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TRUST

TAILORING LAW AND HEALTH INITIATIVES TO PROMOTE INCLUSION ON MENTAL ILLNESS

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MANUAL

COOPERATIVE PRACTICES

HEALTH, LAW, EDUCATION AND COMMUNITY NETWORK

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TECHNICAL SHEET

TITLE

MANUAL ON COOPERATIVE PRATICES ON HEALTH, LAW, EDUCATION AND COMMMUNITY NETWORK

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PART I | INTRODUCTION

https://www.google.com/search?q=mental+health&source

Mental health - neglected for too long - is essential for the general well-being of people, societies and countries and must be universally looked at from a new perspective. The evolution of knowledge on this subject shows how science and sensitivity combine to break down the real barriers to care and cure in mental health. This is because there is a new understanding that offers real hope to the mentally ill: the understanding of how genetic, biological, social and environmental factors combine to cause diseases of the mind and the brain. Today, it is understood that mental and physical health are truly inseparable and how complex and profound an influence of one on the other is.

Mental disorders result from many factors and have their physical basis in the brain and can affect everyone everywhere. And we know that, more often than not, they can be treated effectively.

The history of the United Nations General Assembly demonstrates the growing concern to guarantee the rights of the mentally ill with regard to their protection and care. This concern is based on principles such as the importance of non-discrimination for mental illness. Another idea is that, as far as possible, every patient should be granted the right to have the necessary care in his or her own community and, finally, that every patient should have the right to be treated in a less restrictive and intrusive manner, in an environment that is as least restrictive as possible. Despite these efforts, it is known that much remains to be done. Many people may not be receiving the care they need - which is available and can be obtained at no great cost. Estimates indicate that millions of people currently suffer from mental or neurobiological disorders or psychosocial problems such as alcohol and drug abuse. Many suffer in silence. In addition to suffering and carelessness, there are the frontiers of stigma, shame, exclusion and, more often than we would wish to acknowledge, death.

It is believed that the means and scientific knowledge are available to help those with mental and brain disorders, but more than anything else, greater care is needed by the governments and health communities of the various countries. Public education and awareness campaigns on mental health should be promoted in order to reduce barriers to treatment and care by raising awareness of the frequency of mental disorders, their susceptibility to treatment, the recovery process and respect for the human rights of people with such disorders. The available care options and their benefits should be widely

disseminated so that the responses of the general population, professionals, media, policy makers and politicians reflect the best available knowledge. This is already a priority in several countries and in various national and international organizations. A well-planned public awareness and education campaign can reduce stigma and discrimination, encourage the use of mental health services and bring mental and physical health closer together.

1.1. PROJECT TRUST PRESENTATION

World Health Organisation (WHO) describes mental well-being as a fundamental component to health and places it as one of the major concerns for the years to come (Mental Health Action Plan, 2013-2020). Mental health is being targeted with major investment from all states worldwide, with strategies that empower people with mental health problems to engage on training and employment and also that encourage community-based services that will assure the maintenance of the family and friendship bonds. This is also a concern by the member states in their national strategies for mental health (Portuguese National Plan for Mental Health). For too long mental illness has been kept apart from crucial achievements in the sphere of basic rights, including education and training in its diverse modalities. Also, the lack of knowledge that population show when questioned about mental illness reveals they are full of pre assumptions and need more and better knowledge, including groups of professionals that need to work with people with mental illness, like Law Enforcement Authorities (Lurigio, 2011). Data show these people tend to enter the judicial system with minor offenses, damaging the effectiveness of the system and themselves, and preventing them to receive proper treatment and assistance (https://csgjusticecenter.org/mental-health).

Community agents, including courts, judges and police are making an effort to develop strategies to reduce the number of processes and help people with mental illness receive proper treatment and assistance.

PART II | GUIDING PRINCIPLES

2.1. MENTAL HEALTH AND THE INTERNATIONAL RECOMMENDATIONS

Disabilities and impairments, in whatever form they take, are important strands of human life, leaving some people with challenges that others do not have and may not understand.

According to the World Health Organization (2016), about 15% of the world's population, around one billion individuals, live with some form of disability. The number of people with disabilities is increasing due to the aging of the world population, as well as a higher frequency of chronic diseases and illnesses. It is therefore urgent to take steps in order to protect and promote the rights of persons with disabilities.

People with disabilities, especially mental illness pose a double challenge to the qualification system. On the one hand, there must be openness and flexibility so that their particular circumstances, their diversity, can be welcomed and managed in the context of their intervention. On the other hand, there must be an increased attention and effort in view of their lower skill levels in relation to the general population.

Recalling the principles of the Universal Declaration of Human Rights, International Covenants on Human Rights, the Declaration of the Rights of the Child and the Declaration of the Rights of the Mentally Disabled, the Declaration of the Rights of the Disabled states that people with disabilities have the right to education, vocational training and rehabilitation, support, counselling, placement services and other services to enable them to develop their skills and abilities to the fullest and to accelerate their processes of social integration or reintegration.

At an international level, the United Nations (UN) is working to guarantee the rights of these vulnerable groups, such as people with disabilities, in order to overcome physical and social obstacles. Thus, in order to emphasize the importance of mainstreaming disability issues as an integral part of relevant sustainable development strategies, the Convention on the Rights of Persons with Disabilities emerges, recognizing the importance of accessibility to education, information and communication.

Thereby, the objective is the possibility of access free, quality, inclusive education on an equal basis with others in the communities in which they live, and reasonable adjustments can be provided, where required, to meet individual needs to facilitate their effective education. In order to enable persons with disabilities to learn practical and social development skills

so that they can grasp a full and equal participation in education and as members of the community, it is ensured that persons with disabilities can access higher education, vocational training, adult education and lifelong learning without discrimination and on equal terms, always providing the necessary adaptations for people with disabilities.

2.1.1. WHO

"The world is accepting the concept of universal health coverage. Mental health must be an integral part of UHC - Universal Health Coverage. Nobody should be denied access to mental health care because she or he is poor or lives in a remote place."

Dr Tedros Adhanom Ghebreyesus,
Director-General of the World Health Organization

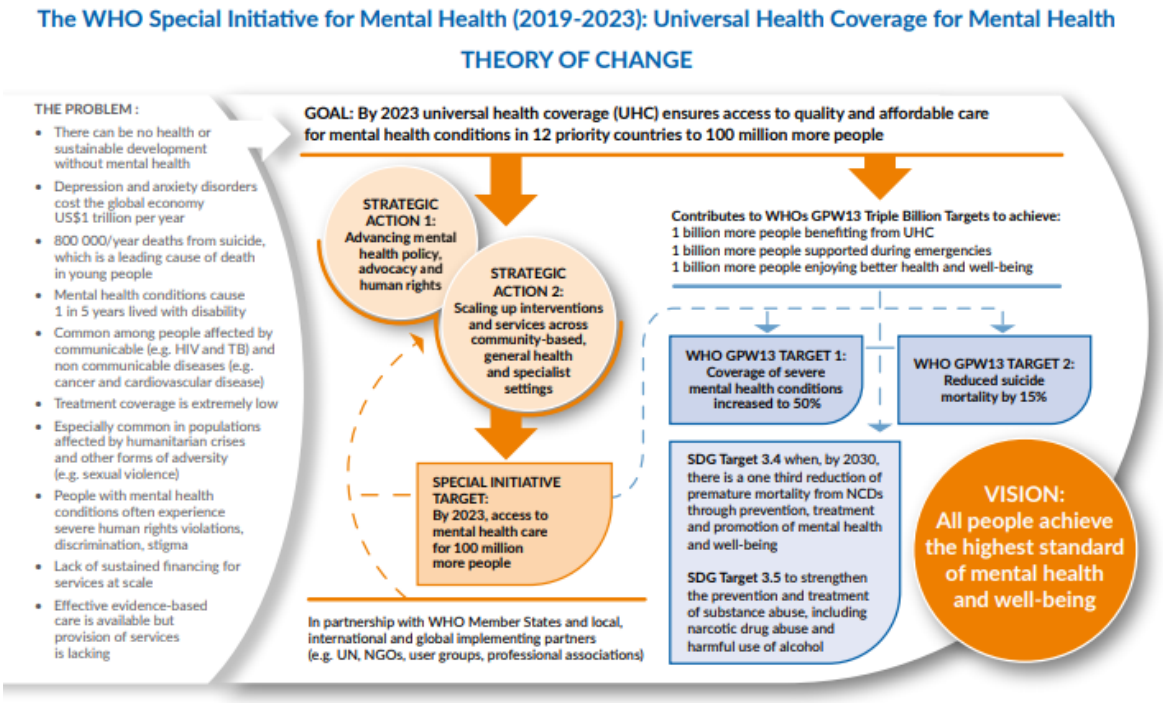
Over time, there has been a growing recognition of the important role mental health plays in achieving global development goals, as illustrated by the inclusion of mental health in the Sustainable Development Goals. Depression is a major cause of disability. Suicide is the second leading cause of death among young people aged 15 to 29. People with serious mental health problems die prematurely - up to two decades before - due to avoidable physical problems.

Despite progress in some countries, people with mental health problems often suffer serious human rights violations, discrimination and stigma.

Many mental health conditions can be treated effectively at relatively low cost, but the gap between people who need care and those who have access to it remains substantial. Effective treatment coverage remains extremely low.

More investment is needed on all fronts: for mental health awareness to increase understanding and reduce stigma; for efforts to increase access to quality mental health care and effective treatments; and for research to identify new treatments and improve existing treatments for all mental disorders. In 2019, the WHO launched the WHO Special Initiative for Mental Health (2019-2023): Universal Health Cover for Mental Health to ensure access to

quality and affordable mental health care in 12 priority countries for a further 100 million people.



https://apps.who.int/iris/handle/10665/310981

Mental health conditions include mental, neurological and substance use disorders, suicide risk and associated psychosocial, cognitive and intellectual disabilities.

The WHO Special Initiative for Mental Health will work towards a vision where all people achieve the highest standard of mental health and well-being. Universal health coverage (UHC) means that all people receive quality health services that meet their needs, without exposing them to financial hardship in paying for them. Quality mental health care refers to care that is safe, effective, timely, efficient, equitable and people centered. This includes ensuring interventions and services are evidence-based and respect human rights.

Two strategic actions will be implemented, each with different expected outputs, shown in the table.

STRATEGIC ACTION 1: ADVANCING MENTAL HEALTH POLICIES, ADVOCACY AND HUMAN RIGHTS	STRATEGIC ACTION 2: SCALING UP INTERVENTIONS AND SERVICES ACROSS COMMUNITY-BASED, GENERAL HEALTH AND SPECIALIST SETTINGS
1. Globally, mental health is positioned high on the development and humanitarian agendas 2. Local champions, people who use mental health services, and their organizations are empowered to participate in the development and implementation of mental health policies, strategies, laws and services 3. Mental health policies, strategies and laws are developed and operationalized based on international human rights standards 4. Media and community awareness about the importance of mental health across the life course is raised 5. Human and financial resources for mental health are brought in line with the needs	1. Quality, affordable mental health care is scaled up across health and social services 2. Quality, affordable mental health care is integrated in relevant programmes (e.g. for HIV, gender-based violence, disabilities) 3. Mental health and psychosocial support is included for preparedness, response and recovery in emergencies 4. Priority interventions for groups in positions of vulnerability (e.g. women, children, youth, older people, staff) are developed and implemented 5. Implementation is documented, monitored and evaluated to improve services

https://apps.who.int/iris/handle/10665/310981

Examples of the types of services countries will implement include mental health care in primary health centres, community-based mental health centres, mental health units in general hospitals, day centres, mobile clinics, and outreach services for home-based support— offering evidence-based treatment, rehabilitation, care and recovery.

