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Best practice of Teaching and Learning

The „Best practice(s) Teaching and Learning“ are practices which contain new strategies in teaching and learning. Strategies which help people to reflect their experiences, to view their lives and stories from a new perspective and to develop new resources.

At the start of the project each partner has reflected his „Best practice(s) in teaching and learning“ and presented them to the other participants in the project.

Best Practice in Teaching and Learning of: Germany

1. What is your definition of experienced based learning?

What is its approach in respect of experienced based learning?

In the course the participants reflect their experiences, which makes them available as knowledge, and then share this knowledge with another, which enables each particpant to extent his knowledge from experience with that from the others (collective knowledge from experience).

Philosophy des Curriculums

Mental Health is a broad concept, which is based upon the wellbeing of all people in a community. Mental Health is a part of our daily life, which concerns every area of our private and social life, and as such she can be understood as a means to judge the personal situation.

Mental Health is also closely associated with phases and events in our life, in which she is shaked, or even completely lost, in which the circumstances require that we think a lot about and come to terms with our need for stability and wellbeing; and in which psychiatric help sometimes appear appropriate.

At such a time we need competent people, who not only take an interest in the special situation, the distinguishing experiences, but also in the influence which the "illness" has on ones health in terms of identity, relationships, possibilities and expectations. Which means that the experiences and hope of the user of psychiatric services are the key-element to the definition of the tasks and the organization of the health system.

As such the question of mental health is especially important to people who use psychiatric services and whose life is influenced by it. People with psychiatric experiences frequently dispose about a large amount of knowledge about themselves and about others, who made similar experiences, and also about which psychiatric services were more and which were less helpful. From this a special expertise develops:

> *"An "Expert by experience" in the Healthsystem is someone who has made aktiv experience with illness, disability, and/or psychiatric problems and who has acquired specific competences , to live with this illness, disability and/or psychiatric problems and can handle the soziocultural and institutional context in which the illness, disability and/or psychiatric problems are meaningful." (van Haaster, Koster 2005)*

The main concern in the participation of "Experts by experience" is the use of the individual experience as a resource. In order to do so the persons concerned must be able to reflect their experiences and the way they coped with them. This includes the willingness and ability to discuss their experiences with others as part of the reflection-process. In order to avoid a point of view which is based solely on the own individual experiences, values and assumptions.

> *"...to become an Expert by experience, it is necessary, to reflect the own experiences and share these with others, who have made similsr experiences. It is necessary, that the experts check and test their experiences in the comparison with other experiences , other situations and other people."*

Educational Philosophy

To avoid the mere reproduction of traditional knowledge and known explications, the project clearly hat the task to develop a course, which builds upon individual experiences.

The first step is to take the individual experiences of the participants as a starting point. Through the reflection and structuration of these experiences the participant can develop an experience-based "I-knowledge".

When we assume, that it is necessary to develop a shared perspective about what attitudes, methods and structures are helpful when supporting people who are in a psychiatric crises, then is it important that the participants discuss their experiences with each other, in order to develop a "We-knowledge". This way the experience of special psychic processes and psychiatric crisis's can be understood on a individual as well as a collective level.

Next to this approach it is important, that the EX-IN course encourages the development of abilities, knowledge and the application of methods. In the transfer of knowledge it is important, to reflect the theory on the base of experience. E.g. if someone would like to work as a teacher, it is important, that he or she knows, which contents and methods support a process in which people learn to understand the perspective of people with psychiatric experience. The EX-IN-Curriculum should strengthen the influence of people with psychiatric experience, their knowledge and their abilities on the psychiatric service-system (Topor, 2001). It should contribute to a better user- and recovery orientation and less discrimination in the psychiatry.

The project should also make a contribution to the improvement of the status of people with psychiatric experiences. We hope that the recognition of the course leads to improved possibilities of occupation and an appropriate payment of people with psychiatric experiences.

2. What do / would you call your best practice?

EX-IN

3. Please write a brief summary of your best practice.

EX-IN is a course with 12 modules, which qualifies people with experiences of crises and the mental health system for work (peer-counseling, peer-support, trainer). In the course the participants reflect their experiences, which makes them available as knowledge, and then share this knowledge with another, which enables each participant to extent his knowledge through experience with that from the others (collective knowledge through experience).

4. When did you start it?

The curriculum for the course was developed between 2005-2007. The first courses started in 2006.

What were the reasons / motives to introduce and continue your best practice?

The project is based upon the conviction, that people, who have lived through psychiatric crises, can use these experiences to understand and support other persons in a similar situation.

Psychiatry is frequently marked by a solely medical understanding psychiatric disorders and a medically focused treatment with psychological and social elements. Good psychiatric praxis is more and more defined by evidence-based treatment.

However there are a lot of aspects, which support people in their recovery process, which an evidence-based care system doesn't take into consideration and many users are dissatisfied with the services offered. Those concerned use many different social and individual resources when trying to get well again. In the science of Psychiatry science many of these are certainly considered as not evidence-based, but outside this particular field scientific acknowledgement exists, especially in fields, which include experience based knowledge.

People who have lived through psychiatric crises and use psychiatric services have an extensive knowledge about supporting attitudes, methods and structures, which is hardly being noted by the traditional care system.

Many studies (Davidson, Chinman, Sells, Rowe (2006); Hardimann, E.R.; Matthew, T.T.; Hodges, J.Q. (2005); Felton, C.J.; Statsny, P.; Shern, D.L. u.a. (1995)) proof , that the participation of people with psychiatric experience in psychiatric services contributes to more empowerment, a better development of social networks, more social activities, more responsibility being taken over, greater potentials for coping and problemsolving and more hope

The services offered become more flexible, offer a greater variety and hold concrete, practical information which is more recovery-orientated (Davidson, Chinman, Sells, Rowe 2005; Hardiman,
Theriot, Hodges 2005). The participation of persons with psychiatric experience enables a better understanding of the processes and the experience of psychiatric disorders and leads to new knowledge about recovery-processes. The participation of persons with psychiatric experience also has the potential, to improve the contents and structures in the education of psychiatric professionals and to lead to a better perception of the needs of the users of psychiatric services.

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What was your starting situation?

EX-IN was developed as an European project. In the countries participating in the project a variety of developments showed the increasing importance of the participation of people with psychiatric experience. People with psychiatric experience were having more and more work possibilities as a recovery-companion or teacher. One problem was, that because there were no structured qualification measures, the persons concerned didn't have a recognized status. The curriculum that was to be developed aimed to strengthen the participation of people with psychiatric experience and to provide a base for a suitable

employment. Therefor the main focus in the course had to be on the reflection of participant's own experiences and the acquisition of abilities and knowledge, which enable the delivery of qualified work based on the perspective of experience. However, it was deemed necessary that to ensure something lasting, also more research would be done on knowledge through experience and the coping strategies of people with psychiatric experience so that the organizations of the people concerned may be strengthened and the work done by people with psychiatric experience, the quality of education and the institutional framework conditions under which they work may be judged.

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International

The World Health Organisation (WHO) advocates and supports the participation of people with psychiatric experiences, as individuals as well as through organizations of those concerned, e.g. in the context of the development of a global forum for community Mental Health. Modeled on the European minister conference 2005 the WHO presented a regional paper in which they stated:

> *Involving service users and their families is an important part of the mental health reform process. The mental health system exists for people with mental disorders and their families, and they can and should make important contributions to defining what works and how the mental health system can be improved. The evidence also demonstrates that the active involvement of people with mental disorders and their families improves the quality of services and care provided. They should also be actively involved in the development and delivery of education, to give mental health workers a better understanding of their needs.(WHO, 2005:107-108)*

The support the EX-IN-project received from the European Union is a clear sign, that this process should be pushed. Crucial factors were the continuing expansion of the influence of people with psychiatric experience as a service provider and as a trainer, not only of professional people, but also of other people with psychiatric experience.

National

In Germany the law was changed in January 2004 in order to lay down formal participation of patients in the Health System. Patient organizations take part in the decision-making process of joint federal committee without having the right to vote. Besides this there were many regional Agreements about the participation of people with psychiatric experience in the service system.
There were no official standards zu user participation, but in more and more areas the perspectives of people with psychiatric experience and their organizations were gaining importance. There had been an increase in experience-led projects, services and educational offers.

F.O.K.U.S. – EXPA

At F.O.K.U.S. the EXPA (EXpert PArtnership) exists since 2002. The EXPA is a competence pool in which people with mental health problems, their relatives and those working in the field of mental health unite together. Its goal is to improve the exchange between the people with mental health problems and those treating them and to raise awareness about the expertise in the handling of mental health crises and illnesses gained by lived-through experience. Politically they want to change the structure of the mental health system and the conditions under which treatment takes place. The EXPA as a contact body takes on work assignments, which are then divided among its members. In the early years work assignments were rarer and existed mainly of lectures.

5. Please describe your Best Practice

Which learning goal/targets does your best practice have?

- To offer the possibility, to develop and recognize the knowledge by experience which the course-participants have in scientific context.
- The improvement of psychiatric services in terms of a the support being more focused on the health and recovery of the people who use the services on offer.
- To create the possibility, that people with different experience backgrounds can participate in an educational program, which enables collective learning from experience. To give the experiences a meaning and to put them into reference to the experiences of other people, is the basis on which a substantial role in the psychiatric services and in the associated training programs can be taken on.
- To prepare the participants to pass on their experiences to others in different roles, whether in the work with individual persons, in teamwork, in the development of organizations, in research, in education and in the promotion of mental health.
- To further the participation of people with psychiatric experience in the mental health sector and the establishment of possibilities to test and extend the significance of such structures in the praxis
- To keep the awareness alive, that life is a continuing learning process and to prepare the participants for the continuation of their personal development after the end of the course.
- To encourage the personal development of the participants in a positive, appreciative, anti-discriminatory, person-centered way.

Which teaching and learning strategies do you use?

The applied strategies mirror the philosophy of the educational program. The acknowledgement of the individuality the learners and with it the diversity of learning stiles which are present in each group of learners, leads to a variety of teach and learning strategies, which take the needs of the individual learner into account.

One of the main concerns in the organization of the course is to put die experiences of the participants in the center of every module. The participants dispose of multitude of experiences with regards to mental health. These experiences are in the course of inestimable value for the development of the own expertise, which is why specific strategies are used to include these experiences in the learning process.

The participants should search themselves a personal mentor, who has enough experience to support them during the course.

During the whole duration of the course the trainer can be addressed, but the mutual support under the participants ist equally important.

During the course a great many of different teach and learn methods are being used.

The foundation for all the modules is the reflection of the own experiences. The modules consist of less formal sessions in which center on new learning processes and more formal presentations in which specific contents are conveyed.

Presentations by the participants themselves are considered to be a necessary part of the personal development.

As part of the course, participants – with the assistance of their tutors - are also expected to organize projects themselves. Innovative thoughts and ideas are being supported, as well as a more differentiated examination and an exploration of theoretical perspectives

encouraged.

In order to promote independent learning the trainers will have information available to further literature and learning materials.

Special attention is being given to group processes. In order to use them as a place of learning it is necessary to ensure that they take place under secure conditions, in which confidential relationships can be build, in which die participants can feel free to express themselves and in which feedback can be given and received in a constructive, agreed upon form and way.

The learn and teach atmosphere comprises ethic principles, which are among others: all participants should have the same possibilities to learn; the possibility to make constructive experiences; respectful handling of different opinions. The trainers as well as the participants have the duty to be discrete about the personal information of the others.

The Trainer-course, which was also developed in the EX-IN-Project, invites the trainers to promote the development of knowledge rather than to convey it. The EX-IN-Course is a learning process for the trainers and the participants.

The portfolio assists the participants to discover their personal qualities, who they are and what they want to achieve with the course. The portfolio offers a good overall view of the capabilities and competences. The participants are invited to describe them by answering specific questions. If someone wants to engage himself in the interest of people with mental health problems, if he or she wants to work as a advocate, as a researcher, or in Education, it is important to know where the own qualities lie and what one wants to achieve. That portfolio also contains a personal action plan for the further development of oneself.

Which (learning or teaching) methods are used?

