Editorial / Uvodnik

The development of mental health care at the primary level: Community mental health care as an opportunity for nursing development

Razvoj skrbi na področju duševnega zdravja na primarni ravni zdravstvenega varstva: skupnostna psihiatrična obravnava kot priložnost za razvoj zdravstvene nege

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Primary health care plays an increasingly important role. Countries which lack quality primary health care will not be able to ensure a universally accessible and financially efficient health system. The World Health Organization has already laid the groundwork for the development of primary health care with the adoption of the Declaration of Alma-Ata, which is now considered the "gold standard" for societal commitment to the development of this field (World Health Organization & United Nations Children's Fund, 2018). However, the development of primary health care must also be accompanied by the concurrent development of the nursing profession, as primary health care is expanded through newly developed programmes in which nurses assume advanced roles (Soares Ferreira, Devinar Périco, & Gonçalves Dias, 2018). New programmes are also emerging in the field of mental health care, primarily in the development of community-based mental health services (Boschma, 2012).

In Slovenian language, the term "skupnostna psihiatrična obravnava" has come to refer to community(-based) mental health care (Jerič, 2015). In the field of nursing, community nursing in mental health care and psychiatry began to emerge in the United States, the United Kingdom and Italy as early as 1954. At that time, nurses were sent from psychiatric hospitals to monitor patients diagnosed with schizophrenia in their home environment. The main duties of these nurses were to monitor and guide patients with mental disorders; and their nursing activities were thus limited to monitoring patients' health and administering medication. Originally, the role of psychiatric nurses was based primarily on the traditional treatment of people with mental disorders in psychiatric hospitals. The community-based approach to treating people with mental disorders therefore also presented a challenge to the development of mental health care and psychiatry. In the advancement of community-based mental health care and psychiatry in the 1960s and 1970s, nurses played the central role in the development of novel community-based rehabilitation procedures and mental health services (Gournay, 2000; Boschma, 2012).

Gradually, community mental health care became established in the system of mental health services around the world, including poorer countries. The Republic of Slovenia has signed several conventions, such as the Declaration Mental Health Action Plan for Europe, adopted at the WHO European Ministerial Conference on Mental Health in 2005, thus committing itself to comprehensive treatment of people with mental disorders at the local level and prevention of such disorders, which can only be ensured through regionalisation of services. According to Švab (2012), the term community mental health care refers to the treatment of persons with mental disorders and thus includes all forms of assistance an adult needs to live safely and independently in their own environment and their own community when experiencing problems with independence due to disabilities or special needs. Community mental health care relies on a network of interconnected services (e.g., selected psychiatrists, selected general practitioners and other health services, social work centres, work environments for people with mental disorders, informal networks of relatives and loved ones) whose role is to care for and support the individual on behalf of and for the benefit of the community (Švab, 2012). In this respect, community health care differs from community nursing. It is a synergy of services and collaborations within informal networks of important people and environments with the aim of helping the person with a mental disorder establish the highest possible level of functioning and enabling them to enjoy the highest possible quality of life.

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In Slovenia, the programme of community mental health care has been developed since 2006. The programme was established on the basis of teams in psychiatric hospitals. It provides support to people with mental health disorders to function in their home environment (Jerič, 2015).

At the primary level of health care, four regional community mental health centres started operating in Slovenia in 2013: the community mental health centres of Posavje, Koroška, Prekmurje, and Dolenjska with Bela Krajina. Operating under the auspices of health centres, these community mental health centres provide outpatient specialised mental health services delivered by a multidisciplinary team of health professionals. One such multidisciplinary team, consisting of two registered nurses, a psychiatrist, an occupational therapist and a psychologist, provides mental health services to 70,000–90,000 individuals. It mainly includes people with severe and recurrent mental health disorders (Doberšek Mlakar, 2017). The most important reason for treating people with mental health problems in their home environment is that this is an effective approach to treatment and support, as it involves a cohesive network of different services and patients' relatives, which leads to better cooperation in treatment. Professional assistance is also provided to those who have been offered help very late in the worsening of the illness and to those who have not yet received adequate support (Švab, 2012).

Švab (2012) adds that a registered nurse, as a member of the multidisciplinary team, performs a very autonomous role in assessing, planning, implementing, monitoring and evaluating the patient's levels of ability and independence in their basic life activities, supports patients with mental disorders and their family members, and coordinates the network of different services and people in the local community. This means that nurses deal with professional content for which they have not been properly trained.

Despite the growing awareness of society about the occurrence of mental disorders and the increasing coexistence with people with mental disorders, their stigmatisation is still extremely widespread (Resolution on the National Mental Health Programme 2018–2028, 2018). For this reason, treating people with mental disorders within their local communities has many benefits (Konec Juričič, 2016). Firstly, this approach ensures easier access to appropriate help and thus faster identification of the needs of people with mental disorders and their families. Community health care for people with mental health problems enables a comprehensive, coordinated, continuous, responsive and individualised treatment based on comprehensive assessment of the patient's needs, an active role of the patient and their relatives, and an equal relationship between the patient, their relatives and the members of the medical team. This leads to patient's greater independence and faster resocialisation as a result of the engagement of experts based on the teamwork of all professional services in the field of mental health, as well as the involvement and attention of local communities and civil society. It is important that a person with a mental disorder is treated in their living environment, in their home, and does not have to fear the 'stigma' of institutionalisation represented by a psychiatric hospital.

