International

Collaborating Network
Of
Community Mental Health Leading Experiences

World Health Organization Collaborating Centres

International Mental Health Network

International Network of Practical Experience Against Social Exclusion

April 2001

International
Collaborating Network
in the field of
Community Mental Health

CONTENTS

1. Purpose of the Collaborating Network
2. Objectives of the Network
3. Values and Principles
4. The Network's Mission
5. The Network's Aims
6. Partnership Organizations
7. Membership of the Network
8. Criteria for Membership
9. The Present Position
10. Next Steps.

Appendices: Supporting arguments for Network objectives
Nine principles for international cooperation in mental health
Initial Network participants
Template

SUMMARY

The establishment of a Collaborating Network, to facilitate international co-operation, is proposed.

purpose is to bring together people and places that have been successful in developing good quality community mental health services, with those that are in the process of implementation.

developmentIn this way a more robust community mental health movement can be sustained, which will be effective in influencing and improving the lives of people with mental health problems.

A Collaborating Network in the field of Community Mental Health

1. Purpose of the Collaborating Network

Over the last thirty years, governments around the world have increasingly developed policies and strategies to introduce community mental health systems to replace the institutional system. However, good quality, comprehensive, effective and socially inclusive services have only been developed in a relatively small number of places. This is particularly true for large cities, although the challenges of large rural areas present particular problems .

In every country challenges and, concerns remain. Many large institutions still exist, but even where they have been phased out, institutional thought and practice are still evident. Comprehensive community mental health services have not been fully implemented, and are not integrated with other community resources, such as education, housing, leisure and work opportunities. Unhelpful boundaries and obstacles, which segregate and exclude remain in place across many communities. This poverty of 'ordinary life', supporting services makes long term care and support problematic for many people with enduring problems. It similarly presents very real problems for people with more 'common' and/or brief mental health problems Even where community mental health services have been better implemented, the experience and expertise of service users has not been well utilized and thus their importance minimized.

The Collaborating Network, to facilitate international co-operation has been established for a number of years, . It is different to existing networks, in that it addresses the concerns that have held back the development of integrated, socially inclusive community mental health services. It also actively promotes the development of good practice learnt from participating organizations. The Network is multi-disciplinary and includes, as partners and advocates, service user and carers' organizations.

The purpose of the Network is to bring together people and places that have been successful in developing good quality community mental health services, with those that are in the process of implementation. With the support of a continuous learning collaboration, organizations may benefit from others' experience. In this way a more robust community mental health movement can be sustained, which will be more effective in influencing and improving the lives of people with mental health problems.

2. Objectives of the Network

The International Collaborative Network of Community Mental Health Leading Experiences will have the following goals:

- The creation of community services which are integrated, non-stigmatizing and coherent. The main focus is to enable the development of community strategies that

address the wider mental health and well being of a given community.

- In order to achieve the first goal, the fundamental starting-point remains a deinstitutionalisation of all services; this aims to supersede not only the psychiatric hospitals, but also the danger of retaining an essentially medical model, which finds expression in current psychiatric practice of only “treating and curing illness”.

- The fragmentation of separate responses for specific needs and individuals should be avoided; this only reproduces separation and depersonalization based on the primacy of bureaucratic categories and ideologies of exclusion. Notions of ‘primary and secondary’, ‘enduring and common’, ‘serious and mild’ prevent the adoption of citizenship and community models of care.

The following basic pre-suppositions are at the heart of the Network’s drive for modern practice intended to produce positive outcomes for communities and people with mental health problems :

- Breaking the domination of the medical paradigm, and reconstructing and endowing individual life-stories with value in a culturally and community appropriate way.

- Acknowledging the possibility of illness or distress as an expression of suffering within the various areas of a person’s life, and the adoption of a therapeutic approach which takes the ‘whole life’ of the individual into full account and which recognises his or her uniqueness as a citizen of a given community who does not wish to be excluded because of a mental health problem and who has the potential to be content with or without the presence of mental health problems.

- Affirming the protection of rights as the fundamental element in the care of any individual. Helping a person to good health will not be at the expense of their status as citizen

Arguments in support of these objectives are set out in Appendix One.

