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7. MEDNARODNI KONGRES
MEDICINSKIH IZVEDENCEV
REPUBLIKE SLOVENIJE

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11. – 12. APRIL 2024
LAŠKO, SLOVENIJA

ZIZRS

THERMANA

7th International Congress of Medical Assesors

11.–12. APRIL 2024, LAŠKO, SLOVENIJA

COLLECTION OF LECTURES

7. th INTERNATIONAL CONGRESS
OF MEDICAL ASSESSORS IN SLOVENIA

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LAŠKO, SLOVENIJA

ZZZS ZPIZ ZIZRS THERMANA

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7th International Congress of Medical Assesors

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PREDGOVOR

Pred nami je že sedmo strokovno srečanje na področju presoje pravic iz obveznih socialnih zavarovanj v Sloveniji. Strokovno srečanje v svojem jedru zasleduje željo po povezovanju različnih izvedenskih, rehabilitacijskih in medicinskih strok v Sloveniji, kot tudi v naši bližnji in širši okolici. Strokovni odbor 7. Mednarodnega kongresa medicinskih izvedencev je zasnoval dogodek s temami, ki sledijo kontinuiteti prejšnjih kongresov in prinašajo uporabno in zanimivo vsebino za vse udeležence.

Tokratni vsebinski poudarki kongresa naslavljajo področje duševnih in vedenjskih motenj glede:
- začasne zadržanosti od dela (zdravstveni absentizem);
- trajnejše in trajne zadržanosti od dela (oceno preostale delazmožnosti, invalidnost);
- uspešnih intervencij vračanja na delo z namenom ohranjanja delazmožnosti;
- poklicne in zaposlitvene rehabilitacije;
- ureditve različnih zdravstvenih sistemov pravic ob zmanjšani delazmožnosti in
- povezovanju socialne varnosti začasno in trajneje zmanjšane delazmožnosti.

Vsebina kongresa daje posebno pozornost na možnostih ohranjanja delazmožnosti bolnikov in invalidnih oseb preko izvajanja medicinskega izvedenstva na področju socialne varnosti na način aktivnega pristopa obravnave zmanjšanje delazmožnosti bolnikov, ki temelji na funkcionalni zmogljivosti ter z dokazi podprtimi in učinkovitimi rehabilitacijskimi metodami. Takšen način obravnave predstavlja temeljni steber za učinkovito in pravično obravnavo pravic bolnikov ob zmanjšani delazmožnosti iz socialnih zavarovanj.
Kongres združuje vsebino priznanih strokovnjakov in predavateljev s področja medicinskega izvedenstva, zavarovalniške medicine, rehabilitacijske medicine in strokovnega področja duševnih in vedenjskih motenj. Ob tem ne bodo zanemarjena tudi druga področja medicinskega izvedenstva in zavarovalniške medicine, kot so posebnosti sistemov zdravstvenega zavarovanja ob zmanjšani delazmožnosti, primeri dobre prakse zakonodajnih intervencij obvladovanja naraščajočega problema zdravstvenega absentizma v Sloveniji in drugod, ter tudi področja sodnega varstva zavarovanih oseb, zavarovalniško medicinskega ter zavarovalniško strokovnega nadzora plačevanja zdravstvenih storitev.

Veseli me, da smo s povezovanjem različnih strokovnih področij tudi v mednarodnem pogledu pripravili zanimivo in vsebinsko bogato strokovno srečanje.

Namesto zaključka, prosim dovolite mojo zahvalo organizatorjem, članom strokovnega odbora, članom organizacijskega odbora in predavateljem za njihov prispevek k izvedbi tega vsebinsko osredotočenega, strokovnega in aktualnega srečanja - hvala.

Mario Bartolac, dr. med. spec. druž. med.
Predsednik Strokovnega odbora

FOREWORD

The seventh scientific meeting of medical assessors of rights from compulsory social insurances in Slovenia is now upon us. At its core, the expert meeting pursues the desire to bring together various mediacal assessors, rehabilitation and medical professionals in Slovenia, as well as in our immediate and wider surroundings. The Panel of Experts of the 7th International Congress of Medical Assessors has designed the event with themes that follow the continuity of previous congresses and bring useful and interesting content for all participants.

This year's congress content focuses on the area of mental and behavioural disorders in relation to:
- temporary reduced work capacity (health absenteeism);
- permanently reduced work capacity (assessment of residual work capacity, disability);
- successful return to work interventions to maintain work capacity;
- vocational and occupational rehabilitation;
- the regulation of the various health entitlement schemes in the event of reduced working capacity and
- linking social security for temporary and permanent reduced work capacity.

The content of the congress pays special attention to the possibilities of preserving work capacity in patients and people with disabilities through implementing a proactive approach to the management of reduced work capacity, based on functional capacity evaluation and evidence-based effective rehabilitation methods. This approach constitutes a fundamental pillar for an effective and equal distribution of the social security rights of people with reduced work capacity because of illness or injury.

The Congress brings together the expertise of renowned experts and lecturers in the fields of medical assessors, insurance medicine, rehabilitation medicine and the professional discipline of mental and behavioural disorders. Other areas of medical assessors and insurance medicine will not be neglected, such as specific features of health insurance policies in the context of reduced work capacity, examples of good practice of legislative interventions to tackle the growing problem of health absenteeism in Slovenia and elsewhere, as well as areas of judicial protection of insured persons and medical supervision of payments for health care services.

I am pleased that, by bringing together experts from different professional disciplines, we have prepared an interesting and content-rich scientific meeting, also in an international perspective.

Instead of conclusions, please allow me to express my gratitude to the organisers, the members of the Panel of Experts, the members of the Organising Committee and the speakers for their contribution to delivering this content-focused, professional and current scientific meeting - thank you.

Mario Bartolac, MD
Chairmain of the Panel of Experts

PREDSTAVITEV SEKCIJE ZA MEDICINSKO IZVEDENSTVO IN ZAVAROVALNIŠK MEDICINO

Aktivnejši razvoj medicinskega izvedenstva in zavarovalniške medicine v Sloveniji se je začel na pobudo in vlogo iniciativnega odbora zdravnikov Zavoda za zdravstveno zavarovanje Slovenije (ZZZS). Glavni strokovni svet Slovenskega zdravniškega društva (SZD) je podprl ustanovitev Sekcije za medicinsko izvedenstvo in zavarovalniško medicino SZD (SMIZM). Skladno s sklepi ustanovne skupščine SMIZM dne 16.07.2015 je skupina zdravnikov, redno zaposlenih ali pogodbenih sodelavcev ZZZS in ZPIZ, postala "strokovna javnost", ki kot šestinšestdeseta sekcija oziroma strokovna podenota deluje v okviru SZD.

SMIZM združuje skupino zdravnikov iz različnih medicinskih strok, ki svoje strokovno znanje in drugo usposobljenost uporabljamo pri izvajanju nalog za potrebe zgoraj navedenih Zavodov. Delo medicinskih izvedencev je usmerjeno predvsem k uresničevanju pravic zavarovanih oseb, ki izhajajo iz socialnih zavarovanj, preko presoje in izdajanja strokovnih in izvedenskih mnenj, tudi na področju zavarovalniško medicinskega nadzora pri izvajalcih zdravstvenih storitev.

Kmalu po ustanovitvi je strokovna javnost novo stroko priznala kot posebna znanja pri SZD. Izobraževanje je pripravljeno v skladu s Pravilnikom o posebnih znanjih, ki je objavljen na spletni strani SZD, program izobraževanja pa je obravnaval in potrdil Glavni strokovni svet SZD (v nadaljevanju: GSS SZD). Izobraževanje v obsegu 400 ur se zaključi z izpitom pred tričlansko izpitno komisijo, izpitne zapisnike pa se GSS SZD tudi predloži, da jih pregleda in izda diplome. Do sedaj sta bila organizirana dva ciklusa izobraževanja, tako da imamo že 65 zdravnikov oziroma zobozdravnikov z diplomo SZD s področja posebnih znanj medicinskega izvedenstva in zavarovalniške medicine ter dodatno še 6 strokovnjakov drugih področij (farmacija, zdravstvene vede), ki so prav tako opravili izobraževanje.

Ta izobraževanja, ki ga izvaja Sekcija za medicinsko izvedenstvo in zavarovalniško medicino pri Slovenskem zdravniškem društvu, se bo nadaljevalo tudi v prihodnje, se dopolnjevalo z novimi vsebinami in se predvidoma nadgradilo v novo samostojno specializacijo medicinskega izvedenstva in zavarovalniške medicine.

Glede na zakonsko opredeljene kompetence so medicinski izvedenci aktivni udeleženci v procesu zdravljenja in rehabilitacije zavarovanih oseb, saj na osnovi svojega strokovnega znanja in kliničnih izkušenj presojajo o pravicah kot je začasna ali trajna delazmožnost, ustreznosti drugega delovnega mesta, telesni okvari, potrebi po stalni pomoči in postrežbi drugega, o potrebi po prilagoditvi prostorov in delovnih sredstev v zvezi s poklicno rehabilitacijo ali zaposlitvijo oziroma premestitvijo na drugo delovno mesto ter dodatnih usposabljanj. Nadalje presojajo o upravičenosti zavarovanih oseb do zdraviliškega zdravljenja in nekaterih medicinskih pripomočkov, s pomočjo katerih se zagotavlja povrnitev zdravja in funkcionalnih sposobnosti po bolezni ali poškodbi.

S pomočjo zavarovalniško medicinskega nadzora se zagotavlja tudi ustrezno uveljavljanje pravic iz obveznega zdravstvenega zavarovanja na vseh ravneh zdravstvenega varstva in standardno ponudbo v smislu strokovno-doktrinarne utemeljenosti zdravstvenih storitev. Pri izvedenskem delu se s strokovno presojo zdravstvenega stanja zavarovanih oseb na podlagi specialističnih izvidov in izvidov laboratorijskih in drugih diagnostičnih preiskav ter na podlagi z osebnim pregledom ugotovljenega kliničnega statusa zagotavlja skrb nad učinkovito porabo sredstev OZZ.

K nadaljnjemu razvoju stroke bi nova enovita pravna entiteta – enotni izvedenski organ pomembno prispevala z ureditvijo položaja teh strokovnjakov kot zdravstvenih delavcev v zdravstveni dejavnosti, primerljivo z drugimi strokami, kar je pogoj za interes za delo in zadostno kadrovsko zasedenost na osnovi rednih zaposlitev.

mag. Jana Mrak, dr. med.

PRESENTATION OF THE SECTION FOR MEDICAL ASSESSORS AND INSURANCE MEDICINE

The active development of medical expertise and insurance medicine in Slovenia started on the initiative and role of the initiative committee of physicians of the Health Insurance Institute of Slovenia (ZZZS). The main professional council of the Slovenian Medical Association (SZD) supported the establishment of the Section for Medical Expertise and Insurance Medicine of the SZD (SMIZM). In accordance with the decisions of the founding assembly of SMIZM on 16.07.2015, a group of physicians, full-time employees or contractors of ZZZS and ZPIZ, became the "professional public", which as the sixty-sixth section or professional sub-unit operates within the SZD.

SMIZM brings together a group of doctors from various medical disciplines who use their expertise and other qualifications to carry out tasks for the needs of the above-mentioned Institutions. The work of medical experts is primarily aimed at the realisation of the rights of insured persons arising from social insurance, through the assessment and issuance of expert and expert opinions, including in the field of insurance and medical supervision of health care providers.

Shortly after its establishment, the new profession was recognised by the professional community as a special skill of the SZD. The training is prepared in accordance with the Special Skills Regulation, which is published on the SZD website, and the training programme has been discussed and approved by the SZD Main Professional Council (hereinafter: SZD GSC). The 400-hour training is concluded with an exam with a three-member expert board, and the exam records are submitted to the SZD GSC for review and the award of diplomas. So far, two training cycles have been organised, so that we have 65 doctors or dentists with a diploma from the SZD in the field of special skills in medical expertise and insurance medicine, and additionally 6 specialists in other fields (pharmacy, health sciences) who have also completed the training.

This training, which is provided by the Section for Medical Expertise and Insurance Medicine of the Slovenian Medical Association, will continue in the future, will be supplemented with new content and is expected to be upgraded to a new independent specialisation in medical expertise and insurance medicine.

According to their legally defined competences, medical experts are active participants in the process of treatment and rehabilitation of insured persons, as they make judgements on the basis of their expertise and clinical experience on entitlements such as temporary or permanent incapacity for work, the suitability of another job, physical impairment, the need for permanent help and assistance from another person, the need for adaptations to premises and working facilities in the context of vocational rehabilitation, or for employment or transfer to another job, and for additional training. They also assess the insured person's entitlement to medical treatment and to certain medical aids to ensure the recovery of health and functional capacity after illness or injury.

Insurance-medical supervision also ensures the proper enforcement of statutory health insurance rights at all levels of healthcare and a standard offer in terms of the professional and doctrinal justification of healthcare services. In the area of expertise, the efficient use of the resources of the EHIC is ensured by means of expert assessment of the health status of insured persons on the basis of specialist reports and laboratory and other diagnostic test results, as well as on the basis of the clinical status established by personal examination.

In order to further develop the profession, the new single legal entity – Unified expert institute would make an important contribution with regulating the position of these professionals as health professionals in the health sector, in a way comparable to other professions, which is a prerequisite for interest in the work and sufficient staffing on the basis of regular employment.

mag. Jana Mrak, MD

PREDSTAVITEV EVROPSKEGA ZDRUŽENJA MEDICINSKEGA IZVEDENSTVA - EUMASS

V Evropi je približno 500 milijonov ljudi vključenih v sisteme socialnega zavarovanja, ki jih financira ali podpira družba kot kolektivno socialno varnost. Odločitve o upravičenosti do dajatev običajno temeljijo na zdravniških ocenah, ki pa temeljijo na evropskem medicinskem znanju in skupnih metodah. EUMASS/UEMASS želi ponuditi platformo za izmenjavo izkušenj na področju zavarovalniške medicine med različnimi organizacijami, povezanimi z zavarovalništvom v Evropi, ki se osredotočajo predvsem na javno socialno varnost.

Za namen doseganja večje učinkovitosti zdravstvenih sistemov, tudi v pogledu ekonomične porabe sredstev in enakomernega dostopa do pravic obveznih socialnih zavarovanj, v evropskem prostoru države aktivno razvijajo stroko zavarovalniške medicine (insurance medicine). Povezovanje in izgradnjo platforme za izmenjavo izkušenj na področju zavarovalniške medicine med različnimi organizacijami zagotavlja zveza nacionalnih združenj in organizacij EUMASS (European Union of Medical Insurance and Social Security). EUMASS je evropska zveza zdravnikov, ki se v svoji državi ukvarjajo z zavarovalništvom in medicino socialne varnosti. EUMASS/UEMASS je bil ustanovljen leta 1972 in je 23. junija 2022 postal neprofitna organizacija v skladu z belgijsko zakonodajo, njena zgodovina pa je že več kot 50-letna.

Trenutno ima sekretariat sedež v Bruslju v Belgiji in 22 držav predstavnic, med njimi tudi Slovenijo (druge predstavnice Belgija, BiH, Hrvaška, Češka, Estonija, Finska, Francija, Nemčija, Grčija, Islandija, Italija, Norveška, Poljska, Portugalska, Romunija, Srbija, Slovaška, Švedska, Švica, Nizozemska, Združeno kraljestvo). Predstavniki držav članic se redno srečujejo (tri srečanja letno), delujejo v delovnih skupinah organizacije; vsaki 2 leti pa se organizira mednarodni kongres – leta 2016 je bil organiziran v Ljubljani. Cilji organizacije so tudi razvoj zavarovalniške medicine, zagotavljanje spremljanja zdravstvene oskrbe (v tem sklopu je tudi nadzorna dejavnost) in stremljenje k prepoznavi zavarovalniške medicine kot samostojne specializacije.

Namen EUMASS/UEMASS je prenos in izmenjava znanstvenega znanja in “dobre prakse” na področju zavarovalniške medicine. To se izvaja predvsem z organizacijo znanstvenih kongresov vsaki dve leti v eni od držav članic EUMASS/UEMASS v sodelovanju z lokalnim organizacijskim odborom. Za zagotavljanje dobre znanstvene kakovosti ima EUMASS/UEMASS strokovni odbor, ki ga sestavljajo izkušeni raziskovalci.

EUMASS podpira in aktivno sodeluje tudi na Mednarodnih kongresih medicinskih izvedencev Slovenije, tako bo tudi na 7. kongresu, ki bo od 11.-12. aprila 2024 potekal v Laškem.

mag. Jana Mrak, dr. med.
Predstavnica Slovenije v EUMASS

PRESENTATION OF THE EUROPEAN UNION OF MEDICINE IN ASSURANCE AND SOCIAL SECURITY (EUMASS)

In Europe about 500 million people are affected by social insurance schemes funded or endorsed through society as a collective social security. Decisions on entitlement to benefit are usually based on medical assessments which in turn are based on European insurance medical knowledge and common methods. EUMASS/UEMASS wants to offer a platform to exchange experiences within the field of Insurance Medicine between various insurance-related organisations in Europe, mainly focusing on public social security.

In order to achieve greater efficiency of health systems, including in terms of economic use of resources and equitable access to compulsory social security rights, countries in the European area are actively developing the profession of insurance medicine. The European Union of Medical Insurance and Social Security (EUMASS), a federation of national associations and organisations, provides a bridge and a platform for the exchange of experiences in the field of insurance medicine between the different organisations. EUMASS is the European federation of medical practitioners working in the field of insurance and social security medicine in their respective countries. EUMASS is a European federation of medical practitioners working in the field of insurance and social security medicine in their respective countries. EUMASS is a European federation of medical practitioners in Europe.EUMASS/UEMASS was founded in 1972 and became a non profit organisation under Belgian law (asbl) on 23rd June 2022.

Currently the secretariat is situated in Brussels, Belgium. It has 22 representative countries, including Slovenia (other representatives Belgium, Bosnia and Herzegovina, Croatia, Czech Republic, Estonia, Finland, France, Germany, Greece, Iceland, Italy, Norway, Poland, Portugal, Romania, Serbia, Slovakia, Sweden, Switzerland, the Netherlands, the United Kingdom). Representatives of the Member States meet regularly (three meetings a year), serve on the organisation's working groups, and an international congress is organised every two years - in 2016 it was held in Ljubljana. The objectives of the organisation include the development of insurance medicine, the provision of healthcare monitoring (this includes surveillance activities) and the recognition of insurance medicine as an independent specialty.

The aim of EUMASS/UEMASS is to facilitate the spreading and sharing of scientific knowledge and "Good Practice" in the field of Insurance Medicine. This is primarily done by arranging scientific congresses every two years in one of the Member States of EUMASS/UEMASS in cooperation with a local Organising Committee. In order to ensure good scientific quality EUMASS/UEMASS has a Scientific Committee of senior researchers.

EUMASS also supports and actively participates in the International Congresses of Medical Experts in Slovenia, and will do so at the 7th Congress, which will take place in Laško from 11-12 April 2024.

mag. Jana Mrak, MD
Representative of Slovenia in EUMASS

ČETRTEK, 11.04.2023 // THURSDAY 11.04.2024

PLENARNA SEKCIJA 1 // PLENARY SESSION 1

DUŠEVNO ZDRAVJE V SLOVENIJI – STANJE, IZZIVI IN PRILOŽNOSTI

Avtor: prim. Nuša Konec Juričič, dr. med., NIJZ

Ključne besede: duševno zdravje, duševne motnje, potrebe, skupnost, nacionalni program

Ključni poudarki:

- K izidom v duševnem zdravju posameznika in skupnosti, bodisi v pozitivnem ali negativnem smislu, prispevajo številni dejavniki in okoliščine, vezani tako na lastnosti posameznika kot na njegovo ožje in širše družbeno okolje.
- V letu 2022 je več kot 60 odstotkov oseb v Sloveniji svoje splošno zdravstveno stanje ocenilo kot dobro ali zelo dobro, kar je enako povprečju držav Evropske unije.
- Prevalenca duševnih motenj je po oceni Inštituta za zdravstvene meritve in vrednotenje v Sloveniji leta 2019 znašala 12,6% in je bila nekoliko nižja od povprečja držav Evropske unije.
- V zadnjih letih se je število vseh zaposlenih v službah za duševno zdravje v Sloveniji povečalo tudi zaradi ustanovitve Centrov za duševno zdravje. Po številu psihiatrov se Slovenija še vedno uvršča v spodnjo polovico držav Evropske unije
- Nacionalni program za duševno zdravje z akcijskimi načrti omogoča participacijo vseh ključnih deležnikov, ki lahko z razumevanjem stanja in potreb, sinergijo ter usklajevanjem prioritet dosežejo številne pozitivne učinke za zdravje in zadovoljstvo vseh prebivalcev.

Stanje/problem: Dobro duševno zdravje je temelj zdravja, ki pomembno prispeva h kakovosti življenja posameznika in skupnosti ter družbeni blaginji. V zadnjih desetletjih beležimo med prebivalci Slovenije porast težav v duševnem zdravju. Med najpogostejšimi duševnimi motnjami pri mladostnikih ter odraslih so stresne in prilagoditvene ter anksiozne motnje, depresivna epizoda, ponavljajoča se depresija, vedenjske in duševne motnje zaradi alkohola, po 65. letu starosti tudi demenca. Med izstopajočimi problemi sta še vedno visoka stopnja samomora ter umrljivosti zaradi zlorabe alkohola, ki sta med najvišjimi v Evropi. Duševne in vedenjske motnje so med vsemi razlogi na tretjem mestu po povprečni dolžini trajanja bolniške odsotnosti. Finančna izguba zaradi slabega duševnega zdravja je ocenjena na 3 do 4% bruto domačega proizvoda, predvsem na račun izgubljene produktivnosti in zgodnjega upokojevanja.

Metode/pristopi: Leta 2018 je bil v Slovenij sprejet prvi Nacionalni program duševnega zdravja za obdobje 2018-2028 (NPDZ). V njem je opredeljenih šest prednostnih področij, katerih ukrepi se izvajajo v okviru obdobnih Akcijskih načrtov (AN).

Rezultati: Ključne pridobitve v okviru NPDZ so vzpostavitev medministrske delovne skupine, 14 interdisciplinarnih delovnih skupin na nacionalni ravni, vzpostavitev 20 centrov na duševno zdravje

otrok in mladostnikov ter 16 centrov za duševno zdravje odraslih v vseh regijah, razvoj in vpeljava učinkovitih programov antistigme, promocije in preventive duševnega zdravja in samomorilnosti ter krepitev kompetenc strokovnjakov na področju skrbi za duševno zdravje. V NPDZ in AN so bile vključene številne dobre prakse, vključno s programi nevladnih organizacij, ki so bile razvite in vpeljane v Sloveniji že pred sprejetjem tega programa.

Zaključki, izzivi: Med ključnimi izzivi ter potrebami na področju skrbi za duševno zdravje so sistemsko uvajanje učinkovitih programov v različna okolja za krepitev psihične odpornosti posameznika, povečanje razpoložljivosti in dostopnosti skupnostnih služb za obravnavo in zdravljenje oseb s težavami v duševnem zdravju, kot tudi okrepitev in razvoj zgodnje poklicne in zaposlitvene rehabilitacije za te osebe.

MENTAL HEALTH IN SLOVENIA - FACTS, CHALLENGES AND OPPORTUNITIES

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Key words: mental health, mental disorders, needs, community, national programme

Key highlights:

- Many factors and circumstances contribute to individual and community mental health outcomes, whether positive or negative, linked to the characteristics of the individual and their immediate and wider social environment.
- In 2022, more than 60 % of people in Slovenia rated their general health as good or very good, which is the same as the average for European Union countries.
- The prevalence of mental disorders in Slovenia was estimated by the Institute for Health Measurement and Evaluation at 12.6% in 2019, slightly lower than the average of the European Union countries.
- In recent years, the number of total staff working in mental health services in Slovenia has also increased due to the establishment of Mental Health Centres. In terms of the number of psychiatrists, Slovenia still ranks in the bottom half of the European Union countries.
- The National Programme for Mental Health, through its action plans, enables the participation of all key stakeholders who, by understanding the situation and needs, synergising and aligning priorities, can achieve a number of positive effects for the health and satisfaction of the entire population.

Facts/problem: Good mental health is a foundation of good health, making a significant contribution to individual and community quality of life and social well-being. In recent decades, there has been an increase in mental health problems among the Slovenian population. The most common mental disorders in adolescents and adults are stress and adjustment disorders, anxiety disorders, depressive episodes, recurrent depression, alcohol-related behavioural and mental disorders, and, after the age of 65, dementia. Among the most prominent problems are still high suicide rates and deaths due to alcohol abuse, which are among the highest in Europe. Mental and behavioural disorders rank third among all reasons for the average length of sick leave. The financial loss due to poor mental health is estimated at 3 to 4% of gross domestic product, mainly due to lost productivity and early retirement.

Methods/approaches: In 2018, Slovenia adopted its first National Mental Health Programme for 2018–2028 (NMHP). It identifies six priority areas, the actions of which are implemented through periodic Action plans.

Results: Key achievements of the NMHP include the establishment of an inter-ministerial working group, 14 interdisciplinary working groups at national level, the establishment of 20 mental health centres for children and adolescents and 16 mental health centres for adults in all regions, the development and implementation of effective anti-stigma programmes, as well as mental health promotion and prevention and suicide prevention programmes, and the strengthening of the competences of professionals in the field of mental health care. Also, a number of good practices, including NGO programmes, which had already been developed and implemented in Slovenia prior to the adoption of this programme, have been included in NMHP and AP.

Conclusions, challenges: Key challenges and needs in the field of mental health care include the systemic introduction of effective programmes in different settings to build mental resilience of an individual, increase the availability and accessibility of community-based services for the treatment and care of people with mental health problems, and to strengthen and develop early vocational and employment rehabilitation for people with mental health problems.

DUŠEVNE IN VEDENJSKE MOTNJE V LUČI ZDRAVSTVENEGA ABSENTIZMA

Avtorji: viš. pred. Ada Hočevar-Grom, dr. med., NIJZ, dr. Ticijana Prijon, dr. med., predsednica Sekcije za medicinsko izvedenstvo in zavarovalniško medicino Slovenskega zdravniškega društva (SMIZM), Slovenija

Ključne besede: duševne bolezni in vedenjske motnje, zdravstveni absentizem, analiza

Ključni poudarki:

- Duševne bolezni in vedenjske motnje (DBiVM) so eden glavnih javnozdravstvenih problemov tako v smislu pojavnosti kot bremena bolezni. Podatki mednarodnih raziskav kažejo, da v EU vsako leto zboli za katero od oblik DBiVM približno 11% prebivalstva, ocenjene finančne posledice zaradi izgubljene produktivnosti, dolgotrajne odsotnosti z dela in nezmožnosti za delo pa znašajo od 3 do 4 % BDP. V Sloveniji so DBiVM četrti najpogostejši vzrok zdravstvenega absentizma (ZA), predvsem dolgotrajne bolniške odsotnosti. Čeprav DBiVM predstavljajo maj kot 2% vseh primerov začasne nezmožnosti za delo, se zaradi navedenih zdravstvenih stanj izgubi približno 7% vseh delovnih dni. (Tabela 1)

TABELA 1: Kazalniki bolniškega staleža pri celokupnem ZA in pri DBiVM, (povprečje 2018 – 2022).

	SKUPAJ ZDRAV. ABSENT.	DBiVM
Število primerov	1.109.324	21.256
Število izgubljenih delovnih dni	17.109.165	1.168.502
% BS	5,09	0,35
IO	18,57	1,27
IF	120,26	2,31
R	15,67	55,19

- Pojavnost DBiVM se razlikuje po spolu in starosti, saj je prevalenca bolezni pri ženskah 2,5-krat večja kot pri moških, trajanje začasne nezmožnosti za delo pa s starostjo strmo narašča. Več kot 30% vseh izgubljenih delovnih dni zaradi DBiVM je posledica reakcij na hud stres in prilagoditvenih motenj (F 43), sledijo anksiozne motnje (F41) z več kot 20% izgubljenih delovnih dni ter depresivne epizode (F32) in ponavljajoče se depresivne motnje (F33), ki so vzrok za 17% oz. 11% ZA zaradi duševnih bolezni. Najdaljša bolniška odsotnost v okviru DBiVM je poročana pri organskih duševnih motnjah (F00 – F09), pri katerih začasna nezmožnost za delo v povprečju traja 148 dni, pri ponavljajočih se depresivnih motnjah (povprečno trajanje nad 137 dni) ter pri shizofreniji in blodnjavih motnjah (F20 -F29), pri katerih je bolniški stalež trajal več kot 117 dni.
- Delovno okolje pomembno vpliva na pojav in razvoj DBiVM. Analiza stanja namreč kaže, da ima več kot četrtina zaposlenih v EU težave v duševnem zdravju, njihova incidenca pa se močno razlikuje po posameznih gospodarskih in drugih dejavnostih (SKD). Z delom povezan stres in ostala psihosocialna tveganja ter slaba skrb za duševno zdravje na delovnem mestu znatno povečuje število bolniških odsotnosti. Podobno kot pri celokupnem ZA je število izgubljenih delovnih dni in

število primerov začasne nezmožnosti za delo zaradi DBiVM največje v dejavnosti javne uprave (O), v zdravstvenem in socialnem varstvu (Q), v finančni in zavarovalniški dejavnosti (K) ter v raznovrstnih poslovnih dejavnostih (N). Najdaljše povprečno trajanje ene bolniške odsotnosti pa je v kmetijstvu in gozdarstvu (A), v rudarstvu (B), gradbeništvu (F) in gostinstvu (I).

- Po podatkih Nacionalnega inštituta za javno zdravje (NIJZ) je bilo v letu 2018 zaradi DBiVM izgubljenih 995.596 delovnih dni, v letu 2022 pa 1.219.308 delovnih dni (22% prirastek), ob tem je bil poročan 15% porast števila izgubljenih dni na zaposlenega (od 1,11 dni v letu 2018 na 1,28 dni v letu 2022). V letu 2018 je trajala ena bolniška odsotnost približno 46 dni, leta 2022 pa že več kot 57 dni. V primerjavi z letom 2018 se je v letu 2022 število primerov začasne nezmožnosti za delo zaradi DBiVM znižalo za 6% (od 21.484 na 21.315 primerov), prav tako smo beležili upad števila primerov na 100 zaposlenih, od 2,39 v letu 2018 na 2,24 v letu 2022.
-
- Na trende ZA je nedvomno vplivala tudi epidemija covida-19. Leta 2020 smo zabeležili 10% upad števila vseh primerov začasne nezmožnosti za delo zaradi DBiVM (od 21.484 primerov na 20.054 primerov), ob tem pa se je število izgubljenih delovnih dni povečalo za dobrih 23% (od 995.596 na 1.226.594 dni), saj se je povprečno trajanje ene bolniške odsotnosti podaljšalo za približno 15 dni (od 46 v letu 2018 na 61 dni v letu 2020). (Tabela 2)

TABELA 2: Kazalniki bolniškega staleža pri DBiVM od leta 2018 do leta 2022, Slovenija

	2018	2019	2020	2021	2022
Število primerov	**21.484**	**23.247**	**20.054**	**20.179**	**21.315**
Število izgubljenih delovnih dni	**995.596**	**1.183.210**	**1.226.594**	**1.217.804**	**1.219.308**
% BS	**0,3**	**0,35**	**0,37**	**0,36**	**0,35**
IO	**1,11**	**1,29**	**1,36**	**1,31**	**1,28**
IF	**2,39**	**2,54**	**2,22**	**2,17**	**2,24**
R	**46,34**	**50,9**	**61,16**	**60,35**	**57,2**

Ozadje: Duševne bolezni in vedenjske motnje (DBiVM) predstavljajo velik javnozdravstveni problem delovno aktivne populacije, saj sodijo med najpogostejše vzroke zdravstvenega absentizma (ZA), dolgotrajne bolniške odsotnosti, invalidnosti in zgodnjega upokojevanja. Po podatkih mednarodnih raziskav ima več kot četrtina zaposlenih v EU težave v duševnem zdravju, predvsem zaradi naraščanja psihosocialnih obremenitev na delovnem mestu.

Metode: S pomočjo retrospektivne analize kazalnikov bolniškega staleža smo opredelili pojavnost in trende gibanja ZA zaradi DBiVM v Sloveniji od leta 2018 do leta 2022 po spolu, starostnih skupinah in po Standardni klasifikaciji dejavnosti (SKD).

Rezultati: Zaradi DBiVM je bilo na letni ravni registriranih več kot 21.200 primerov bolniške odsotnosti (1,9% vseh primerov), izgubljenih je bilo več kot 1.168.500 delovnih dni (6,8% celokupnega ZA), v povprečju je bolniška odsotnost trajala 55,2 dni (15,6 dni pri celokupnem ZA). Število primerov na 100 zaposlenih (IF) je bilo večje pri ženskah (IF = 3,34) kot pri moških (IF = 1,41), najvišji IF pa je bil evidentiran v starostni skupini od 45 do 64. Povprečno trajanje bolniške odsotnosti (R) je bilo višje pri moških (R = 55,26 dni) kot pri ženskah (R = 55,16 dni) in je s starostjo strmo naraščalo. Dejavnosti z najvišjo prevalenco DBiVM so bile: rudarstvo, javna uprava ter zdravstveno in socialno varstvo. Glede na diagnoze so prevladovale stresne in prilagoditvene motnje, depresija in anksioznost. Trend ZA zaradi DBiVM je v opazovanem obdobju naraščal, največji porast pa smo zabeležili v času pandemije

Covida-19 v letih 2020 in 2021.

Zaključki: DBiVM so eden glavnih javnozdravstvenih problemov tako v smislu pojavnosti kot bremena bolezni. Z delom povezan stres, slaba skrb za duševno zdravje delavcev ter posledice pandemije Covida-19 povečujejo verjetnost za bolniško odsotnost in pomembno vplivajo na rast ZA.

Legenda:

% BOLNIŠKEGA STALEŽA (% BS) – Odstotek bolniškega staleža je odstotek izgubljenih koledarskih dni na enega zaposlenega delavca.

$$\%\ BS = \frac{\text{število izgubljenih koledarskih dni x 100}}{\text{število zaposlenih x število dni v letu}}$$

INDEKS ONESPOSABLJANJA (IO) – To je število izgubljenih koledarskih dni na enega zaposlenega delavca.

$$IO = \frac{\text{število izgubljenih koledarskih dni}}{\text{število zaposlenih}}$$

INDEKS FREKVENCE (IF) – Število primerov odsotnosti z dela zaradi bolniškega staleža na 100 zaposlenih v 1 letu.

$$IF = \frac{\text{število primerov x 100}}{\text{število zaposlenih}}$$

RESNOST (R) – Povprečno trajanje ene odsotnosti z dela zaradi bolezni, poškodbe ali drugega zdravstvenega vzroka.

$$R = \frac{\text{število izgubljenih koledarskih dni zaradi enega vzroka}}{\text{število primerov}}$$

MENTAL AND BEHAVIOURAL DISORDERS IN THE LIGHT OF HEALTH ABSENTEEISM

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Keywords: mental and behavioural disorders, health absenteeism, analysis

Key highlights:

- Mental and behavioural disorders (MBD) are a major public health problem, both in terms of incidence and burden of disease. International survey data show that in the EU, approximately 11% of the population develops a form of MBD each year, with an estimated financial impact of 3 to 4% of GDP due to lost productivity, long-term absenteeism and incapacity for work. In Slovenia, MBDs are the fourth most common cause of health-related absenteeism (HA), especially long-term sickness absence. Although MBD accounts for less than 2% of all cases of temporary incapacity for work, approximately 7% of all working days are lost due to these medical conditions (Table 1).

TABLE 1: Sickness absence indicators for total HRA and for M&BD, (average 2018 - 2022).

	TOTAL HEALTH ABSENT.	M&BD
Number of cases	1.109.324	21.256
Number of lost working days	17.109.165	1.168.502
% BS	5,09	0,35
IO	18,57	1,27
IF	120,26	2,31
R	15,67	55,19

- The prevalence of MBD varies by sex and age, with women having a prevalence 2.5 times higher than men and the duration of temporary disability increasing sharply with age. More than 30% of all working days lost due to MBD are due to reactions to severe stress and adjustment disorders (F43), followed by anxiety disorders (F41) with more than 20% of working days lost, and depressive episodes (F32) and recurrent depressive disorders (F33), which are responsible for 17% and 11% of ADLs due to mental illness, respectively. The longest sickness absence under the MBD is reported for organic mental disorders (F00 - F09), with an average duration of temporary incapacity for work of 148 days, for recurrent depressive disorders (average duration of more than 137 days), and for schizophrenia and delusional disorders (F20 - F29), with a sickness duration of more than 117 days.
- The work environment has a significant impact on the occurrence and development of MBD. In fact, the analysis shows that more than a quarter of EU employees have mental health problems, and the incidence varies considerably across economic and other activities (NACE). Work-related stress and other psychosocial risks, as well as poor mental health care at work, significantly increase the number of sickness absences. Similar to the overall HA, the number of working days lost and the number of cases of temporary incapacity for work due to MDB are highest in public administration (O), health and social work activities (Q), financial and insurance activities (K) and miscellaneous business activities (N). However, the longest average duration of one sick leave is in agriculture and forestry (A), mining (B), construction (F) and accommodation and food service activities (I).

- According to the National Institute of Public Health (NIJZ), 995,596 working days were lost due to MBD in 2018 and 1,219,308 working days in 2022 (a 22% increase), with a reported 15% increase in the number of days lost per employee (from 1.11 days in 2018 to 1.28 days in 2022). In 2018, one sick leave lasted approximately 46 days, while in 2022 it will be more than 57 days. Compared to 2018, the number of cases of temporary disability due to MBD in 2022 decreased by 6% (from 21,484 to 21,315 cases), and we also saw a decrease in the number of cases per 100 employees, from 2.39 in 2018 to 2.24 in 2022.
- In 2020, we recorded a 10% decrease in the number of all cases of temporary disability due to MBD (from 21,484 cases to 20,054 cases), while the number of working days lost increased by a good 23% (from 995,596 days to 1,226,594 days), as the average duration of one sick leave increased by about 15 days (from 46 days in 2018 to 61 days in 2020) (Table 2).

TABLE 2: Sickness absence indicators for MBD from 2018 to 2022, Slovenia

	2018	2019	2020	2021	2022
Number of cases	21.484	23.247	20.054	20.179	21.315
Number of lost working days	995.596	1.183.210	1.226.594	1.217.804	1.219.308
% health absenteeism	0,3	0,35	0,37	0,36	0,35
IO (lost working days/employee)	1,11	1,29	1,36	1,31	1,28
IF	2,39	2,54	2,22	2,17	2,24
R	46,34	50,9	61,16	60,35	57,2

Background: Mental and behavioural disorders (MBD) are considered a major public health issue among the working population and one of the most frequent reasons for health absenteeism (HA), long sick leave, invalidity and early retirement. According to international studies, over one fourth of employed people in the European Union suffer from mental health issues, mainly due to the increasing psychosocial stress in the workplace.

Methodology: The retrospective analysis of sick leave indicators provided the means to define the trends and developments of HA caused by MBD in Slovenia between 2018 and 2022, divided by gender, age group and Statistical classification of economic activities (NACE).

Results: Over 21,200 sick leaves due to MBD were registered on a yearly basis (1.9% of all cases) with more than 1,168,500 work days lost (6.8% of all HA), with the average sick leave of 55.2 days (15.6 days of overall HA). The number of cases per 100 employees was higher among female workers (IF = 3.34) compared to the male workers (IF = 1.41), and the highest IF was recorded in the 45-64 age group. The average duration of sick leave was slightly higher among men (R = 55.26 days) than women (R = 55.16 days) and has been growing exponentially with age. Mining and quarrying, public administration, human health and social work are the activities with the highest prevalence of MBD, while stress and adjustment disorders, depression and anxiety are the predominant diagnoses. A growing rate of HA due to MBD was detected in the period observed, with a dramatic escalation during the 2020 and 2021 Covid-19 pandemic.

Conclusions: MBD represent one of the primary public health issues in terms of both incidence and burden. Work-related stress, poor care of employees' mental health and the impact of the Covid-19 pandemic only increase the probability of sick leaves and influence greatly the expansion of HA.

