Care Work with Mental Health and Substance Misuse Clients in the Netherlands

Content

1. Introduction

Dear Student

◆ *Welcome to The Netherlands! We are very pleased to have you here doing your practical study placement and hope it proves to be a productive and pleasant experience for you.*

The purpose of this handbook is to give you an overall view and understanding of the care in the Netherlands. Which support and help is available for those individuals who are experiencing mental health problems. This also includes those individuals who do so as a direct result of substance misuse.

Substance misuse has focussed on drugs and alcohol within this pack. Tobacco misuse has not been highlighted within this booklet but is another serious concern for the Dutch people.

*The pack **has not** made specific reference to children's mental health service provision because it is unlikely that a work placement would be available in this specialised area. It must be remembered that with any care provision it is constantly evolving to meet the needs of the individual. Changes also occur in response to government targets and initiatives to support health in its widest sense. Mental Health and the promotion of mental health for the Dutch people are seen as a priority of the Dutch Government. As a result many new initiatives are being implemented throughout the country.*

Whilst every effort has been made to include up to date information which is accurate at the time of publication you may be introduced to new initiatives as a direct result of legislation and policy which has taken place since publication of this booklet.

A case study of a family has been included in section 7.7. which will illustrate the type of service provision available for this family in The Netherlands.

Depending on where your placement is you may be working with groups or individuals in either a Health or Social Care placement.

This booklet does contain a lot of information and it is hoped you will use it as an information guide prior to coming to The Netherlands. It provides additional information when you are undertaking your work experience. The contents page will allow you to locate the information you require with greater ease.

A glossary of terms in relation to Mental Health and substance misuse has been included to provide additional information for any terms which you may require additional clarification with.

We hope you enjoy your visit to The Netherlands and that this booklet assists in your learning experience.

About The Netherlands

The Netherlands has the highest number of inhabitants per m2 in the European Union. This does not mean that there are no regions in the EU of similar size with higher population densities. But as a country the density is the highest of Europe. The Netherlands has got more than 16 million inhabitants.

About 400,000 professionals work in the field of care and welfare in The Netherlands.
Many of these people, for example those working in home care, have part-time and/or short-term contracts, which means that they only work a limited number of hours.

GGZ nederland

Most people work either in the field of care for the elderly or the disabled. Some 25,000 people have jobs in youth care and about 60.000 people work in the field of Mental Health.

2. The European Union's Policy on Mental Health And Intoxicant Misuse

◆ ***Public health is a major concern within European Union. Therefore health reducing and damaging factors have already been recognised when establishing The European Community. Thus the basis for European level co-operation and promotion of mental health and initiatives and measures to reduce health damages related to intoxicants lays with The Treaty establishing The European Community (in paragraphs 1-2, article 152 dealing with public health):***

"**Community policies and activities complement and support national policies that aim to improve public health and prevent illnesses and diseases. These policies and activities include actions in both prevention and reduction of drugs-related health damage. Member States are encouraged to co-operate to reach stated goals. The Commission will support such efforts via different policies, initiatives and programmes.**" (a)

Extract of the Article 152 of the Amsterdam Treaty:
"A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and disease, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention."

The need for common programmes and policies promoting mental health derives from challenging situation. Approximately 25% of EU's population suffers from some form of mental ill health, most common ones being anxiety disorders and depression. Mental ill health on social level causes also significant economic and social losses, causes far too often stigmatisation and discrimination for people suffering from them. Furthermore their human rights and dignity are neither respected in acceptable manner. Thus Commission outlined launching of common strategy on mental health called **Green Paper: "Promoting the mental health of the population. Towards a strategy on mental health for the EU".**

Importance of mental health in Green Paper is crystallised in following key lines:

- good mental health is a resource for individuals and society – without it nor individuals or society as a whole can be considered well-being. Ill mental health prevents individuals to fulfill their intellectual and emotional potential to full and reducing quality of life – resulting also on social level to lesser social and economical welfare. Mental and physical health are also inter-related: e.g. depression is a risk factor for heart diseases.
- Ill mental health has significant economic and social effects: mental disorders are a leading cause of early retirement and disability pensions – and depression is expected to be the second most common cause of disability in the developed world by year 2020. Unfortunately social exclusion, stigmatisation and discrimination of the mentally ill are still a reality within the Member States.
- Currently, in the European Union app. 58,000 citizens die from suicide every year and there seems to be close connection to mental health as up to 90% of suicide cases are preceded by a history of mental ill health, often depression.

In accordance to Green Paper WHO European Ministerial Conference on Mental Health (Helsinki 2005) announce following priorities:

It is necessary to build on the platform of reform and modernization in the WHO European Region, learn from our shared experiences and be aware of the unique characteristics of individual countries. We believe that the main priorities for the next decade are to:

a) foster awareness of the importance of mental well-being;
b) collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
c) design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
d) address the need for a competent workforce, effective in all these areas;
e) recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

(WHO European Ministerial Conference on Mental Health. Facing the Challenges, Building Solutions Helsinki, Finland, 12–15 January 2005)

The EU-Public Health Programme 2003-2008 constitutes the current instrument for action at Community level in the field of mental health and includes Green Paper's strategic aims. Member States outline their national policies in accordance of EU-level strategies and policies.

The Council of European Union set in 2005 **"EU Drugs Action Plan for years 2005-2008"**.

The drugs phenomenon was considered as one of major concerns of the citizens of Europe and as a major threat to the security and health of European society. The Action Plan was based on EU Drug Strategy (2005-2012).

From social and health care –viewpoint one of Strategy's major aims is "to achieve a high level of health protection, well-being and social cohesion by complementing the Member States' action in preventing and reducing drug use, dependence and drug-related harms to health and society."

From social viewpoint emphasis is laid on prevention programmers: on reducing demand and also on improving methods of early detection of risk factors of potential intoxicant abusers. Furthermore one important result to be achieved in combating drug abuse is to "ensure the availability of and access to targeted and diversified treatment and rehabilitation programmes, referring to services and treatment available for people facing the problem.

3. History

3.1 History and Development of Mental Health Care

◆ The history of psychiatric care is a fascinating story. The actual psychiatric care as known today was developed at the end of the 18th century. Before the 18th century, psychiatric disorders were not seen as a separate disease. In former times the explanation for these diseases were thought to be found in the body or in supernatural powers, ghosts and demons.

Prehistory

In the prehistory and traditional cultures people tried to understand certain things which they couldn't understand relying on magic. Diseases were ascribed to ghosts or demons, or to deceased ancestors, taking control over the body of the ill person.

The medical science consisted out of trying to force the evil spirits to stay away.

The medicine-man or woman and shaman had the ability to communicate with the spirit world.

Often they also had a lot of knowledge of medicinal plants.

In some prehistoric cultures it was thought an evil spirit could be released by drilling a hole in the skull.

In 770 BC in ancient Greece lived Hippocrates, the father of the western medical science.

He was the first one to reject the idea that diseases are caused by evil spirits. He studied body fluids, he thought a wrong ratio of these fluids was the cause of diseases. His treatments include the letting of blood and vomit therapies.

Mental patients were prescribed with hot and cold baths, peace and quiet and a diet. Singing and music were also recommended.

Middle ages

The emergence of Christianity changed the vision on mental patients dramatically.

A step back was taken considering the view of Hippocrates. Mental diseases were once again ascribed

to the devil. It is Gods punishment for the committed sins. Therapies used were exorcism, the banishing of the devil done by a priest.

Another way of exorcism was the stake. During the witch hunts held between 1450 and 1750 a hundred thousand people stood trial which led to forty to fifty thousand executions.

In 1563 Johannes Wier, history's first psychiatrist, protested against the witch hunts. According to Wier the women were no witches, but women who suffered of melancholy. They didn't need a punishment but a treatment. For centuries long melancholy was the term used for all psychoses.

Emergence of mental institutions

At the end of the middle ages, around 1200, the first aid organizations for mentally diseased were founded in the big cities. Hospitals for poor people were built. Distinction was made between the ill and elderly and the mental patients and leprosy patients.

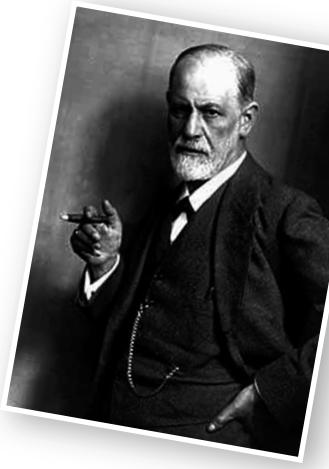
Even though the witch hunts continued until 1750 in some European countries, it was then that the first institutions for mental patients were founded in order to protect themselves and others.

In the Netherlands the first mental home was founded in Amsterdam in 1562 and in The Hague in 1607. If the mental patients became dangerous they were tied up and locked up in a dungeon. If this was not the case, they were transported to a mental home.

1800 – now

From 1880 a lot more research was done especially regarding hysterical patients.

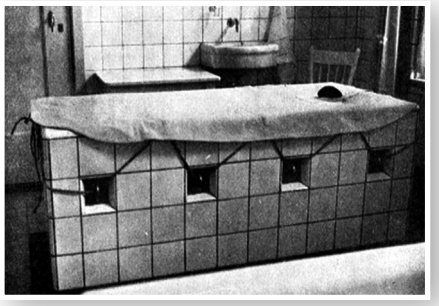
Hypnosis was used as a method. They discovered that a lot of physical complaints had a psychological cause. Sigmund Freud carried out a lot of ground-breaking work in this.



The Netherlands introduced a new Mental Health Act in 1884.

They focused on the bad situations in the mental homes. Nurses treated the patients as if they were criminals. Patients were abused, they got tied up and the sleeping conditions and the food were miserable.

Florence Nightingale was the first one to set up an official nurse education in 1875. Due to this nursing became a job not something you do for religious reasons.



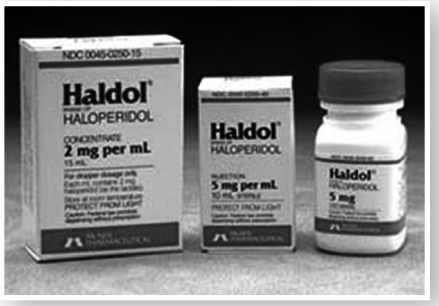
Around 1900 baths of warm water and bed therapies were prescribed a lot. They thought bed therapy had a positive influence on the brains and the blood circulation. They thought of hydro therapy as calming. For most patients these treatments didn't work, because they were too restless. This made it obligatory for patients to stay in a bath for a very long period, sometimes for several months. The bath was covered so they couldn't get out. They could go out a few times to go to the bathroom.

Others were wrapped in blankets so tightly they could barely move.

From 1925 more active ways of therapy were thought of. In these therapies not the sick part was important, but the healthy part. The occupational therapy became a common treatment.

Between 1934 and 1953 patients were treated with insulin treatments, electroshock therapies and sleep therapies. Also lobotomy was practised, a method that was very dangerous.

Halfway through the 20th century a lot of things changed. Because of the arrival of medicines, the treatment of patients improved a lot. This meant that wards that were very hectic became more quiet places. After 1953 also the restless patients, who couldn't be cured completely with medicines, were more approachable. Of course this was a huge change in the work with mental patients.



A few years later more than a hundred psychopharmacological drugs were available.

Patients who sometimes were in the mental home for 10 years or more could be dismissed healthy.

After 1960 therapeutic communities started to emerge. Their goal was to emphasize the self activity. This was a response to the medical model. The

anti-psychiatry was a revolt to the mental hospital as a total institution. Psychosis had a positive appreciation; it was seen as a response to the sickening society. Psychiatry got rejected because it was seen as a social means to control in which psychiatrists were the social police.

The 70s were characterized by democratic psychiatry. It is wrong to isolate people from the society, mental patients need to be treated as regular citizens. A tight cooperation between clients, relief workers, the society and politics is sought.

Through this a lot of small-scale living provisions were founded, decreasing the privacy of patients. Until then the care was hospital-centred, the wards were big and patients got accustomed to the hospital life. But the vision on treatment changed dramatically in this period. Patients were not to be put away in isolated institutions, but were more integrated in the society.

This meant a change also in the lives of patients and their families. Instead of staying
in hospitals, the patients moved to live among other people. They were keeping their contact with their families, homes and society. At the same time it meant decrease in institutionalization.

At the end of the last century there is a revolution in the way people think about mental diseases. Through research of chromosomes and brains, it is discovered that a lot of mental issues have a physical cause.

This could mean that for instance for schizophrenia gene therapy is possible in the future.

A mental disease can be treated easier then. In the future a new approach to the treatment of mental diseases will be developed, by replacing the corrupted gene by a new healthy one.

Scientists expect that a mental disease like schizophrenia won't exist anymore in the future.

3.2 History and Development of Substance Misuse

History of the use
The use of alcohol and drugs dates back to the very beginning of the history of mankind.

At all times people sought drugs to reach a state of ecstasy, sometimes just for pleasure but also often to escape from the harsh reality.

3.2.1 Alcohol

The oldest recipe for brewing beer was found on a 5000 year old Sumerian clay tablet.

Another Sumerian text dated a thousand years later describes beer and wine.

On ancient Egyptian murals dated about 1500 BC, images of drunk people can be found.

Wine was extremely popular with ancient Greeks. They honoured a lot of gods, one of them being Bacchus, the god of fertility. A lot feasts were held in his honour and thus he received the nickname god of drunkenness.

