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FACULTY OF SOCIAL WELFARE AND DISABILITY STUDIES
DEPARTMENT OF SOCIAL EDUCATION AND PSYCHOLOGY

Joint master study programme “Social Work”

2nd year of studies

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**THE POSSIBILITIES OF SOCIAL WORKER’S PRACTICE IN
WORKING WITH PEOPLE WITH MENTAL DISABILITIES IN THE
CONTEXT OF THE MAINTENANCE OF THEIR LIFE QUALITY**

Master’s thesis

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2015

Certification on the Original Authorship of the Master Thesis

I confirm that the submitted master thesis „The Possibilities of Social Worker’s Practice in Working with People with Mental Disabilities in the Context of the Maintenance of their Life Quality” is:

1. Performed independently and is not submitted for another course in the current or previous semesters.
2. Was not used in another institute/university in Lithuania and abroad.
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Master's Thesis Summary

The Master's Thesis deals with the social worker's activity opportunities by improving the quality of life for people with mental disabilities. By applying theoretical and empirical research methods, it was intended to examine the overall conception of the mental disability, disorders and the quality of life, the subjective well-being of people with mental disabilities, to briefly present the situation of people with mental disabilities in Ukraine, to investigate functions of social workers (in Lithuania and Ukraine) and activity opportunities in the support system for people with mental health issues and to examine social and the quality of life support activities of people with mental disabilities while working with these people.

To achieve the Master Thesis's objective, it has been selected a qualitative individual semi-structured interview method and an applied to customers individual in-depth interview. The study involved 6 individuals with mental disabilities, 10 Lithuanian social workers and 12 Ukrainian specialists working with people with mental disabilities.

The theoretical scientific literature analysis and empirical research results showed that people with mental disabilities are closely related to the subjective assessment of the quality of life. According to the respondents, most of such individuals are lacking privacy, understanding and caring by their relatives, safe and adapted to them environment, the completeness of the system which would help to fully integrate into society, and financial resources. Social workers (in Lithuania and Ukraine) have more than one responsibility within their organization and provide various general and special social services that improve the quality of life of people with mental disabilities. Services include communication with the client and his family, counseling them, representating, communication and cooperation with certain institutions, documents preparation, cooking and organizing affitional activities, help with shopping, training of social skills and self-support, solving emergent problems and so on.

This thesis consists of a summary in English, introduction, 2 chapters, conclusions, a list of references (138 sources), a summary in Lithuanian, annexes. The research data is illustrated by 3 pictures and 28 tables. Annexes provide an operationalization, in-depth semi-structured interview questions for customers, semi-structured interview questions for social workers, excerpts of interviews with clients and social workers. The Thesis consists of 89 pages (without annexes).

Keywords: the Quality of Life, a Social Worker, a Person with Mental Disability.

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THE GLOSSARY OF MAIN CONCEPTS WHICH WERE USED IN THESIS

Quality of Life – defined as a comprehensive well-being, which includes objective descriptors and subjective physical, material, social and emotional well-being assessments, it also includes personal development and targeted activities during everything happening in a context of the personal value system (Rapley, 2008, p. 53).

Subjective Well-Being – a more scientific title of phenomenon of what in everyday speech is called happiness. It is a positive emotional state, manifested as self-satisfaction, satisfaction of life and the surrounding world (Šilinskas, Žukauskienė, 2004).

Mental Illness – a disorder, diagnosed by the doctor and approved by the psychiatrist, attributed to mental illness under the current classification of diseases. A mental illness cannot be diagnosed on the basis of political, religious or racial reasons (*LR Mental Health Care Act*, 1995).

The Social Integration of Disabled system consists of supplying the medical, professional and social rehabilitation services, satisfying the special needs with special assistance measures, supporting the employment of persons with disabilities, social assistance, granting and payment of State's Social insurance fund pensions and benefits, granting and payment of Compulsory Health Insurance Fund's benefits, provision of education services, equal opportunities to participate in cultural, sporting and other public events (*LR Social Integration act*, 2004).

Social Worker – a specialist who helps this group's individuals to prepare, to choose the type of psychosocial approaches, assesses individual needs of the customers for changes, their commitment, the awareness of themselves and environment, the quality of their communication (Rogers, Anthony, Lyass, 2004).

Introduction

Scientific problem and the relevance of the research. The group of mentally ill people is still one of the most vulnerable categories of persons with disabilities as they often experience social exclusion and discrimination. Therefore, it is very important to provide such individuals with the necessary assistance in order to integrate them appropriately into the society and to help them to restore lost social skills successfully.

Quality of life studies have proved that the condition of individuals with severe mental illness who live in the long-term treatment or health care institutions is rather worse than the quality of life of individuals who live in the community (Brijūnaitė, 2007). The research that Pyne et al. carried out (1997) shows that the symptoms of depression diminish patients' quality of life in a similar manner as physical illness (Goštautas, 2007, p. 3). Mental illness affects one's position in a system of human relations, family, workplace and society. A person reacts to the disease, treatment, community in the medical institution which may significantly influence the psychological and social adaptation, one's own perceived health (welfare) level. Even if the illness is cured, people often are left with negative emotions about their previous experience, emotional cognitive-behavioral changes, and aberrant relationships with the people around. This can be treated as the deterioration in the psychological and health-related condition of the person. For these people, it is difficult to take care of themselves, to return to their former environment and negative attitude of the society towards people with mental disorders and their relatives further contributes to the social exclusion (Goštautas, 2007).

Mental illness is one of the main reasons causing early retirement and disability pensions. Other intangible costs are related to the way that the society treats mentally ill and disabled people. Despite the fact that medical treatments and psychiatric care opportunities have improved significantly, people who are mentally ill or have mental disabilities are still facing social exclusion, condemnation, discrimination or disrespect of their fundamental rights and dignity („*Žalioji knyga...*“, 2005).

Due to the aging population, the number of people who have mental disabilities is increasing. According to Šumskienė ir Mataitytė-Diržienė (2013), mental illness accounts for about 13 percent of all the world's diseases and by 2020 this number is likely to grow up to 15-17 percent. In 2013, 47,1 percent children were diagnosed with emotional or behavioral disorders („*Lietuvos sveikatos statistika 2013*“, 2014). The data of State Mental Health Center shows that the sickness rate of people with mental disorders in Lithuania is increasing: in 2006, more than 2800 Lithuanians out of 100 000 were diagnosed with mental illness. In 2013 the

number increased to 3500. Mental disorders accounts for one of the biggest groups of chronic diseases which is the major factor causing disability (Davidonienė, 2012).

Studies related to the quality of life of people with disabilities are relevant in the whole world: Australian scientists: Hosain, Atkinson, Underwood (2002) investigated how disabilities influence the quality of life of people who live in the rural areas of Bangladesh, Scottish government (Scottish Government, 2013) has released a publication about the improvement of the quality of life of people with learning disabilities. Scientists from Poland (Cechnicki, Wojciechowska, Valdez, 2008), Canada (Martin, 2009, Finland (Pitkänen, 2010); and India (Raj, 2013) have investigated the issues related to the quality of life of people suffering from schizophrenia. More studies have been carried out on the topic of the quality of life of people with disabilities in Belgium (Morisse, E. Vandamaele, C. Claes, L. Claes and Vandeveld, 2013); Brazil (Mattevi, Bredemeier, Fam, Fleck, 2012); Czech Republic (Jirava, Křupka, Kašparová, Mandys, 2011); England (Roberts, Lenton, Keetharuth, Brazier, 2014); Italy (Gigantesco, Giuliani, 2011); Hong Kong (Ng, Pan, Lam, Leung, 2014); Ireland (Murphy, O'Shea, Cooney, Casey, 2007); United States (Buntinx, Schalock, 2010) and other countries.

The quality of life is relatively quite a new term and in Lithuania it has been investigated more as a medical aspect. Furmonavičius (2001, 2004) states that in medicine, the quality of life is generally associated with the quality of life which is basically determined by the health of a person. Moreover, it is usual to analyze it in quite a narrow sense which means limiting the investigation of the quality of life only to those issues that are directly related to the health of people: physical, psychological and social health level. Studies on the quality of life related to the health are very important and significant as they help to assess the effectiveness of different treatment methods, therapies, disease prevention programs and they are also useful for expedient monitoring of society's health state and also help to develop public health policies.

Medical aspects of quality of life have been widely studied by Furmonavičius (2001); Juozulynas, Čeremnych (2005); Starkauskienė (2011) and others. Sociological aspects regarding the quality of life have been analyzed by Susnienė, Jurkauskas (2009); Butikis (2009); Krutulienė (2012); Gruževskis, Orlova (2012) and others. Features related to the quality of life of people with disabilities have been analysed by Kreiviniene, Vaičiulienė (2013); Valeikienė, Juozulynas (2006) and others. Problems that are concerned with mental disabilities and the need for the aid have been exposed by Germanavičius (2008); Brijūnaitė (2007); Ruškus, Mažeikis (2007); Dembinskas (2003). Various aspects regarding the social services have been analyzed by Išoraitė (2007); Žalimienė (2003); Juozulynas, Reklaitienė, Jurgelėnas (2006) and others. However, studies of the social aspects of quality of life in Lithuania are only in the initial position.

Some of the most important goals of a country include: the improvement of society's health condition, reaching for physical, psychological and social welfare, higher quality of life. Preservation and enhancement of the quality of life in Lithuania is included in Lithuanian Health Program and other documents prepared by the Government which are approved by World Health's Organization (WHO) (Šumskienė, Mataitytė – Diržienė, 2013).

The Disability Act (2005) for integration of people with disabilities is still very significant even today. This law emphasizes the system of social integration which comprises of provision of medical, social and vocational services. It also ensures that people with special needs get any other required disability related services or support which includes State social insurance pensions, Health Insurance Fund payments, educational services, and equal opportunities to participate in cultural, sporting and other public events, social support.

In 2010, The Seimas of the Republic of Lithuania ratified the United Nations Convention on Rights of Persons with Disabilities which promotes the reinforcement of the human rights of all persons with disabilities. This convention also affirms the equal recognition before law, ensures liberty and security of the disabled person, full participation in a society, the right to health, employment and education, the opportunity to participate in political and cultural life.

In the order of Lithuanian Ministry of Social Security and Labor of 2013 No. A1-683 it is stated that professional activities of social workers are designed in order to improve the relationship between people which helps them to adapt to the environment and to integrate into the society more easily.

With reference to the Disability Act for Integration of People with Disabilities (2005), social worker's activities and areas of competence are distinguished in a broad sense: medical, social, vocational, educational and rehabilitation. Therefore, problematic issue is discussed according to the following scopes.

Problematic issue: what roles social workers perform in order to maintain and improve the quality of life of people suffering from mental illness?

Object of the research – opportunities of the social worker's performance to enhance the quality of life of mentally ill people.

The aim of the research– to analyze opportunities of the social worker's performance to enhance the quality of life of mentally ill people.

Objectives of the research:

1. To examine the overall conception of the mental disability, disorders and the quality of life, the subjective well-being of people with mental disabilities.
2. Briefly present the situation of people with mental disabilities in Ukraine.

3. To examine social and the quality of life support activities of people with mental disabilities while working with these people.
4. To investigate functions of social workers (in Lithuania and Ukraine) and activity opportunities in the support system for people with mental health issues.
5. To analyze respondents' with mental disabilities attitude to social worker's activities that support and improve their quality of life.

Hypothesis – the attitude of people with mental health problems towards the services they get from social workers is positive. However, they feel the lack of these facilities.

Participants of the research – 6 people who have mental disability, 10 Lithuanian social workers and 12 Ukrainian specialists working with people with mental disabilities.

Methods of the research:

1. Theoretical: analysis of scientific literature, documents.
2. Empirical: qualitative research, using a semi-structured interview with persons having mental disabilities and social workers who work with them. The data is processed by using content analysis method.

Analytical-critical method is also used for the summarizing the replies received from respondents and for providing proposals.

The structure of the research. This thesis consists of a summary in English, introduction, 2 chapters, conclusions, a list of references (138 sources), a summary in Lithuanian, annexes. The research data is illustrated by 3 pictures and 28 tables. Annexes provide an operationalization, in-depth semi-structured interview questions for clients, semi-structured interview questions for social workers, excerpts of interviews with clients and social workers. The Thesis consists of 89 pages (without annexes).

1. THE QUALITY OF LIFE OF MENTALLY DISABLED PEOPLE AND THE ROLE OF A SOCIAL WORKER

1.1. Aspects of subjective well-being and quality of life of people with mental disorders

1.1.1. The concept of the quality of life

In everyday language and scientific literature we can often find a concept of "quality of life". There are many definitions offered, but so far, there is no agreement on how to define the quality of life. Quality of life has been examined by medics, philosophers, sociologists and psychologists. Some of them define it as both, tangible and intangible well-being while others describe it as an objective mental welfare. These days, the term of the quality of life determined by the health is spreading very rapidly (Juniper, 2005).

According to Vazonienė (2010), the quality of life is a multidimensional social structure, and therefore is perceived in very different ways. Although the term of the "quality of life" seems to be self-evident, the analysis of the scientific literature about it shows that this term is also hypothetically defined as „happiness“ or „intellectuality“ (Gruževskis, Orlova, 2012). Juozulynas et al. (2012) claim that quality of life is determined by many factors but the most important of them are health and material well-being.

The concept of quality of life is closely related to subjective personal criteria. Tangible property is one of the criteria determining the state of quality of life. However, taking into consideration only material goods is not enough to evaluate person`s quality of life. Each individual is trying to create a comfortable, convenient life so that it would be easier to solve any problems that one can face. It can be stated that quality of life is defined as the subjective welfare which is not the same for each person as everyone has different criteria.

Quality of life cannot be considered as a static subject because people can change their priorities and values over time due to changing life experiences and events, illness or cultural changes (Staškutė, 2014). Each individual is made up of many physical and mental components, surrounding environment which determines different attitudes towards arisen situations. Assessment of quality of life very much depends on the type of personality, gender, education, age and state of health. People of different age groups perceive and assess criteria of quality of life not in the same way. Vocational and creative activities, recreation, leisure and intimate life – all these parts of the human`s life all very closely linked. Quality of life depends on the degree of satisfaction in the following areas (Valeikaitė, 2003) (cit. Valantinaitė, Dačiulytė, 2009).

Rapley (2008) states that the definition of quality of life that researchers Felce and Rerry introduced in 1996, is one of the most widely used: „quality of life is defined as all-encompassing welfare which includes objective descriptors and subjective evaluation of

physical, material, social and emotional well-being as well as personal development and meaningful existence within the value system of a person/ in the context of personal values“ (Rapley, 2008, p. 53).

The simplest evaluation of the quality of life can be: happy – unhappy, satisfied – unsatisfied.

Schipper et al. (1996) discern four components of quality of life:

- Physical and psychological condition;
- Surrounding environment;
- Public communication;
- Somatic condition.

All of these components are interrelated and work integrally.

Vaitkienė, Makari and Zaborskis (2007) state that quality of life is evaluated by taking into consideration many factors and they have to cover all areas of a person's life. The research of the quality of life is based on a broad perspective of health: physical, psychological and social functioning and well-being. Authors claim that the concept of quality of life cannot be equated and it should be analyzed as the interaction of many variables.

World Health Organization (WHO) defines quality of life as individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHO, 2008).

Toliušienė and Šeškevičius (2004) provide with Haas` criteria that define the quality of life:

- Quality of life is the assessment of an individual`s current circumstances of life;
- The quality of life by its nature is multidimensional;
- The quality of life is based on individual values and is changing;
- Quality of life includes both, subjective and objective assessments;
- People who are able to carry out a subjective analysis can evaluate the quality of life more accurately.

Haas (1999) claims that the assessment of quality of life is related not only to the positive nuances and identifies several features that influence poor quality of life:

- Constraints;
- Living conditions that are incompatible with life;
- Maintenance of life which includes severe suffering (in case of incurable sickness).

The study of quality of life is based on a broad perspective related to health: physical, sociological, social functioning and well-being. Health condition has an impact on the quality of life, but does not define it (Šumskienė, 2005). According to Furmonavičius (2001), in medicine quality of life is defined as the degree of satisfaction with one's health. Dučinskienė (2004) states that sociological quality of life studies are used to evaluate what needs do people have, to determine the level of welfare, subjective and objective living conditions (cit. Valantinaitė, Dačiulytė, 2009, p. 200).

Ruževičius (2005) provides with a broader concept of quality of life and says that „quality of life is defined as the individual's overall satisfaction with life and personal well-being.“ (p.53). Acree, Longfors, Fjeldstad, A. S., Fjeldstad, C., Schank, Nickell, Montgomery, Gardner (2006) support this idea and supplement: quality of life is influenced by personal values, perception of the welfare, which can change over time.

Other authors, one of which is Starkauskienė (2011) think that „the state of quality of life reflects an individual's response to physical, mental and social everyday life changes which affect the level of satisfaction of one's living environment“. This is not only adequate physical well-being, but also the perception of the welfare and the overall feeling of self-esteem. „The quality of life is directly related to positive values and have no direct connection to specific disciplines“ (p. 22).

According to Skučienė and Genelytė (2010), the concepts of welfare, quality of life and living are closely related. Krutulienė (2012) adds: quality of life as well as welfare and standard of living are concepts that describe good and/or positive life. However, Krutulienė also states that the term of quality of life stands out because of its components (it consists of objective, subjective, tangible and intangible, individual's and society's components of welfare) and even though they are based on well-being, they are not identical.

Bradshaw (2008) and other authors remark that in medicine quality of life is more associated with health and is being examined in more specific, quite narrow way, by taking into consideration only physical, psychological and social aspects. However, Butler and Ciarrochi (2007) propose that quality of life is influenced not only by the state of person's health, but also by the objective social, economic, environmental and other factors.

According to Juozulynas, Jurgelėnas and Prapiestis (2010), good life is mostly determined by financial stability, health, education and other similar factors. Though, the authors also claim that the quality of life also highly depends on the person's attitude towards his/her life. Human's quality of life is also affected by the ability to shape own life in a way that various goals and needs would be easily achieved.

Stevenson and Wolfers (2008) state that high quality of life is not necessarily the result of successful economic development, because the subjective quality of life is more related with dominant personal characteristics and perception of life events.

The state of health and effectiveness of health services are very important for the quality of life of a society. Quality of life is quite a dynamic phenomenon in life. Different conditions form different priorities. Shifting health, social and economic conditions change the preferences of life (Juozulynas et al., 2010).

Diener and Chan (2010) suppose that the overall evaluation of the quality of life is as follows: cognitive assessment of the welfare of a person's life (satisfaction with life); positive emotions and pleasant experiences; relatively little experienced negative emotions.

To sum up, it can be stated that all scientists interpret the concept of quality of life in different ways. However, the main factors, which influence the quality of life: physical, emotional and spiritual well-being, as well as the material and social welfare. The evaluation of the quality of life can be based on the objective facts as well as on the subjective individual's perception. Though, while taking into consideration person's perception, it is necessary to bear in mind that the quality of life is related to an individual's personal development and therefore is variable. Quality of life and factors that may affect it should be considered by taking into account the context of culture, values within which people live.

1.1.2. The quality of life in the context of mental disability

People who are mentally disabled for a long time, have experienced a variety of constraints and public ignorance. Although, the mental health system in Lithuania has changed, a group of mentally ill persons is still one of the most vulnerable categories of people with disabilities as they often experience social exclusion and discrimination. Therefore, it is very important to provide such people with the necessary assistance in order to integrate them appropriately into the society and to help them to acquire lost social skills (Brijūnaitė, 2007). The author also states that the condition of individuals with mental illness who live in long-term treatment or health care institutions is rather worse than the quality of life of those who live in the community. For these people, it is difficult to take care of themselves, to return to their former environment and negative attitude of the society towards people with mental disorders and their relatives further contributes to the social exclusion. Dasevičiūtė (2009) claims that due to illness, people with mental disorders lose their social skills as they are often isolated from the society. Thus, inadequate communication destroys or terminates the relationship with the family and community.

Individuals who have mental health problems are less dangerous than those who are under the influence of intoxicating substances. Gradually, people start to understand that even though some people have mental problems they are also human beings. They also need love, respect, attention, appreciation, and understanding, help (Gaidžiūnienė, 2009). The relationship between the society and disabled people also depends on social, economic, political, religious and philosophical factors. It is also influenced by public education, medicine, culture and science.

Ludziš (2005) states that people with disabilities is a group of a society which faces specific problems and have special needs. According to Pūras, disabled person's return to the society is quite a complex process. There are always more problems in an open society than in the closed one. It seems like after the separation of a disabled person from the community all problems disappear, but actually it is a violation of human rights. Moreover, mentally ill people who live in an open community have an opportunity to discover themselves, their abilities and skills (*Atstovavimo sutrikusios raidos žmonių teisėms pagrindai*, 2005, p. 4).

The main goal of the integration of people with disabilities is to equalize the opportunities which means ensuring that the public system is freely available to everyone, including people with disabilities. Equal rights are characterized by the fact that each person's needs have to be taken into account while planning public life. Persons with disabilities are members of the society and have the right to be full-fledged members of their community in which they have a right to education, training, health care and social services (Žvikaitė, 2000).

Žvikaitė marks the main provisions which are important in order to equalize the opportunities in the society:

- To remain in the community and participate in common life;
- To participate in the preparation of decisions of all levels;
- To receive help in the systems of education, health, social services and other;
- To actively participate in the public's social and economic development, and their needs must be included in the state planning;
- To have an equal opportunity to contribute to the development of the national product.

The criteria of quality of life of disabled person are different from those of healthy people. Such person often encounters situations when she/he has to realize herself/himself as an individual. Intellect, mental or physical disorders lead to the person's separation from the society and a person experiences social exclusion.

Grübe (2002) claims that mental health is determined by positive emotional and spiritual state which gives a person an opportunity to enjoy the fullness of life. Mentally ill people usually

perceive their condition very negatively which is because of the symptoms of depression or self-depreciation, negative public reaction.

Rėklaitienė, Karpavičiūtė and Požėrienė (2010) state that in the National Program for Social Integration of People with Disabilities for 2003-2012, which was developed in 2001, one of the aims is to create equal opportunities for people with disabilities to actively participate in all spheres of public life. It shows that the recruitment of persons with disabilities receive much attention, but the situation in Lithuania remains inferior.