Legend:

% SICK LEAVE (% BS) - Sick leave percentage is the percentage of calendar days lost per employee.

$$\%\ BS = \frac{\text{number of calendar days lost x 100}}{\text{number of employees x number of days in the year}}$$

DISABIOITY INDEX (IO) - This is the number of calendar days lost per employee.

$$IO = \frac{\text{number of calendar days lost}}{\text{number of employees}}$$

FREQUENCY INDEX (IF) - The number of sickness absences per 100 employees in 1 year.

$$IF = \frac{\text{number of cases x 100}}{\text{number of employees}}$$

SERIOUSNESS (R) - The average duration of one absence from work due to sickness, injury or other medical cause.

$$R = \frac{\text{number of calendar days lost due to one cause}}{\text{number of cases}}$$

POMEN DELOVNE DOKUMENTACIJE ZA OCENO DELAZMOŽNOSTI V LUČI IZZIVOV/PRILOŽNOSTI DIGITALNE DOBE

Avtor: Matej Kokalj Kokot, dr. med., specialist medicine dela, prometa in športa; predstavnik Zdravniške zbornice Slovenije v RSK za informatiko v zdravstvu

Izvleček: Ocena delazmožnosti je v osnovi multidisciplinarni postopek, ki je v Sloveniji vključen v delo timov pooblaščenih izvajalcev medicine dela, prometa in športa, centrov poklicne in zaposlitvene rehabilitacije ter izvedenskih organov ZZZS in ZPIZ. Uporablja se tako za sprotne korekcije delovnih mest ob pojavu prvih težav zaposlenih, vračanje na delo po predvidljivo dolgih in dolgotrajnih bolniških odsotnostih ter tudi takrat, ko je potrebno trajno/začasno priznavanje pravnih statusov. Sam postopek je zaradi vključitve številnih profilov večinoma kompleksen in dolgotrajen, zato je za dobro in učinkovito delovanje postopkov nujna dobra komunikacija med njimi.

Delazmožnost je najpogosteje definirana kot ravnovesje med delovnimi zahtevami in individualnimi sposobnostmi posameznika. Pri oceni delazmožnosti je zato pomembna izmenjava že ugotovljenih ugotovitev sposobnosti posameznika v izogib podvajanju dela kot tudi izmenjava značilnosti in zahtev delovnega mesta. Delovna dokumentacija sicer lahko vsebuje oboje, a najpogosteje vsebuje predvsem opis zahtev delovnega mesta in posledično meje, ki jo posameznikove lastnosti morajo preseči, da se lahko varno vrne v delovni proces.

V Sloveniji se kot delovno dokumentacijo v postopku ocenjevanja delazmožnosti najpogosteje uporabljata izjava o varnosti delodajalcev in/ali njen povzetek, ki ga poznamo kot obrazec DD-1 v postopkih priznavanja invalidnosti. Oba dokumenta sta sicer s spremembo trga delovne sile, novih oblik dela in fleksibilnosti procesov v večini podjetij postala neoptimalna in po nepotrebnem onemogočata hitrejšo odzivnost vseh vpletenih v sistemu ocenjevanja delazmožnosti.

Digitalna transformacija v zdravstvu, ki ima podlago v prihajajoči evropski uredbi o evropskem zdravstvenem podatkovnem prostoru (ang. EHDS), je odlična priložnost, da razmislimo o novem, interoperabilnem načinu zajema in izmenjave podatkov, ki bi z orodji, ki so že danes na voljo, omogočila lažje odločanje, hitrejše ukrepanje, ciljano stroškovno analizo sprejetih ukrepov in razvoj novih orodij za vzdrževanje zdrave delovne sile, ki do sedaj niso bila možna. Je pa za to nujno potreben širši konsenz in sodelovanje vseh vpletenih deležnikov.

VALUE OF THE WORK RELATED DOCUMENTATION IN THE PROCESS OF ASSESSING THE WORKING ABILITY AND CONSIDERING CHALLANGES/ OPPURTUNITIES OF THE DIGITAL AGE

Author: Matej Kokalj Kokot, M.D., occupational and sports medicine specialist; Medical chamber of Slovenia's representative in the National governance board for eHealth, Slovenia

Abstract: Assessment of the working ability is fundamentally a multidisciplinary process that is integrated into the work of teams of selected local occupational, traffic, and sports medicine, professionals, work rehabilitation centers, as well as expert bodies affiliated with the Health Insurance Institute of Slovenia (ZZZS) and the Pension and Disability Insurance Institute of Slovenia (ZPIZ). The process itself is utilized for ongoing adjustments of working conditions when initial employee difficulties arise, for returning to work procedures following predictable or prolonged sick leave, and also in cases requiring permanent/ temporary recognition of legal statuses. Due to the involvement of numerous professional profiles, the process itself is generally complex and time-consuming, thus emphasizing the crucial necessity of effective communication among all parties.

Work capacity is most commonly defined as the balance between job demands and an individual's capabilities. Therefore, it is crucial that the assessment of work capacity involves exchange of previously determined findings of an individual's abilities to avoid duplicative efforts. Equally important is to share the characteristics and requirements of the job position. While work documentation can contain both, it primarily includes job descriptions and, consequently, the limits that an individual's qualities must surpass to safely reintegrate into the work process.

In Slovenia, the most commonly used work documentation in the work capacity assessment process is the employer's risk assessment and/or its summary, known as the DD-1 form (short for work related documentation) in permanent disability recognition procedures. Both documents have become suboptimal and unnecessarily hinder faster response times for all involved in the work capacity assessment system due to changes in the labor market, new forms of work, and process flexibility in most companies.

The digital transformation in healthcare, based on the upcoming European Regulation on the European Health Data Space (EHDS), presents an excellent opportunity to consider a new, interoperable approach to data capture and exchange. This approach, utilizing tools available today, would enable easier decision-making, faster actions, targeted cost analysis of implemented measures, and the development of new tools for maintaining a healthy workforce that were previously not possible. However, achieving this requires broader consensus and collaboration among all stakeholders involved.

POSEBNE ZDRAVSTVENE ZAHTEVE ZA DELO V RAZLIČNIH DELOVNIH OKOLJIH, KI LAHKO PREDSTAVLJAJO OVIRE ZA OPRAVLJANJE DELA PRI BOLNIKIH Z DUŠEVNO ALI VEDENJSKO MOTNJO

Avtor: asist. Dani Mirnik, dr. med., specialist medicine dela, prometa in športa, Zavod za varstvo pri delu

Ključne besede: posebne zdravstvene zahteve, delazmožnost, duševne in vedenjske motnje, medicina dela

Izvleček: Posebne zdravstvene zahteve so zdravstvene lastnosti, ki jih kot pogoj za opravljanje določenega dela v določenem delovnem okolju sprejme in vključi v oceno tveganja delodajalec na podlagi strokovne ocene zdravnika specialista medicine dela, prometa in športa. Izpolnjevanje posebnih zdravstvenih zahtev na podlagi opravljenega zdravstvenega pregleda celovito presoja zdravnik specialist medicine dela, prometa in športa.

Namen posebnih zdravstvenih pogojev je varovanje zdravja delavcev in ohranjanje delazmožnosti, varovanje zdravja vseh oseb v delovnem okolju, predmetov dela in varovanje delovnega okolja. Posebne zdravstvene zahteve so lahko prisotnost določenih zdravstvenih lastnosti pri osebi ali odsotnost določenih zdravstvenih okvar.

Z modernizacijo in digitalizacijo delovnih procesov se v delovnih okoljih spreminjajo tudi zdravstvene zahteve iz vidika duševnega zdravja zaposlenih. Duševne in vedenjske motnje lahko okrnijo eno ali več področij psihološkega ali socialnega delovanja, ki vplivajo na zmožnosti izvajanja delovnih nalog in delazmožnost. Najbolj pogoste so motnje koncentracije in pozornosti, motnje motoričnih funkcij, motnje komunikacijskih in socialnih spretnosti, v določenih primerih oz. delovnih okoljih lahko bolezni predstavljajo tudi tveganje za lastno zdravje in zdravje drugih. Pogosto na funkcijo in delazmožnost bolnikov vplivajo zdravila, ki jih prejemajo tekom zdravljenja (npr. antidepresivi, antipsihotiki, itd.), kot tudi v fazi remisije.

V določenih delovnih okoljih, kjer je varnost kritična (npr. letalski promet, železniški promet in ostali poklicni vozniki, delo v jedrskih objektih, itd.), so posebne zdravstvene zahteve tudi iz vidika duševnih in vedenjskih motenj že zakonsko določene ali natančno opredeljene v ustreznih regulativah. Tudi pri poklicnih skupinah, kjer se pričakuje visoka stopnja produktivnosti, odgovornosti in sposobnosti obvladovanja različnih stresorjev (npr. šolstvo, zdravstvo, vodstvene funkcije) so navadno zdravstvene zahteve jasno opredeljene. Nenazadnje pa je ustrezno obravnavati tudi delovne skupine z manjšimi psihosocialnimi obremenitvami, saj lahko hujše oblike duševnih in vedenjskih motenj zmanjšajo (začasno ali trajno) delazmožnost v praktično vseh poklicih.

HEALTH REQUIREMENTS FOR WORK IN VARIOUS JOB ENVIRONMENTS: POTENTIAL CHALLENGES IN PATIENT CARE WITH MENTAL OR BEHAVIORAL DISORDERS

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Keywords: special health requirements, work capacity, mental and behavioral disorders, occupational medicine

Abstract: Health requirements are health characteristics that employers accept as a condition for performing specific tasks in a particular work environment. They are incorporated into risk assessments by the employer based on the professional evaluation of a medical doctos, specialist in occupational, traffic, and sports medicine. The fulfillment of special health requirements is comprehensively assessed by a physician specializing in occupational, traffic, and sports medicine based on a conducted health examination.

The purpose of special health conditions is to protect the health and preserve the work capacity of employees, safeguard the health of all individuals in the work environment, and protect the work environment itself. Health requirements may involve the presence of specific health characteristics in an individual or the absence of certain health impairments.

With the modernization and digitization of work processes, the health requirements in workplaces are evolving, especially concerning the mental health of employees. Mental and behavioral disorders can impair one or more domains of psychological or social functioning, influencing the ability to perform work tasks and work capacity. Common challenges include concentration and attention disorders, impaired motor skills, communication and social skills disorders, and, in certain cases or work environments, diseases may pose a risk to the individual's own health and the health of others. The therapy received during the treatment process (e.g., antidepressants, antipsychotics) often impacts the function and work capacity of patients, even during periods of remission.

In certain work environments where safety is critical (e.g., aviation, railway transportation, professional drivers, work in nuclear facilities, etc.), specific health requirements for mental and behavioral disorders are either legally defined or precisely outlined in relevant regulations. Professions requiring high levels of productivity, responsibility, and the ability to manage various stressors (e.g., education, healthcare, leadership roles) usually have clearly defined health requirements. Last but not least, also considering workgroups with lower psycho-social burdens is crucial, given that severe forms of mental and behavioral disorders can temporarily or permanently reduce work capacity in practically all professions.

ČETRTEK 11.04.2023 // THURSDAY 11.04.2024

PLENARNA SEKCIJA 2 // PLENARY SESSION 2

BREME DEPRESIJE

Avtor: dr. Mirjana Radovanović, dr. med., spec. psihiatrije, Univerzitetna psihiatrična klinika Ljubljana

Ključne besede: depresija, breme bolezni, zdravljenje, delazmožnost

Ključni poudarki:

- Depresija je heterogena in pogosta duševna motnja, za večino bolnikov poznamo učinkovite načine zdravljenja.
- Je javnozdravstveni problem in posledice pomenijo veliko breme za družbo.
- V začetni fazi je delazmožnost lahko zelo zmanjšana, kasneje je delovna reaktivacija pomembni del okrevanja.
- Pri ponavljajoči obliki ali v kronični obliki (distimija) so pomembne prilagoditve na delovnem mestu, delazmožnost pa lahko trajno zmanjšana.

Izvleček: Z izrazom unipolarna depresija (tudi depresija ali depresivna motnja) poimenujemo obliko depresije, ki ni del bipolarne razpoloženjske motnje. Svetovna zdravstvena organizacija (WHO) je napovedala, da bo depresivna motnja do leta 2030 postala vodilni vzrok invalidnosti v svetu. Po podatkih WHO se je delež oseb z depresijo podvojil od leta 1990 do leta 2017. Doživljenjska prevalenca depresije je danes med 11% v razvitih državah in 15% v ekonomsko srednje do manj razvitih državah. V Sloveniji ima v vsakem trenutku 4,5% prebivalstva depresijo. Ekonomsko breme je primerno visoko predvsem zaradi izgubljenih let produktivnosti.

Motnja je heterogena in pogosta, prizadene tako duševno kot telesno zdravje. Pojavlja se v vseh življenjskih obdobjih. Dva in pol krat pogostejša je pri ženskah kot pri moških. Veliko bolnikov ima ponavljajoči potek. Približno polovica bolnikov s prvo epizodo zboli ponovno, več kot dve tretjini bolnikov z dvema epizodama zboli še v tretje, nekaj manj kot šestina bolnikov razvije kronični potek brez obdobij remisije (distimija).

Depresija in sočasno potekajoče motnje so vzrok zmanjšane delazmožnosti. V začetnih fazah poteka in zdravljenja depresije je smiseln polni bolniški stalež, ki pa mora bit aktiven ob upoštevanju morebitnih telesnih oviranosti. Kasneje pa je delovna reaktivacija pomemben korak v procesu okrevanja. Vračanje na delovno mesto naj bo postopno. Pri kroničnem poteku bolezni pa je potrebno v sodelovanju s specialisti medicine dela in delodajalci poiskati prilagoditve, ki bodo omogočale bolnikom ostati čim dlje aktivni, kljub marsikdaj trajno zmanjšani delazmožnosti. Posledice depresije se namreč kažejo v duševnem in telesnem funkcioniranju – med drugimi so lahko zmanjšani zbranost, usmerjenost pozornosti, okretnost razmišljanja, procesi odločanja, porušen je lahko dnevno-nočni ritem, pogosto so prisotni psihični in telesni simptomi anksioznosti ter bolečine. Sočasno potekajoča druga duševna motnja ali kronična telesna bolezen dodatno vplivajo na delazmožnost. Delazmožnost je zmanjšana tudi pri bolnikih z depresijo, ki imajo specifične in klinično pomembne osebnostne motnje.

Posledice depresije imajo tako osebe z motnjo kot njihovi najbližji. Kljub veliko znanja o depresiji je še vedno motnja relativno slabo prepoznana in zdravljena. Razvitih in v uporabi je veliko različnih vprašalnikov, tudi samoocenjevalnih, ki so v pomoč pri diagnosticiranju motnje. Danes imamo na voljo veliko učinkovitih zdravil za zdravljenje depresije, učinkoviti so tudi psihoterapevtski ukrepi, najbolj učinkovita je kombinacija obeh pristopov.

BURDEN OF DEPRESSION

Author: Mirjana Radovanović, M.D., D.Sc., University Psychiatric Hospital Ljubljana, Slovenia

Keywords: depression, treatment, burden of disease, work ability

Key highlights:

- Depression is heterogeneous and common mental disorder with a variety of effective treatments available for the majority of patients.
- It is an important public health problem and burden for society.
- Work ability is often decreased in the acute phases of disease and gradual return to work is important step in recovery.
- In recurring depression or in chronic course (dysthymia) workplace adjustments may be beneficial, and in some patients work ability may be permanently decreased.

Abstract: Unipolar depression (depressive disorder or depression) is type of mental disorder, which is not part of bipolar affective disorder. WHO predicted depression to be the leading cause of disability in the world by year 2030. According to its data proportion of patients with depression doubled between years 1990 and 2017. Lifetime prevalence is between 11% in high-income countries and 15% in middle- to low-income countries. Point prevalence in Slovenia is 4,5% of population. The economic burden of disease is also high primarily due to the lost productivity.

The disorder is heterogeneous and common, affects mental and medical health, and is occurring throughout the lifespan, being two and a half fold more prevalent in women than men. About one half of patients with the first episode of depression develop the second episode, more than two thirds of patients with two episodes develop the third one. Roughly one in six suffer with chronic depression without periods of remission (dysthymia).

Depression and co-occurring disorders are cause of decreased work performance and ability. In acute phase of depression and when introducing medication patients need sick leave. Gradual return to work is an important part of recovery. Nevertheless, the work ability may be decreased permanently in patients with chronic depression or with co-occurring disorders, both mental and medical. Clinically important personality disorders also decrease work ability in patients with depression. Consequences of depression affect mental and physical functioning – among others are decreased focus and attention, thought processes speed and content, decision processes, wake-sleep cycle, mental and physical symptoms of anxiety, pain.

Depression affects patient with disorder and their family members. Despite increase in knowledge about depression it is still relatively underdiagnosed and undertreated disease. Several validated questionnaires can help with diagnostic process. Nowadays there are many effective medications available, the effectiveness of psychotherapeutic interventions is evidence-based, and the most effective is a combination of both approaches.

S STRESOM POVEZANE PSIHIČNE MOTNJE

Avtor: prof. dr. Peter Pregelj, dr.med., sepc. psih, spec. klin. farmakol. Univerzitetna psihiatrična klinika Ljubljana, Univerza v Ljubljani, Medicinska fakulteta

Ključne besede: posttravmatska stresna motnja, stres, akutna stresna reakcija, prilagoditvena motnja

Izvleček: Izpostavljanje stresorjem je pogosto v interakcijah organizma z zunanjim in notranjim okoljem. Vsi organizmi so razvili mehanizme za spopadanje s stresorji. Motnje v odgovoru organizma na stresorje se pojavijo kadar je porušeno notranje oziroma zunanje ravnovesje organizma in ga organizem ne uspe odpraviti. V primeru, da je stres pretiran, predolgo traja ali je povečana ranljivost posameznika (na primer uporablja neustrezne strategije spoprijemanja s stresorji, sočasne psihične motnje) postane stres dejavnik tveganja za razvoj nekaterih telesnih bolezni in psihičnih motenj. Izpostavitve posameznika stresorjem je tudi predpogoj za nastanek s stresom poveznih psihičnih motenj. Mednarodna klasifikacija bolezni 10. revizija (Svetovna zdravstvena organizacija) slednje psihične motnje uvršča v posebno skupino Reakcija na hud stres in prilagoditvene motnje. Kategorija se razlikuje od drugih po tem, da vključuje motnje, ki niso opredeljen le psihopatološkimi pojavi in potekom, ampak tudi glede na prisotnost enega ali drugega dejavnika izmed naslednjih dveh: izjemno obremenilni življenjski dogodek, ki ustvarja akutno stresno reakcijo ali pomembna sprememba v življenju osebe, ki vodi do trajnih neugodnih okoliščin, te pa povzročijo motnje v prilagajanju. Sodobne metode omogočajo merjenje tako izraženosti stresa pri posamezniku kot tudi ugotavljanje ranljivosti in pričakovanega odgovora ne prihodnje stresorje ter omogočajo opredeljevanje posledic izpostavitve posameznika stresorjem. Možno je spremljati stresorje katerim so izpostavljene večje skupine ljudi v okviru ekoloških študij (na primer vpliv ekonomskih dejavnikov na ravni regije ali države) ali spremljanje vplivov stresorjev na ravni posameznika z uporabo različnih metod kot na primer uporaba spletnih vprašalnikov v času epidemije Covid-19 z uporabo analize podatkov z umetno inteligenco ali z uporabo metode psihološke avtopsije z namenom spremljanja stresorjev v obdobju pred smrtjo.

STRESS RELATED MENTAL DISORDERS

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Key words: post-traumatic stress disorder, stress, acute stress reaction, adjustment disorder

Abstract: Exposure to stressors is often in the organism's interactions with the external and internal environment. All organisms have developed mechanisms to cope with stressors. In the event that stress is excessive, lasts too long or the individual's vulnerability is increased (for example, when inadequate coping strategies were used, concurrent psychological disorders are present), stress becomes a risk factor for the development of certain physical diseases and psychological disorders. Exposure of an individual to stressors is also a prerequisite for the emergence of stress-related psychological disorders. The International Classification of Diseases 10th revision (World Health Organization) places the latter mental disorders in the special group Reaction to severe stress and adjustment disorders. The category differs from others that it includes disorders defined not only by psychopathological phenomena and course, but also by the presence of one or other of the following two factors: an extremely stressful life event that creates an acute stress reaction or a significant change in the person's life, which leads to permanent unfavourable circumstances, which cause adjustment disorders. Modern methods make it possible to measure the expression of stress in an individual, as well as to determine vulnerability and the expected response to future stressors, and make it possible to define the consequences of an individual's exposure to stressors. It is possible to monitor the stressors to which larger groups of people are exposed in the context of ecological studies (for example, the impact of economic factors at the regional or national level) or to monitor the impact of stressors at the individual level using different methods, such as the use of online questionnaires during the Covid-19 epidemic combined with artificial intelligence data analysis or using the method of psychological autopsy to monitor stressors in a period before death.

UPORABA KLINIČNIH VPRAŠALNIKOV ZA POMOČ PRI OCENI DELAZMOŽNOSTI BOLNIKOV Z DEPRESIVNO IN/ALI ANKSIOZNO MOTNJO

Avtor: dr. Zvezdana Snoj, dr. med., spec. psihiatrije

Ključne besede: Depresija, anksioznost, klinični vprašalniki, HADS (Hospital Anxiety and Depression Scale)

Izvleček: Depresija in anksioznost spadata med najpogostejše duševne motnje, ki prizadenejo eno od šestih oseb. Depresija je vodilni vzrok nezmožnosti za delo, pri čemer je pri ženskah 2 do 3-krat pogostejša kot pri moških. Kljub temu depresija pogosto ostane neprepoznana in posledično nezdravljena. Nezdravljena depresija pogosto postane kronična, zdravljenje je v takšnem primeru bolj zapleteno in dolgotrajno prav tako je pogosteje povezana s samomorilnim vedenjem in povečano umrljivostjo zaradi drugih bolezni

Za prepoznavanje depresije in anksioznosti se poleg kliničnega pregleda, ki velja za »zlati standard« v diagnostiki, uporabljajo tudi različni vprašalniki. Ti omogočajo zlasti zdravnikom, ki niso psihiatri, hitro oceno depresije in anksioznosti ter usmerjanje bolnikov k nadaljnji strokovni obravnavi. V klinični praksi so še posebej uporabni vprašalniki za samoocenjevanje.

V svetu se za samoocenjevanje najpogosteje uporablja vprašalnik HADS (Hospital Anxiety and Depression Scale), ki sta ga razvila A. Zigmond in R. P. Snaith, namenjen je ugotavljanju simptomov anksioznosti in depresije pri bolnikih s telesno boleznijo. V sklopu naše raziskave, ki je potekala leta 2004/2005, smo HADS prevedli v slovenščino in nato validirali pri neodvisnem vzorcu 220 bolnic. Naša študija je pokazala, da je HADS sprejemljivo in veljavno orodje za merjenje anksioznosti in depresije pri slovenskih bolnicah.

HADS je kratek in preprost vprašalnik, ki bolniku omogoča izpolnitev v 2 do 5 minutah. V nasprotju z drugimi psihiatričnimi vprašalniki se HADS razlikuje po tem, da ne vsebuje somatskih simptomov, ki jih je mogoče pripisati tudi telesni bolezni ali postopkom zdravljenja, zato je posebej uporaben v klinični praksi pri obravnavi bolnikov z različnimi telesnimi boleznimi, vključno z onkološkimi. Ker je HADS enostaven, hiter za uporabo in dobro sprejet med bolniki, se pogosto uporablja pri kliničnih obravnavah pacientov z različnimi telesnimi boleznimi v bolnišničnem in ambulantnem okolju vključno z ambulantami družinske medicine, kjer lahko anksioznost in depresijo spremlja telesna bolezen.

Pomembno je poudariti, da so takšni vprašalniki primerni le za presejanje, dokončno diagnozo pa je treba postaviti s kliničnim pregledom.

USING CLINICAL QUESTIONNAIRES TO HELP ASSESS THE WORK CAPABILIY OF PATIENTS WITH DEPRESSIVE AND/OR ANXIETY DISORDERS

Author: Zvezdana Snoj, MD., Ph.D., Psychiatrist, Slovenia

Keywords: Depression, Anxiety, Clinical Questionnaires, HADS (Hospital Anxiety and Depression Scale)

Abstract: Depression and anxiety are among the most prevalent mental disorders, affecting one in six individuals. Depression stands as a leading cause of work incapacity, being 2 to 3 times more frequent in women than in men. Despite its high prevalence, depression often remains undetected and consequently untreated. Untreated depression frequently becomes chronic, complicating the treatment process and is more frequently associated with suicidal behavior and increased mortality from other diseases.

In addition to clinical examination, considered the ‚gold standard' in diagnostics, various questionnaires are employed to recognize depression and anxiety. These questionnaires, particularly beneficial for non-psychiatrist physicians, enable a rapid assessment of depression and anxiety, guiding patients towards further specialized care. Self-assessment questionnaires prove particularly useful in clinical practice.

Globally, the Hospital Anxiety and Depression Scale (HADS), developed by A. Zigmond and R. P. Snaith, is commonly used for self-assessment, primarily designed to identify symptoms of anxiety and depression in patients with physical illnesses. In the course of our research conducted in 2004/2005, we translated and validated HADS in Slovenian with an independent sample of 220 female patients. Our study demonstrated that HADS is an acceptable and valid tool for measuring anxiety and depression in Slovenian female patients.

HADS is a brief and straightforward questionnaire, allowing patients to complete it in 2 to 5 minutes. Unlike other psychiatric questionnaires, HADS does not include somatic symptoms that could be attributed to physical illnesses or treatment procedures. Therefore, it is particularly useful in clinical practice for patients with various physical illnesses, including oncological conditions. Due to its simplicity, quick usability, and positive acceptance among patients, HADS is frequently utilized in the clinical management of patients with various physical illnesses in both hospital and outpatient settings, including family medicine practices, where it can help monitor anxiety and depression alongside physical illnesses.

It is important to emphasize that such questionnaires are suitable for screening purposes only, and a final diagnosis should be established through clinical examination.

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PARALELNA SEKCIJA 3.1 // PARALLEL SESSION 3.1

OCENA ODSOTNOSTI Z DELA V VELIKI BRITANIJI: PREGLED UREDITVE IZJAVE O SPOSOBNOSTI ZA DELO (»FIT NOTE«), VKLJUČNO S PREDNOSTMI, PASTMI IN REFORMO SISTEMA

Avtor: dr. Charmian Moeller-Olsen, svetovalec za zdravstveno politiko, Ministrstvo za delo in pokojnine, Združeno kraljestvo

Ključne besede: izjava o sposobnosti za delo, potrdilo o upravičeni zadržanosti z dela, bolezen, odsotnost, invalidnost, reforma

Strokovno sodelovanje: Ministrstvo za delo in pokojnine

Ozadje: Izjava o sposobnosti za delo (ang. fit note) je bila v Združenem kraljestvu uvedena aprila 2010 in je zamenjala tedanje potrdilo o upravičeni zadržanosti z dela, da bi se izboljšalo svetovanje glede vrnitve posameznikov, odsotnih z dela zaradi bolezni, nazaj na delo in zmanjšala stopnja odsotnosti z dela zaradi bolezni. Ta ocena ima dva dela. V prvem delu bodo predstavljene glavne značilnosti strukture sedanjega sistema, vključno z načinom uvedbe izjave o sposobnosti za delo in razlogih zanjo ter presojo, kako je ta vključena v splošni sistem socialnega varstva. Ocenjene bodo tudi prednosti in slabosti izjave ter njihov vpliv na oceno bolezni.

V drugem delu bo obravnavano, kako se je izjava o sposobnosti za delo spreminjala skozi čas, pri čemer bo poudarek na zadnje uvedeni spremembi na področju politike in na načrtovanih spremembah sistema izjave o sposobnosti za delo, ki so bile napovedane v jesenski izjavi za leto 2023, vladnemu načrtu porabe in obdavčitve. Obravnavane bodo zadnje spremembe glede tega, kateri zdravniki lahko izpolnijo obrazec, ter prihodnji predlogi za večjo zaposlitveno podporo, ki jih obravnava vlada Združenega kraljestva, in posledice za prihodnost.

ASSESSMENT OF ABSENCE FROM WORK IN GREAT BRITAIN: AN OVERVIEW OF THE 'FIT NOTE' INCLUDING THE BENEFITS, PITFALLS, AND SYSTEM REFORM

Author: Dr Charmian Moeller-Olsen, Medical Policy Advisor, Department for Work and Pensions, UK

Keywords: fit note, sick note, sickness, absence, disability, reform

Professional cooperation: Department for Work and Pensions

Background: The statement for Fitness for Work (known as a 'fit note') was introduced in the UK in April 2010 to replace the existing 'sick note' with the aims of improving back to work advice for individuals on sickness absence and ultimately reducing sickness absence levels. This assessment will be in two parts. The first section will offer an overview of the current system structure including the history of how and why the fit note was developed as well as considering how it fits into the overall welfare system. It will also evaluate its success and failures and what this has meant for the assessment of sickness.

The second section will consider how the fit note has evolved over time with a focus on recent implemented policy change as well as future planned changes to the fit note system which were announced as part of the 2023 Autumn Statement. It will discuss recent changes that have been made around the types of practitioners who are able to complete the form as well as upcoming proposals around enhanced employment support which are being considered by the UK government and the implications for its future.

PODPIRANJE DELOVNE ZMOŽNOSTI

Avtorica: Sirkku Martti, dr. med., specialistka medicine dela, strokovna direktorica področja zdravje pri delu v okviru storitev za poklicno aktivne osebe pri podjetju Mehiläinen, Finska

Ključne besede: delovna zmožnost, zdravje na delovnem mestu, odsotnost z dela zaradi bolezni

Ključni poudarki:

- V ordinacijah zdravnikov medicine dela se pojavljajo blage duševne težave, kot so življenjske krize, ki ne zahtevajo zdravniškega zdravljenja. Namesto tega so podporne samorešitve, kot so krepitev lastnih veščin spoprijemanja, preventivno usposabljanje za obvladovanje življenjskih veščin in močna podpora delavca na delovnem mestu ter začasna sprememba dela, pomembni načini odzivanja na prevladujoče razmere.
- Najpogostejše diagnoze so anksiozne in prilagoditvene motnje ter nespečnost, ki jih mladi doživljajo zlasti na začetku poklicne poti in ob življenjskih prehodih. Pri teh blagih duševnih motnjah obisk pri zdravniku pogosto vodi v pretirano diagnosticiranje in bolniški dopust. Pogoj za upravičenost do bolniškega nadomestila je izpolnjevanje diagnostičnih meril, začetek priporočenega zdravstvenega in rehabilitacijskega zdravljenja ter priprava načrta vrnitve na delo v sodelovanju z delovnim mestom. Bolniški dopust torej ni nadomestilo za manjkajoče zdravljenje in rehabilitacijo in, če se podaljša, ne pripomore k okrevanju po duševni motnji.
- Vsak delavec je odgovoren za svoje odločitve glede zdravja. Duševno zdravje ali njegovi izzivi so tesno povezani z vprašanji, kot so telesna aktivnost, prehrana, spanje in zloraba snovi. Že samo podpora na teh področjih lahko bistveno pripomore k preprečevanju motenj duševnega zdravja. Obstaja pa tudi veliko načinov, kako lahko delodajalci pomagajo zaposlenim.
- Na Finskem je delodajalec odgovoren za spodbujanje delovnih pogojev na področju zdravja in varnosti pri delu. To vključuje redno ocenjevanje psihološkega in socialnega stresa ter dejavnikov virov na delovnem mestu in razvoj delovnih pogojev. Če so delovni pogoji dobri, je tudi tveganje za poslabšanje počutja pri delu manjše.
- Če je kultura upravljanja na delovnem mestu ustrezna, bo delovno mesto zagotovilo načine, ki bodo delavcem omogočili nadaljevanje dela ob začasni izgubi delovne zmožnosti. Za to sta potrebna tako zavedanje delavcev na delovnem mestu kot tudi razumevanje skupnosti na delovnem mestu, da vsi ne morejo vedno dati vsega od sebe, tudi če si to želijo.

Izvleček: Na Finskem imamo več načinov za podpiranje delovne zmožnosti in nadaljnjo zaposlitev na delovnem mestu. Najpogostejši vzrok težav v zvezi z delovno zmožnostjo so mišično-skeletne motnje in težave z duševnim zdravjem.

Ustanova socialnega zavarovanja (Kela) povrne delodajalcem višji delež stroškov za preventivne programe varovanja zdravja pri delu kot za zdravljenje.

Kela zagotavlja finančno podporo za obdobje okrevanja in rehabilitacije ter rehabilitacije za ohranitev delovne zmožnosti.

- **Pravilo 30-60-90**:

  Če je delavec odsoten z dela zaradi bolezni skupno več kot 30 dni, mora delodajalec o tem obvestiti službo medicine dela. Smiselno je, da se ukrepi podpore za delovno zmožnost začnejo izvajati dovolj zgodaj.

- Najpozneje po 60 dneh prejemanja nadomestila za čas bolezni mora Kela oceniti potrebo upravičenca po rehabilitaciji. Upravičencu pošlje dopis, v katerem navede možnosti za rehabilitacijo in izvajalce.

- Po 90 dneh prejemanja nadomestila za čas bolezni mora delavec ustanovi Kela poslati potrdilo zdravnika medicine dela z oceno preostale delovne zmožnosti in možnosti za nadaljnje delo.

Smiselno je, da se ukrepi v zvezi z delovno zmožnostjo začnejo izvajati dovolj zgodaj. Če se invalidnost podaljša, morajo delodajalec, delavec, njegov nadrejeni in služba medicine dela skupaj določiti pogoje in potrebno podporo za vrnitev delavca na delovno mesto ter zahteve na delovnem mestu. Služba medicine dela ima skupaj z delodajalcem pomembno vlogo pri podpiranju delovne zmožnosti. Smiselno je, da se ukrepi v zvezi z delovno zmožnostjo začnejo izvajati dovolj zgodaj.

Ponudniki storitev na področju varovanja zdravja pri delu imajo v skladu s finskim zakonom o zdravstvenem zavarovanju in zakonom o varovanju zdravja pri delu posebno dolžnost podpiranja in ocenjevanja delovne zmožnosti delavcev.

SUPPORTING WORK CAPACITY

Author: Sirkku Martti, MD, Specialist in occupational health. Medical director of Occupational Health Working Life Services, Mehiläinen, Finland

Keywords: work capacity, occupational health, sickness absence

Key highlights:

- Occupational health doctors' surgeries are filled with mild mental health problems, such as life crises, which do not require medical treatment. Instead, supporting self-solutions such as strengthening the employee's own coping skills, life skills training in a preventive way, and strong support from the frontline worker, as well as temporary work modification, are important ways to respond to the prevailing situation.
- The most common diagnoses are anxiety and adjustment disorders and insomnia, which young people experience particularly at the beginning of their careers and at life transitions. For these mild mental disorders, going to a doctor often leads to over-diagnosis and sick leave. Eligibility for sickness benefit is conditional on meeting diagnostic criteria, starting recommended medical and rehabilitative treatment and drawing up a return to work plan in conjunction with the workplace. Sick leave is therefore not a substitute for missing treatment and rehabilitation and, if prolonged, does not help recovery from a mental disorder.
- Each worker is responsible for their own health choices. Mental health or its challenges are strongly linked to issues such as physical activity, nutrition, sleep and substance abuse. Support in these areas alone can make a significant difference in the prevention of mental health disorders. But there are also many ways in which employers can help employees.
- The employer has in Finland a responsibility to promote working conditions in the field of occupational health and safety. This includes regular assessment of the psychological and social stress and resource factors at work and the development of working conditions. When working conditions are good, the risk of a decline in well-being at work is also lower.
- If the management culture at the workplace is right, the workplace will provide ways to enable workers to continue working with a temporary loss of capacity. This requires both awareness on the part of front-line workers and an understanding on the part of the workplace community that not everyone can always give their best, even if they want to.

Abstract: In Finland, there are various ways of supporting people's ability to work and to continue working in the workplace. The most common causes of work capacity problems are musculoskeletal disorders and mental health problems.

Social Insurance Institution (Kela) reimburses the employer for a higher proportion of the costs of preventive occupational health care than for medical treatment.

Kela provides financial support for the period of convalescence and rehabilitation, as well as rehabilitation to maintain working capacity.

- **The 30-60-90 rule:**

  When an employee's sick leave exceeds 30 days in total, the employer must notify the occupational health service. It is a good idea to start work capacity support measures early enough.

- After 60 days of sickness benefit, Kela must at the latest assess the claimant's rehabilitation needs. The claimant will receive a letter from Kela informing him/her of the rehabilitation options and the providers.
- After 90 days of sickness allowance, the worker must submit to Kela an occupational health certificate with an assessment of the remaining working capacity and the possibility of continuing to work.

It is a good idea to start work ability interventions early enough. If the disability becomes protracted, the employer, the employee and his/her supervisor, and the occupational health service must work together to determine the conditions and support needed for the employee to return to work and what this requires at the workplace. The occupational health service, together with the employer, has an important role to play in supporting the ability to work. It is a good idea to start work ability interventions early enough.

Occupational health care service providers have a special duty, in accordance with the Health Insurance Act and the Occupational Health Care Act In Finland, to support and assess employees' work ability.

ORGANIZACIJSKI VIDIKI OCENE DELAZMOŽNOSTI BOLNIKOV Z DUŠEVNIMI IN VEDENJSKIMI MOTNJAMI V FRANCIJI. KAKO SE SPOPASTI S HRUPOM IN PRISTRANSKOSTJO?

Avtor: dr. François Latil, Service des relations internationales, Paris, Francija

Ozadje: »Depresivni« primer psihiatrije

- Usklajenost ocene delovne zmožnosti (WCR) med psihiatri je slaba, tudi ob uporabi testnih lestvic (IFAP 1 in 2) in tudi po intenzivnem usposabljanju[1].
- Dostop do psihiatrov, ki so strokovnjaki za postkovidni sindrom, je še vedno problematičen. To je spodbuda za okrepitev osebja z novimi kompetencami.

Problem: Koncert hrupa

„Hrup je nezaželena spremenljivost presoje. V smislu hrupa je psihiatrija skrajni primer. Predsodki in hrup imajo enako vlogo pri izračunu končnega odstopanja presoje. Sistemski hrup stane stotine milijonov in vodi do dvomljivih presoj. Zavarovalništvo to vprašanje v veliki meri podcenjuje[2].

Dognanja: V nadaljevanju so navedena nekatera Kahnemanova priporočila za zmanjšanje hrupa, ki temeljijo na dokazih:

Uporaba strukturiranega intervjuja, ki veliko bolje napoveduje prihodnjo uspešnost: 65- 69 % kot tradicionalni: 56- 61 %

Vodja primera (case manager) s strukturiranim vprašalnikom zbere merila o šibkosti zavarovanca, da bi ugotovil tveganja neuspešno vračanje na delo: konflikti na delovnem mestu, nizka izobrazba, težave pri dostopu do oskrbe, nestabilno delo, ponavljajoči se zastoji pri delu ali izolacija. Na podlagi tega se razvrsti v pet razredov, od brez tveganja do večje zmanjšane delazmožnosti. Vsak primer se sreča z lastnim postopkom podpore pri zdravniku ali socialni službi.

Uporaba standardiziranega instrumenta za povečanje zanesljivosti

Medicinske sestre (social nurses) zbirajo zdravstvene informacije in spremljajo obiske, upoštevanje zdravljenja, uporabo psihoaktivnih snovi, debelost, nepismenost, razpoloženje in odziv bolnika s pomočjo posebnega vprašalnika za depresijo Hard) in mini testa ICF.

Pridobite več neodvisnih presoj iz različnih strok z dopolnjujočimi se vzorci pred dokončno presojo

Področje dela vodje primera, medicinske sestre in medicinskega izvedenca se le delno prekrivajo. Za neodvisnost njihovega dela je potrebno navedena področja ločiti.

Zaposlite psihologe

Predstavljajo ključne strokovnjake za uporabo psihometričnih instrumentov (IFAP) ter za ocenjevanje bolnikovih percepcij in vedenj (kot vodja primera).

Nadgradite svoje osebje

Zaposliti je dobro, obdržati je še bolje. Del zadovoljstva pri delu izhaja iz izzivov in priložnosti za poklicni razvoj, kot recimo na področju zmogljivosti bolnikov[3]. Na Norveškem in Finskem vodja primera odloča v večini standardnih primerov.

