



# Recovery practices for mental health and well-being

WHO QualityRights specialized training

QualityRights



World Health Organization

Transforming services and promoting the rights of people with psychosocial, intellectual and cognitive disabilities

Recovery practices for mental health and well-being. WHO QualityRights Specialized training. Course guide

ISBN 978-92-4-151674-7

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The accompanying course slides are available here: <https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools>

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(Ireland); Simon Bradstreet, University of Glasgow (United Kingdom); Claudia Pellegrini Braga, University of São Paulo (Brazil); Rio de Janeiro Public Prosecutor's Office (Brazil); Patricia Brogna, National School of Occupational Therapy, (Argentina); Celia Brown, MindFreedom International, (United States of America); Kimberly Budnick, Head Start Teacher/Early Childhood Educator (United States of America); Janice Cambri, Psychosocial Disability Inclusive Philippines (Philippines); Aleisha Carroll, CBM Australia (Australia); Mauro Giovanni Carta, Università degli studi di Cagliari (Italy); Chauhan Ajay, State Mental Health Authority, Gujarat, (India); Facundo Chavez Penillas, Office of the United Nations High Commissioner for Human Rights (Switzerland); Daniel Chisholm, WHO Regional Office for Europe (Denmark); Louise Christie, Scottish Recovery Network (United Kingdom); Oryx Cohen, National Empowerment Center (United States of America); Celline Cole, Freie Universität Berlin (Germany); Janice Cooper, Carter Center (Liberia); Jillian Craigie, Kings College London (United Kingdom); David Crepaz-Keay, Mental Health Foundation (United Kingdom); Rita Cronise, International Association of Peer Supporters (United States of America); Gaia Montauti d'Harcourt, Fondation d'Harcourt (Switzerland); Yeni Rosa Damayanti, Indonesia Mental Health Association (Indonesia); Sera Davidow, Western Mass Recovery Learning Community (United States of America); Laura Davidson, Barrister and development consultant (United Kingdom); Lucia de la Sierra, Office of the United Nations High Commissioner for Human Rights (Switzerland); Theresia Degener, Bochum Center for Disability Studies (BODYS), Protestant University of Applied Studies (Germany); Paolo del Vecchio, Substance Abuse and Mental Health Services Administration (United States of America); Manuel Desviat, Atopos, Mental Health, Community and Culture (Spain); Catalina Devandas Aguilar, UN Special Rapporteur on the rights of persons with disabilities (Switzerland); Alex Devine, University of Melbourne (Australia); Christopher Dowrick, University of Liverpool (United Kingdom); Julian Eaton, CBM International and London School of Hygiene and Tropical Medicine (United Kingdom); Rabih El Chammay, Ministry of Health (Lebanon); Mona El-Bilsha, Mansoura University (Egypt); Ragia Elgerzawy, Egyptian Initiative for Personal Rights (Egypt); Radó Iván, Mental Health Interest Forum (Hungary); Natalia Santos Estrada, Colectivo Chuhcan (Mexico); Timothy P. Fadgen, University of Auckland (New Zealand); Michael Elnemais Fawzy, El-Abbassia mental health hospital (Egypt); Alva Finn, Mental Health Europe (Belgium); Susanne Forrest, NHS Education for Scotland (United Kingdom); Rodrigo Fredes, Locos por Nuestros Derechos (Chile); Paul Fung, Mental Health Portfolio, HETI Higher Education (Australia); Lynn Gentile, Office of the United Nations High Commissioner for Human Rights (Switzerland); Kirsty Giles, South London and Maudsley (SLaM) Recovery College (United Kingdom); Salam Gómez, World Network of Users and Survivors of Psychiatry (Colombia); Ugnė Grigaitė, NGO Mental Health Perspectives and Human Rights Monitoring Institute (Lithuania); Margaret Grigg, Department of Health and Human Services, Melbourne (Australia); Oye Gureje, Department of Psychiatry, University of Ibadan (Nigeria); Cerdic Hall, Camden and Islington NHS Foundation Trust, (United Kingdom); Julie Hannah, Human Rights Centre, University of Essex (United Kingdom); Steve Harrington, International Association of Peer Supporters (United States of America); Akiko Hart, Mental Health Europe (Belgium); Renae Hodgson, Western Australia Mental Health Commission (Australia); Nicole Hogan, Hampshire Hospitals NHS Foundation Trust (United Kingdom); Frances Hughes, Cutting Edge Oceania (New Zealand); Gemma Hunting, International Consultant (Germany); Hiroto Ito, National Center of Neurology and Psychiatry (Japan); Maths Jespersen, PO-Skåne (Sweden); Lucy Johnstone, Consultant Clinical Psychologist and Independent Trainer (United Kingdom); Titus Joseph, Centre for Mental Health Law and Policy, Indian Law Society (India); Dovilė Juodkaitė, Lithuanian Disability Forum (Lithuania); Rachel Kachaje, Disabled People's International (Malawi); Jasmine Kalha, Centre for Mental Health Law and Policy, Indian Law Society (India); Elizabeth Kamundia, National Commission on Human Rights (Kenya); Yasmin Kapadia, Sussex Recovery College (United Kingdom); Brendan Kelly, Trinity College Dublin (Ireland); Mary Keogh, CBM International (Ireland); Akwatu Khenti, Ontario Anti-Racism Directorate, Ministry of Community Safety and Correctional Services (Canada); Seongsu Kim, WHO Collaborating Centre, Yongin Mental Hospital (South Korea); Diane Kingston, International HIV/AIDS Alliance (United Kingdom); Rishav Koirala, University of Oslo (Norway); Mika Kontiainen, Department of Foreign Affairs and Trade (Australia);

Sadhvi Krishnamoorthy, Centre for Mental Health Law and Policy, Indian Law Society (India); Anna Kudiyarova, Psychoanalytic Institute for Central Asia (Kazakhstan); Linda Lee, Mental Health Worldwide (Canada); Itzhak Levav, Department of Community Mental Health, University of Haifa (Israel); Maureen Lewis, Mental Health Commission (Australia); Laura Loli-Dano, Centre for Addiction and Mental Health (Canada); Eleanor Longden, Greater Manchester Mental Health NHS Foundation Trust (United Kingdom); Crick Lund, University of Cape Town (South Africa); Judy Wanjiru Mbutia, Uzima Mental Health Services (Kenya); John McCormack, Scottish Recovery Network (United Kingdom); Peter McGovern, Modum Bad (Norway); David McGrath, international consultant (Australia); Emily McLoughlin, international consultant (Ireland); Bernadette McSherry, University of Melbourne (Australia); Roberto Mezzina, WHO Collaborating Centre, Trieste (Italy); Tina Minkowitz, Center for the Human Rights of Users and Survivors of Psychiatry (United States of America); Peter Mittler Dementia Alliance International (United Kingdom); Pamela Molina Toledo, Organization of American States (United States of America); Andrew Molodynski, Oxford Health NHS Foundation Trust (United Kingdom); Maria Francesca Moro, Columbia University (United States of America); Fiona Morrissey, Disability Law Research Consultant (Ireland); Melita Murko, WHO Regional Office for Europe (Denmark); Chris Nas, Trimbos International (the Netherlands); Sutherland Carrie, Department for International Development (United Kingdom); Michael Njenga, Users and Survivors of Psychiatry in Kenya (Kenya); Aikaterini - Katerina Nomidou, GAMIAN-Europe (Belgium) & SOFPSI N. SERRON (Greece); Peter Oakes, University of Hull (United Kingdom); David W. Oaks, Aciu Insitute, LLC (United States of America); Martin Orrell, Institute of Mental Health, University of Nottingham (United Kingdom); Abdelaziz Awadelseed Alhassan Osman, Al Amal Hospital, Dubai (United Arab Emirates); Gareth Owen, King's college London (United Kingdom); Soumitra Pathare, Centre for Mental Health Law and Policy, Indian Law Society (India); Sara Pedersini, Fondation d'Harcourt (Switzerland); Elvira Pértega Andía, Saint Louis University (Spain); Dainius Pūras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health (Switzerland); Thara Rangaswamy, Schizophrenia Research Foundation (India); Manaan Kar Ray, Cambridgeshire and Peterborough NHS Foundation Trust (United Kingdom); Mayssa Rekhis, faculty of Medicine, Tunis El Manar University (Tunisia); Julie Repper, University of Nottingham (United Kingdom); Genevra Richardson, King's college London (United Kingdom); Annie Robb, Ubuntu centre (South Africa); Jean Luc Roelandt, EPSM Lille Metropole, WHO Collaborating Centre, Lille (France); Eric Rosenthal, Disability Rights International (United States of America); Raul Montoya Santamaría, Colectivo Chuhcan A.C. (Mexico); Jolijn Santegoeds, World Network of Users and Survivors of Psychiatry (the Netherlands); Benedetto Saraceno, Lisbon Institute of Global Mental Health (Switzerland); Sashi Sashidharan, University of Glasgow (United Kingdom); Marianne Schulze, international consultant (Austria); Tom Shakespeare, London School of Hygiene & Tropical Medicine (United Kingdom); Gordon Singer, expert consultant (Canada); Frances Skerritt, Peer Specialist (Canada); Mike Slade, University of Nottingham (United Kingdom); Gregory Smith, International consultant, (United States of America); Natasa Dale, Western Australia Mental Health Commission, (Australia); Michael Ashley Stein, Harvard Law School (United States of America); Anthony Stratford, Mind Australia (Australia); Charlene Sunkel, Global Mental Health Peer Network (South Africa); Kate Swaffer, Dementia International Alliance(Australia); Shelly Thomson, Department of Foreign Affairs and Trade (Australia); Carmen Valle, CBM International (Thailand); Alberto Vásquez Encalada, Office of the UN Special Rapporteur on the rights of persons with disabilities (Switzerland); Javier Vasquez, Vice President, Health Programs, Special Olympics, International (United States of America); Benjamin Veness, Alfred Health (Australia); Peter Ventevogel, Public Health Section, United Nations High Commissioner for Refugees (Switzerland); Carla Aparecida Arena Ventura, University of Sao Paulo (Brazil); Alison Xamon, Western Australia Association for Mental Health, President(Australia).

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## WHO administrative and editorial support

Patricia Robertson, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse (WHO, Geneva); David Bramley, editing (Switzerland); Julia Faure (France), Casey Chu (Canada) and Benjamin Funk (Switzerland), design and support

## Video contributions

We would like to thank the following individuals and organizations for granting permission to use their videos in these materials:

### **50 Mums, 50 Kids, 1 Extra Chromosome**

*Video produced by Wouldn't Change a Thing*

### **Breaking the chains by Erminia Colucci**

*Video produced by Movie-Ment*

### **Chained and Locked Up in Somaliland**

*Video produced by Human Rights Watch*

### **Circles of Support**

*Video produced by Inclusion Melbourne*

### **Decolonizing the Mind: A Trans-cultural Dialogue on Rights, Inclusion and Community**

(International Network toward Alternatives and Recovery - INTAR, India, 2016)

*Video produced by Bapu Trust for Research on Mind & Discourse*

### **Dementia, Disability & Rights - Kate Swaffer**

*Video produced by Dementia Alliance International*

### **Finger Prints and Foot Prints**

*Video produced by PROMISE Global*

**Forget the Stigma**

*Video produced by The Alzheimer Society of Ireland*

**Ghana: Abuse of people with disabilities**

*Video produced by Human Rights Watch*

**Global Campaign: The Right to Decide**

*Video produced by Inclusion International*

**Human Rights, Ageing and Dementia: Challenging Current Practice by Kate Swaffer**

*Video produced by Your aged and disability advocates (ADA), Australia*

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*Video produced by Special Olympics*

**Independent Advocacy, James' story**

*Video produced by The Scottish Independent Advocacy Alliance*

**Interview - Special Olympic athlete Victoria Smith, ESPN, 4 July 2018**

*Video produced by Special Olympics*

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*Video produced by Lebanese Association for Self Advocacy (LASA) and Disability Rights Fund (DRF)*

**Living it Forward**

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**Living with Mental Health Problems in Russia**

*Video produced by Sky News*

**Love, loss and laughter - Living with dementia**

*Video produced by Fire Films*

**Mari Yamamoto**

*Video produced by Bapu Trust for Research on Mind & Discourse*

**Mental health peer support champions, Uganda 2013**

*Video produced by Cerdic Hall*

**Moving beyond psychiatric labels**

*Video produced by The Open Paradigm Project/ P.J. Moynihan, Digital Eyes Film Producer*

**'My dream is to make pizza': the caterers with Down's syndrome**

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*Video produced by End the Cycle (Initiative of CBM Australia)*



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*Video produced by Rethink Mental Illness*

**No Force First**

*Video produced by Mersey Care NHS Foundation Trust*

**No more Barriers**

*Video produced by BC Self Advocacy Foundation*

**‘Not Without Us’ from Sam Avery & Mental Health Peer Connection**

*Video produced by Mental Health Peer Connection*

**Open Dialogue: an alternative Finnish approach to healing psychosis (complete film)**

*Video produced by Daniel Mackler, Filmmaker*

**The Open Paradigm Project – Celia Brown**

*Video produced by The Open Paradigm Project/ Mindfreedom International*

**Open Paradigm Project – Dorothy Dundas**

*Video produced by The Open Paradigm Project*

**Open Paradigm Project – Oryx Cohen**

*Video produced by The Open Paradigm Project/ National Empowerment Center*

**Open Paradigm Project - Sera Davidow**

*Video produced by The Open Paradigm Project/ Western Mass Recovery Learning*

**Ovidores de Vozes (Hearing Voices) Canal Futura, Brazil 2017**

*Video produced by L4 Filmes*

**Paving the way to recovery - the Personal Ombudsman System**

*Video produced by Mental Health Europe ([www.mhe-sme.org](http://www.mhe-sme.org))*

**Peer Advocacy in Action**

*Video produced and directed by David W. Barker, Createus Media Inc. ([www.createusmedia.com](http://www.createusmedia.com))*

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**Planning Ahead – Living with Younger Onset Dementia**

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**Quality in Social Services - Understanding the Convention on the Rights of Persons with Disabilities**

*Video produced by The European Quality in Social Service (EQUASS) Unit of the European Platform for Rehabilitation (EPR) ([www.epr.eu](http://www.epr.eu) – [www.equass.be](http://www.equass.be)). With financial support from the European Union Programme for Employment and Social Innovation “EaSI” (2014-2020) – <http://ec.europa.eu/social/easi>.*

*Animation: S. Allaeyns – QUIDOS. Content support: European Disability Forum*

**Raising awareness of the reality of living with dementia,**

*Video produced by Mental Health Foundation (United Kingdom)*

**Recovery from mental disorders, a lecture by Patricia Deegan**

*Video produced by Patricia E. Deegan, Pat Deegan PhD & Associates LLC*

**Reshma Valliappan** (International Network toward Alternatives and Recovery - INTAR, India, 2016)

*Video produced by Bapu Trust for Research on Mind & Discourse*

**Rory Doody on his experience of Ireland's capacity legislation and mental health services**

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**Seclusion: Ashley Peacock**

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**Seher Urban Community Mental Health Program, Pune**

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**Self-advocacy**

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**Social networks, open dialogue and recovery from psychosis - Jaakko Seikkula, PhD**

*Video produced by Daniel Mackler, Filmmaker*

**Speech by Craig Mokhiber, Deputy to the Assistant Secretary-General for Human Rights, Office of the High Commissioner for Human Rights** made during the event 'Time to Act on Global Mental Health - Building Momentum on Mental Health in the SDG Era' held on the occasion of the 73rd Session of the United Nations General Assembly.

*Video produced by UN Web TV*

**Thanks to John Howard peers for support**

*Video produced by Cerdic Hall*

**The Gestalt Project: Stop the Stigma**

*Video produced by Kian Madjedi, Filmmaker*

**The T.D.M. (Transitional Discharge Model)**

*Video produced by LedBetter Films*

**This is the Story of a Civil Rights Movement**

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*Video produced by Validity, formerly the Mental Disability Advocacy Centre (MDAC)*

**UN CRPD: What is article 19 and independent living?**

*Video produced by Mental Health Europe ([www.mhe-sme.org](http://www.mhe-sme.org))*

**UNCRPD: What is Article 12 and Legal Capacity?**

*Video produced by Mental Health Europe ([www.mhe-sme.org](http://www.mhe-sme.org))*

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**Why self advocacy is important**

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**Women Institutionalized Against their Will in India**

*Video produced by Human Rights Watch*

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*Video produced by the Pan American Health Organization (PAHO)/ World Health Organization - Regional Office for the Americas (AMRO)*

**You can recover (Reshma Valliappan, India)**

*Video produced by ASHA International*

**Financial and other support**

WHO would like to thank Grand Challenges Canada, funded by the Government of Canada, the Mental Health Commission, Government of Western Australia, CBM International and the UK Department for International Development for their generous financial support towards the development of the QualityRights training modules.

WHO would like to thank the International Disability Alliance (IDA) for providing financial support to several reviewers of the WHO QualityRights modules.

## Foreword

Ensuring mental health and well-being has become a worldwide imperative and an important target of the Sustainable Development Goals.

But in all countries around the world, our response has been woefully insufficient, and we have made little progress to advance mental health as a fundamental human right.

One in ten people are affected by a mental health condition, up to 200 million people have an intellectual disability and an estimated 50 million people have dementia. Many persons with mental health conditions, or psychosocial, intellectual, or cognitive disabilities lack access to quality mental health services that respond to their needs and respect their rights and dignity.

Even today, people are locked up in institutions where they are isolated from society and marginalized in their communities. Many are subjected to physical, sexual, and emotional abuse and neglect in health services, prisons, and the community. They are also deprived of the right to make decisions for themselves, about their care and treatment, where they want to live, and their personal and financial affairs. They are often denied access to health care, education and employment opportunities, and are prevented from full inclusion and participation in community life. As a result, people with mental health conditions and intellectual disabilities die 10 to 20 years younger than the general population in low-, middle- and high-income countries alike.

The right to health is fundamental to the World Health Organization's (WHO's) mission and vision, and underpins our efforts to achieve universal health coverage (UHC). The foundation of UHC is strong health systems, based on primary care, that deliver evidence based, person-centred services that respect people's values and preferences.

Fourteen new WHO QualityRights training and guidance modules are now available to achieve this vision. They will enable countries to translate international human rights standards into practice by influencing policy and building the knowledge and skills to implement person-centered and recovery-based approaches. This is what is required to provide quality care and support and to promote mental health and well-being.

Our conviction is that everyone—whether a service provider or member of the community, needs to have the knowledge and skills to support someone who has a mental health condition, psychosocial, intellectual, or cognitive disability.

We hope that these QualityRights training and guidance modules will be used widely and that the approach they offer will become the norm rather than the exception in mental health and social services worldwide.



**Dr Tedros Adhanom Ghebreyesus**  
*Director-General*  
*World Health Organization*

## Supporting statements

**Dévora Kestel, Director, Department of Mental Health and Substance Use, World Health Organization, Geneva**

Around the world, there is increasing awareness of the importance of mental health and providing services and supports that are person-centred and promote a recovery oriented and human rights-based approach. This awareness comes alongside a recognition that mental health systems in high, middle and low-income countries are failing many individuals and communities due to limited access, poor quality services and human rights violations.

It is unacceptable that people using mental health services can be exposed to inhuman living conditions, harmful treatment practices, violence, neglect and abuse. There are many reports of services not responding to people's needs or failing to support them to live the independent lives in their community - instead their interactions with services often leaves them feeling hopeless and disempowered.

In the wider community context, people with mental health conditions, psychosocial, intellectual or cognitive disabilities are subjected to stigma, discrimination and extensive inequalities that permeate all aspects of their lives. They are denied opportunities to live where they choose, marry, have families, attend school, seek employment and enjoy leisure activities.

