2025

Reflections on Recovery

Lessons from piloting a mental health recovery-oriented practice model in Sri Lanka

The Asia Foundation
Improving Lives, Expanding Opportunities

the lotus circle

Authors (in alphabetical order): Kanthi Hettigoda, Kaushi Jayawardena, Mahesan Ganesan, Niluka Wickremesinghe, Omella Outschoorn, Rehan Meemaduma, and Roshan Dhammapala

Illustrations: Nirasha Herath
Design: Kaushi Jayawardena

Foreword

Mental health recovery is not a journey taken alone—it requires the support of communities, meaningful opportunities, and systemic change. This publication documents an initiative that sought to bridge the gap between theory and practice in adopting recovery-oriented practices in Sri Lanka.

By bringing together persons in recovery, their families, mental health service providers, community organizations, and advocates, the project explored ways to foster personal recovery, economic independence, and social inclusion.

Through reflections, real-life experiences, feedback, and key learnings, this book highlights the power of small, intentional actions in transforming lives. Structured to mirror the phases of the project, the chapters offer insights into the processes, challenges, encouraging shifts, and the impact of facilitating recovery-oriented practices. It serves as both a record of the work done and a potential resource for those committed to strengthening mental health support in Sri Lanka and beyond. Whether you are a practitioner, policymaker, advocate, or community member, we hope these stories and lessons inspire you to play your part in creating a more inclusive society where individuals can experience living well.

Acknowledgements

This project would not have been possible without the invaluable support, guidance, and contributions of numerous individuals and organizations.

We extend our deepest gratitude to the staff at the Psychiatric Ward in the Kandy National Hospital, including Dr. Gihan Abeywardana, Dr. Jayantha Herath, Dr. Himali Priyadarshika Jayasekara, and all the personnel who provided support throughout this project. We are particularly grateful to the Psychiatric Social Workers, Nalaka Ekanayaka, Lasanthika Thilakarathna, Lathika Ekanayake, and Wasantha Athukorala, who took up the task of supporting patients with the income generation grants component of the project. Our sincere thanks go to the Ethics Review Committee at the Kandy National Hospital for their rigorous review and approval, ensuring the exploratory qualitative study completed at the beginning of this project adhered to the highest ethical standards.

We would like to acknowledge the contributions of We For Rights and the Gampola Udapalath Prajashakthhi Development Foundation for their collaboration and their commitment to being changemakers within their communities.

We are also profoundly appreciative of our technical consultants, Dr. Mahesan Ganesan, Roshan Dhammapala, Dr. Kanthi Hettigoda, Niluka Wickremesinghe, Omella Outschoorn, Rehan Meemaduma, Husna Shiraz and Kaushi Jayawardena who shaped and steered this work and contributed to the successful completion and publication of this work.

A special note of gratitude goes to The Lotus Circle for its steadfast support of mental health initiatives in Sri Lanka. As a dynamic network of committed individuals and organizations, The Lotus Circle has played a vital role in advancing women's empowerment by strengthening economic, social, and political rights and opportunities for women and girls. Its support was fundamental to the success of this project, helping to bridge critical gaps in recovery-oriented mental health practices.

Finally, we extend our sincere appreciation to Dinesha de Silva Wikramanayake, former Country Representative of The Asia Foundation, and Johann Rebert, the current Country Representative, for their continued support of mental health initiatives in Sri Lanka.

Table of Contents

Chapter 1

Introduction

Contributed by Kaushi Jayawardena

How Did This Pilot Initiative Begin?

This project was initiated in response to an interest expressed by the consulting psychiatrist at the Kandy National Hospital, coinciding with the conclusion of a livelihood grant project implemented by The Asia Foundation's Mental Health and Psychosocial Support Services (MHPSS) Unit and consultants at the National Institute of Mental Health. Findings from the livelihood project highlighted the need for more comprehensive support systems for persons with lived experiences (PLEs). Beyond financial assistance, effective income generation programs required sustained engagement, targeted training beyond entrepreneurial skills, and the involvement of key stakeholders—including families, hospital staff, and external resource people.

Discussions with the staff of the Kandy National Hospital's Psychiatry Unit staff, informed by insights from the MHPSS unit, revealed a broader need: a shift toward recovery-oriented practices that address not just economic stability but also personal empowerment, social reintegration, and long-term well-being. These conversations led to the development of a more holistic model of care for individuals using a recovery approach, shaping the foundations of this project.

Our Team and Our Partners

This project was collaboratively designed and implemented by a multidisciplinary team, including psychiatrists experienced in tertiary care, psychologists, child and adolescent specialists, clinical psychologists, psychiatric social workers, nursing officers, support staff, members of two community-based organizations, Gampola Udapalath Prajashakthi Development Foundation and We For Rights, and psychosocial support practitioners. The team brought together expertise from both hospital and community services, including our project management team. For further details on team members and their contributions, refer to the section at the end of this book.

Chapter 1

Why Was This Relevant to Sri Lanka?

Mental health challenges in Sri Lanka have been increasing at an alarming rate (Alwis et al., 2024; Deivanayagam et al., 2024), with readmission rates as high as 74 percent within the first three months of discharge from inpatient wards (Abesekara & Nettasinghe, 2020). These trends highlight the urgent need for significant changes in treatment and response strategies.

Traditionally, mental health treatment has predominantly followed a biomedical model, focusing on symptom management, distress alleviation, risk reduction, and relapse prevention. However, growing voices from individuals with lived experience have shifted attention toward personal recovery—a concept that prioritizes living a meaningful life, assuming valued roles, and contributing to the community, while learning to manage their mental health challenges (Jacob, 2015; Bredski et al, 2015; Klevan et al., 2021).

This shift has introduced new priorities for mental health service providers, emphasizing the need to support individuals in setting their own goals and taking responsibility for their lives (Guerrero et al., 2024). Recovery is now understood as a complex and dynamic process influenced by personal, social, and structural factors, including family, community, culture, socio-economic status, and history. As a result, the support needed for recovery must also be adaptable and holistic.

> Global research suggests that integrating recovery-oriented practices (ROPs) into mental health services can enhance biomedical approaches by fostering self-empowerment and long-term well-being. These practices help individuals build on their inherent strengths, support families in understanding both the challenges and opportunities of mental health recovery, and create pathways for meaningful reintegration into society. While ROPs have begun to enter the mental health discourse in Asia, research suggests that the concept of personal recovery remains diverse and in its early stages, requiring further exploration (Keuk et al., 2023).