Reference:

1. Kunz R, Von Allmen D.Y, Marelli R *et al.* The reproducibility of psychiatric evaluations of work disability: two reliability and agreement studies BMC psychiatry(2019) 19:205
2. Kahneman D, Sobony O, Sunstrein C, Noise; a flaw in human judgment. WilliamCollinsBooks.com
3. de Vries N, Boone A, Godderis L, *et al* The race to retain Healthcare workers: a systematic review on factors that impact retention of nurses and physicians in hospitals. Inquiry (2023)60:1-21

ORGANIZATIONAL ASPECTS OF PSYCHIATRIC WORK CAPACITY LIMITATION ASSESSMENT IN FRANCE. HOW TO TACKLE NOISE AND BIASES?

Author: Dr François latil, Service des relations internationales, Paris, France

Background: The depressive case of psychiatry

- The agreement on Work Capacity Rating (WCR) between psychiatrists is poor, even using test scales (IFAP 1&2) and after an intensive training[1].
- Access to psychiatrists experts in post-covid is going problematic. This is an incentive to strengthen the staff with new competences.

Problem: A concert of Noise

”Noise is an unwanted variability of judgments. In terms of noise, psychiatry is an extreme case. Biases and noise play the same role in the calculation of overall error. System noise costs hundred of millions and lead to doubtful decisions. This issue is widely underestimated by the stakeholders[2].

Lessons: Here are some of Kahneman’s evidence based recommendations to reduce noise:

Use structured interview which are far more predictive of future performance : 65- 69% than traditional: 56- 61%

A case manager (CM) collects the criteria of claimant’s frailty through a structured questionnaire to identify the risks of non RTW: conflict at work, low education, hardship in care access, unsteady work, repeated work stoppages, or isolation. This lead to a ranking in 5 classes, from no risk, to major disability. Every case meets his own support process towards work physician or social service.

Use standardised instrument to increase reliability

The Social nurses (SN) collect the health information and monitor visits, compliance with care, use of psycho-active substances, obesity, illiteracy, mood and patient’s reaction through a specific questionnaire for depression (Hard) and a mini-ICF test.

Obtain several independent judgements from diverse skills and complementary patterns before aggregating them.

The field of the CM, SN and Social insurance physician only partially overlap. They held separate records so that they may not influence each other.

Hire psychologists. They are the key persons to use mental psychometric instruments (IFAP), and to assess claimant’s perceptions and attitudes as CM.

Upgrade your staff. Hire is nice, retain is better. A part of job satisfaction comes from challenge and opportunities for career development like say on patient capacity[3]. In Norway and Finland the CM decides in most the standard cases.

References:

1. Kunz R, Von Allmen D.Y, Marelli R *et al.* The reproducibility of psychiatric evaluations of work disability: two reliability and agreement studies BMC psychiatry(2019) 19:205
2. Kahneman D, Sobony O, Sunstrein C, Noise; a flaw in human judgment. WilliamCollinsBooks.com
3. de Vries N, Boone A, Godderis L, *et al* The race to retain Healthcare workers: a systematic review on factors that impact retention of nurses and physicians in hospitals. Inquiry (2023)60:1-21

PRAKTIČNE IZKUŠNJE SKOZI PROCES OHRANJEVANJA DELAZMOŽNOSTI IN ZAPOSLITVENE REHABILITACIJE OSEB V DUŠEVNEM ZDRAVJU

Avtor: Edita Dežman Predan, mag. soc. del.

Ključni poudarki:

- V procesu ohranjanja delazmožnosti in zaposlitvene rehabilitacije oseb v duševnem zdravju je pomembno prepoznavanje in razumevanje potreb oseb s težavami v duševnem zdravju.
- Takšnim osebam je potrebna dodatna pomoč, podpora in skrb za motiviranost v procesu zaposlitve.
- Vodenje takšne osebe mora potekati ob strokovno usposobljenem kadru, ki osebo, ki je vključena v process, razume in vzpodbuja, da pride do končnega zastavljenega cilja.
- Praviloma je potrebno predvideti daljši časovni okvir zaposlovanja (vsaj 1 leto), predvsem zato, da osebe pridobijo neko rutino, da skupaj z nami dosežejo zastavljen cilj, da znajo premagovati tudi težave na poti do cilja, ob enem pa na ta način vzpostavljajo in ohranjajo trajnejši odnos, se naučijo sodelovati z drugimi v ekipi, dobijo občutek sprejetosti, pripadnosti. Ob enem pa se na ta način krepi tudi njihova lastna vrednost, samozavest in občutek, da nekaj zmorejo in da so koristni. Motivacija vsakega posameznika, ki je vključen v delovni proces je tudi plača, ki jo prejema in posamezniku predstavlja lažjo samostojnost in neodvisnost od drugih družinskih članov.
- Sodelovanje z drugimi organizacijami ima lahko dodatno pozitiven učinek.

Izvleček: V Zavodu Vitica Gornja Radgona, s.p. se zaposleni v procesih ohranjanja in krepitve delazmožnosti pri osebah s težavami v duševnem zdravju srečujemo v okviru programa javnih del, programa učnih delavnic in zaposlitvene rehabilitacije.

Pri neposrednem delu z posamezniki, ki imajo težave v duševnem zdravju je bistvenega pomena prepoznavanje in razumevanje njihovih potreb in želja, motiviranje ter zagotavljanje učinkovite podpore in pomoči pri premagovanju težav in stisk tako ob vključevanju v kolektiv kot v samem procesu usposabljanja oz. izvajanja delovnih nalog.

Pomoč in podpora, ki jo zagotavljamo udeležencem poteka individualno, kontinuirano in celostno. Individualen pristop je usmerjen v individualne potrebe, zmožnosti in posebnosti posameznika. Ugotavljamo, da je za doseganje želenih rezultatov pri ugotavljanju delazmožnosti minimalen časovni obseg spremljanja udeleženca najmanj 1 leto. To je pomembno tako z vidika vzpostavljanja in ohranjanja trajnejšega odnosa sodelovanja z udeležencem, kar mu daje občutek sprejetosti in pripadnosti ter z vidika postopnosti pri vključevanju v vse zahtevnejše delovne naloge in procese, kar krepi njegovo moč, lastno vrednost in samozavest ter mu daje občutek, da zmore. Pomembno je tudi sodelovanje z drugimi za udeleženca pomembnimi institucijami za zagotovitev bolj celostne in usklajene podpore pri ohranjanju in krepitvi delazmožnosti oseb s težavami v duševnem zdravju.

Skupne karakteristike oseb s težavami v duševnem zdravju, ki so se vključevale v naš zavod so bile predvsem v šibki samopodobi, počutile so se stigmatizirane in socialno izključene ter zadržane glede ocene lastnih sposobnosti ter zmožnosti ali so bile te ocene previsoke oz. nerealne.

V Zavodu Vitica smo zaposleni mnenja, da je za spremljanje oseb s težavami v duševnem zdravju v procesu ohranjanja delazmožnosti in zaposlitvene rehabilitacije ključnega pomena strokovno usposobljen kader, ki bo podprl in načrtoval ter spremljal udeleženca na način, da mu poskuša povrniti zaupanje vase in povrnitev ter ohranjanje in krepitev njegove delazmožnosti in socialne vključenosti. Sočasno pa se posameznik s vključitvijo finančno opolnomoči, kar vpliva na dvig kvalitete njegovega življenja ter posledično izboljša njegovo telesno in tudi duševno zdravje.

PRACTICAL EXPERIENCE GAINED IN THE PROCESS OF MAINTAINING WORK CAPACITY AND THE OCCUPATIONAL REHABILITATION OF PEOPLE WITH MENTAL HEALTH PROBLEMS

Author: Edita Dežman Predan, mag. soc. del., Slovenia

Key highlights:

- Identifying and understanding the needs of people with mental health problems is important in the process of maintaining employability and employment rehabilitation of people with mental health problems.
- These people need additional help, support and care to keep them motivated in the employment process.The management of such a person must be accompanied by professionally qualified staff who understand and encourage the person involved in the process to reach the final goal.
- As a rule, it is necessary to provide for a longer period of employment (at least 1 year), in particular so that the person acquires a certain routine, so that he/she reaches the goal together with us, so that he/she is able to overcome difficulties on the way to the goal, and so that he/she establishes and maintains a more lasting relationship, learns to cooperate with others in the team, and gains a sense of acceptance and belonging. At the same time, it builds their self-esteem, self-confidence and a sense of accomplishment and worth. The motivation of each individual involved in the work process is also the salary they receive, which makes it easier for them to be autonomous and independent from other family members.
- Cooperation with other organisations can have an additional positive effect.

Abstract: At Zavod Vitica Gornja Radgona, so.p., employees are involved in the processes of maintaining and improving the work capacity of people with mental health problems in the scope of public works programmes, training workshops and occupational rehabilitation.

When working with individuals with mental health problems, it is essential to identify and understand their needs and wishes, to motivate them and to provide effective support and assistance to help them overcome their problems and difficulties, both in integrating into the team and in the training or work process itself.

The support and assistance we provide to participants is individual, continuous and holistic. The individual approach focuses on the needs, capacities and characteristics of an individual. We have concluded that a minimum follow-up period of one year is needed to achieve the desired results in determining a participant's work capacity. This is important for establishing and maintaining a longer-lasting collaborative relationship with the participant, which gives them a sense of acceptance and belonging, and for progressively engaging in increasingly challenging work tasks and processes, which increases their strength, self-worth and self-confidence and makes them believe that they can do it. It is also important to work with other institutions relevant to the participant to provide more holistic and coordinated support to maintain and improve the work capacity of people with mental health problems.

The most common characteristics of people with mental health problems who participated in our programmes were poor self-image, feeling stigmatised and socially excluded, being reluctant to assess their own abilities and capabilities, or assessing them too highly or unrealistically.

At Zavod Vitica, we believe that in order to assist people with mental health problems in the process of maintaining their work capacity and occupational rehabilitation, it is essential to have professionally qualified staff who will support and assist a participant to restore their self-confidence, to regain, maintain and improve their work capacity and be socially included. At the same time, the individual is financially empowered through participation, which improves their quality of life and consequently their physical and mental health.

POKLICNA REHABILITACIJA OSEBE Z DUŠEVNIMI IN VEDENJSKIMI MOTNJAMI - PRIMER DOBRE PRAKSE

Avtor: Brstin Kavalar, univ. dipl. pedagog, CRI Celje, d.o.o.

Ključne besede: poklicna rehabilitacija, praktično delo, drug delodajalec, duševna motnja

Ključni poudarki:

- Poklicna rehabilitacija je zagotovo pripomogla k temu, da se je zavarovanka bistveno hitreje vrnila v delovni proces.
- Znotraj usposabljanja si je pridobila prve, predragocene delovne izkušnje na do tedaj popolnoma neznanem področju dela.

Izvleček: Poklicna rehabilitacija s praktičnim delom na ustreznem delovnem mestu pri drugem delodajalcu osebe z zmanjšano delovno zmožnostjo se je izkazala kot najprimernejša oblika poklicne rehabilitacije, saj je osebi, katero bi tedanji delodajalec zagotovo odpustil, omogočila nadaljevanje poklicne poti pri drugem delodajalcu ter po več kot dveh letih začasne odsotnosti z dela omogočila ponovno vrnitev v delovno okolje, preko postopka poklicne rehabilitacije. V predstavljenem primeru poklicne rehabilitacije je prikazano praktično delo na ustreznem delovnem mestu »bibliotekar«, pri osebi s trajnimi omejitvami delovne zmožnosti – zmožna je za psihično manj naporno delo, le z občasnim delom s strankami. Vzrok navedenih omejitev so bile ponavljajoča depresivna motnja, pogosta nespečnost, izrazit energetski deficit, izrazita stresna preobremenjenost in glavoboli tenzijskega tipa.

Zaključki / spoznanja: oseba se je s pomočjo poklicne rehabilitacije usposobila za ustrezno delo pri drugem delodajalcu, kjer strokovno in z velikim zadovoljstvom opravlja delo v skladu z omejitvami delovne zmožnosti

VOCATIONAL REHABILITATION OF PERSON WITH COMMON MENTAL DISORDER - AN EXAMPLE OF GOOD PRACTICE

Author: Brstin Kavalar, univ. dipl. pedagog, CRI Celje, d.o.o., Slovenia

Keywords: vocational rehabilitation, practical work, other employer, common mental disorder

Key highlights:

- Vocational rehabilitation has certainly helped the patient return to work much faster.
- Within the training, she gained her first, precious work experience in a previously completely unknown field of work.

Abstract: Vocational rehabilitation with practical work in a suitable job with another employer for a person with reduced working capacity proved to be the most appropriate form of vocational rehabilitation, as it enabled the person, who would certainly have been dismissed by his/her former employer, to resume his/her career with another employer and, after a temporary absence of more than two years, to return to the workplace through the vocational rehabilitation process. The vocational rehabilitation case presented here shows practical work in a suitable job, „librarian“, for a person with permanent disabilities - she is able to do less mentally demanding work, with only vocational client work. The limitations were due to recurrent depressive disorder, frequent insomnia, marked energy deficit, marked stress overload and tension-type headaches.

Conclusions: with vocational rehabilitation, the person has been trained for a suitable job with another employer, where he/she performs the work professionally and with great satisfaction, in accordance with the limitations of his/her working capacity.

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PARALELNA SEKCIJA 3.2 // PARALLEL SESSION 3.2

IZGORELOST – TEŽAVE PRI DIAGNOSTICIRANJU IN RAZLIKOVANJU OD PODOBNIH STANJ

Avtor: dr. Andreja Pšeničny, Psyche, Inštitut za psihoterapijo in osebnostno rast

Ključne besede: sindrom izgorelosti, konceptualizacija, diagnoza, diferencialna diagnoza

Ključni poudarki:

- Za vrsto strokovnjakov sam koncept izgorelosti Christine Maslach(1), uporabljen v MKB-11(2), ni enoznačno in jasno definiran. Osrednji predmet polemike med strokovnjaki je odvisnost izgorelosti od konteksta (delovno mesto), saj so vir kroničnega stresa lahko katerekoli pomembne življenjske okoliščine, ki vodijo v enake posledice: izčrpanost, cinizem in občutek neučinkovitosti(3).
- Uporaba diagnostičnega instrumenta (MBI)(4), ki je osredotočen izključno na okoliščine dela, vodi v krožno past, saj vnaprej eliminira vse druge možne izvore kroničnega stresa. Odvisnost od konteksta je tudi izvor težav pri diferencialni diagnostiki, okoliščine dela lahko vodijo v izgorelost, vendar pa prav tako lahko sprožijo druge motnje, kot so depresivnost ali anksioznost(3).
- Z natančnejše diagnosticiranje in razločevanje od podobnih stanj je možno uporabiti dodatne diagnostične instrumente. Hallsten(5) tako razločuje med (normalno) delovno izčrpnostjo (wornout) in izgorelostjo (burnout) na podlagi koncepta samovrednotenja po dosežkih (Performance based self-esteem).
- Priporočili bi relativno hitro, a postopno vračanje na delovno mesto (4, 6-urni delovnik).

Teoretična izhodišča:

- Maja 2019 je Svetovna zdravstvena organizacija uvrstila izgorelost v MBK 11 pod šifro QD85, (prej Z 73.00). Izgorelosti ne definira kot bolezen, temveč kot sindrom, povezan s stresom na delovnem mestu.
- Navaja tri diagnostične kriterije (1) občutki pomanjkanja ali izčrpanosti energije; (2) povečana mentalna distanciranost od službe ali občutki negativizma ali cinizma v zvezi s službo; in (3) občutek neučinkovitosti in zmanjšanih dosežkov.
- Oznaka izgorelost se nanaša samo na pojave v poklicnem kontekstu in se ne sme uporabljati za opisovanje izkušenj na drugih področjih življenja.

Težave v praksi:

- Sam koncept izgorelosti ni enoznačno dorečen in je zato nejasen, po mnenju nekaterih celo sporen. V strokovni literaturi najdemo 142 različnih definicij izgorelosti, ki so vse podprte z vrsto empiričnih raziskav. WHO je izbrala najpogostejšo (Christina Maslach), ki pa je lahko problematična že zato, ker zanemarja dejstvo, da gre pri duševnih težavah, torej tudi pri izgorelosti, za prepletanje notranjih (osebnostnih ranljivosti) in zunanjih dejavnikov (stresorjev), saj v ospredje postavi kot

vzrok izključno okolijske dejavnike.

- Diagnostični kriteriji temeljijo izključno na samoopisu (Maslach Burnout Inventory), literatura navaja vsaj 47 različnih definicij izgorelosti, ki izhajajo iz uporabe tega vprašalnika. Diagnoza izgorelosti temelji na tem, da pacienti sami subjektivno pripišejo vzrok za svoje težave zunanjim okoliščinam.
- Posledica je, da ni jasne diferencialne diagnostike s podobnimi stanji, kjer se pojavlja simptom (kronične) utrujenosti:
    - Nepatološka stanja: delovna izčrpanost (wornout), subjektivni razlogi za odpor do dela (konflikti, pomanjkanje strokovnih kompetenc, neustrezna izbira delovnega mesta…),
    - Telesna stanja: hipotiroizem, fibromialgija, motnje spanja, drugi telesni vzroki,
    - Psihopatološka stanja : depresija, anksioznost, SKU, PTSM, bipolarna motnja, osebnostne motnje,
    - Dolgotrajni covid in pokovidni sindrom.

Možna rešitev:

- Razločevanje preko osebnostnih značilnosti, povezanih z izgorelostjo: perfekcionizem, deloholizem, storilnostno samovredotenje, osebnostne motnje (kombinacije diagnostičnih vprašalnikov).

Viri:

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BURNOUT SYNDROME – DIFFICULTY IN DIAGNOSTIC AND DISTINGUISHING FROM SIMILAR CONDITIONS

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Key words: burnout syndrome, conceptualization, diagnostic, differential diagnosis

Key highlights:

- For many experts, Christine Maslach's concept of burnout(1), as used in ICD-11(2), is itself not clearly and unambiguously defined. A central point of controversy among experts is the context-dependence of burnout (the workplace), as any major life circumstance can be a source of chronic stress, leading to the same consequences: exhaustion, cynicism and feelings of ineffectiveness(3).
- The use of a diagnostic instrument (MBI)(4) that focuses exclusively on work circumstances leads to a circular trap, as it eliminates in advance all other possible sources of chronic stress. Context dependence is also at the root of the difficulties in differential diagnosis, work circumstances may lead to burnout, but they may also trigger other disorders such as depression or anxiety(3).
- Additional diagnostic tools can be used to diagnose and differentiate burnout more accurately from similar conditions. Hallsten(5) thus distinguishes between (normal) work exhaustion (wornout) and burnout (burnout) based on the concept of performance-based self-esteem.
- We would recommend a relatively quick but gradual return to work (4, 6-hour workdays).

Theoretical background:

- In May 2019, the World Health Organization classified burnout in ICD 11 under code QD85 (formerly Z 73.00). It does not define burnout as a disease, but as a syndrome resulting from workplace stress.
- It lists three diagnostic criteria: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) a sense of ineffectiveness and lack of accomplishment.
- The term burnout refers only to phenomena in a work context and should not be used to describe experiences in other areas of life.

Problems in practice:

- The concept of burnout itself is not clearly defined and is therefore vague, even controversial according to some. There are 142 different definitions of burnout in the professional literature, all of which are supported by a range of empirical research. The WHO has chosen the most common one (Christina Maslach), which can be problematic if only because it ignores the fact that all mental health problems, including burnout, are an interplay of internal (personality vulnerabilities) and external factors (stressors), by focusing exclusively on environmental factors as the cause.
- The diagnostic criteria are based exclusively on self-report (Maslach Burnout Inventory) and the literature lists at least 47 different definitions of burnout derived from the use of this questionnaire. The diagnosis of burnout is based on patients subjectively attributing the cause of their problems

to external circumstances.

- As a result, there is no clear differential diagnosis with similar conditions where the symptom of (chronic) fatigue is present:
    - non-pathological conditions: work exhaustion (wornout), subjective reasons for aversion to work (conflicts, lack of professional competence, inappropriate choice of workplace ...),
    - physical conditions: hypothyroidism, fibromyalgia, sleep disorders, other physical causes,
    - psychopathological conditions : depression, anxiety, CFS, PTSD, bipolar disorder, personality disorders,
    - long-term covid and post-covid syndrome.

Possible solution:

- differentiation through personality traits associated with burnout: perfectionism, workaholism, performance-based self-esteem, personality disorders (combinations of diagnostic questionnaires).

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MOTNJE KOGNICIJE IN DELAZMOŽNOST

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Ključne besede: kognitivni upad, blaga kognitivna motnja, delazmožnost

Izvleček: Namen prispevka je osvetliti pojem kognitivnega upada, ki je posledica tako različnih možganskih bolezni, kot sistemskih bolezni, metabolnih motenj, tudi jemanja zdravil ter njegovega vpliva na delazmožnost. Potrebno se je zavedati, da kognitivni upad ne pomeni vedno ireverzibilnega stanja in je možno tudi izboljšanje. Kognitivne motnje so pogosto pridružene psihiatričnim boleznim. Največji delež predstavljajo nevrodegenerativne bolezni, ki vodijo v demenco, stanje, ko kognitivne motnje močno vplivajo na izvajanje vsakodnevnih opravil, socialno in poklicno udejstvovanje. Število oseb z demenco se bo v naslednjih desetletjih, zaradi staranja prebivalstva, daljše pričakovane življenjske dobe in zgodnje diagnostike, povečalo. S spremembo pokojninske zakonodaje, se povečuje tudi starost ob upokojitvi. Večina primerov demence je diagnosticirana po 70.letu starosti, redkeje se pojavlja t.i. demenca z zgodnjim začetkom, pred 65.letom. Demenci že več let prej, lahko že pred 65.letom starosti, predhodi blaga kognitivna motnja. Posledično ima lahko že določen delež oseb, ki so še poklicno dejavne, kognitivne težave, ki vplivajo na delazmožnost. Z zdravstvenega vidika je za osebo z blago kognitivno motnjo (ali začetno demenco) dobro, da ostaja čim dlje aktivna, vendar se moramo zavedati zahtev dela in delovnega mesta. Zato so smiselne prilagoditve dela. Večina bolnikov po postavitvi diagnoze ostaja v bolniškem staležu ali pa se upokoji, pogosto tudi zaradi nerazumevanja in nepoznavanja znakov kognitivnih motenj s strani delodajalcev. Še vedno obstaja določen delež oseb s kognitivno motnjo, ki bi želel delati še naprej. Nevrodegenerativni proces bo napredoval, vendar bi bilo smiselno taki osebi omogočiti »mehek« prehod v upokojitev, kajti nenaden odvzem delazmožnosti osebi, ki bi bila še vedno produktivna, sposobna opravljati določena prilagojena dela, v varnem okolju, okolju, ki osebo sprejema, lahko povzroči hude stiske in nadaljnje poslabšanje stanja, predvsem v psihološkem smislu. Vsako osebo je zato potrebno obravnavati individualno in v sodelovanju z delodajalcem. Potrebna je edukacija laične skupnosti, da se zaveda obstoja oseb s kognitivnimi motnjami in kako jim lahko kot skupnost pomagamo, da so še vključene v delovni proces.

COGNITIVE IMPAIRMENT AND DISABILITY

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Keywords: cognitive decline, mild cognitive impairment, work ability

Abstract: The aim of this paper is to shed light on the concept of cognitive decline, which is a consequence of various brain diseases, systemic diseases, metabolic disorders, medications, and its impact on work capacity. It is important to realise that cognitive decline is not always an irreversible condition and that it is possible to improve. Cognitive impairment is often associated with psychiatric illness. The largest proportion are neurodegenerative diseases leading to dementia, a condition in which cognitive impairment severely affects the performance of daily tasks, social and occupational activities. The number of people with dementia is set to increase in the coming decades due to an ageing population, longer life expectancy and earlier diagnosis. With the change in pension legislation, the retirement age is also increasing. Most cases of dementia are diagnosed after the age of 70, while early-onset dementia, before the age of 65, is less common. Dementia several years earlier, possibly even before the age of 65, is preceded by mild cognitive impairment. As a result, a certain proportion of people who are still professionally active may already have cognitive problems that affect their ability to work. From a health point of view, it is good for a person with mild cognitive impairment (or early dementia) to remain active for as long as possible, but we need to be aware of the demands of work and the workplace. Therefore, adaptations to work make sense. Most patients remain on sick leave or retire after diagnosis, often due to employers' lack of understanding and knowledge of the signs of cognitive impairment. There is still a certain proportion of people with cognitive impairment who would like to continue working. The neurodegenerative process will progress, but it would be sensible to allow such a person to make a 'soft' transition to retirement, because the sudden removal of the ability to work from a person who would still be productive and able to do certain adapted jobs, in a safe, accepting environment, can cause severe distress and further deterioration of the condition, especially in psychological terms. Each person must therefore be treated individually and in cooperation with the employer. Education of the lay communities is needed to make them aware of the existence of people with cognitive impairments and how we as a community can help them to remain included in the work process.

ODVISNOST OD PSIHOAKTIVNIH SNOVI

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Ključne besede: odvisnost, komorbidnost odvisnosti in pridruženih duševnih motenj, delazmožnost, zdravljenje odvisnosti, zaposlitvena rehabilitacija.

Izvleček: Sodobno pojmovanje bolezni odvisnosti upošteva njeno kronično naravo, možnost recidivov in telesne, kakor tudi širše psihosocialne posledice. Stopnja rabe drog pri posamezniku se na spektru intenzivnosti lahko kaže vse od občasne uporabe posameznih psihoaktivnih snovi, pa vse do intenzivnega jemanja, s polno razvitimi simptomi bolezni odvisnosti, ki nezdravljena napreduje in vodi v posameznikovo pomembno okrnjeno vsakodnevno funkcioniranje, kar pa nedvomno vpliva tudi na njegovo delovno sposobnost.

Upoštevati je potrebno visoko stopnjo komorbidnosti odvisnosti pridruženih duševnih motenj (tudi do 80% in več), ki so še vedno lahko neprepoznane in nezdravljene; slednje pa negativno vpliva na uspešnost zdravljenja tako odvisnosti, kakor tudi pridružene duševne motnje. Kadar gre za odvisnosti pridružene težke duševne motnje (kot so to npr. motnje psihotičnega spektra), je narava bolezni kompleksna, prav tako pa tudi zdravljenje in lahko pripomore k pomembno okrnjeni delovni sposobnosti – vse do popolne invalidnosti.

Vsak stik posameznika z zdravstvenimi službami predstavlja priložnost za jačanje motivacije v smislu večjega uvida v posledice jemanja psihoaktivnih snovi, kakor tudi morebitnega zdravljenja odvisnosti, v kolikor se to izkaže za potrebno. Programi zdravljenja odvisnosti (bodisi, da gre za t.i. legalne psihoaktivne snovi ali pa za odvisnost od prepovedanih drog) so v Sloveniji visoko dostopni vsakomur in kar zadeva stroške zdravljenja kriti s strani obveznega in dodatnega zdravstvenega zavarovanja. Bolnika z razvito boleznijo odvisnosti je tako potrebno usmeriti v zdravljenje. V zdravljenju odvisnosti zavzema pomembno mesto t.i. psihosocialna rehabilitacija in reintegracija, zato se bolnike praviloma usmerja nazaj v delovno okolje.

Avtorica bo predstavila postopke usmeritve bolnikov in oblike ter možnosti zdravljenja (medikamentozno, kakor tudi psihosocialno rehabilitacijo), ocenjevanje delovne sposobnosti v posameznih fazah obravnave. Posebno mesto za bolnike s t.i. komorbidnostjo pa zavzema zaposlitvena rehabilitacija, kjer ima pomembno vlogo interdisciplinaren pristop, kar v praksi že izvajamo.

SUBSTANCE USE DISORDER

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Keywords: addiction, comorbidity od substance use disorder and other mental disorders, working ability, addiction treatment, vocational rehabilitation

Abstract: The modern conception of addiction takes into account its chronic nature, the possibility of relapses and physical as well as wider psychosocial consequences. The level of drug use by an individual can be manifested on the spectrum of intensity from the occasional use of psychoactive substances to intensive use, with fully developed symptoms of addiction, which progresses untreated and leads to the individual's significantly reduced daily functioning, which undoubtedly also affects his ability to work.

It is necessary to take into account the high degree of comorbidity of addiction and associated mental disorders (even up to 80% and more), which may still be unrecognized and untreated; the latter has a negative effect on the success of treatment for both addiction and associated mental disorders. When it comes to addiction associated with a severe mental disorder (such as, for example, psychotic spectrum disorders), the nature of the illness is complex, as is the treatment, and it can contribute to a significantly reduced ability to work - up to total disability.

Every contact of an individual with health services represents an opportunity to strengthen motivation in terms of greater insight into the consequences of taking psychoactive substances, as well as potential addiction treatment, if this proves to be necessary.

Addiction treatment programs (whether for so-called legal psychoactive substances or for illegal drugs) are highly accessible to everyone in Slovenia, and as far as treatment costs are concerned, they are covered by health insurance.

It is therefore necessary to refer a patient with a developed addiction to treatment. An important place in the treatment of addiction is the so-called psychosocial rehabilitation and reintegration, which is why patients are usually directed back to the work environment.

The author will present patient orientation procedures and forms as well as treatment options (medication and psychosocial rehabilitation), assessment of work capacity in individual stages of treatment. A special place for patients with so-called comorbidity is taken up by occupational rehabilitation, where an interdisciplinary approach plays an important role, which we already implement in practice.

VPLIV PSIHOFARMAKOV NA DELAZMOŽNOST

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Ključne besede: delazmožnost, psihofarmakologija, začasna nezmožnost za delo - bolniški stalež

Izvleček: Za vsakogar, ki obišče psihiatra, se pričakuje, da prihaja zaradi duševne motnje, kar pa vedno ne drži. Številne stiske imajo lahko neko psihosocialno ozadje in so morda »normalne« reakcije in tudi nimajo neke zdravstvene osnove. Pogosto je zabrisana meja ali je to motnjo potrebno zdraviti, ali človek potrebuje pogovor, ali morda tudi zdravilo. Ali pa morda potrebuje počitek, odmor, dopust, kar seveda ni isto kot bolniški stalež. Po drugi strani pa ljudje svoje psihične težave lahko tudi somatizirajo. Zdravniki porabijo za diagnostiko in terapijo pri teh osebah veliko časa in denarja in naj bi predstavljali kar 20 % vseh bolniških odsotnosti.

Ljudje imamo različne lastnosti glede znanja, zmogljivosti in tega kaj hočemo narediti. Razlikujejo se tudi naše telesne in osebnostne sposobnosti, različna pa so tudi dela, ki jih opravljamo, varnost pri delu in vplivi okolja. Ko zdravnik predpiše psihotropno zdravilo pa je seveda pomembna vrsta zdravila, odmerek, čas prejemanja tega zdravila in seveda delovanje zdravila. Tako glede terapevtskih kot neželenih učnikov, na kar pa vplivajo tako posebnosti bolnika, kot tudi rednost jemanja.

Psihotropna zdravila so uvrščena v N skupino, anatomsko – terapevtsko – kemično klasifikacijo zdravil (ATC): anestetiki (N01), analgetiki (N02), antiepileptiki (N03), antiparkinsoniki (N04), psiholeptiki (N05) – antipsihotiki (N05A), pomirjevala in uspavala (N05B in C), psihoanaletiki (N06) – antidepresivi (N06A), psihostimulansi, zdravila za zdravljenje demence (N06 D) in druga zdravila z delovanje na živčevje (N07).

Oblika in vrsta terapevtskih ukrepov, potrebnost predpisovanja zdravil in ravno tako ocena sposobnosti za delo in priporočilo za bolniški stalež, kljub kliničnim potem niso v tolikšni meri standardizirana, kot pri telesni bolezni in zavise tudi ne le od znanja ampak tudi odnosa med bolnikom in zdravnikom in tudi od osebnosti zdravnika.

Avtor bo v prispevku predstavil najpogostejše indikacije za predpisovanje psihotropnih zdravil, trende predpisovanja v zadnjih letih in najpogostejše neželene učinke, ki lahko vplivajo na sposobnost za delo.

IMPACT OF PSYCHOPHARMACOTHERAPY ON WORK ABILITY

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Key words: inability for work, psychopharmacology, temporary inability for work

Abstract: Everyone who visits a psychiatrist is expected to be coming for a mental disorder, which is not always the case. Many distresses may have some psychosocial background and may be „normal“ reactions and also have no medical basis. There is often a blurred line between whether this disorder needs to be treated, whether the person needs a conversation, or maybe even medicine. Or maybe he needs a rest, a break, a vacation, which of course is not the same as sick leave. On the other hand, people can also somatize their psychological problems. Doctors spend a lot of time and money on diagnostics and therapy for these people, and they are said to account for as much as 20% of all sick leave.

People have different characteristics in terms of knowledge, capacity and what they want to do. Our physical and personal abilities are also different, as are the jobs we do, work safety and environmental influences. When a doctor prescribes a psychotropic drug, the type of drug, the dose, the time of receiving this drug and, of course, the action of the drug are important. Both in terms of therapeutic and unwanted effects, which are influenced by both the patient‘s characteristics and the regularity of taking medicines.

Psychotropic drugs are classified in group N, anatomical-therapeutic-chemical classification of drugs (ATC): anesthetics (N01), analgesics (N02), antiepileptics (N03), antiparkinsonian drugs (N04), psycholeptics (N05) - antipsychotics (N05A), sedatives and hypnotics (N05B and C), psychoanalysts (N06) - antidepressants (N06A), psychostimulants, drugs for the treatment of dementia (N06 D) and other drugs with an effect on the nervous system (N07).

The form and type of therapeutic measures, the need to prescribe medication, as well as the evaluation of the ability to work and the recommendation for the patient population, despite the clinical pathways, are not standardized to the same extent as in the case of a physical illness and depend not only on knowledge but also on the relationship between the patient and the doctor and also from the personality of the doctor.

The author will present the most common indications for the prescription of psychotropic drugs, trends in prescription in recent years, and the most common side effects that can affect the ability to work.

KLINIČNOPSIHOLOŠKI PRISTOP TER UPORABA PSIHOLOŠKIH TESTOV PRI OCENJEVANJU POTVARJANJA SIMPTOMOV IN AGRAVACIJE

Avtor: Tristan Rigler, doktor znanosti, univerzitetni diplomirani psiholog, specialist klinične psihologije

Ključne besede: potvarjanje, psihološki testi, simulacija, agravacija, kliničnopsihološka ocena

Ozadje: Potvarjanje predstavlja velik izziv v kliničnih in forenzičnih okoljih, kjer se posamezniki pretvarjajo ali pretiravajo s simptomi, z namenom pridobiti sekundarno korist. Psihološki testi igrajo ključno vlogo pri prepoznavanju potvarjanja in agravacije, saj pomagajo pri natančni oceni ter diagnozi dejanskih psiholoških stanj.

Jedro: Uporaba psiholoških testov za odkrivanje potvarjanja vsebuje pristop, ki vključuje različna ocenjevalna orodja in metodologije. Objektivne metode, kot so *Structured Inventory of Malingered Symptomatology* (SIMS), *Inventory of Problems* (IOP-29) in *Personality Assessment Inventory* (PAI), so pokazali učinkovitost pri razlikovanju pristnih simptomov od namerno izkrivljenih predstavitev. Ti testi ocenjujejo nedosledne vzorce odzivanja, pretirane simptome in neskladja v doživljanjih, o katerih so pacienti sami poročali, ter ponujajo dragocen vpogled v potvarjanje.

Kljub temu uporaba psiholoških testov pri odkrivanju potvarjanja ni brez omejitev in etičnih zadržkov. Interpretacija testa zahteva strokovno znanje in izkušnje, da je možno ločiti med niansami poudarjanju simptomov v primerjavi z resnično stisko. Le to lahko zmanjša tveganje lažno pozitivnih ali lažno negativnih rezultatov. Poleg tega lahko kulturni in kontekstualni dejavniki vplivajo na posameznikove odzive, kar vpliva na točnost zavajajočih ocen.

Etični vidiki uporabe psiholoških testov v primerih potvarjanja zahtevajo uravnotežen pristop. Ključnega pomena je ohranjanje osredotočenosti na dobrobit pacientov ob zagotavljanju celostnega ocenjevanja. Ustrezno usposabljanje in stalno izobraževanje strokovnjakov za etično in učinkovito uporabo testov sta nujna za ublažitev morebitnih pristranskosti ter zmotnih razlag.

Zaključki: Uporaba psiholoških testov pri odkrivanju zlorab nudi dragocena orodja za klinike in sodne izvedence. Medtem, ko te ocene zagotavljajo dragocen vpogled v razlikovanje pristnih simptomov od lažnih predstavitev, njihova uporaba zahteva večplastno razumevanje psihometričnih lastnosti, kulturnih dejavnikov in etičnih vidikov. Vzpostavitev ravnotežja med učinkovito oceno in etično prakso je temeljnega pomena pri uporabi psiholoških testov za obravnavo zapletenih izzivov, ki jih predstavlja zavajanje oz. potvarjanje.

A CLINICAL PSYCHOLOGICAL APPROACH AND THE USE OF PSYCHOLOGICAL TESTS IN THE EVALUATION OF MALINGERING AND AGGRAVATION

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Key words: malingering, psychological test, simulation, aggravation, clinical psychological assessment

Background: The phenomenon of malingering poses a significant challenge in clinical and forensic settings, where individuals feign or exaggerate symptoms for secondary gain. Psychological tests play a pivotal role in identifying malingering behaviours, aiding in the accurate assessment and diagnosis of genuine psychological conditions.

Purpose: The utilization of psychological tests for detecting malingering involves a multifaceted approach, encompassing various assessment tools and methodologies. Objective measures such as the Structured Inventory of Malingered Symptomatology (SIMS), Inventory of Problems (IOP-29) and the Personality Assessment Inventory (PAI) have demonstrated efficacy in differentiating genuine symptoms from feigned presentations. These tests assess inconsistent responding patterns, exaggerated symptoms, and discrepancies in self-reported experiences, offering valuable insights into the presence of malingering behaviours.

However, the application of psychological tests in detecting malingering is not without limitations and ethical concerns. Test interpretation requires expertise to navigate the nuances of symptom exaggeration versus genuine distress, minimizing the risk of false positives or negatives. Additionally, cultural and contextual factors may influence an individual's responses, impacting the accuracy of malingering assessments.

Ethical considerations surrounding the use of psychological tests in malingering cases necessitate a balanced approach. Maintaining a focus on patient welfare while ensuring the integrity of the assessment process is crucial. Adequate training and ongoing education for clinicians in employing these tests ethically and effectively are imperative to mitigate potential biases and misinterpretations.

Conclusion: The utilization of psychological tests in detecting malingering offers valuable tools for clinicians and forensic experts. While these assessments provide valuable insights into distinguishing genuine symptoms from feigned presentations, their use demands a nuanced understanding of psychometric properties, cultural factors, and ethical considerations. Striking a balance between effective assessment and ethical practice is fundamental in utilizing psychological tests to address the complex challenges posed by malingering behaviours.

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PARALELNA SEKCIJA 4.1 // PARALLEL SESSION 4.1

PSIHIATRIČNI POGLED NA ZDRAVLJENJE BOLNIKOV S PSIHOSOMATSKIMI OBOLENJI IN NJIHOVE DELAZMOŽNOSTI

Avtor: izr. prof. dr. Maja Rus Makovec, dr. med., spec. psihiatrije, Univerzitetna psihiatrična klinika Ljubljana

Ključne besede: psihosomatika, diagnostična negotovost, multidisciplinarnost, funkcionalnost

Strokovno sodelovanje: klinično, raziskovalno in ekspertno delo na psihiatričnih aspektih psihosomatike

Ozadje: Izraz psihosomatika nima mednarodno identičnega pomena. Aktualno je še največ strinjanja, da je področje te medicinske stroke 1. razumevanje somatskega in duševnega aspekta kot medsebojno odvisnih in da je ta razdelitev dihotomna le zaradi jasnejše metodologije in komunikacije ter 2. somatske bolezni, ki jih povzročajo ali poslabšajo duševni dejavniki in obratno (Ito, 2013). Psihosomatika ima kompleksen multidisciplinarni okvir, ki ni vezan le na psihiatrijo (Fava & Sonino 2010).

