Recommendations for the treatment of clients with schizophrenia in the mental health care outpatient service in Carinthia

Submitted in partial fulfilment of the requirements of the academic degree
Master of Arts in Business (MA)

Author: Achtschin-Stieger, Sigrid Anna, BA
Registration number: 1510519003

Supervisor: Katja Raitio
JAMK University of Applied Sciences

Second supervisor: Dr. in Klein, Regina
Carinthia University of Applied Sciences

Feldkirchen, August 2017
Statutory Declaration

I hereby declare that:

- the Master thesis has been written by myself without any external unauthorized help and that it has not been submitted to any institution to achieve an academic grading.
- I have not used sources or means without citing them in the text; any thoughts from others or literal quotations are clearly marked.
- the electronically submitted Master thesis is identical to the hard copy.
- one copy of the Master thesis is deposited and made available in the CUAS library (§ 8 Austrian Copyright Law [UrhG]).

_________________________________________________________

(Place, Date)   (Student’s signature)
Abstract

*Purpose:* This thesis considers the wishes and needs of service users of the outpatient mental health treatment structure of Carinthia. The aim was to find out what kind of treatment structure and support people with diagnosed schizophrenia need in order to have self-determined and satisfied lives. Which established facilities, services and approaches from different countries could meet these wishes and needs and which of them could be implemented in the current mental health outpatient structure. Finally, these considerations should lead to recommendations to improve the future mental health outpatient treatment structure.

*Methods:* This thesis was set up on three methods; a literature review about international recommendations, facilities and services for people with a diagnosed schizophrenia. An ethnographic research to have a closer look on the mental health care in Finland and focus groups with the three groups of service users, people diagnosed with schizophrenia, relatives of people diagnosed with schizophrenia and professionals of the mental health outpatient treatment in Carinthia, to find out about their wishes and needs.

*Results:* Carinthian people diagnosed with schizophrenia need to get more respect and recognition within the mental health treatment. They want to be seen as individuals and outstanding humans with individual and unique needs and problems. They request to be equal partners and involved in the planning and decisions regarding their treatment plans and the organization of their lives.

*Conclusion:* The current mental health outpatient treatment structure in Carinthia is not enough person-orientated and client-centred. For people with a diagnosed schizophrenia it is important to be taken seriously, to be heard and to make their own decisions according to their own personal aims concerning their lives. Therefore the whole system has to change the current attitude towards a recovery orientated attitude, to improve the system towards more empowerment and person-involvement means to give people diagnosed with schizophrenia more self-determined and satisfied lives.

*Key words:* Mental Health Treatment, outpatient, people diagnosed with schizophrenia, relatives of people diagnosed with schizophrenia, professionals of the mental health outpatient treatment, Carinthia, wishes and needs, stigmatisation, recovery approach
# Table of contents

*Statutory Declaration* .................................................................................................................. II

*Abstract* ....................................................................................................................................... III

*List of Abbreviations* ................................................................................................................... VIII

*List of Figures* ................................................................................................................................ IX

*List of Tables* ............................................................................................................................... X

*Preface* .......................................................................................................................................... XI

1. **Introduction** ............................................................................................................................ 1

2. **The challenging situation of people diagnosed with schizophrenia** ................................. 6

2.1 **Clinical perspective - Schizophrenia as a disease** ............................................................... 6

2.2 **Stress-Vulnerability Model** .................................................................................................. 8

2.3 **Social-psychiatric perspective – Schizophrenia as stigma** ................................................ 9

2.3.1 Types of stigma .................................................................................................................... 10

2.3.2 Discredited and discreditable ............................................................................................. 11

2.3.3 Self-stigma .......................................................................................................................... 12

2.3.4 People who are affected by stigma ..................................................................................... 13

3. **Conditions and current mental health treatment structures for people with mental health problems** .................................................................................................................................................. 15

3.1 **Mental health and wellbeing in the European context** ....................................................... 15

3.2 **The Austrian health care system** .......................................................................................... 19

3.2.1 Funding of the system .......................................................................................................... 20

3.2.2 Insurance system .................................................................................................................. 20

3.2.3 Access to the health care system ......................................................................................... 21

3.3 **The challenging situation of Carinthian mental health care** ............................................ 22

3.3.1 Topography and geography of Carinthia ............................................................................. 22
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.2</td>
<td>Inpatient treatment facilities</td>
<td>23</td>
</tr>
<tr>
<td>3.3.3</td>
<td>Outpatient treatment facilities</td>
<td>23</td>
</tr>
<tr>
<td>3.3.4</td>
<td>Pro mente Kärnten</td>
<td>29</td>
</tr>
<tr>
<td>3.3.5</td>
<td>Summary of the current treatment structure</td>
<td>32</td>
</tr>
<tr>
<td>4.</td>
<td>Development of Mental Health Care</td>
<td>36</td>
</tr>
<tr>
<td>4.1</td>
<td>Treatment of people with a mental disease during the centuries</td>
<td>36</td>
</tr>
<tr>
<td>4.1.1</td>
<td>Antiquity</td>
<td>36</td>
</tr>
<tr>
<td>4.1.2</td>
<td>The Middle Ages</td>
<td>38</td>
</tr>
<tr>
<td>4.1.3</td>
<td>The Modern Era</td>
<td>38</td>
</tr>
<tr>
<td>4.1.4</td>
<td>The 19th century</td>
<td>40</td>
</tr>
<tr>
<td>4.1.5</td>
<td>The early 20th century</td>
<td>40</td>
</tr>
<tr>
<td>4.1.6</td>
<td>The dark period of National Socialism</td>
<td>41</td>
</tr>
<tr>
<td>4.1.7</td>
<td>Post-war years</td>
<td>42</td>
</tr>
<tr>
<td>4.1.8</td>
<td>Anti-psychiatry and social psychiatry</td>
<td>43</td>
</tr>
<tr>
<td>4.2</td>
<td>Recovery approach</td>
<td>44</td>
</tr>
<tr>
<td>4.2.1</td>
<td>A vision of recovery</td>
<td>45</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Recovery versus supply</td>
<td>48</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Values and dimension of a recovery orientated mental health program (ROMPH)</td>
<td>49</td>
</tr>
<tr>
<td>4.2.4</td>
<td>Recovery in Austria</td>
<td>50</td>
</tr>
<tr>
<td>4.3</td>
<td>Models of professional support</td>
<td>52</td>
</tr>
<tr>
<td>4.3.1</td>
<td>Soteria - an inspired idea in the USA and Switzerland</td>
<td>53</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Run away from traditional psychiatric treatment – Weglaufhaus “Villa Stöckle”</td>
<td>55</td>
</tr>
<tr>
<td>4.3.3</td>
<td>Just living – The Hotel Magnus Stenbock</td>
<td>56</td>
</tr>
<tr>
<td>4.3.4</td>
<td>Diagnosed free zone – possibility for changing the role – the Clubhouse</td>
<td>58</td>
</tr>
<tr>
<td>4.3.5</td>
<td>Interface management by psychiatric outpatient nurses in Finland</td>
<td>60</td>
</tr>
<tr>
<td>4.3.6</td>
<td>Open Dialogue approach – the Western Lapland treatment system</td>
<td>63</td>
</tr>
</tbody>
</table>
List of Abbreviations

AVS Association of Social Aid Carinthia (Arbeitsvereinigung der Sozialhilfeverbände Kärntens)
BBB People with a diagnosed mental health disease give advice to people with a diagnosed mental health disease (Betroffene beraten Betroffene)
CPSR Centre for psycho-social rehabilitation (ZPSR, Zentrum für psychosoziale Rehabilitation)
EU European Union
FGC Focus group clients
FGP Focus group professionals
FGR Focus groups relatives
HPE Support for relatives of people with a mental health problem (Hilfe für Angehöriger psychisch Erkrankter)
KABEG Operating company of the public hospitals in Carinthia (Landeskrankenhauses Betriebsgesellschaft).
KEB Carinthian Empowerment Movement (Kärntner Empowerment Bewegung)
MHiAP Mental Health in All Policies
NIMH National Institute of Mental Health
ÖSG Austrian Health Care Structure Plan (Österreichischer Strukturplan Gesundheit)
RSG Regional Health Care Structure Plans (Regionaler Strukturplan Gesundheit)
RSMH National association for social and mental health (Riskförbundet för social och mental halsa).
UN United Nations
USA United States of America
WHO World Health Organisation
YLD Years lived with disability

Political Districts of Carinthia

FE Feldkirchen
HE Hermagor
K Klagenfurt
KL Klagenfurt Land
SP Spittal
SV Sankt Veit
VI Villach
VK Völkermarkt
VL Villach Land
WO Wolfsberg
List of Figures

Figure 1: Stress-Vulnerability Model (according Hazelden Foundation, 2008) ............... 8
Figure 2: Political districts and provision regions of Carinthia .................................... 22
Figure 3: Carinthia treatment structure for people with schizophrenia (according KABEG, 2017a, KABEG, 2017b, KGKK, 2017b, pro mente Kärnten GmbH, 2017b, Pöcheim, 2015, Ärztekammer für Kärnten, 2017) .................................................................................. 34
Figure 4: Process of a structured qualitative content analysis (according Kuckartz, 2016, p. 100) .................................................................................................................................. 85
Figure 5: Poster - wishes and needs professionals (FGP, 21.09.2016) ......................... 87
Figure 6: Poster - wishes and needs relatives (FGR, 07.10.2016) ................................. 88
Figure 7: Poster - wishes and needs clients (FGC, 10.10.2016) .................................. 88
Figure 8: Connection between the main categories ....................................................... 110
Figure 9: Poster - Warming-up – professionals (FGP, 21.09.2016) ............................. J
Figure 10: Poster - Scale of experiences of past and present – professionals (FGP, 21.09.2016) .......................................................... J
Figure 11: Poster – Conclusion - professionals (FGP, 21.09.2016) ............................... K
Figure 12: Poster - Warming-up - relatives (FGR, 07.10.2016) ................................... L
Figure 13: Poster - Scale of experiences of past and present – relatives (FGR, 07.10.2016) .................................................................................. L
Figure 14: Poster - Conclusion - relatives (FGR, 07.10.2016) ...................................... M
Figure 15: Poster - Warming-up - clients (FGC, 10.10.2016) ...................................... N
Figure 16: Poster - Scale of experiences of past and present - clients (FGC, 10.10.2016) N
Figure 17: Poster - conclusion - clients (FGC, 10.10.2016) ......................................... O
List of Tables

Table 1: Distribution of CPSRs in Carinthia (according Pöcheim, 2015) ..........................25
Table 2: Distribution of psychiatrists over Carinthia (according Ärztkammer, 2017 and Statistik Austria, 2016) .....................................................................................................26
Table 3: Distribution of clinical psychologists and associations financed by insurance institutions (according KGKK, 2017a and KGKK, 2017b) .................................................................28
Table 4: Treatment services of Carinthia and the distribution to the districts (according KABEG, 2017a, KABEG, 2017b, KGKK, 2017b, pro mente Kärnten GmbH, 2017, Pöcheim, 2015, Ärztekammer für Kärnten, 2017) .........................................................................................................33
Table 5: Supply / centre-orientated vs. person / recovery-orientated structure (according Burr, et al., 2003, p. 88) ..........................................................................................................................48
Table 6: Schedule of the ethnographic research in Jyväskylä 12. - 16.12.2016 ...............69
Table 7: Process of the focus groups (inspired by Kuckartz, 2016) ..................................75
Table 8: Main and sub-categories of the individual focus groups ...................................90
Table 9: Overall main and sub-categories of the focus groups .......................................90
Table 10: Main and sub-categories of the analysis of the focus groups with numbers of text sections .................................................................................................................................98
Table 11: Semi-structured guideline for focus groups ....................................................... A
Table 12: Scale of the experience of past and present - professionals (FGP, 21.09.2016) K
Table 13: Scale of experiences of past and present - relatives (FGR, 07.10.2016) .......... M
Table 14: Scale of experiences of past and present - clients (FGC, 10.10.2016) .............. O
Preface

This thesis was designed to give people diagnosed with schizophrenia, their relatives and the professionals a voice. The first impulse was to help them. During the writing process this impulse changed, it was not only the impulse to help them, it became more diverse. A chance to see and feel what the really want; how they want to be treated; how they see and feel their environment, to learn more about different systems, services and approaches and to see where the main problems in the Carinthian mental health outpatient treatment structure are.

For me it was essential to cast off my experiences as a psychiatric nurse who worked at the psychiatric and psychotherapeutic ward for fifteen years and to take a new role, a role with a neutral perspective. This role was helpful to see the real needs and wishes. I had to change my attitude. The attitude I learned during my professional years and is still settled in the current mental health system. The attitude “I am the expert and I know it best” towards the recovery approach. I learned that I do not know it best, that I only can be a partner on the individual way of the people with diagnosed schizophrenia and during this thesis I am the one who will give the people a voice.

This decision was not made from one day to the other; it was a process of one and a half year. The process also influenced this thesis, the wording of the thesis and the results. I had to learn to give subjects new more recovery orientated names, a wording I never used before, because the recovery approach never came to me during my professional work. Words who can change the mind and see circumstances from a new perspective.

I am thankful for this experience, even if I sometimes had the feeling I would fail. On this way I had many people around me who listened to me, gave me recommendations and encouraged when I hit the bottom. These people always strengthened me and this way they led me to my own decisions. So I had my own recovery during the time working on this thesis.

At this point I would like to thank my family and friends for their support, understanding and their faith in me. A special thanks goes to:

- My two supervisors Katja Raitio and Regina Klein, who lead me through this processes and opened my eyes for new opinions and ideas.
- Christina Anticevic-Harrant who spent many hours on this thesis to complete the English language check.
• Sonja Datlinger-Kofler, Nadine Fuchs and Angelika Liebenwein who helped me to get a new perspective regarding the focus groups.
• My sister Birgit Müllner-Stieger who always had an open ear for my personal fears, ideas and opinions.
• My colleagues at CUAS who strengthened me to finish this thesis and never lose the faith that I can manage it.

Especially I will thank the participants of the focus group, they all have been so open-minded and engaged during the three meetings that they helped me to understand their true wishes and needs.

Sigrid Anna Achtschin-Stieger, BA

Klagenfurt, August 2017
1. Introduction

“Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one’s life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.” (WHO, 1986)

The author herself worked as a nurse at the department of psychiatry and psychotherapy at the Klinikum Klagenfurt for 15 years. During this time, there was a considerable amount of contacts with patients with different psychiatric diseases. As a member of a treatment team she accompanied many of these patients more than once. The patients became inpatients after social or psychiatric crises. They usually stayed for several weeks up to several months. The team tried to help the patients to create better living conditions and to guide them to an outpatient treatment programme. But many of the people with a mental health disease returned to the ward after a few months.

The author started to ask herself why this happened but was never able to get a satisfying answer. The team members often argued that these clients have many different problems and that it was not easy to find an appropriate solution. In the end it was always the team who tried to find the best solution, mostly only with a small involvement of the patient.

One situation was very impressive to the author and this situation lead to a change in her mind. One day, about ten years ago, a 45 year old man who was diagnosed with chronic schizophrenia became inpatient and after the acute treatment at the closed ward the man was directed to the ward seven, the rehabilitation ward, where the author worked. After the regular treatment the team started to search for an outpatient living environment for him. They offered the man a psychosocial rehabilitation centre (CPSR) which he declined, because it was too far out of the town. The team tried to find another one which was closer to the town. He said “no” again. Only after the third “no”, the team asked him what he wanted. He told them that he would prefer to live on his own in an apartment in Klagenfurt. Basically this is to be considered a normal and legitimate desire, but very unexpected and challenging for the team. After many discussions, they organised him an apartment, but the unanimous opinion of the team was that with an apartment the patient would have needed an additional outpatient treatment. Again the man declined these offers. The last solution of the team was treating the man as a day care patient of the ward. Finally, he agreed to this
form of treatment and he used this service for ten years. In the last few years, it became such an important ritual for him that he officially came three times a week as a patient and the other four days he visited the ward for a few hours. He didn’t need much, he liked to sit on the balcony smoking cigarettes and listening to other patients and he appeared to be well integrated and satisfied.

As mentioned before his behaviour started to trigger a change in the mind of the author. Is it really so uncommon that a patient tells the professionals how she/he wants to spend his/her life? The case of this patient went on for a period of several months, months in which the man always sticked firmly at his wish, an outstanding and nearly unique case. But not only unique, also impressing; the behaviour of this man inspired the author to go beyond her own borders, to think out of the box and have a closer look at new perspectives, opinions and possibilities.

In a first discussion on this topic the author came across the Ottawa Charter for Health Promotion from the World Health Organization (1986), in this paper the tasks for professionals were described in the following way:

“...the process of enabling people to increase control over, and to improve, their health, to reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living… (WHO, 1986)”

The Ottawa charter was created by the WHO in 1986 the case story took place around the year 2004. There are about twenty years between these two incidents. Do professionals, policy and institutions in Carinthia really act as the Ottawa Charter recommends it? Or are there limitations, financial borders, bureaucratic hurdles or just the fear that it is hard for people with a mental illness to act in and create their lives as they want? These and other questions arose in the mind of the author.

Furthermore the Ottawa Charter explains that:

“The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to pursuit of health” (WHO, 1986).

It has to be more than only to provide clinical and curative services, to promote health means to support the individual needs. The question which arose based on this was does the treatment system in Carinthia support the needs of the individuals; and if the system
does so are these the real needs of the individuals, or are these needs assumed and
generalized and only seen out of a professional perspective? It is difficult for people with a
diagnosed mental health disease to reach a satisfying life. Stigmatisation, the role as
patient, a financial security by the disability pension and at the same time the exclusion from
the labour market, limits their possibilities. However, according to the introductory story it is
possible for people with a diagnosed mental health disease to find personal satisfaction in
life, if the facility takes the wishes of their clients seriously and work together with them
towards realization.

The main focus of this thesis lies on people with a diagnosed schizophrenia. Schizophrenia
has an average lifetime prevalence of about 1% of the total population, Carinthia has a total
population of around 560,000 inhabitants. That means that around 5,600 people could be
affected by schizophrenia during their lifetime, it is also known that schizophrenia affects
people during the process of growing up and the clinical presentation of symptoms varies
widely. Some of the following symptoms can always be observed: thought disorder,
delusions, hallucinations, abnormal affect and disturbances in motoric behaviour. The
course of the disease can be summarized in three different courses, 45 percent of the
people recover after one or more episodes, about 20 percent have unremitting symptoms
and an increasing disability and about 35 percent of the people show mixed patterns with
different degrees of exacerbations and remissions (Barbato, 1998, pp. 4-8). As mentioned
everyone develops his own schizophrenic scheme, and as schizophrenia is individual to the
person the treatment also should be person-centred and adapted to the individual needs of
the person with a diagnosed schizophrenia.

The discussion about the current mental health care system, the own experiences of the
author and different considerations found in literature like the Ottawa Charter and the
European Mental Health Action Plan and others, and the special course of schizophrenia
lead the author to the question:

**What are the wishes and needs of people diagnosed with schizophrenia for a
mental health outpatient treatment structure in Carinthia?**

The World Health Organization (1986) formulated a vision for the future and calls for
international action to plan and implemented health programs to reach this vision in the
Ottawa Charter. Health is created and lived by people, which means that a future treatment
structure should involve service users in each phase of planning, implementation and
evaluation of health promotion activities and future health services. That leads to the
question - are people with a diagnosed schizophrenia only service users or are there other people involved as well? If we take a closer look at the social network of people with a diagnosed schizophrenia we can immediately detect other groups who can profit from a treatment structure.

The second group who is very strongly involved are the relatives of the people diagnosed with schizophrenia. Finzen (2016) explains that the realization that a family member suffers from schizophrenia is unanimously experienced by relatives as a catastrophe that changes everything. They also get service users of the treatment structure and since the 1990’s there is a strong ongoing process of empowerment and self-organisation of relatives. It is also necessary to ask further:

**What are the wishes and needs of relatives of people diagnosed with schizophrenia for a mental health outpatient treatment structure in Carinthia?**

The third group which could be identified are the professionals who work in the outpatient treatment facilities, this group is in a constant exchange with people who are diagnosed with schizophrenia. They get knowledge about the patients’ needs, they also have knowledge about the current structures and the difficulties to combine the individual wishes of the people with a diagnosed schizophrenia with this structure.

So the third question for this thesis was:

**What are the wishes and needs of professionals working in the mental health outpatient structure for people diagnosed with schizophrenia in order to improve the services and structure?**

These three groups are the core group of the triologic process which are based on an equal culture of communication. They should be involved in the development of a subject orientated, fair and democratic treatment structure (Clausen & Eichenbrenner, 2016). Together these groups can answer the final question:

**What kind of treatment structures and support do people with diagnosed schizophrenia need to have self-determined and satisfied lives?**

According to the answers of this four questions the author will prove which kinds of established facilities, services and approaches of the international mental health treatment structure will fit to the wishes and needs of the people with diagnosed schizophrenia of
Carinthia. Therefore the author decides to set up this thesis on three methods; a literature review about international recommendations, facilities and services for people with a diagnosed schizophrenia, an ethnographic research to have a closer look on mental health care in Finland and focus groups with the three groups of service users in Carinthia to find out their wishes and needs. The information, combined with data and facts based on an international literature review, the analysis of the focus groups and the ethnographic research in Finland, will lead to recommendations to improve the future mental health care outpatient treatment structure in Carinthia.
2. The challenging situation of people diagnosed with schizophrenia

“Schizophrenia does not exist or everyone develops his own schizophrenia”
(Dörner, et al., 2004, p. 153)

Schizophrenia is no more an illness that is not treatable, the people who are diagnosed with schizophrenia are not stupid and idiotic or dangerous. People with a mental health problem are able to make rational decisions for their own lives and they can articulate their individual wishes and needs. This chapter examines schizophrenia from a clinical and social-psychiatric perspective and shows the environmental conditions in which people with diagnosed schizophrenia live.

2.1 Clinical perspective - Schizophrenia as a disease

Schizophrenia is the most dazzling of all mental disorders. The course can be easy or difficult. It can be acute and proceed dramatically or creepingly and hardly perceptible for outsiders. Schizophrenia can hold on for a very short time or exist a lifetime and it can occur once or can reoccur in longer or shorter intervals. It can lead to invalidity or be cured. It affects young people during the process of growing up or during the professional development. Schizophrenia equally affects women and men (Finzen, 2016, p. 11).

Schizophrenia is known as a chronic psychotic disorder; that affects how a person thinks, feels and behaves. It appears in late adolescence or early adulthood (between ages 16 and 30). It is estimated that the average lifetime prevalence of schizophrenia would be about 1 percent of the total population. It is considered to be one of the top ten causes of long-term disability. Although this disorder is not as common as other mental disorders the symptoms can be very disabling (Farlex, Inc., 2016 and NIMH, 2016).

The term schizophrenia was introduced in 1907 by Eugen Bleuler. During his observation Bleuler perceived that human beings are increasingly fragmented and disrupted. Earlier Emil Kraepelin described the illness in the form of relapses and an inexorable brain-organic process. Between 1900 and 1950 Schizophrenia was seen as being incurable and people ending in stupefaction (Dörner, et al., 2004, p. 156). The Diagnostic and statistical Manual of Mental Disorders (fourth Edition) describes Schizophrenia as followed:
“Schizophrenia is a disturbance that lasts for at least 6 months and includes at least
1 month of active-phase symptoms (i.e., two [or more] of the following: delusions,
hallucinations, disorganized speech, grossly disorganized or catatonic behaviour,

In the international classification of mental disorders ICD-10, which published is by the WHO
(2016), the following subgroups are mentioned: paranoid schizophrenia, hebephrenic
schizophrenia, catatonic schizophrenia, undifferentiated schizophrenia, post-schizophrenic
depression, residual schizophrenia, simple schizophrenia and other types of schizophrenia.
In addition to these diagnosis groups there are different kinds of progress; Continuous,
episodic with increasing residuum, episodic with stable residuum, episodically remitting,
incomplete remission, complete remission and others (WHO, 2016). Considering this it is
important not to forget that the classification is aimed at professionals; to understand each
other and to deal with the possibilities of diversity. As every human is unique also
schizophrenia is individual, there is no expression or attitude that is typically schizophrenic.
However, some characteristics are specific for this disease; these characteristics could be
found in the thoughts, perception and affection of persons diagnosed with a schizophrenia
(Dörner, et al., 2004, pp. 153-157). After one or more acute psychotic phases, the further
development, in interaction with the initial personality, is probably determined primarily by
psycho-social factors, which results in the enormous variety of prognoses between
complete healing, residual states of different degrees and severe chronic manifestations.
Meanwhile the progress of schizophrenia is seen as an open life course. The progress is
not regularly writeable. In literature the illness is described as schizophrenic episodes,
which can arise once, more than once or in a repeated form. Stigmatization, isolation during
an admission and wrong treatment like use of violence can influence the progress as well
as factors of the familiar environment (Dörner, et al., 2004, p. 156).

The acting of people with schizophrenia characterize the effort to be intangible and
submissive, to be present and absent, to be separate and remain together to the same time.
This means a constant stress for the people and the symptoms are the compensation. The
experience of separating, sharing and tearing lies in the development of people in late
puberty and in the subsequent years. Whereas the world of a child is relatively
unambiguous, new aspects emerge within the young people emerge in puberty. During this
time the adolescents have sort out and order a lot of new information, everything seems
simple and complicated at the same time. The task of this development is separating,
solving established and finding new dispositions. The age between 16 and 30 is the duration
when schizophrenia emerges for the first time (Dörner, et al., 2004, p. 151). It is important
to know that everyone can become schizophrenic, it is a general human possibility. But
there are humans which are less vulnerable, have fewer dispositions and others seem to be more sensible (nearly one percent of the population) so that small inner or external reasons can lead to a violation (Dörner, et al., 2004, p. 176f).

### 2.2 Stress-Vulnerability Model

A common question is, what causes psychiatric disorders? A possible answer is provided by the stress-vulnerability-model. The model can help understand why some people develop a psychiatric disorder and others do not. The stress-vulnerability-model explains the relationship between biological vulnerability, stress, alcohol and drugs and the coping skills of individuals (Hazelden Foundation, 2008). The stress-vulnerability model was introduced by Zubin & Spring in 1977. It was developed for clients who had a disease called schizophrenia. The elements of the stress-vulnerability model are the biological vulnerability, stress and protective factors. Biological Vulnerability combined with stress can lead to a mental illness (Hammer, et al., 2015).

![Stress-Vulnerability Model](image)

*Figure 1: Stress-Vulnerability Model (according Hazelden Foundation, 2008)*
Some people are biologically vulnerable to schizophrenic disorders; this is determined early in life by a combination of different factors like genetics, biochemicals and early experiences in childhood such as the loss of a beloved person. The person is more sensitive to develop a mental health illness but not every person with a biological vulnerability develops a schizophrenic disorder. Stress plays an important role in developing a mental health disorder, it can trigger the onset of symptoms and can worsen biological vulnerability, increase symptoms or cause a relapse. Stress events are, for example, losing a beloved person, being a victim of crime, having conflicts or losing a job. It is often associated with negative events but also positive events can be very stressful, like having a baby, starting a new relationship or performing well in school. The experience of stressful events is very individual, what is stressful for one person may not be stressful for another (Hazelden Foundation, 2008) (Hammer, et al., 2015).

Stress and vulnerability can be negatively influenced by alcohol and drugs. Alcohol and drugs can increase a pre-existing vulnerability and worsen symptoms. Protective factors like coping skills, medication, social support and a meaningful structure reduce the negative stress effects and the person’s biological vulnerability (Hammer, et al., 2015).

Medications can be an important factor, they can help to lessen the symptoms and reduce having a relapse, but if a person uses alcohol and medications at the same time the benefits of prescribed medications will not unfold the full outcome (Hazelden Foundation, 2008). Stress is a normal part of life, and coping skills are important to manage stressful life events. These skills are, for example, relaxation skills, social skills and problem-solving skills. Coping skills can help people with co-occurring disorders to live normal lives as well as their social support or a supportive environment. To be involved in a meaningful activity can protect the person from stress, it gives the person meaningfulness (Hazelden Foundation, 2008 and Hammer, et al., 2015).

### 2.3 Social-psychiatric perspective – Schizophrenia as stigma

It is a fact that stigmatization and related discrimination is still very high in Austria, especially against people with a mental health problem. Stigmatized persons are excluded, discriminated against and they are treated with prejudices. This leads to no or very late treatment, and often inadequate treatment. People with a mental health problem do so
because they are frightened: of stigmatization, of the hospital and the ongoing situation. Before people get ill, they have their own prejudices against affected persons (Rittmannsberger & Wancata, 2008, p. 199).

Stigma means mark or brand, the term was introduced by the Greek. The mark was burnt or cut into the body, mostly on a place where everybody could see it. The bearer was a slave, a traitor or criminal. With the stigma the people rated the person as being negative. In the public this was meant that the person should be avoided (Finzen, 2013, p. 38). Nowadays the term stigma is used in a sociological meaning. The American sociologist Erving Goffman was one of the earliest researchers who wrote about the sociological meaning of stigmatization, his book “Stigma – Notes on the Management of spoiled Identity” in 1963 outlines general assumptions and definitions. Nearly anything in modern sociology and psychiatry that is talked or written about Stigma goes back to Goffman.

People, wherever they live, have certain ideas about how people live, how they behave and how they should be (Finzen, 2013, p. 38). Social settings establish categories and are handed on from one generation to the next. Also people with a mental illness have learned these categories before they got ill. This routine of social intercourse in established settings allows us to deal with strangers without special thoughts or attention. Typically, we do are not aware of our making demands or our prejudice. But sometimes an active question arises and we start thinking about what we do (Goffman, 1963).

2.3.1 Types of stigma

There are three different types of stigma:

1. Physical characteristics – various physical deformations
2. Individual characteristics which are seen as weaknesses – mental disorders, imprisonment, addiction, unemployment, radical political behaviour, unnatural passions or rigid beliefs
3. Social affiliation – race, nation and religion

All stigmatized humans make a similar experience; they have realize that they are different from other people so called “normal ones” and they have to learn to deal with the difference. However, the development differs according to whether a person with an innate stigma was born into the world, whether someone gets chronically ill in the course of his life and develops a deviant behaviour or whether he is born into a community (Finzen, 2013, p. 43). When the stigma occurs later in life, the individual has learned a lot about “normal ones” and the stigmatized persons. It is therefore likely that his particular problem will be his new
identification and it is possible that he will develop a self-denial behaviour. They themselves have grown up with the reservations and prejudices against people with a mental health disease who prevail under the “normal”. Accordingly, they and their relatives inevitably develop a disapproval of themselves. In this way, the stigma becomes the second disease, which can be a barrier to recover (Finzen, 2013, pp. 44-45).

2.3.2 Discredited and discréditable

The term stigma has a double perspective, the discredited and the discréditable perspective. The stigma of people who are discredited is clearly known or visible, people who are discréditable, whose stigma is unknown and can be covered. This is an important difference, but sometimes particularly stigmatized individuals have experiences with both situations (Goffman, 1963).

Physical characteristics are mostly discredited, individual characteristics can be covered by the person for a while, but sooner or later they will be exposed. Social affiliation can be transmitted for example to all members of a family (Goffman, 1963).
People with mental disorders are both be discredited and discréditable. A small group of people, mostly relatives of the person with the mental health problem, know about their health issues, some people can imagine that they are ill but most people do not know. The social distance which the healthy persons keep to people with mental health disorders is larger than the distance to people with unknown mental health disorders. The awareness of reservations and prejudices leads to the fact that many persons and their relatives try to hide their situation. But this hiding has consequences, to hide a part of the identity is very wearing for a human (Finzen, 2013, pp. 46-47).

