenting their impact on mental health and psychosocial well-being; promoting mental health and psychosocial well-being" (IASC, 2007).

The **second level** refers to 'community and family support' and draws attention to the importance of the role played by the community in enabling the maintenance and improvement of the mental health of those affected by mental distress, specifying activities such as 'parenting support programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, for example through women's and youth groups' (IASC, 2007). More specifically, the Guidelines recommend fostering "conditions for community mobilisation".

The **third level**, targeted support, refers to the support provided to people who "require more targeted individual, family or group interventions by trained and supervised professionals" (IASC, 2007).

The **fourth level**, specialised services, refers to services provided to people who experience significant difficulties in basic daily functioning due to intolerable suffering and those with severe mental disorders (IASC, 2007). Assistance should include psychological or psychiatric support, "referrals to specialised services, if they exist, or the initiation of long-term training and supervision of primary/general health workers" (IASC, 2007).

When you have clear the map of services and professionals on the territory that should help you in the path to referral the person to the services for the mental health care, you should try to organize meetings about the "user case management". It will be a cooperation work between different institutions and social actors to create a common path of interventions for the individual, that will be the centre of the activities planned.

The European Mental Health Action Plan defines in the first instance the points on which the need for proper care of people with mental distress is based. The benefits range from an improvement in the quality of life to the efficiency of the health system and the protection of the right to health, which concerns all citizens of every state.

In particular, it is emphasised that the life expectancy of people with mental disabilities, adjusted for age and gender, is several years lower than that of the general population due to comorbidities and interactions between mental and physical health status that are ignored. Inadequate information and stigma are another important factor.

In this framework, multidisciplinary work and collaborations are crucial. All sectors of society are responsible for mental health. Every public body and independent body contribute to it and must make its contribution. This is not to say that no one is concerned about mental health or mental illness. Rather, the opposite is true: it is difficult to find someone who does not show concern and participation, but it can sometimes be difficult to understand which actors should take a coordinating role.

The Objectives of the European Mental Health Action Plan

A total of seven objectives, including four central and three cross-cutting objectives, have been formulated, which define the scope of this Action Plan. For each objective, actions are proposed for Member States and WHO to undertake in order to achieve measurable results at the policy and/or implementation level. Priority among these actions is to be determined according to the needs and resources available at national, local and regional levels.

The four central objectives are as follows:

1. Everyone has an equal opportunity to achieve mental wellbeing at any age and this is particularly true for those most vulnerable or at risk;
2. People with mental health problems are citizens whose human rights are fully recognised, protected and promoted;
3. Mental health services are also accessible financially, competent and available to the community according to need
4. People have the right to respectful, safe and effective treatment.

The three cross-cutting objectives are

5. Health systems provide sound care for the physical and mental health of all;
6. Mental health systems collaborate and coordinate with other sectors;
7. Mental health governance and service delivery are based on reliable information and knowledge.

As can be seen from the above, coordination between different sectors (health, social and education) is crucial. We will focus on how to foster this collaboration.

6. The referral to health services: a care pathway to build to increase the access to mental health care

There are significant concerns about a number of barriers to access to care. These may include stigma (both cultural and self, and stigmatisation), misinformation or cultural beliefs about the nature of mental disorder, social policy or other approaches that limit access to services.

The main mental health problems that should be identified in the wider community are anxiety and depression. Even when people with anxiety and depression do consult their General Practitioner, their disorder often goes unrecognised, partly because many do not present their psychological symptoms overtly.

For many people with a common mental health disorder, stigma and avoidance may contribute to under-recognition of their condition. Pessimism about possible treatment outcomes may further contribute to this. However, GPs themselves can contribute to the under-recognition of these conditions.

More over, different researchers reveal that poorer access to care has been found to be associated with lower social class, geographical location, ethnic minority groups, the presence of sensory or other impairments, the presence of learning difficulties, and particular demographic factors including age and gender (for example, older people or younger men).

This guideline try to point out actions, services and initiatives that may be specifically designed by different social entities to promote access, both for the general population and for specific outreach groups.

We can divide those interventions in the following areas:

- community outreach;
- providing education and information concerning the nature of mental disorder;
- new and adapted models of service delivery which focus on the needs of people belonging to minorities or older people.

Consultation skills

GPs are immensely variable in their ability to recognise depressive illnesses, with some recognising virtually all of the patients found to be depressed at independent research interview, and others recognising very few (Goldberg & Huxley, 1992; Üstün & Sartorius, 1995).

The communication skills of the GP make a vital contribution to determining their ability to detect emotional distress, and those with superior skills allow their patients to show more evidence of distress during their interviews thus facilitating detection (Goldberg & Bridges, 1988; Goldberg et al., 1993).