3. Values and Principles

The values and principles of the Collaborating Network are for integrated community mental health service development and practice that is underpinned by users' needs and desires and the rights of citizens to have their ‘Whole Lives’ taken into full consideration.

Nine principles for international cooperation in mental health are set out in full in Appendix Two. They are:

1. The principle of explicit aims
2. The principle of the credibility of the practices of origin

3. The principle of the definition of our partners
4. The principle of accreditation
5. The principle of an inter-sector approach
6. The principle of specificity
7. The principle of continuity
8. The principle of transmitting experiences
9. The principle of networking

4. The Network's Mission

The Network's mission is to pool the resources of its membership, in order to collectively seek improved outcomes for people with mental health problems and the communities that they are part of. These outcomes include:

- Treatments and care solutions that improve people's life situations
- People having adequate housing
- People being able to obtain employment
- People able to enjoy social networks and access to leisure
- People participating fully and in an integrated way in all aspects of the life of the community and services they may need to access
- People having access to independent advocacy for service users
- Having clear and accessible information
- The development of effective and meaningful user participation, empowerment and organization.
- Restoration of the rights and status of full citizenship

5. The Network's Aims

The aim of the Network is to assist those places that are in need because of social, professional and political issues and conditions. It operates in partnership with the World Health Organization (WHO), with WHO partner organizations, national ministries, and non-governmental organizations.
It is a Network, of people and places that work together to improve community mental services in each participating location, and to further strengthen the international community mental health movement. This will be achieved in the following ways:

- The development of an information web site, describing examples of good practice, with supporting articles, research and evaluation material;

- The production of a quarterly newsletter which will include articles from participating organizations and individuals, and news about developing services;

- Opportunities for staff, who have developed community services, to use their experience and expertise in the development of services elsewhere in the Network;

- Exchange of staff between all participating organizations for study visits, work placements, workshops, research programmes, etc;

- An annual international conference to bring together participating organizations in the network;

- Access to a support network of organizations with similar values, principles and experiences;

- Opportunities for training and education in community mental health development, through universities and participating organizations in the network.

The Network and its members seek a coherent change in policies for mental health and human development at local, national and international level, including legislation.

6. Partnership Organizations

The founding organizations of the Network were the International Mental Health Network, the International Network of Practical Experience Against Social Exclusion, North Birmingham Mental Health Trust (UK), Trieste Department of Mental Health Services (Italy), Lille mental health services (France), and South Stockholm mental health services (Sweden).

The World Health Organization (WHO), through its Department of Mental Health and Substance Dependence, have a strong interest in the Network and its activities, both in terms of having the Network collaborating with its own priority programmes, and in terms of making information about the Network available to its constituency.

The International Mental Health Network and the International Network of Practical Experience Against Social Exclusion bring together the various networks known to them, into one worldwide network, in order to form the Collaborating Network. Some of the places in these networks that could be involved in this initiative are listed in Appendix Three.

The Centre for Community Mental Health at the University of Central England and the International Mental Health Network has offered an administrative base for the Network, at their offices in Birmingham, UK.

7. Membership of the Network

Organizations that aspire to the values and principles of the Collaborating Network will be able to take part its activities. It is a multidisciplinary/multiagency network, with users and carers as equal partners.

The structure of the Network reflects the actual situation in the development of community mental health services, and the rundown or closure of psychiatric institutions, in each participating place.

Participating organizations include those that have been successful in developing good quality community mental health services (described below as "first generation" and "second generation"), plus others that are in the process of development and implementation.

All the Network's partnerships, even those involving the most vulnerable experiences, will be considered as two-way processes of mutual learning, with no colonizing or over-imposing of views and practices.