Also in the Bible there are references to alcohol: Noah was drunk at a party and in another story Jesus turns water in to wine during a wedding-feast.

Another known fact is that in the first centuries AD, several emperors of the Roman Empire were addicted to alcohol.

Still people didn't drink much alcohol in former times, it was very expensive and wasn't always available. Until the middle ages that didn't change. At that time people made wine out of fruit and beer out of barley and honey. The percentage of alcohol in these beverages was very low. Refrigerators didn't exist yet so it didn't take long for the beverages to go bad.

That is the reason alcohol wasn't available all year round.

In the late middle ages the technique of distillation reached our country through the Arabs.

The distillates began to be frequently used as a stimulant. They didn't go bad and the alcoholic percentage was higher.

After 1700

Alcohol remained expensive and thus unreachable for the working class and lower class.

This changed in the 17th century. It was discovered that out of grain and beetroots, spirits could be made. These commodities were cheap so the price of alcohol decreased. Because of this, spirits became easily accessible to the common man.

More people started to drink, but there was no talk of excessive drinking on a large scale.

Beer was being drunk by old and young as a substitute for the polluted drinking water.

After 1780 this situation changed, following French customs more and more wine was drunk and spirits like brandy and gin became immensely popular.

It was drunk everywhere, even by women.

Later there was a decline in the use of alcohol in the Netherlands. This decline started in 1835 and lasted until 1850. After that the use stabilized. From about 1865 the consumption of alcohol increased again.

During the second half of the nineteenth century, a lot of families spent a significant part of their budget on alcohol. Industrialization and urbanization took a great spurt in the Netherlands.

In the growing cities the housing was often below standard.

The wages in the industry were low and the working circumstances were mostly very bad.

For a lot of people drinking became the only thing left to derive comfort from. They escaped from the depressing reality with the intoxication of the spirits.

The massive alcoholism of those days affected the public health. Tuberculosis for instance became a public disease.

The Dutch government took a liberal view on the problem of alcohol misuse; they didn't think it was their problem. When the problem became such a big issue it was to disturb the public peace, the government finally took action. In 1881 the licensing-law was created, this settles where you could legally buy alcohol. Also disturbing the public peace because of alcohol misuse became an offence. Public drunkenness in 1895 was fined with 1 guilder (about 0,50), which was a great amount of money that time.

The emergence of the social thinking in the last quarter of the 19th century changed people's view. They realized gin was an obstacle for the emancipation of the working class.

Alcohol was now seen as a way keep the working class dumb and to take advantage of people.

In newspapers from this period are a lot of awful examples of what influence alcohol addiction had on people. As a response to that, organizations for teetotalism were created trying to point out the dangers of alcohol to the

"de kroeg uit, de beweging in"

public. In 1897 the ANGOB (Dutch teetotalism Union) was founded in The Hague. Their principles were:

The choice of teetotalism as a way to fight the addiction and show sympathy for the victims.

Don't enforce but persuade, give people information and more freedom in their choices.

The ban on alcohol like the one in America was rejected by the ANGOB as a way to fight the alcohol problem.

During the period after the World War II the consumption of alcohol stayed low until 1960.

This was because drinking was a luxury. Between 1960 and 1990 a lot of people started to earn more money. The prices of most products increased, but the price of alcohol stayed low.

The use of alcohol slowly started to become more common and more people started to make a habit out of drinking. Also it wasn't considered strange that women drank alcohol as well.

In 1996 people older than 15 drank 727 glasses of alcohol per person per year.

3.2.2 Drugs

Drugs have always existed. Originally found in nature, the discovery mostly went accidental.

The use of drugs has had three different functions through the centuries: religious, medical and relaxing.

For a long time plants have been the only source of drugs. In search of food, people experimented with different types of plants. They discovered certain plants had extraordinary effect on the spirit. Because they couldn't understand it, they ascribed it to supernatural powers.

In the ancient Egyptian, Greek and Roman civilizations drugs also existed. Priests used plants and herbs to become one with their god.

Also people in the Middle East, Asia, Central-Africa and South America used drugs like hash and coca leaves for religious goals. They also used the drugs as a treatment to numerous diseases. The soothing working of opium has been known since antiquity.

The discovery of America coincides with the first use of tobacco. In 1492 Columbus was the first European to get in contact with tobacco. Later it was discovered that Indians already used tobacco long before the Europeans came.

In more modern times the healing knowledge of plants and herbs was lost. Laboratories synthetic medicines were developed. After many experiments they found a lot of these products couldn't be used as medicines. These were products like LSD and heroin. Even though they couldn't be used as medication, they did become a very successful drug.

Until the beginning of the 20th century alcohol, opium and herbs were also used as a soporific and a sedative. After that the first synthetic drugs were launched. In the beginning of the 19th century they succeeded to derive morphine from opium. Morphine is now used worldwide to comfort severe pain.

In 1884 a Dutch magazine for medical science was very positive about the use of cocaine, the only downside was the price: 9000 guilders per kilo.

Heroin was first launched on the market in the end of the 19th century by a German company called Bayer. Due to a huge advertising campaign in twelve different languages heroin became popular in a very short time. It was meant as a medicine for bronchitis, chronic coughing, asthma and tuberculosis. In a few years it became known that it was very addictive.

It wasn't used much at that time in the Netherlands. It wasn't until 1972 that the use of heroin became a big problem in the Netherlands.

Nowadays drugs have lost all their ancient spiritual connections. They are mostly used for pleasure. Besides, drugs are much more liable to fashion and trends these days.

In the 60s drugs that caused tripping like LSD and hash were very popular. In the 70s people resorted to alcohol, heroin and amphetamines. In the 80s cocaine was used a lot. XTC and smart drugs characterize the 90s. Nowadays drugs are losing its exclusive character and the use of them is becoming more ordinary. Also people mix drugs more and more these days.

Drugs and alcohol are subdivided in to different laws. The drug law (opium law) states that the dealing and carrying of most drugs is illegal.

The licensing-law (alcohol law) states that alcohol is legal, but the distribution is bound to rules. For more info on laws see chapter 4.

3.3 History of the care of addicts

◆ The aid given to addicts nowadays originates from the aid given to alcoholics in the end of the 20th century. This aid for addicted people came into being from the work done by teetotalism organizations.

The first organization especially developed to control the use of gin was founded in 1842.

The members of this organization were mostly developed middle class citizens like clergymen, doctors, teachers and entrepreneurs.

The “abolishers” as the members were called, only focused on spirits. Liquor was seen as the enemy of the enemy, his health and the labour efficiency. Beer en wine weren’t considered dangerous at the time.

A part of the aid to addicts was the probation service, because alcoholics were no strangers to court. In the period after World War II the organization of the aid for addicts changed more in to moral support and the probation service decreased.

Since the moment drug addiction took its entrance around 1970, the Netherlands sought the most effective way of controlling the problem. Due to the growing addiction problem in the 70s, a lot of care organizations were founded each specializing in different things.

Besides that a lot of institutions for the intake of addicts were founded mostly by private individuals. In the Netherlands there are a lot possibilities for addicts to gain aid.

Each addict can have personalized aid: a long term intake or just a conversation once in a while. Intensive therapy and only help with taking care of practical things like debts.

You will find more explanation about this in the next chapters.

4. Present Situation and Future Challenges

4.1 Mental Disorders

Facts and figures about mental disorders

Before 1997 it was unknown how many Dutch adults were suffering from mental disorders. Meanwhile we have come to know that 41.2% of the Dutch population between the ages of 18 and 65 have suffered from some mental disorder at any given time. That 19% have suffered from mood disorders, and 19.3% of anxiety disorders, while 18.7 % has had alcohol or drug-related problems.

In 2003 large-scale research into mental illness was held among the Dutch population. The Nemesis Survey (Netherlands Mental Health Survey and Incidence Study) charted the mental health of the Dutch population. The aims of the survey were:

- To provide an overview of the state of the population's mental health
- Tracing the main causes of mental illness, thus charting risk groups
- Insight into consequences of disorders for the individual and for society (costs)
- Researching the need for assistance
- Charting the services offered by mental health care.

In this chapter the most important data from this survey are presented. In 2008 this research program will be done again. The result of this new Nemesis Survey will be an important source for all kinds of new welfare policy in The Netherlands.

The question may be asked whether the figures present a true picture of reality. If over 40% of the population have suffered from mental disorder, are these data correct?

There are two reasons for the figures being so high:

- The image we have of mental illness. We tend to think of people who have been admitted to a clinic, after being diagnosed with schizophrenia. But all kinds of milder forms such as alcohol dependence and social phobias qualify for the definition as well.
- Shame plays a major role in the way we approach mental disorders. As a result of this a lot of people don't come out into the open about their complaints, whereas in an anonymous survey they do admit suffering from complaints

In the survey the criteria for mental disorder outlined in DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders) have been used.

The survey shows that 41% of the population have suffered from mental

illness once, or more often during their lives. For over 23% this concerned a disorder that occurred during the previous twelve months. Most frequent were anxiety disorders, mood disorders and problems related to addictive substances. (see box below)

One of every five Dutch person have experienced disorders caused by anxiety, the same goes for disorders of the mood. Depression is most frequent.

Some 17% of the adult population have experienced problems concerning the abuse of alcohol or dependence on it. If only the previous year is measured this comes down to 7%. Problems related to the dependence on drugs are far more infrequent, about 3% of the adult population have had to deal with them.

The figures concerning suicide show that there is a decrease of 10% in the last 20 years. Still 94.000 persons commit a suicide attempt every year. Another 410.000 persons feel so depressed that they consider suicide.

Every year a great number of patients visit the ER or are admitted in a hospital because of a suicide attempt. This is probably only the tip of the iceberg.

Every year about 1600 persons (65% male) die because of suicide.

Figures on the incidence of different mental disorders among the Dutch adult population. The Netherlands are populated by some 16,000,000 people.

Depression	1 in 10 men and 1 in 5 women have suffered from depression at least once during their lives. Also 3 to 8% of 12 to18 year olds have suffered from it. 2 to 3% of the elderly suffer from serious depression. A much greater number, 15 to 20% of the elderly have suffered from a mild form of depression.
Eating disorders	Every year more than 30,000 women between the ages of 15 and 29 suffer from eating disorders. Each year they are joined by 1,200 new people suffering from anorexia, and 1,800 people suffering from bulimia.
Anxiety disorders	Almost 20% of all Dutch people have ever suffered from anxiety disorders. This comes down to 1 in 5, about 3,000,000 people!

Mourning	About 140,000 people die every year. The number of surviving relatives is a manifold of this. About 1 in 5 of survivors has suffered trouble adjusting to the loss.
Compulsion	About 2% of the population suffers from obsessive compulsive disorders, men almost as frequently as women.
Dementia	In The Netherlands about 250,000 people suffer from some form of dementia. Of all persons over 65 years of age, 6% suffer from Dementia.
Stress	12 out of 100 consultations of GPs involve stress disorders. It is estimated that 10,000 people a year end up in Disability Insurance because of stress and over taxation.
Schizophrenia	Over 130,000 people will suffer from schizophrenia during their lives.

Gambling addiction – The number of problem gamblers is estimated at 70,000.

Manic-depressive illness – 1 to 2% of the Dutch population suffer from manic-depressive illness, which is more than 150,000 people. Men and women suffer from it equally frequently.

Post traumatic stress disorder – Every year an estimated 1.5 million people become victims of violence or threat. Of all those who fall victim to these or other shocking occurrences, 20% develop a post traumatic stress syndrome (PTSS).

Postpartum depression – Approximately 10% of young mothers will suffer from some form of depression after giving birth. This comes down to some 20,000 out of 200,000 young mothers in the Netherlands every year.

Borderline personality disorders – In The Netherlands 150,000 to 200,000 people suffer from borderline personality disorders. This is diagnosed three to four times more frequently for women than for men.

ADHD	At least 3 of every 100 children in The Netherlands suffers from ADHD, one of them seriously. This comes down to some 40,000 children between the ages of 5 and 14. Approximately 30 to 60% of them are likely to suffer from it as an adult.

4.2 Addiction

The facts

The use of addictive substances was researched in the Nemesis research (for a more extensive report see 4.1). A distinction was made between abuse of substances and dependence on substances. (see box below)

Abuse of drugs and alcohol: someone uses drugs and / or alcohol frequently, despite the problems this causes. There is no addiction as yet.

Dependence on alcohol and drugs: someone uses drugs and / or alcohol frequently and is addicted to them.
This is expressed through:
- more and longer use than planned
- attempts to cut down are hardly successful
- withdrawal symptoms

It appeared that ± 17% of the adult population have experienced problems with the abuse or dependency of alcohol. If only the previous year is taken into account this concerns 7%. Drug dependence related problems are more infrequent; about 3% of the adult population has had to deal with these. ***This means that alcohol abuse and dependence is one of the most frequent mental disorders in The Netherlands.***

Do The Netherlands have substance problems?

In spite of legal prohibition the use of drugs appears to occur in any society, The Netherlands not excepted. Dutch drugs policy is aimed at:
- **preventing the use of illicit drugs and limiting the damage to users.**
- **reducing inconvenience to society.**

Therefore a lot of information on drugs is provided and the necessary attention is paid to the guidance of users.

Alcohol is not prohibited and is not subject to the opium act. The number of people dependent on alcohol is much bigger than that on hard drugs. Therefore the damage to society is much greater, especially through workplace absenteeism and health care costs.