Collaboration between services in the local environment is based on the specific needs of the patient and aims to address all dimensions of the patient's health in a comprehensive and continuous manner. This leads to a higher level of stability and quality of life for people with mental health problems, while continuous monitoring also enables the provision of timely help. Another crucial aspect in this context is also good collaboration with psychiatric treatment at secondary and tertiary levels of health care (Švab, 2012), as modern treatment of mental disorders represents a balance between interrelated hospital and community services (Thornicroft & Tansella, 2013). Along similar lines, since 1998, several Slovenian authors have argued (Škerbinek, 1998; Sedlar, 2002; Švab, 2012; Kramar Zupan, 2013) that the needs of people with mental disorders mostly originate from the field of basic life activities, i.e. the field of nursing, and that these needs are related to the physical and psychosocial functioning and quality of life in the individual's immediate home setting and wider community environment. Therefore, the nursing profession plays the most important role in community mental health care. Thornicroft, Deb, & Henderson (2016) state that the greatest challenge in mental health care is the general disregard for the fact that the vast majority of people with mental disorders do not receive treatment. This means that there is a need to provide most of the relevant services in non-specialist settings, i.e., community-based primary health care services, as these forms of services allow for much greater and easier access.

The experience of the community mental health team at the primary level shows that the key measures of community mental health treatment and rehabilitation include regular visits, which help establish a trusting relationship, support, defusing sessions and motivation for decision-making. These measures establish, strengthen and maintain trust in the relationship between the members of the community mental health team and the person with mental health problems. Trust is often the basic and only instrument used in the therapeutic relationship, especially in cases where the patient refuses medication therapy and comprehensive professional treatment (Doberšek Mlakar, 2017). The therapeutic relationship based on trust between the person with a mental disorder and the nurse is the essence or foundation of all mental health and psychiatric care. Although a good therapeutic relationship contributes significantly

to the patient's successful coping with everyday problems, nurses often do not pay sufficient attention to this aspect of their professional role (Pazargadi, Fereidooni Moghadam, Fallahi Khoshknab, Alijani Renani, & Molazem, 2015). This seems to be especially characteristic of nurses entering this professional field.

According to modern guidelines for psychiatric treatment, people with severe and recurrent mental disorders with frequent relapses who are hospitalised against their will, who participate poorly in treatment, and who may also have been diagnosed with addiction or frequent abuse of psychoactive substances, must be placed in intensive care units of psychiatric hospitals and monitored continuously. Continuous treatment in the community provides this group of individuals with better quality of treatment, timely emergency response, and a higher quality of life, while also having a positive impact on the number of readmissions and shortening of hospital stays (Kauric, Jez, & Mazgon 2012).

The Resolution on the National Mental Health Programme 2018–2028 (2018) was adopted by the National Assembly of the Republic of Slovenia in March 2018. With this resolution, Slovenia was given the opportunity to comprehensively regulate the entire field of mental health from prevention to treatment and rehabilitation. An important part of the resolution is the establishment of a network of mental health centres in local settings, as they provide better access to mental health assistance. Since 2019, in Slovenia we have established mental health centres for adults (MHCA) and mental health centres for children and adolescents (MHCCA), based on the model and experience of community mental health care. Each MHCA consists of two multidisciplinary teams: an outpatient team and a mobile community team. An MHCA multidisciplinary team consists of the following professionals: registered nurses, psychiatrists, psychologists, clinical psychologists and an occupational therapist. An MHCCA consists of registered nurses, a child psychiatrist, clinical psychologists, psychologists, a special education teacher, an occupational therapist, a speech therapist and a clinical speech therapist.

New forms of mental health care also offer new employment opportunities for registered nurses. While an outpatient MHCA team employs one registered nurse, the community team includes five registered nurses. A MHCCA employs two registered nurses, in addition to other experts (Zakotnik, 2019). Currently, Slovenia is experiencing a historical and systemic shift in the care of people with mental disorders from the institutional model represented by the hospital to that of the home setting (Resolution on the National Mental Health Programme 2018–2028, 2018). This new form of treatment in the home setting is also something that nurses have to adapt to by acquiring new knowledge and professional skills to implement different and more autonomous approaches. In the international context, the professional profile of the community mental health nurse has been established in this field (Ryan, 2017).

In Slovenia, the professional community has not yet reached an agreement on the establishment of this professional profile following the example of other countries where the work of a nurse with people with mental disorders in the community is the standard. Of course, it is not only the title that is important, but also the fact that nurses in this field need more knowledge to develop new competencies that are expected of them. These are more independent and advanced competencies than those of a nurse with a general training in nursing. In Slovenia, a nurse in this field needs to be trained as a clinical specialist in the field of mental health (Bregar et al., 2013). A review of the literature (Kalan, 2017) shows that nurses working in the community are authorised to prescribe medication, conduct clinical research, write treatment protocols, conduct psychotherapy, and formulate mental health policies, which fall under the competencies of advanced nursing.

In practice, the intertwining of the nurse's professional individuality with the multidisciplinary team and the simultaneous development of the required competencies represent both a challenge and an opportunity for the development of mental health and psychiatric nursing in Slovenia. At the primary level of health care, the community mental health nurse working in a residential setting is thoroughly focused on the holistic psychophysical state of the patient and their family, and is able to triage and manage daily task that may change on a daily basis. Key attributes for this professional role include the nurse's personal maturity and ability to manage their own emotional responses in stressful situations - for example, when the patient's health deteriorates in their home environment or during initial visits. The nurse must therefore be flexible and open to the peculiarities of different cultural and social environments. The nurse's responsibilities include motivating the patient to follow medication regimens, preparing medications, administering depot medications, and assessing the patient's reactions and side effects. Moreover, the nurse works closely with other members of the health care team and also provides health education through which people with mental health problems gain skills in self-observation and management of their condition.

