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RECOVERY AND RESPECT HUMAN RIGHTS HOUSING MENTAL HEALTH SERVICES: FROM PROBLEM TO SOLUTION

GEMS Northern Ireland

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RECOVERY AND RESPECT HUMAN RIGHTS HOUSING MENTAL HEALTH SERVICES: FROM PROBLEM TO SOLUTION

Edited by

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in collaboration with

ASSOCIATED PARTNERS

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This booklet is the result of in-depth work and rich exchange of experiences among the project partners. All partners, with specific teams dedicated to CIVIC, actively took part in the production of this document.

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Introduction

Access to quality, stable, affordable, and safe housing is considered a universal right, regardless of an individual's disability status and the level of support and services the individual needs in order to achieve recovery. Housing promoting quality of life, wellbeing and recovery is an essential component of community mental health services for persons with Serious mental illness (SMI) who have complex mental health needs.

Quality of housing includes the physical environment and characteristics of a neighbourhood related to transport connectivity, safety, availability of resources for social inclusion as well as availability of various services that provide quality support in relation to individual needs.

People with SMI, complex long term mental health needs have various functional difficulties that impair their organisational skills, motivation, and ability to manage activities of daily living, find work and be included in society. Many of them live in poor living conditions, do not have a place to live or live in a stressful interpersonal environment. Many not only need a place to live, but a different nature of support to live successfully in the community such as daily routine maintenance and support to access community resources and to remain in touch with significant others.

Adequate housing and support with activities of daily living are crucial to the recovery of many patients with a severe mental disorder. Housing problems can contribute to worsening of a mental health condition and frequent hospital admissions; therefore, housing services are needed as an integral component of a whole system rehabilitation pathway for adults with mental health problems.

Housing is more than a supported apartment. It is a system of social facilities into a network of human relations in a safe neighbourhood (HERO, 2016).

A growing number of people with SMI choose to live as independently as possible in their own flat, as shared housing with other mentally ill people feels to them like being in an institution. Housing, which guarantees the freedom to choose, gives a stronger sense of personal responsibility and helps to avoid feelings of dependence on institutions has better results in comparison to those where freedom of choice is not given (Eufami, 2018).

For successful outcome of housing as an intervention promoting recovery and respect for human rights of persons with mental health difficulties, it is essential to ensure that mental health services and social sector services engage and collaborate in a very practical and meaningful way to provide holistic support to housing. These require significant shifts in the knowledge, competencies, and skills of all relevant stakeholders (World Health Organization, 2017).

Housing contributing to mental health is more than a roof over the head, placement, or treatment programme, rather a home that contributes to a sense of identity where people feel safe, have relationships promoting wellbeing within the household as well as in their environment, feel that they belong to community as citizens on equal basis with others.

Housing as an intervention for increasing the mental health of persons with complex mental health needs should be offered in the context of a holistic, person-centred, recovery and rights-based approach.

The aim of this booklet: *it* is through an educational pathway increases competency (knowledge, skills and attitude) of users, their families, mental health professionals as well as others stakeholders for implementing recovery-oriented and a rights respect housing service which supports individuals in

their personal recovery process, focuses on empowering persons with SMI to control their lives and live a meaningful and contributing life in a community as well as fight against the stigma of mental illness.

The booklet is an outcome of the CIVIC project which is complementary to the HERO project on "Curriculum". The HERO project has developed a training curriculum suitable for all stakeholders relevant for the housing of people with serious mental illness. In order to select the relevant thematic areas for the training, the opinions what characterize the quality of housing were examined in focus groups in 4 EU countries with all relevant stakeholders: users and family members, mental health professionals, citizens and various service-provider agencies as well as the policy making.

Based on the analysis of the content from discussion in the focus groups, we identified 9 educational topics relevant for training of all stakeholders. CIVIC, bases on case studies of real- life situations in housing and relate to 9 educational topics offers solutions to the most common obstacles to recovery and right-bases housing.

1. Housing options, funding, and satisfaction of the users
2. Rights, decision making and responsibility
3. Assessment, motivation, and individual recovery plan
4. Rehabilitation, case management and peer support
5. Social inclusion and community resources
6. Flexibility and coordination between the services including NGOs
7. Fighting stigma and discrimination
8. Monitoring and evaluation
9. Lifelong learning

1. HOUSING OPTIONS, FUNDING AND SATISFACTION OF THE USERS

The findings from focus groups of the HERO project revealed the importance of the availability of more housing options, stable and good enough funding for housing programs, good relationship with staff provide support and users' satisfaction with housing.

What type of housing is recommended for people with complex mental health need?

To date there are two types of housing options **supportive** and **supported** which are recommended as the evidence-based housing option for persons with mental health complex need/severe mental illness Traditional custodial housing which include board and care homes and foster families are not recommended as an effective approach for people with complex mental health needs/ serious mental illness.

Custodial housing *(board and-care homes and foster families)* - Evidence from research for custodial housing shows that residents in custodial housing became more dependent, did not show the gains in personal growth, community involvement, and independence as those residing in supportive group homes or supportive apartments. In this type of housing care services is focused on medication and basic needs such as food and clothes rather than rehabilitation promoting autonomy and recovery. Many custodial institutions are located outside populated areas, rooms where people live are often overcrowded, people have no privacy, little control over their lives, most decisions are made by staff, and social inclusion is not encouraged. There is a WHO recommendation that custodial institutions should be transformed toward recovery and rights respect services in the community.

Supportive Housing is a "Treatment First" model of housing, includes group homes, halfway houses, and supervised apartments as a specialized housing programme. The Model consists of residential services settings differing in intensity of care and levels of restrictiveness with consumers matched to residential placements based on their service needs and psychosocial impairment. Treatment is often provided on site by housing staff, who sometimes live in the programme's housing. There are established well defined house rules regarding the life in the house as well as with participations in treatment programme. This housing type select residents who need continued treatment and are ready to follow house rules. In-house staff provide active rehabilitation programmes that focus on the promotion of life and social skills, independence, and work. As residents' functioning improved, they were expected to move to a less restrictive setting. It is possible that part of the therapeutic programme is implemented in rehabilitation programmes outside the home; when this is the case residents are expected to leave their housing during the day and attend treatment, day activities, or work.

Supportive housing model is a type of residential continuum model, the idea is that residents move from one housing model to another as they progress in their rehabilitation and recovery. In practice, there are a number of modifications related to the possibility of permanent residence in group apartments, the presence of staff in the house and rehabilitation programs in house or out of house in the community.

Advantages/ dis-advantages of supportive housing: Supportive housing is associated with positive outcomes for people with serious mental illness, such as improvements over time in terms of reduced hospitalisation and increased competitive work. The Treatment First / continuum model has been criticised for its emphasis on the residential facility as the primary location for mental health treatment and rehabilitation, the residential instability induced by the movements along the continuum as users demonstrate an increased or decreased level of functioning, the loss of social supports associated with

the moves, and the questionable assumption that consumers do not need mental health services once they ‘‘graduate’’ to independent housing.

Experience from the recovery movement suggests that the residential continuum is perhaps counterproductive from the perspective of rehabilitation and recovery requiring residents to change their housing as they improve or regress in functioning is viewed as not “normalising” and possibly harmful as well, as moving persons out of more independent settings into more supervised settings when problems arise is also seen as unnecessarily adding to stress.

Supported housing is a “Housing First” model of permanent supported housing model. This includes independent apartments, housing that is available in the community for anyone (typically private apartments) for the longer term. The objective of Housing First is to provide integrated housing in the community for long-term homeless people with severe mental illness, in some cases combined with substance abuse. Activities of Housing First include intensive and direct support to the person in the household and the integration in local services in all areas, such as health, mental health, social welfare, and judicial services.

Housing First emerged as a model based on integrated, permanent, affordable housing, selected by the person, with flexible supports that are functionally separate, but available as needed and wanted. Housing and support are ‘de-linked’ or are independent of one another. Support staff assist consumers in finding permanent "homes," not specialised housing programmes. There are no requirements that consumers be in treatment, to obtain supported housing, but pathways combine supported housing with Assertive

Community Treatment (ACT) and a variety of other support services to help consumers function independently and integrate within the community provided by staff from outside.

Housing First provides individuals with immediate access to housing, regardless of their functioning or use of substances. Supported housing is premised on four principles:

(1) a home in the community as a basic right for persons with severe disabilities.

(2) normal roles of psychiatric consumers as regular tenants and community members.

(3) empowerment as a practice goal in defining the relationship between consumers and their support staff and

(4) functional separation between housing and mental health support.

In this model due to the separation of housing from support it is possible for psychiatric users to refuse or discontinue support services and remain in housing as long as they fulfil their obligations as tenants by paying rent on time and taking proper care of the rental unit. One type of permanent supported housing—housing ready—may require participation in services and may consider abstinence from alcohol or other drugs a prerequisite for programme entry.

Another type—housing first—does not require participation in services and follows harm reduction approaches to alcohol and other substance use. Given their less restrictive environments, permanent supported housing programmes include people who are in the early stages of readiness or motivation to make global lifestyle changes. According to Housing first guide Europe (www.housingfirstguide.eu) a “mind shift” is often needed to move away from traditional views of step-wise integration — according to which access to regular housing has to be “earned” first — and to give priority to the choices and preferences of service users.

Advantages/ disadvantages of supported housing: Research has provided evidence for supported housing as an effective intervention approach for reducing homelessness, achieving residential stability, and reducing hospitalisation as well as reduction of psychiatric symptoms, increase of social and personal functioning, enhancement of physical health and quality of life increase empowerment and community integration. Evidence is stronger for homeless people. It has been also shown that the housing part of supported housing was more or less transparent, but the social support part often was not in terms of staffing levels, staff-service user ratios and staff's training.

Proponents of supported housing maintain that persons with psychiatric disabilities can assume roles and lifestyles as regular community members in a normal, integrated housing environment, when they are given flexible and individualized mental health support services. Without this, many may be exposed to frequent hospitalisations, social exclusion and a chronic course of the disease with less chance for recovery.

What contributes to users' satisfaction?

Research found that factors contributing to users' satisfaction include choice and preferences, matching service type to clients' needs rather than delivering a prescriptive programme, quality of relationship with the staff and qualification of the staff to provide rehabilitation interventions, location of the house in an environment that stimulates social inclusion.

Choice and preferences - Having choice and control over housing and support, living in the preferred type of housing, being satisfied with housing including physical structure and quality of support, having a permanent housing/ residence stability is associated with users' better mental health such as better independent and community functioning, less symptoms of mental disorder and better quality of life. User preference is a key factor in establishing successful housing arrangements and the skills of the mental health team are critical in helping service users to comprehensively determine and articulate those preferences on an individual basis. The inclusion of choice and preferences increases the opportunity of the house becoming a home rather than a placement or programme.

Matching service options (supportive or supported) to clients' needs rather than delivering a prescriptive programme

Research findings show that users preferred to live in their own place (their own homes or apartments, supervised apartment, social housing), either alone or with a significant other rather than with other mental health consumers. They want staff to be available on a 24. hours basis, but not live-in staff.

Quality of support including relationship with the staff and qualification of staff to provide rehabilitation interventions

A systematic review of the international literature has suggested that supportive housing programmes with a high degree of tenant satisfaction and stability have empathic staff who have expertise in those psychiatric rehabilitation techniques which support informed choice and community participation.

The importance of the location of the housing programme / independent house in an environment that stimulate social inclusion

The research of housing quality indicators according to the HERO project (HERO, 2016) showed that users want residential houses located in a safe area with good transport links, located in an environment with resources that enable social inclusion in various areas of life such as work and leisure.

What we have learned from research for implementation in practice

In summary, research confirms the effectiveness of supportive "Treatment First" as well as supported housing "Housing first" for improvement of mental health, therefore the choice should be guided by the individual needs of users.

On the other hand, research reports problems in a range of different housing community settings such as social exclusion, chronic course of mental disorders and poor physical health conditions, which means that housing type itself does not guarantee the quality of care and outcome, therefore it is necessary to analyse all the factors that contribute to quality of housing and facilitate their implementation in practice.

In order to meet criteria for quality housing research suggests that the following factors need to be considered: choice, preferences and satisfaction of the users, matching service type (supportive or supported) to clients' needs rather than delivering a prescriptive program quality of support including relationship with the staff and qualification of staff to provide rehabilitation interventions; the importance of the location of the housing programme / independent house in an environment that stimulate social inclusion.

The traditional custodial type of housing is not recommended, so if it exists it is necessary for it to be transformed according to the recommendations for the transformation of institutions that promote recovery and respect human rights. Any type of housing which has not transformed towards recovery oriented services can represent the trans- institutionalisation or re-institutionalisation which is not expected to help people with complex mental health need to recover, be socially included and achieve citizenship.

It should not be assumed that there is one solution of housing that fits all as well as the nature and level of support fit all persons with complex long-term mental health needs. Helpful criteria include: users' preferences of type of housing and its location; functioning - level of autonomy and need for support as well as available and affordable options in real life situation.

Different forms of housing should exist or be developed so that users can choose what best suits their needs and can change the housing options when they want to do that. Without the consistent commitment to provide recovery-oriented and rights respect housing services as a basic culture promoting personal recovery supportive and supported housing can become a place of institutionalisation in the community, instead of homes for people who are citizens in their communities.

The attitudes of support and / or rehabilitation staff are important in promoting recovery. Staff must be careful not to hinder the recovery of people who want to achieve recovery with their paternalistic approach but to encourage autonomy and social inclusion. Staff should be trained to balance the facilitation of autonomy and the level of support appropriate to the individual needs of users.

Supportive and supported housing options should work on the principles of recovery. When the support provided by the staff is not based on the principles of recovery and human rights, then there is a risk that these options are more like custodial options that do not encourage recovery but keep people in a dependent "patient" position which restricts their human rights and does not promote empowerment, social inclusion, and citizenship.

Basic attitude to users of housing mental health services should be that they are firstly a citizen in need of mental health service, tenant in his or her housing, a person with rights and the potential to contribute to society, not as a patient or client to be supervised or managed. Working relationships with residents

should be based on mutual trust and respect, rather than on paternalism and coercion, and to enable residents to build and maintain individualised support networks through accessing community based mental health services and other community resources.

Housing services promoting recovery and respect human rights

The recovery orientation of mental health housing services is the capacity of a service to provide care that supports and enables an individual's personal recovery process and facilitates an individual's recovery outcome. Recovery is facilitated through the dynamic interplay of many factors relating to the interaction of personal factors such as motivation and self-identity and environmental factors which include family, work, therapeutical environment, social network as well as society as a whole.

Recovery-oriented services aim to support people in their unique recovery journey and empower people to: take control of their lives, identify and work towards their goals and aspirations in order to lead fulfilling and meaningful lives, make decisions about all areas of their lives including treatment, care and support. These services have declared recovery as a way they work- recovery culture and use principles of recovery as a guiding in helping people to achieve better mental health (WHO, 2019).