Exchange of experiences in Paar- & Groupwork (small groups, larger groups, plenum) with and without presentations, brainstorming, mindmap, Powerpoint präsentations (also interactive), role playing, interviews, impulse lectures from guests, platform discussions, Flipchart and moderation cards, clips out of films, texts, cards with sayings, exercises out of the systemic therapy, exercises with manual tools, placements.

Which themes are addressed?

In the ground course the participants reflect and mutually share their experiences with regards to following themes:

1. salutogenese,
2. empowerment,
3. exclusion and participation,
4. recovery
5. trialogue

In the upper course the focus shifts a little, and as well as reflecting and sharing their experiences the students are given tools which help them to put their knowledge of shared experience into practice. The themes of the modules in the upper course are:

6. (peer)advocacy,
7. self-exploration,
8. assessment,
9. counseling and supporting,
10. crises management,
11. learning and teaching.
12. End-presentations

What requirements do the participants have to fulfill?

To be allowed to start the EX-IN course, participants (officially) must

- have lived through psychological crises
- have been an active participant in self-help, user or expert groups or in trialog seminars
  - or
- be in a situation in which the knowledge gained in the EX-IN-course can be applied in praxis
- be able to reflect his own experiences
- be able to share experiences
- have attained a certain level of self-determination
- not be in a acute crises

To get the certificate at the end, participants also have to

- do two placements. One in the ground course (minimum 40 hours) and one in the upper course (minimum 80 hours).
- make a portfolio in which they reflect their past experiences, take stock of their present resources, interests and needs / limits, and make a plan for the future.
- hold a presentation in the finishing module.

What standards does your best practice have?

- Every module must be led by a trainer team, which consists of at least two trainers, one with a professional background and one who is an expert by experience. Both have taken part in an EX-IN Train the Trainer course.
- To ensure a broad spectrum of experience there must be at least 15 participants, there is no official maximum, but 20-22 persons is regarded as the upper limit.
- EX-IN Deutschland e.V. validates all courses which fulfill the quality standards and issues the certificates for the participants of these courses.

6. What did you learn from your experiences with your best practice?

- The courses benefit the participants personally as well, but as the focus of the course is on qualifying people for work, not everyone who could benefit personally is able and willing to take part in the course.
- Learning through the sharing of experience is possible and makes the participants to "teachers" as well as learners. This strengthens self-confidence and increases the feeling of self-worth.
- It's important to ensure peer-participation at all stages and levels in the development of the project as well as when it is put into practice.
- It is important to have and control quality standards right from the start.
- Local partners and possibilities of financing the courses are important issues which one should start to address at an early stage.

What are the outcomes of your best practice?

Ex-In courses are now widely established in Germany.
After the first EX-IN-Courses, the EXPA expanded and received more work assignments as before. Since then the amount of graduates which has found a job has increased slowly but steadily. Many others have profited from it in their personal development.
The worth of “knowledge from lived through experience” is more generally accepted and its value has increased.

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7. How might these experiences be useful to the Empowerment College?

- In determining the target group.
- In choosing the contents and methods of the modules (some themes are the same or very similar).
- When considering quality-standards and their implementation.
- When looking for partners and ways to finance the Empowerment Colleges.

8. Is there anything else that is important in this context?

With EX-IN we not only gathered experience with developing and implementing a service offer of Rehabilitation through Education, we also gathered experience with experienced based knowledge and which conditions are necessary in order for it to develop.

9. List of Research or Literature in connection with your project:

Jahnke, Bettina: Vom Ich-Wissen zum Wir-Wissen: Mit EX-IN zum Genesungsbegleiter Neumünster: Die Brücke Neumünster 2012.

Jahnke, Bettina: EX-IN Kulturlandschaften. 12 Gespräche zur Frage: Wie gelingt Inklusion? (Neumünster: Paranus Verlag 2014.

Utschakowski, Jörg: Mit Peers arbeiten – Leitfaden für die Beschäftigung von Experten aus Erfahrung. Köln: Psychiatrie Verlag 2015.

Utschakowski, Jörg, Gyöngyver Sielaff and Thomas Bock, Thomas (Hg.): Vom Erfahrenen zum Experten: Wie Peers die Psychiatrie verändern. Köln: Psychiatrie Verlag 2009.

Utschakowski, Jörg, Gyöngyvér Sielaff, Thomas Bock, Andréa Winter (Hg.): Experten aus Erfahrung - Peerarbeit in der Psychiatrie. Köln: Psychiatrie Verlag 2016.

Wer, wenn nicht wir? Erfahrene verändern die Psychiatrie. Deutschland, Dokumentarfilm von Jürgen J. Köster, DVD.

WHO IF NOT US! Improvement in mental health by experienced involvement. Germany, documentation by Jürgen J. Köster, copyright by ciné-ci films, J.J. Koester, DVD

Co-funded by the Erasmus+ Programme of the European Union

Best Practice in Teaching and Learning of

GIP-Sofia, Sofia, Bulgaria

1. What is your definition of experienced based learning?

Our definition of experience-based learning predicates on David Kolb's formulation: "the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience".

Embracing this concept, we perceive experience-based learning as inductive learning – a process in the course of which particular lived experience is processed, structured, transformed and enriched with another type of knowledge in a way conducive to both its full-fledged internalization by the person's psyche, as well as to its extrapolation with a view to bringing in a positive change to the surrounding environment.

Practically, it is a circular process of analyzing the incoming experience and re-working it into concrete conceptualized knowledge to be applied in the internal mentality and external objective reality, entailing positive change and accumulating new experience that further goes through the same cycle.

At the same time, throughout this process the person acquires skills and attitudes that can be applied in other areas of life.

2. What do / would you call your best practice?

The underlying philosophy of all our activities and respectively – the psycho-social rehabilitation programmes, is based on building the person's capacity via education whilst treating them as equal and validating their knowledge and experience. Indeed, self-reflection, sharing, group discussions have always been encouraged and taking precedence over "lecture" materials, provided by the professionals. The latter have always tried to be partners in the process of recovery and not therapists or mentors.

However, the introduction of **experts by experience** practice via training and subsequent employment of the trained experts by experience as co-trainers and social workers in the programmes, run by GIP, catalytically elevated the experience-based learning to a qualitatively new level. Although it is very difficult to trace back the origins and progress of the whole process, we are positive about the results – a tangible change of the whole organization at all levels. We used to voice "declarations" related to equality and empowerment, but it was only after we acknowledged the value of lived experience as equal to the professional one **in practice** that people really understood their implications.

Therefore, we could say that the best practice at this point of development of our organization is the experts by experience training and employment, embodying the following key principles and characteristics: alignment with the people's needs; consistent with their individual circumstances and respecting their human rights and freedoms; structured and described in a program / methodology (observing certain rules); striving for quality; allowing for performance measurement and evaluation, respectively multiplication; constantly changing and evolving.

3. Brief description / goal of your best practice

The goal of our practice is to develop and implement at its best an educational program for experts by experience who would subsequently become a part of the team or of the teams of

other services/ agencies catering to the needs of people with mental illness.

In this respect, it pursues a threefold objective: improving the well-being of the involved experts by experience themselves; enhancing the quality of care and hence the recovery process of people from the same "target group" (by adding the perspective of lived experience, thus building rapport and trust, achieving better understanding of their motives and needs); changing the overall approach to recovery and support – i.e. changing the attitudes and convictions of trained professional carers, managers, service-providers, policy-makers.

4. When did you start it?
What were the reasons / motives to introduce and continue your best practice?
What was your starting situation?

The process of introducing the experts by experience practice in Bulgaria commenced with GIP-Sofia's involvement in a 2-year project, headed "The Missing Link: increasing social inclusion by engaging experts by experience", implemented in the period September 2009 – August 2011 in partnership with 5 other organizations.

Bulgaria's starting situation, as compared with the other 5 countries, was "lower" and we could not implement fully all the activities envisaged. Therefore, our ambitions were limited to developing and approbating an empowerment course for people with psychiatric background, encompassing the following modules: "Human Rights in Mental Health Practices", "Work and Career", "Illness and Symptoms", "My personal Story", "Work in groups" (92 classes).

GIP's participation in the Missing Link was a transcendent experience because it provided an effective mechanism for full-bodied realization of the organization's core values and goals towards humanizing care, empowerment, respect for human rights, organizing users' voice in a meaningful way. Thereby, a follow-up initiative in partnership with Initiative zur sozialen Rehabilitation e.V. (Germany) was inspired. It aimed at piloting the concept for experts by experience in social exclusion (November 2012 – June 2013) and resulted in the official introduction of the profession of an expert by experience in the national register of occupations and the development of the corresponding educational standards and training programs (960 academic classes).

Since then, experts by experience had always been a part of GIP-Sofia's team and they are already recognised as "colleagues" by relevant stakeholders in the field (state and municipal agencies, social service providers and helping professionals with whom they interact).
The truth is that the value of lived experience had not been thoroughly underestimated even before running these initiatives. Users of mental health services, former drug addicts, HIV-affected persons and representatives of other vulnerable groups had sometimes been used in the position of experts (because of their experience), but these had been separate ad hoc initiatives, without formal structure and vision. Neither had there been standardised training courses for those people in order to extend their experience and use it towards professional purposes.

5. Please describe your best practice:
Which learning goal/targets does your best practice have?
Which (learning or teaching) methods are used?
Which themes are addressed?
Which resources are used?
What requirements do the participants have to fulfil?
What standards does your best practice have?

Although “young”, the experts by experience practice had been undergoing various changes and modifications over the time and it is still evolving. The everyday practical challenges it brings provide food for thought and reflection, giving rise to introducing new developments, and yet, there are a lot of issues which, we feel, might have not received the best practical solutions.

It is still difficult to find the balance between:

- professionalisation of the position and, hence, the training itself – as the experts by experience are trained in social work topics, such as: case formulation and case management, social policies and programmes, etc.;
- processing and reworking the lived experience, and acknowledging the uniqueness of the position of the expert by experience, as compared to the expert by profession – primarily in delicate aspects like setting “boundaries” with clients (defining the subtle lines between friendship and good relationship of trust with clients).

Our experts by experience are still struggling to find their identity, as on the one hand they already feel as professionals, on the other hand – they are peers of the people they support, and on the third hand, they still have vulnerabilities related to their mental condition requiring therapeutic support. They feel confused and it is difficult to draw a clear-cut distinction between the supervision required in relation to their work and the support required by their mental illness. We have witnessed situations when some of them felt so healthy and “normal” (which is a positive thing) and after suffering a relapse, they were so deeply overwhelmed by shame, disillusionment and failure that it was difficult for them to return to work.

However, referring to the learning **goals of the training** for experts by experience, ideally after its completion the trainees are expected to have the following knowledge and skills:

<u>General:</u>

- to facilitate helping professionals in the process of establishing first contacts, evaluating the needs of their clients and creating individual care plans;
- to gather information about their clients’ needs of support in recovery, empowerment and social inclusion; evaluate their abilities, strengths and weaknesses;
- to help clients identify and assess existing community resources, such as legal, medical and financial assistance, housing, employment, transportation, assistance with transportation, daily care and others;
- to help clients use social services and support their integration into society;
- to provide support and counselling in crisis situations;
- to participate as co-trainers in seminars and trainings related to empowerment, recovery and social inclusion;
- to assist in evaluating the effectiveness of the measures taken by monitoring and reporting the effect of their application;
- to maintain contacts with other agencies for social services, schools and health institutions involved in providing information and receiving feedback on the overall condition of the users and their development;

<u>Social work – related:</u>

- to know the laws and legislation in the field of social security, social assistance; working with people with disabilities; promotion of employment;
- to know the specifics of recruitment agency: making contact between the unemployed and employers and vice versa;
- to facilitate mediation between their clients and social welfare services and relevant persons and institutions;
- to advocate for their clients’ interests with social institutions and organisations;
- to know and use the documentation mandatory for the institution in which they operate;
- to know and maintain the standards and criteria relevant for the social activities they

perform;
- to inform and guide clients about their rights and about the types of social services they are entitled to;
- to acquaint clients with the types of institutions for social welfare and their functions;
- to know and observe professional ethics in social work;

Expert by experience – related:
- to develop an identity of an “expert by experience”- someone who can use specific personal experience (of illness, in social exclusion) to solve professional problems;
- to be able to address various aspects of this specific experience and integrate them according to the emerging needs and tasks;
- to be able to share various aspects of their experience, if this can be useful for performing a task in a professional context;
- to understand and be able to explain the difference between an "expert by experience” and “expert by training” in psychiatry, psychology, social work, nursing, etc.;
- to be able to formulate and defend a position on a specific work-related problem which is based on their specific personal experience in mental illness.