The main problem is not the tension which comes up during a social contact, but rather to regulate the informations about their blemish; open or not, telling or not, let it out or not, lying or not; and in any case whom, how, when and where (Goffman, 1975, p. 56).

With other words persons who hide their diseases live in constant fear and tension to be identified and thereby discredited. The hiding of the disease may solve some problems, but the fact of hiding also intensifies other problems. In informal conversations the discrimination can be felt in a brutal way. If they would confess their self they would get more consideration and a certain amount of understanding from society (Finzen, 2013, p. 47).
In reality people with a diagnosed mental health disease and formally diagnosed people with a mental health disease need the exchange with other humans, to talk about their problems, their treatment and also their “normal” daily activities. A hidden life is very difficult, it can be very wearing and bring forward relapses. Nevertheless, it seems that finding people whom they can trust, outside the circle of the family, is a very hard task for this group of people. The fear of being rejected and of being devalued is a massive barrier, if the person misjudges, rejection, degradation and discrimination will be the result (Finzen, 2013, p. 48).

2.3.3 Self-stigma

The term Self-stigma has different definitions, the term originally came from sociology and has undergone a change of meaning. The psychiatric meaning for the German area was introduced from Nikolaus Rüsch and Matthias Berger (2012, p. 952).

“Self-stigma occurs when members of a stigmatized group know the stereotypes about themselves, agree with them and turn them against themselves, resulting in self-prejudice and self-discrimination.”

Mental disorders and especially schizophrenia manifests itself towards the end of the second decade of life or later. Until then, the people are fully integrated members of the society. They share their values and prejudices. They find things that others do well or badly and agree or disagree with them. They discriminate other people who in their view do not respect or violate the applicable values and norms. If, during the course of the disease, they perceive that they now belong to this group of people which they have discriminated and devalued before, they walk into a cognitive and emotional trap. The person has no choice other than perceiving and sharing the image of the others, because the prejudices of the others are basically his own (Finzen, 2013, pp. 63-68).

The illness usually does not allow the person with a diagnosed mental health problem to reflect on one’s own situation and to resist the prejudices of others. The overcoming of the self-stigma is a strong desire and the support of other people with a diagnosed mental health disease, self-help groups, professionals, their family and a positive environment is necessary. At the beginning of all the support to overcome the stigma is the awareness of the central dilemma, the value system of healthy days is now directed against itself. The self-stigma is stigma in its most destructive form, because the self turns against the self. So self-stigma can become a second disease, it affects the original disease in a very negative way and delays the acceptance of help and treatment (Finzen, 2013, pp. 65-66).
2.3.4 People who are affected by stigma

Primarily the people who are suffering from schizophrenia or a mental health problem are affected from stigmatization. But also their families are affected. Evidently their social contacts of relatives decrease. They must face a considerable financial burden. On the one hand, many time resources are required for the care and support of the family members with the mental health problem, which leads to a reduction in their professional possibilities. On the other hand, in many cases, the family members need financial support for their living (Rittmannsberger & Wancata, 2008).

The stigma also affects the professionals (doctors, nurses, psychologists, physiotherapists, social workers, occupational therapists and others) who work in the psychiatric field. They must be aware that the society consider them to be at risk, because there is still a strong believe that the disorder is contagious. But society also assumes that they carry out a senseless work being hopeless in terms of success (Rittmannsberger & Wancata, 2008). Furthermore, the institutions for the treatment of mental illness are affected by the stigma. Psychiatric hospitals and departments have a negative picture, especially in Carinthia, as during the time period of National Socialism patients were killed in psychiatric wards and this circumstance is still anchored in the unconscious of the society. (Stomberger, 2002). When non-hospital institutions focus on psychoses, they have to be aware of resistances from the environment.

The stigmatization of institutions is also reflected in the financing of these institutions. Public expenditures on psychiatric disorders do not correspond to the economic significance of this diseases. The order of magnitude of expenditure would have to be about 25 percent of the health expenditure, in fact the expenditure in Austria is only 5 – 6 percent (Rittmannsberger & Wancata, 2008).
We do not know enough about how the people develop in the environment of institutions like clinics, and the different possibilities of the treatments. It is true that an admission in the psychiatric ward will not stop the mental suffer. And it is also true that people with a diagnosed mental health disease have more multifarious wishes and needs for designing their individual lives. The clinic, the professionals and the relatives are main parts of the ecological system of these people. But in order to live independently and self-determinedly it is necessary that the professionals, relatives and the society engage with the life stories of people with mental health issues. It is important to get a feeling for the needs and wishes of the people to create a wholesome environment (Dörner, et al., 2004, p. 170).
3. Conditions and current mental health treatment structures for people with mental health problems

Mental health and wellbeing became in the last year more and more important for European states and every individual citizen. Aside from the individual burden of each person, mental health disorders have a high impact on society and economy. Only about half of the people with mental disorders in the European Union (EU) receive adequate treatment at all the so called treatment gap is significantly larger than that for most physical disorders. This chapter provides an overview about the activities and efforts of the EU, explains the Austrian health care system and shows the challenges of the current mental health treatment structure of Carinthia. For the survey about the wishes and needs of Carinthians people with diagnosed schizophrenia, it is necessary to understand the current system and efforts which could influence the future mental health care system.

3.1 Mental health and wellbeing in the European context

Between the 12th and 15th of January 2005 the European Ministerial Conference on mental health took place in Helsinki. 52 member states signed the Mental Health Declaration for Europe and established the “European Mental Health Action Plan”. The present circumstances motivated all members to improve the mental health and wellbeing for European citizens (WHO Regional Office for Europe, 2005, p. X).

The European countries face major challenges regarding mental and health wellbeing. The prevalence of mental health disorders are very high in Europe and affect every country in the same way (WHO Regional Office for Europe, 2005). The prevalence of adult population (age 18-65) in the EU and Iceland, Norway and Switzerland is 27 percent, that means that more than every fourth had experience with at least one of a series of mental health disorders in the past year. Included are mental health disorder problems arising from substance abuse, psychoses, depression, anxiety and eating disorders. The rates for women are significantly higher than those for men, except for substance abuse were the numbers for men are four times higher than for women and psychotic disorders, where the prevalence is almost the same (WHO Regional Office for Europe, 2016).
The European Union recognized that mental disorders are the largest contributor to chronic conditions. According to the data of 2012 neuropsychiatric disorders rank as the first cause of years lived with disability\(^1\) (YLD), 36.1 percent account imputable to all causes. According to the most recent available data (2000 - 2012 Global Health Estimates 2014 Summary Tables), neuropsychiatric disorders rank as the first cause of YLD in Europe, accounting for 36.1 percent of those attributable to all causes (WHO Regional Office for Europe, 2016).

Aside from the individual burden of each person, mental health disorders have a high impact on society and economy. Mental health problems are a key reason for losses of productive human capital. There are substantial costs at workplace like higher presences and absenteeism and significantly reduced earnings among people with a diagnosed mental health disease. Mental health problems also become a leading cause for people receiving work disability benefits. In the EU the overall financial costs regarding mental disorders; amounts more than Euro 450 billion per year. This amount includes direct medical and indirect costs through care and loss of productivity (Joint Action - Mental Health and Wellbeing, 2016, p. 4)

The wellbeing of the inhabitants has become a central focus for governments of the European Union. Governments play a crucial role in ensuring the mental health of their population. In a time of economic changes with increased unemployment in many countries as well an ageing population, the attention on efficient ways of preserving and maximizing wellbeing across the lifespan became a necessary issue in the policies of European countries. An explicit mental health policy is an essential tool; if properly formulated and implemented such a policy can have a significant impact on the mental health of a population (WHO, 2003, p. 31). To have this significant impact on the population a mental health policy should compromise the following issues:

- Countries should develop community based mental health services and downsize large mental hospitals to reduce stigma and discrimination.
- They need to develop services or initiatives for preventing mental disorders and promote mental health in society.
- A third issue is to strengthen the quality and quantity of human resources to provide excellent service and treatment.
- An important fact would be to involve and empower clients, families and carers in designing and implementing policies, services and initiatives.

\(^1\) YLD are “years lived with disability”, this is a measurement of the burden of a disease, they are calculated by multiplying the prevalence of a disorder by the short- or long term loss of health associated with the disability (National Mental Health Institute, 2016)
• It is essential to improve the equity of access to basic mental health services and care for everyone who is in need.
• Furthermore, it is important to build up a quality assurance and information system to monitor the quality of care continuously.
• Human rights and family rights need to be included into policies and additional countries need to build up an advocacy for people with mental health disorders; this would help to protect the rights of the people.
• A crucial issue is that countries have to take care for secured funding of the services as well (WHO Regional Office for Europe, 2008).

All these issues are related to each other, the European regional office of the World Health Organization (WHO) exerts themselves to reduce the burden, stigma and discrimination; therefore they recognized the importance of mental health promotion and prevention of harmful stress and suicide. They also recognized the treatment gap between the need of treatment and services available, to minimize this gap it is necessary to improve the services by reducing large institutions and strengthen the community based services. The empowerment of clients, carers and families is also one of the main targets; to empower these groups it is essential to reduce the stigma and to design and implement new types of services. The duties need to be secured by law and finance safety. To get all these tasks to be done, it is important that all countries improve and strengthen their mental health policies (WHO, 2003).

Since 2005 more than half of the 42 European countries have adopted new policies or updated their existing mental health policies according to the above mentioned issues. Most countries cover all the subjects in their mental health policies. The most frequent issue is developing community based services (38 of 42 countries). The issue which was less developed is quality assurance (28 of 42 countries) (WHO Regional Office for Europe, 2008, p. 14). Several countries in the European Region provide a comprehensive network of community based services and lead the world in vision and quality of activities, but others are still struggling to implement their strategies. There are still many ambitious strategies which have already been accepted by the governments and also parliaments but not implemented yet. Reasons for obstacles could be the absence of skilled leaders, infrastructure, funding, a competent workforce and partnerships. (WHO Regional Office for Europe, 2008, p.17 and 2015, p. 14).

To meet these challenges the “Mental Health Declaration” and the “European Action Plan” sets the time period for the next decade; their main goal is to promote mental health, reduce stigmatization and prevent mental disorders (WHO Regional Office for Europe, 2008, p. 21).
The “European Mental Health Action Plan” describes three important values on which the vision is based. These values are fairness, empowerment, safety and effectiveness. Fairness should enable all citizen to reach the highest possible level of mental wellbeing and open the way to the support fitting their needs. Empowerment means that all people with mental health problems should have the opportunity to decide about their treatment autonomously, take responsibility and share decisions affecting their lives. The treatment and services have to be safe and effective, so that all citizens are able to improve their mental health and wellbeing (WHO Regional Office for Europe, 2015, p. 2).

During the last years significant efforts, like effective treatments and care for many mental health disorders and their comorbidities have been made by the EU to improve the mental health of the population. However, many people with mental health problems choose not to be part of these treatments because of stigma and discrimination, equally important to negative experiences with treatment and care. Only about half of the people with mental health disorders in the EU receive adequate treatment at all the so called treatment gap is significantly larger than that for most physical disorders. Factors which contribute to this treatment gap are the existing stigma, the aversion of people to seek help, because of their negative experiences, deficits in the quality of services, big stigmatised institutional infrastructures and the lack of training of health professionals. Additional to these factors, there is a lack of awareness and knowledge across the society about mental health. The treatment gap results in a broad set of impacts and associated economic costs. Mental health policies in all EU countries need to combine structural reforms of services with a strong focus on quality and easy and stigma-free access for all persons in need of treatment and care (Joint Action – Mental Health and Wellbeing, 2016, p. 5, WHO Regional Office for Europe, 2015, p. 2).

To improve mental health policies or health policies is a first step to reduce the burden of citizens with mental health problems, but many individual familial and social determinants of mental health derive from non-healthy policy domains, for example social policy, education, employment, taxation and community design. Mental Health can be promoted by strengthening protective factors throughout an individual’s life. To increase the wellbeing of citizens and their environment the Mental Health in All Policies (MHiAP) approach needs to be recognized. MHiAP is a strong approach to all public policies that systematically takes into account the health impact of decisions and builds up synergies and avoids unhealthy effects on mental health in order to improve health and equity for all citizens. The basis for mental health and wellbeing lies in the pregnancy and will be enhanced during the whole life; a safe and supportive environment will increase the mental wellbeing of citizens.
Therefore, all sectors must be aware of mental health impacts in policies and daily life (EU Regional Conference mental Health in All Policies, 2015, Joint Action – Mental Health and Wellbeing, 2016, p. 7).

3.2 The Austrian health care system

Health care in Austria is characterized by the cooperation of different actors; the competencies are generally regulated by law. The Federal Ministry prepares laws for the whole republic and is responsible for protecting Public health and the health policy. The Ministry of Health is also a facilitator between the different players within the health care system. The federal government is in charge of defining the legislation for outpatient care, responsible for structural policies, the structure of the in-patient care and regulations regarding medical devises, pharmacies and education of health professionals (Gesundheit Österreich GmbH, 2013, p. 6).

Austria is a Federal State with nine provinces; many competencies are delegated to them. The provinces are in charge of defining legislation on enforcement and ensuring implementation. They are in charge of hospital care and offer promotion and prevention services. The local governments are responsible for social welfare benefits and services. Public health services and administration are provided by federal, provincial and local authorities (Gesundheit Österreich GmbH, 2013, pp. 6-7).

Key planning instruments are the Austrian Health Care Structure Plan (ÖSG) and the nine Regional Health Care Structure Plans (RSG). These plans are important, because they include planning of resources across all levels of service provision. The ÖSG is designed by the federal government; the RSG is subordinated to the ÖSG and the plans cannot be contrary to the ÖSG. However, the ÖSG leaves enough scope for the distinct design of the RSGs. The RSG includes the inpatient and outpatient care planning for the provinces. The integrated supply planning, adoptions, maintenance and further development have to be coordinated between the government of the province and the health insurance system (Gesundheit Österreich GmbH, 2013, p. 8). Additional to the individual RSG in every province of Austria, there are also mental health plans. In all nine provinces, there are distinct mental health plans. These plans include extensive surveys on the current situation and the activities to improve the current treatment structure. The comparability between the mental health plans is limited. The degree of liability of these plans differs, some of the plans
only cover the social support sector and others are comprehensive and involve the medical and welfare sector as well as the inpatient and outpatient sector (BMGF, 2005).

### 3.2.1 Funding of the system

The system is funded by the federation of Austria, the provinces and the insurance companies. In order to regulate the financing there is a legal agreement called “Vereinbarung gemäß Art. 15a B-VG über die Organisation und Finanzierung des Gesundheitswesen” or short 15a Agreement. The 15a agreement regulates the funding and the organization of the health care and is renewed every seven years (BMGF, 2017c).

Although the system is regulated by the 15a agreement the continuity of care for mental illness suffers from the unprecedented fragmentation of the funding of the care system. The fragmentation is especially fatal in mental health care, because not only the inpatient and outpatient health care has to be coordinated, also other medical and non-medical areas have to be organized, for example the psychosocial area, occupation and housing. An essential characteristic of psychiatric care is the lack of continuity of care for patients with a mental health problem and the extensive lack of coordination between various institutions and financiers in the medical, social, inpatient, outpatient and complementary fields (BMGF, 2005).

Because of the particular vulnerability of the clients with a diagnosed mental health disorder, there is an even bigger need for coordination than in the somatic field. The actually situation of different legal regulations and financing mechanisms makes the coordination of this field difficult and confusing. The new 15a agreement has the aim to promote the outpatient sector, in the next seven years they want to establish more multidisciplinary and interdisciplinary Primary Care Centres. It is also an aim to strengthen the principle of benefits in a way that strengthens the funding by the social insurance. The planning of the ÖSG and the RSG should be developed and the implementation of these plans will be more binding than it was in the preceding periods (BMGF, 2017c).

### 3.2.2 Insurance system

The Austrian health care is based on a social insurance system. Health insurance is compulsory in Austria; that means that some kind of insurance is mandatory and based on legislation. Nineteen insurance institutions provide a health insurance; there is no competition between this companies, because the allocation of the citizens depends on their profession and the place of work. It is not possible for inhabitants to choose the compulsory insurance institution freely, the insured period automatically begins at the
moment of employment. The contribution to the insurance company is also automatically paid with the payroll accounting and is equally paid by the employer and the employee. The amount of the contribution depends on the income and is calculated as a rate. The system is based on principles of solidarity, so there is a compensating system for balancing out differences between persons with higher incomes and less or no income. The insurance system protects around 98 percent of the population (Gesundheit Österreich GmbH, 2013, pp. 7-8).

3.2.3 Access to the health care system

The health care system is based on the principles of solidarity, affordability and universality. The insurance system guarantees all inhabitants an equitable access to all health services. Every patient can choose their general practitioner freely; these physicians usually have a contract with the health insurance institution. In Austria there is no gatekeeper system, to get access to specialize or inpatient treatment it is not necessary to visit a general practitioner first (Gesundheit Österreich GmbH, 2013, p. 10).

Although the health insurance covers many health services in their benefits catalogues, there are also many services, which are not included. For these services or professionals which do not have contract with the health insurance the patient has to pay separately, with so called out-of-pocket payments. Some of these payments may be partially refunded to the insured person by their health insurance institution. However, there is a separate request necessary and it will be approved by the insurance institution. Nearly all health insurance institutions have co-payments as fixed rates for example a prescription fee (in 2017: Euro 5.85) or in form of retention in percentages for example 20 percent (Gesundheit Österreich GmbH, 2013, pp. 12-13).

For persons who are chronically ill or have special needs a wide range of exemptions of co-payment exists. Around a quarter of the insured population is exempted from paying the prescription fee for pharmaceuticals. These are persons whose income is below a defined monthly income or who suffer from a chronic illness (Gesundheit Österreich GmbH, 2013, p. 13).
3.3 The challenging situation of Carinthian mental health care

The Carinthian mental health care system provides inpatient and outpatient treatment for about 560,000 inhabitants. The system is very complex and will be explained in the next sub-chapters.

3.3.1 Topography and geography of Carinthia

Carinthia is the most southern province of Austria, it has the size of about 9,500 square kilometres, and 2,500 square kilometres are populated. Carinthia has ten political districts and 132 municipalities (Joanneum Research Forschungsgesellschaft, 2015). The country has about 560,000 inhabitants, most inhabitants live in towns or around them. The capital city is Klagenfurt with around 100,000 inhabitants (Statistik Austria, 2017). Carinthia is divided in two provision regions, called West Carinthia and East Carinthia. The districts Villach (VI), Villach Land (VL), Spittal (SP) and Hermargor (HE) are related to West Carinthia; in these districts there are around 220,000 inhabitants. The districts Klagenfurt (K), Klagenfurt Land (KL), Feldkirchen (FE), Sankt Veit (SV), Wolfsberg (WO) and Völkermarkt (VK) belong to East Carinthia. In this region about 340,000 citizens live (Joanneum Research Forschungsgesellschaft, 2015).

Most of the larger Carinthian towns like Klagenfurt, Villach and Sankt Veit are situated within the Klagenfurt Basis in the south east; this area is called an inner Alpine sedimentary basin.
or central Carinthia (green ellipse) and it covers about one fifth of the Carinthia area. In this area most of the Carinthian inhabitants are settled. The other four fifth of Carinthia are covered with mountains and valleys. Because of these mountains and valleys Carinthia owns long traffic routes, which makes the accessibility of supplies difficult (Joanneum Research Forschungsgesellschaft, 2015).

Carinthia provides an inpatient and an outpatient structure for persons with mental health problems according to the RSG and the mental health plan for Carinthia. In this thesis, the focus lays on people with a diagnosed schizophrenic disease. The following treatment structure is appropriate for people with schizophrenic diseases. The mental health plan also includes facilities for people with addiction problems, but these facilities are not mentioned in this thesis.

### 3.3.2 Inpatient treatment facilities

Carinthia provides two hospitals with psychiatric wards, one in each provision region. The Klinikum Klagenfurt with the psychiatric and psychotherapeutic ward provides the region East Carinthia with mental health care. The department has 188 beds allocated to ten wards. Two wards are closed wards, one for men and one for women. One ward is for admission of patients and short-term crises, one ward is specialized on people suffering from psychogeriatric disorders, and one ward is for day-care clients. The other five wards are for ongoing therapies after an acute crisis and prepare the clients for their lives after the discharge. The ward also offers eight different walk-in clinics for the inhabitants of Carinthia. The “department of psychiatry and psychotherapy” takes care of around 3,500 people inpatient and 11,000 people in the walk-in clinics each year (KABEG, 2017 a).

The hospital Villach provides a small psychiatric ward and psychotherapeutic medicine, with two wards and one walk-in clinic, the hospital has 50 beds for the region West Carinthia (KABEG, 2017 b). They have no closed wards, so that patients, who are in an acute situation and there is the risk of harming themselves or someone else, have to be brought to the Klinikum Klagenfurt. At the moment, the hospital Villach has too few beds for about 130 clients per year. A new “department for psychiatry” in Villach with 98 beds is planned, and will be constructed till the year 2020 (Österreichischer Rundfunk, 2015).

### 3.3.3 Outpatient treatment facilities

The outpatient treatment structure is a complex system in Carinthia. Most providers are private, they have contracts with the provincial government and the insurance institutions about payment and financial support. Outpatient psychiatric care is the main focus of pro
mente Kärnten. They offer a wide range of supplies, different care and counselling facilities, as well as social psychiatric support for people with chronical and acute mental health illness (ÖBIG, 2005, p. 52). In addition, other associations provide counselling and psychotherapeutic services; these associations are the Arbeitsvereinigung der Sozialhilfeverbände Kärntens (AVS - Association of Social Aid Carinthia) and the local Caritas organization, but also smaller associations like the Frauenberatung Villach (Womens counselling Villach), Ladybird, Lichtblick and Hilfswerk Kärnten (KGKK Kärnten, 2017a). Also important for the treatment are the psychiatrists and the psychiatric emergency and crises services.

The system is regulated by the “Regional Health Care Structure Plan” (RSG). At the moment, the government develops a new mental health plan for Carinthia. Therefore, in the next years there will be some changes in the treatment structure.

**Centre for psychosocial Rehabilitation (CPSR)**

A “Centre for psychosocial Rehabilitation” is a semi-residential follow-up care. The providers are mostly private and organized in a network. This association is called “Zentren für Psychosoziale Rehabilitation – Kärnten”, 20 CPSR’s are member of this association (Zentren für Psychosoziale Rehabilitation - Kärnten, 2017).

The establishing of a CPSR has to be allowed from the government. The CPSRs are meant for clients who are not able or are classified not to be able to live alone, care for themselves or who are in need of a rehabilitation lasting longer than two years. They facilitate a social minimum security through accommodation, meals as well as assistance and support (Bundesministerium für Finanzen, 2017). The CPSRs are mostly settled in rural areas of Carinthia, former farms which were reconstructed. Carinthia has 29 CPSRs all together provide home and mental health services for around 700 people.

Most CPSRs are settled in the district of Sankt Veit and Feldkirchen. If the provision regions Carinthia East and West are compared there is huge difference. In West Carinthia there are two CPSRs, one in the district of Spittal and one in Villach Land. The other 27 CPSRs are settled in East Carinthia.
Table 1: Distribution of CPSRs in Carinthia (according Pöcheim, 2015)

<table>
<thead>
<tr>
<th>District</th>
<th>Population</th>
<th>CPSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feldkirchen</td>
<td>30,000</td>
<td>7</td>
</tr>
<tr>
<td>Hermagor</td>
<td>19,000</td>
<td>0</td>
</tr>
<tr>
<td>Klagenfurt Land</td>
<td>60,000</td>
<td>1</td>
</tr>
<tr>
<td>Klagenfurt</td>
<td>100,000</td>
<td>0</td>
</tr>
<tr>
<td>Sankt Veit</td>
<td>55,000</td>
<td>14</td>
</tr>
<tr>
<td>Spittal (SP)</td>
<td>77,000</td>
<td>1</td>
</tr>
<tr>
<td>Villach Land</td>
<td>65,000</td>
<td>1</td>
</tr>
<tr>
<td>Villach</td>
<td>62,000</td>
<td>0</td>
</tr>
<tr>
<td>Völkermarkt</td>
<td>42,000</td>
<td>2</td>
</tr>
<tr>
<td>Wolfsberg</td>
<td>53,000</td>
<td>3</td>
</tr>
<tr>
<td><strong>Carinthia</strong></td>
<td><strong>560,000</strong></td>
<td><strong>29</strong></td>
</tr>
<tr>
<td>East Carinthia</td>
<td>340,000</td>
<td>27</td>
</tr>
<tr>
<td>West Carinthia</td>
<td>220,000</td>
<td>2</td>
</tr>
</tbody>
</table>

Last year the CPSRs were critized by the IOI Secretary General Günther Kräuter, from the Austrian Ombuds Board. He said that:

“Chronically mentally ill people have a human right to self-determination and participation in the society. The so-called centres for psychosocial rehabilitation (CPSR) in Carinthia do not meet these requirements. Around 700 people in Carinthia are accommodated in often remote farms, contrary to the requirements of the UN Disability Equality Convention. They are not adequately cared for and are thus blatantly disadvantaged.” (Volksanwaltschaft, 2016)

A very hard statement and it is partly true: the quality of the houses is different and also the offers related to the rehabilitations services. Depending on the focus of the house, also the offers are different. It is on reintegration and self-reliance of the clients, or on long-term supply and promoting their daily-activities, the different houses also provide a different quality in services. The problem is that the clients cannot independently choose in which house they want to move. The allocation of the clients lies in the hand of the government and the decision is based on the availability of the beds (Bundesministerium für Finanzen, 2017). The biggest problem is that if the clients decide to live in a CPSR, they have no more the possibility of being funded by the Carinthian Equal Opportunities Act. That means if they want to use other rehabilitation systems (like a psychotherapy in Klagenfurt) it will not be funded. The clients who agree to live at a CPSR will get the full treatment and care from the CPSR (Scheiflinger, 2015).
Psychiatrist

Psychiatrists are an important part in the support and care of people with mental health problems. A stable and self-determined life is build up on a regulated medical treatment. In Carinthia, there are 44 psychiatrists who provide medical care in private medical practices. Only ten psychiatrists have contracts with insurance institutions. Doctors with contracts are allowed to discount directly with the insurance institution, the client has no additional costs. The others are called “Wahlärzte” or “private doctors”, doctors without contracts, the payment is out of one’s own pocket, and has to be paid by the clients themselves. It is possible to send a form with the bill to the insurance institution and a percentage (around 80 percent) of the costs will be refunded (Ärztekammer für Kärnten, 2017).

Table 2: Distribution of psychiatrists over Carinthia (according Ärztekammer für Kärnten, 2017 and Statistik Austria, 2016)

<table>
<thead>
<tr>
<th>District</th>
<th>Population</th>
<th>Psychiatrist</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Without contract</td>
<td>With contract</td>
<td></td>
</tr>
<tr>
<td>Feldkirchen</td>
<td>30,000</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hermagor</td>
<td>19,000</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Klagenfurt Land</td>
<td>60,000</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Klagenfurt</td>
<td>100,000</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>Sankt Veit</td>
<td>55,000</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Spittal</td>
<td>77,000</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Villach Land</td>
<td>65,000</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Villach</td>
<td>62,000</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Völkermarkt</td>
<td>42,000</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Wolfsberg</td>
<td>53,000</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Carinthia</strong></td>
<td><strong>560,000</strong></td>
<td><strong>34</strong></td>
<td><strong>10</strong></td>
</tr>
<tr>
<td>East Carinthia</td>
<td>340,000</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>West Carinthia</td>
<td>220,000</td>
<td>11</td>
<td>3</td>
</tr>
</tbody>
</table>

The table shows the distribution of the doctors all over Carinthia. Most psychiatrists, nearly half of all, are placed in Klagenfurt (Town). East Carinthia has twice as many doctors as West Carinthia, in the group of doctors with a contract similar as well as in the group of doctors without a contract with the insurance institution.
Emergency and crises service
The psychiatric emergency and crises service is a 24/7 supply for all people in Carinthia with psychosocial crises. The telephone hotline is provided by the two hospitals Klinikum Klagenfurt and Hospital Villach. The hospitals are also the bases of the emergency and crises teams. Each hospital is responsible for their region. The teams consist of psychiatrists, psychiatric nurses and psychologists. If the counsel via telephone is not enough, a team of two persons will visit the person who has a crisis and clarify the situation on site. This service is free of charge and can be used by everyone who is in need (Joanneum Research Forschungsgesellschaft, 2015, p. 68).

Psychology and psychotherapy
According to the list for psychotherapists and the list of clinical psychologists of the Ministry for Health and Women, Carinthia has 464 psychotherapists and 728 clinical psychologists. Some of them have a double role, they work as psychologist and psychotherapists, and also some psychiatrists are psychotherapists (BMGF, 2017a) (BMGF, 2017b).

A psychologist needs to study psychology at a university, to treat people he needs the additional education as clinical psychologist. A clinical psychologist is allowed to perform any for clinical-psychological diagnosis and psychological therapy. A clinical psychologist orientates the therapy on the specific problem or disorder of the client, the approach is based on careful research and scientific theories (Madia, 2017).

A psychotherapist also has a funded education which is regulated by law. However, it is not bound to a study of psychology, also other professionals like doctors, educationists, nurses, nursery teachers or others are allowed to pass this education. Psychotherapy is an independent therapy and during the contact to a client there is no fixed scheme, but the psychotherapist is bound to the therapy he has studied by law. He is not allowed to use other kinds of therapies (Madia, 2017).

Every psychiatrist or the departments of psychiatry recommend to visit a psychologist or a psychotherapy regularly. However, the payment of psychologist and psychotherapist is different to that of the psychiatrists. The therapy is a private service and the insurance institution does not pay for the whole therapy. Although the effect of a psychotherapy is positive (evidence-based) and preventive and the costs of the health care system will decrease in medium- or long-term most of the psychologists and psychotherapists have no contracts with the insurance institutions (bestNet, 2017).
The costs for a psychotherapy amounts between €70 and €150, the client has to pay this out of his/her own pocket. If they can verify a necessary reason for the psychotherapy, for example a disease according the ICD10, they can ask for part refunding of the costs at their insurance institution. However, the refunding is a small part of the totally costs. For example the “Gebietskrankenkasse” (the main insurance institution) refunds €21.80 for a 50 minute therapy. The retention for one therapy is around €50 on the average. For a client with a disability pension and the compensation allowance it is almost unaffordable (bestNet, 2017).

To provide psychotherapy for their clients some associations have a special contract with the insurance institutions. This solution is organized differently in every province in Austria. In Carinthia 21 associations have contracts with the insurance institutions, 13 of them are suitable for persons with schizophrenic mental health problems. The others are for children and their families or for people with addiction problems. The contract regulates the number of clients per psychotherapist who get the therapy payment from the insurance institution. The number of clients differs between two and four clients per psychotherapists. If the client gets a free place, the insurance institution pays for 40 therapy units that corresponds with the therapy for one year. For the places there is a long waiting list, and the waiting period is many months (bestNet, 2017).

Table 3: Distribution of clinical psychologists and associations financed by insurance institutions (according KGKK, 2017a and KGKK, 2017b)

<table>
<thead>
<tr>
<th>District</th>
<th>Population</th>
<th>Clinical Psychologist</th>
<th>Association</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feldkirchen</td>
<td>30,000</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hermagor</td>
<td>19,000</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Klagenfurt Land</td>
<td>60,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Klagenfurt</td>
<td>100,000</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Sankt Veit</td>
<td>55,000</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Spittal</td>
<td>77,000</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Villach Land</td>
<td>65,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Villach</td>
<td>62,000</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Völkermarkt</td>
<td>42,000</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Wolfsberg</td>
<td>53,000</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Carinthia</td>
<td>560,000</td>
<td>11</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>East Carinthia</td>
<td>340,000</td>
<td>7</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>West Carinthia</td>
<td>220,000</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
</tbody>
</table>
As mentioned before in Carinthia there are 728 clinical psychologists, not all of them work as self-employed clinical psychologists. The insurance institutions have contracts with elven clinical psychologists for cost takeovers of clinical-psychological diagnoses, but not for the psychological therapy. The requirement for the assumption of the cost is that the client needs a referral from his general practitioner (KGKK Kärnten, 2017b).

