Recovery and the right to health

WHO QualityRights core training: mental health & social services

QualityRights

World Health Organization

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

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

Contents

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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 an 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/

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 <u>not</u> 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

At the end of the training, participants will be able to:

- understand the concepts of mental health and well-being;
- explore what mental health and related services can do to promote people's health and well-being;
- understand the key components of, and barriers to, recovery;
- develop an understanding of the role of mental health and related services in promoting and supporting health and recovery;
- explore how individuals and services can respect, protect and fulfil people's right to health and recovery.

Topics

Topic 1: What is mental health? (1 hour 30 minutes)

Topic 2: Promoting the right to health in mental health and social services (1 hour 45 minutes)

Topic 3: What is recovery? (1 hour and 35 minutes)

Topic 4: Promoting recovery (1 hour 15 minutes)

Topic 5: The role of practitioners and mental health and social services in promoting recovery (40 minutes)

Resources required

- **Accompanying course slides, Recovery and the right to health. WHO QualityRights Core training: mental health & social services (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**

Time

Approximately 6 hours and 40 minutes

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.

Additional resources to print for this training module include:

- **copies of Annex 1: Scenario for Youssef**

Introduction

This module in the series of WHO QualityRights training materials looks at how a human rights-based approach can facilitate recovery for persons with psychosocial, intellectual or cognitive disabilities. It takes participants through the concepts of mental health and well-being, underscoring that these are inherently personal concepts, unique to every individual.

Participants also explore the meaning of the right to health, in order to understand how this right is linked to the enjoyment of all the other human rights and how human rights violations have a huge negative impact on people's health and well-being. The module then highlights how individuals and services can respect, protect and fulfil people's right to health and well-being.

The module also explores the meaning of recovery and highlights the importance of ensuring that people using services drive their own care and recovery. Participants learn how recovery plans can be effective tools for supporting people to live a life they find fulfilling and meaningful and to assert their choices, will and preference for care and support. Finally, the module describes the roles of practitioners and services, as well as family members and care partners, in supporting people through their recovery journey.

Topic 1: What is mental health?

Time for this topic
Approximately 1 hour 30 minutes.

Start by asking participants the following question (5 min.):

What do you understand by the term "mental health"?

Give participants a few minutes to reflect and discuss this and list their answers on the flipchart.

Presentation: What does mental health mean? (25 min.)

Defining mental health and well-being is not easy.

The answer to the question "What is mental health?" is fundamentally personal and subjective. People should be able to define what mental health means for themselves. For instance, it may be:

- a sense of internal well-being
- feeling in line with one's own beliefs and values
- feeling at peace with oneself
- feeling positive and optimistic about life

Misunderstandings to be avoided include:

- Mental health is equivalent to the absence of a mental health condition or disability.
- Mental health can be objectively defined.
- There are specific standards or criteria to determine what good mental health is.

Trying to impose a definition or standards of good mental health that would apply to everybody can be problematic. It may be used to impose beliefs, values and social norms on others and/or to single out people who do not conform to certain dominant beliefs, values and social norms of society. This can lead to exclusion, discrimination and, also, to medicalization of some behaviors that are considered to be "abnormal" in some societies or contexts.

Such beliefs, values and norms may include, for example, that people with good mental health should be able to work, should be able to get married and have a family, should be able to deal with high pressure and should be able to perform in a competitive work environment. These types of standard are often linked to social expectations regarding gender or social roles. Examples may include the belief that men are more assertive and women more emotional.

Mental health and diagnosis (2)

This is referred to in different ways by different groups and individuals – e.g. mental health diagnosis, psychiatric diagnosis or diagnosis of a mental disorder. As a medical term it is used to describe patterns of experiences and behaviours that may cause distress and/or be seen as difficult to understand. It

includes labels such as depression, anxiety disorder, schizophrenia, psychosis and so on. It implies that what people experience are symptoms of a medical condition or illness.

People may have very different views about being diagnosed:

- Some people may find it useful because it provides an explanation to their problems, makes them feel that they do not need to feel guilty or blamed for their difficulties and/or it makes them feel less alone.
- Others find diagnoses stigmatizing because they imply that there is something wrong with the brain. Commonly held beliefs are that mental health conditions are caused by a chemical imbalance or that genetic factors are major determinants, but there is no evidence to support this.
- Diagnoses are based on a judgement about what is "normal" behaviour. However, views about what is "normal" behaviour differ among people, groups and cultures. What is considered as "normal" may also vary greatly depending on what is expected from people on the basis of their gender or social class. Sometimes people receive a psychiatric diagnosis because their behaviour is not accepted in their society or culture.
- People may also find that the diagnosis they are given has a more negative impact on their life and well-being than does their actual distress or experiences because diagnosis brings prejudice and discrimination and stands in the way of living the life they want.

People may choose alternative ways of thinking about their experience:

- For many people, what they experience may be the result of one or more traumatic events that have occurred in their lives and their distress or unusual experiences are natural responses or ways to cope with these events.
- People may also explain their distress as coming from, or being caused by, a difficult context or overwhelming events (poverty, unemployment, challenges in relationships, exclusion, discrimination).
- Others find spiritual, cultural or other meanings for their experience.

These alternative ways of thinking may be useful to people, helping them to overcome difficult situations or experiences and being a key component in their recovery. Consequently, these views should not be rejected or disregarded.

Despite this, people's refusal to accept a diagnosis related to their mental health is attributed to a "lack of insight" by many mental health and other professionals.

It is very important to understand that people have the right to define their difficulties, distress or other experiences in ways that makes sense to them. People who experience distress should be able to access the support they want to reach the state of mental health and well-being to which they aspire. People should retain their right to receive support and accommodation, no matter how they understand or define their distress or experiences. In other words, a diagnosis should not be a prerequisite to receive care, support or accommodation. Useful support may come from professionals or services but may also come from personal relationships, peer support and activities that may include relaxation, yoga and sport.

The inter-relationship between mental health and physical health

Ask participants:

How might living with a physical disability or condition have an impact on mental health and well-being?

Ask participants to list negative impacts or challenges as well as potential positive impacts. If they feel comfortable enough, participants can provide examples from they own experience.

Examples of negative impacts or challenges may include:

- having to deal with pain
- feeling isolated / feeling different
- discrimination.

Examples of positive impacts may include:

- experience in overcoming challenges
- developed resilience
- being part of the disability movement
- positive impact of support networks.

While people with physical disabilities or conditions may face mental health challenges in the same way as everyone else, they nevertheless often find it more difficult to access support for this. This may, for example, because service providers assume that a person's distress is caused by their physical disability and fail to acknowledge the same stresses, strains and challenges that affect everyone's lives. Yet stresses related to work, relationships, life events and so on also affect persons with physical disabilities. In other cases service providers may acknowledge the mental health challenges a person with a physical disability is facing but may not believe that they have the skills to support this person.

It is very important that mental health and social services give the same attention and support to the needs of people with physical disabilities or conditions as they do to the needs of others.

Exercise 1.1: What helps you to enjoy mental health and well-being? (30 min.)

