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SOCIAL WORK WITH PEOPLE WITH MENTAL DISORDERS IN THE CZECH REPUBLIC

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Introduction

In social work, we should see the client holistically, in his complexity as a biological-mental-social-spiritual being. His social problem often also includes a health aspect or, other times, his health problem may be the trigger of a social problem. A mental disorder negatively impacts the person's thinking, behavior, communication and overall lifestyle. Mental disorders encompass a wide range of diagnoses like anxiety, depression, bipolar disorder, schizophrenia, addictions, mental retardation, dementia, behavioral and personality disorders, emotional disorders, etc. The outbreak of a mental disorder may significantly affect the life of a person, who may become a client of social organizations.

Work with people with mental disorders has specific demands on social workers. It is important for social workers to be able to work effectively with this vulnerable group. For this reason, quality preparation of future social workers, which develops their professional competences and skills is important.

The aim of this scientific monograph is to analyze the social services primarily focused on people with mental disorders in the Czech Republic. To examine the process and determine the methods of social work with this target group. Identify the problems linked to helping this target group in the Czech Republic.

We have conducted the research in qualitative methodology, where we have used semi-structure interview for data collection, open coding for analysis and the card sorting technique for evaluation. The research set consisted of workers in social services primarily focused on people with mental disorders in the Czech Republic.

The scientific monograph is structured into three chapters. In the first chapter, we summarize the knowledge, competences and tasks of a social worker in the process of social work with people with mental disorders. We have also analyzed selected approaches and methods of social work, which are specific for work with this vulnerable target group. Specifically, it is social rehabilitation, case management, recovery, crisis intervention and expressive therapies. The second chapter represents research methodology. We state research goals, research methods and the research set. The third chapter presents the results of the conducted research. In the first part, we describe the social services for people with mental disorders – types, target group, daily routine, process of social work, problems of social work with the client, problems concerning the clients, education of social workers and meetings, cooperation with organizations. In the second part, we identify the approaches, methods and

techniques used by the social workers in their work with the clients with mental disorders. In the third part, we clarify the problems encounters by the clients suffering from mental disorders.

1 Social Worker as the Facilitator of Care for People with Mental Disorders

A social worker may work with people with mental disorders as the primary target group in social services (facilities of assisted housing for people with mental disorders, social services homes for people with mental disorders,...) or in healthcare (psychiatric wards, psychiatric clinics,...). But he may encounter people with mental disorders even if his target group is different, because no matter if his primary target group would be seniors in senior facilities or children in children and family centers, even these clients may suffer, inter alia, also from mental disorders. Therefore, we consider it necessary for social workers to have basic knowledge and skills for work with people with mental disorders.

There are two basic models of mental health and mental disease, namely continual and separate. According to the continual model, mental health and mental disorder are seen as two opposing poles of one continuum. Most people fall somewhere between these two poles. The line between health and disease is not rigid, but rather fluent, subject to social effect and environmental effects. According to this model, anyone can get sick, if he is exposed to sufficiently strong stress in his psychosocial environment. According to the separate model of mental health and mental disorder, health and disease are seen as two opposing poles, which form a dichotomous division. According to this model, a person is either healthy or sick, thus meeting the diagnostic criteria of some disease. This model emphasizes a biological approach to the examination of mental disorders and it assumes that these disorders have a genetic, biological or a neurochemical cause.[1]

Mental health can be understood as the absence of mental disorders, which is the narrowest understanding and corresponds to the possibilities of psychiatry and primary prevention. Mental health may be understood as the ability to overcome even excessive stimuli of the external or internal environment and adequately react to them. This understanding exceeds the possibilities of psychiatry, because care belongs not only to medicine, but also other humanitarian sciences. Mental health may be defined as the state of balance between the individual and the surrounding world. Health and sickness are only parts of his existence.[2]

[1] *National Mental Health Program.* 2004, p. 3.
[2] KAFKA, J. et al. *Psychiatry. Textbook for Medical Faculties*. Martin: Osveta, 1998, p. 115.

The World Health Organization defines a psychiatric case as an obvious disorder of mental activities, so specific in its clinical symptoms that it is reliably identifiable as a clearly defined set of features and serious enough to cause loss of the ability to work, or of social status, or both, to a degree, which may be classified as failure.[3]

1.1 Knowledge, Competences and Tasks of Social Worker

A social worker working in the field of care for mental health uses his professional knowledge and skills in the service of helping the vulnerable target group – people with mental disorders. Practice shows that for his work, he needs to know and be able to distinguish between the symptoms of mental disorders, map the social network, impact of social factors, cooperate with other experts in the field of psychiatric care, communicate with clients, plan and implement an intervention. A social worker needs to navigate the International Classification of Diseases, have basic knowledge of symptoms and be able to recognize them in a specific person. He should be able to understand the mental disorder in the context of biological, psychological and social factors. As part of this, the social worker should contribute to stronger individualization of the diagnostic process and to the fact that greater space would be devoted to the psycho-social factors. A social worker should obtain information in an open way and he should be able to put it in relation. This means that the social worker familiarizes himself with previous diagnostic conclusions and he is able to draw data for his own hypotheses in his research. Information on prior attacks of the disease, their course and impact on the client's life, suicidal tendencies and attempts are significant. At the same time, he is able to keep the necessary distance so his thinking process would not be clearly aimed and thus circumvent new information. A social worker must be able to navigate documentation, understand the basic medical, psychiatric and psychological terms and be able to ask questions.[4]

It is important for the social worker to approach the client holistically. Holistic approach in social work means seeing the person not only as a client with a social problem, but in his complexity, which encompasses the biological, psychological, social, cultural and spiritual dimension. Therefore, in social work, it is very important to know the client on all these levels. The whole process of social assessment and subsequent intervention should be subject to this goal. The somatic, mental and spiritual dimensions are integrated into an

[3] MAHROVÁ, G. et al. *Social Work with People with a Mental Disease*. Prague: Grada, 2008, p. 69.
[4] PROBSTOVÁ, V. – PĚČ, O. *Psychiatry for Social Workers. Selected Chapters*. Prague: Portál, 2014, p. 17, 174-176.

indivisible unit and the person as a whole enters into individual social interactions. Thus, the requirement on social work to serve the person as a whole, as we find it in the characteristics of the mission of social work, means the requirement to avoid any theoretical or practical reductionism in helping the client and not only to saturate his needs on all levels, but to carry this out in their mutual unity and for the benefit of the integral development of the person.[5] Also according to the ethical codex, the social worker respects and protect the client's biological, mental, cultural, spiritual and social integrity. He is interested in the person as a whole, as part of his family, community, social and natural environment and strives to learn about all the important aspects of his life. He helps the client to solve problems related to other aspects of his life.[6]

The psychiatric disease covers a number of different client needs, typically all at once and across individual disciplines. Seeing the individual as a biopsychosocial being is already anchored in the helping profession. Therefore, the effective way to help lies in the collaboration of several experts. Interconnectivity is necessary for this - which is the nature of multidisciplinary work. It strives to use complex resources of help and thus contribute to greater effectiveness. Workers from individual fields should therefore be represented in teams working with people with mental disorders, who, at the same time, will have at least basic knowledge of the neighboring fields. A multidisciplinary team may consist of psychiatrists, nurses, caretakers, psychologists, social workers, occupational therapists, art therapists, musical therapists and treatment pedagogues.[7] A multidisciplinary team is based on the idea of collaboration of experts and coordination of procedures. It is not a hierarchical system. Representatives of individual fields bring their specific knowledge to the team and they collaborate with other institutions and persons, who are part of the client's social network. Teamwork is not easy; it is influenced by the willingness of the team members to cooperate and by how the team members are seen by the clients and possibly other service providers. The team leader must be aware of these factors and also about his responsibility to combine understanding and leadership and to coordinate all activities in order to as beneficial to the client as possible. The social worker brings to the team his qualification for work with people's relationships and social conditions, which affect the clients' ability to fulfill their life

[5] BALOGOVÁ, B. et al. *Vademecum of Social Work.* Košice: UPJŠ, 2017, p. 35, 58.
[6] *Ethical codex for the performance of social work in the Slovak Republic*. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.socialnapraca.sk/wp-content/uploads/2025/01/Eticky-kodex-vykonu-socialnej-prace_2024_FINAL.pdf .
[7] HAŠTO, J. et al. *Psychiatric Care Reform in the Slovak Republic.* Trenčín: Publisher F, 1999, p. 71-77. MAHROVÁ, G. et al. *Social Work with People with a Mental Disease.* Prague: Grada, 2008, p. 63, 69.

goals and implement plans.[8] The competency of the social workers is to provide the client with enough information and contacts in relation to the current situation – explain the system of health and social care, including information on financial options (arrangement for a disability pension, employment in protected workshops, etc.), provide information on care options (contacts for facilities and institutions, which may help in a specific situation – rehabilitation, home care, requalification, legal assistance, etc.).[9] The social worker has greater possibilities to meet people with mental disorders and their relatives compared to psychiatrists or nurses. He maps the health and social needs, describes the options, which are missing, or which are present in the environment.[10]

Social workers, who help the client find or keep a job may visit the specific job with him for some time and help him in the first difficult moments – how and whom to approach when starting employment, how to manage the demands of a specific job (division of working hours, management of the necessary administration), help with ordinary tasks (what to do if he wants vacation, is sick, needs to go to the doctor). Essentially it is accompanying him in his job. The social worker supports healthy behavior and attitudes of the client. He gives him competences and develops his social skills. He implements the methods of individual and group social work. The social worker strives to support the health aspects of the client and tries to achieve his social functioning. He may take responsibility for the initiation or help in the activity of self-help groups and he also may take on some tasks related to raising awareness. Tasks that are part of protected housing and family care are especially important, because the social worker bears the responsibility and acts as the organizing factor. There is space at psychiatric wards to fully utilize social workers to assist the patients in their reintegration into life and work. This also includes family therapy and an effort to create an optimum environment for the sick person.[11]

The social worker should support self-determination and empowerment of the client. Self-determination consists in the right of the client to decide freely and pick from options. Respecting self-determination means respecting the client as an individual, independent and self-sufficient person and it is closely linked to the concept of autonomy. Social workers

[8] MATOUŠEK, O. et al. *Social Work in Practice. The Specifics of Different Target Groups and Work with Them*. Prague: Portal, 2005, p. 143.
[9] MAHROVÁ, G. et al. *Social Work with People with a Mental Disorder.* Prague: Grada, 2008, p. 61-63.
[10] PROBSTOVÁ, V. – PĚČ, O. *Psychiatry for Social Workers. Selected Chapters*. Prague: Portal, 2014, p. 173.
[11] MAHROVÁ, G. et al. *Social Work with People with a Mental Disorder.* Prague: Grada, 2008, p. 61-69. HAŠTO, J. et al. *Psychiatric Care Reform in the Slovak Republic*. Trenčín: Publisher F, 1999, p. 74. LIBIGER, J. *Schizofrenie.* Prague: Psychiatric Center, 1991, p. 105. DUŠEK, K. – VEČEŘOVÁ-PROCHÁZKOVÁ, A. *Diagnosis and Therapy of Mental Disorders*. Prague: Grada, 2017, p. 229-230.

should respect and support human right to choose and decide for oneself. Empowerment may be taken as help to the client, which leads to the improvement of his personal, interpersonal and social-economic strengths and the development of the impact on improving his environment. It is about helping people get greater control over their life and circumstances. It is important to note that empowerment is something we can do for the clients, but it is also something, which we can do only with them. [12]

1.2 Approaches, Methods and Techniques Focused on People with Mental Disorders

There are several approaches, methods and techniques that can be used in social work with people with mental disorders. We will present several of them, which we consider important and specific for this vulnerable group.

1.2.1 Social Rehabilitation

Social rehabilitation is an important tool for integration of people with health disability into society. [13] Social rehabilitation represents professional activity for the support of independence, self-support and self-sufficiency of a natural person through the development and practice of skills or through activation of skills and strengthening of self-care habits, in household keeping and basic social activities with the maximum use of natural resources in the family and community.[14] The service is provided in the form of field or outpatient services and contains the following basic activities: practice of skills to manage self-care, self-sufficiency and other activities leading to social inclusion, facilitation of contact with the social environment, raising, educational and activization activities, help in exercising rights, legally protected interests and in handling personal affairs.[15]

One of the techniques of social rehabilitation is the practice of ordinary daily activities. Activities of Daily Living (ADL) include activities people to for the purpose of ensuring daily self-care. They are split into personal (personal, intimate activities each person needs for self-care, which include: eating, personal hygiene, appearance care, etc.) and instrumental (represent more complex activities, which are affected by the environment, where the person lives - city, village, apartment, house, tenancy, household keeping, cooking, money management, social activities, etc.). The techniques and procedures for practicing self-

[12] BALOGOVÁ, B. et al. *Vademecum of Social Work.* Košice: UPJŠ, 2017, p. 44, 49.
[13] ŠTEFÁKOVÁ, L. et al. *Methods and Methodology of Social Work I.* Ružomberok: Verbum, 2016, p. 209.
[14] *Act No. 448/2008 Coll. on Social Services.*
[15] *Act No. 108/2006 Coll. on Social Services.*

care activities include: systemic approximation (division of complex and complicated actions into partial steps, which are learnable within one intervention unit), imitation (learn through imitation, whereby the social worker serves as a model), shaping (shaping of existing behavior to be as close as possible to the required standard), chaining (gradual adding and chaining of individual partial knowledge), commenting of ongoing activity (it may help, for example in adoption of motoric actions) and positive reinforcement of desired actions (where it is necessary to lean on individual preferences of the individual).[16]

Communication trainings are another technique of social rehabilitation, which contain areas of verbal communication (training of coherent speech, respect for the speech of others, suitable terms, respecting the differences in the speech of others), non-verbal expressions (inappropriate gestures, posture body language) effective communication (plea or request, satisfaction or polite refusal, expressing dissatisfaction, critique), familiarizing (addressing, refusal, sharing unpleasant news), dealing with institutions and practice of decision-making in difficult situations.[17]

Routine therapy can be also included in social rehabilitation, which emphasizes the need for a clearly structured order, which offers safety and security. Daily routine and rules give clear and fixed order. Structured ordering of ordinary daily activities is in conflict with the typical disorderly life of the clients and disturbs negative thinking and boredom. It gives a generally accepted idea about what is going on and what will happen next. It is the division of the day into individual time periods and naming their content. Through the effect of a daily routine, the clients renew habits they lost or never had. It is a method build on the foundations of the theory of social learning. It is a source for the acquisition of social habits and disruption of patterns of maladaptive forms of behavior. A well-structured daily routine reflects the reality of an ordinary day and respects the interests and needs of all members. The goal is to achieve the ability of the client to create own daily routine, which he can meet and adjust based on his needs in order to maintain the principles of a healthy lifestyle. The client should know how to prioritize duties before fun in his plans, while not forgetting about relaxation and activities, which are a source of energy for him and give meaning to his life.[18]

[16] KANTOR, J. et al. *Creative Approaches in the Rehabilitation of Persons with a Severe Combined Disorder – Research, Theory and Their Use in Education and Therapy.* Olomouc: Palacky University, 2014, p. 58-63.
[17] MAHROVÁ, G. et al. *Social Work with People with a Mental Disorder.* Prague: Grada, 2008, p. 147.
[18] MAHROVÁ, G. et al. *Social Work with People with a Mental Disorder.* Prague: Grada, 2008, p. 94-95.