Metode: Psihosomatska ocena pacientovih težav naslavlja biopsihosocialne aspekte kot so med drugim tudi področja: bolezensko vedenje, demoralizacija in iritabilno razpoloženje, klinično pomembne duševne motnje, psihosocialni dejavniki in individualna ranljivost, stres, pacientova stališča do zdravja in vedenja v zvezi z zdravjem, socialni suport, osebnost in sodelovalnost (Porcelli, Guidi, 2015). Drugi pomemebni strokovni del psihosomatike pa je spoprijemanje z diagnostično negotovostjo (Meyer et al. 2021), ker diagnostični proces včasih potrebuje dolgotrajno opazovanje, da presežemo kognitivne pristranosti ali gre za somatsko ali duševno bolezensko stanje (Koyama et al. 2018). Ta področja stroke razdelujemo na strokovnih srečanjih s področja psihosomatike v organizaciji tima izvenbolnišnične psihiatrije, v okviru konziliarne službe ter ob timskih supervizijah ter izvedenskih izkušnjah.

Rezultati: opisano multidisciplinarno sodelovanje pomembno pomaga razumeti bolezensko vedenje pacientov in morebitne ovire glede splošne in delovne funkcionalnosti, ki so in ki niso somatske narave. V psihiatriji načeloma delovno aktivnost razumemo kot enega od dejavnikov duševnega zdravja, zato raziskujemo možnosti, da se spodbudi vsaj delna delozmožnost. Pomembno je epistemsko zaupanje med specialisti, da je bil pacient skrbno strokovno obravnavan.

Zaključki: diagnostične, terapevtske in rehabilitacijske dileme si najlažje skupaj razložijo somatske stroke in psihiatrija. To je tudi oporni strokovni okvir za toleriranje nezaupanja pacientov v zdravnikove diagnoze, ki je najvišje v psihosomatiki in tako lažje personalizirano naslavljamo tudi delazmožnost.

PSYCHIATRIC PERSPECTIVE ON THE TREATMENT OF PATIENTS WITH PSYCHOSOMATIC ILLNESSES AND THEIR ABILITY TO WORK

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Keywords: psychosomatics, diagnostic uncertainty, multidisciplinarity, functionality

Professional cooperation: clinical, research and expert work on psychiatric aspects of psychosomatics

Background: The term psychosomatics does not have an internationally identical meaning. Currently, there is still the most agreement that the field of this medical profession is 1. the understanding of somatic and mental aspects as mutually dependent and that this division is dichotomous only for the sake of clearer methodology and communication, and 2. somatic diseases caused or aggravated by mental factors and vice versa (Ito, 2013). Psychosomatics has a complex multidisciplinary framework that is not only related to psychiatry (Fava & Sonino 2010).

Methods: The psychosomatic assessment of the patient‘s problems addresses biopsychosocial aspects such as, among others, the following areas: illness behavior, demoralization and irritable mood, clinically significant mental disorders, psychosocial factors and individual vulnerability, stress, the patient‘s attitudes towards health and health-related behaviour, social support, personality and collaboration (Porcelli, Guidi, 2015). Another important professional part of psychosomatics is dealing with diagnostic uncertainty (Meyer et al. 2021), because the diagnostic process sometimes requires long-term observation to overcome cognitive biases or dilemmas whether it is a somatic or mental disease state (Koyama et al. 2018). These areas of the profession are discussed at professional meetings in the field of psychosomatics organized by the outpatient psychiatry team, as part of the counseling service and during team supervisions and expert experiences.

Results: the described multidisciplinary cooperation significantly helps to understand the disease behavior of patients and potential obstacles regarding general and work functionality, which are or are not of a somatic nature. In psychiatry, in principle, work activity is understood as one of the factors of mental health, so we are curious regarding possibilities to encourage at least partial work capacity. It is important to have epistemic trust between specialists that the patient has been treated professionally carefully.

Conclusions: diagnostic, therapeutic and rehabilitation dilemmas are best explained together by somatic professions and psychiatry. This is also a supporting professional framework for tolerating patients‘ mistrust of the doctor‘s diagnoses, which is highest in psychosomatics; in this way we can more easily address the disability in a personalized way.

TRAJNA SOMATOFORMNA BOLEČINSKA MOTNJA

Avtor: asist. Dr Nikolina Rijavec, dr.med. specialistka psihiatrije, Univerzitetna psihiatrična klinika Ljubljana

Ključne besede: somatoformna bolečina, multidisciplinarna obravnava, delazmožnost

Strokovno sodelovanje: Večletno izvajanje konziliarne psihiatrične službe v Univerzitetnem kliničnem centru Ljubljana

Ozadje/vprašanje/problem: Trajna somatoformna bolečinska motnja (TSBM) v 10. in 11. reviziji Mednarodne klasifikacije bolezni (MKB). Vpliv simptomov na funkcionalno zmogljivost bolnikov. Mesto psihiatra v multidiscplinarni obravnavi z namenom doseganja remisije, ohranjanja delazmožnosti in psihosocialne zaščite.

Metode: Pregled literature, posvet s timom psihiatrov Centra za izvenbolnišnično psihiatrijo Univerzitetne psihiatrične klinike Ljubljana, lastne delovne izkušnje.

Ključni poudarki:

- BOLEČINA IN DUŠEVNE MOTNJE

Bolečina je več kot samo zaznava. Po definiciji Mednarodnega združenja za bolečino je bolečina neprijetno čutno in čustveno doživetje, ki je povezano z neposredno ali možno poškodbo tkiva. Bolečina je zapleteno in raznovrstno neprijetno stanje, ki ga določajo zaznavni, čustveni, socialni in kulturni dejavniki. Lahko se pojavlja kot akutno stanje in ima za posameznika varovalno vlogo ali pa je kronična s preseganjem svoje biološke uporabnosti. Kronična bolečina pogosto spremlja različne duševne motnje, najpogosteje med njimi so depresija, anksiozne motnje in posttravmatska stresna motnja. Razmerje med kronično bolečino in duševnimi motnjami je dvosmerno, poskušamo si ga razložiti s skupno nevrobiologijo in psihološkim ozadjem. Prisotnost kronične bolečine otežuje prepoznavanje, trajanje in izhod duševne motnje[1, 2, 3, 4, 5].

Pri bolnikih s Trajno somatoformno bolečinsko motnjo (TSBM) je poglavitna pritožba trajna huda in zaskrbljujoča bolečina, ki jo ni mogoče razložiti s fiziološkimi procesi ali telesno boleznijo in se pojavlja v povezavi s čustvenim konfliktom ali psihosocialnimi problemi. Rezultat slednjega je bolnikovo trpljenje, upad splošnega in delovnega funkcioniranja, povečana pozornost domačega okolja ter povečana uporaba zdravstvene službe[6].

- TRAJNA SOMATOFORMNA BOLEČINSKA MOTNJA V 10. IN 11. REVIZIJI MEDNARODNE KLASIFIKACIJE BOLEZNI (MKB-10/ MKB-11)

TSBM je v MKB-10 uvrščena med Somatoformne motnje, katerim je osnovna značilnost somatizacija oziroma izražanje čustvenih in psihosocialnih problemov s telesnimi simptomi (6).

Klasifikacija MKB-11 izpostavlja skupne osnovne značilnosti večine sedanjih somatoformnih motenj (vključno s TSBM) in jih opredeljuje kot motnjo telesnega distresa (angl. Bodily Distress Disorder v podpoglavju angl. Disorders of Bodily Distress or Bodily Experience) oz. psihično motnjo (ki se kaže) s telesnimi simptomi. Pri tej motnji so prisotni različni telesni simptomi, na katere se posamezniki odzivajo z distresom, s prekomerno pozornostjo na simptome in zaradi katerih imajo ponavljajoče stike z zdravstvenim sistemom. Ob prisotnosti somatske okvare, je pozornost tem simptomom izrazito

nesorazmerna glede na naravo in potek motnje. Telesni simptomi so vztrajni in prisotni večino dni vsaj nekaj mesecev.

Bolnik ni pomirjen niti z dejstvom, da skrbna klinična diagnostika ni potrdila razlago za tako zaskrbljenost, niti z glede tega podanim zagotovilom zdravnika. Motnja ima vpliv na vsaj eno raven bolnikovega funkcioniranja (na medosebne odnose, učno ali delovno uspešnost, na opuščanje prostočasnih aktivnosti). Pri tej motnji je lahko vključenih več organskih simptomov ali le en simptom (navadno gre za bolečino in utrujenost) in jih ne moremo pripisati telesnemu stanju ali neki drugi duševni motnji (npr. depresiji) oz. sindromu odvisnosti od psihotropnih snovi.

Motnja telesnega distresa je lahko izražena blago, zmerno ali hudo. Pri blažje izraženih somatizacijskih motnjah somatski simptomi pri polovici bolnikov izzvenijo v 6 do 12 mesecih. Posamezniki s hujše izraženo simptomatiko izkušajo bolj kroničen in vztrajen potek[7].

- DIAGNOSTIKA

Pri bolnikih s TSBM je primarna pritožba bolečina oziroma telesni simptom in je posledično prvi stik in obravnava v somatskem delu zdravstvenega sistema, kar je tudi pravilno. Po navadi po več mesecih različnih diagnostičnih postopkov bolnik prihaja v psihiatrično obravnavo. Psihiater opravi psihiatrični pregled, pregleda bolnikovo medicinsko dokumentacijo, po potrebi konzultira kolege iz somatskega dela medicine in poskuša vzpostaviti stik z bolnikovimi bližnjimi zaradi pridobivanja heteroanamnestičnih podatkov ter podpore pri zdravljenju. Po potrebi opravi dodatne diagnostične preiskave ob posebni pozornosti namenjeni preprečevanju iatrogene škode. Diferencialno diagnostično lahko, da gre pri bolniku za somatsko bolečinsko stanje katerega ni možno razložiti s patofiziološkim dogajanjem samega somatskega stanja, funkcionalni bolečinski sindrom (fibromialgija, bolečina v temporomandibularnem sklepu, vulvodinija, nepojasnjena bolečina v križu, specifični visceralni funkcionalni sindromi) ali kakšno drugo duševno motnjo (npr. depresijo, anksiozno motnjo, odvisnost od psihoaktivnih snovi in analgetikov, postravmatsko stresno motnjo, eno od drugih somatoformnih motenj, psihotično motnjo, osebnostno motnjo, poudarjanje telesnih znakov zaradi psiholoških vzrokov, ponarejeno motnjo), katere je del klinične slike lahko tudi bolečina oziroma bolečinska pritožba in kar je potrebno diagnostično opredeliti, kljub v praksi nejasnimi medsebojnimi mejami in višji stopnji komorbidnosti[8, 9].

Psihiater oceni tudi bolnikove osebnostne značilnosti in dosedanje funkcioniranje, kar pomaga pri komunikaciji z bolnikom in je v pomoč pri načrtovanju nadaljnje zdravstvene in socialne obravnave.

- ZDRAVLJENJE

Vlaganje v dober terapevtski odnos z bolnikom se obrestuje že v samem diagnostičnem postopku. Psihiater poskuša delovati pomirjujoče in empatično razumevajoče do bolnikovih težav v okviru postavljanja jasnih meja in diagnostično/terapevtsko/rehabilitacijskih možnosti. Empatičnost je lažje doseči ob zavedanju, da si bolnik svojih simptomov ne izmišljuje, ampak si jih zmotno razlaga. Njegova somatska bolečina je zanj subjektivna resničnost in vir trpljenja. Pri tem je potrebno preveriti tudi zavestno možnost simulacije oziroma agravacije zaradi pričakovanja objektivne koristi in ta del ustrezno nasloviti.

V kolikor je to možno se v obravnavo vključi kdo od bolnikovih bližnjih.

Začetni korak psihološke podpore je psihoedukacija. Z bolnikom se gre razlagalno skozi somatske ugotovitve in se ga seznani osnovno nevrobiološko razlago psihično-telesne povezave. Eden od prvih ciljev zdravljenja je tudi čim boljše funkcioniranje kljub bolečinski simptomatiki. Po končani natančni diagnostiki se bolnik glede na naravo težav in motiviranost lahko vključi v eno od oblik psihoterapije (vedenjsko kognitivna terapija, dinamska psihoterapija, psihosocialne intervencije in dr.) in/ali začne z jemanjem farmakoterapije (večinoma antidepresivi in/ali antiepileptiki). Izogibati

se je treba dolgotrajnem predpisovanju uspaval in pomirjeval. Pri predpisovanju analgetikov se je potrebno posvetovati z algologi, načeloma se izogibamo opioidnim analgetikom zaradi nevarnosti za razvoj odvisnosti. Pri tem je potrebno poudariti, da niso vsi bolniki s TSBM kandidati za intenzivno psihoterapevtsko obravnavo. Psihofarmaki nimajo uradnih indikacij za TSBM, pri izbiri je potrebno slediti profilu simptomov in pričakovani koristi ob počasni titraciji odmerkov zaradi večje možnosti za stranske učinke.

Psihiatrično zdravljenje je prilagojeno vsakemu posamezniku in naravi njegovih težav posebej, pri čemer je težko napovedovati in postavljati natančne časovne okvirje v katerih je pričakovati bistveno izboljšanje simptomatike ter boljše funkcioniranje.

- DELAZMOŽNOST IN REHABILITACIJA

V začetnih mesecih psihiatrične diagnostike in zdravljenja je bolnik z intenzivnejšo simptomatiko TSBM večinoma še nezmožen za pridobitno dejavnost. Bolniški staleži se načrtujejo v podporo aktivacije. Na začetku se svetuje redno gibanje na svežem zraku, sproščajoče dejavnosti, postopna pridobitev fizične kondicije, higiena spanja, organizacija dneva, krepitev medsebojnih odnosov in socialne mreže ter vsaj delno ukvarjanje s hobiji. Po potrebi se uvede psihiatrična farmakoterapija in začne psihoterapevtska obravnava.

Opisana je tudi koristnost vključitve v fizioterapijo in delovno terapijo.

Prve pozitivne učinke psihiatričnega zdravljenja in dodatnih intervencij je za pričakovati po več mesecih obravnave (upoštevajoč mehanizme delovanja psihofarmakov in čas potreben za psihološki del pomoči pri spreminjanju načina razmišljanja in vedenja, ki ojačuje ali sooblikuje simptomatiko TSBM).

Odvisno od bolnikovih težav, poklica in starosti ga potem spodbujamo v sprva delno, potem pa polno delovno aktivacijo, ob možnih občasnih krajših bolniških staležih. V primeru nezmožnosti za opravljanje dosedanjega dela bolnika lahko usmerimo v postopke zaposlitvene ali profesionalne rehabilitacije ter iskanje zaposlitve na ustreznem delovnem mestu.

Ob vztrajanju bolnikovih težav in hujšem upadu funkcioniranja ter izčrpanih vseh farmakoloških in psihosocialnih terapevskih možnostih, predlagamo predstavitev pred invalidsko komisijo in oceno trajne nezmožnosti za delo.

Rezultati: Po MKB-10 TSBM uvrščamo med Somatoformne motnje. Njena osnovna značilnost je stalna, huda telesna bolečina, ki jo ni mogoče razložiti s fiziološkimi procesi ali telesno boleznijo. Osnova vsem somatoformnim motnjam je somatizacija oziroma izražanje čustvenih in psihosocialnih problemov s telesnimi simptomi. Motnja ima dolgotrajen potek, običajno traja več kot 6 mesecev in ovira celotno bolnikovo funkcioniranje.

Klasifikacija MKB-11 je skušala poenostaviti koncept somatizacije tako, da je posebej izpostavila skupne osnovne značilnosti večine sedanjih somatoformnih motenj (vključno s TSBM) in jih opredeljuje kot motnje telesnega distresa oz. psihične motnje (ki se kažejo) s telesnimi simptomi.

Vloga psihiatra pri obravnavi bolnikov s TSBM je vzpostavitev terapevtskega odnosa, diagnostika in zdravljenje duševnih motenj, koordiniranje psihosocialnih intervenc, svetovanje glede komunikacije z bolnikom, toleriranja nejasnosti in diagnostične negotovosti ter zmanjševanje stigme diagnoze duševne motnje.

Pri zdravljenju se uporabljajo različne psihoterapevtske, farmakoterapevtske in psihosocialne metode, katerih učinkovitost preverjamo po več mesecih redne obravnave. Obravnava je individualno prilagojena

bolniku z namenom vzpostavitve remisije in polne funkcionalnosti, kar vedno ni realno dosegljiv cilj. Lažje je spodbujati bolnike k polni delovni funkcionalnosti, odvisno sicer tudi od narave dela, ob občasnih krajših bolniških staležih, lahko pa je dovolj dober uspeh zdravljenja tudi delna delovna aktivacija.

Zaključki / spoznanja: Optimalna obravnava bolnikov s TSBM je multidiciplinarna in individualno prilagojena. Somatsko diagnostiko in zdravljenje je treba opravit smiselno in neškodljivo ter pravočasno začeti s psihiatrično obravnavo z namenom ohranjanja čim večje bolnikove funkcionalnosti.

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PERSISTENT SOMATOFORM PAIN DISORDER

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Key words: somatoform pain, multidisciplinary treatment, workability

Professional cooperation: Multi-year implementation of the consultative psychiatric service at the University Clinical Center Ljubljana

Background/question/problem: Persistent somatoform pain disorder (PSPD) in the 10th and 11th revision of the International Classification of Diseases (ICD). The impact of symptoms on patients' functional capacity. The role of the psychiatrist in multidisciplinary treatment with the aim of achieving remission, maintaining workability and psychosocial protection.

Methods: Literature review, consultation with a team of psychiatrists at the Outpatient Psychiatry Center of the University Psychiatric Clinic Ljubljana, own work experience.

Key highlights:

- PAIN AND MENTAL DISORDERS

Pain is more than a perception. As defined by the International Pain Society, pain is an unpleasant sensory and emotional experience associated with immediate or potential tissue damage. Pain is a complex and heterogeneous unpleasant condition determined by cognitive, emotional, social and cultural factors. It can occur as an acute condition and have a protective role for the individual, or it can be chronic by exceeding its biological usefulness. Chronic pain often accompanies various mental disorders, the most common of which are depression, anxiety disorders and post-traumatic stress disorder. The relationship between chronic pain and mental disorders is bidirectional, and we try to explain it by a common neurobiology and psychological background. The presence of chronic pain complicates the identification, duration and outcome of a mental disorder[1, 2, 3, 4, 5].

In patients with Persistent Somatoform Pain Disorder (PSPD), the chief complaint is persistent severe and distressing pain that cannot be explained by physiological processes or physical illness and occurs in association with emotional conflict or psychosocial problems. The latter results in patient suffering, a decline in general and occupational functioning, increased attention from the home environment and increased use of the health service[6].

- PERMANENT SOMATOFORM PAIN DISORDER IN THE 10TH AND 11TH REVISION OF THE INTERNATIONAL CLASSIFICATION OF DISEASES (MCD-10/ MCD-11)

TSBM is classified in ICD-10 as a Somatoform Disorder, which is characterised by somatisation, or the expression of emotional and psychosocial problems with physical symptoms[6].

The ICD-11 classification highlights the common basic features of most of the current somatoform disorders (including TSBM) and defines them as a Bodily Distress Disorder (in the subchapter Disorders of Bodily Distress or Bodily Experience) or a psychiatric disorder (manifesting) with bodily symptoms. This disorder presents with a variety of bodily symptoms to which individuals respond with distress, with excessive attention to symptoms, and for which they have repeated contact with the health care system. In the presence of somatic impairment, attention to these symptoms is markedly disproportionate to the nature and course of the disorder. Physical symptoms are persistent and present most days for at least a few months.

The patient is not reassured either by the fact that careful clinical diagnosis has not confirmed the explanation for such concern, or by the reassurance given by the doctor to this effect. The disorder has an impact on at least one level of the patient's functioning (interpersonal relationships, educational or work performance, abandonment of leisure activities). This disorder may involve several organic symptoms or only one symptom (usually pain and fatigue) and cannot be attributed to a physical condition or to another mental disorder (e.g. depression) or substance dependence syndrome.

PTSD may be mild, moderate or severe. In milder somatisation disorders, somatic symptoms resolve within 6 to 12 months in half of the patients. Individuals with more severe symptomatology experience a more chronic and persistent course[(7)].

- DIAGNOSTICS

In patients with TSBM, the primary complaint is pain or a physical symptom and, consequently, the first contact and treatment is in the somatic part of the healthcare system, which is also correct. Usually, after several months of various diagnostic procedures, the patient is referred to psychiatry. The psychiatrist performs a psychiatric examination, reviews the patient's medical records, consults colleagues from the somatic part of medicine if necessary, and tries to contact the patient's relatives to obtain heteroanamnestic information and support in treatment. If necessary, he/she performs additional diagnostic tests, with particular attention to the prevention of iatrogenic damage. In differential diagnosis, the patient may have a somatic pain condition that cannot be explained by the pathophysiology of the somatic condition itself, a functional pain syndrome (fibromyalgia, temporomandibular joint pain, vulvodynia, unexplained low back pain, specific visceral functional syndromes), or some other mental disorder (e.g. The presence of pain or pain complaints may be part of the clinical picture and should be diagnostically defined, despite the fact that in practice the boundaries between them are unclear and the degree of comorbidity is higher(8, 9).

The psychiatrist also assesses the patient's personality characteristics and previous functioning, which helps in communication with the patient and in planning further medical and social treatment.

- TREATMENT

Investing in a good therapeutic relationship with the patient pays off right from the diagnostic process. The psychiatrist tries to be reassuring and empathically understanding of the patient's problems in the context of setting clear boundaries and diagnostic/therapeutic/rehabilitation options. Empathy is easier to achieve when the patient is aware that he/she is not making up his/her symptoms, but misinterpreting them. Their somatic pain is a subjective reality and a source of suffering for them. The conscious possibility of simulation or agravation in the expectation of an objective benefit should also be examined and addressed.

If possible, the patient's family should be involved in the treatment.

The initial step in psychological support is psychoeducation. The patient is taken through the somatic findings in an explanatory manner and is given a basic neurobiological explanation of the mind-body connection. One of the first goals of the treatment is to get the patient to function as well as possible in spite of pain symptomatology. Once a detailed diagnosis has been made, the patient may be referred to one of the forms of psychotherapy (behavioural cognitive therapy, dynamic psychotherapy, psychosocial interventions, etc.) and/or started on pharmacotherapy (mainly antidepressants and/or antiepileptics), depending on the nature of the problems and motivation. Prolonged prescription of tranquillisers and sedatives should be avoided. Algologists should be consulted when prescribing analgesics, and opioid analgesics should be avoided in principle because of the risk of developing dependence. It should be stressed that not all patients with TSBM are candidates for intensive psychotherapeutic treatment. Psychopharmaceuticals have no formal indication for TSBM, and the choice should be based on the

symptom profile and the expected benefit with slow dose titration due to the higher potential for side effects.

Results: According to ICD-10 PSPD is classified as Somatoform disorders. Its basic characteristic is constant, severe physical pain that cannot be explained by the physiological processes or physical illness. The basis of all somatoform disorders is somatization, or the expression of emotional and psychosocial problems with the physical symptoms. The disorder has a long-term course, usually persisting for more than 6 months, while hindering the patient‘s overall functioning.

The ICD-11 classification tried to simplify the concept of somatization by specifically highlighting the common basic features of most current somatoform disorders (including PSPD) and defining them as Disorders of Bodily Distress or Bodily Experience.

The psychiatrist‘s role in treating patients with PSPD is to establish a therapeutic relationship, diagnose and treat mental disorders, coordinate psychosocial interventions, advise how to communicate with the patient, tolerate ambiguity and diagnostic uncertainty, and reduce the stigma of a mental disorder diagnosis.

Various psychotherapeutic, pharmacotherapeutic and psychosocial methods are used in the treatment, the effectiveness of which is checked after several months of regular treatment. The treatment is individually adapted to the patient with the aim of establishing remission and full functioning, which is not always a realistically achievable goal. It is easier to encourage patients to work full time, depending on the demands of the work, with occasional short sick leaves, but partial work activation can also provide good results.

Psychiatric treatment is tailored to each individual and the nature of their problems, and it is difficult to predict and set precise timeframes within which to expect significant improvement in symptomatology and functioning.

- WORK CAPACITY AND REHABILITATION

In the initial months of psychiatric diagnosis and treatment, a patient with more intense symptomatology of TSBM is mostly still unable to engage in gainful activity. Sick leave is planned to support activation. Regular exercise in the fresh air, relaxing activities, gradual recovery of physical fitness, sleep hygiene, organisation of the day, strengthening of interpersonal relationships and social networks, and at least partial engagement in hobbies are advised at the outset. If necessary, psychiatric pharmacotherapy is introduced and psychotherapeutic treatment is initiated.

The usefulness of physiotherapy and occupational therapy is also described.

The first positive effects of psychiatric treatment and additional interventions can be expected after several months of treatment (taking into account the mechanisms of action of psychopharmaceuticals and the time needed for the psychological part of the intervention to help change the way of thinking and behaviour that amplifies or co-modifies the symptomatology of TSBM).

Depending on the patient’s problems, occupation and age, he or she is then encouraged to return to work, initially partially and then fully, with the possibility of occasional short periods of sick leave. If the patient is unable to perform his/her previous work, he/she can be guided towards occupational or vocational rehabilitation procedures and finding a suitable job.

If the patient’s problems persist and there is a severe decline in functioning, and all pharmacological and psychosocial therapeutic options have been exhausted, we suggest that the patient be presented before a disability committee and assessed for permanent incapacity for work.

Conclusions/Learnings: Optimal management of patients with PSPD is multidisciplinary, and individually adapted. Somatic diagnosis workup and treatment must be carried out sensibly and harmlessly, and psychiatric treatment must be started in a timely manner in order to preserve the patient's functioning as much as possible.

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TINITUS IN PSIHOSOMATSKA MOTNJA

Avtor: Branka Geczy Buljovčić, ambulanta za ORL in akupunkturo, Medicinski Center Ljubljana

Ključne besede: tinitus, psihosomatska motnja, interdisciplinarna obravnava, zmanjšana delazmožnost, telesna okvara.

Izvleček: Psihosomatska motnja je stanje, pri katerem dolgotrajen psihološki stres vpliva na fiziološko (somatsko) motnjo prizadete osebe do takšne mere, da pri njej izzove stisko in postane neposreden pokazatelj njenega čustvenega stanja. Psihosomatska medicina postaja vedno pomembnejša pri obravnavi številnih bolezni, stanj in motenj, kjer z nobeno sodobno medicinsko diagnostiko ne uspemo objektivizirati organskega vzroka bolezni. Zagovorniki psihosomatske medicine povezujejo kar 80 % vseh bolezni s psihosomatskim ozadjem. Med bolezni s psihosomatskim ozadjem uvrščamo tudi določene vrste subjektivnega tinitusa.

Metode: Prikazali smo dvajset oseb s subjektivnim tinitusom, ki smo jih ambulantno obravnavali med letom 2018 in 2022, in pri katerih smo po zaključeni interdisciplinarni obravnavi ocenili, da tinitus lahko povežemo s psihosomatskim ozadjem. Predstavili smo rezultate avdiološke obravnave in meritve sluha s pomočjo pražne tonske avdiometrije (ADG) in meritve lokalizacije šuma. Uporabili smo vprašalnik o posledicah tinitusa (Tinnitus Handicap Inventory, THI) in vizualno analogno skalo (Visual Analogue Scale, VAS).

Rezultati: Preučili smo diagnostično pot obravnave osebe s sumom na psihosomatski tinitus, ki vodi od družinskega zdravnika, preko otorinolaringologa in avdiologa ter številnih specialistov somatske medicine, do psihiatra, psihologa in psihoterapevta.

Razprava: Podan je pregled diagnostičnih postopkov in optimalnih terapevtskih pristopov pri obravnavi bolnikov s psihosomatskim tinitusom s poudarkom na poglobljeno psihoterapevtsko obravnavo. Podan je tudi razmislek o utemeljenosti trajnih razbremenitev pri delu zavarovancev na posebnih delovnih mestih in telesne okvare pri trajnem tinitusu.

TINNITUS AND PSYCHOSOMATIC DISORDER

Author: Branka Geczy Buljovčić, Medical center Ljubljana, Slovenia

Keywords: tinnitus, psychosomatic disorder, interdisciplinary evaluation, working disability, physical impairment.

Abstract: Psychosomatic disorder is a condition in which psychological stress adversely affects physiological (somatic) functioning to the point of distress. Psychosomatic symptom emerges as a physiological concomitant of an emotional state. Psychosomatic medicine is establishing its place in the treatment of conditions in which contemporary diagnostic methods cannot detect an organic origin of the symptoms. Nearly 80% of diseases can be interpreted in connection with psychosomatic disorders, including some types of subjective tinnitus.

Methods: Interdisciplinary evaluation of 20 patients treated in outpatient office during the years 2018-2022 will be presented who were eventually diagnosed as psychosomatic tinnitus.

The audiologic evaluation including pure tone threshold audiometry (ADG), tinnitus matching and Tinnitus handicap inventory (THI) as well as Visual analog scale evaluation will be presented.

Results: An overview of the development of psychosomatic medicine and clinical cases of psychosomatic tinnitus was provided. The diagnostic pathway of a patient with psychosomatic tinnitus, which leads from the general practitioner, otorhinolaryngology specialist, audiologist, and other specialists of somatic medicine to psychiatrist, psychologist, and psychotherapist, will be evaluated.

Discussion: Diagnostic procedures and therapeutic approaches will be evaluated with the purpose of optimizing the evaluation and treatment of these patients, including psychotherapy. Permanent working disability and physical impairment of persons with tinnitus will be discussed.

SPREMEMBA DELAZMOŽNOSTI OB DOLGOTRAJNI DUŠEVNI BOLEZNI S PRIDRUŽENO PSIHOTIČNO DEKOMPENZACIJO – PRIKAZ PRIMERA

Avtor: Sandra Železnik, dr. med., spec. MDPŠ, Univerzitetni rehabilitacijski inštitut Republike Slovenije Soča

Ključne besede: poklicna rehabilitacija, sodelovanje delodajalca, sprememba delazmožnosti, postopno vračanje na delo

Soavtorica: Ksenija Šterman, dr. med., spec. MDPŠ, Univerzitetni rehabilitacijski inštitut Republike Slovenije Soča.

Ključni poudarki:

- Duševne bolezni, kot so depresija in anksiozne motnje, so v razvitih deželah zelo pogoste in nemalokrat vodijo do sprememb v zmožnosti za delo.
- Za vračanje na delo je pomembna kombinacija kliničnih ukrepov, ki vključujejo redno spremljanje pri specialistih in jemanje eventuelne terapije, hkrati pa ne smemo pozabiti na ukrepe na delovnem mestu.
- Pri procesu vračanja na delo je zelo pomembna opredelitev in vrednotenje duševnega in funkcijskega stanja delavca, kar lahko zahteva sodelovanje različnih strokovnjakov.
- Pri vračanju na delo lahko strah pred stigmo, če delodajalec izve za bolezen, pomembno vpliva na motivacijo bolnika, sam proces vračanja pa mora biti pogosto prilagojen, postopen in dolgotrajen, kar ni mogoče brez dobrega sodelovanja delodajalca.
- Pri uspešni vrnitvi na delo je zelo pomembna socialna podpora delavcu, ki jo nudijo delodajalec in sodelavci, morebitno priznavanje dejavnikov delovnega mesta, ki so prispevali k pojavu bolezni, hkrati pa tudi podpora, ki jo zagotavlja družina in zdravstveno osebje.

Izvleček: Razširjene oziroma pogoste (ang. »common«) duševne bolezni, kot so depresija in anksiozne motnje, so v razvitih državah zelo frekventne in napovedujejo zmanjšano delazmožnost, dolgotrajno bolniško odsotnost, lahko pa tudi brezposelnost ali predčasno upokojevanje. Iz tega razloga so za ponovno vključevanje zaposlenih potrebni učinkoviti ukrepi, procesi vračanja na delo.

Metode: Predstavljen je primer 44-letne diplomirane medicinske sestre, pri kateri je ob dolgotrajni anksiozno-depresivni simptomatiki, šibki osebnostni strukturi ter pridruženem škodljivem uživanju alkohola prišlo do psihotične dekompenzacije. Po dolgotrajnem intenzivnem psihiatričnem zdravljenju in oceni delovnega funkcioniranja smo ugotavljali, da je za delo patronažne medicinske sestre trajno nezmožna. Po rednih stikih z delodajalcem smo zato opredelili novo delovno mesto v ambulanti, z določitvijo delovnih nalog in delovnih operacij, ki bi bile v skladu z njenimi zmožnostmi, dovolj strukturirane in manj odgovorne. Sledilo je vračanje na prilagojeno delovno mesto, s postopnim stopnjevanjem časa in zahtev delovnih obremenitev, pri čemer smo jo spremljali. Hkrati je bila ves čas redno vodena pri psihiatru in vključena v psihoterapevtsko obravnavo, psihično stanje se je tako dodatno stabiliziralo.

Rezultati: Delo je začetno opravljala pod nadzorom mentorja, usvajala je vedno nova delovna opravila. Sčasoma je bilo potrebe po mentorstvu vedno manj, postajala je bolj samostojna. S postopnim vračanjem je pridobivala na obremenljivosti, vzdržljivosti in delovni učinkovitosti, postopno se je po zmožnostih razširil obseg njenih delovnih opravil. Po skoraj enem letu in pol postopnega vračanja na delo je bila zmožna za delo diplomirane medicinske sestre v ambulanti, vendar brez nočnih izmen.

Zaključki: Zaradi pogostih duševnih bolezni, kot so depresija in anksiozne motnje, nemalokrat pride do spremembe delazmožnosti, ki jo je pri vračanju na delo potrebno ustrezno opredeliti. Vračanje je velikokrat postopno, dolgotrajno in zahteva dobro sodelovanje delodajalcev. Podpora delodajalca, sodelavcev, družine in zdravstvenega osebja, ki jo delavec zaznava v procesu vračanja na delo, je esencialnega pomena.

CHANGE IN WORK CAPACITY FOLLOWING PROLONGED MENTAL ILLNESS WITH ASSOCIATED PSYCHOTIC DECOMPENSATION – A CASE REPORT

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Keywords: Vocational rehabilitation, employer cooperation, change in work capacity, gradual return-to-work

Co-author: Ksenija Šterman, MD, Specialist in Occupational Medicine, Transport and Sport, University Rehabilitation Institute of the Republic of Slovenia - Soča, Centre for Vocational Rehabilitation, Slovenia

Key highlights:

- Common mental illnesses, such as depression and anxiety disorders, are highly prevalent in developed countries and often lead to changes in work capacity.
- A combination of work-related intervention approaches and clinical interventions, involving regular monitoring by specialists and potential therapy intake, are crucial for return-to-work.
- During the return-to-work process, it is essential to define and assess the mental and functional condition of the employee, usually requiring collaboration among different professionals.
- The fear of stigma, should the employer become aware of the illness, can have a substantial impact on the patient's motivation throughout the return-to-work process. Process must often be tailored, gradual, and prolonged, which is not possible without the employer's cooperation.
- Successful return-to-work relies heavily on social support provided to the employee from both the employer and colleagues, potential acknowledgment of workplace factors contributing to the onset of the illness, and support from family and healthcare personnel.

Abstract: Common mental illnesses, such as depression and anxiety disorders, are very prevalent in developed countries and predict reduced work capacity, prolonged sick leave, and can even lead to unemployment or early retirement. For this reason, effective measures and return-to-work processes are necessary for the reintegration of employees.

Methods: This report focuses on a 44-year-old registered nurse who, due to persistent anxiety-depressive symptoms, a fragile personality structure, and concurrent harmful alcohol consumption, underwent a psychotic decompensation. After an extended period of intensive psychiatric treatment and a comprehensive assessment of work functioning, it was determined that she could no longer continue to work as a district nurse. Through consistent communication with the employer, a suitable work position was identified within the outpatient clinic. The assigned tasks and operations were tailored to her abilities, providing a well-structured and less demanding work environment. This was followed by a return to an adapted workplace, with a gradual increase in time and demands of workload, while being closely monitored. Concurrently, she received regular psychiatric supervision and participated in psychotherapeutic treatment, contributing to a further stabilization of her mental condition.

Results: Initially, she worked under the supervision of a mentor, acquiring new tasks progressively. Over time, the need for mentoring diminished, and she became more independent. Through gradual return, she gained in workload capacity, endurance, and work efficiency. The scope of her tasks expanded gradually according to her abilities. After almost a year and a half of a gradual return-to-work, she was capable to work as a registered nurse in the outpatient clinic, albeit without night shifts.

Conclusions: Due to common mental illnesses such as depression and anxiety disorders, changes in work capacity often ensue, necessitating a precise definition during the return-to-work process. The return is frequently gradual, protracted, and demands effective collaboration from employers. The support provided by the employer, colleagues, family, and healthcare personnel, as perceived by the employee during the return-to-work process, holds paramount importance.

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PARALELNA SEKCIJA 4.2 // PARALLEL SESSION 4.2

IZVEDENCI MEDICINSKE STROKE V SODNIH POSTOPKIH

Avtor: mag. Živa Gliha, Delovno in socialno sodišče, Ljubljana

Ključne besede: socialni spor, pomočnik sodišča, sodni izvedenec medicinske stroke, izvid in mnenje

Izvleček: V določenih socialnih sporih je za razjasnitev dejanskega stanja potrebno strokovno znanje, s katerim sodišče ne razpolaga. V primeru odločanja o pravicah in obveznostih, vezanih na zdravstveno stanje oseb (npr. zmožnost za delo), v postopku kot pomočnik sodišča praviloma sodeluje sodni izvedenec medicinske stroke. Dokaz z izvedencem v teh sporih običajno predlaga tožeča stranka, lahko pa tudi sodišče samo. Izbira ustreznega izvedenca je odločitev sodišča. Če sodišče presodi, da je izvedensko delo zapleteno, lahko določi tudi dva ali več izvedencev, lahko pa delo zaupa strokovni instituciji.

Izvedenčev izvid in mnenje je strokovni elaborat, ki mora biti obrazložen na način, da ga sodišče in stranke, ki tega medicinskega znanja nimajo, razumejo in lahko o njem razpravljajo. Zato mora biti obrazložitev izvedenskega dela jasna, razumljiva in popolna. V socialnih sporih sodni izvedenec praviloma poda mnenje v pisni obliki. Stranke spora ga imajo možnost izpodbijati. Če je potrebno, sodišče izvedenca še zasliši. Pri presoji izvedenskega mnenja sodišče preizkusi, ali je to podano v mejah izvedenčeve strokovne specialnosti, ali je izvedenec odgovoril na postavljena vprašanja, ali so dejstva, ki jih je vzel kot podlago za svojo oceno in zaključke, objektivno ugotovljena, ali so podana druga pomembna dejstva, ki jih ni upošteval, in ali ni posegel na področje pravne presoje, ki je stvar sodišča. V primeru, da se pomanjkljivosti v izvedenskem mnenju ne da odpraviti niti z zaslišanjem izvedenca, se zahteva mnenje drugih izvedencev.

V prispevku je obravnavana vloga izvedencev medicinske stroke v socialnih sporih in tudi vloga medicinskih organov Zavoda za zdravstveno zavarovanje Slovenije in Zavoda za pokojninsko in invalidsko zavarovanje Slovenije. Predstavljeni so primeri iz sodne prakse.

MEDICAL EXPERTS IN COURT PROCEEDINGS

Author: mag. Živa Gliha, Labour and Social Court Ljubljana, Slovenia

Keywords: social dispute, court assistant, forensic medical expert, report and opinion

Abstract: In certain social disputes, clarification of the factual situation requires expertise that is not available to the court. In the case of decisions on rights and obligations related to a person's state of health (e.g. ability to work), a medical expert is usually involved in the proceedings as an assistant to the court. Expert evidence in these disputes is usually proposed by the claimant, but may also be proposed by the court itself. The choice of the appropriate expert is a matter for the court. If the court considers that the expert work is complex, it may also appoint two or more experts or entrust the work to a professional institution.

The expert's report and opinion is an expert report which must be explained in a way that the court and the parties who do not have this medical knowledge can understand and discuss it. Therefore, the explanation of the expert's work must be clear, comprehensible and complete. In social disputes, the expert's opinion is normally given in writing. The parties to the dispute have the possibility to challenge it.