The entire process of community mental health treatment begins with triage, assessment of the patient's condition, and identification of their specific needs. After the patient's gives their consent, the initial and subsequent visits are conducted and a treatment plan is developed with short- and long-term goals for improving the patient's functioning and quality of life in their home setting and broader community. This plan

also includes cooperation and networking between the various agencies and the patient's relatives, physicians, selected psychiatrists, the employment office, schools, hospitals, NGOs, individuals and family members, and gradual involvement of the patient in various forms of home and other activities. As the person's functioning improves, the frequency of visits, treatment and support sessions gradually decreases. Conversely, as the person's psychophysical condition deteriorates, treatment sessions become more frequent again. Implementation of the treatment plan is adjusted both on a regular basis and bi-annually. The treatment plan is designed to be accessible, understandable and within the capacity and capabilities of the person with a mental disorder. The short-term plan, which is very important, can be a simple agreement about improving personal hygiene or using free time. We continuously educate our patients about these aspects and help them implement what they learn. In addition to health education knowledge, the nurse also needs additional knowledge on how to conduct motivational interviews and how to implement psychotherapeutic and counselling interventions.

Each patient is supervised by their case coordinator, who is also a team member and coordinates the patient's treatment, maintains regular contact with the patient, negotiates agreements, and keeps all documentation. The role of the case coordinator in this process is usually assumed by the registered nurse.

With the introduction of MHCA and MHCCA, mental health and psychiatric nurses were confronted with the challenge associated with the demands of this new professional environment and the need for new formal competencies. Due to the rapid development of mental health centres between 2019 and 2021, we estimate that there will be a great need for additional education, empowerment and provision of specialist competencies in community mental health nursing. We anticipate that the first specialist training in mental health nursing will take place in early 2022, providing a deeper understanding of this area of work. We also expect postgraduate specialisation programmes to be introduced shortly thereafter. There is a clear need in professional practice for in-depth knowledge related to working with people with psychosis, eating disorders, depression, anxiety, obsessive compulsive disorder, addictions, post-traumatic stress disorder, as well as for knowledge related to mental health promotion, forensics, management and psychopharmacology. But most importantly, there is a lack of knowledge in motivational approaches, counselling and psychotherapy, which is the standard for every mental health nurse abroad.

The beginnings of the Posavje Community Mental Health Team were quite a challenge. The community-based approach contains peculiarities which can only be perceived during practical work. The geographically diverse area of the Posavje region has its own cultural and local characteristics. We are dealing with a high tolerance of alcohol consumption, which often leads to addiction and problems in family dynamics and relationships. Entering one's home environment and personal space outside the controlled clinical environment has been shown to be challenging. A person with a mental disorder is often in a state of relapse, showing signs of deviant behaviour and lacking critical judgement. It is often necessary to first go through the basic trust-building phase and only then, sometimes after several weeks, take further steps in treatment. Over the span of several years, we have gained experience, observed and evaluated our own approaches, and identified the best practices. As the concern for one's own safety remains an important factor, most home visits are carried out by a professional team of two people. The lives of people with severe mental disorders (and their relatives) living outside the institutional environment are characterised by very specific features. They often live in disadvantaged conditions and their lives are thus uncertain in terms of psychophysical health maintenance. The integration of patients into the wider social world outside their place of residence can be hampered by geographical diversity, lack of resources, psychopathology, a poor network of NGOs and other rehabilitation services.

It is particularly difficult to take action against the patient's will, as we would damage the therapeutic relationship and lose the patient's trust, thus also losing the chance of favourable opportunities for further work by the community mental health team. The patient's relatives often do not see the severity of the condition, and may express feelings of helplessness and anxiety. According to Doberšek Mlakar (2017), the greatest advantage and "professional privilege" of the work of registered nurses is in that they frequently and continuously visit patients at home, in their residential community. For a person with mental health problems, their relatives, and for staff in other professional fields, the nurse is most usually the most important professional liaison (White & Hall, 2006). The established therapeutic relationship is based on a dynamic assessment of the patient's condition and needs. The nurse is therefore well familiar with the patient's role and abilities in the context of their functioning and life needs in their environment.

This approach enables the citizens of Slovenia to receive treatment at home. This significant breakthrough in the treatment of people with mental health problems has not been followed by the nursing profession. We need to make up for the missed opportunities by working with the National Institute of Public Health as the umbrella organisation for mental health centres. People with mental disorders must receive the optimal and highest quality care. In the international context, the standards for training have already been established. Now the possibility of clinical specialisation in the field of mental health

must also be defined, as does the prospect of autonomy and formally recognised competencies of a specialist nurse.

Slovenian translation / Prevod v slovenščino

Primarno zdravstveno varstvo ima vse pomembnejšo vlogo. Brez kakovostnega primarnega zdravstvenega varstva države ne bodo mogle dosegati sistema zdravstvenega varstva, ki bo vsesplošno dostopen in finančno učinkovit. Svetovna zdravstvena organizacija je temelje razvoja primarnega zdravstvenega varstva postavila že z deklaracijo Alma-Ata, ki pomeni »zlati standard« za družbeno zavezanost k razvoju tega področja (World Health Organization & United Nations Children's Fund, 2018). Z razvojem primarnega zdravstvenega varstva se mora razvijati tudi stroka zdravstvene nege, saj se primarno zdravstveno varstvo širi tudi z novimi programi, v katerih zaposleni v zdravstveni negi dobivajo nove napredne vloge (Soares Ferreira, Devinar Périco, & Gonçalves Dias, 2018). Novi programi nastajajo tudi na področju duševnega zdravja, predvsem z razvojem psihiatrične obravnave v skupnosti (Boschma, 2012).

