

# Social Educational Work within Mental Health

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## Preface

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The AIEJI General Assembly in Luxembourg in April 2013 decided that a project should be carried out on social educational work within the field of mental health. The decision was made in light of the recognition that the work of social educators is crucial to improving the well-being of people suffering with mental illness.

In social education, there has been a change of perspective from *illness* to a focus on *mental health*. Social educators must maintain a positive focus on resources and capabilities rather than on limitations arising from a medical diagnosis. Social educators have the power to make an entirely unique contribution through their work; we hope that this report will help raise awareness of this fact.

Social educators engage with people who have difficulty coping with the challenges of life and who often experience stigmatisation due to their psychiatric diagnoses. Social educators also strive to foster inclusion within society and various systems, which at certain times and in various ways exclude people suffering with a mental health condition.

Our aim here is to encourage and inspire social educators in their work with people suffering with mental illness. Furthermore we hope to impart new knowledge to social educators and other relevant actors and to underline the importance of the social educational work within this field. We hope that this publication will give rise to reflection on the role of the social educator in the recovery process and on the measures and values applied within the field.



Benny Andersen  
President of AIEJI

## **Introduction**

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This AIEJI report focuses on social educational work in the field of mental health. The World Health Organization (WHO) defines mental health as: “*a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*”

The definition highlights the positive aspects of mental health, reminding us that mental health means not only the absence of an illness, but the mental and social *well-being* of a person. The concept of mental health also embraces the individual’s capacity for social participation and integration in the labour market. It is thus a concept that, beyond the health care sector, also has links to various activities in other sectors (Schweizerische Eidgenossenschaft 2016:8).

In accordance with this conception of mental health, AIEJI would like to focus attention on the social educator as someone who helps people suffering with mental illness to take part in society and to cope with and overcome the daily challenges of life. Overall, the aim is to improve the quality of life of people with mental health issues.

AIEJI will refer to the ‘individual having or suffering with a mental illness’ in order to understand individuals as active and independent people. AIEJI rejects the reference to *being* mentally ill, and prefers to say that a person *has or suffers with* a mental illness, thus encouraging a view of illness as separate from the individual. A label or term may determine the individual’s self-perception as well as the light in which others see him or her; it is therefore very important to reflect carefully on the language we use around mental health.

The AIEJI asks what social educators can do to improve the lives and situations of persons suffering with a mental illness. How can social educators help people with a mental illness to regain control over their lives? The current AIEJI report builds on the UN Convention on the Rights of Persons with Disabilities and the argument that “*Persons with disabilities have the right to the enjoyment of the highest attainable standards of health without discrimination on the basis of disability*” (UN

Convention 2006, Article 25). The right to health was first articulated in the Constitution of the World Health Organisation (1946); later it was incorporated in the United Nations' Universal Declaration of Human Rights (1948). States that have ratified the respective treaties are obliged to fulfil the rights within them. The results of inadequate services and inadequate treatment of people suffering from a mental health condition include deterioration in the individual's health and their quality of life.

The aim of this AIEJI report is to raise awareness of the contribution made by social educators within the field of mental health. It describes some of the challenges social educators face and how they address them. It aims to provide an insight into the values underlying social educational methods as applied within the field of mental health. AIEJI strives to provide inspiration to social educators around the world.

The report also aims to contribute to the discussion on how the lives of people suffering with a mental illness can be improved, taking into account aspects such as respect for human rights. We hope that workplaces as well as politicians will be interested in taking part in this discussion.

### **The UN Declaration – Respect for Human Rights**

Social educational work builds on equality. This means that everyone, irrespective of any disability, should have the same rights and dignity. The United Nations Convention on the Rights of Persons with Disabilities is relevant to our discussion of people suffering with a mental illness. The Convention protects “...*those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others*” (UN Convention 2006, Article 1). This definition encompasses the interplay between the individual and his or her physical and social surroundings. It is essential that a disability be considered as relational, meaning that it is in the person's meeting with the surroundings that problems occur – and not through individual ‘failure’. A person's mental health is closely dependent on their surroundings and may change if the surroundings change.

The UN Convention on the Rights of Persons with Disabilities provides a legal framework for promoting the rights of people with mental illnesses and is a step forward in improving their chances in life. The UN Convention includes a number of civil, political, economic, social and cultural rights, which must be respected. These include for instance the right to full legal capacity, personal freedom, self-determination and non-discrimination.

Discrimination against a person with a mental health condition is a central issue. Where it occurs, discrimination violates the individual's rights and hinders their chances in life. Discrimination can for example limit treatment and development opportunities if those working within the field are unaware of prejudices. Article 8 of the UN Convention states that awareness-raising is essential "*...to combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life*" and also "*to promote awareness of the capabilities and contributions of persons with disabilities*" (UN Convention 2006, Article 8).

Non-discrimination is also essential to dignity. In addition to this, a life of dignity includes the opportunity to choose one's place of residence, the right to respect for one's physical and mental integrity, the right to informed consent before medical intervention, the right to full inclusion in the community and the right to the necessary assistance and rehabilitation services (UN Convention 2006, Article 12, 14, 17, 19, 24, 25, & 26). Dignity in mental health was also the overall theme of the WHO World Mental Health Day, in October 2015, which focussed on the above-mentioned human rights. WHO highlights in order to assure a life of dignity, a high level of quality in support and care is essential (World Mental Health Day 2015).

The World Health Organization has received frequent reports of human rights violations of people with a mental illness. Such contravention of rights includes for instance physical restraints, denial of basic needs or limited access to education, employment or housing due to discrimination. The rights of the person with a mental health condition are extremely important to the work in the social field: our orientation towards recovery from mental illness must be based on human rights principles.

### **Interviews in connection with various target groups**

Social educators are hired in mental health contexts involving different target groups. They may be asked to help children and young people with mental health issues, people with two or more diagnoses, and people with both mental health and substance abuse issues.

Most social educators work within *social psychiatry*, for instance at rehabilitation centres or in housing groups. But social educators also have the skills to help people with a mental illness in the field of *treatment psychiatry* as is highlighted in one of the interviews which are part of the empirical studies that inform this report.

The report is based on qualitative interviews with a broad range of social educators working in the field of mental health. Interviews were conducted in Brazil (7), Italy (4), Denmark (2) Norway (1), Russia (1), Switzerland (1) and Spain (1). The interview that took place in Brazil is a collective interview with a group of seven, whereas the other interviews are one-to-one interviews. A short representation of the social educators including their country and work place is given below:

<b>Country</b>	<b>Workplace</b>
Brazil (group interview)	Community Psycho-Social Centres; Workers' Health Care; Therapeutic Communities; Harm Reduction Programme, Health Care Community Centres; Dysfunction Care Centre.
Denmark	Social psychiatry, residential
Denmark	Forensic psychiatry
Italy	Territorial mental health centre
Italy	Residential rehabilitation centre, mental health department
Italy	Residential rehabilitation centre
Italy	Day care and rehabilitation centre
Norway	Emergency psychiatric ward for young people aged 13-18 years
Russia	Family and children support centre
Spain	Pedagogic farm – riding centre for people with disabilities
Switzerland	Social psychiatry, housing group

The social educators interviewed are a relatively heterogeneous group with varying work experiences due to their different workplaces within the field of mental health. Despite these differences there are common traits in their utterances.

The interviews were processed and translated into English in each country. Afterwards the results were analysed, compared and discussed in relation to theoretical perspectives on mental health.

### **Recovery from a mental illness**

‘Recovery’ here refers to the process whereby a person recovers from a mental illness by regaining control over their life and being included in society. This approach reflects the view that people suffering with a mental health condition should not be seen as chronically ill. It is a philosophy or mind-set that is based on the belief that everyone can recover. Recovery is an individual process that features many different aspects and complexities. William Anthony (1993), a pioneer in recovery-oriented mental health studies and director of the Boston Centre for Psychiatric Rehabilitation, defines recovery as:

*“A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”* (Anthony 1993:527).

The overall aim of recovery from mental illness is to achieve a fulfilled and meaningful life, regardless of recurring symptoms. Traditionally, the recovery approach is a clinical one, which requires complete recovery from a disease/illness. This means that recovery is judged to have been achieved when the disease/illness has disappeared and the individual can revert to the same functional level as before.

That is not the case with personal recovery. It is primarily socially oriented, and involves recovering with, or in spite of, the illness. When a person recovers socially, it means that they still have symptoms, but they have found a way to manage their symptoms that allows them to take part in social activities. Some will recover more or less completely from their mental

illness. A further characteristic of personal recovery is that it is up to the individual to assess his or her situation and to define the prerequisites for 'recovery'. Evidence shows that people with mental health conditions can recover. For example, international studies show that 60 per cent of people diagnosed with schizophrenia recover (Hopper et al. 2007, Topor 2001).