This special initiative is designed with multiple assumptions. These include:

- Priority efforts being needed to integrate mental health care across all levels of health care, including community, primary, non-specialist hospital, and specialist services. Such integration of care will be critical to achieving universal health coverage and ensures optimal reach to as many individuals, families and communities as possible.
- Affordable services and interventions for mental health conditions refers to care that does not expose people using services to financial hardship.
- Focusing across the life-course, leaving no-one behind. This includes women, men, girls and boys across cultures, contexts, health conditions and in all phases of life.
- Respecting international human rights standards, particularly the UN Convention on the Rights of Persons with Disabilities, and the principles of legal capacity, liberty, non-discrimination, participation and inclusion of people with mental health conditions.

- Respecting humanitarian principles of humanity, neutrality, impartiality and independence; in addition to other global frameworks and standards for mental health and psychosocial support implemented in emergency settings.
- Being adaptable to local context and their available resources, culture, language, social structures, gender and ability; and in response to social, environmental and economic determinants of health.
- Commitment to a multi-sectoral approach, which may mean the need to work with individuals, families and communities on a prioritized set of interventions at critical phases based on country-specific needs.
- Commitment to collaboration with Member States' ministries of health and other relevant government entities, in addition to other local stakeholders.
- Commitment to collaborating with governments, UN organisations and NGOs, research institutions, global partnerships, and donors.

2.1.2. UNESCO

UNESCO is committed to promote better health and well-being for all children and young people, through a structure its work around two strategic priorities – ensuring that all children and young people benefit from good quality, comprehensive sexuality education that includes HIV education, and ensuring that all children and young people have access to safe, inclusive, health-promoting learning environments.

United Nations Educational, Scientific and Cultural Organization

The result of an extensive consultation process, this strategy provides the overarching framework for concerted action by UNESCO and its partners at global, regional and country levels during 2016- 2021.

Implementation of the strategy will build on UNESCO's guiding principles and its longstanding work on promoting comprehensive sexuality education, safe and inclusive schools and school health through a range of global, regional and national initiatives.

UNESCO priority is supporting national education sectors to ensure that all children and young people have the opportunity to develop the knowledge, attitudes and skills needed for healthy lives and relationships in the context of a supportive learning environment.

The UNESCO's guiding principles are:

- Human rights – UNESCO is guided by international human rights principles, conventions and standards. UNESCO takes a human rights-based approach in all its actions that emphasises equality, non-discrimination and respect for diversity, participation and accountability.
- Gender – UNESCO supports gender-transformative programming that advances gender equality and respect for diversity, and addresses gender roles, cultural norms and power structures that increase young people's vulnerability and adversely affect their health and education outcomes and well-being.
- Country ownership – UNESCO is committed to the principles of national ownership, harmonisation and alignment in line with the Paris Declaration on Aid Effectiveness, and will continue to align its actions with national priorities, plans and processes.
- Evidence – UNESCO supports approaches that are scientifically accurate and grounded in evidence and will support countries to implement evidence-informed education responses that contribute to better health and education outcomes and improved well-being.
- Participation of young people – UNESCO targets actions to meet the needs of children, adolescents and young people and works with youth networks and organizations and initiatives that promote their involvement in shaping the policies and programmes that affect their lives.

The UNESCO strategy will contribute to the achievement of the SDG - Sustainable Development Goals, especially those related to gender equality, poverty, hunger, peaceful and just societies.

3.1 Reduce maternal mortality

3.3 End the epidemic of AIDS

3.4 Reduce premature mortality from non-communicable diseases

3.5 Strengthen the prevention and treatment of substance use

- Preventing early and unintended pregnancy in adolescent girls, through comprehensive sexuality education and links to sexual and reproductive health services
- Preventing new HIV infections in young people and promoting uptake of testing and treatment
- Promoting healthy lives through skills-based education
- Referral for health and counselling services

https://unesdoc.unesco.org/ark:/48223/pf0000246453

The objective is to work in partnership with national governments, other UN agencies, donors, civil society organizations, professional associations, academic and training institutions, organizations and networks of young people, faith-based, community and parents' organizations, the private sector and the media.

2.1.3. UNICEF

All children have the right to survive and thrive. Yet, children and adolescents still face significant challenges surviving past infancy and developing to their full potential.

UNICEF

UNICEF works in over 190 countries and territories to save children's lives, to defend their rights, and to help them fulfil their potential, from early childhood through adolescence.

One UNICEF's major concerns is health. Despite the scale of the challenge, solutions are in sight. Achieving the Sustainable Development Goals requires a global shift from treating diseases to strengthening health systems so that all children, adolescents and women of reproductive age have access to affordable, quality health care.

UNICEF works around the world – including in some of the hardest-to-reach places – to help children survive and thrive. Through public and private partnerships at the global, national and community levels, we focus on:

- Maternal, newborn and child survival. UNICEF works to end preventable maternal, newborn and child deaths by scaling up essential maternal and newborn care services, sustaining immunization programmes, and supporting preventive, promotive and curative services for pneumonia, diarrhoea, malaria and other child health conditions.
- Child and adolescent health and well-being. UNICEF is committed to helping children and adolescents build a solid foundation for adulthood. We support national health plans on adolescent health and well-being, improve age-specific health services for children and adolescents, and help countries combat non-communicable diseases, prevent injuries and better support children with developmental delays and disabilities.
- Strengthening health systems. UNICEF supports primary health care, especially at the community level, to help achieve universal health coverage. We work to strengthen health systems to deliver integrated services for children, adolescents and women of reproductive age – focusing on health; nutrition; early childhood development; HIV and AIDS; and water, sanitation and hygiene. Our work also promotes overall health and well-being by focusing on education, child protection and social inclusion.
- Health in emergencies and humanitarian settings. UNICEF tackles health challenges in places affected by conflicts, natural disasters, migration, urbanization, and political and economic instability, by supporting direct responses to emergencies and helping to develop resilient health systems that can withstand crises.

For UNICEF Primary Health Care is the foundation for quality mental health care. When mental health is integrated into facility and community based primary health and nutrition services, access to care and treatment is improved, and physical and mental health problems can be more effectively managed. In addition to strengthening the capacity of health-care facilities, this involves strengthening school-based mental health and psychosocial promotion and services (i.e., school health programmes that include counselling and psychosocial support and referrals) and awareness-raising through community-based engagement, mass media and social media.

2.2. MENTAL HEALTH AND THE EUROPEAN CONTEXT

Is saying something is “my mental health” necessarily indicating that there is a problem? No. We have discussed already that every individual has emotional, rational, and irrational perceptions of the world and their relationships with other people. Just like talking about ‘physical health’, we can talk about ‘mental health’ as the complete range of human experiences in the realm of mental well-being. And just like physical health, in mental health there is a range from the very fit to the very unfit - there is temporary interruption of mental health, and there is permanent, structural incapacity causing on-going mental health problems.

In the definition of health, there way we talk about health, about being healthy and about being unhealthy, has changed over time. We used to see much of ill health as a matter of morality even recently, some said that a particular illness was a punishment from God of particular behaviours - we used to say that of everything when we lived in highly superstitions times. Medical science brings more understanding of ‘health’, but it still has large gaps, not least around causation - why do particular exposures to risk trigger responses in some people and not others? And arguably, matters of the brain are ones where our

scientific understanding of causation is least developed, leaving a lot of room for fear and prejudice. One of the recent developments in the definition of health is to suggest that being healthy is about being able to cope with one's diseases, with the state in which one finds oneself. Perhaps it is worth considering at this point, how we feel about such a definition. I am not unhealthy when I have a par-titular disease, only when I cannot cope with it. Is this about empowering the individual, or is it dangerously close to blaming an individual?

So, we all have a "mental health", and we all manage it in different ways, with different degrees of success. And it is related to our physical state as well. Some of us are not good on a morning without coffee, or need a sugar intake or a sleep to bring us back to 'our usual selves'. For some of us, 'our usual selves' is cheery, others are melancholic, others angry, others downright unpleasant. This is in no way to diminish mental health, and the problems the people have with mental health - but it is to start thinking about this by acknowledging that there is not an "us" and "them" in this - there is a spectrum, and recognising that we have a relationship with our mental health, and that it changes for things that are within and without our control might be a good way of thinking about the whole spectrum of mental health and individuals' reactions to it.

The state of mental healthcare system in Romania in the European context is reflected by the statistical data available from the World Health Organization's *Mental Health Atlas (WHO, 2017). As with other European former communist countries, despite progress with the legislation in mental health over the past decade, insufficient resources allocated for the mental health sector from the public budget, the lack of involvement of service-users in the delivery of mental health services and policies, and reliance on mental health hospitals continue to be critical (*Krupchanka & Winkler, 2016*).*

Eastern Europe is considered a region with one of the highest burdens of mental and behavioural disorders according to the Global Burden of Disease Study (Lozano et al, 2012) that is linked to the socio economic and political transformations following the collapse of the communist regime in the late 1980s/early 1990s. The harsh economic circumstances and social distress in Romania associated with the transition to capitalism are suggested by high poverty rates. Statistical data from Eurostat indicates that 35.7% of Romanians are at risk of poverty or social exclusions, which is second highest poverty rate after Bulgaria (38.9%). As a consequence, the migration rate has increased dramatically over the past decade with 3.4 million Romanians emigrating, often leaving behind families and vulnerable people, placing the country on the second place globally by emigration growth, after Syria, between 2007 and 2015 (UN International Migration Report, 2017). It is widely acknowledged that both poverty and migration have a negative impact on the mental health well-being of the population (Acri, 2017, Virupaksha, 2014).

As a result, the rates of mental health disorders per capita have recently increased in Romania from 1% in to almost 3% (WHO) which are potentially underrated because of high levels of stigma in the general population, misunderstanding, and negative attitudes towards mental illness and people with mental health problems (Neacsu 2013). This dramatic increase in the population is not reflected in the total expenditure for mental health in Romania, which continues to remain one of the lowest in the EU with $36.3 (per capita) according to WHO (2014), compared to $293.7 in the EU15 countries (Krupchanka).

However, significant efforts have been made in the area of legislation in mental health. Pressured by the international community and in line with the European Union strategies in mental health (CEC, 2005), Romanian authorities have issued the Strategy in Mental Health (2006) followed ten years later by the National Strategy for the Mental Health of Children and Adolescents 2016-2020 (2016). Although the involvement of service users and their families in making these policies is significantly low compared to the EU15 countries, this adds more consistence to the framework for mental health services created by the first Mental Health Law 487/2002 that was revised in 2012 and adapted to the European Convention for Human Rights and Fundamental Freedoms.

Such policies focused on individualising the care plans for people with mental health problems and facilitate their integration into the community are yet to be fully implemented as mental health care continues to be provided in institutional settings. The Romanian mental health system continues to be not only under budgeted and heavily medicalised, but also short of trained staff. WHO-MHA report an alarming number of 36.3 mental health workers and 5.9 psychiatrists per 100,000 population, significantly lower with other EU countries. Instead, the number of beds i.e. xxx per 100,000 population…

Additionally, unlike other EU countries where mental health research has been supporting the development and delivery of mental health services, such activities have been banned in Romania on ideological grounds during the communism (Radhakrishnan, 1991).

Targeting a reformation of the mental health system, Romania aims to align to contemporary trends in healthcare such as the recovery framework, a person-centred approach that prioritises the “person” before the “patient”. A series of obstacles are yet to be overcome in order to reach an adequate balance between community and hospital mental health services.

