MentalPRAC

Training for practitioners who work with people with severe mental disorder

NATIONAL REPORTS ON GOOD PRACTICES ON TRAINING ON MENTAL HEALTH CARE WORKERS

Spain, United Kingdom, Belgium and Germany

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INTRODUCTION TO THE NATIONAL REPORTS

The main goal of MentalPrac Project is to improve the support for people with severe mental disorders through an increase of skills of mental health care workers. The lack of attention given to intervention with people with severe mental disorders led the partners to develop the present project to support mental health care workers that give direct support to people with severe mental disorders, who usually have a low or medium qualification and they use not to receive specific training for working with this target group.

As part of the results, the present document called "National Reports" describes the essential aspects of the situation of mental health systems and training systems, specially for non-qualified professionals, in each of the participating countries in MentalPrac Project. So it can found an individualized report for Spain, United Kingdom, Belgium and Germany.

The general contents of each national report are described in the contents index shown below:

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SPAIN

1. SITUATION OF THE MENTAL HEALTH SYSTEM IN SPAIN

1.1. INTRODUCTION

When conceptualizing the status of mental health in Spain is important to note that both, the reforms and improvements in the mental health system, have fallen behind other European countries, due to the different characteristics that have taken place in our country.

To understand the situation of mental health we consider necessary to make a brief historical review aimed at contextualizing where we started from and where we are now, so that we have an overview of the progress achieved.

The different ways of approaching mental health have changed over the time. Until the mid-twentieth century, the way in which society used to face severe mental disorders was through the internment of people in asylums, contemptuously called "manicomio". These institutions were created to isolate these people from society, based on the idea of incurability of the disease, the fear of insanity, maintaining social control or optimization of resources. These institutions could house thousands of patients in precarious conditions. The function was not the rehabilitation but the containment, besides causing a further deterioration and becoming a place of no-return.

In the second half of the twentieth century, different social circumstances initiated a change in the conception of supporting these people. Advances in medicine, the movement for human rights and the definition of health by the World Health Organization, were the beginning of the shift in attention to mental health.

This movement is known as the Psychiatric Reform, and was carried out from various disciplines involved in mental health, such as medicine, psychology, sociology and anthropology. Thanks to this new approach, this difficult situation of abandonment, stigmatization and precariousness of people with severe mental disorders of all around the world was reported.

Many countries began to reform their care systems through various initiatives:

- Reviewing and reforming mental health systems, pushing aside the idea of institutionalization of these people.
- Increasing human and material resources.
- Creating new lines and priorities on research.
- Modifying the legislative frameworks.
- Developing family and clients associations, giving special attention to recognizing their role in revising and redefining new services.

One of the central elements of the reform has been an approach and perspective change, leading to a modification of the policy based on the patients' deinstitutionalization, adopting the so-called Community model, which aims to organize assistance and patient care within the community. To carry out this strategy the following principles were established:

- Abandonment of institutionalization policy.
- Move back the long-term institutionalized patients to the community with a proper preparation and training.
- Establishment and maintenance of community support systems for non-institutionalized patients.

In Spain, these principles led to the need to undertake a major reform that began in 1985 with the report for Psychiatric Reform, which was the beginning of a series of legislative, budgetary and social support and health system reforms that has not even ended but keeps developing.

In fact, mental health is one of the main international goals (McKee and Berman, 2000), also included in Spain (Tresserras, Castell, Sanchez and Salleras, 2000; NEA, 2000). This interest is due to many reasons among which are the cost of mental disorders for the national health systems and the relevance achieved among the different diseases, as it is estimated that between 20 and 30% of the population will present some type of mental disorder during their lifetime (Lehtinen, Riikonen and Lahtinen, 2000).

Therefore, it is essential to keep working and researching in this issue, establishing policies to address mental health problems and creating a welfare system to ensure an improved care for people.

1.2. MENTAL HEALTH SERVICES STRUCTURE

In Spain, the competences for social services and health are responsibility of the different regional governments. According to the Mental Health Strategy of the National Health System, 2009-2013, a large part of the regions have developed their own plan for mental health, programmes especially aimed to avoid the abandonment of community assertive treatment and clinical care protocols.

The Health Information Institute, through the publication of the *Mental Health Care Guide; Organization in the Regions* (2011) develops and describes the organization of mental health care in Spain. Below, we schematically highlight the mental health care services that exist in Spain:

2.1.1. HEALTH CARE SERVICES

Health care in mental health in Spain is divided into the network of primary, specialized and emergency care, which in turn are made of the following services:

- **Community Mental Health Units (USMC)**

It is a resource where a basic specialized mental health care is provided. It is seen as a first care level service and from this unit the referral to more specialized services in the field of mental health resources is coordinated. It is an outpatient and domiciliary service.

- **Child and Youth Mental Health Units (USMI-J)**

This service is based on specialized support as the target groups are children and young people. It offers outpatient and short stay inpatient resources.

- **Rehabilitation Mental Health Units (URSM)**

This type of unit has as main purpose the training on social skills and social and employment reinsertion of people with severe mental disorder. This works under ambulatory basis.

- **Day Care Hospitals for Mental Health (MSDS)**

It is a resource in between the Community Mental Health Units (USMC) and Inpatient Mental Health Units (UHSM). The care received by people with mental health problems is continuous and during the day.

- **Inpatient Mental Health Units (UHSM)**

This service offers a specialist health care through a full short stay inpatient regime for people with mental health problems.

- **Therapeutic Communities or Medium Term Mental Health Units (CTSM)**

This service provides intensive treatment to people with mental health problems that require specialized mental health care, on full or partial medium stay hospitalization regime.

1.2.2. SOCIAL SUPPORT

This is the set of services and features addressed to the promotion and full development of all individuals and groups within society to obtain greater social welfare and quality of life in a coexistence environment, and to prevent and eliminate the causes that lead to exclusion and social stigma.

- **Day Care Services**

This can be defined as specific and specialized centres for people with severe mental disorder, with significant deterioration of their functioning in their social environment. This are day care centres that usually consist of:

- Intensive programmes of functional recovery and structured leisure time activities.
- Basic social inclusion and daily life activities that may include basic support activities (such as catering).
- Preventing family problems and institutionalization, as the clients use to have a very fragile community support.

- **Residential Care Services**

Residential care services are intended to support family burdens and to promote the autonomy of these people. Also, this can be an alternative to lack of accommodation resources.

The main goal is the social reintegration (neighborhood, family, social group) and, if this is not possible, it is intended to provide a situation as close as possible to their place of origin with greater personal autonomy.

There are different types of resources depending on the level of supervision and support, but in all of them accommodation is provided. Other objectives are: facilitating access and participation in the environment and improving quality of life. These resources provide basic needs care, such as: housing, food, certain basic care (grooming, self care, medication, everyday organization, etc.) and provides interpersonal relationships aimed at improving the client's autonomy. We can highlight the following types:

- **Long stay residential service**: This includes programmes for people with severe and chronic mental disorders that have great difficulties to adapt to their environment and therefore with little likelihood of inclusion into the community.

- **Supervised and monitored apartments**: These are community residential resources organized into apartments integrated in a normalized environment where they share life with other people with severe mental disorders. A flexible, individualized and ongoing support is offered. The degree of supervision is variable, ranging between 24 hours per day to 15 hours per week. Self-management is promoted and it is addressed to maintain a familiar atmosphere as normal as possible.

- **Rehabilitation and Socio-employment Service**

We can find different resources:

- Social clubs.
- Occupational Centers.
- Special Employment Centres.

1.3. LEGAL REGULATIONS

With respect to legislation on Mental Health in Spain, it should be noted that national laws are general and limited, and that the different regions in the country have the competences on health issues.

At a national level there are two laws that are of great importance in the field of Mental Health.

In 2006 it was approved in Spain the **Law on the Promotion of Personal Autonomy and Care for people in situation of dependency**, for which three degrees of dependency are stated linked to their specific resources offered for each degree. This Law regulates the basic conditions for the promotion of personal autonomy and care for people in situation of dependency by creating a National System for Dependency, with the cooperation and participation of all levels of government (regional and local authorities). It works as a channel of collaboration and participation of the Public Administrations and to optimize public and private resources.

In 2013 the General **Law on rights of people with disabilities and their social inclusion** was published, in which measures to promote equal opportunities are supported. Also, it is aimed at recognizing their rights and encouraging nondiscrimination and universal accessibility.

Below we mention the rest of national regulations related to the field of mental health:

- Spanish Constitution (Article 43, 49 148.1.20 and 21).

- Law 14/1986 of April the 25th, "General Law on Health".

- Law 26/2011, of August the 1st, of adaptation to regulations to the United Nations Convention on the Rights of Persons with Disabilities.

- Royal Decree 727/2007 of June the 8th, on criteria to determine the level of protection of the services and the amount of the economic benefits of the Law 39/2006.

- Agreement of January the 22nd, 2007, for the Territorial Council of the System for Autonomy and Care for dependency, whereby agreements regarding assessment of the situation of dependency are made.

- Royal Decree 615/2007, of May the 11th, on the Social Security of caregivers of people is situation of dependency.

- Royal Decree 504/2007 of April the 20th, approving the scale of assessment of the situation of dependency, according to Law 39/2006.

- Resolution of December the 2nd, 2008, by the Secretariat of State of Social Policy, Families and Care for Dependency and Disability, publishing the Agreement of the Territorial Council of the System for Autonomy and Care for Dependency on determination of the economic capacity of the beneficiary and on the criteria for the contribution of the latter in the economic benefit of the System for Autonomy and Care for Dependency.

- Royal Decree 99/2009, of February the 6th, that modifies the Royal Decree 614/2007, of May the 11th, on minimum level of protection of the System for Autonomy and Care for Dependency guaranteed by the General State Administration.

- Royal Decree 73/2009 of January the 30th, on the economic benefits of the Law 39/2006 of December the 14th on the promotion of personal autonomy and care for people in situation of dependency for 2009.

- Resolution of February the 4th, 2010, by the Secretariat of State of Social Policy and Consumer Affairs, publishing the Agreement of the Territorial Council of the System for Autonomy and Care for Dependency, to improve the quality of the economic benefit in the family environment of the System for Autonomy and Care for Dependency.

- Resolution of August the 3rd, 2011, by the Secretariat of State of Social Policy and Consumer Affairs, publishing the Agreement on determination of the services to promote personal autonomy addressed to people in situation of dependency recognized in Grade I.

- Royal Decree 174/2011 of February the 11th, approving the scale of assessment of the situation of dependency established by Law 39/2006 of December the 14th on the Promotion of Personal Autonomy and Care for people in situation of dependency.

- Royal Decree 175/2011 of February the 11th, amending Royal Decree 727/2007 of June the 8th on criteria to determine the intensities of the protection services and the amount of the economic benefits of Law 39/2006 of December the 14th on the Promotion of Personal Autonomy and Care for people in situation of dependency, and Royal Decree 615/2007, of May the 11th, on the Social Security of caregivers of people is situation of dependency.

- Resolution of July the 13th, 2012, by the Secretariat of State of Social Policy and Gender Equality, publishing the Agreement of the Territorial Council of the System for Autonomy and Care for Dependency to improve the System for Autonomy and Care for Dependency.

- Royal Decree 1051/2013 of December the 27th, regulating the performance of the System for Autonomy and Care for Dependency, established in Law 39/2006 of December the 14th on the Promotion of Personal Autonomy and Care for people in situation of dependency.

- Resolution of July the 31st, 2014, by the Secretariat of State of Social Policy and Gender Equality, publishing the Agreement of the Territorial Council of Social Services and the System for Autonomy and Care for Dependency, on the criteria for determining the service contents to promote personal autonomy for people in situation of dependency recognized in grade II and III, and for the year 2013 of the results of application of Law 39/2006 of December the 14th on the Promotion of Personal Autonomy and Care for people in situation of dependency.

As mentioned above, at present health and social services competences and responsibilities are transferred to the regional governments. There are regulations and standards on health care in these areas in all of them.

There are specific sections related to mental health issues, severe mental disorders and psychosocial rehabilitation in those laws regulating health care. Not so in social services regulations, in which people with mental disorders do not usually have specific sections, but they are integrated into the general population or the group of people with disabilities. Only few regions have regulatory standards or specific mental health programmes.

The WHO (2003) suggests that the most appropriate approach to deal with the complexity of people with mental disorders' needs could be having a specific mental

health legislation that would complement a more general legislation. Furthermore, it is contemplated that this legislation should be understood as a process rather than a single event, so that adaptation to scientific advances in the treatment of the mental disorders and the development of a services network would be allowed.

In fact the WHO establishes some basic principles that should be taken into account when setting legislation in mental health (WHO, 1996):

- Integration into the community of people with mental disorders.
- Rehabilitation and monitoring.
- The provision of quality care.
- Access to basic mental health services and the least restrictive care.
- Accessibility to the review of procedures.
- The protection of civil rights.
- Self-determination.
- The protection and promotion of rights in other key areas such as housing, education and employment.
- The prevention of mental disorders and promotion of mental health in different sectors of society.

2. SITUATION OF MENTAL HEALTH TRAINING IN SPAIN

Among the priorities of the Strategy of Mental Health of the National Health System is: *To prioritize the quality of **training and qualification of human resources** of the service of care for mental health, in the case of health professionals – of primary care and mental health nursing - and other related practitioners: social workers, community leaders, public safety and civil protection staff, teachers, etc*.

In this sense, since the adoption of the Strategy in 2006 until its latest update for the period 2009-2013, there have been numerous efforts to improve the quality of training received by professionals, both qualified and non-qualified, working with people with mental disorders.

Thus, in 2013 a document on "Dissemination of the Strategy and professionals training" was approved. It emphasizes that in addition to training professionals of the specific area of mental health, it is necessary to train primary care, hospital care and social support services professionals.