If necessary, the court shall hear the expert further. In assessing the expert's opinion, the court shall examine whether it is given within the limits of the expert's specialty, whether the expert has answered the questions put to him, whether the facts which he has taken as a basis for his assessment and conclusions have been objectively established, whether there are other relevant facts which he has not taken into account and whether he has not encroached on an area of legal assessment which is a matter for the court. If the deficiencies in the expert's opinion cannot be remedied even by hearing the expert, the opinion of other experts shall be sought.

This article discusses the role of medical experts in social disputes, as well as the role of the medical authorities of the Health Insurance Institution of Slovenia and the Pension and Disability Insurance Institution of Slovenia. Examples from case law are presented.

VLOGA SODNE MEDICINE PRI SOCIALNIH SPORIH ZOPER ZAČASNO ZADRŽANOST OD DELA IN OCENO INVALIDNOSTI/PREOSTALE DELAZMOŽNOSTI

Avtor: Silva Demšar, psihiater

Ključne besede: izvedenec psihiatrične stroke, socialni spori zoper začasno zadržanost od dela in oceno invalidnosti.

Ključni poudarki:

- Ocena delazmožnosti pri psihičnih boleznih je kompleksna in interdisciplinarna.
- Potrebno je upoštevati mnenja različnih specialistov, kliničnih psihologov in včasih tudi socialnih delavcev.
- Psihično stanje pacientov je odvisno tudi od vplivov okolja in odnosa strokovnih delavcev do njihove stiske in psihičnih simptomov.

Izvleček: Predstavitev primera reševanja pritožbe preko sodnega postopka. Sodni spori zaradi tega, ker se ljudje ne čutijo delazmožni in se pritožijo na odločitve ZZZS in ZPIZ so pogosti in zapleteni, ker je subjektivna ocena psihičnega stanja ni odvisna le od dejanske intenzitete simptomov, ampak tudi od drugih dejavnikov, kot so kognitivne zmožnosti osebnost, pričakovanja, občutek neupoštevanja in zaradi dolgotrajnosti ali neučinkovitosti postopkov; socialne okoliščine, podpore v okolici in odnosa do njihovih pritožb s strani organizacij in delodajalca tudi zdravstvenega osebja.

Predstavitev primera: Gospoda so odklonili na IK z utemeljitvijo, da zdravljenje ni zaključeno, ker je gospod odvisen od alkohola in ni uspešno zaključil zdravljenja. Ob obsežnem psihiatričnem intervjuju se izkaže, da je imel poškodbo glave in operacijo hematoma, da ima ledvične kamne, nekrozo pankreasa in slabo obvladano sladkorno bolezen, da je ostal po razvezi brez prebivališča, izgubil službo in ostal brez dohodkov. Mnenje izvedenca v sodnem postopku je na podlagi pregleda in preučitve, da ni zmožen za delo in da je odvisnost komorbidna motnja ter le del njegove patologije.

Zaključki / Spoznanja: Za oceno delazmožnosti je potrebna celovita ocena psihiatričnega, somatskega in socialnega stanja, za kar je potrebno tudi mnenje drugih ekspertov.

THE ROLE OF EXPERT OPINION IN SOCIAL DISPUTES AGAINST TEMPORARY AND PERMANENT WORK DISABILITY ASSESSMENTS

Author: Silva Demšar, psychiatrist

Keywords: psychiatric expert, social disputes against temporary suspension from work and disability assessment.

Key highlights:

- Work capacity assessment in mental illness is complex and interdisciplinary.
- It is necessary to take into account the opinions of different specialists, clinical psychologists and sometimes social workers.
- The mental state of patients also depends on environmental influences and the attitude of professionals towards their distress and psychological symptoms.

Abstract: A case study on how to resolve a complaint through the judicial process. Disputes because people do not feel able to work and complain against medical assessments regarding benefits in temporary and permanent disability are common and complex because the subjective assessment of the psychological state depends not only on the actual intensity of the symptoms, but also on other factors such as cognitive ability, personality, expectations, feelings of being ignored and of the length or ineffectiveness of the procedures; the social circumstances, the support of the surrounding community and the attitudes towards their complaints by organisations and employers, including medical staff.

Case presentation: A patient was assessed againts benefits of permanent disability on the grounds that treatment was not completed because he was alcohol dependent and had not successfully completed treatment. An extensive psychiatric interview revealed that he had a head injury and haematoma surgery, kidney stones, necrosis of the pancreas and poorly controlled diabetes, and that he has been left homeless, unemployed and without an income after a divorce. The opinion of the expert in the judicial proceedings is, on the basis of the examination, that he is not fit for work and that dependence is a comorbid disorder and only a part of his pathology.

Conclusions: The assessment of work capacity requires a comprehensive assessment of the psychiatric, somatic and social condition. This in turn requires an interdisciplinary approach with opinions of other experts as well.

MOŽNOSTI NAPOVEDI REZULTATOV ZDRAVLJENJA DEPRESIJE

Avtor: dr. Bojana Avguštin Avčin, specialistka psihiatrije

Ključne besede: depresija, breme, zdravljenja, izid, preprečevanje

Povzetek: Globalno več kot 300 milijonov ljudi, torej okrog 4,4 % svetovnega prebivalstva trpi za depresivnimi motnjami, ki ostajajo vodilni vzrok obolevnosti na področju duševnega zdravja. Svetovna zdravstvena organizacija je depresijo uvrstila med najpomembnejše povzročitelje invalidnosti, depresivna motnja je povezana z znatno obolevnostjo in umrljivostjo. Depresivne motnje preprečujejo ljudem, da bi dosegli svoj polni potencial, zmanjšujejo človeški kapital in so povezane s prezgodnjo umrljivostjo zaradi samomora in drugih bolezni. Veliko breme bolezni predstavlja obremenitev zdravstvenih sistemov, povečana stopnja odsotnosti z dela in zmanjšana produktivnost med delom (prezentizem). Poleg opisanih posledic depresivne motnje za obolelo osebo, je neugoden vpliv bolezni tudi na družbo, blagostanje.. Rezultati raziskav kažejo, da prezentizem tisti, ki predstavlja večji del stroškov. Iz opisanih razlogov ostaja pomemben izziv obravnave depresivne motnje izboljšanje odkrivanja, odziva na zdravljenje in vzdrževanja remisije ter učinkovitih pristopov za preprečevanje in zgodnjih intervenc, zlasti pri ranljivih skupinah. Kar polovica obolelih ljudi z depresijo namreč ni pravočasno prepoznana oz diagnosticirana in posledično ostaja nezdravljena. Pri osebah, diagnosticiranih z depresijo je odločitve glede načina zdravljenja potrebno še vedno sprejemati na podlagi klinične ocene, s pomočjo vprašalnika ali intervjuja ter splošnih smernic. Na voljo so učinkovita zdravljenja depresivnih motenj: zdravljenje z antidepresivi in psihoterapevtska obravnava, ki so vključena v večino smernic kot zdravljenje prve izbire. Kljub dokazano učinkovitemu zdravljenju veliko število bolnikov ne kaže izboljšanja z zdravljenjem. Napovedni dejavniki uspeha zdravljenja, torej, katera oblika depresije se ugodno odzove na katero od znanih vrst zdravljenja (ali kombinacijo le teh), še vedno ni v zadostni meri razumljeno. Končni terapevtski cilj je ugoden odziv, torej umik depresivnih simptomov. Poleg optimiziranja zdravljenja sta izjemno pomembna ukrepa preprečevanje depresije in pravočasno zgodnje prepoznavanje in zdravljenje.

PREDICTING TREATMENT OUTCOMES IN DEPRESSION

Author: dr. Bojana Avguštin Avčin, specialist in psychiatry, Slovenia

Keywords: depression, burden, treatment outcomes, prevention

Abstract: Depression is the leading cause of mental health-related disease burden globally. At a global level, over 300 million people are estimated to suffer from depressive disorders, equivalent to 4·4% of the world's population. Depression is ranked by the World Health Organization as the single largest contributor to global disability and is associated with considerable morbidity and mortality. Depressive disorders prevents people from reaching their full potential, impairs human capital, and is associated with premature mortality from suicide and other illnesses. The high disease burden further strains health systems, increases rates of absenteeism and reduces productivity while working (presenteeism). In addition to the significant personal consequences associated with depression, the economic impact of these trends can be considerable. Previous research suggests that presenteeism accounts for the majority of the costs. Improving detection, response and remission rates in depressive disorder as well as effective approaches for prevention, intervention especially in vulnerable groups remains an important challenge. As much as half of people with depression are not recognized in time and are therefore not adequately treated. Clinical decisions regarding the treatment of depressive disorders still have to be made on the basis of questionnaire- or interview-based assessments and general guidelines. Effective treatments for depressive disorders are available: antidepressant medication and talking therapies are included in most guidelines as firstline treatments. Still, a substantial number of patients do not show improvement with treatment. Predicting who is most likely to benefit from which interventions or approaches is still not largely understood. Matching patients to the treatment they will most likely respond to should be the ultimate goal. Prevention and timely early intervention efforts are necessary to lessen the disease burden of depression.

NOVE SLOVENSKE SMERNICE ZA ZDRAVLJENJE DEPRESIVNE MOTNJE IN NOVOSTI MKB 11

Avtor: doc. dr. Brigita Novak Šarotar, dr. med., specialistka psihiatrije Univerzitetna psihiatrična klinika Ljubljana & Medicinska fakultet UL, Katedra za psihiatrijo

Ključne besede: depresija, klinična slika, zdravljenje, klasifikacija

Povzetek: Depresija je pogosta, resna, ponavljajoča se duševna motnja, povezana z zmanjšano sposobnostjo funkcioniranja, slabšo kakovostjo življenja, medicinsko soobolevnostjo in smrtnostjo. Uvršča se v sam vrh bolezni tudi ob primerjavi s telesnimi boleznimi na podlagi raziskav, ki so preučevale globalno breme bolezni. Na podlagi tega je učinkovito zdravljenje depresivne motnje prioritetna naloga javno-zdravstvenega sistema in je povezano s pomembnim zmanjšanjem bremena, ki ga taka motnja prinaša. Tudi v Sloveniji motnje razpoloženja predstavljajo največji delež stroškov med duševnimi motnjami. Depresivna motnja se pojavi vsaj enkrat v življenju pri 10-15 % ljudi.

Unipolarna depresivna motnja je lahko sestavljena iz ene ali več depresivnih epizod. V predavanju bodo predstavljeni simptomi depresivne epizode ter postopek diagnosticiranja, tudi z uporabo nove klasifikacije MKB 11.

Zdravljenje depresivne motnje se deli na zdravljenje akutne depresivne epizode in nadaljevalno oz. vzdrževalno zdravljenje. Cilj zdravljenja akutne faze je doseganje remisije in povrnitev funkcionalnosti, v nadaljnjem poteku zdravljenja pa preventiva relapsa ali ponovitve bolezni. Pri blagi epizodi lahko terapevtske učinke dosežemo z uporabo farmakoterapije ali psiholoških terapij, pri zdravljenju zmerne in hude depresivne epizode pa se kot začetni način zdravljenja priporoča predvsem farmakoterapija. Pri prvi depresivni epizodi je smiselno nadaljevati z zdravilom v učinkovitem odmerku vsaj 6 do 9 mesecev po doseženi remisiji. Pri ponavljajočih se depresivnih epizodah, ob kroničnih depresivnih epizodah z rezidualnimi simptomi, kot tudi ob družinski obremenjenosti, vztrajajočih psihosocialnih stresorjih, samomorilnosti ali pridruženi psihozi je smiselno nadaljevati z vzdrževalnim zdravljenjem vsaj 2 leti. V kolikor se ob vzdrževalni terapiji ne pojavi relaps depresivne epizode, postopoma ukinjamo antidepresiv. Antidepresiv ukinjamo postopoma preko nekaj tednov, da se izognemo odtegnitvenim simptomom. Predstavljene bodo nove slovenske smernice za zdravljenje depresivne motnje.

NEW SLOVENIAN GUIDELINES FOR TREATMENT OF DEPRESSIVE DISORDERS AND NEW DEVELOPMENTS IN ICD 11

Author: Asist. Prof. Brigita Novak Šarotar, MD, PhD, Specialist in Psychiatry, University Psychiatric Clinic Ljubljana & Medical Faculty UL, Slovenia

Keywords: depression, clinical presentation, treatment, classification

Abstract: Depression is a common, serious, recurrent mental disorder associated with reduced ability to function, poorer quality of life, medical comorbidity, and mortality. It ranks at the very top of the list of diseases even when compared to physical diseases based on research examining the global burden of disease. Based on this, the effective treatment of depressive disorder is a priority task of the public health system and is associated with a significant reduction of the burden that such a disorder brings. Even in Slovenia, mood disorders account for the largest share of costs among mental disorders. Depressive disorder occurs at least once in a lifetime in 10-15% of people.

Unipolar depressive disorder can consist of one or more depressive episodes. The lecture will present the symptoms of a depressive episode and the diagnostic process, also using the new ICD 11 classification.

The treatment of a depressive disorder is divided into the treatment of an acute depressive episode and ongoing or maintenance treatment. The goal of treatment in the acute phase is to achieve remission and restore functionality, and in the further course of treatment to prevent relapse or recurrence of the disease. In the case of a mild episode, therapeutic effects can be achieved by using pharmacotherapy or psychological therapies, while in the treatment of a moderate and severe depressive episode, pharmacotherapy is recommended as the initial method of treatment. In the case of a first depressive episode, it is reasonable to continue with the drug in an effective dose for at least 6 to 9 months after remission has been achieved. In the case of repeated depressive episodes, chronic depressive episodes with residual symptoms, as well as family burden, persistent psychosocial stressors, suicidality or associated psychosis, it is recommended to continue maintenance treatment for at least 2 years. If a relapse of the depressive episode does not occur during maintenance therapy, the antidepressant is gradually discontinued. The antidepressant is discontinued gradually over several weeks to avoid withdrawal symptoms. New Slovenian guidelines for the treatment of depressive disorders will be presented.

PETEK 12.04.2024 // FRIDAY 12.04.2024

PLENARNA SEKCIJA 1 // PLENARY SESSION 1

STATISTIČNI PREGLED PREOSTALE DELAZMOŽNOSTI IN INVALIDNOSTI BOLNIKOV Z DUŠEVNIMI IN VEDENJSKIMI MOTNJAMI V SLOVENIJI

Avtorji: mag. Branka Geczy Buljovčić, dr. med, mag. Vesna Veljović, dr. med, Lidija Šubelj, univ. dipl. pravnica; Zavod za pokojninsko in invalidsko zavarovanje Slovenije

Ključne besede: duševne in vedenjske motnje, trajna sprememba delazmožnosti.

Izvleček: Bolniki z duševnimi in vedenjskimi motnjami predstavljajo vse večji delež bolnikov, ki jih obravnavamo v družinskih in psihiatričnih ambulantah, njihovo število pa narašča tudi v ambulantah somatskih specialnosti kjer se pogosto izkaže, da gre za psihosomatsko motnjo. Skladno s tem se povečuje število zavarovancev, ki potrebujejo oceno na invalidski komisiji zaradi trajno spremenjene delazmožnosti.

Metode: Prikazali smo statistični pregled slovenskih zavarovancev, ki smo jih obravnavali na Zavodu za pokojninsko in invalidsko zavarovanje Slovenije (ZPIZ) zaradi duševnih in vedenjskih motenj v cilju ocene delazmožnosti v petletnem obdobju, med letom 2018 in 2022.

Rezultati: Obravnavali smo 54422 zavarovancev v petletnem obdobju med letom 2018 in 2022. Približno 12% zavarovancev je imelo glavno diagnozo, ki bistveno vpliva na invalidnost iz poglavja V Mednarodne klasifikacije bolezni in sorodnih zdravstvenih problemov za statistične namene (MKB-10-AM, revizija 10 in11): duševne in vedenjske motnje (F00-F99).

V tretjini primerov smo podali trajno izgubo delazmožnosti, pri 34% pa časovno razbremenitev. Ocenili smo, da zdravljenje ni bilo zaključeno le pri 2,5% obravnavanih.

Največ zavarovancev (36%) je imelo diagnozo bolezni iz skupine razpoloženjskih motenj (F30-F39), skoraj četrtino smo upokojili (23%), pri 40 %-tih pa podali časovno razbremenitev. 22 % obravnavanih je bilo iz skupine bolezni shizofrenija, shizotipske in blodnjave motnje (F20-F29) , 54% smo upokojili. 22% so bili zavarovanci z nevrotskimi stresnimi in somatoformnimi motnjami iz skupine (F40-F48), upokojili smo 13%, časovno razbremenitev pa podali pri 39%. Ostalih 20% zavarovancev smo obravnavali zaradi bolezni odvisnosti, osebnostne motnje in kognitivnih motenj.

Razprava: Psihiatrične bolezni so druge po pogostosti kot vzrok nastanka invalidnosti po statistiki ZPIZ-a, takoj za boleznimi mišično-skeletnega sistema. Rezultati so primerljivi z ugotovitvami držav članic EU in Svetovne zdravstvene organizacije. Predstavili bomo prizadevanja pri ohranjanju delovne aktivnosti obravnavane skupine zavarovancev.

STATISTICAL OVERVIEW OF RESIDUAL WORK CAPACITY AND DISABILITY OF PATIENTS WITH MENTAL AND BEHAVIOURAL DISORDERS IN SLOVENIA

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Keywords: mental and behavioural disorders, permanent change in work capacity

Background: Patients with mental and behavioural disorders make up an increasing portion of patients treated in family and psychiatric clinics. In somatic specialties, their numbers are also rising, since a disorder is often found to be psychosomatic. Correspondingly, the number of insured persons requiring an assessment by the Board of Medical Assessors due to a permanent change in their work capacity is increasing.

Methods: We have provided a statistical overview of insured persons in Slovenia with mental and behavioural disorders, who were dealt with by the Pension and Disability Insurance Institute of Slovenia (ZPIZ) with the aim to assess their work capacity over a five-year period between 2018 and 2022.

Results: We looked at 54,422 insured persons over a five-year period between 2018 and 2022. Roughly 12 per cent of insured persons had a principal diagnosis that significantly contributed to their disability as defined in Chapter V of the International Classification of Diseases and Related Health Problems (ICD-10-AM, 10th and 11th revisions) - Mental and Behavioural Disorders (F00-F99).

In a third of cases, a permanent disability was diagnosed, and in 34 per cent of cases, reduced work hours were indicated. The treatment was considered as uncompleted in only 2.5% of those treated.

The majority of insured persons (36 per cent) had a diagnosis from the group of mood disorders (F30-F39), with almost a quarter of them sent into retirement (23 per cent) and 40 per cent entitled to work reduced hours. 22 per cent of those dealt with were from the group of schizophrenia, schizotypal and delusional disorders (F20-F29) , with 54 per cent of them taking retirement. 22 per cent were made up of insured persons with neurotic stress and somatoform disorders from the group (F40-F48); 13 per cent of them took retirement and 39 per cent were entitled to work reduced hours. The remaining 20 per cent of insured persons were dealt with because of addictive disorders, personality disorder and cognitive disorders.

Discussion: According to the statistics of the Pension and Disability Insurance Institute of Slovenia, psychiatric illnesses are the second most common cause of disability, immediately following musculoskeletal disorders. The results are comparable to those of the EU Member States and the World Health Organisation. We will present our efforts aimed to help this group of insured persons to stay in work.

POVEZOVANJE ZAČASNE IN TRAJNE NEZMOŽNOSTI ZA DELO V SISTEMU SOCIALNE VARNOSTI

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Ključne besede: socialna varnost, nezmožnost za delo, obvezno zdravstveno zavarovanje, pokojninsko in invalidsko zavarovanje, izvedenski organi

Izvleček: Ko sistem socialne varnosti ni predmet pogovora in ga štejemo za samoumevnega, pomeni, da deluje dobro. Družbena resničnost je drugačna, saj se o njem nenehno razpravlja v strokovnih, političnih in javnomnenjskih krogih. To velja bolj za zdravstveno, delno za pokojninsko, manj pa za invalidsko zavarovanje. Kljub temu, socialnih zavarovanj ni mogoče obravnavati povsem ločeno, saj med njimi obstajajo pomembne povezave. Tako je enako pomembno kot posvečanje trenutnim težavam, razmislek o prihodnji, zavarovancem in odločevalcem prijaznejši in učinkovitejši ureditvi sistema socialne varnosti.

Pravica do socialne varnosti je trdno zasidrana v mednarodnem, evropskem in našem ustavnem pravu. Njeno vsebinsko in postopkovno uresničevanje mora zagotavljati geografski, časovni, ekonomski in informacijski dostop do vseh vrst pravic do dajatev v denarju in v naravi, v javnem sistemu, ki temelji na enakosti in solidarnosti, kot vezivnem tkivu med članicami in člani vsake družbe. Med tradicionalna socialna tveganja umeščamo tudi nezmožnost za delo. Ta lahko povzroči izgubo dohodka zaradi bolezni, poškodbe, poškodbe pri delu, poklicne bolezni, invalidnosti in materinstva, ki ga je treba v določeni meri nadomestiti. Drugače je lahko pri socialnih tveganjih, pri katerih je oseba zmožna za delo, denimo pri brezposelnosti, starosti, očetovstvu. Posebnost nezmožnosti za delo je, da lahko poleg izgube dohodka povzroči tudi povečane stroške, denimo zaradi zdravljenja, poklicne ali zaposlitvene rehabilitacije, odvisnosti od oskrbe drugega.

Posebnost je tudi dvojno odločanje. Najprej je treba ugotoviti raven nezmožnosti za delo in nato njej prilagoditi pravice iz sistema socialne varnosti. V družbah, kjer je delo posebna vrednota, je treba delovno okolje prilagoditi preostali zmožnosti za delo.

Z vidika zavarovane osebe je pomembno kako čim prej povrniti zmožnost za delo in ne toliko kdo o nezmožnosti odloča. Sistemsko obstajajo pomembne razlike med pravicami iz zdravstvenega in iz invalidskega zavarovanja. Kljub temu, bi bilo smiselno povezati izvedenske organe obeh, v korist zavarovanih oseb in brezšivnega zagotavljanja pravic.

INTEGRATING TEMPORARY AND PERMANENT INCAPACITY FOR WORK IN THE SOCIAL SECURITY SYSTEM

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Keywords: social security, work incapacity, mandatory health insurance, pension and disability insurance, expert bodies

Abstract: When social security system is not subject to public debate and is taken for granted, it functions well. Societal reality is different. It is subject to constant discussions in academic, policy and public circles. This goes for health, partially for pension, and less for disability insurance. Nevertheless, social insurances cannot be perceived separately. They are interrelated. Hence, it might be equally important to tackle immediate issues and longer term consideration on the future of social security system.

The right to social security is anchored in international, European and Slovenian constitutional law. Its substantive and procedural realisation has to ensure geographical, timely, economical and informational access to all benefits in cash and in kind, in a public system, based on equality and solidarity, as a connecting tissue of every society. Incapacity to work is among traditional social risks. It may cause loss of income due to sickness, injury, accident at work, occupational disease or maternity. Lost income has to be replaced to a certain extent. Other social risks, such as unemployment, old-age or paternity are distinct, since a person might be able to work. Incapacity to work might cause not only income loss but also increased costs, due to healthcare, occupational or employment rehabilitation and reliance on long-term care.

Incapacity to work requires double decision making, first on the level of incapacity and second on the suitable rights. In societies, in which work is a special value, working environment has to be adjusted to the remaining capacity to work.

For an insured person, it is essential to swiftly regain working capacity and not so much, who is deciding on it. Systematically, there are distinctions between the rights provided from health and from disability insurance. Nevertheless, it would only make sense to join both expert bodies to seamlessly provide the appropriate benefits.

SODNO VARSTVO PRAVIC V PRIMERU ZAČASNE ALI TRAJNE NEZMOŽNOSTI ZA DELO

Avtor: mag. Živa Gliha, Delovno in socialno sodišče Ljubljana

Ključne besede: socialni spor, sodno varstvo pravic, začasna in trajna nezmožnost za delo

Izvleček: O pravicah, obveznostih ali pravnih koristih iz sistema socialne varnosti odločajo upravni organi v upravnem postopku. Vsako področje ima svoja pravila, določena v zakonih in podzakonskih predpisih. Upravni postopek se konča z izdajo dokončnega upravnega akta. Kontrolo zakonitosti postopka pred izdajo tega akta ter pravilnost in zakonitost akta preverja socialno sodišče v socialnem sporu. Sodno varstvo zoper tak dokončni upravni akt se uveljavi z vložitvijo tožbe na Delovnem in socialnem sodišču v Ljubljani. Spor je dopusten, če tožeča stranka uveljavlja, da je zaradi izdaje izpodbijanega upravnega akta prizadeta v svojih pravicah ali pravnih koristih ali zaradi tega, ker upravni akt ni bil izdan in ji vročen v zakonitem roku.

Pravice v primeru začasne ali trajne nezmožnosti za delo sodijo med pravice iz sistema socialne varnosti. Oseba, ki se z odločitvijo upravnega organa ne strinja, vloži tožbo zoper Zavod za zdravstveno zavarovanje Slovenije ali Zavod za pokojninsko in invalidsko zavarovanje Slovenije in v postopku dokazuje, da je bila odločitev napačna. Navede, kaj zahteva. V dokaznem postopku sodišče izvede predlagane dokaze, za katere oceni, da so potrebni za ugotovitev dejstev, pomembnih za odločitev. Ker je v teh primerih potrebno tudi posebno strokovno znanje, s katerim sodišče ne razpolaga, pogosto angažira sodnega izvedenca medicinske stroke.

Če po izvedenem dokaznem postopku sodišče ugotovi, da je bil postopek pred izdajo izpodbijanega upravnega akta zakonit ter da je upravni akt pravilen in zakonit, tožbeni zahtevek zavrne. Če tožbenemu zahtevku ugodi, s sodbo izpodbijani upravni akt odpravi delno ali v celoti in odloči o pravici, obveznosti ali pravni koristi. V tem primeru ne sme odločiti v škodo stranke, ki je uveljavljala sodno varstvo.

V prispevku so predstavljeni pogosti zapleti in dileme pri odločanju o začasni in trajni nezmožnosti za delo.

JUDICIAL PROTECTION OF RIGHTS IN THE EVENT OF TEMPORARY OR PERMANENT INCAPACITY FOR WORK

Author: mag. Živa Gliha, Labour and Social Court, Slovenia

Keywords: social dispute, judicial protection of rights, temporary and permanent incapacity for work

Abstract: Rights, obligations or legal benefits under the social security system are decided by administrative authorities in administrative proceedings. Each area has its own rules, laid down in laws and regulations. The administrative procedure ends with the issue of a final administrative act. The legality of the procedure prior to the issue of this act and the correctness and legality of the act are subject to review by the Social Court in a social dispute. Legal protection against such a final administrative act is sought by bringing an action before the Labour and Social Court in Ljubljana. The dispute is admissible if the claimant alleges that, as a result of the adoption of the contested administrative act, he or she has been adversely affected in respect of his or her rights or legal interests or because the administrative act was not adopted and served on him or her within the legal time-limit.

In the event of temporary or permanent incapacity for work, these are social security rights. A person who disagrees with the decision of an administrative body brings an action against the Health Insurance Institution of Slovenia or the Pension and Disability Insurance Institution of Slovenia, proving in the proceedings that the decision was wrong. State what you are claiming. In the evidence procedure, the court shall take such evidence as it considers necessary to establish the facts relevant to the decision. As these cases also require special expertise that the court does not have, it often engages a medical expert.

If, after the taking of evidence, the court finds that the procedure prior to the contested administrative act was lawful and that the administrative act is correct and lawful, it dismisses the action. If it upholds the action, it shall, by judgment, annul the contested administrative act in whole or in part and give a decision on the right, obligation or benefit in question. In that event, it may not rule against the party seeking judicial protection.

This article presents common complications and dilemmas in the determination of temporary and permanent incapacity for work.

MODEL ODZIVA NA ZMANJŠANO DELOVNO ZMOŽNOST MEHIŠKIH DELAVCEV ZARADI DUŠEVNIH BOLEZNI ALI OKVAR

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Ključne besede: trajna invalidnost, ocena delovne zmožnosti, začasna nezmožnost za delo.

Ključni poudarki:

- Pravice povezane z oceno delazmožnosti v Mehiki;
- Priporočila za ocenjevanje invalidnosti;
- Posebni vidiki pri ocenjevanju duševnih bolezni in invalidnosti.

Ozadje/vprašanje/tema: Svetovna zdravstvena organizacija ocenjuje, da so duševne motnje med glavnimi vzroki za invalidnost, saj so vzrok za približno eno od šestih let življenja z invalidnostjo. Pričakovana življenjska doba posameznikov s hudimi duševnimi motnjami je v povprečju 10 do 20 let krajša od pričakovane življenjske dobe splošne populacije. Obstajajo različne metode za oceno invalidnosti, v tej predstavitvi pa si bomo ogledali, kako se tega ocenjevanja loteva Mehika.

Teme:

- Splošni uvod v socialno varnost v Mehiki in zavarovanja, ki jih krije IMSS;
- Ugotavljanje pravic pri zdravstvenih poškodbah delavcev, povezanih in ne-povezanih z delom (razlike med tistimi, ki so povezani z delom in ne povezani z delom, vrste posledic, dnevi začasne invalidnosti, trajna invalidnost, smrt);
- Ocena zdravja pri delu, ocena delovne zmožnosti. (vodenje, telesni pregled, ocena delovnih aktivnosti, ocena izgubljene delovne zmožnosti z uporabo meril, prehod iz invalidskih dni v pokojnino, zahteve za dostop do pokojnine);
- Ocenjevanje nepoklicnih pokojninskih dajatev zaradi duševnih motenj (seznam vključenih vrst duševnih motenj, posebne značilnosti, ki jih je treba upoštevati, učinki na delovno zmožnost).

RESPONSE MODEL TO REDUCED WORK ABILITY DUE TO MENTAL ILLNESS OR INJURY IN MEXICAN WORKERS

Author: Emmanuell Alejandro Ramírez Polanco, Specialist in Occupational and Environmental Medicine, Mexican Institute Of Social Security, Medical Technical Coordinator – at Permanent disability Area, Mexican Institute of Social Security (IMSS), Mexico

Keywords: Permanent disability, assessment of the work ability, temporary incapacity for work.

Key highlights:

- Occupational Health Assessment on health damages;
- Recommendations for evaluating disability;
- Special considerations in the evaluation of mental illnesses and disabilities.

Background / question / issue: The World Health Organization estimates that mental disorders rank among the primary contributors to disability, accounting for approximately one out of every six years lived with a disability. Individuals with severe mental disorders, on average, experience a life expectancy that is 10 to 20 years shorter than that of the general population. Various methods exist to gauge disability, and in this presentation, we will delve into how Mexico approaches this assessment.

Topics: The presentation will cover the following topics:

- General introduction to Social Security in Mexico and insurances covered by IMSS;
- Management for the attention of health damages in workers related and not related to work (differences between those related to work and not related to work, types of consequences, temporary disability days, Permanent disability, Death.);
- Occupational Health Assessment, Evaluation of work capacity. (Management, Physical examination, assessment of work activities, Evaluation of work lost capacity using criteria, transition from disability days into pension. Requirements to get access to pension);
- Assessment of non-occupational pension benefits caused by Mental Disorders (Types of Mental disorders included, special features to consider, effects on working capacity).

PETEK 12.04.2024 // FRIDAY 12.04.2024

PLENARNA SEKCIJA 2 // PLENARY SESSION 2

VLOGA ZDRAVNIKA MEDICINE DELA, PROMETA IN ŠPORTA PRI OHRANJANJU DELAZMOŽNOSTI BOLNIKOV Z DUŠEVNIMI IN VEDENJSKIMI MOTNJAMI

Avtor: Grega Avgust Sušnik, dr. med. spec. MDPŠ, ZD Kamnik

Ključne besede: vloga specialista medicine dela, prometa in športa; duševne in vedenjske motnje; odločanje o delazmožnosti; prilagoditve delovnega mesta; promocija zdravja na delovnem mestu;

Izvleček: Zdravnik specialist medicine dela prometa in športa (MDPŠ) se pri svojem delu pogosto sooča z osebami z duševnimi in vedenjskimi motnjami. Tovrstne okvare zdravja predstavljajo zelo širok spekter. Zato se vloga specialista MDPŠ razlikuje glede na posameznika in njegove težave oz. bolezni.

Osnovna vloga specialista MDPŠ je ocenjevanje delazmožnosti, torej tehtanje med zahtevami/obremenitvami delovnega mesta in med sposobnostmi/lastnostmi delavca. Na področju prometa presodi, ali je oseba sposobna varno upravljati vozila, na področju športa pa ali bo oseba varno sodelovala pri športnih aktivnostih in si pri tem ne okvarila zdravja.

Delovno mesto je pogosto mesto, ker se duševne in vedenjske motnje prvič izrazijo. Neobičajno vedenje hitro zaznajo sodelavci ali delodajalec sam, ki v tem primeru lahko izkoristi pravico, da zaposlenega napoti na kontrolni pregled k spec. MDPŠ, kjer se taka oseba prvič sooči z zdravniško obravnavo, zaradi tovrstnih težav. Na tem mestu je pomembno dobro sodelovanje spec. MDPŠ in delodajalca. To se zrcali v poznavanju delovnega procesa, socialnih vlog in načina vodenja podjetja. Specialist MDPŠ mora biti senzibilen za zaznave začetnih odstopanj v vedenju in znati nanje ustrezno odreagirati ter po potrebi izvesti ali napotiti v nadaljnjo obravnavo (psiholog, psihiater, …). Obenem pa se v sodelovanju z delodajalcem že pričnejo pogovori o morebitnih prilagoditvah delovnega mesta - lajšanju obremenitev, ki pa so vedno individualne. Med pogostejšimi ukrepi je skrajševanje delovnega časa in razbremenitve določenih nalog. Slednje je pogosto trd oreh, saj mora biti zanje posluh s strani delodajalca in motivacija s strani zaposlenega.

Pregled pri spec. MDPŠ ima tudi motivacijsko komponento, ki je druge specialnosti nimajo. Izkaže se, da so zaposleni, predvsem tisti z boleznimi odvisnosti, iz strahu pred »negativnim« spričevalom, pripravljeni slediti napotkom specialistov ali se odločiti za zdravljenje.

Pogosto spregledana vloga spec. MDPŠ pa je v prepoznavanju vzrokov za duševne in vedenjske motnje, ki izvirajo iz delovnega okolja. Vzroke zanje lahko iščemo pri odnosih med sodelavci, neustreznem vodenju, prevelikih psihičnih obremenitvah oziroma pomanjkanju kontrole nad svojim delom, nezadostnem počitku in drugih. Tu pomembno vlogo odigra pravilno usmerjena promocija zdravja na delovnem mestu.

THE ROLE OF AN OCCUPATIONAL, TRAFFIC, AND SPORTS MEDICINE SPECIALIST IN MAINTAINING WORK CAPACITY IN PATIENTS WITH MENTAL AND BEHAVIOURAL DISORDERS

Author: Grega Avgust Sušnik, Specialist in Occupational, Traffic, and Sports Medicine, Health Centre Kamnik, Slovenia

Keywords: role of occupational, traffic, and sports medicine specialist; mental and behavioural disorders; work capacity assessment; workplace adaptations; workplace health promotion;

Abstract: An occupational, traffic, and sports medicine specialists (MDPŠ) often work with individuals who have mental or behavioural disorders in their practice. Such health impairments encompass a broad spectrum and cannot be addressed uniformly. Therefore, the role of the MDPŠ specialist varies depending on the individual and their specific issues or illnesses.

The primary role of the MDPŠ specialist involves assessing of workability, meaning weighing the workload and capabilities of the worker. In the fields of traffic they evaluate whether the individual is capable of safely operating vehicles and in the field of sports assessing a safe participation in sports activities without doing harm to health.

The workplace is often where mental and behavioural disorders first manifest. Unusual behaviour is quickly noticed by colleagues or the employer, who can, in such cases, exercise the right to refer the employee for a control examination with the MDPŠ specialist. Often is this the place where the person with such disorder faces medical examination for the first time. At this point, effective cooperation between the MDPŠ specialist and the employer is crucial. This is reflected in understanding the work process, social roles, and the company's management style. The MDPŠ specialist must be sensitive to detecting initial deviations in behaviour, respond appropriately to them, and, if necessary, conduct or refer for further treatment (by a psychologist, psychiatrist, …). Meanwhile he must begin a discussion with an employee about potential workplace adjustments, such as easing burdens, which are always individual. Among the more common adjustments are reducing working hours and relieving specific tasks. But these are often challenging, requiring understanding from the employer and motivation from the employee.

An examination by the MDPŠ specialist also has a motivational component, which other specialties do not possess. It turns out that employees, especially those with addiction disorders, are willing to follow instructions or choose treatment due to fear of a "negative" assessment.

A frequently overlooked role of the MDPŠ specialist is in identifying the causes of mental and behavioural disorders caused by environment at work. Causes can be found in relationships between colleagues, inadequate management, excessive mental stress, ill demand control relationship, insufficient rest, and others. Here properly directed workplace health promotion plays a crucial role.

KLINIČNA OCENA FUNKCIONALNOSTI PRI BOLNIKIH Z DUŠEVNIMI IN VEDENJSKIMI MOTNJAMI

Avtor: prof. dr. Vesna Švab, dr. med. spec. psihiatrije, Medicinska fakulteta, Univerza v Ljubljani

Ključne besede: Ocena invalidnosti WHO, Mednarodna ocena funkcioniranja, Globalna ocena funkcioniranja

So-avtorji: Barbara Zupančič, MA in psychology, Šentprima (SI), Lea Jakič Hiti, BA in social work, BAS in security studies, Šentprima (SI), Ksenija Bratuš Albreht, MA in social work, Šentprima (SI), MSc. Jana Ponikvar, MA in sociology, Šentprima (SI)

Strokovno sodelovanje: Vsi avtorji so enakomerno prispevali k nastanku prezentacije s svojim znanjem in delovnimi izkušnjami. VŠ in BZ sta koordinirali prizadevanja.

Ključni poudarki:

- Ocena delazmožnosti pri psihiatričnem pacientu je načeloma interdisciplinarna in ni dovolj kakovostna, če se to oceno opravi le na podlagi kliničnega stanja.
- Trajno in začasno invalidnost pri duševnih motnjah je potrebno ocenjevati v kontekstu, ki ga postavlja Mednarodna klasifikacija funkcioniranja.
- Manjše zmožnosti pri duševnih motnjah v veliki večini ne predstavljajo trajne invalidnosti, ampak jih je mogoče pomembno zmanjšati ali odpraviti z ustreznimi rehabilitacijskimi ukrepi.
- Na nastanek in posledice duševnih motenj ne vpliva le bolezen, temveč tudi okoliščine, ko je socialna stiska in stigmatizacija.
- Z ustreznimi rehabilitacijskimi in zdravstvenimi ukrepi lahko velika večina ljudi z duševnimi motnjami okreva do mere, da lahko delajo polni ali skrajšan delovni čas z nekaterimi prilagoditvami in tudi polno participira pri organizaciji svojega življenja, zdravljenja in obravnavi.

Ozadje / vprašanje / problem: Ocena delazmožnosti in napotitve na oceno invalidnosti se večinoma zanašajo na ekspertna mnenja specialistov psihiatrov in kliničnih psihologov. Po drugi strani pa ocene invalidnosti pri ljudeh z težavami v duševnem zdravju na Republiškem zavodu za zaposlovanje slonijo na razvitih kompleksnih interdisciplinarnih metodah ocenjevanja, ki slonijo na Mednarodni klasifikaciji funkcioniranja in za to uporabljajo jedrne nize. Kljub svoji vrednosti pa ti instrumenti pri nas še ne uporabljajo ocene zunanjih vplivoV, med njimi tudi stigme ali kršitev pravic.

Metode: Opravili smo pregled literature o ocenjevalnih instrumentih, ki služijo oceni funkcioniranja oseb z duševnimi motnjami. Pregledali smo lokalne in mednarodne znanstvene članke na tem področju in osvetlili instrumente, ki so najpogosteje citirani in uporabljeni v znanstvenih poročilih.