For definitions of principles of recovery see SAMHSA's Working Definition of Recovery (SAMHSA, n.d.)

From the human rights perspective a person using mental health services has the same rights as other members of the community to make decisions that affect their lives, including decisions involving risk, and to be supported in making those decisions where they request support. For people who have difficulty in making decisions different type of support for decision making should be available. For example, it should be available to appoint one or more people to assist the person who needs support for decision making to: obtain and understand information, evaluate the possible alternatives and consequences of a decision, express and communicate a decision, and implement a decision.

People should be free to choose from regimes and arrangements of varying types, intensities and formalities; for example, circles of support, support networks, support agreements, peer support, independent advocates, personal ombudspersons, personal assistance, advance directives, support from family and friends, and online communities (WHO, 2019). The staff should be trained in how to help the person to make a decision, and not to make decisions for the person assuming that it is in the best interest of the person. Human rights training should be mandatory training for all staff in housing service such as WHO QualityRights e-training on mental health Mental Health and Substance Use (who.int)

Receiving information about rights is extremely important for users of mental health services including housing services. They are frequently unaware of their rights and thus unable to exercise them. Users of mental health services should receive both verbal and written information about their rights, how to exercise them as well as how to get support to exercise their rights and how to access available complaint mechanisms when their rights are not respected in a clear and understandable way.

Where quality indicators used in assessment of service culture do not show that the housing services is based on stimulating recovery and respect for human rights, it is recommended to start the process of transformation. In a transformed mental health system, users become active participants in planning, services, and research, with real power, voice, choice, and control.

A major barrier for transformation is attitudes. Building a new vision and values base on recovery and human rights are an important starting point for the transformative changes. For transformative change to occur, many myths and misconceptions about mental illness, including views that people with mental

illness are dangerous, unpredictable, incapable of making their own decisions, and in need of care must be directly confronted and replaced with an alternative vision of recovery and a set of values (citizenship, holistic health, power, social inclusion, and social justice) that guides the journey towards that vision (Sylvestre et al., 2007).

Quality indicators for recovery promoting and respect human rights housing

- ✓ Declared policy of the service is based on recovery culture - the belief that is possible for all service users to achieve control over their lives, to recover their self – identity, increase their self-esteem, and move towards building a life where they experience a sense of belonging and participation in community.
- ✓ Belief in the reality of recovery is shared with all stakeholders relevant for housing service
- ✓ Services respect the right of the service user to choose where and with whom they live
- ✓ Services focus on the strength, recognise the skills and capacities, rather than deficits of the person using services as well as those of the family, friends and care partners who support the person.
- ✓ Services support positive risk taking – support people to explore their potential, new possibilities and opportunities and live life as they choose whether it is engaging in new activities, meeting new people, exploring new ideas and feelings.
- ✓ Services accept that people make decisions about all areas of their lives including treatment, care, and support
- ✓ Services support people to take control of their lives.
- ✓ Services offer help in developing skills needed for everyday life including the skills that are required for managing the negative moments in life and all that can affect wellbeing.
- ✓ Treatment/ support is bases on individual plan with recovery goals agreed with the person in recovery
- ✓ The Individual plan also includes physical health when it is needed.
- ✓ Services identify a person's goals and work towards their aspirations in order to lead fulfilling and meaningful lives.
- ✓ Assessment of goals for recovery includes all life areas relevant to recovery
- ✓ Services acknowledge the personal, social, cultural, and spiritual values, strengths and wishes of the person.
- ✓ The goals of support / rehabilitation are focused on social inclusion, instead of focusing primarily on symptom relief.
- ✓ Services explore all area of a person's life relevant to recovery such as: work, education, leisure time, relationship etc.
- ✓ Services support users to have a written plan to guide their personal recovery journey.

- ✓ Services support users to connect/reconnect with their community as well as with family and friends if the person wishes to do so.
- ✓ Services support people to use available community services and resources to build relationships with other community members and be engaged in the community
- ✓ Services support people to connect to peer supporters or self helps groups that may exist.
- ✓ Services encourages self-determination and self-management
- ✓ Services promote hope, optimism, and possibility
- ✓ Services do not use coercive practice such as nonconsensual treatment and coercive measure such as physical restrains
- ✓ Services facilitate social participation/ community inclusion in a way that is consistent with the individual's own values, choices, goals of personal recovery.
- ✓ Staff acknowledge that recovery is grounded in principles of the individual's empowerment and involvement in their own recovery journey.
- ✓ Staff acknowledge that the person with mental health difficulties is an expert by experience and has capacity for self- management
- ✓ Staff establish a partnership with the person as well as their support network (with the person's consent) in order to empower them and promote recovery
- ✓ The staff are educated in the principles of recovery, human rights as well as in psycho-bio-social model of understanding persons with mental health difficulties and applies them in practice
- ✓ Staff use evidence-based interventions in the treatment and support of persons with complex long term mental health need.
- ✓ Staff acknowledge that recovery is not linear, it has setbacks
- ✓ Staff know the difference between users' responsibilities and their responsibilities
- ✓ Staff take care to strike a balance between autonomy and support according to users' needs
- ✓ Staff know the difference between paternalistic and recovery approach
- ✓ Staff offer flexible support in accordance with the needs of users
- ✓ Services respect users' choice and preference over housing
- ✓ Staff inform users on their rights including the rights to benefits
- ✓ Staff inform users about advance directive
- ✓ Acceptance of housing option including the treatment is based on informed consent
- ✓ Services undertake an addressing stigma programme
- ✓ When service user's do not have stabile housing, services help him/her in finding their options
- ✓ The physical environment, living conditions and the general atmosphere of housing services is pleasant like a home
- ✓ Service rules are flexible not in contrary to human rights

- ✓ Mental health facility provided housing, or independent housing is not isolated from, and unconnected to, the community.
- ✓ Users have access, on a voluntary basis, to short-term community-based services
- ✓ Users have access to services for physical health
- ✓ Services are safe for users as well as for the staff
- ✓ Staff show respect to users
- ✓ Users are active participants in planning, services, and research, with real power, voice, choice, and control.
- ✓ Peer support is available if it is needed.
- ✓ The procedure for evaluation of users for services is established and criteria are transparent
- ✓ The service has enough qualified and experienced staff to provide support/ rehabilitation programme
- ✓ When services do not provide treatment/ support has a link with support service in community
- ✓ Services connect people who want work with employment services
- ✓ Case management support is available when is needed.
- ✓ The service is regularly monitored and evaluated

FUNDING FOR HOUSING FOR PEOPLE WITH SEVERE MENTAL ILLNESS (SMI)

Financing of housing cost for people with severe mental illness who need housing varies from country to country. Here we present examples of five countries that participated in the CIVIC project

Croatia

Housing services are available by Law for adults who, due to illness, infirmity, old age, work incapacity, disability or other unfavorable life circumstances are not able to independently take care of their basic needs, nor can their family members provide them with help in their home.

While such need lasts, the Social Care Services can help to provide them an accommodation:

- social care institution,
- foster family,
- family home,
- residential community,
- therapeutic community,
- sheltered or organized housing.

The funding is covered by the social care fund is only if the funds or property do not exist or are inadequate. Users or their families/carers are obliged to cover housing or other costs if they have means. If they cover the costs completely, then the matters are contractual between the housing users and the housing unit, and usually it takes a shorter time to find housing that way directly.

Various social care services work swiftly or not according to the capacities of the municipality (residency of the user). Either user or their carer can start the process of housing. When possible, social care services take into account the wishes of the user, his expectations, needs, abilities, material possibilities, his cultural habits and other situations that were present before accommodation.

Capacities of various housing structures as well as the urgency procedure are the factors to consider. Whenever possible, housing is provided in the user's local community.

Portugal

In Portugal 84.5 of the social facilities belong to private non-profit organisations that establish cooperation agreements with the state to provide services in the social area and for some years in the health area.

Joint Order No. 407/98 regulated the coordination of the social and health sectors in the provision of psychosocial care for people with disabilities caused by mental illness and made possible the creation and funding of various types of psychosocial rehabilitation devices: Supported living units, protected living units, independent living units and socio-occupational forums.

The decree-law no. 348-A/98, which promoted the insertion of people undergoing psychosocial rehabilitation into the labour market through protected employment. In order to develop community structures for psychosocial rehabilitation and deinstitutionalisation, Decree-Law No. 8/2010 subsequently amended by Decree-Law No. 136/2015, defined the units and teams of integrated continued mental health care, for people with severe mental illness - later integrated into the National Network for Continued and Integrated Care. Such document presented the definition of the typology of community-based residential structures, day centres and intervention teams.

The functioning of social responses is supported essentially by cooperation agreements signed between the state and the entities that integrate the solidarity network (mutual societies, IPSS, misericórdias, associations...), in addition to the contribution made by users or their families and the institutions' own revenues (donations, for example).However, it is important to note that the degree of funding of these institutions is very variable and is to some extent related to the sector of activity in which they operate and the rate of volunteering. Periodically, the Cooperation Protocol established between the MTSSS and the entities that compose the solidarity network (represented by the Union of Portuguese Misericórdias, the National Confederation of Solidarity Institutions and the Union of Portuguese Mutualities) is revised. And it defines how much the state pays for each service and each user. The "third sector" also receives support in other ways. Institutions that are in difficulty, for example, can appeal to the Social Assistance Fund (FSS) to meet expenses.

Or in contributions and support attributed by Local Authorities

There is a strong financial dependence of the IPSS on public transfers" which represent about 42% to 43% of the budget of the institutions. Public financing reflects the revenue obtained exclusively through recourse to state support, in a more significant way at central administration level (e.g.: Ministries and Institutes); as well as, in a less incisive way, at local administration level (e.g.: Municipal Councils and Parish Councils) and also from community funds in order to ensure a fixed monthly value that enables the financial balance of the treasury of these institutions. According to Portaria n.º 196-A/2015, of 1st July, we can see that the cooperation of the State, carried out through the Social Security Institute, I.P. and the

IPSS or legally equivalent may take three distinct forms: a) cooperation agreement; b) management agreement and c) protocols.

✓ Cooperation agreement - 2 Types

i. Typical Agreement - "consists of an agreement whose social response to be contracted obeys a standardized funding value per user or family, in view of the operating expenses that are associated with the development of the social response";

ii. Atypical Agreement - "consists in an agreement whose social response to be contracted implies, as long as duly justified, a change in the standardized criteria, namely according to the characteristics of the territory where the social response is implemented, the population to be covered, as well as the human resources to be allocated and the services to be provided".

✓ Management agreement - may provide for the transfer of a social equipment of a public nature, in one of the following forms:

i. "Management of the operation of the social equipment";
ii. "The management of the operation and cumulatively the assignment free of charge of the building, in a lending regime."

✓ Protocols - fundamentally aimed at: a) "the development of social measures and projects with an innovative character" and, b) the "implementation of new mechanisms of action and different action strategies in response to social needs."

Revenue from Social Games (SCML), Social Games/Social Relief Fund (SCML) and Income from the Social Relief Fund (FSS) represent between them, 7.5% of the overall total financed expenditure, while transfers from the State Budget represent the remaining 92.5%.

Greece

There are no housing projects *per se* in Greece because this concept has not been adopted by the competent authorities. The funding of housing by the government usually takes the form of subsidies. More specifically, the government subsidises the cost of the banking loans taken by low-income individuals to finance the purchase of their homes. The subsidy is usually given to the bank that issues the mortgage or housing loan to the interested party. In this way the bank is able to provide cheap loans to poor or low-income families or individuals. The government authorities responsible for the subsidy are jointly the municipality where the resident belongs and the respective government agency or ministry.

Northern Ireland

In Northern Ireland the **'Supporting People' programme** (Supporting people, 2020) helps people to live independently in the community. The Northern Ireland Housing Executive administers the Supporting People programme in Northern Ireland on behalf of the **Department for Communities.**

The 2015 review of Supporting People recommended the introduction of a strategic, intelligence led approach to identify current and future patterns of need. Consequently, a Strategic Needs Assessment was developed. This evidence base informs decisions on how services can be best delivered, to support future planning and decision making, aligned to wider strategic priorities set by the NI Executive and

Programme for Government. The NI Housing Executive Supporting People Directorate works in partnership with Supporting People funded organisations to enable them to deliver excellent services to vulnerable people.

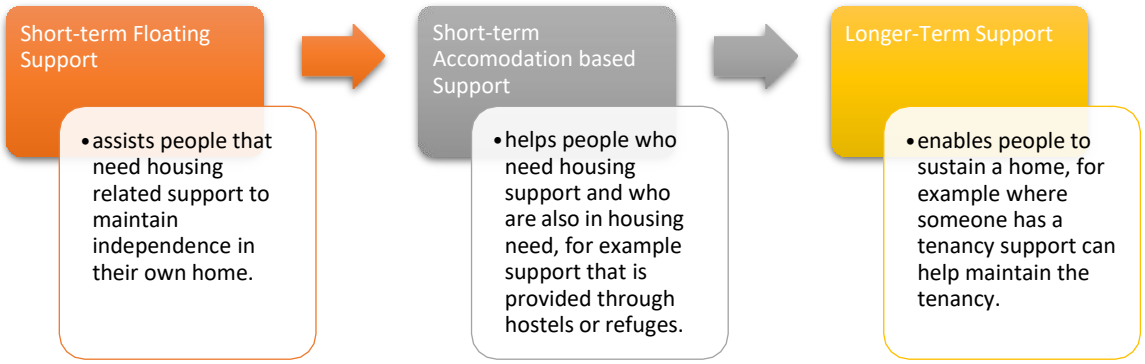
Supporting people service directory

People can search for support in their local area using the Housing Executive (Housing Exexutive, n.d.). This directory gives details about housing support services funded by the Supporting People Programme in Northern Ireland. Services funded by Supporting People are required to submit performance and outcomes data in relation to their clients. Providers of Supporting People services are required to collect and submit outcome information through the Outcomes system. The Provider Investment Fund (PIF) is a competitive fund that aims to support improvements to the delivery of Supporting People Programme. Existing Supporting People providers can bid for support to help them improve their delivery of the Supporting People Programme.

Housing related support services help people live independently or move onto more independent living. This can include support to: develop domestic/life skills, develop social skills/behaviour management, find other accommodation, establish social contacts and activities, gain access to other services, manage finance and benefit claims, set up and maintain home/tenancy, maintain the safety and security of the dwelling

People who can access housing related support through the Supporting People programme in Northern Ireland are: homeless people, people with a learning disability, people with poor mental health, older people, women at risk of domestic violence, young people leaving care, people with drug or alcohol use problems, offenders or people at risk of offending.

HOW ARE PEOPLE SUPPORTED?



CHARGES FOR HOUSING SUPPORT SERVICES

This depends on the type of housing support service accessed. There is no charge for short term services through 'floating support', homeless hostels or refuges.