The Strategy values positively the basic functioning of different specializations that make up the mental health system, and the following is highlighted:

- The need to carry out quality audits for the evaluation and improvement of training processes.
- The different regions should develop a continuous training plan for professionals in the field of mental health, primary health care and other professionals related to caring people with mental disorders, always from a bio-psycho-social approach.

The professional categories (both qualified and non-qualified) of the staff that is part of the multidisciplinary work teams of the care services for mental health, are summarized in the following table:

QUALIFIED PROFESSIONALS	**University**	Psychiatry
		Nurse in Mental Health
		Clinic Psychology
		Occupational Therapy.
		Social Work.
	Vocational Training	Technician care for dependent people.
		Technician in auxiliary nursing care.
		Senior technician in social integration.
NON QUALIFIED PROFESSIONALS	**Professional certificate**	Promotional and educational intervention in people with disabilities.
		Job placement of persons with disabilities.
		Social care to people in residence.
		Social care for dependent people in social institutions.

2.1. QUALIFIED PROFESSIONALS

2.2.1. UNIVERSITY DEGREE

Within the qualified professionals we have to mention those who have a University degree. The ones involved in the field of mental health are:

- **Psychiatry**

As in other medical specialties, to become a psychiatrist it is necessary to study a 6 years degree in medicine, an after to study the specialty, called MIR (Resident Medical Intern) organized by the Government of Spain. The specialty in Psychiatry lasts for four years, after which they can work as a psychiatrist in both the private and in the public health system. The number of vacancies for 2014 is 222 at a national level.

- **Mental Health Nurse**

As in the degree of Medicine, first it is necessary to study the degree in nursing that lasts for four years. After finalizing, there is a national examination (EIR) also organized by the Government of Spain, where you can choose to make the specialty of Mental Health Nursing. This specialty lasts for two years, after which they can work both in the public and private sectors. The number of vacancies in 2014 was 182 at a national level.

- **Clinical Psychology**

The field of Clinical Psychology is also very similar to the previous two. First it is necessary to study the degree in psychology which has a duration of 4 years. Subsequently, to work as clinical psychology, there are two options:

  - To pass a national exam organized by the Government of Spain (PIR), through which you can access to the specialty of Clinical Psychology. This specialty lasts four years, and in the end it can pursue public and private sectors. The number of vacancies for 2014 was 127 at a national level.

  - To study an official General Master in Health Psychology, that lasts for two years and it could be used only to work in the private sector.

- **Occupational Therapy and Social Work**

Both are studies through degrees of four years of duration, in which the field of mental health is reviewed. Although they do not have a very specific specialty, this can be performed later through a master, in which the necessary knowledge and skills in the field of mental health can be developed.

2.2.2. PROFESSIONAL TRAINING

In Spain we have what is known as regulated vocational training. This is composed by structured training programmes with different degrees of difficulty. The main goal is to make the student achieve specific professional and labor skills that facilitates the access to the labor market.

However, within this regulated vocational training there is no specific qualification addressed to qualify professionals who will work with people with severe mental disorders. Nevertheless there are training programmes orientated to working with people in situation of dependency in general. Below we describe those training programmes that include contents related to our target group:

Specifically, there are 2 **medium grade training courses** related to mental health care. To access it is necessary to be graduated in secondary school or higher academic level, a title of Technician or Technical Assistant or equivalent for academic purposes, or having passed the second year of the former Bachelor. The 2 courses are:

- **Care of People in Situation of Dependency Technician**

This certification lasts 2000 hours, and addresses the basic care for people with serious mental illness.

- **Care Assistance Technician**

This certification lasts 1400 hours, and covers the characteristics of nursing assistants with references to people with serious mental illness functions.

On the other hand, there is a **high grade training course** related to support to mental health. The access requires the Bachelor diploma or having passed the second course of Experimental Bachelor, a title Senior Technician, Technical Specialist or equivalent fopr academic purposes, or a university degree or equivalent. This course is:

- **Social Inclusion High Technician**

This certification lasts 2000 hours, and covers the social integration of people with psychosocial difficulties.

2.2. NON QUALIFIED PROFESSIONALS

Within the non academic field, there are so-called Professional Certificates, which certifies, from an official point of view, the skills that someone has acquired, enabling to develop a related activity.

This are issued by the Public State Employment Service and can be obtained in two ways:

- Overcoming the modules that make up the certificate of professionalism.
- Accrediting skills acquired through work experience or non-formal training.

Similar to the case of the regulated vocational training, there is no specific professional certificate aimed at qualifying professionals who work with severe mental disabilities, but the certificates are aimed at people in situation of dependency in general. Still, we describe below those contemplating levels applicable to the population at hand:

- **Promotion and socio-educational intervention with people with disabilities**

This training lasts 450 hours, and the general competence consists of organizing, developing and evaluating interventions for promotion and socio-educational intervention aimed at people with disabilities, in collaboration with the interdisciplinary team, using or creating, if any, resources to achieve the highest degree of personal autonomy and inclusion through accompanying measures, both educational and social, leisure time processes, training in cognitive strategies and the use of new technologies and intervention and their families.

- **Employment inclusion of people with disabilities**

It comprises a total of 470 hours. This certification skills to intervene in the personal, social and labor environment using the methodology of supported employment for easy access and maintenance of the workplace for people with disabilities, making the necessary training of social and labor skills required for inclusion, keeping contact with

the environment and contributing to the analysis of jobs and making the existing information management training, social and labor resources in accordance with the established guidelines.

- **Socio-health domiciliary care**

This certificate lasts 600 hours, and general competence consists of assisting in the socio-health field at home for people with special physical, mental and social health needs, applying the most appropriate strategies and procedures to maintain and improve their personal autonomy and their relationships with the environment.

- **Socio-health inpatient care for people in situation of dependency**

Lasts 450 hours, and the general competence to acquire is to serve people in situation of dependency in the geriatric field at the institution where its activities are developed, implementing strategies designed by the competent interdisciplinary team and procedures for maintaining and enhancing personal autonomy and their relationships with the environment.

3. PRACTICES ON TRAINING FOR NON-QUALIFIED PROFESSIONALS

PRACTICE 1	
TITTLE	**TRAINING IN MENTAL HEALTH AND GERONTOLOGY**
DURATION	40 HOURS
BENEFICIARIES	This training has been focused on non qualified direct care professionals working in residential homes and day care centres for people in situation of dependency of Fundación Diagrama.
OBJECTIVES	**General goal:** - Acquiring the knowledge and strategies to improve their professional practice in the field of mental health needed with elderly people. **Specific objectives:** - Updating knowledge that participants may have in the field of mental health and gerontology. - Identifying those symptoms that may be indicative of a behavioral or emotional disorder. - Encouraging the development of professional and personal skills.
CONTENTS	It consisted of 2 areas of contents: **Part 1:** Topic 1: Introduction to Mental Health. Topic 2: Work Methodology. Evaluation. Topic 3: Work methodology. Intervention and treatment. **Part 2:** Topic 1 Introduction. Mental Health and Gerontology. Topic 2: Dementias. Topic 3: Depression in elderly people. Topic 4: Disorders associated with old age. Topic 5: Cognitive stimulation.

METHODOLOGY	**Classroom-Based Training** **Methodological principles:** - Participatory approach. - Direct attention. - Quality of training materials. - The importance of student motivation. **Dynamics of the training:** - Initial presentation of the course, the teacher and the objectives and results to get to the end of the training. - Theoretical and practical exposure of the relevant content. - Work experience. - Developing solutions to practical proposals. - Practical summary of the session.
RESOURCES	**Humans:** - Psychologist specialist in gerontology. **Materials:** - Equipped training room. - Training Manuals. - Consumables.
EVALUATION	The evaluation was carried out by: - Pre-test and post-test for each pupil. - Two case studies. To consider that the course was passed, participants had to have 60% correct answers in each test. It was also necessary that at least successfully solved one of the case studies. The results were highly satisfactory because 95% of people involved in this training successfully passed the assessment tests of acquired knowledge.

PRACTICE 2	
TITTLE	**INTERVENTION WITH CHILDREN WITH BEHAVIORAL DISORDERS**
DURATION	80 HOURS
BENEFICIARIES	This training was addressed to professionals working with children and/or young people in the centers for the execution of judicial measures of Fundación Diagrama.
OBJETIVES	**General goal:** - Acquiring the knowledge and strategies needed to improve their practice and ensure the welfare of children in care. **Specific objectives:** - Promoting an active role with the minors, regarding the prevention of mental disorders. - Teaching professionals how to work with children to control potentially conflicting situations, enhancing their self-control and strengthening their self-esteem. - Teaching professionals strategies for minors to properly identify emotions.
CONTENTS	It consisted of 2 areas of knowledge: **Part 1:** Topic 1: Concept of Mental Health. Topic 2: Models of mental health intervention. Topic 3: Diagnosis of mental disorders. **Part 2:** Topic 1: Stages of human development in childhood and adolescence. Topic 2: Features of collective care. Topic 3: Work methodology.
METHODOLOGY	**Online.**

	Methodological principles: - Individual attention. - Flexible hours. - Availability of training materials. - Cooperative learning through discussion forums. **Dynamics of the training:** - Initial presentation of the course, teachers - tutors, and the objectives and results to get to the end of the training. - Theoretical and practical exposure of the relevant content via virtual campus. - Making cooperative practices. - Developing solutions to practical proposals. - Individual tutoring for settling any doubts.
RESOURCES	**Humans:** - Child and adolescent psychologist. **Materials:** - Virtual Training Campus of Fundación Diagrama.
EVALUATION	The evaluation was carried out by: - Pre-test and post-test for each subject. - Assessment of practical cases. - Participation forums. To consider that the course was passed, participants had to have 60% correct answers in each test. It was also necessary that at least successfully solved one of the case studies and actively participate in the discussion forums. The results were highly satisfactory and that 100% of people involved in this training successfully passed the assessment tests of acquired knowledge.

4. CONCLUSIONS

After reviewing the current situation of the National Mental Health System and the existing training for professionals working with people with severe mental disorders, we can establish the following conclusions:

- It is necessary to develop specific rules to govern the necessary skills of professionals working with people with mental disorders, both qualified and non qualified. In this sense, there is no training or training activities for non qualified staff addressed to directly work with the group of people with severe mental disorders, but the contents are diluted in degrees focused on people in situation of dependency in general. The development of specific training in the field of mental health would increase quality of care given to these patients by direct care professionals.

- Plans for continuing education for mental health professionals need to match their training needs and be defined based on different profiles that make up mental health and social support services. Specifically, following the document "Dissemination of the Strategy and professionals training" (2013), the development of continuing education plans should be guided by the following principles:

    - Focusing on problems detected by professionals, and considering the morbidity.
    - Prioritizing actions of participatory learning.
    - Taking into account the balance between work and family life.

- The efforts to achieve efficient and effective coordination between the various education provider's agents (universities, autonomous regions, Vocational Training Centres, Unions, etc.) must be increased to ensure that the training given to professionals matches the development of some specific competences in each case, especially in the field of non-formal training for non qualified practitioners.

- According to the National Mental Health Strategy, recognition at the institutional level is necessary as well as the future implementation of training for the multidisciplinary teams.

Currently, the training activities are usually aimed at professionals in specific disciplines. However, the multifactorial nature of the disease requires the coordinated specialists from different working fields, so training activities aimed at the entire multidisciplinary

team would favor an increase in the quality of the actions carried out with the target group.

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UNITED KINGDOM

1. SITUATION OF THE MENTAL HEALTH SYSTEM IN THE UK

1.1. INTRODUCTION

Mental Health (MH) and mental illness are two terms that are related but not interchangeable. It is important that in the discussion of how mental health is envisioned within the United Kingdom (UK), that mental health is clearly defined. The term mental health is often used as a negative euphemism for mental illness, disorders and MH problems (Mental Health Foundation 2013). However, the concept of mental health expands beyond the ability to cope with general stress and depression but encompasses positive states such as happiness, goal fulfilment and enjoyment of life (Mental Health Foundation 2007). Therefore it is evident that mental health is an idiosyncratic concept which helps us to understand that everyone's mental health develops in different ways. One individual's happiness is not identical to another individual and neither is the way they experience sadness. Similarly an individual's mental health is more than the presence or an absence of mental disorder. Therefore mental health is relevant to everyone and not just specifically for those who suffer from mental illness (Hunter Institute for Mental Health 2010).

Mental illness is actually the largest cause of disability within the UK at 22.8%, in comparison to 16.2 % for cardiovascular disease and 15.9% for cancer (WHO 2008). Furthermore, a statistic commonly reported throughout numerous documents on MH within the UK, is that each year 1 in 4 people will suffer from some kind of MH problem (McManus et al 2009); so, even if prevalence rates remain stagnant, then it is estimated that by 2030, 8 million adults will have MH issues (Lawton-Smith, McCulloch 2012) . MH is also a common issue in children and young people, as 10% of children aged 5-16 have a common mental disorder, with one million more children and young people estimated to have mental health problems by 2030(Lawton-Smith, McCulloch 2012) .

Thus it is important that mental health cannot be seen as a distinct entity separate from public health, as these MH issues often have a consequential impact on people's physical health. 70 million sick days per year are said to be because of mental illness and is the

leading cause of sickness absence in the UK (Centre for Mental Health 2007). Reviewing these statistics, it is understandable that the primary focus of MH services in the UK has been to treat mental illnesses rather than focussing on improving mental health. So, with this context and understanding we can review how the mental health services have changed and transformed in the UK.

MH services have gone through a continual transformation throughout many decades, even centuries, arguably more than any other part of the health system. In its early days mental health care was provided by large institutions (hospitals that were often referred to as "asylums") over the years, they have been replaced by a preference to provide care in community settings, this care being provided by multidisciplinary MH teams. These teams are able to support the majority of individuals with mental health issues within their homes but can also ensure that those who need it are cared for in specialist hospital units for short-term acute care and smaller residential units for long-term care.

