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A second chance in life

A comparison between Chile and Norway: to what extent is there possibility for work or study for people who have been diagnosed with schizophrenia?

En ny sjanse i livet

En sammenligning mellom Chile og Norge: i hvilken grad er det mulighet for arbeid eller studier for personer som har blitt diagnostisert med schizofreni?

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Le Penseur
Auguste Rodin *(1880)*

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ABSTRACT

Objectives: This research aims to identify strategies that have been carried out and strategies needed, for the vocational integration of people specifically with diagnosis of schizophrenia. Little is known about the integration into society through work or study and quality of life for people who have this diagnose. A comparison between the two countries Chile and Norway was performed to assess this subject.

Methods: A literature search was carried out with the aim of investigating:
a) the problem and its size
b) what is done in the two countries
c) the obstacles for the patients in this group who want to work
d) employment rates in schizophrenia, incomes and the barriers to work
f) what helped their lives and what did not
g) the factors associated with being employed among people with this condition
h) whether employment influences other outcomes in schizophrenia
i) is it realistic to get this group to work
j) what can be done to help them
k) To what extent does **work** help people with this condition

Results: There are a few studies on this issue in both countries. High level of unemployment in both countries was found for this group. The employment rate in schizophrenia appears to have declined over the last years. Barriers to getting employment include stigma, discrimination, fear of loss of benefits and a lack of appropriate professional help. Working appears to be correlated with positive outcomes in social functioning, symptom levels, quality of life and self-esteem, but a clear causal relationship has not been established for this group.

Conclusions: The comparison between the two countries shows some similarities and differences between the studies. Both countries have adopted various measures with the prospect of integrating people with mental disorders. There is very little research on this topic. Therefore this paper has found limited answers. It points out that the society still has a lot to learn about this group in order to give them the kind of help they are in need of.

Keywords: *schizophrenia, employment, work, vocation, disability, quality of life, integration, vocation, Mental health, Chile, Norway.*

Abbreviations

ACT	Assertive Community Treatment
CIDI	Composite International Diagnostic Interview
FONADIS	Fondo Nacional de la Discapacidad / National Disability Fund
GES	Garantías explícitas de salud / Explicit health guarantees
HE	Health Enterprises
IPS	Individual Placement and Support
IA	Inkluderende Arbeidsliv / Inclusive Workplace
IPS	Individual Placement and Support
NAV	Norwegian Labor and Welfare Organization
NESsT	Social Enterprise in Emerging Markets
MH	Mental Health
MHN	Mental Health Norway
MHP	Mental Health Plan
OIL	Office of Intermediation Labor
PHC	Primary Health Care
PSR	Psychosocial Rehabilitation
RBC	Rehabilitation Based of the Community
SZ	Schizophrenia
SE	Supported Employment
WHO	World Health Organization

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1. Introduction

There is no society that is immune from mental illnesses; from a public health point of view, according to Kohn (2011) [1] advances in psychiatric epidemiology have highlighted the significance of the burden of mental illness in many societies in the world, and the need for greater emphasis on providing adequate mental health care. Mental health is more than the absence of mental illness as is described by the World Health Organization (WHO) [2].

> *.. a welfare state in which the individual is aware of their own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.*

In this positive sense mental health is the foundation for well-being and effective functioning for an individual and for a community. This basic concept of mental health is consistent with its wide and varied interpretation across cultures.

The special *Lancet* series on global mental health, published in 2007[3] document the worldwide burden of mental illness, its links to physical illness, and the widespread underfunding of prevention and treatment programs. *The Lancet* noted that the gap between the need for treatment and its availability is particularly wide in the developing world - up to 90 percent in some low-income countries. Nearly a third of countries around the world have no specific budget for mental health, and one fifth of those, spend less than one percent of their national budgets on mental health.

On the other hand the demand for services is changing, as countries argue for discharging from psychiatric hospitals, patients who need long-term treatment, such as schizophrenia. This gives rise on the increase in demand for community services, wich must assume greater responsibility for mental health care, along side better social acceptance of people who suffer mental illness.

In many countries community services for the mentally ill were developed. However, *The Lancet* noted that 30% of countries do not have any such community services, and among those that have them, many cover only a small proportion of the population in need. It added, patients in some countries are still “living in medieval conditions”.

Furthermore a report by the WHO in 2012[4] noted that, the gap between the need for treatment for mental disorders and its provision is wide all over the world. Additionally the report

pointed out that, mental disorders account for 25.3% and 33.5% of all disabilities in low- and middle-income countries, respectively.

Moreover between 76% and 85% of people with severe mental disorders receive no treatment for their mental health problem in low- and middle-income countries. The corresponding range for high-income countries, although lower, is also high; between 35% and 50%.[4a]

The question arises *to what extent there is integration in society for people who have been diagnosed with schizophrenia?*

The risk of mortality associated with those suffering schizophrenia and major depression, is 1.6 and 1.4 times (respectively) higher than the general population, due to physical health problems (such as cancer, diabetes and HIV infection, as well as the serious consequences such as suicide) [4a].

1.1 Background

The situation of people with schizophrenia, as persons with disabilities, has become a topic of interest to different stakeholders. Government institutions, social and educational organizations, and the community in general, have been actively involved in initiatives to enhance the quality of life of these people.

According to the WHO[4b] schizophrenia affects about 1% of people worldwide. It occurs equally among men and women, but in women it tends to begin later and be milder. For this reason, males tend to account for more than half of patients in services with high numbers of young adults. Since schizophrenia typically strikes in early adulthood, individuals with the disorder need rehabilitation to help develop life-management skills, complete vocational or educational training, and hold a job.

When considering strategies for the rehabilitation of people with this mental disorder, work is considered essential to promote the development of their potential and capabilities. According to Harpaz and Fu, (2002) [5] work plays a central role in people's lives because of their potential to fulfill other functions and needs, such as self-esteem, identity, social interaction and state.

People who suffer from severe mental disorder experience high rates of unemployment. In the United States unemployment rates amongst such people are estimated at 75-85% whilst in the UK rates of 61-73% have been reported[6]. These high rates reflect not only the disability caused by severe mental illness, but they also reflect discrimination (unemployment rates are

higher than in other disabled groups[6a]) and the low priority given to employment by psychiatric services. Despite high unemployment rates amongst the severely mentally ill, surveys have consistently shown that most want to work[6b].

1.1.2. Brief on researches in this field

1.1.3 Since 1994, **Chile** has implemented several policies to facilitate access to integration of people with disabilities by access to education, employment and social life. The most relevant is the Law 19.284, also known "Integration of Handicapped Act"[7].

Whose conceptual basis is stated that

> *(translate) …."disability should be cease to be addressed only from a point of view from humanitarian assistance and or as a issue exclusive of the health and education sector, to be considered a social global problem that can affect all people equally, regardless of sex, age or socioeconomic status"*[7a]

In an exploratory study conducted in Chile by Diaz and Chacon (2006) [8] the authors pointed out that, when the topic of employment in relation to the type of disability was examined, they found that 73% (n = 192 272) of those with deficiencies psychiatric are not in paid employment, compared with 87% (n = 263 286) of those with intellectual deficiencies.

Chuaqui (2008)[9] reports that, in a random sample of 150 companies of large and medium-sized, only 28% believed that a person with schizophrenia could succeed well on simple tasks, with significantly lower rates for complex or stressful tasks. An additional study by Chuaqui (2001, 2002[9a]) shows that a sample of 150 outpatients with schizophrenia in the metropolitan region, only 13.3% worked in competitive jobs.

1.1.4 In **Norway** following, identification that the treatment of people with mental illness was unsatisfactory, the Storting White Paper 25 (1996-1997)[10], was introduced. As a result in 1998 Norway adopted a National Programme for Mental Health aimed at improving treatment with responsibility at national and local authorities as well as by specialist services.

In this plan, the Social Committee emphasized that the goal of services for people with mental illness must be to promote independence, autonomy and ability to cope with life.
To achieve this a number of measures were proposed, including new legislation; economic devices such as subsidies to stimulate local and regional authorities to develop and operate

efficient and effective services; educational policies in order to get qualified graduate staff; sufficient specialists and the provision of guidance from state regulators.

There are few data on the employment rate among persons with schizophrenia in Norway. A study by Helle and Grawe (2007)[11] on employment and education from all out-patients with schizophrenia in Norway, examines the proportion of patients with schizophrenic disorders who had paid employment, social security or social benefits as their main source of income between 2000 and 2004.

The study shows that a total of 4684 people had schizophrenia as the primary diagnosis in registrations between those years; of these it was stated that 335 people (7%) had paid employment as their main source. Those receiving various forms of social security or social benefits as their main source totalled 4144 individuals. The authors found a statistically significant decrease in the proportion of people diagnosed with schizophrenia, who had a regular job as their main source from 2000 a 11% to 2004 an 5%. Further they point out it is crucial that the mental health and vocational professionals cooperate in the implementation of effective models of supported employment to meet the needs of this group of persons; and added, today there is a big difference in follow-up services for people who have jobs and those who have never had. There is almost no government measure aimed at employment for people with psychotic disorders.

1.2 Objectives

This research aims to identify strategies that have been carried out and strategies needed, for the occupational integration of people specifically with diagnosis of schizophrenia; conceptualizing the new paradigms, which at least hypothetically orient the thematic of schizophrenia today. Other definitions that relate to the theme, such as the concept of stigma, normalcy, functionality, integration, inclusion and overprotection are also provided with a view to expanding and enriching the issue.

It evidences also in the course of this investigation, the obstacles experienced by people with this diagnosis, when public policy is not sufficient to fully provide normal their social life.

It was also considered important to analyze information provided by professionals who daily work to support the integration of persons with mental disorder. They provided not only hypothetical but also observational information on the methodology used with youths and adults.

For the purpose of this research, was considered the performance of work or studies a necessity, understanding that the development of a productive activity is a key to increase and grow in the factors of personal dignity, build confidence, believe in the possibility of facing life, strengthens the feeling of being useful and the experience of being able to live an independent life also provides participation with others.

1.3 Research question

Based on the burden of mental illness - with special emphasis on people with schizophrenia, the research investigates and compares to what extent there is integration into society through work or study opportunities for people who have been diagnosed with schizophrenia in Chile and Norway.

1.4 Academic and theoretical background [1]of the diagnosis schizophrenia

The WHO states that Schizophrenia is a severe form of mental illness affecting about seven per thousand of the adult population, mostly in the age group 15-35 years.
A diagnosis can be interpreted as a unit in a classification system, introduced by Emil Kraepelin regarded among other things the founder of modern scientific psychiatry. He was the first to classify psychosis, and noticed that some of those who were psychotic recovered, while others only got worse (degeneration). This divergence in conditions was crucial for the classification and introduced the concepts of manic-depressive psychosis and "dementia praecox", the two states of psychosis[12]. The latter condition was later substituted by the term schizophrenia for Euegen Bleuler, and manic-depressive has been replaced by the term bipolar disorder or bipolar affective disorder[13].
Bleuler reformulated dementia praecox as "the group of schizophrenia", foreshadowed the modern view that schizophrenia is a heterogeneous group of diseases with similar clinical presentations. He also included a lack of affect, as core trait and was the first to describe the symptoms as "positive"[1] or "negative"[2]. Bleuler changed the name on the basis that it was obvious that the illness was not a dementia (not always lead to mental deterioration) and could sometimes occur late as early in life[13a]. His vision of schizophrenia provides the opportunity for recovery. The causes of schizophrenia are not yet fully understood.
We know, however, that biological, social and psychological factors contribute to the

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[1] Symptoms: Positive represent a change in behaviour or thoughts, such as hallucinations or delusions.

[2] Negative represent a withdrawal or lack of function. For example, people with schizophrenia often appear emotionless, flat and apathetic

development of this disorder. Today considering psychological factors; these do not have a decisive role in its debut, but can play a significant role in the course[14].

In schizophrenia has been shown imbalance / activity changes in certain neural pathways in the central nervous system in the brain[15]. We also know that the signal substance dopamine is central in schizophrenia and that dopamine activity is high in some parts of the brain. This may explain symptoms such as delusions and hallucinations, as is often seen in this disorder[15a].

There is also evidence to suggest that several other neurotransmitters are directly or indirectly involved. In recent years the role of serotonin has been further studied in schizophrenia.[15b] Serotonin is important for the regulation of mood, and is probably important for understanding the emotional flattening and tendency to depression that is very common in schizophrenia. The aim of the pharmacological or pharmacological treatment of disorders is to restore balance in these disturbed systems in the brain[16]. Furthermore, a recent study showed that genetic factors[17] (heritability) might play a significant role in the development of schizophrenia. It has also been focused on infectious diseases in utero as a risk factor for later development of this disorder[18].

There are various classification systems for mental disorder, the United States uses Diagnostic and Statistical Manual of Mental Disorders DSM-V. Europe and Norway used - International classification of Disorder ICD-10 as the WHO diagnostic system. These are diagnostic manuals and description of the different sets of symptoms.[19]

Schizophrenia is a severe form of mental illness, affects about 24 million people worldwide and has estimated about seven per thousand of the adult population, mostly in the age group 15-35 years. Though the incidence is low (3-10,000) the prevalence is high due to chronicity.[20]

Care of persons with schizophrenia can be provided at community level, with active family and community involvement. There are effective interventions (pharmacological and psychosocial) available. The cost of treatment of a person suffering from chronic schizophrenia is about US$2 per month in USA[6c]; the earlier the treatment is initiated, the more effective it will be. However, the majority of the persons with chronic schizophrenia do not receive treatment, which contributes to the chronicity.