The box shows figures providing a picture of the scale of substance-related problems in The Netherlands:

- In The Netherlands the number of users of opiates such as **heroin and other hard drugs** lies between 26,000 and 30,000.
- About 85% of the Dutch over the age of 16 regularly have a glass of **alcohol**. In 2003 almost half the students (47%) had drunk a glass of alcohol by the age of 12; at the age of 15 half of them have alcohol on a weekly basis. Alcohol has become a part of social life. For

a great number of people alcohol has become a problem, however: 10% of the Dutch population (1.500.000) are problem drinkers, men more often (17%) than women (4%)
- There are 650,000 chronic users of **sedatives and sleep-inducing drugs**.

People requesting aid

The table contains the number of registrations in 2001 (in 2008 new large-scale research will start) in centres for care of addicts. This concerns people asking for aid who have a problem of addiction or people who request assistance on behalf of a partner, child or parent. The former group of those asking for aid is usually the larger, for some substances the balance is different. The table sums up all the requests for assistance.

Table: Total number of registrations in ambulatory care of addicts in 2001

	total	%
Alcohol	22.107	41
Heroin etc	17.066	32
Cocaine	6.485	12
Hash and weed	3.419	6
XTC	230	<1
Speed etc.	506	<1
LSD etc.	18	<1
Snorting substances (glue, ether)	9	<1
Medication	527	1
Gambling	2.932	6
Various	473	1

(Source: LADIS 2001, IVV, Houten)

Tip of the iceberg

These figures show only the tip of the iceberg. Many people suffering from addictive disorders do not apply to drug treatment centres. This is especially so for socially accepted substances like alcohol and medicine. Only 5 or 6 % of alcoholics apply to drug treatment centres. Those addicted to medicine do not easily apply to drug treatment centres. Someone being prescribed Valium or Seresta easily reasons that if the doctor so orders, it will cause no harm. Of people suffering from drug-related problems an estimated 70% will apply to drug treatment centres.

International comparison

The Netherlands have relatively few drug addicts in comparison to other countries: 2.5 per 1000 inhabitants. Belgium has 3.0, France about 3.9, Spain 4.9, Italy 6.4 and Luxembourg 7.2 per 1000 inhabitants.

Judging by these numbers the conclusion may be drawn that the drug problem may be less serious than in many of the surrounding countries, but that there certainly is a drug problem.

Concerning alcohol the figures show that The Finnish drink a little bit less than the people in the Netherlands or other partner countries. Figures are not always easy to compare. In some

Alcohol consumption, liters per population aged 15+									
	1960	1970	1980	1990	2000	2001	2002	2003	2004
Denmark	5.5	8.6	11.7	11.7	11.5	11.4	11.2	11.5	11.4
Finland	2.7	5.8	7.9	9.5	8.6	9.0	9.2	9.3	9.9
France	..	20.4	19.5	16.0	14.2	14.5	14.7	14.0	.13.0.
Germany	7.5	13.4	14.2	13.8	10.5	10.4	10.4	10.2	10.1
Ireland	4.9	7.0	9.6	11.2	14.2	14.5	14.3	13.5	13.6
Italy	16.6	18.2	13.2	10.9	9.0	8.6	8.6	8.0	..
Luxembourg	13.1	15.6	16.8´¹	14.7	15.4	15.3	14.7	15.5	..
Netherlands	3.7	7.7	11.3	9.9	10.1	10.0	9.8	9.7	9.5
Norway	3.4	4.7	5.3	5.0	5.7	5.5	5.9	6.0	6.2
Sweden	4.8	7.2	6.7	6.4	6.2	6.5	6.9	7.0	6.5
Switzerland	12.1	14.2	13.5	12.9	11.2	11.1	10.8	10.8	10.7
United Kingdom	..	7.1	9.4	9.8	10.4	10.7	11.0	11.2	11.5

countries people brew their alcohol at home ore they go and buy their liquor in a neighbouring country.

For The Netherlands it shows that alcohol consumption in the Dutch population has increased by 270% over the past 43 years, from 3.7 litres (pure alcohol) per adult in 1960 to 9.5 litres in 2004. This rise in consumption has led to increases in alcohol-related harm and disease, and has resulted in a great number of deaths.

This, in turn, has created escalating pressures on our health and hospital services.

Important is that young people, and specially young girls lately drink more alcohol. The number of youngsters that drank alcohol at any time is increased since 1990. This concerns boys and girls of 12 – 14 years.

In chapter 4 there is information on the legislation concerning alcohol and drugs in The Netherlands.

4.3 Interaction between Mental Health and Substance Misuse

◆ The traditional distinction between care of addicts and the mental health care system (psychiatry) is disappearing slowly. In a number of cases close cooperation has led to the integration of a drug treatment centre in a larger mental healthcare institution

There is an ever increasing group of "dual-diagnosis" clients. These patients have been refused by drug treatment centres because of their mental disorder and by psychiatric institutions because of their drug problems. A dual diagnosis also has an adverse effect on treatment.

This chapter explains where the two areas meet. As a result of a mental disorder clients may develop an addiction. Certain substances may calm down a client who is anxious, or may give a person who has little self-confidence a feeling of power. But the abuse of substances may also reveal a latent mental illness.

4.3.1 Describing the Target Population

When describing the target population, the scheme below is often used. Dual-diagnosis clients (a combination of psychiatric and dependence-related disorders) may be divided into four sub categories.

The group we are discussing here is described in quadrant I.

A definition of this group: ***Clients with a combined long-term and / or serious substance-use problem and a mental illness for whom, as a result of the co-occurrence of both types of problem, psychiatry or care of addicts are not sufficient. Apart from this, they show serious socially dysfunctional behavior.***

Size of the target population

Co-occurrence of addiction and mental illness is quite frequent. An estimated 20 - 50% of psychiatric clients are also dependent on substances In drug treatment centre's this percentage is even

Quadrant I **Typing:** Serious psychiatric history with dependence on substances (addiction) **Care:** for this group an integrated approach through care of addicts and psychiatry is necessary	Quadrant II **Typing:** Mild psychiatric history with dependence on substances (addiction) **Care:** clients are off best in regular drug treatment centre's
Quadrant III **Typing:** Serious psychiatric history with abuse of substances **Care:** clients are off best in regular psychiatry	Quadrant IV **Typing:** Mild psychiatric history with abuse of substances **Care:** clients may be treated in both (ambulatory) regular psychiatry and in (ambulatory) regular drug treatment centre's. This depends on the problems and need of care

higher, 60 - 80% of clients also suffer from a mental illness there.

Minor research in a psychiatric ward showed that 70% of inpatients tested positive for controlled substances. They were inpatients who had not been admitted because of their drug dependence. Although they were in a closed ward, these clients proved capable of continuing their use of substances.

Need for care of dual-diagnosis clients

Many clients have difficulty to express their need for care. These clients often have limited awareness of being ill. But there is also a lack of transparency in the range of care services available, and a lot of barriers are created by institutions. Such clients also have little knowledge of their own problems and the possible treatments available.

The need for care concerns the following areas:

- Addiction and psychiatry
- Housing
- Work / studies
- Finance
- Shelter
- Domestic matters
- Daily activities
- Social contacts
- Judiciary matters

Examples

For different mental illnesses there is a strong relationship between the use of substances and the occurrence of a disorder. In clients diagnosed with schizophrenia, the use of drugs such as cocaine or weed may have been the trigger for the disorder revealing itself. A vulnerability that was latently present becomes manifest through the use of drugs and their impact.

Clients suffering from mental disorders such as ADHD and the Bipolar disorder regularly use addictive substances by way of self-medication. Cocaine for instance may enhance the feeling of greatness, which seems attractive to clients in the manic phase.

4.4 Preventative Work and Future Challenges

◆ In view of the seriousness of the problem of addiction and the increasing number of people suffering from mental illness, The Netherlands, and indeed other western countries are faced with a great challenge. There is already a large group of adults, and children too, who cannot cope with the pressures of society. It is expected that their numbers will increase in future.

The papers regularly feature reports on “depression as the number one enemy of the people”, meaning that in our country a great number of people suffer seriously from the consequences of their mental illness.

Due to the complaints that people with mental disorders suffer from,

an enormous burden is placed on healthcare services. This group uses all kinds of healthcare services relatively frequently. Apart from this a great number of patients within this group are (partly) unfit for work. In the Netherlands this group is about 400.000 people. The result of this are enormous social costs.

People having substance-related problems are a great financial burden to society because of all the criminal cases they are involved in. .

4.4.1 Government Policy Concerning Mental Health Care

"The strength and quality of the society is determined through the mutual involvement. This starts with joining in. Working and caring for each other. It is not acceptable that people are standing outside society" (governmental agreement 2007)

The Government is aware of the challenges that have to be faced in the coming decade. In the governmental agreement they explained all the measures they intend to take in the coming period.

The headlines are:

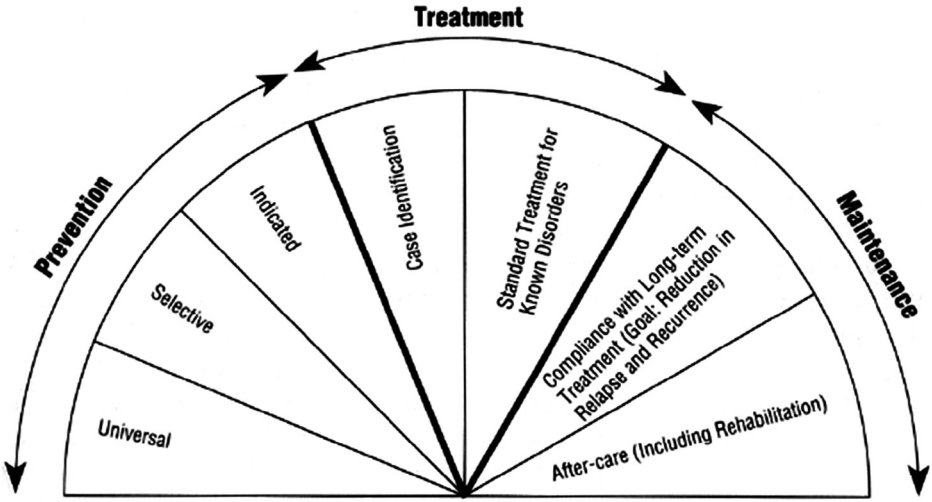
1. Young people and their parents get quick and proper support in the upbringing
2. The waiting lists in Youth care never overstay 9 weeks
3. Child abuse is contested through prevention, pointing out and intervening
4. People from other cultures get a better adaptation program
5. More interest for policy on poverty
6. The quality of the care work have to raise noticeable
7. The clients rights are secured in law and information on this topic is available for everybody
8. The care is more client-centred, innovation and new concept of care have to be developed
9. The care for teenage-mothers has to improve

4.4.2 Prevention

Prevention is a spearhead action in all the programs that are developed.

Various intervention programmes have been developed to cope with problems. A special national support platform has been installed, the National Prevention Support platform. A model used in mental health care is the Mrazek and Haggarty intervention spectrum 1994 (see illustration)

Here one can see the different moments at which one may try to influence (the rise of) a mental illness. A lot of initiatives have been taken in the field of prevention. Below you will find an explanation and some examples of the Dutch approach. Further explanation about the treatment programmes is provided in chapter 6.



Universal prevention is aimed at the general population, no individual risk factors being involved. Examples of these are mass-media campaigns aimed at the total population. The Sire foundation has initiated all kind of campaigns in order to bring to the attention matters such as bullying and aggressiveness. The Pandora foundation features campaigns to draw attention to mental illness. Their best known catch phrase: “Have you ever met a normal person? Did you like it?”. Other examples are campaigns aimed at schools, for instance against stimulants.

Selective prevention is aimed at high-risk groups. Here you can think of people who have recently gone through a far-reaching occurrence. In order to prevent stress from causing a disorder in the longer run, people are advised to seek assistance at an early stage. Another good example is the courses for Children of Parents with Mental Disorders.

Indicated intervention is aimed at individuals who do suffer from complaints or symptoms, but who do not meet the diagnostic criteria for mental illness. A target group included here is people who have a greater risk of developing a mental disorder due to hereditary causes.

Care related prevention is aimed at people suffering from disorders according to DSM-IV criteria. An example is fall-back prevention - preventing other mental disorders from developing due to vulnerability - , and mitigating the consequences of the mental disorder for the environment (psychological education for relatives).

4.4.2.1 Approach in Three Areas

Mental health is influenced by aspects in three areas:

- Personal factors, for instance capacity, physical health, self image and learning skills.
- Social factors, in what way can people take part in social intercourse, tolerance towards fellow human beings, communications skills
- Environmental factors, is the living environment safe and healthy, education, housing, employment

Preventive interventions may be directed at each of these three areas. Prevention has proved to be effective especially when all these areas are addressed in order to influence people.

4.4.2.2 Prevention Programmes

Systematic work has been done in recent years towards the prevention of mental illness and addictions, developing services for high-risk groups. Programmes have been drawn up for the prevention of depression and anxiety disorders, for the support of people suffering from chronic psychiatric disorders, programmes for children of parents suffering from psychiatric disorders, and for the prevention of work-related mental problems. The prevention programmes consist of a related set of interventions.

