



Leonardo da Vinci

LEONARDO DA VINCI Programme II
PHASE 2000-2006

PILOT PROJECT I/05/B/F/PP-154083
“PSYCHO RESCUE - Psychiatric RESidential care
Communities: Upgrading and Enhancing skills and competences
for member of staff professional qualification”



PSYCHO RES.C.U.E.
I/05/B/F/PP-154083

PRELIMINARY WORKING PAPER

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Transnational Project

ITALY - CZECH REPUBLIC - GREECE - LATVIA - NETHERLANDS - U.K.

PRELIMINARY WORKING PAPER

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INTRODUCTION

This working paper is a guide to deepen the main themes concerning the “PSYCHO RES.C.U.E.” Leonardo da Vinci Pilot Project, on the occasion of the first transnational workshop which is a starting point for our project.

A first description of the project, an analysis of the requirements identified to plan the proposal and a “*refreshing*” of the expected targets and results, are followed by some general reflections on the reference context of the planning proposal and some specific reflections on the main themes of intervention: the organization of psychiatric help services, the involved professional figures, the members of staff training and updating and the need and possibility to better define the professional figure of psychiatric community member of staff through a combined definition and validation of his relevant features, formative paths and required competences.

In particular, this paper represents a picture of theoretical reference to implement the research activities planned for the **PSYCHO RES.C.U.E** project. In order to give a note of maximum operativeness to our meeting and direct the start-up phase of the project, we thought it right to insert in this paper some *key questions* and/or *deepening box* in order to draw the participants’ attention to particular themes. With an explicit request of in-depth analysis, debate or evidence, we will propose these expedients to all participants in order to facilitate either **the targeted grounding of a first contribution to the start-up of the project**, contribution that each partner will have to present during the working days of the first workshop, or just to solicit the exposition of different points of view and get used to the main problems of the workers training and systems innovation.

In order to make the participation and contribution of everybody to this delicate planning phase more profitable, we think it right that each person should tell us his own reflections and give his initial contribution to the stated themes.

In order to facilitate the acquisition of tangible and shared results, it is important that, before our meeting, the different partners could acquire useful informations in order to give suitable answers to the different questions. This way it will be possible, already with this first meeting, to count on contributions already well structured and to acquire/share together some tangible results that will enable us to optimize the debate time and that will assure the future maximum planning operativeness.

1. PSYCHO RES.C.U.E. PROJECT PRESENTATION REPORT

1.1. Explanation and content

Our planning proposal aims at the realization of a research-intervention oriented to the definition and validation of the professional figure of Psychiatric Community Worker through the involvement, sharing and comparison between official representatives and key-actors involved in the organization and management of psychiatric residential facilities in the different countries involved in this project.

The planning idea arises out of the analysis of some reference data on the typology and the managerial, structural and care features of rehabilitation, recovery and reception residential facilities for subjects with mental disorders suffering from different psychopathologies. These facilities set up after the widespread process of “de-internalization” of psychiatric care that has affected, in different measure, several EU countries.

The aim of our research-intervention is to analyse the professional figures currently involved in Psychiatric Residential Communities because nowadays this analysis is unclear, particularly fragmented and divided in various figures not so well defined but just “lent” to psychiatric area: OTA staff, nurses, psychologists, health-care workers, OS, etc... showing an organizational picture of the staff rather heterogeneous. If on the one hand this could be positive, on the other hand it is a problem for the involved staff especially in the first working phases because:

- a) it doesn't define the member of staff who could become demotivated, so this could be a damage for the employer (cooperatives, associations, onlus and/or public facilities) ;
- b) it doesn't quickly allow a positive and effective impact of the member of staff in his working environment. The member of staff needs first a period of careful study of the situation in order to learn how to work and how to approach the particular kind of work he has to do, in that particular context, together with his colleagues, patients and the language they share. So his performance is slow down both at the beginning and then in the checking phases often inadequate.

This is because of the lack of a specific and well defined professional figure that doesn't allow the member of staff to approach by his own means and his peculiar and distinct professional competence, with the risk to let all the involved workers feel like “generic unskilled workers” of psychiatry. Besides,

this confusion often produces little communicability among the different teams, a dispersal and overlapping of methods and interpretations and then this produces the impossibility to compare therapeutic-rehabilitative results to the detriment of the users-patients and the health system.