Charges for long term services are dependent on a person's individual circumstances

HOW SUPPORTING PEOPLE SERVICES ARE ACCESSED

HOUSING–SUPPORTED LIVING FOR PEOPLE WITH MENTAL HEALTH NEEDS

APEX (APEX, n.d.) is a system for supported living for people with mental health needs (https://www.apex.org.uk/)

Apex Housing has four mental health supported living housing facilities in Northern Ireland.

For instance, one of them, ballyoan house offers accommodation, support, and care for 16 adults with mental ill health over 25 years of age. It is owned and managed by apex housing association. The accommodation consists of 16 bed en-suite accommodation with shared living, dining and kitchen facilities set in its own secure grounds with landscaped gardens and patio areas situated close to town, shops, and recreational facilities. Ballyoan house provides a safe environment with staff available 24 hours per day supporting tenants to develop skills, take control of their life and get involved in day-to-day decision making. Tenants are involved in the planning of their own support and care service and encouraged to achieve personal goals to become more independent, try new things like education or training, get involved in the local community and take part in activities as arts and crafts, baking, trips and outings, gardening, beauty therapy, relaxation therapy.

Apex staff work in partnership with Supporting People and the Local Health Trust to ensure they meet the individual support and care needs of each tenant.

Italy

SISTEMA SANITARIO REGIONALE ASL ROMA 2					
FACILITIES FOR PEOPLE WITH EXPERIENCE OF SEVERE MENTAL HEALTH ISSUES	**STAFF SUPPORT**	**N. OF USERS**	**AIM**	**KIND OF SUPPORT**	**FUNDING**
Therapeutic communities	H24	12	To strengthen the path towards autonomy within a customized individual project.	The support includes pharmacotherapy, psychotherapy (group and individual therapy), rehabilitation activities	They are funded by Regione Lazio. Users don't have to pay
Residential facilities	H12	10-20	Space management, personal cleaning, shopping, looking for a job.	Pharmacotherapy and rehabilitation activities	They are funded by Regione Lazio. Users don't have to pay
Supportive apartments	From a few hours not every day, up to 8 hours every day	2-5	Developing the ability to live independently, manage everyday life and interpersonal relationships.	Each guest has a customized individual project, shared and signed by the Mental Health Centre team, the housing team and the guest himself.	Supportive apartments are funded by ASL Mental Health Department as regards rent, utilities and assistance of the cooperative workers. Meals are paid by the users.
Supported apartments	Flexible home care network	2-3	Living at home	Each person has his/her personal team at CSM and agrees on individual treatment.	Supported Apartments are borne by users, but there are some financial aids for those unable to meet their costs

2. ASSESSMENT, MOTIVATION, AND INDIVIDUAL RECOVERY PLAN

Assessment of needs of people using mental health services is a process of evaluation of clinical status (symptoms and bio-psycho- social factors relate to mental disorder), functional status, motivation, need for support and nature of support. Assessment is essential for matching housing options (supportive or supported) to clients' needs, development of care/ recovery plan as well as assessment of the disability relate to the right for benefits. The goal of assessment in the area of housing and supports is to enable the service user to accurately identify the type and location of housing, what housemates (if any) are preferred, and the range and level of supports he/she feels are needed to maintain their preferred accommodation.

Assessment of clinical status - Assessment of mental health difficulties/symptoms of mental disorder and psycho-bio- social factors contribute to causes and maintenance of symptoms of mental disorder is based on a clinical interview provided by psychiatrist and other mental health professionals when is needed. The interview should be comprehensive and result in the development of a psycho-.bio -social formulation. Psycho-bio-social formulation is a hypothesis about the causes of mental health difficulties, based on a comprehensive assessment of the interaction between psychological, biological and social factors. It is person-specific relating to the unique life experience of each person. A psycho-bio-social formulation helps to gain a comprehensive understanding of the factors related to the development, maintenance of symptoms of illness and difficulties related to functioning and recovery.

Assessment of functioning - Functioning is the ability to perform and participate in various activities of daily living that are normally expected to be undertaken by an average, healthy individual. The purpose of an assessment of functioning is to identify fields of functional capacities and limitations, as well as the available resources to improve one's functioning, including different interventions and services, that will help people with mental health difficulties to recover as well as exercise their disability rights relating to benefits. One of comprehensive tool for assessment of functioning is WHO International Classification of Functioning (ICF). It is used for assessment of functioning and participation in daily living activities, from daily routine to more complex activities, such as social communication skills, functioning in social roles in different contexts, including family, relationship with a partner, workplace, education and the wider community.

The following areas are assessed in ICF:

1. Learning and applying knowledge - cognitive functioning.
2. Carrying out daily routine – taking care of one's hygiene, self-care, personal safety, household, nutrition, budgeting, etc.
3. Mobility – ability to move independently.
4. Communication, interaction, and relationships – communication difficulties, quality of relationships with other people and social skills in communicating with others.
5. Role functioning – family, workplace, education, community, recreation, and leisure.
6. Social isolation relate to withdrawal from social contact or social exclusion
7. Handling stress - resilience to stress and managing stressful situations.

8. Support – assistance by people in person's environment and asking for and getting help in challenging activities, as well as reaching out to different institutions providing support, including peer support
9. Attitudes – identifying the environmental factor that may be a facilitator or barrier to different activities.

Assessment of nature, intensity and source of support including need for rehabilitation

Persons with complex, long-term mental health needs who require housing needs flexibility of support in respect of the nature and intensity as well as in selection of psychosocial interventions. Many will require a combination of different types of supports and psychosocial interventions with the changed needs over the lifespan (Wagreamaker et al., 2014). Needs for specific nature and intensity of support as well as the interventions is based on assessment of capacities/strengths and limitation in different area of functioning. Assessing what patients/users can do independently and what they need help is key for planning appropriate nature and intensity of support. Linking the functional difficulties with the degree of support required is essential for the recommendation of housing option as well as developing a care/recovery plan to increase capacity for independent living.

Assessment of motivation for change

The motivational interview is often conducted as a part of assessment process for the purpose to understand user's personal stance on the issues that concern them, and to explore their motivations and expectations. Persons with mental disorders with complex need often have low motivation or are ambivalent to change for various reasons. The most often they are ambivalent to make useful decisions that can promote the process of recovery, therefore in the assessment process it is necessary to assess motivation and resolve ambivalence to encourage people to make useful decisions for their life. Motivational interviewing is a collaborative goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. For those interested there are free online training courses available on the internet.

Psycho-bio-social formulation and assessment of needs are crucial in developing an individual care and recovery plan. Tools such as Camberwell (CAN) assessment of need can be helpful in assessment of needs. It is a comprehensive tool for assessing the needs for people with serious mental illness. It connects clinical and functional status with need of support and interventions.

The assessment for housing purpose is provided by collaboration between different mental health professionals, housing provider team, user, and their families. We need to be aware that any functional assessment that has not been made in the person's natural environment may be incomplete. Due to the lack of insight into the disease in some people with mental health complex needs, conducting an assessment may be challenging, accordingly, apart from user's information and personal observation of evaluator during the evaluation interview all available information from different sources such as relatives and other service observation could be helpful.

Individual care/ recovery plan

An Individual Care Plan is an agreement between the mental health professional or rehabilitation team and the patient/user on the goals of treatment/recovery in which patient's preferences are considered to be a priority, along with psycho-bio-social interventions recommended to be implemented to reach identified goals. In order to achieve recovery all aspects relevant to recovery such as symptoms of mental disorder, functioning in all life domains, attitudes, trauma history, social inclusion, protective and risk factor for mental health should be considered. It should always bear in mind that recovery and quality of life in the community is the expected outcome of any provided interventions within the service. The Care Plan is always individual because every person's life experience is unique. The Care Plan should also include a list of professionals and others who will help its implementation. It should also be evaluated regularly.

A special type of recovery plan is a recovery plan made by a person with mental health difficulties with or without the help of professionals as a self-help tool. Although similar and analogous with a care plan, a recovery plan is not the same as care plan. The basis for a recovery plan is Wellness Recovery Action Plan (Copeland 2008). It was designed by a service user for service users aims for developing a personal plan to cope with distressing symptoms, prevent relapse, manage crises and stay 'well'. Personal Recovery Plans should contain an identification of the person's internal and external resources and a plan for how they can use these to take control of their life and achieve their chosen goals. The person should not necessarily have to share their recovery plan with staff: it belongs to them. Detailed guidelines for a Recovery plan can be found in Person-centred recovery planning for mental health and well-being self-help tool (WHO, 2019)

To identify recovery goals in care plan or recovery plan Recovery helm- Holistic approach to mental health & recovery can be used. The helm has been created within the CIVIC project by partner organisation University psychiatric hospital Vrapce.

Helm of Recovery in Mental Health is a tool that helps to determine the recovery goals and develop an individual treatment or recovery plan for people with mental health difficulties, as well as to select the interventions that can help to achieve the identified treatment goals and monitor individual progress.

Using the Helm of Recovery it is possible to evaluate the conditions in life areas that are important for recovery, to assess the areas that need improvements or changes, to choose priority areas for improvement, follow the advancement toward defined goals in different periods, as well as evaluate the results and modify the goals. Ten areas of Helm of Recovery are assessed with ranges from 0% to 100% for each area, where 0% marks the worst, and 100% the best possible state. The point of comparison is the functioning of average healthy person expected in the area of assessment.

The actions in treatment/recovery plan include various psycho-bio-social interventions, support, collaboration with different mental health and other services and using the resources of community that contribute to recovery and social inclusion. The improvement in one area of Helm can influence changes in other areas. The Helm of Recovery is based on a psycho-bio-social understanding of the origin of mental health difficulties, principles of recovery defined in SAMHSA and assessment of functioning and QualityRights recommendations according to WHO. A description of the recovery helm and how to use it is found in the appendix.

Quality indicators for assessment process and care/recovery plan:

- ✓ Mental health status has been assessed

- ✓ All domains of functioning have been assessed
- ✓ Nature and intensity of support needs have been assessed
- ✓ Need for specific psychosocial interventions have been assessed
- ✓ Motivation for change has been assessed
- ✓ Psycho-bio-social formulation was developed
- ✓ Appropriate housing options bases on assessment has been recommended
- ✓ An individual care plan was developed in collaboration with users
- ✓ Users are stimulated to create their own personal recovery plan
- ✓ An Instrument such as Recovery helm is used in identification, evaluation and monitoring of the recovery goals

3. RIGHTS, DECISION MAKING AND RESPONSIBILITY

UN Convention on the Rights of Persons with Disabilities (CRPD, 2006) is an international human rights treaty that reaffirms that all people with disabilities including people with psychosocial disabilities must enjoy all human rights and fundamental freedoms. CRPD recognises that disability results from the interaction between people with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others. CRPD has not introduced any new human rights but emphasises that in order for people with disabilities to be equal with others, they have the right to support such as support in decision making, and social inclusion.

For people with mental health problems, the following rights are particularly important: right to legal capacity (art 12); the right to live in the community, including the right to work and rehabilitation (art. 19, 26) and the right to liberty and security (art 14) All citizens should be able to access relevant information and advocacy services to ensure that they understand and are free to exercise these rights and responsibilities without prejudice.

Right to legal capacity is related to right to decide and right for support in making decision

The CRPD confirms that persons with disabilities including the person with mental illness enjoy legal capacity on an equal basis with others in all aspects of life' and obliges States to provide access to the support they may require in exercising their legal capacity. Legal capacity means the right to make decisions, while decision-making capacity is the ability of a person to make a decision in specific situations.

Some people with mental health difficulties can have difficulties in decision making due to impaired capacity to make decisions. These people in this instance need help in order to make decisions. However, this ability may vary, so a person with reduced decision-making capacity needs support, which means other people can help him or her to make a decision that reflect his or her wishes, rather than having someone else make a decision on his or her behalf. Some people need support for complex decisions, others for simple ones. The person decides whether he or she wants support to make his or her own decisions. In supported decision-making, one shall not simply assume the best interest of the person but support a person to make a decision based on his or her wishes and preferences.

Even when a person obviously does not have the capacity to make decisions, the decision must be made based on knowledge of his or her wishes and preferences. Decision about housing options and treatment/support should be based on free informed consent. That is the right of a person to decide independently on their own and act in accordance with their own decisions.

A person in housing should make two decisions: where and with whom he/she will live and what kind of mental health support services he/she will accept. The rules of informed consent are the same regardless of whether it is consent to housing or consent to treatment. Information about housing and treatment should be provided by authorised professionals in mental health service. Independent advocates shall be available in mental health services, upon request at any time, to provide support to service users to access information, understand their rights and options, and have their rights, will and preferences respected. They must be independent, have appropriate experience and training, and be guided by human rights principles. Mental health services shall facilitate the exercise of the functions of independent advocates (World Health Organization, 2019).

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

For an individual to give valid informed consent**,** three components must be present: patient competency-pertains to the ability of a person to understand the information relevant for a decision-making, **Competency** (decision-making capacity), to understand the relevance of the information in a specific situation, to form a judgment using the information, to choose between possibilities and to communicate decision; **disclosure**--the patient/users got clear information about the purpose of treatment/ housing, expected results, a description of what needs to be done during the treatment, possible benefits and risks, alternatives, and potential risks if the patient/user refuses a recommended treatment/housing and **voluntariness-** implies that patients/user have the freedom to make a decision on their own, without any other influence, coercion, deception, and manipulation, and that their consent may be withdrawn at any time.

People without capacity to provide informed consent cannot understand the information relevant to the decision, retain that information, use, or weigh that information as part of the decision-making process, or communicate their decision whether by talking, using sign language or any other means.

Helping the person to consider and express their choices and preferences, is the most essential way in which the mental health professionals can assist. This is the foundation work in a shared-decision making which brings together two sources of expertise – the knowledge, skills and experience of health and social care professionals and the individual's own knowledge and expertise of their own condition and living situation. The shared decision-making is the basis of truly informed consent. It should be core skill for mental health professionals. Sharing decisions means that the responsibility for the decision is shared, it lies with the therapist and the client. The therapist reports all information about the housing/ treatment options to the client, they can recommend an option and decide on the option together with the client.

The right to live in the community, including the right to work and the right for optimal health and rehabilitation

These rights covered in Art 19. 25, 26, 27 in CRPD are interrelated and represent rights for health and quality of life related to recovery approach such as social inclusion, independent living skills and the implementation of evidence base methods of treatment. Living independently and being included in the community refers to a person's right to decide for themselves where, with whom and how they will live, right to support for social inclusion activities, which includes the right to peer support. Habilitation and rehabilitation (art. 26) refer to a person's right to various rehabilitation programs in order to achieve maximum independence, social inclusion and participation in all aspects of life that a person wants. Rehabilitation should begin at the earliest possible stage and should be based on the multidisciplinary assessment of individual needs and strengths.

Work and employment (art.27) include the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in an open market and work environment that is open, inclusive and accessible to persons with disability.