Full curriculum:

Cycle 1:	**Controlling the illness and recovery**	**No. of classes**
Module 1:	Improving health status. Maintaining good condition and the state of well-being	30
Module 2:	Skills in healthy living	30
Practical placement 1:	Co-trainers in a module for healthy living	30
Module 3:	Controlling the symptoms on one’s own	90
Practical placement 2:	Co-trainers in a module for controlling the symptoms on one’s own	30
Module 4:	Psychopathology and social functioning	30
Module 5:	Recovery: various perspectives and experience gathered	30
Module 6:	Creating a recovery plan	50
Module 7:	Recovery-based evaluation. Planning for people in crisis	30

Cycle 2:	**From using to providing individual support**	**No. of classes**
Module 8:	Experience and participation	30
Module 9:	Empowerment in theory and practice	30
Module 10:	Peer support	30
Module 11:	Advocacy for people like you	30
Module 12:	Crisis card	30
Module	Seeking a job	50

13:		
Module 14:	Maintaining a job	30
Practical placement 3:	Co-trainers in a module for seeking a job	50
Practical placement 4:	Co-trainers in a module for maintaining a job	30
Practical placement 5:	Facilitating a club for job search	30
Module 15:	Basic counseling skills	30

Cycle 3:	**Collaboration and networking**	**No. of classes**
Module 16:	Trailogue	30
Module 17:	Tandem work training	30
Module 18:	Set-up group (a discussion group of expert-by-experience trainees, helping professionals, acting EEs (if possible) and representatives of the management of the service where the position(s) of an EE is (are) introduced that is aimed to discuss the roles of the EEs: mechanisms of collaboration and interaction with professionals, concrete practical cases, relationships, etc.	30
Practical placement 6:	Co-facilitating a set-up group	30

Cycle 4:	**Multiplication**	**No. of classes**
Module 19:	Training	30
Module 20:	Group work	30
Module 21:	Portfolio	30

As can be seen, the training comprises a “lecture” part (presentations, videos, written materials, factsheets, etc.), interactive forms (discussions, case studies, project work) and practical assignments (placements, internships). It is important to emphasise that **all matters are addressed/ taught from the perspective of personal experience** which entails a fair level of reflection, sharing, group work. For example, training in symptoms, hallucinations, hearing voices is equipped with strictly scientific (expert) knowledge, refracted through the lens of one’s own lived experience.

The material preconditions for the training comprise:

- a room seating 18-20 persons with chairs arranged in a circle and 1-2 smaller rooms

seating up to 10 persons with chairs arranged in a circle (for the training formats requiring work in small groups);
- projector with speakers and a white screen;
- flipchart or whiteboard;
- a lab/studio/ practice room – for the practical assignments.

The practical placements could be held in a social service where group work is provided, so that the future experts by experience can practice their skills in group training and facilitation.

The applicants for an experts by experience training are first invited to a structured interview aiming to explore the following areas: experience in mental health and overall life experience; experience in participation in various groups; personality; motivation for participation in the training; how critical they are to their mental health condition; level of insight to their mental health difficulties and awareness of their strengths, competences and skills in various spheres of life; expectations; etc.

The entry interview has been designed specifically to serve the purpose of the EE training selection process and it is motivated by the fact that the training itself requires investment of one's own experience; sharing with a group of other people; learning from one's own experience and the experience of other people; it is time-consuming and demands a lot of energy and efforts devoted to self-reflection, self-preparation, etc.

Although the training itself has a detailed program, sometimes "last-minute" bespoke solutions are necessitated, so that the course is tailored to the needs, interests, and singularities of the participants.

Basically, the training comprises the following main components: * learning and mastering practical skills demanded by the profession of an EE; * learning and mastering skills for team work and collaboration (including tandem work, conflict handling and resolution, communication, etc.); * learning and mastering skills for developing one's own personality (assertive attitude, presenting one's own "business card", etc.).

Although we have elaborated a 960-class program, it has never been taught at one go. Usually the initial training lasts between 5 days and 3-4 weeks, depending on the specifics of the group. If some of the people have participated in similar training as part of their rehabilitation programmes or they have professional knowledge acquired via formal training (degrees in social work, psychology, etc.), obviously they would not need to go through all modules of the course.

After the initial training for experts by experience each newly hired person in this position goes through additional induction training (within a month) and is assigned a coach who supports them along the way (whenever needed). Additionally, each EE is provided administrative supervision, as well as "clinical" supervision related to the cases they work on.

Each EE works in a tandem pair with a social worker, while it is possible for the tandem pair to change. Our experience has proved that in order to be successful in their position, experts by experience require ongoing support.

Also, it might be good for them to have their "therapeutic support" provided by a service provider different from their employer.

6. What did you learn from your experiences with your best practice?

- **What are the outcomes of your best practice?**

The main lessons learned from implementing the experts by experience training so far can be summarised in the following main points:

- The training should be aligned to the needs of the trainees (educational needs, self-realisation, etc.) – it is very difficult to adhere to the same design and contents of the training for each single group of trainees and very often (for good or bad) adaptation is needed.
- As the training draws on the personal experience of the trainees – asking them to be authentic, to share their personal stories and private aspirations, it is highly important that they feel safe and secure throughout the process – to be able to choose the level of their involvement, to have all information available regarding the training (in terms of contents and administration), to have mutually agreed and respected group rules in place, guaranteeing respect for diversity and tolerance during the educational process.
- Despite its flexibility and adaptability, the training needs to be structured, organised, to have a pre-determined programme in writing, clear time frame. Given the specifics of people with mental health problems who very often suffer personality disintegration, failure of life plans, etc., structured approach is of particular importance.
- As the training should allow for quantitative evaluation of the results, benchmarking against a control group and, respectively, multiplying the practice, we have developed measurable criteria (indicators) to assess its efficiency and quality: dropout rate; successful completion of the training rate; employment rate of the people who have completed the training. At this stage, the results of the most recent group of experts by experience are, as follows: 10% dropout; all people out of the remaining 90% applied for a position as an expert by experience on finishing the training and half of them were employed and managed to keep their job.
- Constantly evolving and changing – after the first "issue" of the training we have made changes in the "curriculum" in the direction of strengthening the area related to professionalising the position of an expert by experience – i.e. more in-depth knowledge and skills in social work and parallelly to this, we developed a programme for maintaining the job which could be fully applied by other social services employing experts by experience.
- One of the lessons learned is that additional efforts should be invested in working with the management and the team of the employing organisation, so that the environment is prepared to accept and integrate the expert by experience as an equal team member. It is also important to have succession and continuity – i.e. the knowledge should be transferable and persevere in the organisation.
- Ensuring quality – this is the least explored element requiring further efforts on part of our team.

7. How might these experiences be useful to the Empowerment College?

The developed training for experts by experience, as well as the psycho-social rehabilitation programmes could be used when elaborating the curriculum of an empowerment college.
Furthermore, our work on supported employment and particularly the recent serious involvement in the area of human rights oriented towards developing and piloting supported decision-making mechanisms for people with mental illness as an alternative to full custody, shall inform the development of high quality modules for the College ("My rights" and "Participation and social inclusion").

For the successful implementation of an Empowerment College we could also rely on synergies between the group specialised programmes (symptoms management, communication skills, etc.) as well as the training in key competences (computer literacy, English, Italian, Literature, arts, music, photography) that are run in GIP-Sofia's social services.

8. Is there anything else that is important in this context?

9. List of Research or Literature in connection with your project:

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Co-funded by the Erasmus+ Programme of the European Union

Best Practice in Teaching and Learning of:

ASUITS, Trieste, Italy

1. What is your definition of experienced based learning?

Experience based learning is the capacity of drawing from our own lived experience, to reflect on it and be in a real and authentic relationship with the other person. Every one has an experience based learning and be mindful of it enable the person to accept the fact that we have different experiences, belief systems and motivation. Be a "peer supporter" means therefore relying on this "lived expertise", which enable the person to work on him/her in a ongoing process of recovery.

We think that recovery is not just something for people diagnosed with a sever mental health problem but regards all the people that want to emancipate themselves and grow up. It is the responsibility and duty of each person that act/work in the "helping" sector to not take away hope from those that are in a difficult moment of their life.

Experience based learning is at the core of user movement, that claim the right for service user to be recognized as "expert by experience" ad therefor to have the same amount of power of professionals that are "expert by profession": user lead movements represent the mayor form of challenge to the medical ideology as they overcome the use of diagnosis and claim the dignity of their unusual belief and perceptions. They think that the right question in psychiatry should not be "*what is wrong with you?*" but rather "*what happen to you?*".

2. What do / would you call your best practice?

- Community based mental health services
- Aurisina Rems
- Personal healthcare budget system
- Recovery learning community centred around a recovery house
- Peer support workers
- Widespread day centre

3-4-5. Brief description / goal of your best practice

What were the reasons / motives to introduce and continue your best practice?
What was your starting situation?
When did you start it?
Which learning goal/targets does your best practice have?
Which (learning or teaching) methods are used?
Which themes are addressed?
Which ressources are used?
What requirements do the participants have to fulfil?
What standards does your best practice have?

1) Community Based Mental Health Services:
Trieste is an internationally known experience that started from the first closure of a psychiatric hospital in Europe (1971-1980) as a process of change of thinking, practice and services. The current organization of the Trieste DMH derives from the deinstitutionalization

of the San Giovanni Mental Hospital, which, in its heyday, had approximately 1200 inpatients. While phasing it out, a complete alternative network of community services was set up and today comprises the following:

- 4 Community-based Mental Health Centers, each looking after a catchment area of 50,000 to 65,000 inhabitants, all open 24 hours a day, with four to eight beds each;
- 1 one General Hospital Psychiatric Unit with six beds, mainly used for emergencies at night, with very short stays of usually less than 24 hours;
- the Habilitation and Residential Service, which has its own staff and liaises with nongovernmental organizations (NGOs) in managing approximately 45 beds in group homes and supported housing facilities at different levels of supervision up to 24 hours a day, as well as two day-care centers;

The DMH also collaborates with a network of 15 social cooperatives and promotes a number of programs provided by NGOs, for example, associations of users and caregivers, such as club-style centers, self-help centers, workshops qualified to provide cultural and educational activities, professional training, and cultural promotion on the issues of rights and citizenship. DMH human resources encompass approximately 210 staff, not including NGO support services for housing and community living.

This model of community-based mental health services has been implemented in the whole Region Friuli Venezia Giulia (1.217.864 population) as a regional model, based on “strong” comprehensive 24 hours CMHCs, capable to deal with the most severe conditions and to support clients in their ordinary life in a view of recovery and social inclusion.

2) Aurisina Rems (*engl*: Residence for the execution of security measure).
The date of March 31, 2015, following the Law 81/2014, has marked a historical transition with the final closure of the six forensic psychiatric hospitals in Italy. This law identifies a new pathway of care that involves small-scale high therapeutic profile facilities (Residenze per la Esecuzione della Misura di Sicurezza, REMS) instead of the old forensic psychiatric hospitals. The Law promotes a new recovery-oriented rehabilitation approach for the persons with mental health issues who committed a criminal offence, but lack criminal responsibility and deemed as socially dangerous.

The Friuli Venezia Gulia region has privileged a community based approach consistently to the principles of person centered services operating without seclusion or restraints procedures. Rather, the approach is based on the integration with local care and social services, in a framework of collaboration and shared responsibility at all the different levels. In this way, Friuli Venezia Giulia region has activated three REMS in the regional area, for a total amount of 8 beds divided in three cities: Pordenone (4 beds), Udine (2 beds) and Trieste (2 beds).

The Aurisina REMS, in Trieste, was open in 2015; it is a small unit in a daycare centre that operate “open doors” in co-production with the MHS of Trieste and Gorizia. The choice was made in order to maximize the therapiutic potential right because the unit it is well connected with the day center (and its social network) promoting activities and events that foster health and inclusion counteracting social discrimination and stigma.