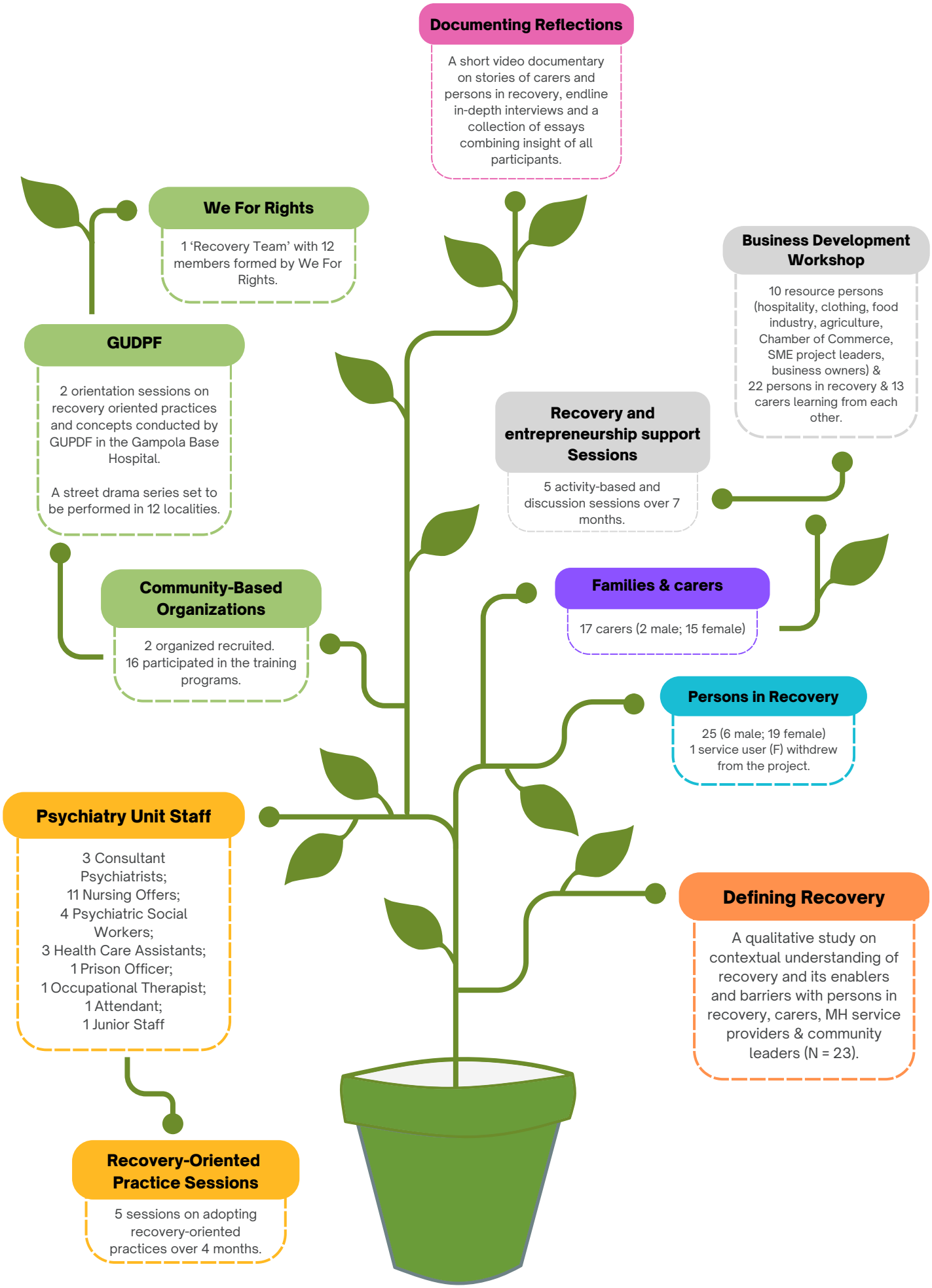
Chapter 1

A Contextually Relevant Holistic Recovery Model for Sri Lanka

This initiative was therefore designed to pilot a model of care incorporating recovery-oriented practices within a tertiary mental healthcare facility with both hospital and community partners, exploring their potential to improve health outcomes for individuals, families, and communities.

Its core components were informed by the work of Helen Glover, a social worker with lived experience of mental health challenges and long-term hospitalization. Glover (2012) identified five key recovery processes that transform individuals' experiences: moving from a passive to an active sense of self, hopelessness to hope, external control to self-control, alienation to self-discovery, and disconnectedness to connectedness. These principles provide a strong foundation for service users to become active partners in their treatment and recovery process.

- Understand and document local perspectives on recovery, including barriers, enablers, and support needs.
- Design and pilot a model that enables mental health service providers to adopt and implement recovery-oriented practices.
- Integrating recovery-oriented practices into hospital-based mental healthcare
- Support Persons with Lived Experience to work towards financial stability and independence through income generation opportunities.
- Equip Community-Based Organizations to understand and integrate recovery-oriented practices, provide early intervention, and facilitate community reintegration for individuals recovering from mental health challenges.
- Enable service users and their families to discover the value of reclaiming their valued social roles and competencies as a component of their recovery from mental illness.


Documenting Reflections
A short video documentary on stories of carers and persons in recovery, endline in-depth interviews and a collection of essays combining insight of all participants.
We For Rights
1 'Recovery Team' with 12 members formed by We For Rights.
GUDPF
2 orientation sessions on recovery oriented practices and concepts conducted by GUPDF in the Gampola Base Hospital.
A street drama series set to be performed in 12 localities.
Business Development Workshop
10 resource persons (hospitality, clothing, food industry, agriculture, Chamber of Commerce, SME project leaders, business owners) & 22 persons in recovery & 13 carers learning from each other.
Recovery and entrepreneurship support Sessions
5 activity-based and discussion sessions over 7 months.
Community-Based Organizations
2 organized recruited.
16 participated in the training programs.
Families & carers
17 carers (2 male; 15 female)
Persons in Recovery
25 (6 male; 19 female)
1 service user (F) withdrew from the project.
Psychiatry Unit Staff
3 Consultant Psychiatrists;
11 Nursing Offers;
4 Psychiatric Social Workers;
3 Health Care Assistants;
1 Prison Officer;
1 Occupational Therapist;
1 Attendant;
1 Junior Staff
Defining Recovery
A qualitative study on contextual understanding of recovery and its enablers and barriers with persons in recovery, carers, MH service providers & community leaders (N = 23).
Recovery-Oriented Practice Sessions
5 sessions on adopting recovery-oriented practices over 4 months.

Chapter 1

Key Components

October - November 2023

Desk Review

The project began with a desk review of global and local literature to examine definitions of recovery, relevant frameworks, key stakeholders, barriers, and enablers, as well as existing mechanisms that facilitate recovery.

December - February 2024

Qualitative Research Study

This was conducted to document perceptions of recovery, support needs, and challenges in the Sri Lankan context.
Approved by the Ethics Review Committee of the Kandy National Hospital (KNH), this study used key informant interviews and thematic analysis, engaging 23 individuals—including PLEs (5), their carers (5), mental health professionals (11), and key community figures (2) working closely with the hospital.