### ***Recovery-oriented work***

Mike Slade and Eleanor Longden, researchers within recovery, have arrived at a set of evidence-based statements, which are worth keeping in mind when considering use of the recovery approach.

1. *Recovery is best judged by the person living with the experience.*
2. *Many people with mental health problems recover.*
3. *If a person no longer meets criteria for a mental illness, they are not ill.*
4. *Diagnosis is not a robust foundation.*
5. *Treatment is one route amongst many to recovery.*
6. *Some people choose not to use mental health services.*
7. *The impact of mental health problems is mixed (Slade & Longden 2015:4).*

In the recovery approach, the relation between the practitioner and the individual is person-centred rather than disease-centred. This means that instead of seeing the patient as passive, as a host for an illness and as the subject of treatment, the individual is seen as self-determinant, knowledgeable and powerful (MacDonald Wilson et al. 2013:258). The concept of recovery may change the way in which practitioners and society treat someone with a mental health condition. Some of the outcomes of recovery that Anthony points out are higher self-esteem, adjustment to disability and empowerment (Anthony 1993:528).

### ***Recovery as a mind set***

Several of the social educators, primarily from Denmark, Italy and Norway stress the importance of recovery as a mind set when working with persons with a mental illness. A social educator from Norway working in social psychiatry says, "*Recovery is very important and essential*"; whilst a Danish social educator also working in social psychiatry says, "*Recovery is*

*our DNA. It is crucial.*” For them, recovery is a fundamental principle of their work.

A social educator in Switzerland says that the recovery approach is not used at her workplace (in social psychiatry), but that she is open to the idea: *“Some team members pursued further training in this topic. If necessary, we could apply it.”*

Recovery might be a lifelong journey, and it is therefore very important that social educators patiently hold on to the belief that a person can recover. Personal recovery should not be understood as ‘progress’ or as a linear process - but as a *dynamic* process. An essential aspect of recovery is that it is based on the individual’s experience of success and is therefore very different from individual to individual.

The above concept was echoed in the interview with a social educator from Denmark who works within social psychiatry:

*“In this place, you get better. Maybe it’s a lifelong process, but you get better, maybe not as good as you were in the old days, but you get better in many different ways. There are some who are mastering more and more things. There was this man, he worked as a baker, but then he got a mental illness, and the administration at that time considered him as chronically ill. Today he makes all the bread in this house.”*

This quotation illustrates how the social psychiatry view of persons suffering with a mental illness has changed – from classification as chronically ill to a placement on the recovery spectrum.

The social educator also explained that many residents were keen to return to the same functional level as before. She feels that it is indeed possible to ‘get one’s life back’ – but this may not mean that the afflicted person can return to the *same* life as they had before:

*“We have a question that we use for guidance purposes: ‘How can you get your life back?’ This is a dream for all of them. Many of them are listening to music from the 80s or watching old movies, they don’t want anything new, they think back to a time before they had a mental illness, and they always want to*

*go back to that point. The challenging thing is to realise that one cannot go back. Suddenly they must face the fact that they are 30 or 40 years old, and not 18 anymore.”*

Someone with a mental illness may perhaps dream of going back to a precise point at which he or she felt better, but this is not the aim of the personal recovery approach. It might be helpful for a person with a mental illness to think back to a certain time, for example to recall what resources they found useful, what they felt happy about, and so on. However, it is important to achieve acceptance that they are now in a different period of their lives and a new setting. To ‘get one’s life back’ means to recover with, or in spite of, the illness – it means to manage one’s everyday life in a new, satisfying way.

Rehabilitation is a collective name for professional initiatives that support the individual’s recovery process. It means maximizing the individual’s quality of life and their social inclusion by encouraging the development of skills and independence. Rehabilitation involves both individual resources and social conditions, e.g. a resocialisation process. The rehabilitation effort builds on the UN Convention on the Rights of Persons with Disabilities. In the following, we examine some of the strategies adopted in social educational practice.

### **Life story work**

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The narrative approach within social educational work is based on the individual’s ‘life story’ as a means of lending meaning through the narrative of the individual’s life and suffering. Life stories that express resilience and resistance reinforce the individual’s ability to overcome future challenges (Cyrulnik 2002).

Working with life stories is one type of recovery strategy that focuses on recognizing and fostering the person’s capabilities, interests and goals. In practice, this means that social educators approach rehabilitation work taking a holistic view of the individual, in order to support the development of competencies and skills. Social educators look beyond the individual’s problems and focus on their desires and the need to build up resilience to any future adversity.

Life stories can be used to describe the individual’s dreams and capabilities and to recall the resources the individual might draw on in order to move forward. Instead of focusing on the

negative aspects of symptoms, life story work can help the individual to see them as useful. They may for instance alert the individual to the need to change, to find new pathways, or to recollect something that was previously ignored. The narrative represents a holistic way of understanding why the mental illness occurred and allows for a constructive approach to recovery. Life story work can also provide a feeling of continuity between past, present and future.

The narrative, or life story, is a kind of situational interpretation that reflects an experience of the 'here and now'. The facts of the narrative may therefore change over time. The individual's life story should not be understood as a precise history, but rather as an expression of what the individual finds important in his or her life. The social educator should therefore understand the individual's life story as subjective, rather than judging between right and wrong.

#### ***Active listening and individual needs***

The importance of listening to and understanding people suffering with a mental illness has been stressed by several social educators. The self-awareness of a person with a mental illness may take its cue from the strategies used and it is therefore very important that staff are aware of different needs (Schweizerische Eidgenossenschaft 2016).

An Italian social educator describes as a principle method the practice of "*individual conversations involving active listening.*" Active listening implies respect for the speaker's point of view, feelings and thoughts.

The Brazilian social educators emphasised in their interviews the need to "*focus on the social skills each person needs to achieve a better life, according to his/hers personal desires and conception of well living. We come to the relation fully prepared to listen and together formulate how each person will address his or her challenges and make decisions.*"

The Brazilian social educators employ life story work as one of their main strategies because they "*believe the life story builds identity, personal context and culture. That is the background against which we can look for the changes each person wants.*" Again, the importance of respecting the person's desires and

needs as well as active listening to achieve understanding is underlined.

The social educator must firstly create a comfortable space in which the life story can unfold, as well as room in which other possible perspectives can develop. This means that the social educator focuses not only on symptoms, diagnoses and losses, but also encourages the recognition of aspects of strength and survival to inform the history. Narratives, such as those provided by spiritualism, self-help and future life paths can help bring new perspectives into the life of a person suffering from a mental health condition.

In relation to the different needs of the individual, life story work varies among the social educators. A social educator from Denmark working within social psychiatry describes life story work in two different scenarios and refers to two specific examples of people with a mental health condition.

The first example is a man who is relatively stable, both physically and mentally. The social educator describes him as a resourceful person, who “...is able to dream, have goals, to hope and so on”. In the second example, a different strategy is required, because, as the social educator says, “*She is not able to do the same, but they [social educators] talk with her about where she used to go to school, live etc. This is also life story work, but the social educators plan it in a different way. They found out that it worked for her.*” These examples show that life story work varies immensely from one individual to another: the social educator must therefore use different strategies to encourage the unfolding of a narrative.

### ***Social educators’ life experiences as motivation***

Social educators’ own experiences or life stories can be used to inspire and motivate persons with a mental health condition. Some social educators find it very useful when their colleagues in the field of mental health have themselves suffered with a mental illness.

A Danish social educator working in the field of social psychiatry gives an example of this. Colleagues give presentations about their own experiences and how they coped with mental illness, ‘mastered voices’, etc. Colleagues who have not experienced mental illness can also relate their life experiences.

The Danish social educator describes how she used her own experience:

*“They can also get inspiration from me. I have not had a mental illness, but I can talk about my experiences and my feelings, for example when I was a teenager, what resources and strategies I used to avoid different situations. I can for example talk about how I said ‘no’ to drugs and so on.”*

This citation shows that others’ challenges and experience of coping can inspire people suffering with mental illness. Thus personal experience can be used as part of a motivation strategy to reduce harm. The social educator underlines the principle of equality when she says that, *“anyone can get a mental illness”*. Equality is a key value within social educational work, and it requires the social educator to work as a person, as another human being, when helping those suffering with a mental health condition.