This exercise is designed to allow participants to explore the elements contributing to their mental health and well-being. As a starting point, this is a good place for the group to brainstorm and share their understanding of the key contributors and determinants of mental well-being.

- What helps you to feel mentally and emotionally well?

Ask participants to split into small groups of 5 persons. Give participants 5–10 minutes to discuss within their group.

After the small group discussion, regroup to enable all participants to contribute their ideas in plenary (i.e. full group discussion) using a spider diagram. Use the flipchart to create a spider diagram (see Figure 1 below), with "mental health and well-being" in the centre and with determinants and elements contributing to mental health and well-being as "legs" branching off. Add each "leg" as participants share their ideas during the discussion. Feel free to add related ideas as bullet points under each leg, and guide participants towards making connections between each category.

One potential way to categorize the key contributors and determinants of mental health and well-being is shown in the figure: attitude about self, relationships with others, purpose in life, overcoming challenges, and physical health.

Note that the spider diagram in Figure 1 is only an example and is not comprehensive. Participants will come up with their own ideas and lists.

It is also important to note that this exercise is about determining what mental health and well-being means *for participants*. They should understand that their answers or responses will be unique and are neither correct nor incorrect. Some people may, for instance, grant high importance to physical health (exercise, eating properly, etc.) for well-being, while others may not. Participants should not feel that all the elements of the spider diagram below need to be achieved for good mental health and well-being.

Figure 1. Example of a spider diagram of elements of mental health

Here are some possible responses that participants may give:

- **Attitude about self**
  - ➤ Having positive self-esteem/having confidence/being happy with who I am/feeling like I matter.
  - ➤ Feeling empowered to speak my opinion.
  - ➤ Having self-respect.
  - ➤ Feeling empowered to reach my full potential.
  - ➤ Not suffering.

- **Purpose in life**
  - ➤ Having hope about life and the future.
  - ➤ Having the desire to live a fulfilling life.
  - ➤ Having a sense of purpose.
  - ➤ Being able to set and achieve goals in life.
  - ➤ Having a positive outlook.

- ➢ Having the ability to enjoy life.
- ➢ Experiencing growth.

- **Relationships with others**
  - ➢ Not being bullied or discriminated against, not subject to violence.
  - ➢ Having a sense of belonging.
  - ➢ Feeling respected as an individual in my own right.
  - ➢ Emotional attachment to family and friends.
  - ➢ Having a community.
  - ➢ Being comfortable with other people.
  - ➢ Being able to like and trust other people.
  - ➢ Being able to express my views and being listened to by others.
  - ➢ Having a network of people that I can trust and that is supportive.

- **Basic needs**
  - ➢ Food and clean water
  - ➢ Shelter
  - ➢ Clothing
  - ➢ Health care
  - ➢ Financial security
  - ➢ Education
  - ➢ Sanitation
  - ➢ Personal security.

- **Engagement**
  - ➢ Engaging in activities that are personally rewarding.
  - ➢ Obtaining satisfaction from work or other activities.
  - ➢ Having access to spiritual, cultural or leisure activities of my choosing.
  - ➢ Having a role and being respected in the community.
  - ➢ Feeling welcomed and participating in community matters.

- **Overcoming challenges**
  - ➢ Confidence to make decisions.
  - ➢ Having resilience.
  - ➢ Being able to cope with frustration.
  - ➢ Coping with changes in environment and in life.
  - ➢ Having a work–family life balance.
  - ➢ Being able to focus and manage activities.
  - ➢ Overcoming barriers to fulfil aspirations.

- **Having control over one's life**
  - ➢ Autonomy.
  - ➢ Being able to shape one's life and recovery.
  - ➢ Having a say in community decisions.
  - ➢ Feeling that one's wishes are listened to and respected.

Control and choice are strongly linked to the right to legal capacity (article 12 of the Convention on the Rights of Persons with Disabilities, or CRPD) *(3)*. This topic is developed in the module on *Legal capacity and the right to decide* and the module on *Supported decision-making and advance planning*.

It is important to note that mental health and other practitioners often focus on addressing just a few limited elements that affect mental health but miss out other key elements which positively affect mental health and well-being – e.g. balance, goals and achievement, and work – despite the fact that they consider these positive elements important for their own mental health and well-being *(4).*

Presentation: Protecting and promoting mental health and well-being (25 min.)

What can negatively affect mental health and well-being?

At the beginning of this presentation, ask participants the following question:

What are some factors that can negatively impact, or act as a barrier to, mental health and well-being?

Allow participants some time to come up with their ideas about this question.

Mental health and well-being are influenced by many factors, both within our control and beyond it. It is very important to note that social factors are crucial to mental health and well-being.

Then show participants the following list of factors:

- **Poverty:** Not having enough income to provide for basic necessities is detrimental to mental health and well-being as it gives rise to a wide range of social and psychosocial problems (stress, anxiety, anger, substance abuse, etc.). Poverty also prevents access to nutritious food, specialized support, proper accommodation, and services and treatment for illness and can have a serious impact on health.
- **Inequality:** Disparities and inequalities between different groups of people in society may affect some people's mental health and well-being negatively when they feel they have fewer resources and opportunities and less security than others. If a person or group experiences disadvantage or barriers to participation compared with another person or group (e.g. if they receive unequal wages for equal work or poorer quality of health care) this can detrimentally affect their mental health and well-being.
- **Social isolation and loneliness**: People living in communities that are not inclusive experience a sense of marginalization and exclusion that negatively affects mental health and well-being. In addition, if persons do not have access to a supportive network of family and friends, their mental health and well-being is also likely to be negatively affected. Isolation has been found to be an important risk factor for mortality *(5).*
- **Low levels of education**: A low educational level reduces opportunities for full and active participation in society, for accessing services and supports, and for employment.
- **Rapid social change**: Rapid social changes (e.g. related to economics, politics, religion, family, education, science, technology etc.) can influence societal values, beliefs and behaviours, and can affect our well-being and the way we live. In addition, certain events in one's life (e.g. loss of family member, loss of job and income, starting a new job, becoming a parent) can produce strong feelings and emotions which can put a strain on a person's mental health and well-being.
- **Emergencies**: During and after emergencies people often face difficult situations (family separation, overcrowding, lack of safety, lack of food and other resources, lack of privacy, detention in refugee camps and other settings) which negatively impact on mental health and well-being and can have long-lasting effects.

- **Stressful work conditions**: Excessive demands, lack of support and encouragement, safety concerns and health hazards in the work environment can make a person feel vulnerable, undervalued and unable to cope.
- **Discrimination and other human rights violations**: Being discriminated against on the basis of social factors – including gender, age, disability, migrant status and other factors – and denied one's rights has a negative impact on a person's feelings of self-worth, confidence, control over their life and hope for the future.
- **Violence and abuse**: In addition to the serious impact on physical health, there are many important negative psychological impacts of violence and abuse – including trauma, fear, loneliness, anger, depression, anxiety, suicidal thoughts, withdrawal and loss of trust in the community. Gender-based violence is also highly prevalent, with many women, girls, transgender and other persons being subject to physical, sexual and emotional abuse which have serious impacts on mental health and well-being.
- **Physical health conditions:** Physical health conditions and illnesses can present everyday barriers and challenges. If a person (or someone close to the person) has a chronic physical illness, they may have more barriers to overcome and adjustments to make to live a fulfilling life.
- **Inexistent or inadequate services or support:** Without access to adequate health or social services and support people may be unable to address these factors. Inadequate services may worsen these problems and cause further human rights violations which in turn has a negative impact on mental health and well-being.