The authors carried out a research in order to investigate the quality of life, working activities and family status of people with physical disabilities. The findings revealed that disabled people who work, evaluated their overall life quality, health, physical and psychological status, independence, social relationships, environment, spirituality and religious areas and sub-areas more positively than unemployed individuals with disabilities. Married people also evaluated all areas more affirmatively than single participants of the research. Skučas (2010) claims that disabled people who exercise have good opportunities to socialize in a community: exercising influences more positive attitude to one's disability, many aspects do not cause them psychological discomfort. Moreover, self-esteem of exercising disabled people (self-confidence, self-assessment of other eyes) is higher than of those who do not take up sports and they are more happy about the quality of their lives.

Rėklaitienė, Karpavičiūtė and Požėrienė (2010) investigated the quality of life of deaf and hearing-impaired people and noticed that their subjective evaluations of own physical, psychological, spiritual, religiousness states are more negative and pessimistic in comparison with the self-assessments of healthy people. Moreover, the results of the study also showed that deaf and hearing-impaired people who participated in the study evaluate their social relations, health, quality of life and environmental spheres of life better than healthy individuals. Deaf or people who have hearing problems also assessed their physical (energy and tiredness) and psychological (positive feelings) welfare as well as social relationships (personal relationships) and environment (physical safety and security, home environment, participation in leisure activities) more positively than healthy people. It can be concluded, that deaf people are able to learn how to live with their disability and can „push it” into the background. In this way, their quality of life can be determined by various environmental and personal factors which also is the case for healthy persons. Of course, not every disabled person is able to maintain this balance and thus highly appreciate his/her quality of life. For some disabled people, the evaluation of their quality of life is determined by taking into account health condition, limited resources, opportunities, lack of knowledge or other environmental conditions. This can be proved by taking into consideration the assessments of physical (pain and discomfort), psychological

(thinking, learning, memory and concentration), area of independence (mobility, ability to work), social relationships (sexual activity), the environment (financial resources, accessibility and quality of health and social care services) domains that had been provided by the participants of the research. Their assessments of these areas and sub-areas are inferior in comparison with the answers given by healthy individuals.

Kreivinienė and Vaičiulienė (2012) carried out a research and noticed that the greater part of the respondents links their quality of life to the micro-social network, almost all of them feel stressed daily because they are worrying about people who are close to them. A disabled person's disorder influences his/her quality of life as much as it determines the possibility to find a job or a partner. All respondents have the opportunity to express themselves, but they relate the quality of life with the employment or the presence of a partner. Respondents also dream of uncontrolled leisure time. People who participated in the study stated that public acceptance also has an influence on their quality of life; there are people who feel alienated because of their disorder. During the investigation, it was noticed that people who depend on the social network and/or belong to various clubs, assessed their quality of life more positively than those with a poor social network.

The study carried out by Kreivinienė and Vaičiulienė (2013) revealed that individuals suffering from mental illness both subjectively and objectively evaluate their quality of life in comparison with the public „norm“. Respondents acknowledged that people with mental disabilities experience stress on a daily basis in different situations, they are afraid to be left alone due to the poor social network, they suffer from bullying, rejection of the society. While evaluating their quality of life, respondents mentioned that it depends on the public acceptance. People that had been interviewed feel marginalized and discriminated because of their health problems, they feel that they are being stigmatized, often face verbal abuse.

The analysis of studies and literature on the quality of life of disabled people provides with the conclusion that for people with mental disorders it is more difficult to adapt to their community than for people with different physical disabilities. As Kreivinienė and Vaičiulienė noted, mentally ill people often are being insulted by other disabled persons. Physically disabled people have more opportunities to realize their potential in both, work and leisure related activities.

1.1.3. The subjective well-being of mentally ill people

Subjective welfare is the correspondence to a scientific term of „happiness“. Such components as satisfaction with life, positive and negative emotionality may be distinguished. It can be stated that a person with a high subjective well-being experiences more positive emotions,

feels satisfied with life (Šilinskas, Žukauskienė 2004). According to the authors, subjective self-assessment is the most important element of subjectivity which is the key criterion.

According to Vazonienė (2011) subjective well-being and social exclusion, as well as its interfaces are not sufficiently analyzed neither in Lithuania nor in the other countries. Studies of welfare (quality of life) are often equated with investigations of standard of living, living conditions which are carried out mainly on the basis of objective assessments (according to certain criteria, indicators) and often only in accordance with separate areas of life.

Skučienė (2012) claims that subjective well-being is one of the dimensions of the quality of life. Subjective quality of life allows to „feel” the quality of life of an individual by taking into account the criteria that are most important to him/her. These criteria generally are influenced by culture, traditions, customs, personal habits, values, individual needs, social status, and religious beliefs. Person`s satisfaction with life is one of the indicators of subjective well-being (Merkys, Brazienė, Kondrotaitė, 2008). Diener (2000) also supports this idea and also claims that person`s subjective welfare is determined by his/her assessment of own life. However, according to author`s opinion, subjective welfare is an important complementary component of the mental health, but it is not the main criterion (Diener, 2000). Keyes and Lopez (cit. Pranckevičienė, 2008) agree that: „only subjective welfare does not correspond to the whole physical health, therefore, it is necessary to examine a more objective criterion – presence/absence of mental disorders“. Keyes defines mental health as a syndrome which consists of positive emotions and successful functioning in life (Keyes, 2005).

There are four typologies of mental health:

- Flourishing – high on subjective well-being and low on mental illness;
- Struggling – low on subjective well-being and high on mental illness;
- Languishing – low on subjective well-being and low on mental illness;
- Floundering – high on subjective well-being but also high on mental illness (Keyes, 2005).

Keyes (2005) (cit. Pranckevičienė, 2008) relates the subjective welfare to the emotional, psychological and social well-being. Thus, the overall mental health is influenced by emotional, psychological and social welfare and the derangement of them. The investigation in which participated more than three thousand Americans revealed that only seventeen per cent of them belong to the flourishing type.

Similar ideas had been developed by Rapaport, Clary, Fayyad, Endicott (2005). According to them, for the full assessment of mental health it is important to take into consideration indicators that are related not only to the disease, but also with the well-being.

Veniūtė (2007) claims that the integration of people with mental disabilities is an important factor which not only improves the quality of life of ill people, but at the same time facilitates the onus for a person and society. Moreover, according to Dembinskas (2003), „people who suffers from mental illness regard employment as the top priority which improves the adaptability in the society and also improves the quality of life“ (p.44).

With regard to persons who have different mental disorders, the results of the research that was carried out by Gee, Pearce and Jackson (2003) revealed that usually people with schizophrenia relate their quality of life and health to 10 areas which are affected by the disease of schizophrenia the most:

Barriers to personal relationships – patients feel lonely and isolated, worry about what other people think about them;

Impaired control of behavior and actions – patients prefer to distance themselves from others in order to avoid any hasty decisions;

Lack of the opportunities to access a vocational role – it is difficult to get a job, feel useful and respected in a workplace;

Limited plans and activities – patients feel financial constraints, difficulties in the development of future plans;

Subjective experience of psychotic symptoms – patients complain about depression, paranoia, having lack of energy, decrease of motivation, sleeplessness, hearing of voices, suspiciousness, exhaustion, nervousness and anxiety.

Extraneous effect of medicaments and attitude towards it – patients express their concern about the usage of medicaments and they also worry about the consequences of not using any medicaments. Several patients relate the extraneous effects of medicaments to the lack of motivation, decrease of self-esteem and feeling of dryness in the mouth;

Psychological response to life with schizophrenia – people who suffer from schizophrenia, indicate the symptoms of reduced self-esteem, morality sense, fear and the feeling of being superfluous or helpless;

The attitude of other people and stigmatization – stigma, which is connected to mental illness, affects the life of sick people in such spheres as: interpersonal relationships, social life and labour;

Concern about the future – patients feel anxious about repetitive hospitalization, progression of illness, they also worry about the future and possible relapses.

Positivity of experience – some of the sick people claimed that this disease helped to improve the relationship with family and to value their own situation.

Resende, Viglione, Argimon (2009) state, that in most cases schizophrenic people suffer from negative symptoms and it downgrades the quality of life. Such people experience the sense of loneliness, they have a tendency to think about the suicide and they also can be characterized as being criminally active.

Talking about depression, in the scientific literature there is stated that the quality of life of depressed people is rather worse. Investigations proved, that the impairment of life quality is linked to the symptoms of depression and its degree. In addition, it was also found out that proper treatment of depression makes the quality of life better (Rapaport et al, 2005; Goldney, Fisher, Wilson, Cheok, 2000; Skarsater, Baigi, Haglund, 2006).

According to the findings of the research, connection between depression and subjective health indicators exists (McCall, 1999; Scocco, Fantoni, Caon, 2006). As Berlim, (2005) claims, being guided by subjective evaluation indicators of life may help to measure the degree of severity. Other authors as Aigner, Forster-Streffleur, Prause, Freidl, Weiss and Bach (2006) confirmed that depression has a great effect on the quality of life as well.

Other scholars also notice that the indicators of the quality of life become worse when, for instance, schizophrenia is led by depression (Norholm, Bech 2006; Law, Chen, Cheung, Chan, Wong, Lam, 2005). Barge-Schaapveld (1999) states that in order to investigate the variation of daily subjective welfare, 63 people suffering from depression and 22 healthy humans had been examined. As the investigation shows, depressed people were less glad about their lives, they experienced lower amount of positive emotions, had more complaints and did not appreciate their life's quality.

As the authors Brieger, Rottig, Marneros (2004) examined 154 people with depression disorder, they identified that sick people evaluate their subjective welfare more negatively in comparison with healthy persons.

To sum up, it could be stated that the emotional state of people with mental disorders is closely related to the subjective evaluation of the quality of life. It can be also claimed that, psychological state of a person is tightly linked to subjective evaluation indicators of life and it also affects the quality of ill peoples` lives.

1.1.4. The position of people with mental disorders in Ukraine

As Bayda (2012) states, according to the official data, there are approximately 2.631.111 disabled people in Ukraine. However, there are some pretexts which allow to think that official facts do not reflect the real situation because of the lack of official findings. There is no

sufficient desire to get the confirmation for the red-tape system for people with a particular disorder, for instance, the equivalence of medical diagnosis or conditions of health (oncological illness or tuberculosis), which do not provide the higher degree of invalidity. In addition, the competence of commission also creates the feeling of uncertainty. The same person in different commissions may hear different diagnosis.

At the moment, in the System of Health Care and System of Psychological Health in Ukraine, revolution occurs. Until now, the fundamental attention to psychic variations occurred in three spheres: transition from the „institutional treatment” to „communal treatment”, transition from social to private treatment. In other words, it is the transition to health care that is based on the insurance and classification of the diseases [TLK-10] diagnosis and the treatment of psychic health disorder. In other terms, Ukraine tries to get over from the national care to private health care. However, so far it occurs just on the basis of theoretical „testing” principle. Instead of mental health care institutes there can be found national hospitals of psychiatry that had been established a century ago. Since 1996, the facilities of health care in Ukraine should have become free, but in real life, the majority of people must pay for the services that they are provided with, they also have to pay for medicaments, because the budget is insufficient (Yankovskyy, 2013).

According to Bromet (2005), by taking into consideration the investigation data of mental health’s survey from Ukraine, it could be stated that the spread of mental illness in Ukraine reaches the number of thirty per cent, but fifteen per cent of people include individuals who experienced depression at least once. Kessler (2007) carried out the analysis of literature and noted that according to the mental health’s survey from Ukraine, it can be noticed that disorders of temper are more frequent among women. There also exists equally strong relation between disorders of mood and the duration of life. Disorders of temper are more common to women that are over fifties. Yakushko (2005) made an investigation of consultation of mental diseases and its perspectives in Ukraine, and noticed that the concern of older people is usually caused by financial issues, lack of trust in the medical system in Ukraine, deficit of medicaments, proper equipment, and they also worry about the low education level of doctors and corruption. The author also observes that the majority of Ukrainians who suffer from mental disorders never had had a consultation with a professional doctor, and those who were consulted by professionals, often talked to specialists or trainees who were inexperienced in this sphere.

Stewart, Ashraf and Munce (2006) highlight the fact that it is universally admitted that there exists the lack of respect to the seriousness of mental illnesses and to the benefit of mental health’s services. During the first decade, after the breakdown of Soviet Union, the reduction of the places or beds for patients in psychiatric hospitals occurred. The reduction of beds had not

been related to the development of treatment of mental diseases and the establishment of innovations in the day care hospitals. The number of day care centers also decreased during that period. The general capability of hospitals related to 5000 free places. The structural obstacles which prevent the effective treatment of mental health disorders still exist in Ukraine.

However, the government of Ukraine makes attempts to improve the system of mental health. The government aimed to improve the degree of psychological services for the older people and for the other groups of people which need social support. The system of social services for senior people has been established during the reform in social care department and during the development of medical social services. The Ukrainian legislator of law (Supreme Rada) created the law of the mental care in 2000, in which there are laid out the legal backgrounds that are necessary for taking care of mental health, it is justified by the principle of human and citizen. However, with regard to the limitation of budget, the quality of treatment and supervision of mental health remains low (*Верховна Рада України, ВРР. "Закон України Про Психіатричну Допомогу", 2000.*).

Bayda (2012) also notices that places of labor and employment can be described as having discriminating characteristics: the places of work are classified as having a tendency to belong to people or to invalid people. According to statistics of unemployment, there is lack of disabled people in Ukraine. At the moment, some of the work places are created specially for the disabled people. Still, many disabled people work in the places that are suitable and created for healthy people.

To sum up, it could be claimed that the position of people with mental disabilities in Ukraine is very poor. The improvement of conditions, on the basis still occurs just on theoretical background. For the sake of improving the general feeling of patients, for people with mental disability, there is a lack of material and humanistic resources. The citizens who have mental disabilities face the difficulties of integrating into their community, labor market, it is hard to maintain the social system that is significant to disabled people.

1. 2. Practices of work with people having mental disabilities in the context of maintenance of their quality of life

1.2.1. The importance of social work in the system of social support

1.2.1.1. Levels of social integration

While building the Lithuanian society and seeking that all people who live in Lithuania would be assured to have the same rights in the country, there had been created many laws and additional legislations that regulate the sphere of disability. The essential accent of the law, newly evaluated disability of a person and his/her opening perspectives. A disabled person cannot choose what he or she wants to do or is able to do, and the responsibility of a society is to help that person to achieve it (*Naujas požiūris į žmogų su negalia*, 2004).

As it is planned in the statute of social intergration of disabled people in the Lithuanian Republic (32, Nr. 83-2983, 2005, 1 of July), the integration system contains medical, vocational and social rendering and rehabilitational services, the satisfaction of special needs by special means of support, assistance, offering of support, appointment of disbursement and its payment, rendering of education services, the arrangement of services for the possibility to participate in cultural, sports and other life's spheres of society. In this statute there are legalized the new concepts and terms, there are replaced the methods by which the disability of children and adults is diagnosed, legally established equal rights and opportunities of disable people.

Vaitiekus (2009) claims, that „*rehabilitation*“ – is a versatile and coordinated system of medical and social means that help to recover disordered organism's functions, its independence and possibilities of integration into social life as much as possible (p. 22).

According to Žalimienė, Lazutka and other authors (2008, p. 92) „the policy of the employment of the disabled people has two main aims – to assure the income for disabled people and to involve them into social and economic life that opens the opportunities to full-fledged life.” However, these two aims are frequently difficult to match. During the recent years, almost in all over the world the policy is reoriented from the assurance of income to enlargement of economic activity.

Employment – is rehabilitation through activity, the benefit of which is influenced by activity, environment and the social worker. „In order to make the employment effective, we have to know ourselves, the environment and activities that we offer to the client “ (Petrauskienė, 2007, p.18).

Medical rehabilitation – tools that help to recover physical health. Medical services can be offered together with the professional and social rehabilitation services. The Ministry of

Health Care is responsible for these facilities (*LR Neįgaliųjų socialinės integracijos įstatymas*, 2005).

Medical rehabilitation provides with the opportunity for people who have mental disorders, to reach for the optimal degree of independent functioning in the society by the help of psychosocial rehabilitation. It is a versatile process that is going by various levels: in the psychiatry hospitals, clients' houses and institutions of community.

Psychosocial rehabilitation – it is „process that offers the opportunity for the people who have mental disorders and disabled people to reach for the optimum degree of independent functioning in the society. It includes the improvement of individual's abilities as well as the replacement of surrounding environment of a person in order to create a more qualitative life of people that have mental disorders as much as possible“ (Petrauskienė, Daunoraitė, 2009).

According to foreign authors as Anthony, Cohen, Farkas (1998), psychosocial rehabilitation occurs in the psychiatry hospitals as well as in the houses of patients or in the day care centers. It helps to function better for the patients and to experience more joyful moments, to change the environment in which they live.

According to Germanavičius (2008), psychosocial rehabilitation is necessary for those patients who had lost their independence or if their abilities to function in the community becomes restricted. Petrauskienė, Daunoraitė (2009) carried out the evaluation of psychosocial rehabilitation and the analysis of literature, in which they emphasizes the findings of scientists Farko, Soydan, Gagne (2000), Acock, Demo (1994). During the period of psychosocial rehabilitation process of preparation that is orientated to person's development, social worker evaluates long-term necessity of disabled person for the changes, motivation, the comprehension of one's self and the environment and the type of the acceptable interaction. By admitting the person's ability to identify his or her needs, also admitting the need of learning and strengthening one's health, specialist seeks to provide a person with the opportunity (Farkas, Soydan, Gagne, 2000) (cit. Petrauskienė, Daunoraitė, 2009). This process includes three dimensions: the positive self-evaluation of a person; learning and comprehension; personal reflection about the environment and ability to communicate (Acock, Demo, 1994). This model is depicted as helping to understand where he or she would like to live and study during the next years. Psychosocial rehabilitation contains three periods: evaluation, planning and interventions (Petrauskienė, Daunoraitė, 2009).

Vocational rehabilitation – implements that recover the ability to work and help to retrain with the involvement of therapies, educational and vocational trainings. The Ministry of Education and Science which co-operates with the Ministry of Health the Ministry of Social Security and Labour is responsible for the training and professional development of vocational

rehabilitation specialists who would be able assess and promote individual`s employability (*LR Neįgalųjų socialinės integracijos įstatymas, 2005*).

Vocational rehabilitation aims to restore and develop the employability of people with disabilities and to increase their employment opportunities. These rehabilitation services are listed in the Law of Social Integration of Persons with Disabilities (2005) which was released in The Republic of Lithuania: vocational guidance, counseling, assessment of vocational skills, restoration or development of new skills and retraining.

Professional rehabilitation services aim to develop or restore the working capacity of individuals with disabilities and increasing their employment opportunities. There are several stages of this rehabilitation:

- Determination of the need for vocational rehabilitation (disability and working capacity assessment);
- After receiving of the conclusion on the assessment of the need for rehabilitation services from Disability and Working Capacity Assessment Office (DWCAO), the individual have to apply to the local Labor Exchange according to the place of residence;
- The local Labor Exchange concludes an agreement by consulting with an institution providing professional rehabilitation services and they develop an individual professional rehabilitation program for the person. If there is a need, Labor Exchange co-operates with the employer, the institution which provides professional rehabilitation services and the municipal organizations and institutions;
- The local Labor Exchange which completes the professional rehabilitation program issues the documents which are required by the institution which provides professional rehabilitation services (the program and planned services) ;

When the professional rehabilitation program is finished, a person should come to the DWCAO where he/she gets a final assessment of capacity for work (*Profesinės reabilitacijos paslaugų teikimo neįgaliesiems standartizavimo galimybių studija, 2011*).

Social rehabilitation – the regulation of relationships in the family and society, the organization of various life and leisure facilities, development of autonomy and social relationships (Lapkauskienė, 2003, p. 161). These services are provided to individuals in order to form or restore their social and independent living skills, to help them to acquire education and to ensure that they would have opportunities to participate in society`s life and in the labor market. County governors and municipal institutions are responsible for the organization of

social rehabilitation services and for the assurance of their quality (*LR Neįgaliųjų socialinės integracijos įstatymas*, 2005).

In order to change public attitudes towards people with disabilities, it is necessary to change the provisions of the whole community of disabled people. It is important to involve as many people with disabilities and their families in the activities of their communities so that they would socialize and be more active, independent. Without these circumstances there it is more likely that there will be no positive attitudes. The more the society sees and communicates with disabled people, the more their perception of ill individuals change. Respect for the disabled people is a very important aspect of the social involvement.

It can be concluded that the system of the integration of people with disabilities which includes medical, vocational and social rehabilitation, can offer many ways and methods that may help a person with a disability to get well, to improve physical or/and mental condition and to socialize in the community.

1.2.2. The influence of social work and systematic approach on a mentally disabled person

It is essential to provide a person with mental illness with social assistance. Social work is: „the activities helping an individual or a family to solve their social problems according to their abilities and with their involvement with due respect to human dignity and by increasing their responsibility based on partnership between the individual, family and the society“ (*Socialinės apsaugos ir darbo ministerija*, 2014).

The regulation of Social Workers Activity in Providing Social Services in Health Care Institutions (*Žin.*, 1999, Nr. 85-2553) highlight the peculiarities of social worker activity: strengthening the ability of the clients to adapt to the environment, providing with social services, helping to integrate to the community and promoting social functioning.

Social workers that work in mental health care institutions are the providers of social (*LR socialinių paslaugų įstatymas*, 2006; *Socialinių paslaugų katalogas*, 2006) and psychosocial rehabilitation services (*Neįgaliųjų socialinės integracijos įstatymas*, 2005; *Psichikos sveikatos strategija*, 2007) and their service spectrum (for example: general social services – social work, guidance and counselling, vocational help and therapy, organization of cultural and leisure activities, health care, psychological support, etc.) is characterized in the regulations of psychosocial rehabilitation services (Mikaliūnas, 2003).

According to Petrauskienė (2011), social workers should aim to create an environment in which people with mental health problems would feel respected. Moreover, the opinion of patients about the services that they get and also social worker`s contribution to the changes of their social life should be assessed. Baltrušaitytė (2007) claims that in Lithuania the prevailing

attitude is that this group of people (mentally ill) is not able to adequately evaluate the services that they get.

Social worker's role in the area of mental health care includes patient`s/client`s and his/her family`s guidance, counselling, informing about possible opportunities of services, motivation to get involved and make use of the services of community rehabilitation or other day centers (Beder, 2006).

Gvaldaitė and Švedaitė (2005) state that social workers often do things that people of other professions cannot or even are not able to.

The model of social integration is based on social – ecological theory. According to this theory, persons with physical or mental disabilities live and adapt during regular activities in the environment and dynamically interact with it. Pivorienė (2003) claims that in accordance of the theory, health is a state of equilibrium while disability is its violation. In individual's life, disability causes stressful situations, disrupts a person – environmental conformity, eliminates previous adaptation and requires a lot of effort while coping with various crises.

