

Leonardo Da Vinci Programme Psycho-Rescue Project Rome, 21/1/08

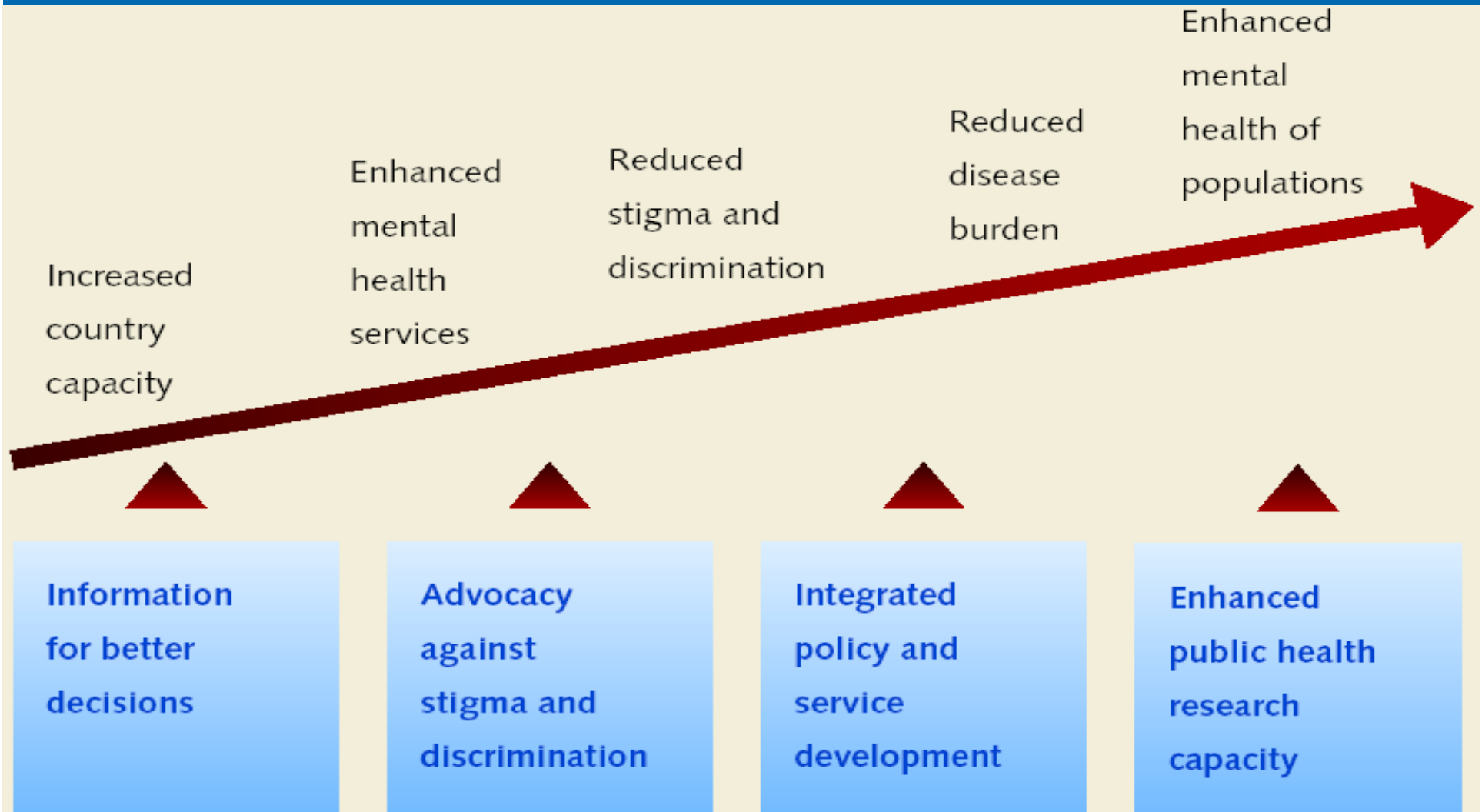
Management of mental health services: Critical remarks and comments

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General framework: political, scientific and ethical background

- Need to raise the awareness concerning the mental health GAP between political statements and principles of mental health policy vs. real setting of practice and services
- Biomedical model is still dominant in practice and scientific publications: the bio-psychosocial model is “no sense” “official” shibboleth in most psychiatric settings

Mental Health Gaps (The mhGAPs) (WHO, B. Saraceno, 2005)




➤ Biomedical model vs. psychosocial rehabilitation models: Towards an integration process

Integration of:

- mental health promotion
- Mental health education
- Assessment of mental health needs of a defined population group
- Model of recovery and psychosocial rehabilitation levels of intervention including: biological-symptoms treatment, understanding of psychopathology, social functioning-social skills approach, subjective and shared-narrative approach
- Assessment quality of life of users and quality of care
- Active involvement and empowerment of users and families
- Innovative management of services and mental health team building responding to the needs of users
- Advocacy and protection of civil rights
- Evidence based psychiatry ↔ values-based mental health

F6. MANAGEMENT OF THE SERVICE

consists of the following:

1. ADHERE TO POLICIES AND PROCEDURES
 2. WORK AS PART OF A TEAM
 3. TAKE AN ACTIVE PART IN MEETINGS
 4. TAKE AN ACTIVE ROLE IN THE IMPROVEMENT OF THE QUALITY OF THE PROJECT
 5. DEVELOP PREVENTIVE APPROACHES TO STRESS AND BURN-OUT
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Topic F.6-1: Policies and procedures

- Create new partnerships and institutional “momentums” with users, families, volunteers, local authorities, key-persons of the community, mass-media
- Share the same vision – co-decision process
- Set a common political agenda to feel the mental health GAP – Promotion through the mass-media


Topic F6-2: Work as part of a Team

- Develop team work culture vs. group of individualistic aims
- Encourage the integration of different social, personal and professional skills→ support the individualized recovery plan of users
- Inter-dependency between observer and observed, strengthen the contextualistic, intuitive, active, partial truth approach
- Implement an external supervision of team dynamics
- Awareness of pathological and de-structuring group defense mechanisms e.g. splitting, paranoid, projective identification, depressive, undoing and withdrawal attitudes

Topic F 6-3: Active part in meetings

- Create an effective process of management of time shecedule
- Make visible the hidden meaning of the institutional conflicts
- Empower a democratic vs. Narcissistic leadership
- Contain the group illusions: maximalistic goals for the users, for the team impact

Topic F 6-4: Active-role of the quality of the project

- Implement an external evaluation and a self-evaluation process
 - Share the meaning of any innovation methodology and the forthcoming benefits for all staff members
 - Integrate any therapeutic and psychotherapeutic approach into a recovery process and vision
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Topic F 6-5: (stress – burn-out)

- Accept the true burden and fatigue of the repetition of today's work
 - Create opportunities of “informal” brainstorming and coming together
 - Invest the outside vs. inside (community links), adopt and manage innovation and critical attitudes coming from visitors
 - Never forget the vision of independent living autonomy and work for our residents: any “residential setting” is a transitional tool the autonomy, not an objective “per se”
- Consolidate the concept of the team as “mental institution” (Hochman J., 1992) e.g. Capacity to share, feel, think, dream together.