### 3.3.4 Pro mente Kärnten

The main provider for psychosocial supplies is the association pro mente Kärnten; this association owns a non-profit organization named pro mente Kärnten GmbH. The association has agreements with the government of Carinthia over funding. They provide different kinds of facilities for people with mental health problems (pro mente Kärnten GmbH, 2017b):

- Outpatient follow-up care
- Social psychiatric Service
- Day Care Centre
- House of psychosocial crises
- Social therapeutic rehabilitation
- Occupational therapy
- Free psychology and counselling
- CPSR (Centre for psychosocial Rehabilitation)

#### Outpatient follow-up care (Home Care)

The outpatient follow-up care is a mobile support for persons diagnosed with acute mental illnesses, psychosocial crises and chronic mental health problems. The service is available in Klagenfurt, Villach, Spittal, Hermagor, Völkermarkt, Sankt Veit and Feldkirchen. The follow-up care starts with an initial interview; in this interview the caregiver and the client generate an individual treatment plan. The duration of the treatment is individual and can be very short for a crises intervention or last some years in case of chronic diseases. The support is based on a home care support and includes individual care and group activities (pro mente Kärnten GmbH, 2017a, pp. 13-15).

#### Social psychiatric services

The social psychiatric service is a special service in the districts Wolfsberg and Spittal. For the inhabitants in this district the way to the next hospital is long and sometimes difficult. The social psychiatric service provides medical treatment and psychological therapy for individuals and specific group therapy and psychosocial counselling. This service is
available in the headquarters Wolfsberg and Spittal and as a mobile service the treatment is offered in the homes of the people (pro mente Kärnten GmbH, 2017a, p. 30).

In Spittal the social psychiatric service is also available at three different field offices once a week. Because of this, the inhabitants of the valleys Drautal, Maltatal/Liesertal and Mölltal have access to an appropriate medical treatment and psychosocial counselling and psychological therapy. In case of an emergency or psychosocial crisis the social psychiatric service also has the function of the emergency and crises service (pro mente Kärnten GmbH, 2017a, p. 32).

**Day Care Centre**

The Day Care Centre provides outpatient care for people with mental health diseases. The service is community based. The Day Care Centre offers social inclusion through professionals and individual treatment plans and group activities. The professional team supports people and gives information and references about other institutions. The centres provide daily activities, regular weekly activities, offers for cultural activities, psychoanalytic and spiritual groups, health promotion groups and group tours for hiking in the Carinthian mountains or to the beach in Italy or Slovenia. Additionally, the Day Care Centres provide occupational therapeutical support like creative workshops with a small shop, cleaning services, ironing service, courier services and postage (pro mente Kärnten GmbH, 2017a, pp. 61-64)

The aim of the Day Care Centres is to increase the quality of lives and the autonomy of their clients. Pro mente Kärnten provides four Day Care Centres in Klagenfurt, Villach, Spittal and Wolfsberg (pro mente Kärnten GmbH, 2017a, pp. 61-64).

**House of psychosocial crises**

The house of psychosocial crises is an alternative to a treatment in a hospital. A psychosocial crisis is a critical live event, which is felt to be unbearable and leads to an emotional destabilization, which seriously challenges existing living habits and in which the available possibilities of problem solving or adaption are not sufficiently available. The house offers a therapeutic and safe environment. The team of the house of psychosocial crises provides psychological and psychosocial counselling. The clients can stay there from one day up to three months. It is a possibility for therapeutic support combined with a living possibility.

In Carinthia, there are two houses of psychosocial crises one in Spittal and one in Wolfsberg; for people with a mental health problem in this regions the houses are a very
good alternative to the hospitals in Klagenfurt and Villach. It is possible for them to stay in their region and determine the admission to the house on their own (pro mente Kärnten GmbH, 2017a, pp. 76-77).

Social therapeutic rehabilitation
A social therapeutic rehabilitation is a long term rehabilitation from one up to two years. The client lives in a therapeutic setting together with other clients. The aim of the rehabilitation is that the clients can live independently in an own apartment after the therapy. In this process, much attention is put on including the relatives. The team of the social therapeutic rehabilitation assists the people with a mental health problem on the way to their self-determined lives. It is about discovering and strengthening the abilities and resources of people in difficult situations. The acquired skills are to evolve the client out of a helpless situation, so that those people can shape their own lives and social environments as much as possible.

Pro mente Kärnten provides two houses for social therapeutic rehabilitation, called House Landskron, near Villach and the called “Übergangsheim” (“transition home”) in Ebenthal near Klagenfurt (pro mente Kärnten GmbH, 2017a, pp. 76-78).

Occupational Therapy
Pro mente Kärnten provides different types of occupational therapy, working projects and temporary working. In the Day Care Centres there is the possibility of working as a temporary option in form of therapy, the people with a mental health problem have the opportunity to earn a certain amount of pocket money. Work training and vocational training are offers for comprehensive work rehabilitation in commercial, administrative and service professions. The duration of the courses is about 15 months. The largest field here is covered by work projects. These work projects provide real working places with full social insurance and pension insurance. The projects are located in Klagenfurt, Villach, Spittal and Wolfsberg. It is possible to work in a gardening project, moving service, cleaning service, copy shop or others (pro mente Kärnten GmbH, 2017a).

Psychology and counselling
The clients of pro mente Kärnten can get free psychology group therapies at the psychotherapeutic walk-in clinic. The walk-in clinic in Klagenfurt provides twelve different group approaches, like a psychosis group, a cognitive improvement group, an assertiveness training, a long-term group and others. In special cases, it is possible to make an individual appointment but this is not a regular supply (pro mente Kärnten GmbH, 2017b).
CPSR (Centre for psychosocial Rehabilitation)
Pro mente Kärnten provides one CPSR in the district of Wolfsberg, it offers place for 29 residents. The aim is to recognize and promote the individual resources of people with a diagnosed mental health disease, to provide a treatment program which is orientated at the resources of their residents and should recover their everyday skills and rebuild social functions. Like the other CPSR’s it is settled in the rural area of Carinthia (pro mente Kärnten GmbH, 2017b).

3.3.5 Summary of the current treatment structure

The Carinthian system is, as mentioned in the chapters above, very complex. In summary, Carinthia provides two types of supply: the therapeutic approach and the living condition approach. The therapeutic approach is placed in the district cities, but not all cities provide the same facilities. It is based on financial and personal resources.

The long-time living facilities, Centres for psychosocial Rehabilitation, for people with chronic mental health diseases are settled in the rural areas of Carinthia. Most of them are placed in the districts Sankt Veit and Feldkirchen. West Carinthia with only two facilities is disadvantaged (pro mente Kärnten, 2015, ZPSR Kärnten, 2016).

At the moment it is not possible to combine the two types of approaches with each other, because of funding rules and the Carinthian Equal Opportunities Act. An additional problem is also the distance and the complicated public transportation system. For many clients who live outside the towns it is difficult to reach all necessary treatments.

The situation concerning psychiatrists and psychotherapists for clients is connected with additional expenditures. If they choose psychiatrists and psychologist without contracts with the insurance institutions they have to pay the treatment partly out of their own pockets. And if they choose those with contracts they have to calculate long waiting periods.

The table shows that good facilities are provided in the towns Klagenfurt, Villach, Spittal and Wolfsberg. Klagenfurt and Villach provide every kind of treatment for people with schizophrenia, except a house of psychosocial crises, but Klagenfurt and Villach provide the hospitals. A CPSR, a possibility for long term rehabilitation in a safe environment, is also not available. Wolfsberg and Spittal also have a comprehensive treatment structure and provide different facilities for people with schizophrenia. Feldkirchen, Sankt Veit, Völkermarkt and Hermagor provide a basal treatment structure with psychiatrists, the possibility for paid psychotherapy in an association and an outpatient follow-up Care.
Very prominent is the distribution of the CPSRs; most of them are in Sankt Veit and in Feldkirchen, the East-West divide here is clearly evident. For people in West Carinthia this means that if they are in need of a long-term care they have to move to East Carinthia.

In the map beneath, the distribution of the treatment structure is marked with different colours and reflects the results of the table.

*Table 4: Treatment services of Carinthia and the distribution to the districts (according KABEG, 2017a, KABEG, 2017b, KGKK, 2017b, pro mente Kärnten GmbH, 2017, Pöcheim, 2015, Ärztekammer für Kärnten, 2017)*

<table>
<thead>
<tr>
<th>Treatment offer</th>
<th>Carinthia</th>
<th>East Carinthia</th>
<th>West Carinthia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>K</td>
<td>KL</td>
<td>FE</td>
</tr>
<tr>
<td>Hospitals</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Emergency and Crises Service</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Psychiatrists (with contract)</td>
<td>44 (10)</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Free Psychology</td>
<td>14</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Outpatient follow-up Care</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Day Care Centres</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>House of psychosocial crises</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Social therapeutic Rehabilitation</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CPSR</td>
<td>29</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>
At the moment there is a good basal treatment for people with schizophrenia, but it depends in which region the client lives. The system is less client-orientated, it is hardly possible for clients to get all information about the system and treatment possibilities. For the author it was difficult as well, there were lots of surprises during the research, for example the little number of psychiatrists with a contract with the insurance institution, or the payment conditions for psychotherapists. Additionally, that it is not possible to combine the care of a CPSR with other treatment services. Without this knowledge it is difficult to start an appropriate decision for ones future life. Empowerment and self-determination are important elements for a self-defined and fulfilled life for each human and this is only possible with a transparent system. In the development of a client-orientated care Carinthia or Austria are nearly twenty years behind the English speaking countries. Where in English speaking countries like England, Canada, New Zealand and parts of the USA the recovery approach is already implemented in the current mental health treatment programs, Austria has not even recognized yet that such an approach exists. However, to implement these
approaches a new orientation of the whole system would be necessary (Schrank & Amering, 2007).
4. Development of Mental Health Care

Dealing with people who have a mental health problem has always been attached to the overall social development. The care of people with mental health problems was influenced by the ideas, opinions and ecological possibilities of the respective time. The question, however, always is: What is the impact of a mental disease for the family, the community, the economy, religion and, as a whole, for the society? (Dörner, et al., 2004, pp. 489-490)

For this thesis, it is important to understand what happened with the people during the centuries, why society treats them as they have done. The knowledge about mental disorders is often handed on knowledge from one generation to the next; only when a family is confronted with a mental disease they begin to understand what their knowledge before was worth and the start to change their minds and opinions.

As Hans-Friedrich Bergmann (*1934) (translated by the author) said:

"Those who do not know the past cannot understand the present.

Whoever does not understand the present cannot design the future" 

To design the future in Carinthia it is necessary to have a look at what has been established outside the borders of Austria and maybe these developments could be a possibility for an outpatient treatment in Carinthia.

4.1 Treatment of people with a mental disease during the centuries

As Brückner (2015, p. 7) says, historical knowledge is an important guide for the professionals in the field of mental health. It opens the diverse traditions of psychiatry in science, as well as how the people with mental illness were treated during the epochs, facilitates the understanding of the biopsychosocial basis and is a foundation for one’s own standpoints.

4.1.1 Antiquity

The history of psychiatry as a clinical institution starts around 200 years ago, but mental health problems are as old as humankind itself. In the first high cultures in Mesopotamia and Egypt diseases were treated and cured by priests. The priests interpreted the disease
religiously and cured them by natural and magical methods. Somatic and psychological problems were treated the same way (Brückner, 2015, p. 10).

The doctors of the early Greek period travelled from village to village and treated wounds without magic, but they neither had a clear idea about the effectiveness of the herbs. (Brückner, 2015, p. 11). People did not think of madness but they believed in divine punishment or demonic possessions. Around 600 before Christ the development of philosophy started. During this period, physicians and philosophers tried to explain the reason for illness, madness itself became an object of scientific speculation. Hippocrates developed the four bodily fluids theory: illness results from an imbalance of these fluids (Burton, 2015). Health was a highly protectable good and the somatic state was as important as the mental wellbeing. The soul as place where the mental wellbeing comes from was, according to Plato, responsible for wisdom, courage and desire. During the Greek period, two different approaches came up: On the one hand the rational medicine by Hippocrates, based on “proofed” knowledge, this knowledge was also used for mental health problems; on the other hand the philosophic considerations about the soul, their aberrations and meaning for human culture. With the Hippocratic approach, opinion was established that the brain is the place where irrational states like mania, melancholia and hysteria arise (Brückner, 2015, pp. 10-17). This knowledge is also manifested in our culture.

During the Greek period people with a mental health problem were treated with violence, different herbs, education and instruction, or according to the four fluids theory with special diets, purgatives and blood-lettings. Additionally, mental illnesses were also treated with healing conversations, based on the philosophic approach. Especially Aristoteles, who was a philosopher and physician and established the term of the good middle “mesotes”, which means that philosophy and medicine belong together (Dörner, et al., 2004, p. 490). During the Greek period, mental health and illness were, conceptually, not strictly separated from each other, they were settled on a continuum and functionally defined in practice. Natural, religious and justice diseases (mental incapacity) were complementary to each other in antiquity. They offered a social-holistic framework for humans in which mental health problems could be understood and arranged. (Brückner, 2015, pp. 20-23)

The knowledge about medicine during the Roman period was based on the knowledge of the Greeks, the four fluids theory was accepted and refined by the Roman physician Claudius Galen (around 129 – 216 post Christ). He developed new differences between symptoms and these medical findings were taught for another 1500 years and were valid right up to the early modern period (1450 – 1850) (Brückner, 2015, pp. 25-26).
4.1.2 The Middle Ages

During the medieval period health care and social care were the duties of the church and religious communities. They managed and organized hospitals, which were open to all who were in need of help for physical, mental and social reasons. Care meant the full perception of all social, mental and physical needs. There were some beds for people with mental illnesses in the hospital mainly if they were alone and belonged to no family. Most of the people with a mental health problem remained within their own family and village community. In principle, the Christian spirit of this time was a comprehensive concept of reason, all people. “Even the least, are children of god and have to be treated equally” (Dörner, et al., 2004, p. 491). People who reported visions were not seen as being mental ill; it was a possibility of how god communicated with humans. However, these visions were proofed by church. The reports could be according to the social context and physical state of the person, a religious inspiration or also a suggestion of devils. With the beginning of the inquisition, which started in the late middle ages, visions were often proofed as demonic work and this evil work mostly was seen as being done by witchcraft and thus had to be banished. The humoral theories of Hippocrates had been supplanted by the prevailing dogma of the Christian church. The increased separation of mind and soul made it possible that people with a mental health problem and other people who were strange or dangerous in the eyes of the church could be punished and murdered. This served as an educational measure for the people and as a representation of the ecclesiastical power (Burton, 2015) (Dörner, et al., 2004, p. 491).

4.1.3 The Modern Era

The first hospital for people with a mental illness and people with a disability were established in Spain during the 15th century. The fact that also people of the upper social classes fell ill with a mental illness leads to the situation that more and more doctors took up the duty of diagnosis and therapy (Clausen & Eichenbrenner, 2016, p. 15). This fact also is connected with the self-development of the humans during this period. The educated Europeans increasingly believed in new natural explanations as in the traditional theological statements (Brückner, 2015, p. 37). Parallel to this development the cities were in competition for domination and trade routes, the rising middle class tried to make their cities increasingly safer and cleaner. Alongside reforms, the discovery of America, humanism and prosperous cities in this time period, there was also a paradigm shift in general morality. All people should work and participate in the development of the city, non-working humans were no longer seen as a possibility for the service to God. Poor people were increasingly
seen as plague. Therefore the ongoing endeavour to clean up one’s city from unsocial, begging, vagabond, unclean, dangerous and disturbing people. It was a personal request of the citizens to make these people invisible and to exclude them all; part of this category were the “poor mad people” who did not belong to a family (Dörner, et al., 2004, p. 15). To “protect” the town from these people, they were introduced to stay out of the towns, jailed in rooms of the town wall or were sent to monasteries in the rural area of the country. The nuns and friars opened their doors for the poor and took care of them (Clausen & Eichenbrenner, 2016, p. 16).

With increasing enlightenment during the 17th and 18th century medicine also made progress. New discoveries were made about the origin and treatment of diseases. Also for psychological diseases, new origins were found based on scientific knowledge and were documented. More and more physicians understood mental illness as a result of a nervous disorder. However, the interest in investigating on the disease was bigger than the interest in the wellbeing of the mentally ill persons. (Brückner, 2015, pp. 58-59)

Between 1750 and 1830, numerous asylums were created throughout Europe for people with mental illnesses. This was promoted by the rising principles of discipline, work and law. People with a mental illness no longer had a place within society and were pushed to the margins. The inhabitants of the towns confined the “sick” and “crazy” ones in the faith to be safe. The increasing fear of mental illness encouraged these processes. In hospitals and asylums, people were treated with very invasive methods to cure them, like rotary machines, dipping baskets, cages, forced jackets, icy baths and starvation (Clausen & Eichenbrenner, 2016, p. 16).

However, not all doctors assumed that those mechanical restraints could cure the illness. Around 1800 the physician Phillippe Pinel (1745-1826) established the paternalistic milieu therapy in France. He treated mentally ill people with in a silent environment, with diets, physical work and strict rules. For very aggressive persons isolation and coercion were possible. His approach was successful and he therefore became one of the founders of clinical psychiatry (Brückner, 2015, p. 70).

The English doctors William Tuke (1737-1822) and John Conolly (1794-1866) advocated more humane treatment methods and rejected violence and coercion. They created treatment in a friendly environment, opened the doors of the institution and established social psychiatric measures. John Conollys Book “The treatment of the Insane without
mechanical restraint” was translated to German and also influenced the German speaking countries (Clausen & Eichenbrenner, 2016, p. 16).

4.1.4 The 19th century

At the beginning of the 19th century psychiatry was introduced as a sub-discipline of medicine. It was also the period of the biggest advances in the sector of medicine. Mental disorders were primarily seen as biological disorders of the brain. The somatic explanations about mental health had a high impact on the development of treatments. This explanatory approach opened the possibility for doctors to become specialists and the ill people were seen as patients. The new institutions and departments for psychiatry had three important public assignments. They had to protect social security, to promote the individual healing and to develop the academic research. Psychiatry was seen as guardian over the boundaries between normality and social dissent (Dörner, et al., 2004, p. 499) (Brückner, 2015, p. 73).

The summary of the observations during this time is still characteristic for the international classifications like ICD and DSM. These findings were supported by Emil Kraepelin (1856-1926) and supplemented by Eugen Bleuler (1857 – 1939). The patients of his time were treated differently but not better than in the preceding period. The doctors’ interest mainly lay on the diagnostic, classifying and descriptive psychopathological research. The patients were seen as somatically ill persons, were increased treated in beds, this led to an increase of hospitalisation. The length of stay went up and the number of hospitals beds was also expanded. The research was mostly done at university hospitals, so the chronically ill or incurable patients were treated in provincial institutes (Dörner, et al., 2004, pp. 499-500). Because of economic reasons and the industrial revolution, many families could no longer care for their mentally ill relatives. The families moved to towns to find work in the new established factories. They no longer had the resources to care for their family members, so they brought them to asylums. These circumstances led to a rapid increase in the number of asylums. From now on, it was the task of the state to take care of the mentally ill people (Clausen & Eichenbrenner, 2016, p. 17).

4.1.5 The early 20th century

Around the turn of the century, different new approaches were established. Sigmund Freud (1856 -1939) created Psychoanalysis, he interpreted hysterical symptoms as an expression of traumas and repressed memories. These symptoms could be cured, if the repressed memories were recognized, revealed and consciously integrated into the life history. For
this reason it is necessary to uphold an intensive work relationship with the patient. Sigmund Freud was a central pioneer of modern psychotherapy. However, the relationship between psychoanalysis and psychiatry remained ambivalent, especially since the analytical treatment of psychosis appeared to be difficult (Brückner, 2015, pp. 117-121).

Between 1918 and 1933 two reform movements which are known as early psychotherapeutic approaches started. “Open welfare” (offene Fürsorge) by Gustav Kolb (1870 – 1938): He promoted family care and established walk-in-clinics for aftercare. The second movement was “active healthcare” (aktive Krankenbehandlung) by Hermann Simon (1867 – 1947). He promoted the working therapy for patients. He was of the opinion that everyone should have something to do. The system was successful, less coercion and violence were necessary to calm the patients down (Brückner, 2015, pp. 123-124).

These positive developments, however, were also reached by invasive therapies treating psychotic symptoms. In the 1920s and 1930s the insulin shock therapy, cardiazol convulsive therapy and electro convulsive therapy were increasingly used. The general believe behind these therapies was that psychotic symptoms can be reduced by artificially triggered spasms (Brückner, 2015, p. 122).

4.1.6 The dark period of National Socialism

During the period of National Socialism in Germany and Austria the development of psychiatry stopped. The central element of the National Socialism health policy was to have a “workable, efficient, defensive and reproductive population”. Not the individual was important, but the nation as a whole. Mentally ill and disabled people could not correspond these racial hygiene requirements, they were seen as a burden for society. Therefore they were subjected to sterilization and euthanasia (Dörner, et al., 2004, p. 501).

Sterilization and euthanasia were also based on scientific approaches; these approaches have been the Social Darwinism (biological concepts of natural selection), the theory of degeneration (genetic theory) by the French psychiatrist Benedict Augustin Morel (1822 – 1884) and the race ideology by Joseph Arthur de Gobineau (1816 – 1882). These three theories were extended by the German psychiatrists Karl Binding (1841 – 1920) and Alfred Erich Hoche (1865 – 1943). They created the term “lebensunwert” (unworthy to live) and argued with economical disadvantages for the national community. The National Socialists incorporated these ideas and implemented them in their ideology. (Clausen & Eichenbrenner, 2016, p. 19).
Euthanasia passed off in two phases from a central killing in extermination camps and after protests from the churches, a decentralized euthanasia directly in the medical and nursing asylums. In Carinthia people with a mental illness were deported and killed as well. After this phase they were killed by the nurses by order of the responsible physician in the wards. From the mental asylum in Klagenfurt 596 people were deported and killed by gas during the years 1940 until 1941 and not less than 87 people were killed by nurses between 1941 and 1945. All in all, in Germany and Austria together, around 296,000 mentally ill people and/or disabled people were killed and around 350,000 people were sterilized by force (Klee, 2010) (Stomberger, 2002). This way the German and Austrian psychiatry was not “abused” by the National Socialist. On the contrary, psychiatry was partly intellectually, personnel and structurally involved in the crimes (Brückner, 2015, p. 133).

The revision of the National Socialist era is still ongoing. Although the main offenders in Klagenfurt were condemned in a trial in 1946, two death sentences were pronounced and executed, the helpers were never prosecuted and they continued their work in the psychiatry ward in the post-war-period. Many events and details disappeared during the post-war period under the cover of secrecy and it will never be possible to discover the whole story of this time period (Stomberger, 2002).

### 4.1.7 Post-war years

In the USA, France, England and Scandinavia there were already “open doors” in hospitals, municipal treatment centres and regional care structures in the 1950s opposite to Germany and Austria the psychiatry during the post-war years still stayed a psychiatry of safe-keeping and the focus of treatment was based on insulin shock therapy, cardiazol convulsive therapy and electro convulsive therapy (Brückner, 2015, pp. 133-138). The emigrated doctors, psychotherapists and scientists, who could give new impulses for the development of psychiatry remained in their exiles. In their new environment, their medical, psychological and sociological ways of thinking could be more easily integrated than in the old system of Germany and Austria (Clausen & Eichenbrenner, 2016, p. 20).

In 1952 the era of the pharmacotherapy started, the first neuroleptic was chlorapromazin; with this medicine psychotic symptoms could be influenced effectively. The drug preceding-anaesthesia had antipsychotic and sedative effects. Neuroleptic drugs also had a lot of known side-effects like extrapyramidal-motoric disorders, vegetative impairments, memory disorders and somnolence. Although the side-effects are well known the medications were used in high doses. It was not possible to separate positive and
negative effects, because the occurrence of the main effect was measured by the occurrence of the side effects. Medicine can, however, only influence the symptoms never the reason for the disease (Brückner, 2015, p. 134). Nonetheless, during the 1950s the use of psychotropic drugs spread all over European and North American institutions. The traditional, safe-keeping function of the often poorly equipped and overcrowded facilities encouraged the use of psychotropic drugs as a means of sedative and disciplinary measure. Compared to the pre-war period the atmosphere in the clinics had changed, this situation was a prerequisite for professional protests in the 1960s, which led to the community care in the 1970s (Brückner, 2015, p. 134 and Clausen & Eichenbrenner, 2016, p. 21).

4.1.8 Anti-psychiatry and social psychiatry

During the 1960s and 1970s there was growing criticism of psychiatry in its existing form. This starting reform process will later be known as the time of anti-psychiatry. The anti-psychiatric movement included different groups with various backgrounds. It was a movement based on the opinion that mental health treatment is often more damaging to the clients than helpful (Clausen & Eichenbrenner, 2016, p. 21). There were also criticism about mental health institutions and calls for improving the conditions within therapeutic communities, the hierarchical relationship between professionals and patients and the social conditionality of classifications of mental illness. Overall, not only the grievance of the institutions were questioned, but also psychiatry as a whole (Lehmann, 2011).

This period was influenced by the books of the American sociologist Erving Goffman (1922-1982). He wrote about stigmatization and total institutions. The psychiatrist David Cooper (1931 – 1986) who coined the term anti-psychiatry believed that psychoses are manifestations of a disparity between the person’s individual true identity and the social identity (the role which we got from society). The British psychoanalyst Ronald Laing (1927-1989) criticised the diagnostic process of mental disorders and the increasing use of neuroleptic drugs (Clausen & Eichenbrenner, 2016, p. 21). The Italian psychiatrist Franco Basaglia was one of the leading persons during the psychiatry reform in Italy. He realized that many stereotypes of mental illness were actually the consequences of institutional conditions. In 1961 he started to establish therapeutically communities and he advocated the process of democratisation of psychiatry. In 1978 a law decreed the closure of the Italian asylums (Lehmann, 2011 and Brückner, 2015, p. 139).

Based on the criticisms on psychiatry and fundaments of anti-psychiatry social psychiatry was established. Social psychiatry includes the sociology as well as the epidemiology of
mental illness and concepts and initiatives for developing outpatient and participatory treatment structures. Community care is the practical aim of social psychiatry and is used synonymous (Psychiatrie Verlag, 2017).

Since 1970 new concepts of treatment were established, in which the civil rights and needs of the mentally ill people were focused on. New therapeutic settings like Day Care Centres, Community Based Centres, therapeutic living communities and self-help groups created new possibilities to support people with mental illness (Clausen & Eichenbrenner, 2016, p. 21). The period of anti-psychiatry also offered some impulses to create new concepts like the Soteria approach and motivated people with a mental health disease to empowerment (Aderhold & Lehmann, 2007, p. 150).

In the early 1980s a new movement called the humanistic anti-psychiatry started in Germany and is carried out by people with experiences of a mental health problem. They refer to universal declaration of Human Rights. They do not want to reform the system of psychiatry, but want to establish a human support system for people in a mentally acute emergency. They are also committed to equality with healthy and somatic people, for the support of the withdrawal of psychopharmaceutic, as well as the protection against outpatient-forced treatment (Lehmann, 2011).

It is only when people with a mental health problem are supported in their efforts for human rights, legal equality, financial protection and support that the current miserable situation can change. A clear view on the existing problems should help (Lehmann, 2011). Maybe the concept of recovery can help to support people with mental health problems in the appropriate and requested way. Recovery emphasizes the importance of the individual life-ways of humans and thus the individual determination of goals. In the German speaking countries, recovery is a new approach and for the institutions and professionals it will be a new challenge to implement it (Burr, et al., 2003).

4.2 Recovery approach

The change in the role of patients as a part of the health service is nowhere as difficult to perform as in the psychiatric ward. This fact cannot be justified by the innovative obstacles of modern society. In fact, many prejudices and stigmatization, with which people with mental health problems are confronted, are aggravating (Burr, et al., 2003, p. 113).
After the first admission in a psychiatric ward, it is expected that the people diagnosed with a mental illness take the role of the patient, in other words they have no choice. Talcott Parson (1902 – 1979) explains the social role of a patient as a subject to social norms. On the one hand, the norm of self-responsibility, a patient is obliged to improve his condition within the scope of his possibilities, and on the other hand the norm of legitimation, to legitimize his condition by visiting a doctor and getting a diagnosis (Siegrist, 2005, pp. 40-41). It is generally expected that people who are mentally ill also keep up this to this norm. The role implies that people with a mental illness are involved in a treatment and follow the recommendations of their physicians and therapists. They only have a minor co-right for co-determination. The choice is made more difficult by bureaucratic hurdles, which also control the access to the services and financial support. Leaving the role is extremely difficult, the hope to change this situation probably lies in the recovery approach (Wallcraft, 2005).

4.2.1 A vision of recovery

Since the beginning 90’s a vision of recovery was nourished in the English speaking countries. After the deinstitutionalization, the person with severe mental illness confronted the society with the fact that just providing symptom relief is not enough. The first representatives of the recovery approach were people with a diagnosed chronic schizophrenia. They were categorized as therapy resistant, but they did not resign to this negative prognosis. Against all expectation, they recovered. This people joined and started a campaign against, in their opinion demoralizing, pessimisms, which the psychiatric ward disseminates. The second aim of the group was to search for conditions and options beyond the state of the art treatments. Soon reform orientated experts from countries like New Zealand, England, Canada and some states of the USA joined the group and made the recovery vision their central concern (Knuf & Bridler, 2008, p. 24).

People with mental illness have multiple residential, vocational, educational and social needs just like other citizens do (Anthony, 1993). This kind of pressure threw the service users, professionals and academics triggered a rethinking towards a more client/patient orientated and social approach (Wallcraft, 2005). The change to a recovery concept was born. When we talk about recovery we have to say that it is not a theory or a certain intervention, also not an evidence practice, it is not a philosophy and it is not a political position (Burr, et al., 2003, p. 79). The literature describes recovery as “a complex individual and self-defined process concerned with regaining hope and independence” (Wallcraft, 2005). With the words of Anthony (1993)
“Recovery is described 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”

This concept does not mean that the suffering of a mental illness disappeared, all the symptoms vanished and the person is cured. It involves much more than recovering from the illness. It means that people have to recover from the iatrogenic effects of the treatment, from lack of opportunities for their further life, from less self-determined decisions, from the fact to be unemployed, from crushed dreams and from stigma (Anthony, 1993). Deegan (1995) explains the concept that it is rooted in the profound realization that people who have been diagnosed with a mental illness are still human beings and the goal of the recovery approach is not to become mainstreamed. The mainstream should become a wide stream, which allows space for all kind of human beings. The goal is not to become “normal” it is about becoming unique and remarkable. Burr, et al (2003, p. 80) interprets recovery as a unique and deeply individual journey to which each individual actor and each individual institution contributes. Planners see the recovery-oriented system as greater as the sum of its parts. A system based on the recovery approach has more possibilities than to leave a person less impaired, less disabled, less disadvantaged and less dysfunctional. The recovery concept can leave a person not only with less, but with more, more meaning, success and satisfaction. The outcomes include more than the specific service outcomes, they are more experienced in a subjective way, such as empowerment, self-determination and self-esteem (Anthony, 1993).

