



# MENTAL HEALTH AS PUBLIC GOOD

## Psychosocial interventions in mental health





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# MENTAL HEALTH AS PUBLIC GOOD

## Psychosocial interventions in mental health

The Republic of Croatia holds the Presidency of the Council of the European Union from 1<sup>st</sup> January 2020 to 30<sup>rd</sup> June 2020. During its presidency, Croatia set its health priorities, in accordance with the health policies advocated by the EU. (Taking forward the Strategic Agenda - 18-month Program of the Council (January 1st 2019 - June 30th 2020 Available on <https://www.consilium.europa.eu/en/council-eu/presidency-council-eu/>). One of the health priorities that the Republic of Croatia singled out during its presidency is: the promotion of lifelong care for the health of the individual. As part of this priority, the protection of mental health is one of the most important priorities in public health care to ensure optimal access to health care for all EU citizens. Health is of particular importance, especially in the circumstances that marked Croatia's presidency of the EU Council, such as the COVID19 pandemic and the earthquake in Zagreb on March 22<sup>nd</sup>, 2020. During its presidency, Croatia decided on the topic of mental health in order to emphasize the importance of mental health as a public good and to encourage the implementation of EU strategies and recommendations in the field of mental health.

The Mental health as public good – Psychosocial interventions in mental health booklet was created by mental and public health experts during the Croatian presidency of the Council of the European Union as Croatian contribution to the European path to mental health. The purpose of the booklet is to encourage EU member states to view mental health as a public good, a key part of sustainable development, stability, and social capital that builds communities of satisfied citizens who in return contribute to the development of society as a whole by taking appropriate actions.

The main goal is to encourage the setup of mental health care through the implementation of various psychosocial programs and interventions that contribute to better mental health, prevention and treatment of mental disorders, and encourage the development of new programs and interventions. In order to encourage governments, experts and all relevant stakeholders in the field of mental health care to analyze the

current situation and encourage positive changes, but aware of the fact that there are significant differences among EU Member States, we have listed evidence-based and/or good practice psychosocial interventions which can be useful in both analyzing the current situation and creating action plans that will result in improvements in the promotion, prevention and treatment outcomes, as well as the implementation of good practices that can change the lives of many people. In the selection of psychosocial interventions we used sources cited in the publications of the EU Commission, EU – Compass for Action on Mental Health and Wellbeing, WHO, Lancet committees, international guidelines for the treatment of mental disorders in clinical practice, scientific publications that include meta-analyses, randomized and control studies and other sources.

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## Letter of Support

The European Psychiatric Association promotes a treatment approach that combines biological (mostly medications and brain stimulations) and psychotherapeutic interventions (such as psychoeducation, family therapy, motivational interview, cognitive behavioral therapy, mindfulness and remediation cognitive therapy... to name just a few most frequently used). An interesting aspect of this booklet is that it also includes psychosocial approaches such as physical exercise, skill training, social activities and group support, which are being used widely, but sometimes aside the usual care. We now have more and more evidence of their significant benefits, meaning all clinicians should be acquainted with these approaches, and the present booklet offers a nice support of the advantages of combining biological, psychosocial and psychotherapeutic approaches.

The recent delivery by the EPA of multiple online open courses for motivational interview and cognitive behavioral therapy is an example testifying that these approaches are considered crucial for the holistic treatment of patients with mental health disorders.

There are now many psychotherapeutic approaches, some of them with overlapping technics such as ACT, CBT or MBCT. Because not all clinicians are familiar with them, and because there are so many abbreviations in the literature, I have no doubt that the included and detailed glossary will be widely used.

We are therefore very happy to congratulate the editors and authors for their booklet which not only describes and promotes evidence-based psychosocial and psychotherapeutic interventions, but also remind us all of the need for individualized treatment plans that target empowerment and recovery.

Indeed, increasing the level of functioning and promoting resilience are important pathways reducing the burden of the disorder, diminishing the frequency of relapses, and has potentially preventive virtue.

If these interventions are proposed early enough in the process of the disorder – ideally during the presence of prodromes, subthreshold symptoms or even in vulnerable groups of patients, rather than when facing already established disorders – we could tackle the factors that are involved in the onset of mental health disorders.

Before getting techniques or agents able to prevent disorders, and as suggested by the authors, we should facilitate psychoeducation, avoiding risk factors, promoting resilient agents, and act against stigmas that are too frequently associated with psychiatric disorders. All these approaches and techniques are well described in the present booklet, which EPA is happy to support and promote.

*Professor Philip Gorwood*

*EPA President*

# 1. Mental health and mental disorders

Mental health is an integral part of health and it is more than just the absence of a mental disorder. Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community (WHO, 2013). It is important to understand mental health as a personal and social treasure from which we draw numerous incentives for personal and social growth and achieve good results that are more than economic gain. It is important to know that we are not automatically born with good mental health, but that we achieve it by interacting with our environment that can encourage or impair the development of mental health. Likewise, we can always improve it in a positive process of interacting with our environment where the quality of our interpersonal relationships is one of the key factors for positive mental health and recovery from mental disorders, along with numerous other resources that protect mental health.

Mental health is the capacity of each and all of us to feel, think, act in ways that enhance our ability to enjoy life and deal with the challenges we face. An aspect of good mental health is connected to self-realization, satisfaction with life, autonomy, the capacity for mutually satisfying and enduring relationships. Support and enhanced resilience are the core components of fostering positive mental health. People who are more resilient to stress have the tools for coping with difficult situations and maintaining a positive outlook. They remain focused, flexible, and productive, in bad times as well as in good times. Their resilience also makes them less afraid of new experiences or an uncertain future. Mental health can be regarded as an individual resource, contributing to the individual's quality of life, and can be increased or diminished by social activities.

Mental disorders and positive mental health are reciprocally related. Increase in positive mental health, prevention of mental disorders and their successful treatment affects mental health in general, therefore it is important to work on the promotion of mental health, prevention of mental disorders and their successful treatment because these are aspects of mental health that can be changed by our interventions.

Helping those affected from mental disorders in increasing their positive mental health can help them to recover.

One of the main obstacles to the promotion and prevention of mental health, and better organization of treatment and the development of services that can improve mental health is the way people think about mental health. Mental health is regarded as something that simply is, i.e. if a person has some sort of mental disorder it is seen as a character flaw, not as a condition that is the result of different influences, i.e. as mental health problems from which a person can recover. Today we know that there are risk and protective factors related to mental health that may have impact on the development of mental disorders as well as on the recovery from mental disorders. (Saxena, Jané-Llopis, Hosman, 2006) Risk factors are associated with an increased likelihood of occurrence, greater intensity or longer duration of mental health problems. Protective factors refer to conditions that improve people's resistance to risk factors and the development of mental disorders.

Protective factors are associated with early relationships, positive empathic bond between mother/parent and child, self-confidence, feeling of having control of your life, a sense of security, skills for managing your life, social skills, ability to cope with adversity, problem and conflict solving, responsibility, tolerance, autonomy, creating and maintaining positive interpersonal interactions, social networks, social support from family and friends, sense of belonging to a community and social inclusion, education, socio-economic security and other.

Risk factors include child abuse and neglect, childhood trauma, exposure to violence, peer rejection, social isolation and discrimination, conflicts in the family, lack of social skills, lack of working skills, stressful events the person has difficulty coping with, problems with education, housing, unemployment, living in a dangerous neighborhood, poverty, care for the chronically ill, war stress, stress at work, stress mothers experience during pregnancy, biological predisposition to mental disorders and other .

The biomedical model of understanding mental disorders that has long been present and unfortunately is still prevalent in some psychiatric practices has shifted towards biopsychosocial approach and now forms the basis of modern psychiatry.

## **1.1 Brain-mind interactions**

Today we know that the mental health of every person can be affected by several social, psychological and biological factors throughout the entire life cycles. The most sensitive period regarding mental health is early childhood, and the trauma from this period can have consequences on mental health in adulthood. There is a growing body of evidence influencing our understanding of a child's brain development and the impact of early interpersonal interactions/ attachment on his or her future health and well-being (NICE, 2012 NICE, 2013, National Scientific Council on the Developing Child, 2004). These evidences give us good arguments for implementing prevention programs at an early age that are healthy and economically viable.

Looking at the occurrence of mental disorders as the result of dynamic interaction among biopsychosocial factors is of paramount importance for promoting mental health, preventing mental disorders, early detection, treatment and recovery. Our genes and our brains are always in interaction with their environment that affects them. Our brain is not only a biological organ, but also a biopsychosocial authority reacting to biopsychosocial factors that may favorably or adversely affect its balanced work from conception to death.

Numerous studies show that early and adverse developmental conditions such as emotional trauma significantly impair psychological development and mental health, and that the link between the brain and psychosocial factors is reciprocal and reversible. Favorable psychosocial circumstances, as well as effective psychosocial interventions at the level of a prevention can significantly affect our mental health and become good emotional "food" for our brain. We now know that our brain permanently retains the ability of neurogenesis – the creation of new neurons and neuroplasticity – the ability to adapt to the stimuli of either psychosocial or biological nature; therefore, anything that promotes positive mental health and prevents mental disorders will be stimulating for balanced brain function that contributes to mental health. It is important to go forward in raising awareness on the importance of psychosocial factors for mental health. Socio-economic and psychological factors of the environment in which people are born, live, go to school, work, age and die can have a protective or risk impact on mental health.

Our mental health is determined by dynamic interaction among biological, psychological and social factors throughout our lives, and the reduction in risk factors as well as the rise in protective factors in order to protect mental health as an individual and public good are a permanent objective at the individual and social level. Adverse socio-economic conditions and lack of adequate treatment have a strong impact on the physical, mental and cognitive consequences early on and later in life. Exposure to multiple risks is particularly harmful due to the accumulation effect.

## **1.2 EU policies and recommendations in the field of mental health**

In the European Union, mental health is recognized as a public good, important for sustainable development, productivity, economic prosperity and the stability of a society that empowers individuals and communities. This message is continuously transmitted to the Member State through a series of documents ([https://ec.europa.eu/health/non\\_communicable\\_diseases/mental\\_health\\_en](https://ec.europa.eu/health/non_communicable_diseases/mental_health_en)) in order for them to take action regarding mental health protection, prevention and effective treatment of mental disorders.

In cooperation with other international organizations such as the World Health Organization (WHO) and the Organization for Economic Co-operation and Development (OECD) and international associations that represent the interests of mental health service users such as Mental Health Europe (MEH) and the Global Alliance of Mental Illness Advocacy Network GAMIAN – Europe, the EU persistently encourages states to take action at the national level to improve mental health of the population. However, it is true that despite the existence of evidence of effective and cost-effective interventions for the prevention and treatment of mental disorders, many people with mental disorders in the EU still do not receive adequate treatment and preventive interventions are insufficient. (The European Framework for Action on Integrated Health Services Delivery, 2016; Patel et al., 2018) There are many benefits from providing activities related to mental health promotion and the prevention of mental disorders and they can be expressed in figures such as reduction of the economic burden of disease due to loss productivity, the number of days spent on sick leave and/or treatment, human destinies such as reduced number of suicides, reduced

disability and other indicators that affect the quality of life of individuals and the entire society.

Economic indicators show that actual costs incurred by poor mental health climb up to billions of euros per year, and the investment in mental health protection could be returned several times over, not only by reducing these costs, but also by building a society worthy of mankind.

Unfortunately, many valuable recommendations printed on thousands of pages of various documents, easily available online, remain only fancy words we have no use for if they have no impact on the lives of people. Therefore, joint efforts are needed to help make the recommendations a part of real life in all Member States, and especially to encourage those who are lagging behind in their implementation. The role of the EU community is to raise awareness of the need to take different actions in the interest of mental health as a public good and show perseverance on the EU path to mental health.

The need to include mental health among the first priorities of public health programs was recognized by the European Union at the launch of the Commission's Green Paper on Improving Mental Health in 2005. Since then, we have been working continuously on a common EU strategy in the field of mental health. In the EU, mental health is a priority from the perspective of mental health promotion, prevention and treatment of mental disorders, and numerous documents with recommendations have been adopted with the aim of improving mental health and organizing treatment and care for mental health patients. Recommendations refer to the development of an efficient and coordinated system of mental health care in the community, with various available institutions and services covering the needs of citizens, including the possibility of treatment through mobile teams at home, rehabilitation services, treatment in general hospitals, cooperation among various sectors including collaboration with service users and their families, increasing the competencies of family physicians for the treatment of mental health disorders, multidisciplinary approach, encouraging the principles of empowerment and recovery, implementation of evidence-based interventions, development of clinical treatment guidelines, application of least restrictive treatment. Recommendations are given for mental health protection at workplace and at school, for the prevention of depression and suicide, for maintaining physical health of people with mental disorders, mental health throughout life, online

mental health. The recommendations also advocate for human rights, fight against stigma and discrimination and the availability of peer-to-peer services provided by people who have experienced mental disorders. Member States are also encouraged to implement the objectives of the WHO's Global and European Mental Health Strategies and Action Plans, as well as the obligations arising from the UN Convention on the Rights of Persons with Disabilities. The EU – Compass for Action on Mental Health and Wellbeing project was conducted from 2015 to 2018 and was dedicated to the identification and promotion of good practice programs.

In the past 15 years of the EU's commitment to mental health care a significant number of reports, guidelines and agreements on different areas of mental health that can help Member States to implement the recommendations for improving mental health of the population more easily. The EU recommendations in the field of mental health are also supported by organizations that represent the interests of people who use mental health services and whose members are largely people with experience of mental disorders such as Mental Health Europe (<https://www.mhe-sme.org/>) and GAMIAN (<https://www.gamian.eu/>).

The key support to mental health as a public good is expressed in Declaration on Achieving Equality for Mental Health in the 21st Century (Global Ministerial Mental Health Summit, 2018). By signing the Declaration, all countries welcome the vision and leadership in building political sponsorship and incentives at the highest government levels to address mental health challenges globally and locally. Adequate investment in the prevention and treatment of mental disorders is a key part of progress towards comprehensive general health care.

### **1.3 Epidemiology of mental disorders and mental health indicators**

Due to their relatively high prevalence, frequent onset in young adulthood, possible chronic course, impaired quality of life and a significant share of health care use, mental disorders are one of the priority public health problems in the EU. In the last decade there has been an increase in awareness of the importance of mental health and the need for prevention, early detection and treatment of people with mental disorders,



as well as the development of various evidence-based psychosocial interventions used by experts and those used as self-help. Unfortunately, the prevalence of mental disorders remains high and does not decline over time (Wittchen et al., 2011; Wittchen & Jacobi, 2005), and the economic burden of disease also increases. Mental disorders take up 20% in the total burden of disease in Europe. Mental disorders are associated with a threefold increase in the number of lost working days compared to people without mental illness. Further growth of the global burden due to mental disorders is expected. It is estimated that by 2030 depression will become a leading cause of global burden of disease. The burden of mental health problems in Europe is also very high in terms of morbidity and mortality. Tens of millions of people across the EU experience at least one mental health problem at some point, and tens of thousands die each year directly from either mental health disorders or suicide. The economic burden is also significant. The total costs associated with mental health were estimated at more than 4% of GDP or over 600 billion euros in the 28 EU countries in 2015. 190 billion euros (or 1.3 % of GDP) is a direct health care cost, an additional 170 billion (1.2 % of GDP) is spent on social security programs, whereas the cost of further 240 billion (1.6 % of GDP) is caused by indirect labor market costs, driven by lower employment rates and reduced productivity due to mental illness.

According to recent estimates of an international research on mental health, more than one of six people in the EU countries (17.3%) had a mental health problem during 2016 – that is nearly 84 million people. The most common mental disorder in the EU is the anxiety disorder, and it is estimated that 25 million people (or 5.4% of the population) live with anxiety disorders, followed by depressive disorders, affecting over 21 million people (or 4.5% of the population). It is estimated that 11 million people across the EU (2.4 %) have problems with drug and alcohol abuse. Mental illnesses such as bipolar disorder affect nearly 5 million people (1.0 % of the population), while schizophrenia affects about 1.5 million people (0.3 %).

Suicide is one of the most common causes of premature death. 90% of suicides are related to some sort of mental disorder (EU Commission, 2010). Although the number of suicides has been declining for the past 15 years, it is still unacceptably high and there are large variations in the suicide rate among countries.

Women have twice the risk of mood and anxiety disorders compared to men, and men have a higher risk of alcohol problems. Mental disorders are associated with high rates of unemployment, leading to premature exclusion from the labor market and spending of social resources on different benefits due to disability and unemployment. It is expected that successful treatment and the availability of programs that encourage social inclusion, including employment, could change outcomes in terms of health, employment and spending of social resources.

A large number of people who need help due to mental health problems do not receive it (Wainberger et al., 2017, Wittchen & Jacobi, 2005). This points to several hidden problems – from failing to recognize the symptoms of impaired mental health, not seeking help because of the stigma and inadequate mental health services not adapted to the needs of people with mental health problems.

The existing indicators for monitoring the state of mental health in the population are for the most part directed towards morbidity and the organized system of mental health care: prevalence of mental disorders in the population, the number of hospitalizations for mental disorders, the number of days spent at a hospital, the number of admissions in primary health care, the number of acute and chronic psychiatric beds, occupancy rate of psychiatric beds, the number of experts in mental health care and the number of services provided in mental health care, and less on positive mental health, such as resistance to stress, recovery, quality of life, social inclusion, the number of employed persons with disabilities due to mental disorder and so forth.

Source for epidemiological data; Health at a Glance: Europe 2018 – European Commission. [https://doi.org/10.1787/health\\_glance\\_eur-2018-en](https://doi.org/10.1787/health_glance_eur-2018-en).

## 1.4 WHO and mental health

The World Health Organization is continuously committed to the promotion, prevention, effective treatment and service setup in mental health care. The WHO Mental Health Action Plan 2013-2020 puts emphasis on the integrated and coordinated prevention, promotion, treatment and support, including the implementation of multisectoral strategies which combine universal and targeted interventions to promote mental health and prevent mental disorders ([https://www.who.int/mental\\_health/action\\_plan\\_2013/bw\\_version.pdf?ua=1](https://www.who.int/mental_health/action_plan_2013/bw_version.pdf?ua=1)).

The plan relies on a number of principles: universal access and coverage, human rights, evidence-based practice, lifelong approach, multisectoral approach and empowering people with mental disorders and psychosocial disabilities. The plan focuses on four key objectives: strengthening effective leadership and mental health management; providing comprehensive, integrated and appropriate mental health and social care services in community-based environments; implementing strategies for the promotion and prevention of mental health and strengthening information systems, evidence and research on mental health. Global Mental Health Action Plan 2013-2020 has paved the way for a new approach to mental health, with an emphasis on treatment and care in the community, an approach to recovery and full respect for the human rights of people with mental disorders and psychosocial disabilities. Political commitment to this approach has been supported at the highest level by health ministers, however this is in stark contrast to the reality. Namely, in many countries the proclaimed objectives have only partially been achieved. WHO is a tireless fighter for mental health and human rights and has published the QualityRights Assessment Toolkit – a tool for assessing the quality of care and human rights in institutions where people with mental disorders are treated or accommodated. The tool is based on the UN Convention on the Rights of Persons with Disabilities (CPRD). In 2017 quality assessments were conducted in 75 facilities in 24 WHO Member States, including 16 EU Member States. The results are published in the document *WHO European Region Report: Mental health, human rights and standards of care* ([https://www.euro.who.int/data/assets/pdf\\_file/0017/373202/mental-health-programme-eng.pdf?ua=1](https://www.euro.who.int/data/assets/pdf_file/0017/373202/mental-health-programme-eng.pdf?ua=1))

The specific objectives of the project were to address gaps in knowledge about the number and characteristics of long-term mental health institutions and to identify deficiencies in current care standards through the lens of the CPRD. The quality of care and protection of human rights in selected institutions in over 20 countries in the Region using the WHO QualityRights toolkit were examined and rated. The findings reveal and confirm that long-term institutional care for people with psychosocial and intellectual disabilities in many European countries is far below the standard. A significant proportion of the assessed institutions were violating the fundamental rights of people with psychosocial and intellectual disabilities, including their legal capacity, autonomy, dignity, liberty and security of person, physical and mental integrity and freedom from torture and ill treatment and from exploitation, violence and abuse. Fewer than a third (28%) of the 2450 ratings of standards made by the 25 national assessment teams were “achieved in full”, indicating enormous scope for improvement throughout the European Region. This indicates that CRPD signatories are at risk or culpable of substantial breaches of the treaty. A number of the assessed care standards could be improved with targeted interventions in facilities, such as reducing the number of beds in wards and introducing personalized recovery planning, whereas other care standards will require more systemic changes, such as in legislation to allow supported decision-making, e.g. advance directives. Although there was appreciable variation within and across participating countries with respect to quality and human rights standards, a number of common deficiencies require urgent attention and action: *lack of knowledge or awareness* about mental health and the protection of human rights; *lack of a personalized approach to care*; *lack of rehabilitative or even recreational activities* in most of the institutions assessed; *lack of legal provisions* or legal representation and a virtual absence of shared decision-making; and *lack of community alternatives*.

WHO has created the QualityRights Initiative, a new project to unite and empower people to improve the quality of care in mental health and related services and to promote the rights of people with psychosocial, intellectual and cognitive disabilities. This initiative works at the ground level to directly change attitudes and practices, as well as through policy to create sustainable change.

The overall aims are:

- Build capacity to combat stigma and discrimination and promote human rights and recovery
- Improve the quality and human rights conditions in mental health and social services
- Create community-based services and recovery-oriented services that respect and promote human rights
- Support the development of a civil society movement to conduct advocacy and influence policy-making
- Reform national policies and legislation in line with the CRPD and other international human rights standards

As part of the QualityRights Initiative, WHO has developed a comprehensive package of training and guidance materials. The materials can be used to build capacity among mental health practitioners, people with psychosocial, intellectual and cognitive disabilities, people using mental health services, families, care partners and other supporters, nongovernmental organizations, organizations of persons with disabilities and others on how to implement a human rights and recovery approach in the area of mental health in line with the UN Convention on the Rights of Persons with Disabilities and other international human rights standards. The ultimate goal of WHO's QualityRights is to change mindsets and practices in a sustainable way and empower all stakeholders to promote rights and recovery in order to improve the lives of people with psychosocial, intellectual or cognitive disabilities everywhere.

The Human Rights & Recovery project represents the next phase in the QualityRights initiative and aims at assisting in implementing changes in mental health institutions according to the principles of recovery and human rights

[https://www.who.int/mental\\_health/policy/quality\\_rights/en/](https://www.who.int/mental_health/policy/quality_rights/en/)).

In order to achieve this, the institutions are expected to base the treatment and care on informed consent, encourage hope and optimism in the recovery, implement procedures that encourage recovery, empowerment, autonomy, personal identity, social skills, prevention of stigma, learning from crisis situations and the dignity of

risk. It is expected that institutions provide support in the decision-making and social inclusion, provide the right to support from lay people, peer-to-peer support, and move away from narrow clinical criteria of recovery towards personal recovery, social inclusion and the quality of life. In this project, the emphasis is on changing the mindset from the belief that recovery is not possible to the evidence-based belief that recovery is possible. This turn is necessary if we want to enable change. To facilitate change and transformation of institutions according to the model of recovery and human rights, the WHO has developed a series of educational materials that are easily available at [https://www.who.int/mental\\_health/policy/quality\\_rights/en/](https://www.who.int/mental_health/policy/quality_rights/en/).

There is also an online training in human rights, available via an e-mail request to: [drewn@who.int](mailto:drewn@who.int)

### **1.5 Overview of guidelines for the setup of mental health services and interventions that increase mental health, prevent mental disorders and increase the effectiveness of treatment**

We present the guidelines and recommendations for:

1. Setup of mental health services
2. Interventions for the promotion of mental health, prevention and treatment of mental disorders

Setup of mental health services in the community according to principles of recovery and human rights

Nowadays, community mental health is considered to be a better way of approaching to mental health services because it leads to more favorable health outcomes. However, this kind of setup in mental health treatment and care is taking longer in younger EU member states. Even when such setup of mental health services in the community exists, it is not a sufficient guarantee for the prevention and successful treatment outcomes if it is not based on the services operating on the principles of recovery, empowerment and respect for human rights and the application of evidence-based procedures.

Recovery is something people see as a personal experience when they become empowered to manage their lives in a way that enables them to achieve a fulfilled, meaningful life and contributes to a positive sense of belonging in their communities (NIMHE 2005). Mental health care that encourages recovery requires that the idea of recovery be made available in the practices of mental health professionals.

Ten points that can contribute to recovery have been identified for mental health professionals: 1) support health recovery, functioning, and identity; 2) offer hope for recovery; 3) ask ourselves in everything we do whether we are doing service or disservice; 4) focus on that which empowers the person, rather than solely on that which poses a difficulty; 5) make a decision with the service user, not instead of him or her; 6) acknowledge that the experience of the service user is as important as our own expertise; 7) cooperate with other stakeholders; 8) accept the dignity of risk of the service user; 9) cooperate with the family and social network of service users as a resource and partner; 10) share and integrate knowledge. (EUCOMS consensus document, 2018).

Here are some documents which can be useful in the setup of institutions and services for community mental health, including the principles of recovery and human rights:

- The Common European Guidelines on the Transition from Institutional to Community-based Care (EEG) expert group of the EU for the transition from institutional care to community-based care in 2012 (<http://enil.eu/wp-content/uploads/2016/09/Guidelines-01-16-2013-printer.pdf>)

These guidelines have provided practical advice about how to make a sustained transition from institutional care to family-based and community-based alternatives for individuals currently living in institutions and those living in the community, often without adequate support.

These guidelines are aimed primarily at policy and decision makers in the European Union and the neighboring countries with responsibility for the provision of care and support services for children, people with disabilities and their families, people with mental health problems and older people.

- **Deinstitutionalization and community-living outcomes and costs: report of a European Study**

<https://www.researchgate.net/publication/30523444>

[Deinstitutionalisation and community living-outcomes and costs report of a European Study Volume 2 Main Report](#)

This project aimed to consolidate the available information on the number of disabled people living in residential institutions in 28 European countries, and to identify successful strategies for replacing institutions with community-based services, paying particular attention to economic issues in the transition. It is the largest study of its kind ever undertaken.

- **WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care (Thornicroft et al., 2010)**

This paper provides guidance on the steps, obstacles and mistakes to avoid in the implementation of community mental health care.

- **Access to Mental Health Care in Europe - Scientific Paper - EU Compass For Action on Mental Health And Well-Being, (Barbato et al., 2014)**

[https://ec.europa.eu/health/sites/health/files/mental\\_health/docs/ev\\_20161006\\_co02\\_en.pdf](https://ec.europa.eu/health/sites/health/files/mental_health/docs/ev_20161006_co02_en.pdf)

The scope of this report is to provide a conceptual framework to inform policy makers about specific issues in access to mental health care for adult people with mental disorders, through a collection and critical analysis of research and administrative data, including recent scientific papers published in peer-reviewed journals.

- **Community Mental Health Organization-EU compass consensus document**

[http://www.horatio-web.eu/downloads/2018\\_compass\\_positionpaper\\_en.pdf](http://www.horatio-web.eu/downloads/2018_compass_positionpaper_en.pdf)

The document outlines the benefits of organizing a community mental health system, describes parts of the mental health system, and encourages the development of related community mental health treatment and care services.



- **Recovery for all in the community; position paper on principles and key elements of community-based mental health care** (Keet R. et al 2019)  
<https://bmcp psychiatry.biomedcentral.com/track/pdf/10.1186/s12888-019-2162-z>

Since 2015 there has been a network of European Community Mental Health Service providers in Europe (EUCOMS, [www.eucoms.net](http://www.eucoms.net)). In a consensus document, this network describes community mental health from 6 perspectives (EUCOMS, 2017): Ethics, Public Health, Recovery, Effective treatment, Community network of care, Experience Expertise

- **Guidelines for Recovery-Oriented Practice. The Mental Health Commission of Canada**  
[https://www.mentalhealthcommission.ca/sites/default/files/MHCC\\_Recovery\\_Guidelines\\_ENG\\_0.pdf](https://www.mentalhealthcommission.ca/sites/default/files/MHCC_Recovery_Guidelines_ENG_0.pdf)

This document describes the dimensions of recovery-oriented practice and the key capabilities needed for the mental health workforce to function in accordance with recover – oriented principles. It provides guidance on tailoring recovery-oriented approaches to respond to the diversity of people living with mental health problems and illnesses –people with a wide range of life circumstances and at different ages and stages of life. It complements existing professional standards and competency frameworks. The experience and insights of people living with mental health problems and their families are at the heart of recovery-oriented culture. Recovery-oriented approaches recognize the value of this lived experience and bring it together with the expertise, knowledge and skills of mental health practitioners, many of whom have experienced mental health problems in their own lives or in their close relationships. Recovery approaches challenge traditional notions of professional power and expertise by helping to break down the conventional demarcation between.