These factors can interact to affect mental health and well-being differently in different groups of people.

We should also remember, in relation to people with psychosocial, intellectual or cognitive disabilities, that it is often the stigma, negative attitudes, discrimination and other human rights violations that they face which have the most negative impact on their lives.

Human rights instruments aim to protect people from the factors described above. Many instruments specifically protect the right to health.

The right to health as a human right

The right to health has been enshrined in international and regional human rights instruments and treaties as well as national constitutions all over the world.

The right to health, including its essential elements, was first articulated in WHO's Constitution in 1946. The WHO Constitution states that "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" and that "*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*" *(6)*

The right to health is also included in other United Nations instruments and treaties, such as the Universal Declaration of Human Rights (UDHR, 1948) and article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966). According to this latter treaty, to enable achievement of the highest attainable standard of physical and <u>mental health</u>, governments need to ensure that health services, including mental health services, are available, accessible, acceptable and of good quality *(7)*.

The right to health is also included in article 25 of the CRPD. This article outlines the implications of the right to health for people with disabilities. The right to health means inclusive health – in other words, governments have a duty to ensure that all people can live in optimal physical and mental health and that no-one is excluded on the basis of their disability. This includes ensuring access to supportive services based on the will and preferences of the person concerned, as well as creating healthy and gender-sensitive environments that are oriented towards inclusion and well-being.

The enjoyment of right to health is linked to the enjoyment of all the other human rights. For example, in order to be able to enjoy the right to health, people need to be free from exploitation, violence and abuses and need to enjoy an adequate standard of living and social protection. Conversely, human rights violations have a huge negative impact on mental health. For instance, if people experience exploitation, violence and abuse, they are more likely to experience emotional distress. In addition, poor living conditions, discrimination and no access to social protection can also have a negative impact on people's mental health.

Show participants the following video to illustrate what is meant by inclusive health:

Inclusive health overview, Special Olympics [3:17] https://youtu.be/CDGpKMgKWbU (accessed 9 April 2019)

Fostering mental health and well-being

It is essential to create environments and living conditions that can contribute to good mental health and well-being. As individuals, we can all play a role in promoting people's mental health and well-being. For instance, we can treat others with dignity and respect, we can be with our relatives when they need emotional support, we can connect people to appropriate support options, and so on. We can advocate for better environments and improved living conditions, fight poverty and social injustice as determinants of poor mental health and we can make our communities fairer for everyone.

Mental health and social services also have an important role and responsibility to ensure that they provide quality care and support on the basis of free and informed consent. This will promote community inclusion, autonomy and respect for the will and preferences of the person. Institutional care is not compatible with these goals or with the right to health. The CRPD calls for professionals to use their knowledge, ability and skills to create, develop and strengthen quality services.

Time for this topic
Approximately 1 hour 45 minutes.

Exercise 2.1: Grand designs (45 min.)

At the beginning of the exercise, make clear to participants that:

- The purpose of this exercise is **not** to imply that psychiatric hospitals or other institutions can become good places to live or to stay in for a long time. People should **never** have to reside in institutions.
- Mental health facilities which are isolated from, and unconnected to, the community should be phased out and replaced with mental health and social services provided in the community.
- When people want to stay somewhere which is not their home, they should have access, on a voluntary basis, to short-term community-based services which fully respect their rights, such as residential housing providing support in the community (e.g. Soteria houses) or high-quality mental health units in general hospitals.

The purpose of this exercise is to ask participants to think about what features they would like to see in mental health services that provide for short-term accommodation and that are available to people with psychosocial, intellectual or cognitive disabilities on a voluntary basis and in the community to make the service welcoming, comfortable and desirable.

Ask participants to divide into two groups.

Then explain the following:

First, think about the **current** environment of a mental health inpatient or residential service (e.g. one where they are currently staying, have stayed at in the past, are working at or have visited).

Then discuss and compare **how it should be**. Document your findings as you will be asked to report back.

Each group will be given different areas to think about and we shall combine the ideas at the end.

Group 1 will concentrate on the physical environment of a mental health inpatient or residential service. Members of Group 1 should think about privacy, safety and what makes for a comfortable environment.

Some questions can be used to start the conversation, if relevant to the participants' context. For instance:

- Is the building in good physical condition?
- Is the building located in the community and is it easily accessible (e.g. through public transportation, etc.)?
- How accessible is the building? Could anyone gain access? What about people who have mobility difficulties, use wheelchairs etc.?
- Do people have comfortable sleeping areas?
- Do they have private spaces, including places to keep personal property?
- Do people have a clean toilet and shower or other bathing facility that allow for privacy?
- Is the environment hygienic?
- Is the environment designed to be safe, secure and without any risks to the person's health or well-being?
- Where and how is food prepared? Is the food prepared by people themselves?
- Is there the possibility for people to personalize the environment on the basis of their culture, interests and personal preferences? Are people able to add decorations and personal items?

Group 2 will focus on the general atmosphere of the mental health inpatient or residential service. Members of Group 2 should think about any unspoken or formal rules for behaving and communicating in these two different environments. They should also consider how each environment relates to, and interacts with, the local community.

Here are some questions to start the conversation:

- How would you describe the general atmosphere?
- Are there any rules about respecting privacy?
- How do people behave towards one another?
- How do people speak to each other in this environment?
- Are people able to speak freely and openly whenever they want?
- Are there opportunities to develop friendships or close social contacts?
- Can people use means of communication (mobile telephones, Internet, etc.)?
- Is there a uniform or can people wear what they like? Do people have to wear pyjamas during the day?
- How are the residents spoken to and addressed?
- Are people able to carry out religious, leisure or cultural activities?
- Are people able to come and go as they please?
- Are there rules around visitors and visiting times?
- Are there regular interactions with the local community? Do people engage in local community activities?
- Are there social and family events?
- Are there differences in terms of power dynamics? (For instance, does everyone have equal status or are there hierarchies in terms of power – e.g. within the service, or between people using the service and staff? Are people who usually would be responsible for making decisions for their household being denied this opportunity within the service, thus leading to feelings of powerlessness?)

Ask each group to report back on their discussions. At the end of the discussion, ask the participants in the full plenary:

Do you think some of the changes discussed could be implemented in the service you know? Would it be difficult?

Conclude this exercise by explaining to participants that:

Both the physical environment and the general atmosphere of mental health and social services have important impacts on people's mental health and well-being. Having a comfortable and stimulating environment where people feel safe, respected and supported is key to ensuring that services meet people's needs and expectations.

