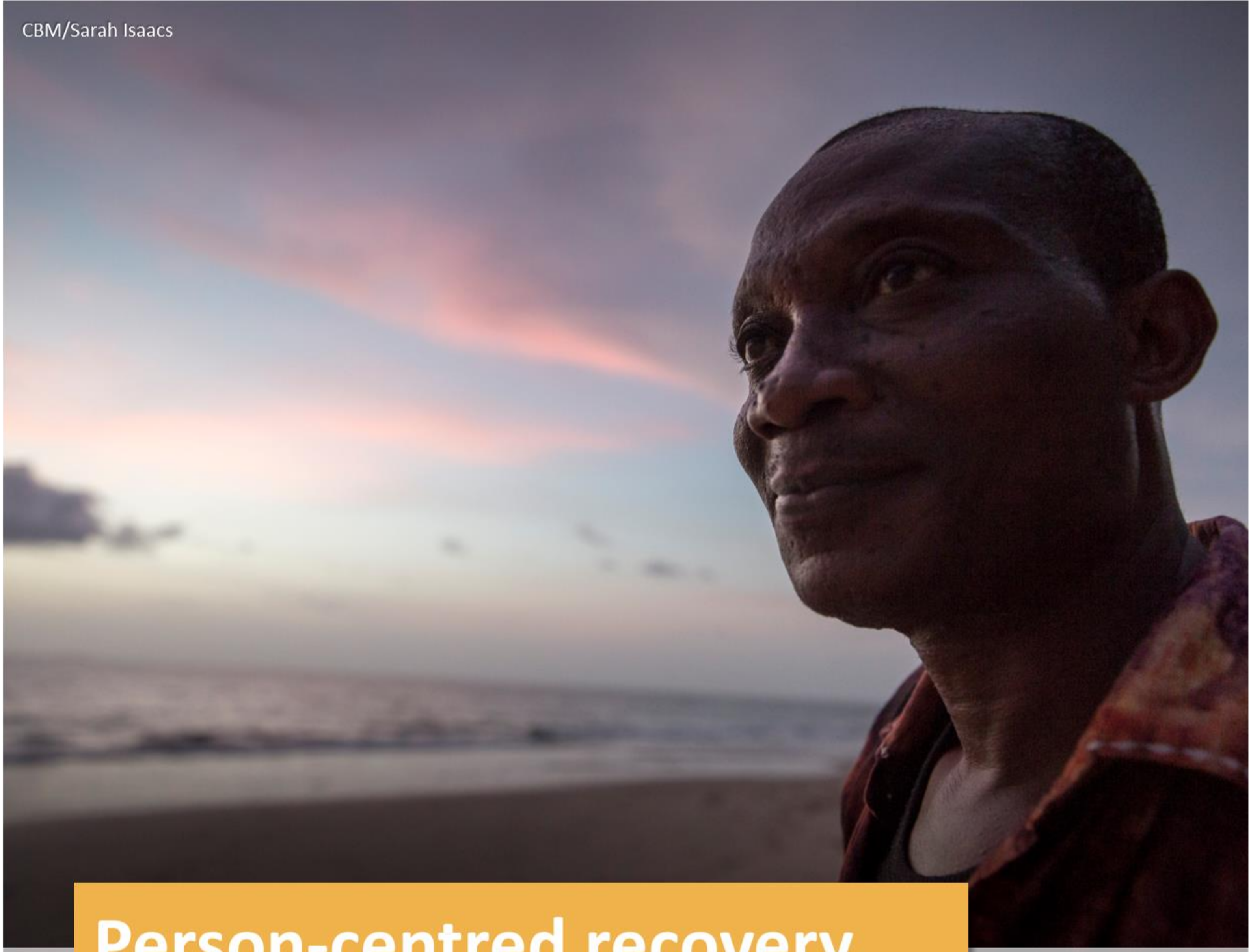
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Person-centred recovery planning for mental health and well-being

WHO QualityRights self-help tool

QualityRights

World Health Organization

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

Person-centred recovery planning for mental health and well-being self-help tool. WHO QualityRights

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

Contents

Acknowledgements ii

Foreword x

Supporting statements xi

What is the WHO QualityRights initiative? xvii

WHO QualityRights – Training and guidance tools xviii

About this training and guidance xix

Preliminary note on language xxii

What is recovery? 1

Part 1: Plan for pursuing dreams and goals 3

Part 2: My wellness plan 8

Part 3: Plan for managing difficult times 12

Part 4: Plan for responding to a crisis 17

Part 5: Plan for after a crisis 31

References 39

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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 not be necessary to cover topic 5 (zooming in on article 12) or topic 6 (zooming in on article 16) since these issues will be covered in much greater depth in the subsequent modules (module on Legal capacity and the right to decide and on Mental 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.