When drafting plans to improve mental health care, it is important to work with service user associations and encourage the development of mental health user associations at national level so that they become equal partners on the EU path to mental health.

Here are some useful GAMIAN - EUROPE publications (<https://www.gamian.eu/>):

- A Pocket Guide to Agitation and What to do in a Crisis:  
<https://www.gamian.eu/wp-content/uploads/Agitation-Pocket-crisis-guide-ENGLISH.pdf>
- A GUIDE TO DEPRESSION AND ITS TREATMENT:  
<https://www.gamian.eu/wp-content/uploads/A-guide-to-depression-and-its-treatment.pdf>
- TAKE CARE AND BE KIND TO YOURSELF: <https://www.gamian.eu/wp-content/uploads/Take-care-and-be-kind-to-yourself-VF.pdf>
- A Charter for the Rights to Treatment and Care for People with Schizophrenia: <https://www.gamian.eu/wp-content/uploads/Patient-Charter-Schizophrenia.pdf>
- Understanding and Managing Agitation: <https://www.gamian.eu/wp-content/uploads/Understanding-Agitation.pdf>
- Call to action: <https://www.gamian.eu/wp-content/uploads/Call-to-Action.pdf>
- A Sustainable Approach to Depression: [https://www.gamian.eu/wp-content/uploads/A\\_sustainable\\_approach\\_to\\_depression-1.pdf](https://www.gamian.eu/wp-content/uploads/A_sustainable_approach_to_depression-1.pdf)
- Breaking the Silence: Sexual Health Impact on Mental Well-Being:  
[https://www.gamian.eu/wp-content/uploads/Gamian\\_Europe\\_Survey\\_Sexual\\_Health\\_2018.pdf](https://www.gamian.eu/wp-content/uploads/Gamian_Europe_Survey_Sexual_Health_2018.pdf)
- Learning to live with schizophrenia: <https://www.gamian.eu/wp-content/uploads/Gamian-Schizophrenia-Guide-2016.pdf>

## 2. Mental health promotion and mental disorder prevention programs

The state of art in prevention programs in the field of mental health raises optimism for better mental health and prevention of mental disorders at the population level. There is a considerable evidence that various mental health conditions can be prevented through the implementation of effective evidence-based interventions. Promotion of mental well-being can prevent mental disorders but, also play a role in the recovery from mental disorders.

Prevention is important also for the sustainable reduction of the burden of mental disorders (WHO, 2014, 2016, EPA, 2012). In this section, evidence-based prevention programs for mental health promotion and prevention of mental disorders are presented in order to raise awareness of their existence and encourage their implementation in real world practice. We have included programs in the field of public health throughout the life cycle. We are aware of the fact that there are a number of other programs which are examples of good practice that we have not presented here. The evidence-based preventive programs have the potential to reduce risk factors, strengthen protective factors, decrease symptoms of mental disorders and disability as well as the onset of some mental disorders, and therefore improve positive mental health.

There are various prevention programs in all life cycles designed for universal prevention that aim to increase resilience and reduce risk for any mental disorder as well as programs designed for specific problems and people at increased risk for impairment of mental health. The main sources for the selection of programs were the programs published within the EU Commission programs such as Joint Action Mental Health and Well-being and those published in The Lancet Commission on global mental health and sustainable development (Lancet, 2018) however, we have also included programs from other sources.

## **2.1 Preventive programs early in the developmental cycle and throughout school age intended for the promotion of mental health and prevention of mental disorders for children, youth and parents**

Investing in child development has long-term positive results, improving health, social capital and well-being throughout life. Preventive interventions aimed at maternal mental health and the interaction between mother and child have positive long-term benefits for both newborns and mothers. Interventions that promote close physical contact with the mother contribute to the child's safety and attachment and reduce the risk of developing a disorder. Parental education and interventions involving family support and parenting skills also show effectiveness in preventing child abuse and reducing children's mental health problems. Most mental disorders in adults have their roots in childhood. Therefore, it is crucial to act early to identify mental health problems and identify risk factors for future mental illness — including violence, neglect, abuse, poverty, and mental disorders in parents (Lancet, 2018).

### **Preventive program during pregnancy and postnatal care**

There is strong evidence of the effectiveness of interventions in maternal mental disorders and the prevention of the occurrence of mental disorders in children. (Lancet, 2018) Pregnancy and postnatal care represent a significant window of opportunity for identification, reassurance and intervention, with long-term implications for psychological well-being of women and their families as well as the costs associated with future care. (Tait Heron, 2010; Dennis et al., 2013). Some countries in the European Union show good practice in this area, for example the United Kingdom, (Malouf et al., 2018; NICE 2018), Germany (Plevka & Scholz, 2016) and Hungary (EU Compass 2018).

**Interventions for increased parenting skills** for the benefit of children are key investments to help break the toxic cycles of transgenerational transmission of violence and mental illness (Lancet 2018). A good parent-child relationship is protective for the mental health of children and families, so in order to promote positive mental health and prevent mental disorders, it is necessary to implement universal programs for everyone as well as targeting programs for families where there

are risk factors that can harm their mental health or there are pre-existing mental health problems. Interventions in the early years can have a significant impact on future mental health and well-being. The evidence-based programs listed here are described in details at <https://ec.europa.eu/social/main.jsp?catId=1251&langId=en> by EU Commission. Many of them are implemented in a number of EU countries, therefore can serve as an example of good practice and stimulate other countries to implement them.

**Incredible Years** is a program that aims to teach parents positive parenting and develop ways of recognizing and behaving towards a child when emotional and behavioral problems arise. It is aimed at parents of children who have been assessed for the risk of developing behavioral disorders including antisocial behaviors, frequent episodes of anger, and propensity to violence.

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=204>

**Generation PMTO – Steps to successful parenting** is the strengthening families' program through the promotion of social skills aims prevents, reduces and changes the development of behavioral disorders in children and young people. More information available at: <https://www.generationpmtto.org/>

**Triple P - Positive Parenting Program** is a teaching skills psychosocial family interventions program that aims to prevent significant emotional and behavioral disorders in children. Skills are developed in parents in order to achieve a positive and caring parent-child relationship, and to increase parental competence, improve parental communication and reduce parental stress. More information available at: <https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=239>

**The Parents Plus Early Years Program (PPEY)** consists of group work for parents and individual work by parents, children and therapists. It is intended for parents of children 1-6 years of age, especially for those parents whose children have behavioral problems or mild developmental difficulties. The goal is to increase family support and the quality of alternative care settings, and to improve the response of the health system to addressing the needs of children with disabilities.

More information available at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=216>.

**The Community Mothers' Program** is intended for first-time parents who live in unfavorable conditions. It is conducted through home visits with the aim of providing support and encouragement for the development of parental capacities and strength. It is conducted by volunteers selected by public health authorities who undergo a four-week training. More information available at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=193>.

**Strengthening Families Program** aims to develop family and youth relationship skills such as assertiveness skills and to protect children from addiction and harmful childhood experiences. It is effective in reducing a number of risk factors for later alcohol and psychoactive substance abuse, the development of mental disorders and delinquency. The program has been evaluated in 17 countries. More information at:

<https://strengtheningfamiliesprogram.org/>

**Lifestart** provides family support. It is conducted in the family homes of parents visited by trained professionals. More information at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=206>.

**The Aprender em Parceria (A PAR)** is an early childhood intervention and parenting support program designed to work with parents to recognize their skills and potentials to empower them. More information at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=187>

**Positive parents platform** is an online parenting program aimed at helping parents improve their parenting skills and their relationships with children over the age of 20.

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=253>

**Parents Plus Children's Program (PPCP)** provides family support, improves the response of the health system to the needs of children with disabilities, ensures the safety of children, and an adequate home and living conditions. It is intended for parents of children aged 6-11 with a mental disorder or behavioral difficulty. It is conducted in a group of parents with two leaders. More information at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=213>.

**New Forest Parenting Program** aims to educate parents about ADHD and ways to influence a child's behavior. It is intended for parents of children up to 3 years old with symptoms of ADHD. It consists of one-on-one parent training lasting 2 hours per week for 8 weeks. Half of the treatment is for the parent and the child, and the other half for parents themselves. More information at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=208>).

**Comet-Communication Method** is a standardized program designed for parents of children 3-11 years of age who exhibit negative behaviors, such as attention and concentration disorder (ADD, ADHD) as well as oppositional defiance disorder. Includes education, short video clips with parent-child interactions, role-playing, homework, hands-on exercises for parents with their children for the coming week. More information at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=192>.

**Parenting skills program (PSP)** is a group parenting program aimed at developing parenting skills and social support, reducing parental stress and working on the child's behavioral problems. It addresses a variety of topics such as assertive communication, conflict resolution skills, empathy development, and emotional self-regulation, parental self-confidence, understanding child development, and mastering child behavior. It affects groups of children 0-5 and 6-12 years and adults 20+. More information at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=267>.

**The Community Parent Education Program (COPE)** is intended for parents of children with externalized problems and diagnoses such as hyperactivity, attention difficulties and behavioral problems. It helps parents develop positive parenting skills with demanding behaviors and in communication with the child. More information at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=237>.

**Connect** is intended for parents of children 8-12 and 13-17 years of age with mental difficulties and significant behavioral problems. The aim is to improve the ability of parents/guardians to assess the unique meaning of problematic and defiant behaviors within the context of the parent-child relationship. It works on the skills of setting

boundaries while maintaining a healthy relationship with a teenage child. More information at:

<https://ec.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=194>

or <http://connectparentgroup.org/>

**The Örebro Prevention Program (EFFEKT)** includes working with parents to detect drinking among children aged 13 to 16. More information at: <https://eu.europa.eu/social/main.jsp?catId=1251&langId=en&reviewId=199>.

## **2.2 Promotion of good mental health in schools**

Within schools, education focused on developing social and emotional skills, problem-solving skills, and increasing resilience to stress is considered the best practice for building emotional and social competencies in children of all ages. (The Lancet 2018). Universal socioemotional learning interventions (SELs) in communities and schools improve social and emotional functioning, academic performance, and decrease the risk of various behavioral problems. SEL interventions can be performed by peers, teachers and counselors. Meta-analyses of a large number of programs have confirmed efficacy in improving social and emotional competencies, better self-regulation of behavior, and learning skills. (Sklad & de Ritter, 2012; Blewitt et al., 2018). Programs should be integrated into all aspects of the curriculum and staff should be trained to deliver it effectively. The staff should promote safe environments which nurture and encourage young people's sense of self-worth, reduce the threat of bullying and violence and promote positive behavior. Teachers and other staff should be trained to identify when children show signs of anxiety or social and emotional problems and offer effective targeted interventions to support children and their parents/families. (Fenwick-Smith et al, 2018; <https://doi.org/10.1186/s40359-018-0242-3>).

The more effective interventions were those that included teaching skills, a focus on positive mental health, a balance between universal and targeted approaches, starting with younger children and continuing with older ones, taking place over a long period of time, using a multi-modal/whole school approach that is integrated within the curriculum, teacher education, parent liaison, community involvement and work with



external agencies. (European profile of prevention and promotion of mental health (EuroPoPP-MH 2013).

**Zippy's Friends** program is a universal school-based program adopted in 27 countries which helps young children to develop coping and social skills and promote resilience. An evaluation found that the program had helped improve the classroom atmosphere, reduce bullying, and improve academic scores. (Clarke et al., 2014).

**Resourceful Adolescent Program (RAP)** is a school-based prevention program that uses CBT and interpersonal skills to significantly reduce levels of depression among adolescents. The program teaches affect regulation, positive cognitive and attribution styles and skills for improving interpersonal connectedness. It also focuses on broader environmental factors, such as enhancing the sense of school connectedness. The program has been shown to be effective in preventing depression in adolescents. (Shochet et al., 2001).

More information at: [https://doi.org/10.1207/S15374424JCCP3003\\_3](https://doi.org/10.1207/S15374424JCCP3003_3))

**Linking the Interests of Families and Teachers (LIFT)** is designed for children and their families living in at-risk neighborhoods. LIFT is a 10 weeks intervention consisting of parent training, classroom based social skills program, a playground behavioral program, and systematic communication between teachers and parents. Youth who participated in the intervention demonstrated statistically significant reductions in physical aggression; in initiation of alcohol and tobacco; and in use over time of alcohol, tobacco, and illicit drugs; compared with control youth (Reid et al., 1999; Reid et al., 2003). More information available at: [https://doi.org/10.1016/S0005-7894\(03\)80034-5](https://doi.org/10.1016/S0005-7894(03)80034-5)

**The Seattle Social Development Project (SSDP)** is a universal prevention program that was tested in elementary schools serving children from high crime urban areas, included a three-part intervention for teachers, parents, and students. The intervention trained teachers in proactive classroom management, interactive teaching, and cooperative learning. SSDP also offered training to parents in child behavior management, academic support, and skills to reduce risks for drug use. It provided training to children designed to affect interpersonal problem solving and refusal skills. SSDP over a six-year intervention, leading to significantly stronger attachment to

school, improvement in self-reported achievement, and less school misbehavior (Hawkins et al., 1991).

**Evidence-Based Interventions for Preventing Substance Use Disorders in Adolescents** There are a number of programs for the school population that have proven to be as effective: Social Resistance Skills program, Normative Education, Competence-Enhancement, Life Skills Training, Brief Alcohol Screening and Intervention for College Students, Family Based Prevention Programs, Family Matters, Creating Lasting Family Connections, Brief Strategic Family Therapy (Botvin, 2000).

### **Interventions to help prevent bullying in schools**

Bullying (e.g. physical intimidation, verbal threats, exclusion, rejection) can affect children and young people of all ages. Both bullying and cyberbullying have been found to be very common; estimates suggest that 30-40% of children and adolescents experience bullying and/or cyber bullying (Brooks et al., 2015). There are immediate impacts of bullying on mental health and emotional well-being, including the risk of self-harm. A meta-analysis of 34 studies found a 2.5 times increased risk of suicide attempts in children who had been the victims of bullying compared to other children. (van Geel et al., 2014) Young people who have been bullied also have an increased risk of depression and psychological distress in adulthood. (Ttofi et al., 2011).

A number of promising interventions to tackling bullying have been identified, reducing the level of bullying victimisation by around 20% (Ttofi & Farrington, 2012). The most frequently used intervention components of cyberbullying interventions included education on cyberbullying for the adolescents, coping skills, empathy training, communication and social skills, and digital citizenship. Parent education on cyberbullying was also found to be important and was included in programs with significant outcomes. (Hutson et al., 2018)

**School addiction prevention programs** are effective in reducing the risk of developing substance abuse and addiction. Universal mental health promotion programs in schools that we described earlier have been shown to be effective in reducing addictive behavior.

These programs most commonly use a combination of education, social skills training, and CBT elements including education on the harmfulness of psychoactive substances (Faggiano et al., 2014; Griffin & Botvin, 2011).

### **2.3 Prevention of domestic violence**

Domestic violence includes physical, mental/emotional, financial or sexual abuse, or control or coercive behavior, towards a current/former intimate partner or adult family member. (WHO and Pan American Health Organization, 2012). Domestic violence, which may be psychological, physical, sexual, financial or emotional, is a major public health problem due to the long-term health consequences. Each form of domestic violence creates interrelated forms of violence, and the "abuse cycle" itself often continues in children exposed to violence in their adult relationships, and ultimately to the care of the elderly (Huecker & Smock, 2019) and therefore it is necessary to work continuously on the prevention of domestic violence as well as to identify effective models of prevention and treatment of victims and perpetrators and implement them in practice. Domestic violence is a multidimensional problem which needs integrated and coordinated responses at all levels. There is an importance of having at your disposal an integrated model of domestic violence prevention measures which combines three different subjects of intervention (offender-oriented, institution-oriented and victim-oriented measures) and three different levels of preventive intervention (European Institute for Gender Equality, 2015).

WHO (2010) survey on effective violence prevention programs reveals the following evidence-based interventions: developing safe, stable and nurturing relationships between children and their parents and caregivers such as parent training, including home visitation from a nurse; developing life skills in children and adolescents such as social development programmes including; reducing the availability and harmful use of alcohol with interventions for problem drinkers; promoting gender equality to prevent violence against women through school-based programmes to address gender norms and attitudes; victim identification, care and support programmes like advocacy support programmes.

Based on research of domestic violence in 28 EU countries, the European Institute for Gender Equality, (2015) recommends training in dealing with domestic violence as a key component of a successful strategy for prevention strategies to tackle domestic violence.

According to The European Institute for Gender Equality (2015), typologies of training in addressing domestic violence include:

[https://eige.europa.eu/sites/default/files/documents/MH0114678ENN\\_WEB.PDF](https://eige.europa.eu/sites/default/files/documents/MH0114678ENN_WEB.PDF)

**Awareness-raising training** for different groups among the general public or for professionals to help inform and to be sensitive to the main features and relevance of the problem.

**Specialised training for professionals** to enhance skills and capacities to respond appropriately to victims and/or perpetrators or persons in contact with them who ask for help.

**Training for trainers or cascade training** for different target groups to promote knowledge transfer within the same professional or community sector.

**Training for domestic violence victims** to rebuild capacities and skills, when necessary, usually to re-enter the labour market or to regain self-confidence.

**Gender training courses** aim at developing participants' self-awareness by engaging them in a transformative process and utilising reflexivity (transformative or reflexivity training), improving participants' knowledge by delving into conceptual issues; by providing new intellectual tools to find new approaches to solve old problems (knowledge-based training); or by teaching people how to utilise tools such as gender impact assessments, procedures or indicators (competence-based training). Training courses might include both transformative and competence-based features. Training is also a powerful tool in changing common beliefs that are shaped by stereotypes. Gender training relies on a modification in people's self-perceptions, way of relating to others, beliefs, problem-setting and problem-solving skills, competences and knowledge. This modification, in turn, may influence organizational and people's behaviour.

**Support services** dealing with domestic violence are specialised organizations or units within general services that provide help to the victims of violence, usually women and their children. They help them escape from violence; seek protection and justice; and recover from traumatic experiences. Options include: listening; advice; advocacy; shelter; self-help; counselling; protection and prosecution; and access to activism. Support services provide a range of options that enable women to create safety, seek justice and undo the harms of violence. Such options include: listening; advice; advocacy; shelter; self-help; counselling, protection and prosecution; and access to activism.

The base on study (Kelly, 2008) aims to develop consensus on minimum standards for support services, their range and extent, core principles and practices of member states and are urged to make resources available to ensure the quality and equitable availability of: free 24 hour help lines; safe shelters; support and advocacy services; accessible services for socially excluded women, especially recent migrants, refugees, women from ethnic minority groups and those with disabilities; access to financial support, housing, residence rights education, training; networking between specialist NGOs; multi-agency co-ordination; training curricula for professionals addressing the continuum of violence against women within a human rights framework; work with perpetrators rooted in women's safety and prevention. (Kelly, 2008) available at: [https://www.coe.int/t/dg2/equality/domesticviolencecampaign/Source/EG-VAW-CONF\(2007\)Study%20rev.en.pdf](https://www.coe.int/t/dg2/equality/domesticviolencecampaign/Source/EG-VAW-CONF(2007)Study%20rev.en.pdf)

In order for prevention and treatment to be effective, cooperation between the health sector, social services, the education system, the police, the judiciary system and also the recognition of such behavior as unacceptable at the level of the entire community and at the national level is needed. The following guidelines are useful in building integrative services for prevention of domestic violence:

Domestic violence and abuse: multi-agency working - Public health guideline (PH50)

Available at: <https://www.nice.org.uk/guidance/ph50>

Domestic abuse: a resource for health professionals

Available at: <https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals>

**Responding to domestic abuse - A resource for health professionals** Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/597435/DometicAbuseGuidance.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf)

#### **2.4 Preventive programs promoting resilience for adults**

Adult programs to increase resilience to stress can be planned in a variety of community programs including the work environment, they can also be part of programs to combat the stigma of mental illness.

**Mental fitness online “Psyfit”** is a Dutch e-mental health program, an example of good practice for strengthening resilience, reducing stress and improving feelings of well-being, consists of 7 self-help modules (based on the principles of cognitive behavioral therapy), a forum and 12 self-assessment tests. It was developed by the Trimbos Institute as an online intervention to promote mental well-being in adults with mild depression. Research has shown a positive evaluation of programs related to increasing feelings of well-being, reducing symptoms of anxiety and depression (Bolier et al., 2013)

**The Resilience Program** is a flexible web-based modular mental health education program that can be used in general mental health promotion as well as in supporting people with mental health problems independent of cause and complexity. The program can be used in any organizational context (e.g., youth work, education, social care) and can be combine with other interventions. Pilot research clearly indicate that following a brief period of training the program can be used by any professional and by lay persons, including parents, and students. The Resilience Program website contains all information and a number of presentations about the Program, which consists of information about resilience, mentalization and self-control, social learning theory, cognitive training, and neurobiology. It is possible to use the Resilience Program as a completely self-directed program. The Resilience Program is currently implemented locally in five European countries and is also being tested in studies (Bak et al., 2015).

**The FRIENDS program** is a resilience program adapted to different age groups. Fun FRIENDS (4-7-year olds), FRIENDS For Life (8-11-year olds), My FRIENDS Youth (12-15-year olds), Adult Resilience (16+-year olds). The FRIENDS Programs teach multiple resilience skills to all age groups as well as prevent and treat anxiety and depression. The FRIENDS Programs can be implemented in school settings, health or community centers, the corporate environment, aging facilities, hospitals, and corrective services. Friends Resilience offers facilitator training for teachers or allied health professionals who wish to deliver the FRIENDS programs in their own clinic, school, organization, community, or country. Friends Resilience has developed a national and international network of Licensed Partners who use the widely tested and proven effective, research-based FRIENDS programs. Developed in Australia and used in schools worldwide, FRIENDS is an anxiety prevention program endorsed by the World Health Organization as best practice for its effectiveness in the prevention and treatment of anxiety and depression, promoting resilience in families, schools and communities. The theoretical model for the prevention and early intervention of anxiety and depression addresses attachment (emotions), physiological (body), cognitive (mind), and learning (behaviour) processes which interact in the development, experience and maintenance of anxiety. More information available at <https://www.friendsresilience.org/>

## **2.5 Protecting and improving the mental health of the working-age population**

Providing a healthy and inclusive working environment can prevent mental health problems and enhance opportunities to enter, remain at or return to work when experiencing such problems. There is evidence that work characteristics may cause or contribute to mental health problems (Noblet, 2006). Interventions to reduce work stress may be directed either at the coping capacity of employees or at the working environment. Stress management training, stress inoculation techniques, relaxation methods, and social skills and fitness training can increase coping capacity. Meta-analyses support that such methods are effective in preventing adverse mental health outcomes in work environments (van der Klink et al., 2001). European Framework Directive on Safety and Health at Work (1989) in the workplace obliges employers to

assess risk and take appropriate preventive measures to make work safer and healthier. There is also the EU Framework Agreement on Harassment and Violence at Work, agreed with trade unions and employers which presents a common position on how to deal with harassment (mobbing). More on the impact of work on mental health in: Mental health policies and programs in the workplace (WHO 2004) available at: [https://www.who.int/mental\\_health/in\\_the\\_workplace/en/](https://www.who.int/mental_health/in_the_workplace/en/)

The following programs are examples of good workplace mental health practices:

**Lamplighter program** was developed at UNILEVER as one of the employee health programs which includes mental health as well as four areas important for addressing the emotional needs of employees: 1) leadership and management; 2) communication and culture; 3) achieving resilience and stress management; 4) support. Research on the implementation of this program in several countries has shown beneficial effects. It has been found that the Lamplighter program has positive economic effects with a return on investment in the program being 4:1 (i.e. 4 EURO return for each investment of 1 EURO) and also it has a beneficial effect on well-being for employees and leads to an increase in productivity. More about the program available at: <https://www.unilever.com/sustainable-living/enhancing-livelihoods/fairness-in-the-workplace/improving-employee-health-and-well-being/our-health-and-well-being-programmes-in-action/>.

**Not Myself Today** is an evidence-informed practical workplace program, developed in Canada, which focuses on three outcomes: building greater awareness and understanding of mental health among the workforce; reducing stigma; fostering safe and supportive work cultures. Members receive ongoing support and a physical and digital toolkit that includes different plan options; materials such as slide decks, videos and posters; six different engagement activities; and evaluation tools. This programme has been associated with almost 100% success in increasing awareness and understanding, prompting conversations in the workplace and creating a more supportive work environment. The program helps managers and employees build a healthy and mentally stimulating work environment as it improves performance at work while also reducing costs incurred due to presentism (presence at work, but without being effective) and absenteeism (absence from work). The program is used



by 450 companies and 380,000 employees and is evaluated annually. More about the program available at: <https://www.notmyselftoday.ca/>

**The Well-being Guild of Entrepreneurs:** The main objective of the Guild project, which is conducted in Finland, is to support the mental well-being of small and medium-sized entrepreneurs and ensure that they have the skills and resources to take early action in case of onset of mental health problems. The core activities were two-fold: a two-day course on welfare (applied mental health first aid); and the Guild's peer group activities, in which expert and peer support were used to develop participants' self-knowledge, stress management skills, and ability to handle loneliness. Peer group discussions focused on coping and on problems related to everyday life and work. This has helped entrepreneurs understand their own coping and identify risks related to mental well-being. Over six hundred entrepreneurs took part in the Well-being Guild of Entrepreneurs program. More about the program available at <https://webgate.ec.europa.eu/dyna/bp-portal/practice.cfm?id=157>

**Mental Health in the World of Work** is promoted by the German Federal Ministry of Labour and Social Affairs. The project aims to reduce work stress and to promote mental health in the workplace. The target group are entrepreneurs, managers, employees in the Human Resources and Health Promotion departments, company medical officers and members of the work council. In order to increase the awareness about the importance of mental health and the exchange of know-how and experiences in this field, the project combines a topic oriented knowledge base with good practice and tools for practitioners to promote mental health in the workplaces: self-assessment tools, guidelines for managers and employees, an audiobook and an e-learning tool. The internet portal [www.psyga-transfer.de](http://www.psyga-transfer.de) provides information about the project and the results. The dissemination in different workplace settings is implemented by 16 co-operation partners.

More information available at

[https://ec.europa.eu/health/sites/health/files/mental\\_health/docs/compass\\_2017workpla](https://ec.europa.eu/health/sites/health/files/mental_health/docs/compass_2017workpla)

**Stress Prevention at Work -The SP@W** project is created in The Netherlands – aims to develop a strategic approach to stress which is practical, integrated and customized. The integrated strategy is a roadmap to identify and deal with stress in the workplace. The comprehensive strategy consists of three components: a roadmap through which companies choose a customized approach, implementation and evaluation; a learning network of companies that makes it easy to learn from experiences of other companies. Organizations from all sectors participate in the network, organised in three regions, that meets three times per year; The digital Occupational Stress platform which is an important resource containing useful instruments and information about effective stress interventions.

[https://www.researchgate.net/publication/318529779\\_Stress\\_PreventionWork\\_a\\_study](https://www.researchgate.net/publication/318529779_Stress_PreventionWork_a_study)

**SOLVE training package: Integrating health promotion into workplace OSH policies** This training package was developed by the ILO International Program for Safety, Health and the Environment (SafeWork) in collaboration with the International ILO Training Center in 2002. Known as SOLVE, it provides a six-day interactive course aimed at integrated workplace health promotion. The program has a workbook for students. [https://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---safework/documents/instructionalmaterial/wcms\\_178396.pdf](https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_178396.pdf)

More about program available at [https://www.ilo.org/global/topics/safety-and-health-at-work/resources-library/training/WCMS\\_178438/lang--en/index.htm](https://www.ilo.org/global/topics/safety-and-health-at-work/resources-library/training/WCMS_178438/lang--en/index.htm)

## **2.6 Programs for psychological first aid in a crisis**

Mass crisis situations, such as pandemics and earthquakes, will cause a stress response in most people who are exposed, which will cause short-term or long-term mental health problems in some people. The organization of mental health care with a strong coordinated system of providing early psychological first-aid procedures can have a preventive effect on the occurrence of mental disorders in the post-crisis period. It is important to point out that psychological first aid is not therapy, but rather helping a

person who is upset by the crisis re-establish his usual functional mechanisms of coping with stress as soon as possible.

**Problem Management PM +** is an evidence-based psychological first-aid intervention developed by the World Health Organization using the principles of cognitive behavioral therapy to be applied by lay people who need education in this intervention. This intervention can be applied to any mental health problem (Dawson et al., 2015)

**The psychological inoculation procedure** is a technique that focuses on reducing cognitive barriers to active coping, which could increase stress resistance (Farchi & Gidron, 2010).