Anthony (1993) described for the recovery process eight basic items

1. **Recovery is possible without professional intervention**
   Only the client holds the key for his/her personal recovery, essential are non-mental health activities like sports, clubs, education and/or churches. For professionals and care providers it is important to recognize that the mental health service is not the only way which promotes recovery, their part is to facilitate recovery (Anthony, 1993).

2. **It needs humans who belief in the person with the diagnosed mental health problem**
   These significant others are not necessarily professionals. It has to be a person in whom one can trust, one who is there when he/she is needed. A person who believes in the person with the mental health problem even when it is not possible for oneself (Anthony, 1993). Especially people from the social environment have a great importance (Burr, et al., 2003).
3. **Recovery is not bound to a causal theory**
For recovery it is not important to know the causes of the illness, it is assumed that the mental health problem can be coped with and influenced by a different way than only with medications (Burr, et al., 2003, pp. 196-197).

4. **Recovery can occur even though symptoms and relapses recur**
The recovery is unique and recurring symptoms are part of the process. People have to find out what works for them and on this journey they need the opportunity to fail and retry. Basically this doesn't stop the process but is part of the process itself (Deegan, 1995).

5. **Recovery takes influence on the duration and frequency of symptoms**
If people have the chance to find out what works for them and what does not, they also have the key for the duration and frequency of symptoms. If a person recovers, it seems that symptoms appear to have changed for better and return, after an exacerbation, more quickly to previous function. (Anthony, 1993)

6. **Recovery is not a linear journey**
There are situations of rapid increase of symptoms or disappointing setbacks, feelings overwhelm one unexpectedly, during the recovery process periods can change rapidly or slowly. Recovery is not planned or systematic (Anthony, 1993).

7. **Recovery from the consequences of the diagnosed mental health problem is sometimes more difficult than recovering from the mental health problems itself.**
Barriers, which are built because of a diagnosed mental health problem, are sometimes more overwhelming than the illness itself. Barriers like the loss of rights and equal opportunities, discrimination by society and barriers which are made by the system (access to services and financial rules) lead to a loss of self-determination and self-esteem. Society does not see the concerned person they only see the illness. This fact crushes dreams and makes the person hopeless; the process to build up self-esteem and new possibilities is a long way (Deegan, 1995).

8. **Recovery from mental illness does not mean that one was not “really mentally ill”**
Often when people recover from severe mental illness, others think that they weren’t “really” mental ill. There is a strong belief that people who have a diagnosed psychosis are not able to recover and will be able to have fulfilled lives. On the contrary, people who have recovered from a mental illness are a valuable source of knowledge about the recovery and
they can help other people during/with their recovery process Anthony, 1993 and Burr, et al., 2003, p. 200).

Recovery does not mean the absence of symptoms but the assurance of personal integrity despite a diagnosed mental illness. It does not mean cure, stabilization or maintenance. Recovery is an attitude, a way of approaching every day’s challenges.

### 4.2.2 Recovery versus supply

A traditional institution is supply-centred, the providers are in a position with authority over the clients. They are control-orientated. It is obsolete to avoid risks and so they act carefully, nearly anxious to protect the clients. The treatment is based on risks and fears. The clients have to adapt to the treatment offers, they must orientate on a fixed timeline and program, they must adjust to the program (Burr, et al., 2003, p. 87).

Recovery orientated treatment focuses on the resources of the client's, the task is to rise the individual feeling for the own strengths and to show the different options people with a mental health disease have. Recovery is built on hope and dreams instead of risks and fears (Burr, et al., 2003, p. 87). With this treatment it is not the client who has to adapt to the services with the consequence that so the institution can withdraw him/her if he/she does not develop positively. Recovery orientated services adapt to the needs and resources of the person with a diagnosed mental health disease and the person decides if he/she wants to withdraw (Burr, et al., 2003, p. 200).

<table>
<thead>
<tr>
<th>Supply / centre-orientated</th>
<th>Person / recovery-orientated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority over people</td>
<td>Arouses individual strength in humans</td>
</tr>
<tr>
<td>Control orientation</td>
<td>Orientation on options</td>
</tr>
<tr>
<td>Based on risks and fears</td>
<td>Based on hopes and dreams</td>
</tr>
<tr>
<td>Clients must adapt to the service system</td>
<td>Provider adapts to the clients</td>
</tr>
<tr>
<td>Promotes disability and disease</td>
<td>Promotes skills and a meaningful life</td>
</tr>
</tbody>
</table>

A recovery-orientated attitude is contrary to the traditional thinking and attitude; therefore it needs a change of attitude. To implement a recovery-orientated system it is necessary that professionals and the whole psychiatric treatment system has to re-orientate as a whole. For professionals it means that they need to think about their own attitudes and values. These fundamental changes can lead to many different problems like fear to lose the control or de-professionalization. In a traditional system, professionals are external experts for the illness, and as such they also enter into a relationship with the clients. Their task is to know
everything about the disease and tell the person with the diagnosed mental health disease how to handle it although they never had the experience with the disease. Recovery enables professionals to become companions and facilitators on the individual paths of life of their clients. It is possible that professionals and clients become equal partners and can learn from each other (Schrank & Amering, 2007). However, in order to perform this new role they have to accept it and realize the new positive options, growing up in a traditional means to rethink your own values and attitudes.

4.2.3 Values and dimension of a recovery orientated mental health program (ROMPH)

The implementation of a ROMPH is based on special values and two important dimensions. The dimensions are organization and staffing. Organization includes program structures such as mission, policies, procedures, record keeping, quality assurance, the physical setting of the program itself and the network of services linked to or controlled by the program. The dimension staffing includes components how the staff for the program is selected, trained and supervised (Farkas, et al., 2005).

Recovered people reported that the most critical facilitators or barriers for their own recovery is how people, especially professionals, interact with them. For a working program, it is important to find staff, which can identify with the program. Staff who wants to be involved in a ROMPH needs to have some basic skills, like engaging persons in a partnership, inspiring hopefulness, supporting and facilitating the individual's recovery. It is important to clarify some aspects of the attitude, like believing of the person in involving participants into the program, believing of the staff in growth potential and hopefulness, having the skills to act on their attitudes and values (Farkas, et al., 2005).

Recovery orientated services include many positive values, there are at least four key values which have to be implemented in the two dimensions. The four key values adapted from Farkas, Anthony and Cohen in 1989 are; person orientation, person involvement, self-determination/choice and growth potential (Farkas, et al., 2005).

**Person orientation** means that all support services must be directed to an individual person, it should be the person's strengths and weaknesses, interests and limits instead of a case or of a diagnosis the person should be seen as whole (Schrank & Amering, 2007).

**Person-involvement** is seen as the right of the clients to have an opportunity for meaningful involvement in the planning and delivery of the services. Especially in the own therapy, but
also in general planning, organisation and evaluation of the mental health programs (Farkas, et al., 2005 and Schrank & Amering, 2007).

**Self-determination/choice** reflects the possibility and opportunity of clients to make their own decisions about their personal recovery process, including their own aims, the types of therapeutic treatments they want to use, the time when they want to use it and also the renunciation (Schrank & Amering, 2007).

**Growth potential** and the recovery orientated service has to focus on the inherent capacity of any person to recover. I doesn’t matter if the person is momentarily overwhelmed by the symptoms, struggling, living with or living beyond the disability (Farkas, et al., 2005).

Recovery from mental illness is a real possibility, it is not a mythos; everyone can recover from a mental illness, but to support a client on this way the professionals and the providers have to rethink their attitudes and values; they have to make a decision whether or not they want to be partners on the way of the recovery process or want to be the outside standing experts. The call for a recovery orientated system also emerges in Carinthia, it is not a loud call like the women’s call for right to vote in 1918, or the call for emancipation during the 1960’s and 1970’s, or even the call about equalization of the homosexuals nowadays. Recovery will not be pushed by the public medias, but it is still there; it started with the people diagnosed with schizophrenia or other mental health diseases. The movement started and it will not stop.

### 4.2.4 Recovery in Austria

The concept of recovery is well known in the field of physical illness and disability; also in the English speaking countries recovery is settled in the services of mental health. Recovery in mental health has not been settled in Austria till now. However, the movement started silently and insidiously with small projects initiated by people with a diagnosed mental illness and their relatives.

An internet research via google and google scholar with the keywords “Recovery Austria”, “Recovery Österreich” revealed no results. Even on the homepage of the health ministry there was no document within the term recovery. However, these were the wrong keywords because recovery itself is nearly unknown but with keywords like “empowerment” or “resources-orientated psychiatry” there are some small projects and documents, which could be found, this information confirms that the movement exists and that people started to talk about it.
Empowerment is not recovery, but it is a start on the way towards recovery. Empowerment in the context of mental health means the recuperation of self-determination, pride and dignity. The question is, how can people with a diagnosed mental illness determine their lives (Knuf & Bridler, 2008)?

The current situation in the treatment system of Carinthia is traditionally patriarchal. The system has authority over the clients, it demands compliance, and if the clients refuse compliance, the system reacts with coercion or with ending the therapeutic relationship. The behaviour of the clients is categorized in different diagnoses, not to find the best treatment. The diagnosis exclusively serves as an assignment. Regardless of the diagnoses that are applied to humans, the treatment and therapies the people receive are similar. Conversations about experiences during crises or coping with symptoms are rare, most conversations are informations about medications. Especially in the inpatient system, this behaviour can be observed (Knuf & Bridler, 2008, p. 25). The outpatient sector is more open minded and client-orientated, but often bound to financial and bureaucratic rules. For people with a mental health problem, however, it is easier to start with changes in their environment.

The “Kärntner Empowerment Bewegung” (Carinthia Empowerment Movement) is a group of people who have experience with a diagnosed mental disease. They movement is integrated in the structure of pro mente Kärnten. Their concern is to support other people with a mental health problem; their aims are (pro mente Kaernten - KEB, 2017)

- to advise, support and accompany people with a mental health problem
- to help people help themselves
- exchange of experience
- learning from each other and together
- participate in organizational development in institutions
- promote and life empowerment
- build, promote and life recovery

Their offers are; promotion of empowerment, four times a year a regular table and empowerment-meetings, help to help themselves, exchange of experience and support in daily issues. The group is promoted and supported by pro mente Kärnten and they already started to involve people with experience with diagnosed mental health diseases in the planning of their services (pro mente Kaernten - KEB, 2017).

The clients of the Day Care Centre Villach and the “Kärntner Empowerment Bewegung” started with a new project. It is called “BBB - Betroffene beraten Betroffene” (people with a diagnosed mental illness give advice to people with a diagnosed mental illness). Every second and fourth Tuesday a month they counsel to people with a diagnosed mental illness.
The counselling's take place at the psychiatric ward in Villach anonymously way and free of charge (KEB, 2016).

Relatives are also very engaged and try to find individual ways to help people with a mental health problem and their relatives. The Association HPE - Hilfe für Angehöriger psychisch Erkrankter (support for relatives of people with a mental health problem) offers counselling and self-help groups for relatives. They also started a project for the rural region in West Carinthia. The project is called “Lichtblick” (ray of hope). It is an offer for people with a mental health problem as well as their relatives to get professional support in their personal environment. The contact to the people is based on patience and empathy. The professionals, the people with the mental health problem and their relatives discuss different possibilities for an individual support with each other. The project is promoted by private donations and subsidies from the Carinthian social services department (HPE, 2009).

Based on these examples it can be demonstrated that the movement towards recovery also exits in Carinthia, as a next step it is necessary to promote the understanding of the recovery concept and its implications among the stakeholders in the care sector. Undoubtedly, the implementation of recovery orientation in mental health care is a more difficult and long lasting process. In this context, it is important to emphasize that recovery orientation does not replace existing roles, tasks, therapies or service structures, the concept should be seen as complementing them.

4.3 Models of professional support

What can I do went I get mad? Where can I get trustful support for a relative or a friend? How can I protect myself against forced treatment? Where can I find liked-minded people to exchange experiences? How can I become active as a friend or relative? What choices do I have when it gets impossible to go on with my work at the psychiatric ward? What kind of treatments or alternatives exist instead of an inpatient treatment?

These and other question have often been asked during the last decades, a lots of different interventions, projects or studies were initiated in the international community to design alternative ways of service and treatment for more humanity and self-determination. The following studies, projects and programs, which are inspired by the spirit of a more human and individual treatment are examples for many more. They show how treatments build on trust, hope, understanding, commitment and partnership. They could help and give hope to a self-determined life. These kind of treatments could be also implemented in Carinthia.
4.3.1 Soteria - an inspired idea in the USA and Switzerland

The concept of Soteria was established by the American psychiatrist Loren Mosher (1933 – 2004). Soteria was developed as an alternative low-drug milieu-therapeutic approach to acute schizophrenia. The project lasted from 1971 to 1983, took place in San Jose, California and in 1984 a second was initiated by Luc Ciompi in Berne, Switzerland (Ciompi & Hoffmann, 2004 and Aderhold & Lehmann, 2007).

People with schizophrenia were treated in a milieu therapeutic setting during acute psychosis (Aderhold & Lehmann, 2007, pp. 150-151). In the context of the Soteria principle, the following basic conditions were defined. Do not harm anyone, treat everyone with respect and dignity and expect to be treated the same way. Refuge, peace, security, support, protection and security as well as food and accommodation are guaranteed. The basic mood can be characterized by the conviction that a recovery from the psychosis can be expected. Accept the inhabitants as experts and let them make their own recovery plans. The basic approach is to be agreed upon with the client. In an attentive but not intrusive way, putting oneself in the position of the person with the psychosis, so that a common meaning of the psychotic experience can be established through the relationship (Ciompi, et al., 2001, pp. 16-17). Unlike the treatment in a hospital Soteria rarely uses neuroleptic medicine, and if the medicine is necessary the resident has full control. That means that the resident is challenged to observe his/hers reactions regarding to the medication. The resident also has to decide if he/she takes the medicine or not (Aderhold & Lehmann, 2007, p. 151).

The therapeutic setting was based on an open familiar environment with easy access especially for people with schizophrenia. The main task of the staff was to be with the disorientated clients without expectations or doing specific actions. The daily routine was relatively informal, roles and hierarchy minimally differentiated, special focus was given to activities outside the house. The duration of the stay was four to five months in average, in general a full or partial improvement occurred after six to eight weeks. The continuity of relationships after the departure of the Soteria was promoted and the social network, which the residents established during their stay was maintained. This way the mental stabilization and social integration helped to a self-determined life (Aderhold & Lehmann, 2007, pp. 153-154).
Mosher was inspired by a phenomenological and existentialistic approach to mental illness, he demands;

“That continuous human closeness with the psychotic patient ("being with") in a small, supporting and protective non-hospital setting allows to achieve similar or better therapeutic effects than with the traditional hospital-based treatment, almost without using antipsychotic drugs.” (Ciompi & Hoffmann, 2004).

Within the research project Mosher was able to demonstrate that with his specific approach people with psychosis could be effectively helped without coercion and highly dosed neuroleptics. The project in California ended in 1983; the idea of Soteria was brought to Europe, the psychiatrist Luc Ciompi, who worked in the Soteria project California for seven years implemented the approach in Berne in 1984. He established a Soteria in the existing social psychiatric structure of Switzerland (Aderhold & Lehmann, 2007, pp. 154-157).

Ciompi modified the Soteria approach; he implemented the approach in the existing social psychiatric treatment structure, offered more family and individual treatments and used more antipsychotic medications. He also implemented the soft room. A room where the people with schizophrenia could be accompanied during their acute psychosis around the clock. The primary task of accompanying was to calm the person down. They did so by silence or talking, simple activities like handcraft, drawing, walking or playing or other activities the person liked. After the acute crisis (phase 1) the person was integrated in the daily activities of the therapeutic community (phase 2). During the last phase 3 of the treatment, the person was prepared for the discharge that involved after-care and relapse prevention (Ciompi & Hoffmann, 2004).

The modified approach in Bern also lead to a positive outcome for people with a diagnosed schizophrenia, the people diagnosed with schizophrenia could be treated effectively. The relaxing Soteria atmosphere could even calm down very aggressive psychotic episodes within days (Ciompi & Hoffmann, 2004).

Even though the frame conditions changed during the last three decades and Soteria Berne also has had to adapt the concept to the conditions, Soteria Berne still exists. The adaption of the concept has always included the core concept and has guaranteed a human and individual treatment. People with a diagnosed schizophrenia and their relatives have preferred this kind of treatment and with innovative programs like increased family involvement, former client group, integrated treatment and treatment for cannabis indicated psychosis, the demand for this kind of treatment is still high (Hoffmann & Leisinger, 2006).

The Soteria model has very much to suggest that the therapeutic environment has been rethought within the acute psychosocial system (Aderhold & Lehmann, 2007, p. 161).
Soteria is not just a romantic relic from the antipsychiatry movement of the 1960s and 1970s, it is rather the good solution for a psychosis treatment in the future. Therefore, it is not surprising that the approach is widespread, especially in Europe other Soteria houses could be established. The idea has also spread within hospitals, so wards with Soteria elements have been developed. Soteria inspired a lot of different treatment possibilities and opened the mind for different future possibilities (Hoffmann & Leisinger, 2006).

4.3.2 Run away from traditional psychiatric treatment – Weglaufhaus “Villa Stöckle”

The Weglaufhaus “Villa Stöckle (run-away house) was opened in 1996 in Berlin. Inspired by the antipsychiatry, run-away houses in the Netherlands and the Soteria movement, the “Villa Stöckle” was established by the crises unit for people over 18 with a social and existential crises. It closes a supply gap for those homeless people with psychiatric experience, who cannot or do not want any other assistance in a crisis situations due to access conditions or their previous experiences. For these people the run-away house provides an entry into the auxiliary system and fulfils a clearing function for connecting support (Verein zum Schutz vor psychiatrischer Gewalt e. V., 2010).

Why do people run away? There are many good reasons to run away from the psychiatric ward. The psychiatric ward treats extraordinary perceptions, conflict situations and personal crises with stigmatizing diagnoses, forced accommodation in closed wards, coercion and neuroleptic drugs with many side effects. Socially isolated, deprived, without work and money, the flight often ends where it began; in the psychiatric system. The runaway house offers a possibility for people to find a home and support to overcome the crisis (Verein zum Schutz vor psychiatrischer Gewalt e.V., 2017).

The special attribute of this house is that it was founded by people who themselves had experienced such a crisis and were involved in the humanistic anti-psychiatry movement. Their aim is/was to help other people with crises. They organized themselves in an association and after 16 long years they finally had enough money, support and the permission to buy and open the house. However, the house was not only founded by people with experience, also half of the staff were/are people with experience who gave support and handed on their knowledge. (Verein zum Schutz vor psychiatrischer Gewalt e.V., 2017).

The offer for the people who come to them is an anti-psychiatric orientation and an alternative to a traditional psychiatric treatment. The house is a diagnoses free zone, no one will give a diagnosis or ask if a diagnosis exists. The inhabitants of the houses stay
voluntarily and the can leave anytime they want. It is a place with very wide borders and it is possible to undergo crazy states. The inhabitants are neither considered as ill or as heteronomous, they remain responsible for their actions and statements. No one is forced to do what he/she does not want, this also includes taking medicine. Quite the contrary, if it is their wish to stop taking medication they will be advised and supported by the staff (Hartmann & Bräunling, 2007, pp. 200-201).

Living together is characterized by a high degree of acceptance and tolerance towards unusual experiences and behaviours. The residents support each other in the form of experience exchange, practical help or joint free time activities. The house itself does not provide a daily structure, it is often based on external framing conditions like appointments with authorities or doctors. The approach is based on the Soterias “be with” concept. Residents who in the beginning have problems with the external structure are supported, but without pressure. The residents have to rediscover their own wishes and goals, to find their own impulse and to implement it at their own pace. The highest aims of the “Villa Stöckle” is to help people help themselves (Hartmann & Bräunling, 2007, pp. 200-201).

4.3.3 Just living – The Hotel Magnus Stenbock

To live independently and autonomously is difficult for people with a diagnosed mental health disease. They can choose between therapeutic settings or try to find a suitable accommodation. However, it often fails because of financial and bureaucratic hurdles. Even as a “healthy” person it is stressful to find an apartment. People with a mental health problem want to have a choice where and how they live, as every other person does, they want to decide how and with whom they spent their free time. A protected accommodation should not be seen as a rehabilitation and it should not be a supplement to a treatment structure. The medical model of psychiatry transforms people who suffer and have problems to disabled people, to patients and chronically ill people. A protected accommodation assists this system, everyone looks at the person as in need and also treats him/her this way. (Jesperson, 1998). To break up with this role the person needs a space where he/she can be what he/she really is. But where can such a place be found?

The Hotel Magnus Stenbock in Helsingborg, Sweden, is such a place. The hotel was established by people with experience within the psychiatric system, they organized themselves first in a self-help group and later in an association the RSMH (Riskförbundet för social och mental halsa, National association for social and mental health). The hotel was established as a project and promoted by the town Helsingborg, but organized and managed by the residents themselves. Several people work in the hotel, some are paid, but
none of them has a professional background. There is no general separation between the people with a mental health problem and the ones who are paid for taking care of others. This fact is precisely very important, because the non-dividing meeting of self-help is a way of breaking the firmly cemented role of patient, disabled or chronically ill (Jesperson, 1998).

Hotel Magnus Stenbock was one of the biggest user-controlled project in the world and unique in Europe. It lasted from 1995 to 2004, and has existed till now. It was also mentioned as a positive example in 2002 by Dr. Fox, a member of the British Parliament during a debate;

“Hon. Members may be aware of examples such as the Hotel Magnus Stenbock, in Helsingborg, which is well known in mental health circles. It is a good example of what might be termed a halfway house for those moving between an institutionalised setting and the community. It has 21 single rooms and offers a balance between private and social space. It offers not just structure and crisis accommodation but a place of safety, and develops a sense of community and acceptance.” (United Kingdom Parliament, 2002)

The Hotel was established as a self-help project and therefore the hotel had to fulfil some requirements. The members of the group looked for a hotel in the middle of the city so that the residents could take part in the city life and use all offers of the town. The house needed enough single rooms for the residents and space for a common room of the association (Jesperson, 1998).

In 2004 the social service of Helsingborg took over the management, but not because the user controlled management didn’t work, it was because of complicated public laws about contracts by the European Union. Between 1995 and 2004 the hotel was democratically managed by the residents. Every resident had an own contract with the RSMH Helsingborg who was the official owner of the hotel. They could check in and depart whenever they wanted (with a 14 day notice period). The basic principal of the concept was that living in the house was not a kind of rehabilitation process. It was just living place, everything else regarding to structure one’s own life was left to the residents (Jesperson, 2007, p. 167).

For the residents it was possible to become a member of the RSMH Helsingborg, as members they could influence the conception, the house rules and the budget. After some problems with drugs and alcohol the residents decided democratically that there should be some house rules. They decided that alcohol and drugs were not allowed in the hotel and that after 22:00 in the evening it should be quiet and visitors would have to leave the building (Jesperson, 1998 and 2007, p. 172).
The Hotel Magnus Stenbock was very economic, one third of the costs were financed by the municipality and two thirds by the residents’ rental. It was a good deal for Helsingborg, a private apartment house or the stay in the hospital would have been much more expensive. However, not only the budget was an extraordinary outcome of the project, especially the social process in the hotel was remarkable. In the end it was not just living, the residents established a community consisting of outsiders who had troubles to build up relationships and hold them. Some of these relationships existed long beyond the check out from the hotel (Jespersen, 2007, p. 173).

4.3.4 Diagnosed free zone – possibility for changing the role – the Clubhouse

During the ethnographic research in Finland, the author got the possibility to visit a “diagnosed free zone”. The Clubhouse Suvimäen Klubitalo in Jyväskylä was founded in August 1999 and has 500 members, each day around 25-35 members visit the Clubhouse. The Clubhouse is organized by a manager and has six employees. Finland has 25 Clubhouses all over the country. The principals of the house are; “Everything is voluntary and all are equal” (Achtschin-Stieger, 2016).

The clients are called members, which is very important fact, because the place is created for persons to find a new role, diagnoses are not important and no one will ask for them. The place is open for everybody and members participate in the tasks, the daily activities and the design of the weekly club program. The staff works together with the members side by side in every function of the house (Achtschin-Stieger, 2016).

Suvimäen Klubitalo is a member of the Clubhouse international community, this a global non-profit organization. They help communities around the world to create Clubhouses. The houses are community-based centres, which give people with mental health problem hope and opportunities to reach their full potential (International Center for Clubhouse Developement, 2017).

The first Clubhouse was opened in 1948 in New York City, it was established as a community place for people with experience of a mental illness. At this time it was unique that members could work productively and have socially fulfilled lives. The so-called Fountain House was the only one of its kind for around thirty years, as opposed to the base mental health programs the Fontain House worked with their members side by side, as peers and partners, they were not fixed in the role as patients. In this position, it is difficult for people with a mental health problem to view themselves as a whole individual human being. The Fontain House never took up these roles, they always saw the people as
members of the Clubhouse. In 1977 the Fontain House got the mission from the National Institute of Mental Health (NIMH) to create a national training program for Clubhouses in the United States. By 1987 there were 220 Clubhouses in the USA Clubhouses in other states have been opened as well (Canada, Denmark, Germany, Holland, Pakistan, Sweden and South Africa). It was clear, because of the universal human values, that Clubhouses could be replicated everywhere in the world. In 1994 the Clubhouse International was established and all Houses were connected to this community, each house was accredited and fulfilled the standards of Clubhouse International, today Clubhouse International helps future Clubhouses all over the world to become an accredited member of the global network (International Center for Clubhouse Development, 2017).

At the moment there are 330 Clubhouses in 34 countries worldwide, 100,000 People each year benefit from the houses, the people find opportunities for education, housing, employment and have access to medical and psychiatric support through the Clubhouses. They find friendship in a single caring and safe environment. They get the chance to recover from their mental health problem, can fully participate as valued and respected human beings of a community. Clubhouses are therefore as cost effective as a one full year of holistic recovery based treatment, but only costs the same as a two week psychiatric hospital inpatient treatment (Clubhouse International, 2015).

A Clubhouse is a powerful demonstration that people with a mental health problem can do “normal” productive work and have fulfilled and self-determined lives. A membership to a Clubhouse is not time limited so it is possible to build up long-term relationships to other members and the staff. To be a member means to share the ownership but also share responsibility for the success of the organization. It also means to belong somewhere and to be welcome every time you enter the house. The side by side work promotes talents and abilities of members, consensus based decision making about all matters concerning the Clubhouse involves the members in the organization of the Clubhouse. The members also benefit from transitional employment programs and Clubhouse supported and independent programs to find a paid employment in the local labour market (International Center for Clubhouse Development, 2017).

In Austria there are four Clubhouses, all of them in Upper Austria. They were established in Linz, Wels, Steyr and Vöcklabruck. The Clubhouse Pro People in Linz is part of the promente Oberösterreich (Upper Austria) and was accredited in 2011, it works based on the International Clubhouse standards (Clubhouse pro people, 2017).

This kind of system gives the possibility for a complete change of perspectives. It is a place without a disability label, members are not asked what they are not able to do, they are
invited to join voluntarily and participate with all their resources. It is a place where they find friends and easy access to other services they may need. A Clubhouse offers the opportunity for their members to be part of a group and to be respected as a whole person. It is an easy and cost effective way to involve people and make them laugh (Achtschin-Stieger, 2016).

4.3.5 Interface management by psychiatric outpatient nurses in Finland

Interface management is one of the very important but also neglected areas of health care management. During the ethnographic research the author got informations how this could be managed in a positive way.

The area Central Finland has about 275,000 inhabitants, they live in an area which is about 19,950 km² wide that is about the double size of Carinthia. The density of population is about 16 inhabitants per km². 21 municipalities belong to Central Finland. About 137,000 inhabitants live in the municipality Jyväskylä, that’s about 55 percent of all inhabitants of Central Finland, the other municipalities have between 19,000 and 760 inhabitants. The health care district Central Finland is the fifth largest health care district and the largest non-university district. The central hospital is situated in Jyväskylä. The hospital has 447 beds, and has an operative wing with 160 beds, a conservative ward with 153 beds an emergency ward with 41 beds and a psychiatric ward with 93 beds. Ten for adolescent psychiatry and 83 for adults (Kanerva, 2016).

Finland established a gatekeeper system; every person is used to go first to a general practitioner or a health centre before he/she gets a specialized treatment in a hospital. The health care system is tax founded and basic health care includes nurses and doctors’ services most based on somatic issues (Kanerva, 2016).

Till the early 1990s three hospital existed in the area of Central Finland, each with hundred beds for people with a mental health disease, to strengthen the outpatient system two hospitals were closed, parallel psychiatric nursing homes and different outpatient support facilities were opened. This system provides more flexibility and individuality for people with a mental health problem (Kanerva, 2016).

Around hundred beds are reserved for an admission in a psychiatric ward. The General Hospital in Jyväskylä provides two closed wards, one semi closed ward for patients with depression or anxiety and one general psychiatry ward for cancer patients and psychosomatic disorders like eating disorder. In Jyväskylä there is a fifth ward for long-term
admission, especially for forensic patients, but this ward is not placed at the General Hospital. The established new system had the new challenge that not all persons who are in need can be admitted. A solution had to be developed where people could be treated well and individually regarding their needs. The solution was to create an interface management with psychiatric nurses (Pelttari, 2016).

This interface management starts at the emergency unit. From Monday to Friday four nurses and one so called telephone nurse work at the emergency unit. They were called psychiatric outpatient nurses because they half work at the emergency unit and half of their time outside the hospital at the polyclinic. The polyclinic is not a hospital or another institution, it is a house in which the psychiatric outpatient nurses rent some offices. Their task is to do the evaluations and assessments at the emergency unit, because there are not enough psychiatrists. Most of the time there is only one psychiatrist available at the hospital. They nurses were called by the triage nurse and do the assessment independently without a doctor. If they think an admission at the psychiatric ward will be necessary they talk with the general doctor on duty. Admissions, however, are rare, the person with the mental health problem has to be very psychotic or suicidal to get an admission. After the assessment they discuss the situation with the team and the general doctor of the emergency. If the patient does not get an admission they will plan a follow up appointment with him for the next day at the office at the polyclinic. It is also possible to make an appointment where the patient lives (Pelttari, 2016).

The nurses are employed at the hospital, two nurses always work in on shift, from 08:00 to 12:00 and from 12:00 to 20:00. The telephone nurse makes calls to patients to stay in contact with them and takes emergency calls; she also is available for doctors from outside who want to bring a patient to admission, she works from 8:00 to 16:00 and afterwards passes the telephone to the afternoon shift. At 20:00 and at the weekends the telephone is forwarded to the psychiatric ward, so that the calls can be answered on a 24/7 basis. The two nurses from the morning shift do evaluations with patients who came to the emergency during the night and stay overnight, normally they do not stay longer than one or two nights. This is not possible at the emergency. During the evaluation they ask the patient why he/she comes to the emergency, how he/she feels now, what he/she might need, how they can support him/her? They also recommend other outpatients services and supports. If the patient needs an admission, the outpatient nurse will take care when the discharge is set. Together with the patient, his/her relatives and the team of the ward, they plan and set arrangements for an outpatient support. In this evaluation and planning process, the family is involved if the patient wants so (Pelttari, 2016).
Five more nurses work at the office at the polyclinic, they have appointments with their clients. The unit in which Ms. Pelttari (2016) is involved, is called acute psychiatric team, other teams are the rehabilitation team and the elderly team.

The patients can be assisted by the acute team for about one or two months; it is for acute crises like a divorce or an accident, if the patients have a chronical disease and need longer support they will be shifted to the rehabilitation team (Pelttari, 2016).