3) Personal Healthcare Budget System:
Personalization has been one of the main themes in social and health care in the last two decades. Deinstitutionalization demanded, and at the same time made it possible, to create person centered responses to human needs. Many experiences in developing personal budgets have shown that it is not enough just to create services around a person but also to fully include them in the community. To engage service users and for them to fully integrate and connect with others there is a need for collective services that not only seek to empower the community but also make it possible for service users to gain more collective contractual power. An independent life is not really possible without social connections, comradeship and solidarity between people. Therefore, personalized health

budget are a shared tool which is able to support social inclusion, capability, recovery processes, facilitating cultural changes and qualification of economical investment.

In the last few years Trieste has built up the possibility of investing large sums of money to help service users through personalized healthcare budgets, by setting up person centered projects with the support of local NGOs. Nowadays 160 clients per year receive a personal budget in order to fulfill the aims of a joint and shared recovery plan in the areas of housing, work and social relationships.

The implementation of Personal healthcare budgets leads to the reduction of therapeutic communities and home-care like environments in favor of independent living opportunities. The personal budgets represented about 17% of the overall budget of the DMH in 2011, while about 4% is devoted to economic aid, training grants, leisure and projects with NGOs (s.c. extra-clinical activities).

4) Recovery Learning Community Centered around a Recovery House:
it is an experience promoted and supported by the MHD through the instrument of "Personal Healthcare Budgets". The collaboration between the MHD, social cooperatives, associations/NGO, family members, users and peer support workers is core of the experience. The Recovery Learning Community offers opportunities for individual service users, their family members and co-workers to work together in new way to examine their life stories and the importance to their recovery journey in a framework of co-production, inclusion and reciprocity.

Individual service users which spend a 6 month period at the Recovery House already receive support and treatment from the Trieste Mental Health Services, many of them hear voices and experience other unusual states but still have a distressing relationship with these experiences. Family members are fully involved in the program from the beginning. The Recovery House location is near San Giovanni Campus. It accommodates six in six rooms; it has a pleasant garden with scope for gardening and horticultural activities with a space for reflection and exercise. The house of Brandesia used to be a long term staying therapeutic facility for people with severe mental health problems. In 2015, through collaboration with the International Mental Health Collaborating Network it became a Recovery House. Over there, over the course of the six months staying, people develops a recovery action plan, local circles of support within their own communities to be supported in their recovery journey even after the staying at the recovery house.

5) Peer Support Workers:
the peer support workers project has started in 2015 with a 390 hours course for 14 service users, organized by MHD with ENAIP (Professional Training Institute). Presently, 6 of them have started a working experience in the field of mental health care, for the first time since the "helper" project. These "experts by experience" are pioneers in the system and their recognition has a groundbreaking value in innovation.

6) Widespread Day Centre:
The actions and activities of the Widespread Day Center address the re-socialization, participatory processes and user involvement, training, social and professional skills learning, working inclusion, well-being, body care and sports activities aimed at tackle stigma, gender-sensitive issues. The idea is therefore to promote social inclusion / integration of people with mental health issues through the development of expressive laboratories, arts and culture, literacy, education and schooling, across the city which are proposed in collaboration with local association and social cooperatives which are essential partners for the development and prosecution of the initiatives. The activities target specific assets:

- "Wellbeing" programs are aimed to awareness improvement, understanding and respect of our own body, stimulating the protagonism by promoting activities - group and individual - general physical education , the organization of courses and activities

relating to general motor skills.

- "Aggregation, socialization and inclusion" activities involve the support and the direct involvement of people or groups with the purpose of promoting the development of capacity and expressive/interpersonal skills other then the re-appropriation of a positive identity, sense of self and autonomy.
- "Self expression and fight to the stigma," through culturally expressive programs, with particular reference to workshops (theater, music, painting), in collaboration with theaters, public places, associations and other public and private entities, finalized to the organization of performances, exhibitions, theatrical piece, concerts and other activities at a local, national and international level.
- “Participation", activation of mixed groups, made up of family members and people with experience in the field of mental distress, as well as professionals, representatives of associations and citizens, in order to promote information and raising public awareness. They participate to the design and implementation of specific programs such as the "peer support worker course". They are actually particularly involved in the enhancement of the role of peer support worker in mental health services, the organization of self-help groups and the involvement in participatory research around service quality in MHSs;
- “Gender Specific" programs aim at growing gender awareness throughout the ongoing dialogue made of participation, exchange and peer support as well as through the 'impulse’ to cultural and awareness activities on gender issues in co-production with other associations and institutional organizations of the territory;
- “Training and job placement", enabling individualized paths of training, pre-training and job placement - supported by "training grants to work" or "individual health budget" - aimed at skills and competences development, in collaboration with the Municipality, the Province and local training institutions.

6. What did you learn from your experiences with your best practice?

A holistic approach:
in mental healthcare, the individual, and not the disorder, is emphasized. There are no patients or clients, but people that uses services for a period of their life. Social exclusion is seen as a result of the medical model with its particular language, hierarchical relations and structure. The ‘relational world view’ is expressed by the following:

- An individual’s needs are assessed on the basis of his personal story/history, which also addresses his social relations, from family to neighborhood.
- In order to meet the needs of a user, personal relations between care workers and users are considered central.
- Services are evaluated in terms of personal routes to recovery and empowerment. To back up this idea, the community service centre is open 24-7.

An ecological approach:
the emphasis is on the social context, the network and the social groups to which an individual belongs. Care is offered by the community, is outreaching, proactive and accessible, and aims at social inclusion. Care workers enter into relationships with the individual and his family, with housing services etc. The community centre offers prevention, as well as basic and specialist treatment for all users in the area for which it is responsible; because of its ‘territorial responsibility’ for users, the community centre cannot transfer patients with complex problems to other centers.

A legal approach:
there is an emphasis on the civil rights of individuals with psychiatric problems, both in a legal and a social perspective. To create a community which guarantees inclusion and the possibility that everyone can exercise their social rights, a support network is essential. Deinstitutionalization means having individual control over one’s own route to recovery:

- Citizenship should be interpreted as a social process that brings about individual and social transformation not a status but a 'practice', which is essentially the exercise of social rights (De Leonardis).
- Hence, it involves a re-distribution of power, and the exercise and development of capabilities (Sen).
- Basaglia affirmed that "recoverability" has a price, and is an economic-social fact more than a technical-scientific one.
- As we demonstrated in qualitative cross-cultural researches, a lived citizenship, 'having a whole life' can be captured to be at the heart of a recovery process, as stated by individuals themselves in their narratives.

The overarching principles of MHSs practice in Trieste:

The experience in Trieste, from 1971 to the present, demonstrates that it is possible to establish a network of mental healthcare services which are totally alternative and antagonistic to the psychiatric hospital, and which are able to respond to the needs of the local population.

The main principles which have inspired mental healthcare practice in Trieste for nearly 35 years now are:

- total opposition to any form of internment or confinement typical of asylum-based or institutional psychiatry;
- the overriding awareness of the paramount importance of the person's needs as the sole point of reference for the organization of the mental health services;
- the need to provide services which are cost effective and which meet overall healthcare budget requirements.
- These principles define a transformation process which is never linear and automatic, but which requires a constant and collective ethical, political, cultural and scientific effort. In fact, the work of deinstitutionalization cannot be enacted by decree but must be conceived – and carried out – as a process, a journey, in which anyone can take part and which involves personal and collective research, primarily practical initiatives and an ongoing verification by all the actors involved.

The following factors are indispensable in order to achieve a successful and effective strategy of community-based mental healthcare:

- a fundamental shift in terms of approach and interventions from the hospital to the community;
- shifting the centre of attention from an exclusive focus on the illness to the person and their social disabilities;
- shifting from individual to collective action focussed on the user and their context(s); a collective work strategy requires (at least) the following conditions:
  multi-disciplinary widening of the skills and abilities employed
  - enhancing/promoting the user's self-help resources
  - enhancing/promoting family resources
  - raising public awareness regarding the mythical nature of the concept of danger and other irrational prejudices concerning the mentally ill through primarily cultural initiatives that can provide a more positive social image of mental illness
    increasing greatly the collaboration of non-professionals
  - re-evaluating the effectiveness of exclusively biological therapies and orthodox forms of psychotherapy
  - utilizing the active forms of solidarity provided by the most aware, attentive and well-disposed social groups, as well as local institutions/agencies open to forms of collaboration
  - the "open door".
- the community dimension of collective action, ie. establishing a theoretical and organizational point of reference made up of a specific territory and population and the progressive assumption of responsibility and organization of the services based upon and referring to that territory and population, and not referred to a single institution

- the practical-affective dimension of the intervention, especially in terms of meeting even the most elementary needs of users and the paramount importance given to collective action in responding to these needs; improving even minimally the user's objective living conditions is of utmost importance.

What are the outcomes of your best practice?

Freedom in care, with no need for new asylums is demonstrated to be successful by a series of data and key-facts/outcomes:

1) Community based mental health services:

- The Trieste MHSs organization has become the regional model for all mh Services in Region Friuli-Venezia Giulia (1.200.000) but not for the whole country, despite the request of family and user organisations.
- Many organisations from all over the world visit Trieste every year (up to 900 persons as professionals, managers, politicians and stakeholders in general).
- The practice was recognised as an experimental pilot area of mental health de-institutionalisation by the World Health Organisation in 1974, became a WHO Collaborating Centre in 1987 and is reconfirmed as such until 2018. This means assisting WHO in guiding other countries in de- institutionalisation and development of integrated and comprehensive Community Mental Health services, contributing to WHO work on person centred care and supporting WHO in strengthening Human Resources for Mental Health.
- Because de-institutionalisation was so successful in Trieste, the community-based approach has been implemented in the whole Friuli Venezia Giulia region and is acting as inspiring model for services, organisations and countries in more than 30 countries - so far particularly in Europe, Asia, South America, Australia and New Zealand.
- Compulsory Treatment Orders (CTOs) discharge rates in the Region Friuli Venezia Giulia are one of the lowest in Italy, with 13 cases per 100 000 population per year compared to a national average of 17 (Ministry of Health, 2011). Moreover, about two thirds of people under the CTOs were treated within CMHCs rather than at GHPU, anyway with an open door policy.

ETHICS	EVIDENCE	EXPERIENCE
No restraint / Open door	Low rate of accidents and offense Low rate of compulsion / involuntary treatments	"Humane" negotiation Innovative practices to avoid closing doors Alternative crisis management Attention to welcoming serices and social habitat High degree of freedom

- Mental health services do no make use of restraint measures, such as locked doors and mechanical restraint.
- Suicide ratio has been lowered from 25/100.000 to 13/100.000 in the city of Trieste over the last 15 years, also as a result of a proactive prevention programme.
- Independent living (instead of institutional or residential care) is supported also for people with severe disabilities as regards to housing, work and social integration.
- The personal budget system is a great aid now: approx. About 160 clients per year receive a personal budget in order to fulfill the aims of a joint and shared plan of

recovery in the areas of housing, work and social relationships.

- About 180 people are in professional training every year on work grants, and 20-25 of these find proper jobs each year in the Trieste job market, many in the field of social cooperation and about a third in private firms.
  - The sustainability is demonstrated because the overall cost of services provided by the MHD is no more than 60% of the cost of the former asylum (with less than the half of staff, and the number of beds decreased from 1200 to 75). Personal budgets is about 20% of the overall budget of the DMH, while about 4% is devoted to economic aid, training grants, leisure and projects with NGOs - s.c. extra-clinical activities.
  - The number of people treated in a more humane system of care is more than 5000 as compared to 1200 in 1971.
  - Hospitality in the CMHCs replaced most of the admissions in the GHPU. Only one person spends a night in the hospital service for every 10 who spend a night in the Community Mental Health Centres throughout the year.
  - Crisis care in the community is effective and sustainable. All figures and rates concerning emergencies, acute presentations and crises decreased. Even the use of CMHC beds constantly decreased through these decades to 1/3 of the original value. Readmission rate to a CMHCs is about 30%.