**SIX Cs model** is a method of empowering people during acute stressful situations, and is based on neurobiological studies of stress and adjustment. The intervention can be carried out by a trained non-professional in situations of mass crises where a large number of people need help. The Israeli Ministry of Health has adopted this model as standard procedure in crisis situations at the national level (Farchi et al., 2018).

**Mental Health First Aid (MHFA)** is developed in the Netherlands. This is a standardized, psychoeducational, and skill-development-program aimed to empower the lay public to approach, support, and refer individuals in distress through improving the participants' knowledge, attitudes, and behaviors related to mental ill-health. The program covers daily life interactions with persons who have mental health vulnerabilities as well as crisis situations. In the MHFA training program, the trainees learn to recognize signs and symptoms of mental health problems including depression, anxiety disorders, addiction, psychosis, and autism. MHFA is a first-aid course to improve mental health literacy in the general population and provide skills to act appropriately and help people with mental health issues, whether in a crisis or with on-going problems. The content of the training is based on guidelines that were generated by panels including clinicians, mental health consumers and their families. More information at: <https://www.mhfa.nl> 27

## **2.7 Preventive interventions for depression and suicide**

Meta-analyses of preventive psychological interventions have shown that prevention of depression seems feasible and might be an effective way to delay or prevent the onset of depressive disorder (Kim van Zoonen, Claudia Buntrock, David Daniel Ebert et al., 2014; Cuijpers, Straten & Smit, 2008). All types of preventive programs may be effective, such as universal programs for school children, adolescents and adults that increase resilience, selective for promoting self-management skills among people ‘at risk’ of developing depression as well as indicated prevention programs directed at emerging depressive symptoms not yet meeting the diagnostic criteria for the full-blown disorder. All of the previously described school programs aimed at increasing social skills, stress coping and resilience as well as preventive interventions for parents can reduce the risk of various mental disorders, including depression. The onset of the depressive episode may develop at any moment over the life course in all age groups, therefore depression prevention programs need to be available for children and young people during their crucial formative years, young mothers at risk of postpartum depression, and people of working age as well as for older adults (WHO 2016).

### **Postpartum depression preventive program**

Postpartum mood disorders constitute the most frequent form of maternal morbidity following delivery. One in seven mothers are affected by postpartum depression (WHO 2016). Moreover, the impact of postpartum depression on newborns can be substantial and long-lasting. Scientific reviews show that psychological interventions are effective, reducing the development of postpartum depression compared to no intervention. The most promising interventions were found to be the provision of intensive, individualized postpartum home visits, which were provided by trained public health nurses or midwives, lay-based telephone support lines, or interpersonal psychotherapy treatment (Dennis & Dowswell, 2013).

There are several good practices related to preventing postpartum depression, such as in United Kingdom (Brugha et al., 2011). For prevention of postpartum depression, nurses need to be trained in recognising depressive symptoms and receive training in psycho-education and basic cognitive behaviour therapy techniques. The key issue is

that nurses learn to establish an open relationship with the new mothers, discuss emotions and feelings of depression while being sensitive to feelings of embarrassment, and then provide the mothers with psycho-education to create a sense of realistic hope (WHO 2016). These interventions should be integrated in the perinatal care setting as a part of a comprehensive health care approach including the mental health. It is worth mentioning that the interventions offer benefits for the mother, but also have positive spill-over effects for the child and the rest of the family.

### **Preventing depression at work**

Depression is one of the leading causes of disability, absenteeism and presentism, which in addition to affecting the personal life of an individual and family level produces economic losses. There are two ways to reduce the disease burden from depressive disorders: treatment of existing disorders and prevention of new cases. The existing pharmacological and psychological treatments cannot reduce the burden of disease of depressive disorders by more than 35%, even under ideal circumstances (Andrews et al., 2004) On the other hand preventive interventions can significantly reduce the incidence of depressive disorders by 22% (Cuijpers et al., 2008).

A meta-analysis has shown good quality evidence that universally delivered workplace mental health interventions can reduce the level of depression symptoms among workers (Tan et al., 2014). All of the previously described prevention programs under section 2.1.5 and 2.1.6 such as “Psyfit, The Resilience, The FRIENDS, Lamplighter, Not Myself Today, The Well-being Guild of Entrepreneurs, Mental Health in the World of Work, Stress Prevention at Work -The SP@W and SOLVE can also have a beneficial effect on reducing the risk of any mental disorder, including depression.

A good example is seen from one large program in a Dutch hospital where nurses were screened for symptoms of stress, burnout, depression and anxiety. Screen-positive nurses were referred to their company physician for consultation. The physicians had received prior training in psycho-education and basic CBT skills. This intervention was successful in decreasing symptom levels and increasing functioning at work, which had favourable economic effects.

## **2.8 Programs for preventing suicide and suicide attempts**

National suicide prevention programs have been recommended to EU member states (Purebl, 2015) as well as to other states in the world (WHO), and in turn many countries have established them. According to the EU consensus position paper on suicide preventions, (Zalsman et al., 2017) national suicide prevention programs should include: screening, education of primary care physicians, chain of care and treatment of depression (pharmacotherapy and psychotherapy) and the public health approach includes helpline, internet based interventions, media training, school based universal program and restriction to access to lethal means. Research has confirmed the effectiveness of these programs in the countries where they are implemented. Matsubayashi & Ueda (2011) investigated the effect of national suicide prevention programs on suicide rates in 21 OECD nations. They found that suicide rates decreased after the government initiated a nationwide suicide prevention program with the strongest effect in youth. The effect of national suicide prevention programs has also been studied in Australia, Finland, Norway and Sweden (Lewitzka et al., 2019). Decreasing suicide rates have been found in correlation with sex and age with the strongest effects in groups aged 25-to-44 years and 45-to-64 years, but also in females aged 45-to-64 and > 65 years.

According to the systematic review Zalsman et al. (2016) two complementary approaches have the highest levels of evidence, public health policy strategies and health care strategies. This includes: Restriction of access to lethal means and school-based universal prevention (public health); treatment of depression (pharmacotherapy and psychotherapy and ensuring chain of care (health care). A recent narrative analysis (Zalsman, Hawton & Wasserman 2016) investigated the effectiveness of different suicide prevention strategies. They assessed seven interventions: public and physician education, media strategies, screening, restricting access to suicide means, treatments, and internet or hotline support.

There is strong evidence in support of restricting access to lethal means in prevention of suicide, also school-based awareness programs have been shown to reduce suicide attempts. They concluded that no one strategy is clearly superior to the others.

Reviews of evidence-based suicide prevention measures conclude that a combination of different strategies is most effective in reducing suicide rates (Hegerl et al. 2013, Zalsman et al. 2016). The combination of approaches may vary by region or in different communities. In support of such flexibility, the World Health Organization (2014) recommends national suicide prevention strategies that allow communities to focus on their own specific needs. A training of general practitioners (GP) is an evidence-based successful suicide prevention strategy (Zalsman et al., 2016). Training help for GPs to improve the detection and treatment of depression, either by the prescription of antidepressants, use of psychosocial interventions or referrals to psychological or psychiatric care. This is supported by a study from 29 European countries showing clear inverse relationships between changes in the prescription of antidepressants and changes in suicide prevalence (Gusmao et al., 2013), some other studies also support this relationship (Henriksson & Isacsson, 2006, Szanto et al., 2007, Roskar et al., 2010).

Some studies show the advantage of collaborative care such as a study conducted in Japan. In this study the use of depression screening and psychiatrist follow-up lowered the rate of suicide by 61%, (Oyama et al., 2010) this is also confirmed in other studies (Comtois et al., 2011; Cooper et al., 2006; Nielsen et al., 2011). Several other interventions have also proven effective such as “Tele-Help” or “Tele-Check,” (DeLeo, Carollo & Buono, 1995.), by following up and providing community support to people who have attempted suicide and has caused a decrease in the number of repeated attempts (Hvid et al., 2011; Bilen et al., 2014, Gysin-Maillart et al., 2016) and suicides (Fleischmann et al., 2008; Pan et al., 2013).

For suicidal adolescents, family-based interventions have consistently shown decreases in suicidal ideation and suicide risk factors (Diamond et al., 2010; Hooven et al., 2010; Pineda et al., 2013; Warff et al., 2012) that are superior to routine interventions. By combining several suicide prevention approaches in a multi-level intervention programme, synergetic effects can be expected (Althaus, Hegerl 2003; Hegerl et al. 2009; Hegerl et al. 2013; Harris et al. 2016), which has been demonstrated in some studies in Germany (Hegerl et al., 2010, Harris et al., 2016). Hungary (Szekely et al., 2013) and Japan (Motohashi et al. 2007).

## EXAMPLE OF GOOD PRACTICE

**The European Alliance against Depression (EAAD)** is an international non-profit organization supporting worldwide activities for improving the health care of patients with depression and preventing suicidal behaviour. The core of its activities constitutes its community-based 4-level intervention program, including activities at following levels: (1) cooperation with primary and mental health care, focusing on training general practitioners to recognize and treat depression early on; (2) public depression awareness campaigns; (3) cooperation with community facilitators and stakeholders to improve care for depression and preventing suicide in the community; (4) support for people at high risk for depression and their relatives. Aside from this the EAAD has implemented the self-management tool and information website iFightDepression in several countries and is available in over ten languages to date. Evidence has shown that the community-based intervention program is effective in reducing suicidal behaviour and in improving care of patients with depression in several countries (Hegerl et al., 2013, 2019). So far, EAAD's community-based intervention program has been implemented in 17 member states across Europe, Australia, as well as Latin America. The European Commission presented the EAAD project as one of the most promising strategies in the area of mental health at the WHO European Ministerial Conference on Mental Health in Helsinki. It is prevention programs that simultaneously address suicidal behaviour and the care of depression. Overall, EAAD may serve as an example of how European community based "best practice" models for improving the care of depressed patients and suicidal persons can be implemented using a bottom-up approach (starting from a regional model project to a national expansion of activities and policy relevant recommendations).

More about program is available at:

<http://www.eaad.net/>, <https://ifightdepression.com/en/>

**The Skill Training on Risk Management (STORM)** is suicide risk management training for health professionals working in primary care, accident and emergency departments and mental health services. A 6-month training period significantly improved suicide risk assessment and management skills. (Appleby et al., 2000) The



sustainability of positive project results requires the support of the institution and regular supervision. (Gask et al., 2006).

**Applied Suicide Intervention Skills Training (ASIST)** is a two-day suicide intervention skills training course. The course was developed by Living Works in Canada and is delivered as a part of many counties suicide prevention strategies. Skills, knowledge and attitudes are developed through educational modules, group discussion and a variety of simulated intervention situations. Evaluation found that ASSIST improves participants' knowledge and skills scores, attitudes towards suicide, willingness to intervene and increases self-reported intervention behaviour. The emphasis is on teaching suicide first aid to help a person at risk stay safe and seek further help as needed. Participants learn to use a suicide intervention model to identify persons with thoughts of suicide, seek a shared understanding of reasons for dying and living, develop a safe plan based upon a review of risk, be prepared to do follow-up, and become involved in suicide-safer community networks. Graduated skills development occurs through mini-lectures, facilitated discussions, group simulations, and role plays. This program has been included in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) [www.livingworks.net](http://www.livingworks.net)

### **Depression and suicide prevention in old age adults**

A systematic review of elderly suicide prevention programs (Lapierre, Erlangsen , Waern et al 2011) found a casemanagement prevention program (Unützer et al., 2002, 2006; Alexopoulos et al., 2009 ), telephone counseling (De Leo et al., 2002) and meaningful personal goals intervention program (Lapierre et al., 2007) successful in prevention of depression and suicide in old age citizens.

**Caremanagement base depression prevention program** offered care manager (nurses, psychologists or social workers) support that included education about treatment options, brief psychotherapy (interpersonal or behavioral) and provided close monitoring of depressive symptoms and medication side effects as well as follow-up of patients for preventions of depression and suicidality in elderly patients (Unützer et al., 2002; Alexopoulos et al., 2009)

**Telephone counseling** program consists of service that provides support and needs assessment telephone calls twice weekly and a 24-hour emergency alarm service. Data

from 1988 to 1998 allowed comparison of 18,641 service users with a comparable general population group of the Veneto region in Italy. Significantly fewer suicide deaths occurred among the elderly service users than expected despite an assumed overrepresentation of persons at increased risk. The service performed well for elderly females (De Leo et al., 2002)

**Meaningful Personal Goals intervention program.** The program was aimed at helping the older adults with suicidal ideation to set, plan, pursue, and realize their personal goals. The positive results obtained from this program could lead to an innovative way to help people with suicidal ideations (Lapierre et al., 2007)

## **2.9 Prevention programs in older age**

Older age carries a risk for cognitive impairment as well as for mental disorders such as depression and Alzheimer disease. In order to help prevent mental disorders in old age it is necessary to plan various activities that will have a preventive effect on cognitive functioning and prevent mental disorders, like depression. Elderly people who are assessed to be at risk of reduced independence and reduced positive mental health should be offered a variety of activities which they can choose from based on their own interests. Programs can include physical exercise, creative activities including various lessons in dancing and singing, learning to use digital technology, practicing hobbies like gardening, various socializing programs, including socializing with volunteers, and active volunteering that provides a useful experience. All activities with involve socializing with other people help to reduce loneliness and social isolation. Multimodal programs that involve a combination of multiple activities have proven to be the most effective (Kropf & Cummings, 2008; Forsman, Nordmyr & Wahlbeck, 2011). Communities should take care to provide citizens with various activities that can be organized by local communities as well as by volunteer organizations and various citizens' associations. These activities are preventive and maintain mental health and should be carried out continuously.

### 3. Evidence-based psychosocial interventions and psychotherapy

Mental disorders reflect the complexity of interactions between biological, psychological, and social factors related to the occurrence, onset, course, and outcome of an illness. There is a sufficient evidence to demonstrate that psychological interventions are both effective and cost-effective in the treatment of mental disorders and that these interventions contribute more broadly to the community and the economy through a reduction in need for access to health services generally and increased functioning and employability.(Levin & Chisholm, 2016). Although there are a large number of psychosocial interventions and psychotherapies that are evidence-based practice (EBP), they are still insufficiently used in practice. Lack of awareness that EBPs exist is a pervasive barrier which has contributed to the ongoing multiyear gap between research outcomes and clinical practice (Dixon et al., 2001).The intention of this review of psychosocial interventions and psychotherapy is to encourage their application in practice, as well as to encourage research in those interventions that we already know are effective in real life practice, but there is a need for more research such as self-help groups, peer work, self-stigmatization reduction programs and other. One of the goals of psychological interventions is improving the person's psychological and social functioning, promoting recovery, what in the long run reduce the person's vulnerability to mental disorders. State of art of psychosocial, psychotherapy as well as pharmacotherapy interventions raise optimism for better mental health, prevention and treatment of mental disorders.

In this chapter, the evidence base for psychosocial and psychotherapeutic interventions for the treatment of mental disorders is presented. A detailed description of a particular intervention can be found in the glossary of evidence-based interventions and good practice at the end of this booklet. We are aware of the fact that most of the EU member states use professional guidelines developed by professional associations for the treatment of various mental disorders, which include guidelines for the use of medication, psychosocial interventions and psychotherapy. Information presented here are in line with these recommendations. It is not our intention to create a new guideline, but to present in one place the evidence base for psychosocial and psychotherapeutic

interventions in order to emphasize their importance for recovery from mental disorder since they are often omitted in the treatment plan and are sometimes considered second-line therapy. We would like to point out that these interventions are not an alternative to medication treatment but are an integrative part of the treatment, without them there is no successful treatment outcome. We would also like to point out that a large number of psychosocial and psychotherapeutic interventions lead to the same treatment results, so they should be applied in accordance with an individual treatment plan that takes into account the assessment provided by professionals, appropriateness of interventions for person in treatment and availability of treatment intervention provided by educated staff as well as the patient's preferences. There are no one-size-fits-all interventions, therefore careful selections and combinations are needed. In this chapter we also present selected examples of good practice that can serve as a model for application and adaptation in other countries and facilitate international exchange of practice and research.

### **3.1 Therapist – patient relationship and therapeutic alliance as an evidence-based intervention**

Continuity and consistency of care and establishing trusting, empathetic and reliable relationships with competent and insightful health care professionals is key to patients receiving effective, appropriate care (NICE 2012). Studies have suggested that therapist-patient relationships, including therapeutic alliance, are relevant to treatment outcomes regardless of the type of treatment provided and regardless of the diagnosis. The therapeutic alliance refers to the commitment of the therapist and the client to work together to help resolve client's issues. Studies confirmed good outcomes related to therapeutic alliance in medication treatment regardless of the diagnosis (Frank & Gunderson, 1990; Chang et al., 2019; Krupnick et al., 1999; Weiss et al., 1997, Gaudiano & Miller, 2006.) as well as in rehabilitation (Chinman, Rosneheck & Lam, 2000; Dziopa & Ahern, 2009; Hicks & Crowe, 2012). There is considerable evidence that the therapeutic relationship/therapeutic alliance makes substantial and consistent contributions to successful psychotherapy outcomes independent of the type of psychotherapy (Norcross & Wampold, 2011; Norcross, 2011; Karver et al., 2006;

Horvath et al., 2011). The relationship acts in alliance with interplay of treatment methods, patient characteristics, and practitioner qualification to provide an intervention. These relational factors include qualities within the therapist such as the client's perceptions of the therapist's empathy and credibility (genuineness), particular behaviours or skills including empathic understanding, defined as the degree to which the therapist successfully communicates personal understanding of the client's experience; positive regard, defined as the extent to which the therapist communicates non-judgmental care and respect; and congruence, or the extent to which the therapist is non-defensive and "real." (Martin, Garske & Davis, 2000). Norcross and Wampold (2011) found that these elements of the relationship were effective: forming a positive therapeutic alliance with patients or their family, cohesion among patients in a group therapy setting, empathy, eliciting patient feedback, goal consensus, collaboration, positive regard and support, elements of congruence or genuineness, repairing alliance ruptures, and managing countertransference. The patient-therapist relationship is an evidence-based intervention, an integral part of all therapeutic interventions, so it is an obligatory element of standard care regardless of the type of interventions (medication, psychosocial interventions, and psychotherapy). The ability to establish a therapeutic relationship is a skill that needs to be learnt. The following skills should be learnt and practiced in order to establish and maintain a therapeutic relationship: active listening, expressing empathy, installing hope and optimism in recovery, recognizing and managing one's feelings (countertransference), recognizing the patient's feelings including transfer, skills in dealing with the patient's feelings, providing information about the disease and its treatment based on biopsychosocial and recovery framework; formulating goals of treatment in partnership with the patient, motivational interviewing, showing warmth, honesty and authentic interest for the patient. The therapeutic relationship is the basic framework in which complex intrapsychic and interpersonal processes take place that lead to the desired changes agreed upon in the therapeutic alliance. The process of change is not an ascending line but a process of successes and failures, an irreplaceable experience from which one can learn. A confident, confidential, empathetic, non-judgmental supportive relationship in which the therapist believes the patient can change, supports him in that change is an essential framework in which change occurs regardless of the therapeutic method applied. Studies comparing the effectiveness of different evidence-based interventions do not

give preference to any method, which points to the fact that although the method of treatment is important, its success is determined by the quality of the therapeutic relationship incorporated within the applied treatment method and the patient's efforts to change: the patient may become increasingly motivated by this relationship and begin to believe that change is possible, and is encouraged to try new, more successful ways of functioning, therefore the therapist-patient relationship is an important element of any treatment methods that makes the difference between successful and unsuccessful therapies.

The therapeutic relationship is the basic framework in which complex intrapsychic and interpersonal processes take place that lead to the desired changes agreed upon in the therapeutic alliance. The process of change is not an ascending line, but an interplay of successes and failures, an irreplaceable experience from which one can learn. A confident, confidential, empathetic, non-judgmental supportive relationship of the therapist who believes that the patient can change, supports them in that change is an essential framework in which change occurs regardless of the therapeutic method applied. Studies comparing the effectiveness of different evidence-based interventions do not give preference to any method, which points to the fact that, although the method of treatment is important, its success is determined by the quality of therapeutic relationship incorporated within the applied treatment method and, on the other hand with patient's efforts to change. Subsequently, the patient becomes increasingly motivated by this relationship and begins to believe that change is possible, and is encouraged to try new, more successful ways of functioning, hence the therapist-patient relationship is an important element of any treatment methods that makes a difference between successful and unsuccessful therapies.

### **3.2 Evidence-based psychotherapy**

Psychotherapy is psychological treatment for a range of psychological, emotional and relationship difficulties and disorders. It involves a variety of approaches. Each approach is based on a well-established body of theory, methodology and research, grounded in a psychology of person and the human condition (The European Association of Psychotherapy, EAP <https://www.europsyche.org/>). There is strong

evidence that, when properly implemented, psychotherapeutic treatments produce robust effects for a range of mental health problems (Woelbert, 2015) in all ages (Carlier et al., 2012; Smit & Glass 1977). Although psychotherapies vary in their theoretical foundations and techniques, there is not much difference in their efficacy. The choice of psychotherapy and its effectiveness will depend on the goals to be achieved, the availability of trained psychotherapists, the preferences and motivation of the patient as well as on establishing a good therapeutic relationship between the patient and the therapist.

The most commonly used psychotherapies in mental health setting include different modalities of psychodynamic, cognitive-behavioural (CBT) and systemic family psychotherapy. Certainly, other modalities are also effective, but there are not subject in this review. Within these modalities, there are several different models that share the common theoretical basis but differ in intervention techniques when it comes to the achievement of treatment goals. Psychotherapies are used in the treatment of various mental disorders and the scientific basis of their effectiveness has been evaluated in numerous studies. CBT therapy and its numerous modalities have been studied the most, and psychodynamic psychotherapy has been studied the least. The low number of studies performed on psychodynamic psychotherapies does not reflect their effectiveness in clinical practice. The evidence for the effectiveness of psychotherapies arising from research and clinical practice confirm them as safe methods of treatment when used by trained psychotherapists capable of establishing a good therapeutic relationship with their patients. Numerous meta-analyses have shown the effectiveness of cognitive behavioural therapies (CBT) for treatment of various problems related to mental disorders (Hofmann et al., 2012; Kazantzis et al., 2018; Butler et al., 2006) this also applies to the new wave CB therapies which include: cognitive-behavioural therapy based on directed awareness, acceptance and commitment therapy, dialectical-behavioural therapy, extended behavioural activation and integrative couples therapy (Hunot et al., 2013). Psychodynamic psychotherapies are also effective in treating a broad range of mental health conditions and related difficulties (Gaskin, 2012). Effectiveness has been demonstrated in short psychodynamic psychotherapies (Abbass et al., 2006; Anderson & Lambert, 1995; Lewis, Dennerstein & Gibbs, 2008). as well as in long-term psychodynamic psychotherapy (Leichsenring & Rabung, 2008; de Maat et al., 2009). In recent times

mentalisation-based psychodynamic psychotherapy (MBT) (Bateman & Fonagy, 2010), initially developed for borderline personality disorder, is now being used for a wide range of disorders. The efficacy has been confirmed in numerous studies (Vogt & Norman, 2018). Group psychotherapy has been used in a wide range of conditions, across the lifespan and in differing health care settings, including inpatients, day hospitals and outpatient settings. Although group psychotherapies may use different theoretical models, what they all have in common is that they use the beneficial effects of group dynamics. The overall finding is that group psychotherapy in general is more effective than waiting lists or standard care controls (Kösters et al., 2006).

A Systematic Review of the Efficacy and Clinical et al Effectiveness of Group Analysis and Analytic/Dynamic Group Psychotherapy (Blackmore et al., 2009) provide evidence of effectiveness of group in both psychodynamic and supportive group treatment for patients with different mental health problems.

There is also strong evidence for an effectiveness of family systemic psychotherapy in a range of different mental health conditions (Stratton, 2016; Carr, 2014) and within different age groups.

Psychotherapy entails more than the alleviation of troublesome symptoms. Within the psychotherapeutic relationship the client has an opportunity to experience more of who they are, increased self-awareness, a greater capacity for self-regulation and a more satisfying life (<https://www.europsyche.org/>), all of which has an impact on promotion of resilience and the prevention of recurrence of mental disorders. Evidence-based psychotherapies are more appropriately considered as a “map” of potential routes, with the psychotherapist’s determining which treatment path to take based on the unique history and presentation of the patient as well as his/ her preferences (Cook, Schwartz & Kaslow, 2017).

Psychotherapy is an effective and cost-effective treatment of persons’ difficulties due to mental disorders, but it is still not widely available in everyday practice, therefore efforts should be made to increase its availability. For descriptions of different types of psychotherapy, see the glossary listing evidence-based interventions and good practice.



### **3.3 Stress management interventions**

Stress management involves a wide range of interventions aimed at controlling the level of emotional distress, especially anxiety, and promote resilience. The following techniques were identified as evidence-based practice: progressive muscle relaxation, autogenic training, biofeedback, guided imagery, diaphragmatic breathing, cognitive behavioural therapy and mindfulness-based stress reduction. These are all evidence-based techniques, easy to learn and practice, with good results in individuals with or without a mental health disorder (Holman, Johnson & O'Connor, 2018). Many of these interventions can be used either as self-help or with a help of professionals. Stress-management interventions also include education about anxiety based on the CBT principles, ways to cope with a stressful situation, promote resilience, better planning, e.g. better time management, conflict resolution, problem solving, self-advocacy, assertive behaviour as well as healthy lifestyle.

### **3.4 Self-management**

Self-management shows potential as an effective intervention across the prevention spectrum (Anekwe & Rahkovsky, 2018). It can help prevent the occurrence of the disease in subclinical patients as well as in the prevention of recurrent episodes of the disease. Self-management empowers a person by giving them direct control of managing their conditions (Crepaz-Keay, 2010). Self-management has been provided through self-help books and self-help programs that are offered over the internet (e-health), as well as in self-help groups and peer support (Simon et al., 2011). Its efficacy has been demonstrated in wide range of mental disorders including a serious mental illness. (Lean et al., 2019). For a group of patients who are in the process of treatment, self-management has been shown to be more effective when performed with a little help from a therapist. (Hirai & Clum, 2006; Spek et al., 2007; Van Straten & Cuijpers, 2009; Olthuis et al., 2016) but a self-guided psychological treatment without therapist support is also effective (Cuijpers et al., 2011; Clarke et al., 2009; Salkovskis et al., 2006). A large number of randomized controlled trials and meta-analyses have demonstrated that internet-based cognitive behavioral therapy (iCBT) is effective in treating depression and anxiety. Clinical outcomes are also found to be comparable

with face-to-face interventions when delivered with professional guidance (Andrews et al., 2010; Olthuis et al., 2016). The WHO (2019) guideline on recovery plan is helpful in developing a personal recovery plan. It is a self-help tool that guides people through the process of setting up a recovery plan for themselves.

### **Self-help group**

The findings from research (Knight, 2006; Magura et al., 2002; Powell et al., 2000; Forquer & Knight, 2001; Yanos et al., 2001) on self-help groups for people with serious mental illness consistently show: reduced symptoms and substance abuse over time; concomitant reductions in crises, hospitalizations, and use of services; improved social competence and social networks and increased healthy behaviours and perceptions of well-being. There is also evidence of good results through online peer support (Naslund et al., 2016).

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## **EXAMPLES OF GOOD PRACTICE**

### **Mind Over Mood**

Comprehensive cognitive-behavioural treatment plan for mood problems. This book, written by American psychologists, is a synthesis of 40 years of clinical practice in the field, and was sold in more than 1.2 million copies in 23 languages. It contains information for better understanding of symptoms, and 60 worksheets, procedures for self-help with depression, anxiety, anger, panic, jealousy, guilt or shame. Readers can acquire skills for solving problems in relationships, for better coping with stress and fear, and for enhancing self-esteem (Greenberger & Padesky, 2015).  
<https://www.mindovermood.com/>

### **Overcoming Paranoid and Suspicious Thoughts**

The first self-help guide to dealing with suspicious thoughts can be used to treat paranoia, step by step. It is miles away from traditional thinking that time patients spend speaking about delusions should be reduced and that antipsychotics should be given in perpetuity. The authors, British clinical psychologists, guide the readers in

developing the understanding of how suspicious thoughts arise and how they can learn to cope with them (Freeman, 2016).

### **Break Free from OCD**

A very practical self-help guide for persons with obsessive-compulsive disorder (OCD), written by three CBT therapists from the United Kingdom. It describes many different clinical presentations of OCD by providing clear information and vignettes and offers action plans how to deal with the problem. Not only would it be useful for persons with OCD, but for their families and friends. We now know that psychotherapy can be of great help for dealing with obsessive, intrusive, unwanted thoughts (and images), especially if paired with antidepressants, particularly if the clinical presentation includes compulsive, repetitive rituals (Challacombe, 2011).