1.5 Brief about regulation and methodology for Mental Health Systems in Latin America and the Caribbean (LAC) [21]

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was developed for countries, particularly those that are low- and middle-income, to assist to carry out systematic monitoring and evaluation exercises of their mental health systems. WHO has defined a mental health system as:

> *"... all structures and activities whose primary purpose is to promote, maintain, or restore mental health and prevent mental disorders."*

This organism -WHO-AIMS- evaluates the different components of a country's mental health system as part of its national health system; specifically, aspects of mental health legislation, national mental health policy and plans, and the basic data on financing of the systems. Human rights protection in the sphere of mental health is also evaluated.

A report by WHO-AIMS (2013) [21a] was carried out to assess of mental health systems in LAC using the WHO-AIMS instrument. The report stated that mental and neurological disorders account for almost one-quarter of the total burden of disease in LAC. The total burden of disease, measured in disability-adjusted life years (DALYs) of mental and neurological disorders accounts for 22.2%. With regard to all neuropsychiatric disorders, the most common are the unipolar depressive disorders (13.2%) and those produced by excessive use of alcohol (6.9%). Despite the magnitude of the burden of mental and neurological disorders, the treatment gap is overwhelming [21b].

Furthermore Saldivia et.al. (2004)[22] pointed out, that the utilization of mental health services in Latin America and other developing regions has received only limited attention from researchers. Only three epidemiological studies using the Composite International Diagnostic Interview (CIDI) have examined rates of use in mental health service among persons with psychiatric disorders in Latin American countries. Two of these reports were from Mexico, one representing Mexico City and the other limited to use of services by persons with affective disorders in rural Mexico. The third study was from a middle-class catchments area in Sao Paulo, Brazil. Each of these reports suggested a high prevalence of untreated disorders. These studies did not examine determinants of use of mental health care or barriers to care.

In addition there are disparities among the countries that have been working on the issue of human rights in the mental health area[21c].

1.5.1 Integration process of Mental Health in Primary Health Care in Chile (PHC)[23]

The first formally idea conceptualized to the community mental health services and integration with PHC was in 1966, with the first national health program mental. Although this program never manages to be implemented due to lack of political support and resources, represented a milestone significant to arrange a group of professionals, to pose public health strategies and to address the high prevalence of mental illness observed in epidemiological studies. This program indicated that psychiatric hospitals were ineffective and costly to meet the mental health needs, proposing instead the development of a network of services based on PHC and general hospitals.

As a result is established in 1968 the first program; along with a pilot community psychiatry experience and provided clinical care in a PHC center in a general hospital. PHC teams were trained in the treatment of alcoholism and promoted the active community participation in solving their most frequent mental health problems (alcoholism, neurosis and cognitive development of children with delay). This pilot project was spread in small scale elsewhere in Chile, especially alcoholism, through self-help groups and APS.

Like many other community and public health initiatives, the practices described were closed by the military dictatorship in 1973. The only initiatives that survived were psychiatric services in general hospitals, the treatment of alcohol dependence in PHC centers and providing them basic psychotropic drugs[II] .

With the return to democracy in 1990, Chile was in a marked change of emphasis in health policy. Various measures for strengthening the public were taken to increase investment in infrastructure and operational budgets, and improving the technical skills of their teams and coordination of facilities. Since mid-1990, began an active process of analysis and proposals that culminated in ten years with the establishment of a profound health reform. Moreover, the Caracas Conference[III] [24]helped to give greater impetus to community programs and especially those based on PHC.

The first policy and national mental health plan was officially promulgated in 1993 by the minister of health[22a]. The Mental Health Plan (MHP) in 1993 contributed to the increase in

[II] Definitions of psychotropic relating to or denoting drugs that affect a persons mental state i.e. chlordiaepoxide, chlorpromazine, haloperidol, amitriptyline and imipramine).

[III] The Caracas Declaration, aimed – among other objectives-- at promoting the respect for the human and civil rights of the mentally ill, and at the restructuring of psychiatric care on the basis of primary health care under the framework of local health systems.

outpatient speciality teams and the installation of the first day hospitals, psychosocial rehabilitation programs and protected community-based homes.

In 1998 and 1999, the mental health team of the Ministry of Health in cooperation with organizations, families, and professionals conducted a series of actions in support of the Community model and greater resources for mental health. Thus a second national plan was formulated in 1999 and implementation began the following year.[22,9b,8a]

The second MHP defines a coherent set of strategies to contribute to improved the mental health of Chileans, including both actions in the health sector and other sectors of government, from promotional and preventive to curative and rehabilitative programs.

Among the priority issues identified in the plan only three - depression, schizophrenia and abuse/dependence of alcohol and drugs, received political support and adequate funding to ensure service availability and accessibility throughout Chile. These three have also been included in the system of explicit health guarantees; (Garantías explícitas de salud, GES) since 2004, as part of health reform. According to the law of GES, the public insurance (coverage of 74% of the population) and private (16% of the population) should provide a set of guarantees of access, quality, relevance and financial protection for 56 diseases priority. These three mental health problems have been integrated to varying degrees in PHC. Greater integration has been for depression; where over 80% of people over 15 years in the public insurance are treated by GPs and PHC psychologists.

The role of primary cares in schizophrenia is only limited to the detection of the first episodes with reference to a psychiatrist as well as actions to promote mental health and prevent mental illness. Considered at the national level has had a low level of implementation due to the lack of political and financial support.

Primary Health Care integrates mental health, and has become an official part of public health policy in Chile. On the political level the allocation of funds for mental health in PHC had increasing from almost zero in 1990 to 0.9% of the health budget in the public sector in 2009.

Newly formulated; National Health Strategy 2011-2020 which has been incorporated, aimed at reducing disability in people with mental illness in 10% and the use of the strategy of early detection and timely treatment of PHC[25].

1.6 Brief about regulation and methodology for Mental Health Systems

The relationship between Norway and the World Health Organisation[26]

Since the formation of WHO, Norway has been one of the key actors in the design of the organization. The WHO Europe, based in Copenhagen, currently comprises 52 countries. These are almost all advanced industrial ('developed') countries in which access to health care is effectively universal. The WHO Regional Office for Europe has a separate unit for mental health issues, with a network of national counterparts on mental health.

The Mental Health Declaration for Europe was signed in Helsinki in 2005 projecting a strong commitment to governments to tackle the enormous challenges facing the mental health in Europe [27] and strongly emphasizes the role of primary care as part of mental health services.

The priorities of the Mental Health Declaration for Europe:

- foster awareness of the importance of mental well-being
- collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process
- design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery
- address the need for a competent workforce, effective in all these areas
- recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

Mental Health Europe - funded in part by the European Commission – was originally an association of national associations of mental health that formed the European Regional Council of the World Federation for Mental Health, but now includes a range of mental health No Governmental Organizations (NGO) in its membership.[27a]

A review by Hurst and Jee-Hughes (2000) in the concepts and performance indicators, instruments and mechanisms that are being developed to measure and improve the WHO, OECD and selected countries, noted that, the comparative evaluation of the WHO is parallel to the OECD production and development of cross-national cooperation of data on health systems and selected countries.[28]

1.6.1 The Organization for Economic Cooperation and Development OECD[29]

The OECD is a world leader in designing structural reforms that promote growth and equity.

It is a forum for cooperation for economic and social affairs, is made up of 34 countries as well as from 70-non members. The mission of the OECD; help countries to develop policies together to promote economic growth and healthy labour markets, boost investment and trade, support sustainable development, raise living standards, and improve the functioning of markets.

It also takes into account the issues that directly affect everyone's daily life, like how much people pay in taxes and social security, and how much leisure time they can take. Also compare how different countries in their school systems are preparing their young people for modern life, and how different countries have their pension systems to look after their citizens in old age. Based on facts and real life experience, recommends policies to improve the quality of life of people.

The OECD states that mental illness is a growing problem in society and is increasingly affecting productivity and well-being in the workplace. A report was carried out by the OECD *Sick on the Job? Myths and Realities about Mental and Work* (2011)[30], shows that one in five workers suffer from a mental illness, such as depression or anxiety, and many are struggling to cope with these problems.

The main findings of this report, including new evidence which questions some of the myths and taboos around mental ill-health and work, is that people with severe mental disorder are too often too far away from the labour market, and need help to find sustainable employment. In addition the majority of people with common mental disorder, are employed but struggling in their jobs, neither are they receiving any treatment nor any supports in the workplace, thus being at high risk of job loss and permanent labour market exclusion.

As a result the policy can and must respond more effectively to the challenges for labour market inclusion of people with mental illness. The report remarks a policy shift will be required by giving more attention to: common mental disorders, sub-threshold conditions, disorders concerning the employed as well as the unemployed, and preventing instead of reacting to problems.

As consequence the OECD governments increasingly recognise that in preventing mental illness policy has a major role to play in keeping people with mental ill-health in employment or bringing those outside of the labour market back to it.

1.7 Norway health sector and mental health

Since 1848 Norway has been involved in psychiatry initiatives; with a proposed law on insane treatment and care that was approved by the Parliament in 1848[31]. The Act of 1848 was by contemporary standards of respect for human insane dignity and it remained until 1961.

On the1950-1960 years, came the modern nerve medicines. They represented a huge advancement, gave both doctors and patients excessive belief that drugs could solve problems. As a result; more medication and drugged patients. In a wider perspective, much has been accomplished in psychiatry. The latest was the action Plan for Mental Health and mental health, which was started in 1990. Though this was completed in 1995, funding continued at the same level in 1996-97. [31a]

In Norway, like in most western countries, the services for people with mental health problems have gone through major changes over the last decades. The number of patients staying in psychiatric institutions has been drastically reduced and most people with mental problems now live outside institutions, reported Mental Health in 2005.[32]
However early in 1990; the problems associated with the reduction of psychiatric institutions appear more clearly, because the reduction of psychiatry had not been accompanied by the development of the corresponding municipal services. The clear problems that existed in services for the mentally ill, led the government release the Storting White Paper 25 (1996-1997). The deficiencie in the provision of services is revealed, and escalation or intensification plan that would give mental health a boost was proposed. As a result in 1998 the Parliament unanimously declares the Escalation Plan for Mental Health. Implementation of the programme takes place between 1999 and 2008.[31b]
Recently, new laws regulating mental health services have been introduced.

The purpose of the Storting White Paper was to arrange the groundwork for better and more consistent services for people with mental illness and being able to cover the needs of the users. To do this a number of measures, including legal instruments, in the form of new legislation was proposed, economic instruments such as subsidies to encourage local and regional authorities in the development and operation of efficient and effective services. In addition, education policies aimed to obtaining an academically qualified staff, sufficient education and guidance from national authorities.

The overall goal of the Mental Health Plan 1999-2006/2008[33]can be assessed as a result of the initiative, both qualitatively and quantitatively of better service for people with mental illness.

According to Intensification or Escalation plan principles; the aim of the services is to promote independence, autonomy and ability to cope with life. Sectors and service providers will have the task of helping to establish treatment networks across sectors and levels of government. The Plan was a very complete reform that was implemented in all 431[35,32a] municipalities.

It is an important objective in the Plan to strengthen the availability of work and labor market programs for people with mental illness. Experience shows that people with mental illness need further study and clarification periods, closer monitoring and greater emphasis on integration into work-related measures than other users of the Administration of Labor and Social Welfare. For this reason work and welfare for this group, put funds available from the Mental Health Plan for the labor market. As part of the implementation of the Plan, in 2004 were allocated noticeable funds for development "Will leads the way", which in the first phase was a method of practical works based on experience collecting, testing and diffusion.

In spring 2006 efforts continued under the designation 'Will - focus on work and mental health in NAV". The initiative was organized as a major project with underlying sub-projects that preserve their own priority: Networking and skills, Job Ability supervision and City Strategy.[34] As a result the Norwegian Labor and Welfare Organization (NAV) was formally established on 1 July 2006. NAV took over the responsibilities and tasks, which were previously handled on an interim basis by the Aetat Directorate of Labour, the National Insurance Administration. NAV's overall goal is to provide the unemployed with the chance to work and be active and whilst ensuring their rights to welfare benefits. [34a,36]

The organisation of the mental health care system in Norway is based on three layers: primary mental health care is provided by the municipalities, specialised mental health care is under the responsibility of the counties, and the highly specialised are supervised by hospitals of the government. An important national organisation is the Directorate of Health, a professional body with three roles as: a health care advisory body to different target groups (e.g. by monitoring trends in health care services); an authority implementing policies (e.g. action plans, campaigns or giving grants); and an administrator of regulations within the field of health care. Together with the Directorate for Labour and Welfare, the Health Directorate has a main responsibility for the implementation and evaluation of the measures of the national strategy on mental health and work.[29]

The government's goal is to; prevent exclusion from working life and facilitate inclusion in working life for people with mental disorders or problems.