1.2. Identification of needs

For a first classification of the planning proposal in the requirements detectable at transnational level, the proposer and his partners begin with an analysis of some reference data, available at European and International level, both on the features of mental health national systems and, in particular, on the typology and structural features of residential communities, rehabilitation, recovery and reception services and other facilities for people with mental disorders, existing in the different EU countries. In a deeper and more particular way we make reference to a preliminar documental analysis of the situation existing in the 6 partner countries which gives us some important informations in support of the planning hypothesis.

Data at European level show that more than 1/3 of european countries don't plan any training for the members of staff working in this field: 1/3 among them don't have any specific mental health policies and the 2/5 don't have any mental health programmes. Besides in about 28 % of european countries the community-based mental health services have just been started (this datum is valid above all for low-income Countries) and, where existing, services are often provided by the same mental hospitals, too big and inadequate, characterized by a scant possibility of choice for patients and their families and by serious problems to gain access to the service; we have also to consider that, unfortunately, 85% of the money spent for mental health is invested to support these facilities.

Also in countries endowed with an advanced health system, the *evidence-based* intervention approaches and methods are not so widespread, in the same way the members of staff formative and updating procedures and the interdepartmental clinical and scientific collaborations are not very developed¹, and we don't have to forget that where various services exist, it doesn't mean that the service is adequately provided, nor that it is provided to everybody². It has come out a constant and broad *treatment gap* between the different kind of treatments that patients need and what the available services really provide³.

¹ Project Atlas: Database. Geneva, World Health Organization. Department of Mental Health and Substance Dependence 2004

² Alonso j et al. Use of mental health services in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. Acta Psychiatrica Scandinavica, 2004, 109 (suppl 420)

³ Sources: Kohn R et al. Treatment Gap in Mental Health Care. Bulletin of the World Health Organization, 2004, 82; Knapp M et al. Financing health care in Europe: context for the Schizophrenia Outpatient Health Outcome Study. Acta Psychiatrica Scandinavica, 2003, 107 (Suppl 416); Teh-wei H. An international review of the economic costs of mental illness. Geneva, World health Organization, 2004

The data transnational analysis of partner countries, developed in the pre-planning phase, has also shown a wide and varied outline that justify the proposed intervention and concentrate on the needs of the selected targets.

For instance in **Italy**, the closing of psychiatric hospitals after the passing of the Bill 180/1978 and the transition from an hospital care modality (the ex OP) to a “community” one, coordinated by the public system through the DSM (Departments for Mental Health), related to the different ASL, marked a radical change of the psychiatric care scenery and, consequently, of the involved facilities and their workers. Examining the PROGRES Study Data⁴ (Phase 1 and 2) of professional profiles of members of staff working in Italian Psychiatric Residential Facilities, we saw that the various professional figures are neither homogeneous nor homogeneously distributed. The majority of staff (31,3%) is embodied by nurses, while psychiatrists are 8,2% of the total, psychologists the 5%, social workers the 4,4% and psychiatric rehabilitation therapists the 1,6%. A great part of the staff is formed by auxiliary technical / socio-care members (19%) and educators (11,2%). Other staff typologies, qualified or not, represent the 19,3%. Besides 30% of members of staff have no particular qualification, and the formative levels of professional educators (11,2%) are very variables, above all compared to the specificity of psychiatric training. A facilities census has shown a huge number of people involved in the mental health field, the majority of them full time. This datum confirms that these facilities have a high load for care and they have to guarantee adequate care to a great number of patients with complex needs. Nevertheless the fact that there is a broad number of members of staff without any adequate training for intensive treatment of seriously ill psychiatric patients is one of the most remarkable results reached by the PROGRES Project and it must be considered when planning specific formative programmes. This datum is in step with the results reached in similar researches, relatively on the partner countries, and done by the WHO (*World Health Organization*). However we have to consider that in 2001 73,4% of italian facilities was characterized by a 24 hours a day care covering, datum that confirms how high is in general the care intensity. Comparing the PROGRES Project Data with those of the Ministry for Health till 31.3.1998, we see how, just in two years, the number of residential facilities has increased of more than 300 units and how the equipment of residential places (PR) has side by side increased of more than 50%.

European situation is varied. There is still a difference between high and low-income countries and, in each country, these differences are much more clear between rural and urban areas⁵.