So there still remains an element of keeping some individuals in institutions, although the focus in these units and wards are on crisis management and recovery. But there has been a programme of deinstitutionalisation, described "as the process of moving patients from large scale psychiatric institutions towards the community…Its main goal is to empower and emancipate people with psychiatric and social problems, enabling them to be fully participating members of society" (Bauduin et al 2002), since the inception of the UK's National Health Service in 1948. Between 1930 and 1960 outpatient clinic attendances increased from virtually zero to 144,000 (Lester and Glasby 2010). Some inroads into the numbers of hospital and secure accommodation residents in the 1960s and 1970s (reducing the numbers by 50,000) (Barham 1997), but the major programme didn't start until the 1980s with Margaret Thatcher's inspired "Care in the Community" programme. This saw the number of MH beds fall to 36,000 in 1988 (from a peak of 154,000) (Warner 2005) and the number has continued to fall to just over 27,000 in 2014 (Various). This programme has led to significant changes to the way services are structured and run.

1.2. MENTAL HEALTH SERVICES STRUCTURE

Within the UK, Mental Health services are defined as services commissioned by the National Health Service (NHS) and local authority commissioners; services that are provided, not only by NHS services but by local authorities, voluntary sector organisations and increasingly by private medical companies (Mental Health Foundation 2013). If not operated directly by the NHS, these will be commissioned service awarded through a contract and tender process. Any person diagnosed as having a mental disorder would be

assessed and treated by one of these services or service providers. In 1948 when the NHS was originally launched, mental health services were structured within the three parts of the NHS- hospitals, general practice and local health authorities (NHS England 2015). This has evolved over the years into a system where, currently, there are 51 specialist NHS Mental health trusts within the UK; each operating as an independent legal entity, not run for profit, within the framework of the NHS. Each country, within the UK, has its own NHS framework.

Another recent change, in 2012, has affected the way the MH services are funded. Responsibility for managing budgets has been devolved to 211 clinical commissioning groups (CCG), which have taken over from traditional NHS primary care trusts (BMA 2013). CCGs are geographical grouping of General Practitioner (GP) surgeries which have been given budgetary control over services. They plan and commission hospital care and community and mental health services each serving a median population size of around 250,000 people (range 61,000 to 860,000) within the UK. This change has meant that mental health services are structured into a range of primary and community based services. These services mirror the transition from acute hospital care to care in the community which aim to deliver crisis resolution, assertive outreach support in the home and early intervention in psychosis for young people (Joint Commissioning Panel for Mental Health 2011). Specifically mental health services are structured according to GP's, community-based services, early intervention in psychosis teams, services for people who are in crisis, day hospitals and crisis houses, assertive outreach teams, forensic mental health services, perinatal and liaison psychiatric services, recovery Colleges, IAPT services (Improving Access to Psychological Therapies) and Child and Adolescent Mental Health Services (CAMHS) (Mental Health Foundation 2013). Most of which are community based and can change, significantly, depending on which part of the country you reside in.

Some individuals have critiqued the structure of mental health services in the UK for failing to account for other existing and potential areas of patient needs. Consequently the care and treatment that people receive for their mental health problems can be variable (Mental Health Care 2014). Although mental health services have been structured to account for specific needs, many people have trouble accessing services, even though the first point of contact for referral to these services is a GP. Referral into these services means joining a waiting list, unless there is concern that the individual is an immediate danger to themselves or others. The waiting times, just for assessment, can be a matter of months. This can mean that many people with mental illnesses do not receive any help at all, with some often not seeking any help.

1.3. LEGAL REGULATIONS

The primary piece of legislation governing MH services in the UK is the Mental Health Act (MHA) 1983. The MHA was amended significantly in 2007, amendments which introduced an increase in supervised community treatment and changes to existing professional roles (Hall and Ali 2009). The definition of mental disorder in the MHA 2007 was also significantly changed from being defined as a 'psychopathic disorder' in the 1983 Act, to 'any disorder or disability of the mind' (Hall and Ali 2009). This change widened the framework for the inclusion of disorders such as autism, personality disorders and behavioural disorders, which were previously unaccounted for and often considered untreatable. However people with learning disabilities are excluded from statutory treatment, unless their disorder is associated with either seriously irresponsible or abnormally aggressive behaviour.

The MHA ensures that people living in England and Wales who are diagnosed as having a 'mental disorder', can be admitted, detained and treated in hospital by appointed authorities, without their consent. Scotland and Northern Ireland have their own laws about compulsory treatment for people with mental disorders. The MHA allows for patients to be detained in the NHS or independent hospitals for specified periods or indefinitely. Someone can be detained under the MHA by doctors or other approved mental health professionals. Additionally, the Crown Court or in restricted circumstances, a Magistrates' Court can also order detention in hospital.

The MHA has different sections which affects how people can be admitted, detained and treated depending on their circumstances. This provides context around the use of the term 'sectioned' in reference to compulsory admission to hospital for the mentally ill. Specifically, section 2 is used to admit someone for assessment, section 3 is employed to treat someone, and Section 4 is enforced in an emergency. Someone sectioned is referred to as an 'involuntary patient', who is admitted into hospital for the benefit of their own health and safety and for the protection of other people. The 'Deprivation of liberty safeguards' procedure ensures that vulnerable people are protected. This makes sure that any decision to deprive someone of their liberty is a thorough legal process.

Recently, it has been reported that during 1 April 2013 and 31 March 2014, the Act was used 53,176 times in England. By 31 March 2014, 18,166 people in England were detained in hospital for longer than 72 hours (Mental Health Foundation 2013). The figure is not representative of the number of people sectioned under the Act because some people can be detained more than once within a year. However it is representative of a five percent increase in comparison to the previous period of 2012 to 2013.

Furthermore, for someone over the age of 16 who 'lacks capacity' to make decisions for themselves, someone else can legally make decisions on their behalf due to the Mental Capacity Act 2005. The Mental Capacity Act suggests that if a person is unable to retain or understand information and communicate decisions, they are classified as 'lacking capacity. People may be classified as lacking capacity because they have impairments such as a brain injury, learning disability or dementia.

Treatment and care under legislation in the UK is directed at the best interests of the patients to ensure this is the best course of action for them (Mental Health Foundation 2013). This ethos is represented by The National Health Service and Community Care Act 1990, which gave local authorities the responsibility to assess people's needs and to plan and provide care in their homes (Bowl 1996), where possible. This was a significant transition from institutional care to home care, day services and respite care (Nicholls 2006). The act had implications for the structure and nature of the services available, and led to changes in training and roles. Due to the act requiring local authorities to carry out assessment of those in need of community care and subsequently create care packages (Ref) , it led to the creation of NHS trusts (referred to earlier) and an internal market for services; with different areas commissioning different services, the level of support available can differ widely.

However there are challenges to legislation regarding mental health within the UK. In March 2014, a House of Lords Select Committee published a report documenting the effectiveness of the Mental Capacity Act. A majority of health and social care professionals were reported to not using the Act to its full potential within their everyday work. Also the deprivation of liberty safeguards were criticised for poorly understanding the needs of vulnerable people detained in care homes or hospitals.

In response to criticisms, the governments across the UK outlined their mental health strategies. The current government responded to the criticisms by publishing the document 'Valuing every voice, respecting every right: making the case for the Mental Capacity Act 2005'. The document outlined goals to construct a new Mental Capacity Advisory Board to raise awareness of the legislation of mental health among professionals and families (Mental Health Foundation 2013). The Scottish, Welsh and Northern Irish governments have mirrored this.

2. SITUATION OF MENTAL HEALTH TRAINING IN THE UK

2.1. QUALIFIED PROFESSIONALS

In the previous section, we detailed changes to MH services in the UK over the last 35 years. But, despite the advent of community based services, over this period, which introduced mental health day centres and therapeutic communities, some issues still remain unaddressed. Although care settings began to diversify, the structure of community based services was still based on the hospital model (psychiatrists, psychiatric nurses, clinical psychologist, approved social workers and occupational therapists).

This meant that many new services, available for treating people with severe and long term mental health issues, were staffed by professionals who were only trained in the old institutions (Ford et al 1997); and, often, any prospect of new training was met with rigid inflexibility. This resulted in limitations on the effectiveness of available, qualified professional treatment.

In attempt to resolve this issue significant reports were published and approaches were devised to improve the coordination between hospital and community care (Bailey, Liyanage 2012). Several needs were highlighted: a call for multidisciplinary working to cater effectively to the holistic needs of service users, greater emphasis on multi-professional training at post-qualifying level and the need improve skill deficits in mental health professionals treating acute patients (Mental Health Foundation 2013). This influenced the National Institute for Mental Health in England (NIHME) to commission The Centre for Mental Health, an independent charity and research body, to develop a single framework of core professional competencies, which all mental health staff, irrespective of professional background, should possess. This framework, the Ten Essential Shared Capabilities (NIMHE 2004), was implemented as part of the National Service Framework (NSF) for Mental Health, a strategic blueprint for MH services across the country.

The Ten Essential Shared Capabilities are as follows:

- Working in Partnership
- Respecting Diversity
- Practising Ethically
- Challenging Inequality
- Promoting Recovery
- Identifying People's Needs and Strengths

- Providing Service User Centred Care
- Making a Difference
- Promoting Safety and Positive Risk Taking
- Personal Development and Learning

To assist in the implementation of these core values a systematic evaluation of training for primary and specialist MH workers was carried out by the Department of Health (Expert Briefing, DoH 2003) and mental health training across the country re-focussed to:

- Skills-based training designed to improve mental health outcomes for service users
- Teaching mental health practitioners to use evidence based interventions that are proven to be effective
- Multi-interdisciplinary training to involve service users and their care givers as active partners in the recovery process

All university courses for the primary roles within mental health services are now structured to have these elements at their centre. Training for specific roles consists of:

Psychiatrist: Training consists of a 5 year medical degree, is followed by 2 years of foundation training as a medical doctor and then 6 years of additional training in the treatment of mental illness. This training, overseen by the Royal College of Psychiatrists, is a combination of examinations, work based assessments and personal development focussed on the science and discipline on understanding and treating mental illness. Diagnosis of mental illnesses and disorders, in the UK, are guided by the International Classification of Diseases 10th Edition (ICD10). This is due to be updated in 2015.

Clinical Psychologist: A psychology degree is then followed by up to 4 years training (accredited by the Royal Psychological Society) which focuses on interventions designed to prevent dysfunctional behaviour and mental distress associated with mental ill-health. Anyone selected for this advanced training is likely to require a first class degree and some work or voluntary experience in a related setting. The selection process is very competitive.

Mental Health Nurse: A 3 year degree course prior to registration as a nurse. The first year is common to all nursing degrees (including Adult, Paediatric and Learning Disability) and is followed by two years of a combination of examination and placement training. This ensures that MH nurses are trained to do most of the support and patient facing work including monitoring symptoms and administering medication.

Approved Mental Health Professional: This used to be a role reserved for Social Workers but has, since 2007, been opened up to other professional disciplines. A 3 year degree course (Social Work, Nursing, Psychology, Occupational Therapy) followed by a 6 month full-time diploma to become an Approved Mental Health Professional . The role has statutory duties under the Mental Health Act 1983, with regard to assessment of people for compulsory admission to hospital.

Occupational Therapists: A 3 year degree course which includes at least on mental health based placement. They have specialist expertise in promoting meaningful occupation as a path to recovery for those undergoing treatment.

A more recent introduction into the workforce has been the **Graduate Primary Care Mental Health Worker**; the role of a graduate mental health worker is to provide increased capacity in the primary care setting to improve the management of common mental health problems. They are, increasingly appearing in GP surgeries, where research shows that 1 in every 4 consultations are with people presenting with mental ill-health. Normally, they would be psychology graduates who have taken a post-graduate diploma particular to the role.

GPs, themselves, have a key role in this new interdisciplinary approach to mental health. In addition to the medical degree and 2 foundation years, their training comprises of 21 different modules taken over 3 or 4 years; but only one of those modules focuses specifically on mental health. The training takes place in a range of settings, some of which are mental health services; around 35% of GPs complete a psychiatry training post (Mental Health Foundation 2013). Although that is significant, it highlights that around two thirds GPs have no direct training experience of working with people with mental health needs, whether complex or otherwise.

So, although there has been a shift, and even some innovative changes, there is still room for improvement. There still remains an issue of qualified mental health professionals collaborating effectively in teams (Bailey, Liyanage 2012). This has led to a lack of post qualifying multidisciplinary training, which negatively affects service users who have been shown to benefit more from teams working together (Carpenter, Barnes and Dickinson 2006). Also due to recent economic cuts and the disbanding of the NIHME, the future implementation of mental health training and educational initiatives has been cast into doubt (Mental Health Foundation 2013). This is because there is no longer any over-arching body ensuring future change and development. In order for training for qualified professionals to progress, so that positive changes for service users and their care givers can occur, these issues will need to be addressed.

To ensure that the required numbers of staff are available to work in the National Health Service, bursaries are available for some of the roles required to operate mental health services. This means that to study to become a Mental Health nurse, an Occupational Therapist or a Social Worker you can have all of your tuition fees paid (£9000 per year) and receive an additional £1000 per year to assist with living costs. There is additional, means tested, funding available for individuals from poorer backgrounds.

Training for these professions is widely available. There are 49 universities offering 75 mental health nursing degree courses in England alone; there are also 32 universities offering 46 Occupational Therapy courses and in psychology there are 147 universities offering 1266 courses.

2.2. NON QUALIFIED PROFESSIONALS

Below the degree and post-degree level qualification of the staff covered in the previous section, the training that is available to staff working with complex mental health issues, and the standard of the training, varies considerably according to where and for whom staff members are working. With the move towards care in the community and our current governments push to bring more private companies into health and social care (particularly in the NHS), it is difficult to get a clear, overall picture. But because of our system it is convenient to look at the training in 2 sections; within the NHS and outside it.

