METHODOLOGICAL GUIDE

FROM INSPIRATION TO IMPACT

EMPOWER.Ment

EMPOWER.MENT.

Empowering people with Severe Mental Health Difficulties through inclusion in every step of the training and therapeutic path

Erasmus+

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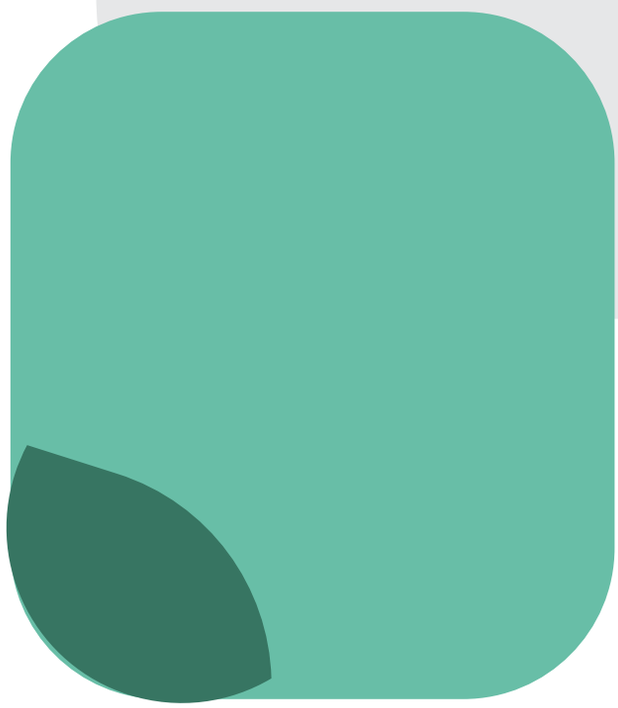
INTRO DUCTION

This Methodological Guide is part of the Erasmus+ project EMPOWER.Ment. Empowering people with severe mental health difficulties through inclusion at every stage of their education and treatment, which aims to offer an alternative, systematic approach to supporting people who experience mental challenges in a way that is inclusive and respectful.

The motives that pushed us to work on this project start from our desire as mental health professionals to come together with people who have been involved with the mental health system from a different path, share our knowledge, and make this program together. We hoped to create an environment where our different points of view, ideas, experiences, and knowledge would integrate and reinforce each other.

This collaboration brought to life an E-learning Program and a Glossary.

This part of the project is here to offer the reader a look behind the curtain and explain the philosophy of the project, how we worked to make it happen and what we hope to achieve. In the following chapters, one can find out about the traditional mental health system, the new, challenging approaches that are arising across Europe, that offer new narratives regarding mental health difficulties, and where we stand in this framework.



Additionally, the EMPOWER.Ment project aspires to serve as an example and an inspiration for more collaborative programs that enrich our understanding of mental health and the attitudes and behaviors towards people with mental health challenges. For this reason, this guide contains a detailed recording of the methodology we used throughout the project, the challenges we faced, and our suggestions regarding how to incorporate the knowledge gained into everyday practice.

A note on the Language...

Before proceeding, it is important to give some clarifications regarding the language used in the project – which is itself a part of it. We share the rationale that language can shape the way we experience our reality and thus new ideas require a new language in order to be expressed. On the other hand, a new language can serve as a catalyst for the creation of new ideas.

Thus, the language we choose to use in this project is in accordance with the wording that makes people with mental health challenges the most comfortable, so that they are truly included and respected. Nevertheless, in order to avoid any misunderstanding, we believe that a detailed exploration of some of the chosen terminology must be provided.

"Severe Mental Health Difficulties"

First of all, we should elaborate on the term "severe mental health difficulties", which is used in order to distinguish a specific group of people that, according to the WHO, experiences the most distress of all other mental health conditions and according to our experience is the most vulnerable to social exclusion, stigma, and discrimination.

This term refers to people who have uncommon experiences, unusual beliefs, have experienced extreme states of being, and/or unbearable feelings of distress. Those people are usually diagnosed with "psychosis", "personality disorder", "schizophrenia", "bipolar disorder" and "depression". People who have been psychiatrically diagnosed with those diagnoses are also considered people with disabilities, according to the UNCRPD.

Here, we must stress that even though the project is about people with severe mental health difficulties, our rationale goes beyond those experiences and we believe that any kind of mental distress is "severe" for the person who is dealing with it. The principles that this project embraces can be applied in order to support people who deal with a variety of situations – regardless if they are considered "severe", "mild" or even "unimportant".

"Distress, Difficulties, and Challenges"

From the beginning of the project, it was clear to us that we would not use medical language, as we already know that it is generally disempowering and stigmatizing, and it hides the person behind the label. More importantly, though, a project about mental health that speaks from the medical model's lens, would not have something new to say and would only regenerate the professionals' views.

Words like "service user", "client", "person with lived experience" or "psychiatric survivor", although can be empowering in many ways, we believe that they refer to very specific groups of people and are not inclusive enough. Additionally, these words have plenty of connotations themselves that would endanger our project of going in a different direction.

Thus, began our journey to find acceptable, relevant, and empowering terms, that would not overshadow people, nor would it minimize their experiences. Some common phrases that have been used by different kinds of groups (e.g. self-help organizations, activist movements, etc.), are: "mental distress", "mental health difficulties" and "mental health challenges". Although we found that all of these terms are generally considered appropriate, we needed to decide on a single one to use throughout the project in order to avoid confusion.

Both "distress" and "mental health difficulties" are terms that focus on the negative aspect of the experience, and the pain it carries. On the contrary, "mental health challenges" can have a more positive note, it indicates that there are difficulties but people can overcome them. Although we have to admit that translating the word "challenge" into different languages can even gain a completely positive meaning, referring to things that can make us grow, thus hiding in a way the pain that one might face.

After long discussions, we decided to mindfully use the term "mental health challenges" throughout the project hoping to give it the positive note that we believe in.

We want to make it clear that this decision does not wish to hide the distress, difficulties, and pain that can be - but not necessarily are - part of these experiences, but it reflects what already we know and what we want to spread: that recovery is possible!

This project is based on the belief that there is a need to offer new narratives for the experience of mental health challenges. By making narratives more inclusive and breaking out of the narrowness and stigmatization that certain words and ideas inevitably bring with them, we believe that a major step forward can be taken toward quality of life, social inclusion, and equality. It is important though, that those narratives become available for everyone. For people with mental health challenges to use them for themselves, for the professionals to use them when interacting with people with mental health challenges, and with each other, for family members, volunteers, and people in training and, in general, society.

It is for these reasons that we decided to make this project and specifically this guide together with people with mental health challenges on an equal basis, hoping to write a new page in mental health for people experiencing mental health challenges, their families, volunteers, supporters, professionals and society as a whole.

PARTNER ORGANIZATIONS

ANIMA

ANIMA is a non-profit, non-governmental organization (NP-NGO) that has been an active member of the mental health community since 2005. ANIMA's vision consists in providing advice and support to empower anyone experiencing a mental health problem. We believe no one should have to face a mental health challenge or difficulty alone.
ANIMA's objective is to become a substantial and positive choice for mental healthcare and to offer high-quality services to those in need. Our aim is the creation of a fully integrated network of services in order to cover the population's needs in levels such as the mental health services system, socio-economic, educational, and scientific documentation.

In order to achieve our objectives:

01 We offer quality services in mental health and in social support that respond to real needs.

02 We focus on developing an effective care service in mental health.

03 We fully inform people on the topics that concern their personal and social life.

04 We form collaborations with other organizations, networks, and agencies with similar objectives and actions for common good.