When applying the ecological systems theory at social work, it is presumed that people themselves are certain systems and are dependent on various other systems which can be found in their environment and those systems may satisfy/ do not satisfy the needs of each individual. The systemic approach means that while solving client`s problems, it is beneficial to take into account the connectivity between the whole system and its parts (Šinkūnienė, 2011).

Ecological systems theory was developed by Bronfenbrenner (1979). In author`s opinion, right in the center is a man who interacts with the closest parts of the microsystem (family, friends) Mesosystem consists of various interconnections between the parts of microsystem. Exosystem`s level consists of factors that are not dependent on the person (social – economic situation of the family, parenting provisions). Exosystem adjoins with the macrosystem and it all exists a particular period, chronosystem which determines a concrete content of factors. The whole system can be illustrated as follows (Figure 1):

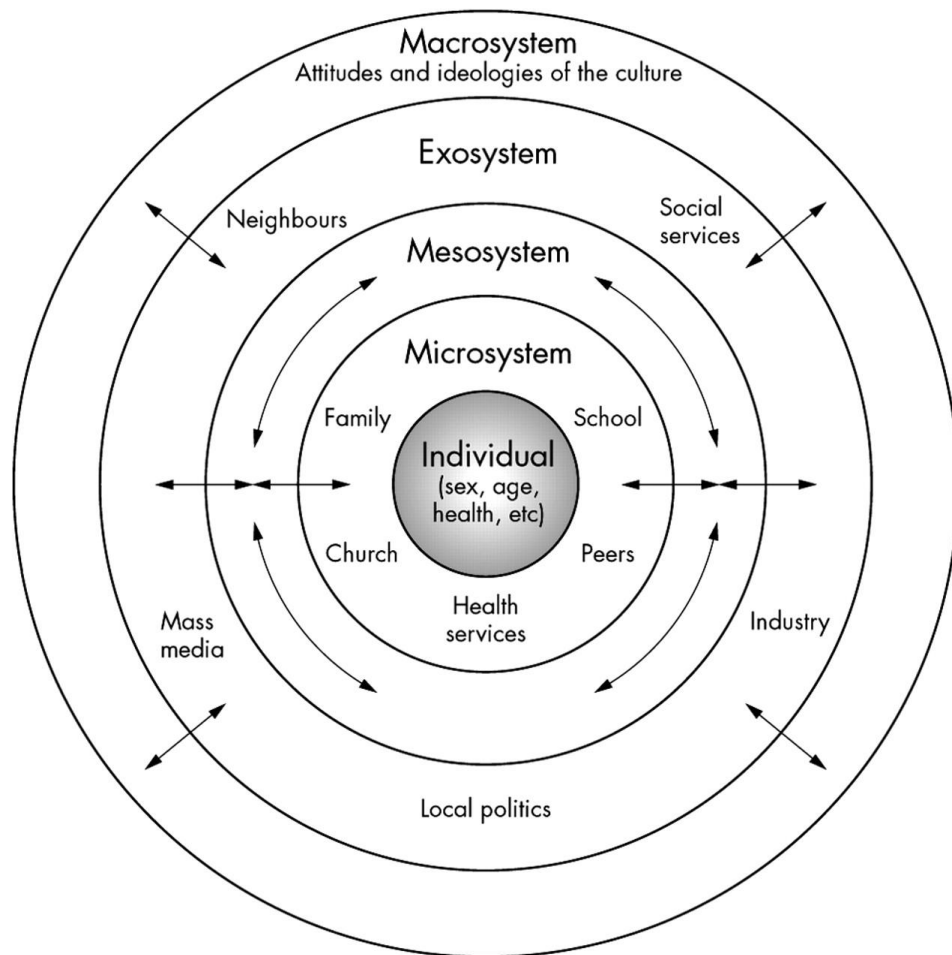


Figure 1. Ecological Systems Theory Diagram (adapted from Lemme, H. B. (2003) „Suaugusiojo raida“, Kaunas: UAB „Poligrafija ir informatika“, p. 65)

According to Šinkūnienė (2010), in the practice of social work, the main aims in micro-, meso- and macrosystems are these:

Microsystem:

- To strengthen the client by helping him/her to solve the problems and to overcome difficulties;
- To restore connections with the system, to help to find support resources, services and expand customers' ability to solve problems;
- To seek professional development by learning from professional supervisors and their practices.

Mesosystem:

- To develop the network of community-based social services. In this case, social worker can be the initiator of the programs, a supervisor, coordinator and consultant;
- To help people at social risk by ensuring social justice and by helping to solve their problems.

Macrosystem:

- To develop and improve social policies;
- Government's enactment of favorable laws;
- To critically evaluate the proposed laws and offer amendments;
- To provide a feedback regarding the problems in practice that appeared because of the implementation of new laws.

With the reference to the foreign authors, Baranauskienė (2014) (Rbble, 1999, Thomlison, 2002) claims that ecological approach in social work occurs when not only the client is involved in the process of the social support and assistance, but also his/her relatives: elements that are interacting and dependent on each other. Regarding the social work, the main principle of a systematic attitude towards the client states that during the process of the formation of individual support plan, the client and his/her environment is an indivisible unit. Therefore, a client must participate in all stages of plan development.

Vaicekauskienė (2009) also notes that the use of this model in social work helps social worker to determine the boundaries of social systems, their interactions and relationships, objectives and ways of functioning and also developmental aspects. This model focuses on environmental changes and the analysis of their influence on a person. Moreover, it aims to preserve and develop different links between the environment and personal systems, to involve individuals in a variety of systems and to help solve social problems with regard to system-based changes.

The main providers of the social services are social workers who are the organizers and coordinators of these facilities. While helping clients, social workers collaborate with other professionals. The main objective of the social worker is to help a person to reinstate his/her ability to take care of himself/herself and to help to integrate a person to the society (*Socialinių paslaugų katalogas*, 2006).

While working individually, with a single person or his/her family, who need a social worker's help, or when working from an ecological perspective, social worker has many roles: a planner, teacher, former of the social skills, intermediary, and an enabler. Social worker's activities in accordance with the distinguished levels can be graphically illustrated as follows (Figure 2):

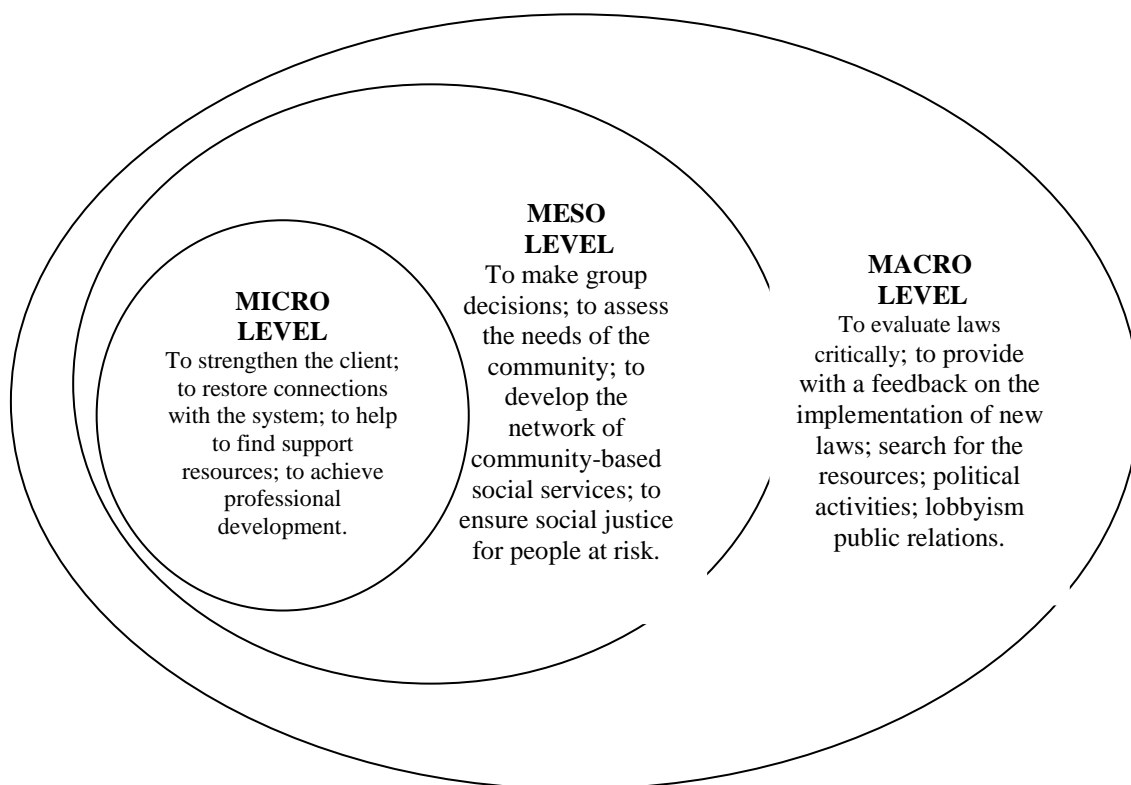


Figure 2. The activities of social worker at the levels of ecological system. Concluded by the author, in accordance with the material of V. Rimkus lectures (2014)

A disabled person can adapt to the community successfully only if he/she has the opportunities to obtain social relationships. Family support, access to required information, knowledge about psychological and physical condition, assistance in realizing abilities are also important factors.

The success of disabled person's socialization and integration process also depends on the social worker. Ivoškienė (2003) argues that the biggest problem which causes other difficulties is the attitude of the social workers towards disabled people and the whole process of integration. It is because the conditions of person's preparation for the independent life depends on a social worker (*Socialiniai neįgalumo aspektai*, 2003).

The goals of social workers: to overcome or reduce patient's social adaptation in the following ways: by solving his/her social problems, promoting restoration of various skills, developing each patient's abilities to adapt the social environment by making sure that he/she is over-taking social services and also helping a person who has mental disabilities to integrate in the society. There are many models of psychosocial rehabilitation implemented in Lithuania. They are supported by the investigation of worldwide literature and the experience of foreign colleagues. The workers that provide social help and assistance not only help to solve juridical,

social and domestic problems but also contribute to the improvement of the abilities of people with mental disorders as well as promote their self-expression and independence by providing the opportunities to engage in their favorite activities.

In terms of the theory of social ecology, disabled people are active and want personal development. Usually, during the time when they are trying to overcome their disabilities, they acquire the skills and attributes that help them to plan and foresee the future (Zastrow, 1999) (cit. Pivorienė, 2003).

To sum up, it can be stated that social worker focuses on the individual customer's attitude and his/her desire to improve the quality of life, his/her strengths, problems and vulnerabilities which prevent the individual from moving forward. Both, psychosocial rehabilitation and social work attempt to discover and highlight individual strengths.

1.2.3. Opportunities of social work through the consolidation and empowerment of social participation

The actualization and realization of social participation of disabled people seem of significant importance when speaking about their social being. The concept of social participation, according to Ruškus and Mažeikis (2007) (cit. Šinkūnienė, 2010), realizes the idea of the integration of disabled people in the society. It also includes empowerment terms, references to the cooperation relations and the creation of networks.

One definition of empowerment cannot be distinguished, as it is a contextual phenomenon and there are various levels of it. Baranauskienė (2014), had analyzed the ideas developed by foreign authors and suggests that empowerment is a life-lasting process which includes positive changes that are related to personal self-esteem and self-image, which helps to create and develop meaningful social relationships (friendship, formal and informal support).

Daugėla (2003) (cit. Šinkūnienė, 2010) defines empowerment as:

- The transfer of solutions, opportunities, values, control and power from the outside of objective reality to a person with a disability;
- A process, because of which a person who has certain disabilities develops with the help of concrete action and more or less can control his/her psychological and social aspects of reality.
- The stage of understanding and awareness;
- The stage of communication and learning, when a person realizes his/her needs, aims to build relationships with other people / groups and gets new information,

acquires new skills. Benefits of this stage: extended possibilities and the range of choices, (new) opportunities;

- Mobilization and action when an individual is seeking for the relationships with other people who have similar interests, learns new skills and becomes ready for actions;
- Contribution to the common activities; it is the final stage of individual empowerment when new resources, skills and knowledge that had been acquired during the earlier stages are being integrated. The mediator or other person who provides social assistance may help for the client and his/her family members to attain and implement all the stages (Baranauskienė, 2014).

Thorlakson and Murray (1996) identified three dimensions of empowerment which enhance the experience of it:

- Positive self-identification;
- Extensive learning and understanding;
- Personal reflection on the environment and the ability to realize the mutual communication (Baranauskienė, 2014).

In conclusion, it may be claimed that empowerment is a strategy of social work which states that the client is able to change the situation him(her)self. Moreover, the client is encouraged to solve his/her problems independently: to be active, to think and to take the responsibility. The client is empowered by providing him/her with the necessary information, support, lessons of social skills, counseling and therapy.

2. EMPIRICAL RESEARCH „THE POSSIBILITIES OF SOCIAL WORKER’S PRACTICE IN WORKING WITH PEOPLE WITH MENTAL DISABILITIES IN THE CONTEXT OF THE MAINTENANCE OF THEIR LIFE QUALITY“ RESULTS

2.1. Methodological study provisions

The study is based on humanism, existentialism and ecological systems theory of philosophical ideas.

Humanists examines man as human qualities, while the existentialists focused on the analysis of the structure of human existence. Existentialism and humanism are perceived as very anthropocentric doctrine exalts man as a value unique, having a potential opportunity to realize ourselves, knows the best of their situation and problems, on the other hand, freedom of choice and responsibility for selecting and decision as well as assigning the same person (Alifanovienė, 2003).

Humanistic – existential direction investigates how a person is able to choose their own models of life and not only managed subconscious or environmental forces. It explains how a person reaches maturity and its objectives; as people experience and understand their own life, its meaning (Palujanskienė, Tamulynaitė, 2009).

Often humanism understood either as an ideal, ie as love for man, his freedom, or as a whole views that reflect respect for human dignity and rights, concern for the welfare of the people, their comprehensive development, the pursuit of human form favorable conditions for public life (Morkūnienė, 1995, 13 p.).

Humanism is based on the assumption that every person has the opportunity to choose their own destiny and to manage it. This optimistic view of the human being, based on love and trust. Humanism's best-known representatives of Abraham. Maslow, Carl Rogers, Victor Frankl – each representative of this trend developed his theory, but can be distinguished general statements, which agrees with all the representatives of this trend:

- a person has to be understood and analyzed as a whole, not perceived as a pre-formed given phenomenon, but as constantly evolving open system;
- human being is unconditionally valuable, so honored and regarded as it is;
- each person is unique, so individual case study at least justified, as statistical summaries;
- everyone has the opportunity to develop themselves in the future to realize that little depends on the personality of the past;

- a person has a certain degree of freedom in relation to the meaning and values that guide the choice;
- human being - active intentional and creative entity of life must be understood as a single human being and the maturation process;
- necessary condition of human existence - communication with other people, acquired traits of humanity (Alifanovienė, 2003; Lobanova, 2010).

Humanistic beliefs system does not reflect the social reality and aspiration: a man in any society must be dehumanize or become a victim of the socialization process. According to Vitkauskaitė (2001) most likely to become victims of the weak members of society: the disabled, children, women, migrants and others.

According to Jaspers (1989), is fatal to man the way he experienced defeat, as can not accept disability: whether he closes before her eyes, and finally overcome if it manages to clearly see and understand that it is impassable limit of its existence; whether it is a fantastic resort to solutions and soothe themselves, or honestly and calmly accepts what is incomprehensible. What makes a person depends on how he experiences his defeat. Sutton (1999) stresses that mental and neurological illness hampers a person to experience the fullness of life.

Humanistic psychology is criticized for being overly care about personal expression issues, not paying attention to social issues or problems (Sutton, 1999).

In order to reveal the importance of the social environment of persons with mental disabilities on quality of life, followed Bronfenbrennerio (1994) ecological theory. The examination of the social structure of the system, is primarily focused on the individual parts and the whole communication. Usually there is a core of the system. This system itself comprises the following items, i.e. subsystems and it is an integral part of other systems. All systems are something more than than the sum of its parts (Johnson, 2003). Person and environment understood only in their mutual communication and interaction terms (Ivanauskienė, 2008).

Biological characteristics of human interaction with the passing and the driving environment, from which the person gaining experience. The individual is surrounded by various systems: micro-, meso-, exo- and macro-systems. (Härkönen, 2007).

In this respect, social context includes microsystems (same family of the disabled) structure, functioning and resources of the meso and exo systems (people with disabilities received social support network, belonging to different communities and so on.) features. Of course, it is important and what macro (covering political, social, economic systems) is functioning person with mental illness the family. Mostly meso system is described as an intermediate system, which combines face and microsystems, exosystems and the

interoperability of the macro, such as belonging to a particular community or educational institution affects family relationships, and so on.

Microsystems – passing personal environment interacting core of family and the individual. As regards disability, passing environment is generally limited to family, relatives and so on. Microsystem people acting influences individual development, but there is no doubt that the personal temperament, habits, physical characteristics and abilities as well as on the environment (Härkönen, 2007).

Mesosystem includes communication and the processes occurring between two or more settings (eg, between home and the workplace, church, day care center, and so on.). Mesosystem microsystems interaction. As mesosystem consists of several micro person has accepted a new role and enters into a new environment meso system expands. Bronfenbrenner (cit. Lemme, 2003, p. 66) states that the most significant adult activities include home and work.

Exosystem – it's part of the environment in which the person is not an active participant, but it is exposed to the environment through one of the micro-systems (eg., City government, social support networks, care institutions, etc.). This is the formal and informal social structures, institutions.

Macrosystem includes the beliefs and values that affect social groups, such as. social classes, ethnic groups or even entire society structure. Macrosystem is characterized by a certain scheme, and a particular social group or society, the majority of microchips, and Exo meso schemes are similar. Macrosystems and components depend on even more public historical context and in this sense they are also changing, evolving. It will take a long time. This chronosystem. All ecological systems interact over time and it changes the impact that the environment has a child, and that child is doing in your environment (Lemme, 2003).

Ecological model – the people as constantly adapting to the environment the mutual interaction, ie, Individuals changing environment and are themselves exposed. For the purposes of ecological systems theory, consider: system, parts of the interactions between the different parts of the relationship, integrity, environmental relationships, communication techniques. Ecological systems theory object – the ratio of the individual and the environment, with emphasis on its disfunction (Jančaitytė, 2010)

The strenght of ecological theory: provides a holistic approach to man and his environment, highlights the environmental impact of the individual and the importance of solving the problems, the structure provides assistance process. *Weaknesses*: Theory is very wide and can be difficult to apply in a given situation; many complex concepts that describe the theory; difficult to verify empirically (Jančaitytė, 2010).

2.2. Study design

Theoretical study analyzed the scientific literature. During consideration of persons with mental illness quality of life and subjective well-being aspects briefly discussed people with mental disabilities situation in Ukraine, presented business opportunities of social workers working with persons with mental disabilities in the context of maintaining the quality of life. This study aims to assess what are the business opportunities for social workers working with persons with mental disabilities in their quality of life in the context of the maintenance or improvement. The overall study design is shown in Figure 3:

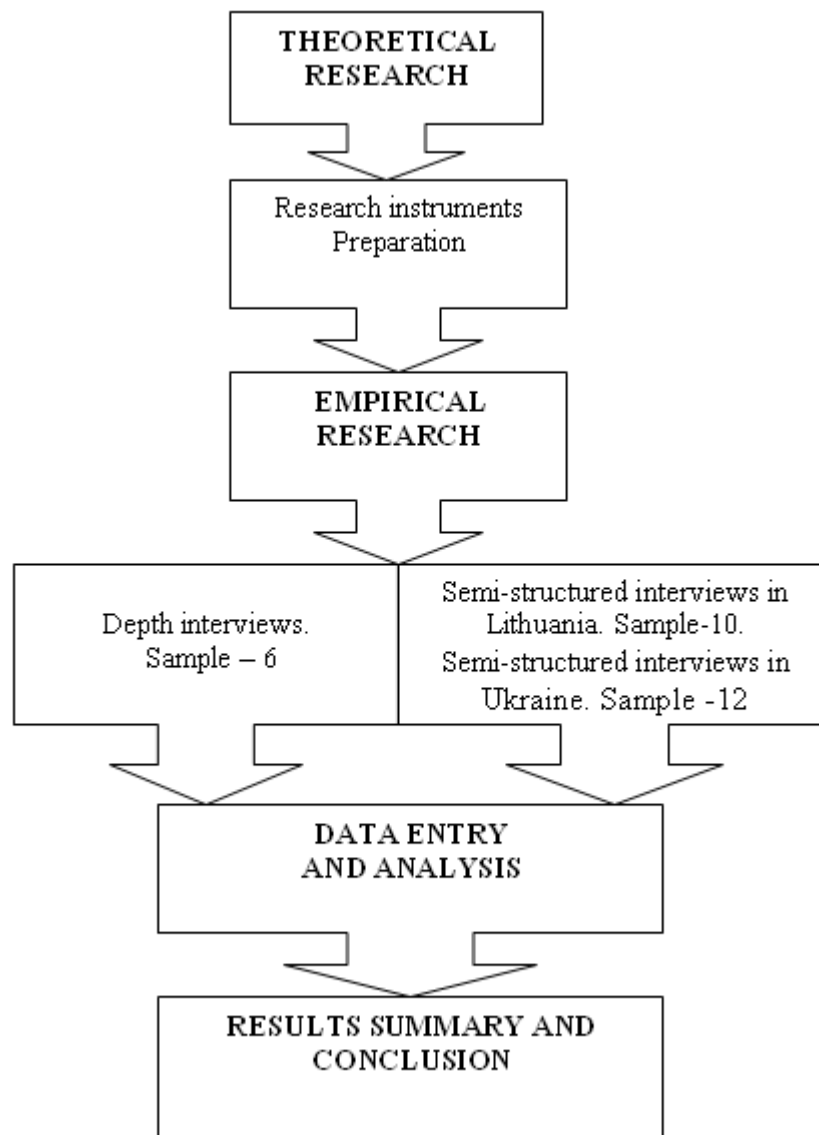


Figure 3. Study design. Made up by the author

2.3. Research Methodology

In order to analyze social work opportunities of people with mental disabilities, quality of life was carried out empirical research and interviewed by social workers who work with persons with mental disabilities themselves and persons with mental disabilities.

Research method. Master's work to achieve the objective was chosen a qualitative Individual semi-structured interview technique and individual in-depth interviews, applied to customers.