Adopting recovery and human rights approaches is essential if we are going to change this situation. A recovery approach ensures that services place people themselves at the centre of care. It focuses on supporting people to define what recovery looks like and means for them. This approach is about helping people to regain control of their identity and life, have hope for the future, and to live a life that has meaning for them, whether that be through work, relationships, community engagement, spirituality or some or all of these.

Recovery and human rights approaches are very much aligned. Both approaches promote key rights such as equality, non-discrimination, legal capacity, informed consent and community inclusion (all enshrined in the Convention on the Rights of Persons with Disabilities). However, the human rights approach imposes obligations on countries to promote these rights.

Through these training and guidance modules developed as part of the QualityRights initiative, the World Health Organization has taken decisive action to address these challenges and to support countries to meet their international human rights obligations. These tools enable several key actions to be realized around: promoting participation and community inclusion for people with lived experience; capacity building in order to end stigma and discrimination and promote rights and recovery; and strengthening peer support and civil society organisations to create mutually supportive relationships and empower people to advocate for a human rights and person-centred approach in mental health and social services.

I look forward to seeing these World Health Organization tools used in countries to provide a comprehensive response to the challenges faced by people with mental health conditions, psychosocial, intellectual or cognitive disabilities.

## **Dainius Puras, Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest attainable Standard of Physical and Mental Health.**

QualityRights offers a new approach to mental health care which is rights-based and recovery-oriented.

This initiative of the World Health Organization is very timely. There is increasing understanding that mental health care policies and services worldwide need to change. Too often services for people with psychosocial disabilities and other mental health conditions are reliant on coercion, overmedicalization and institutionalization. This status quo is not acceptable, as it may continue to reinforce stigma and helplessness among both users and providers of mental health services.

All stakeholders – including policy-makers, mental health professionals and people using mental health services – need to be equipped with knowledge and skills in effective ways to manage change and to develop sustainable rights-based mental health services.

The QualityRights initiative, through specific well-designed modules, provides the necessary knowledge and skills, convincingly demonstrating that change is possible and that this change will lead to a win-win situation. Firstly, persons with disabilities and other mental health conditions, who may need mental health services, will be motivated to use services that empower them and respect their views. Secondly, providers of services will be competent and confident in applying measures that prevent coercion. As a result, power asymmetries will be reduced, and mutual trust and therapeutic alliance will be strengthened.

To abandon the legacy of outdated approaches in mental health care – based on power asymmetries, coercion and discrimination – may not be an easy direction to take. But there is growing understanding that the change towards rights-based and evidence-based mental health services is needed around the globe – in high-, middle- and low-income countries. WHO's QualityRights initiative and its training and guidance materials are extremely useful tools that will support and empower all stakeholders willing to go in this direction. I strongly recommend all countries to take QualityRights on board.

## **Catalina Devandas Aguilar, Special Rapporteur on the Rights of Persons with Disabilities**

Persons with disabilities, particularly those with psychosocial and intellectual disabilities, often experience human rights violations in the context of mental health services. In most countries, mental health legislation allows involuntary hospitalization and treatment of persons with disabilities on grounds of their actual or perceived impairment, plus factors such as “medical necessity” and “dangerousness”. Seclusion and restraints are regularly used during emotional crisis and severe distress in many mental health services, but also as form of punishment. Women and girls with psychosocial and intellectual disabilities are regularly exposed to violence and harmful practices in mental health settings, including forced contraception, forced abortion and forced sterilization.

Against this background, the WHO QualityRights initiative can provide essential guidance on the implementation of mental health services and on community-based responses from a human rights perspective, offering a path towards ending institutionalization and involuntary hospitalization and treatment of persons with disabilities. This initiative calls for training health-care professionals to provide health care and psychosocial support to persons with disabilities in a way that is respectful of their rights. By promoting compliance with the CRPD and the 2030 Agenda frameworks, the WHO QualityRights modules bring us closer to realizing the rights of persons with disabilities.

### **Julian Eaton Director, Mental Health, CBM International**

The increase in interest in mental health as a development priority offers the opportunity to close the huge gap in care and support, enabling people to realize their right to good health care where this has previously been lacking. Historically, mental health services have often been of very poor quality and have ignored the priorities and perspectives of people who were using them.

The WHO QualityRights programme has been instrumental in putting in place the means for measuring mental health services according to the standards of the Convention on the Rights of Persons with Disabilities. This often marks a paradigm shift from the way that services have historically worked. The new training and guidance modules are an excellent resource, facilitating better practice in supporting people with mental conditions and psychosocial disabilities, enabling their voices to be heard, and promoting healthier environments that foster recovery. There is a long way to go, but QualityRights is a crucial resource for service providers and users, guiding practical reform for services that value dignity and respect, wherever they may be in the world.

### **Charlene Sunkel, CEO, Global Mental Health Peer Network**

The World Health Organization's QualityRights training and guidance package promotes a strong participatory approach. It recognizes and values the importance of the lived experience of people with psychosocial, intellectual or cognitive disabilities in promoting recovery, undertaking advocacy, conducting research and reducing stigma and discrimination. The QualityRights tools ensure compliance with human rights standards, implementing strategies to end coercive practices. They show how persons with lived experience can provide peer support and can also contribute to the development, design, implementation, monitoring and evaluation of mental health and social services. Lived experience is much more than just knowledge and skills. Expertise emanates from people's in-depth understanding of the social and human rights impact of living with a psychosocial, intellectual or cognitive disability and the adversities of being shunned, segregated and discriminated against. It emanates from having to struggle to navigate a mental health system that often fails to provide services or support that would be beneficial to the person as a unique individual and that speaks to their specific recovery needs.

The mental health system is not the only societal system that presents barriers through which the person must navigate; access to other life opportunities such as education, employment, housing and overall health and well-being can be equally challenging. The unique and in-depth perspectives of people with lived experience can be the catalyst for change and transformation of all societal systems in order to protect human rights, encourage inclusion in the community, improve quality of life, and promote empowerment – all of which can contribute towards improved mental health and well-being.

### **Kate Swaffer, Chair, CEO Dementia International Alliance**

It has been an honour and pleasure for Dementia Alliance International (DAI) to work with the WHO QualityRights initiative and its collaborators on this very important project. Human rights have generally been ignored in practice for people with dementia. However, these modules introduce a new approach to mental health, and also to dementia which is a neurodegenerative condition that causes cognitive disabilities. In contrast to the current post-diagnostic pathway for dementia, which is a pathway focused only on deficits and leading only to disability and dependence, this new approach and these unique and enabling modules promote rights and encourage and support people with dementia to live more positively.

By promoting the need for clear access to rights, the modules are practical tools that can be used by everyone, regardless of who they are. The modules, which take key human rights principles and make them actionable in practice, are as applicable and effective for health professionals as they are for people with dementia and their family members. For example, highlighting the need and benefits of peer-to-peer support – which is a free service DAI has been offering people with dementia since 2013, even before it was officially launched – and focusing on the issue of legal capacity and its relevance in terms of Article 12 of the CRPD provide tangible ways to better inform professionals and families to ensure that the rights of people with dementia will no longer be denied. I personally have every confidence that these modules will support all people experiencing mental health problems and psychosocial, intellectual or cognitive disabilities to live with a better quality of life.

**Ana Lucia Arellano, Chair, International Disability Alliance**

The United Nations Convention on the Rights of Persons with Disabilities, or CRPD, is the groundbreaking human rights treaty that promotes the paradigm shift from considering persons with disabilities as objects of charity or medical treatment to fully recognizing them as subjects of rights. This paradigm shift is particularly significant for persons with intellectual, psychosocial and multiple disabilities, or for persons with more intense support needs. Article 12 of the CRPD is key in promoting this shift in that it recognizes that persons with disabilities can exercise full legal capacity. This is the core human right that establishes the foundation on which all the others can be exercised.

QualityRights is a superb tool for enabling professionals and health practitioners to better understand and embrace the CRPD. The tool creates a bridge between persons with psychosocial disabilities, users and survivors of psychiatry and mental health services and the health sector, respecting the principles and values of the CRPD. The QualityRights modules have been developed in close consultation with users and survivors of mental health services, linking their voices to messages conveyed to States Parties of the CRPD. The International Disability Alliance (IDA) and its member organizations offer congratulations for the work developed under the QualityRights initiative. We strongly encourage WHO to continue efforts to transform mental health laws, policies and systems until they are CRPD-compliant, echoing the strong voices that call out for “Nothing about us, without us!”

**Connie Laurin-Bowie, Executive Director, Inclusion International**

WHO QualityRights aims to empower individuals and Disabled Persons Organizations to know their human rights and to advocate for change to enable people to live independently in the community and receive appropriate supports. Inclusion International welcomes this initiative which seeks to promote rights that are often denied to people with intellectual disabilities – namely the right to access appropriate mental health services in the community, the right to choose, the right to have a family life, the right to live in the community, and the right to be active citizens. QualityRights is a valuable contribution to our collective efforts to shape and influence policies and practice which enable everyone to be included in their communities.

**Alan Rosen, Professor, Illawarra Institute of Mental Health, University of Wollongong, and Brain & Mind Centre, University of Sydney, Australia.**

Freedom is therapeutic. Facilitating human rights in our mental health services can bring healing. It can ensure that, whenever possible, the person who is living with a mental health condition: a) retains choice and control over the assistance and care provided and b) is offered good-quality clinical and home support, if needed, to live in the community without disruption and "on their own turf and terms".



Following a long history of human rights advocacy in psychiatry, these modules show how the right to adequate care and all human rights and fundamental freedoms can be met without contradiction. Coercion in care – such as restraints, seclusion, forced medications, locked inpatient units, being cooped up in restrictive spaces, and institutional warehousing – must be curtailed. The optimal attainment of liberty in care entails immense change. This includes the widespread systematizing of practical evidence-based alternatives to avoid coercion – i.e. open doors, open respite facilities, open and free access, open communities, open minds, open conversations between equals, supported community living, enhancement of individual and family communication, problem-solving skills and support, advance directives, training in soothing and de-escalation, supported decision-making, the recovery orientation of all services and peer workers, and the co-production of policy with all stakeholders.

The WHO QualityRights programme, based on the United Nations CRPD, has been transformed here into a highly practical set of modules. For our professions, these modules offer a trajectory and a horizon to work towards rather than a finite answer or deadline. As well as optimizing clinical and support services, our political, legal and social actions with service users and their families have to be combined with our own emancipation as professionals from institutional thinking and from being yoked to habitual practices in mental health care. Only then and together can we vastly improve the prospects for an empowered, purposeful, contributing life, with full citizenship and full rights, for persons living with severe, persistent or recurrent mental health problems.

**Victor Limaza, Activist and facilitator of Justice for People with Disabilities, Documenta AC (Mexico)**

Dignity and well-being are closely related concepts. Nowadays, those criteria by which we judge psychological suffering only in terms of neurochemical imbalances are being questioned, as is the view that certain manifestations of human diversity are pathologies that must be attacked to protect the person and society from supposed dangers, even though the interventions used may violate rights and cause irreversible damage. The interdisciplinary and holistic outlook in which subjective discomfort is addressed without undermining the dignity and ability of the person to make decisions, even in critical situations, should be the foundation on which the new mental health care models are constructed, respecting the principles of the CRPD. Understanding the experience of a person facing a critical state in their mental health is possible thanks to the bond generated through empathy, listening, open dialogue, accompaniment (especially among peers), support in decision-making, life in the community and the advance directives under strict safeguards. People with psychosocial disabilities are experts from experience and must be involved in developing the instruments that seek to lead to recovery. The QualityRights initiative of WHO is a good example of this paradigm shift providing tools and strategies for mental health care with the highest standards of respect for human rights. Undoubtedly, the full and equitable enjoyment of all human rights by every person promotes mental health.

**Peter Yaro, Executive director, Basic Needs Ghana**

The WHO package of training and guidance documents is a rich collection of material that aims to enhance work in mental health and rights-based inclusive development. The materials provide a significant step towards effective programming and mainstreaming of disabilities – especially psychosocial, intellectual and developmental disabilities – in interventions to address individuals' needs and rights as provided for in the CRPD. The QualityRights package marks a giant stride towards the longstanding recommendation that persons with lived experience be part and parcel of the conceptualization and implementation of interventions, together with the monitoring and evaluation of the project's achievements. With this guidance, the sustainability of initiatives can be assured and, for this reason, practitioners, service users, caregivers and all stakeholders are encouraged to utilize

the documents. In the approach presented here, there is no place for perpetrating violence and abuse on already vulnerable persons.

**Michael Njenga, Chairperson of the Pan African Network of Persons with Psychosocial Disability, Executive Council Member, Africa Disability Forum and C.E.O. Users and Survivors of Psychiatry, Kenya**

There is paradigm shift in the way we need to address mental health globally. The impetus for this shift has been created by the Convention on the Rights of Persons with Disabilities (CRPD) and by the adoption of the Sustainable Development Goals (SDGs) and the 2030 Agenda for Sustainable Development.

WHO's QualityRights tools and materials for training and guidance build on this key international human right as well as on international development instruments. The QualityRights initiative adopts a human rights-based approach to ensure that mental health services are provided within a human rights framework and are responsive to the needs of persons with psychosocial disabilities and mental health conditions. These materials also lay emphasis on the need to provide services as close as possible to where people live.

The QualityRights approach recognizes the importance of respecting each individual's inherent dignity and ensuring that all persons with psychosocial disabilities and mental health conditions have a voice, power and choice while accessing mental health services. This is an integral element in reforming mental health systems and services both globally and at local and national levels. It is essential, therefore, to make sure that these training tools and guidance materials are widely used so that they result in tangible outcomes at all levels for people with lived experience, their families, communities and entire societies.

## What is the WHO QualityRights initiative?



WHO QualityRights is an initiative which aims to improve the quality of care and support in mental health and social services and to promote the human rights of people with psychosocial, intellectual or cognitive disabilities throughout the world. QualityRights uses a participatory approach to achieve the following objectives:

- 1** Build capacity to combat stigma and discrimination, and to promote human rights and recovery.
- 2** Improve the quality of care and human rights conditions in mental health and social services.
- 3** Create community-based and recovery-oriented services that respect and promote human rights.
- 4** Support the development of a civil society movement to conduct advocacy and influence policy-making.
- 5** Reform national policies and legislation in line with the Convention on the Rights of Persons with Disabilities and other international human rights standards.

For more information: [http://www.who.int/mental\\_health/policy/quality\\_rights/en/](http://www.who.int/mental_health/policy/quality_rights/en/)

# WHO QualityRights – Training and guidance tools

The following training and guidance modules and accompanying slide presentations available as part of the WHO QualityRights initiative, can be accessed at the following link : <https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools>

## Service transformation tools

- The WHO QualityRights assessment toolkit
- Transforming services and promoting human rights

## Training tools

### Core modules

- Human rights
- Mental health, disability and human rights
- Recovery and the right to health
- Legal capacity and the right to decide
- Freedom from coercion, violence and abuse

### Specialized modules

- Supported decision-making and advance planning
- Strategies to end seclusion and restraint
- Recovery practices for mental health and well-being ←

## Evaluation tools

- Evaluation of the WHO QualityRights training on mental health, human rights and recovery: pre-training questionnaire
- Evaluation of the WHO QualityRights training on mental health, human rights and recovery: post-training questionnaire

## Guidance tools

- One-to-one peer support by and for people with lived experience
- Peer support groups by and for people with lived experience
- Civil society organizations to promote human rights in mental health and related areas
- Advocacy for mental health, disability and human rights

## Self-help tools

- Person-centred recovery planning for mental health and well-being – self-help tool

## About this training and guidance

The QualityRights training and guidance modules have been developed to enhance knowledge, skills and understanding among key stakeholders on how to promote the rights of persons with psychosocial, intellectual or cognitive disabilities and improve the quality of services and supports being provided in mental health and related areas, in line with international human rights standards, and in particular the United Nations Convention on the Rights of Persons with Disabilities and the recovery approach.

### Who is this training and guidance for?

- **People with psychosocial disabilities**
- **People with intellectual disabilities**
- **People with cognitive disabilities, including dementia**
- **People who are using or who have previously used mental health and social services**
- **Managers of general health, mental health and social services**
- **Mental health and other practitioners** (e.g. doctors, nurses, psychiatrists, psychiatric and geriatric nurses, neurologists, geriatricians, psychologists, occupational therapists, social workers, community support workers, personal assistants, peer supporters and volunteers)
- **Other staff working in or delivering mental health and social services, including community and home-based services** (e.g. attendants, cleaning, cooking, maintenance staff, administrators)
- **Nongovernmental organizations (NGOs), associations and faith-based organizations working in the areas of mental health, human rights or other relevant areas** (e.g. organizations of persons with disabilities (DPOs); organizations of users/survivors of psychiatry, advocacy organizations)
- **Families, support persons and other care partners**
- **Relevant ministries (Health, Social Affairs, Education, etc.) and policymakers**
- **Relevant government institutions and services** (e.g. the police, the judiciary, prison staff, bodies that monitor or inspect places of detention including mental and social services, law reform commissions, disability councils and national human rights institutions)
- **Other relevant organizations and stakeholders** (e.g. advocates, lawyers and legal aid organizations, academics, university students, community or spiritual leaders, and traditional healers if appropriate)

### Who should deliver the training?

Training should be designed and delivered by a multidisciplinary team, including people with lived experience, members of disabled persons' organizations (DPOs), professionals working in mental health, disability and related fields, families and others.

If the training is about addressing the rights of people with psychosocial disabilities specifically, it is important to have representatives from that group as leaders for the training. Likewise, if the purpose is to build capacity on the rights of persons with intellectual or cognitive disabilities, the leaders of the training should also be from these groups.

In order to liven up discussions, different options can be considered. For instance, facilitators with specific knowledge of a particular part of the training can be brought in for specific aspects of the training. Another option may be to have a panel of trainers for specific parts of the training.

Ideally, facilitators should be familiar with the culture and context of the location where the training is taking place. It may be necessary to conduct train-the-trainer sessions in order to build up a pool of people who are able to carry out the training within a particular culture or context. These train-the-trainer sessions should include persons with psychosocial, intellectual or cognitive disabilities. They should also include other relevant local stakeholders who contribute to improving the quality of mental health and social services and the human rights of people with psychosocial, intellectual or cognitive disabilities.

### How should the training be delivered?

Ideally, all the QualityRights training modules should be delivered, starting with the five core foundational modules. This can be followed by more in-depth training using the specialized modules (see above).

The whole training can be conducted through multiple workshops taking place over the course of several months. Each separate training module does not necessarily have to be completed in one day. It can be divided into topics and can be conducted over the course of several days, as required.

Since the training materials are quite comprehensive and time and resources may be limited, it may be useful to adapt the training according to the existing knowledge and background of the group, as well as the desired outcomes of the training.

Thus, the way these training materials are used and delivered can be adapted according to the context and requirements.

- For example, if participants do not yet have any expertise in the areas of mental health, human rights and recovery, it would be important to conduct a 4–5-day workshop using the five core training modules. A 5 day sample agenda available at the following link: <https://qualityrights.org/wp-content/uploads/Sample-program-QR-training.pdf>
- If participants already have a basic understanding of the human rights of people with psychosocial, intellectual and cognitive disabilities but require more advanced knowledge about how specifically to promote the right to legal capacity in practice, then a workshop could be organized to focus on the module *Legal capacity and the right to decide* on day 1 and on the specialized module on *Supported decision-making and advance planning* (or selected parts of that module) on days 2, 3 and 4.

When adapting the training materials according to specific training requirements it is also important, prior to the training, to go through all the modules to be covered in order to get rid of unnecessary repetition.