Some services, however, will inherently fail to respect people rights and promote well-being (e.g. derelict institutions isolated from the community) and should be closed and replaced by community-based services that respect people's rights.

As an example of community-based service, show participants the following video:

Seher, Urban community mental health programme, Pune. Bapu Trust for Research on Mind and discourse, 2013 (5:12)
https://youtu.be/Ozqq5rET9kk (accessed 9 April 2019).

Exercise 2.2: Does this service adequately support mental health? (25 min.)

Explain to participants that the purpose of this exercise is to explore in more depth what can be done to create a better service environment that benefits everyone. If participants are not directly connected to a particular mental health or related service, have them think of one that they may know of or are otherwise familiar with. This exercise is not about judging or blaming anyone. Encourage participants to share their thoughts openly in the spirit of learning, and to allow an exchange of ideas.

Ask participants to brainstorm answers to the following question:

- How does your service promote mental health and well-being?
- Try to think about the relationship between respect for human rights in the service and the promotion of mental health and well-being.
- Try to go beyond discussing only mental health "treatment". Explore and keep in mind what has been said in previous exercises and discussions concerning the different elements that contribute to mental health and well-being (including the social determinants of mental health).

Write participants' ideas on the flipchart. Note that these answers may vary considerably due to differences between services. Try to encourage participants to describe real situations and examples from their service.

Some possible answers are listed below:

- Having supportive staff who listen to people and treat people as human beings who deserve kindness and respect.
- Not forcing people into treatment and intervention they do not want.
- Recruiting peer workers to offer hope, support and encouragement.
- Promoting autonomy and independent decision-making and respecting service users' will and preferences.
- Providing positive, hopeful messages about well-being and recovery.
- Providing an atmosphere that is supportive and conducive to healing (that is pleasant, safe, friendly, not stressful and is non-discriminatory).
- Providing adequate attention to physical health-care needs.
- Providing adequate and sufficient food and water.
- Providing social and sports activities.
- Providing other opportunities for self-help.
- Supporting people to build their own social networks.
- Providing counselling or psychotherapy.
- Linking people to social supports, services and housing opportunities.
- Promoting access to educational and employment/income-generating opportunities.

Next ask participants the question below. Note that they may have already started to provide some answers when responding to the previous question.

- What can your service do, and how can it improve, to promote mental health and well-being?

Some possible answers are listed below:

- Do not force people into treatment and interventions they do not want; offer alternatives that are acceptable to people.
- Listen to individual concerns; ask people what will make them feel better.
- Support people without discrimination when they need help.
- Empower people to express their own wishes proactively.
- Be flexible in accommodating various needs for support.
- Support people to develop coping skills for use in difficult situations.
- Treat people with dignity and respect.
- Do not shout at people, treat them unpleasantly or be in any way violent or abusive towards them.
- If the service environment is depressing, dreary, uncomfortable or unhygienic, make changes and improvements to it so that it becomes a more pleasant place.
- Make sure people are allowed to see their family and friends when they want so that they can stay connected to their lives and social networks in their communities.
- Ensure that people are not isolated from their social networks.
- Ask people about how the staff and service can improve their care and about what makes them feel better and more satisfied.
- Inform people about a range of options that might help them to recover.
- Talk to people and make every effort to understand them and their particular needs and requirements – including needs related to gender, affordability, language requirements, etc.
- Provide people with access or contact to peer supporters.

- Communicate positive messages of hope and messages that convey the fact that people can lead satisfactory and successful lives with symptoms of mental health conditions.
- Make the environment less oppressive; ensure that people feel free to be themselves and express themselves across all of their diversity.
- Implement gender sensitivity training for service providers.

Presentation: The role of mental health and social services in promoting physical health (15 min.)

The physical health needs of persons using mental health and social services are often disregarded.

- Some treatment provided in mental health and social services (e.g. medication, ECT) can have very serious impacts on physical health *(8),(9), (10)*. It is very important that people are informed about these potential risks in order to be able to give or refuse consent to these treatments.
- In addition, people using services are frequently not offered screening and treatment for physical health conditions.
- This may be problematic because some mental health issues may have physical causes.
- In addition, people with psychosocial, intellectual or cognitive disabilities may be at risk of physical health problems, including diabetes and cardiovascular disease. These may be related to lifestyle but may also result from the direct impact of medication.
- People with psychosocial, intellectual or cognitive disabilities are not always taken seriously when they complain about physical health symptoms because their complaints are disregarded as being the consequence of the mental health condition they are diagnosed with.
- Finally, people with psychosocial, intellectual or cognitive disabilities are sometimes denied health services or have to wait longer for them because other people are given priority.
- As a consequence, these people are often at increased risk of ill-health and premature death.

As we saw in the module on *Human rights*, studies have found that people with severe mental health conditions die on average 10–20 years earlier than the rest of the population *(11, 12).*

It is therefore essential that people have access to the range of physical health services that are available to the rest of the population. In addition, the standards of physical health care they receive should be of equal quality.

Mental health and social services should:

- Provide accurate and comprehensive information on potentially harmful effects of treatment.
- Pay close attention to any adverse effects of medication on physical or mental health (e.g. tardive dyskinesia, diabetes, kidney problems, liver problems, increased suicidal thoughts, agitation, aggression).
- Listen to complaints, regularly ask questions and conduct examinations to find out if the person is experiencing adverse effects.
- Assist in withdrawal of medications when the person desires this.
- Refrain from prescribing multiple drugs.

- Refrain from promoting the idea of chemical imbalance or brain disorder as it can stop people from exploring other non-pharmacological solutions which can be beneficial to understanding and dealing with the emotional distress that they are experiencing.

Exercise 2.3: Does my service adequately support physical health? (15 min.)

Again ask participants to answer the following questions:

- What is my service doing to promote physical health?

Possible answers may include:

- Health complaints of service users are always taken seriously.
- People are referred to general practitioners or to a hospital when they need further assessment or treatment for physical health concerns.
- When people arrive at the service, they are offered a complete physical health examination with treatment as appropriate.

Again, when asking the following question, note that participants may have already provided some of the answers.

- What can my service do to improve access to physical health care and services?

Possible answers may include:

- The service could provide more information on sexual and reproductive health as well as physical health.
- The service could supply healthier food.
- The service could offer more opportunities for physical exercise (e.g. sports, walks, etc.)
- The service could facilitate referrals to other health services.
- The service could facilitate access to support relating to health insurance schemes and procedures.
- The staff could pay closer attention and be more responsive to people's physical health needs.

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Topic 3: What is recovery?

Time for this topic

Approximately 1 hour and 35 minutes

Exercise 3.1: Feeling better (40 min.)

⚠️ **Warning:** This activity can provoke strong emotional responses from some people.

Facilitators should be mindful of this and, prior to this activity, should let participants know that they should feel free to voice their emotions, take a pause or step out of the training session until the end of the activity. The facilitator should also be mindful of any sign of distress shown by participants and should be prepared to provide support (please refer to the document *Guidance for facilitators* for more information).