1.2.2 Case Management

Case management is defined as a client-centered interdisciplinary approach, which is focused on integration of social and health care. It contains the assessment of the needs and preferences of the individual, the development of a comprehensive plan, service management and monitoring and reevaluation of services based on the needs identified by the case manager. The case manager also provides education in the area of disease management, medication use and facilitation of profession help and intervention in the field of transitional care.[19]

In a traditional inpatient facility, the patients' needs (treatment, housing, leisure time, etc.) are provided by a single source – institution. The structure and coordination of care are fixed and are similar for most patients. Departure of the long-term sick from the hospital (deinstitutionalization) allows work with clients based on individual needs. Likewise, it was necessary to ensure a tie-in of services, fluency of the provided care and their coordination. This brought upon the development of procedures designated as case management of the mentally ill (in the US 1970s, in the UK 1980s).[20]

Case management is an approach, which should help to better coordinate the provided services in a fragmentized system of care. It is a specific method of community work, which consists in the coordination of care in a fragmented system of care. It is a specific method of community work, which consists in the coordination of care for a patient by a single key worker. Case management is based on the principle of preserving the continuity of psychiatric care and social services. The goal is to allow people suffering from a mental disorder life in their own environment, outside of a psychiatric facility. It includes a time-limited planning of helping the individual or family in complex problematic situations. Because these situations can seldom be satisfied by the offer of a single worker, they require planning and implementation help by engaging several types of services. It includes the establishment of contact with the client, assessment of his condition, facilitation of service, termination of work and evaluation.[21]

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[19] GREEN, D. M. – ELLIS, S. Proactive Case Management: Social Work Active Engagement Revisited. In *Journal of Sociology and Social Work.* 2017, p. 10.

[20] MATOUŠEK, O. et al. *Social Work in Practice. The Specifics of Different Target Groups and Work with Them.* Prague: Portal, 2005, p. 140-141.

[21] KOLIBÁŠ, E. *The Handbook of Clinical Psychiatry*. Nové Zámky: Psychoprof, 2010, p. 85. MAHROVÁ, G. et al. *Social Work with People with a Mental Disorder.* Prague: Grada, 2008, p. 21, 135. PROBSTOVÁ, V. – PĚČ, O. *Psychiatry for Social Workers. Selected Chapters*. Prague: Portal, 2014, p. 193-194. MOTLOVÁ, L. – KOUKOLÍK, F. *Schizophrenia. Neurobiology, Clinical Picture, Therapy.* Prague: Galén, 2004, p. 335.

The case manager provides services (practice of skills, management of daily problems, establishment of the client's support social network), establishes a long-term with the client, supports the client's identification with himself and internalization of beneficial attitudes and skills.[22] The case manager is a key person not only for the client, but for the whole system of providing care; he is the coordinator of team work and is responsible for the creation, updating and implementation of an individual plan. His task is for the client to use community services and individual organizations available in the system and for the workers providing this care to cooperate and inform each other. He should ensure that the care is not chaotic, without order and purpose and for the client not to misuse the system of social care. The case manager coordinates care for the client between the necessary providers based on his individual needs and provides direct support to the client, especially in his own environment. His specific duties include the ensuring of a fluent transition from the sickbed to the home environment and the participation of the sick person in community programs in the place of his residence. The role of the case manager can be held by different professionals in the field of care for mental health, most commonly, these are social workers and psychiatric nurses.[23] The case manager must know well the history, current situation of the client, situation of his environment, life conditions and community resources. Using this knowledge, he is able to transform the verbally shared or indirectly expressed wishes of the client into a form of set of medial-social needs, the fulfillment of which then may be the goal of a collaboration.[24]

1.2.3 Recovery

The aim of modern care for people with mental disorders is not to reduce the intensity of the symptoms of the disease or their elimination. The important task is to improve the functional capacity of these people and find a satisfactory place in the society for them. In recent decades, this process was designated as the so-called recovery. It is a long-term process or a path of improving the medical condition and personal transformation, which will allow a person with difficulties caused by a mental disorder to live a meaningful life in the social environment according to his own choosing and strive for total utilization of personal

[22] MATOUŠEK, O. et al. *Social Work in Practice. The Specifics of Different Target Groups and Work with Them.* Prague: Portal, 2005, p. 141.
[23] PROBSTOVÁ, V. – PĚČ, O. *Psychiatry for Social Workers. Selected Chapters*. Prague: Portal, 2014, p. 193-194. MAHROVÁ, G. et al. *Social Work with People with a Mental Disorder.* Prague: Grada, 2008, p. 135. MOTLOVÁ, L. – KOUKOLÍK, F. *Schizophrenia. Neurobiology, Clinical Picture, Therapy*. Prague: Galén, 2004, p. 335.
[24] MATOUŠEK, O. et al. *Social Work in Practice. The Specifics of Different Target Groups and Work with Them.* Prague: Portal, 2005, p. 141.

potential.[25] Recovery may also be defined as the ability to adequately fulfil obligations despite certain functional restrictions.[26] Recovery means the acceptance of oneself, the meaning and purpose of life, which exceeds the limits of the disease, manage the disease and adapt oneself to the disease.[27] The rehabilitation understanding of recovery is focused more subjectively on the client and the process and may be interpreted as the successful life adaptation and achievement of a full-fledged life under a long-term mental disease; it is the subjective feeling of the value of life. Recovery is a process, not a final point.[28]

The recovery approach is a way to live a happy and fulfilling life despite the mental disease. Despite the disease the person has, he should live a full-fledged life in interaction with other people. Recovery means that the worker leads the client towards doing ordinary activities despite his disease. It means that he should not withdraw "into his shell" and isolate himself, but to look for a job adapted to the disease, live alone, with support, if necessary, and not in residential facilities, have friends and socialize with them. A person with a mental disorder must not feel that he is useless and that his life does not have a meaning. A mental disorder does not mean that the life stops, but it is necessary to grasp a new meaning of life, which will respect the disease, but it won't be completely restricted by it.

1.2.4 Crisis Intervention

Crisis intervention is a professional method of work with the client in a situation he personally experiences as burdensome, unfavorable and threatening.[29] A crisis situation is a situation, which escalates and exceed the current possibilities of the person to handle it. It is also a situation, which is subjectively experienced as negative, threatening the quality of life or life itself and the person is temporarily not finding a way to solve it at the moment. Crisis is also a situation, which forces the person to look for a solution. For the duration of the crisis, the person is usually motivated to solve the situation and is open even to unusual and creative possibilities. A crisis situation has its time patterns. Usually, it lasts hours, days or a few weeks at the most. It is a relatively short and also important time, during which the person experiences severe tension and his need to solve the situation is great.[30]

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[25] PROBSTOVÁ, V. – PĚČ, O. *Psychiatry for Social Workers. Selected Chapters*. Prague: Portal, 2014, p. 214.
[26] GREEN, C. Fostering Recovery from Life-transforming Mental Health Disorders: A Synthesis and Model. In *Social Theory & Health.* 2004, p. 294.
[27] MATOUŠEK, O. et al. *Social Work in Practice. The Specifics of Different Target Groups and Work with Them.* Prague: Portal, 2005, p. 136.
[28] PROBSTOVÁ, V. – PĚČ, O. *Psychiatry for Social Workers. Selected Chapters*. Prague: Portal, 2014, p. 214.
[29] VODÁČKOVÁ, D. *Crisis Intervention.* Prague: Portal, 2007, p. 60.
[30] VODÁČKOVÁ, D. – BROŽ, F. *Crisis Intervention in Case Studies.* Prague: Portal, 2015, p. 36-49.

Crisis intervention differs from the ordinary intervention in that it is easily achievable (through a wide network of available institutions and forms), continual (its continuation is the subsequent work with the client), preventive (it prevents possible worsening of the condition), activating (it actives the client's hidden potential) and close (it is provided in the least restrictive environment possible).[31] Other features include immediate help, reduction of jeopardy, focus on current situation, intense contact within the designated timeframe and structured, active and directive approach.[32]

Crisis intervention is short-term care regulating trauma, suicidal thoughts or behavior or behavior, which is harmful to oneself or other, and also acute conditions of mental disorders where the individual needs urgent care.[33] From the perspective of safety of the mentally ill person, it is suitable for the person to be available constantly if possible and without unnecesarily overcoming obstacles like ordering. Crisis help should be available when the client needs it, for the whole duration of the crisis. Crisis help should be followed by other professional services like counselling or psychotherapy.[34]

1.2.5 Occupational Therapy

According to the World Federation of Occupational Therapists, occupational therapy focuses on supporting the individual's health and overall wellbeing through work. The primary goal of occupational therapy is to allow people to participate in daily activities. Occupational therapists achieve this goal by trying to help people perform activities, which increase their chance of inclusion or adapt the environment supporting the person's participation.[35] According to the Council of Occupational Therapists for the European Countries, occupational therapy is the treatment of people with a physical or mental disease or disorder, which uses specifically chosen activities with the goal of allowing the persons to achieve maximum functional level and independence in all life aspects.[36] According to the Czech Association of Occupational Therapists, occupational therapy strive to preserve and utilize the skills of the individual necessary for handling ordinary daily, work, interest and recreational activities of persons of any age and different types of disability through purposeful employment. The term employment means all activities the person performs in the

[31] HUNYADIOVÁ, S. *Crisis Intervention in Helping Professions.* Prešov: USVaZ, 2012. p. 36.
[32] ŠPATENKOVÁ, N. *Crisis Intervention for Practice.* Prague: Grada, 2011, p. 15-16.
[33] BISHOP, M. – SCOTT, M. – LEE, H. S. The Crisis in Crisis Intervention: An Analysis of Crisis Care and Community. Mental Health in Northwest Ohio. In *Journal of Sociology and Social Work.* 2017, p. 32.
[34] VODÁČKOVÁ, D. – BROŽ, F. *Crisis Intervention in Case Studies.* Prague: Portal, 2015, p. 36-49.
[35] JELÍNKOVÁ, J. et al. *Occupational Therapy.* Prague: Portal, 2009, p. 13.
[36] JUHÁSOVÁ, A. et al. *Social Rehabilitation of the Disabled People.* Nitra: UKF, 2012, p. 20.

course of his life, and which are seen as part of his lifestyle and identity. Occupational therapy is a profession, which specifically focuses on the performance of activities the client considers useful or meaningful, it considers activity the goal and the means of therapy, it is based on a client-focused approach, where treatment is based on social roles of the person and it is interested in the environment, where the client lives and works, because the performance of activities is affected by the mutual interaction between the client and the environment.

The occupational therapist is one of the members of the multidisciplinary team and his task is to help the client overcome difficulties in performing ordinary daily activities. He helps utilize his potential in order to be able to perform activities, which are necessary for the fulfillment of social roles and engagement in full-fledged life. Occupational therapists work with clients of every age, who have, for some reason, difficulties in performing daily tasks. The difficulties may be caused by physical, sensory, psychological or mental disorder or social disadvantage.

In occupational therapy, we can differentiate the so-called Occupational Performance Model, which includes three basic categories:

1. Activities of Daily Living (ADL), which are further divided into Personal (PADL, which include eating, clothing, personal hygiene, bathing, using the toilet, movement, excretion,..) and Instrumental (IADL, which include making phone calls, travel, shopping, food preparation, housework, medication use, money management, washing of clothes,..),
2. Work, productive activities, which include employment due to financial security, personal development, activities linked to housekeeping, care for another person, education,
3. interest, leisure time activities, which include leisure time and interest activities appropriate to the client's age.[37]

The main areas of occupational therapy include conditional occupational therapy (this is interest activity performed for the purpose of joint meetings in a creative spirit, for example, handwork, garden work, work with clay, etc.), occupational therapy targeted on the handicapped area (this is activity focused on the rehabilitation of the musculoskeletal system), occupational therapy focused on work inclusion (occupational diagnostic plays a crucial role hear, which means comprehensive testing of the client's potential on model work performances or specifically considered work activities with the goal of designing a plan for

[37] JELÍNKOVÁ, J. et al. *Occupational Therapy.* Prague: Portal, 2009, p. 12-13, 66-67, 74.

work rehabilitation given the type of performed work, or possible direct inclusion in the work process), occupational therapy focused on education for self-sufficiency (its role is the training of ordinary daily activities like eating, washing, clothing cleaning, shopping, etc.).[38]

Activities in occupational therapy can be divided into three categories:

1. Activities with own meaning

These are activities, which are often time-consuming (the activity may be split to several days). The performance of this activity creates a product, for example, a cabinet in a woodworking shop, a bag in a sewing shop, etc. In addition to the created product, it is important to evaluate the production process. This type of activity is suitable for the training of work skills and habits like coming in on time, staying all "working hours", independence when working, focus on the task, etc. These activities may not be related to the future occupation of the client. The goal is to train work skills in order to improve function and the overall work potential of the client.

2. Activities copying work activity

   These are implemented, when it is known where the client will work and in the training environment, we strive to simulate individual activities from his scope of work.