05 We are constantly evaluated and improved in light of our efficiency and effectiveness.

ANIMA's activities include a psychosocial rehabilitation unit, an online informational platform about mental health, a creative workshop that connects people with experience of mental distress with the community, accompaniment through crisis, and training in accompaniment through crisis.

AnimaHome: animahome.gr

AnimaCare: animacare.gr

PARTNER ORGANIZATIONS

HUGARAFL

HUGARAFL (e. Mindpower) is an Icelandic peer-run NGO founded in the year 2003 by individuals with a vast personal and professional knowledge of the mental healthcare system. These individuals had the common goal of wanting to change the mental healthcare system in Iceland and make it better. Everything that Hugarafl does is decided upon and done by people with lived experiences of emotional distress and/or professional backgrounds working as equals.

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Some of Hugarafl's activities are:

Hearing voices peer group ● Peer support ● Support groups for friends and families
A podcast and a livestream about mental health ● Yoga ● Mental health education for students
Empowering group work for 18 – 30 year olds ● International collaborative projects
Writing articles, media coverage and legislative input ● Conferences, lectures and workshops
Art work ● Therapy and counseling.

Hugarafl | stærsti virki notendahópur á Íslandi þar sem valdefling er markmið - hugarafl

PARTNER ORGANIZATIONS

L’Ovile

L’Ovile is a social cooperative established in Reggio Emilia (Emilia-Romagna Region, Italy) in 1993, which promotes the inclusion of disadvantaged people. According to Italian law, the organization is a cooperative of types A and B: sector A provides social services and sector B offers employment opportunities. In the field of mental health, L’Ovile runs rehabilitation structures and designs paths aimed at empowering people with severe mental health difficulties and helping them recover from a difficult moment in their lives to feel integrated into society and live in the most autonomous way possible.

Cooperativa L'Ovile – Cooperativa di solidarietà sociale ONLUS

PARTNER ORGANIZATIONS

T-Hap

T-Hap addresses the need of individuals, professionals, and communities for flourishing with finite resources, experiencing collaborative ways of existence, lowering stress and various kinds of anxiety, addressing the different levels of human existence, optimizing mental health and wellness in our lives. T-hap offers related to wellness optimization can be described through three basic tenets: Education, Therapy, and Travelling.

T-hap is a concept. It aims at optimizing opportunities for wellness in people's lives. It provides an umbrella of experts and services for wellness to be established and enhanced. It brings together professionals from various work environments, to work under "win-win situations", creating not just networks, but really cultures of well-meant, highly efficient individuals towards wellness.

T-hap – Optimizing Wellness and Quality of Life

PARTNER ORGANIZATIONS

UNIMORE

UNIMORE has a longstanding tradition (it was founded in 1175) and is considered one of the best universities in Italy for teaching and research. It is ranked 2nd among public universities according to Italy's leading financial daily, and among the top 8 medium-sized Italian universities by the Times Higher Education Ranking 2011-2012.

UNIMORE, which has just over 27,000 students including 3,500 postgraduates, is large enough to offer all the facilities one would expect from a major university (well-stocked libraries, computer rooms, free internet connection, and study support services) but small enough to retain a personal and friendly learning environment.

UNIMORE is composed of 13 Departments, offering a wide range of degree programs at undergraduate level, right up to doctoral studies in most disciplinary areas, from the humanities and social sciences to engineering and technology, and from physical and natural sciences to medicine and life sciences.

UNIMORE is located in the heart of one of Europe's wealthiest and most dynamic regions, which is world-renowned for its production of mechanical parts, engines, sports cars (e.g. Ferrari and Maserati) as well as for its agro-food sector, ceramic tiles, and manufacturing industries.
UNIMORE is located in two cities with the highest quality of living standards in Italy. Both Modena and Reggio Emilia are considered important cities of art and culture, and Modena's cathedral and main square are on the list of UNESCO's World Heritage sites.

Unimore - HomePage

PARTNER ORGANIZATIONS

The Dutch Foundation of Innovation Welfare 2 Work (DFW2W) is an independent, non-profit organization, based in the Rotterdam Region (Holland), which supports professionals (e.g. European institutes, municipalities, councils, provinces, governments, employment agencies, training providers, youth work organizations, non-profit organizations) and young people (aged 14-35) to reach their full potential in the fields of (youth) employment, traineeship, education, social innovation, mental health, social inclusion, and (young) entrepreneurship.

DFW2W

The key staff of DFW2W, Carla de Vreij, Pieter van Schie and Desiree van der Heydt are very experienced in the management of EU-funded projects within the framework of different EU financing programs (ESF, Lifelong Learning, Youth in Action, Integration durch Austausch, Your first EURES job, and Erasmus+ KA1, KA2 and KA3).

DFW2W (dutchfoundationofinnovationwelfare2work.com)

CHAPTER 1
The Background

Recent evidence shows the tremendous increase of people who experience severe mental health challenges and/or are diagnosed with severe mental health challenges over the past decade in European countries.

According to the European Mental Health Action Plan 2013-2020 (the last one available), mental health-related issues are among the most significant public health challenges in Europe and they affect more than a third of the population every year, the most common of these being depression and anxiety.

European Countries are spending a lot of money in order to help and support people with mental health challenges, which are being distributed in different kinds of services depending on each country's economy and/or understanding of mental health in general. Indicatively, we can mention that of all the amount of money spend on people with disabilities, 13,7% is being spent on people who are diagnosed with "Unipolar Depressive Disorder", making it the costliest condition in Europe, with the diagnoses of "Schizophrenia" and "Bipolar Disorder" following in the eleventh and twelfth position respectively.
A great amount of that money is spent on social welfare benefits or pensions, as rates of employment for people with mental health challenges in Europe vary from 18% to 30% with some of this variation depending on diagnosis, with the lowest rates for those with "psychotic disorders''.

Taking this into consideration, we can conclude that the common conception about people with mental health challenges is that they need a lot of support throughout their life, or in other words, that their situation is "chronic" and that because of it they probably won't be able to ever work. This narrative, as well intended as it might be, feeds the vicious circle of people not being able to recover and needing more and more services and benefits.
In the same way, plenty of resources are spent on research in order to better understand mental health challenges, but sometimes the way the findings are understood and presented can promote misconceptions and stereotypes, leading to poorer, not inclusive services and support.
A good example is the research regarding the connection between "mental disorders" and "suicide" which provides strong evidence that people with mental health challenges often commit suicide.

Regardless of the researchers' intentions, those findings usually reach the general population's knowledge just as a fact, without any explanation, which promotes the idea that suicide happens as a "symptom" of the "mental disorder" or because the other symptoms are unbearable. What is usually not mentioned is that people who experience mental health challenges are also the victims of stigma and discrimination, meaning that they cannot equally participate in social life. Under that canon, we could suggest that people with mental health challenges might turn to taking their own life not because of their unbearable "psychosis", but because they are being treated as inferior, excluded, and dismissed, and that can be unbearable.

Other researches - and as a consequence, other financial resources - focus on the comorbidity that occurs between mental health diagnoses and bodily chronic diseases, such as cardiovascular diseases, cancer, diabetes, and metabolic syndrome.
What is rarely recognized though, is that people with mental health challenges have these kinds of pathological issues due to the way we usually treat them. In other words, those health conditions do not just happen to people with mental health challenges but rather to people who are dealing with very complex situations. People with mental health challenges often have poor access to quality treatment, because they lack resources, or because they are primarily seen as "psychiatric patients" and the other conditions they have to deal with are being overlooked. More than that, people who have been diagnosed with psychiatric disorders are usually prescribed psychiatric medications which have a lot of side effects, a higher risk for many chronic diseases being one of them.