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.

What is recovery?

Defining recovery

Many mental health and social services around the world are based on either a clinical understanding of recovery or, at worst, a belief that recovery of any sort is not possible for many people. On the basis of a substantial and growing body of evidence, however, it is now well established that, in the context of mental health, people can and do recover *(1)*.

The traditional or clinical understanding of recovery is when a person is no longer behaving “strangely” or when any “symptoms” related to the emotional distress have subsided. However, for many people, recovery is not about “being cured” or “being normal again”. It is about gaining control of their identify and life, having hope for their life, and living a life that has meaning for them – whether that be through work, relationships, community engagement, or some or all of these.

“What matters in recovery is not whether we’re using services or not using services, using medications or not using medications. What matters in terms of a recovery orientation is: Are we living the life we want to be living? Are we achieving our personal goals? Do we have friends? Do we have connections with the community? Are we contributing or giving back in some way?” *(2)*

“Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment and discrimination.” *(3)*

Recovery is highly personal and its meaning can be different for each person. For instance, some people in recovery may find working in paid jobs very helpful for their mental health because they feel they are contributing and find meaning in their work. For some people experiencing particularly difficult times, certain styles of working may feel overwhelming and stressful and may become a hindrance to the person’s recovery. It is therefore essential to consider the values and preferences of each individual when supporting people in recovery and to provide support and accommodation in line with their wishes and values in order to help them overcome barriers to achieve their life goals and dreams.

What does recovery mean to you?

People who have undertaken a recovery journey have found it helpful to develop a Personal Recovery Plan.

This might include:

1. How you are going to pursue your ambitions and dreams. Decide what you want to achieve in life and how you will set about achieving it.
2. How to keep yourself well.
3. How to manage difficult times. If you can identify your sensitivities and signs of distress when things are not going so well, then you can work out ways to get yourself back to feeling good again.
4. What you and your supporters can do when you are having a crisis.
5. What you can do to move on after a crisis.

How to build and use a recovery plan

1. You do not have to complete the recovery plan at once; you can fill out different parts of the plan as you would like and at your own pace.
2. You can write up the recovery plan on your own or with the help of other persons who you trust. These could include peers, family, friends or mental health or other practitioners. Remember, this plan is *your* plan and it is up to you what goes into it and with whom you share the plan.
3. You can make changes to the plan at any time as you learn more about yourself.

It may often feel that the challenges you experience with your mental health and well-being are completely beyond your control, and it is tempting to believe that only experts can sort them out. While mental health and related practitioners have developed treatments and therapies that can be helpful, each person can become the real expert in their own self-care.

My supporters and how they can help

It can be helpful for people to identify others who can support them to develop a recovery plan and more generally support them at different moments in their life.

A supporter can be a relative, friend, peer supporter or any other trusted person who would be willing to support you, including during times of crisis. A person may decide that they do not want support, or would like support only in specific circumstances. Also, a person can have more than one supporter if they choose.

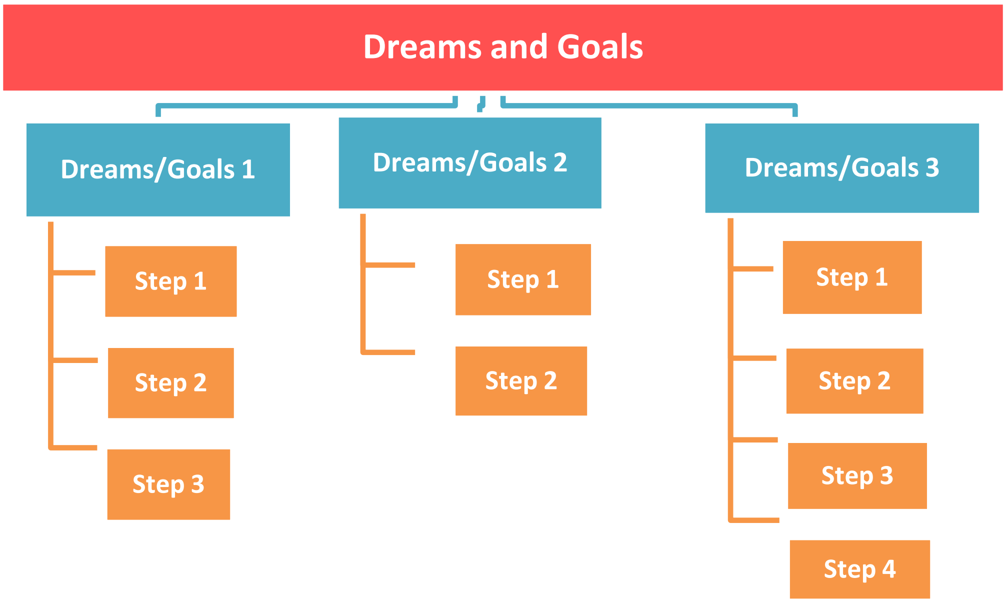
Name	Telephone	How he/she can help
In an emergency		