According to Kardelis (2005), a semi-structured interview technique allows to obtain more detailed information that often complements other studies, such as the questionnaire findings. Tidikis (2003) argues that the interview method is one of the most effective methods of qualitative research. Interview methods of obtaining information is often more detailed than in the quantitative study. Qualitative research gives access to both formal and informal opinions expressed, observations and assessments. Interviews approach helps researchers understand the informants' views, experiences, learn opinions during the question which they express in their own words (Rupšienė, 2007; Bitinas, Rupšienė, Žydžiūnaitė, 2008). Interview advantages are that during the interview the researcher has the opportunity to explain to the respondent one question or answer option makes sense, especially atypical „I do not know“, „no opinion“ responses in nature, in an interview responses absent from incorrect or replaced; you can get detailed answers, especially to open questions can be submitted and additional and revised questions (Tidikis, 2003).

Individual depth interview allows to collect a lot of useful information, important details, often lead to new insights. During the interview seen not only cognitive, but also the emotional aspects of the responses (Bitinas, Rupšienė, Žydžiūnaitė, 2008).

The study validity. One of the interviews of the problem – the information derived from interviews, reliable and extremely difficult to determine the level of reliability of the data received. In order to ensure the internal validity, results of the study were presented to respondents and obtain their opinions on the reliability of the survey results have been used in digital and mechanical data recording and storage media researcher personally participated in the data collection.

In order to study the subject looked at from different points of view, the study included the respondents of different age, sex, place of residence, from different backgrounds and so on.

2.3.1. Interview organization and process

Test Process main phases:

- Survey Instrument (interview questionnaire) preparation;
- The selection of respondents, their information;
- Interviews with respondents;
- Analysis of the findings.

Interview questionnaires preparation. An analysis of the scientific literature, and after a theoretical analysis was prepared operationalization (see Annex No. 1), which was drawn up two interview questionnaires – one for persons with mental disabilities (hereinafter – customer) and other – social workers who work with individuals with mental disabilities. Questionnaires given Annexes 2 and 3.

Frechtling and Sharp (1997) (cit. Bitinas, Rupšienė, Žydžiūnaitė, 2008, p. 159) states that provide early warning of deep interview questions more it codifies, interviews are more detailed.

The research sampling method. It was formed two samples of respondents using a mixed purposeful, ie, Comfortable selection „snowball“ approach. Respondents deep and semi-structured interviews were selected researchers familiar persons from the immediate environment. Several respondents to the survey indicated other potential respondents in line with the study selection criteria. The main selection criteria for study participants – persons with mental disabilities and social workers who work with persons with mental disabilities.

In-depth interviews were interviewed six clients, and semi-structured – 10 social workers in Lithuania. In the Ukrainian data were obtained in writing, interviewed 12 professionals working with persons with mental disabilities. According to Kaffemanienė (2006), the qualitative sample sizes are small, and their conclusion is not so strictly observed statistical reliability requirements.

Preliminary information about the respondents interviewed. Once respondents targeting, „face to face“ and was in contact by telephone with selected respondents and consulted on the timing of the interview. During the conversation, the study presents the objectives, expected duration of the interview, explained why research is selected as a respondent.

Interview process. Interviews with respondents – clients, were carried out in their homes, they are well familiar environment where they feel safe. During the interview, respondents were home alone, without foreign people, so no one are not distracted by their attention. Lighter and create a more intimate atmosphere was the beginning of ingestion of coffee or tea, and familiarized pabendraut informally. Following an interview respondents were rewarded candy or chocolate box for agreeing to participate in the study.

Inquired the respondents, interview data were recorded in the recorder and the help of some of the things of the words. Interviews were transcribed, i recorded verbatim, noting brighter pauses, gasp, laughter and so on.

The respondents – social workers interview was conducted met their workplace during breaks. Several study participants found the publication of a study organized by the social network „Facebook“. Employees who answered were presented the study objectives, the expected duration of the interview, explained why research is selected as a respondent. With the written consent of the respondent, the interview was held by correspondence emails in real time.

Analysis of the findings. The obtained data using the content analysis. Qualitative content analysis consists of 4 steps: multiple text reading material category exclusion based on keywords, categories splitting content into sub-categories, categories and subcategories interpretation and justification based on text evidence (Bitinas, Rupšienė, Žydžiūnaitė, 2008).

Transcribed interviews were read many times, phrases, sentences, isolated, and sometimes entire paragraph was distinguishable marking in different color. It was distinguished categories are subdivided into subcategories, in other cases were isolated sub-categories and summarizes in a category. Categories were linked to the themes highlighted by single meanings.

2.3.2. Ethical aspects

In a qualitative study, ethical problems are more important than the quantitative. Investigators were committed:

- To study participant with all the information about the possible inconvenience;
- Remember to research the possibility to withdraw from the trial at any time;
- Drop the investigation on its own initiative, where the respondent is too many difficulties due to the test conditions.

In accordance with the principles of research ethics, potential respondents were open and honest disclosure of all aspects of the investigation, which could affect the participants' determination to participate in the study or not. Participation in the study – voluntary and spontaneous, participants had the right to decide how far willing to answer the questions, or the question could not respond at all (Bitinas, Rupšienė, Žydžiūnaitė, 2008).

From each respondent was obtained verbal consent, and some social workers – written. Consent means that the research is informed about the investigation and potential threats, so the investigation is a conscious choice. Respondents were explained about the exact progress of the inquiry, its objectives, and the importance of the method. The study participants were guaranteed anonymity and confidentiality of the data received. One of the most effective ways to ensure the

anonymity – nowhere avoid trial participants actually names. Anonymity enhanced data subject's giving codes (C1-C6, S1-S22).

Another very important principle, which is complied with – confidentiality. This survey participants from the public storage of data publishing. This principle is that the researcher must keep secret everything about the person who has filed his information. For this reason, the attachments are provided transcribed interview excerpts from the text would not be possible to identify the person. The study was conducted only in the presence of the researcher and the study participant. The research participant information provided is used only for research purposes (Žukauskienė, 2008).

2.4. The characteristics of research sample

The research was carried out in 2015, from February to April, in Lithuania and Ukraine.

Participants of the research:

- Individuals with mental illness – clients (6 in Lithuania);
- Social workers, working with patients experiencing mental illness (10 in Lithuania) as well as 12 specialists working with patients experiencing mental illness in Ukraine.

Table 1

Characteristics of respondents S1- S22

Serial number of respondent	Code of respondent	Short information about respondents (social workers)
1.	S1	37 y/o woman with higher education. Total work length- 17 years. Works in a city, medical institution with children that are from 3 to 8 years old, married.
2.	S2	41 y/o woman with higher university education. Total work length- 23 years. Works in Šiauliai city, in the Department of mental health with a group of adults who are from 18 to ... years old, married.
3.	S3	27 y/o woman with higher education. Total work length- 2 years. Works in a city, medical institution with adult patients, not married.
4.	S4	40 y/o woman with higher education. Total work length- 19 years. Works in Mūro Strėvininkai village, in a social care home, with elderly people that have mental illness, divorced.
5.	S5	54 y/o woman with incomplete higher education. Total work length- 17 years. Works in Kaunas city, medical institution, with elderly people, widow.
6.	S6	40 y/o woman with higher education. Total work length- 19 years. Works in Mūro Strėvininkai village with adult people who have a mental and psychical illness.
7.	S7	36 y/o woman with masters of social work. Total work

		length- 12 years. Works in Klaipėda city, RKH Department of mental health, with adults from 18 years old. Married.
8.	S8	41 y/o woman with higher university education. Total work length- 23 years. Works in a city, medical institution with middle-aged people, married.
9.	S9	47 y/o woman with higher education. Total work length- 8 years. Works in a city, medical institution with individuals older than 18 years, married.
10.	S10	34 y/o woman with higher education. Total work length- 5 years. Works in Kuršėnai town, medical institution with individuals older than 18 years, married.
11.	S11	Woman with education of social teacher and psychologist. Has been working in a city, telephone service company “Pasitikėjimo linija” with individuals of various age since 1991. Married.
12.	S12	Woman with special secondary education. Total work length- 13 years. Works in the city of Kiev, psycho neurological boarding institution for men, with men who are older than 18 years, married.
13.	S13	Woman with incomplete higher education. Total work length- 4 years. Works in a city, social institution, with elderly people, divorced.
14.	S14	Woman with secondary education. Total work length- 1 year. Works in a city, social institution, with elderly people, not married.
15.	S15	Woman with secondary education. Total work length- 12 years. Works in a city, social institution, with elderly people, divorced.
16.	S16	Woman with incomplete higher education. Total work length- 7 years. Works in a city, social institution, with a group of elderly people, married.
17.	S17	Woman with higher education. Total work length- 2 years. Works in a city, social institution, with a group of elderly people, married.
18.	S18	Woman with higher education (sociologist). Total work length- 35 years (20 years in sociologic sphere). Works in a therapeutic centre of social service, with a group of elderly people, divorced.
19.	S19	Woman with a higher education. Total work length- 12 years. Works in Kiev, therapeutic centre of social services, with a group of elderly people, divorced.
20.	S20	Woman with a higher education. Total work length- 24 years (13 years in a social sphere), therapeutic centre of social services, with a group of elderly people, divorced.
21.	S21	Woman with a secondary education with profession. Total work length 12 years. Works in Kiev, therapeutic centre of social services, with a group of elderly people, divorced.
22.	S22	Woman with a secondary education. Total work length- 20 years (5 years in a social sphere). Works in Kiev, territorial centre of social care, with individuals of various age, not married.

In the 1 table the general information about respondents who participated in the research is presented. Codes that help to maintain the respondents anonymous are also displayed. During

the research ten social workers were questioned; all respondents who participated in the research are females. Fourteen social workers (S1, S2, S3, S4, S6, S8, S9, S0, S11, S14, S17, S18, S19, S20) have higher education, three respondents (S5, S13, S16), of who two are from Ukraine, while one is from Lithuania, have an incomplete higher education. Four respondents (S12, S15, S21, S22) from Ukraine, who are social workers have only secondary education, while one respondent (S7) is a master of social work. Working experience of respondents who participated in the research varies from 1 to 23 years. From twenty two respondents who participated in the survey, only one (S1) is working with children who are from 3 to 18 years old, while all other respondents are working with individuals who are at age of 18 and older. Twenty respondents (S1, S2, S3, S5, S7, S8, S9, S11, S12, S13, S14, S15, S16, S17, S18, S19, S20, S21, S22) are working in cities, while two respondents (S4 and S6) are working in Mūro Strėvininkai foster home in Mūro Strėvininkai village, and only one (S10) is working in Kuršėnai town.

Table 2

Characteristics of respondents C1- C6

Serial number of respondent	Code of respondent	Short information about respondents (clients)
1.	C1.	54 y/o woman. Lives in a city. Has an illness since 21 years old (for 10 years), working capacity – 40%. Secondary – vocational education. Is not working for almost 1 year. Woman is in her second marriage.
2.	C2.	45 y/o woman. Lives in a city. Has an illness for 6-7 years, is disabled for ~6 years, working capacity – 40%. Works in a social company “X dairy,” has to go about 50 kilometres to work. Has secondary education and specialties of waitress, barista, barmaid, and shop-assistant. Woman is in her second marriage, has a teenage daughter from the second marriage.
3.	C3.	27 y/o woman. Lives in a city. Has an ailment since her childhood. Has finished 10 grades. Working capacity – 45%. For a half of year is working in a social company, located 50 kilometres from her home. Lives with her mother, disabled niece, and disabled cohabitant.
4.	C4.	43 y/o man. Lives in a country. Has an illness for 20 years, is disabled for 15 years. Has a secondary (technical) education. Working capacity – 40%. Man is not working and divorced since 1997.
5.	C5.	52 y/o woman. Lives in countryside. Has a group of ailment since being 21 old. Experiences illness since being 18 years old. Does not work. Working capacity – 40%. Has secondary education.
6.	C6.	58 y/o man. Lives in countryside. Has a higher education, profession of physics teacher. Divorced since 1999, children are already grown up. Working capacity – 20%. Has an ailment for 3 years. Has not been working since

		2006. Before becoming disabled had been working public works by labour exchange as well as some casual works appointed by a farmer.
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The age of respondents with mental illness, who participated in the research varies from 27 to 58 years. Two respondents are married for their second time (C1, C2). One respondent is in her first marriage (C5), one participant of the research (C3) is not married, while two respondents who participated in the research (C4, C6) are divorced and do not have second families. Three respondents (C1, C2, C3) live in a city while other three respondents (C4, C5, C6) live in a countryside. Education of the majority of respondents with mental illness (C1, C2, C4, C5) is secondary. One respondent (C3) graduated only in 10 classes, while respondent C6 has a higher education diploma. The majority of respondents (C1, C4, C5, C6) have not been working anywhere. Respondents experience mental illness till 3 to 31 years old, while the rate of incapacity for work varies from 20% to 45%.

2.5. Analysis of results of the research

Were highlighting categories and subcategories (see Table 3):

Table 3

Category	Subcategory
Integration	Skills development
	Physically active occupation
	Provision of information, assistance
	Expression of interests
Interpersonal relations	Communication
	Collaboration
	Social isolation
Self-realization	Occupation
Finances	Financial stability
	Financial resources
Free time	Active free time
	Passive free time
	Does not have a free time
Surroundings	Support
	Stigmatized attitude
Assistance	Non-material assistance
	Material assistance

Results obtained after analyzing questions presented to respondents are displayed in the research. The questions were formulated in accordance with analyzed literature, so the research is the general component of the analyzed topic.

Social services

The main providers or social services are social workers who also are the organizers and coordinators of these services. When assisting the client social workers are cooperating with

specialists of other professions. The main goal that social workers are aiming to achieve is to return to the clients the ability to take care of themselves and integrate into the society (*Socialinių paslaugų katalogas, 2006*).

The activities of social workers are displayed in the following Table 4:

Table 4

The activities of social workers

Serial number	Activity	Respondents
1.	Communication with clients and their families; consulting	S1, S5, S8, S9, S7, S10, S11, S14, S15, S16
2.	Communication and collaboration with other institutions (officers, inspectors, children's rights protection departments, pedagogical- psychological services, health care institutions, etc.)	S1, S4, S6, S7, S10
3.	Cooking	S2
4.	Organisation of occupation (clay therapy, arts therapy, sewing, moving, dancing, multisensory therapies)	S2, S3, S8, S9, S5, S12
5.	Document management	S7, S9
6.	Representation	S1, S5, S7
7.	Solving issues	S2
8.	Shopping	S2, S5
9.	Development of social and everyday skills, teaching of being independent	S3, S5, S13, S14, S15, S16, S17, S18, S19, S21, S22
10.	Encouraging social integration	S8
11.	Emotional support	S10
12.	Crisis support	S11
13.	Care and protection	S12
14.	Medical care	S18
15.	Assistance at home	S20
15.	All provided services	S21, S22
17.	Lectures about communication and behaviour peculiarities with the patients of this category	S11, S13, S14, S15, S16, S17

As seen in the Table 4, all respondents who participated in the research have more than one responsibility in their organisations and provide various general and special social services to individuals who are in need. Services cover communication with client and one's family, consulting, representing, communication and collaboration with certain institutions, document management, cooking and organizing additional activity, assistance when shopping, developing social skills and teaching being independent, solving issues, etc.

Missing social services are displayed in the Table 5:

Table 5

Missing services in accordance with social workers

Category	Subcategory	The most necessary services for clients	The most missing services
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Free time	Daily occupation services	„Daily occupation services are mostly necessary for children“ (S1), „Occupation“ (S5). „<...> psycho social rehabilitation“ (S8).	„Children are lacking free occupation“ (S1), „The most missing services are occupation, working activity“ (S4, S6), „Daily centres for individuals with mental illnesses are the mostly needed“ (S7).
Integration	Skills development	„Daily skills development“ (S2).	„Assistance at home“ (S2, S12), „Full care“ (S13).
	Participation in community life, communication	„There is a lack of participating in cultural life, integration in the society“ (S3).	„Individual work“ (S9), „Restoring socialization, reintegration into the society programs“ (S10).
	Information provision, assistance	„Document management, to accompany the patients to a clinic, to cook“ (S14, S16).	„Medical assistance“ (S15, S16); „to clean the home, assistance when cooking, document managing“ (S17).
	Material help	„Accommodation“ (S11), „Paying the bills“ (S14, S15, S16, S17).	„Accommodation“ (S11), „Paying the bills“ (S12), „material help“ (S14).
Interpersonal relations	Communication	„Communication“ (S4, S6).	

In accordance with social workers, the most necessary services for clients with mental illnesses are occupation, communication („conversations“ (S20)), representation („management of various documents“ (S5, S16); „representation, accompaniment, consulting“ (S4, S6), accompaniment, consulting (two respondents at a time), daily skills development, psycho social rehabilitation (one respondents at a time). Six respondents think that individuals with mental illness are mostly lacking occupation („to accompany for a walk“ (S12, S22); „Reading books“ (S20)), working activity; in respondents' opinion, the clients are lacking the assistance at home as well („whole day and night care“ (S14, S18, S21), „home cleaning“ (S15, S16), „night care“ (S19)), more individual work with individuals who have mental illness, and other services („material assistance“ (S15, S16), „Living in a sanatorium“ (S22). Respondent S7 states that „if a person has social issues, a single most suitable way to solve one's social issues does not exist, so I could not distinct the social services which are necessary more or less. Social services are provided in a complex.“ In accordance with S8 respondent, there is a lack of social workers who could pay more time to a client: „I think that we are mostly lacking the social workers, who would be able to pay more time to the individual in dispensary area. Now

one social worker has to service the whole region, almost one-fifth of the city. How could you work with an individual carefully, when you need to review and inspect a tone of other files and stories?” S9 and S10 respondents agree with such opinion and add: „All services are necessary in accordance with the needs of patients“. In their opinion, the clients should be able to get these services in day care centres in boroughs, towns, villages, because in those areas the occupation is extremely rare. Municipalities, sub district governments, social care centres should organise these services („The services should be provided in the cities by day care centres in every region of the city, towns; whereas the provision of these services is essential in villages, because the occupation is very rare in these areas. Municipalities, sub district governments, social care centres should organise it“ (S1)). Services in day care centres should be provided by social workers or their assistants („Social workers, their assistances“ (S2, S7, S9, S10)), psychologist (S10), occupation specialists („<...> should be provided by occupation specialists“ (S4, S6)). Nevertheless, due to the high number of clients social workers are not capable to provide all these services („Social workers are lacking of time to provide all the services, because there are a lot of clients“ (S9)). Four respondents from Ukraine (S12, S19, S21, S22) answered this question very generally: clients are in the need of all social services. These respondents did not distinct specific and the most necessary services are state that in their social institution all the necessary social services appointed by the law are provided „<...> in our institution all social services are provided in accordance with the law“ (S12).

Respondents-clients who participated in the research are not getting any social services. Relatives and family members living with them help to clean their surroundings, response to the questions. Three respondents (C5, C2, C1) of all who participated in the survey have been getting single social services. Respondents C5, C1 and C2 received social services for one time: C5 in the hospital was having the conversation about life, home, and how she is doing, while the social worker helped respondents C1 and C2 in document management.

Four respondents (C3, C5, C2, C1) of all who participated in the survey met the social worker while two respondents (C4 and C6) have not met the social worker once; these two respondents consider the help of social worker unnecessary because their relatives provide them with the necessary assistance. Respondent C3 has been communicating with the social worker for a while; moreover, she has been invited to various events, excursions. Respondents C5, C1 and C2 met the social worker only once: C5 in the hospital was having the conversation about life, home, and how is she doing, while the social worker helped respondents C1 and C2 in document management. Respondent C2 mentioned that she have seen the assistance provided by social workers to other patients; for example, the injection of medicines.

In general it may be stated, that the clients are mostly missing occupation, the most necessary service, which, in accordance with Dembinskis, is evaluated as the most important priority to patients who have mental illness. „The occupation improves the adaptation into the society as well as quality of life.“ (2003, p. 44). The abilities of social worker are presented in the Table 6.

Table 6

**Areas of activities that should be improved
(In accordance with the social workers)**

Areas	Abilities
Free time	To create the day care centres and actively encourage to take up the suggested activities.
Self-realization	To encourage finish the studies, suggested courses and to assist when employing.
Interpersonal relations	To encourage not to turn in on themselves and communicate more with the surrounding people.
Integration	To encourage the active participation in the community life.
Financial abilities	To help finding the working activity that would satisfy the client.

Social workers believe that the basic social services which could improve the life quality of individuals with mental illnesses are the following: free time, self-realization, interpersonal relations, integration, and financial abilities. It is possible to provide these services only after establishing the day care centres for disabled people, where these people would be encouraged not to turn in on themselves and endeavour to get education, attend various courses, and participate in the community life.

Life quality of the clients (social workers and people with mental illnesses)

Maslow (Želvys, 2007) introduced a theory, where the human’s needs are arranged in a certain order and forms a particular pyramid. In accordance with this pyramid, until the person does not satisfy one’s lower needs, it is difficult to endeavour for the higher ones. People usually tend to consider the maintenance of good interpersonal relationships, finding one’s place in the society, and belonging to certain group or groups as the important needs necessary for one’s happiness. People difficultly endure loneliness, the feeling of emptiness and isolation, which are caused by the insensibility and unfriendliness of the surrounding people.

In accordance with the social workers from Ukraine, the individuals who experience mental illness are satisfied with these factors (see Table 7):

The satisfaction of clients

Category	Subcategory	Supporting statements (social workers)
Integration	Communication	<i>„The majority of clients desire to be noticed, useful, so their involvement into the working and creative processes brings them a lot of happiness“ (S2).</i>
	Living conditions	<i>„Living conditions“ (S4, S7), „Living standards“ (S6).</i>
Assistance	Non-material assistance	<i>„The assistance of social workers“ (S3), „Concern“ (S5).</i>

In accordance with data presented in the table 7, in the opinion of social workers from Ukraine, individuals with mental illness experience a lot of happiness, when the need of communication is satisfied (*„attention, participation“ (S9), „cleaning, conversations“ (S11)*); they get the attention when receiving the necessary help and support (*„care“ (S8), „receiving assistance“ (S10)*). Nevertheless, the greatest dissatisfaction for the patients with mental illness is usually caused by the following factors:

The factors causing dissatisfaction to the clients (in accordance with social workers)

Category	Subcategory	Supporting statements (social workers)
Intrapersonal relationships	Communication	<i>„<...> the issues occurs when children do not have congenial, friends, or when the communication between one’s parents or carers is complicated“ (S1).</i>
	Social isolation	<i>„The majority of patients experience difficulties when looking for the life partner <...>“ (S3); „they have to live in a social isolation from their relatives and family <...>“ (S6, S4).</i>
Self-realization	Occupation	<i>„The main reason is unemployment. When a person has a mental illness, it is difficult for one to find an employee, who would like to hire such person“ (S2); „<...> almost all unemployed patients do not have the reason to realize themselves“ (S3); „do not have a job...“</i>

		(S5).
Financial situation	Financial stability	„<...> not having the financial stability“ (S3); „<...> small disability support pension <...>“ (S8); „unsatisfied because the group of disability is „low“, the received money and discounts are small. For example, there is a big difference, if you have the second or the third group“ (S9); „<...> are not able to purchase something due to the lack of money <...>“ (S6, S4).
Politics	Social security	„Social security“ (S19, S22); „Medicine, the sphere of social services“ (S11, S14).