### **Getting Better Bite by Bite**

The manual stems on 20 years of clinical practice in treating bulimia and binge-eating at King's College and Maudsley Hospital in London. The authors of the book, accompanied by useful illustrations and packed with action plans, are world renowned experts in the treatment of eating disorders, and experts by experience (Schmidt et al., 2016).

### **Addiction Recovery Skills Workbook**

Although mental health problems of persons with substance use disorders usually require long-term, intensive and comprehensive care by the specialist addiction services, they can still profit from following this excellent and useful self-help guide, particularly if stigma or availability of services are the impediments for getting expert help. Two psychiatry professors integrated CBT techniques, motivational enhancements and mindfulness exercises for relapse prevention. The guide contains well written treatment plans and covers skills for better communication and better support from friends and family (Glasner-Edwards, 2015).

### **Breaking Negative Thinking Patterns**

Schema therapy gets widely accepted as an evidence-based treatment for complex emotional difficulties in personality disorders, and various group activities with schema therapy exist around the world. Here is the first workbook with self-help

approach to schema therapy that includes clarifications of schemas in vignettes and offers techniques for overcoming dysfunctional modes and behavioural patterns, written by the pioneers in the field (Jakob, 2015).

### **Living with Bipolar**

Living with Bipolar is aimed at increasing access to psychological support. Users may access worksheets, record their thoughts and any symptoms, schedule activities, and create staying-well plans. Living with Bipolar is expected to support users to learn about their condition, how to manage it, and increase their self-esteem. An online forum for peer support is also available (Lobban et al., 2017). Living with Bipolar significantly improved the quality of life, well-being and recovery compared to the usual treatment (Todd, 2012).

**SUMMIT** (inclusive of access to an Internet forum for peer support) may be used as a stand-alone tool, or with contact with a clinician in an online chat environment and individualized crisis management when the monitoring process signals a crisis. SUMMIT is intended for patients who had been treated for (at least) their third depressive episode (Kordy et al., 2013). The primary aim of the e-resource is the promotion of self-management skills by providing continuous monitoring and supportive feedback, and allowing early detection of critical developments, as well as timely provision of clinical support.

### **FearFighter**

FearFighter is an online program for people suffering from panic and phobias. It is based on a cognitive-behavioral approach. The program teaches users the interrelationship of thoughts, feelings, physical sensations and behaviors. FearFighter is designed to teach you skills to help you overcome your anxieties and fears without taking medication. It has been clinically proven to reduce the symptoms of anxiety, panic and phobia by 63%. FearFighter is a program that has received the highest rating from the National Institutes of Health and Clinical Excellence (NICE) - effective, cost-effective and recommended as a first line in care.

Available at: <https://apps.apple.com/us/app/fearfighter-cbt/id1230258838>

## **The Panic Course**

The Panic Course is a five-lesson online CBT programme. Lesson content is presented in the form of an illustrated comic-style story about a character who experiences panic disorder and gains mastery over their symptoms with the help of a clinician and through the use of CBT techniques. Participants have access to frequently asked questions for each lesson, “Patient Recovery Stories” from former patients at [www.virtualclinic.org.au](http://www.virtualclinic.org.au) and extra resources on key information including: good sleep, assertive communication, healthy boundaries, shifting attention and structured problem solving. Skills covered over the panic program include: psychoeducation on panic disorder, anxiety, diagnosis and treatment, fight-or-flight response, controlled breathing, link between thoughts and feelings, thought monitoring, thought challenging, psychoeducation on the role of avoidance, interceptive exposure, in vivo exposure, continued exposure, key skills review, relapse prevention. The five-lesson Panic Program has utility for treating panic disorders, which translates to primary care. Adherence may be enhanced with therapist contact (Allen et al., 2016).

## **CBT self-help course**

This website provides self-help tools on CBT principles, including worksheets and fact sheets and self-help mp3s. This self-help course will be helpful for people who have problems with anxiety, depression or controlling anger and aggression. The course can be adapted for other problems. Clinicians can use the course with their clients, using one step every week. This 7-step mini self-help course includes techniques that could be helpful to all, but professional help should be sought for complex or long-term problems. Available at: <https://www.getselfhelp.co.uk/step1.htm>

### 3.5. E-mental health

E-Mental Health (e-MH) is the use of digital technologies to support, deliver and enhance mental health services and improve the mental health and well-being of individuals (WPA Position statement on e-Mental Health, 2018). E-mental health services and interventions can be offered across the continuum of care, including mental health promotion and prevention, primary care, secondary care, specialized/tertiary services, and during transitions between services. These e-health solutions can be categorized in terms of their purposes, such as providing information, screening, assessment, monitoring, intervention, and peer support. (Lal & Adair, 2014). Interventions can include self-management tools, communication with service providers, counselling, and various forms of psychological and social therapies. Technologies that have been leveraged for e-mental health services and interventions include, but are not exclusive to, web sites, portals, social media, video conferencing solutions, virtual reality, chatbots, smartphones, apps and wearable devices with sensors (devices that measure physiological and behavioural data, such as heart rate and sleep patterns).

A systematic review of 452 randomized controlled trials (RCTs) showed that telepsychiatry is as reliable as face-to-face psychiatry for conducting assessments, that it performs equally well in terms of treatment outcomes and is more cost-effective. (Hubley Lynch et al., 2016). E-mental health increases the accessibility of mental health services (Lal & Adair, 2014). Live videoconferencing technologies can be used to deliver treatments to patients who are otherwise difficult to reach, and for facilitating collaboration among health care professionals (Shore et al., 2013; Valdagno et al., 2014; Fortney et al., 2011; Fortney et al., 2007).

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#### **EXAMPLE OF GOOD PRACTICE**

Suicide Prevention by Internet and Media-Based Mental Health Promotion (SUPREME)

SUPREME ([www.supreme-project.org](http://www.supreme-project.org)) is a mental health promotion program, which comprises a multi-language, culturally adapted, highly interactive website accessible

to the general public that is particularly aimed at adolescents. The website offered users access to interactive services such as real-time chat communication and a discussion forum moderated by mental health professionals, as well as written information addressing various mental health problems.

The written content aimed to raise knowledge and awareness about mental health and suicide, to combat stigma and to stimulate helping and help-seeking behaviours. The effectiveness of the intervention website was tested in a randomized, single-blind, minimal treatment-controlled, parallel, multi-centre trial. A statistically significant decline in nearly all mental health-related outcomes, such as depression, anxiety and stress, suicidal thoughts and ideation was observed.

### **GET.ON – Online Health Trainings for Improving Mental Health**

The GET.ON Institute is an online mental health service provider that focuses on improving public mental health in the general population through the use of internet- and mobile-based psychological interventions for a variety of mental health problems as a means to prevent psychological disorders such as depression, anxiety, insomnia, alcohol misuse, and chronic pain. The GET.ON Online Health Trainings have been developed and extensively evaluated in clinical trials within a large EU-funded Project at the Leuphana University in Lueneburg, Germany and have since been implemented by the GET.ON Institute. Available at: <https://geton-institut.de/>.

Through the PROMIND project offered by the GET.ON Institute, immediate access to psychological help is provided to individuals with mild to moderate depressive symptoms or stress levels, individuals who have no local or timely access to psychotherapy or preventive services, or those who do not want to access such services for personal reasons such as fear of stigma. GET.ON Stress is, to the best of our knowledge, the best-evaluated stress management training worldwide and the only one in Germany. The online training GET.ON Mood Enhancer is the first online training worldwide for which the prevention of depression has been confirmed in a randomized controlled trial (Ebert et al., 2014).

### **3.6 Psychosocial interventions for prevention, treatment and recovery from addiction**

Drug addiction is a complex mental health problem that is often associated with difficulties in various life domains such as unemployment, homelessness, relational conflicts, problems with courts, and psychiatric comorbidity. A wide range of treatment and support services are available for persons with alcohol or drug addiction problems such as detox programs, drug-free outpatient treatment, methadone maintenance therapy, long-term residential treatment programs, and harm reduction services. Evidence on effectiveness of psychosocial interventions in substance use disorders is available. Psychological interventions are an essential part of the treatment regimen and efforts should be made to integrate evidence-based interventions in all substance use disorder treatment programs. There is good evidence that abstinence rates can be improved when psychosocial treatments such as Relapse Prevention, CBT and Motivational interviewing are combined with pharmacotherapy (Feeney et al., 2002; O'Malley et al., 2015).

The following interventions are evidence-based and should be available on the basis of patients' needs: Screening and Brief interventions, Motivational interviewing, Cognitive behavioural therapy for substance abuse (including Contingency management), Relapse Prevention (RP), Family therapy (FT), Therapeutic communities (TCs) and Self-help groups (SH).

There is substantial evidence of the benefits of screening and a brief intervention for alcohol problems in Primary Health Care settings (Miller & Wilbourne, 1997; WHO Brief Intervention Study Group, 1996).

Screening provides a simple way to identify people whose substance use may put them at risk of health problems as well as those who are already experiencing substance related problems. Screening has other benefits as well. It provides the health worker with information to develop a plan for intervention, and it provides patients with personal feedback about their substance use risks and problems which can prompt them to consider changing their substance use behaviour. It is recommended that screening be carried out systematically using a standardized, validated screening



instrument such as the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST).

The ASSIST is the Alcohol, Smoking and Substance Involvement Screening Test.

It is a brief screening questionnaire to find out about people's use of psychoactive substances. It was developed by the World Health Organization and an international team of substance use researchers as a simple method of screening for hazardous, harmful and dependent use of alcohol, tobacco and other psychoactive substances. The ASSIST is especially designed for use by health care workers in a range of health care settings. It may also be useful for professionals who work with people with a high risk of problems related to substance use. The ASSIST provides information about the substances people have ever used in their lifetime, the substances they have used in the past three months, problems related to substance use, risk of current or future harm, dependence, injecting drug use. The ASSIST can help warn people that they may be at risk of developing problems related to their substance use in the future and it can provide an opportunity to start a discussion with a client about their substance use. It can identify substance use as a contributing factor to the presenting illness. The ASSIST can be linked to a brief intervention to help high risk substance users to cut down or stop their drug use and so avoid the harmful consequences of their substance use.

The manual how to use The ASSIST in primary health care settings to identify people with hazardous or harmful drug use is available at:

[http://www.who.int/substance\\_abuse/activities/en/Draft\\_The\\_ASSIST\\_Guidelines.pdf](http://www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf)

**The AUDIT is a screening intervention for alcohol consumption:**

AUDIT was developed as a simple intervention of screening for excessive drinking and to assist in brief assessment. It provides a framework for intervention to help risky drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking. This intervention is useful in early detection of addiction problems.

The WHO AUDIT manual is available at:

[https://www.who.int/substance\\_abuse/activities/sbi/en/](https://www.who.int/substance_abuse/activities/sbi/en/)

## **Brief interventions for substance use (BIS)**

Key components of BIS that contribute to their effectiveness include FRAMES techniques: Feedback, Responsibility, Advice, Menu of Options, Empathy and Self-McLellan, Meyers. 2004Efficacy (confidence for change). These techniques are also associated with motivational interviewing. Examples of FRAMES techniques are given in the manual. The effectiveness of BIS has been established primarily for alcohol use problems, although they have been applied to patients using other substances including tobacco dependence (Moyer et al., 2002). There is a substantial body of evidence showing their effectiveness in multiple settings such as emergency, general hospital ward and primary care (Fleming et al., 2002).

A BIS manual developed by the WHO is available at:

[https://www.who.int/substance\\_abuse/activities/en/Draft\\_Brief\\_Intervention\\_for\\_Substance\\_Use.pdf](https://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf)

## **Motivational interviewing (MI)**

MI is effective in engaging individuals with treatment and should be part of the assessment process for all those who misuse psychoactive substances (SAMHSA TIP 35 2019) available at:

<https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003>

MI may be used as both a stand-alone treatment and in combination with other modalities (NICE 2008, 2012) and can be delivered in a number of settings, including settings outside substance misuse services, for example, outreach, drop-in centers, educational settings, primary care. Effectiveness of MI has been confirmed in multiple studies cited in the Cochrane database (Vasilaki, Hosier & Cox, 2006; Smedslund et al., 2011). It has been concluded that MI is most effective when combined with other standard psychosocial interventions. (Rohsenow et al., 2001).

Cognitive behavioural therapy for substance abuse (CBTSA) is a time-limited, structured psychological intervention, derived from a cognitive model of drug misuse (Beck et al., 1993). CBTSA includes cognitive and behavioural strategies such as: contingency management, relaxation training, preparing for emergencies, coping with

relapses, social skills training (effective communication, refusal skills), problem solving skills as well as behavioural activation interventions to reduce substance use and depressive symptoms. (Martínez-Vispo et al., 2018). CBT is often rated as the most effective approach to treatment with a drug and alcohol population. (McRae, Budney & Brady, 2003; Weisner, Matzger & Kaskutas, 2003). Evidence for the efficacy of CBT exists for a range of substances including alcohol, cannabis, amphetamines, cocaine, heroin and drugs used by injection. Furthermore, the benefits of CBT may extend beyond the treatment period and protects against relapse or recurrence after treatment termination. NICE guidance (2008, 2011) recommend CBT interventions for alcohol and drugs misuse.

### **Contingency management (CM)**

CM is an evidence-based treatment intervention based on principles of behaviour modification. Most programs focus on positive behaviours, with reinforcement for the desired behaviour. There is strong evidence that CM is an effective strategy in treatment of substance use disorders, particularly, opioids, tobacco and polysubstance use. The evidence suggests that contingency management reduces illicit drug use (Griffith et al., 2000; Lussier et al., 2006; Prendergast et al., 2006; Minozzi et al 2016; Gates et al., 2016) as well as improves adherence to opiate substitution programs (Helmus et al., 2003). Contingency management can be administered by staff with relatively little training and can also be provided alongside other psychosocial and psychotherapy interventions. CM is recommended in NICE guidance (2008).

### **Relapse Prevention (RP)**

RP has been a set of strategies to help the client maintain treatment gains rather than a specific intervention per se. (Jarvis, Tebbutt & Mattick, 2005). It differs from standard CBT in that emphasis is placed on training people who misuse drugs to develop skills to identify situations or states where they are most vulnerable to drug use, to avoid high-risk situations and to use cognitive and behavioural strategies to cope effectively with these situations (Carroll & Onken, 2005). RP program should include identifying high-risk situations and triggers for craving, developing skills to manage cravings and other painful emotions without using substances, learning to cope with lapses and attaining a life-style balance (Wanigaratne, Davis & Preston, 2005).

RP has a considerable evidence-base in the treatment of substance use disorders and helps in producing positive outcomes. RP is effective and can be enhanced by adding pharmacological treatment (Irvin et al., 1999).

### **Family therapy (FT)**

FT has been considered as evidence-based treatment for persons with addiction problems (SAMHSA 2004). There are two types of family therapy, one is family work based on psychoeducation, and the other type of family work is family psychotherapy, which most often uses a systemic approach. (Sexton et al., 2011).

### **Therapeutic communities (TCs)**

TC for addiction are drug-free environments in which people with addictive problems live together in an organized and structured way to promote change toward recovery and reinsertion in society (Broekaert, Kooyman & Ottenberg, 1998).

Although outpatient, medically assisted (substitution) therapy is still one of the most common addiction treatment modalities, there is a significant shift towards recovery-based models in all services dealing with treatment and care programs for people with addiction problems (SAMHSA, 2003).

Recovery-oriented treatment in TCs “community as a method” is a widely accepted concept (De Leon, 1997) and has been implemented on all continents. Length of stay in treatment and participation in subsequent aftercare were consistent predictors of recovery status. (Vanderplasschen, Yates & Mioviský, 2017).

### **Social Behavior Network Therapy (SBNT)**

SBNT and other community reinforcement approaches were developed by adapting cognitive behavioral therapy and community reinforcement approaches. The intervention is based on the principle that people who misuse substances need to develop a social network to promote a positive support for change. This intervention aims to find people within clients’ social network who want to be actively involved in helping them.

### **Individual and group psychodynamic psychotherapy**

There is also some evidence for acceptance and commitment therapy, individual psychodynamic therapy (Crits-Christoph et al., 2008) and group psychodynamic psychotherapy (Sandahl et al., 1998) in the treatment of people with addiction problems.

### **Self-help groups (SH)**

SH have not yet been sufficiently evaluated in research, although their importance has been recognized in the process of recovery from various mental disorders and thus in the field of addiction. A self-help group is any group that has the aim of providing support, practical help and care for group members who share a common problem.

The most known self- help program is 12 steps Alcoholic Anonymous (AA). Some research supports the efficacy of 12-step groups (Humphreys, Blodgett & Wagner, 2014; Witbrodt et al., 2014; Walitzer, Dermen & Barrick, 2009) related to short and long term decreases in alcohol consumption.

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### **3.7 Psychosocial interventions of patients with dual diagnosis**

The psychiatric comorbidity in substance users is about 50%. Depression is the most common comorbidity, with prevalence rates ranging from 12 % to 80% (Torrens et al., 2011), anxiety disorders about 35%, schizophrenia with rates of 30–66% and bipolar disorder ranges from 40% to 60%. Illicit substance use is often associated with a personality disorder, with antisocial and borderline personality disorders being the most frequent. (Langås et al., 2012). The prevailing clinical wisdom on the treatment of individuals with both disorders calls for interventions to be planned and implemented concurrently. Clinical practice suggests a common sense approach to use of interventions that have been shown to be effective in a disorder co-occurring in a single person such as cognitive-behavioural, motivational interviewing, like CBT including contingency management interventions, family treatment as well as combinations thereof. The integrated treatment where comorbid disorders are treated

in parallel could potentially be the best option for treatment of patients with dual diagnosis (Wüsthoff, Waal & Gråwe, 2014). There is a broad consensus, supported by research and current practice experience which concludes that people with concurrent substance abuse and severe and persistent mental illness are best treated in an integrated program or system of services that deal concurrently with both the mental health and substance use problems (Center for Addiction and Mental Health Canada 2002).

Several meta-analyses have been done on psychosocial interventions for people with severe mental illness and substance misuse. The evidence in support of the efficacy of any psychosocial intervention over any other or even treatment as usual (TAU) is insufficient (Cleary et al., 2008). Combined CBT therapy and motivational interviewing for clinical or subclinical depressive and alcohol use disorders has a clinically significant effect in treatment outcomes compared with treatment as usual (Riper et al., 2014). CBT is also recommended in the treatment of other disorders that most commonly occur in comorbidity with substance use (Center for Addiction and Mental Health Canada 2002). A serious mental disorder in comorbidity with substance use (the most common diagnostic categories are schizophrenia and bipolar disorder) requires the use of a wide variety of modalities and services e.g., family therapy, vocational counselling, stress management, lifestyle re-education, case management, in addition to direct treatment of their substance use. Individuals with concurrent personality disorders often fall into this category. Three types of interventions: group counselling, contingency management, and residential dual diagnosis treatment show consistent positive effects on substance use disorders, whereas other interventions have significant impacts on other areas of adjustment e.g., case management enhances community tenure and legal interventions increase treatment participation (Drake, O'Neal & Wallach, 2008).

Family interventions for co-occurring substance use and severe mental disorders (Mueser et al., 2013) show positive effects for schizophrenia, bipolar disorder and depression (Dixon, 2001; McFarlane et al., 2003; Lucksted et al., 2012). The best empirically supported treatment for borderline personality and substance use disorders is dialectical behaviour therapy (DBT), which includes behavioural skills training

(Dimeff & Linehan, 2008). There is some evidence of efficacy for the following programs:

### **Integrated group therapy for bipolar disorder (BAP) and substance use (SUD)**

It is based on a principle of conceptualizing both the disorders as manifestations of a common underlying process called “bipolar substance abuse.” The treatment for this disorder involves abstaining from drugs and substances; adherence to medication; and engaging in a variety of other “recovery behaviours,” such as getting a good night's sleep, recognizing and avoiding situations that present high risk of relapse to either substance use or mood problems, and attending SUD and BAP self-help groups. Some recovery behaviours and their underlying thought patterns are specific to one disorder or the other (e.g. learning alcohol and drug refusal; taking mood-stabilizing medication as prescribed), but many behaviours (e.g. regular sleep schedule) facilitate recovery from both disorders. This program has been significantly effective for both substance use and mental health outcomes (Weiss & Connery 2011; Weiss et al., 2007).

### **Early recovery adherence therapy**

It is a counselling approach directed towards the individual who is in an early phase of recovery from an acute episode of BAP, with a focus to promote abstinence from the substances. It is a combination of principles of motivational interviewing, relapse prevention, and psychoeducational approaches for management of BAP and substance use. It was compared to the twelve step facilitation approach in a randomized pilot study and was found to be effective (Salloum et al., 2008).

### **Interpersonal social rhythms therapy (IPSRT)**

IPSRT is a psychosocial therapy developed specifically for patients with BPAD on a premise that stabilizing the circadian rhythms of the patients is effective in preventing relapse to acute mood disturbances. It helps patients gain insight into the relationship between mood symptoms and interpersonal changes. It involves structuring daily routines of patients, including sleep cycles and addressing interpersonal problems. There is evidence for its effectiveness in preventing relapse, improving interpersonal functioning and improving satisfaction with life, in addition to the effect of medication alone. The stabilization of daily activity schedules and social and interpersonal

relationships are bound to have a beneficial effect even on the substance use disorder (Frank, Swartz & Kupfer, 2000; Miklowitz & Otto, 2007).

### **Modified CBT for psychotic disorders and substance use disorders**

Modified CBT for psychotic disorders and substance use disorders is an integrated approach for patients with schizophrenia and substance use disorders. Therapy includes relapse prevention strategies and motivational interviewing strategies. CBT is modified to account for the cognitive limitations of psychotic disorders. It focuses on a small number of skills. Initially, the skills specific to problem solving and social skills are taught. Later on, they are informed about craving and triggers for substance use. The unique difficulties pertaining to substance use in patients with psychotic disorders are discussed. Structured small group sessions, taken twice weekly for 6 months, with emphasis on social skill and relapse prevention skill building. Improved social skills and abstinence are highly reinforced to enhance self-efficacy of clients. Abstinence is positively reinforced by small amounts of monetary reward for drug free urine test results. (Ziedonis et al., 2005; Bellack & DiClemente, 1999).

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### **EXAMPLES OF GOOD PRACTICE:**

#### **Seeking Safety (SS)**

SS is the most widely used and investigated non-exposure-based treatment to date and a 24-session manualized therapy that focuses on establishing and maintaining safety (Hien et al., 2004; Najavits et al., 1998; Hien et al., 2009). Topics include, for example, detaching from emotional pain, asking for help, compassion, honesty, integration of the split self, community resources, setting boundaries in relationships, coping with triggers, self-nurturing, and recovery thinking. The “Seeking Safety” treatment is designed for clients in the first stage of recovery in which the goal is to reduce substance use and post-traumatic stress syndrome symptomatology. The treatment seeks to: increase clients’ knowledge of both disorders; enhance life structure and increase coping skills in the management of painful affect; and enhance self-care and interpersonal relationships. The results of meta-analyses showed positive evaluation in decreasing symptoms of PTSD and modest effects for decreasing symptoms of substance use. (Lenz, Henesy & Callender 2016; Flanagan et al., 2016).



### **3.8 Psychosocial interventions and psychotherapy for treatment of depression and suicide attempts**

Early and adequate treatment of depression and suicide attempts are important for prevention. Treatment of depression should be person-centred and include pharmacotherapy and different modalities of psychotherapy, computer-based and telephone-delivered psychotherapy as well as self-help management, problem solving behaviour activation, skills training, depending on the intensity of depression (mild, moderate, severe) and patient-centred needs. Mild depression can be treated with psychotherapy or psychosocial interventions only as well as with individual guided self-help based on the principles of cognitive behavioural therapy, computerized cognitive behavioural therapy, a structured group physical activity program. Moderate and severe depression are recommended to be treated with a combination of pharmacotherapy and psychotherapy as well as other psychosocial interventions such as problem solving and behavioural activation including self-management (NICE 2018; Parikh et al., 2009; Abbass et al., 2006). Psychoeducation, stress reduction and stress management as well as strengthening of social support and promoting functioning in daily activities and community life are equally important (mhGAP Intervention Guide - Version 2.0 WHO 2016). Psychoeducation should be recovery oriented and include prevention of self-stigma and suicide.

#### **How to choose a psychotherapeutic method for the treatment of depression?**

Different modalities and forms of psychotherapeutic interventions have similar benefits and no difference has yet been found between individual or group treatment interventions. Several meta-analyses have confirmed that the effects of cognitive-behavioural therapy, interpersonal, short term psychodynamic therapy, behavioural activation treatment, problem-solving therapy, and counselling as well as psychosocial interventions such as social skills training did not differ significantly from each other. (Barth et al., 2013; Cuijpers et al., 2013; Cuijpers et al., 2008; Cuijpers et al., 2011; Abbass et al., 2006). There is also strong evidence for efficacy of psychotherapeutic interventions provided via telephone, or on the internet (Andersson & Cuijpers, 2009). It is important to note that we never treat a diagnosis but a person with symptoms of depression that can be understood by a complex interaction of bio-psycho-social factors which are a unique product of a person's life experience.

Low intensity interventions are recommended in management of depression in primary care such as self-management or guided self-help, computerized cognitive behavioural therapy (cCBT), and psychological counselling as well as high intensity psychotherapy treatment face to face by a qualified psychotherapist if their available. There is also good evidence to support the use of problem solving therapy, particularly in situational forms of depression (that is, those reactive to stressful social circumstances) (Ng, How & Ng YP, 2017; Ramanuj, Ferenchick & Pincus, 2019).

### **Depression and co-morbid non-communicable diseases**

Depression often co-occurs with other non-communicable diseases such as coronary heart disease, stroke, cancer and diabetes. People with chronic physical health problems are approximately twice as likely to suffer from major depression as compared to the general adult population. Furthermore, when co-occurring, major depression is significantly associated with greater reductions in health status compared with depression alone, or with single or multiple chronic physical conditions alone (Moussavi et al., 2017).

The most effective interventions for preventing the development of depression among people with long-term somatic conditions including promoting well-being and healthy lifestyle advice in diverse settings, such as in primary care, the workplace and in social and community settings. (Naylor et al., 2012). Interventions such as behavioural activation or motivational approaches that encourage self-management and/or healthy lifestyle approaches are helpful.

A good example is a practice which has been implemented in several countries in Europe to train health care professionals in primary care, such as nurses, in cognitive-behavioural or motivational approaches that have shown to be beneficial in reducing symptoms of depression among people with long-term conditions. (NICE 2008).

Treatment of depression in older adults should be person-centered, combine psychosocial and pharmacological interventions. The following psychological methods are recommended for depression in older adults: cognitive behavioural therapy; behavioural therapy, problem-solving treatment, interpersonal psychotherapy, reminiscence therapy, cognitive self-help, healthy lifestyle. The

following manuals developed by the WHO could be useful in the treatment of persons with depression:

### **Problem Management Plus**

([https://www.who.int/mental\\_health/emergencies/problem\\_management\\_plus/en/](https://www.who.int/mental_health/emergencies/problem_management_plus/en/)), describes the use of behavioural activation, relaxation training, problem solving treatment and strengthening social support.

**The manual of Group Interpersonal Therapy (IPT) for Depression** describes group treatment of depression

([https://www.who.int/mental\\_health/mhgap/interpersonal\\_therapy/en/](https://www.who.int/mental_health/mhgap/interpersonal_therapy/en/)).

### **Thinking Healthy**

([https://www.who.int/mental\\_health/maternal-child/thinking\\_healthy/en/](https://www.who.int/mental_health/maternal-child/thinking_healthy/en/)), describes the use of cognitive-behavioural therapy for perinatal depression.

### **Evidence-based psychological treatments for prevention of suicide**

From the treatment point of view, suicidal behaviour is increasingly being understood as a symptom in its own right that needs to be specifically targeted in treatment (Oquendo & Baca-Garcia, 2014). It is not enough to focus exclusively on non-suicidal treatment targets such as depression or anxiety. Literature review of research on successful interventions that target suicidality (suicidal ideations, self-harm and suicide attempts) indicate cognitive behavioural therapies (Rudd, Williams & Trotter 2009; Stanley et al., 2009; Guille, Zhao & Krystal, 2015; Brown et al., 2005) as evidence-based first line interventions, compared to other types of psychotherapy for which there is not enough research, however they can also be used depending on the clinical assessment and preference of patients such as supportive psychodynamic psychotherapy and family therapy.