V Sloveniji se je za psihiatrično obravnavo v skupnosti uveljavil termin skupnostna psihiatrična obravnava (Jerič, 2015). Na področju zdravstvene nege govorimo o skupnostni zdravstveni negi na področju duševnega zdravja in psihiatrije, katere začetke opisujejo v Ameriki, Angliji in Italiji že od leta 1954 dalje. Takrat so poslali medicinske sestre iz psihiatričnih bolnišnic za spremljanje pacientov z diagnosticirano shizofrenijo v njihovo domače okolje. Glavna naloga teh sester je bila spremljanje in vodenje pacientov z duševno motnjo zgolj z izpostavljenimi dejavnostmi zdravstvene nege opazovanja zdravstvenega stanja pacientov in aplikacije zdravil. Vloge psihiatričnih medicinskih sester so v začetku izhajale predvsem iz tradicionalne obravnave oseb z duševno motnjo v psihiatričnih bolnišnicah. Zato je bil skupnostni pristop do oseb z duševno motnjo tudi izziv za razvoj zdravstvene nege na področju duševnega zdravja in psihiatrije. Medicinske sestre so imele v nadaljnjem razvoju področja duševnega zdravja in psihiatrije v skupnosti v šestdesetih in sedemdesetih letih prejšnjega stoletja osrednjo vlogo pri oblikovanju novih rehabilitacijskih praks in storitev za duševno zdravje v skupnosti (Gournay, 2000; Boschma, 2012).

Skupnostna psihiatrična obravnava je polagoma dobila svoje mesto v sistemu psihiatričnih služb povsod po svetu, tudi v bistveno revnejših državah od naše. Republika Slovenija je v preteklosti podpisala več konvencij, kot sta Deklaracija in akcijski načrt za področje duševnega zdravja v Evropi, sprejeta na Evropski ministrski konferenci SZO v Helsinkih leta 2005 (WHO European Ministerial Conference on Mental Health, 2005), s katerima se je zavezala k celostni obravnavi oseb z duševnimi motnjami na lokalnem nivoju ter k preventivi, ki jo je mogoče zagotoviti le z regionalizacijo služb. Skupnostna psihiatrična obravnava je po Švabovi (2012) obravnava oseb z duševno motnjo, ki se nanaša na vse oblike pomoči, ki jih odrasla oseba potrebuje, da bi lahko varno in neodvisno živela v lastnem okolju, lastni lokalni skupnosti, kadar ima zaradi oviranosti, bolezni ali posebnih potreb določene težave pri neodvisnem funkcioniranju. Skupnostna skrb temelji na mreži medsebojno povezanih služb (npr. izbrani psihiatri, izbrani osebni zdravniki in druge zdravstvene službe, centri za socialno delo, delovna okolja osebe z duševno motnjo, neformalna mreža svojcev, bližnjih), katerih poslanstvo je, da se v imenu in v korist skupnosti posvečajo posamezniku in mu pomagajo (Švab, 2012). V tem se skupnostna obravnava razlikuje od patronažne obravnave. Gre za sinergijo služb in sodelovanje neformalnih mrež pomembnih oseb in okolij s ciljem, da se vzpostavi najvišje možno funkcioniranje osebe z duševno motnjo in najvišja mogoča kakovost življenja.

V Sloveniji se od leta 2006 razvija program skupnostne psihiatrične obravnave (SPO), ki osebam s težavami v duševnem zdravju nudi podporo pri funkcioniranju v domačem okolju (Jerič, 2015) in se je oblikoval iz timov, zaposlenih v psihiatričnih bolnišnicah.

Na primarni ravni zdravstvenega varstva so v letu 2013 v slovenskem prostoru pričeli delovati štirje regijski centri skupnostne psihiatrične obravnave (SPO): Posavje, Koroška, Prekmurje in Dolenjska z Belo krajino. Gre za zunajbolnišnično specialistično psihiatrično obravnavo, ki jo izvaja multidisciplinarni tim zdravstvenih strokovnjakov. Nosilci dejavnosti so zdravstveni domovi. Multidisciplinarni tim sestavljajo: dve diplomirani medicinski sestri, psihiater, delovni terapevt in psiholog. V SPO je multidisciplinarni mobilni tim izvajal psihiatrične storitve za 70.000–90.000 prebivalcev. V obravnavo so bili vključeni predvsem posamezniki s hudimi in ponavljajočimi se duševnimi motnjami (Doberšek Mlakar, 2017). Najpomembnejši razlog za obravnavo oseb s težavami v duševnem zdravju v domačem okolju je, da gre za učinkovit pristop, ki v zdravljenje in podporo vključuje povezano mrežo različnih služb in domačih ljudi, kar vpliva predvsem na izboljšanje sodelovanja pri zdravljenju. To pomeni višjo kakovost življenja oseb s težavami v duševnem zdravju in njihovih pomembnih drugih. Strokovna pomoč je bila ponujena tudi tistim posameznikom, ki so do potrebne pomoči ob poslabšanju bolezni prišli zelo pozno ali pa ustrezne pomoči sploh še niso prejeli (Švab, 2012).

Švabova (2012) dodaja, da diplomirana medicinska sestra kot del multidisciplinarnega tima opravlja zelo samostojno vlogo ocenjevanja, načrtovanja, izvajanja, spremljanja in ovrednotenja kapacitet in samostojnosti v vseh osnovnih življenjskih dejavnostih, nudi podporo

osebi s težavami v duševnem zdravju in družinskim članom ter povezuje mrežo različnih služb in domačih ljudi, kar pomeni, da se ukvarja s strokovno vsebino, za katero ni nikoli pridobila ustreznih kompetenc.