What we see here, is that although a lot of money and resources are spent in order to support people with mental health challenges, if we do not adopt a more holistic approach, this is a waste and little does it make the lives of people better.
Of all the groups of people with disabilities, people with severe mental health challenges face the greatest level of social exclusion, due to various reasons, stigma being the most predominant one among them. Therefore, it is not the condition per se of the people with severe mental health difficul-ties that prevents them f rom participating in social activities, work, or living like everyone else, but the negative beliefs and attitudes that surround their condition and them in general.

Additionally, mental health challenges tend to be more prevalent among those who are most deprived socially and economically creating even greater exclusion.

This usually translates into various forms of discrimination and violation of human rights.

While acknowledging that European societies have recorded some improvements over the past decades in their approach to mental health, people with severe mental health challenges are still not taken into account within their everyday life and/or therapeutic/treatment process. So there is still enormous work to be done in order to ensure that mental health support is provided in full human dignity and with respect to human rights.

The social environment of people with mental health challenges often cannot comprehend their complex situation and lived experiences. Even when support is very well intended, it can often take very disempowering forms, usually stemming from wrong beliefs such as the person in difficulty doesn't have the capacity to make decisions for themselves, or their condition is permanent and hopeless, or that little progress can be expected from someone who has a diagnosis such as schizophrenia or bipolar disorder.

One of the most common mistakes people tend to make when trying to support or live around people with mental health challenges is that they believe that they cannot have a say about anything, because their condition is so critical that it affects their "straight" thinking or their reason in general. In this way, people with mental health challenges are treated like minors, become less independent and self-responsible, and, finally, act accordingly, losing their "living capability". That way, the vicious circle keeps on reviving the stereotype, and the societal exclusion of people with mental disorders deepens. Often, people who sincerely want to support someone with mental health challenges, lack the necessary skills or tools to do so, or have only had inappropriate examples of support that they are further passing on. Friends and family members, volunteers, students, and professionals within healthcare and psychoso-cial support fields - are usually trained on how to deal with the challenges instead of acting together with the person, towards their wellbeing.

Taking all these into consideration, the current project and guide promote an approach to mental health support that is holistic, fully empowering, and inclusive. People with mental health challenges are acknowledged as persons with capabilities, and their lived experience is valued, especially since they were equal partners in the creation of the project.

A deeper discussion about Stigma

Although we do not wish to turn this guide into an academic paper, one cannot speak about empowerment without considering stigma. Stigma is most often at the root of power loss for people with severe mental health challenges and it goes deeper than one might think.

Stigma consists of labeling, stereotyping (=negative or positive evaluation of a label), and prejudice (=endorsing negative stereotypes), which lead to status loss and discrimination for the stigmatized individual or group.

The consequences of stigmatizing people with severe mental health challenges are dramatic and are often considered to be as important as the mental health challenges themselves. Stigma can undermine many of the life goals and human rights of people with severe mental health challenges, by preventing them from accessing higher education, medical care, employment, and building relationships.

In recent years, stigma in society has become a buzz expression, vaguely placing the accountability for the harmful impact of stigma on some abstract entity and detaching it from specific individuals and structures that perpetuate it.

The table below (link) provides a more comprehensive overview of the forms stigma can take and how they can affect a person with mental health challenges.

A deeper discussion about Stigma

TYPE OF STIGMA	DEFINITION	EXAMPLES
Public stigma	The reaction that people in the general population have to those with mental health challenges	• "I would not want to live next door to someone who has been mentally ill". • "I think that being prone to violence is a distinguishing feature of people with mental illness".
Structural stigma	Regulations, laws or institutions which systematically discrimi-nate against or disadvantage people with mental health challenges	• HB-5639 State of Michigan: increases discrimination by prohibiting mental health agencies from operating within 1000 feet of a school's property line. • Sensationalist headlines of newspapers. • Laws which prohibit individu-als with mental health challenges from being elected to office or serving on a jury.
Self stigma	The internalization of stigma of mental health challenges by the person having them	• "At first I thought I was crazy and I was like okay, do I have a mental illness?...'cause my mom, she has a mental illness of paranoid schizophrenic, and I was thinking I'm going to turn out like her; I didn't want that to happen". • "Believing I'll be sick forever and useless and never able to do what I want to do and will never amount to anything because I have a mental illness".
Felt or Perceived Stigma	The stigma that people with a (potentially) stigmatized mental health condition fear or perceive to be present in the community or society	• Fear that others would associ-ate taking antidepressant medications with being incom-petent or hopeless. • Not applying for a job for fear of being discriminated against.

A deeper discussion about Stigma

TYPE OF STIGMA	DEFINITION	EXAMPLES
Experienced Stigma	Experience of actual discrimination and/or participation restrictions on the part of the person affected.	• Treated differently by the other members of the family. • "I have been shunned or avoided when it was revealed that I have a psychiatric diagnosis".
Label Avoidance	Not seeking out or participating in mental healthcare in order to avoid the negative impacts of a stigmatizing label	• "I feel ashamed about my diagnosis and therefore avoid using mental health treatments". • "I feel embarrassed about having a diagnosis of depression and so hide my medication or peel the label off the bottle".

A milestone for changing direction

Although this situation as described can be underwhelming, the European and Global institutions are constantly working, providing new frameworks and guidelines, in order to achieve better conditions for people with mental health challenges, and for people from sensitive social groups in general.

A big step in this direction is the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which was adopted in 2006 and entered into force in 2008. The convention, which is also embraced by the World Health Organization, does not challenge the traditional models of mental health, according to which mental distress is considered a disability, but instead, it reshapes the idea of 'disability" placing it in the interaction between people and society, instead of inside the person.

According to the Convention "persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (Art 1.) Whereas, "disability" is "an evolving concept and it results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others".

This attitude creates the conditions for new ideas to arise and for more inclusive policies. Disability is not anymore seen as a problem within the person, nor it has only to do with health or well-being. It involves the interaction between the unique features and functions of a person's body and mind and the environment and sociopolitical context in which they live. The Convention represents a new mindset in policies concerning disability and discrimination, promoting, protecting, and ensuring the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities. It doesn't include new rights but it identifies the specific actions that States must take to protect against discrimination on the basis of disability, promoting a cross-disability and cross-sectoral approach.
Those guidelines can serve as a vehicle to protect the rights of people with mental health challenges and guarantee their access to quality services around the world. The Convention promotes full inclusion and participation in community life and access to quality health care services as close as possible to people's own communities (Article 19 – Living independently and being included in the community). This has important implications in terms of de-institutionalization and the development of community-based mental health and social services (Art 12 Equal recognition before the law).
Additionally, the Convention questions the idea that people with mental health challenges, and other conditions that are considered "disabilities", lack the capacity to take charge and make decisions concerning their own lives. It promotes key rights such as the right to own property, enter into contracts, manage one's own financial affairs, marry, work, and retain custody of one's children. Furthermore, the Convention states that people with "mental disabilities" should retain their legal capacity, and, when required, should be provided with support in exercising their legal capacity and their rights (Article 12 Equal recognition before the law).
In 2021 the European Commission launched the Strategy for the Rights of Persons with Disabilities 2021-2030, which aims to pave the way to a barrier-free Europe and to empower persons with disabilities so they can enjoy their rights and participate fully in society and economy. Built on the results of the previous European Disability Strategy 2010-2020, it is closely linked with the Charter of Fundamental Rights of the European Union (CRPD) and with the UN Convention on the Rights of Persons with Disabilities. It promotes an intersectional perspective in line with the United Nations 2030 Agenda for Sustainable Development and Sustainable Development Goals (SDGs).
Based on three main pillars (rights on an equal basis with others, independent living and autonomy, and freedom from discrimination and equality of opportunities), this Strategy bears several promising initiatives for many persons with disabilities, including psychosocial disabilities, in the European Union. The Strategy reveals particular attention toward the rights of persons with psychosocial disabilities and persons with mental health problems. This follows the recommendations by the evaluation of the Strategy 2010-2020, outlining that previously some persons with disabilities were underrepresented, such as persons with psychosocial disabilities.