3. Activities, which do not have own purpose

Individual skills are trained, for example, soft motoric skills by inserting pins into precisely marked places (for observation of speed, accuracy of movement, coordination of the fingers' work, hand-eye coordination, etc.).[39]

The basic principles of occupational therapy include the differentiated approach – each client should be assigned activity, which is difficult to the point where it approaches the upper limit of his current possibilities and also the principle of purposeful work. The work should be performed also in groups in order for the client to have the possibility to learn to communicate with others.[40]

The occupational therapist may also use artistic activities, like, for example, creative workshops focused on work with paper, baskets, sewing, etc. When planning the activities, the occupational therapist focuses on the product, as well as the production process. For some clients, the production process has a therapeutic effect and the product is only secondary. The occupational therapist selects activities with different focus and demands based on need, for

[38] JUHÁSOVÁ, A. et al. *Social Rehabilitation of the Disabled People.* Nitra: UKF, 2012, p. 20-21.
[39] JELÍNKOVÁ, J. et al. *Occupational Therapy.* Prague: Portal, 2009, p. 235-236.
[40] KOLIBÁŠ, E. *The Handbook of Clinical Psychiatry*. Nové Zámky: Psychoprof, 2010, p. 82.

example, mechanical, coarse or fine, time demanding, activities requiring independence, demanding cooperation with another person, activities demanding patience or good memory, which are not demanding of skill, etc. This activization is taken as socialization of clients, retention of skills and mental and physical condition, relief of stress, worries and pain and support of self-confidence and feeling of purposeful activity. Somewhere, the products may be sold to the public and the clients can participate on the sale, which brings they joy when they see that someone likes their products.[41]

The main goal of occupational therapy is to help the clients satisfactorily perform activities in the field of self-care (self-service), productivity, leisure time up to social inclusion.[42] According to the Czech Association of Occupational Therapists the goal of occupational therapy is to: Support the health and mental wellbeing of the person through purposeful activity. Help with approving skills the client needs to manage ordinary daily activities, work activities and leisure time activities. Allow the client to fulfill his social roles. Help with the complete engagement of the client in activities of his social environment and community. Implement client-focused therapy, who is an active participant on the therapy and participates on the planning and process of the therapy. Empower the person in retaining, renewing or acquiring competences needed for the planning and implementation of his daily activities in interaction with the environment (handling the demands of the social and the physical environment).[43]

Work, which includes care for the daily operation of the center is very significant in the care for the mentally ill. These are activities, which are divided based on function. The clients acquire competences and trust in their performance. Occupational therapy is focused on the development of manual kills and social competences. It helps to renew skills that were disturbed due to the disease or trauma and thus builds the person's independence. Occupational therapy means not only help in structuring the day and avoiding damage from inactivity, but it also specifically shows and convinces the disabled people that they can do something.[44] Occupation is considered the most suitable rehabilitation treatment. It is

[41] JELÍNKOVÁ, J. et al. *Occupational Therapy.* Prague: Portal, 2009, p. 224-225.
[42] JELÍNKOVÁ, J. et al. *Occupational Therapy.* Prague: Portal, 2009, p. 16-17.
[43] KRIVOŠÍKOVÁ, M. – JELÍNKOVÁ, J. *The Concept of the Field of Occupational Therapy.* Czech Occupational Therapy Association, http://Occupational Therapy.cz/wp-content/uploads/2018/09/koncepce_oboru_Occupational Therapy.pdf.
[44] JUHÁSOVÁ, A. et al. *Social Rehabilitation of the Disabled People.* Nitra: UKF, 2012, p. 13. MAHROVÁ, G. et al. *Social Work with People with a Mental Disorder.* Prague: Grada, 2008, p. 95-96. HELL, D. – FISCHER-FELTEN M. *Schizophrenia. Basics for Understanding and Orientation.* Trenčín: Publisher F, 1997, p. 81.

necessary to develop occupational therapy given the destructive effect of inactivity and the feeling of uselessness on the human psyche.[45]

1.2.6 Art Therapy

According to the American Art Therapy Association, art therapy is defined as a profession in the field of metal health, which uses the creative process of artistic creation for the improvement or uplifting of the physical, mental and emotional state of well-being of individuals of all ages. It is based on the faith that the as part of the artistic self-expression, the creative process helps people solve conflicts and problems, develops interpersonal skills, behavior management, reduce stress, improve self-confidence and self-awareness and achieve insight.[46]

In the broadest scope, art therapy can be divided into passive and active, and receptive and productive. Receptive art therapy includes visits to exhibitions and galleries, projection of videos or photographs joined with discussions about the perceived artistic artefacts. A productive art therapy means the use of specific creative activities like paining or modelling. Both of these dimensions can be applied in individual and group form. The content, methods and forms of art therapy must be based on an individual approach to the client, taking into account his age, gender, intellectual level, form of mental disorder and interests of the client.[47]

The individual goals of art therapy include relaxation, self-experience and self-perception, visual and verbal organization of experience, knowledge of own possibilities, adequate self-evaluation, growth of personal freedom and motivation, expression of emotions, development of fantasy and overall personality development. The social goals of art therapy include the perception and acceptance of other people, recognition of their value, establishment of contact, engagement in group and cooperation, communication, joint problem solving, experience that others have similar experience and emotions and establishment of social support. The goals of art therapy with clients with mental disorders include creating opportunities for sublimation of negative experience, enabling correction of inadequate conclusions and events, which lead to confused thinking and behavior, provide a realistic view on own disease, provide a vision for change and understanding events and hope for treatment. The aim of art therapy with clients with mental disorders is to help these people

[45] HAŠTO, J. et al. *Psychiatric Care Reform in the Slovak Republic*. Trenčín: Publisher F, 1999, p. 52. KAFKA, J. et al. *Psychiatry. Textbook for Medical Faculties*. Martin: Osveta, 1998, p. 96.
[46] GROHOL, M. *Art Therapy in Psychiatry*. Bratislava: Lundbeck, 2008, p. 23-24.
[47] ŽIVNÝ, H. et al. *Chapters from the Therapy of Addiction to Psychoactive Substances*. Bratislava: OZ Social Work, 2004, p. 27. GROHOL, M. *Art Therapy in Psychiatry*. Bratislava: Lundbeck, 2008, p. 31.

reflect on their own problems through artistic creation – depression, anger, chaos, fear, desperation – and integrate them as part of themselves. The clients are often unable to explain their own anger, but when they draw it, they are able to comment on it. Artistic reflection works as a bridge between the client's internal experience and himself, to better understand his situation. Art therapy serves to map the client's problems, find a way to help, to make amends and to a specific solution.[48]

Artistic creation is specific and has a visual nature. Searching for or expression of hope in artistic creation is a natural process. Art therapy helps the person express suppressed suffering and manage negative experience. It also serves to know oneself. It helps to uncover unknown images and uncover unknown fantasies and impulses. Some emotions are difficult to describe in words, therefore, it is sometimes easier to express them through drawing. The client expresses himself through a painting or an object what he cannot or is not able to describe in words.[49]

The main pillars of art therapy include the creative process (the creative process itself is healing, it also provides space for materialization and externalization of the problem), the symbolization process (through this process, emotions acquire physical nature, this happens trough colors and forms, and also work with symbols is work "in representation", which offers "protection" to the client against direct confrontation with unacceptable content), the process of conversation and interpretation (conversation and interpretation are integral parts of art therapy; creation may trigger important processes and release healing powers) and therapeutic relationships (art therapy relationship differs with the presence of a third albeit painted product).[50]

1.2.7 Musical Therapy

Musical therapy is an interpersonal process, which uses music experience for the purpose of improving, stabilizing and recuperation of health. It is focused on physical, mental, emotional and social problems. It is a purposeful process, during which the musical therapist helps the client improve, keep or restore the feeling of mental wellbeing. Music should be

[48] ŠICKOVÁ-FABRICI, J. *Basics of Art Therapy*. Prague: Portal, 2008, p. 52, 76.
[49] RUBINOVÁ, J. A. et al. *Approaches in art Therapy. Theory & technique.* Prague: Triton, 2008, p. 53. ŽIVNÝ, H. et al. *Chapters from the Therapy of Addiction to Psychoactive Substances*. Bratislava: OZ Social Work, 2004, p. 42-43. STEHLÍKOVÁ-BABYRÁDOVÁ, H. *Expression Therapy with Focus on Painted and Intermedial Expression.* Brno: Masaryk University, 2016, p. 31. LHOTOVÁ, M. – PEROUT, E. *Art Therapy in Context.* Prague: Portal, 2018, p. 32-33.
[50] GROHOL, M. *Art Therapy in Psychiatry.* Bratislava: Lundbeck, 2008, p. 108-109.

applied to the client's problems in order to be therapeutic.[51] The World Federation of Musical Therapy defines musical therapy as the professional use of music and its elements as an intervention in healthcare, education and daily environment of the client, which strives to optimize the quality of his life and improvement of his psychic, social, communication, emotional and mental health.[52] Musical therapy is structure to use musical experience for the facilitation of positive behavioral changes of the client. The ability to enjoy music and react to it is innate to humans. It is generally known that this ability cannot disappear even with handicaps, injuries or diseases and that it is not dependent on musical education.[53]

Based on the means the musical therapy uses, it is divided to receptive and active. With receptive musical therapy, the attention is focused especially on listening to music, sounds, noise or silence. Receptive musical therapy has many methods of working with listening to sounds and music. Other reception channels than just hearing, are used to process the stimuli: it works with ideas, associations, mental images, etc. With active musical therapy the client works with a musical instrument or voice. He may use other artistic methods like movement, dance, dramatization, drawing or poetics.[54]

Musical therapy may be implemented individually or in group. In group active musical therapy, all interactions and relations are taken into consideration, which arise from the group happening. Based on this, improvisation may be: phase-specific (reacts to the current group dynamic – level of cohesion, tension, insecurity,..), situational (based on specific happening, to which the offer reacts – fatigue, resistance, rivalry, leadership,..), thematic (thematizes some phenomenon, goal or norm), associational (offers sounds as a depiction of certain ideas, especially of natural phenomena), relaxing (the goal is relaxation and a good feeling of rest, facilitates relaxation), intermedial (works also with other median than sound, engages movement, dance, drawing, dramatization, etc., in the game), role-playing (facilitates audio representation of certain roles, where the clients repeat their communication schemes, often

[51] VITÁLOVÁ, Z. *Introduction to Musical Therapy and its Use in Social Work.* Bratislava: UoLaSC of St. Elisabeth, 2007, p. 20. ZELEIOVÁ, J. *Musical Therapy – Dialogue Through Vibration. Starting Points Concepts, Principles and Practical Application.* Bratislava: Institute of Musical Science SAV, 2002, p. 28. GERLICHOVÁ, M. *Musical Therapy in Practice. Stories from Musical Therapy Paths*. Prague: Grada, 2014, p. 15-16.

[52] GERLICHOVÁ, M. *Musical Therapy in Practice. Stories from Musical Therapy Paths.* Prague: Grada, 2014, p. 15.

[53] ZELEIOVÁ, J. *Musical Therapy – Dialogue Through Vibration. Starting Points Concepts, Principles and Practical Application.* Bratislava: Institute of Musical Science SAV, 2002, p. 28, 31.

[54] ZELEIOVÁ, J. *Musical Therapy: Starting Points, Concepts, Principles and Practice*. Prague: Portal, 2007, p. 142-143. STEHLÍKOVÁ-BABYRÁDOVÁ, H. *Expression Therapy with Focus on Painted and Intermedial Expression.* Brno: Masaryk University, 2016, p. 22.

non-functional) and integrative (past experiences, relationships, or features of some client are reflected in a prepared scene).[55]

In the social work sphere, musical therapy strives to help in the promotion of social justice, improve the quality of life and develop the client's abilities. It may serve as an assisting diagnostic tool or for the prevention and treatment of various emotional and mental problems. It may be also recommended to people with chronic, physical, mental or psychosomatic disease.

The areas of application of musical therapy include: facilitation of contact with the client, activization of the emotional side, development of communication, development of creative skills, development of aesthetic appreciation and socialization.[56]

Musical therapy uses music or musical elements to achieve non-musical goals. In targeted musical therapy, it is necessary to observe the therapeutic goal (for example, improvement of speech, etc.), but also to monitor how chosen musical elements act upon the client's breath, mood, posture, etc. It is difficult to focus on all aspects at the same time, therefore, it is recommended to pick one dominant goal, to which special attention is given and to deal with the others in the background. The aims of musical therapy are emotional activization, regulation of tension and improving the ability to experience. [57]

Music supports relaxation and self-observation, which leads to improved imagination. Based on the recalled ideas, the worker tries to develop reactions and ideas of the clients and establish symbolic links. He helps the clients to recognize own feelings and understand them better. It is important to reassure the clients that they are not in danger. Also remind them that if the ideas would seem too sinister, they can stop the process at any time. It is important to remind them that they will have the ability to discuss their ideas and they will not have to struggle with unresolved emotions alone. If a client experienced in his mind an especially significant experience and suggests that he needs more time to explore it, he is reminded that he can come back to this place in his mind.[58]

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[55] ZELEIOVÁ, J. *Musical Therapy: Starting Points, Concepts, Principles and Practice*. Prague: Portal, 2007, p. 146.

[56] FELBER, R. et al. *Musical therapy. Therapy through Singing.* Hranice na Moravě: Fabula, 2005, p. 79. ZELEIOVÁ, J. *Musical Therapy – Dialogue Through Vibration. Starting Points Concepts, Principles and Practical Application.* Bratislava: Institute of Musical Science SAV, 2002, p. 39. GERLICHOVÁ, M. *Musical Therapy in Practice. Stories from Musical Therapy Paths*. Prague: Grada, 2014, p. 77. VITÁLOVÁ, Z. *Introduction to Musical Therapy and its Use in Social Work.* Bratislava: UoLaSC of St. Elisabeth, 2007, p. 23.

[57] GERLICHOVÁ, M. *Musical Therapy in Practice. Stories from Musical Therapy Paths.* Prague: Grada, 2014, p. 15-16. ZELEIOVÁ, J. *Musical Therapy – Dialogue Through Vibration. Starting Points Concepts, Principles and Practical Application.* Bratislava: Institute of Musical Science SAV, 2002, p. 33.

[58] MORENO, J. *Igniting Your Inner Music. Musical Therapy and Psychodrama.* Prague: Portal, 2005, p. 49, 60.