The rehabilitation team helps people with a mental health problem during daily life events, they accompany the person and help to make plans for daily living and assist with the medication. The whole family can be involved in the support and the plans can be made together with the whole social environment of the person. In the field of the rehabilitation process it is possible for the nurses to specialize as an addiction or depression nurse, but this specializing is mostly bound on experience and not on formal courses. The duties of the rehabilitation team during home visits are, doing a family care nursing, involve the whole family, see how patients manage their lives, medical care, working with the whole family and plan preventive actions and especially motivation. It is also possible to be a psychiatric nurse in the elderly team, they accompany and support psychiatric problems during ageing (Pelttari, 2016 and Kanerva, 2016).

Ms Pelttari (2016) could watch that during the last five years people who need support are getting younger, and they often have no idea how to cope with their lives. She thinks that there are possibilities to build up an adolescent team for teenagers and young adults to support this group through their personal life events, also to prevent addictions. A second improvement she thinks would be to help people with mental health problems; this is the allowance for nurses to prescribe medications. It is often very difficult to find a doctor who prescribes the drugs the patient needs, it is very time consuming for them. The patient often only has an appointment with the psychiatrist once or twice a year, because there are so few in Central Finland.

With the increasing outpatient treatment and the decreasing hospital beds, an interface management would also be important for Carinthia. At the moment there is no home care by psychiatric nurses established in Carinthia. A possibility like the psychiatric outpatient system of Jyväskylä would also improve the system. To be employed at the hospital and work independently outside the hospital would match the needs of the clients and improve the networking between the hospital and the outpatient treatment structure.
4.3.6 Open Dialogue approach – the Western Lapland treatment system

In the 1980s a group of psychologists and psychiatrists in Western Lapland renewed the classical psychiatric care of people with schizophrenic disease. The result was a method, which for many years showed an outstanding therapeutic success for initial psychoses: the so called Open Dialogue (Kreuz, 2011). The team around Jaakko Seikkula, Brigitta Alakare and Kauko Haarakangas established the new approach according to an analysis of problems in the practical experience and the attempt to solve these problems by a reorganization of the system. To create the Open Dialogue, as it will be introduced in this chapter, different phases were necessary. The important steps were, in 1984, implementing open meetings for family treatment, the establishing of a crises department to organize case specific teams in 1987, and that all psychiatric walk-in clinics started to organize mobile crises intervention teams in 1990. These steps were necessary to implement the Open Dialogue approach (Seikkula & Alakare, 2007, pp. 234-235).

Open Dialogue is a unique health care system in west Lapland, it is not a project it is the health care system in this region and was designed for persons with an initial psychosis. Open Dialogue is described as a democratic system where all involved people meet on the same level. The person who has the crisis, they family members, and other members of his/her social environment are invited to the meeting. They discuss, together with a team of two or three inpatient and outpatient professionals, the reason and a solution for the problem. The solution will be found together, the professionals are not the experts who bring the solution to the people, the solution is hidden in the minds of people and the professionals help to detect it. During the meeting the professionals reflect their thoughts and feelings in front of the person with the crisis and the family and also ask them about their feelings and thoughts. The place of the meeting can be at the home of the client or wherever he/she wants (Open Dialogue, 2011).

The Open Dialogue has been well researched during the last 25 years and according this research seven principals have been established (Seikkula, et al., 2000):

1. **Immediate help**
   After the person in need or some of the family called for help the team arranges the first meeting within 24 hours, to provide this service a 24/7 crises service is organized.

2. **Social network perspective**
   The person within the crisis, family members, and other persons who are key members of the social network, are always invited to the first meeting to mobilize support to the person
and his/her family. Other persons like neighbours, employers and local authorities can also be involved in the meeting.

3. **Flexibility and mobility**
That means the needs of the person within the crisis and his/her family stand in the focus, the treatment and the support will be adjusted to the variable needs of this person. This is guaranteed to the person. There is no fixed treatment schema, each person will be treated individually depending on his/her needs and situation.

4. **Responsibility**
Whoever was contacted by the person is responsible to organize the meeting, in which decisions will be made, the team who takes part in the meeting takes charge for the following treatment.

5. **Psychological continuity**
The team takes the responsibility for the following treatment as long as this is needed, inpatient and outpatient in the same way.

6. **Tolerance of uncertainty**
Is focused by means of building up a safe environment for the ongoing process. To provide safety means to have meetings every day for at least the first ten to twelve days. Neuroleptic medication will not be started in the first meeting, before such a therapy will be started there has to be a discussion about medications in three meetings. An admission in a hospital is only a possibility if the home of the person is not safe enough for him/her. The team and the family will try to create a safe place to avoid an admission.

7. **Dialogism**
The overall focus of the meeting is to promote a dialogue and to promote a change in the person with the crisis or in his/her family. The forum with the dialogical conversation provides the possibility to get more agency in their own lives by discussing the problems and difficulties. With the dialogue it is possible to build up a new understanding between the participants of the meeting. In Open Dialogue, each individual's voice is important, especially the client's own. In an esteeming/appreciative atmosphere, relationships and needs are clarified and health-promoting conditions are created in the home environment. Only when all participants were heard on the same level and have come into contact with each other there can be a solution.

In order to achieve this effect, the training of the specialist staff and the extensive expansion of outpatient treatment teams are necessary. This may cost even more money at the beginning. But the consistent reduction of stationary beds and the reduction of medication can lead to cost reductions in the long term (Kreuz, 2011).
The effectivity of Open Dialogue was proven with different comparative analysis and long-time studies. The outcomes of persons with an initial schizophrenia compared with persons who were treated with a traditional psychiatric treatment are outstanding. Approximately 85 percent of those affected have no symptoms five years after the onset of a psychosis and are back to work or school, instead of fighting with a disability for a lifetime (Kreuz, 2011). Two thirds of the persons who got a treatment with Open Dialogue never got a neuroleptic medication. Only in 15 percent of the cases the initial schizophrenia turned into a chronic schizophrenia. Open Dialogue demonstrated that a person with an early schizophrenia could be healed. The understanding of schizophrenia changed in West Lapland, schizophrenia is not an illness of the brain, a psychosis is closely linked to emotional problems in interpersonal relationships and it is not necessary to treat this problem with medications (Open Dialogue, 2011).

Possibly the positive results of the Soteria approach, Open Dialogue and the Weglaufhaus, the self-determined life in the Clubhouses and in the Hotel Magnus Stenbock, and the interface management of the psychiatric outpatient nurses only mean that psychoses must not be viewed as a sign of a disease but as a way of dealing with crises. Many or most people after a crisis are able to live an active social life again. The programs and approaches also showed that the use of neuroleptics is not as important as the traditional medicine tells us, maybe it is time to rethink the understanding of the problem itself. According to these results we should think whether it is possible that hallucinations are not an imbalance in the brain, they could be a result of real life events and are reactions based on stress, as the Stress-Vulnerability-Model explains. Based on these results we should start to ask ourselves if our treatment system is up to date, and if not, what we should change. To answer these questions the author asked people with a diagnosed schizophrenia, relatives of people with a diagnosed schizophrenia and professionals what they need and wish for the mental health outpatient treatment structure in Carinthia.
5 Methodology

This thesis was set up on three methods; a literature review about international recommendations, facilities and services for people with a diagnosed schizophrenia. An ethnographic research to have a closer look on the mental health care in Finland and focus groups with the three groups of service users, people diagnosed with schizophrenia, relatives of people diagnosed with schizophrenia and professionals of the mental health outpatient treatment in Carinthia, to find out about their wishes and needs.

5.1 Literature

The literature review involved client-centred and patient-orientated methods of outpatient treatment and theoretical concepts. For this thesis literature in German and in English and different kinds of sources were used e.g. books, minutes of conferences, websites, documents of websites, studies, a film and the ethnographic research diary. Many sources where recommended to the author during discussions about the thematic with experts and colleagues. Some others were searched on the internet via google scholar, and EBCSOhost Research Database, provided by the Carinthian University of Applied Sciences with the focus on the databases of PSYNDEx, MEDLINE, PsycINFO and PsycArticles.

Each chapter provides a different focus so the literature review was done separately for each chapter and subchapter, different keywords according to the chapter and the subject matter were used.

Chapter two “The challenging situation of people diagnosed with Schizophrenia” includes the subchapters “Clinical perspective - Schizophrenia as a disease” which describes the illness, symptoms and prevalence. The subchapter “Stress-Vulnerability Model” explains the relationship between biological vulnerability, stress, alcohol and drugs and coping skills. Stigmatisation and related discrimination is still very high in Austria so the subchapter “Social-psychiatric perspective – Schizophrenia as stigma” is important to explain the different types of stigma, self-stigma and consequences of stigma. Therefore, literature from the World Health Organisation, the National Institute of Mental Health, the American sociologist Erving Goffman, the German social psychiatrist Asmus Finzen and others were used.
Chapter three gives an overview about the conditions and current treatment structures for people with mental health problems. The subchapter “Mental Health and Wellbeing in the European context” was based on international guidelines and recommendations from the World Health organisation and the European Union, e.g. “The European Framework for Action on Mental Health and Wellbeing, January 2016”, “The European Mental Health Action Plan 2013 – 2020”, “Policies and practices for mental health in Europe – meeting the challenges, 2008” and other important literature. The second subchapter explains the health care system of Austria and provides an overview of the current facilities for people with diagnosed schizophrenia in Carinthia. For the explanation of the health care system of Austria, literature provided by the federal Ministry of Health was studied.

For the third subchapter “The challenging situation of Carinthian mental health care” mostly sources in German language were used, the websites of the different associations like pro mente Kärnten, AVS, Caritas and “Zentren für psychosoziale Rehabilitation – Kärnten”, which provide mental health care in Carinthia were looked for information about the current treatment structures. To compile quantitative data, sources like Statistik Austria, the Medical Chamber of Carinthia and the KGKK (Carinthian Insurance Institution) were consulted. To present a picture from the point of view of service users, only data was used, which could be accessed and found by service users’ their selves.

The fourth chapter “Development of mental health care” describes the development of psychiatry form the ancient world to now, explains the recovery approach, the meaning of recovery for people with a diagnosed schizophrenia, and different possible tools and facilities which could be implemented in Carinthia. Therefore, a literature mix in German and English, recommended by experts, the film “Open Dialogue” by Daniel Mackler and interviews made during the ethnographic research were used.

In chapter six the focus groups were analysed a structuring qualitative content analysis according the method introduced by Prof. Dr. Udo Kuckartz and with the F4 analysis program developed by Thorsten Dresing and Thorsten Pehl, supervised by Udo Kuckartz was used. His book “Qualitative Inhaltsanalyse. Methoden, Praxis, Computerunterstützung (Kuckartz, 2016)” was a valuable guideline for the author.

For the chapter “Recommendations for a future outpatient mental health treatment structure in Carinthia” the author was allowed to use the new implementation concept of the Carinthian Government “Psychosocial Treatment in Carinthia according the RSG Carinthia 2020”. It was introduced to the public on July 3rd, 2017, and was handed to the author on the July 9th, 2017 with the permission of the representative governor Dr. Beate Prettner.
This concept was compared with the results of the qualitative analysis of the wishes and needs of people diagnosed with schizophrenia.

The complete list of bibliography used for this thesis can be viewed in chapter eight “Bibliography”.

5.2 Ethnographic research in Jyväskylä

To gather more information about the current outpatient treatment situation an internship in the town Jyväskylä (Central Finland) was conducted. The internship was documented with a diary based on the observation and interviews with different persons involved in the mental health treatment structure. During the field visits the author took notes and transferred them into a research diary every evening. Ethnographic research provides an extremely rich insight into ‘real life’ behaviour, and can be used to identify new or currently unmet user needs and unknown mental health services in Carinthia (Government Service Design Manual, 2014).

The ethnographic research was planned between the 12th December and 16th December 2016. The author was supported by her supervisor Katja Raitio from the University of Applied Sciences Jyväskylä. Ms. Raitio planned and fixed the meetings with different persons from mental health services in Jyväskylä. The author was financially supported by the Carinthian University of Applied Science with an Erasmus scholarship.

The planning of the schedule was already in progress during the notice of the internship Via E-mail contact the author clarified possibilities for different meetings with Ms. Raitio. The schedule was set one week before the author arrived Finland.
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10:30</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>13:00 – 14:00</td>
</tr>
<tr>
<td>14:00 – 16:00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 – 09:30</td>
</tr>
<tr>
<td>09:30</td>
</tr>
<tr>
<td>15:00 – 16:00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 – 16:00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thursday 15.12.2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 – 17:00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 – 12:00</td>
</tr>
</tbody>
</table>
12th December 2017

On Monday morning the author met her supervisor Ms. Raitio to fix the schedule for the week. In the afternoon the first two meetings were planned at the central hospital of Jyväskylä with Mr. Jani Korpela and Ms. Anne Karnerva.

Mr. Korpela gave an introduction about the psychiatric ward and the “Nordic Network for reducing the Use of Coercion in Care”. It was also possible to visit one of the closed wards.

Mr. Korpela (2016) explained the process of coercion. If coercion is necessary the ward provides an extra room. This room looks like a prison cell. The bed is fixed to the ground, there is no window and it is closed with two doors. Nurses are allowed to decide when coercion is necessary and when they can end it. They do not need to ask a doctor, during the coercion phase a nurse is always with the patient, it is also possible for nurses to decide whether to give additional medications like neuroleptics or diazepam. Because of the individualized system of coercion, the time was reduced from nine hours ten years ago to three hours thirty minutes.

The Finish law allows patients to stay in a closed ward for four days after this period. The doctor, together with the patient, has to decide if he/she can stay freely, leave the hospital or needs to stay longer. In this process no court is involved (Korpela, 2016).

Ward rounds at the hospital always have to be with the patient, his relatives and when involved, with the outpatient support. Before a day of discharge is set, the staff always have a meeting with the patient, the relatives and the outpatient support in order to plan the next treatment steps. Mr. Korpela (2016) also explained that the psychiatric ward has a strong connection to the outpatient treatment, many former nurses who worked in the hospital, changed to working for the outpatient treatment. The hospital supports the outpatient treatment sector.

Ms. Anne Karnerva gave an introduction about the Central Finland Hospital District in her office, focusing on psychiatry. She explained the funding rules of the Finish Health Care system and gave an outlook for the future. Parts of this Introduction are involved in chapter “Interface management by psychiatric outpatient nurses in Finland”.

13th December 2016

On Tuesday the author stayed at the University of Applied Sciences of Jyväskylä and learned more about the mental health nursing studies.
14th December 2016
On Wednesday the author got the possibility to learn more about the acute psychiatry and the connection to home rehabilitation. Ms. Katri Pelttari explained the new profession psychiatric outpatient nurse. Her information was introduced in the chapter “Interface management by psychiatric outpatient nurses in Finland”.

15th December 2016
The next visit on Thursday was at the Rehabilitation home Niittykoti in Jyväskylä, this is a place for people with a mental health problem who need a longer rehabilitation phase and help with their daily living. The house was introduced by Sari Ruuska (2016) who works there as a nurse. This home is comparable with a Carinthia CPSR, but it provides more rehabilitation than Carinthian CPSRs do. It is a private home for 21 residents. In this rehabilitation home it is possible for residents to stay forever, but the overall target is to support them to lead individual and independent lives step by step. For the next step, for example, they provide two flat-shared-communities with day care support in the city of Jyväskylä.

In Niittykoti the residents rent their own small apartment in the home. They pay the rent for the apartment and a monthly food contribution, the services are paid by the city of Jyväskylä. Before they finally move to the home, there is a trying period to test if the living condition are appropriate for the client. All residents stay on their own accords, if they want to leave they will be supported to find an adequate alternative (Ruuska, 2016).

The rehabilitation home Niittykoti is rather orientated on the recovery of the person than most of the Carinthian CPSRs. The home is placed in Jyväskylä so the residents have the possibility to use the treatment schedule of the house and all other treatment services and cultural offers in the town, this way they are supported by the nursing team. The overall target is to support the clients to get independent, therefore the staff instructs the clients in daily activities like cooking, baking, cleaning the room, and making the laundry, but they also support them with activities outside the house like shopping or visiting a physician (Ruuska, 2016).

Ms. Ruuska (2016) told the author that for every resident an individual rehabilitation plan is made. Targets and actions are planned together with the client. Based on these long-term targets, they plan a weekly schedule and weekly actions with the client to structure their daily living. The plan and goals are evaluated weekly and checked on daily basis. Every
three months the goals and actions are updated. The residents are committed to the plan. The goals depend on how long the residents stay in the home.

It was possible to talk with a client, he lived there for two years, and after his wife died he got mental health problems. Before he got ill, he worked for different international companies and he speaks six different languages. His goal was to learn them all as good as possible to have a normal conversation. He talked German with me and he was very proud about that.

He felt very well supported in this facility and he liked to live there. He took part in different activities and he also went to a role-play club and took a language course in French. His main problem then was that he felt he forgot so much and that worried him a lot.

16th December 2016

On the last day, the author got the possibility to visit the Clubhouse Suvimäen Klubitalo in Jyväskylä. A description about the Clubhouse is introduced in chapter “Diagnosed free zone – possibility for changing the role – the Clubhouse”

The journey to Finland gave the author the opportunity to have an individual view on the Finnish inpatient and outpatient treatment system for people with a mental health problem. The insights gained in this way are characterized by the personal experiences of those who work in this system on a daily basis and who strive for personal support.

The visits from the General Hospital to the Clubhouse gave a good overview of the different support services. The networking of these support services was also very interesting and the possibility for clients to use them in a combined way. Two of these approaches were used and explained as a possibility for Carinthia, also the other services show that Carinthia can do a lot to improve the system and it is not necessary to develop a new system. Sometimes small innovations also can help people with a mental health problem to live fulfilled and self-determined lives.

5.3 Focus groups

The central research element of this thesis was to find out the wishes and needs of people with diagnosed schizophrenia. What kind of infrastructure or support do they need to have self-determined and satisfied lives? To investigate the research question of this thesis three focus groups with participants according the trialogic approach were planned.
5.3.1 Planning and operating the focus group

A focus group is a method of qualitative research that involves discussing a specific set of issues or an area of defined interests with a pre-determined group of people. Other terms which are sometimes used interchangeably are “group interview”, “group discussion”, “focus group interview” or “focus group discussion”. Each group should involve six to eight people, they are pre-selected individuals who share experiences of the research topic and have similar characteristics. During the discussion the members influence each other by responding to ideas and comments of others (Hennink, 2007, pp. 4-6). A focus group is led by a moderator or the researcher who is actively encouraging and attentive to the group interaction (Barbour, 2007, p. 2).

Focus groups are in many items comparable with other qualitative methods. As in all empirical research methods, the process is roughly differentiated into three phases: selection of the research unit, data collection and analysis. Within these phases, it is mainly the fact that individuals are not consulted but groups and so the process is determined by the group activity. The main difference between focus groups and individual interviews lies in the planning phase. The researcher who decides to do the research with groups must be aware that this fact will lead to further consequences and has to be considered from the beginning (Bürki, 2000, p. 103).

The author decided to make focus groups, because a questionnaire would not give the possibility to have a deeper look at the wishes and needs. Another possibility was to make single interviews. For concerned persons it is very important to be in an environment where they feel save. A one to one session would probably remind them of a meeting with a doctor or other professional persons. The risk would be that they would not be as open minded as in a session where they feel comfortable and safe as well as supported by their own peer group. A focus group will enable them to discuss with other people who are diagnosed with schizophrenia and the moderator will lead the discussion and encourage them to speak if it is necessary. This fact was important for the group with clients, regarding the performance of the other two groups there were no such considerations. But the design has to be similar for all three groups and therefore these considerations were crucial for the decision in favour of focus groups.

Also very significant for the author was that comments of one participant may trigger other opinions and opinions of the other participants. These statements and opinions enable participants to reveal their own views and opinions. The strength of a group discussion is to
produce data and insights that would be less accessible without the interaction between the participants. Participants are able to reflect on other comments, and based on this reflection, refinement and justification they can react to the statements, which provide a deeper insight than a single interview (Hennink, 2007, p. 8).

The compilation of a focus group has to be specifically considered for each project. Depending on the objectives and the research question, but also regarding costs and time constraints, each focus group must be decided on the composition of the participants (Bürki, 2000, p. 105). The research question not only determines the design of the data collection it also influences the data analysis. The methods for survey and analysis have to be closely linked to the research question and not based on a fixed analysis method (Kuckartz, 2016, p. 24).

The process of these focus groups was specifically developed for this research question and ran in three phases, as shown in the table below. The first phase, selection of the research unit, started in June 2016. After the research question was formulated and the groups were determined, the semi-structured guideline was developed, in parallel, the recruitment of the participants started and the focus group meetings were planned for the end of September and the beginning October 2016. The three group meetings were performed (second phase) on the 21st of September with the professionals, on the 7th of October with the relatives and finally on the 10th of October with the clients. Directly afterwards the third phase started with the transcription of the audio documented focus group meetings. The other steps were performed from End of November 2016 till end of August 2017.
5.3.2 Design of the semi-structured guideline

The focus group meetings were held on the basis of a semi-structured guideline which was prepared for this purpose. All three focus group meetings were structured according to this guideline to compare and analyse the outcomes. Semi-structured guidelines can be used in interviews or group interviews. The guidelines provide a structure about the process and the subject matter of the meeting. It enables the researcher to get a deeper view into the topic. The meeting starts with an open formulated initial question, which enables the interviewed person to formulate a free answer. Prepared keep-up questions are useful to ensure that the researcher collects the correct material, they are useful when the discussion stops or to lead the discussion into a certain direction (Harrell & Bradley, 2009, p. 35).
The semi-structured guideline for this research was inspired by the appreciative interviews of the appreciative inquiry approach. These kind of questions are written to uncover who and what organizations are when they are at their best. The appreciative interviews were used as a template to discover wishes and needs of service users in Carinthia. Generally, they are structured with an introduction that leads into the topic and a set of sub-questions that explore different aspects of the topic. The structure is based on past, present and future. So called backward questions which come first and explore the past, the inward questions refer to the backwards questions and explore the meaning of high-point experiences and the consequences which are settled in the present. The forward questions typically come at the end and explore hope, dreams and wishes (Whiteney & Trosten-Bloom, 2010, pp. 227-233).

To find out the wishes and needs of clients, relatives and professionals for an outpatient treatment structure in Carinthia and to get a deeper insight in the subject matter the guideline was structured in six chapters and was designed for a two hour session with a twenty minutes break.

- Introduction
- Warming-up
- Part of Past and Present
- Break
- Part of Future
- Cool down
- Conclusion

The Introduction was the opening session in which the researcher introduced herself and explained the purpose of the focus group meeting, the structure and the formalities.

The Warming-up session was a short part in which the participants were asked to explain the current treatment structure in one or two words. It was conducted to get an insight into the present mood and attitude about the current outpatient treatment structure. The statements of the participants were documented on a flipchart paper.

The first main part was the open exploration in the part of past and present. The leading question was: “When you think about your experience with the outpatient structure in Carinthia, what are your thoughts about the situation?” the participants were asked to tell about their thoughts and personal experiences. The participants discussed their personal experiences, added statements to other opinions and discussed different statements. The task of the moderator was to guide through this subchapter and ask keep-up questions when the discussion stopped or questions for more detailed information.
This part was finalized with a **scaling of experiences**. The participants were asked to scale their experiences having discussed before. The scale ranged from zero to ten, where zero was a very positive experience and ten very negative. The task was to write down the statements on Post-its and pin them on the poster with the scale. The participants were allowed to work in pairs to reflect the mentioned experiences before. After they had finished the scale was summarized by the moderator and participants were asked for statements if a classification was not clear. After this very intensive subchapter there was a 20 minute break.

The second main part was the so called **“Part of Future”**. After the participants clarified the past and current situation they were asked to think about their future. The leading question was: “You fall into a ten-year sleep; when you wake up, there are services for people with mental health problems you have always dreamed of. Please tell me about your dream.” This descriptive question was developed to gather information about the wishes and needs of the participants. This subchapter again was an open exploration with additional keep-up questions if necessary.

The **Cool down** sequence summarized the “Part of Future”. The participants were asked to write a list with their wishes and needs and if possible to prioritize them. The list was documented on a flip chart paper.

The final sequence was the **conclusion**, the participants were finally asked to think about a positive word about the current treatment structure. The positive word at the end gives the participants a positively summarized ending. The positive words were again documented on a flipchart paper.

After this the moderator thanked for the participation and ended the meeting officially.

All three groups were conducted in German. The semi-structured guideline was translated in English by the author and is added in the attachment.

**5.3.3 Service user involvement**

The involvement of the clients was an important element of this thesis. In this thesis service users are the three groups consisting of clients, relatives and professionals. Clients as first users, for whom the services are planned and offered and who should benefit most, can evaluate the treatment structure out of a customer perspective. The relatives should benefit from the wellbeing of their family members who use the services, but also use the services for themselves. For them it is possible to describe the system from an indirect outsider position. The professionals primarily offer the services, they are in a constant exchange with clients and what's more, they have knowledge from their own working situation, they can
very well assess the services as experienced employees. All three perspectives together give a complete picture of the system and of the wishes and needs.

Wallcraft, Schrank & Amering (2009) sees the service user involvement as “an evolving and multi-faced area in mental health research that can occur at various stages in the research process and carry varying levels of influence.” In traditional research (without service user involvement) the researchers are seen as experts – they are the only keepers of knowledge, their design of research is based on their thoughts and previous knowledge, the interview their subjects and return to their lonely chambers to describe their findings, meanwhile the one with the experience wait for the final report. It is a traditional hierarchy of research that separates traditional researchers from those with real knowledge. The involvement of service users will improve the quality of health service. The services will be based on the knowledge of people who have personal experiences with the illness and the recovery. They know what works and what does not based on a personal expertise and give clear advice during the planning, implementation and evaluation of research and projects.

The service user involvement in a research or project is outlined in the Ottawa Charter (WHO, 1986)

“The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health”.

This vision should be implemented in every future mental health project to enable all people with a mental illness to achieve their ideal health potential. This is not possible unless they have a codetermination by projects, decisions, services which concern them. Service user involvement starts with the access to information for opportunities, for making health self–determined decisions and goes to an equal partnership with decision-makers (WHO, 1986).

The service user involvement itself is seen by Wallcraft et al. (2009, p. 27) as a continuum from low to high involvement. On this continuum, there are three items “consultation”, “collaboration” and “control”. The boundaries between these three elements are fluent and not fixed.

- **Consultation** is seen when the researcher consults people and asks them about their views and opinions according a subject matter. The power of decision making is held by the researcher.
• At the level **collaboration** the power is shared between the researcher and the service users, it is defined as an active ongoing partnership between the service users and the researcher / project planner.

• **Control** or user controlled research is the highest level of the continuum, the power is held by the service users (Wallcraft, et al., 2009, p. 27).

The focus groups for this thesis are settled on the level of consultation. The aim of consultation is to bring the service user perspective into the research process. From the three items of service user involvement consultation is the level with the least involvement. During consultations service users are invited to participate in discussion groups, workshops, interviews, visits, written feedback or other forms of data collecting by researchers. The power is held by the researcher and service users are invited to comment on the research (Wallcraft, et al., 2009, p. 28).

Although it is the form with the least involvement, it marks a starting point and it can lead to a change of service planning. Furthermore, it is an easy way to acclimatize the researcher with a new way of working and it is also possible for researchers with less experience. It is a step to make research accessible to the service users. Service users have a high amount of experience, expertise and knowledge, the involvement of this information would lead to an improvement of future mental health plans and it will increase the self-esteem and confidence of service users (Wallcraft, et al., 2009, pp. 159-161).

Wallcraft et al. (2009) describes consultation as the lowest level of involvement, but they also explain that it is an effective tool to change mental health services and structures. To researchers who involve service users in their research or project within a consultation, it is recommended to do the consultation as early as possible in the research process and also to provide opportunities for deliberation and discussion for the participants during the process. After the research or project is finished it the researcher should give feedback to the participants.

### 5.3.4 Planning, recruitment and performance of the focus groups

Mostly the focus groups were based on homogenous groups, people with a similar background will influence the group process positively and the discussion will run more fluently because cultural or hierarchical barriers do not exist. A focus group with six – to eight participants allows enough speaking time for each participant and a certain group dynamic will occur. If more than eight participants are involved in the group, the speaking time for each one will decrease, but there will be more diversity in opinion. Bigger groups
are more difficult to moderate, because non interested participants will break away and side dialogues can emerge. If there are less than six participants there is a risk that no group process will occur. It is also strong risk that a rollout will emerge which affects the output. Smaller groups work best if the interest in the subject matter is very high, the participants are equal and respect each other and the moderator is interested in individual opinions. (Bürki, 2000, p. 105).

The people who were asked to participate for this research were people who were diagnosed with schizophrenia and have experiences with the outpatient treatment structure of Carinthia, relatives of people with diagnosed schizophrenia and the professionals who worked in an outpatient treatment facility for more than one year. During this thesis the groups were named “clients”, “relatives” and “professionals”.

The three different groups were selected according to the “Trilogy” movement. “Trilogy” means – in the context of social psychiatry – the consequent and equal inclusion of experts, relatives and professionals in the treatment, teaching, research, counselling and support as well as public relations, quality assurance and planning of psychiatry related issues (Clausen & Eichenbrenner, 2016).

The strength of the trilogy lies in the consideration of a mental crisis as a phenomenon that means, it comprehends the crisis as a human experience and takes it seriously in its different phenomena. It is striving for a common understanding of mental crises and irritating disturbances, which can be linked to the loss of orientation, trust, language and much more. It is also striving for a process of jointly negotiating the prerequisites and needs of treatments. The trialogic principle aims at replacing the reductionist perspective on diagnosis, disease concepts, and auxiliary systems in favour of a real need and subject orientation in everyday treatment and care as well as in the orientation of research and teaching. Only by including all three perspectives can we speak of a democratization of the psychiatric landscape (Clausen & Eichenbrenner, 2016).

Although group members may stimulate each other in the discussion, there is a risk that some participants may dominate the discussion (Hennink, 2007, p. 9). To prevent this risk the moderator must have a closer look at the group and ask more silent participants for their opinion and encourage them to take part in the discussion, so that every member of the group gets the chance to contribute to the discussion. In other situations it also can happen that the participants agree with each other because of a social pressure (Hennink, 2007, p. 9).
For the author it was important to have all three perspectives. Together, they give a complete picture of how the mental health outpatient treatment in Carinthia should be innovated. However, because of the possibility of social pressure and the homogeneity of the groups the author decided to appoint the focus groups separately and combine the three perspectives during the analysis process. So it was also possible to learn something from the different perspectives of the groups and compare them with each other. Same wishes could be based on different backgrounds and reasons in the separated groups; it could be easier to go further detail than in a mixed group. Three individual appointments were made with clients, professionals and relatives. To let every group among its own peers, this also ensures the group homogeneity.

All group meetings were held according to the developed semi-structured guideline and have been documented via audio recording. The participants agreed with their signature that the group discussions were recorded and the author was authorized to transcript the discussions. For further use the texts were anonymised and released in this form by the participants for further processing.

On the next pages the recruitment of the participants and the performance of the groups in order of the performance will be explained.

**Focus group professionals (FGP)**

The first group that gathered was the groups with the professionals. Seven professionals from different outpatient services participated in this group on the 21st September 2016 from 18:00 to 20:15 within a 20 minutes break.

The recruitment started at the beginning of August. First, the author wrote e-mails to different providers of outpatient services in Carinthia. The e-mails were send to pro mente Kärnten, AVS, the emergency and crises service of Klagenfurt, the association of providers for CPSRs and to one independent CPSR (no member of the association). One week later the written organizations were contacted via telephone.