NHS Training for Health Care Assistants and others: Healthcare assistants (HCAs) work in hospital or community settings under the guidance of a qualified professional. The role can be varied depending upon the healthcare setting. Most commonly, HCAs work alongside nurses and are sometimes referred to as nursing auxiliaries.

You can be employed as a HCA without any formal qualifications (based perhaps on work or voluntary experience in a care home or similar environment) but to take a more responsible post employers will be looking for applicants to already have a Qualifications and Credit Framework (QCF) qualification at Level 2 or 3, while others will support HCAs to gain these qualifications once they're employed. (The QCF is a national credit transfer system for educational achievement. For instance a GCSE equates to L2 and an undergraduate degree to Level 6).

Where there is support available for further qualification there are a number of options; it could involve taking a generic Health and Social care course at a local college or they could work towards an appropriate foundation degree linked to the work place. The Open

University (OU) (the largest part time and distance learning university in the UK) has a foundation degree programme in Healthcare Practice for healthcare support workers who are already working, which contains a module on "Mental Health and the Community". The OU do offer a MH Nursing course but you have to have the sponsorship of your employer to enrol, because of the necessity of placement based learning.

So there is training available but through these routes, most of it would only be specific to Mental Health if there was a course available locally. Health Care Assistants that work in NHS MH services are given training but of a more role specific kind. For instance, if they are to work on a secure ward, they would receive a number of mandatory trainings on de-escalation skills, restraint and psycho social interventions. But the training that is available can vary because of the way that the NHS is managed. Individual Trusts are responsible for the operation of services in different geographical areas of the country; they have varying local priorities and budgets which can affect levels of service and training.

In recent years new roles have emerged as part of the move towards community and recovery based services; Carers' Support Workers and Support-Time and Recovery Workers. These roles have a single, nationally agreed induction programme. They have ongoing training and supervision arrangements and work toward a QCF equivalent, Level 2 or 3 qualifications.

Other Service Providers: Outside of the NHS there are a large variety of organisations that provide support and services for people with complex mental health needs. There are voluntary organisations and charities, service user forums, social enterprises and increasingly, particularly over the last 5 years, large private health care companies. Some of these organisations provide support services on a voluntary (free) basis, but the biggest increase has been in non-statutory organisations operating low and medium secure mental health wards, community and residential mental health services and even child and adolescent mental health services. Often these are contracted out by the NHS and they will have agreements in place which guarantee a minimum level of service but it is difficult to find information about the amount of training that they offer their non-qualified professional staff.

There are many one day and two day courses available from private training providers and organisations like MIND, the largest mental health charity in the UK, and the Mental Health Foundation. But most of the courses they offer are for "in-house" delivery; they need to be bought in to deliver to a group of staff. This is obviously a problem for smaller

organisations which lack the capacity or budget to do this and may be a consideration for, profit conscious, private providers.

If you are looking for a longer course that offers more than a two day or week long course but that is pitched at a lower level than a degree, the options, are, nationally very patchy. Many local further education colleges offer generic Health and Social Care courses (QCF Level 1, 2 and 3) but these, generally, have limited mental health content. They are also, mostly, focussed on preparing students for entry on to degree courses.

Courses that focus entirely on mental health are not very easy to find. In fact our research found only 11 colleges across England that provides any specialist mental health courses, at this level.

So the conclusion, about training outside the NHS, is that there is some available although sparsely and that it isn't part of any national system (although the training level can be gauged via the QCF and comparison to the NSF) and that there is not enough information available to gauge how much training is given. Individual organisations have their own policies and procedures and are, as a general rule, not willing to share the details of what they provide to their staff.

3. PRACTICES ON TRAINING FOR NON-QUALIFIED PROFESSIONALS

PRACTICE 1	
TITLE	**Mental Health First Aid (MHFA) is a "community interest company" i.e. A business that works towards a community or social objective.**
DURATION	Raising awareness about mental health conditions through educational training courses which are open to members of the public. This term also means that any profits are then re-invested back into the company to further the original objective, staying true to its mission statement. This programme is internationally recognised, now being run in 20 different countries across the world. The MHFA training was delivered at the Phoenix Centre in Sandwich, Kent, United Kingdom. This resource centre is well equipped for this purpose due to having extensive, high quality facilities.
BENEFICIARIES	This MHFA training was offered free of charge to any member of the public.
OBJECTIVES	This training was developed at the Australian National University by Betty Kitchener and Professor Anthony Jorm in 2000. Using Kitchener's experience in nursing, counselling and teaching, along with Jorm's academic background they set about developing training that would help equip individuals with the necessary knowledge to assist a person experiencing a mental health crisis, in the first instance – hence the title "first aid". "MHFA came to England in 2007 and was developed and launched under the Department of Health: National Institute of Mental Health in England (NIMHE) as part of a national approach to improving public mental health" (mhfaengland.org.uk). The website states that the company has not only delivered the programme to over 85,500 people, but that it has also managed to train over 1000 instructors in England alone. **General Objective**: The general objective of the MHFA England training programme is to educate people about various mental health conditions and the most effective ways in which to initially support an individual in crisis. This programme is intended to be taught within a timeframe of 12 hours, making it more viable for those taking time out of their daily work hours to attend.

	Specific Objectives: The more specific objectives of MHFA include teaching individuals to learn how to recognise and understand the symptoms of specific mental health issues. Practical guidance is also given on how to provide crucial and appropriate first step assistance, and an overview of different methods of longer term care options available. This helps to aid effective signposting to professional agencies and encourages those individuals affected to gain more appropriate support.
CONTENTS	The training course was delivered by a MHFA qualified instructor who has been trained by the company. This training is accredited through the Royal Society for Public Health,an independent charity that aims to improve public health and wellbeing. MHFA offers different types of courses which include different levels of training for various audiences but the Mental Health First Aid Standard course is usually held over a period of two days which educates around four subsections: What is Mental Health? Suicide. Anxiety & Depression. Psychosis. A number of the above courses offer the option to be delivered flexibly in order to suit customer needs, e.g. over a few sessions as opposed to all at once.
METHODOLOGY	The Standard Mental Health Training schedule was rigorous and fast paced, incorporating a vast amount of information within the two days. Despite this, it did not feel too rushed or too compact, as the information was filtered down through stages. Effective learning was encouraged through a wide range of interesting activities and learning techniques. The training was delivered within a framework outlined in the PowerPoint presentation projected onto a large screen which was referred to often. The slides contained information relating to defining mental health as a concept and how this correlates with the reality. The training then went on to explore how to give an individual who is experiencing a mental health crisis "first aid". This employed the use of the anagram "ALGEE" which is broken down into: Assess the risk of self-harm or suicide; Listen non-judgmentally; Give reassurance and information; Encourage the person to get appropriate professional help; and Encourage self-help strategies (MhfaStandard manual p.21). In addition there were subsections devoted to depression, anxiety and psychosis.

	The MHFA Standard manual contains more detailed information and includes additional information such as a list of resources, information on substance misuse and how it interacts with mental health, information on different therapies that can be useful for specific mental health conditions, and also statistics and facts relating to different disorders and behaviours. The training was sufficiently broken up, with many activities that were both interactive and interesting. These were set out in an additional workbook which comprised 11 activities that help to aid understanding and influence more professional attitudes towards the subject of mental health. For example, one is named "Frame of reference" which aims to teach you that each individual looks at the world differently through their own "frames of reference". These frames are built through our own experiences and conceptions, and can affect our ability to provide effective mental health first aid. This exercise is evidence-based, deriving from Jacqui and Aaron Schiff's research on passivity in 1971. Other activities, such as those that involved role playing, brought a realistic ethos to the training and how techniques could be applied in daily life.
RESOURCES	**Human Resources**: The instructor skilfully created an interactive training environment which invited discussion of personal experience and viewpoints on extremely sensitive issues from each trainee. The instructor spoke of her employment background (art therapy) and her frontline experience in working with individuals with mental illness. **Material Resources**: The various resources used (i.e. workbook activities, PowerPoint presentation and manual booklet) created a more interesting and interactive learning environment that facilitated excellent training.
EVALUATION	The training came across as extremely well informed by relevant research and up to date statistics about mental health related illnesses, and so met the claim to be evidence based. Statistics were also used to compare issues in terms of individual differences (sexual, cultural and geographical) which made for interesting learning. The training clearly drew on psychological theories and research journals concerning stress, symptoms, effectiveness of different coping strategies, and self-harm. The interaction between theory and practical guidance and tips was explained very well, to the credit of the trainer. The training successfully transmitted clear values through to the trainees which aimed to better inform people's opinions and any bias that someone

	may have towards this topic. The training promoted a more neutral and professional approach by teaching basic, practical steps in relation to the language we choose to use and for example employing non-judgemental listening skills. These techniques were shown to be ideal when dealing with individuals who are experiencing a mental health crisis. The ethos of guiding the individual towards seeking professional help, in order to prevent inaccurate advice/ treatment being given, and exacerbation of symptoms, was another important element of the training. The training focused very much on each trainee as an individual, with past and current experiences, what we have learnt from these and how they could be of benefit to the training. This encouraged a high engagement level from attendees, and coupled with the information being given, made for stimulating training. So stimulating, that many trainees even reported that the training itself had a positive impact on their own mental health wellbeing.

PRACTICE 2	
TITLE	**Mental Health Awareness Training**
DURATION	One-day course in a group setting, for non-qualified professionals with an interest in improving their knowledge of mental health issues. This training is tailored to clients who do not have a mental health qualification and includes corporate clients, line managers and families. A maximum number of 12 participants allow individuals to work in small groups and the training to be made relevant to their work. Training Practice was Held at Mental Health Foundation, Colechurch House, London Bridge Walk, London SE1 2SX.
BENEFICIARIES	The three participants had diverse backgrounds and specific reasons for undertaking mental health awareness training: one had an interest in utilizing the training for staff within her workplace; one had an interest in utilizing the training for foreign students within a university setting; one had an interest in utilizing the training for clients within a charity. I was the only participant with a specific interest in severe mental disorders. The methodologies used in the training took these interests into account. This was possible because of the small number taking part.
OBJECTIVES	**General Objective**: General objectives are to help people survive, recover from and prevent mental health problems. **Specific Objectives**: is done through three specific objectives: - To improve awareness of specific conditions. - To improve our understanding of how to help those with mental health conditions. - To improve understanding of how to look after our own mental health and prevent burnout.
CONTENTS	The training is based on a social model of mental health. Social model approaches tend to be based on the perspectives of those affected. This would fit in with the organisation's ethos and general objectives: approximately 50% of the staff experience mental health problems. Some of these would be categorised as a severe mental health disorder, for example schizophrenia. A social approach is very evident in areas such as the use of language, the effects of stigma and how it feels to experience severe mental distress. I have used the preferred terminology throughout.

METHODOLOGY	The activities involved individual analysis, group discussion, role play and observation. We were encouraged to be reflective rather than theoretical in our approach to what we did, drawing on our own knowledge and experience of others with mental health issues. Specific objectivities covered: - Improving awareness of specific conditions: Bi-polar condition; depression; general anxiety disorder; obsessive compulsive disorder; post-natal depression; post-traumatic stress disorder; schizophrenia; psychosis. Although this training did not mention bio-psycho-social model, this is evident in the discussion of severe mental conditions that have a biological cause as well as a psychological or social trigger. This area covered: o exploring descriptions, images and general beliefs held about mental illness o the use of negative language ('psycho', 'nutter') o positive mental health language ('condition', not 'disorder' o negative mental health language ('drug-induced psychosis: this is seen as being meaningless to the person affected) o the use of positive responses (respect, rather than judgement) o specific mental health conditions (detailed above): these conditions were not split into neuroses and psychoses but were dealt with in alphabetical order o impact of stigma and discrimination o how it feels to experience severe mental distress in terms of emotion o ways of recognising that someone may be unwell (poor concentration, poor motivation, poor personal presentation, high risk taking, social isolation, increased anxiety, indifference, excessive fear, dramatic change of personality, suicidal thoughts o lack of diagnosis/lack of insight - Improving our understanding of how to help those with mental health conditions. Practical guidance is given on:

	○ creating a calm, non-threatening atmosphere ○ reassurance, calmness and concer ○ Mind Cycle techniques (relaxing, listening, presenting, reflecting, connecting) ○ compliance with unreasonable request ○ contacting appropriate resources, if available (GP, Community Psychiatric Nurse, Community Mental Health Team, police) ○ signposting to appropriate services (Action for Advocacy, Alcohol Concern, Combat Stress, Bipolar Organisation) - Improving understand of how to look after our own mental health and preventing burnout: ○ understanding individual stress triggers: each participant was asked in turn to think of a specific example of a stress trigger; a second participant applied Mind Cycle techniques and the third participant observed how well these techniques were used to diffuse stress. ○ ways to look after your mental health and prevent burnout (talking about feelings, keeping active, eating well, limiting alcohol consumption, asking for help, caring for others, taking a break, accepting who you are)
RESOURCES	**Human Resources**: Training is carried out by one person. Although she was the main 'human' resource, the three participants were also resources for each other in that we worked together, reflected on each other's aims and experiences and utilised the knowledge of others. Because the maximum number of participants is 12, this approach is always adopted in the training sessions. **Material Resources**: Material resources were a flip-chart (rarely used), A3 paper to list contrasting themes and concepts, coloured markers. A handout covered all of the topics discussed, along with more general information on the history of mental health awareness and examples of life stories.
EVALUATION	The strengths of the training were in its practical approach to diffusing challenging situations and helping those with mental health conditions. The social model is very evident in that this training is not theoretical and no mention is made of pharmacology or medical interventions. The first

	two specific objectives are designed to encourage empathy and awareness of the emotions of others, as well as raising awareness of conditions. Practical support is based on what is meaningful to individuals in terms of appropriate language and response, rather than what has been diagnosed. We were encouraged to be reflective in our thinking and to consider our responses from the perspective of those with mental health conditions. These approaches are helpful up to a point but could have been improved upon by combining it with a more medicalised approach. An acknowledgement of the distinction between neuroses and psychoses would have been helpful as the other two participants were not aware of the differences. The bio-psycho-social model was clearly evidenced in discussions of bi-polar and schizophrenic conditions. An acknowledgement of this model would have been beneficial as a way of emphasising the holistic nature of mental health issues. Some areas of this training are too simplistic in their approach. The section on burnout could have been improved upon by taking a more professional approach. For example, seeking supervision rather than 'asking for help' or 'talking about your feelings' is often more appropriate and, in some settings, is a requirement.