Interventions used in many programmes are:

- Courses in which skills are taught on how to cope with complaints
- Organising support groups
- Information
- Education
- Providing consultancy and advice

A special project is the crisis card. This has been developed for those clients who might potentially suffer a mental crisis. The card the size of a bank card contains all kinds of practical information, such as name and address, information about trusted friends and relatives, GP and counsellor, if any. It also contains information on medication used and on what medicine to use or not to use during a crisis.

Apart from this, the client indicates how he wishes to be treated during a crisis. How will the client react towards isolation or particular medication? The card also has room for personal wishes, such as arrangements that have been made with clinics, or practical information, such as the care of pets.

Example – Prevention of depression

Depression is one of the most frequent mental disorders. Since 1996 a prevention programme has been developed aimed at preventing depression-related disorders. There is a course: "In the dumps, out of the dumps. Dealing with complaints related to depression". This is offered to people suffering form depression- related complaints throughout the greater part of The Netherlands. The course teaches people how to cope effectively with their depression – related complaints. Attention is paid to breaking negative thought patterns, engaging in fun activities and coping with stress by means of relaxing exercises. Attention is also paid to learning social skills and assertiveness. The course has proved effective in actual practice, and the number of depression-related complaints has decreased.

The course has also been adapted to special target groups: youths, ethnic minorities (Turks, Moroccans) and for the chronically ill.

Even more alternatives are being developed, e.g. a form of self help: people with depression-related complaints get written instructions, enabling them to develop skills helping them to cope with depressions. The internet also has an increasing number of websites dealing with the subject. There is a website where the young can exchange experiences and learn skills under the guidance of a counsellor.

There are also projects aiming to put mental illness up for discussion. As teachers often have difficulty making problems of the young debatable there is an information project called: 'Are you Mad'. The project is executed in colleges for further education.

5. Legislation and Policy

Introduction

In 1841 the first law on mental health was accepted, called the 'krankzinnigenwet'. Here the patients right were legally registered for the first time. This law permitted the legal responsible person to admit a person in a mental hospital without the patients approval. We call this the 'for your own good (bestwil) criteria'.

The position of a patient or a client in health care has changed a lot over the last few decades. Patients have become more assertive and the relationship between patient and carer has come to rest on a more equal footing.

This tendency is supported and stimulated by the authorities, for instance by means of a number of acts that aim to strengthen the position of the consumer in health care. Standards are set for the quality of care.

In this chapter we shall pay attention to legislation, the Patients' Advocate and the professional codes that have been drawn up for carers. Finally an explanation of the quality care system, which is intended to raise the quality of care to a higher level, will be given.

5.1 Legislation Concerning Care Institutions

◆ Below you will find a number of acts that settle the rights of patients in mental health care.

- **Psychiatric Hospitals (Compulsory Admissions) Act (BOPZ)1994 –** The aim is of this law is to protect people that need to be involuntarily admitted to a mental institution. The 'for your own good criteria' is no longer valid. Now there is a 'danger' criteria, which means that nobody can be taken in a mental hospital against his own will. Unless this person is a danger to himself or society.
  There are two important proceedings, the RM and the IBS.
- **Dutch Medical Treatment Act (WGBO) –** In this law the patients right is the relationship with nurses and doctors are arranged. The patient is the client that is giving the order. The first paragraph gives the patient the duty to inform this caretakers good, honest and completely.. The patient has a right on information, to read his own dossier, protection of his privacy.
- **Dutch Care Institute Quality Act (Kwaliteitswet Zorginstellingen) 1995**

- **Individual Health Care Professionals Act (BIG) 1996 –** This law deals with the quality of the care takers. The goal is to protect patients from any harm caused by unprofessional acting of caregivers.
- **Dutch Act for the Right of Complaint for Clients of the Care Sector (Wet Klachtrecht Cliënten Zorgsector) – 1995**
- **Dutch Act for the Participation of Patients of Care Institutes (Wet Medezeggenschap Cliënten Zorginstellingen) 1996 –** This deals with the right of patients in care institutions to participate in the policy of the institute. They have a platform called the Clients council. Patients have a right to give advice or right to decide on topics that are directly important.

If you would like to know more about these acts it would be a good idea to ask for an explanation at your workplace.

5.2. Legislation Concerning Drugs

◆ If the effects are considered alcohol, coffee and tobacco are drugs as well. They are not so according to the law, however. The opium act, mentioning all the substances considered drugs by the authorities, does not mention these substances. The production, marketing and possession of all controlled substances are prohibited in The Netherlands. The police and the judiciary come down hard on large-scale production (and cross-border) trafficking. For substances on Schedule I of the Opium act (hard drugs such as heroin, cocaine, amphetamines, LSD and XTC) punishment is more severe than for those on Schedule II (soft drugs, sedatives and sleep-inducing drugs such as Valium and Seresta. These substances are not harmless either, but the risk is less serious).

Substances on Schedule I are called hard drugs. According to the law hard drugs are more dangerous than soft drugs. Hash and weed are known as "soft drugs" and they are on Schedule II. Actually, the line between hard and soft drugs is not so easily drawn. There are users of soft drugs who use such great quantities that it could be called "hard" use. The opposite also occurs, though "soft" use of hard drugs is hard to keep up for most people. Sedatives and sleep-inducing drugs generally fall outside the distinction between "soft" and "hard drugs". They take this exceptional position because they are usually prescribed as a medicine. Alcohol and tobacco are as harmful as hard drugs in respect of danger and risk, but they are not considered hard drugs, because they are more or less accepted socially.

5.2.1 Dutch Drug Policy

Police policy is aimed at the production and trafficking of drugs in particular.

No priority is given to tracing the possession of small amounts of drugs for individual use, even if substances from Schedule I are concerned, the underlying thought being that a strict approach of drug addicts will increase rather than decrease problems.

An important goal of **Dutch drug policy** is preventing (problematic) use. In order to achieve this goal the authorities advocate activities of prevention and education. The policy for existing users is to limit health risks. Drug treatment centres offer opportunities for kicking the habit. In cases where a drug-free existence is not possible in the short term, the aim is for an improvement of living conditions of the user. For heroin users this is done by providing a "maintenance dose" of methadone (or another substance) and by providing clean syringes. The authorities also try to reduce the social inconvenience caused by problem users. The emphasis has shifted to force: addicts who are repeatedly picked up by the police may opt for either "punishment or treatment". As of 1st April 2001 there are also possibilities of "compulsion": addicts for whom force is not working out are compelled to kick the habit in prison. Whether this approach is successful will become apparent over the years.

Cultivating weed plants and the possession of weed and hash are always criminal offences, even though only small amounts are involved. In practice, however, there is no active policy to investigate individuals who cultivate up to 5 plants for their own use, or who have a maximum of 30 grams of hash or weed in their possession. (coffee shops are not allowed to sell more than 5 grams a day to any individual customer) The non-active approach towards tracing and prosecution is called "condoning". Minors – people under the age of 18 – suspected of the above criminal offences will be charged.

The police and the judiciary lend priority to tracing and prosecuting the cultivation, trafficking, and possession of larger amounts. These offences also involve much higher punishment. Hash and weed are considered "soft drugs", but hash oil is one of the "hard drugs". The latter are not condoned. The possession of hard drugs incurs severe punishment. The opium act may be found in **www.wetten.nl**.

5.3 Legislation Concerning Alcohol

◆ According to the Dutch Licensing Act weak alcoholic drinks (maximum 15%) may be sold to anyone over the age of 16. For strong drink (over 15%) a minimum age of 18 applies. The Dutch Road Traffic Act prohibits handling a car under the influence of alcohol. The limit is at a maximum of 220 micrograms of alcohol per litre of air exhaled. This comes down to

a maximum of 0.5 pro mille in the blood. This means a driver must not have more than two drinks before driving. This also applies to riders of bicycles and scooters. For those who have been in possession of a driving licence for a period shorter than five years there are stricter regulations. The limit is then at 88 micrograms of alcohol per litre of air exhaled. This comes down to a maximum of 0.2 pro mille in the blood, meaning that even one drink may be one too many. This rule also applies to drivers of mopeds under 24. Whoever disrupts public order or who bothers someone else in the streets is punishable according to the Penal Code.

5.4 Patients' Advocate Foundation (PVP)

◆ The Patients' Advocate Foundation aims to offer advice and assistance to patients who have been admitted to a general psychiatric hospital or to a psychiatric ward of a general hospital, in order to protect their rights. The Patients' Advocate Foundation provides information about the rights patients have. The PVP is not employed by any hospital, but is part of an independent national foundation and takes the side of the patient. The activities of PVP have a legal basis in the Psychiatric Hospitals (Compulsory Admissions) Act and the Patients' Advocate Decree. (BOPZ)

Information of the Patients' Advocate Foundation concerns the following areas:

- Compulsory admission to a psychiatric hospital
- Complaints about staying in a psychiatric hospital
- Discharge and leave from a psychiatric hospital
- Your rights in a psychiatric hospital

There are many sources where clients may obtain information about their rights (and obligations). The website **www.hulpgids.nl/wetten** contains a good overview and explanation of the different acts.

5.5 Harmonisation of External Quality Review in Health Care (HKZ)

◆ The Dutch Government has pointed out three priorities to improve the quality of the Dutch Health Care System:

- making the quality of care visible
- increasing the influence of patients
- higher level of safety in care

HKZ is the model for quality review in health care. The HKZ quality review system applies to all kinds of sections in health care. Hospitals, care institutions for the disabled, youth care, local public health offices and

other care institutes can take part in the HKZ procedure and thus prove that they meet standards set by the authorities, the sector itself, financers and patients.

The fact that health care has developed its own standards is easily explained. First there is increasing vulnerability. Organisations are increasingly sensitive to negative or unexpected influences from within and without, creating a need for control. General management models are not considered specific enough, or practicable. Also the patients have become much more aware of their rights, they act more mature and independent.

The HKZ procedure is quite intensive. If an institution finishes the procedure they get a certificate that proves that they meet the quality standards.

6. Service Provision

6.1 Service Provision for Mental Heath Clients

6.1.1 Introduction

Psychiatric care services resort under Mental Health Care and care of addicts. The Netherlands has been subdivided into twelve areas.

Each region has a general psychiatric hospital, a regional ambulatory mental health institute, and a regional institute for sheltered housing. In a number of areas these institutes have merged.

The ministry stimulates this development in order to bring about joint facilities and offices in each area. In Dordrecht De Grote Rivieren has clustered admission wards, treatment, sheltered housing and ambulatory care. If you get a job placement in Dordrecht, you will be given one at De Grote Rivieren in one of their sectors.

In general the application for mental health assistance should be made to a regional indication body. Without valid medical grounds one is not eligible to a number of care services.

Psychiatric care services are also offered by regular hospitals, in addition to those delivered by General Psychiatric Hospitals. These are the psychiatric wards of general hospitals, the so called PAAZ. In Dordrecht a PAAZ may be found in Albert Schweitzer hospital.

Each area also has local, regional and national initiatives. These may come from a certain ideology, for instance a Christian variation of regional mental health institutes or institutes for sheltered housing (Eleos). Another example is the network for the homeless run by the Salvation Army, who also deliver a lot of services to clients suffering from psychiatric disorders.

Interesting services are offered to clients by the patients' associations and pressure groups. There are associations of clients (Anoiksis), relatives (Ypsilon) and combinations of them. (Basisberaad GGZ). They are very often quite well-informed about the latest developments in care and they also know their way in the generally obscure maze of health care services in The Netherlands. Apart from advice, information and communication, they also offer a range of courses and training services to clients and their relatives.

For care workers there are also all kinds of professional associations that support, build up and represent the profession, and that focus on and promote the quality of good professional practice.

There is an increasing group of clients who apart from psychiatric problems suffer from additional disorders such as addiction, homelessness, social isolation. These clients are generally difficult to reach, they evade assistance. Therefore structures of consultation have been established, involving multiple institutions. Care workers from various disciplines work together in order to handle the oftentimes complex problems.

In this manner a care services network has been brought about in which the police, local health services, drug treatment centres, psychiatry, social services, housing associations, community work and service institutions etc. work together.

6.1.2 Regional Institutes

- **General Psychiatric Hospital.** The core business of general psychiatric hospitals is the admission and treatment of anyone in need of this form of psychiatric care. Additionally, they make arrangements with other psychiatric institutes about admission and continuation of care in these institutes.
- **Regional Mental Health Institutes** are institutes for mental health care. They treat and counsel people with mental problems and psychiatric disorders, offering ambulatory care services.
- **Regional Institutes for Sheltered Housing** offer guidance to people who are in need of assistance living independently, in recreation and in having social contact. The assistance is meant for people with long-term psychiatric and psychosocial problems who are in need of stimulation and support.
- **Psychiatric Wards of General Hospitals** were established in order to put a less negative stamp on psychiatric admissions than before. Therefore admissions are generally short-term and mainly intended as relief during crisis situations
- The **Salvation Army** is an international organisation focused on "doing". The source of inspiration for the Salvation Army is the Word of God. From this mission the Salvation Army wants to care for vulnerable people. In The Netherlands the main activities of the Salvation Army comprise social and community care, mainly for those people suffering from psychiatric or addiction problems.
- **Eleos** offers mental health care, working from a Dutch Reformed identity and in this area has a wide range of facilities for both the treatment and counselling of adults and the young suffering from serious psychosocial and / or psychiatric disorders. Eleos is an institute for mental health care that is bound to the Dutch Reformed identity. The majority of clients belong to one of the Protestant churches.