#### **Complementary methods to suit individual needs**

The interviews with social educators working within the field of mental health revealed a number of different strategies and methods. For example, a Danish social educator working within forensic psychiatry explained that life story work is not a strategy he and his colleagues actively employ. He explained:

*“Many of our patients have difficulties dealing with something that happened 20-30 years ago, therefore cognitive therapy is very useful here. They can only relate to what is happening here and now.”* On the other hand, he also feels *“it would be good to get a more narrative approach to highlight that this is only a period... That there is also something in the future.”*

At his workplace, the cognitive approach is the chosen strategy. Cognitive therapy focuses on the here and now, which is in direct contrast to the narrative method, which focuses on past experiences and future possibilities. Various complementary strategies were mentioned by the social educators in the interviews – which can be explained partly by differences in workplaces and target groups and partly by differing beliefs and understandings of what is meaningful for the individual.

Another example of complementary strategies, in relation to what is meaningful for the individual, is religious or spiritual belief. Certain claims in the literature maintain that spirituality can generate meaning when formulating an understanding of one's 'life situation' (Jensen 2002:20). The importance of religion or spirituality was highlighted by the social educator from Denmark who works in the field of social psychiatry:

*“Like the residents say, ‘well, when everybody is gone, there is only God’. They have lost so much... I think this is a very important part of the work, and there is a need for this, because when you have mental disabilities, and maybe have had them since you were a child, then you often have this need to seek something... It is very reasonable to seek this in religion because it is tolerant.”*

The social educator describes the importance of religion in her work as an element that encourages hope; residents have the feeling that they are supported by something. Religion can thus be used as part of an individual strategy.

One social educator from Spain works at a pedagogic farm which is also a riding centre for people with physical as well as mental disabilities. She describes the use of complementary strategies at her workplace to improve the patient's awareness of the body. The practice of Pilates and the Feldenkreis method aims to improve awareness of the body. They also try to improve body language using the Stanislavski method, which asserts that (unconscious) emotions can be triggered by physical activities. The social educator from Spain describes as characteristic for her work place the fact that *“...our methods are very physical and practical.”*

A crucial kind of physical method used at the pedagogic farm in Spain is equine assisted therapy. This form of therapy also improves the individual's understanding of body language, movements and self-awareness – the social educator describes the horse as a reflection of one's emotions and manner: *“Horses never lie, and you cannot lie to them, they feel and perceive your emotions... They reply and react as a mirror.”*

The social educator goes on to say that in order to make the horse calm and obedient, one must demonstrate calm. It is about “...*working without any violence, convincing him to cooperate with us and to respond positively to our requests. We don't pull on the reins; we communicate to the horse through our body language, for example through position, gestures, voice/tone, breathing, looks, and so on*”, in the words of the social educator. Equine assisted therapy is used to allow the individual to become aware of his or her feelings and to change them in a positive and non-violent way.

The interviewee describes how residents are enthused by the activity and the relationship with the horse – and she thinks that residents can apply non-violent methods to control their emotions: “*The rider must communicate his or her intentions sincerely and in a straightforward manner; he/she must control all his/her emotions, not only the conscious ones, in order to communicate with the animal.*” In this way, the resident might reflect upon what he or she does, and what effect this has on the animal; moreover, they may become aware of subconscious feelings that arise as a result of interacting with the horse.

### **Social inclusion: Participation in society**

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Social inclusion means equal opportunities for everyone to participate in various spheres of social life, the presence of a mental illness notwithstanding. Such opportunities include participating in the local community, politics, the labour market or education.

Structural factors that may either enable or limit participation in society include material conditions such as a lack of funds, or one's housing situation. As the Swedish psychologist Alain Topor stresses, external factors can both hinder and promote recovery (Kristiansen 2015:41). Social educators need to bear external factors in mind when working on the recovery of an individual.

A fundamental ingredient of recovery is access to social, economic and cultural opportunities; however, the requirement goes beyond simple access. Active participation in the community should take place on an equal basis with others, in areas such as education or employment. It is very important that the individual does not encounter barriers to participation.

Overall attitudes and values must be rooted in respect for differences, self-determination and non-discrimination. In order to promote inclusion, an integrated effort among different agencies at all levels, both horizontally and vertically, is needed. Social educators play a crucial role in the inclusive effort at the micro level of residents' everyday lives, identifying opportunities and encouraging individuals to embrace opportunities.

Recognition by the community is a prerequisite for social inclusion. In social communities, such as employment environments, the individual should be recognized as a unique individual and as a citizen of society whose status is the same as everyone else's. The need for recognition is basic to all human beings and is an essential part of the individual's self-awareness and his or her sense of belonging (Honneth 1996:71f). Inclusion is not the same as integration, which refers to a person's ability to fit into society. Recognition and inclusion depend on a society's capacity to make room for different personalities and needs, and to give individuals the opportunity to participate.

It is very important to underline that inclusion exists only where participation is voluntary. If inclusion occurs as a result of forced participation, it becomes a process of normalisation; this is not the true definition of social inclusion. Categories such as 'normal' and 'abnormal' are both time- and culture-determined. Inclusion means that a society embraces diversity, and includes those who do not belong to a majority. The social educators' fundamental task is to include persons who do not fit into the category of 'normal'. This also means people suffering with mental illness. This group deserves respect and should be recognized as equal to other people.

Networks, resources and the local community are therefore very important facilitators of the process of recovery. The holistic rehabilitation effort should incorporate aspects of social inclusion.

### ***Stigmatisation – the role of attitudes***

A diagnosis of a psychiatric disorder can be stigmatising; there is moreover a risk that it might contribute to a focus on individualized 'errors'. Stigma is a major barrier, which hinders recovery of a person with a mental illness.

The American sociologist and author of *Stigma* (1963), Erving Goffman, analyses the social interaction between the stigmatized individual and those stigmatising him or her. Goffman defines stigmatisation as a means of discrediting someone who differs from the norm. Stigmatisation is a result of a social process in which a person's identity is damaged by the reactions of others. Such reactions include judgement and rigid categorisation or labelling. This can lead to stereotyping and failure to treat the individual as such.

Mental illness may even lead to self-stigmatisation in the form of behaviour that seeks to isolate the subject who feels ashamed of their condition. Furthermore the relation between the stigmatised person and the agency of stigmatisation is powerful; he or she imposes limits on an individual's life chances, through for example reduced access to health care or the labour market. Limits to personal development opportunities resulting from stigma in turn lead to loss of self-esteem and self-respect and to further discrimination (Goffman 1990/1963).

Stigmatisation results in exclusion from the civil, political, economic, social and cultural rights afforded to others – which is against the principle of non-discrimination under the UN Convention on the Rights of Persons with Disabilities.

### ***The experience of exclusion***

Due to isolation in psychiatric institutions, persons with mental illnesses are traditionally cut off from participation in society. This is problematic because of the interrelation of social relations and recovery.

The vast majority of people with a mental health condition have experienced exclusion – whether from work, education, their networks or family (Christensen 2012:24). This was mentioned in some of the interviews. In the following quotation, from a Danish social educator working within social psychiatry, exclusion is described in relation to the mental illness and its accompanying feelings of loneliness, isolation and sadness:

*“Many feel alone and lonely, many have been exposed to harassment, actually I think everybody here has been exposed to harassment in their childhood - they have in some way been excluded from the community. And then at a certain point they*

*feel lonely and retreat into themselves, they may have suicidal thoughts. They are hospitalized, given medicine...*”

An example of stigma resulting in exclusion from the immediate social environment is expressed by a social educator from Switzerland who works within social psychiatry: *“There is no public involvement... The neighbours know about the house, but there is no active contact... Some are sceptics”*.

A negative attitude in society towards people suffering with a mental illness may also be apparent in the political agenda, according to a Russian social educator working at a family and child support centre: *“In our country we should make more effort to include children with mental disabilities in society. Because they are really isolated at the moment.”*

The social educators from Brazil state that their main challenge is *“...to deal with social prejudices and the violence our target groups suffer; in our relation to other professionals and public policies, our challenge is to achieve recognition, knowledge about and respect for our profession.”* They go on to say that public involvement is essential if attitudes are to change: *“Through public involvement, we can change social relations.”*

A similar focus is expressed by the Norwegian social educator, who feels that political focus is required to shed light on the taboo surrounding mental illness and that this focus should include *“...campaigns to increase openness surrounding mental disorders.”*

**ONE OF US – displace silence, doubt and taboo surrounding mental illness**

The purpose of the campaign ONE OF US is to destigmatise mental illness in Denmark – and end discrimination relating to people who have, or have had, a mental illness. It is going to be easier for the person with a mental health condition to live a good life as an equal participant in society:

Everyone is, and must feel like they are ONE OF US ([www.en-af-os.dk](http://www.en-af-os.dk))

Awareness-raising as stated in Article 8 of the UN Convention on the Rights of Persons with Disabilities is essential in overcoming stigma – and social educators are conscious of this.