2) Aurisna Rems

- There are no people in forensic hospitals from Trieste from 2006.
- After 18 months of Aurisina Resm: 5 people have been welcomed since June 2015. When the people arrive in Aurisina, welcoming, assessment and planning are made within the 45 days according to the law. This was done in collaboration with the territorial health and social services. There was maximum collaboration with justice in respect of reciprocal roles. It has always been claimed that “social dangerousness” is an aleatory concept; rather, dangerousness should be assessed in each single real situation. People have been discharged after about 6 months on average with respect to the juridical situation always with attenuated security measures and a individualised project planned in collaboration with the MHSs. The follow up is positive as there are is not been any case of reiteration. No one escaped/leaved Aurisina, no police intervention were ever necessary, neither hospitalisation in GHPU or CMHC. This proves the efficacy of the deconstruction of the aspects of restraint, segregation and sanction.

3) Personal healthcare budget system

- The personalized health budget, has shown remarkable advantages in terms of efficiency, effectiveness and, ultimately, cost-effectiveness. More specifically, it showed to be a viable tool to re-qualify and make social the healthcare spending, contributing to build a new welfare community. The partnership relations developed with private non-profit organizations, represent a strategical outsourcing for Public agencies. The process of shared decision-making that brings together many kinds of expertise, allowed to shift from a ‘gift model’ to a ‘citizenship model’ with the individual at the center of the service system. Finally, as Trieste’s experience is demonstrating, within this methodology, it’s possible to move conspicuous resources from residential structures to co-housing projects, supported work training and social programs, more closely to the concrete needs of people, contrasting new forms of institutionalization.

4) Recovery learning community centred around a recovery house

- The Experience of the Recovery Learning Community centered around a Recovery House has been one of the most important happenings of the 2015 in Trieste Mental Health Department and that was co-created by all the people involved though a democratic, bottom-up process. The 6 monthes pilot period lasted till November 2015. Today, 4 groups of young people have joined the experience and some people of the previous group have been employed as peer workers.
- There has been a partecipatory evaluation of the experience taking into account all the

different stakeholders. The results are positive on different levels (i.e. symptoms, recovery stages progression, subgective wellbeing, relationship with MHSs etc.). May 2017 will be the follow up for the first and second group to check whether the good results are mantained onece the person is out of the recovery house.

5) Peer support workers:

- There is a strong group in which people support each other. Many of the Peer support workers are employed by local social cooperatives: 4 of them works whithin the mental health centres in Trieste, organizing activities and self-help groups inside and outside the Centres. Some other peer support workers operate a in different circumstances such as gender specific projects (ie. “Una casa tutta per noi”, “Recovery House”, “Club Zyp” etc) or in the voulontary sector (ie. “Green Recovery”) and participatory groups/forum in mental health (ie.“Articolo 32”).

7. How might these experiences be useful to the Empowerment College?

- A ‘systemic’ vision has to be based on the person’s whole life. Creating personalised itineraries is the organizational-strategic key, in which the person has an active role and contractual power of negotiation. All the pathways of care are aimed at a program of restitution and re-construction of full rights of citizenship for individuals suffering by mental health problems.
- The subjectivitiy of clients, their life stories and their aspirations are considered as the main tools for providing treatments and developing services totally alternative to psychiatric hospitals.
- The community has to be an active part of the process at each single stage.

8. Is there anything else that is important in this context?

9. List of Research or Literature in connection with your project:

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Co-funded by the Erasmus+ Programme of the European Union

Best Practice in Teaching and Learning of:

IGPB, Amsterdam, the Netherlands

1. What is your definition of experience based learning?

Experience based learning is a process of learning that is based on reflection on ones own experiences. These experiences may be experiences from the past, but can also be experiences in the present. The learning process in itself generates new experiences which should be hopeful and constructive for a better way of life. In the process of experience based learning reflections are related to real actions in the real world.

Most of the time experience based learning processes in the context of 'recovery', are communicative processes in which one relates ones own experiences to the experiences of others. In such contexts ones individual recovery has the potential of contributing to the recovery of others, to the building of a community and to reinforce the users' movement. Becoming a "we" (1ste person plural), and being able to recognize oneself in others can be important aspects of recovery.

Users knowledge can be grounded in users practices which are more or less well defined as a method or a way of action, like a WRAP or a self-help group. What is learned is 'held together' by the structure of such a method.

In connection to 'recovery' the experience of ones own crisis(es) and the ability to relate to the crisis(es) of others is essential. Crisis experiences are the ground for learning. In order to grow one needs to relate to that ground.

Experience based learning doesn't happen in isolation. One needs to relate to the knowledge and perspectives of others, peers as well as 'professionals'. Think, for example, of the need to relate to diagnostic knowledge or knowledge about medication. In relation to experience based learning the role of the 'professional' is crucial. He or she can disrupt the process of experience based learning by taking decisions for a client, influence the client by authority based on schooling and positions, or manipulate the clients by his or her function as gatekeeper. In order to support experience based learning it is very important that professionals are aware of their own choices and actions.

2. What do / would you call your best practice?

Best practices in relation to learning are practices which speed up learning processes in a specified time schedule. If they are courses, these courses encourage people to reflect on their own experiences, and share experiences with others. These experiences may be from the past, as well as current experiences and actions. They encourage communication that deals with topics which are essential for recovery.

From the Netherlands we will introduce the Friends houses. Interesting about a Friends house is that current experiences and actions are actually there; it is a house where people live. With our choice for the Friends houses we want to give the topic of the relation between the communication during a course in a 'class room', and the life that people live outside of such rooms a place in our conversations on the Empowerment College. We are not saying that Friends houses are necessarily better for the recovery people than a 'class room' where people come to do a course, but we do say that the relation between the communication during a course and the real lives of people is essential for recovery. We would like to invite all participants to look at this aspect of their respective best practices. Probably concepts like

‘honesty’ and ‘thoroughness’ (compare with the program of the AA), are keys in the relation between the communication during a course, and peoples real lives.

A best practice is something different from a best idea. In a best practice one is allowed to make mistakes and a crisis or conflict is seen as a chance for learning.

In many practices this does not happen. When for example the communication in a practice is organized in such a way that everything is running smooth, conflicts and tensions are avoided, and the practice gets isolated from real life (in a therapeutically context) it may be difficult to generate learning experiences that relate to life outside. A best practice is a practice where the participants try to act according to common and human values and norms, but also where it becomes clear that this is an endeavour, which asks for an effort.

3. Brief description / goal of your best practice

4. When did you start it?
What were the reasons / motives to introduce and continue your best practice?
What was your starting situation?

5. Please describe your best practice:
Which learning goal/targets does your best practice have?
Which (learning or teaching) methods are used?
Which themes are addressed?
Which resources are used?
What requirements do the participants have to fulfil?
What standards does your best practice have?

Friends Houses (Vriendenhuizen, VriendGGZ)
Friends Houses in The Netherlands started in 2010. At this moment (2017) we have 8 houses in different villages and cities. They are houses where 8 – 10 people can live for some time. The residents are supported in recovery. They run a household together. They are supported also in administration, getting social benefits, finding a house, etc.

The Friends Houses are all part of a co-op called Vriend GGZ. The goal of Vriend GGZ is to offer ambulant support to people who have psychiatric and social problems and who have to take effort to participate in society in a, according to themselves, acceptable way. In terms of the German sociologist Jürgen Habermas one could say that the Friends Houses are a lifeworld and not a system. The practices of the different Friends Houses develop in communication between the people that live and work in that house, and is not so much a system imposed from above. The Friends Houses are a lifeworld where you can put on your life on track, where you can feel safe and where you can work on your personal, social and societal recovery. In the Friends Houses people run, together with peer support workers, their own household. People make different steps to participate in society like doing voluntary work, social activities, recreation, sport, and healthy living. In a Friends House people get the chance to develop themselves towards peer support workers who can work in a Friends House on a payed or non-payed basis. If you are a peer-supporter you are expected to support others in their recovery. If you are not or not anymore a resident you can ask for ambulant support, which is also oriented on recovery.

Recovery: self examination
Basis for recovery in a Friend House is that you discover yourself by learning about yourself and examine yourself. People are stimulated to do so. Examining yourself means that you look

at yourself, and accept that others question you. Examining yourself also happens via recognition in others. Peer supporters are role models and give examples about how you can work on your recovery, how you can deal with conflicts and emotions and how to find solutions that fit you best. Experiences with psychiatric diagnostics, psychotherapy and medication are important sources of knowledge which are shared among each other. Exploring yourself may be deepened by psychotherapies or in conversations with other professional workers who are able te create insight in for example the relations between a vulnerability or a survival strategy and an earlier life experience or trauma. It is not only the individual recovery history which is important, but also experiences with for example broken families, or exclusion. Working through these experiences in a Friends House are a start towards new and positive experiences in building a community.

Recovery: new roles

Supporting recovery means that you try to bring hope that recovery is possible. It means f.e. that you can learn to take responsibility for your own decisions and for your share in doing the household in a Friends House. Support starts from our own capacities and strengths, and the capacity to be in control over your own life. Support is not directed towards illness or disturbance, but to deal with your vulnerabilities. Most of the times this means that you have to learn to change non-effective or destructive survival strategies and that you have to look for new ways to deal with conflicts and emotions. It is an aim in the Friends Houses to make use of everyone's ability to learn and to develop and change, not only the ability of the resident, but also the ability of the (peer) supporter, the mental health professional, the family and those who are connected from the broader society.

A fundamental point is that the roles of everybody are interchangeable: everybody can ask for support or give support, everybody has needs and everybody can play a role to fulfil these needs and give attention to others.

A Friends House is not organized as a system world but as a lifeworld where you can learn to fill in your own life.Friends Houses should be safe for the participants, safe enough to deal with yourvulnarabilities, where you are accepted, where you can be yourself, where you find the time to recover in your own tempo and where you find the opportunities to connect to the others (to build a community). Taking care of the safety in the house is a responsibility for all people in the house, and in itself part of recovery.

Peer Experts

Peer experts in the Friends Houses make use of their experiences with personal, social and societal recovery, to generate hope en support each other. They are a role model for others and give examples how to support others, how to act as a peer expert, how to ask for support if necessary and how to accept support if you need that. All peer experts have their own self management plan in which they have written down what are their vulnerabilities, how they can be confronted with these vulnerabilities in their work as a peer expert, how they deal with that and how they want others to take account of it and deal with it in a supportive way.
Peer experts in Vriend GGZ donot have a strict and well described position and function which is laid down in their contracts. They work on the basis of what is asked from them by the residents. It is however important that they are present and generous, that they are able to communicate in an open way, and that they are aware of all opportunities to learn how to cope with problems, take responsibility for own choices and shared choices in the house.

Communication / Courses

Communication is supportive with a basic attitude of listening, and inviting to share experiences.
Not only experiences from the past, but also in the present, in the Friends House, in mental health care or in society. Communication is directed towards giving and receiving feedback. Techniques of non-violent communication and motivating communication are practised and peer experts are trained in an attitude to listen with an open mind, allow to take time, and understand others through recognition. A dialogue can be between two persons but also in

groups, for example in a house meeting where the state of affairs and the distribution of tasks in an Friends House is discussed.
Group meetings are also organized in training sessions or courses, like recovery courses. Examples are training programs on open dialogue, mutual support, and dealing with emotions.

Cooperation with other organizations
Friends Houses work closely together with other services in mental health care and addiction treatment programs, but Friends Houses do not offer treatments themselves. For offering treatments they are dependent on mental healthcare services. One of the endeavours of the Friends Houses is that residents who need special treatments, get a good access to these treatment programs and to take care that these treatments are supportive for recovery. Oftentimes one has doubts about this, especially when there is too much medical treatment or coercive treatment. Peer experts in the Friends Houses support residents to get access to good mental health care and they are discussing with residents what might be good care for them and how to discuss this with a doctor or therapist. If necessary a peer supporter joins a resident to a meeting where a treatment plan is discussed and decided. In practice it appears that different complications have to be confronted like limited accessibility of crisis help, use of coercion, to much orientation on medication and illness approaches while psychotherapy or trauma treatment would be more appropriate.