Pro mente Kärnten was very interested and invited the author to an internal meeting with their staff and the spokesman and spokeswomen of the Carinthian empowerment movement. In this meeting, the author was able to specify the request and to tell about the structure of the focus groups. The head of the Day Care Centre in Villach offered her help in the organization of the client group. The head of the emergency and crises service was also very willing to participate; she also helped to arrange a place for the appointment.
No contact was possible with the AVS and the spokespersons from the association of providers for CPSRs told me via his assistant, that there would be no possible appointment till the end of the year. The head of the independent CPSR was delighted that she was asked and directly agreed to take part in the meeting.

For the appointment seven persons agreed to take part in the focus group. The head of the emergency and crisis service and one of her team members. The head of the CPSR which is settled in the district of Völkermarkt, and four persons of pro mente Kärnten, the head of the Day Care Centre Villach, the head of the CPSR in the district Wolfsberg and two members of the team from the social therapeutic rehabilitation “House Landskron”. Each participant has more than ten years of experience in the field of outpatient treatment, the minimum criteria for this group was one year of experience within the field of outpatient treatment.

The appointment was placed in the evening and the place was at the occupational therapeutic room of ward seven at the Klinikum Klagenfurt, department of psychiatry and psychotherapy. The meeting started with an introduction of the request to the focus group and a self-introduction of the author. After the warming-up of the group the author decided to ask the participants for a self-introduction, because not all participants knew each other and for an ongoing discussion, it was helpful for the participants to know about each other’s work fields and helped to build up trust.

During all parts of the meeting the professionals discussed with each other in a very engaged way. The task as a moderator was to give the meeting a structure according the semi-structured guideline and sometimes to ask for more detailed information, but in the cause of time there was less interruption necessary by the moderator. It was also not necessary to motivate individual participants, the professionals were very interested in each other’s point of view and the discussion was very fluent.

**Focus group relatives (FGR)**

The second group which took place was the group with four relatives. The meeting was held on the 7th of October 2017 from 14:00 to 16:30 with a 20 minutes break.

The four relatives were women, their sons are suffering from schizophrenia. The participants have between five and twenty years of experience and all came from the provision region West Carinthia.
The recruitment was organized after a mail contact with the spokeswoman of the association HPE (Help for relatives of people with mental health problems). After two more telephone calls in which the requests and some details were clarified, the spokesperson agreed to invite some of the members of the association. The criteria for this group were minimum five years’ experience with the outpatient treatment system on the basis of schizophrenic illness of their relatives.

The meeting took place in Villach in a meeting room of the Carinthian University of Applied Science. The atmosphere was full of expectation at the beginning; the relatives had no ideas about what would happen during the group meeting. The details were discussed with the spokesperson but she did not share them in detail with the other participants. Because of this fact, the introduction was more detailed than in the other focus groups. Also the part of past and present was longer than in the other groups. Each of the participants decided to tell their live story from the point when the illnesses of their sons started. During this sequence the ladies more or less held a kind of narrative monologue, interrupted by some questions of the others. The future part after the break was an intensive discussion with many positive and negative examples.

The task of the moderator lies in guiding the meeting and hold up the structure of the semi-structured guideline. Although this group with only four participants was the smallest, all four participants were very interested in the subject matter and they respected each other. It was not necessary to interrupt the discussion or lead them in another direction. The group only consisted of four women, but their openness and personal experience were very impressive, so the group only with four participants was as fruitful as the other groups.

**Focus group clients (FGC)**

The focus group with nine clients took place on the 10th of October 2016 from 10:00 – 12:00 within a 20 minutes break.

The recruitment of the clients began at the end of August. The spokeswoman of the Carinthian empowerment movement was contacted by e-mail. She agreed to speak with other concerned persons of her treatment groups. During the recruitment of professionals, pro mente Kärnten invited the author to a meeting with professionals and spokesmen and spokespersons of the empowerment movement. In this meeting the author clarified the request and the process of the groups. The speakers of the empowerment movement and the professionals carried the request to other people with diagnosed schizophrenia. The clients of the Day Care Centre in Villach were interested to take part in the group. Also the
spokeswoman of the empowerment movement in Wolfsberg wanted to participate. The appointment was arranged with the spokeswoman of the Day Care Centre in Villach. She invited and motivated other clients. The criteria to take part in the group were a diagnosed schizophrenic disease and experience with the outpatient treatment structure. The spokeswoman also integrated the individual health state of the participants. She looked for participants who had a stable health state so that the group would not be interrupted by uncontrolled motoric behaviour or other symptoms of a crisis.

The group took place in a separate room of the Day Care Centre in Villach, nine clients, 4 men and 5 women participated voluntarily in the group. Two of the participants were only present half of the focus group meeting. One from the beginning to the break, she apologized for having an appointment with her doctor and the second participant who took part only during the second half after the break. Throughout the whole time, the focus group consisted of eight participants.

The atmosphere was a little bit tense in the beginning, but the author received a warm welcome. After an explanation about the request and the icebreaker session, the tension was gone and the clients were fully involved in the situation. Each of the client was delighted to contribute his/her experiences to the subject matter. They also discussed their wishes in advance and they prepared a list. This list was presented by the spokesperson and was commented and discussed by the participants.

The situation that the clients in this context were perceived as experts was new for many of the clients, an open and truly free speech was possible when the clients build confidence to the moderator, which came up after the ice breaker session. The part with the evaluation and assessment of experience was considered difficult by clients. To make an assessment was a new and challenging situation for them.

The challenge of moderation was the unconscious expectation of the participants that the moderator was an expert. In the course of the meeting it was necessary to change the role from moderation to a teaching in order to explain either a concept or facts or to call the participants to order when to many side discussions arose.
5.4 Process of analysing the focus groups

To analyse the focus group meetings the author chose a structuring qualitative content analysis according to Udo Kuckartz, who also supervised the F4 analysis program which was used by the author. The qualitative content analysis is a popular qualitative analysis method that can be applied in different research contexts. Because of its different interpretation techniques, but also because of its possibility of inductive and deductive approach, it is flexible and allows the processing of various questions. The aim of the content analysis is to filter a structure out of the material, which could be formal or content related aspects or a certain type. This form of analysis is based on the created category system and defines which text components fall under one category in a step of defining categories. (Kuckartz, 2016, p. 97).

Kuckartz (2016, p. 100) defined seven steps for the process of the structured qualitative content analysis:

1. Initiating text work reading and re-reading, marking important text, writing memos
2. Development of thematic main categories
3. Coding the whole material with the main categories
4. Assembling all texts encoded with the same main categories
5. Inductively determining subcategories on the material
6. Coding the complete material with the differentiated category system
7. Simple and complex analyses and visualisations

Figure 4: Process of a structured qualitative content analysis (according Kuckartz, 2016, p. 100)
Initiating text work - reading and re-reading, marking important text passages, writing memos

After the focus group meetings were performed the audio tapes were transferred with the F4 transcription program to a word by word transcript. Each focus group meeting resulted in two audio tapes. The first one before the break and the second one after the break, so the session after the break started again with the minute zero. To keep them apart the author named them as follows: FGP I / FGP II, FGR I / FGR II and FGC I / FGC II. The names were taken over by the F4 analysis program, and each text section was specified with these names and the paragraph number (e.g. Transkript/transcript FGC I, Absatz/paragraph 154 – This text section is the paragraph number 154 part of the transcript of the clients before the break). The FGP consisted of 49 text pages, the FGR of 46 pages and the FGC of 38 pages.

The Participants were abbreviated in the transcript with the letter P and a Number, the Numbers 01-07 were assigned to the group of professionals, the Numbers 08 – 11 named the participants of the focus group with relatives and the numbers 12 – 20 were allocated to the clients. The letter M was assigned for the moderator. The consecutive numbering was done to identify each participant in the whole material, e.g. P11 was Participant 11 and belonged to the group of relatives.

The transcripts were written in the individual dialect of each person, this dialect has its own grammatical rules; to transfer it in a standard German version would lead to a distortion of meanings and statements. In order to prevent this, the author declined to transfer it to standard German, also because later parts of the analyses were done in English and there could be a slight distortion regarding this fact.

After the transcription and anonymizing was finished the transcripts were send to the participants so they could approve to the transcript. All participants gave the permission to use the transcripts for further analysis. The text was read and re-read by the author and three friends of the author who are not involved in this research field or the mental health care system. The neutral position of the three friends gave an outsider perspective, they helped the author (who also worked 15 years as a professional in the system of mental health) to find new suggestions in the text which maybe otherwise would have been lost, because of the strong involvement of the researcher into the subject matter.
All four persons made memos and marked important sections of the texts. The intensive examination of the texts on the basis of the research question provided a first basic understanding of the wishes and needs of the participants. In a meeting the personal experience of the readers were exchanged. The similarities and differences of the groups were discussed and due to this process the author was able to get a neutral position for the further analysis process.

**Development of thematic main categories**

As a main point of the focus group meetings the participants were asked to prioritize their wishes and needs and write them down on a flipchart paper. By the initial text work it was recognizable that these wishes and needs were discussed from the participants at different times. So the author decided to take these wishes and needs as first main categories, because of the three different groups each group had their own main categories and the individual transcript was coded with the associated main categories. The first analysis with the individual transcripts also serves to answer the research question 1-3.

**Focus group professional:**

0. Networking / Information
1. Individuality / person centred treatment and work
2. Mental health education
   a. Public relation
   b. Start when children have their first social contacts
3. Low-threshold service
   a. Empowerment
   b. Self-help Groups of concerned people
4. Compulsory internship for policy maker
5. Welfare for employees
6. Social equity for all

*Figure 5: Poster - wishes and needs professionals (FGP, 21.09.2016)*
Focus group relatives:

- part time work, hour based work
  - nearby
  - in every municipality
- integration into society
- assisted living
  - also for young people
- more speaking therapy and psychotherapy paid by the health insurance
  - speaking therapy at home
- Treatment structure in all provinces
- Motivation towards health promotion and recreational activities
- More financial resources for recreational activities (vacancy, excursions, sports…)
- More appreciation, acceptance and information/education for/about mental diseases
  - Prevent stigmatisation

Focus group clients:

1. Immediate aid in situations of mental crises
2. Confidence and equity
3. Payed hour based working options
4. Mental health promotion
   a. As school subject
   b. Public relation
5. Accepted with the whole personality
6. No more mental health diagnosis on the letter of referral
7. Research about specific treatment (blood tests)
Coding the whole material with the main categories

The first coding process (or first analysis) was designed in a way that the transcripts of the focus group meetings were individually edited. In doing so each focus group transcript was further processed with its respective main categories. For wishes and needs which were not prioritised by the participants the author added an additional category named “other wishes”.

The text was sequentially edited line by line from beginning to end. For each section of text the author decided to which category it was assigned. Text sections which were not relevant for the research question remained encoded. In cases where a text section contained several topics, it was assigned to more than one category. The process of first categorising was done with the F4 Analyse program.

Assembling all the texts encoded with the same categories

Inductively determining subcategories on the material

The step of assembling all the texts encoded with the same categories and the step of inductively determining subcategories on the material were done in parallel. This decision was made because the F4 Analyse program allows the individual display of the categories. With the tool it was possible to prove if the text section was assigned correctly and to identify the contents of the categories by reading and re-reading to develop inductive subcategories. After this step the categories were exported from the F4 analysis program to a word document. Thereby the program endorsed each text section with the before given paragraph number. The text sections were arranged in a table. The material was very comprehensive, so the author decided to paraphrase every text section. In doing so, the central contents of the text passages were elaborated and reworded.

To get a better overview of the whole material the author made posters before she did the next step. Therefore all paraphrases (inclusive the paragraph number) were printed and arranged on three posters (each group one poster). The paragraphs were now arranged for each group and each category to the scheme: wish – cause of wish – additional background of the wish. The overview made it possible to have a closer look on similar desires between the groups.

Till this moment the main categories for each group were separated, because each group found different names for their wishes. It was also possible to find the individual wishes and needs of the groups and to summarize them to answer the research question 1-3.
In the next step, the material and categories of the three groups were compared with each other to find similar categories by content and standardize the name of the categories across all three groups.

Table 8: Main and sub-categories of the individual focus groups

<table>
<thead>
<tr>
<th>FGPE</th>
<th>FGR</th>
<th>FGC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Networking / information a. general b. between outpatient facilities c. between inpatient and outpatient facilities</td>
<td>Possibilities to work o in every municipality o part time work, hour based work</td>
<td>Immediate aid in situations of mental crisis</td>
</tr>
<tr>
<td>1. Individuality / person centred treatment and work a. treatment b. easy-accessible services c. shared apartments d. work</td>
<td>Integration in to the society</td>
<td>Confidence and equity</td>
</tr>
<tr>
<td>2. Mental health education a. Public Relation b. Start when children have their first social contacts</td>
<td>Assisted living o also for young people</td>
<td>Paid hour based working options</td>
</tr>
<tr>
<td>3. Empowerment</td>
<td>More speaking therapy and psychotherapy paid by the health insurance o and speaking therapy at home</td>
<td>Mental health promotion a. as school subject b. Public Relation</td>
</tr>
<tr>
<td>4. Compulsory internship for policy maker</td>
<td>Treatment structure in all provinces</td>
<td>Accepted with the whole personality</td>
</tr>
<tr>
<td>5. Welfare for employees</td>
<td>Motivation to wards health promotion and recreational activities</td>
<td>No more mental health diagnosis on the letter of referral</td>
</tr>
<tr>
<td>6. Social equity a. Social equity for all b. No diagnoses on the letter of referral</td>
<td>More financial resources for recreational activities (vacancy, excursions, sports…)</td>
<td>Research about specific treatment (blood tests)</td>
</tr>
<tr>
<td>/ Other wishes a. Wishes concerned relatives</td>
<td>More appreciation, acceptance and information in education farabout mental diseases o Prevent stigmatization</td>
<td>Other wishes a. Closed ward – hospital Wilach b. Animals c. Shared apartment d. Day Care Centre</td>
</tr>
</tbody>
</table>

The contents of the coloured categories of each group were similar wishes; based on these contents new main categories and subcategories (seen in the table below) were developed.

Table 9: Overall main and sub-categories of the focus groups

<table>
<thead>
<tr>
<th>Destigmatisation</th>
<th>Work</th>
<th>Improvement of the treatment structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition and respect for individuals</td>
<td>Hourly work – part time – close to home</td>
<td>Empowerment – Free Choice – Self-Determination</td>
</tr>
<tr>
<td>Public Relations</td>
<td>Financial basic security and Possibility to work</td>
<td>Easy accessible services</td>
</tr>
<tr>
<td>Mental health education</td>
<td></td>
<td>Individual treatment and combination of different services</td>
</tr>
<tr>
<td>Mental health diagnosis on the letter of referral</td>
<td></td>
<td>Assisted living</td>
</tr>
<tr>
<td>Equity of disease</td>
<td></td>
<td>Rural treatment structure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid psychotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More time with physicians</td>
</tr>
</tbody>
</table>
Coding the complete material with the differentiated category system

The whole material was coded again with the new categories. This step is named second analysis by the author. Therefore the process was similar to the first coding. Text sections were assorted to the codes, therefore all three transcripts were used. Text sections which were not relevant for the categories remained encoded. In case a text section contained several topics, it was assigned to more than one category. After all text sections were assorted or remained encoded the whole category system was exported to a word document. As during the first coding process the text sections were organized in a table with three columns, text section, paragraph number and paraphrase. Each text section was paraphrased.

Till this moment the whole process was done in German language. The last section “simple and complex analysis” was done in English.

Simple and complex analysis and visualizations

In this section, the first step was to summarize each subcategory, in the second step these summaries will be used to find connections within a main category and between the main categories. Finally, a conclusion according the three research questions based on the first analysis process will be done. The fourth research question will be answered according to the second analysis.

5.5 Limitation

The design of this research was planned and performed very carefully, although various possibilities that could have a negative impact on the results were included right from the beginning of the planning, some effects during the performance could distort the results. In this chapter the author will discuss the discovered limitations.

The chapter "Current treatment structure for persons with schizophrenia in the mental health care in Carinthia" was compiled with data from webpages (associations, medical chamber Carinthia, insurance company...) and reports of these webpages. This was done to verify which information is accessible for service users. This picture is maybe not a complete picture, it could be that some information are too old, for example, one psychiatrist is already retired and there is no successor in the doctor’s office, but the information is still on the webpage. It is also possible that isolated services are not represented on the internet. So
the individual numbers of facilities, doctors and psychiatrists could slightly differ from official numbers of the government.

The second limitation, which could distort the results, are based on the recruitment of the participations in the groups of clients and the groups of relatives. Both groups were formed with volunteers with the help of a representative of the groups, this leads to a reduction of the author’s influence to form the groups.

The group of relatives were formed by the spokeswoman of the association HPE. She motivated three members of the association to participate in the meeting. All four women were mothers of sons and live in the provision region Carinthia West. They were very active during the last years to improve the mental health structure in the provision region Carinthia West, so their main request was to tell me about the situation in this region. Also the fact that in this group only mothers were involved could influence the result. Mothers are more likely to protect their sons, they will support their sons even when others already gave up. Maybe this emotional effect and the aspect of the region Carinthia West would not be so strong if this group had also involved people of the central area of Carinthia and other relatives like fathers or siblings. However, the existence of this group was very important for this thesis and this slight distortion must be in mind when the individual wishes and needs of relatives are considered.

The group of clients was formed by the spokeswoman of the empowerment movement Villach which is based in the Day Care Centre Villach. She recruited clients of the Day Care Centre and integrated the individual health state of the participants in the allocation. That leads to the fact that all participants had a very stable health status and they all lived independently in their own apartments. People who live in a CPSR were not involved in the group. Eight of the nine participants live in Villach, only one participant was from Wolfsberg, so these wishes and needs were mostly influenced by the perspective of the clients of the Day Care Centre Villach, again mostly the perspective of the provision region Carinthia West was considered. During the discussion the clients also discussed only two important health states, the acute state and the health state when they feel well, the time in between was not mentioned by them and there were also no wishes or needs connected to this time period. This composition of the group could lead to a distortion of the results when the individual wishes and needs of clients were considered.

The two limitations of the group composition will not influence the overall result of the thesis, therefore all three groups were analysed together. The consideration of all three groups had
the effect that the strong individual wishes and needs faded into the background and the similarities of the groups received a considerable emphasis.

The specific wishes of the groups which were not included in the overall analysis can be viewed in the attachment.
6. Analysis and results of the focus groups

The analysis of the focus groups were done to find out about the wishes and needs of people with a diagnosed schizophrenia within the mental health outpatient treatment in Carinthia to live self-determined and satisfied lives. Therefore, three focus groups with service users were planned and conducted. First-degree service users are the people diagnosed with chronic schizophrenia, for these groups the services are planned and they should benefit from the services and facilities. Relatives of people diagnosed with chronic schizophrenia are also service users, they benefit from the wellbeing of their family members, but also use the services for themselves. The third group are the professionals, they are of course service providers, but as employees’ users of the facilities and in this way also users. Professionals stay in a constant exchange with clients and benefit from the experience with people with a diagnosed schizophrenia. They have a good knowledge about the current structure and see when the personal needs of the clients cannot be met.

In this chapter the author tries to answer the four research questions

1. What are the wishes and needs of people diagnosed with schizophrenia for a mental health outpatient treatment structure in Carinthia?
2. What are the wishes and needs of relatives of people diagnosed with schizophrenia for a mental health outpatient treatment structure in Carinthia?
3. What are the wishes and needs of professionals working in the mental health outpatient structure for people diagnosed with schizophrenia in order to improve the services and structure?
4. What kind of treatment structures and support do people with diagnosed schizophrenia need to have self-determined and satisfied lives?

6.1 Wishes and needs of clients, relatives and professionals

The questions one to three can be answered with the first analysis of the focus groups. In order to do so, the transcripts of the individual group meetings were categorized, analysed and implemented in this chapter in a summarized form. To answer the fourth question the contents of all three focus groups have to be involved in the analysis. The question will be answered at the end of this chapter.
6.1.1 Clients

What are the wishes and needs of people diagnosed with schizophrenia for a mental health outpatient treatment structure in Carinthia?

According to the wishes and needs clients articulated during the focus group meetings, it could be resumed that they are content with the current structure. They are afraid of a reduction of the existing services and they request these services to be financially protected. Day Care Centres and Home Care are essential services for them. With these services it is possible for them to create their individual lives, they get support from professionals, recommendations and help with daily activities and in the Day Care Centre and they establish a social network with like-minded people.

Their overall wish rather is focused on their treatment within the mental health care system and in society. For them it is very important to be seen as humans and to be treated with respect and trust, even during acute crises; to be involved in decisions about their treatments and plans for their future lifestyles; they consider this to be their right and they demand to be heard by their physicians and therapists. Their wishes should be taken seriously and planned and established together with them.

Regarding the treatment structure they need more psychiatrists where they get short-dated appointments on a regular basis. During the appointment the psychiatrists should have time for them and meet their needs. The possibility to get more appointments with psychotherapists paid by the insurance company should be provided. Psychotherapists for them are persons with whom they can discuss their deepest and private problems, a counsellor who listens to them and works on their problems together with them.

They do not only want to live, they want to create their lives, independently, as respected persons and full members of society.
6.1.2 Relatives

What are the wishes and needs of relatives of people diagnosed with schizophrenia for a mental health outpatient treatment structure in Carinthia?

The group of relatives show a different picture, they were able to reflect the treatment gaps and articulated them during the meeting. Their wish is that their family members can create independent and self-determined lives and therefore the treatment structure has to improve towards more individuality.

For them the services and working options close to the home of their family members are very important. The argued it about the importance of the existing social networks of their sons. Depending on their live stories, they often had to watch their sons leave their environment to get the appropriate treatment and every time they had to leave, they lost the contact to their friends and social environment. To prevent this breach they ask for services in all provinces of Carinthia. The best options would be community based services where the people will be integrated in the community life.

For relatives Home Care is a very important service, the possibility to get treatment in the familiar environment motivates the person with diagnosed schizophrenia and supports the family. This provides more understanding within the family. Speaking therapy is seen as crucially essential also in this group, it motivates the family members towards health promotion and supports the people to handle their problems by themselves. Therefore, they ask for more offers with regard to psychotherapy paid by insurances.

The possibility to work and earn money for people with diagnosed schizophrenia is an aspect that gives them self-esteem and hope, they fell more valuable and get the feeling to be respected by society. Relatives could watch this process in their sons, it was not always possible to keep the work, but when the sons were part of such a working process, the relatives got the feeling that their sons where happy. More working options like projects should be implemented to promote this positive experience.

The group of relatives request that their sons to be accepted as full members of society in the future. The hope that with more community based treatments and the inclusion of people with diagnosed schizophrenia this will increase and that stigmatization and prejudice will decrease.
6.1.3 Professionals

What are the wishes and needs of professionals working in the mental health outpatient structure for people diagnosed with schizophrenia in order to improve the services and structure?

Professionals find it essential to establish a more individual and person-centred treatment, this also includes people with diagnosed schizophrenia who need less support and more social closeness and recommendations.

People with diagnosed schizophrenia should be enabled towards independent living and self-determination. Therefore, treatment plans should be established adapted to the individual rhythm of these people; that means an abolition of time limits of services like in the House Landskron. Home care, assisted living and flat-shared communities could be intermediary steps on the way to independent living. Self-help groups will increase the empowerment and recovery of the clients and help people who need less support.

For professionals the networking between the outpatient facilities and with the hospital are very important as well. In this section, they see a lot of potential for improvement. Networking is important for target promotion of clients. A seamless therapy from the hospital to the outpatient facilities and to other facilities will improve the wellbeing of clients. Because of poor cooperation between these facilities relapses and acute crises can arise and cause the loss of their positive ongoing progress. Networking and cooperation must be improved in Carinthia to support the clients effectively and help them to create their individual lives.

6.2 Treatment structure and support for self-determined and satisfied lives

To answer the main research question; “What kinds of treatment structure and support do people with diagnosed schizophrenia need to have self-determined and satisfied lives?” the analyses were extended over the contents of all three groups.

This chapter starts with a summary of each subcategory according to the second coding process and the connections within a main category. Therefore the content-related categories with the corresponding text sections and paragraphs of the first analysis process were read and re-read. Based on these text sections and paragraphs, the three main
categories “Destigmatisation”, “Work” and “Improvement of the treatment structure” were defined. The subcategories were designed inductively according to the main categories.

In the table below you can see the three main categories with their subcategories and the number of text sections of each subcategory.

*Table 10: Main and sub-categories of the analysis of the focus groups with numbers of text sections*

<table>
<thead>
<tr>
<th>Destigmatisation</th>
<th>Work</th>
<th>Improvement of the treatment structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition and respect for individuals</td>
<td>Hourly work – part time – close to home</td>
<td>41 Empowerment – free choice – self-determination</td>
</tr>
<tr>
<td>Public Relations</td>
<td>Financial basic security and possibility to work</td>
<td>10 Easily-accessible services</td>
</tr>
<tr>
<td>Mental health education</td>
<td>Individual treatment and combination of different services</td>
<td>15</td>
</tr>
<tr>
<td>Mental health diagnosis on the letter of referral</td>
<td>Assisted living</td>
<td>15</td>
</tr>
<tr>
<td>Equity of disease</td>
<td>Community based services</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Paid psychotherapy</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>More time with physicians</td>
<td>13</td>
</tr>
</tbody>
</table>

After allocating the text sections to the subcategories and exporting the text sections to a word document, each text section was reduced to a paraphrase. These paraphrases were used to summarize each subcategory and afterwards the summaries were used to find connections within the main category. This way the author also took steps back to the transcript, the text sections and paraphrases.
6.2.1 Destigmatisation - summaries of the subcategories

In this section the subcategories “Recognition and respect for individuals”, “Public Relations”, “Mental health education”, “Mental health diagnosis on the letter of referral” and “Equity of disease” were explained and at the end of this section the connection of these subcategories will be shown.

Recognition and respect for the individuals

Mental illnesses is negative for society, people with a mental health problem are devalued and treated unequally. As a prejudice in society, it is considered that people with a mental health disease are stupid and following this prejudice, they are treated accordingly. This hinders people with a mental health problem from expressing wishes and needs both in society and within the therapeutic system. All three groups miss the respect for the individual person. A chronic schizophrenia is like every chronic disease; it can be integrated in life, and a strange person cannot recognize it at the first contact. The problems arise when the person must reveal himself/herself. The groups explained that the accompanying role as chronic patient will become a burden for the people with a diagnosed mental health problem. They are treated as second-class humans, have to wait longer for somatic medical treatments and their suggestions will no longer be recognized. As pensioned humans they also lose the possibility to be a productive member of society and so the society starts to ignore them.

A main problem is seen in the lack of knowledge about mental health diseases, people are afraid because this is unknown for them and so it is easier for them to expel people with a mental health problem from the society. All three groups want people with a mental illness to get recognized and be seen as full members of society, their wishes and needs should be respected, they should be seen as equal and their experiences and suggestions should be accepted.

Public Relation

A lack of knowledge in society leads to fear in society and this triggers exclusion and stigmatisation. Only people who are related to mental health problems like the clients themselves, professionals and relatives have knowledge and experience about mental health diseases. Through the illness, however, they experience exclusion by other people and the social interaction with neighbours, friends and family members’ changes. Especially negative reports of single incidents with a person having mental health problems in the public media, will disseminate a negative image about mental health diseases. This causes uncertainty and anxiety in people with mental health problems.
More educational advertising will reduce stigmatisation and promote acceptance and tolerance. Public relation is important for all age groups. Therefore, the groups asks for more positive public relation and educational advertising towards a positive human image. The media should report about incidents in a more sensitive and profound way. Politicians should come to open house days of facilities and talk to people with a mental health problem, if they do so they could benefit from the insights of people with a mental health problem. Finally, they wish for a more general information about mental health problems and not only about fashionable complaints like “Burn out”. Public media should also report about “hard” diagnoses like schizophrenia, manic depression and others.

**Mental health education**

Mental health education is seen as an important aspect for the future. Children should learn as early as possible what mental health problems are, how to prevent them and how to interact with people having a mental health problem. At the moment there is a lack of knowledge about mental health problems in society. A person learns only about this aspect when he/she is involved in the system no matter if he/she is a professional, a relative or a person with the mental health problem. Others have less knowledge, consequently they do not know how to interact with this aspect of life.

The groups demand a school subject for mental health, this subject should be implemented as early as possible. Wellbeing could be learned at the age of four to five, based on this knowledge more and more mental health information could be taught. Additionally, some field trips could be done to deepen the knowledge. Information in schools should be improved as these mental health diseases will also affect children in the future. The general knowledge about mental health could lead to an early detection of diseases and, on the other hand, set the level of interaction with people with a mental health problem on a level.

**Mental health diagnosis on the letter of referral**

Psychiatric diagnosis on the letter of referral should improve the networking between facilities and lead to an adequate treatment of people diagnosed with a mental health disease. The experience of the group shows a different picture. Mental health diagnosis on the letter of referral lead to prejudice in the sector of physical health care. This fact is especially hard, because the treatment and interaction in this sector should be equal for all people. It leads to the fact that the focus of the treatment lies not on the physical illness only, e.g.

“P04: You go to the hospital with a client of the CPSR, he is addressed in an informal way, he can wait for a long time, he is not taken seriously, because he is not asked
for the reason of their coming, they ask me for the reason of his coming (Transcript FGP I, paragraph 84)."²

This behaviour is not a single incident it is nearly a common behaviour, some doctors are even so afraid of treating people with mental health problems that they demand the facilities to send an accompanying person although the person with the mental health problem doesn’t need one. The groups think that the mental health diagnosis on the letter of referral leads to a situation in which the person is not taken seriously anymore, they miss the respect and recognition of the person and they have the feeling that they are treated in a rush by the professionals of the physical sector. Their idea to prevent these situations is not to use mental health diagnosis on a letter of referral basis outside the mental health sector. Thus the professionals have the chance to get to know the person without a prejudice.

**Equity of diseases**

The experience with the mental health diagnosis on the letter of referral leads the participants to the perception that physical diseases and mental diseases are not equal. It is an aspect that cannot be ignored, and as long as this circumstance exists, clients will always be discriminated against. Therefore, the groups demands an equity of diseases. They want the same treatment for the same diagnosis and an equal access to these services.

**Conclusion of the main category – Destigmatisation**

Destigmatisation was an overall category in all three focus groups. Clients, relatives and professionals could see and feel the stigmatisation of people with a diagnosed schizophrenia. Mental health diseases were seen as second-class diseases within society, so much for the experience of the three groups. The general knowledge about these diseases are almost non-existent in the population. The participants of the focus groups see this fact as the reason for the stigmatisation of people diagnosed with a mental health disease, which in further consequence leads to discrimination and a less favourable treatment in the sector of physical health care.

All three groups wanted more recognition and respect for the individuals. Regardless of the membership of the group everyone came to the suggestion that mental health education and effective public relations would increase the knowledge about mental health disease. These interventions will lead to more respect and will reduce the distance of society to

² Original source: Transkript FGP I, Absatz 84, P04: Du gehst mit an Klienten aus dem ZPSR ins Krankenhaus, er wird per du angeredet, er kann ewig sitzen, er wird nit ernst genommen, weil es wird nicht der Klient gefragt warum er da is, i wer gfragt warum er da is.
people diagnosed with a mental health disease, especially to people diagnosed with schizophrenia. The abolition of psychiatric diagnoses on the letter of referrals and the equity of physical and psychiatric diseases would decrease stigmatisation in the sector of physical health care, so much for the opinion of the groups.

People diagnosed with schizophrenia, relatives and professionals want that in the future people with a diagnosed mental health disease to be treated equally and with respect and the interaction with them should be set on an equal level.

6.2.2 Work - summaries of the subcategories

In this section the subcategories “Hourly work – Part-time and close to home” and “Financial basic security and possibility to work” were explained and at the end of this section the connection of these subcategories will be shown.