March - June 2024

Training for Service Providers

Based on these insights, a pilot model was developed to involve key stakeholders in the recovery process and provide income generation support to selected PLEs at the KNH psychiatry ward. Implementation began with training sessions for KNH staff on integrating recovery-oriented practices. (See Chapter 2 for more details)

May - June 2024

Service User Selection

A **Client Intake Form** was created to help psychiatric social workers assess service users' needs, including housing, family income, and interest in income-generation activities. It balanced assessing vulnerabilities with the individual's capacity to engage in these activities and available support systems. An external consultant reviewed applications and selected 24 clients for income generation grants, which were disbursed in full or in installments based on each enterprise's needs (See Chapter 4 for more details).

Chapter 1

Key Components

July 2024

Training for Community-Based Organizations

Orientation and training was provided to two Community-Based Organizations, equipping them with knowledge on recovery-oriented practices, early intervention, and referral support.
These organizations then developed and implemented community-based mental health initiatives with the support of the technical team (See Chapter 3 for details).

July - December 2024

Support Sessions for Service Users & Carers

Service users (25) and their carers (17) participated in training on entrepreneurial skills, received individualized feedback from external experts in small and medium enterprises, and engaged in self-exploration sessions covering personal strengths, identity beyond illness, the five recovery processes, and emotional well-being. Families and caregivers were provided dedicated support spaces to share their experiences, challenges, and successes (See Chapters 4 and 5).

March 2025

Business Development Workshop

Service users and carers were invited to a hospital event where they had the opportunity to showcase their products in small groups and seek guidance on expanding their businesses. The event was attended by 10 small and medium-sized business owners, entrepreneurs, and other professionals who shared their own experiences of growth and challenges, offering valuable insights and support to the participants.

March 2025

Closing Out the Project

A final event was held at the hospital to review project learnings, attended by the hospital director, Psychiatry Unit service providers, persons in recovery, carers, and community organizations. The program featured panel discussions, service user testimonies, and a short documentary showcasing the project's impact in the lives of individual participants.

Documenting the Journey: Reflections on Recovery

This project was an 18-months long collaborative effort involving the implementation team, hospital staff, staff from the community-based organizations, PLEs, and their carers. This publication captures their collective reflections and key learnings. The chapters follow the sequence in which the different phases of the project unfolded, reflecting its natural progression.

Rather than providing an exhaustive description, each chapter focuses on essential aspects of the project, structured as follows:

- What did we do?
- Why did we take this approach?
- What did we observe?
- What did we learn?
- Guiding questions to help practitioners, PLEs, and project teams reflect on adopting recovery-oriented practices (Recovery-oriented care approaches need to be owned and driven by the community and the effort must not rest on the “implementer”. Hence the questions are phrased in a consultative manner as opposed to implying that one entity or an “I” is making all the decisions about the program design).

Through this structure, the publication aims to offer practical insights and encourage meaningful discussions on recovery-oriented holistic care. It serves as both a reflection on the project’s journey and a resource for those looking to implement similar approaches in their own contexts.

Please note that the terms "Persons in Recovery," "People with Lived Experiences," and "Service Users" have been used interchangeably depending on the context.

Helping service users feel a sense of dignity and autonomy by seeking information about health conditions, challenges, or changes directly from service users, rather than relying on family members or carers.

Chapter 2

Mental Health Service Providers

Contributed by Mahesan Ganesan & Kaushi Jayawardena

When it comes to recovering from mental health challenges, service providers play a limited but crucial role—often at a critical moment. Imagine a person experiencing an acute mental health crisis. The first and most significant individuals they encounter, aside from their family members, are healthcare providers. For many, this crisis also becomes their very first encounter with the entire mental healthcare system. Therefore, the response, mannerisms, and approach of mental healthcare providers and all support staff can have a profound impact on every aspect of the person's journey from that moment onwards.

Some service providers may assume that people having an active episode of mental illness have "lost touch with reality" or "lack insight" and, therefore, the way they are treated during this period carries less consequence. However, people recovering from mental health challenges often remember and recall these experiences afterward, and if they are treated in a dehumanizing way—tied up, spoken to harshly, or subjected to forced treatment—their distress is compounded by fear, anger, shame, and self-stigma.

An individual may then struggle with the reactions of others, a diminished sense of self, and reduced confidence in their ability to recover. Their focus may shift from recovery to repairing the harm caused. They may even refuse to cooperate with treatment leading to poor health outcomes. These experiences can lead to lifelong challenges, including altered self-perceptions and the internalization of an identity centered around being "ill."

Chapter 2

Mental Health Service Providers

Who are the Mental Health Service Providers we worked with?

- Counselors based in the divisional secretariat office (for exploratory research).
- Consultants and attending psychiatrists in the tertiary hospital psychiatry ward.
- All nursing officers and matrons in the ward.
- Support staff from the psychiatry ward.
- Psychiatric Social Workers attached to the ward.

What did we do?

- Brainstorming meetings with the leadership of the psychiatry ward to understand the needs and challenges.
- An orientation session with the service providers in the tertiary care setting to discuss the overall concept, process, and experiences of implementing components of holistic recovery at the National Institute of Mental Health (NIMH) in 2022.
- Interactive and discussion-based learning sessions for all staff (consultant psychiatrists, registrars, nursing officers, psychiatric social workers, and support staff) focusing on the following topics;
    - Introduction to the broader concept of recovery: origins of the recovery movement, how it diverges from the biomedical model, consumer definitions of recovery, risks, and dilemmas, and important components of recovery with context-based examples from implementation in Sri Lanka (online). Please refer to the Summary of Training Notes for more details.
    - Support for the care provider: understanding burnout and personal indicators of stress, self-care planning (in-person).

Chapter 2

- Introduction to Glover's Recovery Model (2012): components of hope, connectedness, control, discovery, and an active sense of self, mapping of previous interventions implemented by the service providers previously that align with these components, factors that enable and hinder the process of recovery, and how can service providers support activating any of these components of recovery (in-person).
- Recovery-oriented practice: case study-based discussion, challenges in implementing, explaining the illness to a service user, push and pull factors that support a person's wellbeing during their stay at a hospital ward, modeling the ward to mirror daily lives at home to support re-integration and experiences from NIMH (online). Please see the Summary of Training Notes on the next page for an excerpt.
- Ongoing meetings and informal discussions with the staff and consultant psychiatrist while implementing the other components of the project.

Chapter 2

Summary of Training Notes: How Can We Navigate Challenges in Implementing Recovery-Oriented Practices?

Discussing mental health conditions and medication with service users.

Explaining illness to service users involves guiding them through their recovery journey with understanding and trust. The key reason many continue taking medication is the connection they develop with their practitioner, making relationship-building crucial to behavior change.

Additionally, every service user has a source of hope—a reason to recover, such as returning to education, caring for a child, or supporting a spouse. Identifying and nurturing this motivation plays a vital role in their healing process.

1. Once a service user shows signs of improvement with medication, they are asked about their awareness of their condition.