An Italian social educator working at a residential rehabilitation centre refers to the fact that one of the biggest challenges in his work concerns the “...*fight against stigma, starting from a professional point of view.*” Overcoming stigma is often a challenge, both for people with a mental health condition and their relatives.

A diagnosis gives a basis for treatment, and can contribute to a feeling of order and a reduction in the perceived complexity of issues. But strong categorisation can also be a barrier to processes of change, or overshadow the necessary focus on potential. It is important to see a person with a mental health condition as he/she truly is; as a unique individual; and not as an accumulation of symptoms.

#### ***A person-centred view – overcoming stigma***

The attitudes of society towards the person suffering with mental illness are crucial for the person’s self-confidence, and thus the recovery process. The American psychologist Patricia E. Deegan points out that it is important that the social environment should ‘see the person’ and not the illness, meaning that the person with a mental illness is not regarded as ‘the victim’.

A change in the understanding of mental illness as chronic, and a promotion of the individual’s rights to participation on an equal basis in different spheres of the community can help reduce stigmatisation and discrimination surrounding people with mental illness. This is very important for the recovery process, since the individual’s self-understanding and identity are formed in the interaction with external expectations and attitudes.

The person-centred view of the person with a mental illness is apparent in the interviews with the social educators. One Danish social educator notes that her work place strives to avoid labelling. The interviewer has asked what target group the social educator was working with and the answer is as follows:

*“If we look at their papers when they arrive here, most of them are diagnosed with schizophrenia. But the special thing about our institution is that we don’t like to use these terms, because they are labels and represent a diagnosis that actually doesn’t say much about the person.”*

The social educators were all aware that they should approach the meeting with an individual suffering with a mental illness in the same way as they would a meeting with any other person who may have other resources and opportunities. The literature recommends that society should focus on peoples' resources and their special needs, rather than feeling pessimistic about their health problems (Andersen 2009:5). In that regard, it is important that social educators motivate the individual to participate in various spheres of life and support their goals, for instance of finding a new job or learning new skills. A goal might also be to simply find a daily routine with a purpose and a direction. Being believed in gives us hope, and supports our self-esteem; these are assets when it comes to creating a network or finding a job.

### ***Values of inclusion among the social educators***

The Brazilian social educators describe the biggest challenges for their target group as “...*the need to know how they can reach social support for their needs, how they can understand and be understood by their communities. But also to know what their rights are and how to use, retain and benefit from these rights.*” The role of the social educator is to help promote the rights of people with mental illnesses, including the right to full inclusion. The social educators working in Brazil summarise the fundamental values underlying their work as “*equality, social justice, respect for differences, self-determination, participation and solidarity*”. These values are intertwined with and crucial for inclusion; indeed, they are reflected in all the interview responses.

Values of inclusion are explicitly emphasized by many of the social educators. A social educator from Italy was asked about the most important part of his working day. His response was: “*Inclusion, mental health, and community participation occupy most of my working time.*”

Another social educator, from Norway, working in an emergency psychiatric ward for young people stressed the importance of inclusion in relation to subsequent integration in the local community: “*Inclusion will be a target to work on every day. It is important to improve when it comes to inclusion and integrating in the local environment after discharge from hospital.*”

### **Inclusive strategies on different levels**

Inclusion is an objective of many activities mentioned by the social educators. Inclusion can be on an institutional level, but it may also feature in everyday activities where the individuals are recognized and valued as equal participants. A social educator from Denmark working within social psychiatry says:

*“Today we no longer refer to the institution; instead we say ‘residential home’. I would like to call this a change from ‘slipper-life’ to normal day-to-day life. Formerly residents wore slippers, walked around in the house and had everything there, hairdressers and so forth.”*

This is an example of a social psychiatry that has changed its practices. ‘Residential homes’ encourage residents to go out if, for instance, they want a haircut. Previously it was easy to stay inside the institution and have all their needs attended to. Today, the focus is more on inclusion in the sense that residents are included in the community outside the institution.

A similar community-based mental health ideal is mentioned by the Brazilian social educators. In Brazil an important movement within mental health policy has taken place over the last 30 years. It is sometimes called the ‘anti-asylum movement’ and aims to provide support in a domiciliary setting rather than through asylums or psychiatric hospitals. The social educators from Brazil say that the aim is to close asylums as ‘total institutions’ and create a substitutive network of public services based on CAPS [psycho-social care centres] and CECO [Community Psychosocial Centers and Return Home programs] and income generation services.”

Brazil addressed the challenge of reforming the mental health care system in 1990. The reform increased access to community-based care and promoted recognition and the rights of people with a mental health condition. The intention is that people suffering with mental illness should where possible be treated in the community rather than as long-stay patients in hospital.

A social educator from Norway also describes a political focus “...on downsizing from big institutions, transferring responsibilities to local government, getting help in your home, which is built on the principle of subsidiarity - life is lived locally.”

A report from Switzerland, “Die Zukunft der Psychiatrie in der Schweiz” (2016), shows that multidisciplinary, mobile healthcare crews improve the situation of persons with mental illness. The example is from the Canton of Vaud, where it was found that mobile healthcare crews were able to reach groups of people who were previously difficult to reach and thus undersupplied. Home care support is an opportunity to meet the individual regularly in his or her domestic environment. The individual’s experience of the treatment was improved and the conflicts between the person with a mental illness and other persons decreased. The results also showed that mobile healthcare crews were very useful for people who had been discharged after a long stay in hospital (Schweizerische Eidgenossenschaft 2016:35, 46).

WHO underlines the importance of care in the community as one aspect of protecting human rights. They recommend that community mental health services and home care support replace institutions. WHO argues that large institutions are often associated with human rights violations (World Health Organization Website). The Norwegian social educator explains the effort to include people with a mental illness through a focus on their strengths and the laying down of daily routines, but also through the involvement of family and school, so that the person’s own resources are brought into play:

*“Making daily schedules so that things are predictable, with persons that the subject knows, and with low-demanding activities. Talking about and explaining the psychotic experience. Slowly testing out more stimuli and getting the subject to do things that are considered meaningful. In this way the subject slowly regains a normal life, possibly with adjustments. Getting the subject to recognise their own vulnerabilities and strengths, to manage everyday life and to avoid the recurrence of psychosis. We also have conversations with family and school around enabling participation and providing a good environment for the subject.”*

Supporting people through the practice of daily routines prepares them for life outside the institution. The inclusion of residents after institutional or residential care is also mentioned by an Italian social educator working at a residential rehabilitation centre: *“The challenge is to help patients achieve a degree of autonomy as soon as possible, [so that when] leaving the resi-*

*dential centre they can go into a brighter future.*” The social educators encourage people with a mental illness to participate in everyday life – and do not see them as a ‘victim’ but as a self-determining person.

### ***Involvement and mutual acknowledgement***

Mutual acknowledgement is another form of social inclusion. To facilitate the recovery process, it is important that the relation between the social educator and the person with a mental illness contains the element of mutual acknowledgement, and not just one-way communication. Mutual acknowledgement is expressed in the following quotation, where a social educator from Denmark working within social psychiatry, expresses her feelings in response to rudeness from patients:

*“We also focus on the language we use. It is difficult to repeatedly suffer verbal abuse when bringing medication, for instance. Verbal abuse has the effect of distancing the speaker. Our strategy is to express our feelings, saying for example that their language is hurtful. This has a disarming function and the result is a more equal dialogue. Patients have to include us as much as we include them.”* This aspect concerns recognising one another as fellow human beings – and having respect for one another.

Mutual acknowledgement also means that people suffering with a mental illness have the experience of giving, rather than simply being a ‘passive patient’ (Christensen 2012:28). In practice this means including the individual in different activities – such as everyday chores like preparing medication or food and cleaning. Lack of involvement of the person is often a barrier in relation to the rehabilitation effort.

An example of an everyday activity is the so-called ‘kitchen project’ described by a Danish social educator, where residents help to prepare food. This enhances self-confidence and provides *“...a social community where they can practice their skills. There is for example one man who comes into the kitchen and opens tins for me; he is very, very proud of it.”*

A Danish social educator working within forensic psychiatry describes inclusion as co-determination: *“We try to focus on ways in which we can increase co-determination, which can be an advantage to the patient as well as the community here.”*

Within forensic psychiatry, staff focus mostly on involvement in activities within the institution because the residents have severe issues. The Danish social educator continues: *“On a societal level it is more difficult. We have to take our patients out to socialize and re-socialize, so that they can learn how to function socially and interact with their surroundings. But it is really a complex matter that requires a lot of attempts for many of our patients.”*

### ***Employment integration***

Employment is an important resource in the path to recovery and maintenance of positive mental health. The social and occupational integration of persons with mental illnesses is a wide-ranging issue and is influenced by the local environment. The chances of successful employment integration decline the longer a person with a mental illness has been away from the labour market. A cross-sector action plan that can help reintegrate persons with mental illnesses into employment is therefore needed (The Swiss report Schweizerische Eidgenossenschaft 2016:44 is, among other things, concerned with this).