Part 1: Plan for pursuing dreams and goals

Recovery is about making the most of your skills and abilities when building the life you want to live.

If you have received a diagnosis it can be very easy to focus only on the diagnosis and lose sight of your skills, assets, strengths, interests and capabilities. A very important part of your recovery plan is, therefore, to brainstorm how you will use your assets and strengths, and the possibilities open to you, to make positive changes in your life.

At this stage of developing your recovery plan, you can identify the dreams and goals you want to achieve. Dreams and goals can be what you want to achieve in the near or distant future, such as learning to play an instrument, buying a plot of land, becoming a teacher, accessing decent housing, sending the children to schools, or travelling. Dreams and goals can also be about specific things you want to achieve, such as getting a part-time or full-time job, volunteering with an organization whose work you care about, finding a friend to share hobbies with, or finishing a book you always wanted to read. Each goal can then be broken down into steps which are in essence smaller goals you can tackle one at a time. See below for a visual illustration of this process.



Below is an example:

The first step is to think about your dreams and goals.

In the box below, write or draw your dreams and goals.

My dream(s) and goals

Of these dreams and goals, *pick ONE dream or goal* you want to achieve now

Tips to help you identify your dreams and goals:

- Think about what is important to you – e.g. career, education, decent housing, being part of a group or community, volunteering to help others, or religious/political beliefs.
- Think back to different activities or experiences you have enjoyed.
- Think about things that you wanted to do in your life.
- Think about what gives you joy – what is your passion?
- Look at magazines, newspapers or the Internet, or talk to friends and relatives to get ideas.

Choose a smaller dream/goal to start with and break the dream/goal down into smaller steps.

The DREAM/GOAL I want to work on first is:
How long it might take to achieve this dream/goal:
Possible STEPS to take to achieve this dream/goal – write down *freely* as ideas come to your mind. You will pick specific steps on the next page:

Among the steps you listed on the previous page, select the ones that are most relevant and doable for you to achieve. List them in the box below.

The STEPS I will ned to take to achieve my dream/goal:

To plan for the STEPS for your other dreams/goals, make extra copies of the forms.

In the space below, you can take notes to gather any information or support you may need to carry out the STEPS you outlined.

Information I will need to complete these STEPS and where I will obtain it

Information I will need: Where I will find the information:

Support or help I will need: Who I will obtain support from:

In the table below there is an opportunity to list your own personal assets and strengths. This is an opportunity to reflect on the tools that can help you achieve your dreams and aspirations.

If you are having trouble thinking about your personal assets and strengths, think back to when you have achieved other goals in the past and the skills you used to achieve these successfully.

My personal strengths that will help me achieve my dreams

Part 2: My wellness plan

Routines to remain well

Having a regular routine and things to do can be helpful in maintaining wellness. This can balance your life and give you a structure to build on. Think about the day-to-day things you need to do to remain well. These may be things that you are already doing or things that you want to do because they would make you feel better.

Most routines are quite simple – for instance, things like:

- Preparing and eating healthy meals at regular times
- Going for a walk and enjoying nature
- Working in a garden
- Going to work or college
- Reading a book, newspaper or magazine.

In the following boxes, select and list things that you can do EVERYDAY and SOME DAYS throughout the week to remain well.

In the box below, write down things you can do EVERYDAY to remain well.

Things to do EVERYDAY to remain well

In the box below, write down things you can do WEEKLY or on SOME DAYS OF THE WEEK to remain well.