S1 respondent notices that the dissatisfaction of children is caused by the lack of communication with their parents/ carers; it is presented by her opinion: *„The parents are very busy and pay very little time to the communication with their children. In nowadays society, when the tendency of consumerism is frequent, high competition between the children is occurring, when seeking to have everything what others have, and not paying attention to the abilities of family.“*

In accordance with S7 respondent, not all clients feel dissatisfied. To quote her: *„<...> are individuals who have jobs, find various activities. Of course, the incapacity benefit is usually not sufficient, because before getting sick the person did not obtain the sufficient length of service. It is not taken into consideration that maybe because of illness and due to the assistance not provided in time the individual is not able to work anymore. There are systems completely unrelated with each other: hospital, DWCAO, SODRA (State Social Insurance Fund Board of the Republic of Lithuania) – all these institutions see only the displayed data; there is no way to see into the situation <...>. I think that the most important factor is people not being afraid to call for help, break stereotypes about the „horrors“ of psychiatry – then the assistance will be provided in time, while the person will suffer much less.“* As seen from the answers of respondents, the social workers divided the main sub categories which cause the dissatisfaction of patients: communication (*„many people lack for communication“* (S8), *„moral“* (S18)), social isolation (*„The majority of clients desire to be noticed, useful, so their involvement into the working and creative processes bring them a lot of happiness“* (S12)), occupation (*„<...> are not able to have the favourite job <...>“* (S6, S4); *„<...> lack of creativity when experiencing the occurrence of any disease, lack of day care centres“* (S5); *„lack of attractions – despite the*

fact that there is lack of motivation to any activity; the patients desire for innovations and changes, but are unable to explain what they want specifically“ (S6); „<...> are not able to study <...>“ (S6, S4), „Self-realization“ (S12)), financial stability („<...> express dissatisfaction of the insufficient amount of money to make a living, social support is insufficient, while frequent job, where the person succeeds to employ, is below expectations; patients fail to maintain the work place due to the lack of responsibility and not fulfilled expectations about the future salary“ (S10); „in financial need“ (S13, S15, S16, S17, S18), „material“ (S14, S20, S21). In accordance with clients, the factors mostly determining dissatisfaction are not feeling well and lack of communication.

After asked to evaluate the life quality of their clients, respondents who participated in the research (social workers) gave the points from 1 to 10:

- 2 out of 10 (S2, S14, S18, S19, S20, S21, S22);
- 3-4 out of 10 (S5, S16, S17);
- 4 out of 10 (S1, S7, S8, S12, S15);
- 5 out of 10 (S3);
- 7 out of 10 (S9, S6, S7, S13);
- 8 out of 10 (S10, S11).

After asking the social workers from Ukraine, if they think that the clients are happy, S11 respondent was unable to answer the question („a difficult question”); states that: *„The patients are very different. If a patient is living at home, the care, disease control, and life flow is at least at satisfactory level. The life quality of patients who live alone is much worse <...>“*. Respondent S12 states that *„everything depends on how the clients views one’s disease and how did the disease influence one’s condition. The majority of patients do not have the sense of criticism and evaluation of one’s condition. Of course, such people are in the need of special care and attention.“* 8 respondents (S13, S14, S15, S16, S19, S20, S21, S22) who participated in the research think that their clients are unhappy, while two respondents state that not all the patients are unhappy and everyone is happy in one’s own way.

In accordance with opinion of respondents (social workers), in order to have higher quality of life the clients are mostly lacking of:

Table 9

Clients’ life quality in accordance with social workers

Category	Subcategory	Supporting statements
Environment	Privacy	<i>„<...> You live in accordance with very clear structure, in which is not enough room for privacy. You have to adapt to everybody <...>“ (S6); „<...> such individuals usually are isolated, do not have any friends, <...> are afraid to tell their friends about the occurring</i>

		<i>disability of such kind“ (S8).</i>
	Occupation	<i>„There is a lack of occupation, activity, and specialists who would help to avoid relapse, as well as to maintain the person in the home environment for some longer period of time“ (S7).</i>
Finances	Financial resources	<i>„In my opinion, financial resources“ (S9).</i>

Every individual is formed from multiple physical and mental components, environment that surrounds the person, different reaction to the occurring situations. The evaluation of life quality is very much dependent on the personality type, gender, education, health state, and age- in a different period of one’s age the person is differently perceiving and distinctively evaluating the criteria of life quality. In accordance with Furmonavičius (2001, 2004), the life quality in medicine is usually called quality related to health and it is accepted to analyze it by narrower meaning and by the aspects which are related to the health of examined people- physical, psychological and social health level.

In summary, it may be stated that by working with clients, the social workers notice the areas, activities which could improve the life quality. Moreover, not everything may be bought by money- some things that patients need are free- for example, the care of relatives, supervision (*„The clients are very isolated, they feel rejected“ (S2); „Children experience difficulties, when they are isolated in patient department from their family, friends, and relatives <...>“ (S1); „<...> the care, protection, and attention of relatives <...>“ (S5); „<...> getting into the medical institution, when having disability <...>“ (S5); the care and communication, understanding and tolerance of surrounding people.*

Of course, there is also a lack of financial resources, by which the life quality may be improved (*„<...> safe surrounding environment, adapted to the needs of the disabled person <...>“ (S5); „the system is far from perfect, where they could fully integrate to the society“ (S10); „<...> the medics visiting the patients at home, without calling; the assistance of integral team members at home <...>“ (S5).*

Table 10

Clients’ life quality in accordance with the clients

Category	Subcategory	Supporting statements (clients)
Physical functioning	Well-being	<i>„When you wish to be stronger, but you can not... when you start to coerce yourself, let’s say... you clench your teeth and say to yourself: you have to do it, you can do it“ (C1).</i>
Interpersonal relationships	Communication	<i>„<...> when you want to explain something to someone and say that one should not do that, of course, nobody is listening you <...>“ (C2).</i>

In this survey four of the six respondents assess their quality of lives negatively and maintain that it have got worsen after they got sick: C6 evaluates his quality of life with three points in ten point scale system and maintains that: *„It's bad. I wasn't able to find a woman anymore, they all told me to go to the hell; <...> Firstly, I would love to have a deep conversation, I am afraid to say many things out loud <...>“*.

C5: *„I wouldn't say it's fine... Many things happen... This illness makes me feel very sick and that really annoys me. When you are sick everything around makes you nervous, everything is different comparing to when you are healthy. When you are healthy everything is in order, everything is fine.. But when you are sick - that's it, everything stops. “*

C4: *„My life turned upside-down <...>. Of course life became worse. <...> when you are sick you will always be haunted by the minds that you will fail doing something or you will fail creating new family again after divorce. Your new girlfriend or wife may reproach you with your illness all the time. “*

C2: *„<...> Of course it also concerns financial expectations... It would be great to change many things but it is what it is. Today I couldn't think of any other way to live... Its fine the way it is...“* Respondent evaluated her quality of life with six points out of ten. According to respondent between her and her complete happiness stands: *„I would like my husband to show more respect to me, more sensibility from him... that's what it is... I want to be able to say out loud things what I want and how I want... that's all I need in order to be completely happy... actually that's.... quite a lot... of course I want my husband to pay attention to me... but nobody can change that or do it... he is the way he is, we all are different individuals... “*

Respondent C3 is very happy with her life: *„I am happy, I have a family, happy because I have aunts, I am happy about everything. I have that baby... “* (Points to her guinea-pig). Respondent C3 states that she has enough of everything so far and that their needs are little: *„We don't need much, what we have is enough... “*

In summary, the study shows that people with mental disorders most often suffer from lack of communication (*„My brother doesn't want to communicate, he once said: „I don't need a cripple sister“ , nobody wants to <...> they keep asking if I have disability, I say that I do and then they reply that they don't need such kind of a friend“* (C3); *„<...> I would love to have a deep conversation, I am afraid to say many things out loud <...> “* (C6), self-realization, both at work and in personal life, and also financial stability. They are one of the most important needs which guarantee persons satisfaction of life. Individuals only through communication and self-realization can meet the basic social skills which have a significant impact on people life and their social skills. Finances are as well important because they help people to create their own well-being. The concept *quality of life* is closely related to people subjective criterions in ways

that only particular person understands and accepts. We may assume that quality of life may be defined as a subjective welfare which is different for anyone with their different quality evaluation criterions. Respondents' results from analysis correspond with Brijūnaitė (2007) statement that individuals who have mental disorders and live in residential treatment and foster care facilities have worse quality of life than those who live in a community. Respondents from analysis evaluated people with mental disorders quality of life as average or below average. The highest evaluation on quality of life was 8 points out of 10. According to respondents these people need more privacy, family support and care, safe and personalized environment, financial support and perfect system that would help them to completely integrate into society. Social workers activity opportunities are listed in Table 11:

Table 11

Areas Possible to Work on

According to Social Workers	Opportunity	According to Clients
Privacy	To give opportunity to make their own decisions.	
Occupation	Encourage not to withdraw into oneself, to communicate with people around you and participate in community life as much as possible.	Communication
Financial Resources	Help to find work which would satisfy the client.	
	Encourage to communicate more, to find favorite activities, go to work and most importantly less thinking about your disability and stop feeling sorry for yourself.	Sense of well-being

According to social workers main factors missing in order to improve quality of life are privacy, occupation and financial resources. Clients think what they miss most is communication and sense of well-being. These areas may be improved by developing clients' independence in decision making, encouraging them to participate in different community activities, to look for a proper job and find favorite activity at leisure.

Activities that can improve people with mental disorders quality of life

After we found out what is the value of disabled people's life quality, we decided to ask our respondents and social workers what activities in their opinion could improve people with mental disorders quality of life. Respondent answers are listed in Table 12:

Table 12

Activities that can improve people with mental disorders life quality

Category	Subcategory	Supporting statements (social workers)
		„Occupation“ (S2); „Athletics, theatre, clay work, glee-club“

Integration	Occupation	(S4, S6); „Just occupation“ (S5); „Occupation, establishing day care centers“ (S7); „occupied by personal hobbies, communication“ (S8).
	Professional Activity	„<...> if possible – work“ (S2); „Professional activity“ (S8); „<...> proper vocational training and professional integration<...>“ (S10).
	Expression of Interests	“Expression of interests adapted to individual needs of every client” (S3).
Interpersonal relationships	Communication	„Communication<...>“ (S2, S5); „Good atmosphere among residents and staff members, intercommunion, communication“ (S4, S6); „Communication by all means“ (S8), „<...> mutual communication, assistance groups, feeling that you belong there, that you are rightful member of community“ (S10).
Aid	Immaterial Aid	„All day daycare“ (S13, S14); „people around and state help“ (S15); „caring people around and their help“ (S16).
	Material Aid	„Disability pension size, social sector services“ (S11); „financial situation“ (S21); „pension receiving“ (S22).

In Table 12 we see separated categories and subcategories such as occupation („It’s crucial to pay attention on organizing after-school activities in day cares, schools, etc. Also, it’s important that they would be for free or may have a minimum price.“ (S1); „Thoughtfully spent leisure time <...>“ (S10); expression of interest („opportunity to realize one’s interests (books, movies...)” (S11), „remembering the past” (S18)), integration, communication („understanding” (S19), „taking care of family members” (S17), „society must be informed more about people with mental disorders, only then they will understand and accept them as they are – people who need special help and care, not people who are stupid and dangerous to public. And then they will reveal their desire to help those people and improve people with mental disorders quality of life” (S12), „communication with family members improves their well-being” (S12), „life as a member of family” (S13, S14), „grandchildren” (S15), „attention and care from family members” (S16), „family” (S17), „taking care of them” (S19), finances, material and immaterial aid („caretaking, attention” (S18), „medical care” (S11), „regular medical supervision, opportunity to get social help“ (S20), „professional help” (S21), „care” (S22). According to social workers, these subcategories are the ones which would improve life quality of people with mental disorders. Respondent S7 noticed that „people are most happy when they accept an illness, can notice relapses on time and go into hospital immediately, also survive without raising credits.“

Social workers activity opportunities in this area are listed in Table 13.

Table 13

Areas that can be improved

According to social workers	Opportunities
Extracurricular activity	To encourage graduate school, available

	classes and help to find job.
Communication	Encourage not to withdraw into oneself and to communicate more with people around.
Integration	To encourage participate actively in community life

In social workers opinion extracurricular activity, communication and regular integration may improve life quality of people with mental disorders. These areas may be improved by encouraging them to participate in various sociality and other activities, also looking for job and favorite leisure activity, visit day care centers, where they can find friends and affinity group.

According to Valeikaitė (2003) (cit. Valantinaitė, Dačiulytė, 2009) areas like carrier and creative work, relaxation, leisure and intimate relationship are very closely linked in this persons life (see Table 14):

Table 14

Client leisure activities and hobbies

Category	Subcategory	Supporting statements (clients)
Leisure	Active leisure	„Cycling in the summer, strolling in the winter” (C4); „<...> even in the same Klaipėda...or outdoors go and have barbeque, then come back..” (C2), „<...>, Feed Julia <...>” (C3)
	Passive leisure	„<...>Watch a good movie...even the one that I already got in CD...put in...start watching some kind of soap opera <...>” (C2); „Ekranas” (C6); „Oh I like to watch wrestling matches very much” (C3); „Both me and my husband we are home-birds” (C1).
	No leisure	„<...>When my health has gotten worse I had no interest in doing something <...>” (C5);

Respondent C5 states that when she starts feel unwell she doesn't want to do anything, she walks from corner to corner or just lies down. When she feels fine she does chores because there is no other leisure that could give satisfaction.

Respondent's C1 leisure time is also passive; she admits that she and her husband are home-birds and because they have health problems they don't need any journeys unless if there are necessary with financial opportunity.

Respondent C2 states that she doesn't have time for leisure because of work. She gets home late and does chores and then goes to sleep. There is some time to watch TV or use computer but only when she has day off. During summer time she manages to getaway to the beach or outdoors for one day and tries to keep close relationship with her family – husband and daughter. Also, likes to watch old Indian movies or other melodramas, listens to the peaceful relaxation music. („<...>also the same relaxation music...with my headphones on.. <...>” (C2)).

Respondent C6 in old times liked to read books, to take photographs and to develop them himself. He had his own stand in school. Also, he liked to work with technique. However, because of his physical disability and hand tremors he no longer reads, takes photographs or works with technique.

Respondent C3 believes that her leisure time is when she feeds her guinea-pig or do choirs. Also, she likes listening to the music, watching wrestling matches and sometimes movies. („I spend by listening to the music, feeding Julia” (C3)).

Meanwhile respondent C4 listens to the radio on his leisure time („Listening to the radio, listen to the TV” (C4)), watches TV, sometimes goes cycling during summer time and during winter goes for a stroll.

Social workers also represented their remarks about clients’ leisure time activities (see Table 15):

Table 15

Clients’ leisure time activities according to social workers

Category	Subcategory	Supporting statements (social workers)
Leisure	Active leisure	„<...>picnics <...>” (S4,S6); „<...>sports activities <...>” (S1), „<...> exercise” (S2); „Exercises, Nordic walking” (S4, S6), „<...> group exercising with singing” (S5) „Strolling” (S15, S16, S22).
	Passive leisure	„Children adore creative working, pottery<...>” (S1); „some like needlework” (S2); „Art therapy” (S4, S6); „Drawing <...>” (S5); „all therapies are well-liked (art, music, ergo, motion) <...>” (S7), „Art therapy, relaxing therapies”(S8), „<...> glee-club” (S1).

Social workers maintain that everyone has their favorite activities and they are different. They choose favorite activities according to needs and interests. In hospitals they like individual social works and group psychotherapy a lot.

Summarizing answers from respondents we may say that most of the respondents are passive people („Musical relaxation <...>” (S9); <...>cinema <...> (S4, S6); movies (S9, S14, S17); „ Drawing” (S15); „They like drawing, singing, playing table and sports games” (S12); „Talking, calling and talking, watching TV, reading” (S11); „bird feeding” (S13); „art” (S20); „crosswords” (S21); „checkers” (S22)) and they don’t want to be involved in extracurricular activity, which could help them not to think about their disability and integrate into society much easier. Respondent C6 can’t enjoy his leisure because of his physical health. Hand tremors prevent him from activities that he used to like – book reading, photography, and technical works. Respondent C2 mentioned that she used to like knitting but now she had to give up this activity because of joints pain. She liked reading as well but now her eyes start to flicker and also she feels vertiginous.

Social worker's activity opportunities are listed in Table 16.

Table 16

Activities that can improve quality of life

According to Social Workers	Opportunities	According to Clients
Active leisure	To organize trips to various places of Lithuania.	Active leisure
Passive leisure	To organize cinema nights.	Passive leisure
No leisure	To encourage to participate in community life, visit day care centers.	No leisure

It's recommended to organize various trips, friendly cinema nights, to encourage participate actively in community life and other activities. That will help clients to choose appropriate active or passive leisure activities and also they will spend more time with other people.

Institutions where respondents have been treated (clients' answers)

Today we know that mental disorders are caused by serious illnesses. Doctors and people try more to integrate people with mental disorders into our society and give them the same rights like we have. That's why this question was raised in order to find out what institutions our respondents visit or is treated and who gives them assistance. From respondents answers we see that all six participants of this study get both medical and pharmaceutical treatment. One of the respondents (C3) is treated by a family doctor, also visited psychiatrist. Other five respondents (C1, C2, C4, C5, C6) regularly visit psychiatrist, psychiatry center, psychiatry hospital or psychiatry center: „Psychiatry center” (C6), „Šaukėnai hospital” (C5), „psychiatrist Stulpinas” (C4), „stationary treatment among other people like me<...> “ (C2), „psychiatry center” (C1).

All six respondents are treated by using medical tools, also they drink pharmaceuticals. Respondent C1 participates in day-patient sessions, attends therapy „<...> during visitations in a day care center they let to participate in exercising, give that lamp, that one to improve your condition, for stress relief.” From all respondents only two of them, C1 and C2 are treated not only with pharmaceuticals. Respondent C2 also receives stationary treatment, light therapies: “Yes, light therapy, if I'm not mistaken”. Other respondents don't participate in any extracurricular activities that could help them to relax. Respondent C3 claims that there is one day care center which she would love to participate in but she can't because she is partially paralyzed. That care center accepts only people who are fully paralyzed. „<...> they don't let me in (giggles). They say that I'm healthy and they need a person who can't walk at all. We been there, saw it”.

In summary, we can conclude that people with mental diseases can get help from professionals, but it's important to remember that family, friends, and community have significant role to play here too. Family and friends should encourage ill people to see a doctor and start treatment as soon as possible. That helps not only to ill person but to his family as well. Family support is the most important that's why family members must show their sensibility and be ready to help anytime.

Professionals that help most to people with mental disorders (according to social workers and clients)

This issue concentrates on how respondents with mental disorders get help from social workers and professionals' with non-medical education that are influenced by medics and try to be respondents helpers. Then it was compared to answers received from social workers. Social workers main goal is to help solve rising problems.

Table 17

Professionals that help clients according to social workers

Category	Subcategory	Supporting statements (social workers)
Help	Medical service	„Team of professionals: doctor, psychiatrist, mental health nurse, <...>, psychologist” (S3, S8); „Physiotherapist” (S1); „If there is speaking problems – firstly speech therapist” (S1).
	Non-medical service	„Social pedagogue and special educational needs teacher” (S1), „<...> social worker, <...> occupational therapist” (S3, S8); „ Occupational therapist” (S4, S6, S8).

When we asked social workers opinion what professionals help most to people with mental illness, they answer was that the whole team („Firstly psychiatrist because mental illness needs medical treatment” (S7, S8); „Psychiatrist, psychotherapist, psychologist and social worker” (S11).

Respondents from Ukraine distinguished medical care centers help: „psychiatrist or psychotherapist” (S12), „special institutions” (S13, S14), „medical institutions” (S15, S16), „special divisions” (S17), „at hospital” (S20), „psychologists, psychiatrists” (S18), „psychologist” (19), „ psychiatrist” (S22). Bigger part of respondents from Lithuania (social workers) distinguished professionals that have non-medical education: „Social worker, social assistant” (S4, S5, S6, S8, S9), „ occupational therapist” (S4, S5, S6); „social worker” (S9).

Table 18

Professionals that help clients in clients' opinion

Category	Subcategory	Supporting statements (clients)
		„Doctor” (C2); „My family doctor treated me” (C3).
		„Doctor Juškaitė, doctors in Kelmė” (C5, C6)

Help	Medical staff	„ Psychologists” (C1); „I was hospitalized in Šaukėnai hospital <...> later in Šiauliai” (C5); „I get my medications from psychiatrist <...>” (C6).
		„Psychiatrists” (C1); „at first when I had crisis we went to psychologist <...>” (C4).
		„ psychotherapist” (C1, C4).
	Non-medical staff	„<...> From the very beginning I contacted by phone, I don't remember what help was that<...>” (C2)

After talking with patients who have mental illness we found out those respondents did not get much help from social workers. When we asked if they communicate or collaborate with any kind of non-medical professionals, only one respondent (C2) mentioned that first help that she got was when she picked up her phone and rang to helpline. Other respondents have not communicated with non-medical staff. That's because: „my case is difficult and only professionals can help me” (C1), „incommunicative” (C4). Other respondents did not indicated reasons why they don't communicate with non-medical professionals.

After reviewing respondent answers we see that most of the respondents, both clients and social workers, think that people with mental illness because of their condition should communicate, cooperate be consulted not by one but by several professionals. Respondent C1 mentioned that psychotherapeutic groups help is the best because professional can notice that you need to speak out and gives you that chance. Family plays a big role in patient's life. Family which is ready to help, listen and understand.

Taking care of people with mental disorders (social workers)

Despite improving treatment opportunities and positive changes in mental care people suffering from mental problems or mental illnesses still have to face social exclusion, condemnation, discrimination and disrespect to their main rights and dignity („Žalioji knyga...“, 2005). Definitely the most difficult and important obstacle in our times is being ashamed of mental disorders. This shame gives birth to discrimination by the same people who have disorders, their family, facilities and their staff that provide services to people with mental disorders, and even the place where this facility is.