Within social psychiatry, many people suffering with a mental illness have the opportunity to participate in daily activities outside the institution. One of the social educators from Denmark cites the example of a girl who helps out at a department store: *“A girl told me the other day that a man asked her where he could find the coffee, and this she knew, even though the department store is a very big place, so she was very proud.”*

Domestic environments are central to inclusion and recovery. It is important that the domestic situation offer opportunities for social intercourse with others – whilst also respecting individuals’ different needs for social intercourse, which was pointed out in some of the interviews. In relation to this, the social educator must respect and recognize different personalities.

### **Medicine within the recovery perspective**

Medical pedagogy is a relatively new approach within psychiatry. It aims to inform people suffering with mental illness about their use of medication, and to strengthen their co-responsibility. The approach allows for rehabilitation alongside medical treatment (Ørtenblad & Hansen 2012:9). Some individuals require psychoactive drugs, for a short or longer period, in order to live a satisfactory life. But in a recovery perspective,

medicine is used only as a tool to aid recovery (Ørtenblad & Hansen 2012: 17).

Medical pedagogy is a method used to help the person with a mental illness to better understand the effects and side-effects of psychoactive drugs. It is also used to strengthen the person's autonomy in his or her use of medication. Many patients undergoing psychiatric treatment are not accustomed to participating in their own treatment; but in a recovery perspective, the user's active role is essential.

*Medical pedagogy* is based on a person-centred view of the individual suffering with mental illness. It involves strengthening cooperation between the practitioner and the patient, for example allowing the individual increased responsibility for their medication. A shared understanding of the person with a mental illness as an expert on his/her life, experience of medicine and mental illness may be extremely helpful, with practitioners acting as experts on different treatment opportunities (Ørtenblad & Hansen 2012:10).

Evidence shows that people who are involved with and active in their own health care have better overall health and functionality. A higher quality of life and greater satisfaction with their care are also reported (MacDonald Wilson et al. 2013:258). Hence, cooperation with the patient about their medical treatment encourages the individual to recover by giving him or her a feeling of greater commitment and responsibility. The individual's right to co-determination in their own treatment is a central element in the recovery process because it gives the person the chance to take charge of their own life (Christensen 2012:16; Jensen 2002:20).

### ***Responsibility for medication***

Inclusion in one's own treatment is mentioned in the interviews where an individual with a mental illness is included, for example in an *Open Dialogue*. Here, decisions are made *together* with the person and the network of that person. In this perspective, the mental illness is seen as a crisis within a network of relations. It is therefore important to include the person's network, so that they can better understand the situation and act accordingly. A social educator from Denmark working within social psychiatry describes this method:

*“Some do not want to be a part of this, but it has to do with taking responsibility for their own medicine, their own lives. But most of them participate in the meetings. It is an open dialogue, so decisions are made around that table, not before. The psychiatrist here is also very positive about it.”*

Some of the social educators, mainly Italian and Danish, make use of *psychoeducation groups*, which consists of a facilitator and a group of residents who share their experiences with medication. Life story work and everyday life is central to the psychoeducational method. Through dialogue and reflection residents gain knowledge, motivation and responsibility for their own use of medicine.

A Danish social educator working within social psychiatry says that patients who are able are involved in taking their own medicine: *“We work on the basis of medical pedagogy, where those who are able take responsibility for collection and dosage of their own medicine whilst I sit next to them.”* A social educator from Switzerland, working within social psychiatry agrees: *“Patients are responsible where possible; otherwise we can support them so far as they need.”*

Even though co-responsibility and co-determination are significant, the importance of giving the individual the opportunity to temporarily relinquish that responsibility during periods of crisis is also pointed out. The social educator from Denmark working within social psychiatry was very close to a female resident, who was a manic-depressive. Because she knew her very well, and due to her very structured everyday life, the social educator always knew when the woman needed to relinquish responsibility, and just stay in bed. She accommodated the patient’s specific needs in connection with nervous episodes. The amount of responsibility that can be shared differs from individual to individual. It is up to the social educator to assess whether the patient can handle responsibility and support them when they cannot.

### ***Reducing medication - and complementary strategies***

The social educators report that a focus on medication has been – and still is – a huge part of treatment, but there is an increased focus on other approaches to medicine. Complementary strategies can be very useful in the effort to reduce medication. The Danish social educator working within forensic psychiatry de-

scribes how cognitive therapy also can be used in relation to reducing medication:

*“Earlier focus was on drugs and they are still a huge part of the treatment here, but there are other approaches. We try to use approaches other than purely medicinal. Cognitive therapy can for example be helpful.”*

On the same subject of reduced medication, a social educator working within social psychiatry in Denmark says that they are striving to follow suggestions from the Danish National Board of Social Services, which recommends only one preparation per person: *“All of the residents here have actually had their medication reduced to a single drug, which is moreover unusual within social psychiatry.”*

A social educator from Spain working at a pedagogic farm centre states that one of their primary goals is to reduce medication: *“Reduction in the use of force and medication are definitely our most important goals.”* The Brazilian social educators also highlight the importance of reducing the number of instances of medical diagnosis and medication.

On the other hand, reducing medication should not be a goal in itself. Instead, the focus should be on prescribing the *right dose*. This is highlighted by a Danish social educator within forensic psychiatry. For many of the residents he works with, a life without medicine is not possible: *“...therefore our focus is primarily to give the right dose of medication”*

In relation to reducing medication and the use of force the Norwegian social educators says, *“There are some examples of vicious circles, with a lot of self-harm and other forms of bad behaviour that is curtailed through forced treatment. Treatment without medication is rarely discussed.”* Thus there is little consideration given to a medication-free approach.

When trying to reduce medication and ascertain the right dose, it is important to be aware that reducing medication has some side-effects, such as described by a Danish social educator within social psychiatry: *“We only give medicine to the point where the person feels balanced, but not more than that. We know that it gives rise to a lot of feelings when we reduce the*

*medicine... and then it's important the environment is tolerant."*

People suffering with a mental illness may have concerns about their use of medicine, such as side-effects; whether the medication can adequately control their symptoms, or the possibility of addiction. Therefore it is important for social educators to have tools and methods to support the individual's use of medication. Other complementary strategies social educators make use of are *NADA acupuncture* (cognitive meditative practice), *Walk and Talk*, *Mindfulness* or *Music Cure*.

The methods aim to support the individual's use of alternative strategies as a supplement to, or instead of, medication. One of the social educators from Denmark working within social psychiatry works with people who hear 'voices'. She says:

*"It is invalidating when the inner voice begins to beat your own voice and maybe this voice tells you how bad a person you are, that you should be ashamed and maybe just jump in front of a train to solve everybody's problems."* She further says that, *"Listening to music is a way of mastering 'voices'."*

Complementary strategies are a way of managing problems – whether these are side-effects of medication or symptoms of the illness. *NADA acupuncture* is not a method in itself but a link between therapeutic and medical methods. It is a good supplementary treatment to employ when increasing or decreasing residents' doses of medicine.

*"They may have nightmares, or feel unable to read or watch television. NADA can help the body through that phase, and it is a very effective method"*, says a Danish social educator working within social psychiatry.

A social educator from Italy working at a residential rehabilitation centre describes some of the complementary strategies that she is required to adopt. In addition to psychoeducation groups, these can be *"...graphic pictorial activity, groups of music therapy, problem-solving groups, reading and writing groups or learning groups for self-administration of pharmacological therapy."*

Physical activity is also important for people with a mental illness, as described by the Spanish social educator who uses equine assisted therapy. In locked wards such as are a feature of forensic psychiatry, people should also have the opportunity to join in activities on the ward. Physical activity can improve the ability to manage a mental disorder, which can often be related to physical discomfort as well as to lifestyle diseases relating to drug abuse or taking medicine. Some of the social educators explain their principal function as the encouragement and motivation of individuals with a mental illness to live a healthier life. The motivation part is very important, especially for harm reduction, which is concerned with reducing drug usage.

### **Harm reduction and motivation**

A dual diagnosis may apply when a mental illness and substance abuse occur simultaneously. There are many types of dual diagnosis – a problem may have arisen in connection with a recreational substance and be followed by the development of a mental health condition – or the reverse can happen. People can also receive multiple mental diagnoses at the same time.