This exercise is designed to encourage participants to think about the challenges and helpful factors involved in the recovery process.

Start by asking participants the following:

- **Think about a time when you had to recover from something – it can be now or in the past.** For instance, it may be battling physical illness, losing someone you loved, being the victim of abuse, losing an important opportunity or job. It can be anything you can think of, not necessarily related to mental health.
- What emotional challenges did you have?
- How did you deal with these (either positively or negatively)?
- What was difficult about recovering from the situation?

After this discussion, ask participants the following questions:

- What helped you to get better / overcome this situation?

Give participants 2–3 minutes to think about or write down their personal recovery experiences. It may be useful for them to think of their recovery as a journey. Ask for one or more volunteers to share their experience. The goal is to let the group think about what is involved in recovery in general.

Research based in Scotland has found that important factors on the road to recovery include the following *(13)*:

Recovering identity	Relationships
- Confidence - Hope and optimism - Self-acceptance, responsibility, belief and esteem - Self-efficacy - Self-awareness - Going beyond the label - Reclaiming power and self-determination - Belonging – cultural, social and community identity - Activism - Spirituality - Coping - Taking control	- Friendships - Supportive family relationships - Intimate relationships (i.e. partner) - Parenting - Peers - Pets - Service professional - Mutual trust and recognition - Hopeful relationships
Engagement and finding meaning and purpose	**Services and supports**
- Being valued - Engaging in meaningful roles - Volunteering, employment, career and education - Learning about self and condition - Community and social engagement - Communities and housing - Exercise and creativity - Other people's experiences	- Feeling informed and in control - Continuity and flexibility - Treatments and therapies - Security - Peer support - Relationships, attitudes and power - Housing and community supports - Financial security

- It is important to note that the recovery factors listed in this table do not apply only to people with psychosocial, intellectual or cognitive disabilities. Everyone is recovering or has recovered from something in their lives. Therefore, these recovery factors may apply to everyone.
- However, recovery may be more difficult for some people than for others as people may recover from different things in vastly different contexts. People may also be at very different points in their recovery journey.

Presentation: Recovery (14) (50 min.)

The purpose of this presentation is to introduce the recovery approach. Remind the participants that the recovery approach will be covered in more detail in a separate module on Recovery and the right to health.

The meaning of recovery

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, community engagement, spirituality or some or all of these.

This understanding of recovery moves us away from the idea or goal of "being cured" or "being normal again". Instead, this concept of recovery focuses more in gaining new meaning and purpose in life, being empowered and able to live a self-directed life, despite what one may have lived through and despite any emotional distress that may still be a part of one's life.

At this point, you can show participants the following video:

ASHA International (2015) Reshma Valliappan, India, You Can Recover Project (1:34 min.) https://youtu.be/E0YbpciUxRk (accessed 9 April 2019).

Reshma Valliappan tells her personal story of what recovery means for her life.

- Everyone experiences challenges on the road to recovery.
- Although recovery is **unique and personal**, many elements are influenced by relationships and interactions between people as well as by the social and political environment – including poverty, exclusion and other human rights violations.
- Often, these elements create barriers to recovery.

Barriers to recovery

At this point of the presentation, ask participants:

- What may hinder recovery for people with psychosocial, intellectual or cognitive disabilities?

Ask the group to brainstorm ideas and write them on the flipchart. After the discussion, show participants the following list as a point of comparison with the answers they provided.

Barriers to recovery may include:

- Lack of a sense of identity, self-respect, hope.
- Mistreatment, neglect, abuse or trauma.
- Poverty.

- Lack of educational, income-generating, social and other opportunities.
- Being excluded from family, friends, social/support networks and one's community.
- Feelings of isolation and lack of support.
- Experiencing stigma and discrimination.
- Staff or families' lack of belief in people's ability to get better and claim and reclaim their lives.
- Not knowing or being informed of one's rights.
- Not being allowed or trusted to make decisions for yourself any longer.
- Feeling that one's opinion is not respected by others (mental health and other practitioners, families, others).
- Others defining what they see as recovery or success (e.g. others around us having low expectations or excessively high expectations about our recovery).
- Lack of available/accessible/affordable/acceptable mental health and social services and/or alternatives.
- Being denied, or facing barriers to, treatment or recovery approaches they believe could be helpful, such as counselling or psychotherapy.
- Lack of access to information, treatment and support options, psychosocial alternatives to medication.
- Pathologizing normal grieving processes which can lead to unnecessary and harmful treatment. This also leads people to think they are "not normal", interferes with normal healing processes and discourages people from feeling emotions because they are seen as "symptoms of a disorder".
- Negative effects of medication.
- Negative attitudes from mental health and other practitioners.
- Loss of trust in the mental health system and the people working in the service.
- Overprotection by family opposing discharge from the service.
- Being told that you have a lifelong illness that you won't recover from.
- Lack of contact with other people who have gone through similar experiences or who have been through a recovery process.

Many of these problems can be addressed through good communication and by building a trusting relationship between those people going through recovery and their families, peers, other supporters and mental health and other practitioners. Building a trusting relationship requires a personal connection which cannot be forced. When this does not seem possible, efforts should not be stopped, but it is advisable to seek other persons who may be able to connect to the patient more easily. Efforts should always be made to ensure good communication, understanding and respect for the will and preference of the person who is going through recovery.

The recovery approach in mental health

- In this approach, recovery is understood to be about helping people regain or stay in control of their lives, and having meaning and purpose in life.
- In the recovery approach, recovery may or may not involve treating or managing symptoms.
- **Recovery is different for everyone**. It is a deeply personal process; its significance and what it constitutes will vary from person to person.
- For some people:
- Recovery is an ongoing journey.
- It may mean developing or strengthening relationships.
- It may involve (re)gaining independence, finding a job or going back into education.

- Recovery might mean participating more actively in community life and activities.
- Recovery might also mean an absence of what are considered as symptoms (but not always).
- It involves redefining what people's experience means to them (e.g. identifying themselves as trauma survivors).
- It involves creating safe places to acknowledge trauma and explore ways of healing.

- Recovery is based on <u>hope and optimism for the future</u>
  - ➢ Hope is a core principle of recovery that mental health and other practitioners, family members and other supporters should promote.
  - ➢ Although different people may define hope differently, the essence of hope in recovery is the affirmation that it is possible to live a meaningful life in the presence or absence of "symptoms".
  - ➢ Central to the concept of recovery is a belief that one's situation or circumstances can change and/or that one will be able to manage and overcome the situation. This can be fostered by hope-inspiring relationships.
  - ➢ In the recovery approach, symptoms, illness or disability do not mark the end of dreams, aspirations and possibilities. Therefore, dreams and aspirations need to be encouraged and valued.

- <u>Connectedness</u> is key to recovery
  - ➢ People need to be included in their community on an equal basis with all other people.
  - ➢ Recovery may involve reconnecting with family and friends or developing new meaningful relationships. It may also involve connecting with peer support groups or other groups in the community.