Among CBT therapies, preference is given to Dialectical behavioural therapy (DBT), especially for people with borderline personality disorder (Linehan et al., 2006; Goldstein et al., 2015). The CBT is also effective in treating suicidality in adolescents as well as family therapy and interpersonal psychotherapy (Brunstein, Klomek & Stanley, 2007). European Psychiatric Association (EPA) (Wasserman et al., 2012)

supports a combination of pharmacological treatment, cognitive behavioural therapy (CBT) and comprehensive support in preventing suicidal behaviour. It should be noted that, regardless of which type of psychotherapy is used, a common element which works includes a good patient-therapist relationship (Rudd, Williams & Trotter, 2009). Many social factors, for example loneliness, contribute to suicidal behaviour so it is important to plan psychosocial support from family, friends as well as from other community resources in an individual treatment plan (Rudd, Williams & Trotter, 2009). For all suicidal individuals, a secure relationship with the clinician is crucial, regardless of whether the clinician in question is a psychotherapist of one persuasion or another, a physician knowledgeable in pharmacological treatment, a staff member on a psychiatric ward, or a trusted social worker (Wasserman et al., 2012).

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## **EXAMPLES OF GOOD PRACTICE**

### **The safety plan intervention (SPI)**

SPI is a best practice for a brief intervention that incorporates evidence-based suicide risk reduction strategies such as lethal means reduction, brief problem solving and coping skills, increasing social support and identifying emergency contacts to use during a suicide crisis. In conducting a SPI, the clinician and client collaborate to develop a six-step plan for staying safe. These include identifying warning signs, individual coping skills, people and places for distraction, people to contact for help, professionals to contact for help, and steps for means safety intervention (Stanley & Brown 2012).

### **Cognitive Behaviour Therapy-Suicide Prevention (CBT-SP)**

CBT-SP is a manualized cognitive behavioural treatment for adolescents who recently attempted suicide, but may also apply to adolescents who experience episodes of acute suicide ideation in which precipitants can be identified. The primary goals of this intervention are to reduce suicidal risk factors, enhance coping and to prevent suicidal behaviour.

### **Dialectical behaviour therapy DBT**

DBT is a therapy model developed by Linehan (Linehan et al., 1991) specifically for the treatment of patients diagnosed with borderline personality disorder and chronic suicidal behaviour, although its use has spread to other populations. Efficacy was confirmed in the research (Tarrier, Taylor & Gooding, 2008; Linehan et al., 2006; Linehan et al., 2015).

### **Manual-Assisted Cognitive Behaviour Therapy**

It is a therapy that includes aspects of CBT, DBT and bibliotherapy. It is based on skills training and is used often in patients with personality disorders. It includes sessions with the therapist who also provides plenty of self-help material (McMain, 2007).

### **The Collaborative Assessment and Management of Suicidality (CAMS)**

CAMS is a flexible therapeutic framework in which the patient and therapist work together to assess the patient's suicidal risk and use that information to plan and manage suicide-specific treatment. CAMS, in comparison with treatment as usual, was found to decrease suicidal ideation and related cognitions in inpatients receiving individual therapy from CAMS-trained clinicians (Ellis et al., 2015; Ellis, Rufino & Allen, 2017) The program has been included in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). Available at: <http://cams-care.com/>.

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### **3.9 Psychosocial interventions and rehabilitation for persons with serious mental illness**

An array of evidence-based psychosocial interventions, as well as programs consisting of combinations of these interventions are available for treatment of persons with serious mental illness (SMI). With this said therapists, treatment teams and patients can nowadays choose any of them to develop a patient-centered recovery-oriented treatment plan, guided by the patients' present problems and aims of the therapy.

Meta-analyses, reviews and guidelines give convincing evidence for the numbers of psychological interventions available for treatment of these patients (Lincoln & Pedersen, 2019; Dickerson & Lehman, 2011; Miklowitz & Scott, 2009; Parikh et al., 2012) such as psychoeducation and illness management, social skills training, cognitive behavioural therapy, metacognitive training, cognitive remediation, family interventions, supported employment as well as assertive community treatment and early intervention programs as different organizational forms of delivering care. It is important to notice that none of these methods have an advantage over each other, most often the combination of several methods will be needed to achieve the desired recovery goals.

Contemporary psychiatry is no longer building treatment plans based only on amelioration of symptoms but on many other issues such as housing, financing, vocational support, social support targeting improvement in functional recovery and in quality of life. Biological treatment in severe mental illness is often not enough to help affected persons to reach recovery goals of social inclusion. Biopsychosocial formulation of patient's mental health difficulties is essential for the selection of psychosocial interventions and the development of a patient-centred treatment plan.

The goal of psychosocial and psychotherapeutic interventions in the long run is to reduce the person's vulnerability for psychosis. As addressed before, the therapeutic alliance is an essential element in the application of any of the methods mentioned above. The effect of any treatment method is always related with the quality of the therapeutic relationship. It is important to notice that many persons with SMI due to their developmental history have problems with attachment, therefore a therapeutic relationship is a therapeutic tool with considerable potential through corrective positive

experience of the therapeutic relationship to improve attachment. It can result in better interpersonal and psychological functioning, more social inclusion, less stress and can decrease the risk of psychosis.

Psychoeducation is a basic psychosocial intervention which should be available to all patients with mental health conditions, including patients with serious mental illness. It should be recovery-oriented, self-stigma preventive and include self-management skills. Meta-analysis confirmed the efficiency of psychoeducation on reducing relapses, the frequency of hospitalization and increasing adherence to medication (Xia, Merinder & Belgamwar, 2011).

Patients with psychotic disorders who received self-management education were more likely to improve adherence to medication (Zou et al., 2013). Motivational interviewing as well as good treatment alliance has proven to be a useful strategy in increasing adherence to medication (Barkhof et al., 2013; Vanderwaal, 2015; Chien et al., 2016; Misdrahi et al., 2012; Chang, Roh & Kim, 2019).

### **Illness Management and Recovery (IMR)**

IMR consists of several psychosocial interventions that are integrated into one program (Mueser, Meyer & Penn, 2006). The aim is to help patients acquire skills to manage their illness more effectively so that the illness becomes a less dominant part of their life, allowing them to focus primarily on the pursuit of their recovery goals. IMR has been found to significantly improve client functioning in various psychosocial domains including the ability to cope with symptoms, basic functioning, and overall well-being.

Research has supported the efficacy of training patients in illness self-management (Mueser, Meyer & Penn, 2006; Lincoln, Wilhelm & Nestoriuc, 2007; Cook et al., 2012; Hasson-Ohayon, Roe & Kravetz, 2007; Herz et al., 2000; Lobban et al., 2010; McGuire et al., 2014; Monroe-DeVita et al., 2018). Research suggests that special attention is required for fidelity, IMR duration trainers' education and supervision (Roosenschoon et al., 2016).

### **Metacognitive training (MTC)**

MCT is based on research about the cognitive processes and biases reported in persons with schizophrenia (Moritz & Woodward, 2007). Meta-analyses have shown that MTC for psychoses reduced distress caused by delusions (van Oosterhout et al., 2016; Liu et al., 2018; Eichner, Berna, 2016).

### **Social skills training (SST)**

Social skills training is a psychosocial intervention aimed at enhancing social performance and reducing the distress and difficulties in functioning experienced by people with psychoses therefore making it an essential component of most rehabilitation programs and is in turn a part of their rehabilitation package. Numbers of studies support the efficacy of social skills training for improving psychosocial functioning in schizophrenia and related disorders (we cited a few such as Kopelowicz, Wallace & Zarate 1998; Liberman et al., 2002; Kurtz & Mueser, 2008) also having shown influence on negative symptoms of schizophrenia (NCCMH, 2014; Turner et al., 2014). Compared to standard care, social skills training may improve the social skills of people with schizophrenia and related conditions and reduce relapse rates (Almerie et al., 2015).

### **The Family Interventions**

These approaches can be divided into psycho-educative family interventions, comprehensive interventions that combine information with problem-solving, social and communication skills, and systemic family interventions. The psychoeducational approach builds on the observation that patients with psychosis often rely on relatives for support (Dixon, Adams & Lucksted, 2000).

Psychoeducational interventions that involve family members convey basic knowledge about psychosis, building on the vulnerability-stress models. It aims to convey the relevance of medical and psychosocial treatment, reduce misconceptions and provide a basis on which to promote the self-management skills, improve family coping and reduce relapse (Lucksted et al., 2012). The skill-training approach builds on findings showing higher rates of relapse if a patient's family displays a communication style characterized by high levels of criticism, hostility, or emotional over-involvement "high expressed emotion" (Brown & Rutter, 1966; Bebbington &



Kuipers, 1994; Butzlaff & Hooley, 1998). It builds on the assumption that problems that arise from caring for a mentally ill family member can be solved if the family develops good problem-solving strategies and a supportive way of communicating. The therapist models the verbal and non-verbal communication rules and assists the family to use the communication skills in a series of role-plays. The improved skills are then used to solve practical problems within the family context, using a problem-solving approach. Systemic approaches assume that psychotic symptoms may have arisen from specific interaction patterns within the family.

The therapy aims to identify and change these patterns in order to reduce symptoms. Although the evidence which points to the benefit is most extensive for individuals with schizophrenia (Bressi et al., 2008; Girón et al 2010) controlled studies show positive effects for other disorders, especially bipolar disorder and major depression, as well as for schizophrenia co-occurring with substance use (Dixon et al., 2001; McFarlane et al., 2003; Lucksted et al., 2012). Meta-analyses and other studies of the effectiveness of family intervention show the effect on the reduction of relapse (Pitschel-Walz et al., 2001; Pilling et al 2002; McFarlane 1994; Claxton, Onwumere & Fornells-Ambrojo, 2017; Pharoa et al., 2010, Okpokoro, Adams & Sampson, 2014). There are several programs of family interventions which can be chosen from such as Fallon et al. (2004), Kuipers, Leff & Lam (2002), Hayes, Harvey & Farhall (2013) McFarlane et al. (2003) which can be used in single-family models as well as in multiple family groups.

### **Cognitive behavioral therapy for psychosis (CBTp)**

CBTp builds on the assumption that psychotic symptoms lie on a continuum with normal experiences. The hypothesis is that psychotic symptoms develop when stressors overload a person, causing them to have unusual experiences (Garety et al., 2001). According to this model, the unusual experience itself is not crucial but rather its appraisal is. A huge number of studies (we selected few) support the effectiveness of CBTp on reduction of distress related to positive symptoms of psychoses (Lynch, Laws & McKenna, 2010; Mehl, Werner & Lincoln, 2015; Naeem et al., 2016; Sarin, Wallin & Widerlöv, 2011; Turner et al., 2014).

## **Acceptance and Commitment Therapy (ACT)**

ACT is a therapy that applies mindfulness to teach patients accepting the existence of symptoms rather than avoid them. A meta-analysis revealed ACT as a promising psychological intervention for patients with psychosis (Tonarelli et al., 2016).

## **Cognitive remediation (CR)**

CR aims to improve cognitive deficits in people with schizophrenia/psychoses by targeting several cognitive domains with the goal of improving social functioning. Mild to severe cognitive dysfunctions may be evident in some people with schizophrenia such as decline in spatial working memory and executive functioning which, in themselves, can create interpersonal difficulties such as poor social and occupational functioning. Not all people with schizophrenia show the same cognitive deficits, and they may vary through the course of the disorder (Pentaraki, Utoblo & Kokkoli, 2018). Cognitive dysfunction may also be evident in early phases of the illness and may predate the onset (Deste et al., 2019). Cognitive remediation produces moderate improvements in cognitive performance and when combined with the other methods of psychosocial rehabilitation, also improves functional outcomes (McGurk et al., 2007). Cognitive remediation is an evidence-based approach to improve cognitive as well as real-world functioning in persons with schizophrenia and should also be considered a key strategy for early intervention in during psychosis. (Tan et al., 2019; Barlati et al., 2013). There is also a promising approach that a combination of multiple cognitive methods may increase the effect of cognition such as in cognitive enhancement therapy (Hogarty et al., 2004). Although the effectiveness of CR has been mostly studied in people with schizophrenia, it can also be used in people with other diagnoses depending on their cognitive status.

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## **EXAMPLE OF COGNITIVE REHABILITATION GOOD PRACTICE:**

Neuropsychological Educational Approach to Remediation (NEAR) is a cognitive rehabilitation program developed by Alice Medalia and her colleagues (Medalia & Freilich, 2008) for psychiatric patients to improve learning skills, motivation and neurocognitive function. It consists of several subprograms, the majority of which are computer-based. Two of the three sessions are about cognitive function activities, and

one session is a group discussion on how social skills and training programs can be applied to everyday life. Rehabilitation goals may be in the domains of education, employment, independent living, or leisure, and it is desirable that these goals are specific. NEAR uses both restorative and compensatory approaches. The program has been effective in improving cognition and social functioning (Hodge et al., 2010; Kim et al., 2018).

### **Art therapy**

The goals of art therapy for people with psychosis or SMI are to make it possible for them to experience themselves in a different way and develop new ways of forming relationship with other people; helping people express themselves and organize their experiences in a satisfactory aesthetic form; it is helping people to accept and understand the feelings they experienced during the creative process (in some cases, it may include the aspect of how those feelings developed), at a pace that works best for the person (NICE 2014). Clinical examination shows that art therapies are efficient in reducing negative symptoms in a number of treatment models for patients in both inpatient and outpatient settings (NICE 2014), but also show promising results in first episode patients (Lynch, Holttum & Huet, 2019).

### **Supported employment in severe mental illness (SMI)**

There is evidence of positive influence of employment on symptom severity and number of hospitalization days by schizophrenia patients (Hoffmann et al., 2014; Kilian et al., 2012). Regarding the treatment of first episode psychoses patients, there is strong evidence that an early functional recovery is associated with better long-term outcomes in schizophrenia patients (Alvarez-Jimenez, Gleeson & Henry, 2012). The research (Pinto, Hassen & Craig-Neil, 2018) on Supported Employment identified five key features of successful vocational interventions: (1) a multidisciplinary team that communicates regularly and collaborates, (2) a comprehensive package of services, (3) one-on-one and tailored components, (4) a holistic view of health and social needs, and (5) prospective engagement with employers. Individual Placement and Support (IPS) is the most tested intervention in psychiatric rehabilitation with 24 Randomized Controlled Trials (RCTs) only up to 2017 (Metcalf, Drake & Bond, 2018). IPS is the most successful vocational rehabilitation method at the moment in achieving and

maintaining employment for patients with severe mental illness in the regular labour market (Campbell, Bond & Drake, 2011; Kinoshita, Furukawa & Kinoshita, 2013). Evidence also indicates that its effects are held across cultures, socio-economic systems and levels of health care (Bond, Drake & Becker, 2012). There is evidence that the IPS intervention has positive effects not only on vocational but also on clinical outcomes and quality of life in patients with schizophrenia in Europe (Reme, Monstad & Fyhn, 2019; Kilian et al., 2012; Rossler et al., 2018) and internationally (Hoffmann et al., 2014 Jackel et al., 2017; Drake, Frey & Bond 2013). Cochrane Review found that, compared to other vocational interventions, supported employment increases the length and tenure of competitive employment, and is associated with a shorter period to first employment, amongst people with mental illness (Kinoshita et al., 2013; Modini et al., 2016). The same approach has been implemented and showed to be successful in education of young people (Kane et al., 2016; Rosenheck et al., 2017; Killackey, Jackson & McGorry, 2008). Common factors of successful Supported Education include: 1. specialized and dedicated staffing, 2. one-on-one and group skill-building activities, 3. assistance with navigating the academic setting and coordinating different services and 4. linkages with mental health counselling' (Ringeisen et al., 2017). IPS-Education gives special attention to the "system" around the student making sure that the same age-appropriate and recovery-oriented-goals are followed. The IPS coach has knowledge of schools and rules concerning education. He/she can provide help with choice, administration, application, contacts with school and also structuring and practicing social and learning skills. The IPS Education supports the basic attitude towards the person as a student and not as a patient through the process of education.

Useful links:

<https://ipsworks.org/>

<https://www.centerformentalhealth.org.uk/what-ips>

<https://www.england.nhs.uk/mental-health/case-studies/individual-placement-and-support-offers-route-to-employment-for-people-with-severe-mental-health-conditions/>

<https://www.trimbos.nl/kennis/ggz-erkende-interventies/effectieve-interventies-ips>

IPS, best practice implementation in the Netherlands – Phrenos Center of expertise for severe mental illness

IPS was introduced in the Netherlands in 2002 (Van Weeghel et al., 2002). Until then, the common thought was that a paid job was too much for people with severe mental illness. The implementation of IPS in the Netherlands started in 2003 at four mental health care institutions via an implementation study. The study showed that IPS was feasible in the Netherlands when a new attitude and expectation with regard to client recovery, a new organizational structure, extensive training and new funding mechanisms were met (Van Erp et al., 2007). Since 2008, Phrenos has been coordinating and facilitating the implementation of IPS at mental health care institutions throughout the Netherlands.

The Dutch multisite RCT, completed in 2014, was carried out at four IPS locations. This study showed that people with EPA in the Netherlands also find regular paid employment via IPS more often than via regular work rehabilitation: within 30 months, 44% of the participants who received IPS counselling had a paid job, compared to 25% with clients who received other forms of counselling (Michon et al., 2014). This research has proven IPS as an effective method for obtaining and retaining paid employment in the Netherlands and has been included as a recommended intervention in various multi-disciplinary guidelines and care standards (Van Alphen et al., 2012; van Weeghel et al., 2013; Netwerk Kwaliteitsontwikkeling GGz, 2017). In 2018, the IPS manual will also work! (Van Weeghel & Michon, 2018). Within this framework, an implementation process is offered that consists of information, training (to become an IPS trajectory supervisor) and consultation, completed with an IPS model compliance measurement eight months after the start of the implementation process. In the Netherlands, 460 IPS counsellors were certified between 2008 and 2020. In 2020, the 33 institutions where IPS has been implemented will employ approximately 150 fulltime-equivalent IPS workers.

As part of the IPS methodology, Phrenos coordinates a system of quality improvement. This is done on the one hand through model compliance measurements, which are carried out every two years at IPS programs by two reviewers of the Phrenos. Starting in 2016, knowledge Phrenos is also structurally collecting results every three months on the caseload, placement figures and outflow of IPS programs. A good IPS model

loyalty score is important because at IPS a link has been found between high model loyalty scores and program outcomes (Bond et al., 2012; Kim et al., 2015; Lockett et al., 2016; de Winter et al., 2020). From 2012 onwards, the Dutch IPS practices are part of the international IPS learning community where all new IPS developments are shared. In order to discuss the new developments nationally and to share knowledge, Phrenos organizes national IPS platform meetings twice a year for IPS track counsellors, coordinators and other interested parties. Since 2008 Phrenos has been responsible for the national coordination and registration of IPS implementation programs and the training of IPS workers. Fidelity reviews are done every 2 years by a team of seven trained reviewers from Phrenos. From all the Dutch IPS programs 65.38% have at least a good fidelity (mean fidelity score for all IPS programs = 102.27). The Netherlands is member of the international IPS learning community since 2012.

Useful information available at:

[www.werkenmetips.nl](http://www.werkenmetips.nl)

<https://www.kenniscentrumphrenos.nl/kennisthemas/werk/>

<https://www.kenniscentrumphrenos.nl/phrenos-center-expertise-severe-mental-illness/>

<https://www.iimhl.com/files/docs/IIMHL-Updates/20200113.pdf>

### **Healthy Lifestyles**

Serious mental illness is significantly associated with a high prevalence of somatic problems such as obesity (Dickerson et al., 2006; Vancampfort et al., 2015), cardiovascular disease (Correll et al., 2017), type 2 diabetes (Stubbs et al., 2015) and metabolic syndrome (Vancampfort et al., 2015). 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 (Lawrence, Hancock & Kisely, 2013). People with SMI commonly have poor diets and have a high prevalence of low physical activity (Janney, 2013). In addition, increased appetite and metabolic effects of some psychotropic medicines can result in weight gain. Growing evidence shows that lifestyle interventions are an

effective component of management for patients with mental illness to improve mental health, physical health and quality of life, which is also recommended by (WHO 2018), EPA (Stubbs et al., 2018) as well as by PORT Guidelines for Psychosocial Interventions (Goldberg et al., 2009) and NICE guidelines on management of physical health conditions in adults with severe mental disorders. A systematic review revealed improved physical health after participation in lifestyle interventions (Bruins et al., 2014).

### **Service interventions in care for severe mental illness**

Assertive Community Treatment (ACT) and Intensive Case Management (ICM) provide long-term, community-based care for people with SMI. These assertive approaches to community care are widely implemented in Europe (Vijverberg et al., 2017), but not in central and eastern Europe (Winkler et al., 2017), therefore there is a need to develop these services in this region of Europe. The effectiveness of ACT compared to standard care is well established. Numerous studies demonstrate significant reductions in hospitalizations and associated costs, better engagement and client satisfaction (Marshall & Lockwood, 2000). Similar conclusions have been drawn with regard to ICM from the Cochrane review (Dietrich et al., 2017). These models can effectively reduce hospital admissions and the associated costs in settings where standard community services are underdeveloped or under-resourced. (Killaspy et al., 2014)

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### **EXAMPLE OF GOOD PRACTICE**

#### **A Dutch version of ACT is Flexible Assertive Community Treatment (F-ACT)**

The multidisciplinary FACT team works in a defined catchment area for all people with severe mental illness and can operate in two different ways: 1. Individual case management by a member of the team. Other disciplines can be involved based upon the needs of the patient. 2. Intensive (ACT) team care, which involves the clients having contact with several team members; these clients are listed on the Community Treatment board and the team discusses them every day to decide which form of care should be provided and by which team members. For most clients, individual supervision (1) suffices. But if the psychosis recurs (or threatens to recur), if

hospitalization is imminent or if an individual needs extra care for some other reason, the care is stepped up (2). This is a fluctuating group of 10–20% of the clients in the team’s total caseload. For these clients the team provides team care according to the ACT principle of ‘shared caseload’. This means that all members of the team have been informed about the client and that he or she is monitored and counselled by several care workers in the team. As a result, the client can receive care every day or even several times a day. To ensure good coordination of the care workers’ activities, there are daily meetings to discuss clients on the Community Treatment board. If individual supervision is not enough and more intensive care is required, the client’s name is listed on the board during the team’s meeting. The clients on this board are discussed every day. Partly this group can be recognized as the group for Stein and Test’s ACT model (focused on the most vulnerable 20% of people with severe mental illnesses). This group consists of a high percentage of people with psychotic disorders, usually combined with addiction problems (dual diagnosis). Many of them had been in a hospital (sometimes for a long time) and were caught in the “revolving door” between the hospital and the community.

The Flexible model has not been tested in an RCT. There are however several observational trials, performed in the Netherlands, England and Sweden, indicating that the model is effective, feasible and attractive for professionals (Bak et al., 2007; Drukker et al., 2008; Firn et al., 2016; Firn et al., 2013; Lexen & Svensson, 2016; Nugter et al., 2016; Van Veldhuizen, 2007) The model is widespread in The Netherlands, where a model fidelity was developed: the FACT scale (FACTs). This scale was developed by the CCAF (Certification Center for ACT and Flexible ACT), a non-profit foundation set up by Dutch mental health care professionals and researchers (<https://ccaf.nl>). The CCAF has certified over 300 Flexible ACT teams. The certificates assure organizations, family representatives and mental health care purchasers of the quality provided by these teams.

Early intervention services (EIS) aim to ameliorate the individual and economic consequences of psychotic illness through the early identification of individuals at high-risk of developing psychosis, or those in the early stages of the illness (the prodromal phase), and the provision of evidence-based treatment based on “clinical staging”, wherein the selection of interventions (pharmacological, psychological and



social) are chosen according to illness progression (Marshall & Rathbone, 2011; McGorry, Killackey & Yung, 2008). The EPA considers that an early intervention in patients presenting with a clinical high risk (CHR) of psychosis should not only aim to prevent the first episode of an affective or non-affective psychotic disorder but also the development or persistence of functional, i.e. social, educational, or vocational deficits (Schultze-Lutter et al., 2015). Psychological treatments such as CBT have been helpful in preventing or delaying the transition to a first episode of psychosis, and/or treating symptoms in the UHR period. (Morrison et al 2004) EIS have been implemented widely in Europe. Due to differences in local resourcing and contexts, a number of variants have arisen: the specialist model, a multi-disciplinary, locality-bound team, offering time-limited ICM to individuals with first-episode psychosis (FEP) ; the “hub-and-spoke” model, where a central “hub” provides supervisory, training and administrative support to specialist staff embedded in local CMHTs; and the “integrated” model, where specific CMHT staff are nominated as EI workers and adopt a case-load of service users with FEP (Behan, Masterton & Clarke, 2016, Killaspy et al., 2014). Data generally supports the efficacy and cost-effectiveness of the specialist EIS model. EIS improves engagement with services, and reduces admission rates, symptoms and relapse (Bird et al., 2010). RCTs trails have demonstrated the superiority of EIS in reducing relapse, readmissions and symptoms, when compared to standard care (Bertelsen et al., 2008, Craig et al., 2004). The Treatment and Intervention in Psychosis (TIPS) study found higher rates of functioning and milder deficits amongst EIS service users, compared to non-EIS service users at the 10-year follow up (Hegelstad et al., 2012). Research conducted world-wide supports a variety of psychosocial interventions for ameliorating psychotic symptoms and promoting functional recovery in FEP (Wright et al., 2020) such as cognitive-behavioural psychotherapy, family education, psychotherapy and support, educational and employment support, assertive case management. These evidence-based components often come together in specialized early intervention programs. Studies emphasize continuity of specialized care for up to five years post-psychosis onset in order to consolidate gains achieved through initial treatment (Norman et al., 2011).

Numerous studies indicate that coordinated specialized services offered during or shortly after FEP are effective for improving clinical and functional outcomes among

youth and young adults at risk for serious mental illness (Craig et al., 2004; Petersen et al., 2005; Fowler et al., 2009; McGorry et al., 1996; Mihalopoulos et al., 2009; Uzenoff et al., 2012).

## **Rehabilitation**

Rehabilitation is an umbrella concept that consists of numerous psychosocial interventions with the aim to increase skills for every-day life and/or offer support for the activities of daily living and social participations in the community. The focus of rehabilitation is on addressing and minimizing the symptoms and functional impairment that people may have, with an emphasis on achieving as much individual autonomy and independence as possible. This includes optimal management of symptoms, promotion of activities of daily living and meaningful occupation, screening for physical health problems, promoting healthy living, and providing support for social inclusion. Mental health rehabilitation service users often have prominent ‘negative’ symptoms that impair their motivation and organizational skills to manage everyday activities. This places them at risk of self-neglect. Many also have on-going “positive” symptoms (such as delusions and hallucinations) which have not responded fully to medication and can make communication and engagement difficult (Killaspy et al. 2014).

Psychosocial interventions should be available to persons with mental illness with functional impairments that affect their activities of daily living and social participation as soon as possible, no matter the duration of condition, in order to prevent further impairment and stimulate recovery.

According to NICE guidelines for rehabilitation (2020) for adults with severe mental health conditions, rehabilitation should be offered as soon as it is identified that they have treatment-resistant symptoms and functional impairments that affect their activities of daily living and social participation. Rehabilitation is based on a recovery-orientated approach that ensures individualized, person-centered care rehabilitation and a recovery plan based on biopsychosocial formulation. Recovery-oriented rehabilitation encourages hope and optimism, helping people choose and work towards personal goals, aspirations and motivations, helping people to gain skills to manage their activities of daily living, their mental health and interpersonal relationship,

increase self-esteem, providing access to leisure, education, work and other opportunities for meaningful occupation, and building networks including family, voluntary, and other resources in the community, for example recovery colleges. Staff working in rehabilitation services should aim to foster people's autonomy, promote active participation in treatment decisions and support self-management. Staff should be trained in a recovery oriented approach and assess progress on a regular basis. Peer support is recommended. Studies support the benefit from the rehabilitation program (Dieterich et al., 2017; Bunyan 2016; Lavelle 2011; Macpherson 1999). The World Health Organization (2014) warns of a lack of rehabilitation services and recommends their development. Without rehabilitation services, patients in need for 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., 2014, 2019), in turn being declared "treatment resistant".

Rehabilitation must be individualized because a one-fits-all approach may not sufficiently address the intra- and inter-individual heterogeneity of patients in need of rehabilitation, therefore can also increase the number of treatment resistances.