- For example, if a training is planned, covering all the core modules, then it will not be necessary to cover topic 5 (zooming in on article 12) or topic 6 (zooming in on article 16) since these issues will be covered in much greater depth in the subsequent modules (module on *Legal capacity and the right to decide* and on *Freedom from coercion, violence and abuse* respectively).

- However if an introductory training is planned based solely on module 2, then it is essential to cover topics 5 and 6 of this module, since this will be the only exposure that the participants will receive on these issues and articles.

These are examples of the different and varied ways in which the training materials can be used. Other variations and permutations are also possible on the basis of the needs and requirements of the training in a particular context.

# Guidance for facilitators

## Principles for running the training programme

### Participation and interaction

Participation and interaction are crucial to the success of the training. All participants should be viewed as individuals who can contribute valuable knowledge and insights. By providing sufficient space and time, the facilitator(s) must first and foremost make sure that people with psychosocial, intellectual or cognitive disabilities are being listened to and included. Existing power dynamics in services and the broader society may make some people reluctant to express their views. In general, however, the facilitator must emphasize the importance of listening to the views of all participants.

Some people may feel shy or uncomfortable and not express themselves – which may be a sign of lack of inclusion or a feeling of insecurity in the group. Facilitators should make every effort to encourage and engage everyone in the training. Usually, after people have expressed themselves once and feel they have been heard, they are more able and willing to speak out and engage in discussions. The training is a shared learning experience. Facilitators should take time to acknowledge and as far possible answer all questions, so that nobody feels left out.

### Cultural sensitivity

Facilitators should be mindful of participants' diversity, recognizing that multiple factors have shaped their experiences and knowledge, such as culture, gender, migrant status or sexual orientation.

Using culturally sensitive language and providing examples relevant to people living in the country or region where the training is taking place is encouraged. For example, depending on the country or the context, people may express or describe their emotions and feelings, or talk about their mental health, in different ways.

In addition, facilitators should make sure that some of the issues faced by particular groups in the country or region (e.g. indigenous people and other ethnic minorities, religious minorities, women, etc.) are not overlooked during the training. Feelings of shame or taboo about the issues being discussed will need to be taken into consideration.

### Open, nonjudgemental environment

Open discussions are essential and everyone's views deserve to be listened to. The purpose of the training is to work together to find ways to improve respect for the rights of people using mental health and social services and of people with psychosocial, intellectual and cognitive disabilities within the broader community. During this training, some people may express strong reactions and feelings. It is important that the facilitator provides space during the training for people to express opinions and feelings. This means allowing people time to talk about their experiences without interruption and ensuring that others listen and respond to them in a sensitive and respectful manner.

It is not necessary to agree with people in order to communicate with them effectively. When discussion arises, it may be useful to remind all participants that they all share the same goal: to achieve respect for human rights in mental health and social services and in the community, and that all voices need to be heard in order to learn together. It may be helpful to share some basic ground rules with the group (e.g. respect, confidentiality, critical reflection, non-discrimination) to refer back to when needed.



Note that some people may never before have had the opportunity to speak out freely and safely (e.g. people with lived experience, family members, and also practitioners). Therefore creating a safe space to enable all voices to be heard is essential.

### Use of language

Facilitators should be mindful of the diversity of the participants. People taking part in the training will have different backgrounds and levels of education. It is important to use language that all participants are able to understand (e.g. by avoiding the use of/explaining highly specialized medical, legal and technical terms, acronyms, etc.) and to ensure that all participants understand the key concepts and messages. The language and the complexity of the training should be adapted to the specific needs of the group. With this in mind, facilitators should pause, provide examples when necessary, and take time to ask and discuss questions with participants to ensure that concepts and messages are properly understood. As far as possible, facilitators should use language that allows for nonmedical and/or culturally-specific models of distress to be part of the discussion (e.g. emotional distress, unusual experiences, etc.) (1).

### Accommodations

Accommodating different means of communication – such as by using visual and audio materials, easy-to-read adaptations, signing, providing assistance with writing for some of the exercises, or enabling people to come with their personal assistant – may be necessary at times to ensure that all people are included in the training.

### Operating in the current legislative and policy context

During the training, some participants may express concerns about the legislative or policy context in their countries which may not be in line with international human rights standards, including the Convention on the Rights of Persons with Disabilities (CRPD). Similarly, some of the content of the training may contradict current national legislation or policy. For instance, laws that provide for involuntary detention and treatment contradict the overall approach of these training modules. Moreover, the topic on supported decision-making may appear to conflict with existing national guardianship laws. Another concern may be that national resources for implementing new approaches may be scarce or not available. These preoccupations can lead to questions from the participants about liability, safety, funding and about the larger political and societal context in which they live and work.

First, facilitators should reassure participants that the modules are not intended to encourage practices which conflict with the requirements of national law or policy, or which could put anyone in danger of being outside the law. In contexts where the law and policy contradict the standards of the CRPD it is important to advocate for policy change and law reform. Even though States Parties to the CRPD have an *immediate* obligation to cease violations of this Convention and other international human rights instruments, it is important to acknowledge that achieving full respect for the rights in the CRPD takes time and requires a variety of actions at all levels of society.

Consequently, an outdated legal and policy framework should not prevent individuals from taking action. A lot can be done at the individual level on a day-to-day basis to change the attitudes and practices within the boundaries of the law and to start implementing the CRPD. For example, even if guardians are officially mandated on the basis of a country's law to make decisions on behalf of other

persons, this does not prevent them from supporting those persons in reaching their own decisions and from ultimately respecting their choices.

This training provides guidance on dealing with various topics which are key to fostering the human rights-based approach in mental health and social services. Throughout the training, facilitators should encourage participants to discuss how the actions and strategies promoted in the training materials affect them and how they can be implemented within the parameters of existing policy and law frameworks. Shifts in attitudes and practices, along with effective advocacy, can lead to positive change in policy and law.

### Being positive and inspiring

Facilitators should emphasize that the training is intended to share basic knowledge and tools, and to stimulate reflection in order to find solutions that are useful in participants' own context. It is likely that some positive actions already exist and that participants themselves, or other people or services, are already carrying them out. It is possible to build on these positive examples to create unity and to demonstrate that everybody can be an actor for change.

### Group work

Throughout the exercises, the facilitator will ask participants to work in groups, which may be flexibly composed, by choice or randomly, depending on the preferences of participants. If participants do not feel comfortable in certain groups, this should be taken into account.

Exercises throughout the training are meant to foster participation and discussion. These exercises are designed to allow participants to come up with ideas and to identify solutions by themselves. The facilitators' role is to guide discussions and, when appropriate, to stimulate debate with specific ideas or challenges. If participants do not want to take part in some of the activities of the training, their wishes should be respected.

### Facilitator notes

The training modules have facilitator notes which are in **blue**. The facilitator notes include examples of answers or other instructions for facilitators, which are not intended to be read out to participants.

The content of the presentation, questions and statements that are intended to be read out to participants are written in **black**.

Separate course slides accompanying the training modules to deliver the content of the modules are available at the following link: <https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools>

### Evaluation of the QualityRights training

The QualityRights pre/post-evaluation questionnaires that come as part of this training package have been designed to measure the impact of the training and to improve it for future training workshops.

Participants are required to complete the pre-training evaluation questionnaire before the training starts. 30 minutes should be set aside for this.

At the end of the training, participants should complete the post-training evaluation questionnaire. Again, 30 minutes should be allowed for this.

A unique ID needs to be created for each participant, whether they are completing the form by hand or online. This ID will be the same for both the pre-evaluation and the post-evaluation questionnaire. Unique IDs can be created, for example, by using the name of the country where the training is taking place followed by numbers 1 to 25 (or however many participants there are in the group). For instance, a participant could receive the unique ID of Jakarta12. It could be useful to include the pre and post questionnaires with unique IDs in the participants' folders before the training starts to ensure that the unique IDs are given to the correct participants. There is no need to track who gets which unique ID since the questionnaires are anonymous, but it is important to ensure that each person has same ID on both questionnaires.

Once the post-training evaluation questionnaire has been completed, the facilitator should open the discussion to all participants to express their views about the training, what parts they enjoyed and found useful and what parts they did not enjoy or find useful, as well as any other views they wish to share. This is also an opportunity to discuss what actions and strategies discussed during the training the participants intend to implement.

The pre and post questionnaires should be printed for each participant prior to the training. The versions for printing and distributing are available here:

- *Evaluation of the WHO QualityRights training on mental health, human rights and recovery: PRE-training questionnaire:*  
<https://qualityrights.org/wp-content/uploads/20190405.PreEvaluationQuestionnaireF2F.pdf>
- *Evaluation of the WHO QualityRights training on mental health, human rights and recovery: POST-training questionnaire:*  
<https://qualityrights.org/wp-content/uploads/20190405.PostEvaluationQuestionnaireF2F.pdf>

### Training videos

Facilitators should review all the videos available in the module and chose the most appropriate ones to show during the training. The video links may change over time. It is therefore important to check that the links work prior to the training. If a link is not working an appropriate alternative link to a comparable video should be found.

## Preliminary note on language

We acknowledge that language and terminology reflects the evolving conceptualization of disability and that different terms will be used by different people across different contexts over time. People must be able to decide on the vocabulary, idioms and descriptions of their experience, situation or distress. For example, in relation to the field of mental health, some people use terms such as “people with a psychiatric diagnosis”, “people with mental disorders” or “mental illnesses”, “people with mental health conditions”, “consumers”, “service users” or “psychiatric survivors”. Others find some or all these terms stigmatizing or use different expressions to refer to their emotions, experiences or distress. Similarly, intellectual disability is referred to using different terms in different contexts including, for example, “learning disabilities” or “disorders of intellectual development” or “learning difficulties”.

The term “psychosocial disability” has been adopted to include people who have received a mental health-related diagnosis or who self-identify with this term. The terms “cognitive disability” and “intellectual disability” are designed to cover people who have received a diagnosis specifically related to their cognitive or intellectual function including, but not limited to, dementia and autism.

The use of the term “disability” is important in this context because it highlights the significant barriers that hinder the full and effective participation in society of people with *actual* or *perceived* impairments and the fact that they are protected under the CRPD. The use of the term “disability” in this context does not imply that people have an impairment or a disorder.

We also use the terms “people who are using” or “who have previously used” mental health and social services to refer to people who do not necessarily identify as having a disability but who have a variety of experiences applicable to this training.

In addition, the use of the term “mental health and social services” in these modules refers to a wide range of services currently being provided by countries including, for example, community mental health centres, primary care clinics, outpatient services, psychiatric hospitals, psychiatric wards in general hospitals, rehabilitation centres, traditional healers, day care centres, homes for older people, and other “group” homes, as well as home-based services and services and supports offering alternatives to traditional mental health or social services, provided by a wide range of health and social care providers within public, private and nongovernmental sectors.

The terminology adopted in this document has been selected for the sake of inclusiveness. It is an individual choice to self-identify with certain expressions or concepts, but human rights still apply to everyone, everywhere. Above all, a diagnosis or disability should never define a person. We are all individuals, with a unique social context, personality, autonomy, dreams, goals and aspirations and relationships with others.

# Learning objectives, topics and resources

## Learning objectives

As a result of this training, participants will:

- gain an in-depth knowledge of the recovery approach to mental health care and its key principles and components;
- understand and discuss the role of people with psychosocial disabilities, mental health and other practitioners, family, care partners and other supporters in promoting recovery;
- develop recovery communication skills;
- learn how to apply the principles of recovery-oriented care;
- learn how to create a recovery plan.

## Topics

**Topic 1:** What is recovery? (4 hours if the short option was chosen, 4 hours and 40 minutes if the long option was chosen)

**Topic 2:** Recovery-oriented services and practices (2 hours and 45 minutes)

**Topic 3:** A focus on assets and strengths (45 minutes)

**Topic 4:** Promoting hope (1 hour)

**Topic 5:** Values in recovery (20 minutes)

**Topic 6:** Working alongside people (1 hour)

**Topic 7:** Boundaries within the context of recovery practices (20 minutes)

**Topic 8:** Positive risks in recovery (2 hours)

**Topic 9:** Supporting people to reconnect with their communities (45 minutes)

**Topic 10:** Communication skills (50 minutes)

**Topic 11:** Recovery plans (50 minutes)

**Topic 12:** Recovery Wheel (2 hours and 10 minutes)

## Resources required

- **Accompanying course slides, Recovery practices for mental health and well-being. WHO QualityRights Specialized training (Course Slides), are available here:**  
<https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools>
- **Room requirements: to optimize the learning experience for participants, the room in which the training takes place should be:**
  - large enough to accommodate everyone, but also small enough to create an environment conducive to free and open discussions;
  - seating arrangements that allow people to sit in groups (e.g. “banquet style” where several round tables are arranged around the room, allowing for several participants to sit together around each of the tables. This has the added benefit of encouraging interaction between participants and also of creating ready-made groups for group work exercises.)
- **reasonable accommodations, as required, ensuring inclusive access to the training for all persons.**
- **internet access in the room, in order to show videos**
- **loudspeakers for the video audio**
- **a projector screen and projector equipment**

- **1 or more microphones for facilitator(s) and at least 3 additional wireless microphones for participants (ideally one microphone per group table).**
- **at least 2 flipcharts or similar, plus paper and pens**

#### **Additional resources to print for this training module include:**

- **copies of *Annex 1: Scenarios***
- **copies of *Annex 2: Key components of the recovery approach* for all participants**
- **copies of *Annex 3: The Recovery Wheel***
- **copies of *QualityRights module: Person-centred recovery planning for mental health and well-being – self-help tool***

#### **Time**

Approximately 16 hours

#### **Number of participants**

Based on experience to date, the workshop works best with a maximum of 25 people. This allows sufficient opportunities for everyone to interact and express their ideas.

## Introduction

This module provides comprehensive guidance on practical ways to introduce a person centred recovery approach to services providing mental health care and support. The training provides a detailed introduction to the recovery approach, explaining what it is and how this approach differs from approaches of traditional services. Traditional treatment, care and support have tended to focus on diagnosis, the use of medication, and occasionally psychotherapy, with an emphasis on removing or reducing symptoms. However, recovery is not just about symptoms but is also about a person's life and identity.

The training highlights the importance of understanding what “getting better” means for each person and working with them to achieve this. For many people recovery is about regaining control over their lives, having hope for the future, finding meaning and purpose in life, for example through work, educational pursuits, relationships, community engagement, spirituality or other means.

A series of case studies and exercises in this training module shows participants how people can be supported, through their recovery journey, to identify and harness their strengths, goals and aspirations, explore opportunities, exercise choice and maximize inclusion and autonomy in their communities.

Although the module focuses on mental health and social services, the recovery approach is equally relevant to all people overcoming difficulties and/or loss in their life, with or without disabilities.

## Topic 1: What is recovery?

### Time for this topic

Approximately 4 hours if the short option is chosen. Approximately 4 hours and 40 minutes if the long option is chosen.



### **Exercise 1.1: What does recovery mean to you? (45 min.)**

- Divide the participants into groups of 5.
- Now ask participants to consider the following reflective question:

**Based on your own personal or professional experience, what does recovery mean for people with psychosocial disabilities or for people using services?**

- Allow the groups 15 minutes to prepare their lists.
- Then create the two following lists on the flipchart:
  1. Traditional clinical understanding, and
  2. Understanding based on a recovery approach.
- Ask participants to share their thoughts and allocate the examples provided to the appropriate list (see presentation below for a better idea of what should go under the two separate lists). Help participants to reflect on why their examples fall within one category or the other.

Participants may suggest some recovery-aligned examples, although at this stage early in the recovery training it can be anticipated that many of the ideas will fall within the traditional approach.





### **Presentation: What is recovery? (2) (60 min.)**

After the discussion in exercise 1.1, show the following (examples of traditional/clinical versus recovery approach) to the participants and discuss the similarities and differences in their answers.

<b>Traditional/clinical understanding</b>	<b>Recovery approach</b>
<ul style="list-style-type: none"><li>• <i>When a person is no longer behaving strangely.</i></li><li>• <i>The person is no longer a danger to themselves or others.</i></li><li>• <i>The symptoms have subsided. For example, the person no longer hears voices.</i></li><li>• <i>The person is compliant with medications and the doses are stable.</i></li><li>• <i>A decision has been made by medical staff to discharge the person from an inpatient service.</i></li><li>• <i>The person's family feels that their relative is better.</i></li></ul>	<ul style="list-style-type: none"><li>• <i>When people feel they have control of their life back and can play a role in society.</i></li><li>• <i>When people using services have a better understanding of their emotional distress.</i></li><li>• <i>People feel that they are more independent.</i></li><li>• <i>People may still have symptoms but they are living with them and leading a fulfilling life.</i></li><li>• <i>When people have emotional distress as part of a person's life, but this is not the centre of their lives.</i></li></ul>

### **What does recovery mean? (3)**

The meaning of recovery can be different for each person. For many people recovery is about regaining control of their identity and life, having hope for their life and living a life that has meaning for them whether that be through work, relationships, spirituality, community engagement or some or all of these.”

Within this framework, recovery does not mean “being cured” or “being normal again”. Rather, it is about gaining or recapturing meaning and purpose in life, and being empowered to live a self-directed/determined and autonomous life, despite any emotional distress that a person may have lived through or is currently experiencing. Within a human rights framework, recovery is the right to be included and to be able to participate in all facets of life – political, economic and social – on an equal basis with all other people. All rights are not contingent on “getting better”, being symptom-free or “fitting in” but rather on the acknowledgement of diversity and the inherent dignity of all.

The emphasis on regaining control of life and identify is extremely important for people who have experienced situations where others may have taken decision-making power out of their hands in various aspects of their lives. For example, people may have been admitted to mental health services, treated against their will and put under guardianship measures etc.

“What matters in recovery is not whether we’re using services or not using services, using medications or not using medications. What matters in terms of a recovery orientation is, are we living the life we want to be living? Are we achieving our personal goals? Do we have friends? Do we have connections with the community? Are we contributing or giving back in some way?” (4)

At this point show participants one of the following videos:

1. **The voices in my head** video from Eleanor Longden (14:17 min.), a woman who hears voices and who has gained control over her life.  
[https://www.ted.com/talks/eleanor\\_longden\\_the\\_voices\\_in\\_my\\_head?language=en](https://www.ted.com/talks/eleanor_longden_the_voices_in_my_head?language=en), accessed 03 August 2016.
2. **INTERVOICE: The Hearing Voices Movement**, on individuals in Brazil and how they deal with hearing voices day by day (52: 42 min). <https://youtu.be/RYbjSeEy42c>. (accessed 9 April 2019)

### **What recovery is NOT**

To gain a better understanding of what recovery means, it is important look at the flipside – i.e. what recovery is not.

#### **Recovery is not (2),(5):**

- a cure or the absence of a "condition, diagnosis or symptoms";
  - something practitioners or others “do” to people;
  - a theoretical model;
  - something that has always been done;
  - a reason for closing down mental health services;
  - “blaming” individuals for their situation.
1. **Recovery is NOT** necessarily a cure or the absence of a condition, diagnosis or symptoms because people with psychosocial disabilities can still lead a fulfilling life in the presence of any one of these. In other words, for some people, being free from what they perceive and interpret as symptoms is a key feature of their recovery. Others may continue to have these but still experience recovery.
    - Recovery helps the person to sensitively explore what is going on for them in the moment, what they need to deal with and what pain they are feeling, but it does not stop there.
    - It also involves dealing with many potential difficulties that a person may be experiencing, such as isolation, exclusion, poverty, unemployment and discrimination.
  2. **Recovery is NOT** something that practitioners, families or care partners “do” to people. Recovery is led by the individual concerned. Those involved in the life of people with psychosocial disabilities can be coaches or supporters that can assist a person on their journey of recovery.
  3. **Recovery is NOT** something that has been widely practised despite the common usage of the term in some contexts. Recovery involves rethinking the way mental health and social services and supports are designed and provided.
  4. **The recovery approach is NOT** a reason for closing down services. Some people fear that the recovery approach will be used as a justification for closing down formal mental health and social services and for not providing any support to people. They also fear that the recovery approach is a justification for decreasing spending on mental health. This is based on an incorrect belief that the recovery approach implies that people will achieve recovery on their own, without any form of support. The recovery approach should never be used to justify

reduced spending on mental health; a wide range of services should be available to support people's needs.