Rezultati: Našli smo nekaj ocenjevalnih lestvic, ki združujejo subjektivni, strokovni in pogled svojcev/skrbnikov na funkcioniranje posameznika, za uporabo katerih se je mogoče relativno hitro usposobiti. Ne glede na to pa je MKF orodje, ki vključuje različne aspekte ocene zmožnosti tudi na področju duševnega zdravja, če se uporablja na pravilen način in če vključuje vse- tudi okolijske vplive na invalidnost. Znanje o prej znanih načinih ocenjevanja pa je za uporabo MKF zelo pomembno

Zaključki / Spoznanja: Ocena funkcioniranja z MKF za ljudi z duševnimi motnjami je lahko danes nezadostna, ker lahko spregleda pomembne podatke o okolju in samoocenjevanju pri nekaterih posameznikih.

ASSESSMENT METHODS FOR OCCUPATIONAL ABILITIES REGARDING MENTAL HEALTH DISORDERS

Author: Vesna Švab, MD, PhD, professor, Medical Faculty, University Ljubljana, Slovenia

Keywords: WHO Disability Assessment, International Assessment of Functioning, Global Assessment of Functioning

Contributing authors: Barbara Zupančič, MA in psychology, Šentprima (SI), Lea Jakič Hiti, BA in social work, BAS in security studies, Šentprima (SI), Ksenija Bratuš Albreht, MA in social work, Šentprima (SI), MSc. Jana Ponikvar, MA in sociology, Šentprima (SI)

Cooperation: All authors participated equally in discussions about presentation, as well as with their working experience. VŠ and BZ coordinated the efforts.

Key highlights:

- The assessment of work capacity in a psychiatric patient is, in principle, interdisciplinary and of insufficient quality if it is based on the clinical condition alone.
- Permanent and temporary disability in mental disorders should be assessed in the context set by the International Classification of Functioning.
- Impairments in mental disorders do not, in the vast majority of cases, constitute a permanent disability, but can be significantly reduced or eliminated by appropriate rehabilitation measures.
- The onset and consequences of mental disorders are influenced not only by the illness, but also by the circumstances of social distress and stigma.
- With appropriate rehabilitation and health measures, the vast majority of people with mental disorders can recover to the point of being able to work full or part-time with some adjustments, and also participate fully in the organisation of their lives, treatment and care.

Problem: Work assesment and referrals to disability assessments in Slovenia are mostly relying on the knowledge and skills of specialists psychiatrists and clinical psychologists. On the other hand the Slovenian Employment agency (SEA) developed very extensive inter disciplinary assessment instruments relying on International Classification of Functioning, using core sets for this work. These assessments for people with mental health problems are very valuable, but still lacking assessment of the environmental influences, including stigma and human rights protection.

Methods: Literature review was made to find assessmet tools used internationally in last 20 years to assess functioning of people with mental disorders. Local, as well as international scientific studies were checked to highlit the number of references and use.

Results: We found several assessment tools that combine personal (subjective), professional and carer/familly perspective of functioning with relativelly easy access to trainnig for their use. ICF use nevertheless provides a tool that incorporates different aspects of disability assessment if used correctlly and if it includes all- also environmetal influence on disability. The knowledge from prevous assessment instruments should be used and might improve understanding of ICF.

Conclusions: Assessment of functioning with ICF cores for people with mental health problems at present in Slovenia might overlook some important data about environment and self assessment in some people with mental health problems.

VRAČANJE OSEB Z DUŠEVNIMI BOLEZNIMI NA DELO. REHABILITACIJA NA PODLAGI DOKAZANIH DOGNANJ ALI: "KAJ DELUJE?"

Avtor: Dr. Marco Streibelt, Univerza v Lübecku, Nemčija

Ključni poudarki:

- Duševne bolezni na splošno povzročajo kompleksne težave pri poklicnem udejstvovanju.
- Učinkovite rehabilitacijske strategije s ciljem vrnitve na delo so bile doslej slabo raziskane.
- Zdi se, da so uspešne sestavine močno osredotočene na posameznikovo delovno situacijo ter kombinacija terapevtskih intervencij in intervencij na delovnem mestu.
- Rehabilitacijo je treba obravnavati kot celovito strategijo in ne kot posamezno intervencijo.

Izvleček: Duševne bolezni so povezane z visokim tveganjem za zgodnjo upokojitev. V Nemčiji je skoraj polovica novih upokojitev zaradi trajne nezmožnosti za delo posledica duševnih bolezni. Stopnja tveganja brezposelnosti je pri osebah z duševnimi boleznimi bistveno višja kot v splošni populaciji. Poleg tega so najpogostejši razlog za zadržanost od dela zaradi nezmožnosti za delo prav duševne bolezni. Da bi preprečili težave pri udeležbi in izboljšali možnosti vračanja na delo, so učinkovite strategije rehabilitacije še toliko bolj pomembne.

Rehabilitacija v okviru Nemškega zavoda za pokojninsko zavarovanje (DRV) je namenjena zavarovanim osebam za dolgoročno ohranjanje ali obnovitev delazmožnosti. Najpogosteje uporabljen model je medicinska rehabilitacija. Ta se v primeru duševnih bolezni v Nemčiji izvaja v obliki celodnevnega programa, ki poteka v strokovno usposobljenih ustanovah in traja 5 do 6 tednov. Vključuje usposabljanje, izobraževanje in svetovanje v organizaciji skupine strokovnjakov iz različnih področij. Medicinski rehabilitaciji lahko po potrebi sledijo še delovno-specifični ukrepi in poklicna rehabilitacija.

Postopek rehabilitacije se v Nemčiji zaradi številnih družbenih in političnih izzivov ter novih znanstvenih dognanj nenehno spreminja. V predstavitvi bo prikazan in obravnavan razvoj rehabilitacije na podlagi novih na dokazih temelječih dognanj. Predvsem bo prikazano, da so ukrepi, ki so bolj osredotočeni na individualne zahteve na delovnem mestu, tudi bolj učinkoviti. V prihodnosti bo rehabilitacija oseb s kompleksnimi težavami vedno bolj pomembna. Zato mora biti tako v praksi kot tudi v fazi raziskav prepoznana kot "celovita strategija" in ne zgolj kot "individualen ukrep".

RETURN TO WORK OF PERSONS WITH MENTAL DISEASES. EVIDENCE BASED REHABILITATION OR: WHAT WORKS?

Author: Dr. Marco Streibelt, University of Lübeck, Germany

Key highlights:

- Mental diseases generally cause complex problems in occupational participation.
- Effective rehabilitation strategies with the aim of return to work have been little researched to date.
- Successful components seem to be a strong focus on the individual work situation and a combination of therapeutic and workplace interventions.
- Rehabilitation must be seen as a comprehensive strategy, not as an individual intervention.

Abstract: Mental diseases are associated with a high risk of retirement from working life. In Germany, almost half of all new entrants to permanent work disability pensions are due to mental diseases. The risk of unemployment is significantly higher than in the general population. And mental diseases cause the most days of incapacity for work. This makes effective rehabilitation strategies all the more important in order to avoid impairments to participation and improve the chances of reintegration into work.

Rehabilitation services on behalf of the German Pension Insurance (GPI) are offered to maintain or restore the insured person‘s ability to work in the long term. The most frequently practised model is the medical rehabilitation. Medical rehabilitation in Germany can be defined as a full-day programme lasting 5 to 6 weeks in case of mental diseases in specially qualified rehabilitation facilities. It includes training, education and counselling and is organised by a multi-professional team. Afterwards, there is the option of job-related services and vocational rehabilitation if required.

In view of the many social and political challenges as well as new scientific findings, rehabilitation in Germany is constantly evolving. The presentation will present and discuss new evidence-based developments. In particular, it will be shown that services that are more focussed on the individual requirements at job can be more effective. In the future, the rehabilitation of people with complex problems will become increasingly important. Rehabilitation must therefore be recognised both in practice and in research as a „comprehensive strategy“ and less as an „individual service“.

ZGODNJA POKLICNA IN ZAPOSLITVENA REHABILITACIJA V PROCESU VRAČANJA NA DELO: PREDSTAVITEV PRIMERA

Avtorji: Valentina Brecelj, Petra Štampar, Ana Miklavčič

Ključne besede: oblikovanje delovnega mesta, na uporabnika usmerjen pristop, interdisciplinarno timsko delo, sodelovanje, deležniki.

Ključni poudarki:

- Uspešno vračanje na delo mora temeljiti na individualnem načrtu vračanja na delo. Tega na podlagi funkcionalne ocene pripravi ustrezno sestavljen strokovni tim. V njem so podani predlogi glede časovne obremenitve pri vračanju na delo, tehničnih in organizacijskih prilagoditev delovnega mesta in možnosti uveljavljanja pravic iz naslova zaposlitvene rehabilitacije (če je smiselno).
- Bistveno je sodelovanje delodajalca in zavarovanca.
- Proces temelji na strokovnih izhodiščih zaposlitvene rehabilitacije in pripravi strokovnih podlag za uveljavljanje pravic do poklicne rehabilitacije po Zakonu o pokojninskem in invalidskem zavarovanju.
- Za uspešno vodenja celotnega procesa je nujno sodelovanje med ZZZS in ZPIZ.

Poklicno sodelovanje: Proces zaposlitvene rehabilitacije je izvajal strokovni tim koncesionarja Centerkontura d. o. o. v sodelovanju z delodajalcem. V proces so bili vključeni tudi pooblaščeni zdravniki medicine dela pri delodajalcu in ZPIZ.

Ozadje / vprašanje: Delodajalec je pri izvajalcu zaposlitvene rehabilitacije naročil izvedbo Storitve B – Priprava mnenja o ravni delovnih sposobnosti, znanj, delovnih navad in poklicnih interesov. Delavcu je bila z odločbo ZPIZ priznana pravica do dela na drugem delu z omejitvami. V času napotitve je bil delavec razporejen na čakanje na delo doma. Cilj napotitve je bilo iskanje drugega ustreznega delovnega mesta glede na preostalo delovno zmožnost delavca.

Metode: V prispevku predstavljamo študijo primera starejšega delavca s težavami na področju duševnega zdravja. Strokovni tim zaposlitvene rehabilitacije je v procesu rehabilitacije uporabil bio-psiho-socialni model in na uporabnika usmerjen pristop. V ocenjevalni fazi smo zbrali podatke v skladu s standardiziranim postopkom Storitve B. V nadaljevanju smo uporabili metode dela, ki smo jih razvili skupaj z URI Soča v okviru projekta Zgodnja poklicna in zaposlitvena rehabilitacija v procesu vračanja na delo. Pomemben vidik v tem procesu je sodelovanje z različnimi deležniki, kjer smo uporabili štiri modele sodelovanja: izmenjava informacij, vodenje primera, medorganizacijski sestanki in timsko delo.

Rezultati: Tekom obravnav smo komunicirali z delodajalcem preko kadrovske službe. Delavec delovnih nalog »koordinatorja VI.« ni zmogel opravljati, zato so mu omogočili delo blizu doma, na področju urejanja okolice. Ker to delo ni bilo ustrezno sistematizirano, smo skupaj z zaposlenim in delodajalcem oblikovali novo delovno mesto »vzdrževalec z omejitvami«. V obravnavo smo vključili tudi timskega zdravnika medicine dela. V okviru priprave DD-1 obrazca so imenovani zdravniki medicine dela pri delodajalcu podali mnenje, da delovno mesto ni v celoti ustrezno. Kadrovska služba je podala vlogo za Dopolnilno mnenje o ustreznosti delovnega mesta na ZPIZ, ki je izdal pozitivno mnenje.

Zaključki / ugotovitve: Za uspešen zaključek procesa vračanja na delo je bilo ključno vzajemno sodelovanje vseh deležnikov, ki smo sledili skupnemu cilju**.**

EARLY VOCATIONAL REHABILITATION IN RETURN-TO-WORK PROCESS: CASE REPORT

Authors: Valentina Brecelj, Petra Štampar, Ana Miklavčič , Slovenia

Keywords: creation of the workplace (job stripping), client-oriented approach, interdisciplinary team work, co-operation, stakeholders

Key highlights:

- A successful return to work must be based on an individualised return to work plan. This is developed by an appropriately constituted expert team on the basis of a functional assessment. It makes suggestions on the time commitment for return to work, technical and organisational adjustments to the workplace and the possibility of claiming vocational rehabilitation rights (if applicable).
- The cooperation of the employer and the patient is essential.
- The process is based on the professional foundations of vocational rehabilitation and the preparation of the professional basis for the exercise of rights to vocational rehabilitation under the Pension and Disability Insurance Act.
- The cooperation between the ZZZS and the ZPIZ is essential for the successful management of the whole process.

Professional co-operation: The vocational rehabilitation process was led by the interdisciplinary team of experts from the concessionaire Centerkontura d.o.o. in co-operation with the employer. Authorized occupational medicine doctors from the employer and ZPIZ were also included in the process.

Background / Theme: The employer ordered the vocational rehabilitation provider to execute Service B – The preparation of an assessment about the client's work capabilities, knowledge, work habits and career interests. The client was granted through a decree from ZPIZ the right to work at another workplace with restrictions. At the time of the referral, it had been arranged for the client/worker to wait at home for work. The purpose of the referral was to search for another suitable workplace in keeping with the client's remaining work capacity.

Methods: In this article we present a case study of an older worker with mental health issues. The group of experts responsible for the vocational rehabilitation had applied a bio-psycho-social model and a client-oriented approach in the rehabilitation process. In the evaluation phase we have gathered data in accordance with the standardized procedure of Service B. Further on we used work methods that we've developed together with URI Soča in the framework of the project Early professional and vocational rehabilitation in the process of returning to work. An important aspect of this process is the co-operation of several parties which availed themselves of the following 4 models of participation: information exchange, case management, interorganizational meetings and interdisciplinary teamwork.

Results: During the rehabilitation process we kept regular contact with the employer via the human resources department. The client/worker was unable to fulfil his duties as a »co-ordinator VI.« and was therefore enabled work near his home, in the domain of landscaping. Because this work wasn't properly systematized, we created a new work position together with the client and the employer, i.e., »maintenance worker with disabilities«. In the rehabilitation process we also included the team occupational medicine doctor. In the context of preparing a DD-1 form the assigned occupational medicine doctors submitted an evaluation that declared the workplace not entirely suitable. The

human resources department submitted a form for a supplementary opinion about the suitability of the position to the ZPIZ, which gave a positive response.

Conclusions / findings: For the successful termination of the process of returning the client to work the mutual co-operation of all parties towards a shared goal was crucial.

CENTRALNO IZVAJANJE POKLICNE REHABILITACIJE ZA VZHODNO IN ZAHODNO SLOVENIJO

Avtorja: Peter Šalej, Vanja Iršič, ZPIZ

Ključni poudarki:

- poklicna rehabilitacija;
- predhodno/prelimirano mnenje;
- delodajalec;
- odločitev rehabilitanta;
- izvajanje za vhodno in zahodno Slovenijo.

Izvleček: Zavod za pokojninsko in invalidsko zavarovanje kot nosilec in izvajalec obveznega invalidskega zavarovanja želi čim širšemu krogu delovnih invalidov s preostalo delovno zmožnostjo omogočiti ohranitev oz. pridobitev zaposlitve preko instituta poklicne rehabilitacije. Poudarek daje na hitri in kratkotrajni izvedbi rehabilitacije, kot je prilagoditev delovnega mesta, različne tečajne oblike usposabljanj in izobraževanj ter praktično usposabljanje pri delodajalcu. Dolgotrajno izobraževanje na šolah ne zagotavlja vedno ohranitve zaposlitve, saj neuspeh pri opravljanju učnih obveznosti, kot tudi večletna odtujitev zavarovanca iz delovnega procesa lahko vodi v odpoved pogodbe o zaposlitvi, kar pa ni namen poklicne rehabilitacije.

Zaradi enotne prakse in strokovnega dela se od leta 2021 dalje vodijo postopki rehabilitacije na dveh enotah zavoda, in sicer na OE in IK Celje za vhodni del Slovenije ter na OE in IK Ljubljana za zahodni del Slovenije.

Postopek za uveljavljanje pravic iz invalidskega zavarovanja se začne v večini primerov na predlog osebnega zdravnika. Celotno medicinsko in delovno dokumentacijo pregledata predsednika invalidske komisije v Celju oz. v Ljubljani in izločita vse tiste zavarovance za katere menita, da bi bila smiselna izvedba poklicne rehabilitacije. Slednjim je v nadaljevanju predstavljena vsebina in postopek, ki ga opredeljuje veljavna zakonodaja. Odločitev ali pristopi k izvedbi poklicne rehabilitacije je na strani zavarovanca in posredno njegovega delodajalca. Že ob individualnem razgovoru približno 40% zavarovancev odkloni rehabilitacijo, ostali so napoteni v strokovno obravnavo k izvajalcem poklicne rehabilitacije. Žal timi strokovnjakov pri več kot polovici napotenih zavarovancev ne prepoznajo nobene od možnosti izvedbe poklicne rehabilitacije, kar je v letu 2022 pomenilo, da je od 659 preliminarno prepoznanih rehabilitantov le 20,5% zavarovancev dejansko nastopilo rehabilitacijo.

Na tem mestu se zastavlja vprašanje, ali je pravilno, da na podlagi preliminarnega strokovnega mnenja zavarovanec odkloni izvedbo poklicne rehabilitacije in se postopek nadaljuje na senatu invalidskega komisije z oceno invalidnosti? Posledično ugotovljena kategorija invalidnosti delodajalcu omogoči, ali da zavarovancu ponudi ustrezno delovno mesto, ali pa preko komisije za odpoved pogodbe o zaposlitvi prekine z njim delovno razmerje?

Meniva, da je v primeru ko izvedenec IK strokovno prepozna možnost uporabe instituta poklicne rehabilitacije potrebno strmeti le k temu, v kakšni obliki in načinu bi se ta realizirala kot najugodnejša ohranitev zaposlitve zavarovanca.

CENTRALISED VOCATIONAL REHABILITATION ELIGIBILITY PROCESS FOR EASTERN AND WESTERN SLOVENIA

Authors: Peter Šalej, Vanja Iršič, Pension and Disability Insurance Institute of Slovenia, Slovenia

Key highlights:

- Vocational rehabilitation;
- prior/preliminary opinion;
- employer;
- rehabilitation decision;
- implementation for the Eastern and Western Slovenia.

Abstract: The objective of the Pension and Disability Insurance Institute, as the competent institution and provider of compulsory disability insurance, is to provide vocational rehabilitation to as many as possible disabled workers with remaining work capacity in order to maintain or obtain their employment. The emphasis is on prompt and short-term rehabilitation, such as workplace adjustments and adaptations, various forms of training courses and education, as well as practical on-the-job training with their employer. Long-term school education does not always guarantee job retention, since the failure to meet learning requirements, and prolonged absence from work can result in termination of the employment contract, which is the opposite of what we try to achieve with vocational rehabilitation.

Since 2021, the rehabilitation eligibility processes have been carried out in two Institute's regional units: Regional Unit and Disability Commission in Celje for the eastern part of Slovenia, and Regional Unit and Disability Commission in Ljubljana for the western part, due to the nature of work and to ensure uniform practice.

In most cases, the procedure of claiming entitlements from disability insurance starts with the proposal from the treating physician of an insured person. The full medical and occupational records are reviewed by the Chairmen of the Disability Commission in Celje or Ljubljana, where the insured persons who may qualify for vocational rehabilitation are singled out. Subsequently, the latter are informed of the content and the course of rehabilitation process determined by the applicable legislation. The decision on whether to take-up vocational rehabilitation is left to the insured person and, indirectly, their employer. About 40% of insured persons decline rehabilitation as early as during the individual interview, the rest are referred to treatment with vocational rehabilitation providers. Unfortunately, according to the expert teams, more than a half of the referred insured persons are not suitable for any vocational rehabilitation measures, which means that out of 659 preliminary identified insured persons who could potentially qualify for vocational rehabilitation, only 20.5% actually participated in 2022.

The question that arises is, whether despite of an insured person declining vocational rehabilitation on the grounds of preliminary expert medical opinion the procedure should continue with disability assessment by the Panel of Medical Assessors. Consequently, based on the established category of disability an employer can either offer an insured person an adopted workplace, or through the Commission establishing grounds for termination of employment contract terminate their employment relationship.

We believe that when a medical assessor recognizes the chance of successful vocational rehabilitation, we should only strive to carry it out in the form and manner that would result in the retention of employment of an insured person that is the most favourable to them.

PETEK 12.04.2024 // FRIDAY 12.04.2024

PARALELNA SEKCIJA 3.1 // PARALLEL SESSION 3.1

SHIZOFRENIJA IN BIPOLARNA MOTNJA

Avtor: prof. dr. Rok Tavčar, dr. med., specialist psihiater, Univerzitetna psihiatrična klinika Ljubljana

Ključne besede: Shizofrenija, bipolarna motnja razpoloženja, zdravila, delazmožnost, neželeni učinki

Ključni poudarki:

- Shizofrenija in bipolarna motnja razpoloženja sta hudi in večinoma kronični duševni motnji.
- Shizofrenija se navadno prične v zgodnji odraslosti.
- Tako shizofrenija kot bipolarna motnja razpoloženja navadno potekata v več epizodah.
- Zaradi same duševne motnje in tudi zaradi možnih neželenih učinkov zdravil je delazmožnost lahko močno okrnjena.
- Telesno zdravje oseb z duševnimi motnjami je slabše kot pri primerljivi splošni populaciji.

Izvleček: Shizofrenija in bipolarna motnja razpoloženja sta hudi in večinoma kronični duševni motnji, ki močno vplivata na vsakodnevno funkcioniranje bolnika in posledično tudi na njegovo delazmožnost. Shizofrenija se navadno pojavi v pozni adolescenci ali zgodnji odraslosti, pri moških je vrh zbolevanja med 15. in 25. letom, pri ženskah pa med 25. in 35. letom. Prvi pojav bolezni je torej še v obdobju zaključevanja šolanja ali prve zaposlitve, kar v praksi večkrat pomeni, da bolnik ne konča šolanja ali izgubi zaposlitev, kar dolgoročno slabo vpliva na njegovo nadaljnjo delazmožnost. Nekatere zdravila, ki se uporabljajo za zdravljenje shizofrenije, lahko motijo koncentracijo ali povzročajo druge neželene učinke (motorične, kognitivne, pretirano sedacijo), kar spet omeji možnost opravljanja nekaterih del (npr. vožnja, delo z nevarnimi stroji itd.). Prav tako se sčasoma lahko pojavijo metabolni neželeni učinki (debelost, arterijska hipertenzija, hiperlipidemija). Znano je, da se bolniki z duševnimi motnjami manj udeležujejo preventivnih aktivnosti, redkeje obiskujejo svojega izbranega zdravnika, tako da je njihovo telesno zdravje slabše kot pri primerljivi splošni populaciji.

Podobno vse našteto velja tudi za bolnike z bipolarno motnjo razpoloženja, le da v tem primeru začetek bolezni ni tako zgoden kot pri shizofreniji. Zdravljenje posamezne epizode, bodisi manije ali depresije, navadno traja več tednov ali celo mesecev. V času posamezne epizode bolnik ni zmožen za delo, v času med dvema epizodama pa je lahko delazmožnost le minimalno okrnjena. Pri večjem številu epizod ali celo pri hitrokrožni obliki (štiri ali več epizod v enem letu) je delazmožnost močno okrnjena. Nekatera zdravila za zdravljenje bipolarne motnje razpoloženja (npr. litij in valproat) zahtevajo kontrolo nekaterih laboratorijskih parametrov. Vprašljiva je delazmožnost bolnikov za opravljanje zelo odgovornih del, kjer imajo morebitne napake lahko hujše materialne ali druge posledice. Pomembno je, da se bolniki redno kontrolirajo pri svojem psihiatru in da se držijo nekaterih preventivnih priporočil (higiena spanja, abstinenca od psihoaktivnih snovi).

SCHIZOPHRENIA AND BIPOLAR DISORDER

Author: Prof. Rok Tavčar, MD, PhD, psychiatrist, University Psychiatric Clinic Ljubljana, Slovenia

Keywords: schizophrenia, bipolar disorder, drugs, working ability, side effects

Key highlights:

- Schizophrenia and bipolar disorder are severe and mostly chronic mental disorders.
- Schizophrenia usually begins in early adulthood.
- Both schizophrenia and bipolar disorder tend to have multiple episodes.
- Due to the mental disorder itself and also due to the possible side effects of the drugs, patients' working ability can be greatly reduced.
- The physical health of people with mental disorders is worse than that of a comparable general population.

Abstract: Schizophrenia and bipolar disorder are severe and mostly chronic mental disorders that greatly affect the patient's daily functioning and their working ability. Schizophrenia usually appears early in life with peak incidence in men between the ages of 15 and 25 and in women between the ages of 25 and 35. The first appearance of the disease is therefore during the period of finishing school or the first job, which often has a detrimental effect on patient's further working ability. Some drugs used to treat schizophrenia can affect concentration or cause other side effects (motor, cognitive, excessive sedation), which again limits the ability to perform certain jobs (eg driving, working with dangerous machinery, etc.). Metabolic side effects (obesity, arterial hypertension, hyperlipidaemia) may also occur over time. It is known that patients with mental disorders participate less in preventive activities, visit their family doctor less often, so their physical health is worse than in the comparable general population.

Similarly, all of the above also applies to patients with bipolar mood disorder, except that in this case the onset of the disease is not as early as in schizophrenia. Treatment of a single episode, whether mania or depression, usually takes several weeks or even months. During an individual episode, the patient is unable to work, and in the time between two episodes, the ability to work may be only minimally impaired. With a greater number of episodes or even with a rapid cycle form (four or more episodes in one year), the working ability is greatly reduced. Some drugs (lithium and valproate) require the control of certain laboratory parameters. The ability of patients to perform highly responsible work is questionable. The patients need to regularly visit their psychiatrist and should adhere to certain preventive recommendations (sleep hygiene, abstinence from psychoactive substances).

OSEBNOSTNE MOTNJE IN DELAZMOŽNOST - POGLED PSIHIATRA

Avtor: dr. Zvezdana Snoj, dr. med., spec. psihiatrije

Ključne besede: osebnostne motnje, delazmožnost, simptomatika, zdravljenje

Izvleček: Osebnostne motnje so kompleksne duševne motnje, ki pomembno vplivajo na način, kako posamezniki doživljajo, razmišljajo, se vedejo in vzpostavljajo odnose v zasebnem življenju, delovnem in socialnem okolju.

Z medicinskega stališča so osebnostne motnje opredeljene kot pogoste duševne motnje, ki obstajajo v različnih oblikah, odvisno od izraženosti posameznih osnovnih osebnostnih lastnosti ali potez. Vsaka vrsta osebnostne motnje se kaže skozi specifične simptome in vzorce vedenja. Pogosto so jim pridružene še druge duševne motnje predvsem depresija, anksiozne ali psihotične motnje in bipolarna motnja razpoloženja, prav tako tudi zasvojenosti s psihoaktivnimi snovmi in različnim škodljivim vedenjem.

Etiologija osebnostnih motenj je kompleksna in vključuje kombinacijo genetskih, nevrobioloških in okoljskih dejavnikov. Razvoj osebnostnih motenj se začne v zgodnji mladosti in adolescenci ter se lahko stopnjuje skozi življenje.

Osebnostne motnje lahko pomembno vplivajo na delazmožnost posameznika, saj se odražajo v vzorcih vedenja, miselnosti in interakcijah, kar je odvisno od vrste motnje in stopnje izraženosti simptomov. Pomembno je razumeti, da je vpliv osebnostne motnje na delazmožnost individualen, in da pristop k obravnavi zahteva celostno oceno in prilagoditve v skladu s potrebami posameznika in zahtevami delovnega okolja. Poleg oseb z osebnostno motnjo posledice trpijo tudi njihovi bližnji in sodelavci. Ti se soočajo z dolgotrajnim stresom, ki vodi do različnih osebnih in zdravstvenih težav.

Zdravljenje osebnostnih motenj zahteva celostni pristop, ki vključuje farmakoterapijo, psihoterapevtske pristope in včasih tudi intenzivnejše zdravljenje v hospitalnih pogojih.

Novejše raziskave se osredotočajo na razumevanje bioloških osnov osebnostnih motenj ter razvoj bolj ciljanih terapevtskih pristopov. Raziskovanje v smeri personalizirane medicine kaže na obetavne poti za bolj uspešno obravnavo posameznikov z osebnostnimi motnjami.

PERSONALITY DISORDERS AND WORK CAPACITY - A PSYCHIATRIST'S PERSPECTIVE

Author: Zvezdana Snoj, MD., Ph.D., Psychiatrist, Slovenia

Keywords: Personality disorders, work capability, symptoms, treatment

Abstract: Personality disorders are complex mental disorders that significantly impact the way individuals experience, think, behave, and establish relationships in their private, work, and social environments. From a medical standpoint, they are defined as common mental disorders that exist in various forms, depending on the expression of individual fundamental personality traits or features. Medical classifications, among others, define antisocial, borderline, narcissistic, histrionic disorders, etc. Each type of personality disorder manifests through specific symptoms and behavior patterns. Often, they are accompanied by other mental disorders, especially depression, anxiety or psychotic disorders, and bipolar mood disorder. Substance addictions and various harmful behaviors are also frequently associated.

The etiology of personality disorders is complex, involving a combination of genetic, neurobiological, and environmental factors. The development of personality disorders often begins in early childhood and adolescence and can escalate throughout life.

Personality disorders can significantly impact an individual's work capability, as they manifest in behavior patterns, thinking, and interactions. The impact on work capability may vary depending on the type of disorder and the degree of symptom expression. It is crucial to understand that the influence of a personality disorder on work capability is individual, and the approach to treatment requires a comprehensive assessment and adjustments according to the individual's needs and workplace requirements. In addition to individuals with personality disorders, their close relatives and colleagues also suffer the consequences. All together, they face prolonged stress leading to various personal and health problems.

The treatment of personality disorders requires a comprehensive approach, including pharmacotherapy, psychotherapeutic approaches, and sometimes hospitalization. Co-occurring mental disorders associated with personality disorders should also be treated. Recent research focuses on understanding the biological basis of personality disorders and the development of more targeted therapeutic approaches. Research in the direction of personalized medicine also shows promising paths for more successful treatment of individuals with personality disorders.

For professionals in the fields of psychiatry and medicine, regular updating of knowledge about personality disorders is crucial to effectively address individuals with this complex group of mental disorders.

VLOGA KLINIČNEGA PSIHOLOGA PRI OCENI FUNKCIONALNE ZMOGLJIVOSTI BOLNIKOV Z DUŠEVNIMI IN VEDENJSKIMI MOTNJAMI

Avtor: dr. Špela Hvalec, univ. dipl. psih., spec. klin. psih., Psihiatrična bolnišnica Idrija

Ključne besede: učinkovito opravljanje nalog in dejavnosti, psihodiagnostična sredstva

Povzetek: Merjenju funkcionalne zmogljivosti bolnikov z različnimi boleznimi ali po poškodbah se namenja vse več pozornosti tako z raziskovalnega kot tudi praktičnega vidika. Funkcionalna zmogljivost, ki se nanaša na sposobnost posameznika, da učinkovito opravlja spekter različnih nalog in dejavnosti, ki so potrebne ali zaželene v njihovem življenju, namreč pomembno napoveduje posameznikovo delovanje v vsakdanjem življenju oz. na različnih življenjskih področjih.

Klinični psiholog opravi klinično psihološki pregled, ki je sestavljen iz uvodnega intervjuja (le-ta je usmerjen v pridobivanje anamnestičnih in heteroanamnestičnih podatkov) in aplikacije različnih psihodiagnostičnih instrumentov. V okviru svoje ocene funkcionalne zmogljivosti bolnikov z duševnimi in vedenjskimi motnjami se usmerja na oceno intelektualnih sposobnosti, kognitivnega funkcioniranja (ocenjuje učinkovitost pozornostnih, spominskih, vidno-konstrukcijskih, jezikovnih in izvršilni funkcij), opremljenost z različnimi veščinami in spretnostmi (strategije za spoprijemanje s stresom, reševanje problemov, odločanje, socialne veščine) in različne osebnostne značilnosti, ki so v tem kontekstu pomembne (npr. impulzivnost, upravljanje s čustvi, prilagodljivost).

Na podlagi pridobljenih informacij iz intervjuja, opazovanja vedenja obravnavanca med pregledom in interpretacije dobljenih rezultatov, napiše poročilo o klinično-psihološkem pregledu, v katerem izpostavi posameznikove šibka in močna področja, na podlagi katerih se načrtuje nadaljnje zdravljenje, rehabilitacijo in vračanje v delovno okolje.

Klinični psiholog lahko opravi oceno funkcionalne zmogljivosti posameznika v okviru klinično-psihološke ambulante ali kot član multidisciplinarnega tima.

THE ROLE OF A CLINICAL PSYCHOLOGIST IN ASSESSING FUNCTIONAL CAPACITY OF PATIENTS WITH MENTAL AND BEHAVIORAL DISORDERS

Author: dr. Špela Hvalec, univ. dipl. psych., spec. clinical psych., Idrija Psychiatric Hospital, Slovenia

Keywords: functional capacity, clinical psychologist, effective task performance, psychodiagnostic tools

Abstract: The assessment of the functional capacity of patients with various illnesses or injuries is receiving increasing attention both from a research and practical standpoint. Functional capacity, referring to an individual's ability to effectively perform a range of different tasks and activities necessary or desired in their life, significantly predicts their functioning in everyday life or across various life domains.

A clinical psychologist conducts a clinical psychological assessment, which consists of an initial interview (focused on gathering anamnestic and heteroanamnestic data) and the application of various psychodiagnostic instruments. In assessing the functional capacity of patients with mental and behavioral disorders, the psychologist focuses on evaluating intellectual abilities, cognitive functioning (assessing the efficiency of attentional, mnemonic, visuoconstructional, linguistic, and executive functions), equipped skills and abilities (coping strategies, problem-solving, decision-making, social skills), and various personality traits relevant in this context (e.g., impulsivity, emotional regulation, adaptability).

Based on the information obtained from the interview, observation of the subject's behavior during the examination, and interpretation of the results, the psychologist writes a report on the clinical-psychological examination. This report highlights the individual's strengths and weaknesses, forming the basis for planning further treatment, rehabilitation, and return to the work environment.

A clinical psychologist can assess an assessment of an individual's functional capacity within a clinical-psychological outpatient setting or as a member of a multidisciplinary team.

ZAPOSLITVENA REHABILITACIJA OSEBE S PARANOIDNO SHIZOFRENIJO IN PODPORNA ZAPOSLITEV - PRIKAZ PRIMERA

Avtor: Ksenija Šterman, dr. med., spec. med. dela, prometa in športa, Univerzitetni rehabilitacijski inštitut Republike Slovenije – Soča, Center za poklicno rehabilitacijo

Ključne besede: zaposlitvena rehabilitacija, shizofrenija, podporna zaposlitev, delazmožnost

Soavtor: Sandra Železnik, dr. med., spec. med. dela, prometa in športa, Univerzitetni rehabilitacijski inštitut Republike Slovenije – Soča, Center za poklicno rehabilitacijo

Ključni poudarki:

- V Sloveniji obstajajo različne spodbude za zaposlovanje invalidov kot so kvotni sistem, nagrada za preseganje kvote, oprostitev plačila prispevkov za pokojninsko in invalidsko zavarovanje za invalide, zaposlene nad kvoto, subvencija plače invalidom, plačilo stroškov prilagoditve delovnih mest in sredstev za delo invalidov, plačilo stroškov storitev v podpornem zaposlovanju.
- Vključitev v zaposlitveno rehabilitacijo omogoča brezposelnim osebam s shizofrenijo oz. drugimi težkimi duševnimi motnjami možnost, da lažje pridejo do zaposlitve in da se zaposlijo v podporni ali zaščitni zaposlitvi.
- Tako invalid kot delodajalec pa tudi tekom zaposlitve potrebujeta strokovno in tehnično pomoč.
- Ob poslabšanjih psihičnega stanja je potrebno najprej počakati, da oseba doseže zadovoljivo remisijo, nato pa je potrebno postopno vračanje nazaj na delo ob pomoči strokovnih delavcev.
- Glede na delovno funkcioniranje, dinamiko bolezni, prisotno produktivno in negativno simptomatiko, kognitivne upade ter osebnostno spremenjenost, se nato odločimo za dodatne prilagoditve na delovnem mestu, trajno časovno razbremenitev v smislu skrajšave delovnega časa ali pa upokojitev.

Ozadje: Število delovno aktivnih oseb z diagnozo shizofrenije je zelo nizko. Študije poročajo o zgolj 10-25%, čeprav si jih zaposlitve želi bistveno več. Na zaposljivost vplivajo številni dejavniki, kot so potek bolezni, klinična slika, zdravila, stigma, diskriminacija, razpoložljivost ustreznih delovnih mest ter podpora v delovnem in domačem okolju.

Potek zaposlitvene rehabilitacije: 36-letna ekonomistka, od leta 2001 zdravljena zaradi paranoidne shizofrenije, je bila leta 2012 vključena v rehabilitacijsko obravnavo. Skupno je imela okoli štiri leta delovne dobe, zadnja štiri leta pa ni bila zaposlena. V preteklosti je bila zaradi psihotičnih dekompenzacij štirikrat hospitalizirana. Ob osebnostno šibkejši strukturi smo ugotavljali kognitivne motnje, negativno simptomatiko ter kronificirane slušne halucinacije. Na Rehabilitacijski komisiji ZRSZ je nato pridobila status invalidne osebe in pravico do zaposlitvene rehabilitacije, v katero je bila vključena leta 2013. Usposabljala se je na več delovnih mestih, pri različnih delodajalcih, nazadnje na vrtnarskih in hortikulturnih delih. Potrebovala je dnevno dodeljena navodila ter pomoč pri organizaciji in načrtovanju dela, vendar je delovne naloge postopoma usvajala. Ob menjavah delovnih operacij je občasno potrebovala vodenje in podporo. Delovna učinkovitost je sčasoma naraščala, vendar ostajala znižana. Končno je prišlo je do podporne oblike zaposlitve s 30% subvencijo minimalne plače. Naslednja tri leta večjih težav pri delu ni imela, v obdobju med 2017 do 2023 pa je ponovno prišlo do

psihotičnih dekompenzacij, ki so zahtevale večkratne hospitalizacije. Vzrok poslabšanj so bili stresni dogodki, večinoma v domačem okolju. Kljub poslabšanju psihičnega stanja ji je delodajalec ves čas nudil psihosocialno podporo in dodatno prilagajal delovne obremenitve. Zadnji dve leti dela več ne zmore, je v bolniškem staležu, zadovoljive remisije ne dosega, zato nadaljnja delazmožnost ostaja vprašljiva.

Zaključek: Delovna aktivnost je za osebo s shizofrenijo zelo pomembna, saj izboljša njeno kvaliteto življenja. Za ohranjanje zaposlitve pa je bistvena redna, celostna zdravstvena obravnava ter podporno domače in delovno okolje.

VOCATIONAL REHABILITATION OF A PERSON WITH PARANOID SCHIZOPHRENIA AND SUPPORTED EMPLOYMENT – A CASE REPORT

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Keywords: vocational rehabilitation, schizophrenia, supported employment, work capacity

Co-author: Sandra Železnik, MD, Specialist in Occupational Medicine, Transport and Sport, University Rehabilitation Institute of the Republic of Slovenia - Soča, Centre for Vocational Rehabilitation, Slovenia

Key highlights:

- Slovenia offers diverse incentives to encourage the employment of individuals with disabilities, including a quota system, rewards for surpassing the quota, exemption from pension and disability insurance contributions for disabled employees exceeding the quota, wage subsidies for disabled individuals, coverage of job adaptation and work tools expenses, and the provision of service cost payments in supported employment.
- Engagement in vocational rehabilitation provides individuals, unemployed due to schizophrenia or other severe mental disorders, with increased opportunities to secure employment, including options for supported employment and sheltered work environments.
- Both, the individual with a disability and the employer, require professional and technical support throughout the course of employment.
- During periods of declining mental health, it is crucial to wait for the person to achieve satisfactory remission before initiating a gradual return-to-work with the support of professionals.
- Considering factors such as work functioning, disease dynamics, the presence of productive and negative symptoms, cognitive declines, and personality changes, decisions are made to implement additional workplace adjustments. These adjustments may include permanent time relief through reduced working hours or retirement.

Background: The employment rate among individuals diagnosed with schizophrenia is notably low, with studies reporting only 10-25%, despite a much higher desire for employment among them. Employability is influenced by various factors such as the course of the illness, clinical presentation, medications, stigma, discrimination, availability of suitable job positions, and support in work and home environment.