PART III / RESOURSES AND STRATEGIES FOR INCLUSION

3.1. ACCESSIBILITY AS A REQUIREMENT FOR THE INCLUSION OF FUNCTIONAL DIVERISTY

Is necessary to be aware of the remaining barriers and overcome them in order to combat discrimination and promote equality of persons with disabilities, as such, it behoves all of us think and apply mode strategies to which there is a full integration in society. Describe some accessibility considered important that can help to overcome obstacles.

They are different resources and strategies that are considered important for inclusion of people with disability as [Methodological Guide for the access of persons with disabilities

to the process of recognition, validation and certification of competencies - Basic Level]:

- **Accessibility as a requirement for the inclusion of functional diversity**
- **Support products/technical help**
- **Significant others and attitudes**
- **Services, systems and policies**

WHAT ARE THE STRATEGIES (FACILITATORS) TO MOBILIZE IN ORDER TO OVERCOME THE OBSTACLES?

- The resource to technical help for face to face communication can be a facilitator to use within the process of recognition and validation presenting itself as facilitator to participation. The individual is also to demonstrate that skill with the resource of the facilitators that ensure communication.

WHICH CRITERIA CAN BE COMPROMISED IN A SITUATION WHERE THERE IS A COMPROMISE IN A CERTAIN BODY FUNCTION /STRUCTURE?

- E.g.: fluently may be a problem for people with compromise is in their voice and speech functions but that does not mean that within her functional framework the person does express himself with fluently.

The conceptual model adopts six fundamental conditions for the development of an inclusive society [Methodological Guide for the access of persons with disabilities to the process of recognition, validation and certification of competencies - Basic Level].

ARCHITECTURAL ACCESSIBILITY

- Absence of barriers in the building
- Transport to ensure the presence of the adults on the sessions scheduled
- The institution has qualified professionals in adult assistance (physiological needs, transportation and meals)

COMMUNICATIONAL ACCESSIBILITY

- Using the e-mail as a medium for communication, when the adult cannot move to our facilities
- Plants with equipment to suit various types of disability (computers, adjustable material, etc.).
- Personnel trained in the use and teaching of Information and Communications Technology
- Resource to family and peers

METHODOLOGICAL ACCESSIBILITY

- Institution with a multidisciplinary team of qualified professionals
- Institution in constant dialogue with the community and families, while facilitators of the learning processes and Recognition, Validation and Certification of Competences
- Flexible schedules, appropriate to the limitations of travelling and condition of the adult

INSTRUMENTAL

- Entity provided with several resources facilitators of learning / demonstration of skills
- Mediation tools adapted to the reality / specificity of each adult

PROGRAMMATIC

- The institutions as an active partner in the creation / improvement of public policies
- The whole functioning (rules and regulations) is thought to facilitate the accessibility of persons with disabilities or in disadvantage

ATTITUDINAL

- Training of the staff
- Permanent contact with people with disabilities (Positive discrimination / negative

3·2·SUPPORT PRODUCTS/TECHNICAL HELP

The technical assistance/supportive products are facilitators in the elimination of barriers to the persons involved in processes of Validation and Certification of professional skills.

EXAMPLES:

1) To help the person to receive, issue, produce and/ or process information in different formats (equipment to see, listen, read, write and telephone, and IT equipment)

2) For the mobility of the person (crutches, car adaption, wheelchairs, among others)

A technical assistance / supportive product must allow the person to accomplish the proposed activity with maximum autonomy and efficiency.

3.3. SIGNIFICANT OTHERS AND ATTITUDES

It is important to perceive the beholder of disability as the keystone of all the working process, being for this reason the one responsible and interested. This understanding will enhance his/her involvement and active participation across the process and the defining of aims and results to achieve.

3.4. SERVICES, SYSTEMS AND POLICIES

There are services, support mechanisms and local and national policies that facilitate or create barriers and can improve or worsen the functionality of people with disabilities.

It is all important to define global policies in order to facilitate integration in the community.

We should think in transport, information technology, accessibility, and in the change in mentality of the population so the integration of disabled people to will full, and they can participate actively in an increasingly competitive society.

PART IV | BEST PRACTICES

4.1. HEALTH

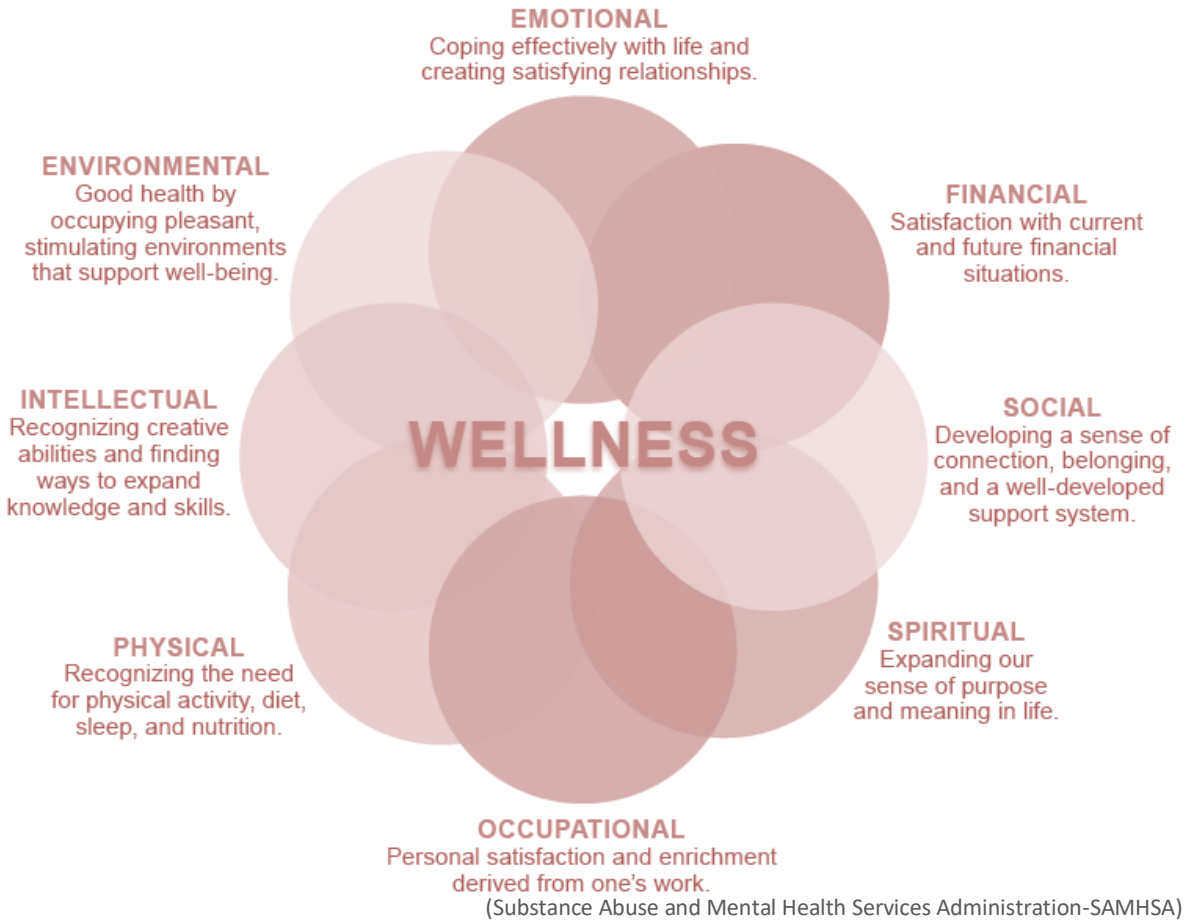
"Health is more than the absence of disease. Health is a state of optimal well-being."

The World Health Organization

When we talk about wellness in the context of mental health, it's not just about treating a specific symptom or problem; it is about treating the whole person – inside and out.

The tripartite model of mental well-being views mental well-being as encompassing three components of emotional well-being, social well-being, and psychological well-being. Emotional well-being represents the capacity to live a full and creative life, and the flexibility to deal with life's inevitable challenges. Emotional well-being is defined as having high levels of positive emotions, whereas social and psychological well-being are defined as the presence of psychological and social skills and abilities that contribute to optimal functioning in daily life.

The Eight Dimensions of Wellness program promotes whole-person wellness in by focusing on eight key aspects of a person's life that contribute to their overall well-being:

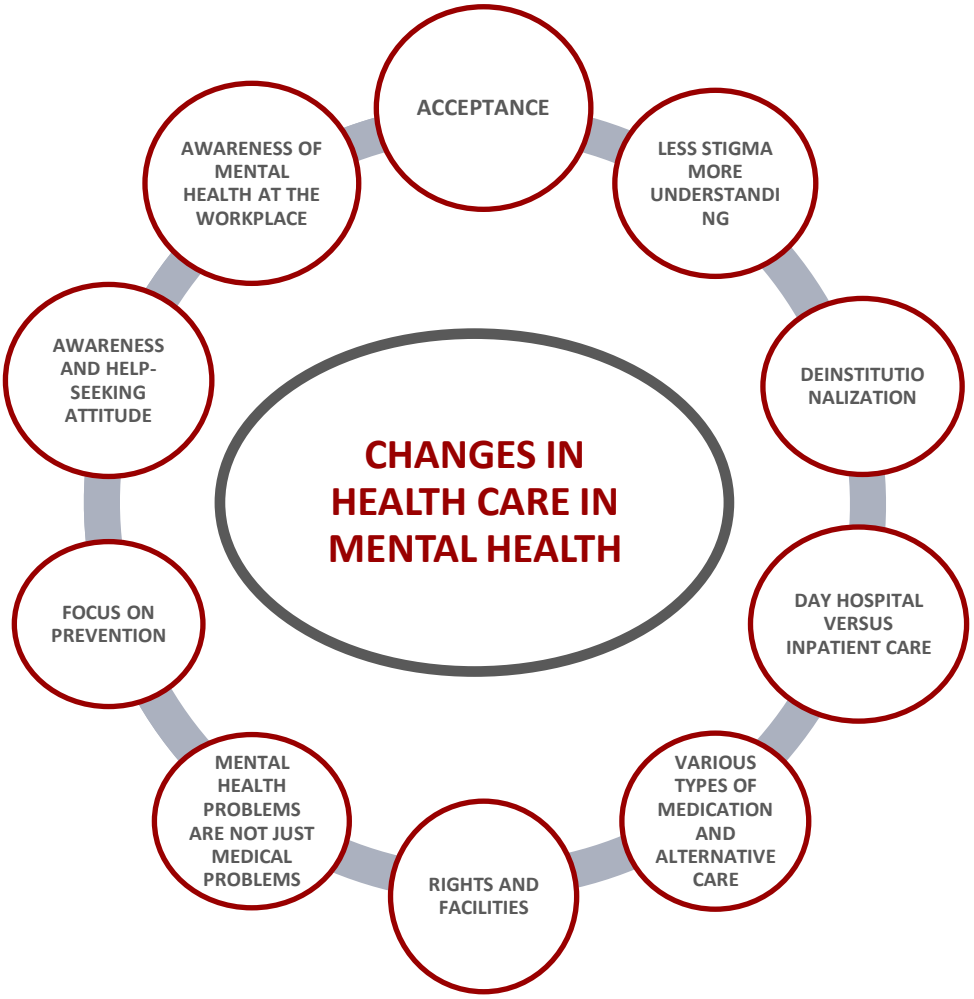


(Substance Abuse and Mental Health Services Administration-SAMHSA)

Wellness is it's a way of maintaining a balanced life. Resources to Recover constantly refers to these facets of total wellness to identify the best treatments and programs serving individuals and families affected by mental illness. Communication among mental health consumers, professionals, and primary care providers about health information is essential to overall wellness.