5. **The recovery approach is NOT about “blaming” the individual** for their situation. It recognizes the social inequalities, discrimination and violations of rights at community, societal and structural levels that lead people to situations of emotional distress and act as important barriers to recovery. It recognizes that policy, legislative reform and social justice at a much larger scale are required to truly promote recovery.



**Presentation: Key components of recovery (6),(2) (30 min.)**

Distribute to participants copies of Annex 2 “Key components of the recovery approach” which summarizes the following presentation.

Recovery is a process that is individual and unique to each person. There may be occasions when the person feels worse or experiences a crisis, but a recovery approach enables the person to learn and gain experience from these setbacks and use the skills developed to help them achieve their goals in life.

The CHIME framework emphasizes connectedness, hope, identity, meaning in life and empowerment as key to recovery (6). Risk-taking, although not included in the CHIME framework, has been included here as an important component of the recovery process (7),(8).

1. **Connectedness: Recovery reconnects people**

- **Inclusion** is important for recovery. People need to be able to access the same opportunities, services and resources in the community as any other person. The services that promote recovery should be influenced by, and based on, the local context and needs. It is also important to remember that inclusion goes beyond the individual to involve the community and society as a whole.
- **Relationships** are key to all people's lives. Therefore friends, partners, family members, health practitioners, support staff, peer supporters and peer support groups all have a key role to play in supporting people in their recovery.

2. **Hope: Recovery is about hope and optimism for the future**

- **Hope** is key to recovery. Without hope people can give up their recovery journey. Hope is often taken away from people when they are told that they have a lifelong, permanent illness and that they need to give up many of their activities and expectations. Research has shown that self-efficacy, self-esteem, empowerment, spirituality, quality of life and social supports are important contributors to hope (9).
- **Belief** that change in one's life or circumstances is possible is central to the recovery approach. This belief can be fostered by hope-inspiring relationships.
- Friends, family, care partners, practitioners and other supporters need to recognize and value successes and encourage dreams and aspirations.

### 3. **Identity: Recovery means exploring your identity**

- **Identity** can broadly be defined as how one sees oneself as an individual and in relation to other persons and the community that one lives in.
- **Identity** is a sense of self that people may feel they never had or that they lost once they received a diagnosis. The recovery approach supports people to (re)connect, (re)build or (re)define their identity as well as overcome the “internalized oppression” or “self-stigma” that can put identity at risk. It is about offering people the opportunity to think about their experiences in ways that make sense to them. This includes their experiences with mental health services and treatment that they may have received.

### 4. **Meaning in life: Recovery supports people to (re)build and find meaning in their lives**

- **Meaning and purpose in life** vary for everyone and people find meaning in very different ways. For instance, some people may find spirituality important, while others may find meaning and purpose through the development of stronger links with friends, family or community.
- **Dreams and aspirations** are key for recovery as they can empower and support people to find meaning and fulfilment in their lives.

### 5. **Empowerment: Recovery is a positive message that empowers people and gives them control**

- **Control and choice are central to recovery.** People are often denied the right to decide about key aspects of their life, including their own care and treatment. In contrast, a recovery approach respects a person’s right to exercise their legal capacity, including the person’s right to make their own choices, with or without support from others. (These topics are covered in detail in the QualityRights training modules *Legal capacity and the right to decide* and *Supported decision-making and advance planning*.)
- **Strengthening skills to help oneself can also be empowering.** These recovery skills enable people to manage the negative moments in life and take control of their own life and well-being.

### 6. **Risk-taking: Recovery involves taking risks (7),(8)**

- **Risk-taking** may be required if people are to embark on a recovery journey. People must be free to take risks and make mistakes as everyone else does in order to have access to opportunities to learn and grow from their experiences. Recovery-oriented practice requires practitioners, families, care partners and other supporters to accept people’s right to take risks.
- **Creativity and courage** are required in order to support positive risk-taking to help people move forward and achieve their goals.

Although qualitative research has identified these as important factors for recovery, it is necessary to acknowledge that the meaning of recovery and what helps or hinders a person’s recovery can vary widely from person to person across many different factors, including culture, ethnic identity, gender, geography, sexual orientation, migrant status, indigeneity, spirituality/religion and age (10),(11),(6),(12),(13),(14),(15),(16),(17). There is no right or wrong way to “recover” and the factors listed above may not be equally important to all people. It is always important to explore these on an individual basis and not to make assumptions or generalizations about what factors are useful for someone’s recovery journey.

- Recovery means that one’s recovery journey is driven by one’s specific needs and understanding of one’s own mental health. However, sometimes standardized recovery models are imposed on individuals, undermining this key principle of recovery. In addition, human rights violations, including coercion in care, are contradictory to any attempts to introduce a recovery approach (15).
- Recovery also involves looking beyond individual characteristics to the social and structural determinants of a person’s mental health (e.g. gender, discrimination, racism, poverty, welfare policies etc.) (18),(19),(20).



### **Exercise 1.2: Supporting recovery (30 min.)**

- This exercise aims to enable participants to start thinking about what supports and what hinders recovery. This topic will be explored more in depth in the following presentation.

#### **Scenario - Miguel**

Miguel visits his family doctor to discuss overpowering feelings of being worried and fearful all the time. He has continued to experience these feelings over the last three years and they have become increasingly difficult to live with. He tells his doctor that he really enjoys the work that he does, but the fear and anxiety that he experiences is particularly overwhelming when he under a lot of pressure.

After a long discussion, Miguel’s doctor is very sympathetic and tells Miguel that this is likely to be a problem he will have for the rest of his life. He suggests that Miguel should consider important life changes which would include leaving his current job to find something “more suitable” with less stress and responsibility.

Miguel leaves the consultation feeling low and hopeless.

- Allow participants a few minutes to think about the following questions.

#### **Ask the group:**

In what ways has Miguel’s family doctor supported or hindered Miguel’s recovery?

Some answers as to how he supported Miguel’s recovery may include:

- He is sympathetic.
- They seem to have a good relationship.
- He takes the time to discuss the situation with Miguel.

Some answers as to how he hindered Miguel’s recovery may include:

- His view of Miguel’s capabilities is very limited.
- He does not take into account what Miguel wants to do.

- He does not provide a message of hope.

How would you feel if you were Miguel?

Some answers may include:

- Hopeless.
- Lack of optimism for the future.
- There is no point in life.
- I will never recover.
- I am incapable.

What could you have done differently to make Miguel not feel so hopeless?

Some answers may include:

- Have a conversation to explore and understand what the anxiety feels like for Miguel, what might be causing the anxiety and what was happening in Miguel's life three years ago when it started. Not to consider Miguel as a vulnerable person needing protection, as this can lead to the realization of a self-fulfilling prophecy, but as someone capable of achieving his goals in life.
- Think about ways that Miguel could be supported to discover and use tools to manage his anxiety.
- Find out how Miguel manages his anxiety in other situations.
- Instill hope for a positive outcome to the situation.
- Work with Miguel to identify his strengths and how to use them to overcome the anxiety he experiences.
- Connect Miguel to supports to help maintain the job he values.
- Connect Miguel to other people in peer roles who have been through similar experiences.



### **Exercise 1.3: What facilitates or hinders recovery? (50 min.)**

The purpose of this exercise is to get participants to explore the concept of recovery, drawing from their own personal experiences. Invite participants to think about a time when they recovered from something in their own lives.

Ask the group:

Think of a time in your life when you have recovered from something (not necessarily related to mental health), such as major health problems, a loss or bereavement (if you feel comfortable discussing your feelings around this event with the group).

- What emotional challenges did you have?
- How did you deal with these (either positively or negatively)?
- What helped your recovery?
- What was not helpful for your recovery?

Divide the participants into groups of 5 and ask each group to discuss and write down in two separate lists what was helpful and what was not helpful.

Request the small groups to briefly present their lists in plenary (i.e. full group discussion).

Participants may identify similar factors that at times hinder or support recovery (e.g. family can sometimes support recovery and sometimes hinder recovery). It may be worthwhile to have a discussion about the reasons why this happens.

Then ask the group:

- Are there common themes and issues?
- Do you think the helpful things you identified are also relevant to you or to people you are working with or supporting?



**Presentation: Recovery facilitators and obstacles (20 min.)**

Research in several countries has identified some common themes regarding what promotes or prevents recovery. The following tables list in detail key factors that people have identified as either facilitating or hindering recovery.

**Recovery facilitators (8)**

Recovering identity	Relationships
<ul style="list-style-type: none"> <li>• Confidence</li> <li>• Hope and optimism</li> <li>• Self-acceptance, responsibility, belief and esteem</li> <li>• Self-efficacy</li> <li>• Self-awareness</li> <li>• Growing beyond the label</li> <li>• Reclaiming power and self-determination</li> <li>• Belonging – cultural, social and community identity</li> <li>• Activism</li> <li>• Spirituality</li> <li>• Coping</li> <li>• Taking control</li> </ul>	<ul style="list-style-type: none"> <li>• Friendships</li> <li>• Supportive family relationships</li> <li>• Intimate relationships (i.e. partner)</li> <li>• Parenting</li> <li>• Peers</li> <li>• Pets</li> <li>• Service professional</li> <li>• Mutual trust and recognition</li> <li>• Hopeful relationships</li> </ul>
Engagement and finding meaning and purpose	Services and supports
<ul style="list-style-type: none"> <li>• Being valued</li> <li>• Engaging in meaningful roles</li> <li>• Volunteering, employment, career and education</li> <li>• Learning about self and condition</li> <li>• Community and social engagement</li> <li>• Exercise and creativity</li> <li>• Other people’s experiences</li> </ul>	<ul style="list-style-type: none"> <li>• Feeling informed and in control</li> <li>• Continuity and flexibility</li> <li>• Treatments and therapies</li> <li>• Security</li> <li>• Peer support</li> <li>• Relationships, attitudes and power</li> <li>• Housing and community supports</li> <li>• Financial security</li> </ul>



## Recovery obstacles (21)

Obstacles that hinder recovery
<ul style="list-style-type: none"><li>• <b>Violence and abuse</b></li><li>• <b>Stereotypes</b> – False assumptions about people (e.g. that they are violent) which can damage their confidence and prevent recovery.</li><li>• <b>Stigma and discrimination</b> – When people are excluded from communities or opportunities in life, or are thought not to be worthy of support, this can hinder their recovery. Multiple forms of stigma and discrimination can intersect to shape inequality and impede recovery.</li><li>• <b>Poverty</b> – Not being able to meet one’s personal and family needs. This can lead to emotional distress and can hinder recovery.</li><li>• <b>Lack of quality health services</b> – People require suitable health services, with access to – and choice regarding – treatment and supports, to maintain wellness and to promote their recovery.</li><li>• <b>Lack of independence and control</b> – Services and individuals can sometimes disempower or create barriers for people, which may hinder their recovery.</li><li>• <b>Lack of services and supports in the community</b> – People may require a range of services and supports and should be able to access them in order to live a fulfilling life in the community (e.g. social support, housing, employment services, educational opportunities, training for independent living, peer support, personal assistance etc.). Without these, people may continue to experience exclusion, which also has a negative impact on their well-being and recovery.</li></ul>

While it is important to promote positive supports that allow for recovery, it is equally important to make efforts to identify and eliminate any obstacles to recovery.

These common themes and factors should not detract from the importance of the very rich and personal experiences that people have lived or from understanding the meaning and purpose that each individual may give to their journey.

In exploring these experiences, people may unexpectedly identify positive elements that have emerged from negative situations and that they have found helpful in their recovery journey.

## Topic 2: Recovery-oriented services and practices

### Time for this topic

Approximately 2 hours and 45 minutes.



### **Presentation: Key defining features (90 min.)**

This presentation defines recovery-oriented services and outlines some key defining features, including self-determination, promotion of human rights, overcoming power imbalances and addressing trauma.

### **Self-determination**

Recovery-oriented services aim to support people in their unique recovery journey, build on their strengths and empower people to:

- take control of their lives;
- identify and work towards their goals and aspirations in order to lead fulfilling and meaningful lives;
- make decisions about all areas of their lives including treatment, care and support;
- choose their own way of understanding their distress

### **Promoting human rights**

- The recovery approach is very much aligned with international human rights standards, including the rights of the Convention on the Rights of Persons with Disabilities (CRPD). For example recovery-oriented services promote human rights such as equality, non-discrimination, legal capacity, informed consent and community inclusion, which are enshrined in the CRPD.
- Being in control of one's recovery and making choices and decisions for oneself, with the support of others if desired, whether about treatment or other aspects of life, is at the centre of the recovery approach. It is also an important element of the right to exercise legal capacity (article 12 of the CRPD).
- On the other hand, involuntary admission and treatment within mental health and social services is directly against the recovery approach and is not compliant with the CRPD because it prevents people from being in control of their lives and leads to harmful and damaging consequences.
- Contrary to the commonly held belief amongst mental health and other practitioners, involuntary admission does not reduce rates of readmission (5). Instead, people fear further admissions or contact with mental health and social services.

The CRPD is explained in depth in the module *Mental health, disability and human rights*.

## **Addressing trauma**

- Recovery-oriented services acknowledge that many people have gone through negative and traumatic experiences during their lives and support them to heal from these traumas.
- Trauma may be caused by violence, abuse or coercion (e.g. forced admission and treatment) within mental health and social services. It may also result from other forms of violence and abuse that people may have experienced, such as during their childhood, with clear negative impacts on physical and mental health.
- A recovery approach involves, for instance, asking the person “What happened to you?” instead of “What’s wrong with you?”

## **Overcoming power imbalances**

- Another important aspect of recovery-oriented services is to create an environment to overcome power imbalances as far as is possible.
- In services, mental health and other practitioners have more power than the people using the service. In addition, the mere threat or possibility of being involuntarily detained and treated can often exacerbate the power imbalance. People feel that they need to adhere to what practitioners prescribe in order to avoid being deprived of their liberty (for additional information refer to the module on *Freedom from coercion, violence and abuse*).

## **What do recovery-oriented services look like in practice?**

Many services around the world are based on a clinical understanding of recovery and believe that recovery is not possible for a large number of people using the services. In this context, treatment, care and support have largely been limited to the use of medication, and occasionally psychotherapy, with a focus on removing or reducing symptoms.

However, recovery is not just about symptoms but is also about a person’s life and identity. This therefore requires an understanding of what “getting better” means for each person and working with them to achieve this.

Recovery-oriented services are not just services where staff have been trained in a recovery approach. The approach involves ensuring that the entire organization of the service is aimed at promoting and facilitating a recovery approach. Recovery is not just a matter of the personal attitudes of service staff. Rather, it needs to be embraced by policies, programmes and the service organization. For example, one effective intervention can be to recruit peer supporters in the service as an effective step to promote a recovery approach and contribute to change in the service culture.

People should have the choice between different types of services or other formal or informal forms of support in order to explore and find out what kind of service or support best meets their needs.

At this point in the presentation show participants the video: Rory Doody on his experience of services within the mental health system (35:36 min.).

Rory Doody is Area Lead for Mental Health Engagement, Cork Kerry Community Healthcare, who also has lived experience of traditional mental health services. In this video he describes his journey towards recovery.

<https://youtu.be/63vK2F1ok7k>, accessed 9 April 2019.

This is an opportunity for participants to hear, understand and discuss how aspects of a traditional medical approach to mental health can disempower and negatively impact people's lives, despite good intentions of practitioners working within this framework. It also highlights the key elements that led to Rory Doody's recovery.

After watching the video, ask participants:

- Why do you think the traditional medical model let Rory Doody down?
- What was it about the recovery approach that worked for him?
- Do you identify with any aspect of this story (as a person using services, a practitioner or a peer supporter)? If yes, why? What type of services have you experienced in your life (in terms of either using services or providing services)? What sort of approach were the services promoting – a medical approach, recovery approach, or a mix?

**Recovery-oriented services start with the question:**

**“What can we work on together to make your life better?”**

In other words, the recovery approach deals with all aspects of the person's life and asks whether people are living the life that they want to be living. This is a highly personal experience and therefore requires highly personalized support which draws upon the values and preferences of the individual concerned.

People using services may not immediately know the answer to this question. It may require time and engagement from others to work out what they like, what makes them feel better, what makes them smile, what makes them sad, what hurts them and so on. It takes time and dialogue and often requires creative ways to support people in finding for themselves some of the answers to this question.

There are many different ways in which practitioners, peer supporters, care partners or others can help people during their recovery journey to identify what recovery means to them and work towards these goals (22). This could include discussion about broad areas of a person's life, for instance:

- Identifying what in the person's life or environment may make their circumstances difficult.
- Reconnecting with family and friends or developing new meaningful relationships.
- Finding a job/reconnecting with the job market.
- Links to educational opportunities.
- Participating more in community life.

What is crucial in all of this is that persons in a supportive role:

- Believe in the people they work alongside, in the decisions that they make and that they can gain control of their lives.
- Learn as much as possible from people who have a psychosocial disability and/or who have used services, as they have considerable knowledge and expertise through their lived experience.
- In order to do this, practitioners and other supporters need to recognize that people with lived experience are “experts” in relation to themselves and their recovery. It also requires them to reflect on the knowledge, skills and values which they themselves bring to the supporting role and what they may need to do differently. This will be discussed in more detail in the following topics.
- Such reflection allows a person to “check in” on how their social position and experience have shaped their beliefs and assumptions (e.g. how they work, or their ideas of those they work with). This is essential in revealing and addressing possible power imbalances in order to better support others.

An essential point is that support outside mental health services from caring, loving and supportive friends and family and/or partner is also key to people’s recovery.

The following table summarizes the main differences between traditional services and recovery-based services (23),(24):

		Traditional services	Recovery-based services
<b>Continuum</b> -----			
<b>Beliefs</b>	Views of mental health problems and illnesses	Pathology No meaning in mental health problems or illnesses	Crisis of being Full human experience
	Philosophy	Maintenance Paternalism	Recovery Self-determination
	Language	Focus is on language that is: <ul style="list-style-type: none"> <li>• Medical</li> <li>• Objective</li> <li>• “They”</li> </ul>	More focus on language that is: <ul style="list-style-type: none"> <li>• Personal</li> <li>• Subjective</li> <li>• “We”</li> </ul>
<b>People</b>	Service users	Passive recipients	Active agents and participants
	Families	Unsupported and grieving	Supported and supporting
	Workforce	<ul style="list-style-type: none"> <li>• Mainly medical</li> <li>• Expert authorities</li> </ul>	<ul style="list-style-type: none"> <li>• Diverse workforce including peers</li> <li>• Collaborators</li> </ul>
	Communities	Fearful and discriminatory	Accepting and inclusive
<b>Services</b>	Main service types	Drugs and hospitals	Broad range of therapies, peer support, recovery education, housing, education and employment support and advocacy
	Service cultures	Authoritarian Segregation from society	Participatory Inclusion in society
	Service settings	Hospitals and clinics	Community, home-based and online services
<b>Outcomes</b>	Social networks	Service community	Natural community
	Housing	Hospitals, group homes and other residential services	Own home
	Work	Pre-vocational services Sheltered workshops Unemployment	Real work for real pay A valued contribution to society



**Exercise 2.1 – Recovery-oriented approach (30 min.) (25)**

Distribute copies of Annex 1 to participants.

Read and reflect on the following extract from Tig Davies’ recovery story (26).