## **Housing**

The people who need supported accommodation services often have severe, complex mental health problems, such as schizophrenia, with associated functional difficulties that impair their organizational skills, motivation and ability to manage activities of daily living. The support they need to live successfully in the community is of practical nature such as shopping, cleaning (Sandhu et al., 2017; Nelson, 2010) but they also require encouragement and support to access community resources and to remain in touch with family and friends (Killspasy et al., 2019). Adequate housing and support with activities of daily living are crucial to recovery of many patients with a severe mental disorder. Housing problems can contribute to relapse and repeat hospital admissions, therefore accommodation services are needed as an integral component of a whole system rehabilitation pathway for adults with mental health problems (Sandhu, Priebe, Leavey et al. 2017). Housing is more than a supported apartment. It is a system of social facilities into a network of human relations in a safe neighborhood (HERO 2018, <http://eufami.org/2018/03/21/housing-and-mental-health-hero/>). A growing number of people with severe mental illness choose to live as independently as

possible in their own flat, as shared housing with other mentally ill people feels like being in an institution. Housing, which guarantees the freedom to choose, gives a stronger sense of personal responsibility and helps to avoid feelings of dependence on institutions which has better results in comparison to those where freedom of choice is not given (HERO 2018). The housing model “Housing first” (HF) is associated with the best results and the greatest satisfaction of persons. (Nelson, 2010) HF is an effective approach, with evidence-based measures, to ending homelessness for people with complex support needs. This approach is effective in diverse European locations, different welfare regimes, and also under complex governance structures. While some flexibility will always be needed to adjust the approach to local conditions, it is important to follow the main principles of Housing First and preserve adherence to the original concept. 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 (Housing first guide Europe [www.housingfirstguide.eu](http://www.housingfirstguide.eu)). The [Housing First Guide Europe](#) is an online resource about Housing First in Europe. It has been designed to explain what Housing First is and how it actually works in a range of European contexts. It sets out the core principles of Housing First and shows how these are implemented in different settings. It can help to implement the approach elsewhere. 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. Its 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 Portugal (Casas Primeiro Portugal) is an example of good practice (EU compass 2016). A concrete result of Housing First is that 89% of the people involved retain their housing option. <http://www.aeips.pt/>

Guidelines for good practice and examples of good practice are described in the handbook in Housing and Mental Health HERO - The European Road through Human Rights Education [www.housing-project.eu](http://www.housing-project.eu)

### **3.10 Psychosocial interventions for people with dementia and their carers**

Dementia is a term used to describe a range of cognitive and behavioural symptoms that can include memory loss, problems with reasoning and communication a change in personality and a reduction in a person's ability to carry out daily activities. In order to slow the progression of dementia, psychosocial interventions should be applied as early as possible upon diagnosing cognitive decline or Alzheimer disease.

Psychosocial interventions to promote cognition, independence and well-being are a range of interventions tailored to the person's preferences that should be available as soon as possible to patients with mild or moderate cognitive impairment or early Alzheimer disease such as: reality orientation (Spector & Woods, 2000), reminiscence therapy (Woods et al., 2018) cognitive stimulation, cognitive training (Bahar-Fuchs, Clare & Woods, 2013) and cognitive rehabilitation (Brueggen et al., 2017). These interventions have been tested in a large number of studies and have been shown to be effective in improving cognitive functions and the ability to carry out activities of daily living when used in those with mild or moderate cognitive impairment and early Alzheimer's disease (Kudlicka et al., 2019, NICE 2018). Training of specific cognitive functions is less useful for patients whose cognitive functions are more impaired but stimulation and activation of everyday functions tends to be more meaningful and successful (Buscherta et al., 2011). These recommendations for psychosocial interventions for person with mild or moderate decline in cognitive functioning or early Alzheimer are also in line with NICE guidelines on Dementia, 2018 available at: [www.nice.org.uk/guidance/ng97](http://www.nice.org.uk/guidance/ng97)

Art therapy/interventions include music, dance/movement, visual arts, and combination of art activities. According to the Cochrane database for art therapy (Deshmukh, Holmes & Cardno, 2018) there is insufficient evidence about the efficacy of art therapy for people with dementia, more adequately powered and high-quality studies using relevant outcome measures are needed. On the other hand, the literature cites studies showing that art therapy has measurable subjective benefits in facilitating functioning through reminiscence and rediscovery of obscured abilities; improving quality of life through affirming the individual's sense of self and promoting psychological well-being; and helping reduce perceived problem behaviours associated with dementia (van der Steen et al., 2017). Art therapy involves sensory and

intellectual stimulation and is considered important in promoting interest, competency and engagement of participants (Camic, Tischler & Pearman, 2014). For people living with dementia who experience agitation or aggression, NICE (2018) recommend personalised activities to promote engagement, pleasure and interest what might include the therapeutic use of creative art based activities tailored to individual preferences, skills and abilities. Music therapy/activities can significantly improve the mood, alertness and engagement of people with dementia, it can reduce the use of medication, as well as helping to manage and reduce agitation, isolation, depression and anxiety, overall supporting a better quality of life (van der Steen et al., 2017; UK National Dementia Strategy Department of Health, 2009).

For people living with dementia who experience agitation or aggression personalized activities should be offered to promote engagement, pleasure and interest. Art therapy is a valuable resource considered to positively affect attention, create feelings of comfort, and alleviate symptoms of dementia, improving social behaviour as well as having a beneficial effect on people's self-confidence. Physical exercise on a routine basis can positively influence cognition in patients with dementia (Olazaran et al., 2010; Livingston et al., 2017), especially combination of aerobic and non-aerobic exercises (Groot et al., 2016).

### **Psychosocial interventions for caregivers**

Family members and those who care for individuals with dementia are faced with challenges that can affect their own health and well-being (Gilhooly et al., 2016). Systematic reviews, many of which include meta-analyses (Clarkson et al., 2017; Corry et al., 2015; Gaugler et al., 2017, Gilhooly et al., 2016) have identified that the most common interventions for caregivers are multicomponent interventions, which might include education about the disease and its course, information about resources, skills training, relaxation strategies, home modification, counselling, and social support, physical activity, CBT interventions and forms of professional services such as respite care and case management. In order to support caregivers of people living with dementia they should be offered psychoeducation and skills training intervention that includes: education about dementia, its symptoms and the changes that can be expected as the condition progresses; help them to develop personalized strategies and building carer skills; training to help them provide care, including how to understand

and respond to changes in behaviour; training to help them adapt their communication styles to improve interactions with the person living with dementia; advice on how to look after their own physical and mental health, and their emotional and spiritual well-being; advice on planning enjoyable and meaningful activities to do with the person they care for; information about relevant services (including support services and psychological therapies for carers) and how to access them; advice on planning for the future.

The support provided to carers should be tailored to their needs and preferences as to what they want achieved (for example, providing information on carer's employment rights for carers who work or want to work); designed to help them support people living with dementia; available at a location they can get to easily; provided in a format suitable for them (for example individual or group sessions, or online training and support) (NICE 2020 Dementia: assessment, management and support for people living with dementia and their carers )

### **WHO iSupport**

WHO iSupport is a manual offering self-help tools for the care of people with dementia, including family members, relatives and friends. The manual is organized into five modules (1) introduction to dementia; (2) being a carer; (3) caring for me; (4) providing everyday care; and (5) dealing with behavior changes that might happen in people living with dementia.

Avialable at: [https://www.who.int/mental\\_health/neurology/dementia/isupport/en/](https://www.who.int/mental_health/neurology/dementia/isupport/en/).

There is also an online support program available at

<https://www.isupportfordementia.org/en>

### **INNOVAGE**

INNOVAGE) is the InformCare Web platform for empowerment of family caregivers available in 27 European countries (Barbarella et al., 2016), publicly accessible at [www.eurocarers.org/informcare](http://www.eurocarers.org/informcare).

Multimodal interventions which combine different psychosocial interventions to promote cognition, independence and well-being combined with physical, art and

other activities as well as caregiver support interventions that are tailored to the person's current mental state and preferences are expected to give the best possible results for cognition improvement other symptoms and the ability to carry out activities of daily living.

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## EXAMPLES OF GOOD PRACTICE

### **MAKS**

MAKS is a multicomponent group therapy intervention consisting of tasks organized into three categories-motor stimulation, practice in activities of daily living and cognition. Each daily session begins with introduction, lasting approximately 10 minutes and is designed to help the dementia patients feel part of the group. It consists of a round of greetings followed by a group song (usually a hymn) or a discussion about a meaningful topic, such as happiness. This is followed by about 30 minutes of motor exercises, such as bowling, croquet, or balancing a tennis ball on a frisbee and passing it to one's neighbour. After a 10-minute break, the patients spend approximately 30 minutes completing a variety of cognitive tasks, ranging from paper and pencil exercises, such as solving word jumbles or matching symbols into pairs, to picture puzzles projected digitally onto a large screen to be solved by the group. MAKS is designed to promote activities meeting an individual's performance limit.

Therefore, therapists match all participants into three homogenous groups according to the individual performance levels (operationalized with MMSE-score) and assign cognitive tasks from one of three difficulty levels to the appropriate group. This is followed by about 40 minutes during which patients practice activities of daily living (such as preparing a snack), engage in creative tasks (such as working with wood, paper, or other natural materials), or do simple gardening.

These multicomponent group interventions conducted in a nursing-home setting has the potential to slow down cognitive decline, in dementia patients and in their ability to carry out activities of daily living for at least 12 months. (Graessel et al., 2011)



## **COPE Care of Persons with Dementia in their Environments**

The COPE program targets modifiable environmental stressors in order to decrease sensorial, physical, and cognitive demands and align with patient capabilities and also to rule out underlying medical conditions that can lead to reduced patient functioning. The intervention seeks to re-engage patients in daily activities and increase functionality, thereby alleviating caregiver burden. The COPE program aims at supporting patients' capabilities by reducing environmental stressors and enhancing caregiver skills. In this multicomponent intervention, all COPE dyads are exposed to the different treatment elements: assessments (patient deficits and capabilities, medical testing, home environment, caregiver communication, and caregiver-identified concerns); caregiver education (patient capabilities, potential effects of medications, pain, constipation, dehydration); and caregiver training to address caregiver-identified concerns and help them to reduce stress. Training in problem-solving, communication, engaging patients in activities, and simplifying tasks, is tailored to address caregiver-identified concerns and patient capabilities. COPE dyads receive up to 10 sessions over 4 months with occupational therapists, one face-to-face session and one telephone session with an advanced practice nurse. Occupational therapists initially interview caregivers to identify patient routines, previous and current roles, habits and interests, and caregiver concerns. They also conduct cognitive and functional testing to identify patient strengths and deficits in attention, initiation and perseverance, construction, conceptualization, and memory. Occupational therapists then train caregivers to modify home environments, daily activities, and communications to support patient capabilities; use problem-solving to identify solutions for caregiver-identified concerns; and reduce stress. For each targeted concern, a written action plan is provided describing treatment goals, patient strengths, and specific strategies. In a home visit, the nurse provides caregivers with health-related information (pain detection, hydration), obtains patient blood and urine samples, and examines patients for signs of dehydration. Patient medications are reviewed for appropriateness, polypharmacy, and dosing using published guidelines. Caregivers are informed about laboratory results by telephone and mailed copies to share with the patients' physicians (Gitlin et al., 2010).

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### **3.11. Mental health services that encourage recovery, respect human rights and fight stigma**

Positive treatment experiences are equally important from the therapeutic aspect of the optimal treatment outcome and the human rights aspect. Human rights and optimal treatment are in dynamic interaction – respect for human rights affects the positive outcomes of treatment and vice versa. It is important to stress that experiences with mental health services vary among patients, i.e. that many patients have negative experiences, so it is important to take measures that will result in positive treatment experiences. The therapeutic environment that encourages recovery processes implies a therapeutic culture in an atmosphere of optimism and hope, treatment based on informed consent, empowerment, principles of recovery, respect for human rights, free from stigma and discrimination. It also involves a biopsychosocial approach to assessing the mental state and choosing treatment interventions that aims to maximize the person's recovery from mental illness, and individually planned treatments in which the patient is an active participant with a key role.

Therapeutic culture of recovery also encourages patient strength, autonomy and provides the support needed for activities that a person cannot carry out on their own, and is free from paternalistic attitudes. The accessibility of mental health services according to the patient's needs has an impact on seeking help and on treatment outcomes. Recommendations on standards for the setup of therapeutic environments can serve as useful guidelines for their improvement. The recommendations relate to a holistic therapeutic environment that includes the physical arrangement of the space, attitudes, behavior, and interactions of staff with patients. Useful recommendations can be found among the standards drawn by the WHO. WHO's QualityRights assessment toolkit enables countries to assess their services against standards derived from the CRPD; NICE guidelines recommend that health care professionals acknowledge patient's individuality and the unique way in which each person experiences a mental health condition and its impact on their life, take into account any social factors and their previous experience of health care that may impact on their health condition and/or affect their ability or willingness to engage with healthcare services as well as to make decisions about their treatment. Continuity and consistency of care and establishing trusting, empathetic and reliable relationships

with competent and insightful health care professionals is emphasized as crucial to patients receiving effective, appropriate care. The importance of increased trust in mental health services from the general public and patients has been recognized by the European Psychiatric Association (Gaebel et al., 2014). The issues of availability of mental health services, confidentiality, continuity of treatment, dignity, safety and avoidance of stigma and coercion are central elements to increasing trust. The EPA points out that increasing trust in mental health care providers and psychiatrists should be regarded as a priority as it may facilitate the rate of mental health care utilization and user satisfaction. In order to achieve this, it is important to further train psychiatrists, especially in establishing empathic professional therapeutic relationship, providing information about services and collaboration with other services.

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### **3.12 Anti-stigma programs**

Stigma and discrimination in relation to mental illnesses have been described as having worse consequences than the conditions themselves (Sartorius & Schulze, 2005). Mental illness-related stigma is major barrier to recovery and full participation in society for persons with mental illness. Unfortunately, stigma exists also among health care providers including mental health professionals, which creates serious barriers to access and quality care. It is also a major concern for workplace culture and may be an issue as a barrier for seeking help, as well as poorer quality physical care for persons with mental illnesses. (Henderson et al., 2014; Knaak, Ungar & Patten, 2015; Stuart, Arboleda-Flores & Sartorius, 2012; Thornicroft, Rose & Kassam, 2007; Schulze, 2007). Stigma can be a precursor to discrimination and a negative influence on investment in mental health care. It 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 (Sartorius, 2007). 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, Druss & Perlick, 2014; Livingston, 2013).

On an individual level, stigma is a significant barrier to housing, employment, income improvement, and health care (van Brakel et al., 2019). Stigma affects health in three

ways: it reduces access to and quality of protective resources and health services, it increases the risk of chronic stress and poor coping responses, it puts stigmatized people at higher risk of assault and injury. Through these three avenues, stigma can lead to adverse mental and physical health outcomes (Report on the State of Public Health in Canada, 2019). By reducing the accessibility and quality of health care, stigma can drive avoidance or delay of health care and non-disclosure of health conditions. This can increase the severity of symptoms and result in higher rates of hospitalization, emergency room visits, and health care-related costs (Evans-Lacko et al., 2014). As an example of stigma's economic impact, mental health stigma increases absenteeism and productivity loss in the workplace (Romeo, McCrone & Thornicroft, 2017; Dewa & Hoch, 2014). It also discourages affected people from seeking necessary health care and treatment, which increases costs to the health care system. Stigma is a major source of psychological stress, whether it is enacted, internalized or anticipated. Excessive and ongoing stress can lead to an impaired immune system and interfere with the body's repair processes. It can also elevate blood pressure, heart rate, and stress hormones, which may have an effect on health over time (Berger & Sarnyai, 2015; Pascoe & Richman, 2009). Research consistently demonstrates that health care providers tend to hold pessimistic views about the reality and likelihood of recovery from mental disorders, which is experienced as a source of stigma and a barrier to recovery for people seeking help for mental illnesses. (Henderson et al., 2014), therefore, it is necessary to continuously work on building a culture of recovery within the health system as well as building the culture of human rights (WHO QualityRight project).

Anti-stigma strategies have been categorized 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) (Corrigan, River, Lundin et al., 2001). There is a prevailing opinion that the interventions containing social contact and first-person narratives were more effective than others (Corrigan et al., 2012; Thornicroft et al., 2016) but education and contact interventions have both been effective (Gronholm et al., 2017; Mehta et al., 2015; Morgan et al., 2018). 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. There is little research on the effectiveness of media based anti-stigma interventions but the most promising approaches include contact-based educational interventions and guidelines developed and shared by authoritative institutions. (Maiorano et al., 2017).

Action to tackle stigma should be sufficiently long term and informed by evidence of effective strategies. According to recommendations from the World Psychiatric Association, in order to make the anti-stigma program 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; program 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 (Morgan & Jorm, 2007; Thornicroft et al., 2014; Hansson, Stjernswärd & Svensson, 2016; Henderson, Stuart & Hansson, 2016). 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. Narrative reviews of research on education – and/or contact-based interventions targeting mental illness stigma among health care providers found some evidence for short-term impacts related to attitudes, knowledge and/or intended behaviour.

All these findings create optimism that the spread of these and similar programs will increase mental health at the level of the entire population and confirm that anti-stigma programs are general prevention programs that increase mental health and prevent mental illness.

## EXAMPLES OF GOOD PRACTICE

### **Mental Health First Aid (MHFA)**

MHFA is one example of an awareness raising intervention. MHFA is an effective standardized psychoeducational intervention for improving knowledge, attitudes, and behaviour about mental health and disorders. The main aim of the program is the empowerment of the public to recognize, approach and support individuals with mental illness, and also help them to seek professional help. According to a meta-analysis (Hadlaczky et al., 2014). MHFA programs show a powerful potential as a public mental health awareness-increasing strategy. The results demonstrate that MHFA increases participants' knowledge regarding mental health, decreases their negative attitudes, and increases supportive behaviours toward individuals with mental health problems, and could be recommended as a feasible, effective method for public health action.

### **The Stigma Watch program**

This program operated since 1999 by SANE Australia is one example (<http://www.sane.org>) of a protest-based activity. People with a mental illness, their friends and supporters identify stigmatizing images presented in the media and submit a complaint to SANE. The submission is reviewed using the national guidelines for media industry codes of conduct and, if the report is found to be inappropriate, Stigma Watch informs the media (or business) about the complaint and encourages an amendment or removal of the item.

Here are some examples of successful programs which can be stimulating for states looking to launch national anti-stigma programs:

#### Time to Change

Time to change is an English national program (<https://www.time-to-change.org.uk/about-us>). It is a growing social movement working to change the way people think and act about mental health problems. Encompasses a number of social sectors, a large number of employees and volunteers working on the program. It has an extensive dissemination network, with an elaborate media guide, and contact lines

for communication with the media <https://www.time-to-change.org.uk/news-media>. The program is continuously evaluated. Data from 2018/19 shows a 3.1% improvement in attitudes amongst the adult population compared to baseline from 2016/17. This equates to a 12.7% change – that’s 5.4 million people with improved attitudes since the campaign began.

### **Opening Minds Canada**

This programme includes a systematic multi-year program that addresses the problem of stigma at multiple levels, from programs targeted at the general population and the workplace to health education programs <https://www.mentalhealthcommission.ca/English/opening-minds>.

Key program elements of “Opening Minds” include: 1. Social contact in the form of a personal testimony from a trained speaker who has experienced mental illness; 2. Multiple forms or points of social contact, where people with lived experience can be seen as educators rather than patients; 3. Focus on behaviour change by teaching skills that help health care providers know what to say and do; 4. Engage in myth-busting 5. Enthusiastic facilitator or instructor who models a person-centered approach; 6. Emphasize and demonstrate recovery as a key part of messaging, including the important role of health providers in this process. MHCC also supported the evaluation of a number of anti-stigma interventions across the country.

### **Like Minds Like Mine**

It is a program implemented in New Zealand by the Ministry of Health as part of a national plan since 1996 (<https://www.likeminds.org.nz/>). From the beginning, people with mental disorders have been involved in the design and implementation of the program, and examples of personal success stories of people with experience of mental disorders are also used, as the main way to convey the anti-stigma message. The program is continuously implemented in cooperation with various partners and includes the application of the program in various social segments, including legislation. It includes the development of media guidelines on non-stigmatizing ways of communicating news related to mental disorders. The economic evaluation of the program indicated that for every \$5 million spent, there was \$720 million in Revenue

through improved employability to reduce discrimination among employers. (Vaithianathan & Pram, 2010)

### **ONE of US**

One of us is a Danish national program implemented with the support of the Ministry of Health (<http://en-af-os.dk/English/About%20us.aspx>) includes actions aimed at young people, the workplace, and people suffering from mental health disorders, families, health care staff, the media and the general population. In 2017, they organized a conference “Overcoming barriers in mind”. Presentations, films and other material from the conference can be found at: <http://www.againststigma2017.com/>

### **Mental Health Commission of Canada’s Opening Minds Initiative (MHCC)**

In order to address mental illness stigma among health care professionals The “Understanding Stigma” workshop was developed to using social contact alongside educational and action-oriented components. The workshop was associated with self-reported changes in attitudes and intended behaviour. A meta-analysis of six replications of the program had encouraging results (Knaak et al., 2017). This research identified a number of key program elements to address mental health stigma for health-care providers, with multiple forms of social contact and an emphasis on recovery identified as the most important for effective programs. (Knaak, Modgill & Patten, 2014).

### **The Global Anti-Stigma Alliance (GASA)**

GASA was founded in 2012 to share learning, methodologies, best practice, materials, and the latest evidence in order to achieve better outcomes for people facing stigma and discrimination related to mental health issues. Information on the various national programs implemented in the EU Member States as well as in other countries can be found at: The Global Anti-Stigma Alliance (GASA) <https://www.time-to-change.org.uk/about-us/what-we-do/our-global-work/global-anti-stigma-alliance>.

### **Interventions to combat self-stigmatization**

Self-stigma or internalized 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 (Corrigan, Larson & Rüsch, 2009), difficulties in recovery and leads to a variety of negative consequence in a vicious cycle of stigma (Sartorius & Schulze, 2005). There are a small number of self-stigmatization prevention interventions that combine different psychosocial approaches that have not yet been investigated in a large number of individuals. (Mittal et al., 2012). 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 patients with mental health services. The following interventions targeting mental health self-stigma may be useful for the prevention and reduction of self-stigmatization: Healthy Self-Concept (McCay et al., 2006); Self-Stigma Reduction Program (Fung, Tsang & Cheung., 2011 ); Ending Self-Stigma (Lucksted et al., 2011); Narrative Enhancement and Cognitive Therapy (Yanos et al., 2011); Coming Out Proud (Corrigan, Kosyluk & Rüsch, 2013 ); Anti-Stigma Photo-Voice Intervention (Russinova et al., 2014). Program for self-stigma reduction (Ivezić, Sesar, & Mužinić, 2017). These interventions are frequently in a group format with cognitive and behavioural elements, such as CBT or acceptance and commitment therapy, and are intended to change internalized stigmatizing beliefs, improve coping skills, support empowerment, and/or build social supports (Büchter & Messer, 2017; Tsang et al., 2016).

Anti-stigma strategies should help people to resist devaluation and discrimination and build strength, resilience, and strategies to ward off stressors. These strategies can include invalidating the negative beliefs associated with stigma, attributing prejudices to ignorance and not to themselves, and drawing upon their identities or social roles for protection (Thoits, 2011; Shih, 2004). So, in order to address that root cause of stigma, 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?" (Report on the State of Public Health in Canada, 2019).

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## 4. Glossary of evidence-based interventions and good clinical practice

**Evidence-based intervention practices (EBP)** are interventions with consistent scientific evidence showing that they improve client outcomes (Drake et al., 2001). Randomized control trials (RCT) are generally perceived as the golden standard for establishing effectiveness (Higgins et al., 2019). It has however been questioned if this is the only and appropriately fitted design for research in psychotherapy and in psychosocial interventions. Namely in psychiatry the therapist-patient relationship is a significant factor influencing the outcome no matter which intervention is performed, on the other hand there are also a large number of patients who cannot be helped by one intervention but need to combine several interventions to achieve the desired outcomes. This EBP emphasizes integrating the best-available research with clinical expertise in the context of the patient's culture, individual characteristics, and personal preferences. The best research evidence refers to data from meta-analyses, randomized controlled trials, effectiveness studies, and process studies, as well as information obtained from single-case reports and systematic case studies. All these approaches are used in guidelines for the treatment of various mental disorders. The guidelines indicate effectiveness by the level of evidence from A to C. Level A refers to good research-based evidence, with some expert opinion. Level B indicates fair research-based evidence, with substantial expert opinion, to support the recommendation. Level C denotes a recommendation based primarily on expert opinion, with minimal research-based evidence. Adequate education is required to provide any of evidence base interventions.

**Alcoholics Anonymous (AA) approach** considers addiction as a relapsing illness with complete abstinence as the only treatment goal and is based on behavioral, spiritual and cognitive principles. As part of the process toward recovery, individuals must acknowledge to themselves (and another people) the harm substance use has caused to themselves and others, admit that they are powerless over drug use and surrender to a higher power for recovery. Individuals are encouraged to accept support from others who are recovering from addiction after undergoing the twelve-step program. Once on the road to recovery, individuals are expected to help others that

suffer from the same addictions. It is accepted that this program may be useful for some people. AA's model has been adopted by other groups such as Narcotics Anonymous (NA), Gambler's Anonymous (GA), Overeater's Anonymous (OA), and other variations. One of the modifications of AA 12 step self-help program without emphasis on the spiritual aspects is Self-Management and Recovery Training (SMART) which is a global community of mutual-support groups. At meetings, participants help one another resolve problems with any addiction (to drugs or alcohol or to activities such as gambling or over-eating). Participants find and develop the power within themselves to change and lead fulfilling and balanced lives guided by science-based and sensible 4-Point Program. More about program is available at: <https://www.smartrecovery.org/> Twelve Step Facilitation (TSF) is another modification developed as a standardized adaptation of 12-step support groups, intended as an early, individual therapy delivered by a counselor, but distinct from the original AA program. TSF helps to introduce many of the concepts of 12-step support groups, and encourages patients to engage in support groups following therapy. TSF is a manual-based program (Nowinski, Baker & Carroll, 1999).

**Acceptance and commitment therapy (ACT)** is a form of behavioral therapy that combines mindfulness skills with the practice of self-acceptance. ACT focuses on the context and function of psychological experiences (e.g., thoughts, feelings, and sensations) as the target of interventions, rather than on the actual form or frequency of particular symptoms. In ACT, individuals increase their acceptance of the full range of subjective experiences, including distressing thoughts, beliefs, sensations, and feelings in an effort to promote desired behavior change that will lead to improved quality of life. A key principle is that attempts to control unwanted subjective experiences (e.g., anxiety) are often not only ineffective but even counterproductive in that they can result in a net increase in distress, result in significant psychological costs, or both. Consequently, individuals are encouraged to connect with their experiences fully and without defence while moving toward valued goals. ACT also helps individuals to identify their values and translate them into specific behavioral goals (Ruiz, 2012).

**Art therapy/ psychotherapy** is defined by the British Association of Art Therapists as a form of psychotherapy that uses art media as its primary mode of communication.

Clients who are referred to an art therapist need not have experience or skill in art. The art therapist is not primarily concerned with making an aesthetic or diagnostic assessment of the client's image. The overall aim of its practitioners is to enable a client to change and grow on a personal level through the use of art materials in a safe and facilitating environment" (BAAT, 2013a, 2013b; Ruddy & House, 2005). Within the general Art therapy literature, a crucial distinction is made between therapy and activity, that is, whether the objectives focus on treatment outcomes, such as reduction of symptoms and/or behavioral improvements, or the process of art as a leisure activity. (Killick & Allan, 1999a, 1999b). Arts-based therapies can be used for the treatment of a variety of mental disorders. Art can be used as a way to express and communicate thoughts and feelings. The aim of art therapists is to work with patients in ways that help them change and "grow" on a personal level. This is done by using art materials in a safe environment that allows this process.

**Assertive Community Treatment (ACT)** integrates case-management and active therapeutic intervention in a single team, which uses a highly integrated approach. This intervention aims to sustain contact with severely ill, "hard-to-engage" service users in the community, reduce hospital admissions and improve psychosocial outcomes by providing multidisciplinary team-based, flexible support, using an assertive approach to engagement. Core features include

client contacts at the person's home or elsewhere in the community a low client-staff ratio, continuous coverage (including the capacity to respond to crises 24hrs per day), a shared team-based caseload (rather than individual case management) and long-term care. The focus is on assisting the person to manage their illness through psychosocial interventions and medication management alongside practical support. Representing a similar approach to ACT, intensive case management also provides long-term, community-based care for people with a serious mental illness, however, in intensive case management, practitioners are responsible for small, individual caseloads (Killaspy et al., 2014).

**Autogenic training (AT)** is a self-relaxation method by which a psychophysiological determined relaxation response is elicited. This relaxation technique was developed by Johannes Heinrich Schultz. AT aims to achieve deep relaxation and reduce stress. In AT the individual learns a set of directions/exercises that command the body to relax

and control breathing, blood pressure, heartbeat, and body temperature. AT consists of six standard exercises that with the use of visual imagination and verbal cues make the body feel warm, heavy, and relaxed. The person learns each exercise by reading about it, guided by recorded audio voice or watching a teacher, then practicing it for a 10 minutes several times a day. Mastering the exercise usually requires 4 to 6 months.