By promoting the right to participation in political and public life, to education, employment, and other rights, the Convention provides a legal framework for putting an end to discrimination experienced on a daily basis by people with mental disabilities and promotes equality.

CHAPTER 2

EMPOWER.Ment project: inspiration, methodology, and challenges

The EMPOWER.ment project aims to support people with severe mental health challenges to occupy their rightful place in society, by ensuring their inclusion in every step of their training and/or therapeutic pathway - from planning to evaluation.
That will be achieved through creating tools for educating volunteers, friends/family, mental health professionals, and university students, on how to ensure the equal participation of people with mental health challenges, in every aspect of their life.

The three outputs created in the project are:

Methodological Guide on EMPOWER.ment:
from inspiration to impact - a guide to incorporate inclusive practices into everyday life, clinical practice, support, and services.

Toolkit "We say, You say, They say":
a Glossary of mental health words, analyzing the existing language in mental health and proposing alternatives or empowering ways to use it.

EMPOWER.Ment e-learning module via MOOC:
for friends, family, mental health professionals, volunteers, and students, on inclusive and empowering support for people with mental health challenges.

CHAPTER 2
EMPOWER.Ment project: inspiration, methodology, and challenges

The active involvement of people with severe mental health challenges in the design and content creation of the outputs was at the core of the methodology used in this project. This was a way to implement the very principles and methods that the project promotes, to live by the very example we are trying to set. People with mental health challenges were part of the project team alongside the mental health professionals from beginning to end, had an equal part in the decisions being made in the project, participated in all work meetings, and had their voices heard. Besides those from the project team, other people with mental health challenges were specifically involved in focus groups, in consultations on certain topics, or in reviewing content.

What inspired us

The philosophy of this project draws inspiration and wisdom from several models and approaches in mental health that are inclusive and respectful of the human rights of people with severe mental health challenges:

THE RECOVERY MODEL

The Recovery Model is a holistic, person-centered approach to mental health care, based on the simple principles that it is possible to recover from a mental health condition and to lead full, satisfying lives and that the most lasting change happens when the person with mental health challenges directs it.
The process of recovery is highly personal and can happen in many different ways. It may include clinical treatment, peer support, family support, self-care, and other approaches.
The recovery model ensures that patients are able to be directly involved in their own treatment.

TRAUMA-INFORMED CARE

Trauma-informed care is an approach in the human service field that shifts from the medical question of "What's wrong with you?" to the question of "What's happened to you?".
The approach assumes that an individual is more likely than not to have a history of trauma, including adverse childhood experiences and that some behaviors and feelings of a person with mental health challenges might be a reaction to the trauma.
Whether an event is traumatic depends not only on the nature of the event itself, but also on how it negatively impacts our emotional, social, spiritual, and physical well-being. We are all affected by traumatic events in different ways.

What inspired us

OPEN DIALOGUE

Open dialogue is a philosophical, holistic approach for people who are going through a mental health crisis and their families, friends, and networks in general. Open Dialogue Groups, often taking place in peoples' houses, involve the person in crisis, their family, and their social network in order to create a supportive environment that, through honest dialogue, can understand, make sense and endure the crisis.
What makes it unique, is that it is not an alternative to psychiatric services, but a psychiatric service itself that started in Finland and is now spreading across Europe.

THE HEARING VOICES APPROACH

The Hearing Voices approach offers a non-pathologizing, open way of understanding and supporting people through the experience of hearing voices. It assumes that hearing voices (as well as seeing visions and other sensory experiences) can be a normal part of human experience with a variety of meanings for people.
The approach is not about getting rid of the voices, but about the person understanding their voices in relation to their life experiences, changing their relationship with their voices so that the voices become harmless and/or helpful, and learning to cope with their voice and the original problems that lay at their voice hearing experience.

What we did

The first output, a Methodological Guide, is a detailed recording of the EMPOWER.Ment project in total. It describes the context and the ideas that made us work on this project along with the methodology we used and the challenges we faced.
In this guide, there are also two chapters dedicated to good practice examples, hoping to inspire and prove that what we support can actually be applied. The first chapter (chapter 3) gives summaries of the practices, while the next chapter (chapter 4) dives more into the core elements that make those practices good, from our perspective, and are also the elements that should be applied to any form of official or unofficial support. More details on each good practice can be found in the Annex.
The good practices were selected by the partner organizations after consultations with the people they support. The testimonials linked to these practices represent another direct contribution by people with mental health challenges to the project, who offered a piece of their personal experience with the practices and how they benefited from them.

In the second output, the Glossary, the project team worked with people with mental health challenges over a period of several months.
Specifically, for the first part of the Glossary, the partners worked closely, with weekly meetings creating a database of words commonly used in mental health contexts. Then, for economic reasons (time and resources), 30 of those words were selected to be included in the Glossary.
Once the thirty words were identified, the partner organizations invited people with mental health challenges to participate in focus groups where the terms would be discussed. In order to find the participants for the focus groups, the organizations reached out to people who were users of their services, people whom they had supported in the past, and also created open invitations through social media. In total, 50 people with mental health challenges participated in the focus groups, ages 25 to 73.

A focus group was created in each country that was meeting once a week. The participants analyzed the terms, the ways in which they are generally used, and proposed some empowering terms to replace them with, or, respectively, more inclusive ways to use them. Minutes were taken in each group and then the entries for the Glossary were created, taking into consideration all of the opinions expressed.
The discussions were also meant to ensure that the language used about mental health is inclusive and comprehensible so that it is not just the treasure of a few, such as professionals, but also belongs to and is mastered and understood by the people directly involved, such as people with mental health challenges and family members. This terminology can play an important role in forming new beliefs about severe mental health challenges, which, in consequence, may lead to a new approach to the social inclusion of people affected by them.

As for the third output, the E-learning Module, its thematic structure is the result of a work session in which professionals and people with mental health challenges, members of the partner organizations discussed and agreed on what would be the necessary themes to address in a course about empowering support. Professional and personal experience are both reflected in its comprehensive thematic structure, and its content, both written and filmed, is created by the same mixt team.
Taking into account the fact that more and more people experience severe mental health challenges, ensuring their participation in the planning and implementation of others' training about matters that are of great relevance for them personally, is a crucial factor for the social inclusion of this social group.

Challenges & difficulties and how to address them

While the project was rich in achievements and outcomes, we also faced several challenges, which we managed to work through and learn from. In this section, we are sharing these challenges with the readers, with the purpose to be thorough in our presentation of the project methodology and create awareness about what this type of project can entail.

As was to be expected, working for 30 months in a team that is spread between 5 countries and consists of very diverse experts, with different cultural, social, and linguistic backgrounds, is not without difficulties. This multiculturality can be a treasure if handled wisely. Yet, for this to happen, a multicultural team has to overcome some inherent obstacles, which was also the case in our project.