“I was in my thirties and at university, having somehow sustained what was probably a three-year massive high when the Grim Reaper himself appeared to take over my life! One minute in the student’s union building, the next Room 1, H ward, acute psychiatric unit! I had experienced a previous and very unsuccessful three-month admission to a psychiatric unit in my late twenties, but I want to tell you about this next experience because of its eventual positive impact upon my recovery.

“Needless to say, the first eight months of this admission had no positive impact! Three months at home ended with me in hospital being told my liver would never take another overdose, a psychiatrist telling me I would never work again, being offered life in a therapeutic community and being told to keep taking the medication – oh, and please stay in the hospital!

“At that point, I truly believed that life as a ‘well person’ for me was over. I was mad and that was that. I was totally devastated but physically and mentally powerless to react. I collapsed into a passive world of nothingness. However, it was to be during the next seven months in hospital where my recovery journey finally began!

“I was heavily medicated, hideously underweight, incapable of thought, desire, motivation or social interaction. My mind was full of dread, fear, voices demanding that I harm myself, that I was dead in all but disgusting body and that this state would remain until death.

“Upstairs at the hospital there was a small patient/visitor café run by Dee. She is probably one of the most genuine, empathic, supportive and fun mental health support workers I have ever met. They called her the ‘coffee shop assistant’. She took ‘serving people’ in that café to new heights. Dee didn’t just serve coffee, she served people. She talked, she shared, she asked, she listened, she cried, she laughed, she spoke the truth as she saw it, she hugged when appropriate, kept her distance when it was right to do so. She joined people to communicate, she took no crap from people, she sought and found understanding of difference – oh, and she made a great mug of coffee! And all of this despite her fear of being in trouble for talking at work! The café and time with Dee became a place of solitude, light and hope for me.

“I was in the café one morning when the new ‘welfare rights worker’ came in – Dave. It transpired we had known each other years before. We talked. He had previously met me during a ‘high’ time in my life and yet being faced with a walking corpse, while upsetting him greatly, brought out in him the most person-centred approach to an individual you could imagine.

“He, Dee and I sat and drank coffee. Then he simply looked at me and asked the most simple and yet profound question I had ever been asked. ‘What do YOU think would help YOU to get well again?’ I was blown away – no one had asked before and I had always been led to believe that the pills, the nurses and the psychiatrists had the plans and the answers. After all, they had written me a care plan!

“I embraced the question in my desperate state and, feeling I had nothing to lose, told Dave and Dee the threads of a dream I had known before. I wanted to be well, I wanted relationships with my family and friends back, I wanted to go home to my flat, and I wanted to work. At the end of this talk I ate and, equally important, ‘enjoyed’ toast and jam and a full mug of chocolate milkshake. At that point I hadn’t eaten more than one digestive biscuit and half a glass of milk a day for over three months! I also smiled. And that felt great. ‘Hope’ had finally returned. I talked. I dreamed. I planned”. -- **Tig Davies. Mental illness to recovery – We hold our own journey plans!**

While experiencing the depths of what she describes as her “desperate state”, Tig identifies ways in which Dee and Dave helped her embark on her recovery journey.

It is important to note that we are not suggesting that the work practitioners do is not centred on people. The difference with a person-centred approach is that the orientation and direction of the work is altered and shifted. From Tig’s story, it appears clear that both Dee and Dave were relating to her in a way that she saw as being different from her other experiences in mental health and social services, and which prompted a turning point that started her journey to recovery.

Ask participants the following question:

- Looking back on Tig’s account, what was it about Dee and Dave’s approach that you would identify as recovery-oriented?
- There are other issues raised in Tig’s account that suggest that the support and treatment she received during her admission was not person-centred. What are these? How could things have been approached differently?



**Presentation: Key recovery-oriented practices (10 min.)**

As we have already discussed, current services in countries around the world commonly focus on *deficits* (what the person is *unable* to do), on maintaining people using services in a “stable” situation in relation to their mental health, and on preventing deterioration of symptoms or functioning levels.

This approach places too little emphasis on the person as a whole and on what they are experiencing and does not harness their strengths, hopes and aspirations.

This does not mean that services should *not* assist people to solve problems, but it does mean that focusing on peoples’ strengths, rather than deficits, is a more effective way to help people address the emotions and challenges that they may be experiencing in their life.

In recovery-oriented services, mental health and other practitioners, family members and other care partners, peer workers and other supporters all have a part to play in a person’s recovery. This includes:

- Focusing on strengths and assets
- Inspiring hope
- Understanding values and preferences of the person
- Working alongside the person
- Maintaining boundaries
- Being aware of potential barriers that may hinder the person’s recovery journey, including power imbalances within services
- Supporting the person in positive risk-taking
- Connecting the person to the community, including peers and family members.

These types of practices also help to promote the societal change needed to end discrimination towards people with psychosocial disabilities.

The next topics will look at the key roles that practitioners, family members and other supporters can play in promoting recovery. Participants will then have a chance to discuss how this differs from the current practice in mental health and social services.



## Topic 3: Recovery focus on assets and strengths

### Time for this topic

Approximately 45 minutes.



**Presentation: Focusing on assets and strengths of the person is central to recovery-oriented care (2),(27) (25 min.)**

Too frequently services focus on people's problems and deficits. An essential part of recovery is for people to identify and build on their assets and strengths. This can be facilitated in several ways:

- Focusing on the strengths and assets (rather than deficits) of the person using services as well as those of the family, friends and care partners who support the person.
- Working in a way that acknowledges the personal, social, cultural and spiritual values, strengths and wishes of the person.
- Establishing a partnership with the person as well as their support network (with the person's consent) in order to better understand and support them identify and build on their assets and strengths.

The deficit approach limits people's opportunities whereas the asset/strengths-based approach widens them.

Focusing on assets and strengths does not mean denying the pain and distress that a person may experience. These feelings should be acknowledged, and the person should be supported to explore them and find ways to overcome them, using their strengths and assets.

Deficit-based approach (27)
<ul style="list-style-type: none"><li>• Starts with deficiencies and responds to problems.</li><li>• Provides support that is limited by the service's specific mandate or policy rather than focusing on the needs of the individual.</li><li>• Treats people as passive recipients of care.</li><li>• Sees problems or deficits as existing within the person themselves and tries to "fix" or "stabilize" the person.</li></ul>
Asset/strengths-based approach: (22),(2),(27)
<ul style="list-style-type: none"><li>• Starts with assets and identifies opportunities and strengths.</li><li>• Sees people as experts in their own recovery and acknowledges that people are capable of making decisions, and do make them.</li><li>• Requires practitioners or other supporters to move from "fixing people" to supporting recovery.</li><li>• Emphasizes collaboration and co-production between the person concerned and practitioners and other supporters in the recovery process and journey.</li><li>• Views and treats the wider community as assets.</li><li>• Empowers people to better take control of their lives and supports them to develop their potential, with an understanding that they themselves hold the answers and solutions.</li></ul>

At this point explain to participants:

In the following scenario (Tom), we will see what the deficit-based approach means in practice and how it is possible to move towards a strengths-based approach.

### **Scenario - Tom**

Tom is a 30-year-old man working as a teacher. He has been married to his wife for three years but their relationship has recently deteriorated and they are constantly arguing. He is finding it more and more difficult to find pleasure in his job and to be patient with and attentive to the needs of his students. Every day feels unbearable. He often finds it difficult to fall asleep at night as he thinks about the day to come and gets anxious about not being able to cope. When he feels like this, he turns to alcohol until he feels calmer. He has consulted his general practitioner who has given him a diagnosis of chronic fatigue and low mood and has talked about possible depression. Despite this, he remains very involved with the local rugby team and derives a lot of comfort from playing and spending time with his friends from the team.

Deficit-based approach	Asset/strengths-based approach
<p><b>Starts with deficiencies and responds to problems:</b></p> <ul style="list-style-type: none"> <li>Chronic fatigue and low mood, possibly depression</li> <li>Alcohol misuse</li> <li>Relationship problems with wife.</li> </ul>	<p><b>Starts with assets and identifies opportunities and strengths:</b></p> <ul style="list-style-type: none"> <li>Love of sports</li> <li>Committed relationship with wife that has overcome previous challenges</li> <li>Involved in the rugby team and good relationship with the team members</li> <li>Willing to seek out new opportunities.</li> </ul>
<p><b>Provides support that is limited by the service's specific mandate rather than focusing on the needs of the individual:</b></p> <ul style="list-style-type: none"> <li>Further assessment of chronic fatigue</li> <li>Referral to community mental health team and substance misuse team.</li> </ul>	<p><b>Emphasizes the role of the wider community and wider organizational assets; sees people as citizens and co-producers:</b></p> <ul style="list-style-type: none"> <li>The local rugby team is very beneficial to Tom in many different ways</li> <li>Possibility to take free carpentry class on Tuesday nights.</li> </ul>
<p><b>Treats people as passive recipients of care. Sees problems or deficits as existing within the person themselves and tries to fix this:</b></p> <ul style="list-style-type: none"> <li>Referral to chronic fatigue clinic</li> <li>Psychology referral for cognitive behavioural therapy</li> <li>Prescription of antidepressants.</li> </ul>	<p><b>Helps people to take control of their lives and supports them to develop their potential, seeing the person as the answer:</b></p> <ul style="list-style-type: none"> <li>Tom evaluates treatment and support options offered by his general practitioner and also considers other ideas and options that he has thought of on his own</li> <li>He decides to try out cognitive behavioural therapy to learn how to deal with anxiety and reduce his consumption of alcohol</li> <li>He decides to take carpentry classes and to seek out new career opportunities.</li> </ul>



**Exercise 3.1: Focusing on strengths and assets (2) (20 min.)**

Now is the chance for the participants to apply the concepts they have learned about focusing on strengths and assets.

Ask participants to consider the following descriptions of Sarah:

Consider the following example:

**Sarah:**

1. Sarah is an obese non-compliant schizophrenic who does nothing to help herself.
2. Sarah requires significant support with her lifestyle choices to attain optimum management of her diagnosis of schizophrenia and weight.
3. Sarah is the proud mother of a two-year-old daughter and has a supportive family. She aspires to go to college to study child care. She has experienced visual and auditory hallucinations since she was 20.

Ask participants to discuss the following questions:

If you were Sarah, which of the descriptions would you prefer was used to describe you? Why?

Encourage participants to think of why some of the descriptions are not suitable.

- Most will identify that the first description is very inappropriate and infringes on Sarah's dignity.
- The second defines Sarah solely by her diagnosis of schizophrenia and weight, but we know nothing about her as a person. The use of the word "requires" in the description also indicates an automatic assumption Sarah will not manage without support.
- The third description frames Sarah as a person who has shown great strength and someone who has dreams and aspirations.

What impacts could these different descriptions have on Sarah?

- Description 1 may lead Sarah to feel insulted, hopeless and to be deprived of her identity. This may also leave her feeling silenced and feel like nothing is likely to help her.
- Description 2 could make Sarah feel like those that are providing her with care view her just as a condition and know nothing about her as a person or how she navigates day-to-day challenges. She may feel like she is being judged and may experience feelings of inferiority because of how she is described. She may also feel that her practitioners are distant and uncaring. Referring to Sarah's "poor" lifestyle choices also places blame on her, ignoring why these choices have been made.
- Description 3 could help Sarah feel much more positive about who she is as a person as it focuses on her strengths, reminding her of the great things she has achieved as well as her dreams and aspirations for the future.

## Topic 4: Promoting hope

### Time for this topic

Approximately 1 hour.



### **Exercise 4.1: Promoting hope (8),(5),(28)? (40 min.)**

The following discussion about promoting hope should take place in the plenary. Ask participants:

#### **What do you understand by the phrase “inspiring hope”?**

After this initial discussion in plenary, ask participants to divide into groups of five. Ask the groups to discuss the following question:

#### **How can practitioners, peers, families and others inspire hope in people they are supporting in their recovery?**

Ask participants to report back on their group discussion in the plenary. Then bring the following list to their attention:

#### **How can we inspire hope in people we work with and support?**

- Valuing the person for who they are and valuing their dreams and aspirations.
- Believing in the person’s worth.
- Having confidence in the person’s skills, abilities and potential.
- Believing in the authenticity of the person’s experience.
- Accepting and actively exploring the person’s experiences.
- Tolerating uncertainty about the future.
- Seeing problems and setbacks as part of the recovery process and helping the person to learn from and build on these.
- To connect individuals with other people who have gone through similar experiences.

Ask participants:

#### **Why might people lose hope?**

Examples of answers may include:

- Lack of confidence from family, friends and staff.
- Others making all important decisions and having one’s own view disregarded.
- Being told that one should not get married, have children or work again.
- Being excluded from the community and being discriminated against (e.g. lack of education, employment, housing, absence of disability-related support).

- Belief that there is nothing positive in the future or that life and circumstances cannot change.
- Loss of confidence in abilities and talents.
- Losing hope because the recovery journey can be hard or involves hard work.
- Poor treatment in mental health and social services resulting in cynicism or loss of hope that things can get better.
- Being given a diagnosis and feeling like medication is the (only) answer.

The facilitator may also raise the issue of why family and supporters may lose hope.

Why family and supporters may lose hope?

Some examples may include:

- Lack of support and/or resources for themselves
- Lack of information
- Lack of understanding from their community.



#### **Exercise 4.2: How hope facilitates recovery (8) (20 min.)**

Ask the group to think once again about a time when they had to recover from something – **e.g. a health problem, a loss or bereavement (if you feel comfortable thinking of that)**. This can be a similar situation to the one you thought about in the earlier exercise of the training.

Then, as a group, answer the following questions:

- What role did hope play in your own recovery?
- When you felt hopeless, what helped you keep going?

Give the group a few minutes to jot down their ideas and then discuss with the rest of the group.

At the end of the exercise it is important to make the point that:

It is important to not minimize very real difficulties that people are experiencing. Hope should *not* be used as a way of avoiding or denying feelings or sadness that people might experience and which might seem overwhelming. It is important to acknowledge how people are feeling during challenging moments in their lives, as the following quotation illustrates:

“Well, for some of us, we do not need to be told that; it is to some people just plain insulting. If your life has been devastated and wrecked by illness, your job has disappeared like a rush of leaves, you are seen as unfit to look after your children, you have no friends, nothing to do, almost no money and the professionals do not even seem to understand your distress, well, sometimes it can feel as though our lives have been wrecked without any hope of repair – the journey is fractured and unwelcome and its end the only bright solution.

“Then in this situation we may not welcome some bright person coming along to empower us on our journey of recovery; we may get downright angry when the end of the day is the furthest we can possibly look, and yet we are being encouraged to develop hope and optimism. There may be an instinctive, ‘How dare you underestimate my despair?’, ‘How dare you ask me to find the slightest degree of hope in the poverty of my life?’” (29)

## Topic 5: Values in recovery

### Time for this topic

Approximately 20 minutes.



**Presentation: Respecting the person means understanding their values and preferences (2) (20min.)**

### Values definition:

- Values are beliefs, principles or standards that a person feels are important in their life and which govern the way they think and act. These are shaped by social experiences and contexts.
- We develop our values through experiences and reflection. Values often underlie preferences and the choices that we make, including in the areas of treatment, care and support.
- In fact, values can often be expressed through wishes, preferences, perceptions, choices, expectations, hopes, disappointments or fears rather than being discussed explicitly.
- Values are one of the strongest determinants of behaviour and anything that goes directly against a person's values can feel like an invasion of freedom and can lead to resistance.

### Values-based practice:

Values-based practice is about working constructively with people's differences and accepting a diversity of values.

### This means:

- Putting the values of people who are using services, as they continue to evolve and develop, at the centre of everything that is done.
- Having an understanding about one's values and the effects of these on oneself and on others.
- Honouring the person's own choices and creativity as the source of their recovery or healing and as a manifestation and development of their values.

It is important that people do not assume that others share the same values as this can lead to approaches, suggestions and interventions which can be unacceptable and fail.

Supporters and mental health and other practitioners should have an open discussion with the person if they cannot provide the support the person wants because it conflicts with their own values. In addition, supporters and practitioners should make extra efforts to understand the values of people who may not express themselves in conventional ways – for instance, by paying close attention to how people react in different situations.

Taking the time to learn people's preferences regarding treatment, care and support is key to building recovery-oriented relationships.

For example, some people may choose:

- To have certain visitors while they are using a service, but not others. This may reflect a value of keeping certain parts of life off-limits to some relationships (such as work relationships).
- To discuss experiences with peers who went through similar experiences and have recovered. This may reflect a belief that wisdom comes through experience more than book-learning.
- To change or stop taking medication. This may reflect increasing knowledge about harms caused by a medication, or a shift in the person's values from seeking immediate relief to experiencing life free from the effects of medication.
- To talk to certain mental health and other practitioners and not others, or not to use mental health services at all. This may reflect a person's values regarding the type of interactions that they find useful for their recovery.

It is crucial not to make assumptions about a person's underlying beliefs and values from their expressed preferences. The person's will and preferences are a statement of what they want in one or more situations. They do not need to explain the basis for a preference.

However, in some contexts it can be worthwhile to explore, on the basis of conversations that take place over time, whether the person has underlying values and beliefs that apply to a more general category of circumstances.

**Values, choice and preferences in the person's life and in relation to treatment and/or support should be explored over the course of the relationship.**

This will require listening and effective communication skills to understand the person's:

- **Understanding and perspectives:** How do people understand what is happening in their lives right now? What do people want/not want from others, including from mental health and social services? How do people view mental health services? What are their views about medication?
- **Identity:** How do they see themselves in relation to others?
- **Boundaries:** What do people see as off-limits in the context of support or service relationships?
- **Beliefs:** Do people have any religious, spiritual or other beliefs that are important to them?
- **Goals:** What goals do people have in their lives?
- **Past experiences:** What are people's experiences (including both negative and positive) of mental health services and the treatments that they have experienced, as well as other services and supports?
- **What has worked** for the person? What has not?
- **What do people hope to achieve** in their recovery?
- **What do people hope for** in their relationships with supporters and/or therapeutic relationships? Are there certain styles and approaches that do not work? Why? What kind of support do people need and want?

Even if all a person's preferences cannot be met – for instance, due to a lack of resources – understanding the values of the person can provide insight into other potentially acceptable options. In addition, certain choices may be expressed as non-negotiable.



## Topic 6: Working alongside people

### Time for this topic

Approximately 1 hour.



**Presentation: What does it mean to work alongside someone? (8) (15min.)**

### Doing with rather than doing to

- Practitioners, care partners, families and others are often seen as “doing to” people using services. Within a recovery approach the emphasis is on “doing with” people and “being alongside” as people take the lead in their recovery journey.
- In this context, the person is making the decisions regarding their lives and recovery journey, while practitioners, care partners, family members and other supporters only support the person if the individual wants them to be involved.
- Supporting is different from directing.
- Supporters need to find a balance between when to support and when to try to make people think about different possibilities and question their habitual ways of doing things.
- Practitioners are resource persons who provide information and support to enable people to identify their own recovery goals and to achieve them.
- Being too challenging may be counterproductive for the person’s recovery and may weaken the relationship and trust between the person and their supporters.
- Supporters should be aware that they may also need support for themselves.

### Resisting the temptation to sort out problems

- The notion of being alongside people may go against both human and professional instincts to “help” or to “sort out/fix problems” for the person.
- Taking a step back from this more active role requires skill, trust in and respect for the person being supported. This places power in the hands of those being supported to lead their recovery.
- It is important to be patient, let people go at their own pace and continually adjust the amount of input offered on the basis of the needs and wishes of the person being supported.
- Demonstrating belief in the person will allow them to develop confidence in their own abilities to manage their life, situation and challenges.



**Exercise 6.1: Working alongside in practice (30) (45 min.)**

Sometimes when a person is having a crisis, is feeling overwhelmed, or is expressing negative attitudes towards family, care partners, practitioners or services, it can feel difficult to engage with them in a personal and helpful manner. We will now discuss a scenario – Suraiya’ experience – to explore the care and support she received in the context of a recovery approach.