Friends Houses also cooperate closely with social services like those who deal with social benefits, insurances, housing, dealing with debts, etc. A lot of residents temporarily lack houses or income or have debts. When a person stays in a Friends House he or she is also responsible for paying rent, but this is of course impossible when there is no income. For those, first aid is dealing with getting social benefits. Residents with debts are supported to get access to a program on solving debts. People without housing are supported to get contact with housing companies. These are the first steps in societal recovery. Next steps are to take responsibility for the communal household in a Friends House. Living together often leads to some conflicts and everyone has to learn to deal with tensions or discontent in a constructive way, leaving behind old survival strategies. These are the main steps toward social recovery. For some it also leads to opportunities to work as a peer expert. This is possible in a Friends House but some may find a job as peer expert in another company.

Friends Houses and Society
Participating in society is a main goal forVriend GGZ. The Friends Houses are get budgets of the local governments which are meant to stimulate participation in society. The Friends Houses give opportunity to make friends, overcome loneliness, become part of a community, create new and positive experiences, work as a volunteer or even in a paid position as a peer worker. A lot of residents do not, at the beginning, feel to be part of society, have withdrawn from society, feel excluded or exclude themselves. Through a Friends House they make the first steps back in society and get control over their life. By being active in a Friends House and outside they contribute to society and may feel good about that too. The democratic processes in a Friends House lead to involvement and engagement. They influence society by being both critical and by offering an alternative to hospitalization, sheltered housing, and stranded mental health care. In its own way Friends Houses are small scale, warm, home made and also fragile initiatives, innovative and critical to exclusive cultures.

6. What did you learn from your experiences with your best practice?

Staying in a Friends House is for the person part of a process of recovery. People in a Friends House stay there, often for a longer period, because they have a problem with their housing-situation and/or the capacity to live independently. The risk is that they consider the Friends House as a ‘waiting room’ before continuing their lives. With this attitude it is possible that their stay in the Friends House becomes damaging, instead of a contribution to their recovery. No focus on recovery, and lack of in depth communication, can make Friends Houses into unsafe places where people act out their problems.

What are the outcomes of your best practice?

In 2016 we made an outcome review on the basis of an effect study. It shows that people come to a FriendsHouse with goals and motives which cover the range of personal, social and societal recovery goals. These goals are all specified in a list of 20 concrete statements. When asked to the respondents whether and to what degree they reach their goals, the majority of responders is positive (++ or +) and a small minority negative (-). When you compare the group with a certain goal or motive (f.e. making more friends) to the group of respondents who did not mention this goal, the positive effects are larger in the first group but also in the second group respondents report positive outcomes. This is seen as positive side effect. The majority in the second group answers neutral (+/-) = no change

7. How might these experiences be useful to the Empowerment College?

The Friends Houses are a context where we could test the empowerment college. In that case it is important to define the starting conditions for a course as well as possible because these conditions differ from a Recovery College. It is especially interesting to discover how a constructive relation can be organized between a recovery practice like a Friends House and an Empowerment Course.

Of course it is also possible to use the evaluative method used in the Friends House (describe the learning effects only on the explicated goals and motives of the learners).

8. Is there anything else that is important in this context?

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Best Practices in Teaching and Learning

Polish Institute of Open Dialogue

1. What is your definition of experienced-based learning?

The distinguishing feature of **experience-based learning i**s that the experience of the learner occupies central place in all considerations of teaching and learning. This experience may comprise earlier events in the life of the learner, current life events, or those arising from the learner's participation in activities implemented by teachers and facilitators. **A key element** of **experience-based learning** (henceforth referred to as EBL) is that learners analyse their experience by reflecting, evaluating and reconstructing it in order to draw meaning from it in the light of prior experience. This review of their experience may lead to further action.[1]

EBL is based on **a set of assumptions** about learning from experience. These have been identified by Boud, Cohen and Walker (1993)[2] as:

- experience is the foundation of, and the stimulus for, learning
- learners actively construct their own experience
- learning is a holistic process
- learning is socially and culturally constructed
- learning is influenced by the socio-emotional context in which it occurs.

2. What do / would you call your best practice?

Before I answer the question: what do we call our best practice? - let us look how Andresen, Boud and Cohen define the characteristics of Experienced-based Learning.

EBL does not lend itself to being reduced to a set of strategies, methods, formulas or recipes. It is possible, however, to recognise within it some features which characterise and distinguish it from other approaches:

EBL appears to demand that **three factors,** each be operating, at some level. These are:

i. Involvement of the whole person—intellect, feelings and senses. For example, In learning through role-plays and games, the process of playing or acting in these typically involves the intellect, some or other of the senses and a variety of feelings. Learning takes place through all of these.

ii. Recognition and active use of all the learner's relevant life experiences and learning experiences. Where new learning can be related to personal experiences, the 2 meaning thus

[1] Lee Andresen, David Boud and Ruth Cohen, Experience-based Learning, Chapter published in Foley, G. (Ed.). Understanding Adult Education and Training. Second Edition. Sydney: Allen & Unwin, 225-239.

[2] Boud, D., Cohen, R. & Walker, D. (eds) Using Experience for Learning Buckingham: SRHE and Open University Press

derived is likely to be more effectively integrated into the learner's values and understanding.

iii.Continued reflection upon earlier experiences in order to add to and transform them into deeper understanding. This process lasts as long as the learner lives and has access to memory. The quality of reflective thought brought by the learner is of greater significance to the eventual learning outcomes than the nature of the experience itself. `Learning is the process whereby knowledge is created through the transformation of experience.' (Kolb 1984:38)[3]

However, EBL varies in practice according to **three possibilities** which represent factors that may or not be applicable in a particular instance. These are:

iv. Intentionality of design. Deliberately designed learning events are often referred to as `structured' activities and include simulations, games, role play, visualisations, focus group discussions, sociodrama and hypotheticals.

v. Facilitation. This is the involvement of some other person(s) (teachers, leaders, coaches, therapists). When such persons are involved, the outcomes may be influenced by the degree of skill with which they operate. EBL often assumes relatively equal relationships between facilitator and learner, involves the possibility of negotiation, and gives the learner considerable control and autonomy.

vi. Assessment of learning outcomes; and in the event that assessment takes place, much depends upon by what means, by whom, and for what purpose it is carried out. EBL is often as much concerned with the process as the outcomes of learning, and assessment procedures should accord with this. Assessment tasks congruent with EBL include individual or group projects, critical essays located in the learner's own experience, reading logs, learning journals, negotiated learning contracts, peer assessment and self-assessment. They might include a range of presentation modes other than writing, so as to enable the holism, context and complexity of the learning to be evidenced.

Summarizing, Andresen, Boud and Cohen say that "**At the personal leve**l EBL draws on learners' previous life experience, engages the whole person and stimulates reflection on experience and openness towards new experience and, thence, continuous learning. **At the societal level** it emphasises critical social action and a stance embodying moral accountability and socio-political responsibility.

Now we can come back to the initial question: what do we call our best practice?

From Poland we will introduce a process called: **"Change the thinking. Change the practice. Change the system".**

[3] Kolb, D. 1984 Experiential Learning: Experience as the Source of Learning and Development Englewood Cliffs, NJ: Prentice Hall

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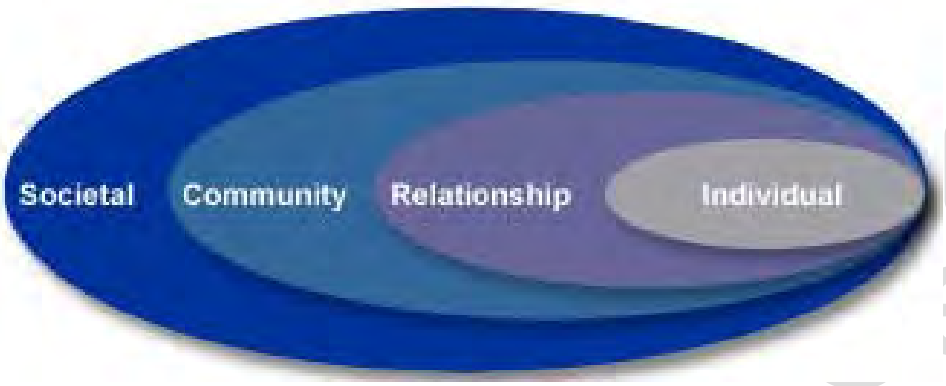
This practice is derived from **personal experience** of one person (the mother) who did not agree on the status quo of mental health treatment applied for her son. The mother was convinced, out of her former life experiences, that "whatever you vividly imagine, ardently desire, sincerely believe, and enthusiastically act upon... must inevitably come to pass![4]. This attitude let her start thinking that in XXI century there must be a better mental health treatment somewhere in Poland or even in Europe. She and her husband ware ready to learn and to act upon finding "better world" for their son. As they found **Open Dialogue**[5] approach in Western Lapland, with unheard so far results of recovery process (one of them was decrease by 90% of schizophrenia[6]), they decided **to build relationships** with professionals from mental health institutions, and other partners, first i**n local community** and later in the **whole country**, who will be willing to change their thinking and their practice, from illness oriented to recovery oriented one. The key element of this process was dissemination of the Open Dialogue **knowledge**, **experiences and results** of the treatment meetings with the person in mental crisis, their family and social network.

As the process came to **societal level** it appeared that it is very difficult to implement from one country to another an effective mental health practice (for example Open Dialogue), if there is not inadequate mental health system in this country. So, the mentioned above family realized that they must rise the need for the **system change** through waking up the moral accountability and



socio-political responsibility the Parliament members and the Government itself.

Experienced -based Learning: from personal experience to system change requirement

3. Brief description / goal of your best practice

The goal of our best practice called **"Change the thinking. Change the practice. Change the system"** might be defined on different levels:

- Individual: instead complaining on the life circumstances - start looking for solution and undertake action to implement this solution in life

[4] Meyer P.J. and Slechta R., 2012, "5 Pillars of Leadership. How to Bridge the Leadership Gap"

[5] Seikkula J., Arnkil T.A., 2005, "Dialogical Meetings in in Social Networks".

[6] Whitaker R. 2011, "Anatomy of an epidemic".

- Societal (generally): develop leadership skills, undertake personal learning process, build relationships with others, be-proactive in local community and, if needed, influence the politicians to make the world a better place to live
- Mental Health: influence changes in the system, through promotion and implementation of **Open Dialogue,** as the heart of community based, integrated services.

Implementing Open Dialogue in Poland and achieved so far results might be an example how **"Change the thinking. Change the practice. Change the system"** might work.

4. When did you start it?

° **What were the reasons / motives to introduce and continue your best practice?**

Context

In Poland, the number of people treated for various mental disorders and illnesses is growing systematically.[7] 1,3 million persons benefit from care in mental health outpatient treatment facilities. At the same time, **mental health problems affect**, directly or indirectly, **about 8 million Poles**! What is more, due to the rise of social risks for mental health, such as unemployment, poverty, violence, loneliness and loosening of social bonds, the further worsening of mental condition is expected to occur in the Polish society.

The occurring mental disorders not only degrade the emotional and mental balance of a person, but also impede relationships with family members, community and the closest social environment. A bad mental condition very often results in **losing job** by a person, which deteriorates his/her quality of life and leads to a sense of exclusion and helplessness, intensifying mental disorder.

The aforementioned problems mostly affect **young people**, causing their social isolation and economic non-existence. Why is it so? Mental disorders most often occur in the puberty period. The lack of early intervention leads to an acute crisis and hospitalization. After hospitalization, it is difficult to come back to education and, what is even harder, to get a job. The study shows that as many as 73% of employees lose their jobs when an employer finds out about their illness.[8] As a result, many people claim for benefits, sickness or disability benefits or similar benefits, which represent a multi-million burden for the national budget. The same study presents that only on benefits going to the persons suffering from schizophrenia **the Polish Social Insurance Institution (ZUS) spends 940 million zlotys annually**![9]

As far as the reintegration into the labour market of those persons is concerned, it appears that a low self-esteem, fear of taking up employment, social stigmatization, but also a lack of experience and appropriate qualifications, make their situation on the labour market extremely difficult. What is more, the consequences of the illness of a family member affect the whole family and, thus, further costs are generated. According to the Ministry of Health, the **annual costs of mental**

[7] The report of the team appointed by the Minister of Health to develop a project of the National Health Protection Programme for 2016-2020, (2015).