These include employment opportunities and career advancement for persons with disabilities in the open market, as well as assistance in finding, obtaining, maintaining and returning to employment; opportunities for self-employment, the development of cooperatives and starting one's own business. People with mental health difficulties have a right to participate meaningfully in individual and community life without discrimination, stigma or exclusion.

The right to liberty and security (art 14) -Coercive practice such as involuntary admission, seclusion, restraint and involuntary medications can cause the trauma and may have long term impact on person's life and can retraumatise people who have a past history of trauma, impede people's recovery, damage therapeutical alliances and be responsible for the breakdown of the relationships with mental health service providers. Many people with experience of coercive practice methods experience feelings of loss of dignity, degradation, demoralisation, dismissal, humiliation, anxiety, disempowerment, helplessness and rejection by the healthcare staff. Coercion may also damage staff morale and traumatise other service users and staff members. Physical coercion, even when used as a 'last resort', carries serious risks of pain, injury, trauma and even death. Trauma related to the use of coercive measures can undermine therapeutic relationships, discourage trust in mental health systems, and repel service users from seeking help in the future.

Coercion can be effectively prevented, reduced, and even completely discontinued. Examples of good practices included 'Six Core Strategies for Restraint Minimisation', 'No Force First' initiatives, advance-planning to avoid or better respond to crises, 'open door' policies in hospitals and other facilities, the use of 'crisis respite houses', family-based interventions. Two prominent service delivery approach which promote minimising coercion are 'recovery-oriented' and 'trauma-informed' services. Mental health housing service must have a policy of prevention of violence and protocols for staff in case of aggression. Staff and users should be informed about it and be educated in aggression preventive strategies.

The re-traumatisation of people with past experiences of trauma, by and within diverse mental health services is highly prevalent. Trauma informed system of care is a programme, organisation, or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. (SAMHSA, 2014)

Key factors for Trauma - Informed Care according to Australian guidelines on Trauma inform treatment and organization of care - by Mental health Coordinating Council 2015/2018 - include: 1. Understanding trauma and its impact - A trauma-informed approach recognises the prevalence of trauma and understands the impact of trauma on the emotional, psychological and social wellbeing of individuals and communities.

1. Promoting safety - A trauma-informed approach promotes safety - Establishing a safe physical, psychological and emotional environment where basic needs are met, which recognises the social, interpersonal, personal and environmental dimensions of safety and where safety measures are in place and provider responses are consistent, predictable, and respectful.

2. Supporting consumer control, choice and autonomy - A trauma-informed approach values and respects the individual, their choices and autonomy, their culture and their values.

3. Ensuring cultural competence - A trauma-informed approach understands how cultural context influences perception of and response to traumatic events and the recovery process; respecting diversity; and uses interventions respectful of and specific to cultural backgrounds.

4. Safe and healing relationships - A trauma-informed approach fosters healing relationships where disclosures of trauma are possible and are responded to appropriately. It also promotes collaborative, strengths-based practice that values the person's expertise and judgement.

5. Sharing power and governance - A trauma-informed approach recognises the impact of power and ensures that power is shared.

6. Recovery is possible - A trauma-informed approach understands that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system; facilitating peer support; focusing on strength and resiliency; and establishing future-oriented goals.

7. Integrating care - A trauma-informed approach maintains a holistic view of consumers and their recovery process; and facilitating communication within and among service providers and systems

Responsibility in mental health care is related to the obligation of various stakeholders e.g. patients, families, mental health professionals, mental health services, government bodies, disability services, local communities, the general public to perform the duty or tasks assigned to them. In the global context related to the CRPD, states that have signed the Convention, (which is the case in most European countries) are responsible for ensuring respect for the rights guaranteed by the Convention, ensuring that all mental health care institutions respect these rights.

The responsibility of institutions is to organise services and provide interventions in a manner that ensure optimal health and promote recovery and respect for human rights. In addition to ensuring the good quality of mental health care at system level, states have responsibility to control the quality of care and respect for human rights through regular evaluation and monitoring. Mental health professionals have the responsibilities to follow the principles of medical ethics, apply assessment and treatment methods based on good standards and evidence-based practice, respect rights of persons with mental health difficulties as well as to collaborate with other services relevant for mental health and advocate for mental health in public.

Personal responsibility of a person with metal health difficulties for his/ her own care is one of the key principles of recovery; it involves taking action and doing what needs to be done to get well and stay well, they have a responsibility to work together with mental health professionals towards their recovery as well as to respect the rights, well-being and safety of other people working in or using these services.

People with mental health problems and mental illness have rights and responsibilities to be informed about and involved in decisions about their own individual treatment. They also have the right to contribute to the formulation of mental health legislation and policy, and to the design, implementation and evaluation of mental health services at national, regional and local levels to ensure that services comprehensively meet their needs. Individual rights should be balanced against the rights of carers, families and the wider community.

Families have responsibilities to take care for their health and support their loved ones in recovery. Communities have responsibilities provide opportunities and resources for social inclusion, address stigma and discrimination. The media also has responsibilities in reporting and public education to lessen rather than add to stigma. It is the responsibility of all stakeholders to empower people with mental disorders and provide support according to their needs, but perception of various stakeholders very often is not transparent enough. Different perceptions of who should be responsible for empowerment,

support, social inclusion, and recovery of individuals with mental health problems may contribute to their unmet needs and hinder the recovery.

Understanding these perceptions can help define relevant stakeholders' roles more clearly, which can improve mental health services and strengthen stakeholder accountability (Pope et al 2018).

Quality indicators:

- ✓ Staff are educated about the Convention on the Rights of Persons with Disabilities (CRPD)
- ✓ Services have a policy of prevention of violence and protocols for staff in case of aggression.
- ✓ Staff and users are educated in aggression preventive strategies.
- ✓ Mental health care has been provided on the basis of informed consent
- ✓ Staff are educated in supporting decision making
- ✓ Staff have understanding of responsibility for mental care of all stakeholders
- ✓ Staff have understanding of their and users' responsibilities
- ✓ House rules are in line with CRPD
- ✓ The media is educated to report on mental illness in a non-stigmatising way

4. REHABILITATION, CASE MANAGEMENT AND PEERWORK

The people who need housing services often have severe, complex mental health problems included impairment of organisational skills, motivation, and ability to manage activities of daily living and use community resource to participate in the community. They often need various types of formal and informal support such as a case manager, volunteers, family, and other source support. Various type of support includes: emotional support (someone to confide in, who provides esteem, reassurance, attachment and intimacy); instrumental support (services, money, transportation); Informational support (advice/guidance, help with problem-solving and evaluation of behaviour and alternative actions); companionship support (belonging, socialising, feeling connected to others); and validation (feedback, social comparison). They need rehabilitation in order to increase their autonomy for management of all sorts of activities and participation in the community such as daily life routine, access community resources for social inclusion including employment, social network, contact with family and fight stigma and discrimination as well as increase resilience and decrease vulnerability for worsening of mental health they need rehabilitation. Without rehabilitation services, patients in need of rehabilitation are at risk of becoming stuck in a hospital or in other facilities that do not enable them to achieve their optimal level of autonomy (Killaspy et al., 2016).

A combination of different evidence based psychosocial interventions is used in rehabilitation according to individual rehabilitation plan promoting recovery. User's - therapist relationship based on empathy, mutual trust, respect, empowerment, optimism, and hope is key factor relate to the outcome of rehabilitation regardless of psychosocial interventions being provided. Staff working in rehabilitation should foster people's autonomy, promote active participation in treatment decisions and support self-management. Staff providing rehabilitation should have skills to form therapeutic relationship and treatment alliances, provide case management, draft individual rehabilitation plan promoting recovery, the joint crisis plan, as well as have training to provide evidence base psychosocial interventions and evaluate progress on a regular basis.

Evidence from research: Meta-analyses, reviews and guidelines give convincing evidence for the numbers of psychological interventions available for treatment of patients with complex mental health needs such as psychoeducation and illness management, social skills training, cognitive behavioural therapy, metacognitive training, cognitive remediation, family interventions, art therapy, supported employment such as Individual placement and support (IPS) as well as assertive community treatment and early intervention programs as different organisational forms of delivering care.

None of these methods have an advantage over the other, most often the combination of several methods will be needed to achieve the desired recovery goals There is also evidence for self- management, motivational interviewing, and lifestyle interventions. People with severe mental illness have a 10–20-year life expectancy gap when compared with the general population; this gap is largely due to physical chronic disease, particularly cardiovascular and respiratory disease. A systematic review revealed improved physical health after participation in lifestyle interventions (Bruins et al., 2014). There is also the Open Dialogue approach on the effectiveness of which numerous studies exist in the treatment of psychosis and serious psychiatric crises (Seikkula 2014).

Availability of case management is one of quality indicators in treatment of people with serious mental illness- It is a treatment approach for persons who have long-term functioning impairment that may be a major barrier to recovery. It includes working with patients at home, comprehensive assessment of needs,

coordination of different services within the mental health services system and other necessary services. The key person is the case manager who takes on responsibility for the long-term maintenance of supportive therapeutic relationship regardless of the patient's location and the number of other services involved in patient's treatment. The case manager's function is to help the patient identify and ensure inner and outer resources required for independent living in the community. The case manager is involved in all aspects of the patient's physical and social environment, including housing, psychiatric treatment, health care, benefits, transportation, family, and social environment.

People with SMI, especially those in supported hosing type also need support from Assertive Community Treatment mobile team (ACT). Effectiveness of case management has been confirmed in various studies. Best researched is the effectiveness of the assertive model. Case management significantly reduces the number of days in the hospital and increases the quality of life.

Individualised peer support is one-to-one support provided by a peer who has personal experience of issues and challenges similar to those of another peer who would like to benefit from this experience and support. The aim is to support people on the issues they consider important for their recovery in a way that is free from assumptions and judgement.

Peer support may be social, emotional or practical support (or all of these) but importantly this support is mutually offered and reciprocal, allowing peers to benefit from the support whether they are giving or receiving it. A peer needs to have more than a shared experience of mental distress in common. The peer also needs to have a shared view of what recovery means, a shared understanding of a diagnosis or experience, and a shared view of particular treatments.

Peer support is central to the recovery approach. Through sharing experiences, listening empathetically, and providing encouragement, peer supporters can support people with psychosocial disabilities to find their own meaning of recovery in order to live fulfilling and satisfying lives. Examples of peer support actions and practices include: sharing experiences, strategies and stories of hope and recovery, encouraging people to take responsibility for their own life and recovery, encouraging people without doing things for them, providing people with relevant information, helping people to build social networks in the community, supporting people to ensure that their human rights are respected.

Peer work have been shown to produce a range of improved outcomes including greater optimism about the future, increased self-esteem, a greater sense of empowerment and reduced self-stigmatisation (Repper & Carter, 2010).

A brief description of the psychosocial interventions used in rehabilitation is described in the glossary.

Quality indicators:

- ✓ Staff have the ability to form honest, respectful and trustful relationships with the people using services.
- ✓ Staff work together with the people who use services to 'co-produce' services which support recovery outcomes.
- ✓ Staff support people skills to increase autonomy and social inclusion
- ✓ The Rehabilitation Plan has been discussed with users and provided on the basis of informed consent
- ✓ The patient has been informed about their rights

- ✓ Evidence based psychosocial interventions such as: psychoeducation, social skills training, cognitive behavioural therapy, metacognitive training, cognitive remediation/rehabilitation, family interventions, art therapy, supported employment/ Individual placement and support (IPS) are available
- ✓ Case-management is available
- ✓ Assertive community treatment is available
- ✓ Peer support is available
- ✓ Programmes for People with SMI with dual diagnosis (psychosis and addiction) are available
- ✓ Staff have competence in delivering 'evidence-based' interventions which will support recovery goals
- ✓ The delivery of evidence-based interventions based on individual rehabilitation plan.
- ✓ Specific measures are used in order to collect date, evaluate outcome and monitor progress

5. SOCIAL INCLUSION AND COMMUNITY RESOURCES

It is well known that an important part of having and maintaining good mental health lies in feeling included within society. Mental illness can limit a person's capacity to participate in society, as well as social exclusion based on stigma and discrimination against people with mental illness. To be equal with others many people with mental health difficulties require support to participate in community. Social inclusion for full participation in society on equal basis with other is also the right according to United Nations Convention on the Rights for Persons with Disabilities (CPRD) what makes government and wider society responsible to respect these rights and provide support in social inclusion to those who need it.

Social inclusion is about being able and have an opportunity to participate in and contribute to community life in economic, social, psychological, and political terms. It is related to experience to be part of and belongs to community and use of resources in the community according to individual preferences. To do this requires having personal skills as well as access to resources in the community such as employment, recreations, sport, cultural, spiritual, and other resources as well as support if it is needed. Social inclusion is also to be free from social exclusion which come from stigma and discrimination which has negative impact on all life areas of person with mental health difficulties. Social inclusion and exclusion are closely linked to each other and to recovery from a mental disorder. Increase of social inclusion will decrease social exclusion and promote recovery and vice versa reduced social exclusion such as decrease of stigma will increase social inclusion.

The World Health Organisation (1980) define social exclusion as "the dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions - economic, political, social and cultural - and at different levels including individual, household, group, community, country and global levels." Social exclusion is related to inability for individuals and groups, such as disabled people, long-term unemployed, etc., to participate in the economic, social, and cultural life of the society where they live. The emphasis here is on non-participation arising from constraint, rather than choice as a result of a range of factors which combine to effectively preclude participation. These factors include unemployment, income, educational attainment, housing, financial exclusion and a lack of financial assets, health and mobility, and for people with mental illness also personal factors such as lack of skills, low self-esteem, social isolation due to stigma.

Social exclusion is more a process than a state which is very often difficult to reverse, therefore it should be prevented and replaced with social inclusion as soon as possible. Viewed in broader way, social exclusion is not just about exclusion from social roles – it is also about reduced access to many of resources in community in area important for quality of life.

Strategies to increase the social inclusion and eliminate social exclusion

Social inclusion of people with mental health difficulties is the process of improving the ability, opportunity, and dignity of people, disadvantaged on the basis of their mental health conditions, to take part in society. The strategies may include influence people's ability for social inclusion and increase opportunities to use community resources as other citizens or a combination of both. Strategies must be individualised because social inclusion may have different meanings and goals for each person. Many service users have desire for more friends and relationships, acceptance by neighbours, employers and families, and more opportunities for different leisure and cultural activities and to be part of mainstream groups and communities.

Strategies include:

Developing recovery and rights respected mental health services

A socially inclusive mental health services to include recovery-oriented practice, an emphasis on social outcomes and participation and respect the rights of people with mental health difficulties, promote citizenship, equality and is free of stigma and discrimination. A key role of recovery services is to support people to gain/regain their place in the communities where they live and take part in mainstream activities and opportunities along with everyone else. All provided interventions should empower people with mental health difficulties and their families to build resilience to stress, develop and sustain social support network, improve employment opportunities, and engage in community according to their choice and preferences.