⁴ Sources: Gruppo Nazionale PROGRES “Le strutture residenziali psichiatriche in Italia: risultati della fase 1 del Progetto PROGRES” *Epidemiol Psichiatri Sociale* 2001; Angelo Picardi, Giovanni de Girolamo e Pierluigi Morosini “Le strutture residenziali psichiatriche in Italia: risultati preliminari della fase 2 del Progetto PROGRES” *Laboratorio di Epidemiologia e Biostatistica dell’Istituto Superiore di Sanità – ISS: Pubblicazioni: Notiziario* 2003 – Vol.16 – n.2;

⁵ Human Resources and Training for Mental Health; European Ministerial Conference on Mental Health – Facing the challenges, Building solutions; Helsinki, Finland; 12-15 January 2005;

Observing greek data, we see that in the last 20 years **Greece** started a radical reform in the mental health area, following the WHO guidelines⁶. Between 1981 and 1995 we saw a remarkable decrease of the bedspace number in statal psychiatric hospitals together with a development of psycho social rehabilitation services and the passage of patients from institutional settings to coummunity-based services (residential facilities and rehabilitation services)⁷. The recent Mental Health Reform brought to a ten-year long plan of action named “Psychoargos Programme”. This programme aims to reform, reorganize and create new mental health services. Maximum priority is given to the de-institutionalization, social integration and de-stigmatization of users with mental disorders. The programme is based on the creation of 300 new community-based services (housing units) and the insertion of about 3000 workers who, before the insertion, will need an adequate training. It is also predicted the creation of Psychiatric Departments in each Hospital, Mental Health Centers, Rehabilitative Diurnal Centers, Social Cooperatives, NGOs etc⁸.

Latvia, since its declaration of independence, directed its efforts towards both the development of mental health facilities and members of staff training. It has a great number of professional workers educated with psychotherapeutic training and other techniques that were not so numerous few years ago. The present system, according to international standards, is still under-subsidized and mainly based on great hospital facilities and traditional intervention models that have a high cost. These institutes absorb the great majority of mental health funds, while community-based services don’t have sufficient investments yet. In 2003 about 62.000 patients suffered from mental disorders; more than 1/3 has been admitted to psychiatric hospitals or to one of the 30 public social-care homes. There are nearly no alternatives to these institutions and so patients must be inserted in long waiting lists to access residential facilities (in 2003 about 1.000 people were still in the waiting list for a placement)⁹.

Czech Republic mental health policies are rapidly changing and renewing. In spite of everything patient treatments are still unsatisfying, above all in terms of social integration and rehabilitation. There is also a lack of financial resources in this field. Although many progresses concerning decentralization, destigmatization and staff training have been made, the majority of treatments are still traditional and don’t satisfy the growing needs.

As to the anglo-saxon situation, the de-internalization process started between the sixties and the seventies, and today **United Kingdom** has a well-organized and complex National Health System (NHS). In the last years many changes eased the access to mental health services. They gave particular

⁶ WHO Report 2001: “Mental Health: New Understanding, New Hope”. Geneva, World Health Organization, 2001

⁷ Madianos M et al, Changing Patterns of Mental Health in Greece (1984-1996), European Psychiatry, 1999; Madianos M et al, The Mental Health Care Delivery System in Greece: Regional Variation and Socioeconomic Correlates, Journal of Mental Health Policy and Economics, 2 (1999)

⁸ Health Care & Welfare in Greece. Hellenic Republic. Ministry of Health and Welfare. Athens, 2003

⁹ Republic of Latvia. Ministry of Welfare. Social Report for 2002-2003

prominence to the development of different levels of community-based and individualized services. Besides the National Health Plan “The HSC 1999/154 Continuing Professional development: Quality in the New NHS” underlines the importance of a continuous staff training. There are specific formative procedures for psycho-social intervention and community staff members, but there is still a lot to do in terms of members of staff on duty updating for a Lifelong Learning. Data show that on average there are 11 psychiatrists, 104 psychiatric nurses, 9 psychologists and 58 social workers every 100.000 inhabitants. Besides there are in total 15.040 occupational therapists, 594 psychotherapists and 856 psychiatric care workers¹⁰.

In **the Netherlands**, the current intervention model within the mental health field arises out in the seventies when the first regional community-based services started. Over the years it has been developed a National Mental Health Plan based on the following principles:

- a personalized model for users care (demand-driven) planned to satisfy the socio-cultural features of the individual
- de-instituzionalization and development of territorial and decentralized intervention
- use of evidence-based models of intervention and qualified staff
- collaboration with social networks for patients social reintegration

Data show an average of 9 psychiatrists, 99 nurses with psychiatric training, 98 socio-health workers and 28 psychologists every 100.000 inhabitants. There are also in total 177 occupational therapists, 856 art-therapy workers, 743 psychomobility therapists, 1546 support workers and other various professional figures¹¹.