1.7.1 Norway Primary Health

Promoting coordination between primary and secondary health care has been at the core of Norwegian health policy the last 10–15 years[37]. Coordination refers to mechanisms to integrate activities among health organizations to facilitate the provision of appropriate services. There have been two major measures proposed and different strategy over the last decades to promote better coordination, in 2005 and in 2009. The first strategy was soon almost laid aside. The government has adopted a new health care legislation based on the second, thus; carrying out administrative, economic and structural reforms from 2012.
The hospital sector of Norway is responsible for the specialist health care service and has been run and owned by national health authorities since 2002 when a major hospital reform took place. The reform contained two major changes. Firstly, the ownership of all public hospitals was transferred from the 19 counties to the state. Secondly, the government decided to set up five (later four) Regional Health Enterprises to manage and run Health Enterprises (HE). During the last decade the sector has been restructured and previous single hospitals have merged into larger enterprises. Fifty-five hospitals in 1999 have been reduced to 21 health enterprises in 2011 [37a]

The HE boards are responsible for organizing a complete set of acute somatic and psychiatric specialist services to the population in the area. Except for a few institutions with advanced rehabilitation services, long-term care does not exist within the hospital sector in Norway. It is, integrated in primary health care. The hospital sector is financed through government grants. The health enterprises are reimbursed with ca. 40% depending on their Diagnosis Related Group-based activity. Sixty percent is block grants. Private health insurance plays a marginal role in the financing of health services in Norway, estimated at 1.8 to 2.3%.[38]

2. Subjects and Methods

2.1 Subjects

The aim of this paper is to answer the following question: to what extent there is integration in society through work or study opportunities for people who have been diagnosed with schizophrenia in both Chile and Norway? And consequently the paper derive the followings questions:

1. *What is the problem and how big is the problem?*
2. *What is done for this group in the two countries?*
3. *What is the employment rate for people with established schizophrenia?*
4. *What are the barriers to employment?*
5. *Have something worked well? What has not worked?*
6. *What are the factors that are associated with being employed among people with Schizophrenia?*
7. *Is there any evidence that being employed may influence other outcomes in schizophrenia?*

What does work for people with this condition*? To what extent:*

a) do they have to come to work with minor symptoms.

b) should they have more or less medication

c) do they need the better living conditions

d) contact with family, friends etc.

To find the answers must be identified data from relevant studies showing an active relationship between people with schizophrenia and vocation.

2.1.2 Methods

Method used to identify relevant studies: a combination of keywords, search filter, time period, also was supplemented by searching of relevant scientific articles, reports, articles and relevant laws and regulations were reviewed.

This systematic literature search was carried out on May 2014. The preference was until the last year 2014 in the following databases:

Medline (1980- 2014), EMBASE (1990 - 2011), CINHAHL (1980 - present year) Psych Info (unlimited years - 2014) ScienceDirect (1950- 2014) The Lancet (1997 - 2014) The Cochrane Schizophrenia Group of Systematic Reviews, Pub Med, Elsevier, SAGE (1847 – 2014) Scielo (1999 – 2013) databases.

All searches used the following keywords to identify papers discussing schizophrenia and vocation: schizophrenia, mental disorder, disability, quality of life, integration, employment, occupation, vocation, Hispanic Health, Latin America, Scandinavia, Mental health services of Chile and Norway and a variety of others combined to answer the particular aims of this study.
An Internet search was also conducted extracting the papers from the governments of those countries that reported the support employment. They included the Mental Health Declaration and Action Plan for Europe and the documents by which they were informed.

The strategy to search used was the PICO method (population, intervention, control/comparator and outcome). The truncation was used to look for different variants of the same word, and Boolean with AND, OR and NOT was utilized to make the search more effective.

Although the main objective of this work is people with schizophrenia, studies that refer to people with mental illness are included to some extent, because it contains people with schizophrenia. It will be made clear when this is the case.
The study is comparative; partly because a comparison is that allow isolating and identifying each causal variable that are maintained through the cases. But it also allows the comparison; explain different degrees as superiority, inferiority and equality, so worthy as any to establish additional or more detailed investigation. In order that the study is comparable the sample is restricted to the two countries Chile and Norway.

Main categories for study inclusion based on the design of the study: online databases. However, because the research was limited, there were no restrictions for other information. In order to adjust the amount of data to the frame, some priorities were made. It is assumed that the institutions that are active both nationally and internationally published its articles in international journals that make available to share information. In this context universities / institutions or first author in relationship at items of interest were taken into account. Checking of reference list was also performed.

Inclusion criteria were:

Study Design: Systematic reviews and primary studies (systematic reviews have clear inclusion and exclusion criteria, it is reported the terms that have been used in the search, the time of the search, which databases were searched, and the time periods include search.)

Population: People with schizophrenia diagnosis

Intervention: Preventive and health promotion; including existing preventive health services, the role of the community, environmental health, new initiatives, low-threshold services as shelter care, GP's role in preventive health care, multidisciplinary public health in the context of performance.

Comparison: No action or other preventive measures

Outcomes: Health-related outcomes comparable to quality of life, integration/employment.

Language: No restrictions on the search. Publications included in English, Scandinavian and Spanish.

Exclusion criteria: Based on the study design those with disability in another context, and bipolar disorder were excluded.

In extracting the papers that reported the issue of interess 8475 references with the criteria of Schizophrenia was found. Because this research is so specifically, very little research in these countries has been carried out. Of tuenty studies in Chile only three identified the criteria. From thirty-five studies in Norway only four of these identified the purpose of this study. All those references that were considered probable relevant were read in full text. Only these seven studies identified the criteria.

The quality of the studies was critically evaluated using published checklists. This is the criteria for study design promoted by international organizations such as The Cochrane Public Health Group. The results show that current and important issues such structural factors like policy and legislation are covered in the systematic reviews together with themes as mental health, and occupational health.

2.1.3 Results

Qualitative studies were found in Chile and in Norway. The sample size is small in both countries. Nevertheless any studies that can help to improve the quality of life, with utilization of different aspects and different expressions, can be helpful.
One of the purposes of qualitative studies is that they provide to researchers and participants an experience. At the same time there is an interactive relationship, between the social and cultural systems.

One of the Norwegian studies; *Working on the edge: the meaning of work for people recovering from severe mental distress in Norway* by Borg and Kristiansen (2008)[39].
This study is on the basis of an earlier study; 13 individuals, six men and seven women with an age range of 26–54 years. They were interviewed about their everyday life. The authors tried to find out what people felt was more helpful to them. Moreover the study identified and discusses the role that having a work plays on the road to recovery for people with severe mental distress particularly for those diagnosed with psychosis.

From Chile, *Occupational Insertion process of People with Schizophrenia: Analysis from Suport Institution* by Díaz and Chacón (2006)[8a] an exploratory study that describes, from the perspective of the participants in an occupational rehabilitation center, the facilitating and limitations conditions for the occupational insertion of persons with schizophrenia. Distinguishing three areas of analysis: social, institutional and personal. Of a total 24 persons (45.8% women and 54.2% men), and the rehabilitation team who work with them a total of eight people; ten individuals decided to participate, five women and five men, with a mean SD age of 37 years and two monitorer with a mean SD age 42 years.

Quantitative studies

From Norway; *Quality of life, loneliness, and social contact among long-term psychiatric patient* by Borge et.al (1999)[40] a view from an institution associated with psychiatric nursing homes, in the rural county of Sogn and Fjordane in 1989 with long-term patients. The aim of this study was to assess how they felt about their situation after a large reduction in the number of psychiatric nursing beds.
From the late 1970s, large psychiatric institutions were reduced in size. The aim was to

provide decentralized care, with emphasis on patients “normalization and integration into the community to improve the patients' quality of life”.
The investigation was performed in 1996, the population 107 patients, all of them had spent at least one year there, and 70 percent had been living in the institution for ten years or more. At follow-up, many patients had moved back to their community of origin after planned discharges. In the institusjon; 75 were alive at the time, one of them did not participate in the study. The remaining; 54 men and 20 women with a mean±SD age of 60.4±14 years, sixty-nine percent met criteria for *DSM-III-R,* diagnosis of schizophrenia. Quality of life, loneliness, contact with others, was assessed. The results; the patients reported a relatively high quality of life. Degree of loneliness, meaningful leisure time activities, and satisfaction with the neighborhood were the variables that best explained the variance in subjective well-being. Health care professionals were the most important persons in the patients' social networks. Eighty-four % had never been married. Thirty patients (41%) were living in nursing homes; 23 patients (30%) remained in the county psychiatric nursing; while 21 patients (29%) had its own house or apartment outside of institution.
In a last review of this study (2000) the authors stated that most long-term patients who had moved out of psychiatric institutions were satisfied with their living situation and reported a relatively high quality of life[41]

A second research from Norway; *Social Functioning of Patients With Schizophrenia in High-Income Welfare Societies* by Melle et.al. (2000)[42] was conducted to show reintegration into the community. A total 81 patients with a DSM-III-R diagnosis of schizophrenia or schizophreniform disorder were admitted in 1980 and 1983 in a short-term ward of a psychiatric hospital in Oslo. These were followed up after seven years. 74 of 76 patients alive at follow-up decide to participate at evaluate community reintegration. The sample size 20 men (27 %) and 54 women (73%), with a mean±SD age at the index admission of 41±13.1 years. The majority of patients were in outpatient treatment throughout the follow-up period. The community reintegration was evaluated by housing, employment, income, and social contacts. The Strauss-Carpenter Level of Functioning Scale and the Social Adjustment Scale measured social functioning. The results of this study shows in the follow-up at 78 percent of patients lived independently, 47 percent were socially isolated, and 94 percent were unemployed. Thirty-four percent had lost employment in the follow-up period.
The authors reported; poor outcome in terms of social functioning and community reintegration was associated with loss of employment and a good outcome was predicted by

short periods of inpatient hospitalization, high levels of education, being married, male gender, and not having a late onset of psychosis. The authors noted, that active rehabilitation is needed to achieve community reintegration, even for patients with developed social skills. The study emphasize about the group of older female patients that their had limited option to rehabilitation services, but the easiest access to disability benefits for the treatment system.

The latest research from Norway; *Sysselsetting og trygd blant personer med schizofrenidiagnose*, Helle and Gråwe (2007)[11a] which makes a gathering of data on employment and education of all outpatients with schizophrenia across the country in 2000 and 2004. The study examined the proportion of patients who had paid employment, social security or social benefits as their main source. The population n=4684, 56% were male, and 44% were women, of these 335 people (7%) had paid employment as their main source, 4144 received various forms of social security or social benefits. The study results; there was a statistically significant decrease in the proportion of people with schizophrenia as the primary diagnosis that had regular employment as their main source from 2000 to 2004 (from 11 to 5%). Those with paid work were in the age group 18-39 year, and people with social security in the age group 40-59 year. Employment was associated with more education, marriage and short duration of mental illness.

Finally, two last studies in Chile 1. *Reintegration Laboral of people with Schizophrenia: Task unfulfilled* Chuaqui (2008)[9a], this research seeks to explore the factors associated with job performance, motivational processes and career of people with schizophrenia and with the purpose to make a comparison of these three types of work for them:
1. competitive jobs ("normal") 2. semi-protected work ("normal" in health institutions with shorter hours and some special considerations) and 3. jobs on ad hoc workshops and social enterprises created especially for those people. The investigation was carried out with surveys in three different years 2004-2006. The result showed at competitive jobs that could be included in the sample. About 20 cases, was found to be very precarious to make valid comparisons. Those who work in semi-sheltered employment, about 25 cases, earn about half the legal minimum wage in Chile. They found about 110 cases. These cover the vast majority of people with schizophrenia who work in sheltered workshops or social enterprises in the Metropolitan Region of Valparaíso Province in the cadastre.
A remark by the author; in the cadastre of social enterprises and sheltered workshops for the mentally handicapped, a social enterprise with a high degree of organizational and financial

autonomy was not found since the companies are integrated both organizationally and financially to health care or rehabilitation centers - The author pointed out that there are no social enterprises for the mentally handicapped in Chile.

Demography: Of the cases studied the first year, 33, l% women and 66.9% men and the second year 29.8% are women and 70.2% men.

Almost all are in productive age: first year: 61.4% in the age group 25-45 years and 28.9% in the age group 45-65 years; the second year, 56.7% in the age group 25 - 45 years and 34.8% in the age group 45 – 65 years.

Monetary income received; very low, more than 70% less than half the legal minimum income and about 40% less than one sixth of that income.

In terms of marital status as is typical in these cases more than 80% are single. In terms of education 18% (year 1) and 14% (year II) have not completed their basic education. 60% (year 1) and 70% (year II) more than four years having worked previously or have never worked.