- <u>Meaning and purpose</u> are important aspects of recovery
  - ➢ Recovery supports people in rebuilding their lives and gaining or regaining meaning and purpose according to their own choices and preferences.
  - ➢ Recovery is also about empowering people to achieve their dreams and goals in life.

- Recovery also means exploring your <u>identity</u>
  - ➢ The recovery approach can help people to accept who they are or strengthen their sense of self and self-worth, as well as to help them to overcome self-stigma that can put one's sense of identity at risk.
  - ➢ Recovery is based on respect for people and their unique identities and self-determination, as people themselves are the experts on their own lives.

- Recovery supports <u>empowerment</u>
  - ➢ Recovery promotes a positive outlook that empowers people and enables them to regain control.
  - ➢ Having control and choice is central to a person's recovery and is intrinsically tied to legal capacity.

- Recovery involves <u>taking risks</u>
  - ➢ Risk-taking can be an important part of embarking on one's recovery journey.

- It is natural to take risks in life and either succeed or fail as a result. This is a learning process that is essential for living. Without taking risks we cannot progress or build a life for ourselves, and this can lead to stagnation.
- It requires courage and creativity to support positive risk-taking to help people move forward and achieve goals.

- Recovery is <u>holistic</u>
  - Recovery in action is not just treating or managing symptoms. Recovery is an approach that looks at the whole person, extending to include social, emotional, physical and other aspects of life.
  - This may involve addressing social adversities (e.g. poverty, unemployment, discrimination) that have a negative impact on people's mental health.

- Recovery involves <u>healing from trauma</u> (15)
  - Trauma-informed services recognize that many people have experienced trauma in their lives (e.g. childhood trauma, trauma due to abuses in service settings, etc.) and this experience negatively affects their mental well-being and quality of life.
  - Services should provide care in a way that is sensitive to this issue and avoid traumatizing or re-traumatizing people. This means that services must refrain from practices of violence or coercion, such as seclusion, restraints and forced treatment, which are inherently traumatizing, hinder recovery and lead to re-traumatization.

- Recovery means being seen as a person and not just as a condition/disability
  - Recovery is about being seen as a whole person, focusing on one's abilities and strengths and using support when needed to achieve one's goals and aspirations in life. What some people may see as a deficit may in fact be an important strength for the person concerned.

- Recovery and human rights are strongly linked
  - The recovery approach respects people's choices and supports them in living fulfilling lives.

Respecting all human rights is essential to implementing a recovery approach. In turn, adopting a recovery approach helps to uphold human rights.

Ask participants to read Youssef's experience and then the two potential outcomes. Then ask participants (Annex 1):

- For each of the two outcomes, explain how recovery was or was not promoted?

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Scenario - Youssef

Youssef has been experiencing deep and incapacitating sadness for several years and is not getting better. He has attempted suicide twice in the past 3 months. Youssef is seeing Dr Sharma. He arrives at his appointment.

Outcome 1: Upon his arrival, Dr Sharma gives Youssef a prescription refill for his antidepressants. Youssef goes to the pharmacy to get his medication and leaves.

Outcome 2: Upon Youssef's arrival, Dr Sharma asks him how he has been doing since his last visit. When Youssef mentions that he has been feeling worse in the last few weeks, Dr Sharma asks why and asks what he can do to help. Dr Sharma also takes the opportunity to discuss Youssef's goals for the future as well as what goals he could focus on right now in order to feel better.

Youssef tells Dr Sharma that he feels very alone in his life and is estranged from his family and friends who do not understand the situation he is facing. Youssef is also stressed because he has not been performing well at work and has had to take some time off to recover. He tells Dr Sharma that he would feel a lot better if he could reconnect with his family and friends and go back to work.

Dr Sharma suggests that, if Youssef wishes, they could arrange a meeting that involves Youssef's closest family and friends to discuss what he is experiencing and how they can all best support him. She connects Youssef with a social worker and local NGOs that support people in managing difficult times and rejoining the workforce. She also gives him a list of local peer support groups whom he can contact in order to rebuild his support network. Youssef and Dr Sharma agree to meet regularly for the coming weeks to continue to discuss and work towards his recovery and recovery goals.

Outcome 1 does not put Youssef at the centre of his care and does not focus on providing him with hope or supporting him to identify goals that he can work towards for his recovery or to find meaning in his life. The only focus is on treating the symptoms with medication.

Outcome 2 illustrates the recovery approach, where Youssef decides on his needs and objectives for recovery, while the health practitioner, by engaging in supportive dialogue, helps him to move forward in his recovery journey. This process takes longer than *Outcome 1* but has more potential to support Youssef to be more effective in the long term.

At the end of this presentation, show participants the following videos:

What is recovery? Mental Health Europe (6:38 min.)
https://youtu.be/kkDi0WvoR4o (accessed 9 April 2019).

Recovery from mental disorders, a lecture by Patricia Deegan (4.08)
 https://youtu.be/ZdONPEyGknI (accessed 9 April 2019)

Topic 4: Promoting recovery

Time for this topic
Approximately 1 hour 15 minutes.

 *Presentation: **What supports recovery? (20 min.)***

One of the key features of the recovery approach is that it is not up to mental health and other practitioners, families or others to decide what recovery will look like for a person. This must be the decision of the individual who is going through the recovery journey.

The role of others, including mental health and other practitioners, is to support people in the best way possible along their recovery journey. Key components of effective support include:

- Using good communication skills (e.g. active listening, using positive messages focusing on hope, etc.). More information on communication skills is provided in the module on *Recovery practices for mental health and well-being*.
- Understanding and acknowledging that the person is an expert by experience and that this expertise is as valid as the skill and expertise that mental health and other practitioners have gained through professional training and experience. A recovery approach means encouraging persons to identify and express what recovery means for them.

Recovery and social inclusion

- Taking part in social, educational, training, volunteering and employment can support individual recovery.
- Services should empower people to move forward and regain or create their place in the community. Institutional models of care which isolate people from the community are therefore incompatible with a recovery approach.
- We all have a role to play in fostering inclusion and openness and, as such, support people's recovery.

Recovery plans

A recovery plan is a document that it is written and implemented by a person to guide them along their recovery journey, regain or stay in control of their life, and find meaning and purpose in life.

A recovery plan can be a useful tool to:

- Support a person to work out a direction and steps for moving forward in life.
- Help a person get the support of important people in their life, if they wish to do so (such as family, friends, peers, health practitioners and others).

It is important to note that a recovery plan is a potential tool for people to use in their recovery, and not an end in itself.

Also, some people may find it more useful to have support and build connections at the moment and may not need a plan to achieve their goals in life.

What does a recovery plan look like?

- A recovery plan outlines the person's own goals in life. Depending on the person, it may include: reconnecting with friends, going back to school, managing difficult situations, etc.
- The plan outlines how the person will work to achieve these goals.
- The plan is driven by the person concerned and reflects their choices, will and preferences for support and care.
- It may include a personal plan for dealing with distress, for which the person can list possible actions that can be taken to prevent the situation getting worse.
- A recovery plan may also include an advance directive about care and treatment.