The collected and pointed out trends indicate an increase in care requirement, but the offer is often inadequate on a quantitative and, above all, qualitative point of view. One can think that on the one hand there are inadequate treatment and rehabilitation intensive plans as regards to the patient needs, and on the other hand that members of staff training is fragmented and not homogeneous. Staff data, keeping in mind that staff is not always endowed with a specific training for the treatment of seriously ill psychiatric patients, could be an indirect proof of this fact.

¹⁰ Becker T., et al & the EPSILON Group (2002). Provision of services for people with schizophrenia in five European regions. *Journal of Social Psychiatry and Psychiatric Epidemiology*. 37; Johnson,S., Zinkler,M., Priebe,S.(2001). Mental health service provision in England. *Acta Psychiatrica Scandinavica*. 104 (suppl 410);

¹¹ The Ministry of Health Welfare and Sport in conjunction with the Timbros Institute (Netherlands Institute of Mental Health and Addiction). (2000). Fact Sheet – Major Challenges to Dutch Mental Health Care.

The pointed out problems, also deducibles with a first analysis of the collected data of typologies and care, managerial and structural features of residential communities and other psychiatric facilities, can be traced back to 3 key-factors:

- **the lack of transparency in the definition of roles, duties and competences required and expected by the different involved professional figures;**
- **the lack of flexible formative means and paths for training and professional updating, in terms of Lifelong Learning, both for young people looking for a job and, above all, for workers on duty;**
- **the lack of a specific and well defined professional figure, the Community / Psychiatric Facility Worker, who has an important and double role: a “psychoeducative” one in the supplied service expected by the users-patients and a facilitation and connection role among the different duties carried out by members of staff in the same facility.**

Deepening box n.1

Synthetic presentation of Mental Health Systems and psychiatric care organization in each Country

(The presentation will have to be synthetic and it will be permitted to support it by slides and/or synthetic reports and/or diagrams that have to be presented and shared with the other partners).

Key question 1

How the de-internalization process of psychiatric care have influenced service organization and competence requirements of the involved members of staff?

Key question 2

Which facility typologies (residential and semi-residential communities, diurnal centers, domiciliary care, etc...) of psychiatric care mainly spread after this process?

Key question 3

How these facilities are organized in terms of governance, financing, human resources, structural and infrastructural resources, management and administration, service supply?

(Also in this case the exposition and presentation of answers will have to be synthetic and it will be permitted to arrange slides and/or synthetic reports and/or diagrams that have to be presented and shared with the other partners).

1.3. Targets and beneficiaries

The planning idea arose out by a transnational analysis of the Mental Health Field with particular reference to data of residential communities and other facilities, reception services, rehabilitation of people suffering from psychiatric pathology, constituted after the widespread process of psychiatric care “de-internalization” that has affected, in different measure, several EU Countries. **The preliminar analysis pointed out that, in support of the process, there are currently innumerable data that confirm the hypothesis that traditional mental hospitals, besides perpetuating patients stigmatization, are often connected to human rights abuses and they can cause a further worsening of patients’ mental health**¹². The de-internalization process encouraged, in many european areas, the development of **new models of cure and the creation of services for community-based mental health care**. These services proved to be more effective both clinically¹³ and economically¹⁴, even if, unfortunately, in many european countries, the transformation process is still far away¹⁵, that’s why it seems to be absolutely necessary the development of new and more efficient *community-oriented* services, adequate support systems and better infrastructures¹⁶.

So the project, formulated according to a prominent sectorial approach - necessarily imposed by the nature and significant high qualification of the involved people - is strongly centred on health and socio-care systems and particularly on mental health services and facility areas as well as, indirectly, on the correlated sub-systems of education and professional training.