The members of the project team had different work roles: mental health activists, people with mental health challenges, psychologists, psychotherapists, psychiatrists, managers, and social workers. We started off with very different bases in our awareness of some of the topics of the project. The views about mental health and support were shaped by these roles and by the specific expertise we each had, and that was reflected in the work discussions.

Language, as an essential component of the change we want to create through the project, was also an obstacle at times. The working language was English, which wasn´t the mother tongue of any of the team members. Ideas and opinions got occasionally truncated or narrowed in the process of translation since none of the members had their complete linguistic toolbox at their disposal. Working on the glossary of mental health terms was particularly challenging since we were discussing the terms in English, but we also had to analyze their meanings and connotations in our languages.

Furthermore, the differences in the national health systems and the legal frameworks existing in each of our countries came up when we were discussing good practices or potential solutions for the systemic problems. In most cases, national realities were too different to allow a certain practice to be proposed for all countries.

We spent a great amount of time in conversation during this project. We had extensive online meetings where we talked about our understanding of mental health concepts and the in-person meetings were very important because they gave us the chance to relate on a more personal level, besides thoroughly discussing every facet of the content we created. The passion and dedication we each have for the topics were our main drives for carrying the conversation in a way that will help us create qualitative outcomes. We stayed open, curious about the others' perspectives, and willing to learn from them. We found consensus about working methods and common ground about concepts, but we also respected and maintained some differences. Our goal was not to uniformize our views, but rather to create a wider vision that encompassed them all.

CHAPTER 3

Good Practices examples of inclusive support of people with severe mental health challenges

In this chapter, we present some of our work to demonstrate that our philosophy and what we stand for can be applied in real-life situations, bringing positive outcomes.
Detailed descriptions and testimonials from the people who have benefited from those practices, can be found at the end of the Methodological Guide.

#1

Title of the Practice

Personalized Projects for Rehabilitation

(see Annex here)

What it is

Personalized Rehabilitation Projects are designed together with the person and not for the person by those who "know better".

Why it is a Good Practice

Professionals and people with mental health challenges are working together to plan the future. Different opinions are equal and the final projects are the products of collaboration. In this way, people are aware & thus engaged in their recovery plan.

Where and When

Reggio Emilia, Italy, L'Ovile Social Cooperative.

Since 2007

#2

Title of the Practice

Low-threshold service

(see Annex here)

What it is

People can address the service directly, without the need for specific -medical- criteria. Personalized support is given immediately.

Why it is a Good Practice

Mental health challenges are seen as something wider than a diagnosis. Direct responses preserve peoples' self-dignity since they do not view themselves as lost cases with no place to go. Quick interventions prevent people from becoming long-term users.

Where and When

Reykjavik, Iceland, Hugarafl

Since 2003

#3

Title of the Practice

Inclusion in decision making

(see Annex here)

What it is

**Every member participates in the decisions that affect the organization, from everyday issues to choosing policies and media strategies.
Equal participation regardless of personal characteristics is secured through transparent information.**

Why it is a Good Practice

**People are connected to each other and together they are part of something bigger.
Everyone's opinion is accepted and valued. People gain knowledge and social skills.
Equal participation minimizes power imbalances and empowers people.**

Where and When

Reykjavik, Iceland, Hugarafl

Since 2003

#4

Title of the Practice

Self-directed recovery

(see Annex here)

What it is

**People are free to choose the activities and support they feel best suits them.
Both professional and peer support are offered.**

Why it is a Good Practice

**The personal meaning of recovery is recognized.
It builds people's self-confidence, commitment, and ownership of their recovery.**

Where and When

Reykjavik, Iceland, Hugarafl

Since 2003

#5

Title of the Practice

Journey to Work

(see Annex here)

What it is

Supporting young people from sensitive social groups in getting and improving new knowledge, skills and qualifications facilitating personal development and responsibility and to ultimately finding job opportunities.

Why it is a Good Practice

**"Work is Treatment, Treatment is Work": being active and working is a very good treatment and is healthy in numerous ways as it promotes social inclusion, and feelings of personal worth and it creates a better economic background.
Going out of the "comfort zone" encourages a change, a new perspective on work, & personal growth.**

Where and When

The Netherlands, Dutch Foundation of Innovation Welfare 2 Work

Since 2018

#6

Title of the Practice

The way we talk

(see Annex here)

What it is

Use of non-medical, inclusive, everyday language.

Why it is a Good Practice

The use of a common, everyday language creates equal relationships, promotes self-determination, minimizes labeling, stigmatization, and exclusion.

Where and When

Athens, Greece, ANIMA Psychosocial Rehabilitation Unit, ANIMA NGO

Since 2006

#7

Title of the Practice

Daily activity at Anima's Psychosocial Rehabilitation Unit

(see Annex here)

What it is

The residents of the unit are encouraged to speak their minds and to state their wishes or needs when organizing everyday planning.

Why it is a Good Practice

Shared planning of daily activities creates a nonmedical environment and minimizes power imbalances. Through taking responsibility for everyday decisions people are becoming freer and independent and this is a core element of empowerment.

Where and When

Athens, Greece, ANIMA Psychosocial Rehabilitation Unit, ANIMA NGO

Since 2006

#8

Title of the Practice

Crisis management

(see Annex here)

What it is

Mental health crises are not considered a medical situation that needs specific responses, instead they are placed in the broader context that shaped them. People are encouraged to express their feeling and thoughts and to choose the type of support that they need.

Why it is a Good Practice

Crises are gaining a meaning instead of a label. No coercive practices are being used, as people are actively involved and their wishes are respected. Crises are managed outside of medical contexts, helping the person maintain their roles and relationships & reducing stigma.

Where and When

Athens, Greece, ANIMA NGO (Psychosocial Rehabilitation Unit and Community Service)

Since 2006

CHAPTER 4
Critical elements of Good Practices

Exchanging examples of Good Practices is a very good way of sharing knowledge and moving forward. Through learning about Good Practices, existing services can have an evaluating point and new services can get inspired and have a plan on how to get organized.
Even for unique people, not necessarily mental health professionals, Good Practices can serve as a way to further their knowledge and improve their understanding.

The issue with Good Practices is that they work under specific situations, so their generalization or their reproduction under different conditions is not always possible. So, what can we get from Good Practices examples that has actually a practical use?
That would be to take the specific elements that constitute each practice and incorporate them into the different settings we find ourselves in. Thus, in this chapter, we point out the single elements that make us believe that the presented practices are “Good”.

We hope that anyone reading this Guide can get inspired by those elements and will find new ways of including them when supporting people with mental health challenges.

1 Respect and Acceptance

No matter the situation in which people are, they deserve to be treated with respect. Different opinions, values, experiences, or meanings must be accepted.
Feelings of being heard, respected, and accepted help overcome the gap between people with mental health challenges and professionals created by long experiences of institutionalization in mental health structures.

2 Honest belief in people's strengths and potentials

The only way people can recover is if we (as in society) believe that they can. No intervention, program, or service can meaningfully support people with mental health challenges if at their core they believe in the narrative of the “chronic mental illness”.

3 Nonmedical language

Using everyday language may seem like something of little importance, but actually, it creates an open environment, where mental health challenges are understood as a human experience and not as something mysterious and confusing. Additionally, avoiding medical language minimizes power imbalances since professionals and people with mental health challenges do not have to carry those heavy and opposing identities.