Things to do WEEKLY or SOME DAYS to remain well

Things to AVOID in order to remain well

It can also be helpful to think about things you should avoid in order to help you remain well. These might be things like:

- Not getting enough sleep
- Sitting around doing nothing
- Having too much caffeine through coffee, tea or soft drinks
- Drinking too much alcohol or taking illicit drugs
- Smoking cigarettes
- Meeting with people who you find difficult to get on with
- Anything else that you find unsettles you or worries you.

In the box below, list the things you need to avoid in order to remain well.

Things to AVOID in order to remain well

You can place the “things to do to remain well” into this schedule to create a wellness timetable. You can make changes to the schedule as you learn what works best for you.

WEEKLY SCHEDULE for KEEPING WELL

	Mon	Tues	Wed	Thu	Fri	Sat	Sun
Morning							
Afternoon							
Evening							

Part 3: Plan for managing difficult times

Another component of the recovery plan is to plan how to manage difficult times in life.

It may be useful to indicate in the recovery plan how you would generally describe yourself. It can help supporters to identify when you are behaving differently from usual and to check with you whether you may need support. It can also help you to remember that you are much more than perceived limitations, a diagnosis or a set of problems.

What generally defines me?

Sociable
A loner
Cautious
Athletic
Happy
Encouraging
Adventurous
Hard-working
Humorous
Playful

Outgoing
Talkative
Introverted
Extroverted
Thoughtful
Responsible
Serious
Friendly
____
____

Impulsive
Quiet
Energetic
A fast learner
Pessimistic
Supportive
Easy-going
Passionate
____
____

Confident
Enthusiastic
Opinionated
Optimistic
Industrious
Curious
Outspoken
Independent
____
____

To manage difficult times, it can also be useful to use a simple traffic light system to easily keep track of one's mood.

The green-amber traffic light system

When you are trying to work out your difficult times in life, it can be helpful to use the following traffic light system to easily keep track. See below for what each colour indicates.

GREEN = You are feeling well. You may experience stress from time to time that can be managed with coping and problem-solving skills.

AMBER = You are noticing signs of emotional distress. It would be helpful to take better care of your mental and physical health and obtain support from friends, family, or mental health or other practitioner(s).

You can use this system to monitor and manage difficult times in life:

1. Use the Daily Recording Chart to keep track of how you are feeling

2. List your:
- Sensitivities
- Signs of distress
- Actions to take for sensitivities and to reduce distress

Tip: As you fill out your Daily Recording Chart, try to observe what happened just before your mood went up or down in order to better understand what tends to provoke changes in your mood.

3. Use the information you wrote on the "things to do to remain well" to stay at the GREEN level, and to go back to GREEN when you reach AMBER on the Daily Recording Chart.

My sensitivities

In order to manage difficult times, the first thing to do is to identify your sensitivities. Sensitivities are things that happen (external or internal events or circumstances) that may cause a person to feel anxious, scared, miserable or discouraged. For some people they might include, for example, people coming too close, not being listened to, being in crowded places, having a big workload, being teased, being criticized, feeling a lack of respect from others and so on.