2. Quality of life of schizophrenia patients of Aymaran ethnic background in the north of Chile by Caqueo-Urízar et.al.[43] (2012). This study takes an approach toward the ethnicity of the Aymara an indigenous ethnic group their to assess the quality of life. The subjects participating in the study were 45 patients divided into 2 groups: The Aymara group (n=26) with a mean±SD age of 36.1±12.6 years, all were male. Non-Aymara group (n=19) with a mean±SD age of 47.9±13.2 years, all were female. The Aymara group constitutes 57.8% of the total sample. All patients attend the Mental Health Services in province Arica, Chile. The regions of Arica-Parinacota and Santiago de Chile have the greatest prevalence of schizophrenia. The first region, located in the pre-mountain and highland strip, is where there is the greatest concentration of Aymara in the country. The Aymara are mainly engaged in agriculture and pasturing. For the Aymara, the world is ordered in 3 dimensions: social relationships, the relationship with the ‘‘gods’’ and the relationship with nature. Besides they do not view themselves as owners of nature but as an intrinsic part of it. Their concept of ‘‘the good life’’ is a harmonious walk. Aymara ethics is based mainly on community life, enters into conflict with the ethics that have become hegemonic in the Occidental world, which are based on individualism and personal achievement.

To assess the quality of life; performed through The Positive and Negative Syndrome Scale (PANSS) and the Seville Quality of Life Questionnaire (AQLQ).

Considering the fact that they belong to a native population, most of the individuals from an

ethnic minority present less social support, less information about community resources, linguistic barriers and a low socioeconomic level. The results showed moderate quality of life levels, with a strong association with the negative syndrome and the general psychopathology of the disorder. No significant differences were found in the quality of life dimensions as regards ethnic background, assessed by Mann-Whitney U test. The authors conclude that the integration of patients in the Community Health Services is positively associated in their quality of life. The integration of the caregivers is considered essential in the treatments administered.

2.1.4. Grading the quality of evidence

To assess the quality of the evidence this paper the GRADE approach is used. The GRADE system is used widely: the World Health Organization, the American College of Physicians, the Norwegian Knowledge Centre for the Health Services, and the Cochrane Collaboration are among more than 25 organisations that have adopted GRADE[43].

This approach was designed for reviews and guidelines that examine; alternative clinical management strategies or interventions, which may include no intervention or current best management, considering a wide range of clinical questions, including diagnosis, screening, prevention, and therapy. For that reason, the system can also be applied to rehabilitation, public health, and health systems questions.[44] Crucially, when using GRADE, rates of evidence, not study by study, but across studies for specific clinical outcomes are used.

Based on the studies, in this context that randomization is not feasible, and considering the GRADE assesment this paper is based on observational evidence, with focus in clinical outcomes that matter to patients – meaning those outcomes that patients themselves are aware of in relation to their condition – for example, quality of life, integration or social functioning, and employment. Treatment comparisons are; given one of four GRADE scores reflecting the quality of the evidence – high-, moderate-, low-, or very low-quality evidence. According to the Clinical Evidence approach it is given four points to evidence that is largely based on RCTs, and two points to evidence based on observational studies and it has allowed deduction of up to 3 points for quality flaws.[45]

Thereby, it is assessed; such as sparse data, follow-up, withdrawals, blinding, allocation concealment, and other quality issues into; two quality category; (Table1) for the reason that, studies of psychosocial interventions have numerous restrictions. Therefore, the strength of the evidence has been reduced. This paper has not evaluated these outcomes “very low”.

By the factor of few participants, that in general makes the strength of the evidence weaker and makes it difficult to draw conclusions about the effect of the three measures.

However we recall that the strength of weak evidence does not mean a fundamental weak point. The Documentation strength tells just the degrees of confidence that we have in the results of the investigations that have been made. Those are based on the information provided by the systematic reviews. Nevertheless when non-randomized studies are initiated at a lower GRADE, it simply decreases our certainty of the observed effects[43a].

From a rating of "low quality" this could be improved; by justified if there is an obvious evidence of the effect of the actions. In other words when there is a balance on the desirable effects of an intervention that clearly outweigh the undesirable effects, it consequently could offer a strong recommendation. Either, if all plausible biases would reduce a demostrated effect[44a].
In this case reduces definitely employment; isolasjon and social contact, as well as the cost to society. Other factors that could affect the strength of a recommendation, on basis of uncertainty or variability in values and preferences similar to disability; Young patients with diagnosis, will invariably places a higher value on the self-sufficiency with rehabilitation rather than restrictions or impediments or just a retirement benefit.

Imprecision: Small sample size which reduces the confidence on the results of the study, and therefore decrease the generalization e.g. a small sample group was recruited from a single institusjon, with that raises issues of potential Bias. The authors acknowledged that such a small sample means that this result is inconclusive.

Besides non-random samples, like random samples, also raise the issue of whether the findings are merely an artifact of the chance of sampling or not. According to Garson (2012 p.7) [46] "there is no statistical way to assess the validity of results of non-random samples".

Limitations; non-randomized studies, is not possible to blind the participants, lost to follow-up, not "Intention-to-treat" analysis.
Consistency; there is a similarity of estimates of effects across studies: population = diagnosis, intervention, outcome measure (surrogate outcome - stigma)

Validity and reliability:

Validity: Studies reflect or assess with accurately the specific concept of what researchers are trying to measure.

Content Validity: For cultural studies, content validity requires researchers to define these domains that are trying to study[47]. According the definition, this paper found that researchers clearly specify what they are measuring, but attitudes such as self-esteem are difficult to assess and therefore may induce bias.

Reliability: Stability reliability (sometimes called test, re-test reliability) is the agreement of measuring instruments over time.[47a] To determine stability, a measure or test is repeated on the same subjects at a future date. Results are compared and correlated with the initial test to give a measure of stability[47b]. According to the definition two studies: Chuaqui (2008)[9c]; the Cronbach reliability in the two years of research in which it was applied, resulting in an Alpha coefficient of 0.4384 for the first year and a notable of 0.9319 for the second year.

Melle et.al. (2000)[41a], intraclass correlations (ICC 1.1) for interval data ranged from .71 to .83. Kappa for the diagnostic categories ranged from .70 at study entry to .73 at follow-up.

Limitations in available studies

The studies are observational designs, and therefore are in the lower parts of the pyramid of knowledge (S Model). On the other hand small sample size, which reduces the confidence on the results of the study, and therefore decrease the generalization.

Regarding to the literature; what the literature lacks is investigations into what factors are most important, and also which are most likely to change. For example the level of knowledge about the benefit system as subsidy of companies as in the case of Chile.

The possible jobs that could make people with SZ has not been established. Such information could be made more accessible to patients and might potentially change the choices people make.

Potential biases in the review process

This systematic review has limitations. A first concern is the possibility that the search strategy may have missed some studies; even when approaches are similar, investigators frequently employ different terms to describe similar concepts that were not easy to capture.

3. Conceptualization of the topic

First, this paper will argue what is meant by social integration; with the introduction of Durkheim (1858-1917) who is considered as one of the pioneers of modern sociology.
He believed that society exerted a powerful force on individuals. People's norms, beliefs, and values make up a collective consciousness, or a shared way of understanding and behaving in the world. This collective consciousness binds individuals and generates social integration, and is crucial in explaining the existence of society. Thus, individuals through their actions and interactions produce the collective consciousness[48].
According to the definition of the Royal Spanish Academy, integrate is "to someone. . . becomes part of a whole"[49]. Therefore a person will be integrated into society when form part of it and participate in it. We understand social integration as all actions and interventions designed to facilitate and enable the person to develop their personal and social skills, assuming the role of protagonist in their own process of socialization. Each person, some with more or less skill, with gaps and needs in a given situation or problem faced different challenging, varied goals and variability. The integration process in this way becomes personalized and flexible.

Which factors imply social integration, and why should we give emphasis in social integration? To achieve full social integration in conditions of personal autonomy and participation in the community the insertion labour is essential[8b]. It also responds to a right, and to an ethical question derived from the permanent exclusion from the work market[8,9,22,32].
However having a mental health problem can cause difficulties and obstacles in all areas of life, it is well-known that the ability of social skills is impaired and that the social network crumbles, and thus leads to isolation and loneliness. Therefore the need for labour insertion programmes including aspects as health and social care in their methods, and not just aspects of occupational training, is essential.
Over the past half-century, we as a society have clearly evolved from a position in the recovery of people with Schizophrenia, that does not was regarded as a reasonable expectation. However nowadays the recovery is not only seen as possible, but fair enough, it is expected. A very important indication of the effect of this new vision occurred on the report; President's New Freedom Commission (NFC) in 2003[50]. This report designated recovery as the single most important goal in its call for the transformation of the American mental health service delivery system. This was a notable development.

As mentioned the aim of this paper is to find out; to what extent there is integration in society through work or study opportunities for people who have been diagnosed with schizophrenia in both Chile and Norway? Consequently the paper must go through diverse issues

3.1 Chile

The total population in 2010: 17 113 688

Income group: Upper middle (WHO, 2011)

The review of national literature casts some information that allows visualize aspects, that can facilitate or obstruct the employment of these people in this country. These researchs were conducted in the years 2006 and 2008 in Chile[8c,9d] In addition new reports created by the government with new measures that have been taken to improve the system of the labor market, are shown to make this analysis.

The result of the three years study by Chuaqui[9e], ranged from 2004-2008 has been used in technical reports and advice on mental health issues.

In the first human rights treaty of the twenty-first century in 2008,[51] the Chilean government is committed to ensure through the mechanisms and means that the United Nations Convention established; the achievement of full inclusion of people with disabilities. It reflects the paradigm shift considering disability as a human rights issue. The axis of the disability no longer focuses on the person and their shortcomings, but in their interaction with the environment and the difficulties it presents to participate fully.

What is the problem and how big is the problem?

Persons clinically diagnosed who are deprived of the access to employment opportunities that will allow them the development of their skills, thus respecting the uniqueness as person. Making functional their deficiencies and use methods and strategies in accordance with their learning styles to the effective achievement of its Labor Inclusion.

Basing the Problem

The basis of the problem described above is given by the conceptualization of disability with a historic develop that have intervened according to evolutionary and complementary models, considering also the political foundations of the country. All with the foundation of research proposal; explains the most important characteristics of people diagnosed with schizophrenia and how organizations have been proposed; including methodology and work with the combination of Supported Employment in the systemic use of alternative systems.

Disability is the negative interaction between health status and the environment, with the consequence; of activity limitations and participation restriction, which affects a person to cope in their daily lives within their physical and social environment.
Disability is defined by the National policy for the Social Integration of Persons with Disabilities, as "any restriction or lack, due to a deficiency in the ability to perform an activity in the manner and within the range considered normal for a human being"[8d,52]

From this broad definition, is necessary to distinguish between mentally handicapped and mental disability, which, without being present in the national legal rules, is collected in operational terms for programs that work in this field. The difference is established by function or failure, meaning deficiency "the loss or abnormality of a structure or function psychological or physiological or anatomical of the person" [52a] or as “problems in function or structure of the body such as a significant deviation or loss” [53]
Mentally handicapped caused by a deficiency determined by a mental health condition such as schizophrenia or psychological type, mood disorder status, or some organic syndrome, among others.[52b]
Mental disability that would be determined by a health condition that causes mental retardation e.g.Down syndrome[52c].
The stigma, myths and misconceptions surrounding mental illness are the root cause of much of the discrimination and human rights violations experienced by people with mental disabilities on a daily basis. The lack of knowledge about mental illness, its causes, symptoms and treatability results in common but erroneous belief that it is caused by individuals themselves or by supernatural forces possession by evil spirits or punishment by God in LMICs[22a]. Moreover stigma has become such, by expressing “I lost sight of the possibility” fra who have suffered a break with the world around them, to regain their rightful place in the "normal" world. In turn, the infrastructure has failed to meet the appellant and growing need of those persons to reintegrate into a society that rejects them, and restore normal activities. Díaz and Chacón pointed[8e] out mentionet that social prejudice is an important obstacle for the social integration of the chronic mentally ill.
Education: people with mental disorders lack educational opportunities and have poorer educational outcomes, negatively affecting opportunities for development; access to education is well recognised as an building block essential of human and economic development due to its wide-ranging impact, including on health, employment, poverty and social capital[54].

The traditional vocational rehabilitation

It consists of programs for restoration or developing skills. Its main objective aims both; at achieving and the maintenance of a job suited for such users. The traditional service model to help people with disabilities and achieve their life goals is called *train-place.*

Train-place programs; is to train persons in the necessary skills to manage their disability, only then placing them in settings where they might accomplish work and residential goals without the fear of relapse. However *Place-train* programs suggest an alternative service paradigm the person with the problem does not need to be totally good to be enrolled in the labor market, but in the transition to be good[55].

Transitional employment programs are intended to provide training and experience to individuals in segregated settings so that they will be able to acquire the skills necessary to succeed in subsequent competitive employment.[55a]

Extended employment programs are designed to be long-term or permanent placements for individuals that will allow them to use their existing abilities to earn wages in the segregated workshop setting[55b].

Methodology Supported Employment

Supported employment has been defined as "The integrated employment in the community within standard enterprises, for people with disabilities or at risk of social exclusion that have not traditionally been able to access labor market, through providing of the necessary supports within and outside the workplace, along their working lives and in conditions of employment as similar as possible in work and salary, comparable with another workers without a disability or equivalent position within the same company"[56]

Sheltered Employment[56a 6d] The main objective of this kind of work is the fulfillment of a productive job, participation in market transactions and maintenance of a remuneration. Such jobs have been developed for persons suffering from a serious mental illness, low social functioning level and who have a lack of sufficient education to take part in standardized labor spaces. Remunerations seldom correlate with the quality of manufactured products or with the achievement of tasks performed and are often low rated. Forms of sheltered employment; workshops, adult activity centers, work activity centers, and day treatment centers.