Interventions involve social skill training in real life situations self-management, employment support, family interventions, coping with stigma and self- stigma may empower the person and facilitate the social inclusion. Access to a well-developed social network may have benefits for individuals over and above improving their subjective sense of 'belonging'. These networks may also facilitate access to economic, cultural and information resources, which then benefit the individual.

Socially inclusive and recovery-oriented services must have strong strategic relationships with the necessary range of social care agencies, for example housing, employment, or community networks. People generally do better in services that embrace social inclusion, with mental health professionals who are able to minimise the impact that illness has on social functioning and with opportunities for people to be included in key social roles, such as employment and personal and social relationships. Delivery of care that uses socially inclusive and recovery approaches, in line with service users' preferences and choices, is likely to lead to better outcomes for service users and enable them to live the lives they want to lead. A number of initiatives have been put into place, both by health care providers and NGOs and voluntary organisations to address social isolation:

Engagement in different activities in community including employment

involvement in various community activities available to all citizens such as participation in meaningful recreational, cultural, art, educational, cooking and other activities alongside other community members without disabilities based on shared interests. Through diverse activities people can develop social skills, improve self-esteem, form interpersonal relationships, improve their ability to live independently, and overcome loneliness.

Although, many people with severe mental health difficulties want to and can work, however they need support to find and maintain a job. There is good evidence that supported employment programmes for people with complex mental health needs is an effective strategy for social inclusion. The possibility of inclusion in work through the social economy and special employment assistance programmes such as Individual placement and support (IPS) is an important social inclusion strategy that has beneficial effects on health. The development of social economy organisations such as co-operatives, associations, foundations, social enterprises, etc. contribute to, the development of formal and informal networks of people, knowledge, and resources. It has potential to engage 'hard-to-reach' people who may be unwilling to involve themselves with government agencies as well as potentially acting as advocacy and empowerment organisations for users. IPS as evidence base model of supported employment for people with serious mental illness is proven that job is powerful tool to facilitate social inclusion with beneficial impact on mental health.

To stimulate social inclusion a booklet or spreadsheet on available community resources and organisations (e.g., income-generating programmes at NGOs in the community; government agencies for social services such as housing, food, or other subsidies; education and vocational skills training opportunities; peer support groups; social and cultural programmes, activities, and events, etc.) is recommended. The booklet can be used by staff or people using the service to connect with other services outside the mental health sector.

Volunteering - Social isolation experienced by individuals with complex mental health needs/ SMI can be tackled through interventions from volunteering organisations, representing an important resource for health services when utilised efficiently. Volunteering is time willingly given for the common good and without financial gain, but volunteers can receive reimbursement of out-of-pocket expenses. The term 'volunteering' covers a wide diversity of activities in society. It can be formal or informal. Informal volunteering includes helping friends and family with things like babysitting, home repairs or caring.

Formal volunteering usually takes place through a charity or other not-for-profit or community organisations. While volunteering provides substantial benefits to society, importantly it also provides significant benefits to the volunteers themselves. Volunteering is related to many benefits; can give a sense of achievement and purpose, help to feel part of a community, improve self-esteem and confidence, share talents, learn new skills and create a better work-life balance, help combat stress, loneliness, help to meet new people, which can help feel more connected and valued and bring meaning and purpose in life. Volunteering also gives the opportunity to practise and develop social skills and promote mental health recovery.

Befriending is a common form of volunteering generally involving supportive one-to-one companionship with a non-professional over a regular period of time. Befriending is facilitated by a volunteering organisation or a health or social service to foster a supportive relationship between a volunteer and an individual with a mental disorder. The greater efficacy may be achieved through balancing the frequency, length, and modality of befriending. The benefit of befriending is thought to be particularly relevant for individuals with psychosis, who experience higher levels of social isolation than the general population.

Evidence for interventions promoting social inclusion: There is a growing body of evidence that demonstrates that people living with complex mental health needs, who are provided with well-planned, comprehensive support in the community have a better quality of life, develop an improved level of functioning and social contacts, self- esteem, self -determination and have fewer relapses as well as taking part in social, educational, training, volunteering and employment opportunities. Befriending has been shown to have benefits for people with both mental and physical illnesses, such as a reduction in symptoms, social isolation, and improved patient reported outcomes, including well-being and quality of life . Befriending programmes for individuals with psychosis have been shown to be a worthwhile experience for both befrienders and patients. However, participation also requires perseverance and flexibility from both sides. Different factors, such as personal motivation factors, participant preferences for frequency of meetings, must be considered in the development and management of a befriending programme in order to provide effective support to both befrienders and users.

Mental health facilities isolated from, and unconnected to the community, which do not include social inclusion as a goal of treatment/rehabilitation hinder recovery. People should be empowered, encourage and support to be able to access the resources in the community which they aspire. People with mental illness living in any type of housing must have the opportunity to be not just patients or users diagnosed with mental illness, passive receiver of treatment and support, but individuals with his/her unique values

as a person, citizen equal with others, who can also contribute to society. To provide this housing services have to operate in culture of recovery and respect human rights as well as promoting social inclusion.

Example of good practice [Video]. YouTube. https://youtu.be/LOZ5u4fuCcs

Urban community mental health programme, Pune. Bapu Trust for Research on Mind and Discourse. (2013) [Video]. YouTube. https://youtu.be/Ozqq5rET9kk

Quality indicators

- ✓ Services support users in social inclusion in various area such as employment, sport, different kinds of workshops cultural activities, volunteering to meet with friends, family member, join community events and more.
- ✓ Communities have easily accessible information about different programs that promote social inclusion

6. FLEXIBILITY AND COORDINATION BETWEEN THE SERVICES

The World Health Organization points out that well-integrated community mental health services are associated with better treatment outcomes refer to increased quality of life, better treatment collaboration, less stigma, housing stability, and work opportunities (World Health Assembly, 2013). To achieve the good quality of care and better outcome for mental health of persons with mental health difficulties, a multidisciplinary and multisectoral collaboration should be established to create a meaningful network of connected mental health, social, employment, NGOs and other services relate to mental health. It should include inpatient, outpatient as well as the housing options for persons with complex mental health needs.

Community mental health is the integrated approach to mental health that uses social resources to ensure that people with mental health problems have the right to accessible care and is supported in their own environment to work on their recovery. Community mental health requires a combination of complementary pharmacological, psychological, somatic and social interventions. This involves an approach within one's own context, and this requires the willingness to use successful interventions in a flexible manner to do justice to a specific situation and the availability of. Together with the user, where possible with their support group, a treatment plan is written from their own context resources.

Mental Health Care cannot do this alone and requires good cooperation with the client and his informal network, the municipality, the general practitioner, and other relevant stakeholders (Keet et al., 2019). Various mental health services and interventions should be used according to patient's clinical condition and assessed social and psychological factors that contribute to mental health problems and are obstacle to recovery. That is why the information exchange and collaboration between various stakeholders should be established and maintained on continuing basis. Established networks between different mental health care services and relate services provide the opportunity for patients to use services and interventions that fit his/ her needs in recovery. It is essential that the whole network of services share the vision of recovery.

Collaboration and coordination between different mental health departments with the aim to help recovery for each individual patient is a creative process to find out what and for whom works best. When needed continuity of care should be guaranteed. Acute hospital services and outpatient mobile team services as well as housing, employment services, programs implemented by NGOs must be linked and transparent. Mental health service users and all stakeholders must be informed about the existence of these services, the content of their work and methods of admission to those services. Mental health professionals have also an important role in linking service users with NGOs services in the community as well as with housing and employment services and other resources in community relevant to recovery of mental health. This requires an ongoing relationship with all stakeholders responsible for improvement of mental health from different, but complementary role.

Non-Governmental Organizations (NGOs) are non-profit organisations, or civil society organisations which play a key role as advocates, service providers, activists, and researchers on a range of issues pertaining to human and social development (Thara & Patel, 2010). For good functioning mental health system with expected recovery outcome cooperation between public and non-governmental organisations should take place on complementary basis and their role within the mental health care

system should be transparent. NGO activities have included treatment, rehabilitation, community care, research, training and capacity building, awareness and lobbying. Service-oriented, non-profit mental health organisations often tend to rely on professional knowledge and are to a great extent organised similar to professional organisations (Thara & Patel, 2010).

Mutual exchange between users and professionals is recognised today in many NGOs where members rely on the professional skills, as well as in the mental health care systems, where interest in ‘‘experts by experience’’ is growing. NGOs often offer with a self- help group or other kind of service such as families and relatives support groups, homeless people or other groups provide different kind of workshops. Some of them have activities in cooperation with the mental health system, aiming to represent the user-movement on director boards or committees, or to participate in staff training.

Quality indicators

- ✓ The Service is a part of community mental health network
- ✓ The Service has well established collaboration with all relevant stakeholders
- ✓ The Service role is transparent for other services in network
- ✓ NGOs are complementary part of network
- ✓ All stakeholders share vision of reality of recovery

Useful videos:

Not Without Us [Video]. YouTube. https://youtu.be/fv9jbKFANZc

7. INCREASING COMPETENCIES AGAINST STIGMA AND DISCRIMINATION

Mental illness-related stigma is major barrier to recovery and full participation in society for people with mental illness. Stigma and discrimination in relation to mental illnesses have been described as having worse consequences than the conditions themselves (Sartorius & Schulze, 2005). Stigma can also create a vicious circle of discrimination, reinforcing negative attitudes, decreasing self-esteem and leading to a poor treatment effect or a high probability of relapse Stigmatization occurs on multiple levels simultaneously – intrapersonal as a self-stigma, interpersonal in relation with others, and structural in discriminatory and/or exclusionary policies, laws, and systems (Corrigan et al., 2014).

On an individual level, stigma is a significant barrier to housing, employment, income improvement, and health care. Unfortunately, stigma exists also among mental health providers (Stangl, et al., 2019).. Research demonstrates that mental health care providers tend to hold pessimistic views about the reality and likelihood of recovery from serious mental disorders such as schizophrenia or bipolar disorder, which is experienced as a source of stigma and a barrier to recovery for people seeking help for mental illnesses (Corrigan et al., 2014), therefore, it is necessary to continuously work on building a culture of recovery and respect for human rights within the health, mental health, and social system (World Health Organization, 2017)..

Stigma is a major source of psychological stress, whether it is enacted, internalised or anticipated, therefore action should be taken in the field of anti-stigma strategies at the global level (Thornicroft et al., 2016; Hansson, Stjernswärd & Svensson, 2016).

Anti-stigma strategies have been categorised in terms of education (replacing myths about mental illness with accurate knowledge), contact (using direct or indirect – i.e., para-social – interactions with people who have a mental illness to challenge prejudice), and protest (attempts to suppress stigmatizing attitudes and representations of mental illness). There is a prevailing opinion that the interventions containing social contact and first-person narratives were more effective than others (Corrigan et al., 2014; Thornicroft et al., 2016); but education and contact interventions have both been effective (Gronholm et al., 2017).

Stigma is also impacted by media representations, which can influence stigma drivers like fear and prejudicial attitudes, so interventions that will reduce stigma in media and increase awareness of the importance of mental health are important. According to recommendations from the World Psychiatric Association, in order to make the anti-stigma programme successful, it should be delivered at the national level and target groups of particular relevance to people with mental health problems, service users must be included in the whole process from planning, through implementation to evaluation, target behavioural change; send a clear message; programme is to be continuous and financed from public funds and supported by government; action is needed at various levels as well as coordination at the local, regional and national levels. (Sartorius & Schulze, 2005).

Narrative reviews of research on mental health stigma identified education – and/or contact-based mass-media campaigns that were associated with improved public attitudes and/or knowledge, including different programs in the EU and around the world. Some were also associated with a reduction in discrimination reported by people living with mental illness, such as ‘Like Minds, Like Mine’ in New Zealand and ‘Time to Change’ in England.

Interventions to combat self-stigmatization Self-stigma or internalised stigma refers to the process of identity transformation related to accepting stereotyped attitudes towards mental illness by a person with mental illness as personally relevant, which leads to a decrease in self-esteem and self- efficacy difficulties in recovery (Corrigan, & al., 2014),and leads to a variety of negative consequence in a vicious cycle of stigma (Sartorius & Schulze, 2005). Given the fact that self-stigma causes a number of negative consequences even more than the disease itself, it is necessary that the prevention of self-stigmatization be one of the goals from the first contact of person with mental health services. For interventions targeting mental health self-stigma useful for the prevention and reduction of self-stigmatization see bibliography and examples of good practice.

The following references may be useful for the prevention and reduction of self-stigma: Healthy Self-Concept (McCay et al., 2006); Self-Stigma Reduction Program (Fung et al., 2011); Ending Self-Stigma (Lucksted et al., 2011); Narrative Enhancement and Cognitive Therapy (Yanos et al., 2011); Coming Out Proud (Corrigan et al., 2013); Anti-stigma photo-vocal intervention (Mizock et al., 2014; Self-Stigma Reduction Program (Ivezić et al., 2017).

So, in order to address that root cause of stigma, according to the Report on the State of Public Health in Canada (2019), we absolutely need everybody to hold that mirror up and ask themselves that really important question, of "how am I implicated in these systems and structures that discriminate, that stereotype, that hurt people. How can I be an agent of change, what can I do to arrest and disrupt those practices and policies that are so harmful to many of us?" ()

Quality indicators

- ✓ Staff are educated about stigma, discrimination, and their consequences on mental health
- ✓ The Service culture is based on recovery, conveys hope, optimism, and reality of recovery
- ✓ The Service takes part in anti-stigma initiatives in the community
- ✓ The Service provides self-stigma prevention program including the skills how to cope with social stigma and discrimination

Examples of good practice

- SANE Australia, http://www.sane.org
- Time to Change
  https://www.time-to change.org.uk/about-us
  https://www.time-to-change.org.uk/news-media
- Opening Minds Canada, https://www.mentalhealthcommission.ca/ English/opening-minds
- Like Minds Like Mine in New Zealand, https://www.likeminds.org.nz/
- ONE of US One of us is a Danish national program, http://en-af-os.dk/English/About%20us.aspx

8. EVALUATION AND MONITORING OF THE MENTAL HEALTH SERVICES

Good quality mental health services should operate in line with evidence base practice with expectation of good outcome measured by good mental health and satisfaction of users. Clinicians and managers need information are the services operate in the most effective and efficient ways to ensure the quality of care. Evaluation and monitoring are tools for assessing whether service works in good direction implementing interventions and programmes which have a beneficial effect on users' mental health measured by quality indicators. Quality indicators provide the key link between evidence-based practice and improved outcomes. They should be relevant for measurement of recovery outcome on individual users' level as well as at service level (McColl et al., 1998).