4 Meet with the people and not the diagnoses

Diagnoses are a medical language, that can be helpful for professionals to communicate but they have little to offer when supporting people. On the contrary, they can limit our understanding and create a barrier in the relationships. Good practices examples do not focus on them, but instead they try to know the people with their personal and unique challenges.

5 Tailor-made interventions

Interventions addressed to persons with mental health challenges proposed in good practices are designed and implemented according to the specific needs, goals, and competencies of each person - and not as the same recipe for everyone.

6 Strong collaboration between operators and beneficiaries

People with mental health challenges are working together with professionals in designing and implementing interventions. The exchange of views between them and professionals is crucial to the empowerment process.

7 Promoting self-awareness

In order to follow their recovery plan, people need to be aware both of their strengths and weaknesses and they should be free to create their understanding and meaning of what makes sense to them.

8 Active participation of each person and responsibility for their own lives language

People with mental health challenges need to be at the wheel and make the decisions about their life, in every aspect.
Professionals, friends, and family's job is to accompany the person in their personal path, in order to support empowerment and ownership of one's own recovery.

9 Placing the mental health challenges in the environment that they occurred

Good practices reveal the importance of interventions' design and implementation focused both on the person and the surrounding system. This way the "problem" is not placed on the single person and the challenges can gain meaning.

10 Information and consent

People with mental health challenges, like everyone, must be properly informed about everything that affects them.
Hiding information or making decisions for them "because they do not know what is best for them" is a violation of human rights and does not help recovery in any way.
People need to be truly informed before every step and their decision must be respected.
No form of therapy must be applied without the informed consent of the person receiving it.

11 Inclusion in everything!

People with mental health challenges, like everyone, can only be truly accepted if their opinion is valued on every matter that affects them. So, from day-to-day activities to choosing therapy and making decisions about mental health the service, people must always be asked and encouraged to express themselves and participate.

CHAPTER 5 Conclusion
Ways to move forward

BEFORE we conclude and finish our guide, we first want to point out that we have made our analysis after the compilation of all the information gathered.
This work has been developed because we think there is a need on the change of narrative about people with severe mental health difficulties (SMHD); how they act toward themselves and also how professionals address this target group.

The aim of this guide is empowering people with severe mental health difficulties and actually include them and acknowledge them in their own education and treatment process.

To us, as professionals there was a need of changing the way of speaking, the narratives and the words we use when we are referring to people with lived experience. Changing this, we will avoid taking part of the stigma and narrowness that certain words and diagnosis can bring to them, this will help to act in an inclusive manner.

After all this processes, one of the most important things are the lessons learned, what do we want to achieve and include after the development of this guide. One lesson is that we share a common ground, we will be able to integrate different mind-sets and perspectives. In this project there have been different professionals coming from diverse backgrounds and countries who have been able to reach a common ground of understanding to create a real tool for integration, that can be also achieved by using this guide in the future.

Empowerment comes from within and it expands towards people with lived experience. They have to believe in themselves and despite the diagnosis and their situation be empowered to achieve what they strive for. To really help with this empowerment, professionals, caregivers and supporters have to be open minded and in some cases, even forget what we have learned previously. The way to really empower people with lived experiences is hearing them in a real way, addressing the issue as: Tell me how you think I can help you.

CHAPTER 5 Conclusion
Ways to move forward

ANOTHER important lessons learned is that we have come up with the constructionism; building something together.

The way to empower, to create real inclusion is to be part of the process along with the person with lived experienced, not take for granted what they need and tell them, but speaking, creating and constructing a process in which they feel included, valued and heard.

And of course, going out of our comfort zone, out of what we use to do, have been doing in the past.

All lessons learned have helped us to change our mind-sets in some ways, the way we address a situation, a feeling and the possible emotions a person is facing regarding the mental issue that s/he is going through.

We can conclude that even when we come from different backgrounds, countries and professional experiences we are fighting and pushing for the same cause, for improving the same situation. We push and pull each other forward, as said before, building together is the way to create a real empowerment.

After this work, analysis and development we do really believe in the continuity and sustainability of this program, that has much to offer to the mental health sphere and social care domain.

ANNEX
Good Practices

Personalized Projects for Rehabilitation - L' Ovile

What it is

A Personalized Project for Rehabilitation is a plan that a member of the team and the person write together after more or less 2 months of knowing each other.
It starts with the identification of the personal abilities and difficulties, general and specific objectives for the personal work to do in the community with the help of the team, considering the desires and priorities of the person. It lasts more or less 3 or 6 months, after this period the parties agree upon the prosecution of part of the project or revise it putting other objectives if the first are achieved or not more interesting for the person.

The project contains the objective the person has, so it takes place in the community (weekly meetings with the referring professional) and outside – whether the person goes out for personal purposes like a job or sport or others.

It's a recovery-oriented approach, meant to support and accompany the person in their personal path. It's an agreement between the parties, the person doesn't withstand passively to an imposed program. We are firmly convinced that change and recovery can be pursued only if the person feels and agrees with the objectives. It's a continuous exchange of views.

In the Community live 11 male users with SMHD, some with a forensic past. Everyone has their own Personalized Project for Rehabilitation.

The objective is to identify personal abilities and difficulties. The former are seen and used as a resource, the latter correspond with the areas to work on. Another goal is to become conscious of personal fragilities and objectives well placed in short-mid-long time.

The final goal is to achieve a better personal knowledge and consciousness, to be aware of their own fragilities, and be stronger while going out of the Community.

Personalized Projects for Rehabilitation
L' Ovile

What it is

In the last period, the team decided to adopt a recovery-oriented approach, also aligning the structuring of the PPRs.
The aim is to cooperate with the person in the drafting of the project, starting from the personal needs and objectives and mediating where necessary, in order to increase awareness of the person's strengths and weaknesses.

Each person in our community has a PPR formulated together with their reference operator and shared with the team, so as to have a framework and short, medium and long-term objectives that serve as a reference in everyday life, as well as a shared outline of the steps necessary to achieve them.

Every 3 months each member of the team compiles a mini-icf on the progress of the project and on how he/she sees the person. Every 6 months the PPR is reviewed, first by holding a specific meeting with the person and then by drawing up a report on the progress of the objectives, sharing it also with the psychiatrist of the mental health service on the territory. In the following project it is decided whether to maintain some objectives not achieved or only partially achieved, in order to work in continuity.

Key success elements

The strength of Personalized Rehabilitation Projects lies in their being designed together **WITH** the person and not for the person by those who "should" know the theory better.
This modus operandi creates greater awareness and adherence because the professionals and the person work together on the opportunity to develop new skills and improve.

We are **inspired** by the association “Il chiaro del bosco”
(Homepage - Recovery (ilchiarodelbosco.org) for the recovery part.
We work in collaboration with the departments of mental health,
NHS (Centri di Salute Mentale - AUSL RE).

Site: www.ovile.coop

ANNEX

Good Practices

Low-threshold service - Hugarafl

What it is

You can become a member of Hugarafl quickly and benefit from the services, there is no diagnosis required and no referral. We don't work with specifications like "severe, chronic etc" . The person decides for themselves if they need or want our services.

You must follow the ethic code: **respect every member, respect confidentiality, use non-violent communication, no using alcohol or drugs. And while people can use it as a sanctuary, it is goal-focused on recovery.**

As a result, we have a lot of members. People are not kept waiting in free fall for support in their recovery. By giving support early, we can prevent people from becoming long-term users of the service system and even hospitalization. By being accepted quickly, people do not experience the rejection of not fitting in the box like for some other services, and it can help preserve a person's self-dignity where they do not view themselves as a lost case with no place to go in their recovery. The goals are to ensure accessibility, that every person who needs the service can find it and access it immediately and to fill in the gaps that are left by other mental health structures.