4. CONCLUSIONS

So what can we make of the foregoing information? Well, it is unquestionable that the MH Services that were set up as part of the formation of our NHS in 1948 have gone through some major changes; particularly in the last 35 years. From 154,000 inpatients beds in the 1950s, to the current level of less than 30,000, (with a population that has increased by at least 15 million since then) means that far more people are being cared for in, and as part of, our communities. This has meant a major change in the way that staff, both qualified and non-qualified, are trained and in their working practices and environments; and although training for professional staff is widely available and of a very good standard, these staff then go to work in a system that seems to be in a constant state of flux and under constant pressure.

But let us look at the some of the positives. MH services are now very focussed on recovery, rather than treating someone who has a serious mental health problem as a lifelong patient who has no chance of getting better. Recent initiatives have also put service user led initiatives at the heart of the process of framing and resourcing new services. One good example of this is the work of Recovery Colleges (CMH, 2012). These are service user-led education and training initiatives, typically located within mental health services that support a substantial array of educational courses, largely taught by service users, to service users, separately or jointly with mental health staff. The theme of many courses is service user empowerment, and training is intended to lead to substantial organisational changes in the configuration and delivery of services. In essence, Recovery Colleges bypass professional mental health staff as a focus for training, and concentrate directly on empowering of service users to manage their recovery through a more collaborative relationship with professionals. It is hoped that Recovery Colleges may lead to a major transformation of the services, from how they are today.

We can also state that training for MH professionals is widely available and of a very good standard, with multi-disciplinary working and the involvement of service users and caregivers at the heart of what the students are taught; a far cry from how things used to be. But next to this we have more service providers from outside the NHS providing MH services and it is almost impossible to get any kind of picture of the training that they provide their support staff.

And the rest of the downside? MH services in the UK, continue to be the "poor sister" to physical health services. They receive only 13 per cent of the NHS budget, despite mental illness affecting around a quarter of the UK population (ONS 2001). Worse still, national

spending on mental health has consistently decreased over the past four years (Mental Health Network 2014). And the trend isn't limited to adult care; mental health services for children and adolescents have also seen a fall in funding. This decline seems even more irrational considering adolescence is the period when many mental illnesses first manifest and those hospitals are recording a rise in admissions for conditions such as eating disorders and self-harm (Pulse Magazine FOI 2015).

A recent survey of GPs revealed that one in five of them had seen patients harmed as a result of "delays or a lack of support" from mental health services, while gaps in services had forced 82 per cent of doctors to act "outside of their competence" (Pulse Magazine Survey 2014); and the huge reduction in MH beds has meant that thousands of mentally ill patients have been forced to travel "hundreds of miles" for treatment in over the last few years (FOI/CommunityCare.co.uk 2014) and even medical students have resorted to asking for greater teaching on psychiatry, highlighting the lack of attention that mental health issues receive as part of their established training (BMA 2014).

Poor mental health can also have a significant impact on a patient's quality of life, and is thought to contribute to poor physical health, having been associated with diabetes, cancer and cardiovascular disease (Mental Health Foundation 2011). And if these ethical concerns are not enough, such neglect of the mentally ill also has cost implications; a recent study by the London School of Economics found that the NHS could save over £50m a year by reversing budget cuts to preventative and early intervention therapy (LSE 2014).

The mental health charity, Mind, suggests that the next government commits to a 10 per cent rise in the NHS's mental health budget over the next five years. Considering the state of mental health care and the current funding disparity between health services, this is not an unreasonable request. But with the continued emphasis, by all of the major UK political parties, on reducing public spending, the requisite investment to address these shortfalls and gaps is unlikely to happen any time soon; so we are left with staff, and a system, that is struggling to cope.

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BELGIUM

1. SITUATION OF THE MENTAL HEALTH SYSTEM IN BELGIUM

1.1. INTRODUCTION

One out of four people will sooner or later have to deal with more or less serious mental health issues. In a period of a year about 700 000 Belgians suffer with mental health issues. This is almost equivalent to the total population of the two largest cities, Antwerp and Ghent.

Mental health issues tend to have an impact on the environment of patients. If you count your family, friends, colleagues, employers, … many more people get in touch with it.

Psychiatric complaints are equally common among men and woman, but they take a different form. Women suffer twice as many from depression and anxiety as men. Men suffer more from psychological disorders related to alcohol abuse.

Flanders has one of the highest suicide rates in Europe. The reason for that isn't clear. The statistics do prove that a lot of inhabitants, including young people, don't see a way out for their problems. Therefore it is important to talk more about mental health.

1.1.1. SOME STATISTICS (RESEARCH BY THE ITINERA INSTITUTE BELGIUM)

If you put three Belgians around a table, then one Belgian will have faced psychic problems. These are high figures and are very confrontational. Various surveys show that 26% of the Belgians are feeling bad.

Belgium remains the global leader in taking up patients in psychiatric institutions. The number of forced hospitalization is increased with 42% between 1999 and 2008, prior to the crisis. Recently in the period of 2004-2008, we see an increase of 10% in the number of hospitalizations in psychiatric hospitals, especially in Flanders.

Flanders has a remarkably high number of readmissions within 30 days in psychiatric hospitals: 25% due to schizophrenia and 20% due to manic-depression.

Psychiatric disorders is the number 1 cause of disability. In the top 10 we do also have alcohol abuse, depression and dementia.

27% of the absenteeism in the workplace (above 15 days) has a psychological cause. Psychological disorder is responsible for 25% of all benefits for work disability.

The presenteeism of people with moderate psychic problems is in Belgium in five years nearly doubled. Belgium jumps hereby over the European average.

Psychiatric patients have an average 15 year lower life expectancy, due to physical causes.

The number of suicides is equal to respectively 17, 24 and 14 suicides per 100.000 inhabitants in Flanders, Wallonia and Brussels. With three suicides a day, Belgium is in the top 3 of Europe. Flanders illustrates with a positive 'state-of-the-art'-plan (policy) that it can pay off. In flanders we noticed a 8% descent of suicides.

30% to 70% of children of parents with serious mental disorders, also develop a mental disorder. It is striking that people who kill themselves had a mental disorder. Almost half of them were treated before. Suicide is usually not an isolated or insulated phenomenon.

The use of psychotropics in Belgium is remarkably high compared to other countries (19.1%). We do clearly talk about an overconsumption of tranquilizers and hypnotics.

46% of people with severe mental problems consult a doctor, but doesn't take medication or therapy. 25% Only get medication and 3,8% therapy. The preference for medication over therapy is mostly cost-driven.

There is a clear link between mental health issues and the socio-economic status. 72% Of the people who rely on a Centre Of Welfare experience a state of psychological discomfort. 58% Of them have a small depression, 36% already made a suicide attempt and 20% rely on the mental health care system.

The start-up of professional care often comes too late. Average: 1 year too late for mood disorders, 16 years too late for anxiety disorders and 18 years too late for substance abuse.

Nearly 1 out of 3 people are looking for professional help. In the social profit for example only 9% talks about mental issues, 31% doesn't know where to find help and 15% doesn't seek help. 32% doesn't seek help due to financial reasons.

60 to 70% of psychiatric patients work. 45 to 55% work with a severe disorder. Patients with no work are a growing group. This reflects also in an increase of claims for benefits.

1.1.2. IT'S IMPORTANT TO TALK ABOUT IT

In our society there's still a taboo about our mental health care and mental problems. We prefer not to talk about it. Almost 60% of those who have mental health issues, doesn't search professional help. However, those problems need our care and attention. It's necessary to appoint it. If someone out of our personal environment is suffering a mental issue we usually say: he has a dip or he's struggling with some problems. We dare not to appoint psychological problems. Accepting that psychological problems are a part of life for a lot of people is the first step to be caring, understanding and learn to deal with it. Psychological problems are often understandable human reactions to specific situations and are not just a biomedical, genetic, neurological response or a brain disease.

1.1.3. A DIP OR A CONDITION?

When you can't longer function for a longer period, we can talk about a mental health issue. You have the feeling that you're no longer in control of your own behavior and reactions. For example: you don't have the energy anymore to do anything or you can't manage your emotions anymore.

A mental illness is not the same as a dip. Sometimes things happen in life: a dismissal, a divorce, a death, … As difficult those events are, we usually adapt quickly. If you have a dip for a longer period, then we talk about a psychological problem. And yet, even psychological problems are often understandable human reactions to specific situations and are not just a single biomedical, neurological, genetic reaction or a brain disease.

1.1.4. NOT NORMAL

We can't draw a line between what is normal and what is considered not to be normal. It also depends on the times. Some things were formerly considered a disease and now not anymore. Homosexuality is one example. Other issues are now considered a disease. In the past a busy child was just a busy child. Nowadays it is often diagnosed with ADHD.

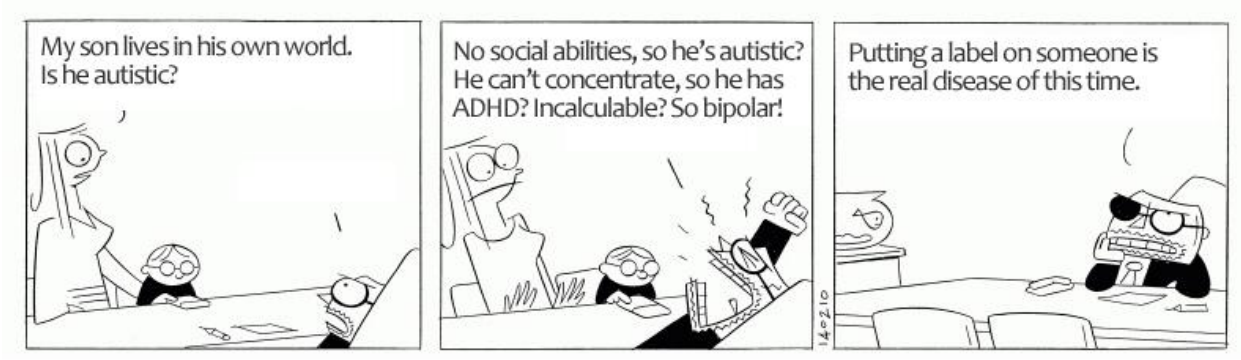
Our mental health can always be better. We do not always see if things are running wrong. In a manic phase someone feels great, while the environment feels that is not the case.

1.1.5. JOY AND SORROW OF THE BODY

We can't draw a line between a psychological problem and a physical problem. Research indicates more and more that psychological and physical problems are closely linked.

1.1.6. FROM SYMPTOM TO SYNDROME

We talk about psychological symptoms when it comes to individual psychological complaints such as insomnia, lethargy, hallucinations, … If there are symptoms that are associated with each other, we call it a syndrome. We need to be careful with putting a label on someone.



1.1.7. RISK FACTORS

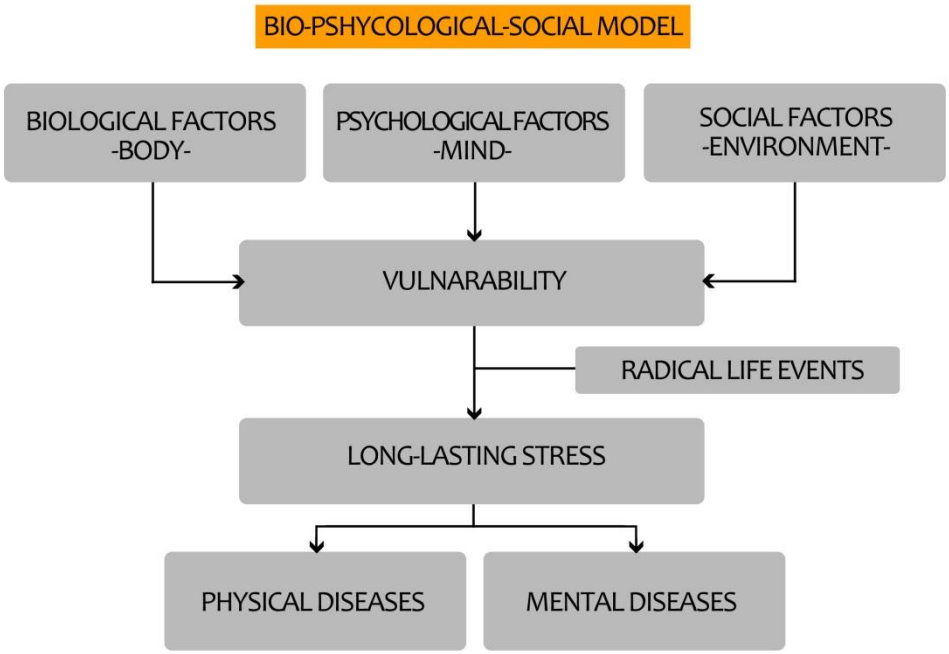
How do you get a mental disease? The direct cause isn't always clear because there's always a combination of factors at the base. Psychological problems are often understandable human reactions to specific situations and not just only a biomedical, genetic, neurological response or a brain disease. But a number of risks may play a decisive role. For example your genetic history, your personality, major events in your life, your age, the durations of your complaints, your sensitivity to stimuli, …

1.1.8. BIOLOGICAL, PSYCHIC AND SOCIAL

Doctors and psychologist call the complex interplay of factors the bio-social model. Social factors are for example your living conditions, conflicts at work, loneliness, … Psychological factors have to do with your personality and the way how you deal with

things that happen in your life. Biological factors sometimes refer to heredity, your physical condition, your nutrition, etc.