6.1.3 Centres of Expertise

- Trimbos **www.trimbos.nl**, the Trimbos institute is the national centre of expertise for mental health care, care of addicts and social care. The Trimbos institute enhances the quality of life by developing and applying knowledge of mental health, addiction and physical illnesses related to these.
- The centre of expertise called Rehabilitation has been established in order to gather, structure and spread the knowledge that has been developed about rehabilitation and recovery, for all those involved in the social rehabilitation of people suffering from psychiatric disorders.
- Since 1964 the Pandora foundation **www.stichtingpandora.nl** has devoted itself to people who have suffered from, or who are likely to suffer from mental or psychiatric disorders. The basis for all Pandora's actions are the experiences of these people themselves. The Pandora foundation protects the interests of its target population in different ways. By offering information, advice and support it aims to help people who have suffered from mental and / or psychiatric disorders, or those who have dealt with such people in their direct environment, to handle these problems.
- The Internet, for instance **www.psychiatrienet.nl**.

6.1.4 Clients' and Patients' Associations:

In The Netherlands there are many organisations protecting the interests of clients, the best known being:

- **The union of clients in mental health care.** The union protects the interests of people who have come into contact with or who are likely to apply to mental health care. The union offers information and telephone assistance.
- **Labyrint~In Perspectief: www.labyrint-in-perspectief.nl** The foundation is an organisation for relatives and people directly involved with those suffering from psychiatric disorders, whether they have been diagnosed as such or not. Specific attention is given to the partners and children of people suffering from psychiatric disorders. The website provides information about the organisation, publications and activities for relatives, both those of the foundation itself and those of third parties.
- **Ypsilon: www.ypsilon.org** protects the interests of relatives of patients suffering from schizophrenia, and of patients themselves. Apart from information about the association itself, the website contains a lot of general information about schizophrenia and psychoses. The brochure "A psychosis for the first time" may be found here as well.
- **The Pandora foundation** promotes the strengthening of the (social)

position of people who have suffered from mental and psychiatric disorders. Experts from experience arrange contacts of fellow-sufferers, provide information and protect interests

- **The Anoiksis foundation www.anoiksis.nl** is an association of patients who have suffered from one or multiple psychoses, or who are schizophrenics.
- **Vereniging voor Manisch Depressieven en Betrokkenen** (The Association for manic depressives and those involved with them) **www.nsmd.nl** protects the interests of an estimated 150,000 patients suffering from manic-depressive disorders, illness or serious mood disorders
- **Clientenbelangenbureau** (Bureau for the protection of interests of clients): **www.clientenbelangenbureau.nl** organises projects based on questions and ideas of (former) clients of mental health care. These projects are executed by (former) clients as much as possible.

6.1.5 The Service Provision of Dordrecht

Below you will find some more information about the institutions in the area of Da Vinci College:

De Grote Rivieren, www.degroterivieren.nl, a mental Healthcare institute in Zuid-Holland Zuidoost

General:

De Grote Rivieren is a professional and modern organisation offering treatment, counselling and support to people with a serious mental or psychiatric disorder. De Grote Rivieren offers ambulatory assistance, part-time and day treatment, clinical treatment, guidance (living, working and leisure time), psychiatric home care and preventive courses and training. They have more than thirty sites in the Zuid-Holland Zuidoost area.

Vision:

"Our clients are people and their networks suffering from mental and psychiatric disorders, as a result of which they experience limitations in their personal and social functioning. In our view of the future we are an organisation that does better than our competitors. Clients, staff members, those referring and financers are eager to use our services. We know the questions of our clients and answer them with expertise and efficiency. Clients are aided rapidly and in a customer-friendly manner. Our organisation is alert to new developments and changing conditions in the market. In order to serve our clients as well as possible "learning from and together with each other"

is at the core of our culture, which stimulates the expertise of staff members. We have a flexible work force, who are open to changes and who are able to utilise new skills if the market asks for them. As an expert in his / her field the individual staff member develops continually in line with the needs of our clients, the organisation and his / her own career goals. Our conduct is aimed at selecting, developing and rewarding those members of staff who contribute towards the success of the company".

Delivery of care services

Dependent on the syndrome the care giver determines together with the client which treatment is suited best, being for instance ambulatory assistance, part-time treatment, or in some cases admission to a clinic.

De Grote Rivieren strives to limit the number of clinical admissions as much as possible. Ambulatory and part-time assistance are much preferred, if possible close to the living environment of the client. Care has been structured into four circuits:

- Children and Youth Circuit, for clients up to the age of 21
- Adult Circuit (Drechtsteden en Gorinchem e.o.), for clients aged 21 to 65
- Elderly Circuit, for clients aged 65 and older
- Rehabilitation Circuit, for counselling in the fields of living, working and leisure time

6.2 Service Provision for Substance Misuse Clients

6.2.1 Introduction

There is a wide range of drug treatment centres for people with addiction problems. In addition to forty professional institutions and sixteen health centres (CAD, Consultation Agency for alcohol and drugs, with a hundred thirty regional establishments), there are fifteen institutes for social assistance when drugs are involved and twenty clinics for addicts.

Three major recent developments play a role in the present supply of care services for clients suffering from substance problems:

- *The social chart for the care of addicts is closely related to the one for psychiatry. Ever since addiction has come to be seen as a psychiatric disorder (chronic disease of the brain) the boundaries between psychiatry and care of addicts have become more vague. Ever more clients with issues of addiction are admitted and treated in psychiatry and on the other hand more and more clients suffering from psychiatric disorders end up in drug treatment centres. Both sectors of care are developing a range of services for either type of clients.*

◆ *In the chapter on history it has already been noted that the care of addicts has originated in the field of welfare. The perception of the care of addicts is shifting dramatically, the medical model is on the rise, due to the insights and knowledge modern brain research is yielding. This has a major influence on the type of care services offered as well.*

◆ *A third major development is the introduction of market forces in health care (everyone who is licensed to do so, may offer care services, competition).*

For clients where the addiction problem have prominence over other disorders there are the regional drug treatment centres that are part Mental Health Care in The Netherlands. The clinics may be described as Categorical Psychiatric Hospitals, causing them to resort under the same care sector (mental health care) as the General Psychiatric Hospitals.

Examples are Bouman Mental Health Care, Jellinek-Mentrum en Novadic-Kentron (regions of Rotterdam, Amsterdam and Noord-Brabant). The so called CAD's, consultation agencies for drugs and alcohol, have existed for more than twenty-five years. Nowadays they are integrated as an ambulatory or outpatients clinic of the categorical psychiatric hospitals.

The drug treatment centres have developed psychiatric wards where clients may be admitted and treated for whom psychiatric disorders have prominence over other disorders. Bouman mental health care has two psychiatric wards, one open and one closed. De Hoop foundation in Dordrecht, a categorical psychiatric hospital, is also developing a psychiatric ward in order to offer aid to these clients.

In view of the increasing public inconvenience that has been caused, policies have been developed at the level of big cities. The authorities have made large funds available in order to reduce the trouble caused by addicts.

A good example of this approach is PGA 700 in Rotterdam. The seven hundred clients causing most public troubles are all offered a route which may involve urging (voluntary) or pressure (obligatory).

To conclude, it is becoming increasingly difficult to speak of a separate social chart for the care of addicts, because the integration of many forms of assistance is becoming more common, and the boundary between psychiatry and care of addicts is disappearing. Therefore, the summary below is an addition to the service provision for psychiatric care. After discussing the general services, we shall focus on Bouman mental health care, which is located in the Rotterdam / Dordrecht

area. De Hoop foundation, located in Dordrecht operates nationwide and also on international level. If you get a work placement in The Netherlands, we shall find you a place in one of these institutes.

6.2.2 Institutes:

- CPZ regional, Categorical Psychiatric Hospital, meaning the drug treatment centres. They have characteristics similar to those of General Psychiatric Hospitals that have been discussed in the service provision for psychiatric care.
- CPZ national. Apart from regional clinics there are also clinics with specific characteristics (as far as viewpoints or target population are concerned) that operate on a nationwide scale. An example of this is De Hoop foundation (Christian care of addicts).
- CAD/FZA, the health service centres for alcohol and drugs have existed since 1909, when the Medical health centre for Alcoholism was founded. They work according to principles that have proved useful in fighting alcohol addiction. Assistance is free of charge, open to all, aimed at diagnosis and advice and if necessary attention for the social environment of the patient.
- SOV, Centre for criminal addicts is a facility that has been established in order to deal with the hard core criminal hard-drug users who systematically cause a great deal of public nuisance in society. So far the traditional approach of punishment and the traditional forms of assistance have yielded little effect for this group. The measure offers the possibility to admit drug users into a rehabilitation programme by compulsion.
- DVA, drugs free wards in penitentiary institutions have been created as part of the policy plan called Working Detention. The capacity of these wards with an adjusted regime is about three hundred. It is the intention for well-motivated addicts to spend (part of) their detention in drug-free wards and prepare actively for treatment and rehabilitation.

6.2.3 Self Help Groups:

- AA, **www.alcoholics-anonymous.org** Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope in order that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is the desire to stop drinking. Their primary purpose is to stay sober and to help other alcoholics to achieve sobriety in all affairs.
- AD, Anonymous Drug Users, same principle as the AA
- AGOG, Gamblers Anonymous, same principle as the AA
- Courageous Mothers, A Courageous Mother is a mother or other relative of an addict, who can no longer bear

the sight of her child perishing as a result of the use of drugs and alcohol. **www.moedigemoeders.nl**

6.2.4 Pressure Groups:

- Junkies' union. Association for drug users, among whom hiv-positive drug users.
- Stichting Verslavingsreclassering GGZ: This mental health foundation counsels addicts who have committed a criminal offence or who are suspected of having done so
- AMOC foundation: **www.amoc-dhv.org/en/background_en.html** provides assistance to foreigners with drug issues, who have gotten into trouble in The Netherlands
- MDHG Belangenvereniging Drugge-bruikers **www.mdhg.nl** (Drug Users' Association) seek to legalise, normalise, emancipate and accept drug users. Another goal is to break the connection between psychiatry and the use of drugs (addiction is not a psychiatric disorder, so a user is not "disturbed")

6.2.5 Professional Associations:

- Vereniging voor verslavingsgeneeskunde Nederland: The Union for medical science concerning addiction is a union of doctors specialising in addiction. On their website you will find articles, regulations, views and a discussion forum about the medical consequences of the use of alcohol and drugs. **www.vvgn.nl**

6.2.6 Regional Institutions

BOUMAN GGZ
Bouwen aan nieuw perspectief

Bouman GGZ www.boumanhuis.nl

The view of Bouman mental health care on addiction is articulated as follows:
"Addiction is a chronic psychiatric disorder that often leads to (permanent) loss of autonomy in the field of emotions, thinking and acting".

By stating the above in 2001 Bouman started the trend for the ever widening innovation of the treatment of addicts. Addiction as a disease on the basis of a biologic vulnerability fits completely in the **bio-psycho-social model**. A wide range of aspects of a biological, psychological or social nature may reveal vulnerability in the shape of symptoms of the addiction.

Addiction is so often related to other mental illnesses or disorders (co-morbidity) that examination for this is required in every patient. Examples of co-morbidity are the combination of alcohol addiction and a bipolar disorder, ADHD and cocaine addiction, or schizophrenia and the abuse of cannabis.

With this approach the care of addicts has become an integral part of psychiatry. We therefore no longer speak of care of addicts but of **psychiatry of addiction**.

Heroin project

In Rotterdam there is a cooperation between Bouman Mental Health Care and the local Health Centre. In this project people who are chronically addicted to drugs are provided with free heroin. These users are often in bad health and suffer from multiple mental problems. The aim is to improve the physical and social functioning of patients and to reduce the public inconvenience caused to society.

Stichting de Hoop www.dehoop.org

De Hoop Foundation is a centre for Christian care of addicts and psychosocial care in Dordrecht, the Netherlands. They work together closely with organisations in The Netherlands and abroad, such as Romania, Suriname and Indonesia.

De Hoop not only offers professional care to people in need but also aims to be a centre for information, training and education.

De Hoop's identity also determines its view of addiction, addicts and the possibilities of care. Addiction is a concept with a very negative emotional connotation. In its view of addiction, De Hoop does not choose between either a *sickness model* or a *moral* or *sin model*.

Considering addiction to be an illness could help define the problem. Because addiction is claimed to be an illness, the problem is made legitimate. The problem can be defined, has certain characteristics and may be described. It has a beginning, a cause and it has consequences.

6.3 Service Provision for Dual Diagnosis Clients

6.3.1 Introduction

People who have multiple, often related, (psychiatric) disorders are frequently called dual-diagnosis clients. In popular speech this is often a combination of problems connected with addiction and psychiatric problems. Now that addiction has become a recognised psychiatric syndrome it has become a combination of two or more psychiatric disorders.

In addition to this, combinations of certain disorders due to dependence on substances occur frequently in the group of dual-diagnosis clients.

The most frequent combinations are:
- ADHD and cocaine
- Schizophrenia and cannabis
- Anxiety and mood disorders and alcohol

As far as care services are concerned these people can apply to psychiatric institutions and drug treatment centres, the most obvious diagnosis (the so called primary diagnosis) often determining where they will be admitted.