Divide the participants into groups of 5 to discuss the scenario. These groups will then be asked to present their thoughts in plenary.

### **Scenario - Suraiya's experience**

Suraiya is a 22-year-old woman who has agreed to be admitted to an acute psychiatric care ward following a suicide attempt. She has a history of serious self-harm and repeated admissions because of severe distress that she has experienced.

As one of Suraiya's professional advocates, you are meeting with her to discuss the situation. She reports that she feels hopeless and unhappy and believes that the psychiatrist dislikes her. She sits quietly and appears very withdrawn throughout the meeting.

### **What might you want if you were in Suraiya's shoes?**

#### **Some answers from participants may include:**

- To see a different psychiatrist.
- To go home
- To have more information on her stay and treatment plan
- To regain control of her life
- To feel like someone understands or empathizes with her situation
- To see a familiar face or someone who she trusts (friend or relative).

### **Based on what you have learned about the recovery approach, how could you support Suraiya?**

#### **Prompt the group to consider:**

- How would you start a conversation with Suraiya?
- What questions would you ask Suraiya?

#### **Examples may include:**

- Ask her what makes her think the psychiatrist dislikes her.
- Acknowledge Suraiya's distress (by really engaging and actively listening). Explore with her what is not going well for her in order to inquire about her well-being and her experience of the service.
- Assure her that she is here by her own choice and that she is not obliged to stay or do anything she does not want to do.
- Invite her to describe what would make her situation better.
- Ask her how you could help to make the situation less stressful (e.g. having certain visitors, having some meaningful belongings brought in from home, activities she would like to do, talking to certain mental health workers, making arrangements so she can go home with the appropriate support, etc.).
- Ask her if there is anyone else on staff who she is comfortable talking with.
- Ask her if it would be helpful to talk to someone who has had a similar experience (e.g. a peer supporter).

***Let's consider how a professional advocate, Jamal, engages with Suraiya:***

At a meeting with Suraiya, Jamal notices that Suraiya appears withdrawn, angry and sad. He asks how she is feeling at the moment. Jamal also asks if there is anything that might make her feel better. Suraiya says that she would like to talk to her friend. Jamal says that he would try to organize that as soon as possible. He also asks in the meantime what else might help.

Suraiya explains that she really needs time on her own in a quiet place to reflect. She said that it has helped in the past to listen to music, in order to get some distance from her situation. The mental health service has established some comfortable quiet rooms over the past year and Jamal proposes that Suraiya spend as much time as she would like there and can listen to music and call her friends at any time. He also lets Suraiya know that he will be here to support her when she needs to.

Jamal also recalls that Suraya thought that the psychiatrist disliked her. He invites her to discuss any concerns that weren't already dealt with, so they can be addressed with those involved and, if relevant, resources and information could be provided about how and where to make complaints.

**In what ways is Jamal's support in line with recovery-oriented practices?**

**Some answers may include:**

- Jamal inspires hope.
- Jamal listens and tries to understand Suraiya's preferences.
- Jamal is respectful of Suraiya's requests.
- He is working alongside Suraiya.
- At all times Jamal is being professional, while at the same time remaining engaged and supportive.

## Topic 7: Boundaries within the context of recovery practices

### Time for this topic

Approximately 20 minutes.



### **Presentation: Understanding boundaries (31) (20min.)**

When discussing with participants the issue of boundaries, it is important to be aware that there may be variations in opinion in the group as to what is acceptable. Ask the group the following question and list their responses on a flipchart:

What do you understand by the phrase “*Maintaining professional boundaries in the context of mental health and social services*”?

After a short discussion on this, resume the presentation.

### **Maintaining boundaries (30)**

Maintaining professional boundaries within the context of the recovery approach means:

- Recognizing and responding appropriately to the boundaries of people using the service.
- Being clear, fair and open about what you can and cannot do
- Not being *over-involved* or *under-involved*.

Ideas of “professional distance” have, in the past, served to maintain a false “us and them” barrier between service staff and people using services, as if they were fundamentally different.

However, the view that practitioners have to remain emotionally detached and personally distant in order to be competent is not supported by what is said by many people using mental health and social services. For example, it can be useful for a practitioner to disclose their own personal challenges or history of trauma when this can provide insight and a way forward to overcome challenges or trauma.

On the other hand, people using services may perceive interventions of mental health and other practitioners as crossing their personal boundaries (e.g. intrusive questions about personal life, forced medication, etc.).

As such, the focus is not on maintaining boundaries but on developing a sustainable relationship in which both parties feel comfortable and which works to the benefit of the person.

It requires finding a balance in which practitioners and other supporters are neither over-involved nor under-involved. The appropriate level of involvement may vary depending on where one lives, so it is important to take into consideration cultural or contextual differences when developing a relationship with a person.

- An example of over-involvement might be when a supporter identifies so strongly with the person that they try to explore experiences that the person finds uncomfortable, unwanted and/or unrelated to the issue.

- An example of under-involvement might be when a supporter disengages with the person completely and sees them as a “lost cause” or ignores their feelings.

Show participants the following table which illustrates what over-involvement or under-involvement might look like between a practitioner and a person using a service

Over-involved	Under-involved
<ul style="list-style-type: none"> <li>• Unclear or stretched boundaries</li> <li>• Chasing people for contact</li> <li>• Violations of personal space and boundaries</li> <li>• Unhelpful or negative personal disclosures</li> <li>• People’s needs being met at the expense of the well-being of the practitioner/other supporters.</li> </ul>	<ul style="list-style-type: none"> <li>• Resenting time or attention the person may need or want</li> <li>• Avoiding contact with people using services</li> <li>• Boundaries used to punish people</li> <li>• Being closed-off from the person and not sharing any personal experiences</li> <li>• Only providing challenges without support</li> <li>• Being detached, uncaring, cold</li> <li>• Remaining uninvolved and disinterested</li> <li>• Not seeming engaged or appearing distracted when talking to the person.</li> </ul>

## Topic 8: Positive risks in recovery

### Time for this topic

Approximately 2 hours.



### **Presentation: Supporting positive risk-taking (32) (30 min.)**

Recovery involves taking risks in life, whether engaging in new activities, meeting new people, or exploring new ideas and feelings. Not all risks are equivalent. Positive risk-taking is not the same as risk-taking that involves “risky” behaviour such as having unsafe sex or driving extremely fast in a car. Those are risks that most of us would deem unwise. Yet individuals may draw the line between positive risk-taking and unwise risk differently (e.g. extreme sports may build a person’s confidence by deliberately facing risk).

Positive risk-taking means that people can explore their potential, new possibilities and opportunities, pursue their dreams and ambitions, learn from positive or negative experiences and live life as they choose. However, mental health and other practitioners, families and care partners and health services generally tend to be risk-averse and actively discourage the people they are supporting from taking risks.

Ask participants the following question:

### **Why do people avoid taking risks in mental health?**

Then show the following slides (8),(33):

#### ***People with psychosocial disabilities:***

- People may be reluctant to take risks for fear of worsening their problems.
- People may avoid taking risks because they fear failure.
- People may also be afraid of the discrimination they may encounter if they take on certain activities.
- People may not want to go outside their comfort zone or may not feel comfortable facing their fears.
- Some people may already have experienced a great deal of risk and bad outcomes in their life, whether from choice or other circumstances, and may be averse to taking more risks.
- Some people may lack a support system to encourage them to take risks.

#### ***Families and care partners:***

- They may fear that their relative might experience distress if they undertake new and challenging activities or tasks.
- They may fear that what they consider as a failure on the part of their relative will bring shame on the family and harm to their relative.

### ***Mental health and other practitioners:***

- Mental health and other practitioners' low expectations (e.g. regarding the ability of people using services to find employment, to care for a family, etc.) can be an obstacle to their supporting a person to take risks and explore new opportunities.
- Practitioners are often afraid of being blamed, liable and reprimanded if something goes wrong.

### **Why is risk-taking important in recovery (32)?**

- Life necessarily involves taking risks, and each person needs to learn, through trial and error, about the kind of approaches to risk-taking that are positive and negative.
- People cannot explore their potential, new possibilities and opportunities, pursue their dreams and ambitions or learn from their experience without taking risks.
- The avoidance of risk can result in the person having no purpose in life and restricts or confines them to having no role other than that of someone with an "illness" or diagnosis.
- If practitioners or supporters only focus on protecting a person from risks, this can actively hinder the person's recovery.
- Recovery is about enabling people to make choices for themselves and achieve their goals. Sometimes these goals may require taking risks.

### **Positive risk-taking is a part of everyday life (32)**

It is not possible to avoid risk in life. Avoiding risks by playing it safe, doing what others have told you is best, or doing what you have done before, carries its own risks. To enjoy fully the right to exercise legal capacity also means to embrace the risks inherent in making choices and affirming and accepting oneself. Taking risks, even if it means being sometimes successful and sometimes unsuccessful, is an essential part of everyone's life if people are to strive to achieve dreams and goals and to learn from their mistakes. Risk-taking, therefore, is an integral part of recovery and personal growth.

For example:

- People would not have friends or partners if they had not risked the possibility of being rejected.
- People would not have qualifications if they had not risked the possibility of failing in examinations.
- People would not have jobs if they had not risked the possibility of being turned down at a job interview.

Some people are naturally inclined to be more risk-averse while others accept risk more easily. There is no shame either way, and there are social and personal benefits to both ways. Being cautious may allow a person to preserve what they have and build slowly, while taking risks may more easily result in a greater number of both successful and unsuccessful ventures. It is important that people get to know what feels right for them, even if it is not right for someone else.

**Supporting people during periods of positive risk-taking is essential if practitioners and other supporters are to actively promote recovery.** Mental health and other practitioners and supporters can support people by assisting them to evaluate or weigh up the potential positive and negative outcomes of taking the risk or accepting a new opportunity, and to work out ways of minimizing any potentially negative outcomes.



### **Exercise 8.1: Positive risk-taking in practice (90 min.)**

The aim of this exercise is to explore what positive risk-taking might look like in practice. Ask for volunteers to read the scenario.

#### **Scenario 1 (30 min.)**

##### **Scenario - Hasan**

Hasan has been using the community mental health service close to his home for the past five years. He has a good relationship with the staff and has found the support of the service very helpful. The staff of the service know Hasan well and have worked hard with him to support him through difficult experiences and to help him to live independently.

Hasan is planning to move to the other side of the country to marry and move in with his fiancé. He announces his decision to his mental health worker Lethabo.

Lethabo and the rest of the staff are concerned that, once Hasan has moved, he will not be able to receive the support of the mental health service. If Hasan finds himself in distress, another service will not know Hasan well enough to support him appropriately, and if anything goes wrong there is nothing they will be able to do.

- **The benefits for Hasan to move:** living with the woman he loves, meeting new people in a new town which can have a positive impact on his well-being and recovery.
- **The risk for Hasan to move:** risk of the relationship breaking down, risk of not being able to integrate in a new city, risk of not being able to receive support if needed.

Despite their concern for Hasan, Lethabo and the rest of the team decide to support Hasan in his decision.

Once participants have read the scenario, ask the group the following and write participants' answers on the flipchart:

As a group, discuss what measures staff of the mental health service can offer to take to support Hasan in his plan to move to the other side of the country.



Write participants' ideas on the flipchart and compare them with the end of the scenario below.

### Scenario - Hasan

After discussing with the rest of the staff of the service who knew Hasan, Lethabo came up with different suggestions to support Hasan and discussed these with him. They agreed that the staff will take the following actions:

- Obtain information about support services available where Hasan is planning to move.
- If they identify a good service, they would put Hasan in contact with the service.
- With Hasan's consent, they would share information about Hasan's requirements and how best to support him with the members of the other service.
- They would keep in touch with Hasan and reassure him that they will support him again if for any reason he decides to come back.

### Scenario 2 (8) (30 min.)

Again, ask participants to volunteer to read out the following scenario.

### Scenario - Mary

Mary is 30 years old and is currently attending a community mental health centre. She is passionate about the well-being of animals and has always been involved in caring for their welfare (through both paid and unpaid work).

Mary's goal at the moment includes going back to work in a similar field. She wants a job that she feels motivated about and wishes to start earning money so she can get her own place and move out of her parents' house. She believes that any previous challenges she has experienced in her recovery are now well under control and feels she is ready to move on. Mary asks staff at the community mental health centre to help her try and find work.

However, her parents are worried about the idea of Mary taking on new responsibilities. She experienced her first mental health crisis when she went from studying into full-time employment as a flight attendant. They are fearful that the pressures of another full-time job will lead her to relapse and undo all the progress she has made to date.

They appeal to Rachel, Mary's mental health worker, to try to convince Mary to wait another couple of years before looking for full-time employment. Rachel explains to them that she will first and foremost respect Mary's decision but that she will raise the issue at their next appointment.

At their next appointment, Mary and Rachel discuss the benefits and risks of returning to work.

- **The benefits of returning to work:** gaining a sense of purpose, being engaged in meaningful work, earning an income which would lead to other benefits, such as moving into her own accommodation.
- **The risks of returning to work:** potentially jeopardizing the progress that she has made because of the stress, and the possibility that the job would not meet her expectations

Ask participants the following and note their ideas on the flipchart:

Based on the discussion, Mary has decided to return back to work. Imagine you are Rachel. Mary has booked a follow-up appointment to discuss her plan to find work.

As a group, try to identify some measures that can be put in place to help and support Mary in her plan to find and return to work.

- Once the group has finished discussing this, share with them the outcome of this scenario (in the following table)
- Then highlight similarities between what participants said and the actions discussed in the following box.

**Let's review the action Mary decided to take.**

### **Scenario - Mary**

#### **The action Mary decided to take**

Mary was really motivated to go back to work, particularly in the field of animal care, so Mary and Rachel explored ways of decreasing the potential stress involved in finding and taking on a new job.

This involved Mary and Rachel looking at the support she had received when she was previously working full-time and discussing how similar support could be put in place now in order to reduce any potential risks and to increase the chance of Mary securing and maintaining employment.

Together, they decide to:

- Look for work opportunities in the field of animal care but opt for part-time work initially, rather than full-time work, with the end goal being to move into full-time employment.
- Create a specific plan for dealing with crises that might occur when Mary is working under pressure.
- Generate a routine which allows her to arrive at work on time and manage any potential stressors.
- Give Rachel's mobile phone number to Mary and her family so they can call if they are worried and want to discuss any concerns.
- Set up a couple of regular meetings between Mary and Rachel throughout this process to discuss how Mary is feeling throughout the job interviewing and job securing process.

**Now imagine there are two outcomes for Mary. Review and compare each below:**

**Scenario - Mary  
Outcomes for Mary**

**OUTCOME 1**

One potential outcome is that Mary was able to secure part-time employment in an area that was meaningful to her and was able to start earning an income, which allowed her to move into her own accommodation.

**OUTCOME 2**

It takes Mary a significant amount of time to secure a job, which makes her feel disheartened. Rachel and Mary's family give her ongoing support to help her throughout this stressful time. Finally, Mary is able to secure a job but finds that she struggles to concentrate for long hours at a time and gets tired quite quickly.

Rather than quitting her job, Mary reaches out to Rachel to discuss these challenges and they arrange a meeting. After discussion Mary decides to discuss with her boss the possibility of taking breaks throughout the day rather than working non-stop through an entire 8-hour shift. Her boss agrees to this arrangement and Mary is able to continue working in a job she loves.

As you can see from the evolution of this scenario, there is no obvious right or wrong choice. There are always possibilities to solve problems even if it seems that a particular choice may have been more challenging than another.

Outcome 2 presented new challenges that were overcome along the way.

## Topic 9: Supporting people to reconnect with their communities

### Time for this topic

Approximately 45 minutes.



**Presentation: Supporting people to reconnect with their communities (34) (15 min.)**

### Why do people lose contact with their communities?

Unfortunately, services in many countries separate people from their communities.

- Legislation exists to forcibly remove people from their homes and community to be placed in inpatient mental health and social services, including psychiatric hospitals, to receive care.
- Long-term inpatient services and psychiatric hospitals are often located far away from people's family, friends and community.
- In some cases, family members see the admission of their relative to a service or hospital as an opportunity to disconnect from that person. Family members may be reluctant to provide the psychiatric hospital with a home address.
- In other cases, families or care partners may not be able, or may not want, to take a person back home once they have been away for some time as they are concerned that their community will look on them negatively.
- As a result, people lose contact with their family and support network, and are left isolated and marginalized from their own community.

### Supporting people to reconnect with their community is a key part of the recovery journey

- Being engaged in the community is often a key goal for people in recovery.
- People can benefit from using available community services and resources, be it for health, leisure, or social services, and interacting and building relationships with other community members.
- A key role of family, practitioners and other supporters therefore, is to learn about available resources and services in their local community and to support the person to access these.
- A key role for practitioners in some cases may also be to assist a person using services, to re-establish contact with lost family and friends if the person wishes to do so.
- In addition, it can be useful to connect people to peer supporters or groups that may exist. People benefit greatly when they are able to receive support from others who have had similar experiences going through recovery (for additional information please see QualityRights guidance modules *One-to-one peer support by and for people with lived experience* and *Peer support groups by and for people with lived experience*).
- Supporting people to reconnect with their community can lead to positive interactions for all and also has the added value of breaking down stereotypes and misconceptions.



### **Exercise 9.1: – Using community resources (15 min.) (2)**

Ask participants to read the following and discuss how community resources can be used to support Sheila and Emma.

#### **Scenario - Sheila and Emma**

Sheila (50) lives at home with her mother, Emma (75), and has a learning disability. She works in a cafe run by an organization that supports people with learning disabilities. She is fond of swimming and dancing, attends local clubs for both activities and has a wide range of friends through work and leisure activities. She needs the support of her mother for the majority of daily tasks such as cleaning, meal preparation, transportation and banking.

Emma is quite active within her local community and is keen to support Sheila in maintaining these links. Emma's sister, Claire, lives far away but stays in regular phone contact with her sister and visits as often as possible.

Emma has had a mild stroke and was admitted to hospital. She has now recovered sufficiently to plan her discharge from hospital, where she has been staying for the past 10 days.

During her hospital stay, Emma has lost some of her ability to move around and look after herself. She is really worried about how she will cope with supporting her daughter Sheila who has her own health needs. She desperately wants them to continue to live together.

When Emma was admitted to hospital, Sheila was placed in a local authority social care home. It became clear during Emma's admission that she had been providing more support to enable Sheila to stay at home than had previously been appreciated.

In view of Emma's deteriorated health and the support required by Sheila, the assessment of staff in the home was that Sheila would require some form of residential or supported accommodation in future rather than returning home.

Ask participant the following and write their answers in a flipchart:

“What support might be necessary to allow Emma and Sheila to continue to live together in their community?”

Answers may include:

- Help to perform household chores can be provided by friends, neighbours or community resources (e.g. paid staff, drop in services, or assistance by other support organizations).
- Home visits by health-care services to provide both Emma and Sheila with their basic health needs at the convenience of their home.
- Transport to work and local clubs can be provided by friends and colleagues to ensure that both Emma and Sheila will continue to work and complete activities that gives them satisfaction and pleasure.
- Community supports and services including peer supports, local community groups and social services can be provided when Emma and Sheila need additional support.

- Emma's sister could spend time with Emma and Sheila in a personal manner and provide support as appropriate.



### **Exercise 9.2: Reconnecting the disconnected (15 min.)**

This discussion will take place in plenary. Write ideas from participants on a flipchart.