Mental health is everyone's business; it affects the lives of people living with mental problems, their careers, and the productivity of society as a whole. The mental health programme at WHO/Europe works with Member States and other partners to develop and implement national mental health policies and plans that reflect the WHO vision of "no health without mental health".

4.1.1. CHANGES IN HEALTH CARE IN MENTAL HEALTH



ACCEPTANCE

Empirical evidence showed that in the past families of people with mental disorders were likely to ignore the problem when their family members experienced discrimination: they hide them from public life in their homes or asylums, delay treatment seeking, or even reject professional help. In present people are more aware that mental health problems exist, WHO reports that one in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide so it's a situation that we cannot hide but work on understanding, accepting and developing services to support this population.

Understanding is the first step to acceptance, and only with acceptance can there be recovery, acceptance is key to managing mental health challenges.

Acceptance is a dynamic process that involves several factors that develop over time. Acceptance shouldn't be seen as the sole responsibility of the person, but a process that includes the effort of the general public to overcome stigma and foster mental wellness in our communities. This process requires moving from a passive state of denial to an active position. Here are some tips how to do:

1. Develop an awareness of the mental health problem and beliefs that support it. The process of acceptance of a mental health problem includes a cognitive piece. Insight is needed to understand that a mental health problem is taking place.
2. Create a positive sense of self in the face of a mental health problem. Persons with mental health problem can still be a fantastic worker, parent, friend, or community member even with a mental disorder. The mental health problem doesn't need to define a person, or become central to your identity, it does need to be integrated as a part of the person.
3. Engage in activities that support acceptance. There is also a behavioural aspect to this process. Engaging in certain activities can reflect and reinforce acceptance of a mental health problem. (taking medication or attending therapy, group support, volunteering for an organization in mental health field, participating on campaigns promoting mental health and the rights of person with mental health problems)

4. Focus on relationships that promote acceptance. Supportive relationships are particularly helpful to accepting a mental health problem. Some people may not accept the mental health problem because of their own stigmatizing beliefs, they might ignore the problem, or simply be unprepared to accept it. Friends, providers, family members, and others might recognize the presence of a mental health problem and support the management of it. Be the person that offers support for persons with mental health problems!
5. Pursue emotional experiences that boost acceptance. Research shows that people also describe the process of acceptance as an emotional experience. This might involve making room for grief and pain and moving past shame. On a positive side, acceptance can also involve sustaining a sense of happiness and hope.

LESS STIGMA MORE UNDERSTANDING

Stigma and negative community attitudes contribute to social isolation and exclusion of person suffering from a mental health problem. Stigma often represents one of the critical obstacles that stand in the way of delivering mental health care. Stigma and discrimination are widely experienced by people with mental disorders in many domains of their daily life, such as in employment, social activities, personal relationships, housing, marriage, and so on. The fear of being discriminated against has been reported to play a significant role in creating barriers and increasing the delay in seeking treatment and may also delay the healing process for people with mental disorders and prevent people with mental disorders from achieving their social rights and full participation in the life of their community.

General education programs and anti-stigma campaigns targeted for specific groups are carried out to reduce stigma. General public could, through greater social engagement and more acceptance of mental disorders, play an essential role in rehabilitating the mentally ill. This is no easy task, since people with mental disorders have often been labelled as “violent” and “dangerous”, and the attitudes of the general public have contributed to exacerbating the conditions of people with mental disorders.

Thornicroft defined stigma as an overarching term that refers to three main elements: problems of knowledge (ignorance), problems of attitude (prejudice), and problems of behavior (discrimination), so intervention to reduce stigma should aim these three areas.

Accurate mental health knowledge may be one of the leading factors that may contribute to reduce stereotypes against people with mental disorders and less discriminatory attitude.
"Mental illness is not a personal failure. In fact, if there is failure, it is to be found in the way we have responded to people with mental and brain disorders," said Dr Gro Harlem Brundtland, Director-General of WHO.

DEINSTITUTIONALIZATION

Deinstitutionalisation is the process of replacing long-stay, unpersonal psychiatric hospitals with less isolated community mental health services for those diagnosed with a mental disorder or developmental disability. Medical opinion as to whether people with mental illness should stay in hospital for months and years or just a few weeks has changed. In the late 20th century, it led to the closure of many large psychiatric hospitals or asylums and small local hospital units established. Patients were increasingly cared for at home, in sheltered accommodation and clinics, and in regular hospitals.
Deinstitutionalisation works in two ways. The first focuses on reducing the population size of mental institutions by releasing patients, shortening stays, and reducing both admissions and readmission rates. The second focuses on reforming psychiatric care to reduce (or avoid encouraging) feelings of dependency, hopelessness and other behaviors that make it hard for patients to adjust to a life outside of care.

DAY HOSPITAL VERSUS INPATIENT CARE

Inpatient treatment is an expensive way of caring for people with acute psychiatric disorders. It has been proposed that many of those currently treated as inpatients could be cared for in acute psychiatric day hospitals. Day hospitals are a less restrictive alternative to inpatient admission for people who are acutely and severely mentally ill. Research found that at least one in five patients currently admitted to inpatient care could feasibly be cared for in an acute day hospital. Patients treated in the day hospital had the same levels of treatment satisfaction and quality of life as those cared for as inpatients. The day hospital patients were also no more likely to be unemployed at the end of their care.

Some argue that reduction in hospital stay leads to 'revolving door admissions' and worsening mental health outcomes despite apparent cost savings, whilst others suggest longer stays may be more harmful by institutionalising people to hospital care.

Persons with mental illness were favouring short-stay hospitalisation for a better social functioning and a greater chance of finding and keeping a job. Studies concluded that the use of acute day hospitals may make significantly more improvement in symptom change in this treatment setting than on traditional wards.

VARIOUS TYPES OF MEDICATION AND ALTERNATIVE CARE

Despite the chronic and long-term nature of some mental disorders, with the proper treatment, people suffering from mental disorders can live productive lives and be a vital part of their communities. Over 80% of people with schizophrenia can be free of relapses at the end of one year of treatment with antipsychotic drugs combined with family intervention. Up to 60% of people with depression can recover with a proper combination of antidepressant drugs and psychotherapy. Various treatment options are now available for their recovery and the diminution of side effects.

RIGHTS AND FACILITIES

There are many ways to improve the lives of people with mental disorders. One important way is through policies, plans and programmes that lead to better services. Over the past decade the protection of the rights of persons with disabilities has been reinforced at both the international and European levels.

Some of the facilities they have: free transport, free entry passes to different events or historical buildings, facilities for employers.

MENTAL HEALTH PROBLEMS ARE NOT JUST MEDICAL PROBLEMS

Scientists haven’t yet found specific genes that can be linked to mental illness. Genetic markers may exist or they may not, they can increase your risk, but it’s not a guarantee. Environmental factors play a significant role in the development of mental health conditions.

These include everything from stress to poor nutrition to substance abuse, death, divorce, neglect and family life. Chronic stress and biological factors combined may also play a role. Stress-diathesis model, attempts to explain the biological relationship between someone's predisposition for a mental health condition and "major or ongoing stressors". The model says that the combination of chronic stressors like finances, work, academics, marital problems, or health and family issues, and a genetic predisposition to a mental health disorder can actually increase your likelihood of developing a mental illness.

There's research that suggests if a family member has a mental illness, your chances of developing it possibly increase. However, you may never exhibit symptoms if you didn't experience any traumatic events as a child, your everyday life is relatively stress-free and you're in a supportive environment.

In a survey in 1990 90% of the participants in the study were seeing their problem as predominantly personal or social than medical. (MIND/Roehampton Institute, 1990). We can define the concept of mental health not just as a health phenomenon, but also as a social and psychological one. Defining mental health separately from mental illness places it into the concept of public health, which exceeds the medical definition of the determination of a "mental illness." The anthropology of health defines the medical treatment as a social practice, which takes into consideration a person's social context, the differences between genders, and the connection between personal and social. It accents the characteristics of social systems, values, and manifestations of social crises through basic concepts and discourses, such as gender and culture.

FOCUS ON PREVENTION

Focus is increasing on preventing mental disorders. Prevention is beginning to appear in mental health strategies, including the 2004 WHO report "Prevention of Mental Disorders", the 2008 EU "Pact for Mental Health" and the 2011 US National Prevention Strategy.

Prevention can change the way mental disorders are looked upon by society. Many of the effective preventive measures are harmonious with principles of social equity, equal opportunity and care of the most vulnerable groups in society. Examples of these

interventions include improving nutrition, ensuring primary education and access to the labour market, removing discrimination based on race and gender and ensuring basic economic security, conflict management and violence prevention both between individuals and between, prevention on bullying in schools, training on coping skills, prevention on abuse and neglect, prevention on substance abuse, intervention at the workplace, strengthening community networks and fostering social inclusion and social support. This creates opportunities to enhance protective factors and reduce risk factors related to aspects of mental and physical health.

AWARENESS AND HELP-SEEKING ATTITUDE

For so long, mental illness has been a taboo topic. People have been scared to talk about because of public perception and make it harder to speak up and seek services. Anticipated individual discrimination and self-stigmatisation are associated with a reduced readiness to seek professional help for mental disorders. When considering the impact of stigma on help-seeking, it is helpful to contemplate how discrimination may affect those seeking help for mental disorders on their help-seeking pathway and to distinguish three levels of discrimination: individual, structural, and discrimination qua self-stigmatisation. Individual discrimination refers to the behaviour of individuals that is intended to have a differential or harmful effect on the members of a stigmatised group), whereas structural discrimination describes the negative consequences for the members of such a group that result from the imbalances and injustice inherent in social structures, political decisions and legal regulations. Self-stigmatisation occurs when members of a minority group internalise the stigmatising ideas of their social environment and start to believe that they are of less value and will be rejected by most people. Structural discrimination of those seeking help for mental illness would include a lack of available mental health services, difficult access to services, or insufficient coverage of mental health care by health insurances.

Intervention studies show that destigmatisation may lead to increased readiness to seek professional help, but other aspects like knowledge about mental diseases seem to be at least as important. Population based time-trend studies show that public attitudes towards help-seeking have improved over the last decade. Nowadays persons with chronic mental health

problems, persons with temporary mental health problems are more opened to access services, like individual counselling, group therapy.

Georg Schomerus, Matthias C Angermeyer (2008) Stigma and its impact on help-seeking for mental disorders:

WHAT DO WE KNOW?

MENTAL AND PHYSICAL HEALTH IS FUNDAMENTALLY LINKED

Mental and physical components of health are interconnected. The associations between mental and physical health are:

1. Poor mental health is a risk factor for chronic physical conditions.
2. People with serious mental health conditions are at high risk of experiencing chronic physical conditions.
3. People with chronic physical conditions are at risk of developing poor mental health.

Understanding the links between mind and body is the first step in developing strategies to reduce the incidence of co-existing conditions and support those already living with mental illnesses and chronic physical conditions.

Some positive lifestyle behaviours that can influence the state of both your physical and mental health: exercise-physical activity, balanced diet, no smoking or any substance abuse.

AWARENESS OF MENTAL HEALTH AT THE WORKPLACE

Work is good for mental health but a negative working environment can lead to physical and mental health problems. Excessive pressure and demands at work can cause stress. There are many risk factors for mental health that may be present in the working environment. Most risks relate to interactions between type of work, the organizational and managerial environment, the skills and competencies of employees, and the support available for employees to carry out their work.