Course of Vocational Rehabilitation: A 36-year-old economist, treated for paranoid schizophrenia since 2001, underwent rehabilitation assessment of work functioning in 2012. She had approximately four years of work experience, but for the last four years, has been unemployed. Due to psychotic decompensations, she had been hospitalized four times in the past. Along with her fragile personality structure, cognitive impairments, negative symptoms, and chronic auditory hallucinations were noted. She obtained the status of a disabled person and the right to vocational rehabilitation from the Employment Service of Slovenia in 2013. During the rehabilitation, she underwent training in various jobs with different employers, including gardening and horticultural work. Daily instructions and assistance in organizing and planning work were necessary due to her needs, but she gradually mastered her work tasks. Occasionally, she required guidance and support during task transitions. Although her work efficiency increased over time, it remained reduced. Ultimately, she transitioned to supported employment with a 30% subsidy of the minimum wage. For the next three years,

she faced no major work-related issues. However, from 2017 to 2023, there was a recurrence of psychotic decompensations, leading to multiple hospitalizations. Stressful events, mainly in her home environment, were identified as triggers for exacerbations. Despite the deterioration of her mental state, her employer consistently provided psychosocial support and adjusted her workload accordingly. Over the last two years, she is no longer able to work, is on sick leave, achieving satisfactory remission remains elusive, and her future work capacity remains uncertain.

Conclusion: Work activity is crucial for individuals with schizophrenia as it enhances their quality of life. To maintain employment, regular comprehensive healthcare and supportive home and work environments are essential.

PETEK 12.04.2024 // FRIDAY 12.04.2024

PARALELNA SEKCIJA 3.2 // PARALLEL SESSION 3.2

NOVOSTI ZAVAROVALNIŠKO MEDICINSKIH NADZOROV

Avtor: mag. Jana Mrak, dr. med., Zavod za zdravstveno zavarovanje Slovenije

Ključne besede: zavarovalniška medicina, medicinsko izvedenstvo, nadzori, zakonodaja, informacijska tehnologija

Ključni poudarki:

- Spremembe zakonodaje v letu 2022 in 2023 so pomembno vplivale na zavarovalniško medicinske in zavarovalniške nadzore, potrebne so bile tudi informacijske prilagoditve aplikacije za izvajanje nadzorov.
- ZZZS je v letu 2023 postal prekrškovni organ, ki izreka globe, ukinjene so bile pogodbene kazni.
- Nadzorni postopek in prekrškovni postopek sta dva ločena postopka, tudi organizacijsko.
- Novi Pravilnik o nadzoru nad izvajalci zdravstvenih storitev je uvedel novo terminologijo (med drugim tudi za vrste nadzorov: finančno medicinski nadzor se preimenuje v zavarovalniško medicinski nadzor, območni nadzor pa v zavarovalniški nadzor) in postopkovno poenostavitev.
- Zdravstvene storitve v javnem zdravstvu se z letom 2024 plačujejo v celoti iz obveznega zdravstvenega zavarovanja, z nekaterimi izjemami za storitve, ki so bile začete pred uveljavitvijo tega. Spremembam sledijo tudi prilagoditve informacijske tehnologije, ki se uporablja pri nadzorih.

Problematika: V letu 2023 so bile implementirane spremembe 63. in 77. člena Zakona o zdravstvenem varstvu in zdravstvenem zavarovanju (ZZVZZ), ki prinašajo novosti na področju zavarovalniške medicine in nadzornih postopkov Zavoda za zdravstveno zavarovanje Slovenije (ZZZS). Sprejet je bil tudi Zakon o spremembah in dopolnitvah ZZVZZ (ZZVZZ-T), ki s 1. 1. 2024 ukinja prostovoljno zdravstveno zavarovanje (PZZ).

Opis: Splošni dogovor za pogodbeno leto je zamenjala Uredba o programih storitev obveznega zdravstvenega zavarovanja, zmogljivostih, potrebnih za njegovo izvajanje, in obsegu sredstev za leto 2023 (Uredba 2023), v pripravi je novi Pravilnik o nadzoru nad izvajalci zdravstvenih storitev (Pravilnik), ki bo izdan s soglasjem ministra, pristojnega za zdravje. Spremembe obračuna zdravstvenih storitev po ukinitvi PZZ bo potrebno implementirati tudi v nadzornih postopkih.

Rezultati: Z Uredbo 2023 je ZZZS postal prekrškovni organ, ki izreka globe za prekrške, ukinjene so bile pogodbene kazni. Nadzorni in prekrškovni postopek sta popolnoma ločena, zato nadzornik da le predlog za začetek prekrškovnega postopka, ko so za to izpolnjeni pogoji. Ugotovitve nadzora pa so vsebina, na kateri temelji odločitev prekrškovnega organa, zato ima ta vpogled v nadzorne zapisnike brez osebnih podatkov. V aplikaciji Nadzori so bile zato potrebne prilagoditve, zaradi česar je izvajanje nadzorov začelo kasneje. V Pravilniku bo uporabljena nova terminologija, uvedena dodatna poenostavitev postopka in ukrepi za odpravo kršitev usklajeni z Uredbo 2023. Tudi v zvezi s tem in implementacijo ZZVZZ-T se urejajo prilagoditve aplikacije Nadzori.

Zaključek: Spremembe zakonodaje so izziv zaradi potrebnih prilagoditev novim pravilom nadzornega postopka ter njihovi ustrezni podpori z informacijsko tehnologijo. Hkrati pa predstavljajo priložnost za

uveljavitev medicinskega izvedenstva in zavarovalniške medicine v podzakonskih aktih in predvidoma tudi v prihodnji zakonodaji.

UPDATE ON INSURANCE MEDICAL AUDITING

Author: Jana Mrak, MD, MSc, Health Insurance Institute of Slovenia, Slovenia

Keywords: insurance medicine, medical expertise, auditing, legislation, information technology

Key highlights:

- Changes in the legislation in 2022 and 2023 had a significant impact on insurance medical and insurance auditing; informational adjustments to the correspondent application were necessary.
- In 2023, the HIIS became a misdemeanor authority that imposes fines, contractual penalties were abolished.
- The auditing and the misdemeanor procedure are two separate procedures, also organizationally.
- The new Rulebook on the auditing of healthcare services providers introduced new terminology (including types of auditing: financial medical audit is renamed insurance medical audit, and regional audit is renamed insurance audit) and procedural simplification.
- From 2024 onwards, healthcare services in the public healthcare syste are paid entirely from compulsory health insurance, with some exceptions for services started before the implementation of new legislation. Changes are followed by adaptations of information technology used in auditing.

Problem: In 2023, amendments to Articles 63 and 77 of the Act on Health Care and Health Insurance (AHCHI) were implemented, introducing innovations in the field of insurance medicine and auditing procedures of the Health Insurance Institute of Slovenia (HIIS). The AHCHI Amendments and Supplements Act (AHCHI -T) was also adopted, abolishing voluntary health insurance (VHI) from 1 January 2024.

Description: The general agreement for the contract year was replaced by the Regulation on the programs of compulsory health insurance services, the capacities required for its implementation and the amount of funds for the year 2023 (Regulation 2023), a new rule book for the auditing health service providers (Rule book) is being prepared, which will be issued with the consent of the minister responsible for health. Changes to the billing of health services after the abolition of the VHI will also need to be implemented in the auditing procedures.

Results: With Regulation 2023, the HIIS became a misdemeanour authority that imposes fines for misdemeanours, contractual penalties were abolished. Auditing and misdemeanour proceedings are completely separate, so the auditor only makes a proposal for the initiation of misdemeanour proceedings when the conditions for this are met. The findings of the auditing form the basis of the decision of the offense authority, granting access to auditing records without personal data. Adjustments were therefore required in the Auditing application, resulting in a delayed start to the execution of auditing. The Rule book will introduce new terminology, additional simplification of the procedure, and measures to eliminate violations harmonized with Regulation 2023. Adjustments to the Auditing application are also being prepared in response to the implementation of AHCHI-T.

Lessons: Changes in legislation pose a challenge due to the necessary adjustments to the new rules of the auditing procedure and their appropriate support with information technology. Simultaneously, they represent an opportunity for the establishment of medical expertise and insurance medicine in by-laws and presumably also in future legislation.

MEDICINSKI IZVEDENCI IN NOVI MODELI PLAČEVANJA V SISTEMIH ZDRAVSTVENEGA VARSTVA

Avtor: mag. Andrej Plesničar, dr. med., spec., Zavod za Zdravstveno Zavarovanje Slovenije

Ključne besede: vrednost za paciente, »Četverni cilj«, integracija storitev, integracija plačil, modeli plačevanja

Ključni poudarki:

- "Četverni cilj" je praktičen okvir sprememb in reform zdravstvenih sistemov, ki vključuje prizadevanja za 1) čim boljšo izkušnjo pacienta na njegovo/njeni poti skozi zdravstveni sistem, 2) boljše zdravje prebivalstva, 3) nižje stroške in 4) večje zadovoljstvo zaposlenih.
- Demografska in epidemiološka tranzicija zahtevajo razmisleke o integraciji storitev in plačil zaradi doseganja čim večje vrednosti za paciente (razmerje med izidi in stroški/viri) s prilagajanjem potrebam starejše populacije in bolnikov z več kroničnimi boleznimi.
- Pri modelih plačil svežnjev storitev in modelih globalnih plačil bi medicinski izvedenci sodelovali pri pripravi, uvajanju in analizi modelov.
- Razvoj trajnostnih in k bolnikom usmerjenih sistemov zdravstvenega varstva ni mogoč brez sodelovanja na različnih ravneh.
- "Jezik opredeljuje resničnost" in zato bi lahko opustili izraze, ki opredeljujejo zdravstvene sisteme iz 19. in 20. stoletja.

Izvleček: Zaradi posledic demografske in epidemiološke tranzicije v zadnjih desetletjih sta integracija zdravstvenih storitev in integracija plačil za te storitve ključnega pomena za doseganje večje vrednosti za paciente in za približevanje »Četvernemu cilju«. Medicinski izvedenci so se tradicionalno osredotočali predvsem na izvajanje finančnih nadzorov, da bi zagotovili ustreznost plačil. V novih plačilnih modelih z integriranimi plačili pa se bo njihova vloga spremenila v dejavno sodelovanje pri širših posvetovanjih, ki bodo upoštevala stališča in dejavnosti bolnikov in drugih strokovnjakov pri določanju prednostnih nalog, ki bodo ob oceni finančnih posledic privedle do optimalnih izidov.

Medicinski izvedenci bodo tako ocenjevali ustreznost in stroškovno učinkovitost zdravljenja, da bi se izognili razsipnosti in zagotovili, da bodo bolniki deležni potrebne oskrbe. V modelih plačil svežnjev storitev bi izvedenci skrbno ocenili storitve, ki so bile opravljene za vsakega pacienta, in določili ustrezne stopnje povračila na podlagi vrednosti in učinkovitosti. V modelih globalnih plačil pa bi analizirali administrativne podatke, da bi ugotovili razlike v prekomerni in premajhni uporabi storitev med regijami, ravnmi izobrazbe, bremenom bolezni in drugim, da bi se še bolj osredotočili na možnosti za zmanjšanje stroškov in optimizacijo virov. Skrbno bi ocenili storitve, zagotovljene različnim prizadetim in ranljivim skupinam prebivalstva, ter določili ustrezne stopnje povračil na podlagi vrednosti in učinkovitosti. S tem bi se izognili nepotrebnim storitvam, s čimer bi bolnikom zagotovili ustrezno oskrbo in tako zmanjšali razsipnost.

S povezovanjem vrednot in dejavnosti bolnikov, izvajalcev, plačnikov in drugih bi izvedenci lahko imeli ključno vlogo pri razvoju trajnostnih in k bolnikom usmerjenih sistemov zdravstvenega varstva. Ti pristopi, ki temeljijo na sodelovanju, bi izboljšali izide zdravljenja bolnikov, zmanjšali stroške in povečali

splošno učinkovitost. Integracija storitev in integracija plačil sta nedvomno bistveni za doseganje večje vrednosti za bolnike in za približevanje »Četvernemu cilju«. Sodelovalni pristop zagotavlja, da se odločitve sprejemajo v najboljšem interesu bolnikov ob upoštevanju finančne realnosti zdravstvenega sistema.

MEDICAL ASSESSORS AND NEW PAYMENT MODELS IN HEALTH CARE SYSTEMS

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Keywords: value for patients, "Quadruple aim", integration of services, integration of payments, payment models

Key highlights:

- The "Quadruple Aim" is a practical framework for health systems change and reform that includes efforts to 1) enhance patient experience, 2) improve population health, 3) reduce costs and to 4) improve the work life of health care providers.
- emographic and epidemiological transitions require considerations on integration of services and payments to maximise value for patients (outcomes/costs or resources ratio) by adapting to the needs of older populations and patients with multiple chronic conditions.
- Medical assessors need to be involved in the design, implementation and analysis of bundled payment models and global payment models.
- The development of sustainable and patient-centred healthcare systems is not possible without collaboration of providers at different levels of healthcare.
- "Language defines reality" and we could therefore abandon the terms used to define 19th and 20th century health systems.

Abstract: Due to the consequences of demographic and epidemiological transition in recent decades, the integration of healthcare services and integration of payments for these services are crucial in achieving greater value for patients and moving closer to the quadruple aim. Traditionally, medical assessors primarily focused on performing financial controls to ensure payment accuracy and appropriateness. However, in new payment models with integrated payments, their role is going to be transformed into active collaboration in broader consultations, incorporating perspectives and activities from patients and other experts to prioritize optimal health outcomes while considering the financial implications.

Medical assessors would assess medical necessity and cost-effectiveness to avoid unnecessary treatments, ensuring patients receive appropriate care. In bundled payment models, medical assessors would carefully evaluate services provided to each patient and determine appropriate reimbursement rates based on value and efficiency. In global payment models, medical assessors would analyse administrative data to identify differences in overuse and underuse of services between regions, levels of education, burden of disease and more to focus further on cost-saving opportunities and optimization of resources. They would carefully evaluate services provided to various affected and vulnerable populations and determine appropriate reimbursement rates based on value and efficiency. By assessing medical necessity, unnecessary treatments can be avoided, ensuring patients receive appropriate care and thus reducing waste.

By bringing together the values and activities of patients, providers, payers, and others, medical assessors could play a crucial role in developing sustainable and patient-centred healthcare systems. This collaborative approach would improve patient outcomes, reduce costs, and enhances overall efficiency. Integrating services and payments in healthcare models is clearly essential for achieving

greater value for patients and moving closer to the “Quadruple aim”. This collaborative approach ensures that decisions are made in the best interest of patients while considering the financial realities of the healthcare system.

ZAVAROVALNIŠKO MEDICINSKI NADZORI NOVEGA MODELA PLAČEVANJA AMBULANTNE PNEVMOLOGIJE

Avtorji: Tina Medved, dr. med. spec., mag. Aleksandra Bola Natek, dr. med., spec., Zavod za zdravstveno zavarovanje Slovenije, Ljubljana

Ključne besede: ambulantna pnevmologija, obračun zdravstvenih storitev, zavarovalniško-medicinski nadzor, celostna obravnava

Ključni poudarki:

- Obračuni prvih in kontrolnih pregledov ter obračuni kategorij (obsegov) pregledov nimajo vedno podlage v verodostojnih zapisih v zdravstveni dokumentaciji, ne sledijo dolgim opisom storitev in drugim merilom iz veljavnega šifranta za obračun Zavodu.
- Nabor (najpogosteje) izvajanih in obračunanih storitev se pri posameznih izvajalcih razlikuje, zaznani so obračuni storitev v obsegih, ki izstopajo od povprečja.
- Pravilo glede obračunavanja medsebojno izključujočih storitev (PUL010, PUL012 in PUL014) je, da se lahko v sklopu diagnostike in obravnave istega zdravstvenega stanja obračuna le eno, četudi sta bili storitvi izvedeni ločeno.
- Obračunavanje posvetov na daljavo (PUL006 in PUL007) ob izdanem mnenju s povzetkom preiskave, predvidene ob predhodnem pregledu in v sklopu obravnave istega zdravstvenega stanja, ter če iz zapisov ni razvidno da je šlo za komunikacijo s pacientom, ni v skladu z dolgim opisom storitve.
- Na podlagi predlogov izvajalcev in ugotovitev iz izvedenih nadzorov so s 1. 4. 2024 v obstoječi seznam storitev vključene nove ter uvedene spremembe in dopolnitve opisov za nekatere pnevmološke storitve, vključno s PUL033 (Poligrafija spanja na domu) in PUL017 (Titracija nadtlaka v zgornjih dihalnih poteh).

Ozadje: Storitve za področje zunajbolnišnične specialistične obravnave se evidentirajo in obračunavajo skladno z zakonskimi določili, dogovorom o programih zdravstvenih storitev za tekoče leto, pogodbenimi obveznostmi izvajalcev zdravstvenih storitev z ZZZS in skladno s seznamom storitev za posamezno dejavnost v SNBO (Sklep o načrtovanju, beleženju in obračunavanju zdravstvenih storitev s Prilogami). Podatki o obračunanih storitvah, ki jih izvajalci zdravstvenih dejavnosti mesečno poročajo na ZZZS, so podlaga za zavarovalniško medicinske nadzore, kjer se preveri skladnost z veljavnimi obračunskimi navodili in seznami storitev oziroma se vsebina zapisov o opravljenih storitvah v zdravstveni dokumentaciji primerja s podatki evidentiranih in obračunanih storitev. V prispevku bodo predstavljene izkušnje po izvedenih prvih nadzorih nad obračunavanjem storitev v okviru novega modela plačevanja ambulantne pnevmologije.

Metode: Zavod je na podlagi sodelovanja z delovno skupino, imenovano s strani Združenja pnevmologov Slovenije, v celoti prenovil seznam storitev v specialistični zunajbolnišnični dejavnosti pnevmologije, ki je bil sprejet v okviru Aneksa *št*. 1 k Splošnemu dogovoru za pogodbeno leto 2022. Cilj uvedbe novega modela je izboljšati dostopnost do pnevmoloških storitev, povečati celovitost obravnav ter zagotavljati obravnave v skladu z najnovejšimi strokovnimi smernicami in priporočili.

Rezultati: V letu 2023 smo na Oddelku za nadzor izvedli osem nadzorov nad obračunavanjem storitev ambulantne pnevmologije. Iz teh sledi, da izvajalci v veliki meri spoštujejo določila za obračunavanje opravljenih storitev, v nekaterih primerih pa so zapisi, pregledani v nadzorih, odstopali od dogovorjenih kriterijev v veljavnih obračunskih aktih. Za zagotovitev celostne obravnave bo pomembno, da izvajalci organizacijske procese približajo pacientu na način, da se ob enem obisku opravi čim več predvidenih storitev.

Zaključki: Ugotovitve iz nadzorov po uvedbi novega modela plačevanja ambulantne pnevmologije bodo v sodelovanju s stroko in ZZZS zahtevale dodatno evalvacijo, predloge sprememb oziroma dopolnitev opisov nekaterih pnevmoloških storitev, ki se nanašajo na pogoje za obračun in/ali onemogočen hkratni obračun določenih storitev, vzpodbude za celostno obravnavo idr.

FINANCIAL MEDICAL AUDITS OVER THE NEW PAYMENT MODEL FOR AMBULATORY PNEUMOLOGY

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Keywords: ambulatory pneumology, billing of medical services, financial medical audits, comprehensive treatment

Key highlights:

- The billing of first and follow-up examinations and the billing of categories (scopes) of examinations are not always based on authentic records in the medical documentation, do not follow the long descriptions of services and other criteria specified in the current billing catalog.
- The range of (most frequently) performed and billed services varies from provider to provider, with billing of services in volumes that are not in line with the average.
- The rule for billing mutually exclusive services (PUL010, PUL012 and PUL014) states that only one service can be billed for the diagnosis and treatment of the same condition, even if the two services were performed separately.
- Billing for remote consultations (PUL006 and PUL007) when an opinion is given with a summary of the examination foreseen at the preliminary examination and in the context of the management of the same medical condition, and when the records do not show that it was a communication with the patient, is not in line with the long description of the service.
- Based on the proposals of the service providers and findings from financial medical audits carried out, new services have been added to the existing catalog of services as of 1 April 2024 and changes and additions to the descriptions for some pneumology services have been introduced, including PUL033 (Home Respiratory Polygraphy) and PUL017 (Continuous positive airway pressure (CPAP).

Background: The recording and billing of healthcare services in the field of outpatient treatment are carried out in accordance with legal acts, the General Agreement on Compulsory Health Insurance service programs for the current year, the contractual obligations of healthcare service providers with the Health Insurance Institute of Slovenia (ZZZS) and in accordance with the document called Decision on Planning, Recording and Billing Health Services. The data on billed services, which are reported monthly by healthcare providers to ZZZS, are the basis for financial medical audits, where the compliance with valid billing codes is verified, the content of the medical records of services performed is compared with the data of recorded and billed services. This paper will present the conclusions following the first financial medical audits over the new payment model for ambulatory pneumology.

Methods: In cooperation with a working group appointed by the Association of Pneumologists of Slovenia, ZZZS has revised the list of services available for healthcare providers to bill in the field of ambulatory pneumology. This list was adopted as part of the Annex No. 1 to the General Agreement for the contract year 2022. The aim of introducing a new payment model is to improve accessibility to ambulatory pneumology services, increase the comprehensivity of treatments, and ensure that the performed treatments follow the latest professional guidelines and recommendations.

Results: In 2023, the Control Department conducted eight audits over the billing of ambulatory pneumology services. It turns out that physicians largely comply with the new rules. In some cases though, the records reviewed in the audits deviated from the criteria agreed in the valid billing acts. To ensure the most comprehensive treatments possible, it will be crucial for providers to bring organizational procedures closer to the patient so that as many services as possible are performed in one visit.

Conclusions: Findings from financial medical audits following the introduction of the new payment model in the field of ambulatory pneumology show that an additional evaluation is required, as well as proposals for changes or additions to the descriptions of some ambulatory pneumology services, about the necessary conditions for the billing of these services, incentives for more comprehensive treatments, etc.

PREDPISOVANJE IN KAZALNIKI KAKOVOSTI PREDPISOVANJA PSIHOFARMAKOV

Avtor: Jurij Fürst, dr. med., ZZZS

Ključne besede: zdravila, kazalniki kakovosti, predpisovanje, poraba

Soavtorica: Anita Strmljan, mag. farm., ZZZS

Ključni poudarki:

- poraba anksiolitikov, hipnotikov in sedativov se zmanjšuje;
- poraba nizkih odmerkov kvetiapina je visoka in odraža neodobreno predpisovanje;
- med območnimi enotami se velike razlike v porabi.

Izvleček: V Zavodu za zdravstveno zavarovanje Slovenije (ZZZS) so bili leta 2011 uvedeni kazalniki kakovosti predpisovanja zdravil za zdravnike splošne/družinske medicine, za področje pediatrije pa leta 2017. Kazalniki za zdravnike splošne/družinske medicine vsebujejo tudi psihotropna zdravila, in sicer anksiolitike, hipnotike in sedative kot enotno skupino pomirjeval. Prvi kazalnik prikazuje prevalenco prejemnikov, to je število oseb na 1000 prejemnikov receptov, ki so prejele vsaj 1 recept zanje, drugi pa porabo teh zdravil v definiranih dnevnih odmerkih na prejemnika.

Kazalniki, pripravljeni za vsakega zdravnika, ki izpolnjuje merila za vključitev, so dostopni na spletni strani ZZZS in ustrezno zaščiteni. Prikazani so za zadnjih 5 let, kar omogoča spremljanje dinamike sprememb. Vsak kazalnik posameznega zdravnika ima tudi podatek o povprečju vseh analiziranih zdravnikov. V zeleni oz. rdeči barvi so prikazana odstopanja v smeri boljših oz. slabših rezultatov, kadar so več kot 20 % večja oz. manjša od povprečja.

Poraba anksiolitikov, hipnotikov in sedativov se v Sloveniji zmanjšuje že vrsto let. Med območnimi enotami se velike razlike v porabi. Kazalniki pa se izboljšujejo v vseh območnih enotah, vendar z različno dinamiko.

Kazalniki so se izkazali kot primerno orodje za preučevanje predpisovanja zdravil in so v veliko pomoč pri izobraževanju.

PRESCRIBING AND QUALITY INDICATORS FOR THE PRESCRIBING OF PSYCHOPHARMACEUTICALS

Author: Jurij Fürst, MD, Health Insurance Institute of Slovenia, Slovenia

Keywords: medicines, quality indicators, prescribing, consumption

Co-author: Anita Strmljan, M.Pharm., ZZZS

Key highlights:

- The use of anxiolytics, hypnotics and sedatives is decreasing;
- low-dose quetiapine consumption is high and reflects unapproved prescribing;
- there are large variations in consumption between regional units.

Abstract: The Health Insurance Institute of Slovenia (ZZZS) introduced prescribing quality indicators for general practitioners in 2011 and for paediatrics in 2017. The indicators for general practitioners also include psychotropic drugs, namely anxiolytics, hypnotics and sedatives as a group of sedatives. The first indicator shows the prevalence of recipients, i.e. the number of persons per 1000 prescription recipients who have received at least 1 prescription for them, and the second shows the consumption of these medicines in defined daily doses per recipient.

The indicators, prepared for each doctor who meets the inclusion criteria, are available on the website of the ZZZS and are appropriately protected. They are displayed for the last 5 years, which allows monitoring the dynamics of change. Each indicator for each doctor also has information on the average of all doctors analysed. The green and red colours show the deviations towards better or worse results when they are more than 20 % higher or lower than the average.

The use of anxiolytics, hypnotics and sedatives has been decreasing in Slovenia for many years. There are large regional differences in consumption. However, indicators are improving in all regions, but with different dynamics.

The indicators have proven to be a useful tool for studying prescribing and are very helpful for education.

RAZVOJ IN UVEDBA NOVEGA MODELA PLAČEVANJA, PRIMER AMBULANTNE PNEVMOLOGIJE

Avtorji: mag. Jakob Ceglar (Zavod za zdravstveno zavarovanje Slovenije), prof. dr. Mitja Košnik (Univerzitetna klinika za pljučne bolezni in alergologijo), Pika Jazbinšek (Zavod za zdravstveno zavarovanje Slovenije)

Ključne besede: pnevmologija, ambulanta, plačilo, seznam storitev, ZZZS

Izvleček: Izziv ključnih akterjev v zdravstvu je tudi povečati dostopnosti do storitev specialistične zunajbolnišnične dejavnosti. Pomemben element pri temu so finančni okvir, ki ga postavi plačnik zdravstvenih storitev, ter vsebina dela, ki jo lahko izvajalci opravljajo in obračunajo plačniku. Tudi zaradi tega je Zavod za zdravstveno zavarovanje Slovenije pristopil, v sodelovanju z Razširjenim strokovnim kolegijem internističnih strok, k prenovi modela plačevanja ambulantnih pnevmoloških storitev. Rezultat sodelovanja je nov seznam storitev, v povprečju za 15% višje cene storitev in posledično boljša dostopnost do storitev.

DEVELOPMENT AND IMPLEMENTATION OF A NEW PAYMENT MODEL, THE CASE OF AMBULATORY PNEUMOLOGY

Authors: Jakob Ceglar (Health Insurance Institution of Slovenia), Prof. Mitja Košnik (University Clinic of Pulmonary Diseases and Allergology), Pika Jazbinšek (Health Insurance Institution of Slovenia), Slovenia

Keywords: pneumology, outpatient clinic, payment, list of services, ZZZS

Abstract: Increasing access to specialist outpatient services is also a challenge for key actors in the healthcare sector. An important element in this is the financial framework set by the payer of health services and the content of the work that providers can perform and bill to the payer. This is one of the reasons why the Health Insurance Fund of Slovenia, in cooperation with the Extended Expert College of Internal Medicine, has approached the reform of the payment model for outpatient pneumology services. The result of this cooperation is a new list of services, on average 15% higher prices for services and consequently better accessibility to services.

PETEK 12.04.2024 // FRIDAY 12.04.2024

PARALELNA SEKCIJA 4.1 // PARALLEL SESSION 4.1

KAKO VAROVATI IN KREPITI DUŠEVNO ZDRAVJE ZAPOSLENIH?

Avtor: dr. Tatjana Novak Šubara, univ. dipl. psih., Nacionalni inštitut za javno zdravje

Ključne besede: duševno zdravje na delovnem mestu, absentizem, preprečevanje težav v duševnem zdravju, psihosocialna tveganja, vračanje na delo

Soavtorji: dr. Ditka Vidmar, univ.dipl.biol., Karmen Stariha, univ. dipl. lit. komp., Nacionalni inštitut za javno zdravje

Ključni poudarki:

- Delovno okolje ima pomembno preventivno vlogo pri preprečevanju težav v duševnem zdravju in s tem ohranjanju delazmožnosti delovno aktivne populacije.
- Zagotavljanje zdravih delovnih pogojev in obvladovanje psihosocialnih tveganj na delovnem mestu varuje zdravje vseh zaposlenih, ne glede na njihovo zdravstveno stanje in druge posebnosti.
- Duševno zdravje na delovnem mestu je možno tudi krepiti s promocijo pozitivnih vidikov dela (možnost uporabe in razvoja različnih kompetenc, visok nadzor nad lastnim delom, podpora pri delu) in izobraževanji na področju duševnega zdravja, pri čemer niso pomembni zgolj individualni, temveč tudi organizacijski ukrepi.
- Vodstveni delavci lahko ključno prispevajo k zgodnjem prepoznavanju težav v duševnem zdravju zaposlenih in jih spodbujajo k iskanju pomoči v primeru težav. To pripomore tudi k zmanjševanju stigme v delovnih okoljih.
- Pri obravnavi oseb, ki so pogosto ali v dolgotrajnem bolniškem staležu zaradi duševnih motenj, je pomembno upoštevati tudi vpliv psihosocialnih delovnih pogojev na njihovo duševno zdravje. Za uspešno rehabilitacijo je ključnega pomena usklajeno sodelovanje med različnimi deležniki (zdravstvo, socialno varstvo ter zaposlitvena in poklicna rehabilitacija), ki sodelujejo pri zdravljenju zaposlenih in njihovem vračanju na delo.

Izvleček: Duševno zdravje je bistvenega pomena za posameznikovo delovno sposobnost in produktivnost. Duševne in vedenjske motnje so v Sloveniji četrti najpogostejši vzrok absentizma in vodilni razlog invalidskih upokojitev 1. kategorije. Stroški slabega duševnega zdravja pri delu so za posameznike, delodajalce in družbo znatni, saj povzročajo znižanje produktivnosti, ki je v EU ocenjeno na 4 % BDP.

Delovni pogoji lahko vplivajo na duševno zdravje zaposlenih tako pozitivno kot negativno. Raziskave povezujejo izpostavljenost neugodnim psihosocialnim delovnim razmeram s tveganjem za slabo duševno zdravje zaposlenih. Prevladujočo osredotočenost na ukrepe na delovnem mestu, usmerjene na posameznika, je zamenjal celovitejši pristop k duševnemu zdravju pri delu, ki je poudarjen v več globalnih pobudah in mednarodnih smernicah. V skladu s smernicami Svetovne zdravstvene organizacije in njihovim skupnim strateškim dokumentom z Mednarodno organizacijo dela so ključne strategije za

preprečevanje slabega duševnega zdravja pri delu (1) preprečevanje škode, kar vključuje obvladovanje psihosocialnih tveganj na delovnem mestu, (2) krepitev pozitivnih vidikov dela, kompetenc in virov zaposlenih ter (3) odzivanje na težave in podpora delavcem s težavami v duševnem zdravju. Kombinacija organizacijskih in individualnih ukrepov za duševno zdravje na delovnem mestu ima lahko pozitivne učinke na duševno zdravje in delazmožnost zaposlenih ter lahko pomeni naložbo s pozitivnim donosom (ROI). Glede na ugotovljeno nizko do zmerno zanesljivost dokazov o učinkovitosti različnih intervencij na delovnem mestu je potrebno več pozornosti posvetiti evalvaciji kakovosti in ustrezni intenzivnosti intervencij za doseganje merljivih učinkov v praksi. Da bi olajšali vračanje na delo, še zlasti po daljši bolniški odsotnosti, bi bilo z vidika zdravstvenih strokovnjakov smiselno vključiti rutinsko preverjanje psihosocialnih delovnih pogojev zaposlenega v klinično oceno in obravnavo težav v duševnem zdravju. Delovna mesta prinašajo velik potencial za izboljšanje duševnega zdravja zaposlenih, kar je moč doseči z interdisciplinarnim pristopom v medsebojnem sodelovanju med ključnimi deležniki, kot so delodajalci, zaposleni in strokovnjaki z različnih področij zdravstva.

HOW TO PROTECT AND PROMOTE MENTAL HEALTH OF EMPLOYEES

Author: Tatjana Novak Šubara, PhD, National Institute of Public Health, Slovenia

Keywords: workplace mental health, absenteeism, prevention of mental-ill health, psychosocial risks, return to work

Co-authors: Ditka Vidmar, PhD, Karmen Stariha, BA, National Institute of Public Health

Key highlights:

- Workplace environment plays an important role in preventing mental health problems and thus maintaining the working capacity in the work-active population.
- Ensuring healthy working conditions and managing psychosocial risks in the workplace protects the health of all employees, regardless of their health status and other specificities.
- Mental health in the workplace can also be enhanced by promoting positive aspects of work (opportunities to use and develop different competences, high control over one's own work, support at work) and by mental health education, not only individual but also organisational measures.
- Managers can make a key contribution to the early identification of mental health problems in employees and encourage them to seek help if they have problems. This also helps to reduce stigma in work environments.
- It is also important to consider the impact of psychosocial working conditions on mental health when dealing with people who are frequently or long-term sick due to mental disorders. Coordinated cooperation between the different stakeholders (health, social care, occupational and vocational rehabilitation) involved in the treatment of employees and their return to work is crucial for successful rehabilitation.

Abstract: Mental health is essential for work ability and productivity. Mental and behavioural disorders are the fourth most common cause for absenteeism and a main reason for early retirement with a category I disability in Slovenia. The cost of mental ill-health at work is significant for the individuals, employers and society, resulting in productivity losses estimated at a 4% GDP in the EU.

Working conditions can influence employee mental health both positively and negatively. Previous research has linked the exposure to adverse psychosocial working conditions to the risk of mental ill-health. Disproportionate focus on individual-level workplace interventions has shifted to a more comprehensive approach to workplace mental health, adopted in several policy initiatives and guidelines worldwide. Following WHO Guidelines on mental health at work and their joint policy brief with ILO, key strategies for preventing mental ill-health are (1) preventing harm, which includes psychosocial risk management, (2) promoting positive aspects of work, worker capacities and strengths and (3) responding to problems and facilitating support to workers with mental health conditions. A combination of organizational and individual workplace mental health interventions is likely to have a positive return-on-investment and a beneficial impact on mental health and work outcomes. However, given the established low-to-moderate evidence of effectiveness more research is needed evaluating the sufficient quality and intensity of workplace interventions to achieve measurable improvements in relevant outcomes. From health professionals' perspective, it is important to include routine inquiries

about employee psychosocial work environment in the clinical assessment and management of mental health problems, particularly in cases when recovery from a mental health condition is delayed and to facilitate return to work process. Workplaces carry a considerable potential for employee mental health that can be best achieved by a collaborative interdisciplinary approach, involving key stakeholders, employers, employees and different healthcare professionals, among others.

SOCIALNA AKTIVACIJA - MODEL ZA POMOČ, PODPORO IN OPOLNOMOČENJE ZA PRIBLIŽEVANJE TRGU DELA. PRIMERI IZ PRAKSE

Avtor: Marinka Vovk, doktorica znanosti, Center ponovne uporabe, socialno podjetje

Ključne besede: socialna aktivacija, opolnomočenje, integracijske strategije, delovna integracija

Ozadje: Prispevek se osredotoča na globalni problem dolgotrajne brezposelnosti in socialne izključenosti, ki izhaja iz ekonomskih, socialnih, kulturnih, psiholoških in političnih faktorjev. Te kompleksne okoliščine vodijo v potrebo po celovitih pristopih za pomoč težje zaposljivim skupinam.

Ključni poudarki:

- Celostni pristop: Program socialne aktivacije na območju Ormoža je uporabil individualiziran in multidisciplinarni pristop, ki je udeležencem ponudil prilagojene rešitve. Aktivnosti so bile zasnovane tako, da so naslovile specifične potrebe vsakega posameznika, vključno z delovno-učno prakso, ki je omogočila pridobivanje praktičnih veščin za trg dela.
- Delovno-učna praksa: Uvedba delovno-učne prakse kot nove metode je bila ključna za uspeh programa, saj je udeležencem omogočila neposredno izkušnjo in pridobivanje veščin, kar je bistveno prispevalo k njihovi hitrejši integraciji v delovno okolje.
- Podpora okolja in skupnosti: Lokalno okolje in skupnost sta igrala pomembno vlogo pri podpiranju udeležencev programa. Ta podpora je bila ključna za spodbujanje in integracijo udeležencev v delovno okolje, kar je pripomoglo k uspešni socialni in delovni integraciji.
- Uspešnost programa: Program je dosegel visoko stopnjo uspešnosti, s 57% udeležencev, ki so bili po zaključku bodisi zaposleni ali vključeni v nadaljnje izobraževanje. Ta uspeh ilustrira, kako prilagojeni in aktivni pristopi lahko pozitivno vplivajo na zaposljivost in socialno vključenost dolgotrajno težko zaposljivih oseb.
- Prispevek k družbi: Socialna aktivacija ni le izboljšala zaposlitvene perspektive udeležencev, ampak je tudi prispevala k socialni koheziji in zmanjšanju socialne izključenosti v lokalni skupnosti. Multidisciplinarni timi strokovnjakov so bili ključni za izvedbo programa, kar poudarja pomen sodelovanja med različnimi sektorji za doseganje trajnostnih sprememb.

Vprašanje: Kako lahko programi socialne aktivacije učinkovito naslovijo te izzive, da bi izboljšali zaposljivost in socialno vključenost ranljivih skupin, ob upoštevanju različnih ovir, s katerimi se soočajo?

Problem: Ključni problem, ki ga prispevek obravnava, je razvoj in implementacija učinkovitih strategij socialne aktivacije, ki ne le spodbujajo zaposlovanje, ampak tudi izboljšujejo splošno kakovost življenja in krepijo socialno kohezijo v družbi.

Metode: V izvajanju projekta socialne aktivacije je bil uporabljen individualiziran pristop, kjer so bile aktivnosti prilagojene specifičnim potrebam in okoliščinam vsakega udeleženca. Vzpostavljen je bil multidisciplinarni tim. Sodelovanje strokovnjakov iz različnih področij (npr. zdravstveni delavci, svetovalci, psihologi, socialni delavci) je omogočilo celovito obravnavo in podporo udeležencem. Poudarek je bil na praktičnem usposabljanju in mentorstvu: kot novo metodo sem uvedla delovno-učno prakso, kar je udeležencem omogočilo neposredno pridobivanje veščin in izkušenj, ki so ključne

za vstop na trg dela. Ta pristop se je izkazal kot zelo učinkovit, zato je bil uporabljen tudi v novem razpisu kot obvezen segment usposabljanja.

Izvleček: Socialna aktivacija kot inovativni pristop za obravnavo dolgotrajno težje zaposljivih oseb, je bila v Ormožu izvedena z izjemnim uspehom, s stopnjo uspešnosti 57%. Ta podatek je ključen pri poudarjanju nujnosti aktivnega pristopa v politikah zaposlovanja in socialne skrbi. Program socialne aktivacije v Ormožu je bil zasnovan kot celostni pristop, ki zajema več plasti pomoči: od izobraževanja in usposabljanja do psihosocialne podpore in pomoči pri iskanju zaposlitve. Ključnega pomena je bilo individualno pristopanje k udeležencem, kar je omogočalo prilagojene rešitve za vsako posamezno situacijo. Uspešnost programa je bila merjena z več vidikov: povečanje zaposljivosti udeležencev, izboljšanje njihove samopodobe in motivacije ter dejanska zaposlitev po koncu programa. Statistični podatek uspešnosti kaže na to, da je bila več kot polovica udeležencev po zaključku programa bodisi zaposlena ali vključena v nadaljnje izobraževalne aktivnosti, kar je pomemben indikator uspešnosti. V razpravi o socialni aktivaciji je pomembno poudariti tudi vpliv programa na lokalno skupnost. Ta pristop ne le izboljšuje posameznikove zaposlitvene možnosti, ampak prispeva tudi k socialni koheziji in zmanjševanju socialne izključenosti. Poleg tega je potrebno izpostaviti vlogo multidisciplinarnih timov, ki so sestavljali hrbtenico programa. Sodelovanje različnih strokovnjakov, kot so socialni delavci, psihologi, svetovalci in izobraževalci, je bilo ključno za uspešno izvajanje programa. Zaključno, primer socialne aktivacije v Ormožu ponuja dragocene uvide v to, kako aktivni pristopi v obravnavi dolgotrajno težko zaposljivih lahko prispevajo k pozitivnim spremembam, tako za posameznike kot za celotno skupnost. V zaključku, razlika v kazalnikih uspešnosti med pričakovanim in dejanskim rezultatom programa v Ormožu kaže na potencial in učinkovitost inovativnih, prilagojenih in celovitih pristopov v programih socialne aktivacije. To je pomemben prispevek k razumevanju, kako lahko učinkovito podpiramo dolgotrajno težko zaposljive skupine in spodbujamo njihovo aktivno vključevanje v družbo.