Table 19

Inadequate care for persons with mental disabilities by social workers

Category	Subcategory	Supporting statements
Environment	Support	„<...>question of incompetence<...>” (S4, S6) „<...> you need half a year to finish paperwork for getting incompetence” (S5) „<...>safe houses<...>” (S4)
	Stigmatized attitude	„<...> one of the biggest problems is society's stigmatizing attitude towards person with mental illness” (S10).
Interpersonal relationship	Cooperation	„<...>missing system between different institutions related to mentally ill people that could help to communicate easier

		<i>with each other“ (S1).</i>
	Communication	<i>„It’s hard for family members to understand what is an illness. Very often they think that disabled people are just messing around or put not enough effort. In the course of time they get tired and turn away. In stationary hospitals they get help but they lose it <...> when they come back to reality. <...>“ (S7).</i>
Financial status	Lack of finances	<i>„<...>not all laws function because of the same lack of finances“ (S9).</i>

In summary, we may state that 20 respondents out of 22 (S2, S3, S4, S5, S6, S7, S9, S10, S11, S12, S13, S14, S15, S16, S17, S18, S19, S20, S21, S22) think that we don’t care enough for the people with mental illness, because we haven’t solved incompetence problem, not all laws function because of the same lack of money, these people don’t have safe houses, only stigmatized attitude towards them. (*„Countries attitude is stigmatized “ (S2)*), there’s no support for independency (*„<...>supporting independency“ (S4, S6)*), also lack of family support. Respondent S12 claims that: *„Of course we create projects but they are developed to slow. Society looks at mentally ill people with incomprehension, danger and fear“*. Respondent S10 thinks that, there’s *„enough of primary help, especially medical, but later on during the reintegration time opportunities of self-realization are missing“*. Also, other two respondents (S1 and S8) think that there is enough of care. Respondent S1 claims that *„<...>aid is granted, but we are missing one common system between different institutions related to mentally ill people that could help to communicate easier with each other. That would make everything much easier especially for the patients, also information would be available to all professionals.“* Respondent S8 thinks that *„Non-governmental organizations take care of people with mental illness, they use European Union funds to establish day care centers, hospitals.“*

Table 20

Social worker potential activity areas

According to social workers	Opportunities
Financial support	To look for opportunities how to improve quality of life, how to raise disability pension or find sponsors who could support with food, clothes or financially.
Stigmatized attitude	Spreading the word about people with mental disorders, their problems and their solutions.
Cooperation	Cooperate with all possible institutions which can help your patient.
Communication	Provide information to patient families and support them, encourage them to communicate with their ill family member.
Lack of finances	Help finding job or other opportunities how to improve quality of life, raise pensions or find sponsors that could help with food, clothes or financially.

In order to improve areas that according to professionals we don't pay enough attention and to improve people with mental disorders quality of life, it's recommended: to look for opportunities how to improve quality of life by raising disability pension or finding sponsors who could support with food, clothes or financially; spread the word about people with mental disorders, their problems and their solutions to both their families and society. Communicate and cooperate with other various institutions; to encourage getting profession, and provide help during job searches.

People with mental illnesses well-being in community (according to social worker and clients' opinion)

In order to change society's opinion about disabled people we need to change community's attitude towards disabled ones. It's important to involve disabled people and their families into community work where they can socialize, find themselves, and be more active and independent. Without this development there will be no positive attitude. When community will be able to meet, communicate with disabled people then they will know more about them and their attitude towards them will change faster. Very important social aspect is to respect the difference.

Five social workers from Lithuania state that people with disorders feel different in community: *„They definitely feel different. For example, during trips they attract healthy people attention. Once we were in public swimming pool and I heard negative remarks towards them like what these fools were doing there“* (S4, S6); *„They think they are forgotten, unwanted“* (S9); *„Yes, you can feel from their intonation that they feel outcasted, unpopular, derivative“* (S3); *„They feel different because society looks at them through prism and maybe they are afraid of them“* (S2). One of respondents (S7) claims that everything depends on the persons and his attitude, if he feels sorry for himself or not. She thinks that other people treat them as different more than they treat themselves: *„When a person feels sorry for himself then he treats himself as different, and often he complains that people around him are afraid. However, I think that strangers treat them as different more than they do themselves. Very often they hide in what hospital they have been treated, hide from their friends or neighbors that they been seeing shrimp. Also, don't want to show up with a social worker publicly in case they may be recognized or linked with psychiatric hospital.“* Three respondents (S5, S1 and S10) occasionally encounters with people who are not self-critical and don't complain or feel that they are different. Very often children want to belong together with non disabled people. However, they are insulted a lot and feel disappointed and retire into oneself: *„Normally, people who are not self-critical don't complain“* (S8); *„ I didn't noticed them feeling different. Even if they do, they don't show that and don't say anything“* (S5), *„Children until they become teenagers don't feel any special difference between normal and mentally disabled people. Disabled children*

when they are older still try to adapt with healthier one. They try to please them and keep up with them. However, very often they became mocking and bullying objects. After experiencing frustration disabled children distance themselves, become self-contained, angry and negative. “ (S1).

One respondent (C3) at work communicates only with people who are disabled: „Yes, we communicate... They are also disabled.“ She proposes that colleagues who don't have health problems can't understand them and asked does that make her feel rejected, she answered: „We do... <...>“. Other three respondents from this study (C1, C4, C6) also feel rejected and unwanted: „<...> had to hide why I got ... this disability, hide that it is a depression because it is inappropriate in this society. I told everyone it is a spine problem.“ (C1); „<...> country doesn't need people like us <...> if you became disabled <...> you have no connections<...>, no money or even more you are poor<...> every cripple who was healthy before and became disabled can confirm it<...>. You are true outsider, nobody needs you, you are not able to adapt, that's what I thought when I was healthy“ (C6).

Couple of respondents (C5 ir C2) doesn't feel rejected or ignored by community. They feel normal, communicate with neighbors and co-workers and haven't noticed that people look at them differently: „no, no, no... I am what I am... those who were my friends before disability speak and communicate with me now as well, it hasn't changed, everything is the same...like now“ (C2), „I don't think so, everyone's so supportive and pity that I have such disease“ (C5).

In Lithuania we still have negative medical attitude towards disabled people. Disabled person is seen as a unit of one or several diseases that needs to be treated. Peculiarity of medical attitude is that person is considered as a problem (for society, family, school) which can't be cured and that's why discriminative help is suggested: to imprison disabled people in specialized institutions (Ruškus, 2007). Social workers were asked into what group they think mentally disabled people would assign themselves. Mentally disabled people were asked into what group they would assign themselves. Results listed in Table 21.

Table 21

Social groups to which client assign themselves (according to social workers)

Category	Subcategory	Supporting statements (social workers)
Physical functioning	Non-disabled people group	„Unemployed“ (S5, S10); „...normal people“ (S5); „<...> same like other community members“ (S4, S6); „healthy and full-fledged people“ (S16).
	Disabled people group	„Assign themselves to disabled people usually if they can understand that “ (S4, S6, S8, S7); „ often call themselves as cripples“ (S9); „think of themselves as disabled, invalids“ (S3); „as a disabled person“ (S2).

One respondent (S7) states that „ *everything depends on people personal skills, they vary. However, most of them assign themselves as disabled ones. Sometimes others say they don't feel different. It depends on the illness.* “ Respondent S1 works with 3-18 year old children, and states that „*Children and teenagers try to assign themselves to a group which is popular in the community <...>. Children with mental illness easily surrender themselves to a persons or groups influence which has biggest authority to him or manages to involve him into a group that exists. However, these children later on became victims or common principals because these type of children are used-up by bad people or groups.* “

None of respondents with mental illness assigned themselves to disabled people group. They identify themselves as citizens with good health, workers, and house wives: „*Group of workers*“ (C2); „*Category of house wives* “ (C1, C5); „*Healthy ones*“ (C3); „*ordinary people group*“ (C4); „*Loner*“ (C6).

Summarizing answers from respondents in Ukraine we may state that according to Ukrainian specialists' opinion most people who have mental illness feel different. („*With chronic patients, the disabled*” (S11); „*Rejected*” (S12); „*Hopeless*” (S13, S14); „*group of sick and inadequate*” (S15); „*with a child*” (S17); „*most miserable*” (S18, S22); „*unwanted people*” (S19); „*old, sick*” (S20); „*forgotten*” (S21). Social workers who cooperate with them feel and understand that and wish to reduce this social isolation by helping them to integrate into community. In order to change this opinion we need to bring them and their families more often into community's life. 7 Lithuanian respondents out of 10 think that clients assigned themselves to disabled people group. However, results show that clients don't want to be assigned to disabled people group and assign themselves to other groups like: house wives, workers, healthy, normal people, and loners.

Changes in public attitudes (responses from social workers and clients)

With the examination of the previous question we have established the well-being of individuals with mental disabilities in the community. Both the responses from these individuals and the responses from social workers reveal that clients feel different. With regard to the next question, it was sought to hear respondents' advice, which they believe could change public attitudes towards people with health disorders while also reducing social exclusion (see Table 22):

Table 22

Public attitude change from the perspective of social workers

Category	Subcategory	Supporting statements (social workers)
	Inclusion	„ <i>More integration into society is needed</i> ”(S2);

Integration	Education	„More positivity and a spread of transparent information” (S4, S6); „More education, material and social support is necessary” (S9). „It is necessary to change not only the attitudes, but also the very environment in which the child lives and with what kind of children he or she communicates” (S1). „Relatives have a hard time accepting that their loved one is suffering from a mental illness, behaves inadequately because of that illness, becomes rude, disrespectful and etc.”(S5).
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Respondent S1 thinks that parents themselves by protecting their children from the environment actually harm them, because it becomes more difficult for these children to face the real world: „Often parents, who are raising children with disabilities, try to protect their child from the environment in which this child lives as much as possible. However, the outcome is such that once the child is exposed to the real world, it is more difficult for this child to accept everything he or she was protected from”. Respondent S7, through the personal work experience, has noticed a number of incoming students who are afraid to interact with mentally disabled persons, and choose internships in the hospital only because there are no other options left. However, at the end of it, students often leave having changed their opinion: „It can often be observed with what kind of fear young students come to the hospital to do an internship, they are especially afraid to visit hospital departments and talk to people. But, at the end of the internship, fear withers away. I asked several students why they chose an internship in a psychiatric hospital, and they said that there were no other places left”.

Table 23

Public attitude change from the perspective of clients

Category	Subcategory	Supporting statements (clients)
Integration	Inclusion	„<...> business has to develop in order to provide people with employment <...> this is also financial assistance <...>” (C2).
	Education	„A little bit, even the media and television covers it, and now, whenever they say something, I am just sitting in front of the TV screen thinking that never have I heard about us being the way we are portrayed. If there was at least someone who would make a decent speech, because now you can only hear brief references <...>.” (C6).

Only two respondents with a mental illness, who participated in the survey, gave advice on how to facilitate the integration of disabled people into society, so that the minimal social exclusion would be felt. They suggest informing the society about these people and their illnesses, and allowing them to engage in work and leisure activities („Persons with mental disabilities should be actively involved in the public life with the help of specialists” (S8)).

In summary, it can be argued that social workers with considerable experience in their field have a number of suggestions on how to reduce social exclusion. Social workers as well as clients think that there is a lack of information dissemination and common activities. They also hold that there is a need for more integration into the community and for a change of the very attitudes towards the surrounding environment, and it is necessary for families to be more understanding towards the relatives who are ill.

Table 24

Social work opportunities when changing public attitudes

According to social workers	Opportunities	According to clients
Education	To familiarize families and the community with people who have mental disabilities, the problems they encounter and possible solutions. To prepare articles for the local press, community website and other.	Education
Inclusion	To organize and promote participation in common activities, events, trips, and employment workshops.	Inclusion

In order to alter public attitudes towards people with mental disabilities it is recommended: to familiarize families and the community with people who have mental disabilities, the problems they encounter and possible solutions while also actively spreading relevant information about persons with mental disorders and their problems with the help of the media, the Internet and television.

A social worker becomes semi-invisible changer of public attitudes towards persons with disabilities by working within meso-, exo-, macro-systems.

Clients' well-being (physical health, sleep, recreation) (social workers and clients)

Furmonavičius (2001, 2004) points out that health, related to the quality of life, is normally examined in a narrower sense, limited to those aspects that are directly linked to the health of people, i.e. physical, psychological and social health levels. Health-related quality of life research is of a great importance and significance, because it helps to assess the effectiveness of treatment, and of programs designed to improve health and prevent diseases, it is also useful when monitoring the state of public health and developing country's health policy.

Social workers in Ukraine were asked whether the moods of clients change frequently. Respondent S12 believes that: *„everything depends on various factors: how we communicate with the client? What task is before him? Who talks to him? Whether the requirements are met? Even the weather has an impact. This is why work with such clients requires special abilities and skills. Generally, complaints about health arise in the spring or autumn periods, usually mental*

aggravation takes place during these periods” (S12). 8 respondents (S11, S13, S14, S15, S16, S17, S20, S21) are constantly faced with mood swings, one respondent (S18) faces mood swings periodically, for one respondent’s clients (S22), moods change even in her presence, and another respondent (S19) asserts that she does not come across mood swings.

Respondent (S1) who works with 3-18 years old children in Lithuania, states that children who live under normal regime rarely have complaints about physical disorders or a lack of rest, *„Children rarely complain about physical disorders. Their sleep and rest, living according to normal rhythm, are not negatively affected”*. The respondent says that children usually complain about rejection and bullying: *„Children often complain that they do not have friends, that they are rejected and bullied in the classroom. Children from financially struggling families cannot be equal with their peers in terms of possessed items and hobbies.”* From the view of respondents S4 and S6, complaints depend on a type of person: *„depending on an individual, as everywhere else. One is more tolerant, the other whines about everything.”* Respondents who took part in the survey, social workers, claim that complaints are the main topic of their clients: *„First they complain about health, then about financial situation, since they find it difficult to get a job”* (S2); *„They often complain, claiming that their entire body hurts, that their head is heavy, blood pressure is elevated, that they are in no mood and etc. <...> inactivity, feeling unwell, fallen energy potential”* (S3); *„People suffering from a mental illness often do not want to do anything, are not interested in the surrounding environment, spend the whole day in bed complaining how tired and unwell they are feeling”* (S5); *„Lack of communication and health”* (S8); *„It hurts everywhere to them, they have sleeping disorders. Naturally, when they sleep poorly, the physical health is also worse than after having a good rest”* (S9); *„In the beginning, rehabilitation clients very often have complaints about their physical health, insomnia, and anxiety attacks. They often claim that they have spent a sleepless night”* (S10).

Respondent S7 claims that *„Sleeping disorder is one of the psychological disorders, meanwhile, good, undisturbed night sleep and waking up well rested is a sign of recovery. Sometimes clients also have somatic disorders. Often this is the consequence of a mental illness, sometimes – a psychological disorder.”* It is also said that complaints depend on a specialist: *„when speaking to a doctor, health disorders are usually discussed, when speaking to a social worker, it comes to discussing social problems and social exclusion”*. One respondent (S11) asserts that client complaints are not common, while other ten respondents (S13, S14, S15, S16, S17, S18, S19, S20, S21, S22) claim that they hear complaints very often or on a daily basis.

Respondent C6 is afraid to both boast and scold his well-being, and claims that *„it is better than sitting in a wheelchair, I am able to walk little by little <...> it is better to move, even*

briefly, so that some muscles could be restored.” Falls asleep or rests only with the help of drugs or alcohol, „drugs or, also, alcohol.” Respondent C3 has kidney problems, gets tired quickly: „well this is true, with the kidney problems I get tired quickly. Kidneys, I want to lie, lie, lie <...>”. As regarding sleep, there were no complaints, she says that sometimes she sleeps well, sometimes not, it all depends on her going to bed early „<...> you go to sleep early, then you wake up half past five, and then you fall asleep again, then you sleep poorly and then again wake up early.” Respondent C5 claimed that she does not know how to describe her physical well-being: „<...> it feels bad on the whole. <...> it does not hurt, but I somehow feel inferior”, she does not complain about the lack of sleep or rest, but says that after getting up in the morning there is nothing she wants to do, „<...> you wake up in the morning and walk from one corner to another”. Respondent C4 claims that there are people who are in a far worse situation than himself: „those not controlling their arms, those who cannot walk, those sitting in a wheelchair <...>”, he says that without medications he would be worse off, and that by stopping to use them he risks to end up in the hospital. Respondent C2 suffers from spine and leg pains, and she wants to lose part of her body weight, „if the spine and back pain was removed, if the legs I had 20 years ago were returned to me <...> my body weight was reduced...then my physical condition would be entirely different...” She claims that she needs only little sleep, she sleeps well, but cannot fall asleep if someone from the family is not at home, she worries, „<...> I will definitely not fall asleep until they return <...>”. Respondent K1 complains about both physical and psychological health, „you walk home all angry... then you come home, go to sleep because you do not feel well...you do not have the strength to go to the store, you have some sleep and only then you go to that store”.

After analysing the responses of respondents, both social workers and clients, we notice that all clients have mood swings, complaints, physical and psychological health disorders, which they complain about and which complicate their daily routines. Physical and psychological problems are inhibited with the help of medications. Social work opportunities for improving clients’ health are presented in Table 25:

Table 25

Social work opportunities for improving the health of clients

According to social workers	Opportunities	According to clients
Physical health	To encourage more movement, attendance of sports activities.	Physical health
Psychological well-being	To promote activeness so that a person would think about his or her disability as seldom as possible, and would not feel sorry for himself/herself.	Psychological well-being

Physical health and psychological health are the spheres most complained about by the clients. In order to improve their physical and psychological health it is recommended: to promote active engagement in physical activities so that a person would think about problems less and would not pity himself or herself.

Attendance of non-medical institutions (responses from people with mental disabilities)

Successful activities and life of disabled people is determined by person's activeness, personal qualities, family stance and its support for the affected individual. Various forms of informal education provide an opportunity to alter community attitudes towards the disabled. The participation in the events is made available not only for the affected individuals, but also for their family members.

In the summary of study findings, it is evident that respondent C5 attended Kelmé Association of People with Disabilities 20 years ago, but today she does not belong to any organization. Respondent K6 does not attend anything yet; one of the obstacles is his residence and the lack of transport options. Nevertheless, he would like to attend massage treatments or yoga. He would not mind attending some sort of organization connecting people with disabilities, but he does not have enough information, he does not know whether such organizations exist in Kelmé, and the major problem is communication – „*need to travel*”. The other four respondents who participated in the study (C2, C3, C4, C1) are not involved in any activities organized by non-medical institutions. Respondent C2 claims that she was invited to attend activities of the organization for the disabled people, but she refused and did not mention any reasons behind the refusal. Respondent C3 says that she would like to be a part of one centre, but she is not welcome there because she suffers from partial paralysis while the centre accepts only completely paralysed individuals. When asked whether they are familiar with the activities undertaken by the disabled people in non-medical organizations, in response to this question most of the respondents mentioned sports (tennis, checkers, chess), going to matches, having an opportunity to use fitness equipment, play games, read books, and to stay alone for a while if necessary. Two respondents, C3 and C5, did not express their opinion on this question, and two respondents, C6 and C4, do not have a general view on activities of non-medical organizations since they have never heard or encountered them.

To summarize the responses received, it can be concluded that clients are not provided with enough information about non-medical organizations and their organised activities since only two respondents out of six have identified activities that can be undertaken at these institutions.

The respondents do not have an opinion about the benefits of attending non-medical organizations for people with mental disabilities. They do not know if this helps, whether it improves life or not. Respondent C4 thinks that it would not help him, while respondent C2 claims that he thinks that maybe it might help: *„In fact, yes...if a person attends such an institution, if he has any questions or concerns, or anything else...well this disorder...in fact, who else would he approach, only this specialist is at hand. If a person from the street works there and he will not know how to deal with this individual...I think it is exactly those people who are found over there...”*

Financial support received from the state (opinions of social workers and clients)

During the course of the study, the aim was to find out the opinion of all respondents who participated in surveys on the topic of financial support, whether it is sufficient to secure a good quality of life. All six respondents who participated in the study and who have a mental disability (C1, C2, C3, C4, C5, C6) receive disability pensions, which are supposed to contribute to the improvement of respondents' material quality of life, given that the majority of respondents do not have employment opportunities or their employment chances are hindered by poor health. Only two respondents (C2, C3) who participated in the survey are employed. Some respondents claim that their income is sufficient for subsistence; others say that it is not enough. Respondent C2 finds disability beneficial as of this day, she claims that if she was healthy it is doubtful whether she had a job, thus, current remuneration and allowance is enough for her, the husband also receives a salary, *„husband has a salary, wife has a salary, I contribute aswell, hence, two salaries are two salaries, after all...”* Respondents say that: *„I felt better when I could work, because I felt like I could fully support myself, but now when I am left with a disability, it is true, there is stable permanent income provided, of course it ensures financial security, but I felt better when I was paid for my work”* (C1); *„<...> so that it would be enough for drugs and everything else, I do not know how much a person has to receive in a form of pension, for example, I have no clue how much they have to get”* (C4); *„Well yes, it is very difficult <...>”* (C5); *„<...> How much pension money do I get, I do not get much. Enough to cover flat-related expenses and that's it”* (C3); *„The fact is that I do not have any special needs, at least I have something to eat here <...>”* (C6).

Respondent S1, who works with children, claims that their finances are managed by parents, *„Children only receive disability-related money, but those are managed by their parents. Children with mental disabilities are not worried about subsistenc”*. Seventeen respondents (S2, S3, S7, S8, S9, S11, S12, S13, S14, S15, S16, S17, S18, S19, S20, S21, S22) claim that allowances received by people with disabilities are not sufficient, and it is difficult to survive on them alone: *„They really have low income, because a lot of it is spent on medications.*

It is especially difficult for young people, who do not have seniority and receive benefits” (S2), „Challenging” (S3); „it is difficult to survive only on the social benefit money. Work incapacity benefit, in case there is enough seniority or ability to work is lost at a young age, allows for a freer life. Of course it is possible to subsist, given that there are sufficient social skills, and expenses and income is properly calculated” (S7); „It is really hard to subsist. Some are assisted by relatives, others additionally receive food coupons and other support from the state” (S8); „I think, not. It is a very small amount of money, having in mind that a person has a disability, is partially or completely unable to work, and needs drugs, and so on” (S9). „No. Unfortunately, disability benefits and pensions are so low in our country, that it becomes very difficult to meet minimum needs based on current prices” (S12).