Being aware of these risks some of the companies take measures to overcome mental health problems and motivate employees by facilitating access to counselling and trainings on communications skills, coping skills, time management they also provide places to recreate like library, swimming pool, gym.

Interventions and good practices that protect and promote mental health in the workplace include:

- implementation and enforcement of health and safety policies and practices, including identification of distress, harmful use of psychoactive substances and illness and providing resources to manage them;
- informing staff that support is available;
- involving employees in decision-making, conveying a feeling of control and participation;
- organizational practices that support a healthy work-life balance;
- programmes for career development of employees;
- Recognizing and rewarding the contribution of employees.

4.1.2. IMPACT OF COMMUNITY BASED HEALTH SERVICES IN MENTAL HEALTH

"The provision of mental health care is undertaken primarily at community level, so as to avoid the displacement of patients from their familiar environment and to facilitate their rehabilitation and social integration" (Mental Health Law 36, 1998, Portugal). The law in Brazil simply states that a person has the right "to be treated, preferably in community mental health facilities" (Mental Health Law No 10.216, 2001 Brazil), while in Rio Negro (Argentina) the law states, "Hospitalization shall be a last resort, all other treatment options having been exhausted … In all cases, length of stay shall be as short as possible." Referring to previously hospitalized patients, this law states "recovery of their identity and dignity and respect for patients with mental disorders, translated into their reintegration in the community, is the ultimate aim of this Act and all actions prescribed by it". (Promotion of Health Care and Social Services for Persons with Mental Illness Act 2440, 1991 Rio Negro, Argentina.)

The past decade has witnessed a shift in the provision of mental health services from traditional, hospital-based treatment models to more integrated, community-based services are accessed on an out-patient basis. Current research and practice indicate that community-based mental health services have a positive impact on the help-seeking behaviour by reducing the levels of stigma and changing norms and attitudes toward professional help-seeking. It is well known that stigma around mental health issues and attitudes towards help-seeking are recognized structural barriers to accessing mental health services. Reports from the WHO and European Commission also suggest that community-based services can reduce the stigma in relation to mental health problems by moving away from the stereotypical, historical, "asylum" rhetoric.

Community-based mental health services, which are emphasized in the World Health Organization's Mental Health Action Plan, are well-recognized to effectively and efficiently address the challenges associated with the burden of mental disorders and promotion of mental health in the population. Community care contributes not only to improved access to services, but it also enables people with mental disorders to develop and maintain relationships while receiving treatment, therefore facilitating early treatment and psychosocial rehabilitation. Furthermore, community mental health care is associated with continuity of care, greater user satisfaction, increased adherence to treatment, and better protection of human rights.

4.1.3. TYPOLOGIES OF ANSWERS

The symptoms and complications of mental illnesses may led to serious functioning difficulties in several areas of life, often including work, social relationships, residential independence, money management, and physical health and wellness.

By the time they start receiving community services, they are likely to have experienced failure, discrimination, and stigmatization, and their hope for the future is likely to be quite low so the mission of community-based services is to promote participants

independence, rehabilitation, community integration, and recovery, and to prevent homelessness, unnecessary hospitalization, and other negative outcomes.

Lisa Dixon (2000) Assertive community treatment: Twenty-five years of gold.

Until the 1970s, it was common for those suffering from mental disorders to remain in an institution for most of their lives, but in most of the countries of the world, they are now managed in the community with one of several different types of intervention.

CASE MANAGEMENT

Case management is the coordination of community-based services by a professional or team to provide people the quality mental health care that is customized accordingly to an individual's setbacks or persistent challenges. Case management seeks to reduce hospitalizations and support individuals' recovery helps clients discover their abilities and interests. It is the link between the client and care delivery system, it connects client to services.

Case management empowers clients to make decisions and to be an active participant in their recovery, helps them achieve autonomy and sense of responsibility. Through the process they discover their support system, needs, strengths and opportunities. Case management is a pillar of community psychiatry, care coordination includes traditional mental health services but may also encompass primary healthcare, housing, transportation, employment, social relationships, recreation and community participation.

Case management is a cyclic process and has the following tasks:

1. Assessment- clear picture of an individual’s needs and strengths
2. Planning- a plan that contains clearly specified outcomes
3. Implementation- the plan is to be put in action by the users with the help of their support contacts, agencies that best meet the identified needs
4. Monitoring- the progress towards the specified objectives
5. Relieving- evaluating the outcomes, re-evaluating the needs, reassessment

RESIDENTIAL

For many patients, sheltered accommodation may represent 'homes for life'. Discharged long-term patients across the world report improved subjective quality of life, satisfaction with services and a marked preference for continued living in the non-hospital settings. There are varied models of supported housing with marked variations in staffing, environmental characteristics and support and supervision arrangements.

Long term mental health care facilities range from apartment-based communities in urban settings to farm-based group homes. Clients have the opportunity to both learn and practice the relationship and life skills needed to take charge of their lives and reach the highest possible level of independence by being an integral member of a supportive community.

Clinical Residential Treatment Programs offer a home-like atmosphere and strong sense of community that help residents build self-esteem, develop relationships, and improve life skills. In clinical residential treatment programs, clinicians can view the full picture of a resident's functioning and use that perspective and insight to fine-tune psychiatric therapy.

Group Residential Communities offer family-like atmosphere in group homes as a major therapeutic tool, providing increased quality of life and continued growth. It is stable, long-term living arrangement. Residential treatment in a group home helps people with psychiatric disorders repair self-esteem, build skills, develop relationships, and learn to manage their mental health symptoms.

Farm-Based and Work-Based Residential Programs is another residential option where residents participate in daily work, which plays a key role in their growth and recovery. Meaningful, necessary work provides tangible results by teaching new skills, building self-esteem, and fostering supportive connections among teammates. The program offers a range of therapeutic work opportunities, which may include clerical work, agricultural work, building maintenance and repair, and retail sales, a great opportunity to learn skills that can be marketable.

Apartment-Based Communities are a type of mental health treatment communities where residents live in individual or shared apartments while participating in a program of

therapeutic activities, supportive relationships, and psychiatric treatment. Clinicians often spend time in residents' homes each day to gain insight that enhances treatment and recovery. For some, this style of residence minimizes the perceived stigma of living in a mental health facility.

OCCUPATIONAL

Occupational therapy promotes healing through active engagement, making crafts, painting, beading, sawing, and gardening can part of occupational therapy. Colouring has been recognised as an activity which has been proven to significantly lower the levels of depressive symptoms and anxiety.

Christiansen and Bum (1997) defined occupational therapy as a health discipline concerned with enabling function and well-being. The occupational therapy process focuses on leisure, personal care and occupation in relation to the physical, psychological, social, economic and spiritual aspects of a person's life, enhancing the competence of the individual rather than highlighting areas of disability or malfunction. The health promoting value of purposeful participation in activity is inherent in the concept of self-actualization: through *doing,* people are confronted with the evidence of their ability to function competently and take control of their lives as far as they are able. Personal dignity and beliefs are enhanced and a sense of self-worth, human potential is developed.

Occupational therapy interventions may be effective in improving occupational performance and well-being among people with a mental health diagnosis and should be an integral part of rehabilitation services in mental health.

VOCATIONAL TRAINING AND SUPPORTED EMPLOYMENT

Unemployment rates are high amongst people with severe mental illness, yet surveys show that most want to work. Vocational rehabilitation services exist to help mentally ill people find work. Traditionally, these services have offered a period of preparation (Pre-vocational Training), before trying to place clients in competitive (i.e. open) employment. More recently,

some services have begun placing clients in competitive employment immediately whilst providing on-the-job support (Supported Employment).

Pre-vocational Training and Supported Employment are two different approaches to helping severely mentally ill people obtain employment. The key principle of Pre-vocational Training is that a period of preparation is necessary before entering competitive employment. In contrast, the key principle of Supported Employment is that placement in competitive employment should occur as quickly as possible, followed by support and training on the job. A systematic review found that people who received Supported Employment were significantly more likely to be in competitive employment than those who received Pre-vocational Training.

Crowther R, Marshall M, Bond GR, Huxley P (2001): Vocational rehabilitation for people with severe mental illness

Organizations have a responsibility to support individuals with mental disorders in either continuing or returning to work. Research shows that unemployment, particularly long term unemployment, can have a detrimental impact on mental health. Some initiatives like flexible hours, job-redesign, addressing negative workplace dynamics, and supportive and confidential communication with management can help people with mental disorders continue to or return to work. Access to evidence-based treatments has been shown to be beneficial for depression and other mental disorders. Because of the stigma associated with mental disorders, employers need to ensure that individuals feel supported and able to ask for support in continuing with or returning to work and are provided with the necessary resources to do their job.

At a global policy level, WHO's Global Plan of Action on Worker's Health (2008-2017) and Mental Health Action Plan (2013-2030) outline relevant principles, objectives and implementation strategies to promote good mental health in the workplace. These include: addressing social determinants of mental health, such as living standards and working conditions; activities for prevention and promotion of health and mental health, including activities to reduce stigmatization and discrimination; and increasing access to evidence-based care through health service development, including access to occupational health services.

Article 27 of The UN Convention on the Rights of Persons with Disabilities (CRPD) provides a legally-binding global framework for promoting the rights of people with disabilities (including psychosocial disabilities). It recognizes that every person with a disability has the right to work, should be treated equally and not be discriminated against, and should be provided with support in the workplace.

RECREATION THERAPY

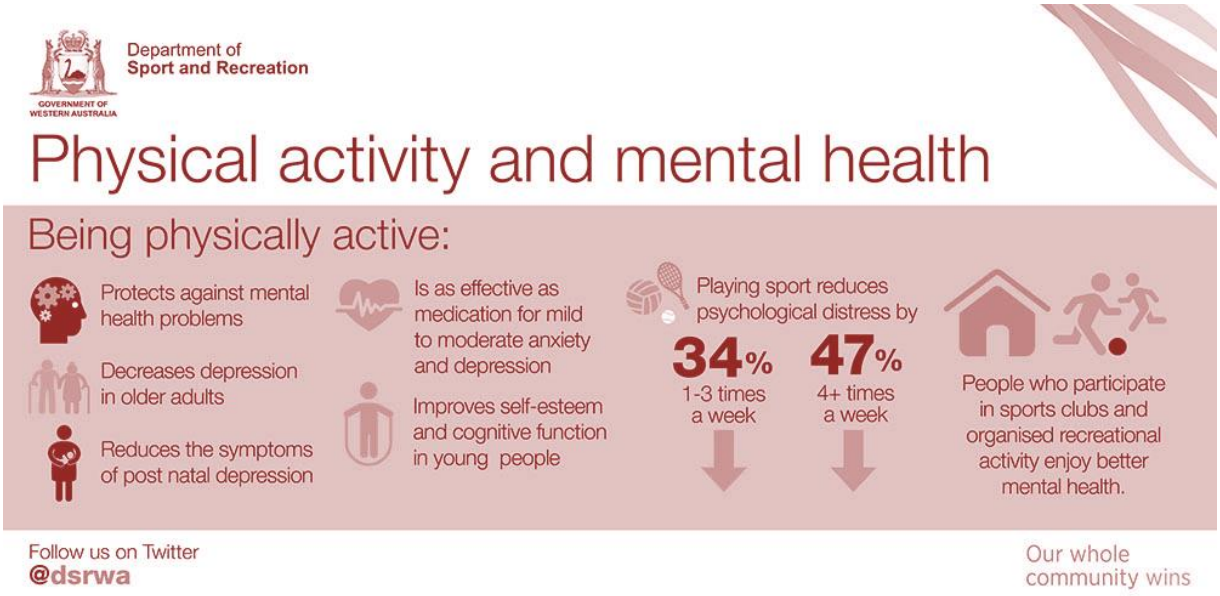
Recreation therapy promotes healing through physical exercise that can improve mental as well as physical health. Playing sports, walking, cycling or doing any form of physical activity trigger the production of various hormones, sometimes including endorphins, which can elevate a person's mood.