The issues faced by the social educators working with people with a dual diagnosis are more complex than where mental illness is the sole issue. Moreover, recovery can be very challenging for people with a dual diagnosis. Also, heavy use of psychiatric drugs can hinder the process of recovery (Christensen 2012:28). Many people stay on medication or continue to abuse a substance because they are unaware of alternative options (Hall 2012:8). There is a risk that persons suffering with mental illness *and* drug abuse are left behind because the psychiatric service cannot help in cases of ongoing drug or alcohol addiction. It can be very difficult for the system to treat individuals with such complex issues. Harm reduction can be a way of handling drug abuse by someone suffering with a mental illness.

The Harm Reduction Coalition describes harm reduction as “...a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs” (Harm Reduction Coalition Website). There is no universal method for implementing harm reduction, and as the American mental health advocate, Will Hall, says, “*There is no single solution*

*for each person, no universal standard of 'success' or 'failure'" (Hall 2012:7). But what is highly characteristic of social educational work is practitioners' specialist knowledge of complex issues and the absence of definitive ideas of what will work. The work involves experiment to see what works for the individual.*

The harm reduction approach is a way of reducing risks and harm caused by licit or illicit psychoactive drugs. It is not necessarily about reducing drug consumption, or getting rid of the problem – it is rather a matter of informing people about the options and resources available to them and supporting them in making informed choices that reduce risk and result in a healthier lifestyle (Hall 2012:8).

The social educators from Brazil describe harm reduction as one of their main tools: “...when we work with community groups we work with the personal options and control of drug consumption instead of abstinence, as a target to reach.” They state that it is very important to take the individual's resources into account. Often complete abstinence is impossible; instead, they must be helped to control their consumption.

Within forensic psychiatry, many people receive a ‘triple diagnosis’. This implies a mental illness, drug abuse and involvement in a criminal act. A Danish social educator within forensic psychiatry describes harm reduction as a way of recovery in relation to drug abuse or crime as well as to mental illness:

*“The goal is not that they have recovered from their mental illness, but that they have reached a point where they can live a tolerable life. To believe that they recover 100 percent is not realistic. So, it's a place in between.”*

Harm reduction may also be understood in relation, for example, to overeating or an addiction to sugar. The social educators find it important that individuals are approached as equals – and that lecturing on what is harmful and what is good should be avoided. In this respect, a Danish social educator working within social psychiatry stressed motivation, which is a huge part of her daily work.

*“It is hard to say to a person with so many other difficulties: ‘maybe you should not eat white bread’. Basically it’s about responsibility. So it’s all about motivating them to take that responsibility.”*

As mentioned earlier, motivation is a vital part of harm reduction. A social educator from Switzerland describes motivation work within social psychiatry as crucial for the residents’ everyday life: *“The clients have to be motivated. They have a set of goals and try to achieve these goals. I am supporting clients to cope with daily challenges. Motivation work is very important and often necessary. They are for example not very active.”*

Trying to keep the residents active and healthy is important in relation to their mental and physical health.

A Danish social educator working within forensic psychiatry, describes what he does, for example when a person wants to quit smoking: *“Instead of focusing on why the person began smoking, we talk about what advantages there are if they quit. And then we begin the motivating dialogue.”*

The paths to harm reduction depend very much on the individual. Some people do not need to make any lifestyle changes. Others need to make changes in their lifestyle, or establish a new, stronger network. Some may need to focus more on self-care, or the use of complementary strategies –which can be many different things. Such strategies include exercise, diet plans, conventional therapy, stress relief, NADA acupuncture and music therapy. What is very important is that the social educator demonstrates acceptance and patience (Hall 2012:8).

### **The importance of aesthetics for mental health**

Aesthetics has to do with the sensory experience of beauty. In social educational work with people with a mental health condition, this is of great importance for the rehabilitation process. Participation in arts and culture helps people suffering with mental illness participate in the wider community and consequently contributes to their self-esteem, confidence and ability to build social networks.

Within the aesthetic approach there is a process called the *aesthetic learning process*, which has to do with aesthetic activities that usually involve experience, realisation, impressions and

expression, rooted in sensory perception. This may for example take the form of drama, music, art or handicraft. It may also be food preparation or appreciation.

The aesthetic learning process involves interaction between cultural forms of expression and the individual's aesthetic experiences – it is relational. This means that the individual shapes cultural forms of expression through their creativity; in turn, aesthetics also shape the individual's identity. Aesthetic activities give the individual the opportunity to reflect on new roles, narratives and values. It opens the mind towards different realities. This self-development process, whatever the activity, needs to be one of freedom and joy. Co-determination and participation on a voluntary basis are therefore crucial, as underlined in the section on social inclusion (Siersted 2008:522).

The aesthetic learning process is usually non-verbal. Instead, it is a physical, sensual and holistic experience. It expresses and processes the inexpressible, including emotions. It is transcending; it transforms fragmented impressions into an expressed whole (Siersted 2008:523). Painting, for instance, is a way of expressing one's self – a painting is a unique creation that reflects the unique individual. It is also something for which the individual can be recognised.

Creative and aesthetic processes have many physical, as well as psychological, benefits. Several studies within a range of fields emphasize our relation to a sense of beauty through art, culture and music. For instance, a population-based health study in central Norway stresses the positive outcomes of receptive and/or creative cultural activities. The health-related outcomes include greater satisfaction with life and lower anxiety and depression scores (Cuypers et al. 2011).

Other studies show that intense enjoyment of aesthetic processes includes the perception and experience of discovery and connectedness. Art brings meaningfulness and existential reflection into the individual's life. It also promotes emotional and spiritual needs, self-understanding and emotional integrity. Hence, it can be very helpful in encouraging hope (Moutamid & Funch 2012:437, Csikszentmihalyi & Robinson 1990:22,178).

### *Aesthetics in practice*

There are various examples of aesthetic activities in the interviews with the social educators. Especially within Spanish, Swiss, Danish and Norwegian contexts, aesthetics is described as important. A Spanish social educator working at a pedagogic farm says, "...*there are many things related to aesthetics in our job.*" A Norwegian social educator working at an emergency ward for young people describes aesthetics as "...*a daily framework.*" Some mention the beautiful surroundings of the institution, for instance; one Swiss social educator refers to the location as a "...*nice house in the countryside with a pond.*"

A Danish social educator says, "The *residents have decided how they wanted the rooms to be arranged.*" Some describe the décor of the rooms, which might for example have paintings on the wall, while others describe aesthetics as activities such as painting or food preparation. The Brazilian social educators describe art as one of their tools, which they use as "...*a pretext to work together and discuss themes about social relations.*" Not all of the social educators focus on aesthetics in their daily work, but those who do find it very beneficial.

When the interviewer asked a Danish social educator about creative work within forensic psychiatry, the social educator said that although it existed as an option, residents were not really interested in it: "*It challenges their identity. It would be an activity for only a few, and it would be difficult to establish. But there are no limits. If somebody wants to play an instrument to unfold their creativity we would like to give them the opportunities.*"

According to the Danish social educator working within social psychiatry, preparing food together with residents is an excellent means of inclusion – but also of getting to know them, and encouraging them to reflect on different kinds of experience involving food. The social educator knows the favourite dish of every resident. The aesthetic experience is a different way of forming a close relationship with residents:

*"It creates a good relationship with the residents, like when you ask: 'What did you like the most?', 'What kind of feelings do you relate to it? 'What do you dream of to eat that you have not tried before?' And then we try to fulfil their wishes."* Staff allow residents to co-determine outcomes when they participate

in food preparation. If they want to taste or prepare a different kind of food, they may.

The interview further mentioned cooperation with the local priest about a reading-project in the church. Here, an aesthetic, non-verbal experience includes listening to music:

*“I think this is also a part of the social educational work, a kind of pastoral care, not like the priest does, but just on a human level. The group of residents who go to church at night are very happy about it, they light candles for those they have lost, and they sit in this enormous room listening to music. We do not talk much, but always on the way home there is a feeling of relief.”*

An enrichment of the individual’s ‘inner life’ is essential for taking the next step in changing his or her life situation. The creation of art and learning how to enjoy it are vital aspects in the development of the individual’s potential and identity.

### **Cross-professional work**

Positive cross-disciplinary work within mental health is crucial for the provision of a good and effective service and consistent treatment for the person with a mental health condition. Good cooperation and a healthy workplace are the fundament which supports good mental health among residents, because they represent an accommodating, accepting environment.

The importance of interdisciplinary cooperation is emphasized in the EU project RESME (On the Borders between Residential Child Care and Mental Health Treatment in Europe, 2012-2015). One aspect is cooperation within an institution; another important aspect stressed by RESME is the cooperation between sectors. Often individuals with a mental illness transfer between institutions, and sometimes they ‘fall through the cracks’ of the system because of a lack of cooperation between sectors. Interdisciplinary cooperation must therefore improve (Groen & Jörns-Presentati 2015:138).