Stigmatizacija oseb z duševno motnjo je kljub vedno večjemu ozaveščanju družbe o pojavnosti duševnih motenj in vse večjem sobivanju z osebami z duševno motnjo še vedno zelo velika (Resolucija o nacionalnem programu duševnega zdravja 2018–2028, 2018). Obravnava oseb z duševnimi motnjami v lokalnih skupnostih ima zato mnogo prednosti (Konec Juričič, 2016). Najprej omenimo večjo dostopnost do ustrezne pomoči in s tem hitrejše prepoznavanje potreb ljudi z duševnimi motnjami in njihovih bližnjih. Skupnostna obravnava oseb s težavami v duševnem zdravju ponuja celovito, usklajeno, nepretrgano, hitro odzivno in posamezniku prilagojeno obravnavo, ki temelji na celoviti oceni potreb, dejavni vlogi pacientov in njihovih svojcev ter enakopravnem odnosu med pacientom, svojci in člani tima. To vodi v večjo samostojnost in hitrejšo resocializacijo, kar pomeni profesionalno delo strokovnjakov, ki temelji na timskem sodelovanju vseh služb oziroma vseh strok s področja duševnega zdravja, vključevanje in upoštevanje lokalnih skupnosti in civilne družbe. Pri tem je bistveno, da je oseba z duševno motnjo obravnavana v svojem okolju, na svojem domu in se ji ni treba bati »stigme« institucionalizacije, ki jo predstavlja psihiatrična bolnišnica.

Gre za vzpostavitev sodelovanja med službami v lokalni okolici glede na potrebe pacienta z namenom celostne in kontinuirane obravnave vseh dimenzij njegovega zdravja. Tako se vzpostavljajo višja stabilnost in kakovost življenja oseb s težavami v duševnem zdravju ter zaradi kontinuiranega spremljanja pravočasna pomoč. Pomembno je tudi dobro sodelovanje s psihiatrično obravnavo na sekundarnem in terciarnem nivoju zdravstvenega varstva (Švab, 2012), saj naj bi sodobna obravnava duševnih motenj predstavljala ravnotežje med seboj povezanih bolnišničnih in skupnostnih služb (Thornicroft & Tansella, 2013). Podobno že od leta 1998 več slovenskih avtorjev trdi (Škerbinek,1998; Sedlar, 2002; Švab, 2012; Kramar Zupan, 2013), da se potrebe oseb z duševno motnjo izražajo večinoma na področju osnovnih življenjskih dejavnosti, torej na področju zdravstvene nege, in se po vsebini nanašajo na fizično ter psihosocialno funkcioniranje in kakovost življenja v ožjem domačem in širšem okolju posameznika. Ravno stroka zdravstvene nege ima torej lahko v skupnostni psihiatrični obravnavi največji pomen. Thornicroft, Deb, & Henderson (2016) navajajo, da največji izziv pri oskrbi duševnega zdravja predstavlja visoka stopnja neupoštevanja dejstva, da se velika večina oseb z duševnimi motnjami po vsem svetu ne zdravi. To pomeni, da je nujno zagotavljanje večine storitev v nespecializiranih okoljih oziroma v primarnih storitvah zdravstvenega varstva v skupnosti, saj je dostopnost do teh oblik storitev mnogo lažja in večja.

Izkušnje tima skupnostne psihiatrične obravnave na primarni ravni kažejo, da so redni obiski in s tem vzpostavljanje zaupnega odnosa, podpora, razbremenilni pogovori in motivacija za sprejemanje rešitev ključni ukrepi skupnostnih psihiatričnih obravnav in rehabilitacije. Našteto vzpostavlja, krepi in vzdržuje zaupanje v odnosu članov skupnostnega psihiatričnega tima do osebe s težavami v duševnem zdravju. Zaupanje je pogosto temeljno in edino orodje terapevtskega odnosa, zlasti v primerih, ko oseba s težavami v duševnem zdravju odklanja medikamentozno terapijo, zdravljenje in celostno strokovno obravnavo (Doberšek Mlakar, 2017). Prav terapevtski odnos, ki temelji na zaupanju med osebo z duševno motnjo in medicinsko sestro, je bistvo oziroma temelj celotne zdravstvene nege na področju duševnega zdravja in psihiatrije. Kljub temu da dober terapevtski odnos bistveno pripomore k uspešnemu soočanju osebe z duševno motnjo z vsakodnevnimi težavami, medicinske sestre tega vidika svoje profesionalne vloge pogosto ne upoštevajo dovolj (Pazargadi, Fereidooni Moghadam, Fallahi Khoshknab, Alijani Renani, & Molazem, 2015). Slednje je še posebej značilno za medicinske sestre, ki na novo vstopajo na to področje.

Sodobne smernice psihiatričnega zdravljenja zahtevajo poleg intenzivnega zdravljenja v psihiatričnih bolnišnicah tudi nepretrgano spremljanje skupine oseb s hudimi in ponavljajočimi se duševnimi motnjami, ki se jim bolezen pogosto ponavlja, ki jih hospitalizirajo proti njihovi volji, slabo sodelujejo pri zdravljenju in imajo dvojne diagnoze z odvisnostjo ali pogostimi zlorabami psihoaktivnih substanc. Nepretrgana obravnava te skupine oseb v skupnosti zagotavlja boljšo kakovost obravnave, pravočasne nujne posege, izboljša kakovost življenja, vpliva na število ponovnih sprejemov in lahko skrajša obdobja hospitalizacije (Kauric, Jez, & Mazgon 2012).

Resolucijo o nacionalnem programu duševnega zdravja 2018–2028 (2018) je državni zbor Republike Slovenije sprejel marca 2018. S tem smo v Sloveniji dobili možnost, da celostno poskrbimo za področje duševnega zdravja od preventive do zdravljenja in rehabilitacije. Pomemben del resolucije je ustanavljanje mreže centrov za duševno zdravje v lokalnih okoljih, saj omogočajo boljšo dostopnost do pomoči na področju duševnega zdravja. Od leta 2019 v Sloveniji iz modela in izkušenj skupnostne psihiatrične obravnave razvijamo centre za duševno zdravje odraslih (CDZO) in centre za duševno zdravje otrok in mladostnikov (CDZOM). Posamezni center za duševno zdravje odraslih sestavljata dva multidisciplinarna tima: ambulantni in skupnostni tim, ki je mobilen. Multidisciplinarni tim CDZO je sestavljen iz naslednjih strokovnjakov: diplomiranih medicinskih sester, psihiatrov, psihologov, kliničnih

psihologov in delovnega terapevta. CDZOM sestavljajo diplomirani medicinski sestri, pedopsihiater, klinični psihologi, psihologi, specialni pedagog, delovni terapevt, logoped in klinični logoped.