Monitoring and evaluation is necessary to assess whether or not a programme, project or intervention is achieving its desired results. Therefore, the implementation of any programme or interventions requires monitoring, review, and evaluation to determine whether the required actions are taking place and outcomes being achieved. Monitoring refers to the visits, observations and questions we ask while a programme is being implemented to see if it is progressing as expected. One of the key issues, in monitoring programmes is also to ensure that the programme is doing no harm. When done correctly, monitoring and evaluation uses information to demonstrate positive, negative, direct, or indirect changes that have occurred and targets reached or not reached, while providing lessons for consideration in future work.

Monitoring and evaluation are also necessary for learning, contextualisation, adapting programmes and accountability. It is important that monitoring and evaluation information, in appropriate formats, is shared with the individuals and communities involved in the work and others who may benefit from reviewing the results (such as other organisations, donor and national or regional government authorities). Similarly, to monitoring which monitors progress, evaluation, refers to examining a programme at the beginning, middle, and after it has been completed to see if it achieved the desired results. Obviously, it is important to know what the desired results are in order to evaluate them. That is why indicators are needed, Indicators are a unit of measurement that specifies what is to be measured; indicators are intended to answer whether or not the desired impact, outcomes or outputs have been achieved. Indicators may be quantitative (e.g., number of hospitalisations) or qualitative (e.g., knowledge, capacity). Monitoring and evaluation are two linked but separate practices.

Monitoring is the systematic gathering of information that assesses progress over time, evaluation assesses specific information at specific time points to determine if actions taken have achieved intended results. Monitoring refers to the routine tracking of key elements of the organisation's activities, while evaluation refers to a process of systematically assessing the value and effectiveness of an activity. Evaluation is essential for understanding whether the organisation is having the impact that is anticipated. Both monitoring and evaluation will also help to identify factors that are facilitating the organization's goal(s) and objectives or acting as barriers to achieving them.

A special type of evaluation is an impact evaluation. An impact evaluation relies on rigorous methods to determine the changes in outcomes which can be attributed to a specific intervention based on cause-and-effect analysis. Impact evaluations need to account for the counterfactual – what would have occurred without the intervention through the use of an experimental or quasi-experimental design using

comparison and treatment groups. Impact evaluations often serve an accountability purpose to determine if and how well a programme worked. Impact Evaluations can also help answer programme design questions to determine which, among several alternatives, is the most effective approach. The World Bank has developed the guidelines for determination when an impact evaluation may be useful.

It is not feasible to conduct impact evaluations for all interventions. The following are examples of the types of intervention when impact evaluation would be useful: if it is an innovative intervention scheme, such as a pilot program, if the intervention is to be scaled up or replicated in a different setting, if the intervention is strategically relevant and will require a great deal of resources, if the intervention is untested, if the intervention results will influence key policy decisions. More on impact eval see Principles for Impact Evaluation, OECD (n.d.).

Measurement of recovery organisational culture and individual recovery process

The systematic analysis of data on internal consistency, convergent validity and factorial structure of instruments for measuring the recovery at individual level and evaluated mental health services' orientation towards recovery recommended the following instruments service assessment use in practice :A Recovery Self-Assessment (RSA), INSPIRE, Recovery Assessment Scale (RAS); Illness Management and Recovery Scales (IMR), Stages of Recovery Instrument (STORI), Recovery Process Inventory (RPI), Recovery Oriented Systems Indicators (ROSI), Recovery Promotion Fidelity Scale (RPFS) (Burgess et al., 2011).

User outcomes are the most important criteria for evaluating both intervention and implementation strategies. The following instruments evaluate the process of personal recovery meet the reliability, convergent and construct validity criteria and assess change: Recovery Assessment Scale (RAS); Mental Health Recovery Measure (MHRM), Illness management and Recovery Scale (IMR), Stages of Recovery Instrument (STORI) Stages of Recovery Scale (SRS), Questionnaire on Process of Recovery (QPR), MHRS (Mental Health Recovery Star) and RPI (Recovery Process Inventory).

Assessment, evaluation and monitoring recovery orientation and human right respect in mental health institution

The WHO (2017) Quality Rights Tool Kit is based on the United Nations Convention on the Rights of Persons with Disabilities. It provides practical guidance on: the human rights and quality standards that should be respected, protected, and fulfilled in both inpatient and outpatient mental health and social care facilities; preparing for and conducting a comprehensive assessment of facilities; and reporting findings and making appropriate recommendations on the basis of the assessment and stimulate facilities to develop and put into place an improvement plan. Assessment theme include : 1.Right to an Adequate Standard of Living (CRPD Art 28); Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (CRPD Art 25) ;Right to Exercise Legal Capacity and to Personal Liberty and the Security of Person (CRPD Art 12 & 14);Freedom from Torture or Cruel, Inhuman or Degrading Treatment or Punishment and from Exploitation, Violence and Abuse (CRPD Art 15 & 16) The Right to Live Independently and Be Included in the Community (CRPD Art 19).

More information at WHO Quality Rights Tool Kit (World Health Organization, 2017).

Quality indicators for supporting recovery at an individual and organisations level:

- ✓ Staff recovery-promoting relationships base on key principles of recovery such as hope and optimism, empathy and empowerment
- ✓ Services use the reliable instruments for assessment of recovery culture
- ✓ Service use the reliable instruments for assessment of process of personal recovery
- ✓ Service undertakes a self-assessment for quality of service such as QualityRights Tool Kit.
- ✓ An independent body monitors the services on regular basis
- ✓ Service has a peer support service
- ✓ Service has a policy for reduced/end coercion practice
- ✓ Service users feel that staff in services are trying to help them in their recovery
- ✓ Service bases treatment on individual care plan with the goals of recovery
- ✓ Services support social inclusion
- ✓ Services have a procedure to support development of user's recovery plan
- ✓ Recovery plan includes identification of personal sensitivities and signs of distress as well as crisis intervention plan
- ✓ The institutions monitor the quality of mental health care based on recovery and respect for human rights

9. LIFELONG LEARNING

Lifelong learning is defined as the continuous process, either formal or informal, of development and improvement of one's knowledge, attitudes and skills. Lifelong learning in housing is a basic requirement to guarantee the quality of housing, and it should be available for all those involved in housing: mental health professional staff, users, families, volunteers and others. Lifelong learning brings reinforcements of and challenges to already acquired knowledge, skills and attitudes.

A Recovery and human rights approach is a challenge for lifelong learning because it tests all our previous knowledge about mental disorders, especially biomedical approach, prognosis and possibilities for recovery. This relatively new approach requires a change of attitudes from paternalistic approach toward shared decision making and treatment base of informed consent, the implementation of new practice such as peer works persons who are experts by their experience, move from clinical outcome to social inclusion and personal recovery.

In summary, all educational topics covered in this booklet should be part of lifelong learning in order to increase the competencies of all stakeholders involved in housing services. Learning should include various model of learning such as supervision, lectures, self-education, online courses and more in a comprehensive way so that different forms of education are complementary to each other. Supervision is an important part of education. It ensures that the service program is being delivered with some degree of fidelity and is useful for addressing any issues that may arise, especially personal and interpersonal issues that may affect an employee's performance or the performance of the program as a whole. Frequent team meetings and individual supervision are beneficial in this way.

Quality indicators

- ✓ Lifelong learning is regularly carried out in the service
- ✓ Lifelong learning is mandatory for all employees

10. FROM PROBLEM TO SOLUTION

Knowledge, competencies and skills of all relevant stakeholders needs for housing should be based on recovery and respect for human rights. In this section there are some examples of problems and solution from real life situation common to many housing service for people with serious mental illness, which might be useful for the readers of this booklet.

Julia and Mario from a rehabilitation community aged between 30 and 40, both diagnosed with psychotic disorder, are in romantic relationship, now for? years. About a year after the beginning of their relationship, they decide, also with the support of the operators, to go and live together in a rented apartment. She has always maintained a protective and caring attitude towards her partner. Until her mother dies. Before the death of her mother, the woman was protective and nurturing, she took care of the management of the house: payment of utilities, shopping, preparation of meals and organisation of free time were all managed by her; as well as took care of the care and control of the nutrition of her partner, who was overweight. The relationship following the death of the woman's mother changes she withdraws from the tasks previously managed. The partner starts shopping, cooks, takes care of her health. He spends a lot of time with his partner. There is a reversal of roles after the death of Julia's mother. Julia is depressed relate to the bereavement process and not to be able to function in her previous role taking care of everything.

Problem: How to handle a crisis situation?

Solution: A crisis situation is always an opportunity for improvement. People can learn from the crisis; it is a chance for increase resilience and personal grow. In this example It is important to understand that crisis, loss of the mother leads to Julia's depression, that is the Julia's way to cope with stress of loss. As a consequences of depression she has not been able to carry out her previous overprotecting role toward her partner what might create another stress for Julia due to her perception of role of the women, make her feels guilty, what can be one of psychological factor which can prolong depression. In a crisis, the partner has shown that he is able to care for Julia and has demonstrated good skills to perform the activities of self-care needed for everyday life. Julia needs professional help to get out of depression. which may include the introduction of antidepressants and talking to both partners about each other's roles in the activities of everyday life and the possible shared responsibility for carrying out the activities of everyday life. There will be the need to talk about their perceptions of women and man's role in partners relationship.

Maria, age of thirty, who has been living in a supported apartment, support by the operators of a cooperative that collaborates with the Mental Health Centre (CSM) with two other women. The operators are present in the apartment for four hours a week. After two weeks living in the apartment, she calls alarmed her psychiatrist at the CSM where she is followed for a mental health problem diagnosed as borderline personality disorder. She reports that the boiler of the apartment is out of order and that the house is cold and there is no hot water.

Problem: The problem here is how to act in a stress situation which can happened to everyone in everyday life.

Solution: People who provide professional support in the housing system need to know that people respond individually to stressful situations and that many people with mental disabilities cope worse with

stressful situations. Not having skills to cope adequately put people at risk of worsening of their conditions. Maria needs help to increase her abilities to better cope with stress and seeking help when she cannot solve the problem by herself alone.

There is the need that Maria's individual treatment / recovery plan developed in cooperation between operators in housing service as well as staff in CSM should include stress management and problem solving skills. More on problem solving see: Problem management plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity (WHO, 2016).

Laura is a 35 years old women of Romanian origin, who arrived in Italy very young, but already marked by painful experiences. Laura was abandoned by her mother when she was a child, her father was an alcoholic and was raised by her grandmother. She married when she was 18 and after the birth of her first child, she had a puerperal psychosis following which she was hospitalized, and the child was taken away and given up for adoption. She later divorced and came to Italy in search of work but was initiated into prostitution and lived on the street for a while. She had another child, also given up for adoption. Relations with relatives in Romania are very conflicting and Laura, in all the relationships she initiates, oscillates between the fear of being deceived and the desire to finally find someone to take care of her. Laura displays a paranoid attitude that makes her relationships difficult, especially at the workplace. She often tends to rely on those who promise to help her and take care of her, without carefully evaluating the person in front of her, sometimes perfect strangers whom she seems to trust blindly, putting herself in "risky" situations. The tendency to trust promises pushes her to accept underpaid jobs and conditions of exploitation, while mistrust in social services does not allow her to get help in looking for work, He currently lives with two other young women in a supported apartment (presence of an operator for three hours four times a week).

Problem and solution: The main problem of Laura is to establish trusted and safe relationship with others, therefore she need long term therapeutical relationship to help her to stabilize her psychological functioning and address her trauma experience. She has difficulties to manage her interpersonal relationships and be in control of her feelings, therefore she needs to talk with somebody with expertise in psychotherapy with whom she could established therapeutical relationship base on trust in order to help to improve her mentalization (to understand more how she project her desire for good relationship in a "head" of people without check it for the reality of their intentions). At the housing service the long term trusting relationship with staff also could help if they understand what mentalization is and how it can be supported.

Ana and Maria diagnosed with psychosis, aged between 25 and 35, both in need for housing have been treated in mental health Center. They established a good contact, so they plan to move in together in a rented apartment a few months later. Their decision has been supported by the staff in mental health center. But before that, one of the two is hired in a hospital that is far from the apartment where the girls are going to live together. This event creates anxiety for both. The girl who got job has doubts about the plan to live together in apartment. She is afraid that changed situation (she has a job, the other one is staying at home) can create, envy, guilt what can produce a problem in their relationships, therefore she want to give up from previous idea to live together in co-habitation project.

Problem: Right to make decision about where and with whom live

Solution: Everyone has the right to change their minds if they judge that for any reason for him/her is an unfavorable situation. The fears of this girl could be unrealistic, because the second girl regardless of whether she has a job can organize a meaningful life without the first girl. It is good to help the girl who has doubts to explore more the reasons why she has doubts that she can reconsider/ change her previous decision where and with whom she want to live, however she has the right to make decisions even when her fears are not realistic, as might be in this case

Giuseppe is 40 years old and has been living in a supported apartment with the presence of operators 6 hours a day for 7 days a week for two years with three other people, two women and a man, his peers. He has lost both his parents and the house he lived in with them, as he is no longer able to pay rent. He worked when he was younger. His mental health problems started at his workplace where his colleagues was teased him that he tried to look taller by putting paper in his shoes, due to his short stature. He developed a paranoid disorder and gradually isolated himself, losing contact with friends and the desire to meet other people. After a period of about three years spent in a rehabilitation facility - therapeutic community where the operators were present 24 hours a day, he agreed to move in a less supervised shared apartment with presence of operators 6 hours a day for 7 days a week. He is quite autonomous in managing the house and gets along well in the kitchen too, but he doesn't feel like engaging in outside activities. He is not motivated to find a job. In general, he feels uncomfortable with his peers who have led a "normal" life, work, have married and have children. In comparison with them it makes him feel anxious less valued. He has a negative self-identity. He also has a problem with physical health. He has problem with his heart and sleep apnea. Doctor suggests him that he should change his diet, but although he is aware that his physical problems are relate to overweight he has difficulties to maintain suggested diet. The biggest current problem is that he is unable to maintain a correct diet: he has gained a lot of weight and seems to "fill" the emptiness of his days with large feasts of pizza, chips, desserts, but also steaks and pasta that he prepares after dinner. G. is does not accept help from the operators, he perceives that the operator wants to control him.

Problem and solutions: Giuseppe has two problem one is problem with low self-esteem, self-respect and self-stigma due to his negative self-perception due to diagnose of mental illness, what make him feel depressed. This problem is also connected with his problem with weigh gain, as consumption of food function as defense mechanism to protect him from the anxiety relate to his feelings of inadequacy, that is why he has difficulties to accept recommended diet.