There used to be quite a large group of people ending up between these two types of care and for them Double Diagnosis Clinics were started in The Netherlands. A concrete example is LOODDS in the Rotterdam area

Shortly two new dual diagnosis clinics will be opened in Brabant (Bergen op Zoom) and in Deventer, both to be established in the grounds of a general psychiatric hospital. There is a clear tendency of cooperation between psychiatric institutions and drug treatment centres in order to offer care services for this difficult group of clients.

6.3.2 Present Care Services

It is clear that specific facilities for dual-diagnosis clients should aim at the most serious group within this spectrum; clients with serious long-term problems of addiction and serious psychiatric problems (especially psychotic disorders and personality disorders).

Clients suffering from less serious disorders should be able to apply to the regular mental health clinics and the treatment centres for addicts. In this respect it is necessary, however, that the cooperation between both circuits in the fields of referral, consultation and combined treatment should be improved.

At a national level little experience has been gained, and hardly any experience built up concerning integrated treatment of dual-diagnosis clients in specific institutions. The offer of care services is still being developed and perceptions of proper care differ widely. It is difficult to estimate the extent of care services required by the target group.

Parnassia www.parnassia.nl/home
Parnassia in The Hague (a general psychiatric hospital also owning drug treatment centres) has had a ward with 8 places since 1996.
The Psychiatric Care for Drug Addicts features:

- intensive clinical treatment (duration 3 to 6 months)
- Long-term rehabilitation
- A short-lasting treatment of Korsakov patients

Preferably, specific facilities at a regional or super-regional level should be available for dual- diagnosis clients suffering from serious long-term addictions (drugs and / or alcohol) and serious psychiatric disorders.

7. Working with Clients

◆ In order to explain what practice settings are like, we shall describe in this chapter care services for clients in both care of addicts and psychiatry by means of the actual practice in two institutions. These two institutions have already been described more extensively in the service provision, because they are institutions where international students may find a work placement.

7.1 Basic Assumptions/ Working Principles:

- **Care by request:** Nowadays the client's request for help is leading instead of the services offered by the institute. The individual wishes of the client are taken into account as much as possible. De Grote Rivieren formulates this as follows: "each person is different. Therefore we pay serious attention to the request of the client. The assistance provided should match the client's request for aid. Therefore the form of assistance will change when the need changes". This is what we call care by request, the basic assumption being that care services are made to measure.

- **The role of the client** has more or less shifted from that of a patient to that of a client who decides for himself what he wants and needs. The client has become more self confident and assertive and also has access to a lot of information about his problems and about the services that are available. The client also has multiple alternatives to choose from among different care providers. A client may choose to receive a budget to buy care services himself (the Personal Budget). The client is expected to play a more active role in putting together his treatment and way of spending the day. He is also supposed to set goals and to make clear his wishes for the short term and for the long term.

- In the care of Substance misuse the assumption used to be that the client suffering from an addiction was able to choose either to use or not to use. The motivation of the client was crucial to being treated properly. Over the last few years a different view has come about. Bouman mental health care is progressive and leading in what is called the bio-psycho-social model of illness.

The basic assumption of the bio psychosocial model: "Addiction is a chronic psychiatric disorder, which often leads to a (permanent) loss of autonomy in the field of emotions, thinking and acting."

By stating this in 2001 Bouman set the fashion for the ever widening innovation of care services for addicts. Addiction as a disease on the basis of a biologic vulnerability fits completely in the bio-psychosocial model.
A wide range of aspects of a biological, psychological or social nature may reveal vulnerability in the shape of symptoms of the addiction. This starting point is a new one and means that clients suffering from an addiction often lose their autonomy and self-determination and must therefore be aided to break with their addiction.

It may also mean that abstinence (quitting and no longer using substances) is not always feasible. The wishes of the client are primary and the perception of rehabilitation is also applied. Support has been directed at much more than just becoming abstinent of substances. Bouman mental health care writes the following on this subject:

"Besides the seriousness of the addiction those additional illnesses have a great adverse influence on the ability of patients to give direction to their lives with or without our assistance. This ability is summarised by the term autonomy. Apart form medical diagnosis the measure of autonomy plays an important part In deciding what kind of treatment we advise. Sometimes treatment is compulsory – in case of serious danger combined with the almost complete loss of decision making capacity. Usually a treatment can be started in accordance with the wishes and goals of the patient, building on the healthy aspects still remaining. In such cases we speak of recovery and rehabilitation."

7.2 Working in an Interdisciplinary Team

◆ The same disciplines as in psychiatric care are encountered in the care of addicts. A new discipline is the rehab worker or rehabilitation worker.
This employee specifically charts the questions and wishes of the client and keeps an overview of all the types of care services the client receives. Further there are generally fewer nurses than in psychiatry.

Psychiatric care facilities employ various disciplines:

The Nurse is found in the psychiatric hospital most frequently. Nurses often work together in wards with social workers. The nurse focuses on the medical aspects, but has also been trained in social science. The social worker focuses on social aspects and is often a group worker. Both of them counsel clients on a daily basis, but they also arrange meetings such as weekend discussions, group discussions, psycho education etc. A social worker is a personal counsellor, living counsellor or occupational therapist.

The Social Worker is usually the one who maintains contacts with relatives and other care givers. The social worker is often responsible for continued placement, after-care, and all kinds of general matters such as housing and income.

The Psychologist Has the role of an expert on behaviour and contributes to diagnosing, treating and counselling of clients. Often has the role of an adviser and a consultant. The expert on behaviour also provides training, such as social skills and sometimes he is involved in psycho education

The Psychotherapist – is an expert providing psycho therapy, individually and in groups

The Psychiatrist always carries final responsibility for treatment. He is the one deciding on medication for the clients. The SPV have taken on many of the tasks of the psychiatrist, as a result of which fewer and fewer psychiatrists have direct contact with clients. Psychiatrists play a major role in crisis situations where it is necessary to make a quick judgment whether treatment is necessary or about the measures to be taken.

The SPV-er Is a specialised nurse who is often employed as a professional who treats people with psychiatric disorders. Nearly always works under the supervision

of a psychiatrist and has a lot of responsibility for treatment and the provision of medicine. SPV are often employed as part of mobile treatment teams and crisis teams deployed to go to clients suffering from serious psychiatric disorders who are in need of treatment. Think of the acute services of health centres, ACT's and mental health care outpatients' clinics.

The physical therapist – Is utilised in sports activities and of course in all forms of physical therapy. Jogging therapy is part of the treatment of many institutions

The Creative Therapist – Is to be found in the many forms of day care services and treatment centres. Often provides care by means of creative therapy, in which working creatively instead of talking stimulates the client to express and shape emotions and experiences.

The Musical Therapist – Is responsible for a therapeutic programme with forms of music that is also part of the treatment

The occupational therapist – Is responsible for different kinds of play, activities etc. and together with the client tries to work on the development of hobbies and the orientation on (volunteer) work.

7.3 Moral Dilemmas

◆ In mental health care there are a lot of moral dilemmas because you are dealing with people who are dependent on assistance and medication due to their illness / handicap / disorder.

When caring for any individual it is very important to try and be non-judgemental. You have to prevent your own values from influencing the care which you give to the client. This can be very difficult in some cases because we all have a value base from which we live and work. But it is essential that care workers adhere to a professional value base at all times and follow the professional code of practice which applies to them (see 6.5. for working codes).

Students and staff within the work placement area will at times experience ethical dilemma's which they have to deal with. As a student you would discuss your concerns/worries with your mentor who would provide support, guidance and explanation as to why a particular treatment was being given/with held and the reasons for this. The legislation, policy and procedures regarding care delivery is different in each country and this may lead to misunderstandings regarding certain aspects of care delivery. You must therefore voice any concerns in a professional manner being mindful of confidentiality at all times.

Professionals can become upset and frustrated on behalf of those they are caring for. When they know that for example they desperately need the services of a counsellor or therapist, but due to the demands on that particular service there is a waiting list of 3 months. The client will have to wait for this specific service provision.

Sometimes people have to be protected against themselves when their health and welfare are in danger. Then one sometimes has to infringe on their privacy, their autonomy (self-determination). Clients sometimes have to be locked in / separated and treated with medication by force.

Moreover, there are a lot of subjects clients are occupied with and it is not always easy to deal with these carefully and respectfully. Think of suicidal behaviour, eroticism, euthanasia, abortion, criminality etc.

Addiction has for decades provoked discussion whether the use of substances should be accepted or not. Although most substances are officially prohibited, the use of drugs and controlled substances has become more acceptable.

Club drugs are used in great quantities, soft drugs are used by many and are to a certain extent accepted in Dutch society.

This causes moral dilemmas for care workers in their care of clients suffering from addictions:

- The freedom and autonomy to use substances that may be harmful to yourself, but also to others (pregnant women who use, aggression towards direct relatives / family) sometimes cause difficulty in deciding what should be proper treatment.
- Integrity, non-discrimination and respect are not always easy to apply when more interests are at stake than those of the client. A concrete change in ethics is the arrest and compulsory treatment of heroin prostitutes instead of organising a workplace for these women that is as safe as possible. Thus the soliciting zone in Rotterdam has been shut down and most prostitutes have been taken into treatment, whether by compulsion or not.

7.4 Communication

◆ Communication is crucial when caring for any individual. It is fundamental to all caring relationships and it is essential that the service user/client is treated with respect at all times. They must be included in all decisions that are made about them and the care they receive. When an individual is mentally unwell their named person may need to be involved in making decisions for the person concerned as they are too ill to do so themselves. For those who have completed an Crisis Card their wishes and preferences will be recorded for all relevant health professionals to view and comply with.

It is essential that all professionals speak to those they are caring for in a way that does not patronise the service user/client and present the information in a way that can be understood, allowing the service user to make decisions and choices.

We communicate with those we are caring for in many different ways including verbal and non verbal communication. It must be remembered that communication is only successful if both the sender of the information and the receiver understand the same information as a result of the communication which has taken place. This can be difficult and challenging for people who have a mental health disorder and even more challenging for those under the influence of alcohol or drugs.

There can be many barriers to communication and those who are mentally ill or who are under the influence of drugs or alcohol are definitely barriers to effective communication. It is essential that you are aware of this when on work placement and that a client may not remember a previous conversation you had with them. You must also be very aware of your non verbal communication and body language at all times. The client group you will be working with can become very upset and distressed if you look at them in a particular way which they find offensive and this can lead to a potentially volatile situation.

The language that is used must allow the client as far as is reasonably practicable to understand exactly what is happening to them. This may be difficult in some instances particularly if the client/service user is ill. The tone of voice, the positioning of where you are sitting, language used, eye contact can lead to the interaction being positive or negative and this is something that you must be very aware of as a student in a foreign country on a work placement. It is essential that all care professionals listen to what is being said by the client/service user at all times.

The importance of the service users input, particularly in relation to the

Mental Health (Care and Treatment) (Scotland) Act 2003 has been fully explained in section 6.2 the role of the client.

7.5 Professional Code

◆ It was Florence Nightingale who around 1875 wrote the first professional code in The Florence Nightingale Pledge. She was way ahead of her times, started a training school for nurses and she was of the opinion that women should be paid for the work they did. After the Second World War codes were developed at an international level. The Dutch professional nurses associations declared they would conform to the ICN code (International Council of Nurses) which was drawn up in 1953. In 1990 a code was developed that was better suited to the Dutch situation.

The Individual Health Care Professionals Act demands for professional groups in health care to have a professional code. There are a number of reasons to develop a professional code:

- In actual practice there are a lot of complaints by clients stating that care givers do not stick to the acts and regulations intended to protect the interests of clients, such as the Dutch Medical Treatment Act.
- The quality of care may be safeguarded better
- It offers clients protection against harmful professional error
- It will diminish the position of power care givers have
- By professionalizing the occupation the demands made of care workers will become more transparent. Through the professional code there is a check on professionals by the occupational group

Different professional groups work in Mental Health care. Professional codes have been developed for those groups. In chapter 12, the appendix, professional codes have been included for nurses and social workers.

7.6 Working Methods:

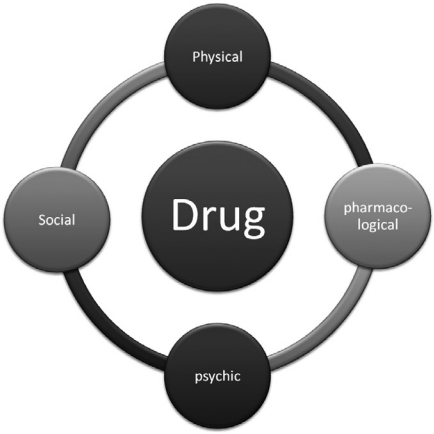
1. Wherever you are in mental health care, you will come across a **plan of action**, which is often called a Counselling Plan, Support Plan, Activities Plan or a Personal Support Plan. The way it is drawn up and the method of working with this plan is described clearly, and progress and evaluation are fixed components. The plan directs the care for the individual client and many disciplines are involved

in drawing up, carrying out and evaluating the plan. This has brought a lot of professionalism and transparency to what is really being done for clients.