Music penetrates even the most sensitive areas of a person. It may help the client to know himself, open up, uncover things so far unknown or difficult to overcome and get rid of fear or loneliness. Listening to music or playing it means handing over part of yourself, insert your emotions and experience in it, penetrate the secrets of oneself and reach a cathartic experience.[59] Music has also psychophysical effects – experience with musical therapy may trigger healing processes in the organism: fulfillment of physical, emotional, intellectual, social and other needs of the clients. Music subconsciously soothes pain and balances emotional life.[60] It was discovered in research focused on the effect of musical therapy on the brain of people suffering from depression that musical therapy significantly decreases signs of depression and anxiety.[61]

1.2.8 Drama Therapy

The National Association for Drama Therapy defines it as the intentional use of dramatic procedures for mental and physical integration and growth of personality. It leads the client to experience emotions, obtain motivation, develop self-confidence, create a sense of responsibility and integration.[62]

Drama therapy uses individual and group activities aimed at theater, work with the body, facial expressions, gestures and language. Drama therapy means relaxation and the development of interpersonal relationships for the development of social competences and personality aspects. In drama therapy, it is possible to model social interactions, vent emotions, etc. Drama therapy is focused on expression, development and control of emotions – expression of emotions, through which the client gets rid of tension and negative emotions. Another goal of drama therapy is the development of relationships in group – the important techniques here are focused on role-playing, interaction and cooperation in group. Given the development of the individual, techniques leading to the deepening of perceptual abilities, self-knowledge and self-acceptance are also important. Through drama therapy, the clients

[59] VITÁLOVÁ, Z. *Introduction to Musical Therapy and its Use in Social Work.* Bratislava: UoLaSC of St. Elisabeth, 2007, p. 51.
[60] STEHLÍKOVÁ-BABYRÁDOVÁ, H. *Expression Therapy with Focus on Painted and Intermedial Expression*. Brno: Masaryk University, 2016, p. 22.
[61] FACHNER, J. – GOLD, Ch. – ERKKILÄ, J. Music Therapy Modulates Fronto-Temporal Activity in Rest-EEG in Depressed Clients. In *Brain Topogr*. 2013, p. 338.
[62] JUHÁSOVÁ, A. et al. *Social Rehabilitation of the Disabled People.* Nitra: UKF, 2012, p. 25.

can examine the psychological dimensions of their problems not only during a conversation about their problems, but rather through searching for conflict situations.[63]

Through the liberating experience of dramatic depiction, the drama therapy stage offers active, but also protected space, where it is possible to dynamically examine problems with the support of the drama therapist.[64]

1.2.9 Bibliotherapy

Bibliotherapy means treatment through books. The term bibliotherapy is based on the Greek words *biblion* = book a *therapeia* = treatment, nursin.[65] As part of bibliotherapy, the text becomes a therapeutic tool, which supports the treatment effect of the environment. Reading relieves inner tensions of people. [66]

From the formal perspective, bibliotherapy is divided into receptive (reading and listening to literary text), perceptive (working with the text after reading it) and expressive (the client writes a text and presents it, for example, life story, letters, poems, journals, which also uses completion of words, sentences or stories).[67]

Bibliotherapy may be in the form of organized reading of selected texts or individual reading of recommended books.[68]

Bibliotherapy can also be differentiated into:

1. Cognitive

This type of bibliotherapy is characterized as a process of learning from well-written materials (professional, educational) due to the therapeutic focus. The main goal is to acquire information and subsequently obtain skills (competences). It helps the clients to learn and understand their own destructive throughs and patterns of behavior and also subject them to revision, which leads to improved rational and realistic thinking and behavior.

2. Affective (emotional)

This type of bibliotherapy uses fiction and other high-quality literature to help the client, in the process of identification, to combine emotional experience with own actually

[63] STEHLÍKOVÁ-BABYRÁDOVÁ, H. *Expression Therapy with Focus on Painted and Intermedial Expression*. Brno: Masaryk University, 2016, p. 24-25. MORENO, J. *Igniting Your Inner Music. Musical Therapy and Psychodrama.* Prague: Portal, 2005, p. 16.
[64] MORENO, J. *Igniting Your Inner Music. Musical Therapy and Psychodrama.* Prague: Portal, 2005, p. 16.
[65] KOVÁČOVÁ, B. – VALEŠOVÁ-MALECOVÁ, B. *Bibliotherapy in Early and Pre-school Age.* Bratislava: UK, 2018, p. 6-7.
[66] BALOGOVÁ, B. et al. *Vademecum of Social Work.* Košice: UPJŠ, 2017, p. 81.
[67] KOVÁČOVÁ, B. – VALEŠOVÁ-MALECOVÁ, B. *Bibliotherapy in Early and Pre-school Age.* Bratislava: UK, 2018, p. 11.
[68] KAFKA, J. et al. *Psychiatry. Textbook for Medical Faculties*. Martin: Osveta, 1998, p. 97.

experienced situations. It is based on the assumption that people use defense mechanism to protect themselves from pain. Bibliotherapeutic stories offer an insight into personal problems by creating a safe distance, which allows the client to indirectly get to the sensitive questions, about which it is otherwise painful to talk. Another aspect is the identification, examination and reflection on emotions. Through identification with the literary characters, the clients are exposed to a range of emotions, from which they can find out something about themselves.

3. Clinical

The goal is to support a perspective of change in behavior and attitude up to the improvement of mental health. The client and the worker discuss the problem, on which they focus, and examine its alternatives in the sense of subsequent solution. The bibliotherapist's task is to make it easier for the client to express emotions and find a possible solution to the problem.

4. Developmental

Developmental bibliotherapy is used preventively. The aim is to try to anticipate and prepare for (developmental) needs and specific crisis situations of individuals even before the problems arise. It may be used in ordinary daily problems during the individual developmental periods, like, for example, anger, onset of bulling, problems with adaptation in the collective, building of friendships, fear of school, problems with self-respect, etc. Bibliotherapy may help children go through the predictable life stages by providing information about what they may expect and examples of how other people handle similar developmental tasks and provide them with skills to know how to react, if this situation occurs.[69]

1.2.10 Animal Therapy

Animal therapy uses the presence and contact with animals for therapeutic, educational, motivational, recreational and other purposes. The animal helps the client to relax, motivates him to activity, develops soft motoric skills, reduces anxiety and stress, develops emotional expression, provides a feeling of safety and security and supports immunity through the psyche.[70]

There are two main methods of using animals in various health and social facilities, namely in the form of: animal-assisted activities (AAA) and animal assisted therapy (AAT).

[69] KOVÁČOVÁ, B. – VALEŠOVÁ-MALECOVÁ, B. *Bibliotherapy in Early and Pre-school Age.* Bratislava: UK, 2018, p. 11-14.
[70] JUHÁSOVÁ, A. et al. *Social Rehabilitation of the Disabled People.* Nitra: UKF, 2012, p. 28-30.

These are commonly referred to as animal assisted interactions (AAI).[71] Animal-assisted activities (AAA) provide motivational, educational, recreational or treatment opportunities for improving life quality. It is provided in different environments with specifically trained professionals, semi-professionals or volunteers, with the participation of animals that meet certain criteria. It includes activities like "meet and greet", which may be repeated in the same way in many cases with different clients without a particular treatment goal or individual customization. Their course is more or less spontaneous, duration not limited and they are not recorded in the patient's medical history or personal file. An example are visits to senior facilities once a week by volunteers and an appropriately trained and health-tested dogs, with the assistance of the personnel. Another example are visits of children facilities and hospitals for the purpose of play, distraction or education. The general goals of AAA include: Temporary change in the distribution of forces between the personnel and the clients and the possibility to see each other in a different situation. Improvement of the clients' comfort. Encouragement of clients to focus on a positive activity. Help the clients focus their attention to the outer world. The presence of the dog and the mediator are both equally important to achieve these goals. The dog breaks the ice and sparks conversation; the dog handler preserves and directs it. Animal-assisted therapy is a purposefully focused intervention, where the animal meeting specific criteria is an integral part of the treatment process. AAT is guided and/or performed by a professional of the health or social facility with relevant expert training and as a part of performance of his profession. AAT is designed to support the improvement of the person's physical, social, emotional and cognitive skills. It is provided in different environments and may be individual and in a group. The whole process is closely recorded and evaluated. Key features are the presence of specific goals and tasks for individual clients and an objective measurement and recording of their progress. AAT may be used in, for example, the formation of physical skills (improvement of soft motoric skills, standing, walk, balance, wheelchair control, etc.), mental skills (improvement of verbal interactions in group, improvement of the ability to concentrate on a task and maintain attention, improvement of memory, development of communication skills, improvement of self-confidence and self-control, reducing the feeling of loneliness and anxiety, etc.), education (improvement of vocabulary and pronunciation, improvement of knowledge and concepts like size, color, number, etc.) and motivation (improvement of the willingness to engage in a group activity

[71] GALAJDOVÁ, L. – GALAJDOVÁ, Z. *Canis Therapy. Dog a Doctor for the Human Soul*. Prague: Portal, 2011, p. 96.

and cooperate with other, improvement of the relationships with the personnel, improvement of physical activity, etc.). Another example is teaching children empathy. Here it is important for the psychotherapist and dog handler to be two different people to maintain greater control of the situation. The therapist may talk to the child about the dog's feelings, how the dog would like to be treated and what he doesn't like, create parallels between behavior and the child's feelings and comment on the reaction of the dog to the child, whether positive or negative. In case of negative reaction, it is necessary to suggest to the dog handler to move the dog to safety, while the therapist uses the situation for the planned goals. An experienced therapist may skillfully use even negative reactions to discuss the reasons, why the dog was afraid of the dog or why he wanted to get away from him. The model of separate role of the dog handler and the therapist allows the therapist to focus on the client and the dog handler on the dog.[72]

There are several types of animal therapy; the most common are canis therapy (with a dog), hipo therapy (with a horse), other known therapies include feline therapy (with a cat), dolphin therapy, as well as therapies using small animals (rabbit, guinea pig, hamster, etc.).[73]

The same rules apply to each animal therapy: No one (client, worker, visitor) cannot be forced into contact with the animal. The institutions must have rules and instructions regarding the use of animals in given facility in written form before the start of the program. Dogs and dog handlers must undergo training, selection and tests, on then their participation in the program is possible. Clients with contradictions (allergies, phobias, uncontrollable or unpredictable behavior) must be excluded from the program in advance. The rights of the people, who do not wish to come into contact with the animal must be respected. Neither the client, nor the visitor should ever be left alone with the animal. It is important to respect and secure the rights of the animals under all circumstances. This includes appropriate treatment, protection against excessive stress and access to water and free range.

Animal therapy has a number of benefits. In research conducted with 162 socially endangered children aged 6-8, it was concluded that the relationship to animals was not affected by the original type of early bonding. Quite the contrary, the relationship to animals was rather close and intimate. The results of this research support the hypothesis that relationship to animals may break the pattern of unsafe bond transfer in children. If the child is able to establish a safe bond with the social animal, it will be easier for him to establish a

[72] GALAJDOVÁ, L. – GALAJDOVÁ, Z. *Canis Therapy. Dog a Doctor for the Human Soul*. Prague: Portal, 2011, p. 96-99.
[73] JUHÁSOVÁ, A. et al. *Social Rehabilitation of the Disabled People.* Nitra: UKF, 2012, p. 28.

similar relationship with a person. Another research was conducted with 75 children with an unsafe bond aged 7-12, who were split into three groups at random. All children were exposed to the Trier social stress test, whereby they measured the level of the stress hormone cortisol in blood. Each group was given a differed consolation option: a plush dog, a life dog or a friendly adult person. The cortisol levels of the group with the live dog were shown to be lower. The children from this group sought more physical contact with the dog and they were more active and emotionally expressive. The more they petted the dog and talked to him, the lower the cortisol levels. The dog was able to provide greater support in stressful situations to the children than a person. So, animals may affect the development of empathy in children. This is caused by the effect of a safe bond. Many children use a home animal as a reliable port and a safe base. Furthermore, this is caused by unconditional love, which positively affects the children's sense of self-worth.[74]

In addition to unconditional friendship, the dog also offers constant company. If a person is a lone, he has a tendency to needlessly think too much and a dog does not allow this. He attracts attention and if the person does not give it to him, he even gets mad. He pulls the person out of thinking, pulls him among people, in nature and thus works also no the mental and physical health of his owner. If the person is sad, the dog puts his head in his palm, lays at his feet or starts bringing toys. Each dog has his unique form of expression. Also, the client's anger often quickly turns into curiosity, distraction into interest and stress into relaxation. The dog pulls these clients out of their shells, leads their attention from being focused on their own internal problems to the outer world and thus provides immediate relief from mild depression, sadness, anxiety or worries. A dog may also have an incredible effect on people in a depressive mindset, because he has no limitations of physical contact and thus may express his interest or care by snuggling, etc. Sometimes, his happy greeting is enough – many clients have not had such a greeting for many years. Furthermore, it was proven that a loved animal, to which the owner has a strong emotional connection, causes the secretion of oxytocin in the owner, especially when petting or touching the animal. It seems that some dogs have a greater ability to stimulate the production of oxytocin in people than others.[75]

[74] GALAJDOVÁ, L. – GALAJDOVÁ, Z. *Canis Therapy. Dog a Doctor for the Human Soul*. Prague: Portal, 2011, s. 90, 96.
[75] GALAJDOVÁ, L. – GALAJDOVÁ, Z. *Canis Therapy. Dog a Doctor for the Human Soul*. Prague: Portal, 2011, p. 51-52,91, 97, 130.

In conclusion, it is necessary to emphasize that canis therapy does not mean sacrificing the dog in favor of the person, but a mutual mental effect and the resulting mental and physical benefit. Unless it is pleasant also to the dog, canis therapy is dog abuse.[76]

[76] GALAJDOVÁ, L. – GALAJDOVÁ, Z. *Canis Therapy. Dog a Doctor for the Human Soul*. Prague: Portal, 2011, p. 67.

2 Research Methodology

Our aim is to analyze social services primarily focused on people with mental disorders in the Czech Republic. Examine the process and determine the methods of social work with this target group. Identify the problems related to helping this target group in the Czech Republic.

We chose the qualitative method to achieve the set goal. We conduct the qualitative research using the method of a deep semi-structured interview. We have created research questions. First, we chose the basic research question (What social services and methods of work with people with mental disorders are being used?), subsequently we have derived specific research questions from it (What social services are focused on people with mental disorders? What methods are used by the social workers in their work with people with mental disorders? Which social problems does the target group of people with mental disorders encounter?) and from them, we have defined specific research questions. Since it was a semi-structured interview, specific questions were different for specific participants and were often adapted to individual testimonies.

We have used open coding to analyze the data. We have transcribed the recorded interviews and selected data snippets. Subsequently we created codes and grouped them into categories. The evaluation is done using the "card sorting" technique. The "card sorting" technique consists in the fact that the categories contained in the categorized list of codes is organized by the researched into a picture, which suggests mutual relationships between them and based on this, he organizes the text in order to retell the content of the individual categories. It is not necessary to include all categories in the resulting analysis; the selection criterion should be the relevance to research questions and also what relationship is there between them.[77]

The research set consisted of workers in social facilities primarily focused on people with mental disorders in the Czech Republic. The research sample consisted of 13 workers (referred to P1-P13 in the results).

[77] ŠVAŘÍČEK, R. – ŠEĎOVÁ, K. et al. *Qualitative Research in Pedagogical Sciences*. Prague: Portal, 2007, p. 226-227; KNAPÍK, J. *Adaptation and Socialization of Greek-Catholic Theologians*. Prešov: Publisher Michala Vaška, 2014, p. 59.

3 Social Work with People with Mental Disorders in the Czech Republic

This chapter presents the results of our research in social organizations in the Czech Republic, which are primarily focused on helping people with mental disorders.

3.1 Social Services

The first area, on which we focused were services provided to people with mental disorders and the process of social work.