Sensitivities	Actions to take for sensitivities

My signs of distress

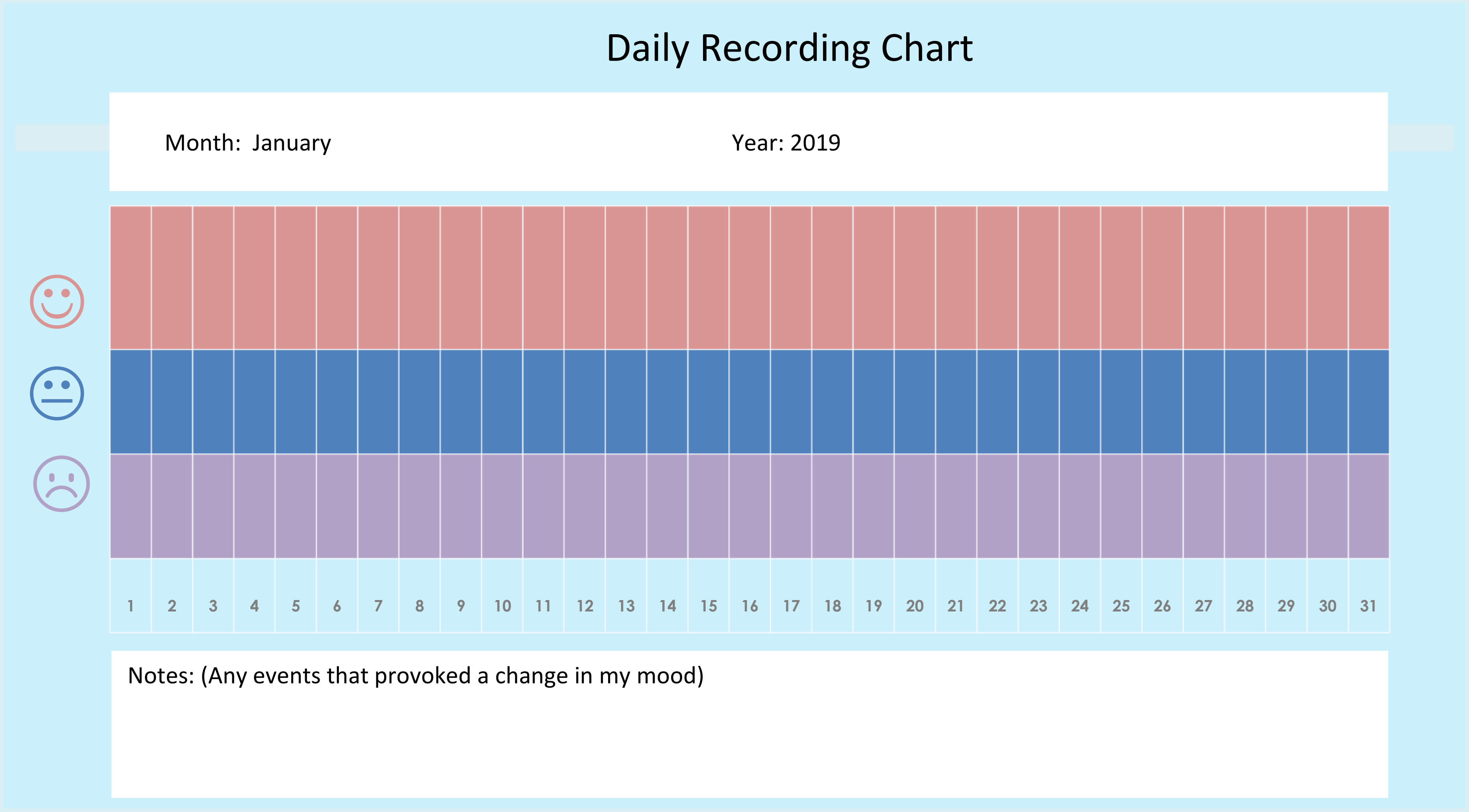
Signs of distress are changes in your feelings, thoughts or behaviour that suggest a crisis may develop. Signs of distress are important because if you recognize them and take action early you may be able to prevent a crisis from occurring. List your signs of distress in the box below. Please remember that this is not an inclusive list.

Examples of common warning signs:

- Feeling anxious or fearful
- Feeling depressed
- Not sleeping enough or waking up early.

My signs of distress	Actions to take to reduce distress

You can make copies of this **daily mood recording chart**. It is also helpful to write down any **events** that have provoked a change in your mood – whether good or not so good – to help better understand your sensitivities and to reinforce the use of your recovery skills.



Daily Recording Chart

Month: January

Year: 2019

☺																															
😐																															
☹																															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Notes: (Any events that provoked a change in my mood)

Part 4: Plan for responding to a crisis

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

It is helpful to have in writing your preferences for treatment and types of support you would like to receive from people, as well as information about the treatment, support and services that you are receiving at present. This is so that your support person and others around you can best help you when you are experiencing an emotional or mental health crisis. This is also a time to write down specifically what you do NOT want with regard to supports and services.

It is often difficult to coordinate help in the most personalized way while you are in the midst of a mental health crisis, so it is recommended that you plan ahead by filling out this document in case you experience a crisis in the future.

By filling out this document you will be able to provide directions and information on when, how, where and from whom you would like to receive support and care.

In some countries, people may make their will and preferences legally binding in certain situations. It may be interesting to check if the law in your country allows for this possibility.

About me – When I am experiencing a crisis

This section of your plan can be difficult to do and it may take some time. The aim is for you to describe the signs that might indicate that you would like to be offered more support. This is so that others can support you in keeping safe and in making decisions.

You have already listed the factors which indicate that things are not going so well and a crisis is looming in Part 3 *Managing difficult times* of this recovery plan. It might be helpful to look back at this and ask yourself “What happens next? What am I like when I am experiencing a crisis?”