**AUDIT Screening intervention for alcohol consumption** was developed as a simple method of screening for excessive drinking and to assist in brief assessment. It provides a framework for intervention to help risky drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking. The AUDIT also helps to identify alcohol dependence and some specific consequences of harmful drinking. Of utmost importance for screening is the fact that people who are not dependent on alcohol may stop or reduce their alcohol consumption with appropriate assistance and effort. The manual is particularly designed for health care practitioners and a range of health settings, but with suitable instructions it can be self-administered or used by non-health professionals. Use among patients in primary care carries many potential benefits. The AUDIT was developed and evaluated over a period of two decades, and it has been found to provide an accurate measure of risk across gender, age and cultures.

WHO AUDIT manual available at:

[https://apps.who.int/iris/bitstream/handle/10665/67205/WHO\\_MSD\\_MSB\\_01.6a.pdf?jsessionid=D5D1BD0AC9632AE36A76923A6197EE98?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/67205/WHO_MSD_MSB_01.6a.pdf?jsessionid=D5D1BD0AC9632AE36A76923A6197EE98?sequence=1) )

**Behavioral therapy (BT)** is based on theories of learning which emphasize that every behavior, including pathological ones, are learned. The aim of therapy is to modify or undo learnt behavior through a variety of strategies and techniques such as techniques relying on classical conditioning which involves forming associations between stimuli (flooding, systematic desensitization, aversion therapy) and operant conditioning which focuses on how reinforcement and punishment can be utilized to either increase or decrease the frequency of a behavior. Behaviors followed by desirable consequences are more likely to occur again in the future, while those followed by negative consequences become less likely to occur. Techniques rely on the principles of operant conditioning, utilize reinforcement, punishment, shaping,

modeling and related techniques to alter behavior. Some of the techniques and strategies used in this approach to behavioral therapy include token economies. Clients are allowed to earn tokens that can be exchanged for special privileges or desired items. Modeling involves learning through observation and modeling the behavior of others individuals to learn new skills or acceptable behaviors by watching someone else perform those desired skills.

**Behavioral activation (BA)** is a low-intensity intervention using goal setting and activity schedules to encourage people to engage in activities they have previously avoided due to factors such as bad mood or low motivation. It is a time limited, structured psychological therapy, in which the therapist and patient work collaboratively to identify the effects of behaviors on current symptoms, feelings, and/or other psychosocial problems and seek to reduce symptoms and problematic behaviors through tasks such as reducing avoidance, graded exposure, activity scheduling, and reinforcing positive behaviors. Behavioral activation for depression aims to identify the effects of behavior on current depressive symptoms, mood and problem areas. Behavioral activation as a part of treatment for depression often involves stimulation of pleasant activities and the increase of positive interactions between a person and his or her environment. Social skills training could be also a part of the intervention.

**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; this could be provided as an adjunct to any psychological or pharmacological intervention. The befriender may for example accompany the befriender 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 current episode of the mental disorder, or earlier episodes developed based on an assessment of the interaction between psychological, biological and social factors within the unique life history of the patient. A psycho-biosocial formulation helps us gain a comprehensive understanding of the factors related to the development, maintenance of symptoms of illness and difficulties in functioning and recovery, it serves as a basis for planning the treatment. A PBS is patient-specific because it is based on the unique life experience of each person. It is a dynamic hypothesis based

on available information at the time of assessment and can be extended or changed during the treatment, based on information collected.

**Brief intervention for substance use (BIS)** aims to help the patient understand that their substance use is putting them at risk and to encourage them to reduce or give up their substance use. BIS can range from 5 min of brief advice to 15-30 min of brief counseling. In general, BIS are targeted at problematic or risky substance use and are not intended to treat people with serious substance use problems/those who are addicted or dependent. However, patients with more serious dependence problems may be referred to a specialized drug treatment service. Because of the brief nature of these interventions, they can be delivered opportunistically like when a patient presents in primary care, general hospital and so on, in both inpatient and outpatient settings by a range of specialist and other professionals who have been trained in the use of these. The effectiveness of BIS has been established primarily for alcohol use problems, although they have been applied to patients using other substances as well, including tobacco dependence. (Moyer, Finney, Swearingen, Vergun 2002).

**BIS manual** developed by the WHO is available at:

[https://www.who.int/substance\\_abuse/activities/en/Draft\\_Brief\\_Intervention\\_for\\_Substance\\_Use.pdf](https://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf)

The purpose of this manual is to explain the theoretical basis and evidence for brief interventions and to assist primary health care workers to conduct a simple brief intervention for risky or harmful drug use. Together with the ASSIST guidelines for use manual, this manual presents a comprehensive approach to screening and brief intervention which is tailored to the specific circumstances of primary care and is designed to improve the health of populations and patient groups as well as individuals. The manual describes: the rationale for brief interventions in primary care, a model of behavior change, the components of brief interventions that work, principles of motivational interviewing and essential skills, how to link screening and brief interventions, giving feedback, how to conduct a brief intervention for people at moderate risk, information and self-help resources for patients. Although the manual is particularly aimed at primary health care workers, it may also be useful for others who work with people who engage in risky drug use such as hospital physicians and nurses, social workers, or prison and probation officers.

**Collaborative Assessment and Management of Suicidality (CAMS)** is best understood as a therapeutic framework that emphasizes a unique collaborative assessment and treatment planning process between the suicidal patient and clinician. This process is designed to enhance the therapeutic alliance and increase treatment motivation in the suicidal patient. Central to the CAMS approach is the use of the Suicide Status Form (SSF), which is a multipurpose clinical assessment, treatment planning, tracking, and outcome tool. CAMS emerged as a problem-focused clinical intervention that is designed to target and treat suicidal “drivers” and ultimately eliminate suicidal coping. The effectiveness of CAMS (and the clinical use of the SSF) is demonstrated in several randomized clinical trials (RCT). Although licensed professionals usually implement the program, case managers and paraprofessionals may be trained as well, either as individuals or in groups, to engage in hybrid versions of the intervention. Dissemination occurs through the developer’s website (<http://cams-care.com>), which includes program information, training options, research information, and background resources (Ellis et al., 2015; Ellis, Rufino & Allen, 2017).

**Cognitive behavior therapy (CBT)** is a psychological approach based on the premise that cognitions influence feelings and behaviors, and that subsequent behaviors and emotions can influence cognitions. The therapist works with individuals to identify unhelpful thoughts, emotions, and behaviors. CBT has two aspects: behavior therapy and cognitive therapy. Behavior therapy is based on the theory that behavior is learned and therefore can be changed. Examples of behavioral techniques include exposure, activity scheduling, relaxation, and behavior modification. Cognitive therapy is based on the theory that distressing emotions and maladaptive behaviors are the result of faulty patterns of thinking. Therefore, therapeutic interventions such as cognitive restructuring and self-instructional training are aimed at replacing dysfunctional thoughts with more helpful cognitions, which leads to an alleviation of problematic thoughts, emotions, and behavior. In CBT the person works collaboratively with the therapist to identify the effects of thoughts, beliefs and interpretations on current symptoms, feelings states and problem areas. They learn the skills to identify, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms or problems, and appropriate coping skills. Duration of treatment varies depending on the disorder and its severity but for example for people with



depression it should be in the range of 16 to 20 sessions over 3 to 4 months; for people with generalised anxiety disorder (GAD) it should usually consist of 12 to 15 weekly sessions each lasting 1 hour. CBT has shown effectiveness in the treatment of various mental disorders in a number of controlled studies (Hofmann et al., 2012).

**Cognitive Behavior Therapy-Suicide Prevention (CBT-SP)** is a manualized cognitive behavioral treatment for adolescents who recently attempted suicide. The CBT-SP was developed using a risk reduction and relapse prevention approach and theoretically grounded in principles of cognitive-behavioral therapy, dialectical behavioral therapy, and targeted therapies for suicidal youths with depression. Although CBT-SP was implemented with suicide attempters, the theoretical approach and strategies may also apply to adolescents who experience episodes of acute suicide ideation (as opposed to chronic, unremitting ideation) in which precipitants can be identified. The primary goals of this intervention are to reduce suicidal risk factors, enhance coping and to prevent suicidal behavior. This approach focuses on developing skills (cognitive, behavioral and interactional skills) that will enable the adolescent to refrain from further suicidal behavior. CBT-SP is designed to help adolescents use more effective means of coping when faced with their stressors and problems that trigger suicidal crises. Parents meet with the therapist for family sessions focused specifically on suicide risk reduction strategies. CBT-SP is based on a stress-diathesis model of suicidal behavior. A core feature of the treatment is the development of an individualized case conceptualization that identifies problem areas to be targeted and the specific interventions to be employed during periods of acute emotional distress. The CBT-SP consists of acute and continuous phases, each lasting about 12 sessions, and includes a chain analysis of the suicidal event, safety plan development, skill building, psychoeducation, family intervention, and relapse prevention. (Stanley et al., 2009)

**Computerised cognitive behavioral therapy (CCBT)** is a form of cognitive behavioral therapy that is provided via a stand-alone computer-based or web-based program. It should include an explanation of the CBT model, encourage tasks between sessions, and use thought-challenging and active monitoring of behavior, thought patterns and outcomes. It can be used with no or minimal therapist involvement (self-

guided) or augmented by regular contact with therapist (guided CCBT). The intervention typically takes place over 9 to 12 weeks, including follow-up.

**Cognitive behavioral therapy for psychosis (CBTp)** builds on the assumption that psychotic symptoms lie on a continuum with normal experiences. The hypothesis is that psychotic symptoms develop when stressors overload a person, causing them to have unusual experiences (Garety et al., 2001). The aim is using CBT principles to re-evaluate patient's perception and beliefs in respect to the symptoms for which he/she is treated in order to reduce the stress associated with the symptoms of psychosis and improve functioning. CBT allows the patient to question evidence supporting their beliefs and brings them to self-observe, to record their thoughts and behaviors, and to explore various coping strategies. Patients learn to cope with psychotic symptoms not controlled by medication and to reduce their impact on everyday life using structured techniques. Working with the patient may involve modification of beliefs, focusing on changing the meaning and normalisation of the experience of psychosis. Different treatment protocols exist. Intervention may include monitoring of thoughts, feelings and behavior related to the symptoms or the reappearance of symptoms and/or encouraging alternative ways of coping with symptoms and/or reduction of stress and/or improving his overall functioning. **In the modification of belief**, the therapist shall thoughtfully encourage the patient to examine their beliefs, and his grounds for this belief to be true. **In reattribution** one usually deals with chronic auditory hallucinations. The therapist encourages the patient to elaborate on their hallucinations in a very detailed way in the process of associating the symptoms with daily functioning and helps him focus hallucinations on internal sources. **In the normalization of psychotic experience**, the therapist helps the patient understand the connection between his symptoms and the everyday stressful situations, which make them look normal. In CBT for psychoses a person is taught to establish a connection between his thoughts, feelings and behavior related to the current or previous symptoms of the disease and/or re-evaluate his perception and beliefs in respect to the symptoms for which he is treated. Intervention may include monitoring of thoughts, feelings and behavior related to the symptoms or the reappearance of symptoms and/or encouraging alternative ways of coping with symptoms and/or reduction of stress and/or improving his overall functioning. There are many studies that confirm the

efficiency of CBT therapy in reducing the frequency and severity of positive symptoms and emotional stress associated with.

**Cognitive therapy for addictions** is based on the principle that thoughts and feelings are closely related and the way we interpret those thoughts and feelings which then influences behavior. CBT helps individuals to modify the way they think about their substance misuse and behavior. The aim of CBT is to help the client identify which behaviors and beliefs might need to be changed and how this could be achieved. The client and the therapist work together to understand the thoughts, emotions and behavior involved in their substance misuse. This process enables the client to have an insight into their substance misuse and develop appropriate coping strategies and skills to achieve their goals. Typical behavioral strategies employed are coping with cravings for substances, cue exposure, promotion of non-drug related activities. Relapse prevention cognitive behavioral therapy is utilised to help clients identify risky situations, behaviors, emotions and beliefs and help them to develop appropriate coping strategies to deal with them (Beck et al., 1993).

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**CBT - stress inoculation training** consists of three phases: education about stress and its causes; acquisition and rehearsal of skills in cognitive restructuring (e.g., identifying irrational thoughts and replacing them with rational thoughts); and developing and practising new cognitive, emotional and behavioral “scripts” for responding to stressful events. Their evaluation revealed that the CBT intervention decreased stress to a greater extent than a peer support group and a passive listening group (Meichenbaum, 1977).

**Cognitive stimulation for persons with cognitive difficulties** is related to engaging in a range of activities and discussions (usually in a group) that are aimed at general improvement of cognitive and social functioning.

**Cognitive training for persons with cognitive difficulties** is a guided practice on a set of standard tasks that are designed to reflect particular cognitive functions. There may be a range of difficulty levels, to fit the tasks to each person's level of ability.

**Cognitive rehabilitation for persons with cognitive difficulties (CR)** has been defined as the therapeutic process of increasing or improving an individual's capacity to process and use incoming information so as to allow increased functioning in everyday life. This includes methods to train and restore cognitive function and compensatory techniques. CR aims at identifying functional goals that are relevant to the person living with dementia, and working with them and their family members or carers to achieve these. The emphasis is on improving or maintaining functioning in everyday life, building on the person's strengths and finding ways to compensate for impairments, and supporting independence.

Cognitive rehabilitation does not aim to improve cognition, but addresses the disability resulting from the impact of cognitive impairment on everyday functioning and activity. CR is a personalised approach, based on a problem-solving framework, which enables people with cognitive difficulties/ dementia to engage in, or manage everyday

activities, function optimally, and maintain as much of their independence as possible. The goal of cognitive rehabilitation is to improve functioning in areas that the recipient identifies as relevant and important to them. These targeted areas are typically outlined in the form of personal goals that the individual wishes to attain. Cognitive rehabilitation for people with dementia is usually conducted in the person's home setting, or the environment in which the targeted activities generally occur (Clare, 2008; Kudlicka et al., 2019)

**Cognitive remediation (CR)** is an intervention targeting cognitive deficit (attention, memory, executive function, social cognition, or meta cognition) using scientific principles of learning with the goal of improving functional outcomes. Its effectiveness is enhanced when provided in a context (formal or informal) that provides support and opportunity for improving everyday functioning. CR targets those who experience cognitive decline and aims to help individuals to function better in everyday situations such as school, work, or social situations through improved cognitive function. CR can be divided into compensatory and restorative approaches depending on the intervention. Compensatory approaches are designed to assist with managing cognitive decline by acquiring new skills or changing the environment, aiming to improve behavioral adaptations. On the other hand, restorative approaches aim to restore cognitive function through repetitive practice based on brain plasticity. CR uses a variety of learning strategies, such as errorless learning, reinforcement, and massed learning, and these strategies are applied differently depending on the type of intervention. Evidence for cognitive remediation (CR) has accumulated that supports its efficacy for treating schizophrenia. More recently, CR has been successfully applied in the treatment of depressive disorders, bipolar disorders, attention deficit/hyperactivity disorder, and anorexia nervosa and mild cognitive impairment and dementia.

**Cognitive enhancement therapy for schizophrenia** is a multidimensional, developmental approach that integrates computer-assisted training in neurocognition with social cognitive group exercises. Enriched supportive therapy fosters illness management through applied coping strategies and education. Many cognitive deficits and related behaviors of patients with schizophrenia in stable phase of illness are improved when sufficient exposure to relevant rehabilitation is provided.

**Contingency management** is based on the principles of social learning theory and behavior modification. Using this approach, behavior change occurs through the use of positive reinforcement, where the desired behavior is rewarded or punished. It is specific types of behaviors using a structured, transparent approach that increases learning of desired behaviors. Incentives or privileges are contingent upon agreed behavior set by the therapist. This could be in the form of vouchers for personal items such as food or leisure activities. Contingency management may be provided alongside other interventions such as motivational interviewing. Most programs focus on positive behaviors, with reinforcement for the desired behavior. The elements of a contingency management program are: clear definitions of the desirable behavior (e.g. opioid abstinence); regular monitoring for the presence or absence of the desired behavior (e.g. regular urine tests); specified rewards for the desired behavior (e.g. money, vouchers, take-home methadone doses or lottery tickets); positive personal feedback from staff for the desired behavior. Contingency management can be administered by staff with relatively little training. Contingency management has shown some benefit in reducing relapse to heavy drinking and reducing attrition rate.

**Case management** applies to people with mental illness with long-term difficulties in recovery, in the majority of cases, from psychotic disorders, but also from other kinds of mental disorders accompanied 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 assists clients with problem solving, offering solutions to address practical problems, and coordinating social services across multiple areas of need. Case management involves frequent in-person contact between the clinician 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). Relevant professionals evaluate and record progress towards the objectives at each review, provide support in decision making (as appropriate), ensure that people are aware of their rights to and

the availability of local advocacy services. A case manager ensures that the patient receives coordinated, continuous and comprehensive care. The number of patients for each case manager, case load, depends on the severity of illness and the patient's disability levels. **Successful treatment of individuals with SMI often requires a high degree of coordinated care which is effectively delivered using a case management model.** 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.

**Counselling** is a short-term supportive approach that aims to help people explore their feelings and problems, and make dynamic changes in their lives and relationships. The intervention usually consists of six to ten sessions over 8 to 12 weeks. Reviewed literature suggests two distinct forms of counseling: non-specific, generic form that serves largely supportive function; and model specific form, often based on the work of Carl Rogers.

**Diaphragmatic breathing** is defined as a manipulation of breath movement, contributing to a physiologic response characterized by (a) the presence of decreased oxygen consumption, decreased heart rate and blood pressure, and (b) increased theta wave amplitude in EEG recordings, increased parasympathetic activity accompanied by the experience of alertness and invigorating. Patients are taught by a trained professional, manual or audio how to inhale and exhale deeper and slower. They need to practice several times a day, or as needed, for a few minutes to see immediate benefits. The diaphragmatic breathing has been incorporated in many relaxation programs.

**Dialectical behavior therapy (DBT)** is a kind of CBT. The overall goal is the reduction of ineffective action tendencies linked with deregulated emotions. It is delivered in four modes of therapy. The first mode involves a traditional didactic relationship with the clinician. The second mode is skills training which involves teaching the four basic DBT skills of mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Skills generalisation is the third mode of therapy in which the focus is on helping the individual to integrate the skills learnt into real-life situations. The fourth mode of therapy is team consultation, which is designed to support clinicians working with difficult clients. DBT is a therapy model developed

by Linehan (Linehan et al., 1991) specifically for the treatment of patients diagnosed with borderline personality disorder and chronic suicidal behavior, although its use has spread to other patients such as substance use. The standard DBT treatment package consists of weekly individual therapy sessions (approximately 1 hour), a weekly group skills training session (approximately 1.5–2.5 hours), and a therapist consultation team meeting (approximately 1–2 hours). DBT is a comprehensive program of treatment consisting of individual therapy, group therapy, and a therapist consultation team.

**Early Intervention Services (EIS)** is a team-based, multi-element approach to treating FEP that has been broadly implemented internationally. Component interventions include assertive case management, individual or group psychotherapy, supported employment and education services, family education and support, and low doses of select antipsychotic agents. EIS is intended primarily for youth, adolescents, and young adults ages 15–25, although some programs extend eligibility to age 30. At its core, EIS is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. EIS emphasizes shared decision making as a means for addressing the unique needs, preferences, and recovery goals of individuals with FEP. Collaborative treatment planning in EIS is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. EIS services are also highly coordinated with primary medical care, with a focus on optimizing a client’s overall mental and physical health. EIS for first episode psychosis: is a type of treatment that uses a team of specialists who work with the client to create a personal treatment plan. The specialists offer psychotherapy, medication management, case management, family education/support, and supported employment/education, depending on the individual’s needs and preferences. The client and the team work together to make treatment decisions, involving family members as much as possible. Case managers help clients with problem solving and coordinate social services. The case manager has frequent in-person meetings with the clinician, the client, and the client’s family. EIS team leader coordinates the client’s treatment, leads weekly team meetings, oversees treatment plans and case review conferences, and develops transitions to and from the EIS program to some other program when is required. The experience of FEP disrupts the person’s sense of wellness and often derails confidence and pursuit of pre-illness life goals. Psychotherapy—individual or group—aims to



restore the person's feelings of personal wellness, reinforce coping and resilience, and lessen the likelihood of subsequent psychotic episodes and prevent or treat comorbidities. Psychotherapy for FEP emphasizes resilience training, illness and wellness management, and general coping skills. Treatment is tailored to each client's needs. Family education and support teaches relatives or other individuals providing support about psychosis and its treatment and strengthens their capacity to aide in the client's recovery.

**Eye movement desensitisation and reprocessing (EMDR)** is a type of CBT treatment developed by Francine Shapiro to assist clients exposed to traumatic events. The technique uses bilateral stimulation, right/left eye movement, or tactile stimulation, that is said to activate cognitive processes to release emotional experiences that are "trapped" or buried. Although EMDR may be used for different mental health problems, it has been primarily used in trauma therapy. During an EMDR session the clinician helps the client to revisit the traumatic event(s) and connect with the associated thoughts, feelings, and sensations. While doing this the clinician holds a finger about 45 centimetres from the client's face and moves the finger back and forth asking the client to track the movement with his or her eyes. While the client is tracking the movement and recalling the specific traumatic event the clinician works to move the client to more positive thoughts, hence helping him or her to resolve the negative and stressful feelings associated with the event. The treatment should normally be 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week). The only element of EMDR therapy that is unique is the use of eye movements or of other types of attention-grabbing techniques, such as the use of sounds or finger tapping to get the client to focus their attention while discussing their feelings about emotionally laden experiences. The Cochrane review came to the conclusion that the use of EMDR is superior to no treatment at all for addressing issues with trauma and stressor-related disorders.

**High intensity treatments** are delivered face to face by a qualified therapist in group or individual settings and include different modalities of psychotherapy such as

cognitive behavioral therapy (CBT), interpersonal therapy, behavioral activation, short term psychodynamic psychotherapy (STPP).

**Environmental adaptations** refer to strategies that modify the physical environment, with the goal of supporting and enhancing everyday competencies of persons with physical or cognitive functional challenges. There are three basic forms of environmental adaptations: assistive technology, structural changes or home modifications, and material adjustments.

**Family interventions/therapy** addresses the problems people present within the context of their relationships with significant people in their lives and their social networks. An approach is based on the idea that a family is—and behaves as—a system. Interventions are based on the presumption that when one part of the system changes, other parts will change in response. Family therapists therefore look for unhealthy structures and faulty patterns of communication. Family therapy addresses the interdependent nature of family relationships and how these relationships serve the identified patient and other family members for good or ill. 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. Family therapy rests on the systems perspective. As such, changes in one part of the system can and do produce changes in other parts of the system, and these changes can contribute to either problems or solutions. Family therapy is a collection of therapeutic approaches that share a belief in family-level assessment and intervention. Therapy based on this point of view uses the strengths of families to bring about change in a range of diverse problem areas, including substance abuse.

### **Family training to reduce high EE**

Different studies of patients with different psychiatric disorders have shown that living in a family with a tense atmosphere where criticism is commonly used, without expressing empathy and warmth, as well as overprotective behavior towards the ill member of their family, who is often considered unable to care for himself/herself, is related to a risk of deterioration of the patient's mental state. The described way of communication in the family is known as high expressed emotion factor - EE factor. The goal of family communication skills training is to break negative patterns of

communication, introduce active listening and empathy, and learn how to balance criticism and praise. Working with family involves psychoeducation, working on communication skills, conflict resolution, and dealing with stigma. The goal of working with families is to optimize the capacity of family members to support the patient, as well as to get help for themselves when they need it (Kuipers, Leff & Lam, 2002).

**Attachment-Based Family Therapy (ABFT)** is the manualized family therapy model specifically designed to target family and individual processes associated with adolescent suicide and depression. ABFT emerges from interpersonal theories that suggest adolescent depression and suicide can be precipitated, exacerbated or buffered against by the quality of interpersonal relationships in families. It is a trust-based, emotion-focused psychotherapy model that aims to repair interpersonal ruptures and rebuild an emotionally protective, secure-based parent–child relationship. Attachment theory (Bowlby, 1969) provides the overarching framework for understanding and intervening in the clinical process. ABFT aims to repair ruptures in the attachment relationship, and establish or resuscitate the secure base so important for adolescent development. The ABFT manual “Attachment-Based Family Therapy for Depressed Adolescents” was published by the American Psychological Association in 2014. ABFT is listed on the Promising Practices Network as a "proven" treatment. ABFT has been reviewed by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP).

**Family-focused therapy** is defined as a systemic model integrating elements of several theoretical models such as eco-structural family therapy and emotionally focused therapy. It is a home-based intervention. The program is committed to family preservation and reunification unless it is not in the child's best interest. The hours are flexible to meet the family’s needs and 24-hour crisis intervention is provided. Services are multifaceted: counselling, skills training, resource coordination and more. Intensity and duration of services are customized for each client. Staff members carry small caseloads to permit more interaction with each family. The program is committed to empowering families to set and achieve their own goals. The services use a wide range of research-based interventions. Participatory assessments permit the

family to be in charge of the process. Families in crisis receive services within 48 hours of referral. More information available at

<http://www.familycenteredtreatment.org/the-fct-model>.

“**Exeter Model**” is manualised couples therapy. It has been approved by the Association for Family Therapy (AFT) as an evidence-based practice with couples for depression. Information at: <http://cedar.exeter.ac.uk/cpd/coupletherapyworkshop>

**Group Analysis and group analytic/psychodynamic psychotherapy is a form of psychotherapy by the group, in the group, including its conductor** in which a group is a therapeutic factor per se. The method and theory of group analysis is concerned with a dynamic understanding of the inner working of the human mind as a social, multi-personal phenomenon (Foulkes, 1975). It combines psychoanalytic insights with an understanding of social and interpersonal functioning. In the group analytic situation communication is the prime therapeutic factor. Free-floating discussion of the group represents meaningful communication at an unconscious level. All events are considered to be communications, they are accepted as signs, symbols or other messages, meaningful when decoded and put into the appropriate context. Psychoanalytic/psychodynamic group psychotherapy strives to uncover and re-work trauma experiences, object relations, defenses, primitive fantasies and transference. **The group has specific healing factors such as group cohesion that favorably affect the process of the desired change.** Group psychoanalytic psychotherapy is used in the treatment of persons with different mental disorders. Therapeutic techniques can be modified in relation to treatment goals. **Group analysis aims to achieve a healthier integration of the individual in his or her network of relationships.**

**Group Therapy** is a form of psychotherapy where there are multiple patients led by one or more therapists. It uses the power of group dynamics and peer interactions to increase understanding of symptoms of mental disorders and improve social skills. There are many different types of group therapy (e.g. psychotherapy, social skills, substance abuse, multi-family, parent support). They all use the benefits of group therapeutical factors to facilitate the treatment goals.

**Guided imagery** utilizes the subject's personalized images to promote relaxation/stress reduction. Exploration of an image of a safe, comfortable place specific to the participant is involved including sensory recruitment (visual, auditory, olfactory, tactile, and kinesthetic), particularly focusing on linking elements of relaxation in the image to the physiologically relaxed state simultaneously being experienced by the subject.

**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.

**Illness management and recovery (IMR)** is a manualized evidence-based treatment focused on teaching illness self-management to persons 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. IMR can be provided either in an individual or group format and general takes between 5-10 months to complete as individuals work progressively through the 10 modules (Gingerich & Mueser 2005).

**The Individual Placement and Support (IPS)** is a new model of supportive employment for persons 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 can start immediately as a part of the treatment team around the person. The other big paradigm shift is 'zero

exclusion'. IPS intervention can start immediately if person expresses the wish to get back to school or work no matter the severity of the underlying psychiatric condition. IPS is designed to follow individual wishes of a person and systematically develop the working carrier by offering continuous personalized support. Job-coaching following IPS principles integrates team-work with different treatment disciplines and expertise, working with a person with SMI, and acquisition of jobs by networking with potential employers. The IPS job coach focuses primarily on helping a person in making choices, supporting their ideas and helping intensively in the search and applying for jobs or education. Practical support is given in the finances and administration if needed. The IPS job coach keeps contact with the person during this whole process as well as with the mental health team and the employers. Besides coaching of the patient, the IPS job-coach has to invest at least a quarter of their time for acquisition of jobs. He or she creates their own network of employers and is continuously searching for new connections to meet individual aspirations of persons in coaching. This is important since a large obstacle for many employers is the fear of lacking the support and expertise to employ a "psychiatric patient".

**Individual Treatment/recovery plan** is an agreement between the therapists 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.