3.1.1 Types of Services

We identified the following services, which are focused on helping people with mental disorders:

- **Mental Health Center**

The mental health center is a major element in the network of services for people with a mental disorder. The aim of the center is to provide community and multidisciplinary service focused on prevention of hospitalization or its shortening and help with re-integration of people with a severe mental disease into the common community. The multidisciplinary team works in the form of case management and provides flexible, individualized services to the necessary clients. A large portion of the center's services is provided to the clients in their natural environment. Health and social services are interconnecting in the center. As part of providing social services, the mental health center provides care through social rehabilitation, which in connection to health services follows the maximum possible social integration and clinical and social recovery of the clients. The center cooperates with other providers of social services and subjects active in the field of employment, education, housing, leisure time activities, etc. Given that the center should fulfill a community function within the natural region in the provision of services, its activity should also be focused on active collaboration and cooperation of all the relevant service providers, offices and other sources of community support of the client. In the setup of the natural region, the center uses the prevalence of severe mental diseases in the population, character of given region (for example, urban

agglomeration vs. mountainous peripheral region) and the possible extent and availability of the provided services.[78]

There are multidisciplinary teams consisting of social workers, nurses, psychiatrists, psychologists and peer consultant that work in the center. *"Our mental health center is operated in cooperation with the psychiatric hospital, so we work on the basis of contractual cooperation, whereby the medical personnel are always hospital employees and the social personnel are employees of our organization, but we work together is one team. I think that all team members feel like members of the mental health center rather than our or hospital employees. The healthcare workers are employed only for this center. They are hospital employees so as part of overtime and shifts, it is possible to cover shifts also in the hospital, but their main employment is in the mental health center."* (P3).

In one of the mental health centers, we encounters also a service, which they themselves called the so-called "living room". The living room serves as a waiting room for the psychiatrist or psychologist, but also as a person, where people can come throughout the day and have coffee.

"There's always one of us on duty there, if people have the need to just talk to someone. There's also a computer there, if they need to go on the Internet. There's also TV, where they can relax and nothing is expected of them. It is not a daily center, but we don't have a need to turn it into a daily center, so that people would go regularly there, because we rather try to offer people other services or possibilities in the common community like leisure time centers, which are not primarily focused on people with mental disorder, but we don't want to stigmatize people and we don't want to gather them in a center. We think it's better to try to work with them outside, so they would be able to go for coffee alone, rather than come every day to us. In order to be in contact with the common community, I don't want to say healthy, just the common one." (P3).

- **Daily Services Center**

According to the Act on Social Services, the daily services centers provide outpatient services to people, who have reduced self-sufficiency due to age, chronic disease or disability, whose situation requires help of another natural person. The service contains these basic activities: help with personal hygiene or provision of conditions for personal hygiene, provision of food or help with provisioning food, educational and activization activities,

[78] MINISTRY OF HEALTH OF THE CZECH REPUBLIC. *The Standard of Services Provided by the Center of Mental Health for People with Severe Chronic Mental Disease*. 2021. https://mzd.gov.cz/vestnik/vestnik-c-8-2021/

facilitating contact with the social environment, social-therapeutic activities, help with the exercising of rights and legally protected interests and handling of personal affairs.[79]

The daily services center operates as a stationary and it is open for clients from Monday to Friday. There is a regular program in the center a month in advance. There are different workshops (sewing, woodcarving, gardening,...) and support groups may also be included (educative,..)

- **Daily Stationary**

According to the Act on Social Services, daily stationaries provide outpatient services to people with decreased self-sufficiency due to age or a handicap, and people with chronic mental diseases, whose situation requires regular help of another person. This service contains these basic activities: help with the managing of ordinary tasks of care for oneself, help with personal hygiene or provisioning of conditions for personal hygiene, provision of food, educational and activization activities, facilitation of contact with the social environment, social-therapeutic activities, help with the exercising of right, legally protected interest and in the handling of personal affairs.[80]

- **Daily Sanatorium**

A daily sanatorium is a healthcare facility, the interventions of which are paid from health insurance. It operates across the entire city. It provides psychotherapy (individual, group), psychological and psychiatric services expressive therapies (art therapy, musical therapy, drama therapy, dance and movement therapy,...), and also a self-help group. Non-verbal therapies often serve also to express matters from the unconscious or to manifest what they are unable express with words (for example, they paint, play,...). Expressive therapies may only be performed by a person, who completed the appropriate course for given therapy.

- **Social-therapeutic Workshop**

According to the Act on Social Services, social-therapeutic workshops are outpatient services provided to people with decreased self-sufficiency due to disability, who are not placed for this reason in the open or protected labor market. Their purpose is long-term and regular support of improving work habits and skills through social work therapies. The service contains these basic activities: help with personal hygiene or provisioning of conditions for personal hygiene, provisioning of food or help with securing food, training of

[79] *Act No. 108/2006 Coll. on Social Services, § 45.*
[80] *Act No. 108/2006 Coll. on Social Services, § 46.*

skills to manage care of oneself, self-sufficiency and other activities leading to social inclusion, support of creation and improving basic work habits and skills.[81]

The social-therapeutic workshop is an outpatient social service, where the clients come for a morning and an afternoon program. The clients live home or in protected housing or they are hospitalized at the psychiatric ward. It is a training service, where the training of practical, work and social skills take place. It is a training of skill, which are necessary for them to be included in the society, which is social rehabilitation. It is an effort to return people back in life.

- **Support of Independent Living**

According to the Act on Social Services, the support of independent living is a field social service provided to people with decreased self-sufficiency due to a disability or a chronic disease, including mental disease, the situation of which requires the assistance of another person. The service contains these basic activities: help with housekeeping, educational and activization activities, facilitation of contact with the social environment, social-therapeutic activities, help with the exercising of rights, legally protected interests and with the handling of personal affairs.[82]

- **Protected Housing**

According to the Act on Social Services, protected housing is a residential service provided to people with decreased self-sufficiency due to a disability or a chronic disease, including a mental disease, the situation of which requires the assistance of another person. Protected housing has the form of group or individual housing. The service contains these basic activities: provisioning of food or help with the provisioning of food, provisioning of housing, help with housekeeping, help with personal hygiene or provisioning of conditions for personal hygiene, educational and activization activities, facilitation of contact with the social environment, social-therapeutic activities, help with the exercising of rights, legally protected interests and with the handling of personal affairs.[83]

- **Leisure Time Club**

The clients miss activity; they like to engage in activities, because they are oversaturated with the treatment, therapies and not doing anything at home. Therefore, some organization included leisure time activities, where there is a chance to go to cultural events,

[81] *Act No. 108/2006 Coll. on Social Services, § 67.*
[82] *Act No. 108/2006 Coll. on Social Services, § 43.*
[83] *Act No. 108/2006 Coll. on Social Services, § 51.*

walks or trips. They prepare events for the whole month, outdoors and indoors (cards, games,...). These clubs are most often lead by peer workers.

- **Community Team**

Community teams fall under the multidisciplinary teams operating mainly in the field, whereby they do not have to be part of the Mental health center and may also work independently. Their activity is diverse and depends also on the client's needs. Common activities include accompanying the client to offices, housing support, arrangement of benefits or invalidity pension, but also healthcare, when the nurses take care of the mental and somatic health.

The community teams try to work without queues, *"If the person shows interest, we want to always have the capacity and time for him. It happened in the past that we had queues and some services still have it. It is very important to accept the client and not create queues, where people wait. In this area of work, it cannot be about waiting. If the people are not supported, their condition might needlessly worsen."* (P1).

- **Crisis Beds**

One of the examined organizations also had the so-called crisis beds. *"Another service we offer are crisis beds, of which we have 4. These are beds, which should serve people in crisis. It may also be prevention of relapse, rather than for the person to go to hospital. If he feels his condition has worsened, he can come to us. If the whole team decides so. A plan must always be written down if people go to the beds. The doctor examines the person if he is suicidal or not. It is one of our conditions that if there would be someone at a high risk of suicide, we do not accept him, because we are not adapted to it. A hospital would be more suited for this. So, it is not like we would be able to accept people in any condition to the crisis beds. We can accept the person here for a couple of days (3, 10,..). Thus, people avoid hospitalization, which would not be 3, 7 or 10 days, but 1-3 months. Given that we also have a psychiatrist here, we can discuss with him also the health aspect. He can get stabilized after a week and he can go home, where he works normally."* (P3).

- **"24-hour" Line**

Crisis services also provide a non-stop phone service for people in crisis. In one examined facility, where there are crisis beds, they also have this service. *"We provide a 24-hour service. The health workers are on the phone and when someone needs to call at night for some reason, they are available. The health workers are always here, they serve, also because there are crisis beds here."* (P3).

- **Crisis Team**

The crisis team works during business days from 16:00 to 20:00 over the phone – due to safety (also in person, but only after an agreement over the phone). The vision is for this to be available all day long. The crisis team often solves suicidal, depressive and anxiety states. Sometimes parents call that they need advice. Sometimes chronically ill people, when it is necessary to limit them, what they need here and now. Other times people call only to vent or for support (listening,...).

- **SOS Phone**

Case managers, who have service phones, through which they are available to the clients during their business hours. *"If I'm unable to answer it right away, I call back. I try to call immediately, the same day, as soon as I'm able to, but to handle it within a day. It's rare for me to have a missed call where I would call back the next day, that doesn't happen to me. But we're not a crisis service. The clients know that if they need some crisis intervention, they must contact crisis centers, because I might not pick up at the moment. If I have a meeting with another client, I'm in the field. We call, write each other."* (P1). Additionally, some multidisciplinary teams also have one more phone - contact or SOS, which is on until 20:00. *"We have extended working hours, so each day someone is on duty between 16 and 20 hours. We take turns. It is for clients, who need to call."* (P1).

3.1.2 Target Group

The target group of the examined facilities are adults with a mental disorder (in some examined facilities, they are call people with experience with mental illness), but several organizations accept also people in acute crisis with signs of a mental disorder, but without diagnosing it. Schizophrenia, bipolar disorder, depression and personality disorders are the most prevalent mental diseases. These are people in acute as well as stabilized condition. *"We work with anyone, who is mentally ill, but also with those, who feel to be in crisis. We do not have any criteria for diagnoses. We only have it limited to 18-80 years and geographically, that they must reside in this region. And we have to talk to them, so that there won't be any communication barrier. These are people with depression, attention deficit disorders, ADHD, anxiety, etc. Some come here regularly, others not so much."* (P11).

Some participants told us they are addressed by people, who do not fall in the scope of their competencies. These are mainly child psychiatric clients, people addicted to drugs and people with a mental disorder, since these groups require specific help. As the participants told us, these people are not automatically rejected, but they try to facilitate contact with the

competent organizations. *"We have a system where we do not reject people immediately and we have mapping meetings a whether this falls under our services. We are contacted more by people from organizations and give us people, who are not our target group, because we are in the field and we have a good name. For example, we are contacted a lot, because not all drug and alcohol services work in the field. At one time, we were contacted by patients with somatic states. And another time we were contacted by people with children and we don't have that established it, the child psychiatric care and we don't have a lot of experience with it, it's rather a minimum and we tried to transfer them."* (P12). *„The only type we don't accept, or only after consideration and discussion with the team, are people with a combined disability – mental retardation, behavioral disorders – this is a big burden for group treatment. This is a specific disability. If someone comes to us and we discover that he has mental retardation, we recommend him the relevant services. It's not like we don't accept you and goodbye. Each service must provide basic social counseling, which means not rejecting the person, but give him advice and contact where to go. We can help the person this way."* (P5).

We asked in the organizations if their clients have the mental disorder from birth, or if they developed it throughout their life. The majority of the participants responded that they have mainly patients, who developed the mental disorder throughout their life. Some god sick when they started university, because they were unable to handle the study pressure. Others, when they started to work and could not handle it, for example, when there was conflict, which was not even so severe, but from the client's perspective this may be completely different.

3.1.3 Daily Program

The daily program of the social-therapeutic workshop is divided into morning and afternoon. In the morning, only clients with a contract can attend, and there are mutually set rules on which day and at what time they come and the facility insists on them coming like this, because the clients practice regularity this way. If they cannot come, they should excuse themselves. This is a practice of work habits – if they cannot come to work, they have to excuse themselves. They do not require receipts, but they do require them to let know – call, write a message or email. If the client does not excuse himself within 14 days, they call him and try to find out what is wrong. Because they do have situations that they have clients with suicidal tendencies. Unfortunately, it has happened that the client did not call for a long time and then they learned he committed suicide. The condition of some clients deteriorates and

they are in hospitals and they do not have the ability to call. The morning program is more strict and structured. Even the client must learn that this has limits, structure. The client does not attend whenever he feels like it. The afternoon program is focused on work and practical skills. The practical skills include the statutory activity, like the preparation of food and personal hygiene. The clients practice cooking in a joint program several times a week, many have even a cooking instructor. They practice washing using the washing machine in the workshop and they also learn ironing.

The afternoon program is free, it contains leisure time activities. There, the clients can attend whenever and as often as they like. They can pick anything from the offered activities, for example, knit, paint, model clay, etc. On some days of the week, there is also a regular joint program, like the sewing group, where clients learn to repair clothing manually and using a sewing machine. There is also a discussion group, a film club or an English conversation group. Then there are irregular or monthly activities, like going to cinema, on a trip or attend lectures. The lectures are aimed at things, which are important to the clients. *"Lectures about things, not that we think are important to the clients, we did those, but they were not important to the clients. Two years ago, we created a questionnaire of the clients' needs and some very interesting things came out of it about what they need and want. Basic needs like housing, work and partner, this is the same for everyone – healthy and sick. Also to focus on areas of interest with the lectures. When we try to foist them something, it doesn't work."* (P5).

3.1.4 The Process of Social Work with the Client

The social workers also explained the individual stages of work with their clients to us:

- **First Contact**

The first contact with the organization varies, sometimes they are contacted by the psychiatric hospital or an outpatient doctor – psychiatrist or a general practitioner. Or people look for help and find it on the Internet. Or they learn about the possibilities of help from friends, relatives or fellow patients. Sometimes they are contacted by the family. *"Sometimes we are contacted by officials from the office that the client behaves strangely and it's difficult to work with him."* (P1). The first contacts are always done in pairs – due to safety.

At the beginning, it is necessary to establish an atmosphere of trust and a feeling of safety. It is difficult to help the client without trust.

It may be that the workers will have people, who do not care about cooperation, but someone else evaluated that they need help. In cases like this, the social worker tries to establish and motivate for cooperation. The social workers see queues as a barrier for motivation for cooperation, therefore they try to work without queues. However, it is important to differentiate how long does it make sense to motivate an uncooperative client. *"Sometimes we decide to let the client go, because he doesn't want the cooperation, he refuses. But we always assess the purpose. In some cases, we decide this after a year, in orders, after a month, it is individual. If he doesn't want to, there aren't a lot of things we can."* (P1).