3.1.2 How big is the problem?

The incidence of schizophrenia in Chile can be calculated at 12 new cases per 100 000 inhabitants per year, observing that 5 out of 1000 people older than 15 years old present this pathology[57].

The prevalence of schizophrenia in 2004 was estimated as 1% of the general population, regardless of other pathologies[57a].

- The regions of Arica-Parinacota and Santiago de Chile have the greatest prevalence of schizophrenia[42a].
- A psychiatric Prevalence Study shows that approximately one in three individuals in the population had a lifetime psychiatric disorder in Chile, and more than a fifth had a disorder in the last 12 months[57a]
- A survey of national socio-economic on disability shows that Chile has 1.119.867 people with Disabilities, equivalent to 6.9% of the total population[58].

3.1.3 What is done in this country? In a wider perspective; rehabilitation process, development and use of personal skills, and exercise of social roles.

Several measures have been adapted since the most relevant the Law 19.284, also known "Integration of Handicapped Act"[8f,58a].

The National Policy for the Social Integration of Persons with Disabilities states in its conceptual basis for public policies to people with disabilities should be raised to *"promote individual training and capacity development* (. ..) [for that] *persons, without exception, are inserted in the national development "*, among its objectives is that people *"may have greater autonomy and independence as possible"*. [8g,58b]

Since 2003, the Senadis incorporates the National Project Competition in a line of action on Prevention - Rehabilitation, Community Based Rehabilitation Project; as a core strategy, generating initiatives across the country[58c].

There are several institutions in Chile working on- training and employment of persons with disabilities. Only in the Metropolitan region there are at least 13 business workshops that engage in such tasks, moreover 19 more rehabilitation programs serving more than fifteen hundred people[8h]. Chile's government, through FONADIS, since 2002 developed a program of intermediation employment for people with disability, articulated from the creation of the Office of Labor Intermediation (OIL). Through this effort, has been incorporated into the formal labor market to 413 people, of which 15% are mentally disabled and 8.2% a

psychological disability. Furthermore, for protection of persons with mental illness, a National Commission was organized.[8i,58d]

Community Based Rehabilitation

For this investigation it has been considered; the Rehabilitation Based of the Community (RBC) this is a strategy of community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities[58e]. The RBC is a concept integrates 25 years ago, being revised and updated in 1994 by WHO[58e]. RBC involves a set of strategies to the people with disabilities, their families through parent organizations, government and private entities, both in the area of health, education and social work for the achievement of the stipulated objectives. This concept covers a significant importance to validate the form of law and equal access to opportunities [52d,58f].

The Chilean government has implemented various measures in the last years to facilitate employment including:

1. On the basis of a tax exemption to companies; are allowed to be exempt 1% of their taxes by the training of their workers.

2. The subsidy for the recruitment of workmanship through the Undersecretary of Labor program, which subsidizes companies that decide to hire people who are unemployed, in addition to providing funds to train the users.

3. Subsidy of recruitment in the Business area; provides bonus for training workers with disabilities to incorporated into the company. In 2009 bonus included hiring labor up to 300 people with some degree of disability. The actual execution for the same year was 32 beneficiaries. A bonus of 40% in 2010 was raised to 80% in 2011. For 2010 the bonus was included in the companies up to 150 to people with some degree of disability who are participating in a program developed by SENADIS. For 2011 the subsidy rate and the amount of training for vulnerable line, specifically for SENADIS increased[52e,58g,].

4. In 2013 introduce a new paradigm - social enterprises NESsT Chile[59] (Social Enterprise in Emerging Markets) promotes investment in social enterprises, this is of great importance considering that there are critical social problems that neither the private sector nor the public have been resolved successfully, as well as the prevalence of models to solve social problems that are not sustainable and are sustained only through charity.

What is a Social Enterprise? Is a business operated by a charity or non-profit organization that sells goods and/or services in the market place, for the dual purpose of generating income and achieving a social and/or cultural environmental. The mission of social enterprise has a profound and positive impact on participants; improve their skills, employability, financial stability, housing, health, relationships with friends and family, self-esteem, and overall well-being. Moreover create more stable economic opportunities for marginalized communities and to integrate the chronically excluded members of society into the formal economy.[59a]

3.1.4 What is the employment rate and income in people with established schizophrenia?

Information on this topic is limited in cases of people with schizophrenia who work in competitive jobs . Two limitations were presented in Chuaqui study (2008)[9f], institutions with potential employers, regarding to the confidentiality; their records are confidential. Subsequently a private center that reintegrated social and labor to people with mental illness "Reunions" also had limitations in this regard. On the other hand many users refused to cooperate for fear (because of the stigma associated with the disease) to their employers to know their disease.

However on basis of the study performed by Chuaqui, can reports that is very low.
1. In competitive jobs “normal”, in the sample about 20 cases,
2. Semi-protected works or in semi-sheltered employment; jobs in health institutions with shorter hours and some special considerations. Those who work in semi-sheltered employment, about 25 cases, earn about half the legal minimum wage in Chile
3. Work that is, workshops and social enterprises created especially.
Cover the vast majority of people with schizophrenia, about 110 cases in the Metropolitan Region and in the Province of Valparaíso. Receiving very low monetary income as mentioned earlier in this paper.

3.1.5. What are the obstacles and barriers to employment?

There are several areas to consider; the legal system, social context, attitudes and conducts of both employers and coworkers.

a) The legal system

Referring to the legal system as an obstacle; a central adversary element, on the legal protection of job loss appears: the welfare pension is lost when gets a job.

This element constitutes a contradiction between efforts to employment and protection system that did not integrate the work as an opportunity for these people.

First Person view from a instructor; translate*…" of the classical difficulty of welfare pension, because … is incomprehensible, on the one hand, it are giving a pension that says you can not work, retired, unable to work, (...) but otherwise has being rehabilitating …. rehabilitated to enter the labor market,(…). but with uncertainty (...) it is strange"*[8j].

b) In the social context

Regarding the barriers that facing people with schizophrenia to join the workforce, the experience coincides with the literature in terms of the presence of certain discuss concerning interpersonal dynamics of abuse (bullying). Similarly, one may see the relevance of stigma in the workplace as a barrier to obtaining and maintaining employment. Both employers and coworkers, considering the user as a crazy and dangerous person then clearly appears as an element complicated to the insertion[9g].

An addditional study by Chuaqui[9g]; a sample of 150 large and medium businesses showed that, only 28% believed that a person with schizophrenia could perform well on simple tasks. In addition was pointed out that the employers considered the most of them aggressive, violent or dangerous. Moreover, the employers expressed great ignorance of the disease (72% incorrectly answered more than half of a list of features of the disease, also attributing some features of other diseases like (hysteria). This indicates the strength of the social stigma associated with the disease, but this is only one part of the problem.

Nevertheless the stigma is not the only explanation for the low labor integration. Using the criterion of social adaptation is a challenge, because raises opposition e.g. if a man is pressured, could appears a resistance to follow the rules, or submitted passively[9g]. In the latter case the principal negative consequence, it is becoming habituated to not make their own decisions, own decisions necessary to carry out positions of greater responsibility.

According to Chuaqui;[9h] adaptive treatment inhibits attitudes necessary in positions of responsibility and therefore relegates people in treatment to lower occupational activities as a result of imposed social seclusion.

Another factor that helps explain the problem of low insertion in competitive jobs, are the most common attitudes that adopting the families.

In a second investigation (unpublished) by Chuaqui a sample of about 100 tutors

schizophrenic outpatients, almost all retired, illustrated that the impact of the disease through misinformation and initial disorientation, difficulty of diagnosis and treatment, family problems caused and its members, suicide attempts of patients, difficult to control during crises; as a result causes high stress and low emotional objectivity of the evaluation of their job skills, thereby having overprotective behaviors, it appears that, the assessing the ability of users for the family is to secure jobs, not for competitive jobs.

First-person perspective

Furthermore social networks are configured as hindering into absence or poor family relationships: *They walk heads down walking listless.....cranky, what's wrong? He doesn't say….Tell? but, what's wrong? if you did this job very well yesterday and now you're doing it wrong? Then they say … leave me alone;… in the house they no, my mom not, that my dad not, my brother not , that my job, no, my parents will not let me go out of the house…*[8k]

About the relationship as a limiting, in the relation between users, the labor market would be impeded if they have interpersonal problems that are difficult to resolve, since often have troubles to resolve the conflicts[8l].

On the relationship between users and team members have a limiting when there are differences in the design of the components of the intervention, such as what are the habits[8m].

Finally, the presence of welfare attitudes in the institution would be configured as a limiting process of employment, with that means the role of institutions or existing rehabilitation devices. This is due to the conception that dominates the health services and rehabilitation centers welfare, having a "protective" attitude, which by their nature do not cause at users to be subjects of their own fate, reinforcing their dependence as incapable of taking independent decisions[9i]. Moreover not face the people to their own situastion, and keep in the healthcare "protective" has a negative result, wich obviously deviates the attitudes to find a "normal" job[9j]. Further, the structure of the institution would limit the process, to the extent that there is no prior preparation on monitors for working with people with schizophrenia[8n,9k].

Furthermore the labor workshops; production demands limited the learning of some users.

On the other hand, the intervention would be limited by the monotony of some of the tasks performed, as also not considered certain prerequisites for the integration of these people in work the workshops[8o,9l].

Also one of the essential conditions of all true work is to provide financial independence that keeps monetarily who serves in it (which is not given in these works) and face individuals to the real conditions of economic survival valid for any adult "normal" in our society[9m]. Chuaqui made a comparison in three years, pointed out that there are few who earn more than the minimum wage, and none in the second or third year; moreover, having very precarious competitive positions of work.[9n]

3.1.6 Have something worked well?

The Sheltered workshops seems to reach integration and quality of life - results shows that considering that most of those involved in the workshops, before doing so were at home doing very little and totally dependent on their families, participating in workshops represented a remarkable change in their lives[9o].

According to the sociologist Jorge Chuaqui's approach, the workshops do not solve the labor problem. However in terms of self-esteem and human relations plays a key role, especially when the person has been isolated and mentally impaired before participating in the workshop. Moreover he pointed out, that the stay should be brief in those workshops, since it is oriented to be a short stage, to confront the person with the actual conditions of economic survival.

Semi-protected jobs into simple tasks have been promoted, as e.g. couriers, gardeners, etc., in health institutions specifically in the Hospital Barros Luco Santiago de Chile, with shorter (six hours) days,[9p] found out the study by Chuaqui. Nevertheless, in general, acquired jobs are temporary and salaries are often below the average defined by the labor market.

Regard to the community, the individuals lives embedded in the community seems to have a better quality of life and a brief history of psychiatric hospitalizations[8p9q]

Another factor as money; also appears as linked with the ability to develop independence, in that it allows autonomy to improve the economic[9r]

6a) What has not worked?

Analysis of the results, regarding profession shows that this condition is not given[9]. The researchs shows that the users have uncertainty in their vocational interests, prefer many different areas of work activity and in moderation, which could be because they are willing to work "on anything", which coincides with another sample from "normal" people which are

occupationally segregated (people who apply for jobs for the unemployed in the municipalities).

3.1.7 What are the factors that are associated with being employed among people with schizophrenia?

Improves health, prevent relapse and accelerates recovery from any point of view. It allows the person to form their own family and stably interact with her/his couple to share life. Participation through work in economic and social life, the most important cure against segregation and isolation, platform that has harassed most to all disabled. Further, there is a claim without going beyond of personal fulfillment that aspires to every human being. Finally it has to do with a person worthy of survival when they are out their parents or protector. It is essential for the person to have a minimum of autonomy in decision making, without being restricted by the economic dependence on others and in this sense is a requirement to be a full citizen[8q,rs].

From an Individual Context

In the interviews conducted by Díaz et.al.(2006)[8r] the personal characteristics of the user as a facilitating factor also appears, indicated that characteristics such as honesty, loyalty, transparency and solidarity are conducive to insertion. Also, the user expresses a perception of self-efficacy respect to their ability to acquire new skills and to make decisions.

Asessment from a supervisor, (translate)

…… people who have acquired skills and are apt to be inserted, there are even some that are embedded in types of work semi protected or competitive, *"…. it has cost them achieve what they have, is very well appreciated for them to get a job, then obviously they are responsible and also there such a thing as honesty, which is absent in people without disabilities, there is great honesty, great transparently and fair, that is, how they will not have loyalty, if a person gives you a chance, that somehow becomes important part of your network and supports you, then obviously there is…"*

3.2 NORWAY

The total population in 2012: 5 054 000[61]

Income group: Upper (WHO, 2011)

What is the problem

The Plan emphasizes that people with mental disorders should be included in a community, avoiding social isolation and have access to meaningful activities such as work (Proposition to the Storting no.63 (1997-1998)). Today is the big difference in follow-up services for people who have an employment and those who have never had this. There is almost not any government measures aimed at jobs for people with psychotic disorders stated Helle and Gråwe (2007)[41b]

According to Labour and Mental Health:[62]

- The Plan emphasizes the importance of work and so-called meaningful activity
- Marked increase in disability benefits among young people with schizophrenia
- Work rate for people with schizophrenia is between 13 and 26% in recent Norwegian study
- Approximately 11% of the country's disability benefit (under 40 years) has a diagnosis of schizophrenia.
- From 2000 to 2004, the number of individuals with schizophrenia with regular employment as their main source down from 11% to 5%
- In contrast to this there are between 50 and 70% who want to be employed

This discrepancy between the desire to be employed and actual employment rates is probably related to external social factors as well internal as disease-related factors. It is often considered that the work is not the most suitable for the people with this diagnosis and therefore, the measures provided by NAV are not used.