8. Criteria for membership of the Collaborating Network

8.1 First and second generation organizations - common criteria

First and second generation organizations will be developing community services with the following features:

- The large psychiatric institutions have been closed or there is an actual plan for closing them ;
- Users are fully involved in the process of developing services;
- Mental health service providers have strong partnerships with local community organizations that can provide housing, work, education and leisure opportunities for users;
- Community health and welfare services, capable of providing support over 24 hours of each day;
- Integrated and socially inclusive in their components;
- Using the least restrictive environments for crisis and emergency care;
- Organizations have clear written policies on ‘Whole Life’ values and principles, that recognize that maintaining or improving the user's desired quality of life is the central aim of the service;
- A clear policy of intention to evaluate local services and to disseminate good ideas, practice and the results of research and evaluation;
- A commitment to sharing with others who wish to influence similar services around the world;
- There is an explicit acknowledgement of the value and importance of diversity and to address the needs of minority groups and a commitment to provide culturally appropriate services.

In addition, the following criteria will apply:

8.2 First generation organizations

Integrated community mental health services will have the following features:

- The successful development of an integrated community mental health system for a population of at least 150,000 people;
- The service has been operational for at least three years.

8.3 Second generation organizations

The practical development of an integrated community mental health system will show:

- At least two years of progress in developing a community mental health system for a population of at least 40,000 people;
- A written strategy, which demonstrates the intention to complete the implementation of a comprehensive service to a population of at least 150,000 people;
- The large psychiatric hospitals have closed, or will be closed within 4 years;

8.4 Developing organizations

Services that have the intention or desire to change from a total institutional service to community-based services will have:

- A written intention of the organization to close the institution and to develop community alternatives;
- An openness to new ideas and a willingness to learn from experiences elsewhere in the world;
- People of sufficient seniority and power to bring about change in the mental health organization;
- Small schemes which have developed, either in or out of the institution, that demonstrate the intention to make change;
- A commitment to users being involved in the development of community mental health services.

9. The present position

The World health Organization has initiated collaborating centres participation in assisting places to develop community mental health services.

In Kosovo a task force has devised a national plan, which is innovative and based on evidence of good practice from around the world. Three collaborating centres are assisting the implementation of this: Trieste, Asturias and Birmingham.

10. Next steps*.*

At a meeting in Geneva on 31st January 2001 the founding organizations (listed in section 5 above) of the Collaborating Network agreed:

- To seek funding from various sources;

- To list activities in course in each site that can be offered as immediate opportunities for synergies, putting them at the network's disposal;

- To set a common agenda, based on partnerships, of the above-mentioned activities and opportunities;

- To state and further agree on every organization's expertise and peculiarities in different aspects of service development, innovative programs, research, training, cooperation, etc;

- To influence mental health policies in many countries according to identified, agreed orientations;

- To identify, in consultation with WHO, organizations in developing countries that can be empowered by joining the network as quick as possible, also in order to organize the first official international conference of the network.

Appendix One

Supporting arguments for Network Objectives

1. Total Institutions

No form of effective community mental health care is possible without the demise of psychiatric hospitals of any type or size, given that such institutions remain the primary location for the reproduction of psychiatry and the dehumanisation, exclusion and impoverishment of persons who have mental health problems . The task of moving away from such institutions should continue until it acquires a global dimension, thereby both declaring and realising the end of the asylum age.

There are several fundamental indicators for this drive to create a community-based practice:

- No coercion
- No constriction
- No practices which violate the body
- No confinement
- No incarceration
- No services that socially exclude or stigmatize
- No denial of Citizenship and rights
- No withdrawal from Community .
- No rejection of everyone's right to hope for and work towards Recovery

2. Community Service

2.1 Values

The integrated community service must represent the central strategic and organisational focus in the prevention, treatment and recovery practices reflected as a unified community mental health issue.

The service's "vision", its intentions and its system of values, in social and therapeutic terms, must always and invariably be based on the central importance of the primary user and his or her process of recovery, his or her "comeback", and his or her life possibilities within the framework of accepting the importance of the person's 'Whole Life' rather than just their illness.

The concept of community responsibility for mental health must also be able to redefine issues of social control. Such redefinition must take into account and mediate between the points of views of all those involved, as stakeholders, but above all with the protection of vulnerable and socially excluded people as the top priority.