### ***Positive attitudes towards cross-disciplinary work***

The social educators interviewed see cross-disciplinary work as essential within psychiatry and, moreover, as advantageous because the different professional approaches complement each other. An example of this is expressed by the Swiss social edu-

cator working in the field of social psychiatry. *“It is good to be a social educator in this context. We have also psychiatric nurses and this mix is very helpful.”* A similar experience is voiced by a social educator from Russia, working at a family and child support centre: *“For the client it is more effective if we work as a team, we can help more.”*

There are very different ways of thinking among the different professional disciplines. Often they complement each other. An example of this is cited by a social educator from Norway working within social psychiatry, who sees many opportunities in this cooperation, for example *“...ideas from different perspectives, more people to discuss each case, and coordination of observations and treatment plans.”*

The social educators from Brazil say that *“...cooperation brings us the opportunity to think about our daily work, exchanging techniques, self-criticism, enlarging our view, learn, updates... and review of our beliefs.”*

Another example of the experiences of different disciplinary approaches complementing each other is given by a Danish social educator within social psychiatry:

*“When nurses enter a pedagogical field they also learn a lot from us, they have another kind of knowledge, they look for something somatic, we are not so good at this, and if we do it we always have a more holistic way of assessing it. Maybe the nurses say there is diabetes, maybe we focus more on diet, sports and so on. In this way we complement each.”*

A social educator from Italy working at a residential and rehabilitation centre underlines the advantages of cross-professional cooperation, because it allows different professions to learn from each other and subsequently agree upon the best treatment for the resident: *“I think that the cooperation can improve the knowledge and consequently the skills of the different practitioners. The opportunity of the integration of skills is to find a good compliance.”*

In continuation of this, a Danish social educator within forensic psychiatry points out that in connection with the activities with the residents; it is an advantage for staff to adopt different positions:

*“We also have different professional standpoints, and we want to make use of that. So sometimes we differentiate the activities according to the different professional competences. With the different approaches, we can shed light on different aspects of the activities.”*

Furthermore he says that because of the challenging field in which they work, they need to support each other:

*“We can have our professional disagreements, but we are still a team. And because we are dealing with very complex issues, we need to support each other. But there is always room for improvement.”*

### ***The challenges of cross-disciplinary work***

Although many positive outcomes result from cross-disciplinary work within the field of mental health, naturally it can also give rise to certain problems, challenges, and dilemmas, within as well as between different institutions, systems and sectors. Knowledge bases and professional backgrounds are an advantage, but can also be a challenge. Specialized knowledge of a certain field is essential for the quality of work – and of course empowers the practitioner to solve a problem. Conflicts may however occur when the exponents of diverse specialized knowledge sets are required to cooperate with each other (Lauritsen 2008:91).

The social educators working within mental health cooperate with representatives of a variety of other fields, such as social workers, psychologists, nurses, doctors, physiotherapists and occupational therapists. Consequently, they face complexity in their daily work, with many actors attempting to solve certain issues from their own specific point of view. This also becomes apparent in the interviews.

It can be very stressful for both resident and practitioner if the latter is uncertain of his or her role and the role of others. A social educator from Denmark working within social psychiatry describes how lack of cooperation impacts the residents in a negative way:

*“It is obvious that if the staff feel stressed it influences the residents. So we have to make sure that the agreements about the*

*residents are clear, and to remember what role you have in relation to that. It is really good that we have so many professions, but it is also a challenge.”*

The Brazilian social educators say that within mental health cross-professional cooperation is improved if focus is not exclusively on diagnosis and the medical view of the person, but rather centres on the individual: *“We believe a medical centred method reduces the quality of inter-professional cooperation, because it creates a hierarchy among professions and knowledges.”*

A Danish social educator working within forensic psychiatry also describes the complexities of cooperation and differences in the way of thinking among the different practitioners. He gives an example from his daily work with occupational therapists who *“...have so many tests; they can put people into a pigeonhole.”* He feels that social educators do not put people into categories to the same extent as healthcare practitioners. If different professionals learn from each other and complement one another it is an advantage.

#### ***Defining the social educational role***

Certain factors affect cooperation within as well as between institutions. Focus in the RESME project is in particular on professional *roles* and *responsibilities*. Our interviewees are also concerned these issues, as we have seen in the previous section. The roles of professionals are influenced by cultural and social factors that are key elements of professional discourse and the treatment decision. Problems may include competing values and ethics, as well as an uneven distribution of power and status. The dividing line between different disciplines is often the specific view of humanity and development that they incorporate (Lauritsen 2008:90). Despite these barriers, there is a potential for improved cooperation.

The social educator from Spain working at a pedagogic farm sees knowledge-sharing as a good way of understanding the roles and realities of other professions:

*“We have the chance to learn a great deal of other professions in the way they understand and define reality, as well as in the different realities of the patients. Each one of us has his/her own way to approach and solve problems.”*

In a cross-professional field like mental health, it can sometimes be difficult to define the role of the social educator. This aspect is mentioned in several of the interviews with the social educators. For instance a Danish social educator working within forensic psychiatry maintains that there is a need for more social educators within treatment psychiatry to strengthen the professional role: *“A strong mono professional competency is crucial for a strong cooperation. This means to give the possibility for more pedagogues to enter this field to strengthen their mono professional competency.”*

To give the person with a mental illness the best treatment possible, it is important that each practitioner has a cross-professional way of thinking. The social educators must understand the scope, strengths and limitations of the socio-educational profession within psychiatry. If the social educational role is not clearly defined, the work can become very demanding; moreover, the requirement to fulfil different responsibilities and tasks incurs intense stress. It is therefore important to clarify the various roles and responsibilities. This implies that the practitioner must understand the spheres of action of other professions, as well as their own role and responsibilities (Smith & Del Valle 2015:11).

The importance of defining the social educational role within mental health is also highlighted by the Brazilian social educators. They think that working relationships could be improved if their colleagues from other disciplines were more familiar with social educators’ skills, competences and methods as applied to the field of mental health.

*“Then our co-workers will understand better how we can help people with their needs, and they will be better at evaluating in which situations we can be asked to collaborate, and in understanding the importance and the effect we have on people we work with.”*

The characteristics of social educational work as represented in some of the interviews suggest a focus on what is meaningful for the individual. They do not define an aimed-for ‘normality’ or a certain way to perform an activity, as described in the section on inclusion. A Danish social educator working within forensic psychiatry gives a specific example to illustrate his

experience of the difference between his own and other professional approaches within mental health:

*“It took me a very long time to understand what the difference was, for example between an occupational therapist and a social educator within this field. But the occupational therapist looks at an activity to either screen or improve the activity.”* He goes on to underline his understanding of the fundamental tenet of social educational work: *“The recognizing approach to our patients, and to support their resources - to try to make these visible.”*

Similarly, a social educator from Norway working in an emergency psychiatric ward for young people describes her understanding of a social educational aim: *“Focusing on each individual’s resources to manage the situation, and making a treatment plan that fits the patient’s wishes.”*

The social educators from Brazil define their competencies as: knowledge of how society works and of the citizen’s rights; communication skills relevant to the target group, families, relatives and other practitioners; and group guidance techniques. Another characteristic of their work, they say, is to *“...respect each individual we work with.”*

In continuation of this, a Danish social educator within social psychiatry says: *“...we [social educators] never see the person as “sick”, because our background is not in the hospital field. We have much more focus on the creative, on the whole human being, the holistic way of thinking, to encourage hope, to help them through the daily life.”*

Common to many of the social educators’ descriptions of their daily work is a focus on the individual’s unique abilities. A successful cooperation means that the practitioner adapts to the cross-professional work by supplying his or her skills, whilst recognising the competences of other practitioners. To summarise, a crucial factor in this relationship is mutual respect for each discipline’s strengths.

### ***Different competences – same language***

A successful cooperation needs good coordination, timing and logistical planning by members of the different professions. A good and coherent plan of action for those suffering with a mental illness should furthermore be promoted, rewarded and addressed in social policy so that social educators working with people with complex needs are valued and receive adequate training. Shared knowledge and competences are essential to successful cooperation. This includes continuing professional development courses *together* with different practitioners and the exchange of experience with professionals working in other sectors. A crucial aspect, which was highlighted in the RESME project, was the opportunity to network, to discuss case studies from an interdisciplinary perspective and to engage with the relevant research literature (Groen & Jörns-Presentati 2015:151).