Moreover, low expectations and therefore caution the NAV and health teams, in conjunction with increased symptoms and relapses contribute to the low number of jobs.

Studies shown that, more and more young people in Norway ends with a disability pension after being affected by mental illness. Statistics shows the increase was 10 percent from the second half of 2011 to the second half of 2012.[63,a p,17]

The figures show that disabilities with mental illness receive; benefits earlier, and are disabled longer than those with other disorders. Many of them had never, or too late, receive help [63,a p,17] The permanent disability is the most striking, but sick absences related to these disorders are also significant.

In addition Community reintegration has been one of the explicit goals of deinstitutionalization[41c]. The study conducted by Melle et.al (2000) [41c] that assess the level of reintegration into the community of patients with schizophrenia (n=81) shows; a poor outcome in terms of social functioning and community reintegration that was associated with loss of employment. Insufficient efforts were aimed at social, instrumental rehabilitation stated the authors, and the level of unemployment was alarmingly high. The results shows at the end of the follow-up 47 % were socially isolated, and 94%were unemployed.

3.2.1 How big is the problem?

It is estimated that between 12,000 and 16,000 people in Norway are living with a diagnosis of schizophrenia. Each year, 600-800 people are diagnosed[63].

The study by Helle and Grawe (2007)[11b]shows records on 2000 and 2004 a total of 4684 people had schizophrenia as the primary diagnosis 56% were male, and 44% were women.

Data from Statistics Norway show that 8-900 000 persons of working age are excluded, on the outer edge or are temporarily out of work. For a quarter of these are mental illnesses / problems are a major cause of this. The trend is an increasing proportion of mental disorders / problems among both on sick leave and disability pension[64].

Persons with variable or reduced work registered in the Labour / Labour and Welfare Service generally increased sharply in the period 1998-2005 - from 53,100 to 93,300 Up until 2005, the proportion with mental illness smoothly from 17% to 23% ie. from 9300 to 21000. During 2006, the number of people with variable or reduced work capacity reduced to 89,500, of which a total of 20,500 with mental disorders (about 23%). Out of nearly 59,900 people in variable or reduced ability to work, had a total of 13,800 (23%) psychiatric disorders.[65]

In addition to a high proportion of disability for all people of working age, are characterized in the counties of Agder[66] that the most receiving pensions are youth with disabilities. According to the report (2009) the Agder counties; has relatively most young people with disability pension at the start of 1998 and most young people with disability pension in the years 1998-2001. The youth people in this context are persons under 35 years of age.[66a]

At the beginning of 2008 still Aust-Agder; tops with disabled young people with 3.2 percent, compared with a national average of two percent. It is also Aust-Agder with the highest percentage of new young people with disability pension in 2007, with a growth of 5.3 percent, compared to an average growth nationally of 3.7 percent. By mental disorders were 24 percent of men and 11 percent of women received a disability pension[66b].

3.2.2 What is done in this country

Norwegian government policy is to increase the supply of psychiatric services both by increasing the number of personnel, and by increasing productivity in the psychiatric outpatient clinics. Escalation Plan observes increased accessibility for the last years for Mental Health 1999 – 2008, that add up to a significant strengthening of mental health in municipalities and mental health care (specialist care). Services for people with mental illness are undergoing major changes. Institutional capacity is built sharply while locally based offers in terms of municipal services and community mental health centers (specialized health services) are built up.[66]

In Report No. 8 (1998-1999) about action plan for disabled 1998-2001, the government has set a goal that most disabled people should have the opportunity to participate in the labor market[68]

Several projects as Will (Vilje Viser Vei) established in 2004 to enhance opportunities and increase participation in the labor market for persons with mental disorders.[65a]

Qualification Program; the purpose of the qualification program and associated qualifying benefit is to help more people in the target group is going to work. The offer shall be given to persons who are considered to have an opportunity to get work through closer and more binding assistance and follow-up.

Lasting adapted work, (Varig tilrettelagt arbeid, VTA) NAV and municipality offers individuals who are granted permanent disability and in need of a workplace where tasks are individually adapted.

IA agreement - inclusive workplace;. IA agreement is a means of achieve a more inclusive labor market and preventing the transition from work to social security. The agreement has been signed between the Ministry of Labour and Social Inclusion and the social partners.

One of the objectives of the agreement are to get hired more workers with disabilities than today[69]

The Parliament gives to Mental Health Norway (MHN) the mission to design and anchor a center. This center, National resource center for user and relatives' expertise in mental health has been in operation for the period 2006-2008 under the name of Mental Health Competencies. While Mental Health Competencies include both users and systematization /

research and diffusion of user experiences, largely has focused on measures to users through the so-called Growth and mastering projects and national package resource in user training[70].

Work Proficiency monitoring (JMO)[71] is a joint project between the Directorate of Health Labour and Welfare under the auspices of the National Strategic Plan for Work and Mental Health (2007-2012). The project's overall goal is that more people with severe and prolonged mental illness to come to work, and to establish working models and common knowledge of the significance of work for mental health. The project has been conducted in those counties Telemark, Buskerud, Vest-Agder, Nord Trøndelag, Oppland and Oslo.

In 2009, the Directorate of Health started an initiative against people with severe mental disorders, which have a limited reach of existing health services. Thus establishes ACT team as part of the initiative. ACT stands for Assertive Community Treatment. In Norwegian, this can best be explained as "active outreach treatment"[72]. Moreover, ROP; national expertise service for simultaneously substance abuse and mental illness. Some of the users who have mental health problems will in addition also struggle with substance abuse problems[73].

Individual Placement and Support (IPS) is a standardization of development work with its own manual. This method has strong empirical support to help those with serious mental illness to get a job and keep it. In Norway IPS is known as Labour's labor market, “Working with assistance.” IPS is referred as a "place-and-train" approach that quickly helps users into regular employment and utilizes prolonged work-with-assistance measures to help the individual to cope and keep job[74].

Considering the various measures undertaken by Norway that this paper has not included, makes a summary; Norway has a well-developed social welfare system. The national health insurance ensures all inhabitants free inpatient medical care. The insurance also covers expenses in excess of an annually regulated patient's share for outpatient treatment, as well as medication for patients with long-term disorders including major depression and psychosis. Also finances sickness benefits, as well as rehabilitation, disability, and old-age benefits. The extent of the benefits is based on the person's income and number of working years. Persons without any previous income, such as students and homemakers, have a right to a low minimum benefit after one year of medical disability. Persons without income or with very

low incomes are entitled to social security benefits that cover the basic necessities of food, clothing, and housing[38a]

3.2.3. What is the employment rate and income in people with established schizophrenia?

The studies reported a low employment among people with mental health diagnosis. According to Work and mental health; a follow-up study found that 94% in the group with schizophrenia were unemployed[62a].

As mentioned previously; study on employment and social security among people with schizophrenia shows that 11% of patients with schizophrenic disorders has the wage employment as their main source in 2000 and 5% in 2004.[11b] Is specified; of 4,684 people, of which 335 had employees (7%) who have employment as their main source, the remaining 4144 received various forms of social security or social benefits.

Most had disability pension as their primary source, and there was an increase in the proportion who received sickness or rehabilitation benefit 2000-2004 (from 14 to 19%).

It is worth noting, among those with paid work were significantly more who had studied at the university, college, secondary and vocational education, compared to those with social security. There were significantly more patients who received Social Security, which had only primary and lower secondary level.

Another study performed in 2008 with 13 individuals shown that the most were engaged in part-time employment, and their income is supplemented by social security. Two were employed full-time in salaried jobs. Three were unemployed and over the age of 50 years[39b].

3.2.4 What are the obstacles and barriers to employment?

The lack of prior work experience and long-term in the social security system can be possible barriers in relation to employment for people with mental disorders.

Norway has a well-developed social security and social services, which can also reduce the economic pressure to participate in the labor market.

Changes in the labor market affect employment in the normal population and in people with schizophrenia diagnosis. Although Norway has generally low unemployment rate compared to other countries, there is a certain general percentage of unemployment.

According to the study by Helle et.al.(2007)[11c] at the end of April 2000 was 2.6% of the population unemployed, and in September 2004 the corresponding figure was 3.8%. This may explain some of the reduction in employment among those with schizophrenic disorders.

Employment rate among those with a diagnosis of schizophrenia can also be affected by investment in mental health noted the authors. Labour market measures is central to the 1999-2006 National Action Plan for Mental Health (Proposition no. # 63, 1997-1998), and according to this the labor market administration should be strengthened so that 4,000 new users with mental disorders should be offered work-related measures.
The measurements were made in 2000 and 2004 in this study indicate that the measures are implemented, have not had the desired effect stated the authors.
Moreover the study indicates that education level is an important predictor of employment in people with Schizophrenia diagnosis. People with lower education have fewer skills that make them attractive in the labor market. This may make it harder for them to obtain regular employment. This means that the employment rate can be improved by implementing interventions in this area.
Another possible explanation for the low employment rate may be that healthcare professionals insufficiently encouraging to work, or directly discourages patients with serious mental illness to take regular employment, to reduce the risk of disease worsening.[11e]

3.2.5 Have something worked well?

A study by Borg and Kristiansen (2008)[39c] shows that the majority found that through their own initiative, efforts or informal sources was the most that had helped, the authors stated that often unique experiences which may appear mundane to others but were significant milestones or turning points on the personal road to recovery.

Many factors in the work setting were recognised and appreciated as important aspects in success at work. This included sympathetic and flexible managers, understanding and helpful co-workers and being surrounded by people conveying messages of trust, hope and positive belief and expectations.
This evaluation not only corresponds to those who live the situation, also extends to professional in their attitude to a more positive view; statement from a trained professional *"To be included in the project, for several of our patients strengthened the hope and belief that they are" welcomed back into society after a psychosis" "Working with you has also made me who treat more optimistic… with respect rehabilitation of these - often severely affected and relatively young patients."* [75]

3.2.6 Is there any evidence that being employed may influence other outcomes in schizophrenia?

Many studies have reported an association between employment and other social outcomes, Bentsen et.al., (1998)[76] conducted a study to examine the relationship between socio-demographic characteristics with the criticism and hostility of the relatives of patients with schizophrenia or related psychoses.

Sociodemographically, the patient sample was young (mean age+SD, 28.5 ± 6.5 years), predominantly male (64%), living at home with family members (72%), and had at some time been in paid employment *(55%* previously only, 32% currently). Clinically, 35 patients (75%) fulfilled the DSM-III- R criteria for schizophrenia, six patients had a schizoaffective disorder, two patients had a schizophreniform disorder, and all patients had a psychosis.

The sample was 47 recently hospitalized patients (with schizophrenia or related psychoses) and 72 relatives.

The results shows that the risk of getting a lot criticism was much lower when the patient was "currently employed" than in other circumstances as e.g. more than 3 previous hospital admissions, more troublesome behaviours.

The contrast was much more marked between the groups that were "currently" employed and "only previously employed" rather than between the groups that were "currently" employed and had "never been employed". The most robust predictors of high levels of criticism were, lack of paid employment and lack of employment. However being the relative of a patient with current employment was completely predictive of no hostility.

An interesting result of this study with respect to hostility; the most unexpected finding by the authors was; high levels of criticism were strongly linked to ***better*** cognitive functioning of patients. Anxiety and depression, was also reported; impairment of working ability of patients may contribute to criticism and hostility by causing stress in relatives, especially due to the fact that their expectations are not being fulfilled. Alternatively, both job failure and relatives' criticism may be caused by the patient's social disability.

Furthermore a report on the social functioning of patients with schizophrenia (N=76) in Oslo, suggested that the correlations between outcome areas such as marital status, independent housing, work and social contacts were low, except that at seven year follow up poor social functioning was significantly related to unemployment.[42a]

3.2.7 What does work for this condition; do they have to come to work to have minor symptoms or have more or less medication?

The study by Borg and Kristiansen (2008)[39d] shows that several participants expressed the conviction that being inactive, bored or socially isolated may be as or more harmful than having too hectic and busy lives..

First-person assertion

> ……*"For me it's important to have a few definite positive things going. Unemployment and inactivity are distress-provoking for people like me with severe mental health problems. I need to have some good projects going, that's fine for me. Working with the computer and writing ... that blocks out the voices and gives me some peace."*

Another participant of the same study *"'I have to be challenged, to have a life that can be pushed. Opportunities ... I need to do something creative. .."*.

Is also given to know that although the work activities and workplaces have been described as demanding or stressful, informants choose to give priority to this type of configuration, and prefer to deal with the barriers that appeared.

With regard to the use of medication, an issue of concern, due to the adverse side effects, but at the same time with the feeling of helps of these.