Two respondents claim that it is enough for partial subsistence; however, if you want these people to stand out from the crowd less, it is necessary to invest in their appearance, *„Partially, yes, but if you want the person, who is taken care of, not to differ from others in terms of clothing, haircut, lifestyle, it is necessary to plan and calculate everything” (S4, S6). S5 respondent who took part in the survey claims that for people, who have disabilities, received benefits are sufficient, because they get a range of compensations, „I think it allows, since those who have low pensions, also get compensations for various services, such as heating, hot water” (S5). In respondent’s S10 opinion, it depends on a person, because some rush to spend money on services and products that are not of primary necessity, „Depends on an individual and on the place where he lives. There is a type of clients, who, once received, hurry to spend social benefit money on things and dainties that are not of primary necessity”.*

We can conclude that persons with mental disabilities find it difficult to subsist only on the basis of received benefits, and it is also hard if they happen to live alone. Financial situation is facilitated by working family members or the disabled people themselves if they are able to work. Social workers also think that allocated allowances for the disabled are too low to secure a good quality of life.

Problems that persons with mental disabilities have to face (responses from social workers and clients)

The problem can be defined as a situation that does not satisfy us, but we do not know how to overcome it, the task that we cannot solve, the situation that requires theoretical or practical knowledge. All of us react differently in different situations, some problems seem to be huge for some people, while others see no problem there, but find an opening opportunity instead. Tables 26 and 27 identify the main problems that persons with mental disabilities encounter, from their own and social workers’ perspectives.

Clients' problems according to social workers

Category	Subcategory	Supporting statements (social workers)
Physical functionality	Well-being	„<...> health problems <...>” (S3, S4); „Mainly, health and communication problems” (S8); „<...> also faced with physical problems <...>” (S10).
Environment	Lack of skills	„<...> lack of skills <...>” (S3); „problems related to inability to leave the territory of a care centre by oneself, due to disability” (S6); „Questions related to the receipt of pensions in case of a sudden illness of their close relative (with impaired consciousness)” (S5).
	Inter-personal relations	„Loneliness, insularity, intolerance of society” (S2); „Loneliness” (S3); „Faced with the longing for loved ones <...>” (S4).
Finance	Financial problems	„Financial” (S15, S16); „economic” (S17).

In the view of respondent S1, „Children's families often face problems when they have to send their children to the kindergarten or school – what to choose, spec. education institution or general education? In most cases, the decision is determined by such factors as child's level of disability and where is the best place for him to be educated better and more effectively, in an attempt to avoid bullying and other negative experiences.” Respondent S7 has noticed that persons with mental disabilities tend to use quick loans, and, subsequently, a number of problems arise, „Currently, most of the issues arise when solving problems related to quick loans. For instance, quick loan companies give loans if a person receives a work incapacity pension, then these people are not able to repay, and borrow more, and, subsequently, end up being forwarded to bailiffs, courts and so on.” Also, social workers distinguish the lack of social skills as one of the arising problems („Today, most of problems arise when dealing with problems related to quick loans” (S7, S9); „Often one does not know how to manage his or her finances, lacking communication skills” (S8); „<...> the lack of motivation for treatment <...>” (S10); „inability to look after yourself” (S13); „helplessness in a household” (S18, S19, S22); „utilities” (S20); „helplessness” (S21)), as well as loneliness („broken personal relationships” (S10); „loneliness” (S14); „indifference of close people” (S15)) and insularity.

Respondent S12 claims that: „very often problems arise not for clients with psychological disorders, but rather for their relatives, firstly, because for them it is difficult to understand, accept and inform their loved one about the illness, and secondly, because they have to find a specialist who could help. They seek assistance from psychologists, while the psychiatrist help is required. Also, one of the problems to date is the cost of treatment.”

Clients' problems according to clients themselves

Category	Subcategory	Supporting statements (clients)
Physical functionality	Well-being	„Deterioration of health” (C1); „Illness that turned the life upside down, in a negative sense” (C4).
	Emotional state	„Emotional state” (C2).
Inter-personal relations	Lack of skills	„Employment when having a disability” (C1).
	Inter-personal relations	„Divorce <...> No one to communicate with” (C6).
No problems		„I don't have any problems” (C3).

As we can see, there is a respondent who is satisfied with her current situation and does not identify any problems in this stage of life (C3). Respondent C3 regards herself as a simple, normal human being, even though she realizes that she has a trauma from childhood, „hmmm...let me think...well..I..think as everyone else, like normal people, it doesn't matter, we are all the same, we belong to a group, all of us. I also wanted to be healthy. <...>”. However, the majority of respondents – five out of six – do not deny that they have problems, and are not afraid to name them. Respondent C6 holds that his biggest problem is not having with whom to communicate; he only has two companions in the village, daughter and sister, who visit on weekends whenever they can. Others, in his opinion, only want to profit once they find out that respondent C6 does not realize when he is being robbed (money, alcohol). Respondent C4 claims that when he got ill, his life changed completely in a negative sense, „people around you do not consider you to be normal.” For respondent K2 the biggest obstacle is emotional instability, desire to hurt oneself (this was done more than once), inability to handle oneself and a wish to escape from oneself. For respondent C1 the biggest problems arise from deterioration of health, not only depression, but also a number of related diseases that do not improve client's condition, and also from the decrease of opportunities to work.

When respondents are facing problems, they lack any kind of information, often people from the closest environment help. Specialist from Ukraine, who works with persons having mental disabilities, holds that „the majority of clients do not know where to seek help. This is why I think that the public has to provide cognitive information about places where they can go to get help. Therefore, the information has to be transmitted through the media.” (S12). Four respondents (S13, S14, S15, S16) think that the help is provided by social services, other five respondents (S18, S19, S20, S21, S22) think that social workers provide this help.

Persons with mental disabilities have for a long time experienced public ignorance, isolation from the community. Although Lithuania's mental health system has changed, ill people remain one of the most vulnerable groups among the disabled people, who experience

social exclusion and discrimination; this is why it is very important to provide proper help for these people, in an attempt to achieve proper integration into society while regaining lost skills (Brijunaite, 2007).

The effect of employability on self-esteem (responses from clients)

When examining individuals with mental disabilities who are seeking to integrate into the society, it is very important to find out their own view on employment and working, and how they assess all this. According to Ruškus (2002) ‘Work leads to the positive self-perception thanks to recognition from others, it determines harmonization of oneself, as a personality, because work environment is specific: fixed working hours, specific tasks for which you are responsible. Only by working with different people and material, you are able to get to know and manage your own and other people’s movements’.

Only two respondents (C2, C3) who participated in the survey are currently employed. Respondent C3 is very satisfied with her current job, *„I like glaze mixing and yogurt selection very much, I have a very good master, who allocates tasks at work.”* Respondent C2 is satisfied with her job, she likes stability, *„I am used to my work, colleagues”*, and she would not want to change anything. Four respondents do not work due to reasons related to health disorders (C5, C1) or they are not accepted because of their illness, the stay in a psychiatric hospital (C4), they think that there is no job left for them (C5). Respondent K1 has mentioned that she felt better when she was able to support herself financially, but she was ill for more days than she was able to work, therefore, it was difficult, she used all of the sick days, which are 90. Respondent C6 thinks that if he could work, his quality of life would change for the better, not only due to financial gains, but also due to rising self-esteem, going out into society, communication with people. Respondent C6 had acquired computer skills, but no longer knows how to use it. He would like to restore these lost skills and work on the computer.

From the presented responses it becomes evident that only two respondents (C4 and C6), out of four unemployed, would like to engage in work-related activities, both respondents are men. We can conclude that women respondents express themselves more in household activities, and are more insular than men respondents who would like to work only if their health would allow or if anyone would give an opportunity to work.

If it was possible to change one’s life... (responses from clients and social workers)

Table 28

Suggestions for changes in clients’ life

Category	Sub-category	Supporting statements (social workers)	Supporting statements (clients)
		<i>„Firstly, it is necessary to</i>	<i>„What would I</i>

Physical functionality	Health	<i>put efforts into their recovery” (S2); „<...> so that they would not have a mental disability” (S10).</i>	<i>change...health...” (C1).</i>
Social relations	Cooperation	<i>„I would establish more day-care centres, with accommodated safe environment and activities of their interest” (S5); „I would encourage relatives to seek help, to try to understand” (S7); „I would promote work therapy, encourage activeness outside from home and care centre. I would encourage moving and acting more” (S9).</i>	

Three respondents with mental disabilities have shared their thoughts on what they would change in their lives, if they had an opportunity, they would want to have better health, to change their profession, and to turn back time, so that they would not repeat the same mistakes. Respondent C4 stated that *„I have no idea. Where to start, so that things would go the way one wants.”*

Ukrainian social workers would change the following areas: *„Country’s attitudes, funding” (S11); „I would strengthen supervision in determination of diagnoses and disabilities, I would also want to explain to the public that people with mental illnesses are not so dangerous as we usually see them being portrayed in movies, that they are the simplest human beings, only a little different, or rather special, and that they, as any of us, have desires and needs, feelings, that they are alive, that they exist” (S12); „living conditions” (S13, S16); „relations with the close ones” (S14); „standard of living” (S17); „in spec. institutions (care, treatment, nutrition, medicine)” (S18); „environment” (S19); „increase pensions” (S20, S21); „boarding-schools” (S22).*

Lithuanian social workers would change *„Lifestyle, political system, certain laws” (S4, S6)*. Two respondents, S1 and S7, hold that there is no need to change the lives of others, instead, it is necessary to help them, and say that: *„We never attempt to change people’s lives. We try to show the places that require most attention, so that children and their families would understand on their own what needs to be changed in order for their lives to move in a better direction. Only in this way, when they can see for themselves, where was the source of problems, they are able to*

work effectively in order to prevent the reoccurrence of these mistakes” (S1); „We cannot change it, we can only contribute to the improvement of these people’s quality of life.” (S7).

In social workers’ view, we should know:

- *„What is important, is that by purposely educating and working with a child since his childhood, it is possible to achieve such a result that, in the adulthood, he will become an autonomous, self-confident individual who will become a part of the society” (S1);*
- *„It is important to provide help for a disabled person; continuous application of motivation; communication; conversations; teaching subject-specific skills” (S4, S6);*
- *„Let them live safely, taken care of by qualified professionals. Relatives could visit calm after work, not exhausted, missing their loved ones. Get advice on a disability from the specialists” (S5);*
- *„The supply of hygienic products is required (diapers, pads, rehabilitation products)” (S18, S22).*

Conclusions

- The main factors, based on which the quality of life can be measured, can be assessed through individual's physical, emotional and spiritual state, and also by the material and social well-being. The assessment of the quality of life can rest on objective facts and on individual's subjective perception. Well-being of persons with mental disabilities is closely related to a subjective assessment of the quality of life. According to the respondents, these persons mostly lack privacy, the understanding and care from the close ones, safe and adapted environment, completeness of the system, which would help them to fully integrate into society, and financial resources.
- The situation of people with mental disabilities in Ukraine is very bad. The improvement of conditions for the most part takes place only in theoretical terms. There is a lack of material and human resources in order to help people with mental disorders and improve their well-being. For citizens with mental disabilities it is very difficult to integrate into the community, labour market, to maintain a social network what is very important for people suffering from the illness.
- Persons with mental disabilities tend to be passive and often engage in passive leisure activities (watching movies, listening to music), and do not want to engage in additional activities that would help them to integrate into society more easily and maintain the quality of life. The main social services, which could improve the quality of life of the disabled people, are: leisure, self-realization, inter-personal relations, integration and financial opportunities.
- Social workers (in Lithuania and in Ukraine) have more than one responsibility in their organization, and provide different general and specific social services that improve the quality of life of the mentally disabled people. The services include communication with a client and his family, counselling, representation, communication and cooperation with certain institutions, document preparation, cooking and organization of additional activities, help with shopping, development of social skills and autonomy, dealing with the emerging problems and similar.
- Individuals, regarding their condition, consult, communicate, cooperate and ask for help from more than one specialist. The help for mentally disabled people can be provided by professionals, but it is important to remember that an important role is played by relatives, friends and community. Family and friends have to encourage the affected person to seek medical help and to start treatment as soon as possible. This helps both, the mentally disabled individual and his family. Mentally disabled persons mostly lack communication, self-realization at work and in personal life, and financial stability.

These are some of the most important needs that determine human satisfaction. Only through communication and self-realization an individual can meet the basic social needs that have a significant impact on human life and development of social skills.

- Persons who have mental disabilities do not get sufficient care, there are some unresolved questions of incapability, not all laws address financial shortages, there is no protective housing for these individuals, state's attitudes are stigmatized, there is no autonomy support, there is also a lack of support from relatives. For mentally disabled persons it is difficult to subsist only from received benefits and to live without families. Financial situation is facilitated by working family members or these people themselves if they are able to work.

Recommendations

- Purposeful work with the local community is necessary, familiarizing the residents with people who have mental disabilities, their problems and ways to solve these problems;
- It is recommended to include these people and their families in communal life more often, so that the disabled people would not feel excluded from the community or different, so that they would hear less offensive comments;
- To develop communication skills of mentally disabled people in employment workshop groups;
- To include family members in rehabilitation programs, during which mentally disabled people gain and develop skills;
- It is recommended that institutions which prepare social workers organized seminars and workshops in a field of organization of services for the disabled people, while also encouraging diversity and quality development the social system;
- It is recommended to grant more autonomy for people with mental disabilities;
- To establish more employment centres and jobs.

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Summary

Magistro darbe nagrinėjamas socialinio darbuotojo veiklos galimybės, gerinant žmonių su psichikos negalia, gyvenimo kokybę. Taikant teorinius ir empirinius tyrimo metodus, buvo siekiama išanalizuoti bendrą psichinės negalios, sutrikimų bei gyvenimo kokybės sampratą, asmenų su psichine negalia subjektyvią gerovę, trumpai pristatyti žmonių su psichine negalia padėti Ukrainoje, ištirti socialinių darbuotojų (Lietuvoje ir Ukrainoje) funkcijas ir veiklos galimybes pagalbos sistemoje asmenims, turintiems psichikos sveikatos problemų bei išanalizuoti socialines, asmenų, turinčių psichinę negalią, bei gyvenimo kokybės palaikymo veiklas dirbant su jais.

Tyrimo tikslui pasiekti buvo pasirinktas kokybinis individualusis pusiau struktūruotas interviu metodas bei individualusis giluminis interviu, taikytas klientams. Tyrime dalyvavo 6 asmenys, turintys psichinę negalią, 10 Lietuvos socialinių darbuotojų ir 12 Ukrainos specialistų, dirbančių su asmenimis, turinčiais psichinę negalią.

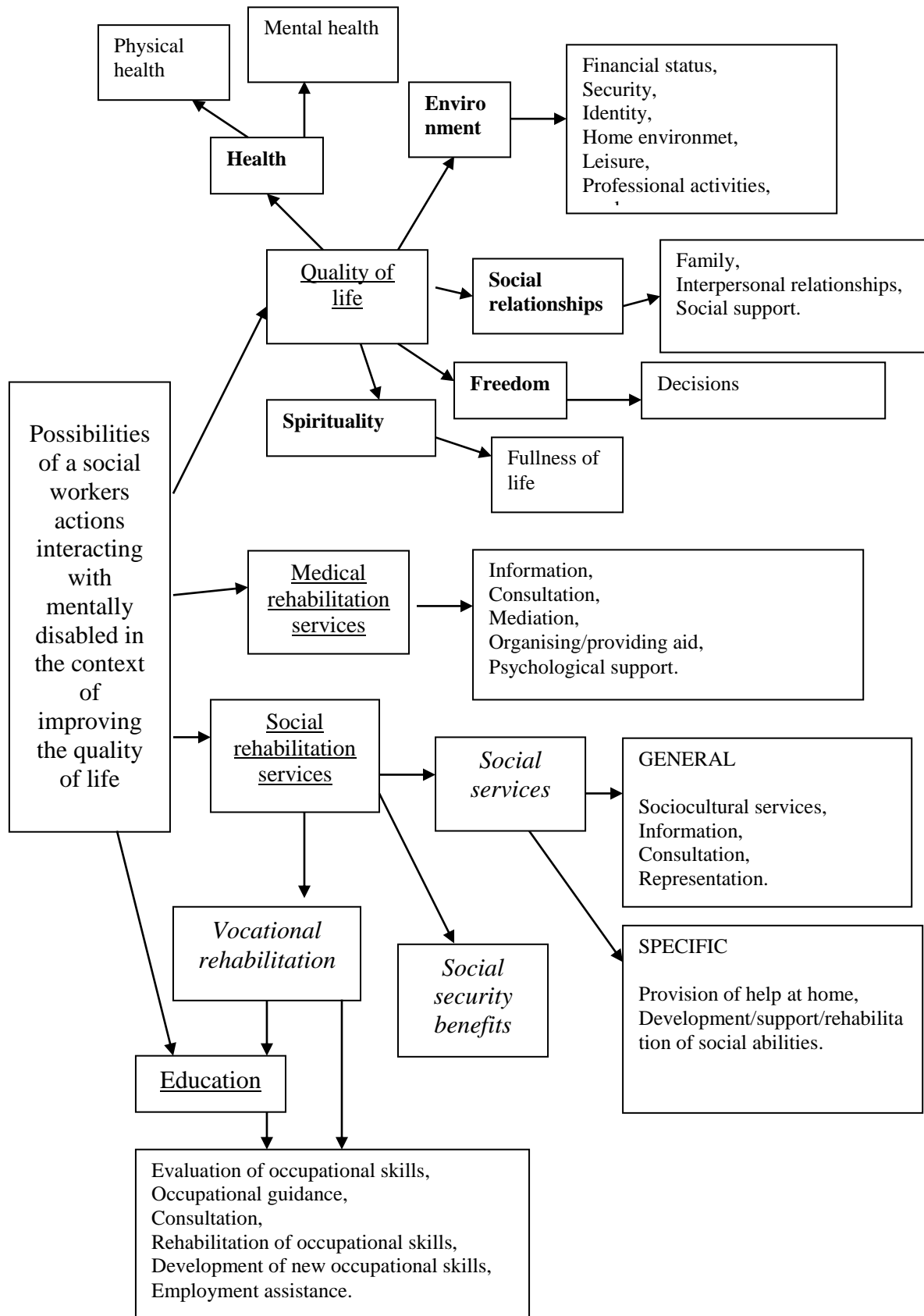
Teorinė mokslinės literatūros analizė bei empirinio tyrimo rezultatai atskleidė, kad psichinę negalią turinčių asmenų savijauta glaudžiai siejasi su subjektyviu gyvenimo kokybės vertinimu. Respondentų nuomone, tokiems asmenims labiausiai trūksta privatumo, artimųjų supratimo ir globos, saugios, jiems pritaikytos aplinkos, sistemos išbaigtumo, kuri padėtų pilnavertiškai integruotis į visuomenę, bei finansinių išteklių. Socialiniai darbuotojai (Lietuvoje ir Ukrainoje) turi daugiau nei po vieną atsakomybę savo organizacijoje ir teikia įvairias bendrąsias bei specialiąsias socialines paslaugas, kurios gerina asmenims, su psichine negalia, gyvenimo kokybę. Paslaugos apima bendravimą su klientu ir jo šeima, jų konsultavimu, atstovavimą, bendravimas ir bendradarbiavimas su tam tikromis institucijomis, dokumentų ruošimas, maisto ruošimas ir papildomos veiklos organizavimas, pagalba apsiperkant, socialinių įgūdžių lavinimas ir savarankiškumo mokymas, iškilusių problemų sprendimas ir pan.

Šį magistro darbą sudaro santrauka lietuvių kalba, įvadas, du skyriai, išvados, naudotos literatūros sąrašas (138 šaltiniai), santrauka anglų kalba, priedai. Tyrimo duomenis iliustruoja 3 paveikslai, 28 lentelės. Prieduose pateikiama operacionalizacija, giluminio pusiau struktūruoto interviu klausimai klientams, pusiau struktūruoto interviu klausimai socialiniams darbuotojams, interviu su klientais ir socialiniais darbuotojais ištraukos. Darbo apimtis – 89 puslapiai (be priedų).

Raktiniai žodžiai: Gyvenimo kokybė, socialinis darbuotojas, asmuo su psichine negalia.

ANNEXES

Operationalization



Questions of the individual in-depth interview for clients

Demographic characteristics

Age

Sex

Education

Residence (City, village)

Number of years with disability

Marital status

Occupational activity, employment

Working capacity

Medical:

1. Where do you get your medical treatment from? Which institutions do you visit for medical assistance?
2. What medical treatment do you receive? (Pharmaceutical, therapy, etc.). Does the treatment make your life easier?
3. Which professionals provide medical assistance to you? (Doctors, physicians, social workers).
4. Which of these professionals do you think helps you the most?
5. Have you met any professionals that are assisting/have assisted you, but had no medical education, were not doctors?
6. What was the biggest problem you were faced with?
7. Who helped you resolve this problem?
8. Who informed, provided guidance for assistance, when you were faced with difficulties?
9. Was there a person, whom you had a conversation with, who listened, advised and helped you, in the time, when you were faced with difficulties? Who was that person?
10. Have you encountered a social worker during your treatment? How do you think a social worker helps people?

Social rehabilitation:

1. Do you visit any non-medical institution? (Day care centre, employment centre, NGO, association of persons with disabilities, etc.)
2. What activities are you engaged there in?
3. What kind of specialists work there?
4. How do visits to these institutions help you?
5. What do these visits, to said institutions, mean for you?

6. If you do not visit any of these institutions, what do you think people with disabilities do there, who is working there?
7. Why do you think people with mental disabilities visit these kinds of institutions?
8. Do you think that visits to these institutions better the condition of life for a person with mental disability in any way?

Social services:

1. What social services are you receiving/have received?
2. Where do you receive/have received these services: at home, at the visited office?
3. Who provides/ have provided them?
4. Whom do you turn to for help, when you have insufficient information, do not know something?
5. Do the provided services have improved your condition, situation of life? In which way?
6. What social services are needed/were needed the most?
7. What social services are missing that would have the ability to improve your life?
8. What services do you wish for?
9. Who should provide them?
10. How do you spend your leisure time?
11. Do you have any hobbies? What are they?

Social security benefits:

1. Which of these do you receive: Social assistance pension, work incapacity (disability) pension, vocational rehabilitations, social pension, fuel compensation?
2. Where do you get your pension from? (Sodra, support unit)
3. Who helped you organize the required application documents for social support?
4. Does the monetary support contribute to the improvement of your life?
5. Does the monetary support make you feel more secure and stable?
6. Would you feel better if, in addition to the received support/pension, you would also have the ability to earn money?