- **Social Anamnesis and Administration**

The social workers determine the social anamnesis of the client. They map his life situation and social problems. They also keep administration. *"Someone from the team puts this together and he does the anamnesis, consent and documentation at the beginning and maps and documents this way, and this is how it is, only faster. I did the paper work later. I give space I listen, I ask and only then I do the paperwork. But it's important. Sometimes, it backfires, that I don't have consent and need it and I can't do a good intervention. At a certain time, we should all have it. But if it suits me better that a client come and I listen to him and manage 2 meetings in the field and then, after I know him a little, then I write the documentation with the client. I explain to him what he signs, why he signs it and what the law says. And I do this only after the first third. Some do it immediately. Both are correct. A person must feel it as good and natural. Sometimes, when I feel the client has a problem with this, for example, he's paranoid, it's something that irritates him, then I wait and try to explain it."* (P1).

- **Planning**

After mapping the situation and problems, goals and methods are formed, which lead to their fulfillment. *"After mapping the situation of the person, there is gradual motivation to get out of his undesirable situation into a relatively acceptable. This means that it's always pointed out what is primarily most important and through gradual steps what the client wants is set. We strive to leave this competence to the client."* (P4).

- **Social Intervention**

As part of social interventions, the organizations use a wide range of methods or activities, which help the client improve his situation. Whether this is social-legal counselling, help with filling out the forms, objections, appeals, different court proceedings in the field of

relations, finances, housing, etc., then there is the accompanying of the client to offices and different institutions, help with looking for a job or completing education and also options for leisure time activities, sport activities, cinemas, etc. This may also be help with reestablishing family relationships. It is important to keep in mind that the social worker will not solve the problem for the client, but he helps him to look for possibilities of solving it and reassures him that he will support him. The client is the one responsible and competent to solve his problem. However, there may be exceptions, where the client is in a crisis and the social worker does things for the client. *"We try to support the client, not with the intention of doing things for him. But in some crisis, it's necessary. In a crisis, we are a sort of guides, we are the contact with the world, we are maybe the only ones, who care about him at the time, support him and try to help. Then it's up to us to go shopping, wash the dishes, change the bedsheets, wash his hair, pack things for the hospital, simply anything. We always think about what we do for the client at the moment, why and how long do we want to do it. Sometimes, we have to do the service. It changes a lot. A colleague of my even dyed hair. It's always up to the worker. Each of us has some personal prerequisites and limits. In the team, it should always be split in a way, where the worker doesn't have to go beyond his limit, so go beyond something, which is too much for him. I go swimming and it's OK for me. A colleague of mine never went swimming with a client. For me, it would for example difficult to shower a client or dye her hair, it's intimate to me. And when I say this in the team, no one will force me to do it."* (P1). However, the social workers are always careful that their relationship to the client is professional and not friendly.

3.1.5 Problems Concerning Clients

The most common problem pointed out by the participants was **dependency on the service**. Then the question arises, whether the service was sufficient and whether it makes sense to continue to work with the client or to send him someplace else, so that even he would find competences to solve his situation. *„I see development in community services, where there is a trend to not keep the clients and not establish dependent relationship and especially in the field team. If it's not working, then we look for options, for example, we often work with the clients' families.* (P12).

Another problem is that **there is no tie-in social service**, where the client could be moved to advance.

Refusal to accept the diagnosis is a serious problem. Then there is a lack of real insight into the life situation and the clients thus set goals, which are not realistic for them (for

example, they work three jobs and they get mentally completely exhausted). Sometimes, they refuse treatment, which worsens their condition.

Cooperation with families is another problem. *"Some family members hold opinions, which are incorrect, but the clients take them that they are "saints" and their opinions are the best and this causes problems."* (P6).

3.1.6 Education of Social Workers, Supervision and Meetings

The organization provides employees with 24 hours of education a year and 12 hours of supervision – group and individual. They also have discussions between each other, where they can exchange experience. Regular meetings are also included. Multidisciplinary teams have large meetings, on which all employees participate, which are once a week, and small meetings with only currently present employees, each day. Each organization has an established system of recording the clients and the intensity of their crisis (accordingly, the necessary intervention), some use electronic programs, others a regular large paper with a table and marks. *"We have meetings every day. We work with an electronic system adopted from Holland. We work with people in crisis. We add different marks, from acute, through worsening of condition up to a new client. We discuss clients in crisis and acute state every day. We have an overview of them. If it's necessary we discuss every day who and what will do with them. Because these are people in crisis, who need greater attention in given period. If the client gets better, then there are tools for this in the electronic system – program, that the client moves someplace else. But the As – which were 9 clients today, we discuss those every day and every day we say what will happen or what has happened."* (P3).

The second electronic tool we encountered in the organizations was the so-called shared calendar. *"We all work in a shared calendar, so everyone knows what's happening. A big advantage is that if a worker sits with a client, who may have an increased need to see a doctor, you don't have wonder when the doctor will have time, you just open the shared calendar and see that tomorrow 11 to 12 the doctor doesn't have anyone, so he just writes him in and the doctor is not asking. So we sign up the client for our doctor or psychologist. I know that tomorrow I won't be in work and the clients needs this and this, the clients needs to see someone tomorrow, so I can look in the calendar at my colleagues if they're free and write the client there. The whole multidisciplinary team uses this calendar, everyone writes what, when and where he has and other can write him stuff as well. But this isn't about control, it's about moving the client."* (P3).

After the meeting, each worker works on his plan. He has his case – 10-15 clients, whom he meets based on their need and intensity of crisis. With some clients he meets several times a week, with others once a week, with other once a month or even less; it always depends on the specific order of the person. The case manager has to create his own plan about how he will work in order to have time for all clients. Each team – nurses, social workers – has its leader. One of the things the leader is responsible for is to monitor and help the workers in their case management.

3.1.7 Cooperation with Organizations

The organizations focused on helping people with a mental disease actively strive to establish cooperation with other organizations, as well as the community.

The organizations cooperate with each other: *"We cooperate also with other non-profit organizations in our city, we do not feel anger, but we mutually tell each other that this is a small field. Many clients go from one service to the other, as do the workers."* (P1). Cooperation with healthcare facilities is important: *"We are very good in engaging other subjects, like social workers and doctors in treatment facilities, to improve the situation, because it's necessary."* (P4). Local governments are another important institution: *"It's a long work for the authorities to know about us. We let the municipals authorities know about us. The caretakers go there, so also they can contact us."* (P1). The participants assessed the cooperation with the clients' caregivers positively: *"We cooperate with the caretakers, because a number of our clients has restrictions in their legal competence. I think we currently have above-standard cooperation with the caretakers."* (P3). The organizations aso cooperate with asylum shelters: *„Communication with the asylum shelters is good. We have joint meetings when a client gets there, which is a big plus, that there is a contact social worker, whom I can contact. We are interlinked. If one of our clients lives there, then we consult it with them, but with the client's approval, his consent is recorded, that we can exchange messages so that the work isn't unnecessarily duplicated. So that we wouldn't do the same, so that it would be effective for all of us."* (P4). There is also cooperation with the leisure time centers: *„We cooperate with leisure time centers, where we can offer our clients their activities, which are for all members of the community."* (P3). The organizations cooperate also with financial advisors: *"We cooperate with organizations focused on financial counseling, because most of our clients are unstable in the areas of work, finances and housing. So we strive to leave also these things to the client as much as possible, but we also cooperate with experts, like financial advisors."* (P4).

Establishing work with the police was assessed negatively: *„We greatly miss cooperation with the police, whereby it is a subject, which often intervenes. They often have a distorted idea about mental diseases. Most of the clients with a mental disease are often victims of domestic violence.“* (P4). *„We try to establish cooperation with the police, which isn't currently going very well for us. The thing is that if someone will be part of a situation, where the police has to intervene and it may seem to the police that the person is not completely well, that he might theoretically have some mental disease, our effort for the future is for the police to have it encoded that they should call us, which eliminates the risk of the person, who isn't well, to confront the police, which is some force, which we all have in our heads, that the situation might take a dramatic turn. It is a model from England, where the police cooperate with the centers for mental health. Whether it's a crime or he is a witness to the crime, as soon as they start taking his testimony, they call someone, who understands the issue. It's about facilitating communication, for the mediator to be there, because police officers are not mental health experts.“* (P3).

3.2 Approaches, Methods and Techniques

In this section, we summarize and describe the approaches and methods of social work used in the Czech services primarily designed for people with a mental disease.

- **Multidisciplinarity**

In the Czech Republic, there are very well-established multidisciplinary teams for helping people with mental disorders. A team consisting of social workers, nurses, psychiatrists, psychologists and peer consultants deal with the client. Some teams even have a lawyers as an external worker. The nature of the multidisciplinary teams is an effort to provide the clients with as comprehensive spectrum of services as possible, which they could need as part of the rehabilitation process. *„There are 22 of us in the team; there are 6 social workers, 10 nurses, 2 peer consultants, 2 psychologists (working half time), 1 psychiatrist and 1 of the social workers is a specialized addictologist (some clients have a diagnosis linked to substance abuse). A work consultant is also a member of the team, who operates in the labor market and he tries to find a job for our clients based on their order.“* (P3). *”In our team, I've been here for 6 years and from the original model, when we were only social workers, we have gradually taken on healthcare personnel, nurses in the beginning and later doctors and psychologists. We were only a social team and the healthcare area expanded our perspective and possibilities. Sometimes, the clients are not capable of handling the healthcare things, it's*

complicated. Sometimes, they let the nurse go before the social worker. The clients approach this differently. For example, in terms of hygiene and self-care. Even the social worker has basics of physical care, but that's different. We're glad, I didn't expect for this to have such a positive impact." (P1).

At the beginning of the activity of the multidisciplinary teams, there were problems with the definition of competences. *"Regarding the definition of competences, we used to fight this more in the past, but now we have a defined system of work, we know who can do a knows what, and what not."* (P12). It is important for to competences to be clearly set and for the individual professions in the team to know what they can, what they must and what they cannot.

Team coherence is important; rules should be set and the whole team must adhere to them in uniformly. The client should not look for a worker, with who he can get away with something. The case manager sets boundaries for the client, announces them on the team meeting and then everyone should observe them against the given client. The rules are individual from client to client, with respect to their diagnosis.

In the Czech Republic, there are social workers, peer consultants and work consultants for people with mental disorders. A peer consultant is a worker with own experience with a mental disease. He teaches the clients how to live with a mental disorder and gives them hope for a quality life despite their disease. *"Peer workers do something between a social worker and a psychologist on a friendship level, they are a model and a motivation for the client. They are stabilized people and are capable of work. They certainly have their own help. They have reduced working hours in the team."* (P12).

A work consultant is a person, who operates in the labor market and looks for a suitable job based on the clients' needs. From his perspective, it is a lot of work not with the clients, but mainly with the employers. He actively searches for employers and talks to them about the target group, with which he works. He actively tries to disprove the myths in order for the people to be able to employ mentally ill clients. *"In our team there is also a work consultant, because we think that work is one of the most important things. So we said to ourselves that we need this person directly in the team. The work consultant focuses only on searching for employment for the clients on the open labor market as well as a protected workplace."* (P1).

We also asked the participants about the function of the healthcare personnel in the multidisciplinary team. They said that a number of their clients have neglected somatic health.

The nurses accompany them to the doctors, make appointments, keep an eye on what's important (dates, medications,..). A nurse can intervene with clients, who are not capable to go anywhere, or only with big effort. Sometimes, the clients are prescribed depot treatment. Depot means an injection containing anti-psychotics, which are administered by injection and based on the dosage and to whom they are administered, they work for 14 days, 3 weeks or a month. Depot is good for people, who do not use medicaments to much or they forget or they do not want to. And so they have an injection, where the substance is released gradually. Depot replaces the use of peroral medicaments, so it is more comfortable for the client that they receive an injection once and they do not have to take medicaments. So, some clients may work for several years only on injections. And the nurse can provide the depot treatment. Depot for a specific medicament is prescribed by a psychiatrist and it may be administered also by a nurse in the household of the client.

For some employees, the job is also their profession, they do not only take it as work, but as a service and they care about the clients. *"It shifted a lot, when I started as a supervisor 3 years ago, the work was focused more about if the client wants to or not. And if he didn't want to, then we just moved on. There was more work with a specific order. Now we moved forwards and we focus more on relationships, that we want to help the client, not just solve the situation."* (P1).

- **Field Social Work**

In the Czech Republic there is a well-developed field social work for people with a mental disease. The social workers, together with other members of the multidisciplinary teams visit the clients in their homes. This has several advantages. One is that sometimes, the client is incapable to come to the facility himself and if there was no field service, he would not receive the necessary help. Another preferred advantage is that the client learns to work in ordinary natural conditions and that it is not stigmatizing for him, like a stay in an institution. The advantage of field social work is also that the client's fear of workers is reduced. *"The client comes to the office for an outpatient service for often in fear. However, if the worker comes to the client's home, to his natural environment, then he is visiting there, the client is in his own, he feels safe, he says more, it's different, especially in work with the family. Field work is very important, it should be mandatory. The client behaves and speaks differently."* (P2).

The workers also go to hospitals as part of the field social work, where they establish contacts with long-term hospitalized patients, so that after their discharge, they would have continuation of other services in their community.

The field service also includes care of own safety. *"We don't go to the home environment during the first consultations, and if we do, then always in a pair, because we don't know what to expect on the other side, it's due to safety. It's important to protect the interests and needs of the client, but ours as well. After mapping the situation, we provide the client with the necessary activities and services."* (P4).

The workers perform different activities as part of the field social work. From social counseling, practice of ordinary household activities, accompanying them to offices an doctors, practice of things the client fears, up to interviews related to venting.

- **Case Management**

The client also has his case manager, who is a key person for him. *"Each client has a case manager – who's more than just a key work. A key worker focuses on the social area, whereby the case manager is a sort of guide and solves everything."* (P8).

The case manager is a sort of guide through life (it is about relationships), he also relieves the family (the client "throws" his problems on the worker and not the family) and represents continuity (even for life). The case manager uses different methods of work, from regular, like the practice of social skills, up to creative, like running or swimming.

A social worker is sought for each client – based on personality skills, they are not forced upon them, because not everyone is a fit personality-wise. There are approximately 15 clients for one worker (it depends also on the time requirements the client's condition requires).

In case management, there is also a co-working worker, which means that if a case manager would get long-term sick, then the co-working worker keeps information about the client. If necessary, he is capable to substitute the case manager. Substitution should be general, but this substitute worker should have more information about given client. *"We also have meetings, where we discuss all the clients, so we strive for all team members to know all the patients. We have 170 patients. But it doesn't work all the time. But of the 170, there are always going to be people, who aren't often in crisis. Therefore, we put also new clients in the electronic program on the board and we leave them there for 14 days, so they would be discussed on a meeting every day and all workers would learn about them. We also due it, because the medical staff works shifts and covers here even the night shifts. The social*

workers have regular 8 working hours a day Monday to Friday. There are only 2 healthcare workers on the daily and 1 on the night shift. So we leave the new clients longer, so the information would reach all, even the nurses. When we are sure everyone knows the client, they know, who he is, then we can remove him from the electronic board and it's no longer necessary for him to be there as a new client." (P3).