Hourly work – Part-time and close to home

People diagnosed with schizophrenia can assess their resilience very well, they know that it is not possible for them to work in a full-time job. However, work or occupation for them is important. They feel more valuable through the occupation and that can raise their self-esteem. Even if they aware that the work is not always manageable for them, they would like to have a chance to try. It is clear to them that work will not prevent them from an acute crisis, but it helps to find a sense in life and to work harder towards the recovery. A two to three hour job per week would be very important for the clients, it would be possible to meet other people outside the protected environment and to prove themselves. These kind of jobs are very rare and hard to find for clients.

The Work-Training-Centre is seen critically, because there is no interaction with people outside the sector of mental health care. The Day Care Centre provides small jobs paid with a pocket money, but is also within the protected environment. The only possibility is in the laundry of the Klinikum in Klagenfurt, in the others cities such a possibility is not available. Sometimes it is possible to work in a work project, but these projects are sometimes a long distance from the place of residence away. Thus, the people have long travel roads and hard working days, in the long run such a project is not manageable for them. They need time to rest between the work and so all groups agree that people with schizophrenia need jobs with less hours and within a short distance from the place of their residence. They wish companies would create such working possibilities, a job in a copy-shop, in a boutique or grocery were they refill the empty shelves could be such options. For people who need a protected environment, small working projects like gardening projects, where they can help
when they want, could be a solution. Volunteer jobs also give the people recognition and self-esteem, but it would be nice when there is a possibility to get a financial recognition too.

Financial basic security and possibility to work
People would like to work and although it would be manageable for them it is only possible if they accept a financial loss. Most of the clients receive a disability pension of around €400. Additionally, they get an equalisation supplement of about €400. So together with a rent subsidy and prescription remission it is possible for them to finance a self-determined life. If they work in a mini-job (maximum payment €425) they will lose the equalisation supplement and maybe also the rent subsidy and other remissions. In the end they will pay more for the job than they will earn. Some of the clients tried it, but were frustrated, because they thought that they were punished for their engagement. The groups really wish for an option of financial basic security and the possibility to earn some additional money. People would like to work in order to get recognition, feel valuable and increase their self-esteem, but in the current situation it is very difficult for them by bureaucratic hurdles.

Conclusion of the main category – Work
Occupation or work is seen as an integral part of life, also people diagnosed with schizophrenia yearn for a job and the possibility to feel more valuable and increase their self-esteem. It should be possible to get a mini-job on the regular labour market. Full-time work is hard to manage for people diagnosed with schizophrenia, mini-jobs would be a possible alternative for them. At the moment mini-jobs are hard to become, the labour market doesn’t promote such jobs and even when there is such a job financial rules according to the disability pension will punish the engagement. Mini-jobs also should be close to the place of residence as the relation between the travel time and the working time should be balanced. Working in regular jobs also promotes the integration of people diagnosed with schizophrenia into society and clients really would like to build up a social network outside their protected environment.

All groups agree that regular employment positively affects the recovery and therefore opportunities should be created to integrate people with a diagnosed mental diseases back into the labour market.
6.2.3 Improvement of the treatment structure - summaries of the subcategories

In the following summaries the groups discussed some options to improve the given structure according to their wishes and needs. The subcategories "Empowerment – free choice – self-determination", "Easy-accessible services", "Individual treatment and combination of different services", "Assisted living", "Community based services", "Paid psychotherapy" and "More time with physicians" were explained and at the end of this section the connection of this subcategories will be shown.

Empowerment – free choice – self-determination
This category has the highest share of text sections with 45, and will be an important aspect in planning of services and facilities for the future.

The empowerment of clients’ increases, professionals and relatives could watch this process. More and more clients network with each other, they get to know each other in the hospital and facilities and stay in contact, and they share their knowledge about different treatments and give recommendations. They also are willing to support each other. The clients of the Day Care Centre Villach established a project to help each other in crises situation, therefore they go to the hospital and talk with the patients (see chapter “Recovery in Austria”).

People diagnosed with a mental disease are able and willing to choose their own care, but they are hindered by rigid structures such as the regional allocation to facilities, the allocation to CPSRs by the government, the financial regulations and limited knowledge of possible options. During years full of experience what happens when they try to protest against the system, they learned that it is better not to talk too loudly about wishes, needs or feelings. So the groups thinks that clients are directed by others. They want to have a self-determined and free choice for clients, but they are often not trusted. In the future the self-determination should be given back to the people with diagnosed mental health diseases. Clients should make their own decisions, support should only be given when they ask for it. The treatment, beginning in the hospital and ending in the outpatient sector, should lead to a self-determined life. The recovery must get individual. Therefore it must be accepted that clients have a different view on various aspects of life, if this perspectives are shared, in the future a relationship based on trust and respect could arise. Clients will be able to tell their wishes without fear for consequences and get the chance to take up the self-organisation for their lives, so much for the opinion of the participants of the focus groups.
Easy-accessible services

All groups agree that there is a lack of easy-accessible services, this means services for people who need support for daily living activities and a place where they can meet and talk about their problems, but they do not need a person who fixes the problem. They need recommendations, how to solve it by themselves. Such slight offers are not established and often also not possible for the existing facilities because of little time and human resources.

People who live in an own apartment often only need a motivating conversation with somebody they trust and it does not matter if this conversation is by telephone or face to face. People need to know where they can go if they are in need of help. Such possibilities could be given in form of more short visits by Home Care or meeting points for clients outside the given treatment structure e.g. a café for people with mental health problems regardless in which treatment structure they participate. A place where they can come and go when they want, speak with each other that also would strengthen the empowerment of clients, maybe the café could be managed by clients that would provide some jobs.

A different solution was introduced during the groups of professionals’ e.g.

“P05 We have a former resident in our CPSR who left the institution 2 years ago, he has regular contact to us. Yesterday he called and asked if he can come for one day, because he does not feel good. We have the offer for all our former residents, if the need help they can come to us and use the psychotherapy or other group activities of the house. Today he was here, he participated in the groups, met his friends and enjoyed the day. In the evening before I left the house to come to the meeting, he told me that he feels better now and can look positively to the near future. It was not a big effort to help him, maybe a call one time per month, and maybe all three months one day in the house.”

3 Original source: Transkript FGP I, Absatz 48, P05: Ja wir haben Bewohner, grad jetzt, heut is wieder ana kuman, der is schon vor zwa Jahr ausgetreten. Zudem haben wir regelmäßigen Kontakt und der hat auch das Angebot nach wie vor ins Haus zu kumen um eben die psychologischen Gespräche, die Alkoholnachbetreuungsgruppe und einfach die ganzen Angebote die wir im Haus haben anzunehmen. Und er hat gestern angerufen und hat ggsagt; es wieder so a Zeit, es passt irgendwie nit, er is so unstrukturiert es alles so a auf und ab ob er nit wieder kumen kennt. Und heut hat er wieder den ganzen Tag im Haus verbracht. und jetzt kurz bevor i herkommen bin, is a ghfahren und hat ggsagt, das hat ihm so guat getan. Er hat wieder Bekannte gesehen, das Team kennt er, wir haben kurz Gespräche geführt und er is einfach jetzt wieder, wieder so auf der Bahn. Und das san nit viel Ressourcen de ma braucht aber es jetzt wieder gefestigt und er wird sich sicher, er meldet sich dann amal im Monat und sagt es passt alles und vielleicht in drei Monat meldet er sich wieder und dann is wieder so a Tag und dann kann er das bei uns in Anspruch nehmen.
Independently living humans need a social structure where they feel safe and recognized, if such a network doesn’t exist they will use more expansive structures like the hospital, because they are afraid to be lonely. A reference person who they know from a former service provides an easy access, they trust such a person and overcoming the fear to ask this person is not as big as if they ask a strange person. With such a service many crises could be prevented and it saves money on a long run. Especially for people with a mental health disease it could be a big effort, such services give them safety and wellbeing, they can strengthen their empowerment and self-determination.

**Individual treatment and combination of different services**

At the moment there are only two options for people diagnosed with schizophrenia, to live independently in an own apartment in the city or the overall treatment in a CPSR in the rural area of Carinthia. An option in between is not offered. Although the groups are fine with the CPSR they are concerned about young adults because a treatment in a CPSR is not ideal for them. The treatment should be individual for the person, so a combination between this treatment structures is desired. Each person should be allowed to arrange the treatment according to his/hers wishes and needs to get the best possible benefit.

Facilities should be allowed to define their own care services, and this should be individually used by the people with mental health problems, like a person decides which restaurant he/she prefers. This way clients should decide which services they need for their recovery. Time limits are also a problem in some facilities. A person has his own rhythm during his/her recovery it cannot be fixed in one and a half or two years, some people need more time and others maybe less. The individual development process of humans is never finished, even at an advanced age the desire for change cannot be excluded. Individual treatment and the combination of different services would make people’s lives easier. Each institutions should provide the services as long as the person needs them and in parallel prepare him/her for the next step; this leads to more motivation and autonomy of the person.

**Assisted living**

As mentioned before a CPSR is not always the best solution for a person with diagnosed schizophrenia. The solution between a CPSR and an own apartment could be a flat-sharing community with support of a professional. They person doesn’t live alone but has a professional support for daily activities and professional conversation at the same time. Even for young people where parents maybe are afraid to let him/her alone, this could be a possibility for their way to autonomy. This flat-shared-communities should be placed in the
middle of the town so the access to cultural offers and the mobility of clients is guaranteed. For people who do not want to live in a flat-shared community the support of the Home Care should be extended. At the moment the Home Care is on its limit. The groups want such flat-shared-communities to be established in every town and the Home Care to be extended to support people who live independently and help them to live in their own way.

**Community based services**

In Carinthia a good structure is provided in the cities Klagenfurt, Villach, Spittal and Wolfsberg. The other cities provide less services, facilities, psychotherapy and psychiatrists. This fact is especially recognised in the province Hermagor where no treatment structure at all is established. People who are diagnosed with schizophrenia have to accept long-distance routes or have to move, but if they do so they lose existing social contacts. As a result of the central expansion of the supply and the under-supply in the rural areas, there are many massive relapses of people who live in these provinces. Community based services are important to support people in rural areas, to preserve their social networks and to strengthen the recovery of the people, but also to reduce the distance to the society and decrease discrimination.

**Paid psychotherapy**

Psychotherapy and conversations with psychologists are seen as an important tool of prevention by all groups. In the therapeutic facilities as Day Care Centres there is less time to speak about private problems, therefore a psychotherapy would be necessary. Especially clients prefer therapeutic conversation to taking numerous medication, they want to talk about their problems and not suppress them with medication. At the moment there are too few possibilities for paid psychotherapy, the offers from the associations are limited and clients have to wait from five up to six months for a first appointment. The possibility for private psychotherapy is given, but it is too expensive for the clients and with a financial support of their parents it is not possible to continue on a long term. Often these long waiting periods lead to demotivation and relapses.

Knowing that psychotherapy could reduce many expensive treatments, such as an admission in the hospital, the groups ask for therapies paid by the insurance institutions for associations as well as private psychotherapists. This would make therapy accessible and affordable for many people and it will reduce expensive relapses.

**More time with physicians**

The last common category affects the physicians and psychiatrists. Clients have the feeling that they are quickly treated by doctors’ e.g.
“P12 it starts like this you go to the doctor, he/she already holds the recipe block, do not laugh (to the group), yes that’s the beginning but this behaviour is beneath one’s dignity (Transcript FGC II, paragraph 65)”.

“P15 At the doctor you are quickly handled, only the medication is spoken about and then you can go again (Transcript FGC II, paragraph 69).”

This situation is also recognized by the professionals and relatives. Especially people with a chronic schizophrenia are not heard by the doctor and when they go to the general practitioner with a physical health problem the treatment is focused at the mental health disease. The clients were not asked for the reason of their coming and there is too little time that personal problems could be talked about, mostly the conversation is based on the treatment with medicine.

The desire for a respectful treatment and time to express their wishes is big, but there are too few psychiatrists in Carinthia. The clients have to wait two up to three months for an appointment, before they can enter the ordination, they have to wait two or three hours and this for an appointment that takes five minutes. All groups are aware that there are not enough specialists, so they propose that a doctor organizes a consultation in the Day Care Centre once or twice a month. If the clients of the Day Care Centre need an appointment they could sign up in a list and it will be possible to talk about their important needs. This would reduce long waiting periods and maybe also hospital stays. In the end more psychiatrists with a contract with the insurance institution would be needed in Carinthia.

**Conclusion of the main category – Improvement of the mental health treatment structure**

As seen in chapter three Carinthia provides different services and facilities for people with a diagnosed mental health disease. These facilities and services were recognized as good by all groups. However, they also fear that some services could be reduced or closed down. In some of the facilities there are not enough human resources so they are limited. Especially Day Care Centres are important for the clients, because they provide a regularity comparable to a job and a social network. The groups assume that there are too few structured offers for people who only need less support. As a hindrance they detect the given structure and financial rules, it is not possible to find individual solutions for clients.

---

4 Original source: Transkript FGC II, Absatz 65, P12: Es fangt ja so an du kummst zu Arzt, der packt glei den Rezeptblock aus, net lachen (zur Gruppe), ja so fangts aber an, unter jeder Würde.

5 Original source: Transkript FGC II, Absatz 69, P15: Da wird ma a schnell abgfertigt, wird nur über die Tabletten gredet und dann kann man schon wieder gehen.
and circumstances are difficult to change. Home care and psychotherapy are seen as very important but they are rare.

All the improvements suggested by the groups have an important commonality; the determination of the treatment should be given back to the people with a diagnosed schizophrenia. They are willing and able to self-determine their lives. Therefore, the treatment must become individual and person-centred. The desire for a respectful individual treatment is huge. The person with the mental health problem should decide independently which treatment works best for his/her recovery and he/she should choose which treatment as well as the duration.

6.3 Connections between the main categories

The main categories “Destigmatisation”, “Work” and “Treatment” have the overall connection that people with a diagnosed schizophrenia want to be seen as full members of society. They want to make decisions for their lives and are willing to take the risk if it doesn’t work. People with a diagnosed schizophrenia want the chance to test themselves, to expand their potentials, competences and knowledge. They don’t see themselves as ill, e.g. “P12 the person who has this disease, doesn’t see it as disease (transcript FGC I, paragraph 86).”

They have the competence to include the illness into their lives. “P13 I have recognized that the disease does not impede me to live my daily life (transcript FGC I, paragraph 213).” They want to be accepted, respected and treated equally in all parts of life and contribute to all these parts of life. As human beings, people with a mental health disease want to be seen as unique and remarkable and take up their individual lives. To get this opportunities the three groups agree that there must be an improvement in the current treatment structure.

6 Original source Transkript FGC I, Absatz 86: P12 Aber der Mensch selbst wenn er diese Erkrankung hat, sieht es eben nicht als Erkrankung, das ist ja das.

7 Original source Transkript FGC I, Absatz 213: P13 Was i eigentlich merk, die Krankheit selber eigentlich behindert mich nit im alltäglichen Leben
The three main groups are connected and influenced by each other. To reduce stigma also means to bring the treatment closer to the society. Community based treatments, flat-shared communities and individual treatment options, like the groups demand, bring the people with a diagnosed schizophrenia back into the middle of society, interaction and positive personal experiences will lead to a decrease of stigma. If society gets the chance to become familiar with people with a diagnosed schizophrenia, the fear will decrease and inclusion can be started.

Work at the labour market also gives society the possibility to become more familiar with the person with a diagnosed schizophrenia. This will open the way to more mini-jobs, the employed people feel more valuable and get a sense in their lives. Jobs contribute to mental health promotion and reduce stigmatization, especially self-stigmatisation.

Treatment is often seen as an alternative to work. It is a kind of occupation during the day and a possibility to get to know other people who have the same problems, to build up a social network, find friends and support each other. Treatment can prepare people to find a job, which will promote the self-esteem and self-determination of the people with a diagnosed schizophrenia.
“Destigmatisation”, “Work” and “Treatment” influence each other positively, they give people diagnosed with schizophrenia the possibility to find fulfilled and self-determined lives and contribute to equal and respected lives.

6.4 Results according the fourth research question

What kind of treatment structure and support do people with diagnosed schizophrenia need to have self-determined and satisfied lives?

In the introduction four questions were formulated which this thesis should find out. The answers of the research question one to three show that clients need to be treated with more respect and trust and that they need a structure to develop independent and self-determined lives. Relatives want a community based treatment structure, which guarantees that their family members have the possibility to live close to their social environment. The group of professionals see it as important that the treatment has to become more individual and person centred and that they have to improve the networking and cooperation with other services to guarantee a seamless treatment.

During three focus groups twenty participants discussed their wishes and needs for a future mental health treatment structure in Carinthia. In the end individual treatments were not in the focus of the discussion, for the participants it was more important how people were treated in the current system and how this fact could be improved in the future.

At the moment people are not seen as customers with individual needs and the mental health care system does not meet these needs. People with diagnosed schizophrenia were seen as petitioners or patients who need services in which professionals tell them what to do. There are less possibilities for the people to introduce their individual wishes and needs. This fact is not true due to the professionals not being willing to listen to them, it is because of a lack of time and limited human resources. According to the focus groups there are also a lot of bureaucratic hurdles and financial rules, for example the disability pension hinders people to get a job, or time limits in different services hinder people to find their own rhythm of recovery. The centralized settlement of services in the towns Klagenfurt, Villach, Spittal and Wolfsberg also makes it difficult to live in their established social environment; they have to move to these towns to get the support which they need or accept long, time and cost intensives ways. Especially for people who need less support it is difficult to get this kind of support, because it has not been established yet, they are dependent on the good
will of their former caregivers and relatives. These facts make it difficult for people to create self-determined lives.

Improvement suggested by the groups go towards more individuality and person-centred treatments. The decision which treatment would be necessary must be given back to the person who will consume it. Therefore, it must be possible to combine mental health services according to the needs of the individuals. Facilities should improve their offers and make them more accessible for the clients. The aim is that each person can arrange the services of their individual treatment and personal recovery to get the best possible benefit. The task of professionals would be to provide information about different kinds of opportunities and take the position as a consultant of people with diagnosed schizophrenia. This especially holds true for medical services. People with diagnosed schizophrenia want to be recognized and treated with respect; therefore, they want to be seen as individuals and remarkable humans with individual and unique problems. For unique problems there must be a possibility to solve them in a unique way. Individual treatment and the combination of different services would make people's lives more self-determined.

The overall wish of the groups is that people with schizophrenia are seen as equal humans in society, they should be seen as unique and remarkable individuals and with all aspects of their personality. Therefore, it would be necessary that society get the chance to become familiar with people diagnosed with schizophrenia. A treatment structure which is more community based would promote this wish. Flat-shared-communities in the neighbourhood and mini-jobs at the labour market will bring society nearer to the people with mental health problems and it is possible to learn from each other.

In the end it can be summarized that not the structure itself hinders people diagnosed with a schizophrenia to have self-determined and satisfied lives, it is the circumstance how these people are treated in the given structure rather than anything else. Of course, the group members request more human resources and an extension of the structure towards more community based services, but the main wish is more respect and recognition for people with diagnosed schizophrenia. Their wishes and needs should be the focus of an individual treatment plan and according this plan it should be an individualized and person-centred care. Therefore it is not necessary to change the structure, some improvements towards more individual, respected and recognized care and the possibility to make own decisions will promote self-determined lives for people with diagnosed schizophrenia in Carinthia.

For the overall wish to be accepted as a human member of the society not the structure must be changed, the attitude of the caregivers, politicians and society has to change.
Maybe the suggestions of the groups towards more Public Relation and mental health education would influence the attitude of society.
7. Recommendations for a future outpatient mental health treatment structure in Carinthia

The outcome of the thesis covers results for the future outpatient mental health treatment structure in Carinthia. The contents of the recommendations are based on the theoretical foundations, the results of the focus groups and the ethnographic research in Jyväskylä. The wishes and needs which were discovered with the analysis, were compared with the presented tools in this thesis. Some of these tools will be introduced as recommendations to comprehend the results of the survey.

Within the next three years the current mental health care structure will be extended, therefore the Carinthian government published a new concept called “Psychosocial Treatment in Carinthia according to the RSG Carinthia 2020” on the 3rd of July 2017. These new aspects will be included in the recommendations to improve the outpatient mental health treatment structure.

On the basis of the survey of this thesis the results show that the service users in Carinthia want more recognition and respect within their treatment and services. People with diagnosed schizophrenia need easy-accessible services and they request to adapt these services individually so that they are ideal for their personal recovery. At the moment a basal treatment for people with schizophrenia exists, but the intensity of the services depends on the region the person lives. The system is not client-orientated and the patients only have a minor right for co-determination. People with diagnosed schizophrenia are still humans and as humans these people also have multiple residential, vocational, educational and social needs the same way other citizens do; the current system does not meet these individual needs. Therefore, the services are too much supply-centred and control-orientated. Individual efforts of professionals to make them more individual exist, but these efforts are rare because of time limits and a lack of personal resources.

7.1 Recovery approach

The recommendation to get more respect and recognition for people with diagnosed schizophrenia within the mental health care is to implement the recovery approach, for the outpatient treatment system as well as for the inpatient care system. To improve the system
towards more empowerment and self-determination would mean to change the system from the traditional approach to a more recovery-orientated approach. That means that the professionals and the whole mental health treatment system have to re-orientate completely (Schrank & Amering, 2007).

The results show that people diagnosed with schizophrenia want to have more self-determined and person-orientated care, they need to have an opportunity to get involved in the planning of their own therapy. These are also three of the four key values of recovery-orientated services. Person-orientation means that all services have to focus on the individual person, the person must be seen as a complete entity and not only the illness, which has to be, treated (Schrank & Amering, 2007).

Person-involvement is also a key value; people with diagnosed schizophrenia should be involved in the planning, organisation and evaluation of their therapy and, even more, in the whole development of the mental health programs. This also will fulfil a part of the visions according the Ottawa charter. In 1986 the WHO already called for a share of health promotion in health services among individuals, health professionals, communities and the government. It was mentioned that all groups work together during the planning, organisation, evaluation and implementation of mental health services (WHO, 1986).

Self-determination is very important for a future mental health system, as the people requested during the focus groups. It is a desire of them to be taken seriously, to be heard and to make their own decisions according to their own personal aims in life. People with diagnosed schizophrenia are able and they want to make their own choices, therefore they need to know about their possibilities and opportunities. If people diagnosed with schizophrenia, get the possibility for an individual person-orientated treatment, are involved in this treatment and have the chance to self-determine their services than the fourth key value, the growth potential of any person who recovers, could emerge (Farkas, et al., 2005).

The movement of the recovery approach started in the 1990’s; now it is time to implement this approach in Austria, but this will not be an easy, way because each member of the system has to change his/her attitude, and only if this happens the whole system can be changed. The professionals need to become partners and look at the person with diagnosed schizophrenia as an expert of his/her illness and life. The recovery-orientated mental health treatment is based on hopes and dreams and supports human strength. Professionals should promote individual skills towards a meaningful life, when they do so recovery will enable them to become companions and facilitators in the individual life of the person with a mental illness (Schrank & Amering, 2007).
The persons who are involved in the system, no matter if people with diagnosed mental health problems, the professionals, the relatives, but also society, have to accept that recovery is more than disappearing symptoms and to be cured from the illness. It means to recover from the side effects of the illness, the crushed dreams, the lack of opportunities, from decisions which were made by others and from the role as a patient which was assorted by society. It means to find the individual way of life, according to one’s unique resources (Anthony, 1993).

Recovery from mental illness is a real possibility, everyone can recover from a mental illness and also from the circumstances of a mental illness, but to support a client on this way the professionals and the providers have to rethink their attitude and values. This is a long lasting process and cannot happen within one day, one month or even one year. It is hard work for everyone and no linear journey.

7.2 Easy-accessible services

One problem which was discussed during the groups was the fact that people who live independently and need less support are difficult to support. They do not need the full treatment, which the services provide. They rather need human closeness and social support, recommendations about how they could fix their problems and just a person to talk with. The current facilities are not geared at this kind of minimum support and regular appointments with psychotherapists are too expensive. The groups created the idea to open a café, so they can meet and support each other; that would strengthen the empowerment of people with diagnosed schizophrenia and other mental health problems.

A step further would be to open a Clubhouse for people with mental health problems. A Clubhouse would be a meeting point for exchange, a save environment and even more it provides work and an equal community without hierarchy. Diagnoses are irrelevant in this environment it is the whole person who will be seen. It is an opportunity to discover their resources and hidden abilities and to promote self-esteem and self-respect. The members of the Clubhouse have the responsibility to create a daily program, they can test their organisational and creative talents and are deeply involved from the planning start to the end of the realisation and this means responsibility for them (Clubhouse International, 2015).

A Clubhouse in Carinthia would create a social environment, where people can be what they are, still a unique person. It would open a space for personal involvement and discovery
of one’s own abilities and resources, each person can contribute to the Clubhouse as much as he/she likes; without pressure or a treatment plan so everybody can find his/her personal recovery.

With the support of the Clubhouse it would also be possible to form an independent self-representing association of people with mental diseases and self-help groups. At the moment there are only the empowerment movements of pro mente Kärnten, which are active in this environment, outside pro mente Kärnten there is no such an association. To establish a self-representation association means to strengthen the empowerment of people diagnosed with mental illness and to form a basement which could be included in the future development of mental health programs.

7.3 Psychosocial Treatment in Carinthia according the RSG Carinthia 2020

In parallel to the research of this master thesis the Government of Carinthia developed a concept to improve the outpatient mental health treatment structure. The new implementation concept “Psychosocial Treatment in Carinthia according the RSG Carinthia 2020” (Psychosoziale Versorgung in Kärnten nach dem RSG Kärnten 2020) was introduced to the public on the 3th of July 2017. It contains different concepts for the care of children and adolescents, adults and elderly persons. This sub-chapter provides an overview and an introduction of the new concept of services for adults. Afterwards these services will be looked at critically and compared with the results of the survey.

7.3.1 Introduction of the new concept

The concept was developed for a comprehensive advancement of the Regional Health Care Structure Plan (RSG), it involves the aims for:

- easy-accessible services,
- regionally balanced and closely located,
- integrated and developed to promote the collaboration of different facilitators and to prevent supply gaps and overlaps of services,
- need-orientated and multi professional

The current structure should be improved and not replaced by the new services. The concept provides new information centres, outpatient clinics and mobile social psychiatric
care/support teams and it follows the principle: “as much central and inpatient as necessary and as much de-central and outpatient as possible” (Ratschiller, 2017).

It is planned to build up four new outpatient clinics with mobile social psychiatric care/support teams. This will expand psychiatric treatment and will provide an easy access for people with mental health problems without the fear to get inpatient. Even if this is a good alternative, it will not be established decentralized, the four outpatient clinics will again be located in the towns Klagenfurt, Villach, Spittal and Wolfsberg. The concept planners are of the opinion that community based services in every province or municipality is inexpedient because of economic reasons and utilisation frequency of community based services. According to the concept, it was assumed that it would be wiser to establish services in the provision regions Carinthia East and West, with a focus on the four cities as it was before (Ratschiller, 2017).

The new outpatient clinics will have the task to be a primary contact point for all questions regarding mental health, for all inhabitants (located in the service area) and for distributors. The outpatient clinics should take over patients from the inpatient sector and guide them to an outpatient treatment. They also should guarantee a service for emergency and crises, this way they have to collaborate with the current emergency and crises services. The outpatient clinics will offer a psychiatric “state of the art” treatment and a case management with an outpatient treatment plan (Ratschiller, 2017).

The mobile social psychiatric care/support team will also be integrated in the outpatient clinics, to establish a treatment in the familiar environment of the people with a mental illness. These teams will replace the existing outpatient follow-up care (Home Care) of pro mente Kärnten, or rather the outpatient follow-up care will be integrated in the new mobile social psychiatric care/support. The new teams will consist of psychiatrists, psychiatric nurses, social workers and other professionals. Psychiatrists will only be mobile in individual cases if necessary, but they have to make consultations in nursing homes and CPSRs and hospitals without psychiatric wards (Ratschiller, 2017).

For the cities Hermargor, Feldkichen, Sankt Veit and Völkermarkt it is planned to establish information centres with a day structure. These centres are designed as information points and anchor points for people with mental health diseases and will provide consultations by psychiatrists. The first centre will be built in Hermargor, because Hermargor at the moment has the least treatment capacity in Carinthia (Ratschiller, 2017).

The RSG does not include living facilities, but the new concept includes ideas to build up three more houses of psychosocial crises and two more houses for social therapeutic
rehabilitation. Additionally, they also rethink building places for longer rehabilitation. The so-called CPSRs will be renamed and in the long run reduced. Because the CPSRs only have few rehabilitation treatment plans the new name will be “housing with psychosocial orientated day structure” (“Wohnversorgung mit psychosozial orientierter Tagestruktur”) and nursing plans should be developed (Ratschiller, 2017).

The new concept wants to strengthen the self-representation of people with a mental illness and relatives. The trialogic process is seen as very important and so it has to become a part of the mental health treatment structure. They plan to promote self-representation of people with mental health problems, because at the moment there is no such general association. Such a self-help group will be integrated and supported by the associations of self-help groups. The establishment of a self-representation association doesn’t mean to offer services of psychosocial treatment, but the association will be involved in the trialogic process (Ratschiller, 2017).

7.3.2 Recommendations to the new concept according the results of the survey

The new concept comprises the following services which will extend the current system:

a) four outpatient clinics with mobile social psychiatric teams
b) four information centres with day structure
c) three emergency and crises houses
d) two houses for socio therapeutic rehabilitation
e) promotion of self-representation of people with mental illness

a.) The four outpatient clinics could be an effort to reduce long waiting periods for appointments with psychiatrists for people with mental illness; a medical treatment would be easier. The networking between the outpatient and inpatient sector could be improved and a seamless treatment would help the people recover. With the mobile teams a support within the personal environment could be implemented and people would be treated according to their needs. So far three wishes of the groups could be realized with the outpatient clinics.

At the moment there is a big lack of personnel required in Carinthia, there are not enough psychiatrists and also most psychiatric nurses’ work in the hospital. In the outpatient sector only some psychiatric nurses are located. It can become difficult to establish the outpatient clinics, because the lack of human resources. At the moment
the two hospitals in Klagenfurt and Villach are the only facilities with enough psychiatrists and psychiatric nurses.

The government wants a cooperation with the operating company of the hospitals Klagenfurt and Villach, the KABEG (Landeskrankenanstalten Betriebsgesellschaft). The outpatient clinics should be organised and managed by the KABEG. The outpatient clinics will be placed outside the hospital and with different financial settlements (Ratschiller, 2017). If this will be manageable, the psychiatrists of the hospital could take over the work in the outpatient clinic. This is certainly an interesting idea, but the hospital provides the personnel required for the inpatient supply without any personnel resources. If, in the future, psychiatrists have to work in both facilities, the hospital and their walk-in-clinics will lose quality in a long run. As a consequence, the question about the staff has to be discussed carefully.

But it could be an interesting workplace for psychiatric nurses if the same operating company owns both the hospital and the outpatient clinics, it could be possible to combine both working places, nurses could partly work in the hospital and partly in the outpatient-clinic; that would promote a seamless treatment for patients and a new working perspective for nurses. The networking between the hospital and the outpatient-treatment structure could be improved. Therefore the Finish model of psychiatric outpatient nurses could be used as a template.