Education, vocational rehabilitation:

1. Are you employed?
2. Where would you like to be employed, if you are not employed?
3. Do you think that you have the required competences for this job?
4. Have you heard about the vocational training for the disabled?
5. Did you have to retrain, learn a new profession after the disability?
6. What new skills did you have to learn, if you had to learn any?
7. Where did you learn them? Who taught them?

8. Would acquiring a new occupation, skills, retraining, reorientation, change your life?

9. Would these changes be positive?

Quality of life:

Physical health

Please describe your physical health?

How would you assess your abilities to complete daily household works?

Maybe you exercise, do sports?

Are you sleeping well? Do you relax?

(Depending on the answers, additional questions could be provided).

Mental health

Please describe your mental health?

What, usually, causes positive feelings for you?

Do you have negative feelings often?

Do you feel stressed or psychological tension often?

How much are you satisfied with your body and looks?

Environment

Living environment. Are you satisfied with your home-living environment? (Noise, pollution, water, air, etc.).

Identity. Which social group would you assign yourself to?

Security. Do you feel safe in your living environment?

Do you feel socially secure?

Work. Are you satisfied with your occupation, work?

How would you assess the possibilities to realize yourself?

Leisure. Are you satisfied with the possibilities for you and your family to spend their leisure time?

Which activities help you relax, rest, provide satisfaction?

Finance. How would you assess the financial situation of your family?

Social relationships

Social support. Are you satisfied with your social interactions?

Do you have connections (and what connections) with your family, neighbours, relatives, friends, colleagues, community members and other people?

Family. Please tell me about your family. Are you satisfied with the harmony in your family?

Are you satisfied with your sex life?

Freedom/Independence level

Could you state that you are in control of your own life?

How much decision making freedom do you feel you have?

Spirituality

How important is religion, belief in your life?

How would you assess your spiritual state?

Do you live your life to its fullness?

Please tell me what makes you happy?

If you could change your life, what would you change?

What else should we know that we did not ask of, but is important?

Questions of the semi-structured interview for social workers

Age

Sex

Education

Work experience

Marital status

Workplace (Social or medical institution)

Geographic location (City, village, township)

Working group (For example teenagers)

What do you think the client's quality of life is? Do you think that the government, professionals and society take sufficient care of people with mental disabilities?

Which area would you think that the clients feel displeased with the most?

(Is it that they are unemployed, or that they cannot find a life partner, or that the pensions are too small, or that the invalidity group is too small, etc.)

Whom do your clients attribute themselves to the most, which social group they attribute themselves to? *(Unemployed, disabled, house keeper, etc.) The answers to this question will reveal if the person stresses the fact of his disability, or if he identifies himself as a member of the "normal" group like other people, and is ignoring his disability.*

Do the clients complain about their physical health often?

Do you think that the received social support and work incapacity (disability) pension allows them to "make a living"?

Which specific activities do you perform at your medical institution?

Which activities would you believe have the ability to improve the quality of life for people with mental disability?

Which professional would you believe is helping people with mental disability the most?

What are the most common problems that the clients have to face?

Who, usually, helps resolve these problems?

Whom do the clients address at first, when faced with difficulties?

What aspires people with mental disability to form and rehabilitate social and independent living skills?

What social services do you provide?

What are the most necessary social services for the clients?

What social services the clients are lacking the most?

Who should provide them?

Do you encourage your client to receive an education, occupation, if not, who does that?

Maybe you had to teach your clients new skills after the disability?

Which activity is favoured most often among the clients?

If you could change the client's life, what would you change?

What else should we know that we did not ask of, but is important?

Extracts from interviews with the clients

<...> and which Professional do you believe helps you the most?

The most helpful are... Psychologists... in those groups... I do not know how to even identify them... Those, who participate, in those conversations at the day groups...

Psychotherapy?

Psychotherapy...

So a psychotherapist?

Psychotherapist...

How does he help?

Simply, by letting you speak. Not allowing everyone to speak at the same time, but allowing you to speak, when he sees that you need it... you can discuss your problems.

So that means, that there is a lack of communication?

Well... it is unacceptable in the society...

Have you met any professionals that have helped you in the past or are helping you at the moment but did not have a medical education? That were not doctors or some kind of medical staff?

I probably have not met any of these people in my life, because I clearly understand that the only people who can help me are professionals.

In general, what was the biggest problem, when you were undergoing the treatment? What problem were you faced with? Was it the lack of information, or maybe you just did not know something? If you were faced with a bigger problem, who helped you to resolve this problem

I do not even know... the hardest... probably was... when I was work incapacitated for a year... and the hardest problem... was to get employed... because it was a continuing work incapacitation... It was... now my work incapacitation got extended until retirement. I will not need to extend it anymore. It was a real headache... getting these extensions... When you know that it will expire soon, and you do not know if it will get extended or not. And the hardest part is to get employed, I had signed up at the labour exchange then... and... when you do not have the physical health, and they send you everywhere... they send you anywhere, and you cannot refuse.

So, that means that they do not take it into account...?

No.

...with some kind of nature of recommendations?

You have to present a certificate of work incapacity from the doctor... or you have to leave the labour exchange. And... also hard... I returned to the same workplace... And I had to hide the real fact why I got work incapacitated... That it was depression, because the society does not accept it. I told everyone that I had problems with my spine.

What made you decide that they do not accept it?

Because... you hear insults, behind your back, about other people.

Can you describe these insults?

“I can also suffer from depression, I already suffer from depression”. They do not understand what it really is like to suffer from depression. Ignorant people... It is also hard working part time... because, when you have to stand up and leave your work place you hear snarky comments “You are so lucky that you are already leaving for home”... “Oh, good for you”... or that one sentence, “if I was work incapacitated, I would not work at all”

These people, they really do not understand what does it feel like?

Yes, because they do not even know why you suffer from depression. Because... because when you take medicine, you become like everyone else... Only... a person... who is suffering from depression can understand what does it feels like... the mental state in which you get up at in the morning and how long does it take you to get used to it throughout the day.

What kind of state is it actually?

You do not want anything in the morning, you do not need anything... You take medicine regularly... you have to take it. You have to watch yourself...

And it is not only a mental state it is also a physical state? How does it reflect physically?

You don't have strength, you suffer from a lot of anxiety throughout the day, and you have mood swings <...>

<...> and what is needed for society to change this view?

A bit of coverage from the media and the television, is anyone, currently, talking anything about this, I have been sitting in front of the TV, and I have never heard anything about us people, such that we are. I have never heard anyone speaking something about this on the TV. They do, incidentally, say things, but I have never heard them say something, like that, that would make people understand, that we are normal people too, and that we just need help. Sometimes I read the newspaper, but I watch television constantly, radio, I just do not hear that someone would explain this to the people, maybe the educated ones out there know, but us, simple people, they do not understand these things, they say that we are pretending, you hear they say the word pretend, but what do I pretend to do, I do not understand myself. How can I understand this,

Vineta? What can I pretend to do? Is it fun to pretend that I have problems? Is it fun to pretend that I will not be able to organize my funds and documents anymore? Anger comes over me, already then, can you imagine. I can understand, if one would say, ouch, my leg hurts, then I understand how you could pretend, but how could you pretend to be in a situation like I am, I cannot understand. I do not know of such person that would like to pretend these things.

So the disability is only interfering with your life?

The injury does not interfere as much as the depression does. The depression interferes the most.

Then, which society group would you attribute yourself to?

How can you attribute, I do not even know.

Well, let's say this. Do you, currently, live alone? Would you attribute yourself to the lonely ones or the ones with disability? Or to the educated ones, you have a degree of education and are well read, who would you attribute yourself to today?

I can attribute myself to all three groups, one day this, the next day that, third day this, it depends on the mood.

Then who would you identify yourself to?

A loner now, in general, I do not want to identify myself to the ones with disabilities, but I know that I am like this, but I, egregiously, do not want to. I do not want to accept my situation. No way. An educated person, I do not know, I try to be well read, but I cannot always.

If you could change your life? What would you change? If you had the possibility to change it?

Firstly, I would change my occupation, nevertheless, the depression and my occupation has fed me up, I would change my occupation.

What would you change it to?

I would become a builder, because I associate it with how I was before, that one summer, happy. I would become a builder and would be a road worker. <...>

<...> **so you could say that your life became worse after the disability, did it not?**

You can say that my life went upside down, there, you can say that.

But in which direction? Did it become worse or better?

My life, of course, got worse. Really worse. Because, you know, these thoughts, will haunt me forever, that you are an ill person, and that you will always fail at something. You will try to create a family after your divorce, but you will fail, you will not create a good family. An even harder experience, if you fail. Maybe you will find a girlfriend or a wife that will constantly remind you of your disability. I can bluntly say, that even if you find someone in some chatroom,

and if that person will call you stupid or something like that, that you are this or that, you will, literally, get a slap in the face, literally.

Who do you communicate with? What is the closest circle right now? Friends, family, relatives? Whom do you communicate with the most?

You can say that there is this circle of close ones is. Well, like... Pop, I talk to children, even though, as you could say it is forbidden. I talk to children. I chose my friends, I do not communicate with everyone, like all the time. And maybe, simply, this life, is a little bit better, I am saying it that now, in comparison to when I got sick, of course, everything went upside down for me, maybe the promise, that I will stop drinking alcohol, helped me, there, the fact that I do not drink alcohol anymore is a big plus. And the attitude towards me, if, for example, I would drink and take medicine at the same time, I imagine, that I would not leave the hospital at all. I would be isolated from the society and would not be able to communicate with anyone, and everything else. And how can you better that of people that view, maybe in the future they will change their view towards people like us, view of the surrounding people. Maybe after some, I do not know, how many years, maybe there will not be anyone and myself around anymore, but when the attitude towards people like us will change, maybe the conditions of life for people, suffering from this illness, will change.

What is needed for change? What do you think?

What is needed...? What is needed for change... well, it is hard to say. When suffering from this illness, when your leg or arm hurts, people have different attitude towards you. Because when I would say that my soul is ill, I have a spiritual illness. I cannot imagine how someone would be able to change that. I believe, that when a person wants to change, of course it depends, you cannot let your hands down, you have to simply fight, you have to fight, put some effort in, because when you are taking medicine, this medicine is strong. It is not that simple, like, I take the medicine and feel like I am on wings- it is not like that. Simply, they do not only have positive effects, they also have negative effects. You have to have a really strong will to live, when you are taking this medicine. Because when I was taking some kind of medicine, they had various effects, because there is different medicine for every person, as I understand, there, they prescribe different medicine to different people, some medicine might not work for some, and it is like that. I, for example, believe that. <...>

<...> what assistance have you received there?

Well, they would prescribe medicine there, and there were all kinds of activities there, everything in that hospital.

How would you say, what assistance which professional has provided? Were those doctors?

Well, doctors, well.

And have you encountered any professionals without a medical degree?

Well not, no.

For example with a social worker?

Well, there are social workers at the hospital itself, they come, inquire.

What do they inquire about?

Well, how do you live, about everything. When you need to contact your home, they mediate, or when they release you home, they tell you, well, after that, they call you at home.

So, some sorts of an intermediary?

Well, yes an intermediary at that hospital.

And when you were faced with difficulties, who helped you the most?

I do not really know... Well, you are sent to the hospital immediately and receive treatment, well.

And, in general, if you are faced with difficulties in life, some sort of crisis, who helps you?

Well, I do not know... Daughter, daughter.

Family?

My daughter, geez.

What more could you tell me about your family?

Nothing. I have a daughter and a son, and a husband, there. I buried my mother last summer, buried my mother.

How do you get on with your family?

Normally.

Whom else do you communicate with?

Well, with my neighbours, we walk sometimes. At the moment, I do not want to go anywhere, anything. To go on a walk or such.

How do your neighbours react to you? How do they view you?

No reaction in particular, normally. <...>

When you heard about your diagnosis, that so called invalidity group, how did you react, how did you feel?

No reaction, in fact... no such fear... or to be afraid of... or to feel some humiliation... of other people or such, I have never had to face something like that... but... in fact... I have the feeling of weakness inside of me, that I have a need for help, in fact, I had this need for a long time

already, because I am human, until it, until you materialize it... until you come forth to a doctor for help... in fact, the beginning, all this became like this... in fact, that you felt like you are feeling today, in fact, nobody had “threw” something like this at me, that I am like this, not like others... you have become something else... became disabled.

You do not feel different?

No, no, no... I am the way, I am... Who were my friends, till the disability, are still my friends today, our relationship did not change at all, and is the way it was before...

Then which group of the society would you attribute yourself to? Working people, healthy, with the disabled?

With the working people...

Of working-age, hard working.

In fact, I go to work as much as my physical health allows me to, in fact, I work at a social company together with other disabled people, and in fact, part of those people are healthy, in fact, performing our jobs, we perform them the same... of course, when you come home, in the evening, you take the same pill and take medicine, you rub it... with medicine... in fact, it is harder, but that at work...

You withstand that whole load?

... We withstand it in the same way like healthy people... You come to work, and the jobs have to be done...

You have mentioned, that it feels like there is a divide, between the disabled and healthy people in the workplace, and that there also is something like jealousy or something else?

In fact, there is a lingering feel of jealousy at the workplace, because everyone gets the same salary... how much we earn... but... they, actually, nag us, people with disability, about the fact that we get additional money, so this is where the jealousy comes from, that we, in fact, get additional money... but they do not understand... that we need that money... that we spend this money on medicine... and there are a lot of these nuances... how to explain it... in fact, you do not want to be part of the invalidity group... to have these privileges... I do not find any privileges in this, I just do not... find any advantages in this... there are not any... because, for real, the medicine is very expensive... and you are not the way you should be... still, there are also, other diseases from outside, there are a lot of illnesses... not just this one.

And what was your family reaction to this, when the disability became part of your life?

How did your family react, did they support you?

Actually... none... none from my husband and also none from daughter. Absolutely none... There was no difference did have the disability or I did not... there was no difference.

Was there a conversation, on this topic?

No, no, no, absolutely, absolutely no questions... neither from my husband, neither from my daughter, that, there, our mother is disabled now... and she is different... I have not heard anyone say that I am different ... that, well, now, you have become something else... <...>

Is mother the closest person to you?

Mother. Knows, it is hard for me to speak, fluently, mother understands, I do not speak fluently, what I want, what do I want to say. It is hard for me to write messages, when my hands are shaking. Well, mother helps me with everything. She understands. My husbands is starting to help me, barely, to understand what am I saying, what I want, what I demand, we keep together as a family.

And how do co-workers interact with you at work?

Also, nice. They communicate, understand, sometimes they do not understand, they say that “I know, we are like this, we have invalidity group”. The healthy ones also come up to talk to me, we talk, communicate. There are also healthy people, we talk also, communicate, they say “do not be afraid, you will learn”.

They even encourage you, help you?

Yes, yes, encourage me. The shift manager also, everyone. I ask for a day off, the manager gives me a day off. She says do not worry, you are healthy, and we are all living.

If you could change your life, what would you change?

Oh, I would do so that I would not be disabled.

The only thing you would change is the fact that you have a disability?

Yes. I would like to change, I would like to change everything, and I want to have a healthy leg.

What is wrong with your legs?

I cannot wear high heels.

Oh, so you want to wear high heels?

Yes. I would like to change my face, I have scars... from my childhood... mother grabbed my face.

Where did you get the scar from?

Mother grabbed my face. She was pregnant.

Oh, mmm.

I wish for a lot of things.

So you are not very satisfied with the way you look?

No.

And would you change your life itself? There, you say you wish to be healthy, to look beautiful...

Sure, yes. I wish, I wish, in fact, to be healthy, to have such lean, to be a mannequin, as the fashion world portrays, I would like to be, to help my mother, husband, to take him to cure his diabetes, to cure my mother.

Extracts from the interviews with social workers

What do you think the client's quality of life is? Rate it from 1 to 10?

8.

What is missing for a 10 rating?

The system is not perfected enough to allow them to fully integrate in the society.

Do you think that the government, professionals and society take sufficient care of people with mental disabilities?

I believe primary and medical aid to be sufficient, but at the later stages of the reintegration, people lack the possibilities to realize themselves. It is hard for him to find a suitable occupation, and establish himself there, they lack rudimental skills, he does not have enough funds to support himself, and he lacks a continuous support from professionals. Also, one of the bigger problems is the stigma-like view of the society on the person with mental disability.

In which area would you think that the clients fell displeased the most?

The group of clients, with which I am working, mostly complains about the lack of funds for living, social support is inadequate, and most often, the occupation they managed to get employed- does not meet their expectations. They do not manage to stay employed because they lack responsibility and the salary does not meet their expectation.

Whom do your clients attribute themselves to the most, which social group they attribute themselves to?

My clients usually attribute themselves to the unemployed group.

Do you think that your clients feel "different" from the other members of the society?

I do not think so, I haven't heard them saying that they attribute themselves to a "different" group.

Do the clients complaint about their health often? How do they sleep, relax?

At the beginning of the rehabilitation process the clients complain about their health, insomnia, anxiety attacks very often. They often claim to have had a sleepless night.

What do you think the client's quality of life is? Rate it from 1 to 10?

3-4.

What is missing for a 10 rating?

The rating I gave was already too generous. For example: a safe, nurturing environment suited to the needs of the disabled, home visits from doctors, without calling, assistance at home from the

members of the integral team, access to medical institutions for the disabled, aid, nursing, time taken care of relatives after work- all this is missing.

I could list a lot of criteria for the quality of life, but I do not find any of them meeting the rating of 10. This is the reality of my surrounding environment.

Do you think that the government, professionals and society take sufficient care of people with mental disabilities?

Not sufficiently, even getting a certificate of incapacity takes half a year.

In which area would you think that the clients feel displeased the most?

Unemployment, lack of activities, they lack day care centres for people with such disability.

Whom do your clients attribute themselves to the most, which social group they attribute themselves to?

Unemployed. They attribute themselves to normal people.

Do you think that your clients feel “different” from the other members of the society?

Usually they are not self-critical, they do not express their complaints.

What is needed in order to change the view of the society on people with mental disability?

For changes to happen not only does the view have to be changed, but also the environment itself, in which the child is living and what children does he communicate with. Usually parents, themselves, raising a child with a disability, are trying to secure the child from the environment. But the consequences are that, when the time comes, it is too hard for the child to take in the world, he was being secured from.

Do the children complain about their health often? How do they sleep, relax?

Children rarely complain about their physical health. Their leisure and sleep does not suffer while living according to the rhythm of a normal life.

What are the clients complaining about the most?

The children most often complain about the fact that they do not have any friends, that they are rejected and jeered at school. Children, living in families with financial difficulties, usually complain about the fact that they cannot align themselves with other children in terms of things that they have and hobbies.

Do you believe that the social support and work incapacity (disability) pension is enough for them to “make a living”?

Children only get support for disability, but these funds are controlled by their parents. Children with mental disability, do not worry about the possibilities to make a living.

What specific activities do you provide at the institution you are working at?

At the institution we interact with children and their families. We cooperate with the police, juvenile inspectors, child protection services, educational and psychological institutions, other medical institutions, social support services, townships, schools, social working supervising families.

Which services do you think could improve the quality of life for people with mental disability?

It is very important to provide more attention organizing after school activities at day care centres, schools, etc. for children. It is important that these activities would be free of charge or at least cost a bare minimum. It is very important for these children to develop: social, communication, housekeeping, self-regulation, hygiene, skills. After development, these skills, will allow them to adapt more easily to the conditions of living.

Which professional would you believe is helping people with mental disability the most?

The need for a professional depends on the disorder. If it is a disorder of speech or a disorder of motor skills, then a speech therapist, physical therapist, social and a special educator is in order. A professional must help to educate the parents to an extent, where they would be able to work with the child in their own environment and achieve the set goals.

What do you think the client's quality of life is?

Poor.

Rate it from 1 to 10?

2.

What is missing for a 10 rating?

Clients are very segregated, they feel rejected. And how can you feel well, when you are rejected?

Do you think that the government, professionals and society take sufficient care of people with mental disabilities?

The view of the society is stigma-like, the government could put more effort in taking care of them.

How could they take care of them?

Establish more day care centres, were clients would be able to interact not only between themselves.

In which area would you think that the clients fell displeased the most?

The main problem is unemployment. It is hard to find an employer who would employ a person with a mental disability.

Whom do your clients attribute themselves to the most, which social group they attribute themselves to?

They attribute themselves to the disabled, of course.

Do you think that your clients feel “different” from the other members of the society?

They feel “different”, because society, itself, views them from a different lenses, and probably are also afraid of them.

What is needed in order to change the view of the society on people with mental disability?

To provide as much as possible integration to the society.

What social services the clients are lacking the most?

I believe that we lack social workers, who would provide more attention to the person, at the outpatient level, the most. Today, one social worker has to provide assistance to the whole district, almost one fifth of the city. How can you attentively work with a patient, when you have a mountain of other medical history to sort through? There is a major lack of day care centres for people with mental disability.

Who should provide them?

I will repeat myself, social workers at the outpatient level, day care centres.

Do you encourage your client to receive an education, occupation, if not, who does that?

Psychosocial rehabilitation provides the services of disability and working capacity assessment office. If the person is motivated, we, of course, encourage him to obtain the suitable occupation.

Maybe you had to teach clients new skills after the disability?

Usually we try to teach them to correctly asses their funds and expenses, also to communicate more.

Which activity is favoured most often among the clients?

Usually they favour therapies at the hospital (art, music, ergo, motion), they also favour individual social work, psychotherapeutic groups.

What makes your clients happy?

People are excited the most, if they manage to accept their illness, if they can spot their setbacks on time, not to postpone checking in to the hospital, managing getting by without the provided services of credit institutions.

If you could change the life of the clients, what would you change?

I would encourage relatives to seek help, to try to understand the illness of their close ones. Loneliness has a very hurtful impact on the patients.

What do you think the client's quality of life is?

Subscriptions are very different. If the patient is getting his treatment at home then the level of care, control of the illness, flow of live is at least adequate. The life quality of the mental patient living alone is worse. But social workers and medical services are trying to manage the disorders, provide various services.

Do you think that your clients are happy?

It is hard to say...

What do you think makes your clients happy?

Well-being, fullness, warmth, the possibility to realise their interests (books, films...).

How many of your clients do you think are happy with the quality of their life?

Most of them, about 80 percent.

Do you think that the government, professionals and society take sufficient care of people with mental disabilities?

No.

In which area would you think that the clients fell displeased the most?

Witch medical area and the sphere of social services.

Whom do your clients attribute themselves to the most, which social group they attribute themselves to?

With chronical patients, disabled.

Do the clients complaint about their health often? How do they sleep, relax?

Not often.

Do they have a lot of mood swings?

Yes.