Some protective conditions makes it's possible that a mental disease isn't a problem. The way you look at your condition and the way you deal with it is one of them. A compassionate environment is also a protective factor. It's important that you are surrounded by people who see you as the person you are. But also intelligence, resilience, social skills, etc, can provide more capacity.



1.1.9. BALANCE

A psychological illness often occurs when there's no balance anymore between what you can handle and the weight off your shoulders. That balance is different for everyone because every person is vulnerable in its own way. If you are dealing with metal problems you have the feeling that you aren't yourself anymore. You do feel different, act different and it's hard to enjoy or relax. Psychological problems interfere your daily life. Working, shopping, raising the kids, … all daily concerns are a life-size problem.

1.2. MENTAL HEALTH SERVICES STRUCTURE

1.2.1. THE GENERAL PRACTITIONER

If you think you are struggling with a mental health issue, it is best to make an appointment with you general practitioner. After all, a general practitioner knows you the best and has a good view on your background and history. If he redirects, then he or she gets all the information about the treatment. This prevents that information gets fragmented.

1.2.2. IN THE REGION – HOME ENVIRONMENT

If you have mental health issues you recover best in the home environment. You can stay in the familiar environment and you can maintain your social contacts with community-based help. In Flanders there's a whole range of care circuits and care networks that helps and coordinates ambulatory care. Each region in Flanders has a coordinator. He or she is central figure if you are looking for a caregiver. On the website of the different health care regions you can find all the information you need.

1.2.3. CAW – CENTRUM VOOR ALGEMEEN WELZIJNSWERK (CENTRE FOR WELFARE)

You can go to a CAW if you experience difficulties in your personal life. That can be financial difficulties, relational problems, loneliness, stress, addiction, etc. Also offenders and victims of a crime can get guidance in a CAW. A CAW also has domestic violence shelters. A CAW-team generally consists of social workers, counselors and therapists. The caregiving depends on the income of a person, cheap or even for free. If necessary, the CAW will refer clients to other institutions or caregivers. If you are younger than 18 years old, then you can go to a JAC. A JAC is a youth advice centre and can be reached by e-mail, chat or simply by going along.

1.2.4. CLB – CENTRUM VOOR LEERLINGENBEGELEIDING (CENTRE FOR EDUCATION AND LEARNING)

Every school in Flanders works with a CLB. Parents, teachers, managers and children can consult the CLB for information or guidance. A CLB employs several professionals: doctors, nurses, social workers, psychologists, pedagogues, etc. Together with the school team they ensure that every child or youngster can develop knowledge, talents and skills.

1.2.5. CGG – CENTRUM VOOR GEESTELIJKE GEZONDHEIDSZORG (CENTRE FOR MENTAL HEALTH)

The Flemish centres for mental health (CGG'S) annually take care of more than 50 000 persons with severe mental or psychiatric problems. Children, youngsters, adults and elderly people can go to a CGG (Consultation, not a hospitalization). A team of a CGG consists of psychiatrists, psychologists, social workers, etc. All these professionals work together and search the approach that is the best answer for a care question.

Who can go to a CGG

You can go to a CGG if you are redirected for example by a GP, a CLB, etc. A CGG is intended for people with serious mental and psychiatric problems or a problem that can get worse.

What kind of care does a CGG offer

A CGG offers multiples forms of care, which all have the same characteristic: caregiving exists out of consultation and coaching moments, which are pre-arranged. In other words: you only can visit a CGG if you have an appointment. There is no hospitalization. What happens first is the exploration and assessment of the problem. On this basis, a treatment will be developed.

1.2.6. INDEPENDENT CAREGIVERS

Many caregivers also work, either part-time or full-time independently. These caregivers are psychologists, psychiatrists or other therapists. The advantage of independent caregivers is that you can access them more quickly than a CGG (Centre for mental health) or a centre for alcohol and drugs (CAD).

1.2.7. PSYCHIATRIC UNIT IN A GENERAL HOSPITAL (PAAZ – Psychiatrische afdeling in een algemeen ziekenhuis)

A psychiatric unit in a general hospital provides residential psychiatric care. If you are hospitalized in a PAAZ you stay day there day and night. Some PAAZ-units do offer care by day hospitalization. Mostly adults and elderly people are patients in a PAAZ but some departments also take care of children and young people.

A PAAZ focuses on short hospitalizations, for example a short-term treatment of psychiatric crises and after suicide attempts. You can also go there for a short-term treatment of depressions and other mood disorders, anxiety disorders and addiction.

The team of a PAAZ consists of psychiatrist, (psychiatric) nurses, occupational therapists, social workers, movement therapists, etc.

1.2.8. PSYCHIATRIC HOSPITAL

A psychiatric hospital provides residential psychiatric care. A patient stays day and night. Some psychiatric hospitals have a specific program for children en younger ones.

In contrast with a PAAZ, a psychiatric hospital offers long-termed treatments. Psychiatric hospitals have different departments with more specialized programs such as depression, psychosis, personality crises, addiction, eating disorders, etc.

The team of a psychiatric hospital consists of psychiatrists, psychologists, psychiatric nurses, occupational therapists, creative therapists, movement therapists, social workers, etc.

In a psychiatric hospital the patients get a variety of individual therapies (individual or in group), training (for example social skills, assertiveness) and other treatments.

1.2.9. PSYCHIATRIC DAY CARE CENTRE

In a psychiatric day care centre, which belongs mostly to a PAAZ or a psychiatric hospital, patients can be hospitalized for an intensive part-time treatment. In the evenings and at weekends patients can stay at home. In this way tyou can combine your treatment with your family-life, social life and hobbies.

The team of a psychiatric day care centre consists of psychiatrics, psychologists, (psychiatric) nurses in addition with occupational therapists, creative therapists, social workers, etc.

1.2.10. OTHER FORMS OF CAREGIVING (OTHER CENTERS)

Besides PAAZ and psychiatric hospitals in Flanders there are also other forms of caregiving such as therapeutic centers, centers for psychiatric rehabilitation (treatment of schizophrenia and mood disorders) and centers for outpatient rehabilitation of children

and young people (ADHD, mood and behavior disorders). A number of therapeutic centers are focused on a particular issue or target group, such as rehabilitation centers for drug and alcohol addiction.

1.2.11. SHELTERED HOUSING

People with a long-term psychiatric illness can live independent with a good supervision. This guidance is organized by the services of assisted living.

In Flanders there are also a number of houses where people with psychiatric issues live together. Recently, there's an evolution towards individual sheltered housing.

1.2.12. TELEPHONIC AND ONLINE ASSISTANCE

If you need someone to talk to anonymously and in privacy, then telephonic and online care assistance are interesting. In some organizations you can go for a phone call or an online chat. Often there's someone available 24 per hour. If you are really down and you can't reach anyone, an online chat or telephonic conversation can be enormously supportive.

The most-common in Flanders: Tele-Onthaal, Zelfmoord 18-13, De Druglijn, Awel (De vroegere kinder- en jongerentelefoon).

1.2.13. SELF-HELP GROUPS AND SUPPORT GROUPS

Self-help groups for people with mental health issues and their families can be a huge support. People who experience the same problems do understand each other better. The can exchange experiences and tips on handling problems. The good thing of support groups is that you are among equals. A lot of self-help groups provide information for the public. This helps to break the taboo around mental health. It also helps to get people out of their isolation.

Key organizations in Flanders (Belgium): Kopp Vlaanderen, Similes, Uilenspiegel, Ups & Downs, Het Vlaams patiëntenforum.

1.2.14. PERSONALIZED (CUSTOMIZED) CARE

In Belgium there exist also organizations that deal with specific mental health problems. So you have counseling for addiction problems (for example medical social shelters) and

initiatives like 'De Sleutel', 'De Kiem', 'Het Kompas','Katarsis', … All these treatment centers often have an ambulatory and residential component. They also provide crisis care. More info on www.verslaafdenzorg.be

1.2.15. PSYCHIATRIST, PSYCHOLOGIST OR THERAPIST

1.2.15.1. PSYCHIATRIST

A psychiatrist is a doctor that is specialized in psychiatry. He studied medicine and then specialized in psychiatry. Some psychiatrists followed afterwards an additional training in psychotherapy.

Psychiatrists can prescribe medication, psychologists may not. You can visit a psychiatrist for a consultation, diagnosis and treatment. Some psychiatrists offer psychotherapy. Psychiatrists are usually associated with a hospital, psychiatric hospital, a centre for mental health care (CGG) or other psychiatric departments. Usually they work independent within these organizations. A lot of them also have a private practice. Consulting a psychiatrist is (partially) compensated by the health insurance.

1.2.15.2. PSYCHOLOGIST

A psychologist earned a master or licentiate degree in psychology in a university. Psychologists are active in various working fields: in schools (for example school psychologists in a CLB), in companies (corporate or industrial psychologists), research organizations, etc.

Clinical psychologists have been trained in clinical psychology. In addition they received (not always) therapeutic education. A psychologist can't prescribe medication. Clinical psychologists work for example in a CAW, CLB, CGG and in (psychiatric) hospitals. Some of them work independent.

Therapeutic conversations with clinical psychologists aren't compensated by the RIZIV. A couple of health insurances do provide a partial compensation for treatment and therapy by clinical psychologists.

1.2.15.3. INDEPENDENT THERAPISTS

In Flanders the title therapist or psychotherapist is (still) not protected. This means that (for the moment) everyone can call themselves a therapist, whether you are trained in

psychology or not. The term psychologist is legally protected. In Belgium there's a list of legally protected psychologists.

A number of psychotherapy training can only be followed by people who have a master or licentiate degree in psychology or psychiatry. It is always good to check the background of the therapist a patient wants to consult and check experiences of other patients.

1.2.15.4. OTHER PROFESSIONS IN MENTAL HEALTH CARE

Besides doctors, psychiatrists, psychologists there are other profession in the mental health care sector:

- Psychiatric nurses: they observe, guide, supervise, nurse, care, etc, the patients.
- Social workers: they help patients with administration, the search for education, work, financial administration, housing, etc. They also can help mediate between a patient and other people (for example a landlord, employer, etc).
- Occupational therapists help you to do practical things and in increasing your self reliance.
- Movement therapists, dance therapists, drama therapists, music therapists, etc.

1.2.16. PRIMARY CARE PSYCHOLOGISTS

For several years in Flanders primary care psychologists are integrated in mental health care. A primary care psychologist works together with general practitioners or community health centers. They provide short-term help. If more support is needed a primary care psychologist will redirect the patient to other professionals (CGG, psychiatrist, etc). For now there are only a few subsidized experiments in Flanders with this new feature. A number of organizations decided themselves to employ a primary psychologist without the support of the government.

1.3. LEGAL REGULATIONS

Consolidated legislation:

- Consolidated legislation on the protection of a person (bescherming van de persoon).
- Consolidated legislation on the protection of good (bescherming van goederen).

Laws:

- Law June 2, 2016: Repayment of care and residence of undocumented migrants and asylum seekers in psychiatric hospitals and psychiatric nursing houses. (Zorgen voor en verblijf van mensen zonder wettig verblijf en asielzoekers in psychiatrische ziekenhuizen en psychiatrische verzorgingstehuizen voortaan terugbetaald. 30/06/2006).
- Law concerning the rights of a patient (29/06/2002 (Wet betreffende de rechten van de patient).

Decrees:

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- Decree on the quality of health and welfare services (10/11/2013). (Decreet betreffende de kwaliteit van gezondheids –en welzijnsvoorzieningen).
- Decree concerning the classification of health regions, cooperation and programming health and welfare organizations (06/06/2013). (Decreet betreffende de indeling in de zorgregio's en betreffende de samenwerking en programmatie van gezondheidsvoorzieningen en welzijnsvoorzieningen).
- Decree on mental health care (17/07/1999) (Decreet betreffende geestelijke gezondheidszorg).
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- Decree on a integrated quality system in healthcare organizations (05/02/1997). Decreet betreffende de integrale kwaliteitszorg in de verzorgingsvoorzieningen.

Royal Decisions:

- Royal decision on the function of a ombudsman in hospitals. (12/03/2007) (KB dat aantal zaken inzake ombudsfunctie in de ziekenhuizen regelt (onder meer onverenigbaarheid met bepaalde andere functies, vereisten i.v.m. eigen telefoonnummer, e-mailadres en ontvangstruimte).
- Royal decision to determine the conditions of the insurance comitee in concluding agreements. (07/11/2006). (KB tot vaststelling van de voorwaarden waaronder het

Verzekeringscomité met toepassing van artikel 56, par. 2, eerste lid, 3°, van de wet betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen, gecoördineerd op 14 juli 1994, overeenkomsten kan sluiten voor de financiering van de therapeutische projecten inzake geestelijke gezondheidszorg).

- Royal decree – statement of hospitalization (14/04/2007) (Decreet bij opname in een ziekenhuis).
- Royal decree – Program criteria for psychiatric hospitals and services (12/05/2003) - Programmacriteria van de psychiatrische ziekenhuisdiensten).

Ministerial decisions:

- Ministerial decision on the change of the ministerial decision of 18/11/2005. (06/10/2006) (MB tot wijziging van het ministerieel besluit van 18 november 2005 tot vaststelling van het bedrag en de voorwaarden waaronder een tegemoetkoming kan worden toegekend voor de verstrekkingen, omschreven in artikel 34, eerste lid, 13°, van de wet betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen, gecoördineerd op 14 juli 1994).
- Ministerial decision on the compensation of the obligatory insurance for health care and benefits in psychiatric hospitals (29/12/2003).
- Ministerial decision on de realization of the quality decree in mental health care centers (06/08/1999). MB betreffende de tegemoetkoming betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen, in de psychiatrische verzorgingstehuizen.