All people have the right to live in their own private space, regardless of the nature and extent of the mental health problem they are experiencing , This right should be protected to prevent the risk of new forms of the asylum and institutionalisation and the consequent, exclusion and de-personalisation of the individual .

The right to have a productive, or at least an active, role within society through employment, job placement or forms of social enterprise, should also be guaranteed.

The services must recognise and value Diversity in all its forms. Differences of gender, "race", sexual orientation, disability and culture are important for the development of strong communities as well as fundamental to the concept of equal rights. Thus, should also be fundamental to health and well being policies and practices.

The fight against Stigma and discrimination should be central to all organisations , not only in the sense of overcoming the medical paradigm, but also by expanding forms of access to, and participation in, the life and the development of services, from planning to management, for everyone involved. This might include user committees, consultation groups made up of users, operators and people from the community and possibly new forms of governance based on mutuality and cooperation between users, professionals and citizens from the community.

2.2 Criteria

Its organisation should be based on:

- Co-ordination between all t parts of the service network and strong connections with the wider community, in order to guarantee therapeutic and social continuity ;
- The accessibility of all services, which should be re-evaluated and redesigned, based on user and community needs. Clear, jargon free information should be available across the community;
- Programmes and approaches which are flexible and modulated, as opposed to rigid and determined by oppressive or service driven protocols;
- Not selecting, rejecting or avoiding people solely on the perceived ‘seriousness’ of their mental health problem or perceived ‘social nuisance’;
- The integration of service and community resources, in order to respond comprehensively to the support, material and relationship, needs of individuals;
- Avoiding unnecessary or prolonged hospitalisation, through the development of a range of community interventions in times of crisis or breakdown of existing supports;

- Confronting the most difficult situations, with the highest content of personal and social suffering, within the community itself, and thus avoiding the delegation of such situations to closed institutions and containment structures, both old and new.

Services must shift from a 'pathological' clinical model based on the illness and the associated symptoms to one which is 'Whole Life' in its vision and approach and which is based on "shouldering the burden", or assuming the importance of addressing all the user's needs, aspirations and meanings.

2.3 Resources

Mental health practices must involve other people, resources and social processes that go beyond specialist psychiatric staff, to include the users themselves, members of the social network and the community network.

Modern approaches to mental health demands the decisive development of the role of non-professionals in strategies of assistance and social reintegration. However, the struggle must continue, so that services worldwide can be guaranteed adequate human and material resources, whether through local means or international efforts.

Services must be conceived as organic realities that need to constantly evolve, open to change, both responsive to and interacting with new needs, as they emerge from society. They must also be able to identify, and overcome, new forms of institutionalism.

2.4 Facilities and Programs

The keystone of a modern community mental health approach is one which is capable of reacting to the problems that emerge within communities over the full 24 hours of the day Systems should be designed to move away from the need for medium or long term psychiatric hospitalisation but also designed to overcome inappropriate forms of short-term stays in a medical environment.

A range of small-scale domestic living situations should be developed , which are not clinical, but based on the real situations of daily life. They should be transitional, offering flexible time periods, be adjustable to individual needs, and be able to sustain and develop the capacity for self-management and experiences of community participation.

The organization will need to 'organically' connect structures and programs. It must not allow them to remain in separate contexts or to operate independent of each other, but articulate them into pathways, which permit the user to make choices of opportunity at the right time and in the right way.

Therapeutic, recovery programs should be viewed from the perspective of integration between a wide range of approaches and interventions, as opposed to models, which are sectorized, or based on technical, philosophical or professional divisions.

The avoidance of standardised approaches which are pre-fabricated and which fail to guarantee that it is the uniqueness of the individual, and the construction of his or her own 'Whole Life' meaning, which guides the therapeutic approach. Treatment and support can only occur if one begins from the user's active involvement in his or her own therapeutic programme , recognising in him or her the power, authority and autonomy to make the therapeutic contract within his or her unique community.

It is therefore not treatment models, which are needed, but integrated projects for mental health, health in general and "social" and economic well being. Such projects must take into account institutional situations, but cannot be applied within total institutions; otherwise they risk being perverted into strategies of mystification, of false recovery and of consensus management.