In the proposal we determined different levels of receivers of the planned actions, so the project is **addressed to:**

direct receivers:

- young unemployed people and employed and unemployed adults who need an initial and updated training;

¹² Mental health policy and services guidance package: Organization of services for mental health. Geneva, World Health Organization, 2003

¹³ Sources: Leff J et al. The TAPS Project. 22: A five-year follow-up of long-stay psychiatric patients discharged to the community. British journal of psychiatry, Supplement: 12-17; 1994; Marks IM et al. Home-based versus hospital-based care for people with serious mental illness. British journal of psychiatry, 16 – 1994

¹⁴ Sources: Knapp M et al. The cost consequences of changing the hospital-community balance: the mental health residential care study. Psychological medicine, 27– 1997; Knapp M et al. Home-based versus hospital-based care for people with serious mental illness: controlled cost-effectiveness study over four years. British journal of psychiatry, 172 - 1998

¹⁵ Sources: Goldberg D. Findigs from ‘London’s Mental Health’: a service in crisis. Acta psychiatrica scandinavica: Supplement: 399 - 2000; Haug HJ & Rossler W. Deinstitutionalization of psychiatric patients in central Europe. European archives of psychiatry and clinical neuroscience, 249 – 1999

¹⁶ See note 12

- psychologists, social and socio-health workers of the National Health System
- psychologists and members of the social tertiary area (social cooperatives, Onlus, private entrepreneurial).

indirect and final receivers:

- Psychiatric residential communities and/or facilities and other mental health services (semiresidential facilities and diurnal centers);
- National and Local Health System (Departments for Mental Health);
- Social Tertiary Area (social cooperatives, Onlus, private entrepreneurial).
- Training/updating facilities
- Final Users (disadvantaged people with a mental pathology, concerning the services)

Deepening box n.2

Synthetic presentation of educational/training systems and their available formative offer in terms of training/updating of psychiatric care workers in each Country

(The presentation will have to be synthetic and it will be permitted to support it by slides and/or synthetic reports and/or diagrams that have to be presented and shared with the other partners).

Key question 4

Which professional figure typologies are required and work in the community-based facilities of your Country?

Key question 5

How these professional figures are selected and destined to these facilities?

Key question 6

Do the members of staff show any particular training/updating requirement?

(Also in this case the exposition and presentation of answers will have to be synthetic and it will be permitted to arrange slides and/or synthetic reports and/or diagrams that have to be presented and shared with the other partners).

1.4. General and Specific Aims

The first and necessary intervention concerns professional figure transparency and the qualification of community-based Psychiatric Facility Worker through an explicit and shared definition of the required and needed competences. Today this professional profile, in the different national situations probed, is totally unclear, in fact it seems disintegrated and split in various under-figures neither well defined nor qualified, but just “lent” to psychiatric area: OTA (Auxiliary Technical Workers), nurses, psychiatrists, psychologists, social workers, socio-health workers, entertainers, educators, rehabilitation technicians, etc... This phenomenon has various causes: some of them seem to be inherent to the organization of National Health Systems that haven’t set clear specific training plans for psychiatric service workers yet, destining human resources on the basis of bureaucratic-administrative requirements, showing this way little regard for clinical and operational principles; other reasons should be sought in the way social cooperatives and, in general, private and entrepreneurial social area select, train and destine psychiatric service workers whose they’re responsible for, directly or by convention with other local health facilities. Even if there are not important and systematized data yet, everybody knows that psychologists, domiciliar care workers, educators, OTA, OS, nursers and others are taken on to work, in the social tertiary area, as workers in residential facilities and other psychiatric services (Diurnal Centers, Therapeutic Community, personalized care servicez, etc...). The final result is an organizational setting rather vague and heterogeneous that hides, almost in any case, the lack of contents and satisfies bureaucratic-administrative needs than an improvement in rehabilitative therapeutic service.

On the one hand this could be positive because the integration of various experiences and contributions would allow a deeper and faceted consideration, but it is certainly a big problem, especially in the first phases of the worker’s impact with the service and later in the checking phases of results. The worker destined, for example, to a residential facility, before starting to work, must go through a long period of “informal apprenticeship”, absolutely necessary and strategic, that deserves an enhancement and needs a systematization.

In connection with the great number of context elements gathered during the planning proposal phase and the problems emerged, partners have detected and defined the following **specific aims**:

- To redefine and formalize the member of staff formative procedure, even on the basis of an exchange at transnational level of praxis, curricula and previous and developed experiences in different european contexts;

- To define much better and more precisely the member of staff intervention ambits, establishing and strengthening his competences;
- To define flexible methods and training instruments useful to workers training and, above all, updating for a Lifelong Learning;
- To agree on a common language and method (evidence based medicine), comparable and transferable among various psychiatric services;
- To promote qualification transparency through shared systems of formal education, identification of formal and non-formal learnings and their respective certification;
- To propose: a method, organizational and programming instruments, continuous checking instruments of results and qualitative standards.