According to Goldberg and colleagues (1980a and 1980b), ten behaviours are associated with greater detection. These include factors such as making eye contact, having good interview skills, asking well-formulated questions and focusing on more than just a symptom count. Attempts to improve GP behaviour have been successful (Ostler et al., 2001; Tiemens et al., 1999), although results are mixed (Kendrick et al., 2001; Thompson et al., 2000) and interventions sometimes fail to impact on patient outcomes despite changes in clinician behaviour (Gask et al., 2004).

Case identification

The fact that common mental health disorders often go undiagnosed among primary care attenders has led to suggestions that clinicians should systematically screen for hidden disorders. The Map that you find in the previous pages of this paper, should help you as a professional to contribute to the identification of the case, in order to alert the system that should care him/her.

Stepped care model

We can consider as a case study the UK mental health system, that is organised around the principles of stepped care. Stepped care (Scogin et al., 2003) is a framework that is increasingly being used in the UK to provide a structure for best-practice clinical pathways to care. It is designed to increase the efficiency of service provision with an overall benefit to patient populations. The basic principle is that patients presenting with a common mental health disorder will 'step through' progressive levels of treatment as necessary, with the expectation that many of these patients will recover during the less intensive phases. High-intensity treatments are reserved for patients who do not benefit from low-intensity treatments, or for those who can be accurately predicted not to benefit from such treatments. Thus, stepped care has the potential for deriving the greatest benefit from available therapeutic resources (Bower & Gilbody, 2005).¹¹

Concerning our topic, **the main problem of the stepped care model is that the position for people with disabilities is not recorded at all in most sites**, making it difficult to see how commissioners and providers can discharge their responsibilities to promote access to services for disabled people but we can try to apply the stepped-care frame to the opportunities of social support provided in different nations to people with mental disabilities.

We can state clearly that the care pathway for adults with mental disability has to be based more in the community and not only in the care system. Social, educative and informal actors could have a fundamental role for the general wellness and also to accompanying the person to the self-care for their mental issues. We can base our actions on the European action plan mental health recommendations and try to operationalise it in several coordination steps.

The 2-objective useful for that are the 6th and 7th of the European action plan for them we consider the guidelines that can inspire our way of working as a node in the professional network taking care of a person with intellectual disability and - eventually - with mental distress.

Objective 6: mental health systems collaborate and coordinate with other sectors

Collaboration between different services is crucial in the field of mental health and care for people suffering from mental disorders. In each country, this is functionally delegated to different authorities at national, regional or local level, or generally to different offices of these authorities. The different bodies must circumscribe their functions and responsibilities by organising appropriate systems of coordination between them. It is necessary to identify bodies with decision-making powers and the different bodies must be able to work in an integrated manner.

The procedures for referring a user from one service to another may be complex, involve different access routes and assessment processes. Few service providers understand the procedures in place at other organisations, even if they belong to the same geographical area. It is possible to agree on uniform assessment procedures can be agreed upon, provided that staff are informed of the requirements of other organisations.

In many countries, the financial resources allocated to mental health, public health and social work services come from sources and items in the budget. Social care services come from different sources and budget items, so that different payment or reimbursement rules may compromise good practice. Funding bodies should come to new arrangements for payment or even share their budgetary resources in order to improve efficiency and equity. In some cases, it is the users themselves and their families who know best how to allocate resources effectively and efficiently, which strengthens their effectively and efficiently and this strengthens their role.

Results

Objective 6 aims to achieve the following outcomes:

- (a) access by people with mental distress to the benefits and services to which they are entitled;
- (b) access to care, including specialised services, through an integrated assessment procedure;
- (c) funding systems offering incentives for efficient working arrangements;
- (d) resource allocation choices related to care are made by harnessing the expertise of service users of services and their families.

Proposed actions

The following action is proposed to Member States:

- (a) clarify the roles and responsibilities of general and specialist mental health agencies in the different sectors.

Objective 7: Mental health governance and service delivery are based on reliable information and knowledge

- Correct, relevant and state-of-the-art knowledge and information are indispensable in order to enable any component of the mental health system to assess the mental health of the population and the effect of public health interventions, ensure the quality, effectiveness and efficiency of mental health services, monitor staff numbers, distribution and transfers, and evaluate the benefits brought by innovation.
- The various stakeholders and components of the system need different information. In an area as broad as mental health, there is a need for input, processing, output and outcome data related to socio-economic and environmental variables. Such data should only be requested in cases where their collection is reliable and their use is essential, as unnecessary requests for data may consume resources otherwise necessary for the delivery of quality care and have an effect on the quality of care.
- Transparency and accountability are key to demonstrating and safeguarding the safety and quality of mental health services and the rights of users and their families.
- Innovations must be introduced on the basis of studies evaluating effectiveness and identifying essential elements to be disseminated among decision-makers. Innovations are introduced in all areas of the Region, so coordination of research and dissemination activities within the Region will benefit of all Member States. Special attention must be paid to ethical and other aspects in research that concern people with mental disorders, especially in the case of children.
- The sometimes confusing and ambiguous terminology used in the field of mental health can affect the collection and interpretation of data, hindering the achievement of a consensual basis among stakeholders.