The separation or opposition between places of treatment and recovery work must be overcome. They should have synergy and be considered in terms of the context of the individual.

4 Community Networks

"Enhancing a community" should be of prime importance in the delivery and planning of community services. Such services must be able to produce networks, and to work with networks, which already exist. Particular attention must be given to primary networks (family, neighbours, friends, the workplace).

Attention must also be given to formal or official networks, and wherever possible working towards the integration of health and social services., The service should develop effective partnerships with all social and health services. The community medical services and primary care should be designed to ensure maximum accessibility for people with mental health problems.

It is also necessary to ensure that the entire social-health network is committed to the development of non-institutionalized services and, in the movement towards the formulation of 'Whole Life' socially inclusive health and well-being projects, which seek to "de-medicalise" wherever possible.

Finally, networks of networks must also be promoted through an real commitment to connect associations and groups , both inside and outside of the field of mental health.

Networking should not be seen as an alternative to the work of developing good services. It is not essentially about cost reduction but evidence suggests that such an approach will make for more efficient use of resources and allow for reallocation of resources to more socially inclusive projects. However, it does not reduce the need to actively promote the fair allocation of resources for mental health. And a continuation of

seeking the development of strategies external to the official services .

It is also concerned with recognising, in a very real way, the finite limits of welfare and assistance systems. It is a way of preventing policies from being dictated from above, without taking into account the role of individual human beings, their interests, their values and their ideologies.

Networks, which result from this approach, become vehicles for strong values and empowerment, and should be seen as mobile, equal and horizontal organisations, which comprise organisations and individuals who have shared goals.

All services must function as an interfaces with the community. To best achieve this aim, a number of basic actions are seen to be necessary:

- Participation in the services must be encouraged for everyone the service encounters, as individuals or where they are organised in groups or associations ;

- Users should be involved in the services through coming together, the promotion of self and mutual-help, relationships with associations, and forms of consultation and participation in decision-making as part of the empowerment process. At the same time, these actions are not sufficient in themselves, and must include or be based on the availability of real resources, and the ability to use and profit from them, through strategies of citizenship training and information;

- Non-professional and “extra-clinical” resources must be fully exploited and developed , not only in the therapeutic-recovery work, but also in community mental health projects;

Positive physical and mental health should be rigorously promoted, by both encouraging the social integration of users, and by stimulating the awareness of the public about the realities and ‘normality‘ of problems arising from poor mental health, and by planning for positive and active dialogue“ with the community;

- Approaches and practices of inclusion and social belonging should be encouraged in a way, which supports and sustains the construction of identity and of multiple social roles, and which do not oppress the service user in his or her role as such, but support his or her uniqueness as an individual and fellow citizen;

- All forms of collective and participatory action which encourage mutuality and cooperation through reciprocity and the overcoming of the constraints I of institutional roles should be sought out and encouraged;

- Educational and “empowerment” strategies should be seen as the building of autonomy and the reduction of social barriers, which impede the exercise of the full rights of citizenship;

- The recognition and strengthening of networks should also be carried out in order to help in the transformation of the service and to accelerate the anti-institutional work;

- The service must actively and dynamically intervene in the culture of the community to dispel the myths and legends of mental health and with the intention of overcoming social exclusion, stigma and discrimination.

By means of such actions, tolerance need no longer be a paternalistic concept, but can become the goal for real processes of social inclusion.

Appendix Two

Nine Principles for International Cooperation In Mental Health*

*Based on a draft proposed by Dr B. Saraceno.

1. The principle of explicit aims

International cooperation must have explicit aims. The fight against social exclusion, stigma and discrimination must spread and extend itself, take on local cultural forms and strengthen its actors mutually. Therefore, cooperation must have, as its primary aim the construction of a common and international mode of values against social exclusion, while at the same time being based on diversified, local, policies.