Nove oblike organizacije pomoči na področju duševnega zdravja predstavljajo tudi nove možnosti zaposlitve diplomiranih medicinskih sester. V ambulantnem timu CDZO je zaposlena ena, v skupnostnem pa pet diplomiranih medicinskih sester. V centru za duševno zdravje otrok in mladostnikov sta poleg ostalih strokovnjakov zaposleni dve diplomirani medicinski sestri (Zakotnik, 2019). Danes smo v Sloveniji torej priča zgodovinskemu in sistemskemu organiziranemu premiku skrbi za osebe z duševno motnjo iz institucije, ki jo predstavlja bolnišnica, v njihovo domače okolje (Resolucija o nacionalnem programu duševnega zdravja 2018–2028, 2018). Z novo obliko obravnave v domačem okolju se pri nas soočajo tudi medicinske sestre, ki si morajo za drugačne in samostojnejše pristope pridobiti nova znanja in veščine dela. V tujini se je na tem področju uveljavilo delovno mesto *community mental health nurse* (Ryan, 2017).

V Sloveniji stroka še ni dosegla dokončnega dogovora glede imenovanja navedenega delovnega mesta po zgledu tujine, kjer delo medicinske sestre z osebami z duševno motnjo v skupnosti predstavlja standard. Pri tem seveda ni pomemben le naziv, treba se je zavedati, da medicinske sestre na tem področju potrebujejo več znanja, da bodo prevzele nove kompetence, kot se od njih pričakuje. Gre za samostojnejše in razširjene kompetence, kot jih ima medicinska sestra s splošno izobrazbo iz zdravstvene nege. Zato je v slovenskem prostoru medicinsko sestro na tem področju treba izobraziti kot klinično specialistko s področja duševnega zdravja (Bregar et al., 2013). Pregled literature (Kalan, 2017) namreč kaže, da so medicinske sestre v skupnosti pooblaščene za predpisovanje zdravil, izvajanje kliničnih raziskav, pisanje protokolov, izvajanje psihoterapije, oblikovanje politike na področju duševnega zdravja, kar spada med kompetence napredne zdravstvene nege.

Prepletanje profesionalne individualnosti medicinske sestre z multidisciplinarnim timom in istočasno sledenje kompetencam sta se v praksi izkazala kot nov izziv in priložnost za razvoj zdravstvene nege na področju duševnega zdravja in psihiatrije v Sloveniji. Skupnostna psihiatrična medicinska sestra je na primarnem nivoju zdravstvenega varstva v skupnosti, kjer ljudje živijo, podrobno orientirana na celostno psihofizično stanje posameznika in družine ter sposobna triažirati in upravljati številne dnevno spremenjene prednostne naloge. Za njeno profesionalno vlogo sta pomembni osebna zrelost in sposobnost obvladovanja lastnih čustvenih odzivov v stresnih situacijah – na primer pri poslabšanem zdravstvenem stanju pacientov v domačem okolju ali ob prvih obiskih. Biti mora prilagodljiva in odprta za posebnosti različnih kulturnih in socialnih okolij. Njene pomembne naloge so: motivacija za jemanje medikamentozne terapije, priprava zdravil, aplikacija depo terapije, ocena odzivov in neželenih učinkov. Zdravstveno vzgojo izvaja z namenom, da si osebe s težavami v duševnem zdravju pridobijo spretnosti obvladovanja bolezni in samoopazovanja, ter tesno sodeluje z drugimi člani zdravstvenega tima.

Celoten proces skupnostne psihiatrične obravnave se prične s triažo, oceno stanja in ugotavljanjem potreb osebe s težavami v duševnem zdravju. Ob privolitvi pacienta sledijo prvi in nadaljnji obiski ter sestava načrta obravnave s kratkoročnimi in dolgoročnimi cilji za izboljšanje funkcioniranja in kakovosti življenja v ožji domači in širši skupnosti, sodelovanje in povezovanje ustanov in ljudi, ki so pomembni za bolno osebo (centri za socialno delo, izbrani zdravniki, izbrani psihiatri, zavod za zaposlovanje, šole, bolnišnice, nevladne organizacije, posamezniki v družini in kraju), postopno vključevanje pacientov v različne oblike domačih in drugih dejavnosti. Obiski, obravnave in podpora se postopno zmanjšujejo ob boljšem funkcioniranju. Osebe se pogosteje obravnava ob poslabšanju psihofizičnega stanja. Izvajanje načrta se vrednoti sproti in obdobno na šest mesecev. Načrt obravnave je sestavljen tako, da je dosegljiv in razumljiv ter v okviru kapacitet in zmogljivosti osebe z duševno motnjo. Tako je zelo pomemben kratkoročni načrt lahko le preprost dogovor v zvezi z izboljšanjem osebne higiene ali izrabe prostega časa, o čemer pacienta dlje časa učimo in ga podpiramo pri uresničevanju. Poleg zdravstvenovzgojnega znanja je potrebno dodatno znanje o izvajanju motivacijskega intervjuja, psihoterapevtskih in svetovalnih ukrepih.

Za posameznega pacienta je odgovoren koordinator primera, ki je član tima in skrbi za organizacijo obravnave, stalne kontakte s pacientom, izvedbo dogovorov, dokumentacijo. V tem procesu je diplomirana medicinska sestra največkrat koordinator primera.