[8] Andrzej Kiejna prof., MD, PhD, the report "Schizophrenia. Social perspective. Situation in Poland", (2014).

[9] Ibidem.

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illness are estimated at 5 billion zlotys[10], being two times bigger than the NHS budget for psychiatric care![11]

° **What was your starting situation?**

The starting point was the year 2010 when my son was three times hospitalised without his will, and he spend together 7 months in one year at three asylums. So, we (me and my husband) raised to ourselves a few question:

To start: Why do we have such situation in our family? How does other families experience mental illness of their relatives? How does mental health institutions in other regions of Poland operate?

The answers were overwhelming! The organisation of mental health system in our country **reflects the way of thinking,** which has been perpetuated over decades, about the mentally ill and **mental** illness. It's a type of thinking based on the following assumptions:

1. A mental illness is incurable and a person diagnosed as "mentally ill" will remain ill through the rest of his/her life.

2. The best place for the treatment of persons with a mental health problem is a psychiatric hospital because mentally ill persons can be dangerous for themselves and for the society, that is why they should be subjected to treatment in an isolated place.

Actual facts:

At the end of 2014, there were **49 psychiatric hospitals** in Poland, offering **17,7 thousands beds** (which represented 1,3%, i.e. 231 beds, more than at the end of 2013). 201,6 thousands patients were treated there, which was 3,1% (6 thousands) more than a year ago. [12]

3. Due to the long-term course of illness, many persons lose their ability to live independently in the society and, then, in the case of no support from a family, they should be placed in a social care centre (Dom Pomocy Społecznej, abbreviated as DPS in Polish) or in a residential medical care facility (Zakład Opiekuńczo-Leczniczy, abbreviated as ZOL in Polish).

Facts:

In 2015, as many as **18 679 persons were residents of social care centres** (DPS) for persons with mental health problems and **4 956 persons were placed in residential medical care facilities** (ZOL).[13]

4. The system of psychiatric care has to be directly linked to the judicial system to be able to issue decisions on:

[10] The Regulation of the Council of Ministers on the National Health Programme for 2016-2020, (2015).

[11] The NHS Financial Plan for 2016.

[12] Data of the Central Statistical Office of Poland (GUS): Health and its Protection, Warsaw, 2014.

[13] Data of the Central Statistical Office of Poland (GUS): Health and its Protection, Warsaw, 2014.

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- ➢ a compulsory treatment in a psychiatric hospital of a person experiencing mental health crisis;
- ➢ a compulsory treatment of a long-term patient in a social care centre;
- ➢ a use of safeguard measure in a form of the compulsory placement of a mentally ill person in a forensic unit of a psychiatric hospital.

Facts:

In 2014, there were **2360 persons** placed in national and regional forensic psychiatry centres, and an average time of detention of a person in a forensic unit was 4,5 years.[14]

5. Financing the activity of 24/7 inpatient psychiatric wards is based on the rule „**we pay for each hospital bed occupied"** and not for the effect of treatment.

A few months later (in 2011) we raised another questions: How do mental health systems function in Europe? What are their basic principles? What effects do they bring in the health and wellbeing of people?

At that time we discovered a sensation (it was for us): For more than 50 years, the countries of Western Europe have been in a process of profound changes of the system of mental health care. As the European experiences show, the process begins with **the change of paradigms** in three spheres:

1. the way of thinking about a person and recovery;
2. the way of providing health care services;
3. the way of integrating health care services and social support in one system

ad 1. **The most important is a person** – his/her rights as a human being, life history, individual needs and also family and social network support, which all constitute resources for recovery. Thus, the change in the way of thinking occurs, from orientation to the "process of being ill" to concentration on the "process of recovery", from "isolation" to "integration", from a "fear of the future" to "hope for recovery".

ad 2. **The system of health care services is oriented to an early contact with a person in need of help,** which gives a possibility to detect an illness in its early phase, to create a therapeutic relationship, to respond to individual needs of a person and to include a family and social network in the process of recovery. The hospitalization in psychiatric units (created in general hospitals) is a final form of help, a sort of last resort used in the situation when the other forms are ineffective.

ad 3. **Health care and social services are integrated and provided to inhabitants of a given catchment area** (a powiat/region or a district of a big city), which favours taking responsibility for a specific group of patients by the system, their social inclusion and reintegration into the labour market. As a result, these persons take control over their lives and move from the role of a "*passive service user*" to that of an "*active participant of the recovery process*"

[14] Ibidem.

Two regions in Europe - Western Lapland (Finland) and Triest (Italy) are the worth to learn examples of the effectiveness of mental health system change.

5. Please describe your best practice:

- **Which learning goal/targets does your best practice have?**
- **Which (learning or teaching) methods are used?**
- **Which themes are addressed?**
- **Which resources are used?**
- **What requirements do the participants have to fulfil?**
- **What standards does your best practice have?**

As stated above, the objective of our best practice **"Change the thinking. Change the practice. Change the system"** is "influence changes in the mental health system, through promotion and implementation of **Open Dialogue,** as the heart of community based, integrated services".

To reach this goal we have undertaken in years 2011 - 2016 following activities:

1. Conferences and seminars to build in the society new understanding of mental health and need of change from institutional to community oriented system, in which "The person" is in the middle of the recovery process.

   Result: about 5000 participants of 12 conferences and 15 seminars

2. Trainings for professionals, who are providing mental health and social services, is the Open Dialogue Approach, to open new thinking and develop new practices in their daily operation Result: 250 persons were graduated after 1-year course

3. Empowerment of people with lived experience, mainly through Ex-In workshops, to become experts who know best how to help others with mental illness and advocate for changes in Poland.

   Result: 100 people participated in Ex-In workshops organised in Wroclaw, Cracow, Gdynia, Katowice

4. Improving peoples live by organising in their local community integrated services: Prevention - Treatment - Social support

   Result: we have started these activities in 2014 from small scale - 20 families from one municipality, 1 year project and now we are close to start country based project, financed by EU funds (15 000 families from 25 municipalities, 3 year project, 20 partners in the whole country)

5. Advocacy towards reform of Polish mental health system on the governmental level.

   Result: we have been invited since 2014 to Polish Parliament, National Advisory Board for President of Poland, Ministry of Health, Ministry of Development, Ministry of Family.

6. Multinational projects, study visits, bilateral cooperation with foreign organisations to take advantage in European heritage in Mental Health.

   Results:

   a. We and our partners organised 15 study-visits to 7 countries, in which participated

about 150 people

b. Open Dialogue is well known in the whole country and will become "The heart" of 25 Community Mental Health Centers which will be founded within 3-years EU project; this project will be the **pilot for the reform of Polish Mental Health system**.

We think, that It is high time to see that not only the countries of Western Europe, **but also those of Middle-East Europe, have exceeded Poland** in fostering the basic human rights, in changing the way of thinking about mental illnesses and in creating the mental health care system with the **human being at its centre**. The time has come in Poland to move away from the system based on isolation, forced treatment and oppression, because, as Italians put it, "*this is the oppressive system that induces aggression in people experiencing a mental health crisis*."

Due to the urgent need of change, **the vision of the future of Polish mental health system** was defined on the basis of good European practices and recommendations of the World Health Organization. The following principles depict this vision:

41 **Mental illnesses are curable,** and a person experiencing mental disorders is the one who needs help and not the one who poses danger. #

51 **Prevention - Treatment – Social Support -** constitute three pillars of the system, representing a holistic approach to the human being and ensuring the integration of activities and therapeutic continuity, which has influence on **the efficiency of the system** both in health and economic dimensions.#

61 **The system is pro-active,** which means that through prevention we build the social awareness, making it possible to provide the right professional care in the first episodes of mental disorders. Nowadays, we have a reactive system, which means that we wait until the acute symptoms of illness occur, and then we react in placing a person in a psychiatric hospital (mostly without his/her permission).#

71 **The system covers children and youth**, because mental disorders mostly begin in adolescence; the early intervention is a necessary condition of success of all actions taken up.#

81 **Primary mental health care services** are community-based through a network of **Community Mental Health Centres** (with special importance of mobile teams), which gives a possibility of early intervention and includes family and social network as resources for recovery. Now, there is a network of outpatient mental health care institutions and Community Treatment Teams, but they have small contracts, which leads to long waiting periods and the lack of comprehensiveness of the services provided.#

91 T**reatment is individualized** – what is important is a person, his/her life history, individual problems and needs, and that where he/she lives, studies or works.#

:1 The Community Mental Health Centre **coordinates health care services**, providing **an effective cooperation with a 24/7 psychiatric ward** in a local general hospital (or in a local psychiatric hospital).#

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;1The Community Mental Health Centre **coordinates health care and social services,** covering also the needs in terms of housing and employment, as this is a prerequisite for regaining independence and taking control over one's life. The coordination of the aforementioned services can only be possible thanks to a local partnership.#

<1The Community Mental Health Centre **cooperates with GPs** on a given area.#

10. The Community Mental Health Centre **is responsible for providing care to the inhabitants of a given area** (a powiat/region or a district of a big city), which favours the social inclusion of the patients (the clients of the system) and their reintegration into the labour market and, consequently, leads them to take control over their lives and fosters their independence. These persons move from the role of a "*passive service user*" to that of an "*active participant of the recovery process*."

11. The system is based on **an effective model of financing of the primary psychiatric care**, provided by the Community Mental Health Centres, which takes a form of "global budget" calculated on the basis of the "per capita rate". Today, the NHS pays for individual medical services.

12. Persons affected by a mental illness, the clients of the system, are partners for mental health institutions, because they know best what helps them recover; they are "experts by experience" and bring hope for recovery to those in crisis.

13. The family and social network members of the mental health system user are involved in every phase of recovery, i.e. starting from prevention efforts, through treatment, to social rehabilitation.

6. What did you learn from your experiences with your best practice?

- **What are the outcomes of your best practice?**

During last 6 years, since we have met first time **Open Dialogue** - it serves us as an inspiration, indication and a practical tool in the process of **changing our thinking and our practices**. The first basic training in Poland started in 2013, and soon was followed by another nine in different cities. These actions created a breeding ground for further actions and practice. Altogether there is now over 250 trained people – mostly among professionals of mental health field – psychologists, psychiatrists, nurses, but also social workers and people with experience of psychological crisis.

This group of 250 people is as well **group of advocates of changes** in the mental health system.

They have build 'Open Dialogue islands' on the map of Poland and seem to create a growing web of good practices. Discrepancies between places concerns f.eg. types of financing. In Poland neither National Health Found nor insurance companies pay for treatment shaped around Open Dialogue**.** It is mostly a mash of private, charity or short-term EU or departmental projects funds. Needless to say that such a situation challenges professionals to search for sources of financing that could give their work basic sense of stability.

Also institutions involved in Open Dialogue movement vary – from psychiatric hospitals and psychiatric inwards in general hospitals, through daily care units, community help-care centres, family support centres, finishing on social welfare centres. In such a wide range of institutions

there are professionals pioneering in Open Dialogue, searching for their own way of implementing their ideas, creating their own projects and dealing with institution-specific obstacles – such as hierarchical structure, housing conditions limitations, colleagues. Nevertheless, fruits of good practices pays back with growing work and personal satisfaction and promising outcomes.

The most important outcome of our best practice **"Change the thinking. Change the practice. Change the system"** is the decision of Ministry of Development to dedicate 60 mln Euro for 20 municipalities for 3-years innovative project called "Deinstitutionalization of health and social services for people with mental health problems"[15]. In 10 out of these 20 regions there are "islands of Open Dialogue". The project is based on **the vision of the future of Polish mental health system**, described above.

7. How might these experiences be useful to the Empowerment College?

Our best practice might be **inspiration for the courses** provided by Empowerment College.

Why?

In each country, independently of the level of society development, we need people who:

- instead of complaining on the life circumstances - start looking for solution and undertake action to implement this solution in their life
- develop leadership and professional skills, undertake long-life personal learning process
- build effective relationships with others
- are pro-active in local community and, if needed,
- influence the politicians to make the world a better place to live.