2. The principle of the credibility of the practices of origin

The desire to engage in cooperation is not enough. The practices, which we intend to use, must have at least achieved, in their areas of origin, what we wish to achieve in those countries where we want to carry out cooperation efforts. We cannot aim at closing psychiatric hospitals in distant places only because we have bean unable to close those in our own countries. Our collective practices, and our individual biographies, must be credible in order for our cooperation to be credible

3. The principle of the definition of our partners

Our local partners must also be credible. Regressive practices and ideologies exist everywhere (and the worldwide diffusion of international psychiatric associations, with the aid of the pharmaceutical industry, encourages the growth of such practices and ideologies). It is necessary that the intentions of partners, and the embryonic experiences which already exist, identify common areas for the realization of projects and goals.

4. The principle of accreditation

Cooperation must be accredited with the countries (or local communities) where we intend to work. The promotion of experiences, without any formal or political (even local) recognition, inevitably results in the creation of private networks, which merely produce episodes of cooperation, instead of creating realities which can influence the social-health policies of these countries. We must constantly strive to maintain a balance between cooperation, which is politically accredited, and local experiences. The separation between the two levels only results in failure, as has already been widely experienced: on the one hand, the NGO's (Non-Governmental Organizations) minimalist approaches without accreditation and, on the other, the WHO's approach which has the political accreditation but lack the local, basic, practices.

5. The principle of an inter-sector approach

The general goals of cooperative interventions should be the fight against social exclusion, stigma and discrimination, the promotion of citizenship, peaceful coexistence and tolerance. Cooperative interventions must therefore move towards an inter-sector approach, by working on the many forms of exclusion that exist within a given area, rather than on one separate sector (psychiatric hospitals, institutions for the elderly, institutions for the disabled, prisons, abandoned children etc.). Population-based approaches must take precedence over thematic ones (psychiatry, disability, women, children). Cooperation means working with places and persons, not with "problems".

6. The principle of specificity

However, the inter-sector approach must not become an excuse, for abandoning the historical specificity of the fight against the psychiatric hospital, and the creation of a community-based system of mental health care, understood as the concrete centre for the evolution of processes of citizenship, and as an emblematic model in the fight against social exclusion. Against a globalization of the ideology of neo-liberalism, which renders the centres of power diffuse and refractive, we must be careful not to oppose a generic globalization of the fight against exclusion. Instead, there should be the obstinate re-proposal of the fight against the psychiatric institution.

7. The principle of continuity

Cooperation must be sustainable, that is, it must create scenarios that do not disappear at the end of the intensive phase of cooperation. Because this is a difficult goal to achieve, it is necessary to guarantee a continuity of the intervention after this intensive phase. It is much better to have a few "fronts" which are open but solid, rather than an inflation of minor cooperation efforts, which are destined to a rapid disappearance.

8. The principle of transmitting experiences

There exists an obligation to document experiences. This requires languages, which are comprehensible worldwide, and effective instruments of communication and dissemination. It is necessary to overcome the phobia of the quantitative, in order to be able to provide convincing data. Cooperation should also be a vehicle for training. It is necessary to abandon the use of cooperative jargon and create a language, which communicates (as well as knowing the languages of the countries in which one is working).

9. The principle of networking

The different experiences, individual actors and institutions involved, must network constantly. A constant goal must the empowerment of peripheral experiences through the creation of a network of consultants and permanent exchanges This network should begin by enhancing the resources of those actors/experiences, which are weakest first.