We keep track of people who register and who attends in groups and in-house to evaluate the quality of the meetings and our services. We post anonymous questionnaires regularly to gather feedback on our meetings (after every module of six weeks.)

The practice takes place in Hugarafl, including 150-200 adults every year who are recovering from mental health challenges or from difficult times in their lives.

Low-threshold service - Hugarafl

Key success elements

1. **Providing the service when it's needed**
2. **Seizing the opportunity for growth and change**
3. **Preservation of the person's dignity.**

Testimonial

"What has made my recovery possible is that I have a service that I can count on when I need it.
For me it is important when I experience a crisis that I have a service that grabs me at that moment. If I am put on a waiting list my crisis might develop into a more serious situation.
My crises are also an opportunity to develop new skills and make progress and if I don't get the support I need I kinda miss that opportunity. Low threshold service where I can get assistance fast and on my time terms is a valuable safety net for me that keeps me from having to use more heavy service to maintain good mental health."

Site: www.hugarafl.is

ANNEX
Good Practices

Inclusion in decision making - Hugarafl

What it is

It is a consistent practice of decision making: people can exercise this at least once a week, in the main meeting of Hugarafl where everyone is encouraged to attend and different matters are being decided on, like the schedule, projects we get involved in, the position we take on different policies or what's going on in the media. It is a democratic process, where every member has a vote.

It can be about very simple matters like where we place the cups in the kitchen, but also about more complicated matters like how to respond as an organization to a wrongful portrayal of mental health matters in the media.

The goal is to support people to (re)gain their personal power.

This practice produces faster and better results towards personal recovery by giving a voice and decision power, by acknowledging that everyone's opinion matters. It can restore things that have been taken away, like dignity, confidence, agency. It creates a sense of belonging and gives people the feeling that they are helping to build something.

The practice takes place in Hugarafl, including 150-200 adults every year who are recovering from mental health challenges or from difficult times in their lives.

Key success elements

1. **Constantly encouraging participation in decision-making**
2. **Non-discriminatively, regardless of age or other characteristics**
3. **Transparent information, everyone having the same amount of information on each matter being decided on**

Site: www.hugarafl.is

ANNEX
Good Practices

Self-directed recovery - Hugarafl

What it is

The person chooses for themself what is going to benefit them in their recovery, instead of chasing some standards of recovery that someone else sets for them. Different things work for different people and deciding for yourself what will benefit you is an empowering experience.

When someone becomes a member of Hugarafl, they are presented with the available group activities and individual support and they choose what to attend to, either from the professionals in the organization or from the peers. There is a weekly "rehabilitation group", where participants are invited to set goals for the week related to their recovery plan and to discuss their progress.

The result is a high rate of successful recovery. People graduate from our services when they feel they have accomplished recovery. People learn a lot about themselves, enjoy better mental health, and develop different skills.

The objectives are to support empowerment and ownership of one's own recovery, which helps the person be more committed and therefore more successful in their recovery.

The practice takes place in Hugarafl, including 150-200 adults every year who are recovering from mental health challenges or from difficult times in their lives.

Key success elements

1. **It helps build people's self-confidence, commitment and ownership of their recovery**
2. **It is an opportunity to learn with and from the peers you share your recovery steps with.**

Site: www.hugarafl.is

ANNEX
Good Practices

Journey to Work
Dutch Foundation of Innovation Welfare 2 Work

What it is

Journey to Work is a Dutch-Scottish collaboration, between the Dutch Foundation of Innovation Welfare 2 Work (DFW2W) and Werkcenter Scotland which is built on award winning good practices Werkcenter Papendrecht (IDELE 2006), Future Move (2012) and Future Move Part II (more details here).
The Scottish Government specifically requested to formally start up a similar youth employment scheme in Scotland.

Journey to Work was designed to address structural causes of youth unemployment. Joblessness lasting more than 6 months is a major factor preventing young people with fewer opportunities and young people with special needs from getting (re)hired, with potentially grave consequences: lost production, increased social spending, decreased tax revenue and slower growth. On a personal level the impact on the young job seeker is no less devastating and includes; loss of confidence & self-reliance, depending on social benefits, etc. In any given month, a newly jobless young worker has about a 20 to 30 % chance of finding a new job. By the time they have been out of work for 6 months, though, the chance drops to 1 in 10. The skills mismatch on youth labor markets has become a persistent & growing trend.

Many of these young people are young people with special needs (mental issues , health issues, depression, borderline, etc.) and fewer opportunities, early-school leavers, lacking qualifications, relevant skills & work experience. More and more it affects third-level graduates who cannot find a first job as well. Nordström/Skans (2011) show that an unemployment spell of more than 51 days after graduation increases the probability of unemployment 5 years later. By request of the Scottish Government (SG) & Edinburgh Capital City Partnership (CCP), Skills Development Scotland (SDS), Ingeus and the Joined Up for Jobs network we will do anything in our power to support recent graduates from VET-schools in their Journey to Work.
That's why Werkcenter Scotland in collaboration with DFW2W have already run six KA1 project applications. Currently, Journey to work 6 is in progress.

Journey to Work
Dutch Foundation of Innovation Welfare 2 Work

What it is

Journey to Work believes that being active, working is a very good treatment and is healthy in numerous ways: Work is Treatment, Treatment is Work.
More than 350 young people with special needs and fewer opportunities have completed the Journey to Work Programme. Each flow was with around 6 participants.. Experience learns that you have to recruit up to more than 3 times as much to be able to recruit eligible young people.

Journey to Work's 1-2-3 methodology ("EU Good Practice 2006, 2012 & 2014") delivers work experience to young people with fewer opportunities as they are asked by potential employers about their work experience before they even have the chance to obtain any work experience.

The approach is to support and guide young people with special needs and fewer opportunities in getting and improving new knowledge, skills and qualifications to facilitate personal development and responsibility to obtain basic work experience and qualifications and/or participation in the local, national and EU labor market.
We place the young people on a structured Journey to Work.

The 1-2-3 Methodology of Journey to Work has 3 phases:

In the assessment phase the preparation training of Journey to Work takes place.
This is required to get the young people ready for the internships abroad.

The key success elements:

The intensity of the Journey to Work programme empowered the above 3 key elements really stand out. The 6 weeks of working and living in a new surrounding, a foreign country (Holland) accelerated the personal development and own responsibility of each young person, more than you could have achieved in a year in the UK.

The employment statistics are: An average of **80%** of young people are into jobs (5 years, covering six Journey to Work programmes).
Journey to Work 6 is still work in progress.

Testimonials

The Journey to Work statistics only have meaning if it's backed up by good reviews of their participants.
The story of Jamie, 5 years after completing his programme 'From Work to Work':
Before 'Going Dutch' I was just your average unappreciative teenager leeching off their parents... I never thought I would start making a life from this programme but already I was starting to change' ... ' If it wasn't for the Going Dutch programme I would never have gotten anywhere near as far as I am.

Links

- The Journey of Jamie Alexander
- From Boy to Man
- A testimonial from Ally
- Keep Calm and Go Dutch

Site: https://fromworktowork.wordpress.com/

ANNEX
Good Practices

The way we talk - ANIMA

What it is

Ever since the beginning of our psychosocial rehabilitation unit in 2006, inspired by the Open Dialogue approach and other similar alternatives to the mainstream mental health system, we have initiated the following language to use inside the unit:

- We have denounced all labeling and diagnosing among the personnel and also between the residents and the staff, no one talks about symptoms, diagnoses, relapse etc.