Key question 7

Which strategies/directories/formative praxis have mainly been adopted in your Country to support the formative procedure of psychiatric community worker?

(During the debate one will be permitted to propose directory and praxis examples briefly).

Key question 8

What kind of results have these strategies/praxis produced up to now in terms of competences and internal organizational improvement of services and therapeutic results?

(On the occasion of the first Workshop, we will try to investigate, all together, the strong and weak elements as well as the ties and opportunities in the different strategies/praxis presented)

(Also in this case the exposition and presentation of answers will have to be synthetic and it will be permitted to arrange slides and/or synthetic reports and/or diagrams that have to be presented and shared with the other partners).

1.5. Expected results and products

The expected results of the project have a strong “systemic” and transnational connotation and their purposes, through the initial deepening of research and analysis phases of contexts and requirements, are:

- The definition of the Professional Figure of PSYCHIATRIC COMMUNITY WORKER and his basic, transversal, theoretical, practical and behavioural competences needed to foster both the realization of therapeutic and rehabilitative programmes for users, and the improvement of teamwork required to the involved members of staff;
- The redefinition of the formative procedure of psychiatric community worker;
- The definition, in terms of Lifelong Learning, of flexible formative paths (standard and forms) planned by partners and some institutional referents who belong to this area;
- The definition of educational methodologies in order to strictly integrate theoretical training with practical performance and to optimize and share, as an enrichment way for teamwork, the work experience among members of staff;
- The definition of models and educational instruments to meet workers formative requirements;
- The definition of a language, a common and shared (evidence-based) method and instruments to programme and check in order to define and strengthen members of staff competences.

The intermediate products of the project, making reference to the initial phases of research and analysis of contexts and requirements, will produce instruments of survey and return for researches/analysis drawing up: national research reports (for each partner country) and transnational comparison reports on contexts and requirements.

Always making reference to the intermediate steps of the project, we will continue with the combined definition of:

- Prototypes of flexible formative paths useful to workers initial training and subsequent updating;
- Educational and formative models and instruments;

- Model Prototypes to programme, organize, support human resources and check therapeutic results.

Based on testing actions and prototypes validation, the expected final results have been identified with:

- The output of a **brochure and an Handbook about the community-based Psychiatric Facility Worker** containing descriptions of this professional profile, his formative procedure, required competences, ways to get these competences through formal, non-formal and informal learnings, the available resources in his area in order to participate apprenticeships and additional formative paths needed to recognize his qualification;
- The output of **flexible and dynamic models and instruments of learnings, on paper support and CD ROM**, that have to be distributed both to the various training facilities specialized in the socio-health area and to the entrepreneurial and social private facilities (Social Cooperatives, Onlus, etc...) that manage community-based Psychiatric Facilities;
- The output of **Guidelines containing good praxis, models and instruments to programme, organize, support human resources, check the follow-up and therapeutic results, in order to support the quality and transparency of various services produced, strengthen member of staff motivational features that have to represent a support, a continuous checking of the various interventions and a control of the burn-out and mobbing risks for workers, facilities and users.**

Deepening box n.3

Synthetic presentation of possible good praxis/models/instruments to programme, organize, support human resources, check the follow-up and therapeutic results used in psychiatric care facilities in each Country

(The presentation will have to be synthetic and it will be permitted to support it by slides and/or synthetic reports and/or diagrams that have to be presented and shared with the other partners).

2. GENERAL REFERENCES AND DEBATE STRATEGIES

On the basis of the previous section which contains a general “*refreshing*” about the proposal and project contents, the first steps of deepening and reflection, they emerge the first general guidelines of the realization strategy and the way to conduct our first workshop in Rome.

Thinking of our first meeting and the consequent debate among partners, it has emerged the need to manage and direct the typology and contents of the expected speeches/comments in order to draw attention on themes and aspects that converge in the aims of the workshop and the planning phase. In particular the approach of the working methodology, both for the workshop and its following developing phases, planned by the ISS Promoter together with the CHI Onlus representatives and researchers during various preliminary meetings, focused on:

- ✓ **the aims that have to be shared:**
 1. to improve the professional standard of the worker category
 2. to reduce the burn-out and mobbing risks for the worker
 3. to improve the service quality through:
 - a) verifiability and transparency of results
 - b) communicability and applicability of methodologies
 - c) a better clinical course and follow-up
 - d) the results of comparative analysis among systems
- ✓ **the arrangement of instruments of preliminar synthesis to focus and manage preliminar contributions by partners**
- ✓ **the planning of "instruments" to conduct and stimulate the workshop.**

As to the first and second point, we relied on both the previous detailed presentation of the preliminar analysis carried out during the pre-planning phase and the bibliographical sources we consulted and the detailed sharing of the expected aims, targets and results/products that have to be carefully analyzed by everybody in order to give answers consistent to what is asked for in this paper.