It can often be helpful to ask your supporters, family, peers, mental health or other practitioners or friends what they notice about you when you are experiencing a crisis.

Remember, you should write down what others might notice because other people may also be using this plan to support you. For instance, “I neglect my personal hygiene”, “I think I am someone I am not”, and “I don’t get out of bed at all”. Try to be as specific as possible so people know exactly what to look for.

It is very important to continue updating this document as you grow and learn as a person, and as your needs and the way you respond to situations also change.

Signs that show I am in crisis and would like others to support me in my care, keep me safe and help me make decisions

Supporters

In the box below, you may write down 1) who your supporters are and 2) your preferred contact person(s) in times of emergency. Your supporters can be your family members, peers, friends, or other people you trust – such as neighbours or members of your faith in your community.

It is also important to discuss in advance with the supporters you list here to ensure they are willing to help in times of crisis.

1. Contact person in times or emergency/crisis

Person(s) to be contacted in emergency		
Name	**Their connection to me**	**Telephone and/or email**

2. Supporters

Name	Their connection to me (e.g. friend, relative, social worker)	Telephone and/or email

3. People I do not want involved in my care

It’s important to have supporters, but it is also important to consider people you would like to avoid when experiencing a crisis.

People I do not want to be involved if I am experiencing a crisis	
Name (relation)	**Reasons why I do not want them involved (optional)**

How my supporters can help me

When you are experiencing a crisis, there may be several things that need to be taken care of – such as requesting leave from work, feeding your pets, looking after bills, telling others that you are feeling unwell, cancelling appointments, etc. In the box below, list the persons who can help you with specific tasks when you are unwell.

Things I want my supporters to take care of when I am in crisis	
Name	**What I would like this person to take care of while I am in crisis**

What people can do to help when I am in a crisis

When you are experiencing a crisis, there may be some things that people do which make you feel better and other things that make you feel worse. It may be useful to think back to people who you found helpful when you were experiencing a crisis in the past – what was it that they did?

Perhaps they:

- Just spent time with me without speaking or talking about the crisis
- Stayed with me when I was feeling scared or alone.

What people can do that is HELPFUL for me when I am experiencing a crisis (please list)

What people may want to do that is NOT helpful

You might also say what people do that does not help and why. For example:

- You may not find it helpful when friends try to encourage you to manage your distress by drinking alcohol.
- Or you may not find it helpful when family members tell you that you have to “try to relax” as this makes you more upset and you would prefer people just to be with you during these difficult times.
- Or you may not like it when mental health or other practitioners offer you a new medication before finding out other ways that you can alleviate your distress.

Fill out your own list below:

What I do NOT find helpful	Why is it not helpful

Services and supports that are useful

In the box on the following page, you can list services and supports that you find useful. Such as:

1. **Services or supports that you are currently receiving** like cognitive behaviour therapy (CBT), counselling, psychotherapy and peer support groups.
2. **Services or supports that have helped when you have been in crisis in the past**, like a group therapy, mindfulness, going to the gym, anxiety management, going for a walk or having a friend stay with you.
3. **Services or supports that you do not want and why you would prefer to avoid them**. For instance, you might say “ECT (electro-convulsive therapy) because of its potential negative effects”, “group therapy because it makes me feel anxious to speak publicly” or “seeing my sister because we do not get along”.
4. **Services or supports to deal with family issues or other critical situations** in your social life, work, friendships or life changes.

Services or supports that you are **currently receiving**
Services or supports that **have helped when you have been in crisis in the past**
Services or supports that you **do NOT want** and **why you would prefer to avoid them**
Services or supports to **deal with family issues or other critical situations**

Medication

On the following page, list any information about your medication that would be helpful for your supporters and mental health and other practitioners to know when you are experiencing a crisis. This is so that they can help you in the best way possible (e.g. by avoiding medications that were unhelpful for you in the past).

In the tables below, list which types of medication you are currently taking (including medication not related to your mental health). You/your supporter can seek advice from your doctor or other practitioner if you are unsure about your medication and dosage.

Current medication (List all medications for all health problems)	
Name of medication	**Dosage (mg)**

Medication preferences and allergies

In the table below, write down your medication preferences and any allergies to particular medications for everyone to be aware of.