2. If they acknowledge it, the mental health challenge, symptoms, and effects of medication are explained, followed by discussions about their future goals and regular follow-ups.

3. If a service user refuses medication or discards it, the focus should be on building trust and making an effort to explore/understand the reasons for the refusal rather than criticism. It is important to help them understand its importance without coercion. Just as people often stop taking medicine for other illnesses once symptoms fade, service users with mental health conditions face an even greater challenge in adhering to long-term treatment, often without appreciation.

Note: This is not a prescriptive guide for all conversations with service users about illness and medication but rather a transcription of how this discussion took place within the training session of this project.

Chapter 2

Summary of Training Notes: Experiences shared by a psychiatrist in the technical team on implementing simple and practical changes based on recovery-oriented practices at the National Institute of Mental Health (NIMH).

The changes made at the NIMH emphasized the importance of modeling the ward environment after a home rather than a hospital, ensuring a smoother transition to daily life after discharge. Since mental health conditions do not impair physical ability, assuming incapacity can lead to unnecessary dependence and lethargy.

Service users were required to make their own beds rather than relying on support staff. While hospital regulations set standards, the focus was on giving service users responsibility. Service users prepared their own meals using rations from the main kitchen. Despite concerns about safety, allowing them to handle knives and fire fostered trust and built on their pre-hospital skills rather than disempowering them. They cleaned ward toilets, just as they would at home. They watched television in a shared common room alongside service users from both the male and female wards.

Unlike in many wards, the NIMH allows service users to keep their spectacles, despite concerns about potential harm. Restricting glasses can limit participation in activities and social interactions, ultimately hindering recovery.

At the hospital's Outpatient Department, tea was offered to service users and families—funded through in-kind donations—transforming the atmosphere. This simple gesture eased tensions, creating a calmer environment and fostering warmth between staff and service users. At the Mulleriyawa branch, service users took responsibility for their own medication, using a wooden box labeled with days and times. Open discussions between service users and practitioners about medication intake reinforced trust and shared decision-making, modeling the routine they will follow at home.

The National Institute of Mental Health, Sri Lanka is the only state hospital solely dedicated to the provision of tertiary care for persons living with mental health issues. It acts as a hospital, a research institution, and a hub for practitioners in the field of mental health to learn and engage in discourse.

Chapter 2

Why did we do what we did?

- A service user's experience in the ward is shaped by both **push and pull factors**—elements that either encourage them to stay and focus on recovery or make them want to leave. When service users are given the freedom to choose and the trust to manage their own responsibilities, they feel less need to "escape" and can engage more in their recovery. If a service user wants to leave, asking them why and addressing their concerns can prevent misunderstandings and improve their experience. Similarly, when service users can take care of themselves and contribute to household tasks, families may see them as less of a burden and become more open to discharge.

- On the other hand, an unpleasant hospital stay can create a negative cycle where service users dread returning, worsening their condition than before admission. Building empathetic connections and fostering a supportive environment are crucial in breaking this cycle.

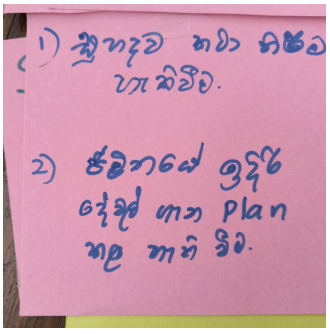
- Therefore, healthcare providers were recognized as essential contributors to the recovery process. As a result, fostering recovery-oriented, supportive behaviors among them became a key focus of this project.

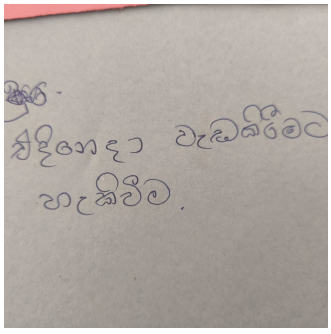
- Given the distance of the technical team from the pilot location and the demanding workloads and staff schedules, a more traditional training approach was adopted.
  - This involved designing 1.5-hour learning sessions held once a month.
  - Each session was delivered twice a day so that the staff could take turns participating while attending to their duties.
  - All sessions were audio recorded and shared with the staff who could not attend the session, alongside the slides and supplementary material.

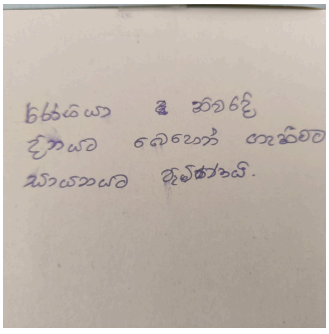
- Although more frequent in-situ observations and direct feedback during clinic hours, ward rounds, and general practitioner-PLE interactions might have enhanced the learning process, this approach was deemed less feasible, as it risked causing discomfort, defensiveness, or feelings of criticism among participants.

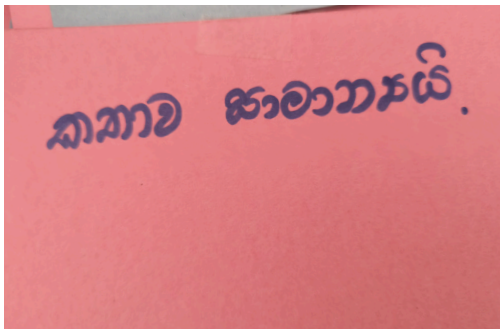
Chapter 2

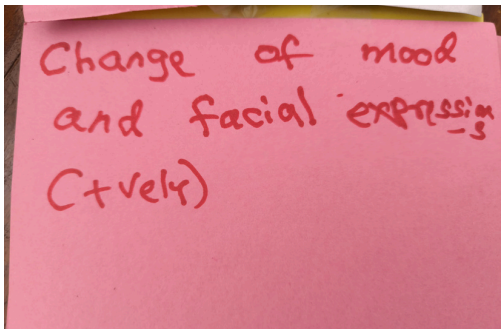
Indicators of Recovery Highlighted by Service Providers During Training Sessions