Ask participants the following question:

**In what ways can mental health or social services support people to connect to their community?**

**Some answers may include:**

- The person using the service can be encouraged to identify the ways in which they would like to connect with their community and specific community groups or activities.
- Gather as much information as possible about the activities the person is currently interested in or was previously involved in as part of their local community.
- Encourage the use of community leisure facilities.
- Link individuals to job, vocational or educational opportunities available in the local area, with the person's consent, and, as appropriate, engage with employers, companies, academic institutions, income-generating organizations and NGOs to help them better understand and accommodate any requirements they may have.
- Making sure that people have the supports that they require to live in the community
- Establish peer groups for people in recovery (or, where peer groups exist, connect people to these groups).
- If the person wishes, connect them with local faith-based groups, or religious or community leaders' interest groups, or other NGOs/allies.

## Topic 10: Communication skills

### Time for this topic

Approximately 50 minutes.



### **Exercise 10.1: Communication is crucial in recovery-oriented care (10 min.)**

Ask participants:

**Based on your experience (personal or professional), what skills are important for good communication with people undertaking a recovery journey?**

**Some answers may include:**

- Listening attentively (e.g. listening without distractions such as mobile telephone and focusing fully on the person).
- Making an effort to truly understand what the person is saying/the person's perspective.
- Seeking to understand the views and values of the other person (i.e. suspending one's assumptions of the person while recognizing that one's views can vary across factors such as culture, gender, religion, etc.).
- Taking a moment to think about what the person is saying before responding (i.e. not reacting immediately).
- Being respectful.
- Talking to and treating the person as an equal.
- Talking calmly.
- Speaking in a way that is understandable, simple and straightforward.
- Not interrupting.
- Being patient.
- Using humour if and where appropriate.
- Being nonjudgmental and using nonjudgmental language.
- Using simple, clear and concise language.
- Paying attention to nonverbal language and behaviours (i.e. gestures, facial expressions, eye contact).
- Finding a space to speak which is safe and allows for privacy.



### **Presentation: Key communication skills in recovery (8) (15 min.)**

Good communication skills are key to creating a therapeutic relationship between practitioners and people using services. The recovery approach re-emphasizes the importance of these skills and additionally requires a shift in the power dynamics towards more balanced and equal relationships.

## **Active listening**

Active listening skills are of particular importance. Active listening involves really engaging with what the person is saying in order to better understand and explore their thoughts and views. It is completely different from passively hearing what a person is saying.

Active listening is about listening to the verbal and nonverbal content of what is being said. This includes the use of body language and facial expressions as well as being attentive to what might lie beneath the words that are being spoken – i.e. understanding the underlying meaning of what the person is saying and checking this with them, and then reflecting back on what is said and, in doing so, taking the opportunity to reframe issues to focus on strengths and solutions.

### **An example of active listening:**

- **Person using the service:** “I’m really frustrated that my family has not come to visit me today. I have so much to tell them and really need them here for support.”
- **Person assuming a supportive role:** “It sounds like today has been really difficult for you and that the involvement of your family is very important to you. I can definitely relate to that.”

### **Conversations that flow both ways: Moving from monologue to dialogue**

- It is important to recognize that people have their own unique identities and experiences. Thus, their views, ideas and opinions might be very different from those of mental health and other practitioners, families, care partners and other supporters.
- An open dialogue should be established with the person to understand and support them, as opposed to communicating the opinions or demands of practitioners, family members or care partners.
- Moving from monologue to dialogue means that mental health and other practitioners, care partners and families alike need to use different language when providing advice (e.g. saying, “Well I think...” rather than “You must...”).

Partnerships need to be formed to find a way forward through differences of opinions. For instance, instead of saying “You need to receive psychotherapy”, one can say “I think receiving psychotherapy could be beneficial for you. What do you think?” In this way it is possible to share an informed point of view rather than to dictate “absolute truths” and then listen to the other person’s point of view to see if this is a useful option to be pursued.

### **In difficult situations, mental health and other practitioners, families and other supporters may have strong reactions and emotional responses**

When strong emotional responses occur, it is important to:

- Recognize and understand why such responses might be occurring in order to avoid automatic immediate negative reactions and to communicate better.
- Take a moment to imagine how the person is feeling or the reason behind their current actions or behaviour.
- Even when a person appears, on the surface, to be saying things, acting or behaving in a way that appears upsetting to others, it is important to be mindful that the person may be communicating important information.





### **Exercise 10.2: Putting active listening skills into practice (8) (25 min.)**

Consider the following scenario:

#### **Scenario – George**

George had been receiving services in an inpatient mental health unit of a general hospital for a couple of weeks. He was ambivalent about staying in the unit but wanted extra support and had nowhere else to go. On several occasions he has lashed out in a volatile way and angrily threatened to leave whenever challenged or when he feels unhappy with what is being said. In the last incident he pushed a staff member to the ground. He constantly criticizes the staff and says that no-one tries hard enough.

#### **1. Imagine you are sitting with George. Now write down your:**

- initial thoughts ...
- feelings ...
- beliefs/ideas ...
- bodily reactions ...
- **likely actions or behaviours ...**

**Some answers can include:**

- You may be frightened of George, or concerned that he might be “unpredictable” and “volatile”.
- Believe that George is manipulative and unappreciative.
- Be angry.
- Have heightened senses.
- You may believe that George never listens to your advice.

#### **2. How might your thoughts and feelings reflect those of George?**

**Some answers can include:**

- If you are feeling anxious or afraid of George, these may be emotions that he is also experiencing.
- You may feel that George is not listening to your advice and perhaps this is because he also feels that he is not being listened to.
- You may feel that you cannot identify with George, and he may also feel the same towards you.

#### **3. Write down three possible things you could say to George which would demonstrate your desire to work with him in a constructive and recovery-focused way.**

**Some answers can include:**

- Expressing your concern about his emotional state in a reflective manner. Concern should centre on George’s well-being and perspective, rather than those of others. For instance, “You seemed very upset today, I wanted to discuss with you how we could make this less stressful for you.”

- Allow him to talk about his experience from his viewpoint, to gain a better understanding of what is going on. For instance, “You mentioned before that no one tries hard enough here – can you tell me more about that?”
- Ask him what would be most helpful to him from this point forward. How would George like staff to help him? For instance, “I’d really like to know your thoughts on how we can best support you when you become distressed, angry or upset”.

## Topic 11: Recovery plans

### Time for this topic

Approximately 2 hours and 10 minutes.



### **Presentation: Making a recovery plan (35),(36),(37) (15 min.)**

The following presentation introduces the group to the idea of a recovery plan, which is a practical tool for people to take control of and navigate their own recovery.

Provide training participants with the recovery template in Annex 3 to use during the presentation.

People may benefit from having a written plan to guide their personal recovery journey, which can be referred to as a **recovery plan**.

**A recovery plan is a user-driven document** that is written and implemented by the person themselves. It is a living document which can change over time to reflect the person's recovery journey and their evolving wishes and preferences.

- People may consult mental health and other practitioners, families and peer supporters to help them formulate their plan, but ultimately it is up to the person to decide what they would like to include.
- It is important to have choice and options for the recovery process. Therefore, when making a recovery plan, the person should be supported by and consult with individuals who are aware of various care and support options, including alternatives to medication.
- A recovery plan can be more effectively implemented if all relevant people know about its existence and content, even if they have not been involved in its development.

### **A recovery plan should identify the needs, strengths and assets of the individual**

- The person concerned should identify their needs, strengths and assets. It can also be useful for the person to talk with other people they wish to involve.
- Mental health and social services should offer a comprehensive assessment that takes into account a person's social context, including health, employment, education, housing, culturally and spiritually relevant factors and beliefs to support the person in identifying their needs, strengths and assets.
- The possibility of creating a recovery plan should be offered to all people using the service, and not only to those who are seen as "doing better" by practitioners.

**Depending on the wishes of the person preparing a recovery plan, mental health and other practitioners, peer supporters, and other supporters who are trained in the recovery approach can help:**

- Introduce the person to the purpose and structure of a recovery plan. It is important to note that this is probably a new experience for many people who in the past have not had their views and opinions about their recovery and treatment listened to.

- Assist the person in assessing strengths, resources, background, dreams, goals and progress towards recovery before building their recovery plan, as well as throughout the recovery journey as needed.
- Support the person in building and implementing their recovery plan.
- Help assess progress towards recovery throughout the recovery journey, as needed.

**A recovery plan may have several components, including:**

- a plan for pursuing dreams and goals
- a wellness plan
- a plan for managing difficult times
- a plan for responding to a crisis
- a plan for after a crisis.

For additional information on advance plans, please refer to the [QualityRights training module Supported decision-making and advance planning](#).

**An alternative is the Recovery Wheel**, which can be a useful tool for facilitating discussions with the person concerned, family members, practitioners and others. The Recovery Wheel offers an alternative approach for those who would prefer a less structured way to approach the planning of their recovery journey. [This is described in more detail in Topic 12.](#)

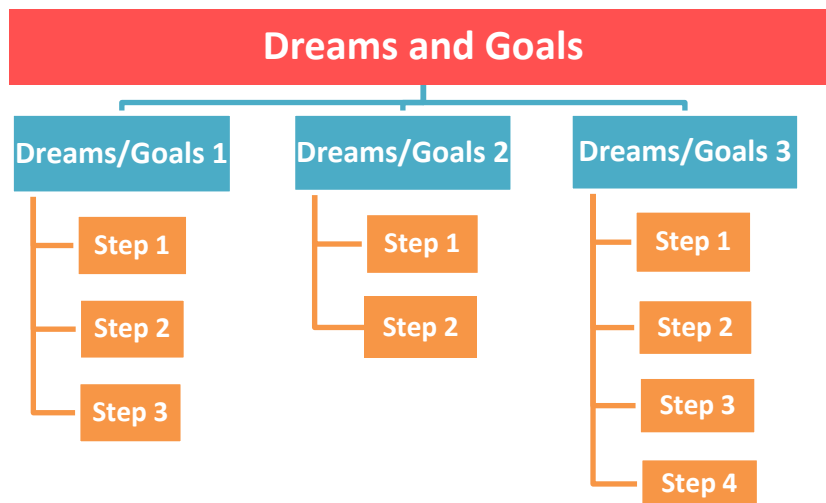


***Presentation: 1. Plan for pursuing dreams and goals (36) (20 min.)***

Some people may find it helpful to work towards goals that will help them lead fulfilling lives. Consequently, an important component of a recovery plan is to create a plan (or subplan) for pursuing dreams and goals.

- As a first step, the person identifies their dreams and goals.
  - For some people these dreams may be big, and for others they may be small – either is fine.
  - For some people who may struggle to think of a goal, it might be useful to consider the dreams they may have had in the past.
  - Dreams and goals can also be about specific things people want to achieve – e.g. getting a part-time job or a full-time job, doing volunteer work in an area of interest, finding a friend to share hobbies with, or finishing a book they always wanted to read.
- For each dream or goal, the person can identify what steps need to be taken to achieve these goals or dreams. In essence, these are little goals that can be tackled one at a time.
- It is very easy to only think about problems and lose sight of the person’s skills, strengths, interests and capabilities, as well as those of the people around them. An important part of the recovery plan is to identify these and how they can be harnessed to bring about positive changes in the person’s life.

Show participants the diagram below, explaining how for each goal or dream, steps can be identified in the pursuit of the goal or dream.



**OPTIONAL EXERCISE:**

Ask the group to complete the section on identifying and planning how to achieve dreams and goals in their copy of the *QualityRights Person-centred recovery planning for mental health and well-being –self-help tool*.



**Presentation: 2. Wellness plan (36),(37) (20 min.)**

A wellness plan helps to identify the routines that enable people to keep well in addition to routines that can have a negative effect on mental health and well-being. Some examples may include:

**Positive routines**

- Getting up at a reasonable time
- Preparing and eating healthy meals at regular times
- Going for a walk or getting some exercise
- Going to work or school

**Negative routines**

- Going out with friends every night and getting drunk
- Getting over-tired
- Sitting around doing nothing
- Drinking too much alcohol or taking illicit drugs.

**OPTIONAL EXERCISE:**

Ask the group to complete the section on my wellness plan (but not including the weekly schedule) in their copy of the *QualityRights Person-centred recovery planning for mental health and well-being – self-help tool*.

This exercise is useful in highlighting that all people, whether they have disabilities or not, have to deal with challenges in life.



**Presentation: 3. Plan for managing difficult times (36) (30 min.)**

Another component of the recovery plan is planning for managing difficult times in life.

It may be useful for the person to indicate how they would generally describe themselves. This can help supporters to identify when the person is experiencing distress and might need support. It can also help the person to remember that they are much more than perceived limitations, a diagnosis, or a set of problems.

**What generally defines me?**

Sociable	Outgoing	Impulsive	Confident
A loner	Talkative	Quiet	Enthusiastic
Cautious	Introverted	Energetic	Opinionated
Athletic	Extroverted	A fast learner	Optimistic
Happy	Thoughtful	Pessimistic	Industrious
Encouraging	Responsible	Supportive	Curious
Adventurous	Serious	Easy-going	Outspoken
Hard-working	Friendly	Passionate	Independent
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When people using services are trying to work out difficult times, it can be helpful to use a simple traffic light system to easily keep track of moods.

The traffic light system outlined below can be useful.

- **GREEN:** You are feeling well. You may experience stress from time to time that can be managed with coping and problem-solving skills.
- **AMBER:** You are noticing signs of emotional distress. It would be helpful to take better care of your mental and physical health and obtain support from friends, family, or mental health or other practitioner(s).

**The green-amber traffic light system**

When people using services are trying to work out difficult times, it can be helpful to use a simple traffic light system to easily keep track.

**GREEN** = You are feeling well  
**AMBER** = You are noticing signs of emotional distress

**To help manage emotional distress people can learn to identify (35),(36):**

- sensitivities
- signs of distress.

If people can identify sensitivities and signs of distress and take action quickly, they can greatly reduce the chance of finding themselves in crisis. It is also important for others to be aware of sensitivities and signs of distress so they can discuss these with the person who they are supporting. At the same time, it is important that others do not cross any boundaries by forcing or taking over control.

**Sensitivities** are things that happen (external or internal events or circumstances) that may cause a person to feel anxious, scared, miserable or discouraged.

These can include:

- Hearing shouts or yells, or being shouted/yelled at
- Not being listened to
- People getting too close
- High workload at the job
- Not being able to sleep
- Being teased.

**Signs of distress** are changes in feelings, thoughts or behaviours that suggest a crisis may develop. They are different for everybody but some common examples include (38),(36):

**A. Signs that the person can identify:**

- Feeling anxious or fearful
- Feeling depressed
- Not sleeping enough or waking up early
- Experiencing distressing thoughts
- Things you usually do easily are more difficult to do
- Feeling unable to trust those closest to you
- Feeling unable to carry on with your day-to-day activities
- Over-reacting or responding irrationally to ordinary events or things people do
- Having unusual experiences that others do not seem to share – such as hearing or seeing things or feeling you are being controlled by persons or forces external to yourself
- Racing thoughts
- Feeling a lot of fear or hopelessness
- Feeling as if you are not in control.

**B. Signs that others can identify as well:**

- Getting into arguments with other people
- Nervousness
- Restlessness
- Sleeping too much.

## OPTIONAL EXERCISE:

Ask the group to complete the main tables in the section on managing difficult times in their copy of the *QualityRights Person-centred recovery planning for mental health and well-being –self-help tool*.



### **Presentation: 4. Plan for responding to a crisis (36),(37) (30min.)**

Although recovery plans encourage people to take actions to avoid crises when they experience high levels of distress, there may be times when crises do occur – times when, despite a person’s best efforts, things continue to get worse.

A plan for responding to a crisis may give mental health practitioners and other supporters a better opportunity to understand the person and what they want so that their will and preferences are respected.

- For instance, people can provide directions and information on when, how, where and from whom they would like to receive support and care.
- It also allows people to specify “no” to a range of treatment and support options offered.
- In addition, there may be several things that need to be taken care of, such as requesting leave from work, feeding your pets, paying your bills, telling others that you are feeling unwell, cancelling appointments, etc.

Planning for these may be particularly important for people who may be less able to communicate their will and preferences when they experience a crisis. They are also likely to encounter practitioners who are not their regular health-care provider.

In some countries, people may make their will and preferences binding on others in certain situations. It may be interesting to check if the law in your country allows for this possibility (For more information see the module on *Supported decision-making and advance planning*).

### **Examples of components of advance planning:**

#### **Preferences for treatment and care**

- Specifying which medication works or does not work and what medication(s) one will not accept to take.
- Specifying which care options (such as one-to-one counselling, group therapy) one finds helpful or unhelpful, acceptable or unacceptable.

In some countries, there may be no acceptable options for people to choose from. Countries must develop a wide range of services to respond to the need of people who may be experiencing a crisis.

#### **Place of care**

- Specifying the place where they want to receive care, treatment or support (e.g. home, respite, mental health or related service).
- Specifying the place(s) where they do not want to receive treatment, care or support.



### People I want involved

- Friends and family members the person can trust and who can offer support.

### People I do NOT want involved

- The person may want to specify people they do not want to involve (e.g. because that person makes them feel more stressed or threatened).

### Statements and actions that are helpful

- Statements that people say or actions that people can do to help the person in times of crisis.

### Statements and actions that are NOT helpful

- Statements that people should NOT make or actions that people should NOT do in times of crisis.

### OPTIONAL EXERCISE:

Ask the group to complete the section on “Plan for responding to a crisis” in their copy of the *QualityRights person-centred recovery planning for mental health and well-being –self-help tool*.



### Presentation: 5. Plan for after a crisis (35),(36) (15 min.)

Now, the final component of the recovery plan is to create a plan for after a crisis:

- It is helpful to have a plan for how to get back to daily life and maintain wellness after a crisis.
- This part of the recovery plan is all about planning for the few days and weeks just after a crisis, so people can continue their recovery journey. The plan includes:
  - Getting back into a routine
  - Making a timetable for the next few weeks
  - Plans to resume responsibilities and activities
  - What have I learned from this crisis (e.g. any sensitivities or early signs of distress I have identified).

### OPTIONAL EXERCISE:

Ask the group to complete the section on “Plan for after a crisis” in their copy of the *QualityRights person-centred recovery planning for mental health and well-being –self-help tool*.

## Topic 12: Recovery Wheel

### Time for this topic

Approximately 30 minutes.



### **Presentation: *The Recovery Wheel (30 min.)***

The Recovery Wheel is inspired by the Outcomes Star™ (39). It uses the image of a ship's steering wheel to show that recovery is a personal journey and that people decide for themselves what is important to them and where this journey will take them. The Recovery Wheel can be an alternative tool for people who would prefer a less structured way to approach recovery. It highlights different areas that individuals could potentially identify as key to living a fulfilling life. It can be used as a means of opening up discussions between the person concerned and their family, mental health and other practitioners, peer supporters and other supporters about what people consider important for their recovery.

### **Using the Recovery Wheel**

The person involved should first ask themselves, or be asked, whether they identify with any of the domains within the Recovery Wheel. People can indicate the different areas that are a priority for them by writing "AP".

They can use the rating scale (1–3) to indicate how satisfied they are with each of these priority areas. The numbers provided within the wheel indicate the importance or significance within the individual's life.

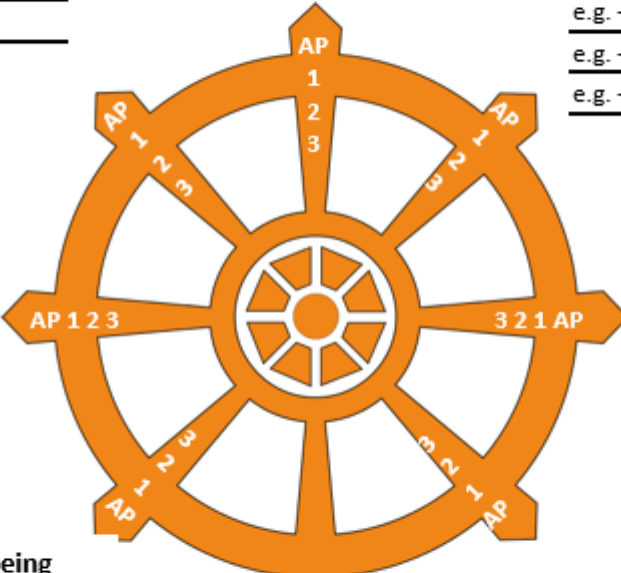
Once the person has identified the key domains which are a priority for them, they can then explore specific and concrete actions within each of the priority areas.