A study on non-clinical adult population have shown that in some cases, physical activity can have the same impact as antidepressants when treating depression and anxiety.

People who participate in sports clubs and organized recreational activity enjoy better mental health, are more alert, and more resilient against the stresses of modern living. Participation in recreational groups and socially supported physical activity is shown to reduce stress, anxiety and depression. Participation in group recreation provides a sense of value, belonging and attachment.

COUNSELING AND PSYCHOTHERAPY

Psychotherapy is the general term for scientific based treatment of mental health issues based on modern medicine. It includes a number of schools, such as gestalt therapy, psychoanalysis, cognitive behavioral therapy and dialectical behavioral therapy.



Individual therapy is a joint process between a therapist and a person in therapy. Common goals of therapy can be to inspire change or improve quality of life. People may seek therapy for help with issues that are hard to face alone. Individual therapy is also called therapy, psychotherapy, psychosocial therapy, talk therapy, and counseling.

Therapy can help people overcome obstacles to their well-being. It can increase positive feelings, such as compassion and self-esteem. People in therapy can learn skills for handling difficult situations, making healthy decisions, and reaching goals. Many find they enjoy the therapeutic journey of becoming more self-aware. Some people even go to ongoing therapy for self-growth. Therapy can help treat mental, emotional, physical,

and behavioral issues. Even if therapy cannot cure a condition, it may result fewer relapses and can help people develop healthy coping skills.

GROUP THERAPY

Group therapy involves any type of therapy that takes place in a setting involving multiple people. It can include psychodynamic groups, activity groups for expressive therapy, support groups, problem-solving and psychoeducation groups. Group therapy is a specific type of mental health treatment that brings together several people with similar conditions under the guidance of a licensed mental health care provider.

Expressive therapies are a form of psychotherapy that involves the arts or art-making. These therapies include music therapy, art therapy, dance therapy, drama therapy, and poetry therapy. It has been proven that music therapy is an effective way of helping people who suffer from a mental health disorder. Results of a study show that group music therapy for adults with mental illness may help to reduce psychiatric symptoms related to anxiety. Also, patients perceive music therapy as helpful and improves attitudes toward help seeking and openness about one's problem.

A support group provides an opportunity for people to share personal experiences and feelings, coping strategies. Persons with mental health problems realized that their experiences they once wanted to hide are not isolated. There are others who can relate to their story and provide solidarity and support, feeling accepted can make all the difference. For many people, a health-related support group may fill a gap between medical treatment and the need for emotional support. A person's relationship with doctor or other medical personnel may not provide adequate emotional support, and a person's family and friends may not understand the impact of a disease or treatment. A support group among people with shared experiences may function as a bridge between medical and emotional needs.

Psychoeducation refers to the process of providing education and information to those seeking or receiving mental health services, such as people diagnosed with mental health conditions and their family members. Psychoeducation may be defined as the education of a person with a psychiatric disorder regarding the symptoms, treatments, and prognosis of that illness

Social support, social networks and social cohesion provided by group activities enhance the mental health and wellbeing of a community.

CRISIS INTERVENTION

A mental health crisis is defined as an event or experience in which an individual's normal coping mechanisms are overwhelmed, causing them to have an extreme emotional, physical, mental, and/or behavioural response. Individuals experiencing a mental health crisis may or may not be affected by mental illness.

Mental health crisis can take many form self-harm, panic attacks, suicidal ideation, getting in trouble with the law, planning or considering hurting one's self or others but no matter what kind of crisis someone might be going through, you can help. When de-escalating someone from crisis, communication is key. It is *essential* they feel heard and understood, so make sure to give them your undivided attention. This is more than just listening, but also using body language, like eye contact, to *show* you're listening. You can also use active listening techniques such as reflecting feelings and summarizing thoughts to help them feel validated. It's essential to use an empathetic, non-judgmental tone.

People with mental health problems may not have networks of support such as family, friends and careers. To complicate matters, people with mental disorder can have critical downturns in their mental health creating a revolving-door of care, where service users are discharged from hospital when considered stable and well, only to go back into hospital again when their mental health becomes worse during an acute episode or crisis. Crisis-intervention and homecare packages have been developed as a possible solution to these problems.

Crisis care, where support is provided during a crisis for service users, either in their home or a community setting, was found to provide a package of support that was worthwhile,

acceptable and less expensive than standard care. Furthermore, crisis care avoided repeat admission to hospital; improved the mental state of services users more than standard care; was more acceptable and satisfactory to service users and placed less burden on families and careers.

4.1.4. EXAMPLES OF SUCCESS

MENTAL HEALTH ORGANIZATIONS

Non-governmental organizations (NGOs) are formally organized, private, non-profit organizations, with an important role within the network of community treatment providers in planning and decision-making within the health and social care, and in the development of cooperation within care providers' networks.

The role of NGOs

- the service role (high quality, increased fairness, lower cost/improved efficiency, specialization)
- innovation role (increased flexibility, accessibility to everyone, the incubator for new ideas, the source of innovation in resolving social and individual problems)
- advocacy role (changes in government policies or social conditions, advocacy policy, the inclusion of service users)
- expressive and development role (promotion of cooperation, voluntary work advocate, protecting the interests of various groups, enabling the expression of personal potential, influencing markets by ensuring plurality)
- expressive and development role (promotion of cooperation, voluntary work advocate, protecting the interests of various groups, enabling the expression of personal potential, influencing markets by ensuring plurality)

The main tasks of NGOs in the health system are providing services and health advocacy, rehabilitation, therapy and long-term care, prevention, health promotion and education.

Provision of services includes medical, social and psychological services as well as, integration activities, care and nursing, material and financial support, educational and information services and training. Health advocacy is a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or program.

NGOs can play a transformative role by developing specific programmes on mental health or integrating mental health into existing programmes. There are good examples of NGOs doing this across a broad range of sectors, such as by strengthening community mental health care, enabling people to access livelihood opportunities and integrating psychological first aid into emergency response.

PEER-GROUPS

Peer support groups are a valuable service and resource that brings together people affected by a similar concern so they can explore solutions to overcome shared challenges and feel supported by others who have had similar experiences and who may better understand each other's situation. Peer support groups are run by members for members so the priorities are directly based on their needs. Peer support groups can be provided on a formal basis with paid 'specialist' trained peer group facilitators or on a more informal basis with volunteer peer facilitators.

Recovery is believed to be facilitated by self-help groups for persons with severe mental illness, emphasizing relationships among key components. Self-help organizations have proliferated over the past several decades, as advocacy groups, alternatives, and supplements to conventional services, often in the spirit of helping foster empowerment and recovery. Although mental health self-help groups vary in their focus and dynamics, they are member-governed, and emphasize self-advocacy and taking an active role in treatment decisions.

These groups are believed to provide social support and knowledge gained by interaction with 'peers,' those who also have a diagnosis of mental illness, so that stigmatized individuals find acceptance, a vital step in making cognitive changes that lead to improved functioning and quality of life. This is consistent with self-attribution theories that indicate when persons with mental illness are embedded in meaningful groups and engaged in productive activity, their sense of self is enhanced. Self-help is believed to combat stigma by demonstrating that persons with a mental illness can manage their own lives and programs. Participation in groups of people with stigmatized identities like mental health self-help groups may be self-enhancing because it helps align a problematic social identity with valued personal identities, helps create new identities, taking the place of problematic ones, enhancing self-worth. Members may also serve as a favourable comparison group to reference one's level of self-worth and functioning.

USER'S ASSOCIATION- ASSOCIATION FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

User's association are made up of psychiatrist users, the association is representing the interests of persons affected by mental illness and advocates for their rights. The main objectives are: advocacy, information and education, anti-stigma and discrimination, patients' rights, co-operation, partnerships and capacity building. User's associations promote continuous formation for members with trainings to create or recreate functional skills so to increase the chances to be admitted in a work place. They carry out activities of information and awareness against stigma, workshops, seminars, sport meetings, it allows participants to get acquainted with people they tend to perceive as "strange", get familiar with mental health users and respect them with their goods and weaknesses.

The organisations produces responses and statements with respect to relevant EU developments impacting on mental health, to ensure that the voice of patients is included in the debates and discussions that concern them, they are actively involved in EU-funded research projects and organises meetings involving its members to provide feedback and input in these projects, with the aim to ensure relevance for those affected by mental health problem.

CARER'S ASSOCIATION

Non-profit organisation of carers, family members that work together to help both themselves and the people they care for. A carer is someone who provides unpaid care and support to family members and friends who are living with a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue.

The mission is to represent all family members of persons affected by severe mental ill health so that their rights and interests are recognised and protected. Supporting others can be mentally and physically exhausting so carers also need support for themselves, they organize support groups to debrief, discuss about challenges, along with tips and suggestions that have helped them. Failure of mental health systems to involve family carers has resulted in the growth of family self-help organizations. Some of these organizations have developed their own information, education and support programs, they use their personal 'lived experiences' of day-to-day coping with mental illness in a close relative as the basis for teaching other families how to cope.

"ONE MIND CAMPAIGN" OF THE INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE

Mental illness and other emotional or psychological crises affect people of all demographics. Often family members rely on law enforcement to interact with loved ones who need treatment. In other cases, law enforcement may respond to calls for service involving individuals affected by mental illness who are suspected of committing a criminal offense or are victims of crime themselves. Additionally, persons affected by mental illness may be a danger to themselves or others, thereby necessitating law enforcement intervention.

The International Association of Chiefs of Police (IACP), as the world's largest and most influential professional association for police leaders, is committed to advancing the safety of communities worldwide. They made it a priority to focus on law enforcement interactions with individuals in the community who are affected by mental illness. Through the Campaign, law enforcement agencies are declaring their commitment to improving police work involving this vulnerable population. The One Mind Campaign seeks to ensure successful interactions between police officers and persons affected by mental illness. The initiative focuses on uniting local communities, public safety organizations, and mental health organizations so that the three become "of one mind." Responding to situations involving individuals in crisis officers need to make difficult judgments about the mental state and intent of the individual and necessitates the use of special skills, techniques, and abilities to effectively and appropriately resolve the situation, while minimizing violence. The campaign suggests some practices: establishing a clearly defined and sustainable partnership with a community mental health organization, developing a model policy to implement police response to persons affected by mental illness, training and certifying sworn officers and selected non-sworn staff in mental health first aid training or other equivalent mental health awareness course, and providing crisis intervention team training

4.2. LAW, JUSTICE AND HEALTH

4.2.1. INTERNATIONAL MENTAL HEALTH CARE LAW

a) International Principles

- Promotion of Mental Health and Prevention of Mental Disorders
- Access to Basic Mental Health Care
- Mental Health Assessments in Accordance with Internationally Accepted Principles
- Provision of the Least Restrictive Type of Mental Health Care
- Self-Determination
- Right to be Assisted in the Exercise of Self-Determination

b) International standards and guidelines

International standards and guidelines are all general statements of principle meant to guide governments and service providers. They are not binding or enforceable in any way if they are not followed.