In particular, as to the second point concerning the arrangement of instruments of preliminar synthesis to focus and manage preliminar contributions by partners, it is strictly correlated to the deepening boxes and key-questions linked to different parts of the planning proposal.

This organizational choice would like to represent a first synthetic return, to the coordination team for the first phases (ISS Promoter and CHI Onlus), of all contributions that will be presented to partners during the first workshop phase.

Boxes and key-questions will have to be considered as the grounding of “guidelines”/”list” for each speech/comment.

We think it is a general and shared belief, in a wide partnership like ours, that the more the project results depend on the work of many and their different competences, the more they are susceptible; so the possibilities and conditions of success for our work deeply depend on:

- the motivation and involvement of partners
- the quality of preliminary papers
- the quality and validity of all partners’ contributions
- the quality and variety of praxis, experiences, equipment and documentation that can be acquired and shared by all partnership;
- the optimization of resources and competences in the allocation and undertaking of tasks.

So, during the preparation of our speeches/comments, it is better to keep in mind that, on the occasion of this first workshop, we’re trying to:

- ✓ deepen each other’s acquaintance and form a teamwork;
- ✓ report the problems identified in the pre-planning phase through a simple documental analysis, preliminar testimonies and contributions of the involved qualified partners which could redefine the intervention margins at national level and the real requirements as regards to the main themes dealt with.
- ✓ examine and deepen some aspects of the planning themes even in the light of possible implementational differentials of systems in the partner countries, and testing the possibility to deal with good praxis already carried out at national level.

So, during this phase, the required analysis will have to focus on the description, collection, organization and critical observation both of context elements (rules, organization of systems, facility typologies, etc...) and experiences (projects/like initiatives, formative and members of staff requalification paths, strategies to improve the formative offer and/or organize services, etc...) already carried out or still under experimentation at national level and, in some contexts, the planning

prospects/proposals/positions/guidelines that, even if they have not been carried out yet, can be connected to the organizational and training problems of members of staff and opened to experimentation.

We identified some physiological steps needed to plan following works:

- ✓ to gather information
- ✓ to think
- ✓ to organize inputs and resources

and we want to run through them with the presentation and sharing, within the transnational workshop, of concrete and/or linked to references and/or documental and/or praxis etc... situations linked to some fundamental elements emerged after the preliminar work and synthetized, for everybody, in this paper.

We want to remind you that the results of your preliminar synthetic contribution will be fundamental to let us refine and improve the general organizational quality of this project and the same workshop and define some very important details linked to the next operative phases of the project, for example:

- to foreshadow a subsequent working pattern and optimize competences and results
- to share a methodological approach to direct the first two research phases

Even as to the exposition and sharing of each partner's contribution to the workshop, we thought to give you little standard references to better benefit from these fundamental inputs.

As you can also see by the workshop programme, we planned the following parameters:

- length of each speech/comment: 15 minutes + involvement times during the debate and the round table
- each speech/comment will have to be supported by a power point presentation of synthetic slides, written in english in order to be projected and photocopied for use and support of all participants
- other possible support documentation (in english) that, for instance, could synthetize the stated contents (patterns, reports of synthesis, etc...) and could be shared during the workshop for use and easier understanding of all partners

As to the last point concerning the planning of "instruments" to conduct/stimulate and value the workshop and to first organize and share the debate results, we are planning :

- a monitoring questionnaire about the rating of the workshop in all its aspects and the future expectations of all participants; we will hand the questionnaire out at the end of the works and it will represent the first element of internal monitoring, self-assessment and checking the quality of the project and partnership

- layout/posters that will enable us to collect, relate and synthesize step by step, during the workshop and making reference to the different presentation, each key-elements of some deepening macro-areas, emerged with boxes and key-questions. This instrument could be a common reference for the shared reflections and the debate time on the stated themes. Of course, in this preliminar phase, we don't expect that all contributions, making always reference to the stated themes and key-questions of this paper, are exhaustive but we would be pleased to have a sort of "exemplarity" for each contribution presented and we will try to collect and share these first results even through the instruments of directing our meeting.