The Recovery Wheel can also be used at different points in time to enable the person to monitor their progress in these different domains throughout their recovery journey.

## The Recovery Wheel (39)

Distribute copies of Annex 3 to participants.

Ask the group to complete for themselves their “recovery wheel” –. Participants can work on their own or in pairs for this exercise.

<p><b>Hope</b> For example – Not losing hope in my capabilities and capacities in life</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/>	<p><b>Community inclusion</b> For example – Going to work, getting my own accommodation, enrolling in a course</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/>	<p><b>Social life</b> For example – To reconnect with my family, to start spending time with my friends again</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/>
<p><b>Meaning &amp; purpose in life</b> For example – Finding meaning through spirituality, go to church weekly</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/>		<p><b>Empowerment &amp; gaining back control</b> For example – Choosing what I want and don't want for my treatment</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/>
<p><b>Health &amp; well-being</b> For example –Working on my fitness, having a regular sleep schedule</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/>		<p><b>AP = A priority for me</b></p> <p><b>1 = Not at all satisfied</b></p> <p><b>2 = Satisfied</b></p> <p><b>3 = Very satisfied</b></p>

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# Annexes

## Annex 1: Scenarios

### Topic 1: *Exercise 1.2 – Supporting recovery, Miguel*

Miguel visits his family doctor to discuss overpowering feelings of being worried and fearful all the time. He has continued to experience these feelings over the last three years and they have become increasingly difficult to live with. He tells his doctor that he really enjoys the work that he does, but the fear and anxiety that he experiences is particularly overwhelming when he is under a lot of pressure.

After a long discussion, Miguel's doctor is very sympathetic and tells Miguel that this is likely to be a problem he will have for the rest of his life. He suggests that Miguel should consider important life changes which would include leaving his current job to find something "more suitable" with less stress and responsibility.

Miguel leaves the consultation feeling low and hopeless.

### Topic 2: *Exercise 2.1 – Recovery-oriented approach, Tig Davies<sup>1</sup>*

"I was in my thirties and at university, having somehow sustained what was probably a three-year massive high when the Grim Reaper himself appeared to take over my life! One minute in the student's union building, the next Room 1, H ward, acute psychiatric unit! I had experienced a previous and very unsuccessful three-month admission to a psychiatric unit in my late twenties, but I want to tell you about this next experience because of its eventual positive impact upon my recovery.

"Needless to say, the first eight months of this admission had no positive impact! Three months at home ended with me in hospital being told my liver would never take another overdose, a psychiatrist telling me I would never work again, being offered life in a therapeutic community and being told to keep taking the medication – oh, and please stay in the hospital!

"At that point, I truly believed that life as a 'well person' for me was over. I was mad and that was that. I was totally devastated but physically and mentally powerless to react. I collapsed into a passive world of nothingness. However, it was to be during the next seven months in hospital where my recovery journey finally began!

"I was heavily medicated, hideously underweight, incapable of thought, desire, motivation or social interaction. My mind was full of dread, fear, voices demanding that I harm myself, that I was dead in all but disgusting body and that this state would remain until death.

"Upstairs at the hospital there was a small patient/visitor café run by Dee. She is probably one of the most genuine, empathic, supportive and fun mental health support workers I have ever met. They called her the 'coffee shop assistant'. She took 'serving people' in that café to new heights. Dee didn't just serve coffee, she served people. She talked, she shared, she asked, she listened, she cried, she laughed, she spoke the truth as she saw it, she hugged when appropriate, kept her distance when it was right to do so. She joined people to communicate, she took no crap from people, she sought and found understanding of difference – oh, and she made a great mug of coffee! And all of this despite

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<sup>1</sup> Realising Recovery learning materials (page 97). Edinburgh: NHS Education for Scotland (NES) and the Scottish Recovery Network (SRN); 2011. ([http://www.nes.scot.nhs.uk/media/376420/13875-nes-mental\\_health-all\\_modules.pdf](http://www.nes.scot.nhs.uk/media/376420/13875-nes-mental_health-all_modules.pdf), accessed 2 February 2017).



her fear of being in trouble for talking at work! The café and time with Dee became a place of solitude, light and hope for me.

“I was in the café one morning when the new ‘welfare rights worker’ came in – Dave. It transpired we had known each other years before. We talked. He had previously met me during a ‘high’ time in my life and yet being faced with a walking corpse, while upsetting him greatly, brought out in him the most person-centred approach to an individual you could imagine.

“He, Dee and I sat and drank coffee. Then he simply looked at me and asked the most simple and yet profound question I had ever been asked. ‘What do YOU think would help YOU to get well again?’ I was blown away – no one had asked before and I had always been led to believe that the pills, the nurses and the psychiatrists had the plans and the answers. After all, they had written me a care plan!

“I embraced the question in my desperate state and, feeling I had nothing to lose, told Dave and Dee the threads of a dream I had known before. I wanted to be well, I wanted relationships with my family and friends back, I wanted to go home to my flat, and I wanted to work. At the end of this talk I ate and, equally important, ‘enjoyed’ toast and jam and a full mug of chocolate milkshake. At that point I hadn’t eaten more than one digestive biscuit and half a glass of milk a day for over three months! I also smiled. And that felt great. ‘Hope’ had finally returned. I talked. I dreamed. I planned”.

**Topic 3: *Presentation – Focusing on assets and strengths of the person is central to recovery-oriented care, Tom***

Tom is a 30-year-old man working as a teacher. He has been married to his wife for three years but their relationship has recently deteriorated and they are constantly arguing. He is finding it more and more difficult to find pleasure in his job and to be patient with and attentive to the needs of his students. Every day feels unbearable. He often finds it difficult to fall asleep at night as he thinks about the day to come and gets anxious about not being able to cope. When he feels like this, he turns to alcohol until he feels calmer. He has consulted his general practitioner who has given him a diagnosis of chronic fatigue and low mood and has talked about possible depression. Despite this, he remains very involved with the local rugby team and derives a lot of comfort from playing and spending time with his friends from the team.

**Topic 6: *Exercise 6.1 – Working alongside in practice, Suraiya (1)***

Suraiya is a 22-year-old woman who has agreed to be admitted to an acute psychiatric care ward following a suicide attempt. She has a history of serious self-harm and repeated admissions because of severe distress that she has experienced.

As one of Suraiya’s professional advocates, you are meeting with her to discuss the situation. She reports that she feels hopeless and unhappy and believes that the psychiatrist dislikes her. She sits quietly and appears very withdrawn throughout the meeting.

**Topic 6: *Exercise 6.1 – Working alongside in practice, Suraiya (2)***

At a meeting with Suraiya, Jamal notices that Suraiya appears withdrawn, angry and sad. He asks how she is feeling at the moment. Jamal also asks if there is anything that might make her feel better. Suraiya says that she would like to talk to her friend. Jamal says that he would try to organize that as soon as possible. He also asks in the meantime what else might help.

Suraiya explains that she really needs time on her own in a quiet place to reflect. She said that it has helped in the past to listen to music, in order to get some distance from her situation. The mental health service has established some comfortable quiet rooms over the past year and Jamal proposes that Suraiya spend as much time as she would like there and can listen to music and call her friends at any time. He also lets Suraiya know that he will be here to support her when she needs to.

Jamal also recalls that Suraya thought that the psychiatrist disliked her. He invites her to discuss any concerns that weren't already dealt with, so they can be addressed with those involved and, if relevant, resources and information could be provided about how and where to make complaints.

### **Topic 8: Exercise 8.1 – Positive risk-taking in practice, Hasan (1)**

Hasan has been using the community mental health service close to his home for the past five years. He has a good relationship with the staff and has found the support of the service very helpful. The staff of the service know Hasan well and have worked hard with him to support him through difficult experiences and to help him to live independently.

Hasan is planning to move to the other side of the country to marry and move in with his fiancé. He announces his decision to his mental health worker Lethabo.

Lethabo and the rest of the staff are concerned that, once Hasan has moved, he will not be able to receive the support of the mental health service. If Hasan finds himself in distress, another service will not know Hasan well enough to support him appropriately, and if anything goes wrong there is nothing they will be able to do.

- **The benefits for Hasan to move:** living with the woman he loves, meeting new people in a new town which can have a positive impact on his well-being and recovery.
- **The risk for Hasan to move:** risk of the relationship breaking down, risk of not being able to integrate in a new city, risk of not being able to receive support if needed.

Despite their concern for Hasan, Lethabo and the rest of the team decide to support Hasan in his decision.

### **Topic 8: Exercise 8.1 – Positive risk-taking in practice, Hasan (2)**

After discussing with the rest of the staff of the service who knew Hasan, Lethabo came up with different suggestions to support Hasan and discussed these with him. They agreed that the staff will take the following actions:

- Obtain information about support services available where Hasan is planning to move.
- If they identify a good service, they would put Hasan in contact with the service.
- With Hasan's consent, they would share information about Hasan's requirements and how best to support him with the members of the other service.
- They would keep in touch with Hasan and reassure him that they will support him again if for any reason he decides to come back.

### **Topic 8: Exercise 8.1 – Positive risk-taking in practice, Mary (1)**

Mary is 30 years old and is currently attending a community mental health centre. She is passionate about the well-being of animals and has always been involved in caring for their welfare (through both paid and unpaid work).

Mary's goal at the moment includes going back to work in a similar field. She wants a job that she feels motivated about and wishes to start earning money so she can get her own place and move out of her parents' house. She believes that any previous challenges she has experienced in her recovery are now well under control and feels she is ready to move on. Mary asks staff at the community mental health centre to help her try and find work.

However, her parents are worried about the idea of Mary taking on new responsibilities. She experienced her first mental health crisis when she went from studying into full-time employment as a flight attendant. They are fearful that the pressures of another full-time job will lead her to relapse and undo all the progress she has made to date.

They appeal to Rachel, Mary's mental health worker, to try to convince Mary to wait another couple of years before looking for full-time employment. Rachel explains to them that she will first and foremost respect Mary's decision but that she will raise the issue at their next appointment.

At their next appointment, Mary and Rachel discuss the benefits and risks of returning to work.

- **The benefits of returning to work:** gaining a sense of purpose, being engaged in meaningful work, earning an income which would lead to other benefits, such as moving into her own accommodation.
- **The risks of returning to work:** potentially jeopardizing the progress that she has made because of the stress, and the possibility that the job would not meet her expectations

#### **Topic 8: Exercise 8.1 – Positive risk-taking in practice, Mary (2)**

##### **The action Mary decided to take**

Mary was really motivated to go back to work, particularly in the field of animal care, so Mary and Rachel explored ways of decreasing the potential stress involved in finding and taking on a new job.

This involved Mary and Rachel looking at the support she had received when she was previously working full-time and discussing how similar support could be put in place now in order to reduce any potential risks and to increase the chance of Mary securing and maintaining employment.

Together, they decide to:

- Look for work opportunities in the field of animal care but opt for part-time work initially, rather than full-time work, with the end goal being to move into full-time employment.
- Create a specific plan for dealing with crises that might occur when Mary is working under pressure.
- Generate a routine which allows her to arrive at work on time and manage any potential stressors.
- Give Rachel's mobile phone number to Mary and her family so they can call if they are worried and want to discuss any concerns.
- Set up a couple of regular meetings between Mary and Rachel throughout this process to discuss how Mary is feeling throughout the job interviewing and job securing process.

### **Topic 8: Exercise 8.1 – Positive risk-taking in practice, Mary (3)**

#### **Outcomes for Mary**

##### **OUTCOME 1**

- One potential outcome is that Mary was able to secure part-time employment in an area that was meaningful to her and was able to start earning an income, which allowed her to move into her own accommodation.

##### **OUTCOME 2**

- It takes Mary a significant amount of time to secure a job, which makes her feel disheartened. Rachel and Mary's family give her ongoing support to help her throughout this stressful time. Finally, Mary is able to secure a job but finds that she struggles to concentrate for long hours at a time and gets tired quite quickly.
- Rather than quitting her job, Mary reaches out to Rachel to discuss these challenges and they arrange a meeting. After discussion Mary decides to discuss with her boss the possibility of taking breaks throughout the day rather than working non-stop through an entire 8-hour shift. Her boss agrees to this arrangement and Mary is able to continue working in a job she loves.

### **Topic 9: Exercise 9.1: Using community resources, Sheila and Emma**

Sheila (50) lives at home with her mother, Emma (75), and has a learning disability. She works in a cafe run by an organization that supports people with learning disabilities. She is fond of swimming and dancing, attends local clubs for both activities and has a wide range of friends through work and leisure activities. She needs the support of her mother for the majority of daily tasks such as cleaning, meal preparation, transportation and banking.

Emma is quite active within her local community and is keen to support Sheila in maintaining these links. Emma's sister, Claire, lives far away but stays in regular phone contact with her sister and visits as often as possible.

Emma has had a mild stroke and was admitted to hospital. She has now recovered sufficiently to plan her discharge from hospital, where she has been staying for the past 10 days.

During her hospital stay, Emma has lost some of her ability to move around and look after herself. She is really worried about how she will cope with supporting her daughter Sheila who has her own health needs. She desperately wants them to continue to live together.

When Emma was admitted to hospital, Sheila was placed in a local authority social care home. It became clear during Emma's admission that she had been providing more support to enable Sheila to stay at home than had previously been appreciated.

In view of Emma's deteriorated health and the support required by Sheila, the assessment of staff in the home was that Sheila would require some form of residential or supported accommodation in future rather than returning home.

### **Topic 10: Exercise 10.2 – putting active listening skills into practice, George**

George had been receiving services in an inpatient mental health unit of a general hospital for a couple of weeks. He was ambivalent about staying in the unit but wanted extra support and had nowhere else to go. On several occasions he has lashed out in a volatile way and angrily threatened to leave

whenever challenged or when he feels unhappy with what is being said. In the last incident he pushed a staff member to the ground. He constantly criticizes the staff and says that no-one tries hard enough.

## Annex 2: Key components of a recovery approach

(2,3)

### Summary: Key components of recovery

1. **Inclusion** – This is important for recovery as people need to be able to access the same opportunities as any other person and be included in the community.
2. **Relationships** – These includes friends, partners, family members, mental health and other practitioners, and peers – including peer supporters and groups in the community. All these relationships have an important role in supporting people in recovery.
3. **Hope** – This is seen as key to recovery, and without it people can give up their recovery journey.
4. **Belief** – Believing that a change in one’s situation is possible is central to the recovery approach and can be fostered by hope-inspiring relationships.
5. **Identity** – Redefining or rebuilding identity is a central component of recovery because people often lose their sense of self when they are given a diagnosis.
6. **Meaning and purpose** – This can vary for everyone but it is important that people find ways to build and find meaning in their lives.
7. **Dreams and aspirations** – People should be empowered and supported to develop and to achieve their dreams and aspirations in life.
8. **Control and choice** –People have the right to exercise their legal capacity to make their own choices and to receive supports to do so whenever this is seen as helpful by the person.
9. **Managing difficult times** – Recovery enables people to develop skills that are required to manage negative moments in life.
10. **Positive risk-taking** – This is essential for recovery as it allows individuals to learn and grow from their experiences and it is important that people are supported while embarking on positive risk-taking.

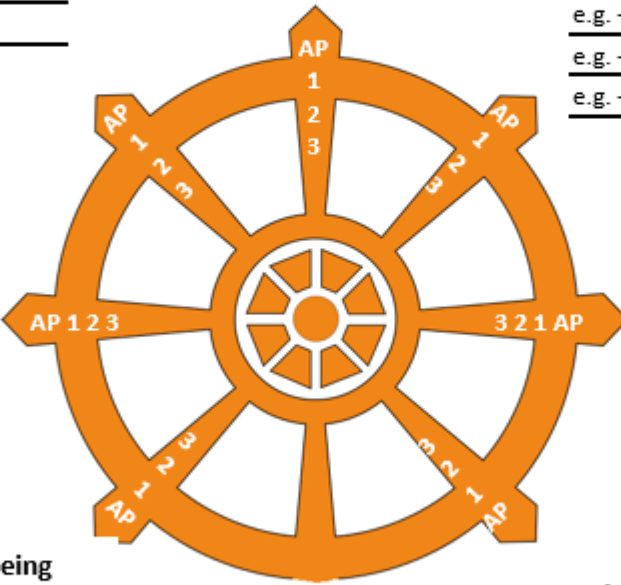
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<sup>2</sup> Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry*. 2011;199(6):445–52. doi: 10.1192/bjp.bp.110.083733.

<sup>3</sup> The 10 Essential Shared Capabilities for Mental Health Practice: learning materials. Edinburgh: NHS Education for Scotland (NES); 2011. ([http://www.nes.scot.nhs.uk/media/351385/10\\_essential\\_shared\\_capabilities\\_2011.pdf](http://www.nes.scot.nhs.uk/media/351385/10_essential_shared_capabilities_2011.pdf), accessed 26 February 2017).

## Annex 3: The Recovery Wheel

(4)

<p><b>Hope</b> For example – Not losing hope in my capabilities and capacities in life</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p>	<p><b>Community inclusion</b> For example – Going to work, getting my own accommodation, enrolling in a course</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p>	<p><b>Social life</b> For example – To reconnect with my family, to start spending time with my friends again</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p>
<p><b>Meaning &amp; purpose in life</b> For example – Finding meaning through spirituality, go to church weekly</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p>		<p><b>Empowerment &amp; gaining back control</b> For example – Choosing what I want and don't want for my treatment</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p>
<p><b>Health &amp; well-being</b> For example –Working on my fitness, having a regular sleep schedule</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p> <hr/> <p>e.g. –</p>		<p><b>AP = A priority for me</b></p> <p><b>1 = Not at all satisfied</b></p> <p><b>2 = Satisfied</b></p> <p><b>3 = Very satisfied</b></p>

<sup>4</sup> The Recovery Star: Outcomes Star [website]. Brighton: Triangle Consulting Social Enterprise Limited; 2009–2015. (<http://www.outcomesstar.org.uk>, accessed 26 February 2017).

The World Health Organization's QualityRights training and guidance modules focus on the knowledge and skills required to provide good quality mental health and social services and supports and to promote the rights of people with psychosocial, intellectual or cognitive disabilities.

Through exercises, presentations, case scenarios, extensive discussions and debates, the **QualityRights training modules** unpack some critical challenges that stakeholders are facing in countries everywhere. For instance:

- How do we respect people's will and preference, even in challenging situations?
- How do we ensure people's safety and at the same time respect each person's right to decide about their treatment, their life and their destiny?
- How do we end seclusion and restraint?
- How does a supported decision-making approach work if someone is unable to communicate their wishes?

The **QualityRights guidance modules** complement the training materials. The guidance modules on *Civil Society Organizations* and on *Advocacy* provide step-by-step guidance on how civil society movements in countries can take action to advocate for human rights-based approaches in the mental health and social sectors in order to achieve impactful and durable change. The guidance modules on *One-to-one peer support* and on *Peer support groups* provide concrete guidance on how to effectively set up and run these critical but often overlooked services.

The ultimate goal of the WHO QualityRights modules is to change mindsets and practices in a sustainable way and empower all stakeholders to promote rights and recovery in order to improve the lives of people with psychosocial, intellectual or cognitive disabilities everywhere.