Implementation of Open Dialogue in Poland and its role in influencing the change in Polish mental health system is an example that the best practice called **"Change the thinking. Change the practice. Change the system"** is worth to be promoted.

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[15] https://www.power.gov.pl/nabory/1-22/

Co-funded by the Erasmus+ Programme of the European Union

Best Practice in Teaching and Learning of:

ImROC, Nottingham, Great Britain

1. What is your definition of experienced based learning?

Experience based learning is an education model based on self-reflection and development of knowledge and skills through active participation in experiences. Students are engaged and drive the pace and focus of their learning rather than passive recipients of knowledge, such as through didactic.

2. What do / would you call your best practice?

Coproduction is a central tenent to recovery colleges. Shared, equal relationships between co-tutors where equivalent value is placed on lived experience and subject specific knowledge breaks down hierarchical power imbalances, reduces stigma and promotes enriching environments for student to experience greater self-control. Staff are coaches who help people find their own solutions.

Learning together without restrictive labels of diagnosis or mental health condition help students see the opportunities available to them, what other student have achieved and enables organic social networks and friendships to emerge.

Each element and operation of a recovery college is co-produced. For example, quality and assurance panels made up of members with lived experience and subject specific knowledge review the structure, content and evaluation of courses for the college.

3. Brief description / goal of your best practice

Recovery colleges shift treatment to education. A patient becomes a student. Courses give students information, knowledge and time for reflection and self development. Being in a classroom with other student provides hopes through seeing what others have achieved and reduces both stigma and isolation frequently reported by people supported by mental health services.

Recovery colleges provide one way of supporting people achieve their life goals. The ambition of the college is not for students to stay with the college forever but to develop skills, gain knowledge and lead their life beyond the college to other challenges and journeys.

Investment in recovery colleges also provides welcome cost savings to scarce resources within health and social care. By attending a recovery college students are less likely to need ongoing support from community mental health teams and are less likely to be re-admitted to expensive in-patient facilities. Learning skills, experiencing an identity beyond being a patient and establishing social links are firm foundations for recovery and resilience. Staff within host organisations where colleges are located, such as NHS Trusts, as benefit from attending courses and reflecting on the nature and culture of their practice.

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4. When did you start it? What were the reasons / motives to introduce and continue your best practice?

Recovery colleges in the UK were first established by Rachel Perkins (South West London and St George's Recovery College) and Julie Repper (Nottingham Recovery College). After visiting Recovery Innovations in Arizona, the concept of recovery colleges was brought to England and amplified through the work of ImROC. In 2012 ImROC published the first practical briefing paper on recovery colleges and plans to publish a new revised paper shortly building on new evidence.

Recovery colleges provide a concrete example of a recovery innovation. They can be developed slowly from pilot phase to a fully operational college with hubs and spokes. This offers minimal risk and requires minimal financial invest at the early stages. However to be benefit from a sustainable college, the supportive and enabling infrastructure within an organisation or community to essential to its continuation.

What was your starting situation?

When ImROC began there were no recovery colleges, there are now above 40 colleges within the UK and significantly more internationally. ImROC supported the establishment and piloting of the majority of these colleges through sharing the learning and challenges from the early adoption of recovery colleges in Nottingham and South West London.

ImROC worked with 36 organisations from 2011 and many selected recovery colleges as the focus on their development work. Today recovery colleges continue to be a core area of support ImROC works with sites both within the UK and internationally to establish and enhance.

5. Please describe your best practice: Which learning goal/targets does your best practice have?

Recovery colleges promote self management. Each student is offered an individual learning plan (ILP) to record a plan for their learning and development. Students will select courses they would like to attend based on their personal interests. Decisions over the direction of their learning and content of the plan are made by the student with guidance and suggestions from the tutor. Each student may have a different ILP. By working through the ILP and reflecting, refreshing and pushing further the ambition for life goals, students ultimately take back control of their lives.

Which (learning or teaching) methods are used?

Coproduced, cofacilitated and cofacilitated.

Accessibility, and appropriateness / relevance for all students, is essential therefore all courses need to utilize a range of different learning methods to meet different preferences and needs of students.

Which themes are addressed?

Co production, self management, reducing stigma, peer support, social networking and reduced

isolation and loneliness.

Which resources are used?

In most cases a physical base is needed to deliver courses although a small and growing number of colleges are introducing virtual, on-line based learning opportunities.

Course tutors (part-time or full time) are required to structure the course content and agree on delivery materials and techniques.

What requirements do the participants have to fulfill?

Students attend the courses and participate as much or as little as they wish. The skill of the course tutors lies in their ability to flex their learning style to accommodate the students in the room.

What standards does your best practice have?

Quality and assurance panels review the effectiveness of each course and consider if the course should be revised, continued or closed.

ImROC has clearly defined core characteristics of a recovery college:

1. Co-production between people with personal and professional experience of mental health problems
2. There is a physical base (building) with classrooms and a library where people can do their own research
3. It operates on college principles
4. It is for everyone
5. There is a Personal Tutor (or equivalent) who offers information, advice and guidance
6. The College is not a substitute for traditional assessment and treatment
7. It is not a substitute for mainstream colleges
8. It must reflect recovery principles in all aspects of its culture and operation

6. What did you learn from your experiences with your best practice? What are the outcomes of your best practice?

Outcomes for the organisation / community are that recovery colleges reduce the demand placed on mental health provider services (in patient and community based).

For the individual they can be pivotal in their recovery journey to regain control and take the next step away from sole resilience on services.

Recovery colleges also begin to change the culture of an organisation and demonstrate the organization's commitment to recovery-orientated practice. For example, where the Chief Executive co-develops and delivers a course on living with bipolar through both disclosing openly their lived experience and committing their time to acting as a trainer help give the college a firm place within the organisation.

7. How might these experiences be useful to the Empowerment College?

ImROC's learning experiences from establishing and developing recovery colleges at scale offers a range of knowledge and experiences that can be considered and adapted for use in the Empowerment College.

For example,

- ImROC's core defining features of a recovery college
- Staffing and workforce: recruitment, training, staff progression, wellbeing and support
- Course development and evaluation
- Training the trainers
- Marketing and communications
- Engaging local communities and collaborative learning

8. Is there anything else that is important in this context?

9. List of Research or Literature in connection with your project:

Shepherd, G., McGregor, J., Meddings, S., & Roeg, W. (2017). Recovery Colleges and Co-production. In M. Slade, L. Oades, & A. Jarden (Eds.), Wellbeing, Recovery and Mental Health (pp. 169-180). Cambridge: Cambridge University Press. doi:10.1017/9781316339275.016

Central and North West London Annual Report 2013-2014 (2014) http://www.cnwl.nhs.uk/wp-content/uploads/CNWL-Recovery-College-Annual-Report.pdf

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Meddings, S., Byrne, D., Barnicoat, S., Campbell, E. & Locks, L. (2014). Co-Delivered and Co–Produced: Creating a Recovery College in Partnership. Journal of Mental Health Training, Education and Practice, 9(1), 16-25.

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Meddings, S, Campbell,E., Guglietti, S., Lambe, H., Locks, L., Byrne, D. and Whittington, A. (2015 / in press). From Service User to Student – The Benefits of Recovery College. Clinical Psychology Forum.

McCaig, M., McNay, L., Marland, G., Bradstreet, S. & Campbell, J. (2014). Establishing a recovery college in a Scottish university. Mental Health and Social Inclusion, 19 (2), 92-97.

McGregor,J. (2012) Nottingham Recovery College – Education and Transformation:*'It is not just education, it is about you'* Unpublished paper Nottinghamshire Mental Health Trust

McGregor, J., Repper, J. and Brown, H. (2014), 'The College is so different from anything I have done'. A study of the characteristics of Nottingham Recovery College, Journal of Mental Health Training, Education and Practice, **9**(1), 3-15.

Rinaldi,M. Morland,M. & Wybourn,S. (2012) Annual Report South West London Recovery College (Unpublished) SWLSG Mental Health Trust

Watson,E. (2013) What Makes a Recovery College? A Systematic Literature Review of Recovery Education in Mental Health, Unpublished M.A.
University of Nottingham

Zucchelli,F & Skinner,S. (2013) Central and North West London NHS Foundation Trust's (CNWL) Recovery College: the story so far
Mental Health & Social Inclusion 17 (4) 183-189.

Stories / Narratives:

http://www.cnwl.nhs.uk/wp-content/uploads/2013/05/CNWL_mental_health_employment_recovery_booklet.pdf

http://www.cpft.nhs.uk/Downloads/DVD-Documents/Recovery/Recovery%20College/Recovery%20Stories%20book2%20Feb%202014.pdf

http://www.recoverydevon.co.uk/index.php/creative-cafe/the-stories-gathered-so-far

Videos

· **South West London Recovery College - YouTube**
► 5:24► 5:24
*www.**youtube**.com/watch?v=VSOeQbkMVqc*
12 Oct 2011 - Uploaded by SWLSTG
South West London *Recovery College* is the UK's first mental health recovery study and training facility ...

· **The Recovery College - YouTube**
► 7:17► 7:17
*www.**youtube**.com/watch?v=QFc_9nZNy_k*
16 Jan 2014 - Uploaded by Sussex Partnership NHS Foundation Trust
A short film about success of two *Recovery Colleges* held within Brighton & Hove and Hastings and Rother.

· **CNWL Recovery College - YouTube**
*www.**youtube**.com/user/CNWLRC*
Central and North West London (CNWL) NHS Foundation Trust The CNWL *Recovery College* courses and workshops are open to anybody to attend. For more ...

· **Recovery Colleges - Centre for Mental Health**
*www.centreformentalhealth.org.uk/**recovery**/**Recovery_Colleges**.aspx*
A *Recovery College* embodies the transformations that are central to driving ... about the *Recovery College* in South West London can be viewed on *YouTube*.

· **The Recovery College - Southern Health**
www.southernhealth.nhs.uk › Health and wellbeing › Recovery
The *Recovery College* offers courses designed to help increase your knowledge and skills about ... The *Recovery College* takes an educational approach to equip you with the knowledge and skills to ... Facebook · LinkedIn · Twitter · *YouTube*.

· **St Mungo's Broadway Recovery College**
*www.mungosbroadway.org.uk/st_mungos_**recovery_college***
recovery college, skills, *recovery*, *college*, homelessness. ... 'It's refreshing that, just because *you*'ve been homeless and experienced some difficulties, *you* don't ...

· **Devon Partnership NHS Trust: Recovery - supporting you to ...**
*www.devonpartnership.nhs.uk/**Recovery**-supporting-**you**-to-live-well.52...*
Recovery has evolved to have a particular meaning in mental health settings. ... Films of people's stories are also available on our *YouTube* channel. ... Working in partnership with Exeter *College* and Mind Exeter and East Devon, Devon ...

· **2Gether NHS Foundation Trust: Coaching for recovery ...**
www.health.org.uk/areas-of-work/.../2gether-nhs-foundation-trust/
The first involved developing pop-up '*recovery colleges*' where a curriculum wa ... the site and will only be used if we need to contact *you* about your comment.

· **Recovery College - South West London and St George's ...**
*www.swlstg-tr.nhs.uk/.../first-uk-**recovery-college**-minister-highlights-rol...*
29 Sep 2011 - Health Minister Paul Burstow MP opens the UK's first *Recovery College*. ... View the South West London *Recovery College's YouTube* video.

· **The Recovery College - Mersey Care NHS Trust**
*www.merseycare.nhs.uk/info/imroc/**recoverycollege**/*
by M Care - 2013
For further information on the *Recovery College* please email: ... Navajo BrowseAloud NHS Jobs NHS Choices NHS Direct PALS Twitter Facebook *YouTube*.

- **Recovery College East**

http://www.youtube.com/watch?v=l6cV9DvTk_E

- **Sussex Recovery College**

https://www.youtube.com/watch?v=QFc_9nZNy_k

- **Mersey Care Recovery College video**

https://www.youtube.com/watch?v=e8-SwJx0P5E&feature=youtu.be

Websites

Recovery Devon http://www.recoverydevon.co.uk/
Recovery College East http://www.cpft.nhs.uk/about-us/recovery-college-east.htm
Sussex Recovery College [https://www.sussexrecoverycollege.org.uk/