- **Peer Workers**

In the Czech Republic, there are also the so-called peer consultant jobs. This is a worker with own experience with a mental disease. He teaches clients how to live with a mental disorder and gives them hope for a quality life despite the disease.

- **Recovery**

The recovery approach is a way of living a satisfying and fulfilling life despite a mental disease. Even despite the disease the person has, he should life a full-fledged life in interaction with other people. Recover means that the person leads the client towards performing ordinary activities despite his disease. It means that he should not retrieve "into his shell" and isolate himself, but to search for a job adapted to the disease, live alone or with assistance if necessary, and not in housing facilities, have friends and socialize with them. A person with a mental disorder must not have the feeling that he is unnecessary and that his life has no meaning. The mental disease does not mean that life "stops", but it is necessary to grasp a new meaning of life, which will respect the disease, but it will not be completely limited by it.

Recovery means to give hope, establishing a relationship with the person and perceive a client as an equal person. It also means to give him good examples of other people in the process of healing.

Many clients are dependent only on the disability pension (sometimes even partial), which limits them financially. Therefore, as part of the recovery, some activities are selected based on the client's financial possibilities, because the organizations try to find additional financial resources for some financially more demanding activities. *„We work a lot in the natural environment of the client at home. We go to them and we want to do everything where they live. We don't try to pull them here. We aren't completely successful, we would like to be in the field like in a natural world, but this is slightly in conflict with the clients' financial possibilities. They don't have a lot of money, to go sit someplace is a burden for them and we would like to change that. We have some money for outdoor activities, the workers and clients together. Originally, we called it a benefit for activities, that we want to support the clients to*

have ordinary activities outdoors (clubs, coffee shop,...). This is in relation to the idea of recovery. To support them to live like other people in the community and do things like other. Their budget is totally tight and there is nothing left for some additional thing. We have therefore created money, with which we can help them. We can use it to, for example, go swimming with the client – there, the goal is for the client to be able to pay the deposit for they key and take the key; it's ordinary for us, but she might not do it on the first try and so she needs to do it several times, because she is disoriented, confused. Suddenly someone stands there and she doesn't know what to do. She needs to practice it in her head. After 4 meetings, she managed it herself. Another step will be that I won't go swimming, but I only wait for her. The next step will be that she will go swim on her own. The goal is that she will be able to do it on her own and she will go swim by herself. We have a plan for this and she is very excited that she advances. Only that it's not immediately, that it needs time. Even exhibitions where we go. Our peer consultants also use benefits to take 2 clients and go bowling, which our clients are unable to afford, because this is a big expense. But they gradually learn to look for activities. Experience happiness." (P1).

As part of protected housing, they even teach clients about vacations. Many know only the housing and hospital and they do not know what it means to go out of the city and take a break from the daily affairs. So they also teach them to rest during vacation. *"Once a year, who can, we go for 5 days to a boarding house outside the city to learn to rest. The clients are often in a circle: housing and hospital. On a vacation, they can take a break from the problems in the city, they are on a vacation for 5 days and they don't deal with anything."* (P8).

Some organizations include also a new element in recovery, specifically discovery. *"We try to go for activities among the common population, not to create a "ghetto", but many are afraid of this or they don't want to. If several of them go, including the worker, then sometimes they go, but if they should go alone, then they often don't go there. In addition to recovery, we also focus on discovery."* (P13).

- **Social Rehabilitation**

Social workers provide social rehabilitation, as stipulated by the law. Through social rehabilitation, they support clients in ordinary life situations.

According to the Act on Social Services, social rehabilitation is a set of specific activities aimed at achieving self-support, independence and self-sufficiency of people through the development of specific abilities and skills, strengthening of habits and training of

ordinary activities necessary for an independent life through an alternative method using the preserved skills, potential and competences.

The service is provided in the form of field and outpatient services and contains the following basic activities: the training of skills necessary to manage self-care, self-sufficiency and other activities leading to social inclusion, facilitation of contact with the social environment, education and activization activities, help with exercising own rights and legally protected interests and with handling of personal affairs.[84]

- **Individual Plans**

Social services like protected housing and social-therapeutic workshop also have individual plans, which are focused on developing the client in the area, he needs. *"We also do individual rehabilitation plans, this is very important. At the beginning of the cooperation, we form it, where the client formulates his goal aloud, why he wants to come here and the reason why he wants to come here. And then we solve it and write down the steps to achieve it. It's possible that we revise the basic plan after 2-3 months. We say that you managed 1 day a week, so let's move it to 2-3 days. If the client knows some handiwork, then we engage him in the production of hand-made products."* (P5). *„We also work with a tool called personal profile. It is a mapping of needs. You discover topics you can discuss."* (P3).

- **Help with the Exercising of Rights and Legally Protected Interests**

The social workers know the rights and possibilities the clients have under the law and they use their knowledge to facilitate the clients with everything to what they are entitled to under the law. *„We use legal options and our knowledge to arrange matters for them. We try to go through the process not for, but with the client. And I don't have to know everything, I can always ask the team. We always learn to do new things. We don't try to be experts, who only come and dictate. Some knowledge, we all have. But then everyone in the team is specialized on something. For example, I specialize in work with a dual diagnosis, family affairs and benefits. A colleague specializes on care allowance.* (P1).

- **Accompanying the Client to Offices and Doctors**

Many clients have a trauma or fear of communication with officials. So the worker accompanies them to these appointment and represents a supportive person for them. *„We accompany them to offices, because the clients often fear the authorities and communication with the officials and overall fear of people."* (P2) *„We complete the offices with the client*

[84] *Act No. 108/2006 Coll. on Social Services, § 70.*

and then we discuss how it is to manage this and what the client should do, if the officials are particularly forthcoming. Sometimes, there are administrative barriers, bureaucracy." (P1).

- **Distribution**

The organizations know their competences and when the client has requests, which are outside their competences, they address the client to another organization, which could solve this, or they go with him there. Legal matters are a common case: *„Every social worker has a general legal education, so he should know the basics for appeals or writing remedies, appeals against judgements - we can handle those ourselves. But if these are more complicated cases, we use legal counselling of other organizations (for example, legal counselling of the Labor Office). If I don't understand something, for example, calculating the disability pension and why the client doesn't meet the conditions. What was written in legal language, that was Greek to me. I accompanied the client to social security to a contact officer and based on the situation we were asking for, she gave us a consultation. Even she called for a lawyer, who explained it the client and me. So not all things we try to solve ourselves. I don't think it's effective."* (P4).

- **Relapse Prevention – Planning for Help**

Many workers do a so-called relapse prevention with the clients. *"Talk to the client, so he would recognize his worsened condition, when it comes, or what to do if he'll be hospitalized, like who will take care of the apartment or the dog. What will happen, etc. What can they say to the medics. However, there are things, about which we do not negotiate with the client and say (for example, that the client has icterus,...), what endangers others, we do not negotiate whether they agree to it, they have to. Sometimes, we are directs. But these are rules of living in a society."* (P8).

- **Support of Strengths**

The social workers try to work with the strengths of the clients, so to focus not only on the problems, what the client struggles with, but also what he is good at and support him in it. *„I have a feeling that in the past there was a lot of work with what the client doesn't know and let's go teach him, but we make him insecure with that. Then, there is greater care and dependency on the service. For example, the client is incapable of tying his own shoelaces, so I will force him in some way – teach him using ergotherapeutical procedures and he won't be good at it, he'll lose patience and I will reprimand him and force him to do it and he'll eventually collapse from this or there'll be some conflict. I will only frustrate him, so we try to start with what he's good at, what he's capable of, those are the fundamental things. For*

example, if someone is nice to others, or he can pull the collective together, then I encourage him to develop this. And it's the same with work experience. Our work is also built on praising people for what they can do. Even though they cannot do much, encourage them despite this in what they can do." (P5).

- **Mental Support**

Mental support is an integral part of working with people, which is implemented through communication and through the so-called "be with a person". *"During the contact with the client, when we do practical matters, we always include mental support there. Especially in the field with specific things, when the people are on edge. So I think, bear it with them, that you won't only go to the office and submit the application is only one thing, but the trip to the office and the process with the official, you experience it with the client in mental support. Because in essence, there are clients, who have such a big trauma of communication with officials that they have to take medication before and after. So it requires a support person – social worker. So every social worker implements mental support. You cannot be silent."* (P4).

- **Open Dialogue**

The open dialogue method is one of the innovative methods, which are used in work with people with mental disorders. This method was developed in Finland as part of the transformation of psychiatric care. It gradually spreads to other countries as well. We encountered it in one of the examined facilities, where they told us that they successfully use this method. *„When we meet a client, we talk about how he feels and what the problem occurred. We talk to relatives and friends. We talk together and other listen and comment on what the person said. It is a sort of interconnection and listening. No one should dominate there, it is an equality of voices and you don't interrupt anyone."* (P11).

- **Work with Family and Family Meetings**

Many organizations strive to work with the client's family as well, for the family to support the client and to be a source for him. *"Work with the whole family is based on the principles of psychiatric reform. If one member of the family gets sick, it affects the whole family. The whole team engages in work with the family, social workers, psychologists and even psychiatrists. We do the so-called family meetings."* (P2).

From a family perspective, it is also important to involve fathers. According to other research, while most fathers expressed a desire to co-parent equally, they reported structural and cultural barriers to participation. These included inflexible work schedules, lack of

support from healthcare staff, and social assumptions that mothers are the default caregivers. Several fathers noted the emotional burden of simultaneously providing financial stability.[85]

- **Case conferences**

A case conference is a planned structured meeting of experts, the client and even his family, for the purpose of finding a joint, most suitable solution of the client's situation. Case conferences may be used as part of helping people with mental disorders, for example, in case of solving a changed life situation after a long-term hospitalization, solving the housing question or becoming independent. Thus, a case conference represents a tool for activating the client and his family, and it is also a way of networking resources – experts, who may be helpful to the client. *"We also use case conferences, especially in psychiatry, where there are long-term hospitalized. The psychiatrist, psychologist, social worker of psychiatry and protected housing and the case manager (if the client has one) are invited)."* (P8).

- **Expressive Therapies**

In regards to expressive therapies, we have encountered the option, where the daily sanatorium offers therapies, which is a healthcare facility and the interventions are paid from the health insurance. It works across the entire city. It provides psychotherapy (individual, group) and expressive therapies (**art therapy, music therapy, drama therapy, dance and movement therapy, poetic therapy**, etc.). Especially the non-verbal therapies often serve also to express subconscious matters or to express what they are unable to express with words (for example, they paint, play,...). This is also because many social services for people with a mental disease operate in field form and do not have established conditions for the implementation of expression therapies in their facilities. And if they do, it is rather painting and musical activities rather than explicitly expressive therapies, which would be led by qualified therapists. Although, of course there are organizations, which offer them to their clients directly in their facilities.

- **Creative Workshops**

Various objects from paper, clay, wood or fabrics are made in the creative workshops. Some organizations sell the products and use the finances for their activities, others do not sell the products, they only make them for pleasure and the clients can take them or give them to someone. *"We produce an assortment of fabric decorations and other things. We don't have regular sales, we sell them one-time on various markets. We have 5 coffee shops and places*

[85] LAPKOVÁ, T. – STEJSKALOVÁ, J. – BALOUN, I. *Paternal involvement in families with disabled children: a medical-social perspective on care, stress, and developmental outcomes*. Ukrainian Educational and Scientific Medical Space, 2024, (3-4), 42-47. https://doi.org/10.31612/3041-1548.3-4.2024.06.

here in the city, where we give our products. Wo don't work for performance. The clients are not rewarded for their work, we are a free service taken voluntarily. But we want for the client to engage in the production of these decorations also for a feeling of cohesion and some meaning. Because they are asking, did you sell those? Do people like them? Some of them even come sell them with us, they see it and they feel great about it, it gives them something. Who doesn't know how to sew or knit, they stuff toys or put labels on them, etc." (P5).

- **Leisure Time Activities within the Organization**

The organizations provide various activities directly within their facilities, for example, a sewing club, cooking club, discussion groups, film club, movement activities, relaxation, anti-stress coloring, etc.

- **Outdoor Leisure Time Activities**

Several organizations do activities also outside of their facility. They go with the clients on trips, to nature, exhibitions, planetarium museum, theater, etc. *"The clients miss activity, they like to engage in activities, because they are oversaturated with therapies and not doing anything at home. We offer them the option to go to cultural events, walks or trips."* (P2).

- **Training of Cognitive Functions**

Many outpatient services also include trainings of cognitive functions. *"We have regular groups for training of cognitive functions, where people can train memory, attention, speech and other brain functions, which may be weakened due to the sickness. They can improve a lot by regular training."* (P12).

- **Ensuring Hygiene and Low Threshold**

One of the examined facilities offers people with mental disorders also the option of handling personal hygiene in the context of low threshold. *"Our facility is low threshold. We have established conditions for providing hygiene like shower, washing machine and dryer. We get people with mental disorders, who are homeless, or they live in unfit housing conditions."* (P10).

- **Self-help Groups**

Some organizations also established self-help groups, which are mainly led by peer consultants. For their members, they prepare various activities like discos, teaching of English, trips or exhibitions. But they mainly create space for mutual sharing and support. People can talk here about the difficulties of the mental disease with people with the same experience.

- **Pastoral Counseling**

A person is a bio-psycho-socio-spiritual being. He also has spiritual needs. Some church organizations, who also deal with people with mental disorders have pastoral advisors, who serve people with mental disorders.

Services and Methods in the Field of Employment:

- **Social-therapeutic Workshop**

The social-therapeutic workshop serves to practice work, social and practical skills. It is not employments, but a practice of work skills. The clients do not enter employment relationships.

For some clients, the social-therapeutic workshop serves to form a daily routine. *„They want to practice daily routine, because if someone is hospitalized in the psychiatric hospital for 5 years, then although there is some routine, but the people fall off the ordinary – natural life. So we get a lot of clients just so they would wake up in the morning and get here, practice a daily routine and leave in the afternoon, so they would go to lunch at a certain time. The work skills, that the people learn handiwork, that's a byproduct, but the most important is that they learn to come on time, communicate with others, observe breaks, focus on work, train to ask for some things, bear criticism, behave politely, also bear more difficult situations as is the case in the workplace and learn to communicate with people, with whom they don't get along very much."* (P5).

The social-therapeutic workshop serves also to practice practical skills, like cooking, washing and ironing. *"We teach clients also practical skills like cooking – we have a cooking instructor, wash in the washing machine and iron* (P5).