Having a work situation that encouraged and supported getting away from problematic areas of life and 'being and becoming someone' was central for everyone, found out the authors of this study. Borge and Kristiansen argue; they found that they were able to perform well in ordinary work roles despite periodic or ongoing mental distress if their own experiences were positive and if work environments were supportive and flexible.

3.2.8 To what extent is this condition adapted, to work or school?

By having cognitive difficulties naturally has functional consequences; affects the ability to learn new skills, solve problems in everyday life, and function socially at work or at school. More specifically, cognitive difficulties can be expressed as problems with distraction and concentrations, regards work under time pressure and handle multiple tasks simultaneously[77]. Both in terms of work and education, it may be necessary to adapt the tasks, workload and work to the individual's cognitive difficulties. Examples of adaptation may be to encourage to work shorter days, take more breaks, remove distractions, introducing the use of the PC, repeat important messages, give assignments both written and oral, as well as providing frequent feedback.

To increase the ability of the person to be able to return to work or education pointed out Ueland, (2008)[77a] should be established responsible groups with patients, relatives, school / NAV and therapists. NAV can help with advice, guidance and practical arrangements with a view to finding solutions from the employee's and the employer's needs.
When it comes to education, says Education Act § 5-1 that students, who are in treatment for mental health problems, are entitled to special education with individual education plan. This may partly involve training in small groups, to take individual subjects, to spend longer on the exam and to undertake education over several years than is usual. Both in terms of work and education, it may be necessary to adapt the tasks, workload and work to the individual's cognitive difficulties[77b].
In the past 20 years, cognitive training programs have been developed and tested for people with severe mental disorders, including schizophrenia. Norway has tested cognitive training previously in relation to adolescents with psychotic disorders and shown good effect on attention. Recently, has conducted a pilot project with 20 hours of training in 10 patients with first time psychosis, by Section for Psychosis Research, Ullevål University Hospital. The results showed that participants improved on all the trained cognitive functions. In addition, participants were satisfied with the project, and many reported that the program had a positive effect on coping and self-esteem (Ueland, unpublished data, 2007).
According to Ueland, the project will now be held in a larger randomized controlled trial in which training should be integrated with school and work rehabilitation. The aim is to integrate training in a relevant rehabilitation context that may have a positive effect on both the participants' cognitive function and recoveries (that they are able to work, complete exam, etc.).

4. Discussion and Cross-Cultural Comparisons

For the purpose of this paper a comparative method is carried out, there are numerous reasons for doing a comparative research; from a normative point of view, comparisons have served as an instrument to assist development in classifications towards the social phenomena and to determine whether shared phenomena can be explained by the same causes[78]. Consequently, globalization is a major factor, obtains a better understanding of different societies, their structures and institutions. In addition the benefit of a comparison is coming close to the goal of knowledge, that a results or an observed relationship has nearly, worldwide validity. This is consistent with the general scientific goal of more and more comprehensive explanations.

Regarding to the objective, surprisingly few studies have been found to report on this issue, and become even more evident with such specified destination as Chile and Norway.
To begin, there is a growing interest in the field of community care for people with severe mental illness, vocational rehabilitation and employment issues, new initiatives and a growing number of measures and all kind of research contributing with new knowledge in this important field are performed.
As we now know, schizophrenia is a complex disorder of the brain, being considered caused by a chemical imbalance. Research reports that the best basis for recovery involves active participation of the individual and family in ongoing treatment. This includes education, training and skills development not only for coping with schizophrenia but with life in general. The increasing presence of seriously mentally ill persons in the community gave rise to the recognition that some persons with schizophrenia and similar disorders could function, to varying degrees, in society despite their conditions. Then quickly became clear that there were difficulties reintegrating serious mentally ill persons into society.
Initially, this problem was addressed by caregivers focusing on the social aspect, different to the medical aspects of the disease. The primary goal of care became to increase patients' ability to "function" in society, as opposed to the traditional focus on attempting to diminish or eliminate the symptoms of the disorder. Interestingly, the term function began to include the resources, as well as the skills needed, to succeed in an environment.
The term "psychosocial rehabilitation PSR" started to be used to describe this approach, which stressed the "rehabilitation" of those with the disability, as opposed to medical "treatment" of the condition of Schizophrenia. Importantly, the principles of PSR include in emphasis of; "customer choice", "strengths" and "consumer empowerment".

What we know today about the productive activity and employment of persons with severe mental disorders

People diagnosed with schizophrenia. In fact, this is the largest group in quantitative terms, and which is affected by a higher prevalence of problems of employment: around 90% are unemployed in our societies[4b], and most those who obtain, tend to lose, on average, no more than six months. It is also the most with greater complexity when considering effective ways to help its members become and stay active occupationally[4b].

Activity and employment in people with schizophrenia: Interests and Difficulties

Considering the multiple roles assumed by what we call "work"[5a] in the lives of all of us, and especially in people with schizophrenia. Indeed, in summary we can consider its role as:

- Activity productive, which can serve itself as a stimulus of development cognitive, as an organizer of everyday life and, and as a vehicle of social relations[79] all functions that may be of particular importance in the lives of people.
- Activity gainful, which allows the necessary economic autonomy to play an active social role[79a] and,
- Activity socially valued, that increases self-esteem through of social role of worker and social recognition, which implies, in direct relation to the specific type of social valuation of work done (company image, product quality, job level, etc.)

Difficulties, which are reflected in the high levels of unemployment as already has mentioned to, affect these people, based on various factors that depend fundamentally on:

- The condition itself, affecting many different areas of the person (cognitive, perceptual, emotional, relational, etc.) with very different evolutions and often unpredictable [8,9,]
- The impact of the condition; on the personal history of each one, certain basic preconditions for the future laboral activity determining educational deficiencies, lack of social skills and attitudes, values and aspirations usually inadequate.
- The effects of the own treatment, including side effects of medication, inadequate rehabilitation strategies, interference between temporary employment and health care, etc.; and,
- The set of social barriers developed over time that include aspects from; the usual disincentive effect of pensions the whole complex of attitudes articulated by the social stigma that affects the subjects themselves, their families, professionals and other actors such as employers, trade unions, co-workers, etc.

Moreover barriers among which shall include ignorance of the peculiarities of this condition, and that carried beyond good intentions, theoretically determined by programs oriented to promote their access to employment, working again as reinforcing mechanisms of exclusion.

4.1 Cross-Cultural Comparisons - Chile and Norway

To explain similarities and differences this paper takes first qualitative studies.

The attention that qualitative research devotes to context reminds us that human experience takes place in very clearly delineated social spaces, in such a way that events and phenomena cannot be adequately understood if they are separated from those social spaces.[59]

In the review of these studies, given the richness of its essence, this paper may, indeed, conclude that there is a similarity between the two cultures regarding the job experiences of these informants. In these investigations it is expressed joy and satisfaction to be doing an activity with others, often describing their workplaces and provide a sense of being "normal" again. Surveys indicate that most people with severe mental illness want to work, and this is clearly confirmed by the informants. In Chile and Norway some are engaged in part-time employment or workshop. Normaly the income is very low and in addition they receive social security.[8t,39e]

Regarding money, it could appear as a motivation, related to certain autonomy, and improvement of economic situation. But according to the report of the studies is not the monetary value that influences their participation in the labor. (Diaz and Chacon[8s] - teamwork)*"..money is not everything, there are people here that although they did not receive a payment would come just because of the importance the work itself, ...the work has incredible intrinsic value and if you've been unemployed (...) people who have been out of work know how important it is and..*

In addition Borg et.al. [39f] states *"was not necessarily paid work that the informants were concerned with, but any activities needed to be experienced and perceived as useful, both by themselves and by others…. voluntary work, writing about mental health issues for the media or involvement in mental health education".*[39f]

There is a small but significant literature on the barriers to employment, nevertheless documents; problems stigma, discrimination, concerns over benefits, and attitude not geared to supporting people in getting back to work is displayed in both countries. Little has been written about what allows people with schizophrenia to work, although support in the workplace seems to be important, and this may be one of the active ingredients of IPS.

Social recovery in schizophrenia, of which occupational recovery is an important part, may be affected by the macro-economic situation in the countries[80]. The effects of the economic situation in the employment rate in the general population could affect the employment rate in schizophrenia. Regarding this comparison a significant difference between countries; Norway has, a well-developed social welfare system and low unemployment rates. The Human Development Index ranked the country number one in 2012. On the contrary Chile was classified as number 40[81] and the welfare system is accord to the ranking.

Direct comparisons must be treated with caution in that both education and employment or other factors reflect the differing social and political climates of two societies[54a].
Regarding the vocation or education, the studies shows a similarity. It's not possible to analyze, because the vagueness of the individuals.[9u,39g] Another similarity, both countries shows concern and take measures on this issue.

Employment rate

The investigation carried out indicates that the employment rate of people diagnosed with schizophrenia is generally low; this is likely to be related to the severe social disabilities as schizophrenia often involves. Even so all studies emphasize concern about this theme.
Where follow-up data are reported, a substantial fall in employment rate had usually taken place. For example in Norway; (Melle et.al, 2000)[41d] in the seven years of follow-up reports; thirty-four percent had lost their jobs (n = 74). The research from Helle and Grawe (2007)[11d] also reports the employment rate with a fall; eleven persent in 2000 to five in 2004.
On the other hand, Chile Chuaqui (2008)[9v] pointed out, that a study from 2001-2002 from a sample of 150 outpatients with schizophrenia in the metropolitan region, only 13.3% worked in competitive jobs. In addition Diaz and Chacon (2006)[8t] found that 73% (n = 192 272) with deficiencies psychiatric are not in paid employment.
These results showed clearly that the employment rate is lowere in Chile than in Norway, but should be kept in mind; the total population of the countries differ; Chile 17,619,708 people in 2013 and in Norway 5,096,000 people in 2013[81a].

The methods of study vary in differnt ways making direct comparisons difficult. The differences include the method of study, the study scope and the way it discloses integration. However on the level of Community Based Rehabilitation or Community reintegration, both countries have the same strategy about the role of community depends on treatment resources,

individual and family resources, and general community resources.
The availability of housing, employment and the level of development of the social welfare system are different, perhaps reflecting the different social and political climates of two societies.

Insertion or community reintegration and independent living

The most important among these disabilities is that interfere with living independently and working. Programs as Place-train suggest an alternative service paradigm in contrast to train-place[56a]. According to this perspective, relatively rapid placement in vocational and independent-living situations is essential for helping persons achieve their goals; the idea is to teach the person skills for success in their immediate work and living environment.
Probably the two programs or paradigms tend to choose different ways regards to the caution with which people with disabilities are placed in real-world environments. Which is correlated with; the patient should be cautious and not try to work or having independent goals until to be certain that a relapse will not occurs. On the other hand is the realization; is not possible to know with certainty about success until the patient attempts the goal in the real world according to Place-train.

The trend lines show that, the labor insertion is performed by places the person in a "normal" job with therapeutic support, what is called supported employment or insertion via workshops; this is clearly evident in the three years of investigation in Chile by Chuaqui, (2008) [9w]. The information shows that there is a positive relationship subjective, between factors of improvement in personal situation and performance due to participate in the workshops. On the other hand the follow-up performed by Melle et.al.(2000)[41e];community reintegration with housing, employment, income, and social; shows short periods of hospitalization, high levels of education, being married, male gender, and not having a late onset of psychosis predicted a good outcome. A poor outcome in terms of social functioning and community reintegration was associated with loss of employment.
At the community level both studies shows good outcome, but on the unemployment is not possible make a comparison, due only Norway takes this variable.

Independent living

The differences between studies could be appreciated with regard to live independently. Surprisingly this difference is more evident within research in Norway; variables of independent living indicated good outcomes in this area. This was attributed to the Norwegian welfare system that ensures all inhabitants a place to live and a minimum income.

On the contrary in Chile some of them, live with their parents, near relatives or in institution. Considering this issue, it could be argued there may be a difference in cultures; in Norway is common for young people to move out of parents house early. However; in Chile they move out in some cases when they get married, or still living with parents, even when they are married for economy reasons.

Family

Many features of family life have a relation on mental health and mental illness[82a]. It's emphasizes that family factors can protect against, or contribute to, the risk of developing a mental illness. Such as supportive families and good sibling relationships can both protect against the onset of mental illness or significantly reduce the risk of relapse. On the other hand, a family environment marked by severe marital discord, overcrowding, and social disadvantage can contribute to the onset of mental illness[82b]. The family protective factors or risk for mental illness vary across ethnic groups. But research has not yet reached the point of identifying whether the variation across ethnic groups is a result of that group's culture, its social class and relationship to the broader society, or individual features of family members, thus still an enigma unanswered. As once again is confirmed clearly, with the measures made within Chile, between Aymara group and non-Aymara group [45a]; that could not find any difference, between variables, e.g. quality of life.

Citing the most important networks of the persons, the similarities are manifested in their families, for some one spouses and parents and for other healthcare providers. The results of a study from Norway indicate a little significance, toward an increase in support from siblings, children, and friends.

With regard to marital status the highest percentage is found in one study in Norway; 30% of 74 individual[41g] on the contrary in Chile the marital status is low in these individuals more than 80% are single of 135 individuals,[9x] without exceeding; marital status is generally low in both countries.