<table>
<tr><th colspan="2">Any medication you would prefer to take in a crisis</th></tr>
<tr><th>Type of medication</th><th>Reasons I would prefer to take it</th></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><th colspan="2">Medications you will NOT take</th></tr>
<tr><th>Type of medication</th><th>Reasons I would prefer to take it</th></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><th colspan="2">Medications you are ALLERGIC to</th></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2"></td></tr>
</table>

Where I would like to be when I am in crisis

When you are experiencing a crisis, it may be helpful to stay where help and support is available from family, friends, supporters or mental health and other practitioners until you feel well again, instead of staying by yourself. In the boxes below, list your preferences for where you would like to be when experiencing a crisis. Examples are: stay with my parents, admission to hospital, stay at home with a home treatment support team (e.g. mobile crisis unit, if available in the community), going to a respite house, staying at home with visits to outpatient services.

First preference
Second preference (if first preference is not possible)
Third preference (if second preference is not possible)

Sometimes you may want to go to a specific hospital or an acute setting on a voluntary basis. However, there may be other places where you do not want to go. It is important to remember that this choice may not always be available.

I PREFER to go to	
Name of hospital/ward/service	**Why I would prefer to go there**
I prefer NOT to go to	
Name of hospital/ward/service	**Why I would prefer to go there**

Special needs

On this page, list all your special and personal needs that it is important for other people to know about.

Health conditions
Religious or cultural needs
Food and dietary needs (including food allergies)
Things I want to have with me if I am admitted to the hospital (e.g. my spectacles, telephone)
Things I dislike
Other things people should know about me
Other special needs

Actions and situations that could worsen a crisis

Sometimes specific actions by others may worsen a situation when people are already experiencing emotional distress.

Some examples may include:

- Feeling like I am not being listened to
- Lack of privacy
- Being stared at
- Loud noises
- Room checks.

In the box below, list some of these actions or situations that your (mental) health workers and other supporters (e.g. family, friends) should be aware of in order to best help you to avoid these situations, or to help you when they occur.

Things I would like people to be mindful of

If I am in danger

Sometimes during crises people can act in ways that can be harmful to themselves. It is therefore useful to include in your plan actions that others could take to support you during such moments. In the box below write what you would like your supporters to do or not do during at these moments.

If I am doing dangerous things, I would like my supporters to
If I am doing dangerous things, I DO NOT WANT my supporters to

Remember to:

1. Make sure your supporters and mental health or other practitioners and other supporters (such as family, friends) have a copy of this Advanced Planning document so that they know it exists and what it says.
2. Keep a copy of this document for yourself so that, if you are experiencing a crisis, you can show it to people who you see.

About my plan

I developed this plan on (date):

With the help of (list who helped you to develop your plan – if there was anyone):

Any plan with a more recent date on it replaces this one.

Signed (your signature): **Date**:

Witnessed by:

Name **Signature:** **Date:**

Part 5: Plan for after a crisis

Continuing your journey after a crisis

Continuing your journey after a crisis can be hard. It is always difficult to restart things that you have not done for a while. It can take some time for these challenges to disappear completely. Your confidence may have been shaken by your crisis. Because of your crisis you may not have seen people who are important to you for some time; you may feel that you have upset some of your friends, relatives and others who you care about, or you may feel very thankful for the support others have provided while you were in crisis.

Whether you were in hospital or at home during your crisis , it is sensible to start thinking about your plan for continuing your journey after the crisis as soon as you are able to.

You do not have to be feeling fully well to start taking back responsibility for doing some of the things that you enjoy and that are important to you. Although it may not always be easy, starting to get back into your usual routines can make you feel better and can help you to move forward in your recovery. Many people find it helpful to go back to a routine gradually.

For instance:

- Start off by seeing a few close friends at home and build up to going out with a wider circle of people.
- Begin going back to work by meeting up with your manager or workmates. Plan a gradual return to work and then build up your hours and duties over a period of time.

About this document section “Part 5. Plan for after a crisis”

Whether you are home, at someone’s else’s place or in hospital during a crisis, it is helpful to have a plan for how to get back to your daily life and maintain wellness. This part of the recovery plan is all about planning for the few days and weeks just after a mental health crisis so that you can continue your recovery journey.

This might be the first part of your recovery plan that you fill in if, for instance, you are just recovering from a crisis and have not yet done the other parts – this is perfectly fine.

Preparations for going home

(Fill in points 1 and 2 below only if you have been staying somewhere other than your home)

Name two people who could support you to settle back in your home and life.