Z vzpostavitvijo CDZO in CDZOM smo se medicinske sestre na področju duševnega zdravja in psihiatrije soočile z izzivom potreb novega strokovnega okolja in doseženih formalnih kompetenc. Zaradi hitrega razvoja centrov za duševno zdravje med letoma 2019 in 2021 ocenjujemo veliko potrebo po dodatnem izobraževanju, opolnomočenju in omogočanju specialnih znanj na področju skupnostne psihiatrične zdravstvene nege. Pričakujemo, da se bo v začetku leta 2022 odvilo prvo izobraževanje iz specialnih znanj za področje psihiatrične zdravstvene nege, ki bo omogočilo globlje razumevanje našega dela. Pričakujemo tudi čimprejšnje izvajanje specializacije. Praksa kaže potrebe po poglobljenem znanju o delu s psihozami, motnjami hranjenja, depresijo, anksioznostjo, obsesivno kompulzivno motnjo, odvisnostmi, posttravmatsko stresno motnjo, promocijo duševnega zdravja, forenziko, geriatrijo, managementom in psihofarmakologijo. Predvsem

nam primanjkuje znanja s področja motivacijskih pristopov, svetovalnega dela in tudi psihoterapevtskih znanj, ki za vsako psihiatrično medicinsko sestro v tujini predstavljajo standard.

Začetki tima SPO Posavje so predstavljali izziv. Področje skupnostnega pristopa vsebuje posebnosti, ki jih zaznaš šele pri praktičnem delu. Geografsko pestro razvejano področje Posavja ima svoje kulturološke in lokalne značilnosti. Srečujemo se z visoko toleranco do pitja alkohola, iz tega izhajajočo odvisnostjo in težavami v družinski dinamiki odnosov. Izkazalo se je, da vstopanje v domače okolje in osebni prostor, ki ni nadzorovano klinično okolje, ni preprosto. Oseba z duševno motnjo je pogosto v poslabšanju, z odklonilnim vedenjem in nekritična. Najprej je treba skozi fazo vzpostavljanja osnovnega zaupanja, šele nato, včasih po več tednih, sledijo nadaljnji koraki obravnave. S sodelavci smo pridobivali izkušnje, opazovali in vrednotili lastne pristope ter v večletnem procesu prepoznali uporabne pristope dela. Pomemben dejavnik še vedno predstavlja tudi skrb za lastno varnost, zato večino obiskov na domu izvedemo v strokovnem paru. Obstajajo pomembne posebnosti življenja oseb (in njihovih pomembnih drugih) s hudo duševno motnjo izven institucije. Razmere, v katerih živijo, so pogosto blizu socialnega dna in rizične za ohranjanje psihofizičnega zdravja. Vključevanje v širši socialni svet izven naslova bivanja ovirajo geografska raznolikost, pomanjkanje sredstev, psihopatologija, slaba mreža nevladnih organizacij in drugih rehabilitacijskih služb.

Na terenu je posebej težko ukrepati proti volji pacienta, saj s tem izgubljamo terapevtski odnos in zaupanje ter s tem ugodne možnosti za nadaljnje delo tima skupnostne psihiatrične obravnave. Tudi svojci pogosto niso kritični do resnosti stanja, izražajo občutke nemoči in zaskrbljenosti. Temeljna prednost in »strokovni privilegij« dela diplomirane medicinske sestre je (Doberšek Mlakar, 2017), da osebo pogosto in kontinuirano vidi na njenem domu, v skupnosti, kjer živi. Za osebo s težavami v duševnem zdravju, njene bližnje in sodelavce drugih strok je medicinska sestra najpogosteje ključna strokovna vez (White & Hall, 2006). Razvije se terapevtski odnos, ki temelji na dinamični oceni stanja in potreb. Tako medicinska sestra dobro in lažje razume vlogo in zmožnosti pacienta v kontekstu funkcioniranja in izražanja življenjskih potreb v njenem / njegovem okolju.

Državljanom Slovenije je tako omogočeno zdravljenje v domačem okolju. Takšnemu razvojnemu preboju obravnave oseb s težavami v duševnem zdravju stroka zdravstvene nege ni sledila. Zamujeno je treba nadoknaditi v sodelovanju z Nacionalnim inštitutom za javno zdravje kot krovno institucijo centrov za duševno zdravje. Oseba s težavami mora dobiti največ in najboljše. Standard izobrazbe v tujini že obstaja, zato naj bo opisano tudi možnost za razvoj klinične specializacije na področju duševnega zdravja, priložnost za avtonomijo in formalne prepoznane kompetence medicinskih sester na tem področju.

Conflict of interest / Nasprotje interesov

Avtorica izjavlja, da ni nasprotja interestov. / The author confirm that there are no known conflict of interest.

Literature

Boschma, G. (2012). Community mental health nursing in Alberta, Canada: An oral history. *Nursing History Review*, 20(1), 103–135. https://doi.org/10.1891/1062-8061.20.103 PMid:22360000

Bregar, B., Živič, Z., Jambrošič, I., Lapanja, A., Roljić, S., Stopar Stritar, A., Stevanović, N., & Peterka Novak, J. (2013). Specializacije v zdravstveni negi: primer psihiatrične zdravstvene nege. In B. Skela Savič & S. Hvalič Touzery (Eds), *Zahtevnejše oblike dela v zdravstveni negi: Mednarodni pristopi in stanje v Sloveniji: 6. posvet z mednarodno udeležbo Moja kariera – Quo vadis, Ljubljana, 27. marec 2013* (pp. 63–77). Jesenice: Visoka šola za zdravstveno nego Jesenice.

Doberšek Mlakar J. (2017). Vloga zdravstvene nege v timu skupnostne psihiatrične obravnave na primarni ravni. In S. Majcen Dvoršak et al. (Eds), *11. kongres zdravstvene in babiške nege Slovenije, Brdo pri Kranju, 27. in 29. november 2017* (pp. 76–85). Ljubljana: Zbornica zdravstvene in babiške nege Slovenije - Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slove nije, Nacionalni center za strokovni, karierni in osebnostni razvoj medicinskih sester in babic.