Layout/poster sample to collect contributions:

Deepening Areas and References	Stated Contents					
	- ITALY	- CZECH REPUBLIC	- GREECE	- LATVIA	- NETHERLANDS	- U.K.
Contexts (Box n.1 Key-questions 1)	<i>Mental Health System and organization of services</i> <i>Main normative references:</i> <i>De-internalization process effects</i> 	<i>Mental Health System and organization of services</i> <i>Main normative references:</i> <i>De-internalization process effects</i> 	<i>Mental Health System and organization of services</i> <i>Main normative references:</i> <i>De-internalization process effects</i> 	<i>Mental Health System and organization of services</i> <i>Main normative references:</i> <i>De-internalization process effects</i> 	<i>Mental Health System and organization of services</i> <i>Main normative references:</i> <i>De-internalization process effects</i> 	<i>Mental Health System and organization of services</i> <i>Main normative references:</i> <i>De-internalization process effects</i>
Facilities (Key-questions 2-3)	<i>Facility Typologies of Psychiatric Care</i> <i>Facility features:</i> - Governance - Financing - Resources - Management <i>Main features of services</i> 	<i>Facility Typologies of Psychiatric Care</i> <i>Facility features:</i> - Governance - Financing - Resources - Management <i>Main features of services</i> 	<i>Facility Typologies of Psychiatric Care</i> <i>Facility features:</i> - Governance - Financing - Resources - Management <i>Main features of services</i> 	<i>Facility Typologies of Psychiatric Care</i> <i>Facility features:</i> - Governance - Financing - Resources - Management <i>Main features of services</i> 	<i>Facility Typologies of Psychiatric Care</i> <i>Facility features:</i> - Governance - Financing - Resources - Management <i>Main features of services</i> 	<i>Facility Typologies of Psychiatric Care</i> <i>Facility features:</i> - Governance - Financing - Resources - Management <i>Main features of services</i>

Educational/Training Systems (Box n.2)	<i>Description of the systems and formative offer for the involved professional figure</i> <i>Paths</i> <i>Certifications</i> <i>Competences</i>	<i>Description of the systems and formative offer for the involved professional figure</i> <i>Paths</i> <i>Certifications</i> <i>Competences</i>	<i>Description of the systems and formative offer for the involved professional figure</i> <i>Paths</i> <i>Certifications</i> <i>Competences</i>	<i>Description of the systems and formative offer for the involved professional figure</i> <i>Paths</i> <i>Certifications</i> <i>Competences</i>	<i>Description of the systems and formative offer for the involved professional figure</i> <i>Paths</i> <i>Certifications</i> <i>Competences</i>	<i>Description of the systems and formative offer for the involved professional figure</i> <i>Paths</i> <i>Certifications</i> <i>Competences</i>
Human Resources and Workers (Key-questions 4-5-6)	<i>Professional Figure Typologies involved/required by community-based facilities</i> <i>Selection ways and modalities</i> <i>Certifications and competences required by the different facilities</i> <i>Workers formative requirements</i>	<i>Professional Figure Typologies involved/required by community-based facilities</i> <i>Selection ways and modalities</i> <i>Certifications and competences required by the different facilities</i> <i>Workers formative requirements</i>	<i>Professional Figure Typologies involved/required by community-based facilities</i> <i>Selection ways and modalities</i> <i>Certifications and competences required by the different facilities</i> <i>Workers formative requirements</i>	<i>Professional Figure Typologies involved/required by community-based facilities</i> <i>Selection ways and modalities</i> <i>Certifications and competences required by the different facilities</i> <i>Workers formative requirements</i>	<i>Professional Figure Typologies involved/required by community-based facilities</i> <i>Selection ways and modalities</i> <i>Certifications and competences required by the different facilities</i> <i>Workers formative requirements</i>	<i>Professional Figure Typologies involved/required by community-based facilities</i> <i>Selection ways and modalities</i> <i>Certifications and competences required by the different facilities</i> <i>Workers formative requirements</i>

Strategies/directories/formative praxis (Key-questions 7-8)	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>
Good praxis/models/instruments to manage and check the services (Box n.3)	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>	<i>Description</i> <i>Qualifying Elements</i> <i>Possible results/effects</i>