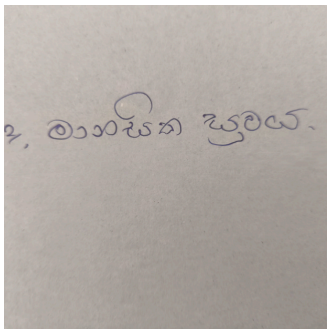


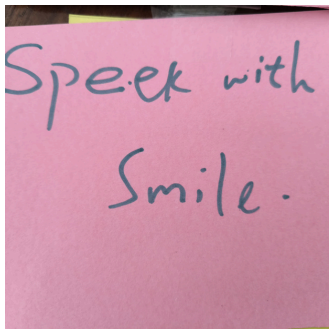


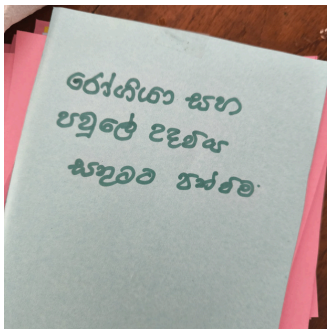


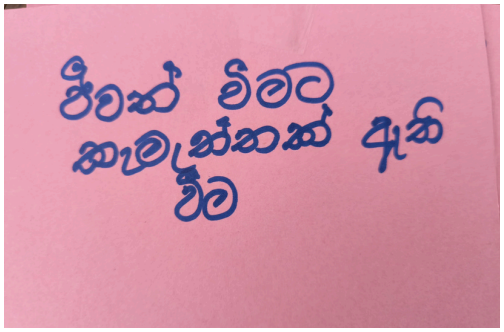


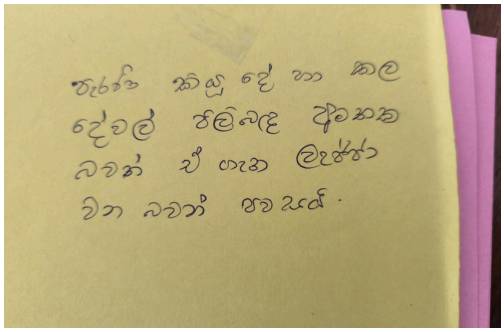












Chapter 2

What did we observe?

- Initially, some participants found it challenging to fully grasp the concepts presented. However, when practical examples of interventions that have been successfully implemented in other tertiary care hospitals to encourage autonomy, discovery, and connectedness were introduced, these ideas seemed to resonate more clearly with the group.

- The staff were also able to connect the work they had done to principles of recovery-oriented practices. They mentioned the below as examples during a discussion focused on things they felt had been helpful in their diverse roles.

01. Encouraging small changes

Encouraging a person struggling with alcohol abuse to set alcohol-free days at home each week, helping them rebuild trust with their family.

02. De-escalation through creating a sense of safety and support

Speaking kindly to a person who had been physically restrained upon admission due to aggression and offering them a meal, which helped them calm down.

03. Reducing medication and addressing root causes

Helping a 17-year-old gradually discontinue unnecessary high doses of antipsychotic medication and facilitating family therapy to repair their strained relationship with their mother, addressing the root cause of distress.

04. Providing critical information

Offering essential information about options related to rehabilitation, treatment options, and available support services, which prevented injury to both the PLE and the family.

05. Keeping confidences

Respecting the privacy of a neighbor receiving mental health support by not disclosing their situation even to their family, which encouraged them to continue treatment and maintain trust in the service.

06. Creating space for psychoeducation

Explaining the nature of the illness and medication to service users in a way they could understand, empowering them to manage their condition more effectively.

07. Instilling hope

Assisting a hospitalized child in sitting for important exams, preserving their hope for future employment and personal growth.

08. Support & motivate the caregiver

Actively listening to a caregiver's concerns, and providing them space to express their struggles, which helped them feel supported and motivated to bring the service user for regular treatment.

09. Making oneself available in case of a crisis

Offering a person struggling with mental health challenges the option to call when experiencing distressing thoughts, which prevented a fatal self-harm attempt.

- Participants were more open and comfortable to share their thoughts and experiences when they were among their peers.
- While the concepts of recovery were shared openly, it was noted that participants did not always engage in directly challenging the facilitators on the concept or its practicality. Such open challenges and discussions would have supported the learning process further and promoted active reflection.
- Some staff began incorporating the discussed concepts in small but meaningful ways. For instance, a nursing officer improved her relationship with a service user by remembering and acknowledging their birthday and by greeting them by name.

Chapter 2

What did we learn?

- Shifting from a provider-centered approach to one that places the service user at the center requires careful consideration, time, and engagement, as well as the support of additional resources within the healthcare system. While many healthcare providers are already exploring alternative care approaches, the absence of multidisciplinary teams—such as psychotherapists, counselors, psychosocial practitioners, and individuals with lived experience—can sometimes limit the full adoption of client-centered practices. Within this framework, the primary metrics of measuring success for medical practitioners then often become limited to 'medication and discharge' or readmission rates.

- The biomedical model has been instrumental in guiding care and fosters a structured environment where treatment plans are often determined by the medical team, with other staff ensuring medication adherence and service user safety. In this process, the medical team plays the most active and important role. While this supports relief from distress and reduction of symptoms, a question remains whether this truly enables long-term recovery through rebuilding a person's sense of autonomy, social connectedness, and lifelong learning. Transitioning to a more service user-centered approach may present an opportunity to reassess some of these dynamics in a way that enhances service user care without disrupting the valuable structures that are already in place.

- Such cultural and systemic shifts take time, sustained engagement, and the necessary infrastructure to support them. The question remains: How can individuals or organizations who are not part of the immediate medical team support them to make these changes in a way that fosters collaboration, respect, and engagement without causing discomfort or undermining the hard work of healthcare professionals?

- Service providers identified several barriers to implementing recovery-oriented practices. These include a cultural tendency to seek quick solutions through medication, the lack of insight persons experiencing an acute mental health crisis have during acute psychotic episodes, and the strict control exerted by family members, which helps them manage their caregiving role more easily. To overcome these challenges, service providers need support and opportunities to discuss and experiment with different approaches, enabling them to integrate recovery-oriented practices more effectively.

Guiding questions to support service providers and Persons with Lived Experiences reflect on adopting Recovery-Oriented approaches and practices.

- What can be done to transform the environment of the clinic or hospital ward to a safe space for the service users and families/carers? How can these changes be driven by the service users?
- How can all practitioners and personnel, at all times, convey an attitude of respect for the person and a desire for an equal partnership?
- How can the service users and families/carers be given enough information to make informed decisions?
- How can the service user be supported as much as possible to discuss difficult choices they may have to make?
- How can the service user and families/caregivers be included in regularly assessing recovery outcomes to improve treatment and recovery goals?
- How can service users be proactively linked to other services and support systems that will facilitate their process of recovery?
- How can the families and carers be proactively linked to other services and support systems that will assist them in their caring role?
- How can practitioners and other personnel request and utilize feedback to improve service delivery?
- What steps could be taken to embed recovery-oriented practices across the whole service system?

Guiding questions to help you support other hospital and clinical mental health service providers in adopting Recovery-Oriented approaches.

- Who are the key service providers involved in the recovery process?
- What changes need to be made to ensure that these service providers are actively engaged in every aspect of the recovery process—not just treatment?
- How can all medical and support staff—beyond psychiatric social workers, if it is at a tertiary hospital setting— be supported to actively engage in income generation components, ensuring full collaboration in encouraging service users' recovery?
- What will help service providers support service users to engage in meaningful income-generation activities based on personal strengths and interests?
- How can an external party to this context gain greater buy-in and conviction from healthcare providers within the system about the value and impact of service user-centered recovery processes?
- How can implementation teams spend enough time with clinical and hospital staff to align everyone on the implementation of recovery-oriented practice components?
  - Can 3 to 4 months be dedicated to building relationships and establishing trust?
  - What strategies can be used to enable healthcare providers to reflect on and fully understand the concept of recovery and its practical implications before they decide to shift from a biomedical to a service user-centered model?
  - How can a safe space be created for service providers to discuss changes in established systems and power dynamics resulting from this shift, without feeling defensive or confronted?