Gournay, K. (2000). Role of the community psychiatric nurse in the management of schizophrenia. *Advances in Psychiatric Treatment*, 6(4), 243–251. https://doi.org/10.1192/apt.6.4.243

Jerič, A. (2015). *Zadovoljstvo z obravnavo pri bolnikih s hudo duševno motnjo: primerjava standardne in skupnostne psihiatrične obravnave* (magistrsko delo). Univerza na Primorskem, Fakulteta za vede o zdravju, Izola.

Juričič, N. (2016). Drugi viri pomoči in podpore. In N. Konec Juričič et al. (Eds.), *Prepoznavanje in obravnava depresije in samomorilnosti pri pacientih v ambulanti družinskega zdravnika* (pp. 87–92). Ljubljana: Nacionalni inštitut za javno zdravje.

Kalan, A. (2017). *Kompetence, aktivnosti in področja dela medicinskih sester v psihiatriji* (diplomsko delo). Fakulteta za zdravstvo Angele Boškin, Jesenice.

Kauric, A., Jez, A. S., & Mazgon, K. S. (2012). Evalvacija programa skupnostnega psihiatričnega zdravljenja v Psihiatrični bolnišnici Idrija. *Socialno delo*, 51(1/3), 177.

Kramar Zupan, M. (2013). Skupnostna psihiatrična obravnava kot multidisciplinarni timi v osnovnem zdravstvu. In *Interdisciplinarno povezovanje za pretok znanja med teorijo in prakso: zbornik prispevkov mednarodne znanstvene konference* (p. 179). Novo mesto: Fakulteta za zdravstvene vede Novo Mesto.

Kert, S. (2021). *Zagotavljanje enakosti v primarni zdravstveni oskrbi v povezavi z organizacijo dela in sistemom financiranja v Sloveniji in primerjava z državami centralne in vzhodne Evrope* (doktorska disertacija). Univerza v Mariboru, Medicinska fakulteta.

Pazargadi, M., Fereidooni Moghadam, M., Fallahi Khoshknab, M., Alijani Renani, H., & Molazem, Z. (2015). The therapeutic relationship in the shadow: Nurses' experiences of barriers to the nurse–patient relationship in the psychiatric ward. *Issues in Mental Health Nursing*, 36(7), 551–557. https://doi.org/10.3109/01612840.2015.1014585 PMid:26309175

Resolucija o nacionalnem programu duševnega zdravja 2018–2028 /ReNPDZ18-28/ (2018). Uradni list RS, št. 24/18 (13.04.2018). Retrieved from http://www.pisrs.si/Pis.web/pregledPredpisa?id=RESO120

Ryan, D. (2017). Mental health nursing in community care. In M. Chambers (Ed.), *Psychiatric and mental health nursing: The craft of caring* (3rd ed., pp. 428–426). Abingdon; New York: Routledge, Taylor & Francis Group. https://doi.org/10.1201/9781315381879-55 PMid:27759075

Soares Ferreira, S. F., Devinar Périco, L. A., & Gonçalves Dias, V. R. F. (2018). The complexity of the work of nurses in Primary Health Care. *Revista Brasileira de Enfermagem*, 71(Suppl. 1), 704–709. https://doi.org/10.1590/0034-7167-2017-0471 PMid:29562031

Sedlar, T. (2002). Dolgoročne strategije razvoja zdravstvene nege na področju duševnega zdravja. *Obzornik zdravstvene nege,* 36(3), 143–151. Retrieved November 15, 2021 from https://obzornik.zbornica-zveza.si/index.php/ObzorZdravNeg/article/view/2403

Škerbinek, L. (1998). Pasti psihiatrične zdravstvene nege. *Obzornik zdravstvene nege,* 32(5/6), 181–183. Retrieved November 15, 2021 from https://obzornik.zbornica-zveza.si/index.php/ObzorZdravNeg/article/view/2223?articlesBySimilarityPage=3

Švab, V. (2012). *Skupnostna psihiatrija.* Retrieved 15, 2021 from https://www.varuh-rs.si/fileadmin/user_upload/word/STROKOVNI_CLANKI_-_razni/Skupnostna_psihiatrija_-_Vesna_Svab.pdf

Thornicroft, G., & Tansella, M. (2013). The balanced care model: The case for both hospital-and community-based mental healthcare. *The British Journal of Psychiatry*, 202(4), 246–248. https://doi.org/10.1192/bjp.bp.112.111377 PMid:23549938

Thornicroft, G., Deb, T., & Henderson, C. (2016). Community mental health care worldwide: Current status and further developments. *World Psychiatry*, 15(3), 276–286. https://doi.org/10.1002/wps.20349 PMid:27717265; PMCid:PMC5032514

Zakotnik, J. M. (2019). Resolucija o nacionalnem programu duševnega zdravja 2018–2028. In L. Šprah (Ed.), *Z več znanja o motnjah razpoloženja do izhodov iz labirintov: izkušnje in razmisleki* (pp. 35–40). Ljubljana: Založba ZRC SAZU.

White, P., & Hall, M. (2006). Mapping the literature of case management nursing. *Journal of Medicine Library Association*, 94(2), 99–106.

World Health Organization (WHO), & United Nations Children's Fund (UNICEF). (2018). *A vision for primary health care in the 21st century: Towards universal health coverage and the Sustainable Development Goals.* Retrieved November 14, 2021 from https://apps.who.int/iris/handle/10665/328065

WHO European Ministerial Conference on Mental Health. (2005). *Mental health: Facing the challenges, building solutions: Report from the WHO European Ministerial Conference*. Copenhagen: World Health Organization Regional Office for Europe.

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