The following international documents set out a range of standards and guidelines that are particularly relevant to people with mental illness:

- United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
- United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities
- United Nations Basic Principles for the Treatment of Prisoners
- United Nations Standard Minimum Rules for the Treatment of Prisoners

- United Nations Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment
- World Health Organisation Mental Health Care Law: Ten Basic Principles (1996)
- United Nations World Program of Action Concerning Disabled Persons

4.2.2. MENTAL HEALTH AND HUMAN RIGHTS

- The UN convention on the rights of persons with disabilities - Convention on the Rights of Persons with Disabilities (CRPD)
- The Convention on the Rights of Persons with Disabilities (CRPD) was developed by the United Nations. Australia ratified this treaty in 2008 and has also ratified its Optional Protocol. The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all hu-man rights and fundamental freedoms for all people with disability, and to promote respect for their inherent dignity.
- The CRPD does not define 'disability' or 'persons with disability' but in Article 1 it is made clear that the class of persons to whom it applies includes persons with long-term impairments. This certainly includes people with mental health conditions.
- The Optional Protocol to the CRPD allows an individual to make a complaint to the United Nations Committee on the Rights of Persons with Disabilities if they believe one or more of their rights set out in the CRPD have been violated, where there is no reasonably available domestic remedy for that violation.
- The CRPD comprises 50 articles, 20 of which articulate specific human rights as they relate to the needs and concerns of persons with disability. Among these rights are some that have particular significance to the specific forms of human rights violation disproportionately experienced by persons with mental health conditions. These include the right to equal recognition before the law (Article 12), which recognises and protects the right of persons with disability to exercise legal capacity, protecting the integrity of the person (Article 17) which seeks to protect persons with disability from unwanted, non-consensual interference with their person, and living independently and being included in the community (Article 19) which recognises the right of persons with disability to live

in the community with support and prohibits institutionalisation. The right to Health (Article 25) and the right to Habilitation and Rehabiliation (Article 26) also contain elements that have specific significance for persons with mental health conditions in that they both stipulate that health care and rehabilitation must be provided on a voluntary basis, and seek to protect persons from involuntary treatment. Additionally, the right to Habilitation and Rehabilitation recognises and protects the rights of per-sons with disability to receive rehabilitation in the community in a manner which supports inclusion rather than segregation from community life.

- International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR)
- The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) are the two main international treaties that expand in detail on the principles in the Universal Declaration of Human Rights and set them out in a legally binding agreement between countries. Both are treaties developed by the United Nations. Together with the Universal Declaration of Human Rights, these treaties are sometimes referred to as the 'International Bill of Rights.' The Second Optional Protocol to the ICCPR enables individuals to make a complaint to a United Nations committee if they believe one or more of their rights set out in the ICCPR have been violated, in circumstances where there is no reasonably available domestic remedy for this violation. Article 12 of the ICESCR recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- Convention on the Rights of the Child (CRC)

4.2.3. CHANGES IN LAW IN MENTAL HEALTH

Mental health legislation is essential for protecting the rights of people with mental disorders, who comprise a vulnerable section of society. Mental health advocacy is a relatively new concept, developed with a view to reducing stigma and discrimination and promoting the human rights of people with mental disorders. It consists of various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations.

Legislation should strike a fine balance between the individual's rights to liberty and dignity on the one hand and society's need for protection on the other. There is no national mental health legislation in 25% of the world's countries, accounting for nearly 31% of the global population, although countries with a federal system of governance may have state mental health laws. It should be noted that the existence of mental health legislation does not necessarily guarantee the protection of the human rights of persons with mental disorders. In some countries, indeed, mental health legislation contains provisions that lead to the violation of human rights.

Some of the more important issues to be addressed in legislation include:

SUBSTANTIVE PROVISIONS FOR MENTAL HEALTH LEGISLATION

- THE PRINCIPLE OF THE LEAST RESTRICTIVE ALTERNATIVE;
- CONFIDENTIALITY;
- INFORMED CONSENT;
- VOLUNTARY AND INVOLUNTARY ADMISSION;
- VOLUNTARY AND INVOLUNTARY TREATMENT;
- INDEPENDENT REVIEW BODY;
- COMPETENCY AND GUARDIANSHIP.

SUBSTANTIVE PROVISIONS FOR OTHER LEGISLATION IMPACTING ON MENTAL HEALTH

- HOUSING;
- EMPLOYMENT;
- SOCIAL SECURITY.

The increasing number of individuals with mental health and substance use conditions in the criminal justice system has enormous fiscal, health, and human costs. Diverting individuals with mental health and substance use conditions away from jails and prisons and toward more appropriate and culturally competent community-based mental health care is an essential component of national, state, and local strategies to provide people the supports they need and to eliminate unnecessary involvement in the juvenile and criminal justice systems.

In order to reduce involvement, support those who need services, and promote fairness throughout the criminal justice system, leaders in the mental health system, law enforcement officers, public defenders, prosecutors, court personnel, advocates, legislators, and others in the criminal justice system must come together to create a system that will improve outcomes for all. This includes:

- Keeping people out of the juvenile and criminal justice systems;
- Supporting people with services;
- Eliminating discriminatory practices and punishments.

In Portugal the Mental Health Law (Law no. 36/98 of 24 July), establishes the general principles of mental health policy and regulates the compulsory internment of people with mental abnormalities. Since its entry into force, the discipline of compulsory internment of the person with mental illness has changed and is now determined by a judicial decision of the competent court.

The Mental Health Law provides that the protection of mental health is effective through measures that help to ensure or restore the psychological balance of individuals, to encourage the development of the capabilities involved in personality building and to promote their critical integration into the social environment where they live.

By enshrining the principles of necessity and proportionality of the compulsive internment of those with psychic abnormalities, the regime provided by the Mental Health Law ensures respect for the rights, freedoms and guarantees of persons.

This law thus constitutes a fundamental instrument for the protection and promotion of the mental health and individual rights of the internee, a particularly important aspect due to the vulnerability potentially arising from the presence of psychic anomaly.

After two decades of this law, and in the context of the very evolution of society, it can be seen that a number of developments have emerged both in the provision of care, on the one hand, and in the new legal requirements for the protection of fundamental rights, on the other. In medical matters, internment should be the last option, and the necessary compulsory outpatient treatment can be guaranteed, in the least restrictive and most guaranteed means of freedom, restoring health as a fundamental right. On the other hand, a model of medical intervention has increasingly been affirmed that guarantees the full freedom of the citizen in general and of the bearer of a psychic anomaly in particular, and it is important to abandon a paternalistically protective model, which in civil legislation has also recently been translated into the passage of the interdiction institute, which favoured representation, to the figure of accompaniment, which favours assistance, in the new wording given by the Civil Code and by the Code of Civil Procedure conferred by Law no. 49/2018, of 14 August. Finally, by ratifying the Convention on the Rights of Persons with Disabilities, adopted in New York on 30 March 2007, through Resolution of the Assembly of the Republic No. 56/2009, published in the Official Gazette, 1st Series, No. 146, of 30 July, Portugal undertook, in the area of human rights, to comply with and pass on to national legislation the provisions of that Convention.

In these circumstances, it is necessary to revise Law no. 36/98, of 24 July, in order to incorporate the new developments arising both from scientific developments and from the provision of health care, as well as from the level of fundamental rights, and it is necessary to

create a Working Group to review and present a proposal for revision of the Mental Health Law.

This Working Group should submit a proposal for revision of the Mental Health Law, approved by Law No. 36/98 of 24 July, as currently drafted, to be submitted to members of the Government with powers in the areas of justice and health.

Without prejudice to other matters that may be considered relevant in the course of the work, it is incumbent on the Working Group to prepare a proposal for revision of the current Mental Health Law, adapting it to scientific developments and new models of health care provision, in compliance with international obligations to which the Portuguese State has bound itself, with regard to the recognition of the fundamental rights of people living with mental illness processes.

4.2.4. EXAMPLES OF SUCCESS

WHAT IS COMPULSORY HOSPITALIZATION?

It is an internment by judicial decision of the bearer of severe psychic anomaly.

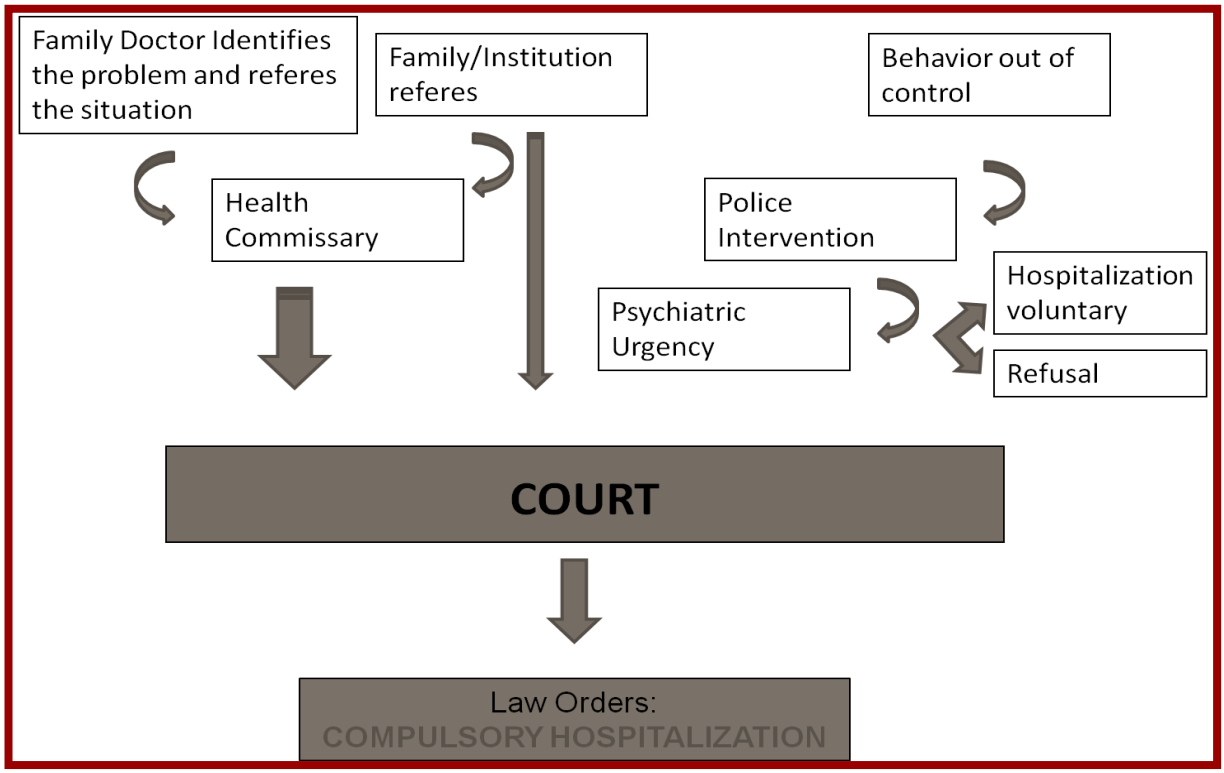
WHEN CAN IT BE APPLIED?

- A person with a severe psychiatric disorder that creates a danger to legal property of significant value, whether of his own or others, of a personal or property nature, and refuses to undergo the necessary medical treatment may be admitted to an appropriate establishment.
- Patients with severe psychic abnormalities who lack the necessary discernment to assess the meaning and scope of consent may also be admitted when the absence of treatment significantly deteriorates their condition.

WHEN CAN THERE BE POLICE INTERVENTION?