Guiding questions to help you support other hospital and clinical mental health service providers in adopting Recovery-Oriented approaches.

- How can small, impactful changes that can make a big difference be facilitated and supported? For example:
    - Implementing “protected time” for staff in residential wards so that they can spend casual time with service users.
    - Acknowledging and thanking families for their care, visits, and support in residential wards.
    - Calling service users by their name and greeting them warmly. Remembering their birthdays, their hobbies, or other personal details.
    - Praising service users for changes and improvements.
    - Allowing service users to choose their own clothes and wear spectacles if needed in residential wards.
    - Inquiring directly with service users about their sleep, medication adherence, and symptoms, rather than relying solely on carer feedback.
    - Asking service users for permission before discussing their mental health with their family members.
    - Involving service users in decisions about changing, increasing, or decreasing their medication.

These small changes can foster a more service-user-centered environment and contribute to a more respectful and empowering recovery process.

Guiding questions to help you support other hospital and clinical mental health service providers in adopting Recovery-Oriented approaches.

- Are there resources to facilitate learning sessions outside the hospital / clinical setting to minimize disruptions and foster more sustained engagement?

- Is it possible to train healthcare professionals on the recovery model in a way that enables Master Trainers within the healthcare system to provide in-situ observations and feedback for early-career service providers?

Most importantly:

- How can the voices and feedback of people with lived experience play a more central role in this process?

> **A member of the technical team reflected on a pivotal moment early in his career**
>
> I remember attending a conference in Geneva organized by the World Health Organization. There were about 15 mental healthcare providers and 15 individuals with lived experiences of being hospitalized for an acute mental health condition. For the first day or two, we simply listened to the PLEs share their stories. They cried — describing what it was like to undergo electroconvulsive therapy, the side effects, and the experience of being tied and being treated as less than human. They spoke about the lack of explanations or information given to them.
> To hear it directly from them - it was such a powerful experience.
>
> Dr. M. Ganesan

Some reflective questions are adapted from the Australian National Framework for recovery-oriented mental health services (2013) while the others are reflections of the implementation team.

Creating safe community spaces equipped with foundational knowledge, where people can come together to learn about and support the recovery of individuals in their community.

Chapter 3

Engaging the Community

Contributed by Rehan Meemaduma

Community involvement is crucial in supporting individuals with mental health issues, helping them regain agency, self-efficacy, and a sense of belonging, which aids recovery and reduces symptom exacerbation.

Empirical evidence shows that community-based interventions enhance social inclusion while addressing both clinical and psychosocial needs (Jordan et al., 2018). Although Sri Lanka's centralized mental health care system, which traditionally follows a biomedical approach, has introduced community and rehabilitation services, these remain extensions of hospital care, where individuals are still defined by their illness.

Chapter 3

Engaging the Community

Contributed by Rehan Meemaduma

Post-discharge, the lack of social care and reintegration structures leaves psychosocial aspects of recovery unmet, contributing to higher readmission rates. This underscores the need for decentralized, community-based care models that expand the reach and impact of recovery-oriented interventions, particularly in resource-constrained settings (World Health Organization, 2022).

This project, therefore, explored how individuals and groups within communities can actively support recovery by fostering a socio-ecological approach, piloting an initiative that helps individuals shift away from an illness identity to assume meaningful social roles while receiving community support and acceptance.

Chapter 3

Engaging the Community

What did we do? Why did we do it?

- To ensure broad community engagement, inclusivity, and long-term impact, the project partnered with two community-based organizations: Gampola Udapalatha Prajashakthi Development Foundation (GUPDF) and We For Rights (WFR).

- The partner organizations were shortlisted based on their interest in learning about mental health and responding to psychosocial needs in their communities, the organization's close engagement with the community, and compatibility with project objectives.

  - GUPDF has a focus on supporting women and girls affected by gender-based violence, many of whom face socio-economic hardships.
  - WFR, a consumer-led organization, focuses on working with individuals living with physical and mental impairments and issues.

- Both organizations worked with groups of people who are vulnerable to mental health and psychosocial challenges (with unique recovery needs influenced by their marginalized contexts), but also engaged with the broader population to ensure the groups they worked with were not further marginalized.

- Furthermore, both organizations also had close ties with the local hospitals and other key actors who could support them - this would later become an important element in sustaining the work beyond the project period. By collaborating with these organizations, the project sought to reach communities that are usually underserved and include diverse MHPSS needs of marginalized populations.

Chapter 3

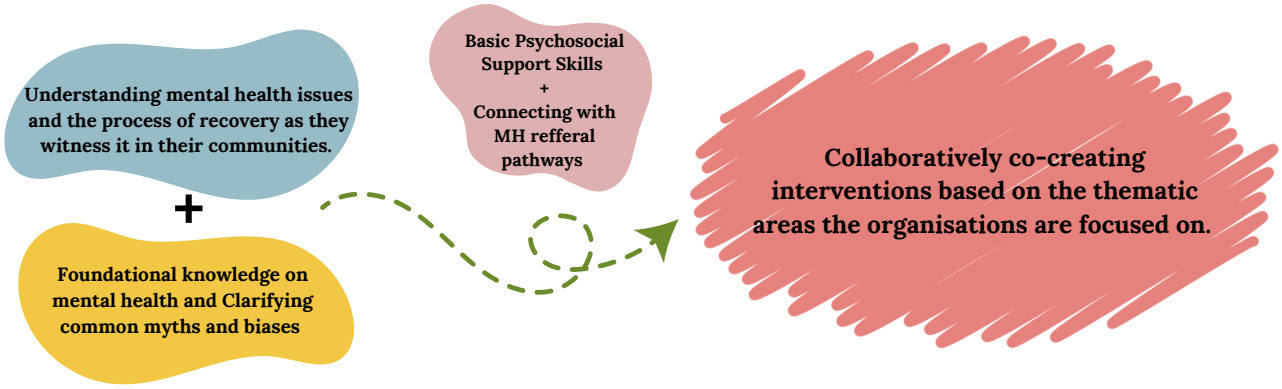
Orientation Program and Co-Designing Interventions

The initiative commenced with a two-day orientation and training program on mental health and recovery, designed to support community organizations in integrating recovery-oriented principles into their work and promoting mental health awareness.

This pilot program aimed to equip participants with both foundational knowledge—such as understanding mental health issues and recovery, how these manifest in community contexts, their root causes and prevalence, and the facts and stigma surrounding mental health issues—and practical tools, including identifying and responding to individuals living with mental health issues, connecting with mental health professionals in their localities, and understanding and utilizing referral pathways.