2. SITUATION OF MENTAL HEALTH TRAINING IN BELGIUM

2.1. QUALIFIED PROFESSIONALS

- Bachelor in mental health care – 3 years (bachelor after bachelor and master possible –specializations).
- Bachelor in psychology – 3 years (bachelor after bachelor and master possible – specializations).
- Master in psychology – 4 years (University – different specializations).
- Psychiatrist -6 years study medicine and 4.5 years of psychiatry or geriatric psychiatry (University – different specializations).
- Psychotherapist – 6 years study medicine and 4.5 years of field psychotherapy (University – different specializations).

Other education in the field of mental health care:

- Psychiatric nursing – 3 years (bachelor and master - different specializations).
- Social work – 3 years (bachelor and master – different specializations).
- Occupational therapist – 3 years (bachelor and master).
- Bachelor in nursing – through the Flemish Job Agency (VDAB) or adult education.
- Bachelor caretaker – through the Flemish Job Agency or adult education).

2.2. NON QUALIFIED PROFESSIONALS

- On the job volunteers (for example Flanders buddies).
- See also: http://www.geestelijkgezondvlaanderen.be/zelf-iets-doen-voor-anderen-waarom-niet-als-vrijwilliger.
- Several therapists (creative, dance, drama, movement, …) – Centers for adult education and VDAB (Flemish Job Agency).
- Several workshops – specializations for therapists – Centers for adult education and VDBA (Flemish Job Agency).

3. PRACTICES ON TRAINING FOR NON-QUALIFIED PROFESSIONALS

PRACTICE 1	
TITTLE	**TRAINING EMOTIONAL DEVELOPMENT OF PEOPLE WITH MENTAL DISSABILITIES (SENSEO)**
DURATION	7 Modules
BENEFICIARIES	The training is especially developed for organisations who provide support for people with learning disorders (whatever the type) and want to implement the concept of emotional evolution in their operations.
OBJECTIVES	In past decades became the concept of 'emotional evolution' more and more a key concept in providing support for people with learning disorders (with or without behavioural and/or psychical problems). Mostly Anton Došen contributed a lot with his evolutional dynamism. With the growing interest for this approach and the efforts to turn them into practice, it became clear that there is a need for additional help. Support is required, both on estimating the persons' level of emotional evolution, and with the translation of these insights to a level of support. With the Flemish project SEN-SEO (2009 -2011) knowhow was gathered, and was wide spread and carried out. This resulted in a number of publications on the products of this project, mainly the scale for emotional evolution (SEO) for people with learning disorders. This gives a background and insights in emotional evolution. To get these project results and vision on emotional evolution implemented on the long term, they count on organisations, caretakers, educationists, psychologists, GPs, students, families and other members of the person with learning disorders' network. To achieve that SEN vzw together with the SEN – SEOs' steering

	committee published a training, and trainers were educated to become SEN – SEO trainers. The training consists of 7 modules and its goal is to provide a basic training about emotional evolution. The training lets you taste the thoughts, and gives you a start to get on with it in your own organization.
CONTENTS & METHODOLOGY	**MODULES** 1. The concept emotional evolution 2. An instrument for self - evaluation 3. From estimating to supporting 4. The scale (SEO-R) 5. Co – morbidity 6. Family and network 7. Integrative framework **The concept of emotional evolution.** In literature there is not a lot to find on people with learning disorders' emotional evolution. However this could help to clarify what we are talking about, and could provide us a common language. This training focuses on definition of emotions, feelings and affects. This together with the needs they bring, motivates people to react accordingly. Those reactions try to guide the support, stimulate of just to reduce support. The dynamical evolutional framework is helping to indicate if the behaviour is adapted, deviant or is almost sickly different. Besides that they determine if the behaviour observed corresponds with the cognitive evolution. **Scaling.** The training module about scaling provides the scales' background, the dynamical evolutional framework. They look at where the different phases in evolution come from, and show parallels differences in normal/dysfunctional evolution. They also cast a light on other scales that chart the emotional evolution, and look at the pro's and con's in the use of SEO-R. Than they look at the point of difference with the first version, and make a scale using a case study. So they can experimentally see the scales' possibilities, feel the way of working, see the guidelines given with the score and interpret them. After this training the participants must be able to scale a person with learning disorders. **The instrument for evaluation.**

Within the multidimensional approach of mental healthcare for people with learning disorders it is important to know the importance of the emotional evolution. However, the concrete anchoring of this dimension in our daily look at people, planning of care and support of this target group, is far from easy. To have guaranties that this dimension is fully, determined and qualitative imbedded in the substantive operation of an organisation you need an integral approach. From experience we learn that often people work with parts of a visons' interpretation, this leads to colleagues and coaches being confused and disappointed. In this training you learn to look at all facets of your organisation by using the evaluation instrument. So you can determine where your organisation is doing a good job, or where you have to adjust. Than you determine work points to implement the emotional evolution of people with learning disorders in you organisation.

From estimating to supporting.

This training learns you, once you have gathered all the estimated elements, what elements can help you supporting. We are looking at big anchor points in supporting people like, distance and proximity in a relation, supporting style, the set-up and limitations someone needs, activities and communication. In each phase we are also looking at problematic behaviour. This course 'from estimating to supporting' gives you a practical and concrete guidebook of approach, that at the same time also gives you the possibility to reflect. The case is now further analysed with this guidebook, this results in a plan of support for the person involved.

SEN.

The project SEN – SEO states that the content of the first 4 modules is indispensable when working with emotional evolution. Qualitative and professional working from this framework of emotional evolution is a total story where vision and policy (instrument for self - evaluation) knowledge (conceptualisation) instruments (SEO -R), your approach, support and mandate (VINO),... have their importance and place, and when possible all at once. The last three modules are best when there is already a lot of knowledge about emotional evolution in the organisation.

Who is the trainer.

Practitioners in working with people with learning disorders - with special

	attention for emotional evolution - are trained to be trainers. They get intensive training and SEN together with the steering group SEN - SEO is continuously following them up about content and methodology **Themes (elements involved).** Making an image, protocols and guidance, screening, action orientated diagnostics, cognitive functioning, orientation in time and space, specific syndromes (CVI, Down syndrome, Asperger,...) communication, treatment and support, mourning, communication, executive functioning, etc.
RESOURCES	**Human Resources.** **Trainer:** Els Van Rechem (Group Ubuntu) - employee of group ubuntu accredited trainer by SEN VZW **Material.** Resources: - SEN - SEO box - Emotionele ontwikkeling bij mensen met een verstandelijke beperking (Sen-Publicaties nr.4) - L. Claes, K. Declercq, L. De Neve, B. Jonckheere, J. Marrecau, F. Morisse, E. Ronsse, T. Vangansbeke (Red.) - SEO-R-Schaal voor Emotionele ontwikkeling bij mensen met een verstandelijke beperking - Revised (Sen-Publicaties nr. 5) - L. Claes & A. Verduyn (Red.) - De draad tussen cliënt en begeleider. De emotionele ontwikkeling als inspiratiebron in de begeleiding van personen met een verstandelijke handicap - G. Vigner - Set van 4 schema's bij Emotionele ontwikkeling bij mensen met een verstandelijke beperking - L. Claes e.a. **More information:** http://www.senvzw.be/wg/werkgroep-sociaal-emotionele-ontwikkeling/content/emotionele-ontwikkeling-van-personen-met-een-verstandelijke-beperking-vormingspakket **Website** SEN VZW: www.senvzw.be

EVALUATION	'The modules convince you to have attention for the social and emotional evolution. Caregivers are motivated to immediately work with the scale' - Levedale VZW'. 'The modules are very intensive and complete. In a short period of time a broad spectrum of emotional evolution is framed. Both for caregivers and staff members the modules are interesting because steps can be taken on macro, meso, and micro level.' Service centre for people with learning disorders. 'The training is a good introduction on the use of the SEO-R scale, given insightful. It also gave sight on the possible application/translation in our daily work.' - Huize Rozenwingerd.

PRACTICE 2	
TITTLE	**MENTAL AND BEHAVIORIAL DISORDERS OF PEOPLE WITH MENTAL DISABILITIES** 
DURATION	4 Days
BENEFICIARIES	Caregivers and volunteers who work with people with learning disorders.
OBJECTIVES CONTENTS & METHODOLOGY	One out of two people with learning disorders suffer from psychiatric disorders and/or behavioural problems. In the day to day support of these people this shows in: aggression, automutulational behaviour, being very sensitive for stress, very fluctuation levels of dealing with stress, claiming, OCD, using caregivers and playing them out against each other.... This behaviour is causing feelings of impotence, confusion, anger, disillusion... for caregivers. In this training we are looking for the function and the message of the behaviour and the clients feelings behind. During this training insights are provided on how this problematic behaviour is looked upon from perspective of the dynamical evolutional theory (theory of A. Došen) and how it gets visualised. Participants learn to start from the social emotional evolution to give support. This means that the caregiver tunes in on the client, rather than wants to 'change' the client. As framework for diagnostics, assessment, and treatment the 'integrative diagnose' is used. During the training it is possible (in smaller groups) to make an integrative diagnose for a client whom you work with. In cases with specific psychiatric disorders, these are the things we look at: psychotic disorders, bounding disorders/ trauma, and mood disorders. Than the following items come about: symptomatology, detection and diagnostics, dynamics and treatment.
RESOURCES	**Trainer.** Filip Morisse who is an ortho –agogue and therapeutic coordinator at De Steiger and the policlinic, centre for psychiatric care Dr. Guislain (Ghent).

	De Steiger is a residential department within the psychiatric care for temporal observation and treatment for adults with a (light/ moderate) learning disorder and additional psychiatric disorders and/or behavioural problems. Besides that Filip is a consultant and adviser, provides training and education for a lot of Flemish and Dutch organisations and services.
EVALUATION	A very good basic training – filled with real life case studies.

4. CONCLUSIONS

How healthy is our Belgian mental healthcare? Besides our number of suicides, Belgium is in the fields of Psychic wellbeing and the cares quality mid ranked compared to other countries. We are running behind when you look at the socialisation of caregiving and the forming of networks needed to do that. Still the tendency is to much to medicalise, sometimes with lack of knowledge and support with first line support. Psychotherapy is still underused. The elimination of under – detection, and under – treatment is a good, and needs further support in the future, just like the attention for overtreatment. This by not letting us lead by dogmas and ideologies, but with firm knowledge of the instruments available in society, the margin for improvement can narrower.

The crisis amplifies the psychic problems, but on the hand it is also a lever to make structural changes. Mental healthcare is on a crossroad. Either it embraces the changes needed, how threatening they can be for the existing structure of organisations and the profession. In that case the mental healthcare has the liberty to make its own future, preserving what is good now. Or they take defensive positions, in that case the government will be forced to intervene in a more demanding way to make change happen. The disadvantage of such an intervention, is that it is possible the changes will not be that effective.

The government itself has in short term the possibility (duty?) to make the puzzle by means of financing, law making, human resources, policy of quality, education and innovation, and Ict policy. Therefore the mental healthcare is changed by going through a renewal of goals and initiatives. Some policy agencies are now clearly taking steps forward. Last but not least, there is an urgent need for research in mental healthcare.

Recommendations from the Itinera institute (independent thinktank) for optimizing the Belgian mental healthcares' health

1. Set priorities and goals concerning quality, equality, efficiency for the mental healthcare, to translate to all levels of policy and actors.

2. Reform the way financing the available care, and put the accent on quality and building networks. The relation with the goals set must be clear. Set a system for days present , cfr hospitals.

3. Eliminate unfavourable effects of the current system of patients contributions in mental healthcare. Start a debate about the additional insurances who exclude the psychiatric treatment.

4. Make the switch from the many positive projects to a systematic and wider implementation in the whole field of mental healthcare.

5. Enhance the first lines focused trainings and mechanisms of referral.

6. Convert the means of one third of the current residential beds to alternatives according to article 107s' philosophy. Also include reticent partners.

7. Reform the human resources policy with shifts in tasks and differentiation in functions. Everyone is getting better when the support implemented.

8. Connect the separated worlds existing in mental healthcare by means of chain care and continued coordinated care with a protective effect as a result. This concerns the adjusting of the several schools for psychotherapy and care tendencies, however we already see a strong positive evolution.

9. Make the key players of education and employers aware of their responsibilities.

10. Integrate mental healthcare and social care.

11. Enhance the forensic psychiatric centres and care for the internees. The first priority should be a wider approach than the offer of two additional centres for detention.

12. Invest more in positive activation and supporting, in combination with encouragement instead of inhibitory incentives. Therefore redefine the roles.

13. Enhance ICT, innovation and research in mental healthcare, with a focused role for FWO, IWT,… Make use of existing data. You can ask yourself if the argument of privacy isn't counteracting the core mission of the mental healthcare. Privacy could also enhance the stigmas and taboos. Technical wise are both goals combinable with the recent security.

14. Give practitioners a more prominent role, both within or outside the policy making, to counteract stigmatisation and discrimination. This also concerns the systematisation of the interactions with education and other sectors.

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GERMANY

1. SITUATION OF THE HEALTH CARE SYSTEM IN GERMANY

1.1. INTRODUCTION

Because of the political structure of Germany, this report is referred in particular to the Region of Bavaria.

The policy for people with disabilities of the German federal government have changed in the last six years. In the biggest reform since the seventies, the governments and legislators have established the main principles so that disabled people can manage as far as possible their lives by themselves.

This aim can only be reached when people with disabilities are supported by different actors in order to reach the highest level of autonomy and to be able to manage their own lives.