**Mentalization-based therapy (MBT)** is a psychodynamic treatment rooted in attachment, cognitive and neuropsychology principles (Bateman & Fonagy, 2016). Mentalization describes the common psychological process that people use to understand mental states (ie, emotions, beliefs, desires—intentions that underlie interpersonal interactions). It covers a wide territory of psychological activity that determines the way people manage their emotions and thoughts coherently; effectively respond to their own experience and that of others; maintain satisfying relationships; and understand themselves, thereby stabilizing their sense of self (i.e. identity). In other words, it is the capacity to think about one's own and others' mental states (thoughts, emotions, needs) and their impact on interpersonal interaction.

Mentalization therefore lies at the root of psychological health and resilience as a common process relevant to all psychotherapies. This capacity is deeply dependent not only on individual genetic factors, but also on the quality of early object relationships and attachment. The central feature of MBT is to establish a safe attachment environment within which internal states can be represented, thought about and discussed and thereby the patient's mentalizing capacity can be developed and strengthened, resulting in patients being better able to manage their intense emotional states and to respond to life's challenges in more adaptive ways. MBT is an evidence-based psychotherapy for borderline personality disorder (BPD) now being developed for other disorders and applied in a number of different groups, for example with families and adolescents.

**Metacognitive training (MCT)** is a modality of new wave CBT therapy which aims to raise patients' (metacognitive) insight and self-awareness of cognitive distortions. MCT aims to extend patient's knowledge of cognitive biases and to provide corrective experiences with the goals of attenuating the symptom of the mental disorder. MCT for use in different mental disorders is available in a group format (access at no cost in 33 languages through [www.uke.de/mct](http://www.uke.de/mct)) and as an individualized intervention (MCT+; access at no cost in 10 languages through [www.uke.de/mct\\_plus](http://www.uke.de/mct_plus)).

**Metacognitive training for psychoses (MCT)** is designed to address positive symptoms in patients with schizophrenia. MCT aims to extend patient's knowledge of cognitive biases and to provide corrective experiences. Implementing a wide range of examples and exercises, patients participating in a MCT group training are encouraged to identify and gain insight into these cognitive biases and reduce conviction in delusional ideas. MCT aims to reduce overconfidence in false interpretation of reality through an element of surprise ("aha" experience), which improves insight and instills doubt on one's beliefs. This process can counteract the tendency to make quick decisions, which may lead to inaccurate interpretations of reality. Talking about cognitive biases is therefore a good starting point that may pave the way for confronting psychosis-specific contents. (Moritz & Woodward, 2007) The modules for implementation of this treatment are freely available in over 30 languages ([http://clinical-neuropsychology.de/metacognitive\\_training-psychosis.html](http://clinical-neuropsychology.de/metacognitive_training-psychosis.html))

Music therapy/activities

Music is a strong elicitor of emotion but also facilitates regulation of emotion.

Music therapy is described as the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts (World Federation of Music Therapy Music Therapy <http://www.musictherapyworld>).

**Music as medicine/Relaxing music (RM).** The beneficial effect of RM is related to the effect on the autonomic nervous system by reducing sympathetic excitability. RM reduces the secretion of stress hormones - cortisol, stimulates the secretion of oxytocin, which plays a role in the feeling of satisfaction. Music affects a large number of brain regions, and thus affects the limbic system, which is the part of the brain that plays an important role in regulating emotional reactions. Relaxing music stimulates slower brain waves, which facilitate relaxation and sleep.

Mindfulness-based cognitive therapy and mindfulness-based stress reduction

Mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR) are treatments that emphasise mindfulness meditation as the primary therapeutic technique. MBCT and MBSR are used to interrupt patterns of ruminative cognitive-affective processing that can lead to depressive relapse. In MBCT and MBSR, the emphasis is on changing the relationship to thoughts, rather than challenging them. The aim is to raise awareness at a metacognitive level so that an individual can fully experience cognitions and emotions that pass through the mind that may or may not be based on reality. The goal is not to change the dysfunctional thoughts but to experience them as being real in the present time and separate from the self. The technique assumes that greater awareness of the here-and-now will provide clearer and more accurate perception, reduce negative affect and improve energy and coping.

**Motivational Interviewing/Motivational enhancement therapy** is used to help the client develop intrinsic motivation by helping them to gain an insight into the discrepancy between their perceptions of current behavior and their goals. It is a client



centered style of interaction which directs people to explore and resolve their ambivalence about their problem (the “good things” versus the “less good things”) and move through the stages of change. It is especially useful when working with clients in the pre-contemplation and contemplation stages, but the principles and skills are important at all stages. Motivational interviewing is based on the understanding that effective treatment assists a natural process of change, and that motivation for change occurs in the context of a relationship between the client and the health care worker, even though the time spent together may be brief. The principles of MI include expressing empathy through reflective listening, developing discrepancy between patients’ goals or values and their current behaviors, avoiding argument and direct confrontation, adjusting to client resistance and supporting self-efficacy and optimism. For this the skills of the therapist are very important to encourage positive change as well as to create a therapeutic partnership that encourages the process of change

**Interpersonal therapy (IPT)** is a brief, structured approach that addresses interpersonal issues usually used for people with mild to moderate depression. The underlying assumption of IPT is that mental health problems and interpersonal problems are interrelated. The goal of IPT is to help clients understand how these problems, operating in their current life situation, lead them to become distressed and put them at risk of mental health problems. Specific interpersonal problems, as conceptualised in IPT, include interpersonal disputes, role transitions, grief, and interpersonal deficits. IPT explores individuals’ perceptions and expectations of relationships, and aims to improve communication and interpersonal skills. Interpersonal therapies aim to help people interact more effectively with others, and through this improve the psychological health. This therapy is based on the idea that difficulties interacting with other people can cause psychological symptoms such as depressed mood, which then make the difficulties with interaction worse, causing a cycle. Interpersonal therapies aim to help people interact more effectively with others, and through this improve the psychological symptoms. Therapy typically focuses on relationship issues such as conflict, difficulty starting or maintaining relationships, grief and loss, and life changes. The person works with the therapist to identify the effects of problematic areas related to interpersonal conflicts, role transitions, grief and loss, and social skills, and their effects on current symptoms, feelings states and problems. They seek to reduce symptoms by learning to cope with or resolve such

problems or conflicts. The intervention usually consists of 16 to 20 sessions over 3 to 4 months.

**Low intensity interventions in primary care** include low intensity treatments that are brief and have minimal (or sometimes no) input from a trained professional, such as guided self-help, computerized cognitive behavioral therapy (cCBT), and psychological counseling,

**Psychopharmacological treatment/Pharmacotherapy** is used in a number of mental health disorders as part of a comprehensive bio-psycho-social model of treatment. There are a number of guidelines that define the application of psychopharmacological methods, issued by national leading psychiatric institutes or societies, and are supported by national health authorities. Psychopharmacological practice in Europe is relatively uniform for most mental health disorders. The guidelines are subject to change as new drugs emerge however the guidelines are also changing based on experience from clinical practice. In addition to the clinical picture of the mental health condition that is the reason for prescribing medications, attitudes towards medications are also important in the choice of medication. Education about treatment and side effects must contain information on the effects of the drug prescribed as well as their side effects so that the patient can make a decision about treatment, and in order to support drug compliance. There is continuous medical education in this area, such as the courses of the European Psychiatric Association (EPA), like the “itinerant courses” <https://www.europsy.net/epa-itinerant-courses/> which are carried out regularly, in different countries, at the request of the Member States. Evidence-based pharmacological treatment is defined by the levels of scientific evidence and forms the basis of guidelines for pharmacological treatment developed by the world leading professional institutions. Levels of scientific evidence are defined by the quality of data and studies in the appraised scientific literature. The highest levels of evidence are derived from randomized controlled studies, meta-analyses and systematic review studies, followed by not randomized studies, case reports and professionals' consensus. The recommendation on a specific pharmacological approach developed by professional authorities/professional groups is then based upon the levels of evidence. These guidelines are usually provided by the world leading professional associations, while many national guidelines incorporate these leading guidelines, usually with

modifications according to the local context. Evidence-based practice is based upon rational application of medication which is scientifically and clinically proven to be effective and safe for use, within effective dose ranges, and tolerable side effects, taking into account the individual context of the patient. Pharmacological treatment is a part of an integrative and comprehensive individualized treatment approach, following the bio-psycho-social treatment model.

**Psychoeducation** is a systematic, structured, didactic information on the illness and its treatment, and includes integrating emotional aspects in order to enable patients or family to cope with the illness (Rummel-Kluge & Kissling, 2008). Psychoeducation involves the provision and explanation of information to patients about what is widely known about the characteristics of their diagnosis. Psychoeducation also provides information about identification of stressors, protective and risk factors important for preventions of relapse, as well as information on interventions promoting recovery. It is usually provided by a healthcare professional, and supported by the use of written materials. All information about the mental disorder must be evidence-based, established on the psycho-biosocial understanding of the mental disorder and its treatment, free from misconceptions based on stigma and recovery oriented. Psychoeducation can be short or continuous interventions. Psychoeducation is a basic psychosocial intervention that must be available to all patients regardless of diagnoses on a regular basis. Information should be tailored individually to each patient, taking into account his clinical condition and treatment goals. The aims of psychoeducation are also to develop self-management skills for self-monitoring symptoms and strategies to support adherence to treatment including medication, psychological techniques, lifestyle and social support.

**Progressive muscle relaxation (PMR)** is a technique for reducing stress and anxiety by alternately tensing and relaxing the muscles. It was developed by American physician Edmund Jacobson in the early 1920s. Jacobson argued that since muscle tension accompanies anxiety, one can reduce anxiety by learning how to relax the muscular tension. PMR entails a physical and mental component. The physical component involves the tensing and relaxing of muscle groups over the legs, abdomen, chest, arms and face. In a sequential pattern, with eyes closed, the individual creates tension in a given muscle group purposefully for approximately 10 seconds and then

releases it for 20 seconds before continuing with the next muscle group. The mental component requires that the individual focuses on the distinction between the feelings of tension and relaxation. With practice, the patient learns how to effectively relax in a short period of time.

**Psychoanalytic or psychodynamic psychotherapy (PP)** draws on theories and practices of psychoanalysis and other related psychological theories. One of the central assumptions of psychodynamic psychotherapy is that factors we are not consciously aware of are important drivers for our behavior. Although psychodynamic psychotherapies are various, the role of early development, unconscious processes and the transference significance of the therapeutic relationship are to some extent common to most. PP is a therapeutic process which helps patients understand and resolve their problems by increasing awareness of their inner world and its influence over relationships both past and present. It differs from most other therapies in aiming for deep seated change in personality and emotional development. Seven features reliably distinguished psychodynamic therapy from other therapies 1. Focus on affect and expression of emotion. 2. Exploration of attempts to avoid distressing thoughts and feelings. 3. Identification of recurring themes and patterns. 4. Discussion of past experience. 5. Focus on interpersonal relations. 6. Focus on the therapy relationship 7. Exploration of fantasy life. There are different psychodynamic psychotherapies related to goals and duration.

**Short-term psychodynamic psychotherapy (STPP)** is a brief, focal, transference-based therapeutic approach that helps individuals by exploring and working through specific intrapsychic and interpersonal conflicts. It is characterised by the exploration of a focus that can be identified by both the clinician and the individual. This consists of material from current and past interpersonal and intrapsychic conflicts and interpretation through a process in which the clinician is active in creating the alliance and ensuring the time-limited focus. Short-term psychodynamic therapies are generally indicated for individuals on the more mature developmental spectrum. One of the most commonly used psychodynamic psychotherapies is **supportive psychodynamic psychotherapy**, whose main goal is to empower the ego to cope better with stressful situations, without analyzing the impact of past relationships on current symptoms and behavior. Psychodynamic psychotherapies can be applied to a

variety of mental disorders with or without modification of the technique depending on the needs of the patient. Psychodynamic psychotherapy takes place on a continuum between supportive and expressive psychotherapy in which, depending on the needs of patients and the goals of therapy, a more supportive or analytical insight-oriented approach is applied. Supportive psychodynamic psychotherapies have been shown to be effective in people with a variety of diagnoses including people with schizophrenia and similar disorders. (Rosenbaum, Martindale & Summers, 2013) The goals of psychodynamic therapy extend beyond symptom remission, and include fostering the positive presence of psychological capacities and resources, developing a potential capacity to find greater enjoyment and meaning in life (Shedler, 2010).

**Psychosocial rehabilitation (PR)** consists of combinations of evidence-based psychosocial interventions described in this booklet 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 (Adapted from USPRA 2007). According to WHO (1996) psychosocial rehabilitation aims to provide the optimal level of functioning of individuals and societies, and the minimization of disabilities and handicaps, stressing individuals' choices on how to live successfully in the community. Rehabilitation is a whole systems approach to recovery from mental illness that maximizes an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy to give them hope for the future (Killaspy et al., 2005). PR should be planned based on an assessment of the patient's real life difficulties and should be carried out in the environment where the person lives (Bachrach, 2000). Rehabilitation focuses both on the abilities it seeks to build, and the disability it seeks to overcome or help compensate by organised support.

**Prevention of mental illness** - Mental disorder prevention aims at reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society ( WHO 2004; Mrazek PJ & Haggerty RJ eds, 1994). Primary prevention can be universal (targeting a whole population group), selective (targeting individuals or subgroups at some risk of developing a mental illness) and indicated (targeting those at high risk). Secondary

prevention aims to lower the number of established cases (prevalence) through early detection and treatment of those diagnosed with the disorder. Tertiary prevention encompasses interventions which seek to reduce disability, enhance rehabilitation and prevent recurrences or relapses of the disease.

**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. WHO (2004)

**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.

**Peer-based recovery support for addiction** is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery. Peer support can also be organized by self-help groups which are voluntary, small-group structures formed by peers to assist each other in their struggle with substance dependence.

**Problem-solving therapy** is a psychological intervention in which the following elements had to be included: definition of personal problems, generation of multiple solutions to each problem, selection of the best solution, the working out of a systematic plan for this solution, and evaluation as to whether the solution has resolved the problem. The therapist works with the patient to identify and prioritize key problem areas, break these down into specific, manageable tasks, and develop appropriate coping behaviors

**Recovery and recovery practice** Traditional conceptualisations of clinical recovery/remission, specifically symptom remission and a return to pre-morbid levels of functioning, are now complemented by an emphasis on personal recovery, defined by

Anthony (1993) as a “deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”. Recovery is an experience of empowerment, where people lead their lives in a way that allows them to reach the desired goals, lead a meaningful life, and have a positive sense of belonging in the community (National Institute for Mental Health in England, 2005 according to NICE 2014). Recovery is an ongoing process whereby the person is supported to build up their confidence and skills and resilience, through the setting and achieving goals to minimize the impact of mental health problems on their everyday life. (NICE 2020). The recovery goals should be integrated into the user's individual treatment plan.

**Recovery oriented services** aim to integrate recovery principles in recovery culture of providing treatment. Treatment should be organized in such a way that the therapeutic environment, including the therapeutic relationships between service users and staff, fosters hope, optimism, empowerment, the right to choice, conditions that help people recover, use their full potential and participate fully in the community. Achieving personal goals such as having friends, getting a job, community belonging and having a useful role in the community is important in recovery, which is different from clinical goals that are often focused on eliminating symptoms by taking medication. (WHO QualityRights Tool Kit, 2019). The recovery model includes both the subjective experiences of the services user and the establishment of recovery-oriented services as well as human right approach.

**Recovery colleges** deliver peer-led education and training programs within mental health services or stay alone. They provide education as a route to recovery, not as a form of therapy. The courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals.

**Reminiscence therapy for dementia** stimulates conversation about the past It has some positive effects on people with dementia in the domains of quality of life, cognition, communication and mood. (Woods et al., 2018).

**Reality orientation therapy for dementia** repeatedly uses the presentation and information with regard to the orientation of the patient, aiming to provide an increased understanding of their surroundings. The therapy consists of providing information about personal and current situations that are trivial for the patient's daily living, for example their name, address, date, and where the person currently is located.

**Reminiscence Therapy (RT)** involves the discussion of past activities, events and experiences with another person or group of people, usually with the aid of tangible prompts such as photographs, household and other familiar items from the past, music and archive sound recordings. Reminiscence groups typically involve group meetings in which participants are encouraged to talk about past events at least once a week. RT involves the discussion of memories and past experiences with other people using tangible prompts such as photographs or music to evoke memories and stimulate conversation. RT is implemented widely in a range of settings using a variety of formats.

**Relapse Prevention for substance used (RP)** has been a set of strategies to help the client maintain treatment gains rather than a specific intervention per se. (Jarvis, Tebbutt & Mattick, 2005). It differs from standard CBT in the emphasis on training people who misuse drugs to develop skills to identify situations or states where they are most vulnerable to drug use, to avoid high-risk situations and to use cognitive and behavioral strategies to cope effectively with these situations. (Carroll & Onken, 2005) RP was originally designed as a maintenance program following the treatment of substance use disorders although, it is also used as a stand-alone treatment program. An individual or group-based RP program should include identifying high-risk situations and triggers for craving, developing skills to manage cravings and other painful emotions without using substances, learning to cope with lapses and attaining a life-style balance. RP is effective and can be enhanced by adding pharmacological treatment (Irvin et al., 1999) and there is good evidence that abstinence rates can be improved when psychosocial treatments such as RP, CBT and motivational enhancement therapy (MET) are combined with pharmacotherapy (Feeney et al., 2002).

**Self-help** involves self-help books or internet-based self-help programs. Self-help preventive interventions can be offered as guided self-help (bibliotherapy or e-health)



with, for example, weekly follow-up phone calls by a health professional or therapist. Self-help therapy is used as either an adjunct to traditional therapy or as a standalone treatment. Most self-help programs are based on CBT principles and typically combine psychoeducation with skills training, including homework tasks. In self-help programs, individuals read books or use computer programs to help them overcome psychosocial problems. In facilitated self-help a trained practitioner typically facilitates the use of self-help material by introducing it, and reviewing progress and outcomes. The intervention consists of up to six to eight sessions (face-to-face and via telephone) normally taking place over 9 to 12 weeks, including follow-up. Non-facilitated self-help is defined as a self-administered intervention, which makes use of written or electronic materials based on the principles of CBT and of an appropriate reading age. The intervention usually involves minimal contact with a practitioner (for example an occasional short telephone call of no more than 5 minutes) and includes instructions for the person to work systematically through the materials over a period of at least 6 weeks. Self-help on line CBT programs include: psychoeducation, relaxation, analysis of behavior, behavioral activation, basic communication and interpersonal skills, emotional recognition, dealing with strong emotions, problem solving, cognitive restructuring (identifying thoughts, challenging unhelpful/negative thoughts), mindfulness and relapse

**Group-based peer support (self-help) program for depression and comorbid physical health problems** is delivered to groups of patients with mental health problems. The focus is on sharing experiences and feelings associated with having a mental illness or some other condition such as a chronic physical health problem. The program is supported by practitioners who facilitate attendance at the meetings, have knowledge of the patients' chronic physical health problem and its relationship to depression, and review the outcomes of the intervention with the individual patients. The intervention consists typically of one session per week over a period of 8 to 12 weeks.

**Self-help groups** include people with a common bond who voluntarily come together to share, reach out, and learn from each other in a trusting, supportive, and open environment. The common bond is defined as the collective experience related to being diagnosed as having a mental illness and receiving services from the mental

health system. Self-help is based on the principle of helping oneself and others at the same time. Thus, self-help is a mutual process, without a dichotomy between the helper and the person being helped. Membership in self-help is neither mandated nor charity. The role of professionals is to give referrals and engage in other supportive acts outside the group, not to run the groups, which would defeat the workings of self-efficacy.

**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 is intended to empower individuals in their recovery by providing the skills and confidence they need to take active steps in recognising and managing their own health problems. Self-management also shows potential as an effective paradigm across the prevention spectrum by establishing a pattern for health early in life and providing strategies for mitigating illness and managing it in later life. (Anekwe & Rahkovsky, 2018). 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.

**Supportive psychotherapy** is a psychotherapeutic approach that integrates various schools to provide therapeutic support within the framework of positive patient-therapist relationship. It includes components from therapeutic schools such as psychodynamic, cognitive-behavioral, and interpersonal conceptual models and techniques. The aim of supportive psychotherapy is to reduce or to relieve the intensity of manifested or presenting symptoms, distress or disability. It also reduces the extent of behavioral disruptions caused by the patient's psychic conflicts or disturbances. The objective of the therapist is to reinforce the patient's healthy and adaptive patterns in order to reduce the intrapsychic conflicts that produce symptoms of mental disorders. The aims of supportive psychotherapy is helping the patient to establish better psychological balance by using more mature defense mechanisms, improving mentalization, coping ability, restore or improve self-esteem and facilitate more appropriate patterns of behavior. Supportive therapy also offers education about illness, it offers help to weak ego to increase adaptive functioning. (Hellerstein & Markowitz, 2008)

**Social Behavior Network Therapy for substance abuse** Social behavior network therapy was developed by adapting cognitive behavioral therapy and community reinforcement approaches. The intervention is based on the principle that people who misuse substances need to develop a social network to promote a positive support for

change. This intervention aims to find people within clients' social network who want to be actively involved in helping them.

**Systematic desensitization** is an exposure therapy in which clients develop a hierarchy of stressful or anxiety-provoking situations, and then learn relaxation techniques. The therapist and the client work together to have the client imagine the least stressful situation on the list while engaging in relaxation techniques. This allows the client control over their feelings of stress or anxiety, and eventually they are able to tolerate the stressful situation. Once the client can handle the least stressful situation, they move down the list to the next anxiety-provoking event and repeat the process. This process continues until the client can tolerate the most anxiety-provoking or stressful situation on the list.

**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

**Supportive long-term psychotherapy** is defined as a form of psychological treatment through a long-term therapeutic relationship that provides psychological support to the patient due to his/her reduced capacity to manage his or her life without long-term support (Bloch, 1979). The goal is restoring the patient's confidence in their own capacity to live their lives in a productive and satisfying way. It also helps the patient adapt to their situation in the best possible way and thus avoid unnecessary dependence.

**Supported accommodation** Supported accommodation is an umbrella term covering the terms supported housing, residential care and floating outreach. Supported housing services are shared or individual self-contained, time-limited tenancies with staff based on-site up to 24 hours a day who help the person to gain skills to move on to less supported accommodation. The expected length of stay is around 2 years but only around a third of people manage to move on in that time.

**Supported employment** is an evidence-based practice designed to promote employment for people with serious mental illness (SMI). It emphasizes collaboration

between employment and mental health services, rapid job search, individualized access, and available support at work. In this approach, supportive employment professionals are part of the patient's treatment team. The goal of supported employment is to help a person with SMI get a competitive job in the community. (see also Individual Placement and Support -IPS)

**Therapeutic Community (TC)** treatment is group-based approach for people with long-term mental health difficulties. TC principles are based upon a collaborative, democratic and deinstitutionalised approach to staff-patient interaction. Its principles can be applied to the therapeutic care of a wide range of patient groups in different settings, including the community. The Therapeutic Community offers a safe environment with a clear structure of boundaries and expectations where members have the opportunity to come to terms with their past through re-enactment within a treatment setting involving other members and staff. TCs also offer the individual experiences to awaken creative and social abilities. Members tend to learn much through the routine interactions of daily life and the experience of being therapeutic for each other. The day-to-day experience of living and working together is felt to be as important as formal therapy, and the structure is such that the two are closely integrated and inform each other – the living–learning experience. – an openness to questioning: An important underlying principle is the “culture of enquiry” that all involved are encouraged to be curious about themselves, each other, the staff, the management structure, psychological processes, the group process, the institution and everything else pertinent to events and relationships within the community. Symptoms of illness or behavioral disorders in therapeutic communities are considered problems of an individual in his/her relationship with other people. Therapy is a learning process, learning new skills on how to connect with others, better understanding self and others, and better coping with stress.

**Therapeutic communities for addictions** can be regarded as recovery-oriented programs that produce change regarding substance use, legal, employment, and psychological wellbeing outcomes among drug addicts with severe and multiple problems. TC programs have usually been evaluated from an acute care perspective with a primary focus on abstinence and recidivism, while a continuing care approach including multiple and more subjective outcome indicators is necessary from a

recovery perspective. If residents stay long enough in treatment and participate in subsequent aftercare, TCs can play an important role on the way to recovery. The aim of TCs rehabilitation programs is to help people develop the skills and attitudes to make long-term changes toward an alcohol- and drug-free life-style. Programs usually include activities such as employment, education and skills training, life skills training counseling, RP and group work. Evidence from research supports efficacy of TCs for people with addictive problems, by being better with substance use and legal outcomes among TC participants including superior employment and psychological functioning. Length of stay in treatment and participation in subsequent aftercare were consistent predictors of recovery status. (Vanderplasschen, Yates & Miovský, 2017).

**Therapist – patient relationship** is key therapeutic agent regardless of the type of therapy applied. Bordin (1979) conceptualized an alliance consisting of three components: goal agreement, task agreement, and affective bond. It represents the interaction between the therapist and the patient, aiming to achieve positive change in the patient. It is a professional relationship that must be safe for the patient, respecting professional, legal and ethical boundaries. The therapist-patient relationship is an important therapeutic environment and an important therapeutic tool that stimulates the process of change and promote recovery. The ability to establish a therapeutic relationship is a skill that one should learn and that is comparable to learning to apply different therapeutic interventions such as medication therapy, family therapy, group psychotherapy, and other therapeutic interventions. Therapist patient relationship is an evidence-based intervention.

**Treatment alliance (TA)** refers to the commitment of the therapist and the client to work together to help the client resolve their issues. It is a component of the therapeutic relationship that guarantees the professional attitude of the therapist and responsibility of the patient and therapist to work together on the agreed treatment goals. The therapeutic alliance is a joint decision - an agreement between a therapist and a patient on the objectives of treatment and therapeutical methods that help them achieve these goals. TA is a joint agreement between the therapist and the patient in which they define the patient's problem and work together to resolve it.

**Trauma-focused CBT** is a type of CBT specifically developed for people with PTSD that focuses on memories of trauma and negative thoughts and behaviors associated

with such memories. The structure and content of the intervention are based on CBT principles with an explicit focus on the traumatic event that led to the disorder. The intervention normally consists of 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week).

**Vocational training** Vocational training includes a range of programs designed to help patients find and retain employment.

**Wellness Recovery Action Plan (WRAP)** is a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be. It was developed in 1997 by a group of people who were searching for ways to overcome their own mental health issues and move on to fulfilling their life dreams and goals. It is now used extensively by people in all kinds of circumstances, and by health care and mental health systems all over the world to address all kinds of physical, mental health and life issues. WRAP has been studied extensively in rigorous research projects and is listed in the National Registry of Evidence-based Programs and Practices.

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## 5. Booklet summary

Despite significant research advances regarding prevention, promotion and treatment of mental disorders as well as psychosocial determinants of mental health, translation into real-world impact has been slow at all levels of prevention. One of the key reasons is the way of thinking about mental disorders, the possibilities of their treatment and prevention, burdened with the stigma that is present not only in society but also in treatment services. Although numerous professional guidelines for the treatment of various mental disorders recommend a biopsychosocial approach, the application of combination of biological (most commonly medications), psychosocial and psychotherapeutic interventions based on individualized treatment plan as well as encouraging recovery and empowerment, the biological approach with its focus on eliminating symptoms is prevailing over psychosocial interventions which contradicts the evidence of their effectiveness.

The prevailing biological approach, although effective and necessary in clinical practice to treatment of mental disorders, fails to accurately reflect the diversity and complexity of mental health needs of individuals or population in general, especially psychosocial needs. Due to the fact that mental health is significantly affected by psychosocial factors, neglecting their influence and not applying psychosocial methods that contribute to their elimination and recovery from mental disorder can lead to unnecessary chronicity of the disorder and reduce the possibility of recovery.

This booklet wants to emphasize that there is a large number of evidence-based psychosocial interventions at all levels of prevention that need to be applied more in practice. Training in their application is needed to enable successful treatment of mental disorders, as well as their prevention. The importance of the application of psychosocial interventions is in improving functioning and promoting resilience, as well as symptoms which all reduce the risk for development and relapse of mental disorder, therefore they should be available at all levels of prevention. Depending on individual needs, in clinical practice psychosocial interventions can be used in different therapeutic settings as a single intervention, but more often in combination with different psychosocial interventions as well in combination with psychotherapy and pharmacotherapy.



In order to achieve the best results, these methods should be applied as early as possible. Effective approaches to prevent mental disorders should be seen as one whole of interconnected parts. Improvements in any part of the intervention can have a beneficial effect on other parts. We want to stress that an array of evidence-based psychosocial interventions is available on all levels of prevention.

On the level of treatment of persons with mental disorders from this array of evidence-based psychosocial interventions therapist/treatment team and patients can choose, guided by the present problems and aims of the therapy, but increased effort is needed in terms of dissemination and implementation of these therapies in clinical practice as well as the prevention strategies at the population level. We also want to stress that promoting resilience is a key strategy for decreasing the risk for mental disorders, and should therefore be available at all level of prevention.

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