- We do not accept the key terms “mentally ill”, “mental illness” or “patient”

- We describe everything we see in plain everyday language and do not use scientific terminology for mental health

This has led to a differentiated approach where residents feel more inclusive and accepted than in every other situation in their lives

The practice takes place in the unit and in all activities of the organization and involves all fifteen residents of the unit, volunteers and the personnel.

The objective is to break the exclusion consequence of the biomedical model and create an inclusive space regardless of the mental health situation of the person.

The practice is rooted in respect of human rights, the philosophy of organization around mental health and inclusive vocabulary, and respect for the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Our philosophy is reflected upon the following principles:

- Mental health is the well-being and the potential every person has to be able to receive satisfaction from their everyday life and not merely the absence of a problem or a disorder. Mental health is depending partially on each individual’s opinion of themselves and there aren’t ideals that each person should live up to.

- Mental health is strictly related to economic, social, cultural and political factors, e.g. suicide cannot be considered as a mental disorder in times of crisis, it’s a much more complicated issue of the society, that needs effective management.

The way we talk - ANIMA

What it is

We are strongly convinced that unconditional acceptance, empathy and genuineness constitute an environment in which a person can achieve the maximum of their potential without inhibitions and guilt and eventually achieve personal fulfillment.

Multifaceted information is the first step that can lead to proper healthcare and support for people with psychosocial problems.

Key success elements

1. **The inclusive vocabulary, the fact that we give space, acceptance as equals and respect for human rights. No need to separate between the “professionals” and the “sick people”, who someone can impose treatment on.**

2. **Also, it is very important to form a new normality. Having recognized that the main problems our unit’s residents face are chronic institutionalization and confinement, and not their "mental illness", we continuously work with them on a daily basis in order to help them regain the lost time and to "relearn how to live."**

Testimonial

“If we use medical terms it feels like we are in an institution or a hospital. The way we talk in the unit is more familiar. It feels like it is my home.” B.

Site: www.animahome.gr

Site: www.animacare.gr

ANNEX
Good Practices

Everyday activities - ANIMA

What it is

Everyday activities in the Unit are meant to empower our residents to take responsibility for their own lives and to become truly free and more independent. We organize them all together. Every morning right after breakfast, all residents participate in a group, along with the personnel, in order to decide what they will do for the rest of the day and how. Residents are encouraged to speak their minds and to state their wishes or needs so as to take into consideration in everyday planning. For example, the group decides on the walks, the food, the chores, and everybody is aware of the needs within the unit.

The practice involves all fifteen residents of the unit, volunteers and the personnel.
The goals are inclusiveness, human rights respects, equal participation, empowerment.

We follow the rules of psychosocial rehabilitation according to Ministry of Health and we stay faithful to our philosophy, which is reflected upon the following principles:

- Mental health is the well-being and the potential every person has to be able to receive satisfaction from their everyday life and not merely the absence of a problem or a disorder.

- Mental health is depending partially on each individual's opinion for their self and there aren't ideals that each person should live up to.

- Mental health is strictly related to economical, social, cultural and political factors, e.g. suicide cannot be considered as a mental disorder in times of crisis, it's a much more complicated issue that needs effective management.

We are strongly convinced that unconditional acceptance, empathy and genuineness constitute an environment in which a person can achieve the maximum of their potential without inhibitions and guilt and eventually achieve personal fulfillment.

Multifaceted information is the first step that can lead to proper healthcare and support for people with psychosocial problems.

We are constantly evaluated and improved in the light of our efficiency and effectiveness. In case something branches off, we change it and we take feedback both from residents and the personel.

Everyday activities - ANIMA

Key success elements

1. **The belief that each person, regardless of the psychosocial treatment they might need in order to improve their life, can become a productive member of society with equal rights**
2. **The belief in human freedom of choice**
3. **Rejection of violence in all its forms, physical, psychological, verbal**
4. **The fact that we give space and we keep our words.**
5. **The vocabulary we use**

Testimonials

"I like the way we organize our day together. We need to have collaboration otherwise our [the residents'] day would be empty. The way we do it makes me feel that I am part of something, I am part of the group. If it was otherwise, it would feel like we are ostracized with nothing to do all day" B.

"The only other mental health unit I had been to before was a private psychiatric unit and I thought it would be pretty much the same here. It is so different! It is a house here! You even have pets and the tenants are taking care of them! I was in the living room and D. [name of a tenant] went to the balcony, she just took the mop, cleaned something and brought it back. That is a normal, house-like image. I did not expect to see that here!" C.

Site: www.animahome.gr

ANNEX
Good Practices

Crisis management in the Psychosocial Rehabilitation Unit or in the community - ANIMA

What it is

Whenever there is an incident of a crisis or an extreme state of being, regardless if it is about someone in the unit or a demand from the community (crisis intervention), following the philosophy of Open Dialogue, we approach the situation under these principles:

- We do not assume that there is indeed a crisis. We ask a lot of questions about what is happening and we want to gather information both from the person who is in crisis and whoever is around them.

- We do not go by diagnoses, labels, or medical information from the past, so we never accept demands as "the person has schizophrenia, please come quick". Instead, we expect descriptions of the actual incidents that are taking place.

- We encourage the person dealing with mental distress to express themselves and their needs and make some kind of sense of their experience.

- We give as many alternatives as possible and we propose different kinds of support so that the person involved has enough options to choose from.

- We do not impose anything, treatment, service, or other, and we do not propose forced hospitalization or forced medication.

- We try to understand how the situation has evolved in order to support the person and the people in their environment.

- There is no such word as "relapse" in our vocabulary.

At least two people respond to any community – based crisis intervention.

From our experience when people feel heard, accepted and respected, they feel more relaxed and the tension tends to deflate.

The practice takes place In the Unit or at the person's house, if we are dealing with a demand from the community. So far, the fifteen residents of the Unit (plus the past residents) and ten people from the community were involved.

ANNEX
Good Practices

What it is

Apart from the residents of the Unit, our approach is for everyone and we offer it on demand. Whenever someone feels that they are going through a crisis or something extreme they can ask for our support and we always respond, remotely or in person, regardless of who they are.

The goals are to prevent forced hospitalization and forced medication and to promote overall mental health model over the biomedical model.

The community is not informed about a different, humanistic approach in mental health and the power balance is leaning towards the biomedical model, so we are pressured to go along with traditional practices like forced hospitalization/medication. Although what we propose is promising, the reality puts a lot of pressure on the person and the family or friends to support the ineffective traditional biomedical model.

Key success elements

ANNEX

Good Practices

Testimonial

"Sometimes you are going through something and you need support, but maybe you cannot understand it at the time. The usual practice is that you end up being forcefully hospitalized. That is an abusive procedure...
Instead of getting help, you are getting abused. Having support at your house is way different, you don't have to suffer like that.
And also, the professionals meet your family... Maybe you are not the problem, but they and if you go to the hospital the doctors see only you" H.

Testimonial

"One can say a lot about supporting someone to get through a crisis, but for me, one of the most important benefits is that the person and the surrounding system are able to make sense of what is happening.
Crisis says something and if you suppress it and try to get rid of it without listening, it will come back, one way or another.
But when people have support to express what is inside them and make some sense of it, then they get stronger and they can truly move towards recovery and mental health." M.

Site: www.animahome.gr

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