Outcomes

Objective 7 aims to achieve the following results:

- (a) selection of a set of outcome indicators, relevant to the needs of the target audience;
- (b) independent quality and safety audits carried out with the involvement of service users and relatives;
- (c) coordinated research activities and international dissemination of results;
- (d) availability of data on staff, their distribution and the reasons for it;
- (e) internationally agreed terminology definitions

Proposed Actions

The following actions are proposed to Member States:

- (a) complete and dispatch the Global Mental Health Action Plan indicators (Appendix 1);
- (b) outsource the assessment of quality and safety to bodies independent of service providers that provide transparent reports;
- (c) develop information-sharing measures between providers and agencies that respect privacy personnel;
- (d) Quantify the effects of public health interventions through mental health impact assessments;
- (e) support research to assess needs, design effective innovations and evaluate results;
- (f) make users and their families an integral part of quality control.

The following actions are proposed to the Regional Office:

- (a) work in collaboration with WHO headquarters, the European Commission and other intergovernmental organisations and intergovernmental organisations to identify a set of indicators suitable for European standards;
- (b) develop in collaboration with stakeholders and publish a set of definitions of terms related to mental health;
- (c) monitor the involvement of service users and their relatives.

¹¹ COMMON MENTAL HEALTH DISORDERS - Common Mental Health Disorders - NCBI Bookshelf (nih.gov)

Coordination steps: a summary of action to foster the referral process¹²

COORDINATION

- Activate or establish mechanisms for intersectoral mental health and psychosocial support (MHPSS) coordination
- Coordinate programme planning and implementation, including development of a MHPSS strategic plan.

ASSESSMENT, MONITORING AND EVALUATION

- Conduct assessments of mental health and psychosocial issues
- Ensure that assessments are coordinated between different public and private actors
- Collect and analyse key information relevant to mental health and psychosocial support of beneficiaries' target
- Conduct assessments in an ethical, rigorous and appropriately participatory manner.
- Collate, disseminate and use assessment results with the community and other actor, ensuring confidentiality and respecting the Do Not Harm principle, including protection risks.

PROTECTION AND HUMAN RIGHTS STANDARDS

- Activate or establish social protection mechanisms, building local protection capacities where needed.
- Respond to protection threats by taking appropriate, community-guided action.

HUMAN RESOURCES

- Aim to hire staff who have knowledge of the local context and insight of local culture and appropriate modes of behaviour.
- Balance gender in the recruitment process and include representatives of key cultural and ethnic groups (when needs)
- Carefully evaluate offers of help from individual mental health professionals
- Organise and attend on orientation and training of social workers in mental health and psychosocial support
- Prepare a strategic, comprehensive, timely and realistic plan for training
- After any training, establish a follow-up system for monitoring, support, feedback and supervision of all trainees, as appropriate to the situation
- Document and evaluate orientation and training to identify lessons learned, to be shared with partners and to enhance future responses

- Address potential work-related stressors.
- Ensure access to health care and psychosocial support for staff.
- Provide support to staff who have experienced or witnessed extreme events (critical incidents, potentially traumatic events).
- Make support available during the employment

COMMUNITY MOBILISATION AND SUPPORT

- Coordinate efforts by different stakeholders to mobilise communities.
- Assess the social environment
- Facilitate the participation of marginalised people.
- Promote community mobilisation processes: support community initiatives, actively encouraging those that promote family
- Provide short, participatory training sessions about the specific mental health issues, reaction or coping, where appropriate, coupled with follow-up support

HEALTH SERVICES

- Assess and map the provision of care.
- Include specific psychological and social considerations in provision of general health care
- Include specific social considerations in providing general health care.
- Facilitate referral to key resources outside the health system.
- Orient general health staff and mental health staff in psychological components of health care, including psychological first aid

EDUCATION

- Promote safe learning environments.
- Make formal and non-formal education more supportive and relevant.
- Prepare and encourage educators to support learners' psychosocial well-being.
- Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties

DISSEMINATION OF INFORMATION

- Facilitate the formation of an information and communication team.

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¹² Source IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. For a detailed explanation, see the IASC Guidelines. The source was adapted for the objective of this specific guideline note and target



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