This topic is developed further in the module *Recovery practices for mental health and well-being.* In addition a recovery plan template can be accessed in the module entitled *Person-centred recovery planning for mental health and well-being..*

![pencil icon] **Exercise 4.1: The role of the individual as well as families, friends and other supporters in promoting recovery (20 min.)**

The purpose of this exercise is to allow participants to explore how promoting a recovery approach can start with the person. It then explores how family members, friends and other supporters can also play an important role in the recovery process.

Ask the group:

- How can people promote their own recovery?

Some possible answers may include:

- Develop practices that make you feel better and identify strategies that promote and maintain well-being.
- Seek out cultural and spiritual practices for growth and self-knowledge.
- Reject disempowering labels and narratives that limit one's potential.
- Seek out relationships with those who can act as peers and equals who value one another's knowledge and autonomy, whether or not the person has had the same type of lived experience.
- Do not blame yourself for having been abused or for having been discriminated against.
- Be clear with others that recovery is possible and that they are at the centre of their recovery and that they drive all the decisions about their own life.
- Develop their own plan based on strategies that they find helpful along their recovery journey.
- Listen to others' experiences and share your own story.
- Explore opportunities to be more active and engaged in the community.

Once participants have had the opportunity to discuss the first question, ask the group:

- How can families and other supporters promote recovery?

Some possible answers may include:

- Make sure that services and supporters respect the opinions, decisions and choices of the individual on their treatment, care and other areas of life rather than making decisions on their behalf. (For more information on this topic, see the module on *Legal capacity and the right to decide* and the module on *Supported decision-making and advance planning*).
- Acknowledge that differences of opinion can arise but that, ultimately, the individual's decisions should be respected. Support their right to make their own choices, and to establish their own identity and understanding of what they are experiencing.
- Find out more about the support options and strategies that the individual finds it helpful to maintain to improve wellness.
- Support individuals to be actively engaged in their local community.
- Include the individual in family life and decisions on an equal basis with other family members.
- Support the individual to ensure that they are being treated fairly and without discrimination by health services and local agencies.

 Exercise 4.2: Personal recovery stories (20 min.)

Select 3 personal recovery stories from among the videos available from the Open Paradigm Project:

> **Open Paradigm Project:**
> https://youtu.be/wbu6VWhe86U (accessed 9 April 2019).
>
> - Celia Brown (7:15 min.): https://youtu.be/7cEj_rE5Z-c (accessed 9 April 2019)
> - Oryx Cohen (4:03 min.): https://youtu.be/0k0odQZZlBI (accessed 9 April 2019)
> - Sera Davidow (5:46 min.): https://youtu.be/IEvYDb7f7dk (accessed 9 April 2019)

Personal experiences available through the above link Include: Celia Brown, Oryx Cohen, Sera Davidow, Sean Donovan, Dorothy Dundas, Will Eberle, Dr Dan Fisher, Jenna Fogle, Marty Hadge, Leah Harris, Michael Kerins, Amy Long, Daniel Mackler, Iden McCollum, Steven Morgan, Matt Samet, Cheryl Sharp, Laura Nicole Sisson, Ciceley Spencer, Lauren Spiro, Leonard Roy Frank, Lauren Spiro, Michael Therrien Jr, Faith Rhyne, Anne Weaver, Paris Williams, Michael Wilusz).

The following 3 people from the list above have made important contributions to these training materials:

After watching three videos, ask the participants to share their thoughts and comments on what was important for people during their recovery journeys.

Topic 5: The role of practitioners and mental health and social services in promoting recovery

Time for this topic
Approximately 40 minutes.

Exercise 5.1: Improving practices to promote recovery in mental health and social services (40 min.)

The purpose of this activity is to encourage participants to think specifically about a mental health or related service they are familiar with and how to translate what they have learned about recovery into sustainable changes within it. It is important that participants think about specific day-to-day actions that they can implement in their service, in addition to broader forms of action such as advocacy and awareness-raising.

For this exercise, draw three columns on the flipchart (as in the table below).

Column A: Change in staff and service practices to support a recovery approach
Column B: Potential barriers
Column C: Steps to overcome the barriers

First, ask participants to brainstorm about changes that should happen in the service to better support mental well-being and to implement a recovery approach. List all their ideas for change in column A.

A) What changes/improvements are required for staff and service practices to support a recovery approach?

Some possible answers are:

- Immediately end coercive, harmful and abusive practices.
- Respect people's ownership of their own lives, bodies, narratives and recovery journey.
- Take responsibility, at the service level, to undertake immediate actions to remedy the situation.
- Focus more attention on achieving inclusion in the community
- Support people's empowerment and decision-making power.
- Support people in overcoming social isolation and in building their own social support networks, including by reconnecting with family and friends, peer or others, in line with their wishes.
- Link people to other mainstream community services and supports, such as social services and benefits, housing, employment agencies.
- Link people to training and skills-building opportunities (e.g. vocational training, paid employment and any other relevant skills or educational training).
- Promote and encourage peer support in the service.

- Create a relaxed and welcoming environment where people feel free to consult with their mental health or other practitioners when they wish to do so.
- Encourage people to discuss their concerns, express their opinions and take ownership of how they want to live their life.
- Encourage people to identify their personal goals for recovery and, if useful, to draw up and follow a recovery plan on their own or with the assistance of a trusted person.
- Demonstrate compassion and kindness.
- Support people's wishes to access spiritual, religious and cultural resources and experiences if requested (e.g. prayer room, religious scriptures, traditional cultural healing).
- Help people to access uplifting and therapeutic experiences – such as art, music, nature, sport, journal writing, self-help – in line with their personal preferences.
- Ensure that people are informed about the different support options available to them.
- Ensure that staff are trained about people's rights and are familiar with international human rights standards.
- Ensure that staff have the skills to provide counselling, information, education and support to individuals and their families and care partners.
- Promote self-reflection and critical evaluation among staff about how staff might be helping or hindering recovery for different people (e.g. discrimination, gender-sensitive services, how to best address diverse people's needs and contexts, etc.).
- Be open to learning from and being changed by people with psychosocial, intellectual or cognitive disabilities or any other person using the services
- Recognize people as experts by experience.
- Involve people with psychosocial, intellectual or cognitive disabilities at all levels of the service, including service reform, management and governance.
- Welcome the involvement of family, care partners, friends and other supporters in the planning and delivery of the service.
- Adopt a trauma-informed approach to recovery which recognizes and addresses trauma that has been experienced by some people.

Some participants, in particular mental health and other practitioners, may express concern that they lack resources and time to carry out all the above actions. This should be openly discussed. At this point the facilitator may emphasize that advocacy and lobbying are also key to making changes and moving in the right direction. The facilitator might also emphasize that simple reflection, such as this activity, is a crucial first step in improving services.