The social-therapeutic workshop also serves to practice work skills; it focuses on the production of various objects. *"In our workshop, we work most often with paper. We make notebooks, in which we paste historic photographs and cut-outs from old newspapers. These are then available to tourists, for whom they are a souvenir. We also make cardboard magnets, where we always come up with a new shape (animals, objects,...), we color them and glue a magnet at the back."* (P6).

Learning some handiwork is a byproduct, it is more important that they learn to come on time, communicate with others, observe breaks, focus on the work, learn to ask for some things, bear criticism, behave politely, bear more difficult situations as is the case in the workplace and learn to communicate with people, with whom they do not get along very much. All of this is related to the practice of work skills.

At the beginning of the cooperation, the clients tell the workers about their possibilities, whether they have difficulties getting up in the morning, if they live far, if they do not get a bus often, etc. So, each client has individual attendance, whereby the shortest time in the morning program of the workshop are 2 hours a day and the longest are 4 hours. *"At the moment, none of the clients come from 9 to 13. Everyone has it adapted. And of course, we work on them gradually taking on more days, it can always be changed."* (P5).

- **Training Jobs**

It is short-term work for half a year or a year. The person should train and prepare for a higher level of employment. *"We have a coffee shop, we want to teach the client for the natural environment. We accompany the clients in the process of employment and we support them."* (P12).

- **Social Companies**

In the Czech Republic, there are several social companies, which are focused primarily on employing people with a mental disorder. Most often they are social companies like laundry, coffee shop (care for public gardens and snow in the winter), or a sewing shop (sewing of bags, promotional items). Work in a social company is long-term. At the beginning for a finite time, then for longer, up to indefinite time. *"In our social company we work on business days from 8:00 to 20:00 on three shifts, usually for 4 hours (morning = 8-12, afternoon = 12-16, evening = 16-20), sometimes even for 3-6 hours, based on the employees' possibilities. The employees have reduced working hours. Therefore, we have more employees, if several cannot come due to their disease. The employees have regular vacations, sickness absence and overtime. Each shift has its own supervisor. The tasks of the supervisor include mainly searching for and addressing new customers, communication with the customers, acceptance of orders, accounting, work with finances, turning machines on and off, dividing employees into shifts and supervising them. If there are few employees, the supervisor gets engaged."* (P9).

- **Employment Support Team, Job Consultants**

Some organizations have an established individually working team for employment support or they have a job consultant in the team. In their work, they often use the **IPS method** (*Individual Placement and Support*) and focus on searching for work for people with mental disorders, primarily on the open labor market. *„The IPS method essentially says that if someone wants to work, then this is possible. We have to find the ideal employment the client imagines. For example, now I have a client, who is an alcoholic. Few years ago, he would not*

be able to get an ordinary job. Today, he works in the afternoon, because he is able to be sober at the time. So the system is essentially about finding the ideal solution. But many clients also drop out, or they are very difficult, because they have specific requirements. Sometimes, from our perspective, there are only small things, like the client not being able to make coffee during work." (P7).

IPS states that a meeting with the employer should take within 30 days. The clients can have a meeting immediately after the first phone call, thus avoiding the situation where they want work one day and not the next, so the consultants appreciate the speediness. *"I think we employed 50-60% of the clients. But there are several aspects there, because there are clients, wo do not attend most of the meetings or they just refuse it. But those, who want to work and are capable of work, we find work for them."* (P7). The search for suitable employment is based on the client's requirements. The clients often do not believe in themselves, they have fears and think that they can handle only simpler work. However, the job consultants create profiles with the clients and determine what they enjoy and what kind of work would they actually like to do and subsequently they try to find them such work.

Members of the employment support team search for potential employers, they communicate with people with mental disorders and they try to connect them, so there would be a mutual fit. The job consultants also create a network of employers (a job consultant has approximately 20 employers), who accept clients to protected and unprotected jobs. However, they do not limit themselves only to the database and they try to search for a job anywhere, based on his requirements. In the Czech Republic, there must by 1 disadvantaged person employed for 25 people, or the company must pay a fine, or they must purchase products from companies that have more than 50% of disadvantaged people. Therefore, the employers themselves turn to the employment support team if they can recommend them someone. *"We are getting a lot of calls from employers if we have clients, because there are a lot of people at the Labor Office, who don't want to actually work and we have motivated clients and the process of starting the job is relatively quick."* (P7).

The job consultants use different forms of searching for and addressing employers. Sometimes, they reply to advertisements or they send information emails. Other times they just call and say from what organization they are, with whom they work and they try to get a personal appointment. *"For the time I've been doing this, it happened to me only twice that the employer would refuse me. Sometimes, the employers are surprised who we are."* (P7). Some organize evening events for large companies, where they meet new employers and

build contacts. At the same time, this is space for the employers to exchange experience with employing people with mental disorders.

Of course, there are also problems with searching for new employers. *"Some companies have quite strict policies, because international companies will determine an area they will focus on, for example children, and everything outside of it is not suitable, because this is PR and they present themselves to the society and our target group is not good PR, because people have heard various negative stories about people with mental disorders. So, it's quite difficult to convince the employers, because these are not small children, single mother or other target groups, which are friendly. It's also difficult to get to someone, who is competent, because the companies have only email and we don't get to someone from the HR department. So, we would like to advance in this aspect. If some large companies would stand behind our target group, it would be easier, because some famous companies have refused mentally ill people in the past, but today, they employ our clients, but other companies still say that they don't want our clients."* (P7).

Social workers strive to help the client find a suitable and real employment, which he can handle given his health condition, in order to avoid unnecessary overloading and mental collapse. *"Because when the client reaches his goal – get employed, the client starts working and this changes his daily routine. There is suddenly immense pressure, he has to wake up to an alarm clock, he has to wake up regularly, he must wake up early in the morning, which is a big problem for most of the clients, who are medicated. They are often in interactions they don't understand. And suddenly they can't handle it. There is significant stress and they start to decide on their own and they have the option to talk about it with us. Because it's immensely important not that you started a job, but that you manage it. So, we try to balance it, also that they don't have high demands on themselves, that they get burned out, that they take main employment and an agreement on the side."* (P4).

Members of the employment support team also offer the clients their company for the job interview. *"Employers, who are in contact with us, know about our clients and we talk to the clients and support them and we have the condition that we will accompany them to the job interview. But if the clients themselves find a job, then we meet with them and talk to them and they often don't want us on the job interview. When we are on the interview, we have the feeling that the chances of them getting a job are higher, because the employers sees that there is an organization behind the client, which he can address and it's easier."* (P7).

Even after the client gets a job, at least at the beginning, the job consultant remains in contact with the employer in order to have feedback from both sides and would know to work out the deficiencies.

- **Assistance at the Workplace**

Another method in the field of employing people with mental disorders is assistance at the workplace. As part of their comprehensive services (whereby they do not have to focus only on the area of employment), several organizations offer the clients the possibility that they will help them during the first days or weeks in their new employment. It is not assistance directly in the performance of their work, but, for example, with integration into the collective, learning the environment, communication with the employer, etc. *„As part of assistance at the workplace, I was with a client in her new job for the first couple of days. She had rather manual labor, where she needed to see well, so the first days, I helped her turn the worktable and lamp suitably, and to not be nervous about it and be able to function there, surrounded by other employees."* (P11).

- **Types of Work**

The clients need to work, not only because of self-actualization, but due to the existential need to be able to afford own or at least joint housing and to be able to fulfill their basic needs. People with a mental disease are more suitable for calmer work for shorter hours. The social workers also do career counseling and also solve with the clients the issue of discrimination due to their health condition.

„Most of our clients have a disability pension, for example, three quarters, but many of them work, for example, half of my clients work part-time; we also have clients, who work full-time. " (P12).

Services and Methods in the Area of Housing

One of the most difficult problems is finding suitable housing for people with a mental disease. Some live with families, but if they want to be independent and they don't have the finances for own apartment, they have to look for available commercial housing, which is also financially difficult. However, some clients need help also with housekeeping; they miss many practical skills. Then comes protected housing, but there isn't enough for it, or different asylum shelters for people without home or cheaper boarding houses, which however are not suitable and the clients' health condition often decrepitates there.

- **Housing Team**

Some organizations have independently working teams of protected housing and support of independent housing.

- **Protected Housing**

Protected housing can be divided into community (in a shared building specially designated for this, or at least in part of it) and individual (the organization purchased individual apartments in ordinary residential houses, whereby they are not designated accordingly and the neighbors might not know that this is protected housing). The accommodation process has three stages: accommodation in the room accommodation in the housing estate and accommodation in the society. The help of social workers to the clients in protected housing is built on 3 pillars, namely a good neighbor (not to antagonize the neighbors and respect the natural rules like silence), service recipient (regularly meet the worker) and pay rent (the company also has orders from the client – rules he must follow). As part of housing, the social workers teach the client practical skills like cleaning, cooking, using the washing machine and other electric appliances, help with shopping, financial management, etc. It is a practice of skills, so that he will be able to do it by himself in time.

The **Housing First** approach is used in housing support. This concept was developed by Dr. Sam Tsemberis, founder of the Pathways to Housing organization in New York in 1992. The approach is based on the idea that housing is a human right. The nature of this approach is that the client is given immediate access to long-term housing with the support of workers. It begins by accommodating people directly from the street, without prior conditions. Subsequently, basic needs in the field of mental health, addiction, healthcare, income and education are solved with the client, with the goal of helping the client to integrate and welcome him back in the community and the society. Eight basic principles of Housing First have been identified, namely housing as a human right, ability to choose and control on part of the client, separation of housing and support, emphasis on recovery, harm reduction, active engagement without forcing, individual planning and flexible support for as long as necessary. [86] Housing is a basic human right and basis for social life. Interventions in the area of housing, like, for example, Housing First, have been introduced and shown greater

[86] PLEACE, N. *European Housing First Guide*. Prague: Government Office of the Czech Republic, 2017, p. 19-35.

engagement in the society, improvement of life quality and reduction of mental disease symptoms.[87]

Ž Unfortunately, the NIMBY (*Not in My Back Yard*) syndrome occurs in the solution of protected housing, when the residents are against the construction of a building or a structure in their vicinity, but they are not against its construction at another place. *"We don't want to get an apartment building, because we don't want to create a ghetto, but rather put them in different places. Mental diseases are stigmatized and quite negated by the society. One time an acquaintance of mine told me that they were opening protected housing and civil association were immediately created there that they don't want it there, because it would cause a lot of damage and that they are afraid of their children. It was difficult, but I think a lot of people realized they make a lot of fuss about something, about which they don't know much. The housing is there and there are no problems. Work with mentally ill people doesn't mean danger and the environment doesn't have to be afraid."* (P3).

In one protected housing they told us that the clients are taught vacations, through which they teach them to rest. *"Once a year we go for 5 days to a boarding house outside the city, so that the client would learn to rest. The clients are often in a circle: housing and hospital. On a vacation they can take a break from the problems in the city; they are on vacation for 5 days and they don't deal with anything."* (P8).

We have also encountered the experience of the participants that the mentally ill people often do not want to live alone, yes in a room, but not in an apartment, because if they get out of their room, they want to have at least someone they can talk to or spare a word.

After protected housing they go either to own housing (if they are able to afford it financially), or to commercial lease or to a cheaper boarding house (but the environment is often harmful).

- **Support of Individual Housing**

The client lives at home and goes to the social workers for advice, or they go home to him. Thus, the client lives in his own household and not in protected housing.

3.3 Social Problems

Social exclusion of people with mental disorders is one of the social problems. *"People with a mental disorder are quite excluded, quite rejected, lonely, or they feel that they don't belong to the world, that they are not able to function completely in a society like*

[87] STERGIOPOULOS, V. – GOZDZIK, A. – O'CAMPO, P. – HOLTBY, A. R. – JEYARATNAM, J. – TSEMBERIS, S. Housing first: exploring participants' early support needs. In *BMC Health Serv Res.* 2014.

healthy individuals.“ (P1).

Another area is family support. According to one study, proactive measures to create space for fathers' involvement, provide targeted resources for fathers, and remove cultural and institutional barriers that prevent their involvement. Recognising and supporting the full emotional and practical contribution of fathers is not only a matter of gender equity but a prerequisite for holistic, sustainable family care.[88]

Stigmatization is also problem related to this.

The **availability of social services** for people with mental disorders is another major issue. The availability of services is better in bigger cities. In smaller cities, it may happen that there are no services for the mentally ill people.

[88] LAPKOVÁ, T. – STEJSKALOVÁ, J. – BALOUN, I. *Paternal involvement in families with disabled children: a medical-social perspective on care, stress, and developmental outcomes*. Ukrainian Educational and Scientific Medical Space, 2024, (3-4), 42-47. https://doi.org/10.31612/3041-1548.3-4.2024.06

Conclusion

The university studies of social work prepare the students for work with different target groups. One of the most vulnerable groups are people suffering from a mental disorder. It is important for the social workers to know the symptoms of mental disorders in the clients' behavior and know the necessary approaches and methods of social work, so that they would be able to effectively work with the clients and thus improve the quality of their life.

The aim of the scientific monograph was to analyze the social services primarily focused on people with mental disorders in the Czech Republic. We have identified a wide portfolio of services aimed at people suffering from mental disorders. It includes the center of mental health, daily services center, daily stationary, daily sanatorium, social-therapeutic workshop, support of independent housing, protected housing, leisure time club, community team, crisis beds, 24-hour phone line, crisis team and a SOS phone.

The second aim was to examine the process and determine the methods of social work with people with mental disorders. The following approaches, methods and techniques are used in the Czech services primarily designed for people with a mental disorder: multidisciplinarity, field social work, case management, peer support, recovery, social rehabilitation, individual planning, help in exercising own rights and legally protected interests, accompanying the client to offices and doctors, distribution, relapse prevention – planning for health, support of strengths, open dialogue work with family and family meetings, case conferences, expression therapies, creative workshops, leisure time activities within the organization, outdoor leisure time activities, training of cognitive functions, securing hygiene and low threshold, self-help groups and pastoral counseling. The services and methods in the field of employment include social-therapeutic workshop, training jobs, social companies, employment support team, job consultants (the IPS method – *Individual Placement and Support)* and assistance at the workplace. The services and methods in the field of housing include services of the housing team, protected housing, support of individual housing and use of the Housing First approach.

The third aim was to identify the social problems related to helping people with mental disorders. Social exclusion of people with mental disorders are seen as an issue by the Czech organizations. Stigmatization is a related issue. Another serious issue is the availability of social services for people with mental disorders. The availability of services is better in bigger cities. In smaller cities, it may happen that there are no services for the mentally ill people.

This scientific monograph may help in the preparation of future social workers and workers from other assisting professions for their work with clients with mental disorders. Also, to expand the knowledge of social workers in the field of methods of social work with people with mental disorders, which they can use in their daily practice. It may also be beneficial for the lay public, especially for the relatives of people with a mental disorder, to better understand their behavior and to look for possibilities to help.

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