> During the sessions:
>
> - Participants reflected on their experiences observing and responding to mental health issues in their communities. The opening activity created space for them to share, make sense of what they had heard or seen, and demystify misconceptions about mental health. Given that both organizations had extensive experience in their contexts, understanding these perspectives was key to designing effective interventions.
>
> - This was followed by a conversation on the circumstances that contribute to mental health challenges, focusing on changes in thoughts, feelings, and behaviors.
>
> - The components of recovery, based on the Recovery Star Model by Glover (2012), were introduced, emphasizing key elements such as hope, agency, and social connectedness. Additionally, discussions explored the importance of inclusivity, its inherent challenges, and actionable strategies for fostering meaningful participation across diverse groups.

Chapter 3



Following the orientation, the organizations participated in a co-design process facilitated by our resource team. Together, they conceptualized strategies to integrate recovery-oriented principles into their community initiatives, aligning these with their unique contexts and populations.

The goal was to ensure that these organizations were not only equipped with knowledge but also had the practical tools necessary to engage with and include people living with mental health problems in their current initiatives.

After reaching an initial consensus on the plans, each organization was given a week to refine their ideas into detailed concept notes. These drafts were submitted to the technical team for review and feedback, ensuring the interventions were both practical and impactful.

This collaborative approach empowered the organizations to tailor recovery-oriented activities that addressed specific mental health needs in their communities.

Chapter 3

The Gampola Udapalath Prajashakthi Development Foundation Intervention

Gampola Udapalath Prajashakthi Development Foundation leveraged its existing network of women leaders across 25 villages in the Kandy district, who served as focal points for women's self-help groups, capacitating them on mental health and recovery-oriented care perspectives, thereby enhancing their role as focal points.

They also included youth leaders in the programs —a long-standing organizational goal, to enhance community awareness and capacity.

GUPDF, in collaboration with the Gampola Base Hospital (teaching) and our resource team, conducted two orientation sessions on mental health, recovery concepts, and basic psychosocial support skills for first responders, encouraging participants to reflect on local perceptions of mental health and addressing misconceptions.

GUPDF facilitated referral networks to specialist mental health support by strengthening its collaboration with the Gampola Base Hospital (teaching) and district counselors. To further embed learning and spark dialogue, the organization designed a series of street dramas encapsulating the learnings from the training programs. They are set to be performed across 20 localities, creatively conveying key mental health and recovery themes. Each performance will be followed by a structured discussion, allowing audiences to reflect on the issues presented, with opportunities for one-on-one conversations and referrals for those seeking further support.

Chapter 3

The We For Rights Intervention

We For Rights integrated mental health, recovery-oriented care, and psychosocial issues into its disability rights work by forming a "Recovery Team" of 12 members with diverse disabilities, acknowledging that disability often compounds existing psychosocial challenges.

Engaging persons with lived experience was crucial to address the psychosocial needs of individuals with disabilities.

The team participated in four rounds of training and networking sessions led by psychiatrists and resource persons specializing in community development and disability studies, focusing on psychosocial issues, support strategies, mental health services, and referral pathways.

After receiving basic psychosocial support training, the WFR team visited mental health clinics and rehabilitation centers, followed by an assessment of their learnings under a psychiatrist's supervision. The networking events with hospital social workers, community-based psychosocial counselors, local NGO representatives, and community policing officials, strengthened their referral network as recovery-oriented care requires a multi-sectoral approach to address the diverse recovery needs of individuals and families.

Chapter 3

What did we observe and learn?

Participation in the program yielded significant insights into the integration of recovery-oriented care within community settings;

- **Recovery-oriented care is built on values such as agency and active participation of the person in recovery**, which must be intentionally facilitated by those around them. These values are crucial and must be considered when selecting state or non-state partners—whether for awareness programs or referrals to directly support individuals and families.

- **Organizations and community groups often need time to fully grasp mental health concepts**, especially when participants have limited prior exposure to this field. Open discussions about their perceptions and experiences help address misconceptions, demystify mental health, and create a stronger foundation for implementing recovery-oriented practices. Establishing ongoing feedback mechanisms and maintaining consistent engagement with community-based organizations are essential for reinforcing these learnings, ensuring long-term adaptability, and fostering sustainable, community-driven interventions.

- Both organizations recognized the relevance of mental health within their thematic focus areas and demonstrated a willingness to embed it meaningfully into their ongoing activities. This reflected **an enhanced awareness of how mental health intersects with their core missions, such as women's rights, entrepreneurship, and disability rights.**

Participants developed a deeper understanding of mental health, including:

- How misconceptions—such as the belief that persons with mental health issues pose a threat to others—contribute to stigma.
- The often-invisible psychosocial struggles faced by persons with disabilities.
- How community definitions of "abnormal" behavior and how our corresponding reactions may be harmful to individuals and their families.

This enriched perspective allowed organizations to approach community challenges with greater sensitivity and alignment to the unique contexts of those they serve.

Chapter 3

What did we observe and learn?

The program **facilitated opportunities to build connections with both state and non-state stakeholders**, which could improve referral pathways and expand access to mental health and psychosocial resources for community members.

Collaborative work and co-designing take time, effort, and patience, often requiring multiple rounds of discussion between community-based organizations and the technical team. This process is essential due to the nuanced nature of mental health and recovery-oriented care. However, investing in this approach strengthens community ownership, enhances cultural relevance, and increases the likelihood of long-term sustainability.

Tailored training and capacity-building initiatives equip community stakeholders with the tools and confidence to act as effective recovery enablers, fostering localized support systems. **Integrating activities such as storytelling and sharing testimonials** further strengthens this process by humanizing mental health struggles, building empathy, and reducing stigma within the community. Studies have shown that community-led interventions enhance the capacity of non-specialist service providers to support mental health and promote recovery (Jordans et al., 2018).

Involving individuals with lived experience of recovery can inspire others, create inclusive spaces, and play a pivotal role in promoting recovery-oriented care. The diverse backgrounds of recovery team members further enriched learning opportunities, as many—particularly those from disadvantaged backgrounds—demonstrated remarkable passion and effort, driven by their commitment to the cause and a sense of personal growth. Evidence suggests that peer-led interventions can reduce stigma and enhance social support in community settings (Repper & Carter, 2011).

Participants, particularly persons living with disabilities, valued the opportunity to engage in meaningful discussions on mental health and psychosocial disabilities. Many had never had the chance to participate in such programs or contribute to societal recovery efforts. This inclusion validated their personal struggles and gave them a sense of purpose by allowing them to support others. Community-based interventions in low-resource settings often thrive on participants' intrinsic motivation and the relevance of the program to their lived realities (World Health Organization [WHO], 2022).

Guiding questions to facilitate the adoption of Recovery-Oriented approaches and practices in communities.