After this brainstorming exercise, go back to each change listed in column A and ask the group to think about:

B) **What barriers are going to make it difficult to implement these measures?**

C) **What can be done to overcome these barriers?**

It is important to ask participants to sort options into what can be achieved in the short, medium and long term. This is an opportunity to highlight that changing the culture within a service takes time, and that not all results will be achieved immediately.

The following table includes examples of steps that can be taken to implement a recovery approach and to support people along their recovery journeys. The facilitator can select a few examples to discuss with participants in addition to their own ideas.

Implementing a recovery approach in service X		
A	**B**	**C**
Changes in staff and service practices to support a recovery approach	**Potential barriers**	**Steps to overcome the barriers**
Example 1: Support people to integrate into the community by finding employment and becoming financially stable.	Very few jobs available for all people. Lack of time and resources for staff to undertake this role.	Staff can link people to NGOs which may provide income-generating opportunities and/or training for income generation. Lobby for policy change and additional resources.
Example 2: Work with people to identify their personal goals for recovery and work together to develop a recovery plan.	This approach requires more time and attention for each person, which may be difficult in low-resource services where there is a lack of health practitioners. Following up with people to update the plan and discuss progress is also time-consuming. Challenges in communicating personal goals. Staff may feel that they know what is best for people's treatment and recovery.	Train more people (including non-health practitioners) who can provide support in developing recovery plans. Develop a programme or system across the service to give people opportunities to discuss, develop and review recovery plans according to their wishes. Explore different methods of communication, including nonverbal methods, to ensure that the recovery goals of the individual are understood. Change the institutional culture and staff attitudes about recovery. Training on recovery within the service would be an important means to achieve this. Identify champions in the service to take the recovery principles forward.
Example 3: Use two-way communications by asking for people's preferences when recommending particular services or care options, instead of one-way, prescriptive communications (e.g. "These are the care options available. What do you think would be most helpful to you?" instead of "You should have this form of care/treatment.")	Insufficient time within appointment sessions can limit the ability to ask and discuss people's preferences. If people do not agree to the treatment recommendations, staff may not be aware of alternatives to suggest or may be concerned that they are not providing the best care.	Set aside time in the appointment for discussion about care options and preferences; or allow people to think about options and preferences until the next appointment and agree to discuss and possibly decide then. Ask people for reasons why they do not agree with recommendations, listen to them and respect their concerns. Discuss ways to address those concerns, as well as other possible options. Remind oneself that individuals have a unique social context and that recovery is personal and staff do not always know what is best for people. Remind oneself that people should be encouraged to drive forward their own care and recovery. Remind oneself of how it may feel to have one's choices taken away and to be forced to take a treatment one does not want. Treat every person with compassion, dignity and respect.

Example 4: Inform and talk with colleagues and people using the services of the recovery approach.	Colleagues may feel overwhelmed with their existing work, without learning about new ways to practise mental health care. They may also think that they are already practising recovery-oriented care even if they are not.	Provide factsheets or online links to websites or stories/videos on recovery so people using or working in the services may read or watch them in their own time.
Example 5: Make a booklet or spreadsheet on available community resources and organizations (e.g. income-generating programmes at NGOs in the community; government agencies for social services such as housing, food, or other subsidies; education and vocational skills training opportunities; peer support groups; social and cultural programmes, activities and events, etc.). The booklet can be readily used by staff **or people using the service to connect with other services outside the mental health sector.**	Staff may not have enough knowledge about all the resources in the community or time to make a comprehensive resource guide.	Make it a group activity where each staff member researches and contributes different pieces of the resource guide; share knowledge and workload with other agencies in the community to make the resource guide; have people using the services give input into what types of community resources they would like to learn about, get access to or have accessed.
Example 6: Use active listening skills to help people feel understood and listened to.	Staff may feel burnt out at times and unable to be fully attentive to people's needs. Staff may not have had adequate training on how to practise active listening.	Acknowledge feeling burnt out and pay special attention to finding time and space for self-care, either at work or at home. Talk to supervisor or colleagues for support. Consult with supervisor on the topic, and/or learn by using books, workbooks or online resources.
Example 7: Put up informative or decorative materials (e.g. posters, artwork, etc.) around the service to convey messages of hope and recovery.	Staff may not know where to find those materials, or the service may not have funds allocated for such materials. Staff may not feel sure about what kind of materials or decorations they should put in the service.	Search online for (free) materials; Encourage people who are using or have previously used the services to create material portraying messages of hope and recovery around the service. Give people control and ownership of these activities. If relevant, give people adequate remuneration for their work. Request funding from management to purchase materials. Ask people for their ideas and opinions; learn from other services that have created recovery-oriented space; or read books or articles on the topic to come up with ideas.
Example 8: Support and educate staff on how to best approach recovery and service delivery in ways that are gender-sensitive and diversity-sensitive.	Staff may feel unprepared or unable to attend to diversity and complexity of people beyond their experience (e.g. needs related to gender, culture, or socioeconomic status).	Set aside regular training time, meetings and/or conferences to discuss and brainstorm how to best assist the recovery of individuals facing social barriers to well-being. These sessions can be informed by people with lived experiences, other services and community groups that advocate for non-discrimination in mental health care.

 Concluding the training (5 min.)

Ask participants:

What are the 3 key points that you have learned from this session?

Follow the discussion with these take-home messages from the session today.

- Mental health, well-being and recovery are inherently personal.
- Respect for human rights is key to protecting mental health and well-being and promoting recovery.
- Stimulating the development of fair and inclusive communities is an essential but neglected part of supporting mental health and well-being.
- Individuals and services can do a lot to support people along their recovery journey.

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Annex

Annex 1: Scenario

Topic 3: *Presentation: Recovery* **- Youssef**

Youssef has been experiencing deep and incapacitating sadness for several years and is not getting better. He has attempted suicide twice in the past 3 months. Youssef is seeing Dr Sharma. He arrives at his appointment.

Outcome 1: Upon his arrival, Dr Sharma gives Youssef a prescription refill for his antidepressants. Youssef goes to the pharmacy to get his medication and leaves.

Outcome 2: Upon Youssef's arrival, Dr Sharma asks him how he has been doing since his last visit. When Youssef mentions that he has been feeling worse in the last few weeks, Dr Sharma asks why and asks what he can do to help. Dr Sharma also takes the opportunity to discuss Youssef's goals for the future as well as what goals he could focus on right now in order to feel better.

Youssef tells Dr Sharma that he feels very alone in his life and is estranged from his family and friends who do not understand the situation he is facing. Youssef is also stressed because he has not been performing well at work and has had to take some time off to recover. He tells Dr Sharma that he would feel a lot better if he could reconnect with his family and friends and go back to work.

Dr Sharma suggests that, if Youssef wishes, they could arrange a meeting that involves Youssef's closest family and friends to discuss what he is experiencing and how they can all best support him. She connects Youssef with a social worker and local NGOs that support people in managing difficult times and rejoining the workforce. She also gives him a list of local peer support groups whom he can contact in order to rebuild his support network. Youssef and Dr Sharma agree to meet regularly for the coming weeks to continue to discuss and work towards his recovery and recovery goals.

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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.

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