Giuseppe needs to get more understanding about the problem from the person he trust (operator or mental health professionals out of therapeutical community, peers), be motivated by use of motivational interview to make his decision to change perception about himself to more positive one and decide to accept weight reduction program together with the help how to handle his impulse to take the food due to food craving. It should be communicated to him in a gentle way that his health, both physical and mental is his responsibility and others such as operators and other staff, peer worker, roommates can help him in process to gain more health and achieve the recovery, but only if he can accept it as his personal goals, take active part and collaborate. It is also possible that he has given up hope that he can recover, so the first step to do is to renew hope. People need times to make decisions, therefore the people who help them must be patient, because any rush, although out of good intentions can be perceived as pressure that will result in the opposite effect. To help him to see himself as an equal citizen as other people regardless of his mental health problem he will need self-stigma reduction intervention.

WHAT TO DO IN CASE OF …

When choosing a house, is it considered whether the user has any restrictions or preferences regarding the quality of housing such as position of housing in rural or city area, roommates etc?	**This is an important point for the success of the Housing Project. It's connected to the right of every person to choose where and with whom to live. [Art. 19 CRPD] The conditions for this do not always exist. It will be the responsibility of staff who decide about the option of housing to talk openly with person in need of housing about of possibility in real life situation and together decide whether it is preferable to remain in the current situation or move to the new home, even if it does not fully meet the user's wishes.**
How does participation in the Housing Programme affect access to mental health care for homeless people with mental disorders?	Regardless of a person's economic or social situation, every person has the right to optimal treatment based on informed consent, therefore there must be no restrictions regarding access to mental health care. Users should be informed that there are accommodations that require treatment and those that do not require treatment
How much do participants contribute with their monthly income?	It depends on country regulation how housing has been paid. The users of housing service should be fully informed about who pay the housing cost for example who pay the rent for house, food, hygiene needs, clothing, cultural and social needs. Depending on the country, you can receive precise information on this issue, by contacting the Social Services or mental health workers who take up housing.
Which actions can be developed by family associations to claim for the lack of enough housing/ mental health services according to needs of persons with serious mental disorder?	In every country there are national and local bodies that are responsible for organising housing for people with serious mental disorders, there are also different national and international guidelines for developing housing services as well as services in the field of mental health, therefore families individually or through associations can request that these guidelines are respected and an implementation plan is made
User satisfaction is an essential for quality of housing and mental health services. How to test user satisfaction with service quality?	Social services and mental health services should be familiar with instruments for testing satisfaction of users, use it on regular bases and discuss the results of investigation in order to use it for improvement of quality of care.
When the legislation exists, but it is not implemented in practice What is the role of civil society?	Civil society, associations and the services involved have the responsibility to request and stimulate the responsible institutions to implement the laws.

Is it legal for an employer to demand that a person should undergo a medical examination in order to determine whether or not is suffering from a mental illness or not?	The employer does not have the right to find out if the person is being treated for a mental disorder. The diagnosis of any illness is a private information and this privacy is protected by law. In most countries if an employer suspects that person has some health problems that prevent him to work, including mental ones, refer the person to specialist for occupational medicine or general practitioners depending on the national legislation, who will then write a certificate that the person is able or not able to work, and will not write a diagnosis of the disease.
When a pupil/student shows signs that something is not well how can he/she be referred for help? Is it OK to do this without letting him/her know?	No one without their consent, except in situations regulated by law, can be referred for an assessment of their health condition, including mental health. As a rule, for a minor child, especially at an early age, the parent should be informed
When someone is referred for training should he/she mention that he/she is experiencing mental health problems?	No one is obliged to reveal their diagnosis, it is their private matter whether they want it or not
How to deal with the situation of a user who has a serious loss and lives in the house with others?	Staff should have training on how to act in crisis situations, how to reduce anxiety and provide support. Other residents should also be educated on how to provide support to a person in crisis. People who have a mental disorder should have access to interventions that increase resistance to stress, which they can use in different stressful life situations.
How to deal with the situation of a user who finds work and leaves the other for a long time at home alone.	The employment of a person with a mental disorder should definitely be supported, it should also be assessed when people leave the housing service or change to more independent one, whether that person needs specific support from a professional at the workplace as well as the support from mental health service. The person should be informed about this and helped to reach the necessary services that they will need to maintain their job as well as the mental health.
What to do if a roommate gets engaged in romantic relationships and the previous balance breaks?	People have the right to romantic relationships, if the deterioration of mental health state is linked to entering a romantic relationship, then it is resolved like any crisis, which is always an opportunity to learn something from it.

How to help apartment guests to maintain a proper diet?	The issue of diet is also a personal issue. First a person should decide that he wants to change his diet and seek support. After that, it is necessary to make an agreement on the implementation of the nutrition as well as physical activity plan and how to resolve crisis situations of difficulties in fulfilling the plan. Any failure to reach an agreement should be treated as a learning experience that will help in the long-term implementation of the plan
What to do if a user who lives with others puts themselves in "Risky" situations (like: like to accept underpaid jobs and/or conditions of exploitation, etc.)	Every person has the right to risk. The person who provides support should be open to talk with the user about the situation, give his opinion and help him decide about what to do in that situation.
What to do if there are conflicts between the inhabitants of a house, due to the entry of a new user.	The staff should have training on how to resolve conflicts, allow everyone to express their opinion and, after discussion, propose a solution that is realistic in the given situation. Resolving conflicts in real situations is an excellent way of in vivo training of social skills necessary life skills important for independent living
What to do when an apartment is kept in very neglected condition?	The basic question is whose responsibility is the maintenance of the apartment, whether the person can do it alone, does he need support for it, or is it someone else's responsibility. If it is the person's responsibility, it is necessary to discuss the reasons for the difficulty of maintaining the apartment and seeking a solution, or through increasing the ability to maintain and/or organize support.
What to do when someone in the house does not respect the agreed rules (shifts of house cleaning, personal hygiene, respect for common areas, etc)	It is always necessary to discuss why someone does not follow the rules and to find an agreed solution to follow the rules. The rules should also be reviewed to see if they are in line with the principles of recovery and respect for human rights. Flexible rules should also be considered in relation to someone's health condition. When housing service includes rehabilitation, then it is possible to discuss this problem at a meeting of the therapeutic community. Likewise, everyone should know the consequences of non-compliance with the rules in terms of termination of housing service.

What to do when there is a conflict due to different lifestyles associated with belonging to different cultures?	The Housing programme should be responsive and respectful to the cultural, gender and value needs of diverse people and groups. These culture differences should be disscussed wihin the housing program in order to increase mutal understanding and acceptance of persons wiht different cultural bacground or even to be enriched by different culture.

APPENDIX

HELM OF RECOVERY

COMPRENHENSIVE APPROACH TO MENTAL HEALTH AND RECOVERY

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Helm of recovery in mental health is a tool that helps in determine the recovery goals and develop an individual treatment or recovery plan for people with mental health difficulties, as well as to select the interventions which can help to achieve the identified treatment/recovery goals. Helm of recovery is founded on holistic approach of understanding the protective and risk factors that influence mental health, principles of recovery defined by SAMHSA, assessment of functioning according to the WHO international classification of functioning and recommendations from WHO QualityRights. It includes three areas of recovery: recovery from the symptoms, recovery of functioning, and recovery of identity.

With the Helm of recovery it is possible to evaluate the conditions in life areas that are important for recovery, to assess the areas that need improvements or changes, to chouse priority areas for improvement, follow the advancement toward defined goals in different time periods, as well as evaluate the results and modify the goals. It can be used by experts in assessment of psycho-bio-social factors that contribute to development of mental health difficulties and in developing the treatment plan, and by people with mental health difficulties in developing the personal recovery plan.

All people that use the helm of recovery should be familiar with the principles of recovery. Recovery is not the same as medical term remission relate to full recovery from symptoms and functioning, but relate to the process of personal strengthening and managing one's life in a way that enables the achievement of personal goals, living with the sense of purpose and experience of belonging to the community, whether the person still has some of the symptoms of mental health difficulties or/and some of the difficulties in functioning.

Instructions for use

Assessment of the current condition- use Table 1 to assess the condition in ten areas described in Helm of recovery. Range from 0% to 100% for each area, where 0% marks the worst condition, and 100% the best possible condition. The point of comparison is expected functioning of average healthy person in the area of assessment.

When the Helm of recovery is used for planning of treatment/recovery, the percentage should be agreed upon with the person whose condition is assessed. Mark the results of the assessment in the table 1 and/or on the graphic diagram of the Helm.

It should be noted that the assessment of recovery areas at recovery helm might differ between the assessment of expert and the assessment of the person with mental health difficulties.

Table 1 Area of assessment and assessment results

Note: Before the assessment, explain to the person what recovery is and ask what recovery would mean to them

Area of assessment & description	Questions to ask to develop a treatment/recovery plan and record the result on a scale from 0% to 100% Note: the questions are indicative, adapt them to the situation. After the assessment to develop a recovery plan ask: **Do you want to change anything in this area? What could help you with that? Also suggest what you think might help**	**Results** **1-100%**
Symptom control, physical health and healthy lifestyle- this refers to assessment of mental health difficulties /symptoms of an illness, physical health and a healthy lifestyle. It includes control/managing symptoms of mental health difficulties with the help of medications and/or psychosocial methods, collaboration in treatment, taking care of one's physical health and adopting a healthy lifestyle. Removal of symptoms, diminishing and successfully managing symptoms are important for mental health of many people in recovery.	Do you have mental health difficulties/symptoms of mental illness? What are the difficulties? How do you deal with them? What helps you? How do mental health difficulties affect your life? How is your physical health? Are you physically active and do you follow the recommendations for a healthy diet?	
Hope and optimism for the future - hope and optimism are always a priority, because without hope people can give up on recovery. Hope is the engine of motivation to change. Hope relates to the belief that change is possible as well as that there is always a solution for any difficult situation, no matter what happens. Hope and optimism for recovery must encompass those who receive help as well as those who provide help. When a person feels helpless, when hope is lost, when there is no motivation for change- the first step of formal and informal helpers must be renewal of hope that recovery is possible and encouraging the motivation to change.	Do you believe, and to what extent, that you can recover from a mental disorder? Do other people in your environment (mental health professionals, family, friends and others close to you) believe that you can recover?	

Purpose, meaning of life and motivation to change- refers to recognition and support of personal values, worldviews, traditions connected to purpose and meaning of life. Purpose and meaning of life differ from person to person. People find meaning in different ways, and religion is a significant source of a sense of purpose, but meaning is also found in daily activities such as job, education, creative work, family life, social activism, and many others. Personal plans and wishes can empower persons in finding meaning in their life. Purpose and meaning of life can be a strong motive to start the recovery process. Formal and informal support providers should support people in finding their meaning in life and motivation for change	What are your values that drive your motivation to achieve life goals and satisfaction in life? If you don't see them now, what were your values before? Has the mental illness affected your life perspective? What would you like to restore? Supporter must be careful not to impose their own values, but to encourage the values of the person they support.	
Identity, self-esteem/self-respect and empowerment - Identity is connected to perception of oneself as a person in relation to others and the community in which the person lives. Assessment is related to positive or negative perception of one's own identity, as well as "patient identity ", and regulation of self-esteem and self-respect in situations of perception of threat to self-esteem and self-respect. Positive experience of oneself as a person capable of achieving goals, worthy of respect, accepted and respected by others is connected to mental wellbeing and feeling of empowerment, contrary to experience of oneself as person less valuable and incapable of achieving goals, disrespected and rejected by others which is connected to risk for mental disorders. Personal self- perception as an individual with mental health difficulties is often connected to self-stigmatisation and marks the experience of a negative, less valuable self-identity. There is a a self- identity transformation due to the fact that diagnosis of mental illness is experienced as a weakness of character. The empowered person is free from self-stigmatisation, experiences the difficulties in mental health as just one of his/her traits that is not a dominant trait of a personality in their life, because he/she has many other traits in comparison to „patient identity" in which an illness becomes a dominant trait of his/her personality. Activities that encourage building/rebuilding a positive identity and improve self-esteem and self-respect are crucial for improvement of mental health and recovery from mental illness.	How would you rate your self-confidence and belief in your abilities? How much has your mental health condition affected your self-confidence and self-esteem? Do you feel that others respect you, respect your opinion? Do you believe you are less valuable because you have a mental disorder? Do other people treat you differently because they know you have a mental disorder?	

Trauma, coping with stress and resilience - refers to the influence of a person's traumatic experiences and/or negative life events (in the past and present) on the condition of his mental health, his resilience to stress, his degree of tolerance of usual everyday life stress, his ways of reacting during anxiety and stress (defence mechanisms and coping skills), as well as on the assessment of the need for interventions that increase the resilience to stress. Coping with stress and the anxiety it produces is key in the protection of mental health and prevention of mental health difficulties. Therefore stress management and increasing resilience to stress is one of the key interventions in the protection of mental health, promotion of recovery and reduction of the risk of developing mental health difficulties, including the prevention of episodes of mental disorder.	Have you had negative experiences during your childhood, youth or adulthood that you consider to have had a negative impact on your mental health? How do you react in stressful situations? How does stress affect your mental health? Are you scared, worried, withdrawn, unable to function etc?	
Skills for independent life - relates to having capabilities and skills important for independent life in the community, which includes self -care, social skills, functioning in expected social roles, and using the resources of the community in social inclusion. *Self-care* includes abilities to maintain the activities of daily routine such as personal hygiene, appropriate nutrition, buying groceries, keeping a budget, tidiness, cleaning one's own place, safety in the house, taking care of one's health, cooperation in a treatment protocol and using public transport, and other activities important for everyday life. *Social skills* include: ability to communicate and interact with others, expression and control of emotions, problem solving and conflict resolution and functioning in family, workplace, education, and social roles. *Usage of community resources* refers to assessment whether and how the person uses the community resources to acquire a sense of belonging in the community which encourages recovery. Skills and independence are key factors for many people in recovery- they enable people to take control of their own lives. Recovery means managing difficult situations, and developing the skills needed to manage negative life situations. In the process of recovery, many will need support in different areas of life in order to be able to live in the community on an equal basis with others.	How do you assess your skills in carrying out the usual daily routine activities such as personal hygiene, shopping, taking care of the household, communicating with people? How independent are you in performing these activities, do you perform them yourself? Do you need support in carrying out your daily routine, social contacts and other activities? How does your mental health affect your life skills?	