Sometimes the different practitioners can entertain divergent attitudes and expectations. It is therefore important to communicate experience. Communication with practitioners from other areas ensures a better understanding of their work tasks, but also of the complex needs of the person with a mental illness. In order to make constructive decisions it is important that different approaches are combined into a single joint action plan, where the different approaches complement each another.

A social educator from Italy working at a day care and rehabilitation centre remarks: *“Every professional uses his professional instruments to treat the patient and his or her problems. Teamwork makes interventions coherent, holistic and oriented in one direction.”*

The social educators from Brazil explain that they *“have these matrix support meetings where we meet other professionals to exchange methods, techniques and points of view about how to deal with some particular situations.”* The importance of sharing knowledge is also emphasized by the social educator from Switzerland: *“The sharing of knowledge is a very good opportunity to stay motivated and also a good prevention concerning burnout. We have also supervision sessions. It is always interesting to hear the opinion of others.”*

A good way to avoid talking at cross-purposes within the work on mental health is to gather the different practitioners together

to enable a sharing of experience and knowledge and where possible to offer courses that allow a shared attitude and language to develop. This is emphasized by a social educator working within social psychiatry in Denmark: *“Today we believe, and we know - also articulated in the [Danish] Government’s 2020 Goals - that it is possible to recover if you have the right methods and possibilities. So today, when we are at meetings, we talk about the same.”*

### **Financial resources and political prioritisation**

Social educators work within a framework of limited resources, which affects the options available to them. They navigate a field of tension, between demands and expectations on the one hand and flexibility and their professional judgement on the other hand. It can thus be argued that there is a tension between economic progress and human progress – or in other words, between economic efficiency and social well-being. A political focus and prioritisation of mental health within national policies and the national budget are crucial for social educational work and the recovery of people suffering with a mental illness.

WHO states that financial resources are a barrier to effective work in the field of mental health: *“Governments need to dedicate more of their health budget to mental health. In addition the mental health workforce at each level of the health care system needs to be developed and trained to ensure that all people have access to good quality mental health services that promote recovery and respect for human rights”* (World Health Organization website). WHO also stresses the fact that governments need to prioritise mental health, to protect the human rights of people with a mental health condition and to contribute to the recovery process. The question of limited resources was reiterated by the interviewees.

The social educators were asked whether political focus was directed towards issues of mental health and how budgeting priorities were set and grants awarded in their country. The welfare systems and economic prioritisation differed from country to country. Several of the social educators stress the importance of economic prioritisation within the national budget and referred to limited resources for continuing professional development as well as for treatment of people with mental illnesses.

The Russian social educator states that they “do not work with grants” and the Swiss social educator notes that the field of mental health “is part of the social insurances. At the moment there is no priority.” A social educator from Spain working at a pedagogic farm remarks: “In Spain psychiatry is not really a political focus, I believe. It is very difficult to obtain a grant in our field.” The other social educators describe similar problems. An Italian social educator cites limited resources in relation to improvements in education: “I think we need more financial resources dedicated to lifelong learning.” Another Italian social educator describes the unequal distribution of economic resources: “Health Care Finance in Italy has high costs but not in mental health field.” A social educator from Denmark working within social psychiatry states that the budget does not follow the increased number of persons with a mental illness.

WHO’s suggestion, as referred to in the section on *social inclusion* is that institutions be replaced by community mental health care. Some political proposals focus on this. For example, the Norwegian social educator mentions the reduction in beds at institutions and treatment of people at home. There was a similar trend in evidence in the answers of the Danish interviewees. A very important aspect is that community-based support needs to be backed up by the availability of beds in psychiatric care as well as practitioners – if there is a shortage of beds in treatment psychiatry, there is a risk that persons who are not ready to live on their own will be left to themselves.

A Danish social educator working within forensic psychiatry remarks that the political focus in Denmark, resulting in cut-backs on beds within treatment psychiatry and on staff, disadvantage people suffering with severe mental illnesses. The Danish social educator points out the consequences of sending people home too early, especially in view of the fact that home surroundings are much more complex than those of an institution, where it is possible to observe the person with a mental illness. The social educator says, “Patients fall through cracks of the systems when they are discharged from the psychiatry as fast as possible.” The social educator argues that more beds within treatment psychiatry are needed – as well as increased funding for this field. If people with a mental health condition are not given prompt and comprehensive treatment, there is a risk that their mental health will decline. Therefore, it is very

important that they are not left in the care of a community that is under-resourced, but discharged only when they are ready to live on their own.

The Norwegian social educator working in an emergency psychiatry ward, says that the focus on New Public Management (NPM) includes a policy to optimize the public sector by e.g. decentralizing management, making more cutbacks (in response to criticism that the public sector is ineffective) and focussing on the needs of the individual/the service user. Within the orientation of New Public Management the individual is to a higher degree responsible for his or her own development. Recovery orientation also focuses on the individual, but in a more relational way, which incorporates a focus on the surroundings and the need for the change in surroundings as well as in the individual. The approach is more inclusive.

The Norwegian social educator says, “*Money decides a lot...*” He continues to explain the question of “*How we get the maximum of treatment out of a minimum of money.*” Services must be effective whilst observing limits on expenditure. Social educators must apply instrumental rationality, wherein the needs of the person suffering with a mental illness must be balanced against structural demands. Often, this involves contradictory ideologies and sometimes contradictory goals. In this respect, New Public Management is criticized for focusing too much on efficiency and marketisation.

The Italian social educator working at a rehabilitation centre states that some political priorities are not implemented, for instance in relation to the Basaglia law. “*Attention and implementation of Law 180 of 1978 [Basaglia law], has not yet become operational, as it was designed. It would be helpful for the establishment of a National Commission on Mental health at the Ministry of Health.*” The Basaglia law in Italy is built on the idea of replacing institutions with community-based services as prescribed by WHO – on the basis that people with a mental illness should not be segregated from the rest of the society, for example by placement in mental hospitals. But the social educator feels that more political attention should be devoted to the issue.

## Conclusion

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Social educators have many valuable skills to offer to the field of mental health, especially with regard to recovery-oriented work. As we have seen, the interviews with social educators reveal a person-centred approach, which is of great value to the recovery process. To summarise, the vital factors for the recovery process include:

- A change in orientation from pathology to health and strength.
- Hope is central to recovery.
- Recovery is closely linked to social inclusion, including meaningful relations in the local community.
- The (re)discovery of a personal identity that is defined by issues other than mental illness.
- Support is very important for a recovery process – both from the professional practitioner and the individual's relatives and network.
- A focus on individual needs.

Social educators also face challenges within the field of mental health. They mention, as some of their greatest challenges, prevailing attitudes and prejudices in society regarding persons suffering with mental illnesses. Overcoming stigma is a huge problem, which is a barrier to recovery. From a human rights perspective, societies need to be more inclusive and accommodate individual differences. Furthermore, the political prioritisation of recovery-oriented mental health measures is crucial.

Another challenge is the need to define the special competencies that social educators can bring to the field of mental health. This report acknowledges that social educators have a very strong focus on the autonomy, empowerment and inclusion of persons with a mental illness. These factors are important if we are to improve the life situation of individuals with mental health conditions and to ensure that their rights are respected.

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## **Annex 1 – Interview guide**

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### **Introductory data**

- 1) What kind of workplace within the psychiatry are you working at?
- 2) What target group do you work with?
- 3) What tasks are you hired to perform?
- 4) What other professions do you cooperate with?
- 5) For how long have you been employed at your workplace?
- 6) What challenges does this target group/do these target groups you are working with have?
- 7) What capabilities/competences do you use in your social educational practice when you support this target group/these target groups in your daily work?

### **Target group(s) and the social educational practice**

- 8) Can you give an example of how you work social educational with a concrete person and how this is making a difference for that person?
- 9) Can you identify specific methods you are working with in your daily work? If yes: What methods?
  - How do you share information about working with methods/the use of them in practice?
  - Are these methods documented? If yes: how?
10. What do you experience as the biggest challenge in your work?

### **Cross-professional cooperation**

11. What does your cooperation with other professions consist in?
12. What opportunities do you see in this cooperation?
13. To what extent are these opportunities expressed in your daily work?
14. Do you think that this cooperation can be improved for the benefit of the persons/clients you are working with? If yes: What can, in your opinion, improve the working relationship?

### **Values in the social educational work**

15. What do you think about the following ideas in relation to your work – and to what extent are these a part of your working day at your workplace?

- Recovery
- Inclusion
- Health
- Mental health
- Harm reduction
- Reduction of force and medicine
- Life story work
- Public involvement
- Aesthetics

16. How would you describe the fundamental value/s behind the effort you make towards the target group/s at your work place?

### **The overall structure**

What possible efforts within the psychiatry are brought into political focus in your country?

How is your field of work prioritized political in relation to economic grants?