It´s not only about the policy of people with disabilities, but also the policy on how to promote cooperative partnerships. For this reason associations, organizations, and groups of self-support of people with disabilities will be taken into account.

1.2. MENTAL HEALTH SERVICES STRUCTURE

The health care system is separated in three different sectors. There are the outpatient care, the hospital sector and itinerant agencies for the rehabilitation.

As actors in the health care system we can consider organizations and interest-groups of the different providers as well as workgroups, health insurance companies, quality agencies, the health care system, and also organizations of patients and self-help groups. The structure of the German health care system is decentralized, self-governed and it is composed by many actors.

The regions (Bezirke) of the federal states (Bundesländer) are obligated to run in the limits from its capability the necessary institutions of psychiatry and neurology (Art. 48 BezO). The full responsibility of the psychiatric and medical care belongs to the regions of Bavaria.

1. Practicing Doctors and specialists of general medicine

They are the first responsible for general medicine, when a person is suffering a mental illness.

2. Practicing Doctors and specialist of psychiatry, psychotherapy and psychosomatic medicine

They take a big part of the outpatient treatment. They treat all the psychic illnesses.

3. Psychologist, psychotherapeutic, and psychotherapist for children and young people

They will be a support from proceedings of structural adaptation and for the treatment of mental health disorders.

4. Psychiatric outpatient

In Bavaria every psychiatric and psychotherapeutic hospital has an outpatient institute. According to the legal requirements, the treatment offer focuses on mental patients that, due to the type, difficulty and duration of their illness, need the outpatient treatment through an Institution. That means, these are patients with specific problems.

5. Social psychiatrist services

They have been developed as an important part of the outpatient care in Bavaria. The aim-group of their services is specially people with mental illnesses who suffer from complex necessities.

They motivate patients with mental disorders, who instead of their needing don´t want more to being treated. They bring services such as cooperation and coordination; they plan and control the different kinds of help.

6. Homecare psychiatric treatment

The homecare psychiatric care solves a care gap in the outpatient sector that especially benefits old people. However they can also care for young people who don´t suffer a physic illness.

7. Socio therapy

The socio therapy services according to article 37 SGV V (social insurance code), support people with mental disorders, who cannot receive the require services from the doctor because of the difficulty of their illness.

The socio therapy covers the necessary coordination of the require service as well as the support and motivation for its utilization. This service contributes to the supervision of people with psychic illness in an individual way. This is a sector not so expanded as expected.

8. Public health services

They dedicate their efforts to the health needs of people with mental disorders as well.

9. Crisis service

The goal of the crisis intervention is to intercept situations of crisis and try to avoid the stationary treatment. Besides they initiate necessary stationary treatments. The target groups are people with several psychiatric, psychotherapeutic and pschicosocial crisis as well as their relatives and also the social environment.

10. Psychiatric-psychotherapeutic Hospital treatment

This service will be guaranteed through the specialist hospitals of the regions as well as through the psychiatric/psychotherapeutic local clinics, independent charitable organizations and university clinics.

11. Support for the self-sufficiency and the social participation

11.1. Sheltered housing

Sheltered housing is an itinerant service for the integration of people with mental illnesses in their home habitat. There will be support services particularly in the range of

the self-supply, the communication, the making of social contacts and daily structures as well as the interventions in case of crisis.

Sheltered housing includes different types of housing: Alone, with the partner, with relatives or in small or big groups. This service can be provided in the own home or by a psycho-social institution.

11.2. Daily structuring measure

This includes selected daily care centers, and also club-homes, leisure time meetings, tearooms, and similar institutions. They facilitate the access for people with mental several disorders through their working method.

11.3. Residences

Residences for people with psychological disorders are stationary institutions that provide integration support. The aim-groups are composed by people who need a long-term support because of their chronic and complex problems.

11.4. Support in working life

People with mental problems need not only daily care and general life planning support, but also support in their job environment. Otherwise employment and occupation have an integrative function.

11.4.1. Institutions of rehabilitation for people with mental disorders.

They offer services for supporting people's work life, and also medical services for the rehabilitation an additional psychosocial support.

11.4.2. Transition Institutions

They offer services in the work or social field as a complex service for a group of people that do not need more medical treatment in residences, however they are not able to manage a normal daily routine.

11.4.3. Workstations for people with disabilities

They offer opportunities for the occupation of people who are not able to integrate in the job market because of their several disabilities. The aim is to introduce these people in the vocational and occupational training. There are special workshops for people with mental illnesses.

11.4.4. Integration Projects

They offer supervised work-places for people with mental illnesses. This is a tool for integration in the working life and for permanent occupation.

11.4.5. Services of Integration

This kind of services should be orientated, on behalf of the integration department, by employment offices and other institutions of rehabilitation for people with several disabilities and they have to guarantee the psychosocial support.

Also they have counseling functions for workers that are in charge of people with mental disorders under rehabilitation programmes.

11.4.6. Additional work places

These are protected supported work offers, specialized for people with mental disorders. These places are offered in order to give them a useful and paid work.

11.4.7. Occupational training and vocational training centers

These centers offer the chance to take part in a high-quality occupational training and their promotion increase the work opportunities.

1.3. LEGAL REGULATIONS

On the one hand we have to do reference at the **social Insurance code** in Germany. Concretely we have to pay attention at the ninth, fifth, and eleventh book of this social insurance code.

The ninth book refers to the "Rehabilitation and participation of disabled people". In its first article they have mention to the autonomy and participation of people with

disabilities in the society. Besides this book attention is paid to the services that different public institutions offer to reach a self-determined live of people with disabilities.

The fifth book refers to the public health insurance in Germany and their services. Concretely the article § 43b mentions the paramedical services for adults with mental disorders or multiple disabilities. According to this article these people can be supported with paramedical professionals, e.g. physiotherapists, ergotherapists, psychotherapists, and clinical psychologists.

The eleventh book refers to the social nursing care insurance. We have to focus on the article 14 which mentions the care needs (Pflegebedürftigkeit). People with care needs are people who because of a physically or mental disorder cannot afford the daily life and they have to be evaluated to obtain a care need grade.

There are different kinds of services for people who have a grade of care needs. The services of the nursing care insurance are provided in form of care money in case of the attention by their own family, care attention at home by different institutions, as well as basic care and household assistance. They also have the chance to assist to day care centers, or residences where they can be attended by different professionals.

On the other hand there is the 9th July 2003 **Bavarian law for the equality, integration and participation of people with disabilities and for the modification of other laws** (Bayerisches Behindertengleichstellungsgesetz und Änderungsgesetze – BayBGG und ÄndG).

The aim of this law is to protect the life and the dignity of people with disabilities, eliminate their disadvantages as well as to ensure the equal participation in the society, promote their integration and facilitate the self-determinate life.

Control Agencies

Psychiatric, psychotherapeutic, and psychosomatic standards of quality should stay to optimize the processes especially where the necessity is urgent. Here also belongs the regular check of the user satisfaction of people with mental disorders in the care area.

There are independent complaint offices which act as a mediate organization in case of conflicts between people with mental disorders (included their familiars), and the organizations that support these people. They contribute in the same way for an important system of quality focus on the people.

2. SITUATION OF MENTAL HEALTH TRAINING IN GERMANY

There are different kinds of trainings for the people who want to join in the professional health care system in Germany but not specifically in the mental health care sector.

On the one hand there are opportunities to study at the university a three years study in the social and care sector and the possibility of doing an additional year or two years in order to obtain a master degree. On the other hand in Germany there are three years professional trainings which combine the theory in a school with practices in different companies (Dual System).

In the non qualified area there are also trainings which combine the theory with the practices and these trainings usually during one year.

There is an opportunity of doing a six week's course in the area of health care as well, and also since 2015 according to the article 87 b SGB (Social law book) another chance to do a training course in the health care area of two months, this training course form people to support the professional care assistants in their daily work.

We structure all the different training in the box below.

QUALIFIED PROFESSIONALS	**University Education**	Nursing science
		Social pedagogy
		Social Work
	Professional Training Dual System 3 years	Support Teacher
		Pedagogue
		Dual training Doctor assistant
		Dual training therapeutic
		Dual training care assistant
		Dual training nursing care

NON QUALIFIED PROFESSIONALS	**Training Dual System 1 year**	Nursing Assistant
		Social assistant
	Training course 2 months	Support of professional care workers

2.1. QUALIFIED PROFESSIONALS

UNIVERSITY STUDIES

Nursing Science

Duration: Three years.

Content of the studies: this study is divided in seven obligatory modules: Basic principles, health care science, care management, quality management, formation and advisor in the care as well as a practice project.

Conditions: At least a three years care occupation, a three years dual training in a social or health care work.

Degree: Bachelor of Science "Gesundheits- und Pflegewissenschaften" with a statement of the correspondent Work-qualification as a supplement.

Social Pedagogy

Duration: Three years.
Content of studies: health care science, palliative care, organization development and management as well as care investigation.
Conditions: At least a three years care occupation, or a three years dual training in a social or health care work.

Master Study Pedagogy for care and health care work

Duration: 2 years.
Content of the studies: It contents two technical disciplines as well as pedagogy and teaching methodology. In the last semester is written the masterwork.
Conditions: University degree in a care science study with a good qualification. Work experience at least of 1.500 hours.

PROFESIONAL TRAINING (DUAL SYSTEM)

This kind of training is offered as a Job offer for the different companies, associations, public and private institutions which works in this sector. The people interested in these trainings should apply with a Curriculum and a motivation letter in order to get these kinds of trainings.

There are a lot of different possibilities of dual training programs; it depends on the companies that offer these programs. Some examples below:

Social assistant

Duration: 2 years.
Tasks: They work in the families, with children and in general where people with disabilities need to be attended, accompanied and supported.
They can work in residences, institutions for the care of people with disabilities, in itinerant services and in private homes.
Degree: Social-pedagogue.

Nurse

Duration: 3 years.
Tasks: They support and care people with illnesses or care needs, they manage and assist medical tasks as analysis and treatments, as well as the documentation of patients.
They can work in hospitals, residences, itinerant institutions among others.
Degree: Nurse.

2.2. NON QUALIFIED PROFESSIONALS

Nurse assistant

Duration: 1-2 years.
Tasks: They support the nursing staff by the care and treatment of patients. They contribute with therapy measures and they take care of the hygiene and cleanness. They work in hospitals, clinics, residences and itinerant institutions among others.
Degree: Nurse assistant.

Care Assistant / daytime companion (Betreuungskraft / Alltagsbegleiter)

Duration: This kind of training is regulated by internal regulations of the company or institution which offers the training and the duration can be different depending on the company requirements.
Tasks: They support people with care needs and held the qualified workers.
They can work in institutions for old or disabled people (for example: Residences, day care centers), also for itinerant care services and in private houses (for example shared flats for old people or people with disabilities).
Degree: Care Assistant

Care Assistant (Betreuungskraft) according to the article 87 b section 3 of the social insurance code (two months course)

Duration: 2 months. 160 hours theory, 95 hours of practices.
Content: Comunication and dialogue technices, dement illneses, basic knowledge about the care and medical documentation, higiene, psicology, leisure time actitivies.
Tasks: They support the qualified care workers, they also take care of the alimentation and mobilisation, the occupation and home care needings of people with disabilities. They work in residences or itinerant care services, and also in daily care institutions.

3. PRACTICES ON TRAINING FOR NON-QUALIFIED PROFESSIONALS

PRACTICE 1	
TITLE	**Training for medical staff of the primary attention system**
DURATION	50 hours
BENEFICIARIES	Destined to the medical staff of the primary attention system.
OBJECTIVES	**General Objective:** - Equip the primary attention staff with the knowledge for the detection of psychiatric problems **Specific Objectives:** - Know the different types of mental illnesses. - Recognize the symptoms and signs of the mental illness. - Know the resources of the primary attention system and the mental system.
CONTENTS	- The severe mental illness, symptoms and signs. - Evaluation of the severe mental illness - The primary and mental attention system and its resources
METODOLOGY	On-site course run to medical staff of the primary´s attention systems. The professionals join the course once a week. The course has duration of 10 weeks, with a lesson of 5 hours each week. It will sent documentation per email so that the students check the different sources at home.
RESOURCES	**Human Resources:** - Specialized teacher in mental health **Material Resources:**

	- Teaching materials. - Blackboard. - Projector and computer - Videos regarding with the subject
EVALUATION	At the end of the course it will be managed an evaluation of the students through a questionnaire. The mentioned questionnaire, multiple-choice, it's guided to answer questions based in practical cases. Those people who approved this test obtain a certificate.

4. CONCLUSSIONS

According to the report of the situation of the mental health system in Bavaria as well as the training and studying opportunities of people who work with people with mental disabilities, we can establish the next conclusions:

The necessity of the regular training for all the family doctors in order to fortify the skills and knowledge about the early diagnosis and the detection of psychic illnesses in order to reach the best possible treatment of their patients.

There are different actors but an effort would be necessary to improve the cooperation between these actors who pay attention of people with these diseases in order to manage the best way of treatment. A better communication between the actors can reduce the time of waiting for the treatment or the correct support of these people and this only benefits the people who suffered this kind of illness.

There are different articles in different regulations but there isn´t a specific law that regulates the situation of people with several mental disorders, instead of that there is in the majority of the cases normative about disabled people in general. For this reason, it is recommendable to implement specific regulations about people with mental illnesses, due to the complexity of the illness of these patients when we speak whether the treatment or the social and occupational integration of them.

It is also necessary to develop a specific normative that regulate the necessary competences of the professionals which works with people with several mental disorders.

Regarding this, there are no professional trainings or training measures for non qualified or qualified people who work with several mental disabled people. Instead of this, the trainings are running to attend people with care needs in general. For a better training and subsequently work between these actors we consider that the best way is to implement specific trainings to support people with mental illnesses, so that the professionals can manage well and with the necessary knowledge their work.

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