Police can intervene in two situations:

- Law orders
- Out-of-control behavior



Questions and complaints about procedures in this area can be sent to the following email:

comissaointernamentocompulsivo@dgs.pt

COMPULSORY HOSPITALIZATION

Compulsory hospitalization of mentally disturbed people and unwilling treatment are viewed as legal and ethical issues that require specific application criteria. Compulsive measures raise multiple questions, and various constraints are felt by practitioners in everyday practice. Patients with severe mental disorders may experience periods in which their ability to make

decisions about their treatment is severely compromised and may put themselves and others at risk, where effective and timely treatment is imperative.

Through the analysis of international documents, the importance of recommendations related to the duty to provide information on patients' rights and knowledge of available legislation, but also for health professionals to see their training needs.

WHO (2005) warns of the importance of mental health legislation in order to protect people's rights and maintain a balance between freedom and dignity, as well as the need to protect society? That is, account must be taken of justice, the right to treatment, the protection of the rights of the people with mental illness, and the general well-being.

4·3· EDUCATION

4.3.1. CHANGES AND IMPACT OF EDUCATIONAL PROGRAMS AND TRAINING IN MENTAL HEALTH

Policies and initiatives in the area of adult education and training in Portugal have reflected the awareness that the country has, both at the level of ordinary citizens, and at the level of organizations, public or private entities and policy-making bodies, to the low levels of school and professional certification of its adult population. They also reflect the effects of the new challenges facing Portugal, in the context of the European commitment to the transition to a knowledge economy and to social cohesion. This strategic bet presupposes the correlation between innovation, competitiveness, levels of well-being, quality of life and education and training of the population, capable of ensuring sustainable human development.

It is recognized that, overall, the main constraint facing the education and training of the adult population, despite the undeniable advances of recent years, still remains the substantial number of adults with low levels of education. Given that the level of basic education strongly affects the willingness and propensity to invest in further and continuing learning, are facing a deficit, which is reflected in the limited demand for education and training among the least educated and skilled, which translates into heavy costs at the country's development levels.

In fact, Portugal is one of the countries with the weakest levels of educational and professional qualification of its adult population. The existence of 62.6% of the adult population, whose level of education does not exceed 6 years, creates a worrying social context in the European context, also reaffirmed by the National Literacy Study (Benavente, 1996). As this author states (1996: 59) "Portugal has very low levels of literacy and probably even lower levels of certification. People learn at work, in social life, in civic life and are never credited for this knowledge […]. Everything that people accumulate as self-knowledge is not credited to them for certification

purposes, for obtaining diplomas. “It is also a general observation that the citizenship deficit of the Portuguese population is hardly separable from the lack of education and training.

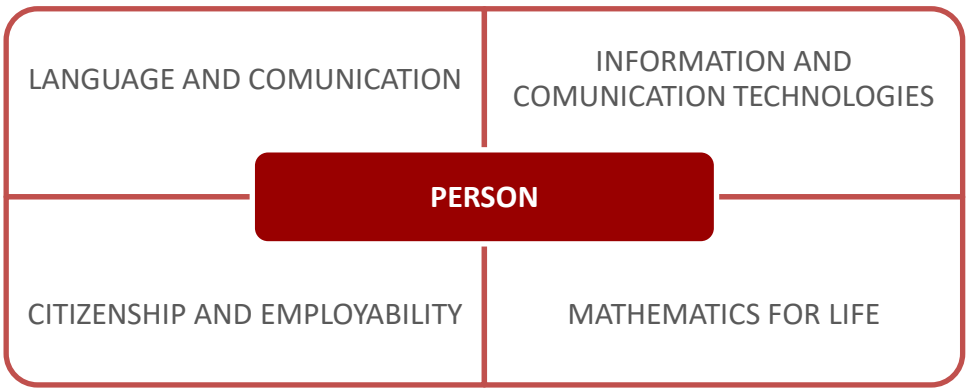
4.3.2. TYPOLOGIES OF EDUCATIONAL AND TRAINING PROGRAMS

From 2000 onwards, by reinforcing concerns about adult education and training, we witness the development of the option for new integrated responses in this area, specifically addressed to low-educated and low-skilled adults, together with the creation of a system for recognizing, validating and certifying knowledge and skills acquired by adults throughout their personal, social and professional life.

Recognizing, validating and certifying key competences of the adult population is an innovative process that stems essentially from lifelong learning and training strategies. As a strategic framework, the concept of lifelong learning, as first proposed by UNESCO in 1996 and then by the European Commission (2000), recognizing that all contexts can be learning truly emphasizes the need to consider three strongly interrelated axes: formal learning acquired in institutional education and training systems; non-formal learning, the product of other non-institutional training activities, such as some of a professional nature; and informal learning, arising from daily living activities , work-related, family or leisure. In this context, lifelong learning is seen as a social, complex and dynamic construction, as a "continuous uninterrupted" process that considers the temporal dimension of learning, just as it considers the multiplicity of spaces and contexts of this learning. This learning process integrates active citizenship, individual development and social inclusion by focusing, beyond the employment and work dimension, on the social, historical, cultural, political and emotional dimension of learning. Individuals are understood as the main actors in this process and their lives as sustainability relations for the emergence of learning.

4.3.3. EXAMPLES OF SUCCESS

In this connection, the key competency recognition, validation and certification processes have the Key Competency Framework as a reference frame in order to adjust to each adult and each group in their life contexts, valuing meaningful learning for each individual´s life project, starting from the personal recognition of these learnings, guiding and organizing these learnings in order to facilitate the recognition and validation processes and those of formation. Only in this way will it become a relevant and significant instrument for the personal and social change of the adult. At the basic level, the framework design is based on a four core areas organization and an area of knowledge and competencies contextualization, all considered necessary for the formation of the person / citizen in today's world. The core areas are: Language and Communication (LC); Information and Communication Technologies (ICT); Mathematics for Life (ML) and Citizenship and Employability (CE).

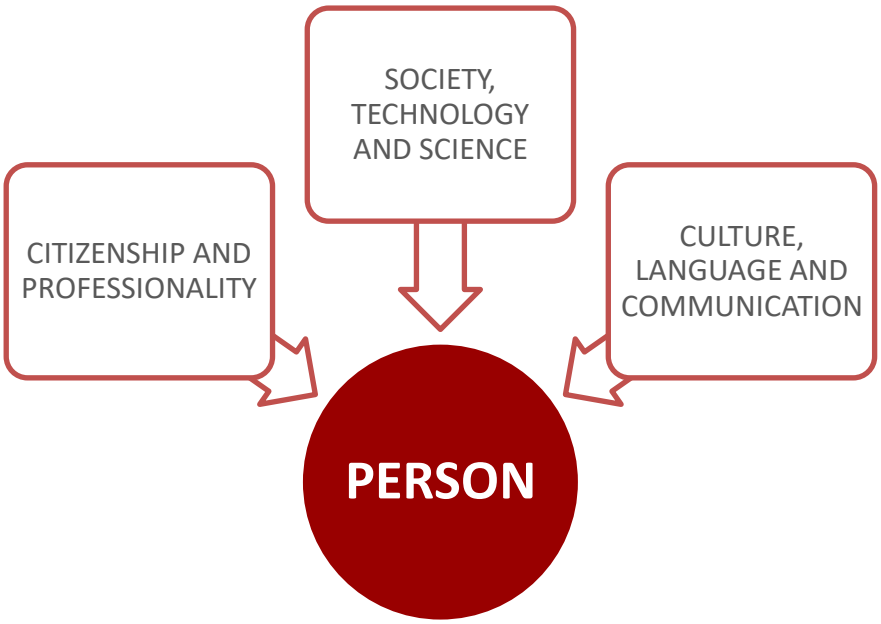


Key Competency Areas of Secondary Level

At the secondary level, the framework is based on an organization in three Key Competency Areas: Citizenship and Professionality (CP). In this area, the aim is to highlight, recognize and certify key competencies of and in democratic citizenship as a result of reflective learning and

/ or the (re) attribution of meaning to experience and prior knowledge; Society, Technology and Science (STC), as one area that works to reveal key competences in fields that involve

increasingly complex formalized and specialized knowledge, through an integrated three-dimensional view of citizens' lives - science, technology. and society; Culture, Language, Communication (CLC), an area that focuses on key competences that can be highlighted, recognized and certified in three distinct dimensions - cultural, linguistic and communicational - that complement and articulate themselves in an integrated and contextualized way.



Key Competency Areas of Secondary Level

Concomitant with this process, there has always been a concern to create an inclusive network that can also serve and work people with disabilities and incapacities, with functional diversity, allowing them to integrate into the general structures, open to all citizens, in a context of maximum possible participation, articulating and complementing each other with specialized resources, when relevant.

In the case of the development of the processes of recognition, validation and certification of competences, the dynamic nature of the references requires a permanent (re) updating /adaptation to changing contexts, as a result of their application in working with adults, for a

better adaptation of the reference to the target public of adult education and training activities. In this context, it is important to organize the conditions for it to be even more open and flexible in its dynamics and operationalization processes, keeping as general and universal reference the principles, rules and general criteria that shape it, namely in terms of the competences that allow verifying, recognizing and certify, in an intervention framework that ensures personalized and possibly specialized support to those who need them, allowing the management of the functional diversity of people in qualification courses.

In order to comply with the principles of the Convention on the Rights of Persons with Disabilities and Decree-Law 34/2007, for guidance, it was created, in 2009, the Methodological Guide for Accessing Persons with Disabilities to Skills Recognition, Validation and Certification Process - Basic Level, which identifies the adjustments to be made to the dynamics of the processes of recognition, validation and certification of competences in order to support the individualized and flexible operationalization of these principles and methodologies, that takes into account the functional specificities of each person. At the level of environmental factors, technical aids/support products, attitudes and significant people, services, systems and policies are considered relevant for the adequacy of intervention practices in education-training systems. Technical aids /support products are facilitators in removing barriers to people's participation. While products and technologies cannot eliminate deficiencies and disabilities, they can remove any limitations on functionality, as well as favoring the accessibility of the various environments and enabling the performance of activities with maximum autonomy and effectiveness. It is up to the Centers to assess the need for technical aids / support products and to prescribe them, in cases where candidates have changes in their functions that might cause limitations on the activities inherent to the Recognition, Validation and Certification process, which can be resolved via technical aids / support products in those cases where they are not yet allocated. Assistive products are listed on a List Approved by the National Institute for Rehabilitation (INR) and are classified according to the International Regulation Standard ISO 9999, entitled “Assistive Products for Persons with Disability: Classification and Terminology”. Regarding attitudes and significant people, the objective is to foster a good relationship between the technical-pedagogical team and the candidates, with attention to language, communication style, posture and attitudes in general, which can be facilitators or obstacles, depending on the adequacy of the relationship with the person with disabilities. Another point, and a relevant one, relates to the

participation / collaboration of significant people of the person with disabilities in the process, which can also be regarded as facilitators of the process. In addition to the previously discussed dimensions, according to the challenges posed by the biopsychosocial model, services, systems and policies also constitute one of the dimensions that facilitate or create barriers, expanding or reducing the functionality of people with disabilities. Thus, regulatory instruments are fundamental to guide the work of centers and to meet the needs of people with disabilities, maximizing their potential.

The Methodological Guide, in terms of functionality/disability, considers six different types of changes in body functions, namely, vision, hearing, mental - intellectual, mental - mental illness, neuromusculoskeletal and movement-related, and finally voice and speech. For each of these alterations of the referred functions, the adaptations to be considered in the operationalization of the process of recognition, validation and certification of competences will be considered, having as a guidance benchmark the Framework of Key Competences of Adult Education and Training - Basic Level and the diagnosis by the Technical and Pedagogical.

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Tailoring Law and Health Initiatives to promote Inclusion on Mental Illness
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