A remark, the researchs both from Chile and Norway has reported very vague information about the family. Considered by the evidence in which the family is as an important factor.

Finally; the following questions will be discussed:

a) *for the patients in this group who want to work, what are the obstacles?*
b) *is it realistic give work to this group?*
c) *what ought to be done?*

a) The first obstacle may be; when it's time to think about getting work discover that they are out of touch with the needs of employers or they are no qualified to do the job that they once did[66]. So getting back into work can be one of the biggest challenges that a person living with schizophrenia will face during their recovery.
The authors Borg and Kristiansen (2008)[39a] pointed out; the long-standing belief that "conditions" such as schizophrenia is chronic and incurable

… Today it is believed that symptomatic improvement and stability in schizophrenia patients is common, and that achieving symptomatic remission is a prerequisite for a satisfying level of overall functioning.

b) is it realistic give work to this group?

Given the importance of the link between employment status and outcome in schizophrenia, this paper takes into account diverses researches with different views. Those studies have reported that patients suffering from schizophrenia may achieve a favorable and promising course of illness, providing more and more evidence that the traditional understanding of a generally poor outcome may have been overstated. Such results should encourage care providers, relatives, and patients to work on improving not only the patients' psychopathological symptoms, but also their employment status with the knowledge that improvement is possible.
Besides should promote a positive effect of supported employment, and achieve a more responsive attitud toward hiring people with this disease.
The first research on the association between work and outcome in schizophrenia reported Schennach et.al. (2012)[82] a study by Brown et.al. from 1950s; 97% of the patients in a working position succeeded in staying out of the hospital, compared with a group of patients who never worked at all, in which less than half were able to avoid rehospitalization.
In the study by Ucok et al. they examined 295 patients with chronic schizophrenia of these; forty patients participated in full time job or study, 29 patients were involved in part- time work/study, and 13 patients were engaged in work/ study less than 50% of the time, but their job were classified as regular and independent, and two-thirds of the study participants were unemployed.

One research of eighteen randomised controlled trials of reasonable quality demonstrated;[7a] on the primary outcome (number in competitive employment) Supported Employment (SE) was significantly more effective than Pre-vocational Training; for example, at 18 months 34% of people in SE were employed versus 12% in Pre-vocational Training (RR random effects (unemployment). Clients in Supported Employment also earned more and worked more hours per month than those in Pre-vocational Training.

An evaluation in predictors of remission and recovery in schizophrenia patients within a one-year follow-up period, shows that having a job was a significant predictor of recovery on one year after discharge.[83]. Although on basis to this result, and when discussing the role of the patient's employment status, should be kept in mind; e.g. a patient with less illness chronicity is more likely to have a job due to a shorter duration of his or her illness or better response to treatment, as a result a better outcome. The better outcome is also associated with the low level of patient chronicity itself. The link between work and outcome is complex and influenced in many ways.

The renowned study (summarized in 1987 by Harding) The Vermont Longitudinal Research Project followed 269 patients with schizophrenia over an average of 32 years. Of these patients, 118 met retrospectively the DSM III criteria for schizophrenia. Overall, 34% of patients were fully recovered and another 34% had considerable improvement[57]. Additionally, forty-five percent of the sample displayed no psychiatric symptoms at all,[58] Harding (1988) pointed out that, even though professionals who have encouraged patients to take their medication have been well meaning, in this study all of the patients who fully recovered were among the 50% who had stopped taking their medication. This could mean either that the healthier patients feel freer to stop, despite their doctors advice, or that the medication, helpful in the short run, prevents full recovery[59]. There were subjects in the sample who were considered to be functioning well e.g. working, with good family relationships and fnends.

A surprising indisium regarding antipsychotic drugs and outcomes; a 26-year Evidence-Based Approach by Harrow at.el.[84 p.305]. Early young patients (n = 97) with psychotic disorders from the Chicago Follow-up Study; 60 with schizophrenia, were assessed during the acute phase and then followed-up seven times over the next 26 years. The 26-year longitudinal data raise questions about the assumption that all SZ need to be treated with antipsychotic medications throughout their lifetime and suggest the role of non-treatment factors which may influence both psychosis and periods of recovery. Those authors mean that the work disability in SZ may be increased by antipsychotics, which block dopamine receptors and reduce motivational

salience. This suggestion is an opening to a possibility to restore the skills. Besides they stated that those with greater neurocognitive impairment and those with more vulnerability to anxiety are more likely to be treated over a prolonged period with antipsychotic medications and less likely to be experiencing periods of recovery.

In relation to the studies conducted in Chile and Norway*;* Chuaqui (2001) of 150 outpatients with schizophrenia in the metropolitan region, showed at 13.3% worked in competitive jobs and according to the conservative criteria, was determined that 68% of them were trained and mentally stable to work in competitive jobs. This is an opening to the possibility to facilitate access into employment, since was expected at in 2013 with the new paradigm of NESsT Chile, of conduct a social enterprise with a high degree of organization and financial autonomy as mentioned earlier, and since there is no social enterprises for the mentally handicapped Chile when the research was conducted; could facilitate access into employment and thus increase the rate of employment.

In addition the observational study by Chacon, states by professionals involved in pro-labor inclusion of people with schizophrenia pointing out**:**

First-person perspective *translate "...people with schizophrenia can learn more complex jobs because they do not have intellectual problem, but people with mental retardation they can perform more repetitive tasks without requiring further challenges; in people with schizophrenia (..), they get bored, they want other things, that is, (...) has to keep them more active, more aware, people with schizophrenia er able to function therefore they can access training and therefore more qualified jobs, not people with mental retardation that can access up to a certain level of work low-skilled" .*

Finally Norway as mentioned previously; Helle et.al. (2007) shows that of 4,684 people, 335 had employees (7%)[68c] who have employment as their main source. Borg et.al. (2008) reports; two were employed full-time in waged jobs, a few had created their own jobs, such as authoring books or being involved in education or service provision evaluation.

Besides is worth to mention Arnhild Lauveng and her well-known novel *"I morgen var jeg alltid en love"* she overcame the disease, and today she works as psychologist.

Furthermore, the renowned case of John Forbes Nash, Jr. diagnosed with paranoid schizophrenia in 1959, and after a long period overcome the disease and received the Nobel Prize in Economics in 1994.

What ought to be done?

Give central emphasis to the person, as a source of information, to explore employment options, the eventual formation obtained, worksheet, values, interests and aspirations realistic. Stimulating social behavior in relationships according to their interests, the interaction of personal fulfillment, with regard to work and make their own decisions. Also track the factors or barriers that affect the results either to a successful process in employment or truncated. Promote appropriate therapies re-oriented towards reintegration under the principle of personal fulfillment, to making part of these to psychiatric and occupational therapists whom are involved with the person. In addition, to promote technical support between countries for the development of services, research and training.

Regarding to potential employers or educators, arguing their fears and obstacles to the acceptance of the person, see beyond the diagnosis, to see the person who really is and the most important, nobody is immune to mental illness. Regarding salary, pay at least the prevailing wage (not sub-minimum wages).

Despite the widespread misconception that people with schizophrenia have no chance of recovery or improvement, the reality is much more hopeful. It can be treated and managed with medication and supportive therapies. Thus, to change this misconception, should be used the media, indeed, is the most powerful resource to change the attitudes / behaviors as stigmatization. By using publication, presenting reports in a positive way, could abolish the stigmatism, which is one of the causes of the reduced acceptance to the recovery.

This is in line, with the WHO statement,

"*no service, even one offering the most updated treatments, will ever be effective in the absence of major efforts to challenge, through political action and public education, the stigma associated with mental disorders and psychiatric treatment*"[21a].

CONCLUSION

This document, reviewed studies of Chile and Norway making a comparison, found some similarities and differences. Very little research on this subject has been carried out in these countries. This paper notes that it has not found enough answers to the concern**.**

Finally both countries have taken several measures with the perspective to integrate people with mental disorders that involve; rehabilitation process, development and use of personal skills and exercise in social roles. Therefore this paper concludes; both in Chile and in Norway more research is needed to make the society better able to understand and help people with Schizophrenia than is the situation today.

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Table 1.

Type of evidence		
Initial score based on type of evidence	+ 4	RCTs/ SR of RCTs, +/– other types of evidence
	+ 2	Observational evidence (e.g., cohort, case-control)

Outcome employment = Question: What is the employment rate for people with schizophrenia?

Nr studies (N=Participants)	Design	Limitations	Inconsistency	Indirectness	Imprecision	Publication Bias	Quality
2 (470)	Observational	Serious	no serious inconsistency	no serious indirectness	Serious	None	Low ⊕⊕OO
1. Helle and Gråwe 2. Chunqui							

Outcome quality of life = Question: What is the quality of life for people with schizophrenia?

Nr studies (N=Participants)	Design	Limitations	Inconsistency	Indirectness	Imprecision	Publication Bias	Quality
4 (278)	Observational	Serious	no serious inconsistency	no serious indirectness	Serious	None	Low ⊕⊕OO
1. Borge et.al. – 3. Borg and Kristiansen 2. Chunqui – 4. Diaz and Chacón – 5. Caqueo-Urizar							

Outcome social function = Question What is the global social functioning for people with schizophrenia?

Nr studies (N=Participants)	Design	Limitations	Inconsistency	Indirectness	Imprecision	Publication Bias	Quality
2 (181)	Observational	Serious	no serious inconsistency	no serious indirectness	Serious	None	Low ⊕⊕OO
1. Melle et.al. 2. Chunqui							

Helle and Gråwe (2007) Employment rate: Statistically significant decrease paid employment from 2000 11% to 2004 to 5%.

Melle et.al. (2000) Global social functioning as measured by the SAS showed a steady decline from a mean±SD score of 2.1 at the index admission to 1.7 at follow-up (paired t test=2.63, df=73, p=.01). Good global social functioning was defined as an SAS score of 3 or higher. At the index admission 27 patients (37%) had good global functioning; this number declined to 12 (16%) at follow-up (p=.02, Fischer's exact test).

Work and independent income: the number of months employed during the preceding year of follow-up decreased significantly (paired-sample t test=−5.5, df=68, p<.001). However, the number of patients who were living on social security benefits or who were provided for by their family decreased significantly (z=−3.6, p<.001, Wilcoxon signed rank test). The main source of income at both time points was disability benefits.

Chuaqui (2008) Model of Human Occupation Screening resulting in an Alpha coefficient of 0.4384 for the first year and 0.9319 for the second year.

Borge et.al. (1999) Quality of life: the overall satisfaction (binomial probability, p<.001). Subjective well-being was strongly negatively correlated with degree of loneliness (r=−.64, p<.001) and was moderately to strongly positively correlated with the various life domains (r values ranged from .34 to .64, p<.05). The correlation was strongest for leisure time activities (r=.64), neighborhood (r=.62), apartment or room (r=.59), and treatment or help (r=.57). Subjective well-being was only weakly correlated with mean scores on the Brief Psychiatric Rating Scale (BPRS), Rehabilitation Evaluation of Hall and Baker (REHAB) and Global Assessment of Functioning (GAF) (r values ranged from .02 to .13).

Caqueo-Urízar et.al. (2012) Quality of life was measured for Seville Quality of Life Questionnaire (CSCV). CSCV: Ethnic group; favourable factors; mean of 49.6 (SD = 10.80; range, 23--65). Disadvantageous factors; mean of 103.5 (SD = 38.2; range, 45--179)
Non-ethnic patients favourable factors; 47.6 (SD=13.6; range=24--65) disadvantageous a mean of 107.2 (SD = 36.02; range, 54--197)
The total CSCV score classified both patient groups, as being in a moderate level of quality of life.
To analyse the existence of significant differences in the patients' quality of life by their ethnic group, was applied Mann-Whitney *U* test. This should be contrasted whether the values obtained for a variable were similar in different groups. Not difference among the Aymara and the non-Aymara patients, the favourable function (U = 224.5; P = .6) or the disadvantageous factor subscales (U = 236; P = .8).

Chile

Map

This map is an approximation of actual country borders.

Statistics

Total population (2012)	**17,465,000**
Gross national income per capita (PPP international $, 2012)	**21,310**
Life expectancy at birth m/f (years, 2012)	**77/83**
Probability of dying under five (per 1 000 live births, 2012)	**9**
Probability of dying between 15 and 60 years m/f (per 1 000 population, 2012)	**110/56**
Total expenditure on health per capita (Intl $, 2012)	**1,606**
Total expenditure on health as % of GDP (2012)	**7.2**

The first South American country to join the OECD, Chile is one to the fastest growing Latin American economies. But despite making considerable progress in reducing poverty, inequality is still a massive challenge needing to be faced.

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Norway

Map

This map is an approximation of actual country borders.

Statistics

Total population (2012)	**4,994,000**
Gross national income per capita (PPP international $, 2012)	**66,960**
Life expectancy at birth m/f (years, 2012)	**80/84**
Probability of dying under five (per 1 000 live births, 2012)	**3**
Probability of dying between 15 and 60 years m/f (per 1 000 population, 2012)	**73/44**
Total expenditure on health per capita (Intl $, 2012)	**5,970**
Total expenditure on health as % of GDP (2012)	**9.0**

Norway is a strong supporter of multilateral efforts to address global challenges and promote human and economic development around the world.

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