Rezultati: Delovno - učna praksa kot integracija je ključni koncept pri obravnavi oseb z več povezanimi težavami, kot so dolgotrajna brezposelnost, socialna izključenost, zdravstvene težave ali osebne ovire, saj omogoča hitro integracijo v socialno in delovno okolje. Z izvajanjem celostnega pristopa, individualizirane podpore, povezovanja z delodajalci, nadzorom in spremljanjem napredka ter vključevanje v skupnost na konkretnem primeru uspešne delovno-učne integracije, ki ilustrirajo, kako ta pristop v praksi izboljšuje življenja posameznikov in prispeva k bolj vključujoči družbi. Analizirali smo vplivne faktorje in ugotovili, da je podpora okolja eden izmed ključnih faktorjev uspeha v socialni aktivaciji. Lokalno okolje in podpora skupnosti sta namreč igrala ključno vlogo pri spodbujanju udeležencev in pri njihovi integraciji v delovno okolje, kjer so jim podjetja in ustanove omogočile vključitev in s tem razvoj zlasti socialnih veščin. Ekonomsko ozadje in trg dela so pokazale, da razmere na trgu dela v regiji in Ormožu ter splošno ekonomsko ozadje so lahko vplivale na visoko stopnjo vključevanja udeležencev programa na trg dela.

SOCIAL ACTIVATION - A MODEL FOR HELP, SUPPORT AND EMPOWERMENT TO APPROACH THE LABOR MARKET. EXAMPLES FROM PRACTICE

Author: Marinka Vovk, Doctor of Science, Reuse Center, social enterprise, Slovenia

Keywords: social activation, empowerment, integration strategies, work integration

Background: The paper focuses on the global problem of long-term unemployment and social exclusion arising from economic, social, cultural, psychological and political factors. These complex circumstances lead to the need for comprehensive approaches to help harder-to-employ groups.

Key highlights:

- Integrated approach: the social activation programme in the Ormož area used an individualised and multidisciplinary approach, offering tailored solutions to participants. Activities were designed to address the specific needs of each individual, including work-apprenticeships that provided practical skills for the labour market.
- Work-learning placement: the introduction of work-learning placement as a new method was crucial to the success of the programme, as it allowed participants to gain first-hand experience and skills, which contributed significantly to their quicker integration into the work environment.
- Environmental and community support: The local environment and the community played an important role in supporting the programme participants. This support was crucial to encourage and integrate the participants into the work environment, which contributed to their successful social and labour integration.
- Programme success: The programme achieved a high success rate, with 57% of participants either employed or in further education after completion. This success illustrates how tailored and active approaches can have a positive impact on the employability and social inclusion of people with long-term employability difficulties.
- Contribution to society: Social activation has not only improved the employment prospects of participants, but has also contributed to social cohesion and reduced social exclusion in the local community. Multidisciplinary teams of experts were key to the implementation of the programme, underlining the importance of cooperation between different sectors to achieve sustainable change.

Question: How can social activation programs effectively address these challenges to improve the employability and social inclusion of vulnerable groups, taking into account the various barriers they face?

Problem: The key problem addressed by the paper is the development and implementation of effective social activation strategies that not only promote employment but also improve the overall quality of life and strengthen social cohesion in society.

Methods: An individualized approach was used in the implementation of the social activation project, where the activities were adapted to the specific needs and circumstances of each participant. A multidisciplinary team was established. The collaboration of experts from various fields (e.g. health

professionals, counselors, psychologists, social workers) enabled comprehensive treatment and support for the participants. Emphasis was placed on practical training and mentoring: as a new method, I introduced work-learning practice, which enabled participants to directly acquire skills and experience that are crucial for entering the labor market. This approach proved to be very effective and was therefore also used in the new tender as a mandatory training segment.

Abstract: Social activation, as an innovative approach to dealing with people who have long-term difficulties in finding employment, was implemented in Ormož with exceptional success, with a success rate of 57%. This information is crucial in emphasizing the necessity of an active approach in employment and social care policies. The social activation program in Ormož was designed as an integrated approach that includes several layers of assistance: from education and training to psychosocial support and assistance in finding a job. The individual approach to the participants was of key importance, which enabled customized solutions for each individual situation. The success of the program was measured from several aspects: increasing the employability of the participants, improving their self-image and motivation, and actual employment after the end of the program. The performance statistics show that more than half of the participants were either employed or involved in further educational activities after completing the program, which is an important indicator of success. In the discussion of social activation, it is also important to emphasize the impact of the program on the local community. This approach not only improves the individual's employment opportunities, but also contributes to social cohesion and reducing social exclusion. In addition, it is necessary to highlight the role of the multidisciplinary teams that formed the backbone of the program. The cooperation of various experts, such as social workers, psychologists, counselors and educators, was key to the successful implementation of the program. In conclusion, the example of social activation in Ormož offers valuable insights into how active approaches in dealing with longterm hard-to-employ can contribute to positive changes, both for individuals and for the entire community. In conclusion, the difference in performance indicators between the expected and actual results of the program in Ormož shows the potential and effectiveness of innovative, adapted and comprehensive approaches in social activation programs. This is an important contribution to the understanding of how we can effectively support long-term hard-to-employ groups and encourage their active integration into society.

Conclusions / learnings: Work-learning practice as integration is a key concept when dealing with persons with several related problems, such as long-term unemployment, social exclusion, health problems or personal obstacles, as it enables rapid integration into the social and working environment. By implementing an integrated approach, individualized support, connecting with employers, monitoring and monitoring progress, and integration into the community on a concrete example of successful work-study integration that illustrates, how this approach in practice improves the lives of individuals and contributes to a more inclusive society. We analyzed the influencing factors and concluded that the support of the environment is one of the key success factors in social activation. The local environment and community support played a key role in encouraging the participants and in their integration into the working environment, where companies and institutions enabled them to integrate and thereby develop especially social skills. The economic background and the labor market showed that the conditions on the labor market in the region and Ormož and the general economic background could influence the high level of integration of program participants into the labor market.

PSIHOSOCIALNA PODPORA OSEBAM S TDZ OB ZAPOSLITVI

Avtor: Elen Uršič, univ. dipl. psih.

Ključni poudarki:

- Moč skupnosti pri skupini s TDZ je nujna zaradi intenzivnejše potrebe po varnem okolju in predstavlja ustrezno mrežo informacij in psihološke podpore, ki je nujna pri iskanju priložnosti, za ranljive posameznike, na trgu dela.
- Zdrava socialna mreža – oblikuje nove izkušnje in nova izhodišča in tako tudi temelj varnosti in opolnomočenja.
- Podporne oblike pomoči – individualne oblike podpore, skupinske oblike podpore (skupina vrstnikov in skupina svojcev, družinska in partnerska obravnava, skupina podpore z umetnostjo oz. kreativnimi vsebinami), partnerska oblika podpore in udeležba na brezplačnih seminarjih tujih strokovnjakov in uporabnikov s področja Open dialoga.
- Pristopi po meri posameznika – vse oblike podpore upoštevajo pravilo »nič o rehabilitandu, brez rehabilitanda« in izhajajo iz spoštovanja individualnih potreb in tudi specifičnih ranljivosti.
- Kontinuiteta spremljanja – skupina TDZ potrebuje več spremljanja v daljšem časovnem obdobju, ker potrebuje več časa za razrešitev preteklih travm, ponavljajoče se simptomatike in učenja novih, bolj učinkovitih načinov povezovanja s socialnim okoljem. Tudi samo delovno okolje potrebuje več časa za prilagoditev metode dela in delovnih nalog ranljivim posameznikom.

Izvleček: Moč skupnosti je danes največkrat zreducirana na družinsko celico, ki pod pritiskom številnih zunanjih zahtev in spremenljivk sama pogosto razpade in/ali ne zmore slediti vsem potrebam ranljivega posameznika.

Zato nas je procesu spremljanja oseb s TDZ ob zaposlovanju vodilo zavedanje o pomenu oblikovanja, krepitve in ohranjanja zdrave socialne mreže posameznika. Dvomi vase in v možnost lastnega uspeha, strah in dvom okolja, v posamezniku krepijo brezup, nemoč in pasivnost, kar ohranja ali celo stopnjuje simptomatiko osnovne zdravstvene slike. Zdrava skupnost pa je za posameznika lahko nosilec prepričanja in verovanja, da je rehabilitacija možna in izvedljiva.

V ta namen smo aplicirali različne podporne oblike pomoči:

Skupino vrstnikov, svojcev in poleg individualnih, tudi obravnave parov in družin, kreativne delavnice ter udeležbo na brezplačnih seminarjih tujih strokovnjakov in uporabnikov s področja Open dialoga (OD). Dodatno so nas navdihovala spoznanja nevroznanosti (nevrogeneza in nevroplastičnost, »možganski krožnik«….), ki ponujajo nekoliko drugačen pogled na duševne stiske in zdravje. Pri delu smo se opirali na ideje pristopa OD, humanistične psihologije, Imago terapije, NLP-ja, coaching, neverbalnih in art tehnik, čuječnosti in drugih meditativnih tehnik ter upoštevali:

- Princip dialoškosti v obravnavi;
- »Nič o rehabilitandu brez vključitve rehabilitanda«;
- Validacija posameznikovega doživljanja in izkušnje;
- Krepitev pozitivnih in močnih plati v posamezniku ter odkrivanje njegovih talentov in potencialov za rast;

- Ustvarjanje prostora varnosti in zaupanja;
- Vztrajanje v odprtosti, radovednosti, sprejemanju in tudi negotovosti.

V pomoč nam je bila velika mera strpnosti pri vseh udeleženih (tudi delodajalcev) in pa pričakovanje, da se nekatere težave, ob pozitivnih priložnostih in dejavnikih, včasih razrešijo same skozi življenje, včasih pa nam kljub podpori in dobrim namenom spodleti.

Predstavili bi 3 primere zaposlitve rehabilitandov spremljanja pred, med in ob zaposlitvi, ki potrjujejo potrebo po pristopih po meri posameznika in po kontinuiteti spremljanja, saj se proces uspešne vključitve v delovno okolje ne zaključi niti po 1 letu uspešne zaposlitve.

THE PSYCHOSOCIAL SUPPORT WITH INDIVIDUALS WITH MENTAL HEALTH DISORDERS (MHD) AT WORK

Author: Elen Uršič, univ. dipl. psych., Slovenia

Key highlights:

- Community power in a MHD group is necessary because of their deeper need for safe enviroment and also presents information and psychological support network that's essential in finding oportunities in the labour market for vulnerable individuals.
- Healthy social networks are creating new experiences and new starting points that are fundamental for safety and empowerment.
- Methods of help in supporting individuals individual methods of support and group methods (peer group, kin group , family and couples therapy,art and creative methods of support in a group), and participation in seminars (free of charge) led by foreign experts and »survivors« in the field of the Open dialogue therapy.
- Individual focused help nothing about the client without a client is a fundamental principle applied in all methods of support respecting individual needs and specific vulnerabilities.
- Continuing support MHD group requires more support in a long run, for releasing past traumatic experiences, ongoing health crisis and relearning of new, more effective ways of connecting with social enviroment especially in a labour market. And the labour market usually needs more time to adjust methods of work and work settings for individual needs.

Abstract: Community power is nowadays mostly reduced to a family unit that is often unable to survive the pressure of outside demands and variables thus being unable to support the needs of vulnerable individual.

The process of continual support of individuals with MHD made us aware of the importance for creating, strengthening and maintaining their healthy social networks. Self doubts and lack of trust in possibility of success in the individuals as well as fear and doubt of their social setting strengthens individual's powerlessnes, helplesness and pasivity, which can lead to maintaining or even severing health issues. Healthy community holds the pillar of conviction and belief for the individual that rehabilitation is possible and doable.

Having this intention in mind we applied diferent methods of help in supporting individuals (beside individual therapy):

Peer group, kin group , family and couples therapy,creative workshops and participation in seminars (free of charge) led by foreign experts and »survivors« in the field of the Open dialogue(OD) therapy. We found additional inspiration in neuroscience (neurogenesis, neuroplasticity, »brain plate«…) that offers different outlook on mental health issues. We also used methods of OD, Humanistic Psychology, Imago therapy, NLP, coaching, nonverbal and art methods, mindfulness and other meditative techniques considering:

- Dialogic practice;
- »Nothing about the person with disability without the person with disability«;
- Validation of the individual experience;
- Enhancing individuals strengths and unlocking the talents and growth potencials;
- Creating the circle of trust and safety ;
- Sustaining the intention of openess, curiosity, acceptance and uncertainty.

We found additional support in great measure of tolerance in all participants of the process (including the employers) and expectation that some difficult issues (when positive opportunities and factors present themselfs) can be resolved in the process of life itself. But sometimes inspite of the best of our intention and support we fail anyway.

We'd like to present 3 individual cases of continuing support of the clients before, during and after the employment. Succesfull employment cases present the evidence for the need of individual focused help and continuing support of the individual in the work setting even longer than a year after employment.

PRIMERI DOBRE PRAKSE EDUKACIJE DELODAJALCEV ZA PREPREČITEV NASTANKA ALI ZMANJŠEVANJA ZAPLETOV ZARADI DELOVNEGA OKOLJA ZAPOSLENIH S TVEGANJE ZA RAZVOJ ALI ŽE RAZVITIMI DUŠEVNIMI IN VEDENJSKIMI MOTNJAMI

Avtor: Barbara Zupančič, univ. dipl. psih., Šentprima

Ključne besede: razumne prilagoditve, duševno zdravje, podporne storitve, zaposlitvena rehabilitacija

So-avtorice: Lea Jakič Hiti, dipl.varst, soc.del., Šentprima, Ksenija Bratuš Albreht, mag.soc.dela, Šentprima, Vanja Rodošek Kretič, dipl.del.terap., Šentprima, Megan Zajec, mag.psih., Šentprima, mag. Jana Ponikvar, univ.dipl.soc., Šentprima

Ozadje / vprašanje / problem: Osebe s težjimi duševnimi boleznimi so izključene iz trga dela in potrebujejo podporo pri iskanju trajnih zaposlitev. Veliko ljudi s težavami v duševnem zdravju najde delo, vendar obstaja veliko večje tveganje, da bodo zaposlitev izgubile oz. bile v času svojega življenja izključene iz trga dela (OECD, 2012). Za ustvarjanje trajnih in kvalitetnih delovnih mest ter delovnih okolij za osebe s težavami v duševnem zdravju so ključni delodajalci, ki zagotavljajo razumne prilagoditve dela ter se redno strokovno izpopolnjujejo. Duševno zdravje lahko vpliva na različne vidike posameznikovega življenja. Ima pomemben vpliv na doseganje maksimalne delovne učinkovitosti. Pomemmbno je, da se delodajalce izobražuje o razumnih prilagoditvah delovnih mest, ki so nujne, da bi osebe s velikimi ovirami na področju duševnega zdravja lahko usposabljajo in zaposljujejo. Večina razumnih prilagoditev zahteva minimalni ali nikakršni strošek in predvsem investicija časa in načrtovanja delovnega procesa.

Metode: Z analizo primerov vključenih oseb s TDZ v zaposlitveni rehabilitaciji ter pri spremljanju oseb v podporni zaposlitvi smo raziskali vrsto podpornih storitev, razumnih prilagoditev in metod dela pri usposabljanju in zaposlovanju oseb s TDZ. Izvedli smo tudi analizo potreb mreže delodajalcev, ki usposabljajo in zaposljujejo osebe s TDZ.

Rezultati: Pripravili smo nabor metod dela v okviru strokovne podpore osebam s TDZ ter delodajalcem in delovnem okolju, ki jih zagotavljamo v okviru procesa zaposlitvene rehabilitacije ter kasneje v okviru zaposlitve ter priporočila za nadaljnji razvoj podpornih storitev in razumnih prilagoditev v slovenskem delovnem okolju.

Zaključki / spoznanja: Na področju razumnih prilagoditev obstaja velik nabor možnih prilagoditev. Ali bodo delodajalci omogočili podporo, ki jo oseba s TDZ potrebuje, je odvisno od številnih dejavnikov. Na eni strani gre za objektivne okoliščine organizacije (velikost, vrsta del, itd.) ter subjektivnih, na katere je možno vplivati, kot npr. usposobljenost mentorjev, razvitost vključujoče organizacijske kulture, podpora vodstva, itd..

EXAMPLES OF GOOD PRACTICE FOR EMPLOYER EDUCATION TO PREVENT OR REDUCE WORKPLACE COMPLICATIONS FOR EMPLOYEES AT RISK OF DEVELOPING OR WHO HAVE ALREADY DEVELOPED COMMON MENTAL DISORDERS

Authors: Barbara Zupančič, MA in psychology, Šentprima (SI), Lea Jakič Hiti, BA in social work, BAS in security studies, Šentprima (SI), Ksenija Bratuš Albreht, MA in social work, Šentprima (SI), MSc. Jana Ponikvar, MA in sociology, Šentprima (SI)

Keywords: reasonable accomodation, mental health, supported employment, vocational rehabilitation

Problem: People with severe mental health problems (MHB) are excluded from the labour market and need support to find sustainable employment. Many people with MHP find work, but there is a much higher risk of losing their jobs or being excluded from the labour market during their lives (OECD, 2012). Employers are key to creating sustainable and quality jobs and working environments for people with MHP, providing reasonable work accomodations and regularly upskilling leadership. A mental health condition can impact various aspects of an individual's life. It impacts also the ability to achieve maximum productivity in the workplace. Therefor, when needed, it is important to educate employers about reasonable accomodations. Majority of accomodations can be made for minimal cost (if any), and a small investment of time and planning.

Methods: By analysing cases of persons with MHP involved in vocational rehabilitation and providing services in supporting employment, we explored a range of support services, reasonable accommodations and working methods in vocational rehabilitation and later in employment of persons with MHP. We also carried out an analysis of the needs of employers who provide training and employ people with MHP.

Results: We have prepared a set of methods within the framework of professional support for persons with MHP and working with employers and working environments, which we provide within the framework of the process of vocational rehabilitation and later after the employment. Recommendations for further development of support services and reasonable accommodation in the Slovenian working environment for people with MHP were prepared.

Conclusions: There is a large range of possibilities for reasonable adjustments in the work environments. Whether employers can implement reasonable accomodation for an individual candidate, depends on many factors, some of them are objective (size of organization, type of work, etc.). Some of them are subjective and can be improved, like qualifications of mentors, the development of an inclusive organizational culture, management support, etc.

PETEK 12.04.2024 // FRIDAY 12.04.2024

PARALELNA SEKCIJA 4.1 // PARALLEL SESSION 4.1

PREDSTAVITEV NACIONALNEGA PROGRAMA DUŠEVNEGA ZDRAVJA 2018-2028 Z DOSEŽKI

Avtor: asist. Matej Vinko, dr. med. spec. javnega zdravja, Nacionalni inštitut za javno zdravje

Ključne besede: strateško načrtovanje, javnozdravstvena politika, center za duševno zdravje, zdravje v vseh politikah

So-avtorji: Rade Pribaković Brinovec, dr. med. spec. javnega zdravja (NIJZ), Marjeta Ferlan Istinič (NIJZ)

Ključni poudarki:

- Program MIRA: Prvi celovit strateški dokument za izboljšanje duševnega zdravja v Sloveniji, ki povezuje obstoječe in uvaja nove službe ter strukture.
- Cilji programa: Vzpostavitev podpornega okolja za varovanje in krepitev duševnega zdravja ter zagotavljanje dostopnosti storitev, ki nudijo celovito podporo osebam s težavami v duševnem zdravju.
- Medsektorski pristop: Duševno zdravje je tesno povezano z drugimi vidiki našega življenja, kot so izobraževanje, zaposlovanje itn. Program MIRA je spodbudil širitev in razvoj različnih dobrih praks, izvedel ozaveščevalne kampanje, povezal partnerje ter spodbudil raziskave za razumevanje potreb prebivalstva in razvoj trajnostnih rešitev za krepitev duševnega zdravja v Sloveniji.
- Obravnava bolnikov z duševnimi in vedenjskimi motnjami: V kontekstu programa MIRA je pomembno poudariti pomen celostne obravnave oseb v stiski, ki jo omogočata principa interdisciplinarnosti in obravnave v skupnosti.

Izvleček: Program MIRA je nacionalni program duševnega zdravja v Sloveniji za obdobje 2018 do 2028. Gre za prvi celovit strateški dokument na tem področju, ki povezuje obstoječe in uvaja nove službe ter strukture za izboljšanje duševnega zdravja prebivalcev. Cilj programa je vzpostaviti podporno okolje za varovanje ter krepitev duševnega zdravja in zagotoviti dostopnost storitev, ki nudijo celovito podporo osebam s težavami v duševnem zdravju. Program vključuje prednostna področja delovanja, ki segajo od zagotavljanja skupnostnega pristopa v skrbi za duševno zdravje, preprečevanja samomorilnega vedenja, zagotavljanja dostopne mreže služb za duševno zdravje do izobraževanja, raziskovanja in evalvacije.

Naloge nacionalnega in regionalno-lokalnega upravljanja implementacije 10-letnega programa duševnega zdravja izvaja Nacionalni inštitut za javno zdravje (NIJZ). V ta namen je vzpostavljena struktura upravljanja, ki jo sestavljajo Strokovni svet, Interdisciplinarne delovne skupine in nacionalna strokovna koordinacija na NIJZ. V podporo implementaciji programa MIRA je vzpostavljena stalna medresorska delovna skupina za duševno zdravje, ki je namenjena usklajevanju dejavnosti posameznih ministrstev na področju duševnega zdravja, spremljanju implementacije programa ter oblikovanju predlogov ukrepov za obravnavo na Svetu Vlade RS za duševno zdravje.

Velik uspeh programa MIRA je vzpostavitev mreže centrov za duševno zdravje za otroke, mladostnike in odrasle, ki nudijo celostno pomoč osebam v stiski in omogočajo interdisciplinarno obravnavo v

skupnosti. Z medsektorskim pristopom, ki vključuje različna ministrstva, smo prepoznali, da je duševno zdravje tesno povezano z drugimi vidiki našega **življenja**, kot so izobraževanje, zaposlovanje itn. Program MIRA je spodbudil **širitev** in razvoj različnih dobre prakse, izvedel ozaveščevalne kampanje, povezal partnerje ter spodbudil raziskave za razumevanje potreb prebivalstva in razvoj trajnostnih rešitev za krepitev duševnega zdravja v Sloveniji.

PRESENTATION OF THE NATIONAL MENTAL HEALTH PROGRAMME 2018-2028 AND ITS ACHIEVEMENTS

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Keywords: strategic planning, public health policy, mental health centre, health in all policies

Co-author: Rade Pribaković Brinovec, dr. med. spec. javnega zdravja (NIJZ), Marjeta Ferlan Istinič (NIJZ)

Key highlights:

- Programme MIRA: The first comprehensive strategic document for improving mental health in Slovenia, linking existing services and introducing new structures.
- Programme objectives: The programme aims to create a supportive environment for the protection and promotion of mental health and to ensure the availability of services that provide comprehensive support to people with mental health problems.
- Cross-sectoral approach: Mental health is closely linked to other aspects of our lives, such as education, employment, etc. The MIRA programme has promoted the dissemination and development of a range of good practices, carried out awareness-raising campaigns, brought partners together and stimulated research to understand the needs of the population and to develop sustainable solutions to strengthen mental health in Slovenia.
- Treatment of patients with mental and behavioural disorders: In the context of the MIRA programme, it is important to stress the importance of holistic treatment of people in need, facilitated by the principles of interdisciplinarity and community-based treatment.

Abstract: »MIRA for mental health« is the national mental health programme in Slovenia for the period 2018 to 2028. It stands as the first comprehensive strategic document in this field, linking existing services and introducing new ones to enhance the mental well-being of the population. The programme›s objective is to establish a supportive environment for the protection and promotion of mental health, ensuring the accessibility of services that offer comprehensive support to individuals with mental health issues. The programme encompasses priority areas, spanning from ensuring a community-based approach to mental health care, preventing suicidal behaviour, safeguarding an accessible network of mental health services, to education, research, and evaluation.

The responsibility for implementing the 10-year mental health programme nationally and regionally is vested in the National Institute of Public Health (NIJZ). For this purpose, a management structure has been established, comprising an Expert Council, Interdisciplinary Working Groups, and national coordination at NIJZ. In support of the programme's implementation, a permanent inter-ministerial working group for mental health has been established to coordinate activities of various ministries in the mental health field, oversee programme implementation, and propose actions to the Government Council for Mental Health.

A notable success of the MIRA programme is the establishment of a network of mental health centres for children, adolescents, and adults, delivering comprehensive support to individuals in distress and facilitating interdisciplinary care within the community. Recognising the interconnectedness of mental health with other aspects of life such as education and employment, the MIRA programme has encouraged the expansion and development of various best practices, conducted awareness campaigns, fostered partnerships, and promoted research to understand the population's needs and develop sustainable solutions to enhance mental health in Slovenia.

MREŽA SLUŽB IN STORITEV ZA DUŠEVNO ZDRAVJE

Avtor: Mojca Zvezdana Dernovšek, dr. med. spec. psihiater, redni profesor, Ministrstvo za zdravje

Ključne besede: Duševno zdravje, mreža služb, storitve, načrtovanje mreže, potrebe populacije

So-avtorji: Branko Bregar, docent, Ministrstvo za zdravje, Blaž Janež, Ministrstvo za zdravje

Ozadje / vprašanje / problem: V Resoluciji o nacionalnem programu duševnega zdravja 2018 – 2028 je mreža služb za duševno zdravje izpostavljena kot ena od prioritet. Duševno zdravje postaja vse večje socialno in ekonomsko breme za posameznika in družbo. Mreža služb in storitev se mora hitro in učinkovito odzivati na spreminjajoče se potrebe populacije.

Metode: Opravljena je bila analiza služb in storitev, trendi v zadnjih letih in pripravljene so projekcije za naprej.

Rezultati: Podatki kažejo pomanjkanje kadrov in določenih storitev. Trenutno število razpoložljivega kadra, in sicer 257 specialistov psihiatrije (še 71 na specializaciji), 39 specialistov otroške in mladostniške psihiatrije (še 35 specializantov) ter 162 specialistov klinične psihologije (še 109 specializantov) še ne omogoča dostopne zdravstvene oskrbe, prav tako še niso ustanovljeni vsi centri za duševno zdravje, kot to določa resolucija. Z vidika enakopravne dostopnosti je problem predvsem Jugovzhodna statistična regija in območje Ljubljane ter Gorenjska statistična regija. Pridobljeni podatki prav tako kažejo, da se je število hospitalizaciji v ustanovah, kjer izvajajo bolnišnično psihiatrično ali pedopsihiatrično obravnavo, vrnilo na predkoronsko raven. Čeprav sta bila v letu 2023 vzpostavljena subspecialistična tima za obravnavo odraslih ter otrok in mladostnikov z nekemičnimi oblikami zasvojenosti in komorbidnimi stanji, še niso vzpostavljeni vsi subspecialistični timi za določene duševne motnje in stanja, ki jih določa resolucija.

Zaključki / spoznanja: Populacija v Sloveniji se stara in s tem se povečuje število oseb z demenco. Pri odraslih in mladih se kažejo problematične rabe tehnologij in nekemične zasvojenosti. Mrežo služb in storitev je zato treba oblikovati na način, ki omogoča fleksibilno odzivanje glede na dejansko stanje. Analiza služb in storitev je pokazala , da potrebujemo kazalce stanja in njihovo redno spremljanje. Podatki so ključni za načrtovanje financiranja storitev. Potrebujemo prilagojene oblike financiranja in povezovanje služb preko protokolov sodelovanja med njimi, tako da je pot uporabnika v mreži služb brez preprek in da hitro in učinkovito prejme pomoč.

NETWORK OF MENTAL HEALTH PROVIDERS AND SERVICES

Author: Mojca Zvezdana Dernovšek, psychiatrist, full professor, Ministry of Health, Slovenia

Keywords: Mental health, network of providers, services, network planning, population needs

Co-authors: Branko Bregar, assistant professor, Ministry of Health, Blaž Janež, Ministry of Health

Background/question/problem: The Resolution on the National Mental Health Programme 2018-2028 highlighted the network of mental health services as one of the priorities. Mental health is becoming an increasing social and economic burden for the individual and society. The network of providers and services needs to respond quickly and effectively to the changing needs of the population.

Methods: Analysis of providers and services has been carried out, trends in recent years and projections were prepared.

Results: Gathered data shows a lack of health staff and certain services. Currently, 257 psychiatry specialists (another 71 in specialisation), 39 specialists in children's and adolescent psychiatry (another 35 in specialization) and 162 specialists in clinical psychology (another 109 in specialization) do not yet provide good access to medical care, additionally not all mental health centres are established. Regarding equal accessibility, the problem is mainly the Jugovzhodna and Gorenjska statistical region and the area of Ljubljana. The data obtained also show that the number of hospitalisations in psychiatric institutions has returned to pre-COVID19 levels. Although 2 sub-specialist programmes were set up in 2023 for adults as wells as children and adolescents with non-chemical forms of addiction and comorbid conditions, not all subspecialist teams for certain mental disorders, as specified in the resolution are in place.

Conclusions / knowledges: The population in Slovenia is ageing and number of people with dementia is increasing. The use of technologies and non-chemical addictions are problematic among adults and young people. The network of providers and services should therefore be designed in a way that allows for a flexible response to the reality. The analysis has shown that in the field of mental health we need indicators and their regular monitoring. We need tailor-made forms of funding and integration of services through cooperation protocols between different providers, so that the patient faces no obstacles and receives help quickly and efficiently.

ZAPOSLITVENA REHABILITACIJA – PRIMER DOBRE PRAKSE VKLJUČEVANJA POSAMEZNIKOV S TEŽAVAMI NA PODROČJU DUŠEVNEGA ZDRAVJA V DELO

Avtor: mag. Ana Petrović, univ. dipl. psih., spec. klin. psih., Center za poklicno rehabilitacijo, URI Soča

Ključne besede: zaposlitvena rehabilitacija, primer dobre prakse, duševno zdravje, zaposlovanje

Ključni poudarki:

- Zaposlitev in ohranjanje le-te predstavljata pomembna varovalna dejavnika za osebe s težavami na področju duševnega zdravja.
- Obstajajo precejšnje razlike v izvajanju programa zaposlitvene rehabilitacije v povezavi z različnimi diagnozami s področja duševnega zdravja, glede na potrebe in zmožnosti vključenih oseb.
- Osebe z osebnostno motnjo so v splošnem težje zaposljive, znotraj programa zaposlitvene rehabilitacije pa se srečujemo z večjo intenzivnost doživljanja pri delu, občutki frustracije in neopremljenosti, težavami znotraj sodelovanja in skritimi diagnozami brez ustrezne obravnave.
- Proces zaposlitvene rehabilitacije je v primeru diagnoze osebnostne motnje pogosto dolgotrajnejši, zahteva močno vključenost celotnega tima in tudi drugih pristojnih inštitucij.
- Izhodi programa zaposlitvene rehabilitacije so pri osebah s to diagnozo pogosto manj uspešni ali manj stabilni, ne le zaradi narave motnje, temveč tudi stigme, rigidnosti zahtev / organizacije delovnega okolja in pomankanja ustrezne podporne mreže. V predstavitvi bo sicer predstavljen primer uspešnega izhoda v zaposlitev, a po večkratnih manj učinkovitih poskusih.

Izvleček: Zaposlitvena rehabilitacija predstavlja kompleksen, multidisciplinaren proces, ki zajema storitve usmerjene v cilj, da se oseba z invalidnostjo usposobi za ustrezno delo, se zaposli, zaposlitev obdrži in v njej napreduje ali spremeni svojo poklicno kariero. V pričujočem prispevku bo predstavljen primer dobre prakse zaposlitvene rehabilitacije osebe s težavami na področju duševnega zdravja. V začetku obravnave je bila poudarjena diagnoza s področja telesnega funkcioniranja, a so se že znotraj ocenjevalnega obdobja in kasneje v samem programu izkazale težave, ki so nakazovale osebnostno motnjo in so velikokrat bolj oteževale proces dela, kot same telesne težave s področja vida. Zaposlovanje oseb z osebnostno motnjo je dokaj šibko raziskovalno podprto. V splošnem imajo osebe z osebnostno motnjo na delovnem mestu pomembno večjo mero bolniških odsotnosti, razvijejo stresno motnjo na delovnem mestu ali kronično nezmožnost za delo, so šibkeje socialno funkcionalne ter težje ohranijo zaposlitev. Prav tako so težje zaposljive, kot tiste z diagnozo velike depresije ali psihoze, njihova oškodovanost na zaposlitvenem področju pa je večja, kot tista na področju splošnega psihosocialnega funkcioniranja. Tudi v našem primeru smo se soočali z nestanovitnim socialnim funkcioniranjem osebe, slabšo prilagodljivostjo, manj konstruktivnimi načini reševanja težav, umikanjem v somatske simptome ter posledičnimi težavami z ohranjanjem zaposlitve. Omenjeno je zahtevalo različna usposabljanja na konkretnih delovnih mestih, specifične prilagoditve dela, stalno podporo mentorjem/osebi in širše interdisciplinarno sodelovanje. Soočali smo se s stalnimi izzivi, program zaposlitvene rehabilitacije je bil podaljšan. Individualno načrtovana obravnava je bila podprta s svetovanjem in učenjem regulacije emocij ter reševanja problemov. Močna podpora celotnega tima je privedla do nekoliko boljšega

sprejemanja težav in ovir v funkcioniranju, integracije različnih izkušenj z ustrezno izbranim delom ter nenazadnje do zaposlitve znotraj običajnega trga dela. Zaradi stalne potrebe po podpori in specifičnih prilagoditvah vezanih na težave z vidom je bila izdana odločba o podporni obliki zaposlitve, oseba se redno poslužuje podpore z naše strani.

VOCATIONAL REHABILITATION – AN EXAMPLE OF GOOD PRACTICE FOR THE WORK ACTIVATION OF PERSONS WITH COMMON MENTAL HEALTH DISORDERS

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Keywords: vocational rehabilitation, case study, mental health, employment

Key highlights:

- Employment and maintaining employment are important protective factors for people with mental health problems.
- There is considerable variation in the implementation of an occupational rehabilitation programme in relation to different mental health diagnoses, depending on the needs and capacities of the people involved.
- People with a personality disorder are generally more difficult to employ, and within an occupational rehabilitation programme there is a greater intensity of experience at work, feelings of frustration and disempowerment, difficulties in working together and hidden diagnoses without adequate treatment.
- The process of vocational rehabilitation is often more lengthy in the case of a diagnosis of a personality disorder, requiring a strong involvement of the whole team as well as other relevant institutions.
- The outcomes of an occupational rehabilitation programme are often less successful or less stable for people with this diagnosis, not only because of the nature of the disorder, but also because of stigma, rigidity of the demands/organisation of the work environment and the lack of an adequate support network. This presentation will provide an example of a successful transition to employment, but after repeated less effective attempts.

Abstract: Vocational rehabilitation constitutes a complex, multidisciplinary process encompassing services aimed at enabling individuals with disabilities to acquire suitable employment, maintain it, progress within it, or transition to another professional career. This presentation includes a case study of good practices in vocational rehabilitation for an individual facing mental health challenges. Initially focusing on physical functioning, the assessment period and subsequent program revealed issues indicative of a personality disorder, often presenting greater hindrances to work processes than visual impairments themselves. The employment of individuals with a personality disorder lacks comprehensive research support. Generally, individuals with this disorder exhibit significantly higher rates of work absenteeism, develop workplace stress disorders, or manifest chronic work incapacity, displaying weaker social functioning and struggling to retain employment. They are also more challenging to employ compared to those diagnosed with major depression or psychosis, experiencing greater impairment within the employment sphere than in general psychosocial functioning. In this specific case, we encountered unstable social functioning, reduced adaptation skills, less constructive problem-solving approaches, over-presentation of somatic symptoms, and consequent challenges in job retention. Addressing these issues required diverse work-specific training, specific work

adaptations, continuous mentor/personnel support, and broader interdisciplinary collaboration. Persistent challenges extended the vocational rehabilitation program duration. Individually tailored interventions were supported by counselling, emotional regulation learning, and problem-solving skills training. Intensive team support facilitated a slightly improved acceptance of challenges, integration of various work experiences, and eventually, employment within the regular job market. Due to the constant need for support and specific adjustments related to visual impairments, a decision on a supportive form of employment was issued, the person regularly uses our support.

PREDSTAVITEV DRUŠTEV ZA POMOČ UPORABNIKOM Z DUŠEVNIMI IN VEDENJSKIMI MOTNJAMI V SLOVENIJI

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Ključne besede: psihosocialna rehabilitacija, okrevanje, društva na področju duševnega zdravja.

Ključni poudarki: psihosocialna rehabilitacija, preventivne aktivnosti, socialna vključenost, nevladne organizacije.

Izvleček: Društva, ki izvajajo skupnostne oblike pomoči namenjene osebam z dolgotrajnimi težavami v duševnem zdravju, so v slovenskem prostoru prisotna že tri desetletja. Delujejo v javnem interesu na področju socialnega varstva (Altra, Šent, Ozara, Vezi, Novi Paradoks) ter izvajajo psihosocialno rehabilitacijo in indicirano preventivo, ki zajema pomoč in podporo osebam po zaključenem zdravljenju v psihiatrični bolnišnici. Poglavitne dejavnosti, ki jih izvajajo so: namestitveni programi, dnevne, svetovalne in strukturirane aktivnosti, skupine za samopomoč, svetovanje, varovanje pravic ter raznovrstne individualne ter skupinske oblike pomoči, ki uporabnikom omogočajo okrevanje in lajšanje posledic duševne motnje. Namen indiciranih preventivnih aktivnosti v društvih je predvsem krepitev varovalnih dejavnikov, kot so krepitev socialne mreže, izboljšanje socialno-ekonomskega statusa, bivanjskih pogojev, spodbujanje uporabnikov v socialno vključenost in družbeno življenje, krepitev njihove čvrstosti in odpornosti, asertivnega vedenja, telesne kondicije ipd., ki ščitijo pred poslabšanjem duševne motnje in omogočajo okrevanje uporabnikom z že diagnosticirano duševno motnjo.

PRESENTATION OF NGOS ACTIVITIES TO HELP USERS WITH MENTAL AND BEHAVIORAL DISORDERS IN SLOVENIA

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Key words: psychosocial rehabilitation, recovery, NGO's programmes

Key highlights: psychosocial rehabilitation, preventive activities, social inclusion, NGOs.

Abstract: NGO's on the field of mental health are providing community service for people with long-term mental health problems in Slovenia for almost three decades. They have status of public interest in the field of social protection (Altra, Šent, Ozara, Vezi, Novi Paradoks) and provide psychosocial rehabilitation and indicated prevention, which include help and support to patient after treatment in a psychiatric hospital. The main activities they provide are, as follows: group homme programs, daily, counseling and structured activities, self-help groups, counseling, protection of rights and various individual and group forms of assistance that enable users to recover and alleviate the consequences of a mental disorder. The purpose of indicated preventive activities is primarily to strengthen protective factors, such as strengthening the social network, improving socio-economic status, living conditions, encouraging users to social inclusion and social life, strengthening their strength and improvement, assertive behavior, physical condition, etc., which protect against the risk of mental disorders and the need for recovery of the user with an already diagnosed mental disorder.

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