2. A much heard of and applied method of treating patients is called **Rehabilitation**. Various forms and modules are in use and it has seen quite a number of years of development: apart from treatment, guidance is aimed at rehabilitation and learning to live with psychiatric disorders. The Rehabilitation circuit assists clients to live as independently as possible with a quality of life that is as high as possible. Important in this approach is developing possibilities, qualities and skills of clients in order to be able to live, work, learn and be involved in social contact successfully and satisfyingly. Rehabilitation offers a wide and composite range of services, aimed at:

- Treatment
- Guidance routes
- Accommodation
- Occupation
- Labour and reintegration
- Training and courses

Everything is being done to offer the client a sensible and socially active life again. The starting point is the possibilities and wishes of the client. This is done by examining the questions and wishes of the client extensively and by recording them and finding an answer to them by means of different kinds of support and aid.



3. A model to provide insight in problems that addicts have to cope with are the **Van Dijk circles**. Prof. Van Dijk from Groningen University drew up his model of the Circles. This model provides the start of a capacity to understand things. There are four, actually five, circles. In the middle there is the circle of the "substance", the substance or activity one has become addicted to or is in danger of becoming addicted to. Revolving around it are a physical, pharmacological, mental and social circle. The social circle has a small extra circle that reflects people's own interaction with the environment.

4. Characteristic to modern care of addicts is the **bio-psycho-social model**. This has consequences for treatment:

- There are closed wards with separate departments.
- For the relief and treatment of addicted prostitutes a complete range

of care services has been developed including facilities for intensive sheltered housing.
- The heavily maligned (convicted) medical model is now being partly introduced in the care of addicts, and medicine and (cognitive) behavioural therapy are on the rise.
- It is becoming increasingly accepted that certain groups of chronic users prove to be therapy resistant (impossible to treat with respect to their addiction). Therefore they are treated by providing them with methadone and heroin. The aim is to get them out of the criminal circuit and to let them find some rest. This enables them to work at building up social contact again, to have useful recreational activities and to start settling down instead of wandering.
- A number of types of sheltered housing have been developed comparable to social guesthouses. In these houses homeless addicts who wandered about for years are provided with relief. The assumption is not to get them under control, but to offer them a roof over their heads and from there to offer them room to work on different matters. The aim therefore was not abstinence, or to keep them "inside ", and not to impose all kind of rules on them. Now it appears that more rest has come so that the possibility arises to tackle the underlying psychiatric problems. They use less "extra substances" (extra drugs in addition to the methadone provided) and the clients are more active in their search for a useful way of occupying themselves.

5. For multiple / dual-diagnosis clients there are sometimes more specific methods than those of psychiatry or care of addicts. Within this group there are great differences in the underlying problems. For this group, treatment may roughly be organised in two ways:
- Integrated treatment, in which both the mental disorder and the addiction problem are treated in one place.
- Parallel treatment in which first the one disorder (usually the psychiatric problem) is addressed, and after stabilisation a bridge is built towards an institute where the addiction problem may be treated.

  Experiences in existing dual-diagnosis clinics in the country have proved that combining psychiatric expertise and knowledge of addiction offers an important extra value.

7.7 Case Study

◆ The De Vries family live in a three bed roomed apartment on the outskirts of the city. There is a high level of unemployment in the area where they live and many of the families in the neighbourhood are living in crowded conditions. There are families of a variety of different cultures living in this area.

In this district there is little solidarity between the different cultural groups. They have no family members who live near them to provide support.

The De Vries family comprise of Mrs De Vries (33years), Mr De Vries (34 years), Maarten De Vries (16 years) and Laura De Vries (9 years).

Mr and Mrs De Vries married when they were very young and Maarten was born when they were 17 and 18 years of age.

Mrs De Vries always wanted to go to college to study child care but having a young baby of her own prevented her from pursuing this dream. Mrs De Vries currently works as a nurse in Home Care which she enjoys.

She has suffered from depression periodically during the last 5 years. She has had time off work in the past but has recently returned to her job as a home help.

Mr De Vries worked as a bus driver until last year when he lost his job. He has been struggling with the use of alcohol for most of his adulthood. His father died three years ago, an event that he had great difficulties dealing with. He has been drinking heavily for the past two years and this was one of the reasons he lost his job. He has been unemployed since loosing his job and is having no success in obtaining new employment. He is continuing to drink excessively. This causes a lot of tensions in the family.

Maarten De Vries is studying at the local secondary school and is due to go for his examinations. He appears to have poor motivation to do well in school and he is no longer attending school on a regular basis. This is causing great concern to both the school and his parents as he was predicted to do well in these examinations prior to the recent behavioural concerns. Maarten has recently been mixing with a group who experiment with illegal drugs and he has now started to experiment with these drugs himself.

Laura De Vries attends the local primary school and is a shy, quiet girl who has difficulty mixing in a large group. She is a bright girl but lacks confidence in her own ability.

Mrs De Vries is extremely worried about her family, particularly Maarten. She has the idea that everything is getting her down and she feels unable to cope or to make any decisions about how best to support her family. She feels alone and her husband is unable to offer the support to her or the children at this time.

How can the De Vries family be supported at this time?

Possible support system which could be put in place.

Mrs De Vries would likely approach her family doctor who would listen to her concerns and discuss possible support methods for the whole family.

The doctor would write a letter to refer the family to the policlinic of an institute for substance abuse care. Here they can have counselling discussions to check out how serious the problems are. It is important that both mr. de Vries and Maarten are motivated for the help that is offered. In this policlinic they offer family therapy, so all the family members are part of the treatment. If this will happen depends on the attitude of the family members.

The doctor will discuss the concerns of Mrs De Vries with her. He could decide to prescribe anti depressant medication depending on the assessment which is made of her current health status. He might have contact with her psychotherapist that treated her in the years she suffered a serious depression. It is very important that she is supported to have the strength to keep things going. If necessary she can start again with counselling.

Patient confidentiality is crucial and the doctor can only talk with Mr De Vries when he needs help himself. But Mrs De Vries can talk to him and advise him to see the doctor.

So he advises Mrs De Vries to discuss this with her husband as Mr De Vries has recently visited the First Aid requesting help with his alcohol addiction. They send him away with the advise to go to his doctor, but he didn't go.

Six months ago he was prescribed medication to assist him in his struggle to stop drinking.

Mrs De Vries has discussed her visit to the doctor with the family. They had a very emotional discussion were Mr De Vries was very angry at first. But when she said that she wanted help for the family or she would go for a divorce her husband broke and admitted he needs help.

After this emotional breakdown Maarten also confessed that things were getting out of hand and he needed help. Laura started crying and said she feels very insecure in school and that she is bullied by a couple of girls in her class.

Mr De Vries sees the doctor to discuss his desire for help to control his misuse of alcohol. He discusses with his wife the possibility of having to be admitted to an Institution to take part in treatment programme. Because he is drinking heavily for quite a long time he thinks he needs residential treatment.

After waiting three weeks they have their first contact on the policlinic. The

talk with one of the psychotherapists. Mr and Mrs De Vries have three diagnostical interviews and one with the children.

Two weeks after the last interview they get a report with the results. The outcome is that the therapist suggests that Mr De Vries will have an residential treatment. He will be treated with the Minnesota model treatment. This is a twelve steps program, the first month he will be in the institute, the second phase of the treatment will be ambulatory.

The program starts with detoxification and there are individual, group and family therapy sessions during the week. The Treatment focus is on Education (health care, alcohol education, financial coaching, skill development) and Relapse Prevention.

There is coaching on the relationship between Mr and Mrs De Vries.

He is aware that he will have to focus on issues which have influenced his drinking habits and how he could deal with them in the future without relapsing to drinking alcohol.

Maarten is a young adult and he is directed to Youth Care (Bureau Jeugdzorg). Unfortunately they also have a waiting list. But because of the urgency of his problems he can go to the CIT, the crisis Intervention Team. He discusses his problems the next morning with a social worker and tells about all the things going wrong at the moment.

The worker and Maarten are able to implement a realistic care plan which allows small steps to be taken in the first instance. Maarten wants to stop taking drugs and one of the areas discussed is harm reduction. Maarten used to enjoy taking part in sport before his dad lost his job and he would like to take up some of these interests again. The worker is able to access information for Maarten about what is available in the local area. He gives Maarten this information to allow him to make choices about what he wants to enjoy. The worker has also been able to access a local support group for young people in a similar situation to himself and he is considering if he would like to join this group.

They also decides that he will have contact with the policlinic of the institutes for addiction care. There he will start with handing in urine samples to prove he is dealing with his drugs problem.

A very important topic in the counselling discussion is how to build a network of friends that are non users. They have a discussion together with Maartens tutor on school and a homework support is organised to help him to get his diploma.

After things have settled down Maartens is opening up more and more and tells about the pain he has to deal with in seeing his father drinking and his mothers depression.

So they decide to take part in a group called the KOPP (Children with parents that suffer from psychiatric diseases). This is offered through the GGZ (mental health care organisation). Both he and Laura meet other children that have suffered more or less the same problems. They learn a lot how to cope with the painful feelings.

Laura requires to have her confidence and self esteem built up and requires stimulating activities to enjoy as well as someone to confide in. The social worker in her school invites her to have contact on a regular basis. There they discuss the problems that she encounters in her class. She learns skills how to deal with the bullying and the teacher is supporting her. She invents activities to cooperate with other children.

Together with her brother she is attending the KOPP training.

8. A Day in the Life of a Social Worker

8.1 De Beukmolen

(by Manon van Putten)

◆ The Beukmolen is a ward situated in a residential quarter in Papendrecht. In a couple of houses in a row people are living that are suffering from psychiatric diseases.

08.30 – 09.00 hrs.
As my day begins we start in the attic office of the premises by transferring and assigning the tasks for the rest of the day. We always have a look at the agenda to see whether there are extra things to be done such as someone having to consult a doctor or having another appointment.

09.00 – 10.00 hrs.
At around nine o'clock we go downstairs. First we wake up everybody. This is only done with a group who need this; the others are responsible for getting up themselves. At our location there are four groups. We call them 200, 198, 196, 194 (the house numbers), which is easy to remember. The gardens of all four groups are adjacent. Each group has its own particulars, rules and learning points. Each client has his own points for development, which are described in his or her rehabilitation plan.

At another location in the same quarter, there is a house where clients live and where we go every morning to bring some shopping money and to see how the land lies. We join them for dinner about twice a week.

So we wake up everybody and see to it they all get downstairs dressed. This does not always work out, though. In the meantime we hand out the morning medication.

10.00 – 12.30 hrs.
First we have breakfast. The clients´ coach is also present at the time. On Mondays we make a plan for the week's meals together with the clients. In the morning we draw up a shopping list for the client who will do the shopping for the day. A number of the clients in this group will get guidance when doing so. For them it is a learning goal. So you go along with the client and do the shopping. In this way the client also gets a chance to do his own shopping, e.g. buying tobacco. The amount of time spent shopping takes differs by client and by day. After the meal we clear the table and the clients can do their own thing.

At this moment it will be around 10.30 hrs. and the group in house number 198 will be started up. Here everything is quite different. At 10 everybody is woken up and asked to be downstairs for group session at 10.30. At that time we all have coffee together and distribute assignments. If necessary

we offer guidance. Usually we have a small chat about this, that and the other thing. Here the coach will be present until 11.30 hrs.

In the meantime a coach will be on the way to the social meeting centre in Papendrecht in order to start up things there and support the worker present. In the social meeting centre you can have something to eat and find the company of people. The social meeting centre is open from 11.30 to 13.00 hrs.

In the other groups the clients start up the day themselves. Here they need less support, and work on their assignments much more independently. The life counsellors only assist when necessary.

12.30 – 15.30 hrs.
In the group where a lot of support is needed, the counsellors are present. Clients are responsible for organising lunch and for clearing up afterwards. In the meantime the coach goes upstairs to have some lunch and draw up his reports.

In the afternoons there is some time to do recreational activities with clients, for example walking, cycling, or going to Alblasserdam to the social meeting centre. At around 13.00 hrs the afternoon medication is handed out.

15.30 – 17.00 hrs.
At 15.30 hrs. you go into the office in order to make the reports. The late shift will start at 16.00 hrs., but first there is some time to discuss the important matters for the day. Transfer will last till 17.00 hrs. Then it is time for the day shift to go home and for the night shift to begin.

17.00 – 22.30 hrs.
The night shift starts by handing out pills and by assisting during cooking. During the evening the coaches have a number of meetings with their clients. This differs every evening. The night shift lasts till 22.30 hrs. By the end of the evening the final medication is distributed. We close up and leave.

8.2 RIBW

◆ **A day in the life of an assistant in a residential institution for people with Social Psychiatric needs.**

An early shift today; I took a train to Rotterdam and arrived at the home at 8.00

The early shift starts at 8.15 so I have time to read the reports.

Today there are also some notes on my desk to remind me of a few things. I start the computer to print the agenda, get the reports and look at the notes. G. has a job interview with an organisation that can offer him a training and voluntary work. He has trouble getting up early so he avoids appointments that can cause him trouble. I have to wake

him at once, because he has to be there at 9.00.

I walk into G's flat; he has been living here for a year now together with 3 others. I knock on his door and ask him if he is up; and if he knows that he has an appointment. I get an answer immediately; but he isn't up yet. I tell him I'll be back and that he has to hurry. I go upstairs to the living room to check how their evening has been; they've eaten; because everything is still on the table; and the sink is more than full again. So this Group will give me something to do today…….