Appendix Three

Initial participants in the Network

Albania
Argentina
Athens, Greece
Auckland, New Zealand (Peter McGeorge)
Avon & Wiltshire, UK (Roger Pedley)
Bangladesh (Nazmal Ahsan)
Bangor, North Wales (Alun Davies)
Beograd
Boulder, Colorado, USA
Bradford, England (Pat Bracken)
Caboolture, Queensland, Australia (Kalyanasunfram)
Chile
Cork, Republic of Ireland (Pat Madden)
Cuba
Derry, Northern Ireland (Bernard MacAnaney)
Dominican Republic
Glasgow, Scotland (Tim Davison)
Johor Bahru, Malaysia (Abdul Kadir Abu Bakar)
Keene, New Hampshire, USA (Fran Silvestri)
Kerala, India (Dr Mani)
Kosovo (Liliana Urbina)
Leros, Greece
Lille, France (Jean-Luc Roelandt)
Lisbon, Portugal
Lower North Shore, Sydney (Alan Rosen)
Macedonia
Madison, Wisconsin, USA (Ron Diamond)
Monahan, Republic of Ireland (Geoff Day)
Montenegro
Mozambique
North Birmingham, England (Sashi Sashidharan)
Oviedo, Asturias, Spain (Victor Basauri)
Palestine
Plymouth, UK (Phil Confue)
Prague, Czech Republic (Jan Pfeiffer)
Prato, Italy (Pino Pini)
Rio de Janeiro, Brazil
Somerset UK, (Paddy Cooney)
South Stockholm, Sweden (Filipe Costa)
Trieste, Italy
Vancouver, Canada
Wellington, New Zealand (Peter McGeorge)

Appendix Four

International Mental Health Network

International Community Mental Health Leading Experiences

World Health Organization Collaborating Centres

TEMPLATE FOR SERVICE PROFILE OF COLLABORATING NETWORK MEMBERS

The purpose of this template is to create a database of accurate information about each member's present services. This will be used for validating members current position in the Network, for exchanging information, and for identifying expertise to assist other members in the development of their services.

NAME OF THE ORGANIZATION____

NAME OF RESPONSIBLE OFFICIAL____

TOWN____

REGION____

COUNTRY____

Catchment area:

- Population size____
- Ethnicity of Population____

____

- Geographical Size____
- Description of Area____

____

____

____

Budget:

- Hospital services ____
- Community services ____

<u>Services provided at present</u>:

A HOSPITALS

· No of hospitals____

Name of hospital	**Location**	**Number of staff**	**Budget**	**Number of beds**					
				Acute	Long stay (under 65)	Long stay (over 65)	Children (under 18)	Learning disability	Total Number of beds

B COMMUNITY SERVICES

Name of service	**Type of service** (day hospital, community team, community hostel, etc)	**Location/population served**	**Number of places**	**Number of staff**	**Budget**	**Year started**

COMMUNITY SERVICES (continued)

Please continue answers on a separate page if necessary

- How are these services integrated with each other and with other community facilities in the local area

____

____

____

- Do they provide 24 hour support and treatment for each client, and if so, how?

____

____

____

- How are the different parts of the service co-ordinated to guarantee therapeutic continuity? How do you avoid fragmentation of service provision?

____

____

____

- How are the services made accessible in a timely and effective way for the consumer and the communities they serve?

____

____

____

- How do you provide a wide range of social and welfare resources in order to respond to the material and relational needs of individuals?

____

____

____

- Do you try to avoid hospitalisation through the development of community crisis interventions? How does it work?

____

____

____

____

____

____

____

- Do you use any restrictive environment for crisis care? What kind?

____

____

____

____

____

____

- How do you confront the most difficult situations, for the people with the highest level of need within the community? What are the strategies?

____

____

____

____

____

____

Do you have strong partnerships with local community organizations that can provide the following opportunities?		What do they provide?	How does the partnership work?
Housing	Yes / no		
Work	Yes / no		
Education	Yes / no		
Leisure	Yes / no		

Plans and strategies

- Does your organization have a written plan outlining the development of services over the next few years?

____

____

If yes, does this include?

- The run down and closure of the psychiatric hospital? _________________________
- The development of community mental health services? ________________________

(Please enclose a copy of your plans when you return the questionnaire)

- Do you have clear written policies on values and principles that recognize that the user's quality of life is the central aim of the service? (Please enclose)

____

____

- Do you have any user organization involved in the process of developing services?

____

____

____

- Does the organization have a clear policy of intention to evaluate local services? (Please enclose)

____

- Does the organization have a clear intention to disseminate good ideas, practice and the results of research and evaluation? ____________________________________

- Does the organization have a clear commitment to sharing with others who wish to influence similar services around the world?
  ____

SIGNED ……………………………………………………………………………………………

ON BEHALF OF ORGANISATION………………………………………………………………

DATE……………………………………………………………………………………………