Also interesting are the mobile socio-psychiatric care/support teams, a new element in this teams will be the psychiatric nurses, because never before were psychiatric nurses involved in the mobile services (except the emergency and crises services). To work in a multi professional team would increase the service possibilities for people with mental health problems. The outpatient clinics Klagenfurt and Villach are planned to open in 2018, hopefully the personnel settings will be resolved, because if not, the outpatient clinics will not bring more benefits to the people with mental illness than the current structure does. In what way the two other outpatient clinics in Spittal and Wolfsberg could be established is not clear, there are different options for the design. A decision will be made till the end of 2019.

b.) The four information centres in the cities Hermagor, Völkermarkt, Feldkirchen and Sankt Veit are very welcome, at the moment in all four cities don’t have enough service. Especially Hermagor is undersupplied. The relatives of the focus group demand a facility for mental health in Hermagor. These centres will provide information for the local inhabitants, a small Day Care Centre with occupational offers, psychosocial support and regular visits of a psychiatrist.
c.) The new houses for crises are also welcome and also mentioned as an alternative for an admission in the hospital by the participants of the focus groups. It is not obvious where these houses will be opened, possibly in Hermagor, Klagenfurt, Klagenfurt Land, Völkermarkt, Feldkirchen and Sankt Veit.

They are important for persons with crises when an admission in a hospital is not necessary. Crises could be managed at an early state and prevent bigger relapses. They are cost-effective and sustainable. It would also be interesting to combine these facilities with the Soteria approach or the vision of the run-away house. This would strengthen the empowerment of people with a mental illness and create workplaces for people with mental health problems, it would improve people’s help-yourself ability.

d.) Two more houses for socio therapeutic rehabilitation are useful, at the moment there are long waiting periods to get access to this treatment, especially for young adults the socio therapeutic rehabilitation it is important to learn to live independently. Relatives are involved in this kind of treatment and the reintegration after such a therapy is very good. The only bitter pill to swallow in this therapeutic setting is that they are time limited; after one and a half, maximum two years the person has to leave the facility. Some would need a longer rehabilitation, but there are no such places. It would be interesting to establish a home like Niittykoti in the middle of the town for long time rehabilitation. The aim of these homes should be to promote people to live independently step by step without time pressure. These homes could be the transition between the socio therapeutic rehabilitation and the independent living of clients. The central element would be the possibility to use all other mental health services and cultural and educational offers of the town. Another possibility would be flat-shared-communities with a day care treatment, this also could be a step between the socio therapeutic rehabilitation and the independent living of people with mental health problems.

e.) The establishment of a self-help group or self-representation group of people with a mental health disease will be actively promoted from the government. They agreed to support them with a suitable infrastructure, but it also said that they will not be allowed to offer services of psychosocial treatment. Empowerment does not only mean to establish a treatment structure, it is more important that people with a mental illness will get the possibility to support each other; it is necessary that people get enabled to establish a social structure and in the future will be seen as experts and become a main
part of the planning and organisation of treatment structures. A first step in this direction would be not only to establish a self-help group; it is more important to create a place where people can meet each other without being labelled as patients. If the government supports people with infrastructure why not go one step further and provide them with a Clubhouse, a diagnosed free zone, where they can meet each other as unique persons.

The new structure as it is planned will not improve the overall need of the groups, to be seen as equal persons in the society and it remains questionable if the new system will improve the relationship between professionals and people diagnosed with mental disease. This needs a change of attitude and there is no recognisable change in the concept or society. Additionally, this concept was planned without the involvement of relatives and people with a mental illness and if there was such an involvement it is not stated or recognisable.

The planned structure will increase the access to support and treatment in the cities, the access in the rural area will remain difficult. The long travel ways hinder people to get the necessary treatment; the decision will be the same as before, stay undersupplied or move. Hope lies in the new mobility socio-psychiatric care/support teams, but it remains to be seen if they can reach every valley of Carinthia or if they will be bound to the region where the services are based.

The new services especially the integrated case management will bring a more seamless treatment for people with diagnosed mental health diseases, but it remains questionable how much the people will be integrated in decisions regarding their treatment plans or if these plans will be made by the professionals and presented to the clients as given schemes. It seems as if financial rules stay unchanged and services of different facilities will not be combinable, so a self-determined choice of an individual treatment plan to get the best personal recovery will stay difficult for people with mental health problems.

In summary, the new services will bring some small benefits for the people diagnosed with mental health problems, the main wishes to be treated with recognition and respect and more offers for small supports are not mentioned in the concept. A better treatment structure in the rural areas will neither be achieved, hopefully the new mobile socio psychiatric care team will support people with a mental illness in the rural area according to their individual wishes and needs.
8. Conclusion

Schizophrenia is no more an illness that is not treatable, people who are diagnosed with schizophrenia are not stupid and idiotic or dangerous. It is a researched fact that one percent of the population has a lifetime prevalence to develop schizophrenia, but it depends on their personal stress-vulnerability if and how the disease will occur. The symptoms of schizophrenia and mostly the circumstances (integration in the family, stigmatization, bureaucratic hurdles and financial rules) of the treatment could be very disabling to these people. However, people with schizophrenia are still humans and as humans, these people have multiple residential, vocational, educational and social needs the same way other citizens do.

The care of people with mental illness was always linked to the ideas, opinions and the ecological possibilities of the respective time. During the early Middle Ages it was generally accepted that every human person is a child of god and has to be treated the same way, so a community based care was present everywhere. With the industrial revolution, during the modern era and the 19th century a new principle was developed; all people should work and participate in the development of cities and the state. People who were not be able to work were banished to the margins of society. This principal is also recognizable in 21st century. Although movements like anti-psychiatry and social psychiatry started to improve this attitude, the majority of the current society of Austria, however, belongs to a performance society and has little understanding for people who cannot perform accordingly. People with a mental illness are stigmatized and discriminated against; this fact also can be attributed to the lack of knowledge about mental health problems in society.

At the moment Carinthia owns a complex mental health outpatient treatment system. There are two types of supply: the therapeutic approach and a housing approach. The therapeutic approach is mostly settled in the cities Klagenfurt, Villach, Spittal and Wolfsberg and the housing approach (CPSRs) is settled in rural areas of the districts Sankt Veit and Feldkirchen. Most providers are private, but they have contracts with the Carinthian government and the insurance institutions concerning payment and financial support. The biggest provider of services for mental health problems is pro mente Kärnten GmbH, they offer a wide range of supplies, different care and counselling facilities and psychiatric support for people with chronical and acute mental health diseases. Although these facilities were seen as good, they are not enough client-orientated and individual and it is hard to combine services of different approaches and different providers. For people with
diagnosed schizophrenia who live in the rural area this means that getting access to the treatment involves long and time consuming travel routes or to moving to the bigger cities. A movement often means to lose the existing social network and developing new ones is difficult.

During this thesis a survey was conducted to find out what kind of treatment structure and support people with a diagnosed schizophrenia need to have to lead self-determined and satisfied lives. Therefore, three focus groups with service users were planned and realized. The three groups were people with diagnosed schizophrenia, relatives of people diagnosed with schizophrenia and the professionals of the outpatient mental health treatment structure. Twenty participants joined three groups, discussed their wishes and needs for an outpatient mental health treatment structure.

The results show that people with diagnosed schizophrenia need to be treated with more respect and trust and that they need a structure enabling them to develop independent and self-determined lives. Relatives want community based treatment structures which guarantees that their family members have the possibility to live close to their social environment. For the group of professionals it is important that the treatment has to become more individual and person-centred and that they have to improve the networking and cooperation with other services to guarantee a seamless treatment.

Summing up, individual treatments were not in the focus of the discussions; for the participants it was more important how people are treated in the current system and how this fact could be improved in the future. Improvement suggested by the groups go towards more individuality and person-centred treatments. The decision which treatment would be necessary must be given back to the person who will consume it. Therefore, it must be possible to combine mental health services according to the needs of the individuals.

The overall wish of the groups is that people with schizophrenia are seen as equal humans in society, they should be seen as unique and remarkable individuals and as a single but complete. Therefore, it would be necessary for society to get the chance of becoming familiar with people diagnosed with schizophrenia. A more community based treatment structure would promote this wish. In the end it can be summarized that not the structure itself hinders people diagnosed with a schizophrenia to have self-determined and satisfied lives, it is rather the circumstance of treatment in the given structure.

People with diagnosed schizophrenia are able to make rational decisions for their own lives and they can articulate their wishes and needs. It is time to rethink the present attitude towards people with a mental health problem; they have more diverse wishes and needs.
for designing their individual lives, than only psychiatric treatment. To change this system it would be necessary to implement the recovery approach in the inpatient and the outpatient mental health treatment structure of Carinthia. In the development of a client-orientated care Carinthia or Austria are nearly twenty years behind the English speaking countries. Whereas in English speaking countries like England, Canada, New Zealand and parts of the USA the recovery approach has already been implemented in the current mental health treatment programs, Austria hardly recognizes that such an approach exists.

Recovery from mental illness and also from schizophrenia is a real possibility, everyone can recover from a mental health disease. This concept, however, does not mean that suffering from a mental illness has disappeared, all the symptoms have faded and the person is cured. It involves much more than recovering from the illness. It means that people have to recover from the iatrogenic effects of the treatment, from lack of opportunities for their further lives, from less self-determined decisions, from the fact to be unemployed, from crushed dreams and from stigma (Anthony, 1993).

To implement a recovery orientated system, it is important for professionals and the whole mental health treatment system to re-orientate themselves completely. For professionals it means that they need to think about their own attitudes and values. They have to make a decision: Do they want to be partners on the way of recovery process or do they want to be the outside experts. A process that will take a lot of time, because it is not possible to change the attitude of a person within one day, one month or one year. In this context, it is important to emphasize that recovery orientation does not replace existing roles, tasks, therapies or service structure, but wants to complement them. Positive examples could be found in other European countries and different treatment programs like “Soteria” in Switzerland, the Open Dialouge Approach in West Lapland, the “Weglaufhaus Villa Stöckle” in Berlin or the International Clubhouse system all over the world.

To promote people in the long term is only possible if people with schizophrenia are involved in the support from the beginning and they also agree with it, this fact must be realized in Carinthia; and if this will happen then every kind of mental health structure will support people with schizophrenia towards a self-determined and satisfied lives.
9. Bibliography

Reference books:


Scientific papers, journals and reports:


Web-pages:


• KGKK Kärnten. Kärntner Gebietskrankenkasse. 2017b. [online]. URL: https://www.kgkk.at/portal27/kgkkportal/content/contentWindow?viewmode=content&contentid=10007.698968 [04. 06. 2017].


**Interviews during the Ethnographic research:**

• Kanerva, Anne. (12. 12. 2016). Central Finland Health Care System. [Interview].


Others:

## 10. Attachment

### 10.1 Semi-structured guideline for focus groups

**Table 11: Semi-structured guideline for focus groups**

<table>
<thead>
<tr>
<th><strong>Semi-structured guideline for focus groups</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To find out about the wishes and needs of clients, relatives and professionals for an outpatient mental health treatment in Carinthia.</td>
<td></td>
</tr>
<tr>
<td>Developed by Sigrid Achtschin-Stieger</td>
<td></td>
</tr>
</tbody>
</table>

**Introduction**

- Thanks for the participation in the group
- Introduction of the moderator
- Explanation of the purpose of the focus group, documentation and anonymization process, declaration of consent
- Process of the event (duration, timing, breaks)

**Warming-up**

- Icebreaker: one word about the current treatment structure in Carinthia
- Max. 2 words
- Atmosphere, attitude

**Professionals:** Inducement and passion for the Job

**Relevant:** Sense and living with a concerned person

**Concerned people:** Open questions about sense and living with the disease

- This part should be short
- Everyone should tell a word
- Questions concerned with the situation
- Encourage people who didn’t want to speak

**Part of Past and Present**

Intersection individually planned according to the situation

<table>
<thead>
<tr>
<th><strong>Subject area</strong></th>
<th><strong>Keep-up questions for the speaking person</strong></th>
<th><strong>Keep-up question for the group</strong></th>
</tr>
</thead>
</table>
| **Open exploration** | • How was the situation in detail?  
• Which aspects embarrassed you especially? | • Have you experienced anything similar?  
• How was that for you? |

<table>
<thead>
<tr>
<th><strong>Intervention</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interface</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Influence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carinthia, what are your thoughts about the situation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Experience, Change</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What makes this situation/encounter so remarkable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What did you contribute to this situation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What was positive/negative in this situation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tell me 2 positive and 2 negative experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• How far in the past was this experience?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What has changed since then?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What has changed in the past 5-10 years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What do you feel is best at the current situation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• When you hear this report, what do you think of it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What similar / different situations did you experience?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What was special for you when you look back on your experience?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Which aspect of this experience is most noticeable for you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If you spontaneously think about it, what comes to your mind?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If this situation were to be presented today, what has changed in your opinion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What has changed in the past 5-10 years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What would happen today?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scaling of experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invitation to evaluate the experiences mentioned before</td>
</tr>
<tr>
<td>(scale 0 – 10, pin board, post-it’s or cards)</td>
</tr>
<tr>
<td>Pair work</td>
</tr>
<tr>
<td><strong>Subjective evaluation</strong></td>
</tr>
<tr>
<td><strong>Participative negotiate values</strong></td>
</tr>
<tr>
<td>• Please write about each of your previous experiences on a post-it</td>
</tr>
<tr>
<td>• Please, also mention further experiences we didn’t speak about</td>
</tr>
<tr>
<td>• How do you rate your experience on a scale between 0 – 10</td>
</tr>
<tr>
<td>• Where 0 is very well and ten is very poor</td>
</tr>
<tr>
<td>• Exchange with your seat neighbours</td>
</tr>
<tr>
<td>• What is good – quite good – quite bad - bad about your experiences</td>
</tr>
<tr>
<td>• As a whole</td>
</tr>
<tr>
<td>• Aspects</td>
</tr>
<tr>
<td>• Elements</td>
</tr>
<tr>
<td>• This experience was the most discussed here, what is so interesting / exciting for you</td>
</tr>
<tr>
<td>• This experience was shared only once, was it perhaps experienced</td>
</tr>
<tr>
<td>Part of Future</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>You fall into a ten-year sleep, when you wake up, there are services for people with mental health problems you have always dreamed of. Please tell me about your dream. <strong>wishes and needs</strong></td>
</tr>
</tbody>
</table>

- Tell us about this type of care
- Would you also use this service?
- What do you dream for yourself?
- What can you contribute to make this become a reality?
- Are there any special services that you would particularly like to use?
- How should it be designed?
- What is special, unique in this service
- How do you feel about these choices?
- What would you like to add to this supply?
- What must be changed for you, so that you will use it?

<table>
<thead>
<tr>
<th>Cool down</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritize your needs and wishes together (Flipchart and pens)</td>
</tr>
</tbody>
</table>

- What is especially important?
- Are there things that occupy a common place?
- What is very important in your opinion?
- What is not important?
- This wish is particularly frequent, why is this so important to you?
10.2 Specific wishes and needs of the individual groups

The overall wishes of the groups – “Destigmatisation”, “Work” and “Improvement of the treatment structure” - have shown the similar wishes and needs of the groups. In this section the specific wishes of the groups will be explained. These wishes are results of the first analysis and were only discussed in the individual groups. During the second analysis process they were excluded, but nevertheless these wishes are important for the individuals.

10.2.1 Specific wishes of the relatives

For the relatives there are two more important requests:

a. Motivation of people with a mental health disease towards health promotion
b. Financial resources for recreational activities

c. Motivation of people with a mental health disease towards health promotion

Relatives made the experience that their family members often follow recommendations easier when they come from a strange person. It seems that the recommendation of a person who is not related to the person with a mental illness has a bigger influence, even if relatives and the strange person say the same, e.g.

“P08: So if friends came and asked him to participate in a group activity of their association, he agreed and went with them, if we as a family told him the same “Today the group makes this or that, go down and have a look” he disagreed and stayed at home. (Transcript FGR II, Paragraph 265).”

8 Original source: Tanskript FGR II, Absatz 265, P08 des is so wenn die Außenstehenden kumman und sagen:
This circumstance leads the relatives to the opinion that if a professional will recommend people with a mental illness towards health promotion they will except this proposal and do more for their health e.g. healthy eating, fitness, sports and more leisure activities. Relatives think if they did more for the health their sons will also stay in a stable phase for a longer time. Through motivation the people learn a lot about themselves and by positive results their self-esteem will increase.

**b. Financial resources for recreational activities**

Some years ago, there was a budget for holidays and short trips, for the clients it was big change to the usual daily life and a big benefit for their wellbeing. Meanwhile this budget was cancelled. The relatives would be very happy if such trips were possible again. Their family members always had a lot of fun on these tours, because they could forget their situation for some hours or days. Trips and vacations far away from home allow the people to step out of their roles and become an ordinary tourist.

**10.2.2 Specific wishes of the professionals**

In the group discussion of the professionals there were four wishes which could not be illustrated in the overall analyses.

These requests are:

a. A better cooperation and networking between the outpatient services and between the hospitals and outpatient services.
   
b. A compulsory internship for policy-makers
   
c. More welfare options for employees
   
d. More resources to work with relatives
   
**a. Cooperation and networking**

A good transfer and cooperation is important for the clients’ care and it allows the institutions to build on previous successful results. Although estimate the networking between the institutions as highly important, at the moment this kind of cooperation is only reported in individual cases. It is a huge request of the professionals to encourage all institutions to network and cooperate for the benefit of their clients.

"Kumm mit und geh." na dann gehts, aber wenn die Familie sagt: "Schau heute machen se das und das." Dann is er a nit gangan, Überhaupt nit.
During the discussion the professionals explained two different problems: the cooperation between the outpatient institutions and the cooperation between the inpatient (hospital) and outpatient system.

Between the outpatient services there is a competition, although the clients were allocated to the institutions and nobody must fear about decreasing client numbers the institutions do not collaborate, transfers of patients are often problematic. The information necessary to continue the treatment is often not provided and so the institution has to roll up the information by themselves. This circumstance cause drawbacks at the client’s expense. The information of the last years would be sufficient, but even this information is not available. The unordered behaviour is a product of decades of reciprocity based on tit for tat. Reasons for this behaviour are seen in the competition, the lack of human resources and the different documentation systems.

For the professionals it is also a question of perspective, because the client should stand in the centre of the overall focus and not the institutions and their profit. They personally attempt to change this behaviour, since they regret it very much. To improve the networking they suggest meetings of the institutions, helpers’ conferences to support individual clients and a uniform documentation system.

The second area where they see an urgent need for action lies in the cooperation between hospital and the outpatient services. Mental health care is, according to the opinion of professionals, dominated by hospitals. When clients get a crisis they need to go inpatient; it can happen that rushed decisions lead to an abrupt change in the clients’ lives, e.g.

“We had two clients who fought for two years to have self-determined lives with their own apartment. It was hard for them to build up a new social network; they lived in their apartments with minor support for two years. After a crisis they got inpatient and there the decision was made that they were transferred to a CPSR, nobody asked us or involved us in the decision. The clients that did not get the chance to see their apartments again (Transcript FGP I, paragraph 181)”

---

9 Original source: Transkript FGP I, Absatz 181, P06: also wir hama 2 Fälle ghabt, die 2 Fälle waren zwei Leit bei uns, ganz ganz mühsam zurückgekämpft in das Leben, sag i a mal, ins möglich selbstständige Leben, 2 Jahre sind lang, find i, mit natürlich auf und abs, ja, und mit Wohnung organisieren mit vorbereiten mit soziales Netzwerk aufbauen, ham dann a wirklich, da ane hat glab i was i wohl um de 2 Jahr in der Wohnung glebt, ja mit geringfügig betreut. Ham dann a Krise ghabt, sind ins Krankenhaus kuman und vom Krankenhaus zapp-zarapp direkt in ein ZPSR. Ohne zu fragen, in einer Krise eine Entscheidung zu treffen de so massiv is. de haben die Wohnung nie mehr gesehen, das is Zack Zack,
The professionals think that life-changing decisions should not be made during an acute crisis and that the outpatient system should be involved in these decisions. The hospital knows the clients only in acute crises, but the professional of the outpatient services knows them in their stable phases and assess the resources and potential of clients in a more precise way.

Often the professionals of the outpatient system do not feel that they are taken seriously by the hospital staff members. Especially in crises situations when the client needs to become inpatient and the professionals want to provide information, they will be rejected by individual hospital employees, depending on who is on duty. Some nurses are very happy about the information and some of them are angry and reject the information. The outpatient service employees also feel betrayed by the hospital employees in a situation when the clients, who need therapeutic support urgently according to their assessment, were sent home. They believe that the hospital staff members do not recognize their competence. A circumstance which should be improved very soon, because when the systems do not work together, people with a mental health problem will be the loser.

b. A compulsory internship for policy maker
Professionals have the impression that by a lack of knowledge political decisions are sometimes made to the disadvantage of people with a mental health problem. Due to different and changing areas of political responsibility, planning is made more difficult. They want a person in the government which has practical experience in the field of mental health care, at the moment this does not exist and so it is not possible to get decisions based on the individual needs of the clients, because there is less understanding for the problems of people with a mental health problem. They also have the feeling that policy makers do not trust them and their competences. The performance-orientated support system cannot be provided for many clients, so it would be necessary to have more individual based decisions. The decisions based on individual needs and a person-orientated well-developed outpatient care would save long-term costs. To close this gap and increase a good communication system with the government the professionals created the idea of a compulsory internship for policy-makers and employees of the government. With a one-month internship the communication could be improved and the knowledge from employees about mental health problems would increase, so much to the opinion of the professionals.

c. More welfare options for employees
Employee care should be expanded to prevent employees from “burning out”; professionals believe that only healthy employees can create a healthy environment for the people with a mental illness and support them in the best possible way. Their wishes are that employees with a physical illness should be supported in a better way; they would like to have one
more week of vacation to recover from this hard and emotional job. It would also be nice to have a paid leave for a half year in order to be able to recover sufficiently.

d. More resources to work with relatives
At the House Landskron, cooperation with relatives of people with a mental health problem is normal and integrated in every day’s work. It is a philosophy of the house that the social network of the clients must be involved in the treatment plan. This aspect is not settled in other institutions. The exchange on a regular basis is important to create understanding and tolerance for the support of the clients and their relatives. However, the institutions do not have enough human resources to establish a service like House Landskron. The professionals can muster understanding for the family, but cannot provide an immediate solution for misconceptions and insults of the last twenty years; therefore, an intensive, long cooperation would be necessary.

The association HPE provides very good work for the relatives; they organised themselves and help each other. They also help parents to acknowledge problems when their children becomes mentally ill. The professionals fully acknowledge the work of the association, and hope themselves that they will have more time for cooperating with the relatives.

10.2.3 Specific wishes of the clients

In addition to the wishes described in the chapter before, the clients find most important immediate aid in situations of mental crises and research about specific treatments (blood test), other wishes which were not outlined on the poster, but also discussed were treatments with animals and a closed ward at the hospital Villach.

a. Immediate aid in situations of mental crises
A situation of a mental crisis is a very drastic experience for people with a mental health problem; they were overwhelmed with emotions and the immediate help of the emergency, police and other first aid helper’s triggers anxiety, e.g.

“P13 Clearly if one gives me an injection or they want to bring me to the hospital, I become completely afraid automatically. In this situation it would be helpful if not the whole emergency comes to me, police, emergency, doctors and emergency and crises service. It would be better if they let me rest maybe one person who is with me, to get the knowledge what the person in the crisis really needs. I never had the chance
They wish to get more empathy from the involved helpers that decisions are made with them and not for them. They wish to receive aid without being immediately handed over to the nearest institution. This was their wish in the first place, it is very important for people with a mental health problem to be seen as a humans and also be treated in a human way in crises situations.

b. Research about specific treatment (blood test)
The last point on the clients ranking was research about specific treatment methods. This wish was not based on the treatment structure but also reflects the everyday lives of the clients. In the future clients would like to have blood tests to find and determine the right medication and doses. Clients suffer from the search for the right medication in the long run, there are still a lot experiments. They also have the feeling that doctors are not really empathic to them, they get a recipe after a short conversation. Sometimes they need to take medications with an addictive potential. And the subsequent withdrawal is experienced as drastic, massive and difficult. Substitute medications with a lower potential of addiction do not have the effect to lower the deprivation, which leads to problems in their daily lives. Therefor the hope for the clients lies in the research to get specific tests in the future.

They did not rank, but also discussed wishes like animal supported treatments and a closed ward at the hospital Villach. Animals are experienced as sincere and the clients very quickly find access to animals, especially to dogs. They also receive attention and sympathy from dogs. However, trained therapy dogs are very expensive for individual persons and are not affordable for the clients, so they would wish for dogs in the institutions.

The hospital Villach at the moment a minimum bed number for the region West Carinthia, so the clients have to wait up to three weeks for an admission, if they need a care at a closed ward they have to be brought to Klagenfurt. For them it means rare visits of their friends and families, because it is too far away and the travel costs are too high for their friends. For them the solution will be more beds and a closed ward in Villach.

---

10.3 Posters of the individual focus groups

In the thesis the posters with the wishes and needs of the individual focus groups are included. The other posters of the group meetings are presented here in the attachment.

10.3.1 Focus group professionals


Warming-up

One word to the current situation

- Absolute uncured
- Developable
- Insufficient resources
- Incomplete
- To less facilities for day structure
- Person-orientated vs. cost-orientated

Scale of experiences of past and present

[Image of the poster with a scale and notes]

Figure 9: Poster - Warming-up – professionals (FGP, 21.09.2016)

[Image of the poster with a scale and notes]

Figure 10: Poster - Scale of experiences of past and present – professionals (FGP, 21.09.2016)
Table 12: Scale of experience of past and present - professionals (FGP, 21.09.2016)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>German</th>
<th>Personal experiences</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 very positive</td>
<td>viel Kreativität in der Arbeit möglich</td>
<td>Possibility of lotsl of creativity in the job</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arbeitsklima</td>
<td>working atmosphere</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Modernisierung der Einrichtungen</td>
<td>modernisation of the facility</td>
<td></td>
</tr>
<tr>
<td>1 – 2</td>
<td>große Motivation der Mitarbeiter, großes persönliches Einsatzbemühen</td>
<td>high motivated staff, high personal commitment</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Vernetzung, Information</td>
<td>Networking Information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vernetzung (regional im Raum Villach)</td>
<td>Networking regional in Villach</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Wertigkeit des Bereichs</td>
<td>Valence of the sector</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Personalschlüssel</td>
<td>patient-staff ratio</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vernetzung / Information</td>
<td>Networking / Information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Konkurrenz</td>
<td>competition</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Betreuungsschlüssel, Stundenressourcen</td>
<td>patient-staff ratio, time resources</td>
<td></td>
</tr>
<tr>
<td>10 very negative</td>
<td>Bürokratie</td>
<td>bureaucracy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kooperation, Austausch</td>
<td>cooperation, exchange - networking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vernetzung</td>
<td>networking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stigmatisierung der Ärzte bei Überweisung Behandlung</td>
<td>Stigmatisation of doctors during a referral</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion

One positive word at the end
- Individual engagement of employees
- Live with the clients
- Learning with each other
- Learn new perspectives of each other
- Creative freedom
- Working atmosphere
- Diversity
- Every day brings something new

Figure 11: Poster – Conclusion - professionals (FGP, 21.09.2016)
10.3.2 Focus group relatives

07.10.2016

Warming-up

One word to the current situation
- Incomplete
- Difficult
- Too far away
- Short interventions in Villach are well
- Not supplied adequately
- Too less

Scale of experiences of past and present

Figure 12: Poster - Warming-up - relatives (FGR, 07.10.2016)

Figure 13: Poster - Scale of experiences of past and present – relatives (FGR, 07.10.2016)
### Table 13: Scale of experiences of past and present - relatives (FGR, 07.10.2016)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>German</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 very positive</td>
<td>Psychologe und Schwestern im LKH</td>
<td>Psychologist and nurses at hospital</td>
</tr>
<tr>
<td></td>
<td>Haus Landskron</td>
<td>House Landskron</td>
</tr>
<tr>
<td></td>
<td>Haus Landskron</td>
<td>House Landskron</td>
</tr>
<tr>
<td>2</td>
<td>Arbeitsprojekte</td>
<td>Working projects</td>
</tr>
<tr>
<td></td>
<td>AVS Gesprächstherapie</td>
<td>Speaking therapy at AVS</td>
</tr>
<tr>
<td></td>
<td>Verständnis der Burschenschaft</td>
<td>Appreciation of the fraternity (social environment)</td>
</tr>
<tr>
<td>6</td>
<td>Zu wenig psychologische Betreuung auf Krankenschein</td>
<td>Too less psychological support paid by health insurance</td>
</tr>
<tr>
<td></td>
<td>Zu lange Wartezeiten</td>
<td>Too long waiting periods</td>
</tr>
<tr>
<td>8</td>
<td>Wenn er nicht will kann man nicht helfen?</td>
<td>If the concerned person doesn’t want, nobody can help him/her.</td>
</tr>
<tr>
<td>10 very negative</td>
<td>Erkrankung, Suizid</td>
<td>Disease, suicide</td>
</tr>
<tr>
<td></td>
<td>Erinnerungen</td>
<td>memories</td>
</tr>
<tr>
<td></td>
<td>Facharzt - Führerschein</td>
<td>psychiatrists – driving allowance</td>
</tr>
<tr>
<td></td>
<td>Keine Angebote im Bezirk Hermagor</td>
<td>Undersupplied regions (no treatment structure in Hermagor)</td>
</tr>
</tbody>
</table>

### Conclusion

One positive word at the end

- Partly pleased
- Be in expectation
- Future-orientated
- Hope for positive enhancement
- HPE
- solution-oriented
- Walk-in clinic of the hospital Villach

*Figure 14: Poster - Conclusion - relatives (FGR, 07.10.2016)*
10.3.3 Focus group clients

10.10.2016

Warming-up

One word to the current situation

- Day Care Centres
- Follow-up care
- Emergency and crises service
- Socio psychiatric treatment
- Positive
- In Carinthia the situation is suitable
- Day Care Centre in Klagenfurt is very good
- Assisted living
- House for crises in Wolfsberg
- good networked
- De la tour – treatment organisation

Scale of experiences of past and present

Figure 15: Poster - Warming-up - clients (FGC, 10.10.2016)

Figure 16: Poster - Scale of experiences of past and present - clients (FGC, 10.10.2016)
### Table 14: Scale of experiences of past and present - clients (FGC, 10.10.2016)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>German</th>
<th>Personal experiences</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 very positive</td>
<td>Medizinischer und psychosozialer Bereich war und wurde ich gut betreut</td>
<td>I was treated well according to medical and psychosocial needs</td>
<td></td>
</tr>
<tr>
<td>Tagesstätte war positiv</td>
<td>Day Care Centre was positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Krisendienst</td>
<td>Emergency and crises service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tageszentrum</td>
<td>Day Care Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Familie</td>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Tageszentrum</td>
<td>Day Care Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lebensbedingungen</td>
<td>Living conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Familie</td>
<td>Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Aber es gehört noch einiges im seelischen und geistigen Bereich getan</td>
<td>There must be done more in the spiritual and mental sector</td>
<td></td>
</tr>
<tr>
<td>Die Ursache der Krankheit</td>
<td>The cause of the mental health disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verwandtschaft</td>
<td>relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Das eigene ich negativ, Daheim kommt immer alles hoch lebe allein</td>
<td>The own person, is negative, to live alone is a burden</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Stigmatisierung</td>
<td>stigmatisation</td>
<td></td>
</tr>
<tr>
<td>Angst vor den „normalen“ Menschen</td>
<td>Fear of the “normal” humans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 very negative</td>
<td>Seelische Käte der Menschen</td>
<td>Mental cruelty of humans</td>
<td></td>
</tr>
</tbody>
</table>

### Conclusion

One positive word at the end

- Community is a family
- Day Care Centres – one is well cared for
- Caregiver
- Humans who are interested in the situation of people with a mental health disease
- together

*Figure 17: Poster - conclusion - clients (FGC, 10.10.2016)*