Housing - the conditions of housing are assessed, including homelessness and the quality of interpersonal relationships in the household. Providing suitable living conditions, with support in independent living and inclusion in the community, when necessary, promotes recovery.	How satisfied are you with your living conditions? Do they affect your mental health? Do you need help with household chores, socializing with other people in the community, organizing your free time etc?	
Job, education, income, benefits - refer to the motive of work and education, assessment of the need for professional or educational support, the right to disability benefits and a liveable income and the influence of work environment on mental health.	Are you employed or studying? Do you have difficulties at work related to your mental health? Do you want to find a job or get an education? How does your work status-schooling affect your mental health? Do you have any financial income related to mental health problems, disability, etc.? Does your financial situation affect your mental health?	
Relationships, support and social inclusion - Quality of relationships with others, experience of connectedness with others, including support, acceptance and social inclusion are important for recovery. Relationships and connectedness with others include informal and formal relationships like with members of the family, close friends, intimate partners, work colleagues, neighbours, therapeutic relationships with mental health professionals, peer workers, social and healthcare providers. People can hardly recover without support. Support includes understanding, respect, encouraging hope, not criticising, support in independent decision making, active involvement in treatment and other life activities, as well as instrumental support in activities that the person has trouble performing alone. The person is given support always in those areas that she needs, wants and asks for. People who help persons with mental health difficulties, whether they are informal or formal supporters, are fellow travellers on the way of recovery. People who support the process of recovery, including the mental health professionals, should always ask themselves whether they are helping or not helping the process of recovery. Social inclusion refers to using the resources of community connected to work, leisure activities, social contacts - it is the prevention of social exclusion that is related to ill mental health. Activities in the community might be: sports, cultural, political activities, volunteering, education, inclusion in a faith community or group of friends, also the involvement in treatment	Are you satisfied with your relationships with family, friends, coworkers, neighbors? How do your relationships with others affect your mental health? Do you wish your relationships were different? What would you like to change? Do you feel that you belong to the community where you live? Do you feel excluded from the community?	

programs and social inclusion in any formal or informal system of mental health care.		
Responsibility - refers to the personal responsibility of a person with mental health difficulties in fulfilling obligations and participating in different activities that are important for recovery, including making decisions, relating to others, treatment, social inclusion, as well as responsibility of others in providing the resources for facilitating recovery. Personal responsibility might refer to things such as responsible financial behaviour, maintaining good relationships with people, doing the chores at home, taking responsibility for their actions and decisions, health, medical procedures, way of life and obeying the law, it also includes the right to risk, but accepting the consequences of that risk, and learning from these situations. Leading their own life, choosing between options and make decisions in important areas of life, including health and housing is key in recovery. It includes the right to make your own decisions with or without the help of others. Assessment of others' responsibilities such as health services and employment are connected to availability of services that facilitate recovery including the availability of support in community.	How do you assess your responsibility for/involvement in improving your mental health, setting recovery goals, creating a recovery plan, and taking respective action ?	

Individual treatment/recovery plan

Use table 2 to develop an individual recovery plan.

Choosing priority areas of change and goals that the person wants to accomplish- After the assessment chose the areas where person wants changes and identify specific goals and actions that can contribute to change/recovery.

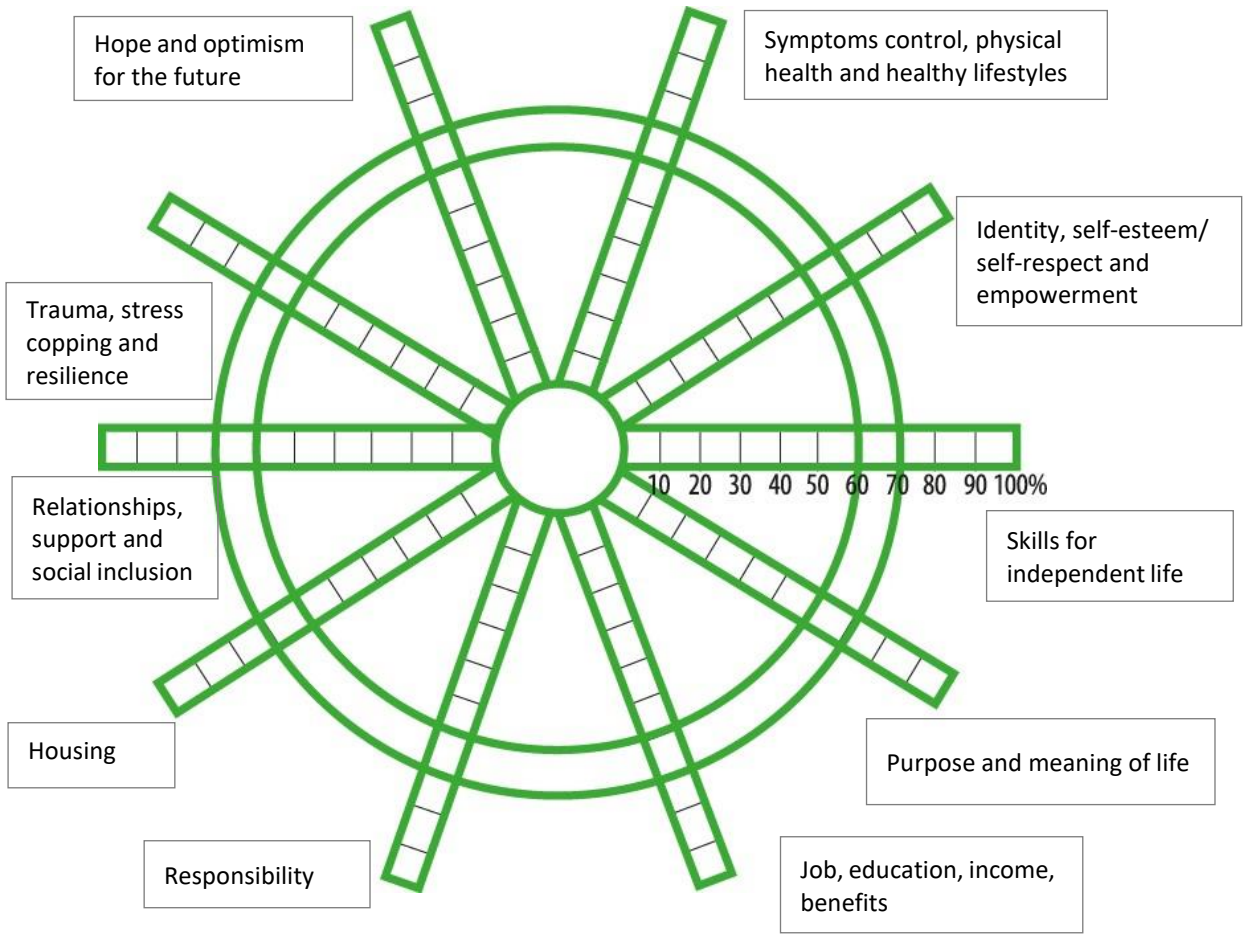
The choice of actions that contribute to change/recovery- actions in the plan of treatment/recovery include different psycho-bio-social modalities of treatment, support, collaboration with different services outside of health and using the resources of community that contribute to recovery. The choice of actions will depend on assessment of reasons (psycho-bio-social) that contribute to difficulties in certain areas. For example, reasons can be connected to symptoms of an illness, lack of motivation, lack of skills, difficulties in interpersonal relationships, social isolation, unemployment, inadequate housing, stigma, lack of support and other. It is important to mention that the improvement/change in one area of helm can influence changes in other areas, for example employment can lead to improvement of mental health, housing conditions and increase of connectedness with others.

Table 2 Individual recovery plan

Note: An individual treatment/recovery plan is an agreement between the person with mental health condition and the mental health professional or team on the treatment/recovery goals, the choice of interventions to achieve the goals, and the persons and other services that will be included in the implementation of the treatment/recovery plan.

Area of assessment	Baseline (%)	Intervention priority and plan	Re-evaluation (%)	Comments
Control of mental health symptoms, physical health and healthy lifestyles				
Hope and optimism				
Purpose and meaning of life				
Identity, self-esteem/self-respect and empowerment				
Trauma/stress coping and resilience				
Skills for independent life				
Housing				
Job, education, income, benefits				
Relationships, support and social inclusion				
Responsibility				

HELM OF RECOVERY



You can download the Helm of recovery at https://www.dropbox.com/s/4orw8798skc71dc/helm-EN.pdf?dl=0

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GLOSSARY

Advance directive Every person of legal age shall have a right to make advance directives with regard to health care interventions specifying any or all of the following, namely: (1) the way the person wishes to be supported and treated; (2) the way the person wishes not to be supported or treated; (3) the individual or individuals, in order of precedence, they want to appoint as their nominated representative or supporter to make or communicate decisions on their behalf. The document shall state the moment or circumstances in which the advance directives enter into force.

Befriending is an intervention based on the involvement of a volunteer or peer worker who meets and talks with someone with a mental health problem usually once a week. The befriender may for example accompany the befriend on trips to broaden their range of activities and offer practical support with ongoing difficulties

Biopsychosocial formulation (PBS) is a hypothesis about understanding how the episode of the mental disorder developed based on an assessment of the interaction between psychological, biological and social factors within the unique life history of the patient.

Case management applies to people with mental illness with long-term difficulties in recovery, with serious difficulties in functioning. It includes working with patients in different community services and their homes, comprehensive assessment of patients' health and social needs, coordination of different services within the mental health system and those from the patient's own natural environment, placing the patient in the center of attention in order to help him achieve his or her own personal goals and find their own personal way of recovery.

Case management involves frequent in-person contact between the case manager and the person and their family (if it is appropriate), with sessions occurring in clinic, community, and home settings, as required. Case management role also includes development of a recovery plan, in agreement and reviewed with the involvement of the person, their family members or carers (as appropriate). The number of patients for each case manager**,** case load, depends on the severity of illness and the patient's disability levels. Case managers take on the responsibility for long-term maintenance of supportive therapeutic relationship regardless of the patient's location and the number of other services involved in patient's treatment.

Evidence-based interventions (EBP) are practices with consistent scientific evidence showing that they improve client outcomes. Adequate education is required to provide any of evidence base interventions.

Family interventions/therapy addresses the problems people present with in the context of their relationships with significant people in their lives and their social networks. The focus of family therapy treatment is to intervene in these complex relational patterns and to alter them in ways that bring about productive change for the entire family.

Illness management and recovery (IMR) is a manualized evidence-based treatment focused on teaching illness self-management to people with serious mental illness. The emphasis is on recovery by helping clients set and pursue personally meaningful goals. The aim is providing information, support, and skills to help the patient manage their mental illnesses and move forward in their own recovery process. IMR includes 10 modules that deliver psychoeducation about mental illness, cognitive-behavioral approaches to medication management, planning for relapse prevention, social skills training to strengthen social support, and coping skills to manage symptoms of mental illness. (Gingerich & Mueser, 2005).

Informed consent involves informing the patient about all the important facts they may need to make a decision about treatment, or give consent to treatment which includes: information about their illness, the treatments recommended, the benefits as well as the harms that could arise from the proposed treatments, what are the other possibilities what will be the consequences if they refuse the treatment, as well as an information that he/she has the right to withdraw consent .

Individual Placement and Support (IPS) is a new model of supportive employment for people with severe mental illness (SMI) which aims to help people with SMI acquire a regular job in a competitive job market or start/proceed with standard education. The main difference to traditional methods is "first place, then train" with the person providing IPS (the job-coach) trying to help the person to find a regular job and then providing support during employment (either directly on the work floor or behind the scenes). The work reintegration process occurs simultaneously with other aspects of psychiatric treatment. The IPS job coach keeps contact with the person during this whole process as well as with the mental health team and the employers.

Individual Treatment/recovery plan is an agreement between the therapist or team and the patient on the goals of treatment/recovery in which patient's preferences are considered to be a priority, along with treatment procedures that need to be applied to reach identified goals, as well as professionals and other persons who will help in achieving the goals. The individual treatment plan is made on the basis of a free informed consent. A treatment/recovery plan must be evaluated continually.

Peer support is social and emotional support and at times instrumental support that is offered or provided among people with the same or similar mental health problems in order to achieve the desired social and personal changes. Peer support is provided by trained peers, who have recovered from mental illness and are stable. Trained peers should be supported by the team, and supported and mentored by experienced trained peers.

Person with Serious mental illness (SMI)/ complex mental health needs has a severe mental disorder in need of treatment, not in remission; person has severe limitations in functioning in various domains of life; There is a long-term condition ; There is an indication for a coordinated network of professionals and services.

Promotion of mental health and well-being - Mental health promotion promotes positive mental health by increasing social and psychological well-being, competence, resilience, and creating supportive living conditions and environments. World Health Organization (2013)

Psychosocial rehabilitation (PR) consists of combinations of evidence-based psychosocial interventions aim to facilitate recovery. Psychosocial rehabilitation services focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice. Rehabilitation focuses both on the abilities it seeks to build, and the disability it seeks to overcome or help compensate by organised support.

Self-management

The World Health Organization (WHO) describes self-management as putting patients or service users in direct control of managing their conditions by enabling them to cope in one or more of the following areas; problem solving, goal setting, identifying triggers, and indicators of deteriorating health; and responding to these themselves before relying on clinician-led intervention". (Crepaz-Keay, 2010). Self-management has been provided through self-help books and self-help programs that are offered over the Internet (e-health). It has demonstrated its efficacy in wide range of mental disorders.

Social skills training refers to methods that use the principles of learning theory to promote the acquisition, generalization and durability of skills needed in social and interpersonal situations. It's a manual based intervention aims to increase different types of skills needed for everyday functioning. The goals include improving social performance, reducing stress and difficulty in social situations and improvement in the functioning in different social roles (e.g. family, work, and community). Training should be focused on a specific area of deficit and provide learning opportunities of specific behavior selected to be improved.

Social skills training starts with a detailed assessment and analysis of the performance of individual social skills, followed by individual or group interventions, using positive feedback to boost self-confidence and performance, determine goals and shape behavior. Training should take place in the context of real everyday life experiences, not in closed, unrealistic settings. Goals include improving social performance, reducing stress and difficulties in social situations, and improving functioning in different social roles (for example, family, work, community).

Training should be focused on a specific area of deficit which should be improved and provide systematic learning opportunities of specific behavior that is important for being successful in social interactions. Skills are learned through a combination of therapist demonstrations that serve as a model for interactions, videos, role-play, positive reinforcement and corrective feedback, and homework assignments practised between the sessions. Homework is usual to help practice skills "in vivo" outside the therapy situation Social skills training can be performed individually, but is usually carried out in small groups of 6 to 8 patients. Numerous studies have confirmed the effectiveness of social skills training. Social skills training is used in people in whom a lack of skills is associated with mental health difficulties regardless of the diagnosis of the difficulties. At the end of the training patients are encouraged to practice the newly learnt skills in daily life.

Support is part of all therapeutic interventions. It is a non-specific therapeutic approach that is part of the various treatment interventions. Support means showing interest for people who need help and the desire to help them. Supportive relationships provide empathy for what patients are experiencing, give them comfort, hope and trust in the person's ability to solve their problem

Supported decision-making is a form of assistance to facilitate the exercise of legal capacity of person who has difficulties to make decisions, that entails support in: (1) understanding the options, responsibilities, and consequences of a person's decisions; (2) accessing, collecting, and obtaining information that is relevant to a given decision; (3) understanding such information; and/or (4) implementing the person's decision, including assistance in communicating the person's decision vis-à-vis third parties.

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Suggested Links

- SANE Australia
- Time to Change
- Opening Minds Canada
- Like Minds Like Mine in New Zealand
- ONE of US
- KeyRing Network Mode, UK, Ireland