First choice
Name:
Contact information:

Second choice
Name:
Contact information:

I would like the following person(s) to stay with me when I return home or to help me settle in when I return home:

First choice
Name:
Contact information:

Second choice
Name:
Contact information:

Things I need to sort out

After a crisis, you may want to think about whether there are challenges that arose during the crisis, such as financial difficulties or medical problems that need to be resolved.

In each case it may be sensible to think about the things you need to sort out as soon as possible and deal with things that can wait until you are feeling stronger.

It can also be useful to give some thought to when you will do each thing, how you will do it and whether you want anyone to support you (e.g. receiving advice for financial difficulties; obtaining emotional support from friends or family as you sort out problems; finding transportation to certain places, etc.). You can make plans for these in the table below.

What I need to do	What help I will need	Which supporter I will need to contact	When I need to do it

Establishing a routine

Getting into a regular routine as soon as possible can help you to enjoy your life again, and many routines may be quite simple. For instance:

- Getting up by a certain time and going to bed by a certain time
- Preparing and eating three healthy meals a day
- Going for a walk or taking some exercise.

Things to do EVERY DAY to help me enjoy my life after a crisis			
Things to do	When I will do them		
	Morning	Afternoon	Evening
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Things to do on SOME DAYS a week to enjoy my life after a crisis (and which days I will do them on)							
Things to do	Days I will do them on						
	Mon	Tue	Wed	Thu	Fri	Sat	Sun
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

It can also be helpful to think about things you should avoid in order to help you remain well. These might be things like:

- Getting over-tired
- Sitting around doing nothing
- Drinking too much alcohol or taking illicit drugs
- Meeting certain people you don't get along with.

Things to avoid while I am recovering from my crisis

My timetable

Some people find it helpful to draw up a weekly timetable to get themselves back into a routine and gradually add more items to it as they feel up to it.

1. The first timetable on the following page is for the first week after you had a crisis. You may specifically plan day by day and gradually build your schedule throughout the week.
2. The second timetable on the following page_is for the time following the first week after a crisis as you stabilize your life and return to the daily and weekly routines and activities that you planned in “Part 2. My wellness plan” of this document.

Use these timetables to schedule activities to keep well:

Timetable for my first week after a crisis

	Day I	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Morning							
Afternoon							
Evening							

My weekly timetable for stabilizing my life

	Day I	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Morning							
Afternoon							
Evening							

What I have learned from my crisis

Experiencing a crisis is a learning opportunity. After you went through a crisis, you may have learned new things about yourself, as well as new coping skills.

You can make changes to your recovery plan, as well as the Advance Planning part of the plan, to reflect the changes. You can also delete things you have previously written in the recovery plan if they are no longer meaningful to you.

What I have learned from my crisis

Section	Changes I want to make
My goals (Part 1)	
My wellness plan (Part 2)	
My sensitivities (Part 3)	
My signs of distress (Part 3)	
Plan for responding to a crisis (Part 4)	

References

1. Rights and recovery in mental health. SRN Briefing Paper. Glasgow: Scottish Recovery Network (SRN); 2015. (https://scottishrecovery.net/wp-content/uploads/2015/06/srn_connectingrandr_oct15.pdf, accessed 18 January 2019).
2. Quote by Pat Deegan. Excerpt from The 10 Essential Shared Capabilities for Mental Health Practice: learning materials (page 21). Edinburgh: NHS Education for Scotland (NES); 2011. (http://www.nes.scot.nhs.uk/media/351385/10_essential_shared_capabilities_2011.pdf, accessed 26 February 2017).
3. Mental Health Commission. Blueprint for Mental Health Services in New Zealand: how things need to be. Wellington: Mental Health Commission; 1998. (http://www.moh.govt.nz/notebook/nbbooks.nsf/0/0E6493ACAC236A394C25678D000BEC3C/%24file/Blueprint_for_mental_health_services.pdf, accessed 18 January 2019).

The World Health Organization’s QualityRights *Person-centred recovery planning for mental health and well-being self-help tool* guides people through the process of setting up a recovery plan for themselves.

The tool has been designed so that people can use it on their own or in collaboration with others. For example it can be used as a framework for dialogue and discussion between people using services and service providers or other supporters.

The self-help tool starts by introducing what recovery is and what it means for people in their lives. The tool then takes people through an exercise of identifying their dreams and goals, how to create a wellness plan as well as planning ahead for difficult time or crises during their recovery journey.

People using this self-help tool will be taken through a series of self-reflective exercises that encourage an understanding of self, and how to draw on their network of support.

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World Health Organization