I am going back to the office to read; and 15 minutes later I am visiting 3 other apartments in our Group. I do not have much time to start everything today, because D is visiting us; he lives on his own in an apartment nearby and I meet with him every week; sometimes at the office at 9.30 and sometimes at his home. I start cleaning up the place where I have arrived now; I clean up the sink; put the kettle on; and clean the table in the living room so we can drink coffee together. One after another the residents arrive; there are 7 people living here. We usually start the day with coffee and a smoke. The room fills up with smoke and we pour coffee. I keep telling them to have breakfast first; and then start drinking coffee and smoking; but most of them don't eat till the afternoon or even in the evening. I ask about their plans for today; and remind several of them of the appointments that have been made for today. I'll be back at lunchtime to have lunch with those who will be home. All residents must attend all the meals when they don't have anything to do during the day; or when they don't study or work.

I hurry to the office because it is almost 9.30, I go over D's file to see what we discussed last week; and I get D's mail. I received some more bills; so today we are going to call 2 providers of mobile phones. D. has 2 subscriptions; he has lost one phone; and now the other has disappeared as well. I suspect him of having sold them because he needed money; but I can't get a clear answer. During our talk I notice that he is in a very good mood; I am not used to this; and it turns out that he has received a credit card for a shop and the he has bought quite a lot..... I am totally surprised; because he is in a special program for people with debts. and cannot make any new debts. I don't want to ruin his good mood; but I point out to him that I hope that he hasn't made a high debt. I can persuade him to hand me the card; and that we will cancel the card next week. He has spent €800 on a tv, a dvd-player and some dvd's in three days!!

After this talk I go to a different apartment from where I've had coffee; to residents have left for work; and two others are nowhere in sight. It is eleven o'clock by now and time to get up. I knock on doors and from 1 one

door there is no reply; so I call that I am coming in; open the door with my key and the resident is not at home. I expect him to have spent the night at his fathers house; and this is against all regulations. He was supposed to be back on Monday; but it's Tuesday now. I have a chat with the other resident while we are having a cup of coffee; after this I return to the office to write a few reports..

I check my voicemails; and answer them; they are for residents that get personal guidance.

By lunchtime I go back to the first apartment and have lunch with the 2 residents; after lunch we go to the market and go for a walk down town together; this is our routine on Tuesdays. . They need several things and we talk about their future and the plans for this coming weekend.. As turns out they are expecting people to stay with them. I will discuss this with the team so find out if this is all right. The resident who is expecting these guests will discuss this in his home tonight; and I will this discuss this with my colleague.

Tonight when I return from the city centre I will write the individual reports for all residents and for the groups. I also write general reports for all issues that are less objective and that are meant for the team. I also report a few phone calls about a resident that are meant for colleagues. I quickly do the washing up in the kitchen of the office; clean the toilet and mob the floor in the office. I hope to be ready by three to hand things over properly at 15.00.

One of the colleagues is early and because she wants to smoke; we sit on the balcony and discuss her weekend. We sit outside because we can't smoke inside anymore.

Once our other colleague has arrived we discuss how the day has gone and what has happened.. We also discuss the matters that we'll have to discuss with residents and we think of things to discuss during our team meeting of Tuesday or Thursday.

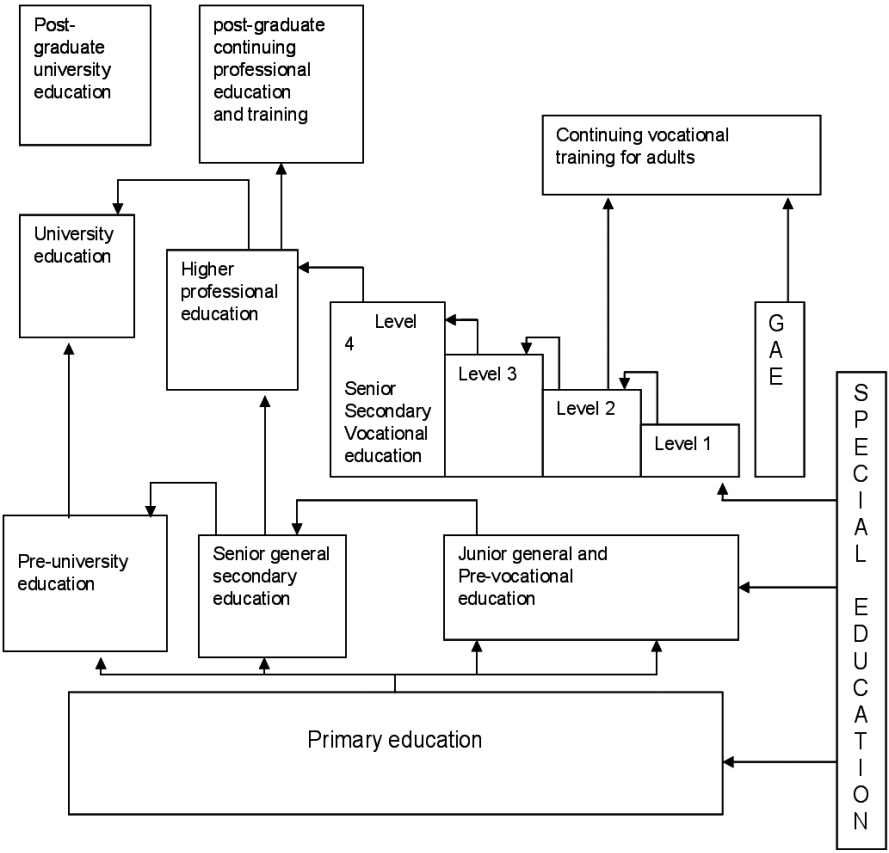
Our Supervisor also drops in; he is also Supervisor at another group and we discuss things till about 4 o'clock. My shift is over now; I go home and the others start work. On my way home I look back upon this day; and I think it has been a fairly quiet day. Tomorrow I have a late shift; group meeting at the home I am responsible for; and there will be a new resident.

But that's all for tomorrow……

9. Education and Training

9.1 The Educational System in The Netherlands

◆ Full-time education is compulsory in The Netherlands for all children between five and sixteen. Children start their school careers at the age of four in Primary Education (BO) or Special Education (SO). Later, most of them move on to Secondary Education (VO), which branches into pre-University (VWO), Senior General secondary (HAVO) and Pre-Vocational (VMBO) education with different types of routes.



After the first stage of Secondary Education, students move on to Secondary Vocational Education or the second stage of Senior General Secondary (HAVO) or pre-University (VWO) at around the age of sixteen. Apart from the mainstream types of education, children with special needs are educated in Special Secondary Schools (VSO).

Young people aged seventeen and eighteen must continue their education at least on a part-time basis. A proportion continues beyond this age in University Education (WO), Higher Professional Education (HBO) or Secondary Vocational Education (SBO, divided into Vocational Training route (BOL) and Apprenticeship Route (BBL). There are also three levels of Adult Education courses (BE) plus Adult General Secondary Education (VAVO).

Flows of funds

The minister of Education, Culture and Science is the main financial source for the types of education described. The funds are paid directly and indirectly from the Ministry to the educational institutions. The main flows of funds go via the local authorities (for example, to pay for adult education and, since 1997, primary and secondary school accommodation) and via students themselves, as school tuition fees paid to secondary vocational and tertiary institutions. Institutions are also free to generate additional income, for example by requesting voluntary parental contributions, by participating in local government projects.

Local government offers around €365 for each child in primary education and around €90 - €140 for each student in secondary and vocational education.

In the figure on page 38 you can see a diagram of the structure of the education system.

9.2 Secondary Vocational Education / Qualification Structure

◆ Good vocational education is of great importance to any labour market.

Vocational training should better meet the demands of the labour market and the requirements expressed. The development of the Dutch qualification structure is of vital importance for economic growth in The Netherlands. Since 1996 all training courses in social and health care have been combined into one single system. The qualification structure gives a detailed description of knowledge, capacities and attitudes one must have to start as a professional. All vocational descriptions consist of a number of partial qualifications.

The Dutch qualification structure of secondary vocational education has four different levels:

LEVELS OF QUALIFICATION	TRAINING	DURATION
1. Simple, operational tasks	Assistant training	6 months – 1 year
2. Operational tasks	Operational tasks	2 – 3 years
3. Completely independent execution of tasks.	Secondary Vocational Education	3 – 4 years
4. Completely independent execution of tasks, with capability of wide ranging deployment, or specialisation	Middle Management Training	3 – 4 years
	Specialist Training	1 - 2 years

In the qualification structure on the next page you will find an overview of the qualifications in health and social care. After that we will describe which partial qualifications a student must pass to get his or her diploma and the attainment targets they have to achieve during their work placement period.

10. References/ Bibliography

This booklet came into being with the help of a couple of people. We specially would like to thank the working life colleagues. They took their time in reading the draft versions and in giving feedback so the materials could be improved.

Specials thank to Mrs. Margreet Knops, head of the education department of De Grote Rivieren. She was involved in the part of the book that deals with psychiatric care.

Websites:

www.trimbos.nl

www.hulpgids.nl

www.dehoop.org

www.degroterivieren.nl

11. Appendix

Glossary

Professional Code for Social Worker and Social Care Worker

Providing assistance and services to clients

As a professional

As a social worker / social care worker
- I adhere to the professional code
- I provide assistance to people without discrimination, and accept the situation they are in
- I have insight in my capabilities and inabilities and I know how to handle them
- I take responsibility for my professional conduct and I am able to justify it
- I know why I do my work and I take care not to lose my motivation

Dealing with clients

As a social worker / social care worker
- I put the right of self-determination at the centre and I am aware of the rights of clients
- I oblige myself not to divulge any information about clients and I abide by the existing legal regulations (e.g. the privacy act)
- I make no attempts at developing sexual relationships and I shall not respond to advances made by clients
- I do not approach clients in an aggressive manner
- I respect the standards and values of others

Working from and in a residential institute or care provider

As a social worker / social care worker
- I talk to my colleagues about their conduct if they do not abide by the code
- I contribute towards the development of policy within the institute
- Cooperation and negotiation with colleagues are at the service of the client and his or her treatment

- I support colleagues when they have come into trouble due to acting according to the professional code
- I take care of optimum conditions in order to make cooperation and negotiation with my colleagues possible

Working towards professionalism

As a social worker / social care worker
- I talk about my occupational group and my profession in a positive manner
- I keep in touch with social developments influencing my profession and occupational group
- I oblige myself to spend part of my time on (continuing) education
- I support and participate in activities creating conditions for professionalism en improving the quality of professional conduct
- I advocate the conditions that contribute towards optimum professional conduct

EXPLICATION

Why a professional code?

Professional ethics is the reflection on the morals of professional conduct. In psychosocial assistance, where the meeting of other people is primary, one cannot ignore morals. Social workers and social care workers have to cherish a uniform aura for themselves and others. A code may contribute towards this.

A code is a guide of professional conduct, but may also offer information about what is to be expected from a social worker or social care worker. It also strengthens the image of the professional and makes it clear to outsiders what is essential to social workers and social care workers. The professional code comprises a number of arrangements that social (care) workers should adhere to ethically.

In this respect it distinguishes itself from “things you are able to” (competences and qualifications as described in “The Creative Professional”.)
In a changing community where new demands are being made on social (care) workers all the time, and where the issues are becoming ever more complex, it is important that the code should stimulate discussion about the profession and its ethics.
The professional conduct of a worker may be tested by means of the code.
A committee or board of supervisors treating and judging complaints and questions about professional conduct should abide by the regulations.

The Care Plan

The counselling plan has become indispensable in the care and counselling of clients. When making a plan one works according to a fixed method. This method is composed of six steps:

- gathering information
- determining the need for assistance
- setting goals
- Planning how to accomplish the goals
- accomplish the goals
- evaluation of the Care

Gathering information
You start by gathering data and information. In this phase the conceptualisation of the client is important. You try to gather as much information as possible about events and the way the client has experienced them by asking questions to the client and / or relatives. In this way you try to get a complete picture of his life's history.

Determining the clients need for assistance
Once the information has been gathered the need for assistance may be determined. What is important for this client, in what respect does he need support / guidance / assistance? The possibilities and wishes of the client are the starting point when determining the need for assistance. Not all clients are able to indicate what need of aid they have, though. The counsellor may then determine the need for assistance in talks with relatives or legal representatives of the client.

Setting goals
First of all you look at the future, what is the client aiming for? It is important that the image of the future should be decided by the client, if possible. From this image of the future you will set the counselling goals. You can set goals for the longer term, the primary goal. The question may be what a client wishes to achieve a year from now. Subsequently, subsidiary goals (for the short term) may be derived. These working goals may differ by area and by discipline.

Planning how to accomplish the goals
In doing this it is especially important that clear arrangements about counselling should be made. It should be clear who does what, when, how and with what. You should also think of recording the results. You should record what has already been achieved and how things have worked out.

Accomplish the goals
You set to work and you take care of adequate records of the results. You should write things down as accurately as possible. Reports are of great importance in this respect.

Evaluation of the care
A counselling plan is never finished, therefore you should evaluate regularly

during the counselling process. You evaluate the primary goal and the working goals (actions) and decide whether the perspective is being approached. An evaluation may lead to determining the perspective anew and that new goals may be set. It is important to determine at what time the goals will be evaluated.

For setting the goals the **SMART** method is used.

S – specific
M – measurable
A – acceptable
R – realistic
T – time related

Specific: the goals must be described clearly, not vaguely

Time related: when should the goals be achieved?

Measurable: you should be able to measure whether the goal has been achieved

Realistic: the goals should be attainable in daily practice

Acceptable: do the goals suit the client, the team and the organisation

Notes

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