- Who are the key stakeholders within the community that can play a role in supporting individuals reclaiming or resuming their social roles following an episode of illness? How can they be collectively identified?
- What role do each stakeholder envision for themselves in this process, and how can they be supported in fulfilling that role?
- How can the active involvement of individuals with lived experiences of mental health issues and recovery be ensured in shaping these efforts?
- What role do local government officials (e.g., Grama Niladhari), public service providers (health, education, social services), respected community leaders (e.g., teachers, religious figures), and informal influencers (e.g., youth leaders, cultural figures) currently play in supporting mental health and recovery? How can their involvement be strengthened?
- How do local NGOs, faith-based organizations, and community members define “Inclusivity”? Are certain groups being excluded (intentionally or unintentionally) due to physical disability, mental inability, or socioeconomic/cultural standings? How can more inclusive participation be ensured?
- Within the specific community, who can work together to identify and reduce obstacles to recovery?
- How can community organizations be engaged in integrating mental health and recovery-oriented care into their existing missions and priorities in a way that aligns with their values and capacities?

Guiding questions to facilitate the adoption of Recovery-Oriented approaches and practices in communities.

- What can be done to engage with and reduce barriers for community members to participate?
- How can grassroots organizations and peer networks sustain recovery initiatives?
  - What are the internal measures they need to take?
  - When should they/who should reach out for external support?
- What skills, tools, knowledge, and methods do community members feel they need to effectively promote mental health and recovery-oriented care? Are these resources available in the community or do they need someone external to support them?
- What feedback mechanisms can be established within the community to continuously refine and adapt recovery initiatives based on lived realities?
- How can stronger partnerships between government agencies, NGOs, and local stakeholders be fostered to ensure shared accountability and resource mobilization?

Supporting individuals in recovery to experience hope, develop independence, and strengthen their belief in their ability to contribute to their families and communities.

Chapter 4

People with Lived Experiences

Contributed by Roshan Dhammapala

Many people living with and recovering from a mental illness are at risk of experiencing profound and multiple losses beyond material means. These losses could include their sense of purpose, decision-making power, esteem as contributing members in their families, and a diminished perception of themselves.

In an effort to move beyond a restricted illness identity, our Recovery Project chose to engage with a group of aspiring home-based entrepreneurs, whose livelihoods had been disrupted by mental illness.

We identified 25 such individuals living with a mental health condition, along with their carer or a key family member who met the selection criterion for a seed funding grant. The criteria considered their level of vulnerability, interest, family support, and their capacity or skills to work on an existing income generation activity or to initiate one.

The hospital's psychiatric social workers assisted in the selection and evaluation process, given their ongoing relationship with these individuals through an outpatient clinic. The selection was finalized by an independent evaluator to ensure an unbiased outcome.

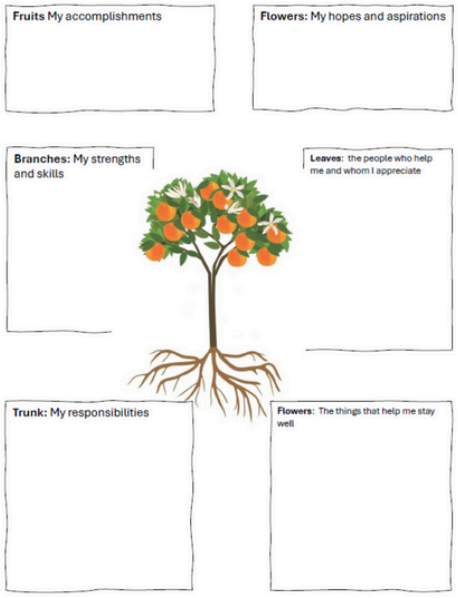
Chapter 4

What did we do and what did we observe ?

A series of workshops and group discussions were organized with the selected individuals and their carers with the objective of identifying existing entrepreneurial knowledge, skills, and talents, and identifying areas for growth and recovery in relation to their economic security, social integration and mental health.

Entrepreneurship:

Using the "Tree of Life" template we worked with the selected individuals and their carer/ family to revisit or conceptualize their entrepreneurial venture.



They mapped out existing strengths and skills, their aspirations and prior accomplishments alongside the support they had received, responsibilities they must own, and the discoveries they had made which contributed to staying well.

Developing Business Plans:

We invited the group to bring their products or product concepts to this session, during which time they discussed product quality, feasibility, ideas for expansion or innovation, packaging, pricing, and access to markets with a resource person with business development expertise.

Each individual was given one-on-one time with the business consultant to discuss any specific questions and receive feedback on their product samples. A time for reflection and relaxation was woven in using a Mandala colouring activity to wind down after the intensive session discussing business plans.

Each individual varied in their skills, capacities, and experience. Listening to the discussion and questions raised by peers proved to be informative to the group as a whole.

Financial Management:

This session was conducted by a resource person with a finance background but drew on the social workers to break this down to practical home economics, sustainability, and savings.

It was important to understand each individual's financial context, expenses, and their relationship with money. This influenced how they would project their profit margins; for example, whether it would simply generate the necessary income for survival or eventually lead them to growth.

Individualised support was necessary to develop a feasible financial plan.

Recovery Themes:

In the context of discussing business and financial plans, we talked about relationships, support, losses and gains, and listened as they shared lessons learned through their lived experience. The salient themes are described in the next page.

Chapter 4

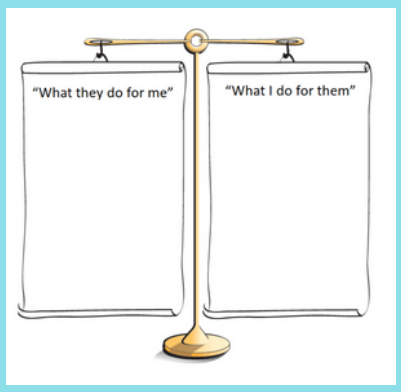
Recovery Themes Discussed during the Sessions

Dignity through reciprocal relationships

Care and protection have the potential to become a source of friction as carers and family members attempt to coax their loved ones back to normality or attempt to take control to curb risks.

Meanwhile, people recovering from a mental illness might be either struggling to accept and adjust to certain changes in their life, be motivated to act on goals, or consequently attempt to recommence previous activities without being reminded of their illness episodes. Anxious family members/carers may compromise the emergence of agency and a robust sense of self by doing things for their loved ones, as they may fear the recurrence of illness episodes that have previously been destructive or traumatic.

We used a "Scales" worksheet to talk about reciprocity and exchange within their closest relationships and explored opportunities to bring balance to their relationships by stepping into the role of a valued contributor and reciprocate care for their loved ones.



Individuals with lived experiences of mental illness talked about their efforts to reclaim control, respect, acceptance and autonomy. They also talked about loss, rejection, hurt, and shame because of their diagnosis. For some, reconciliation with extended family or partners/ spouses had not been possible. While this made some of them defiant and determined to prove their worth and capability, others were still working through these losses or reconciliations.

Recovery Themes Discussed during the Sessions

Dignity through reciprocal relationships continued...

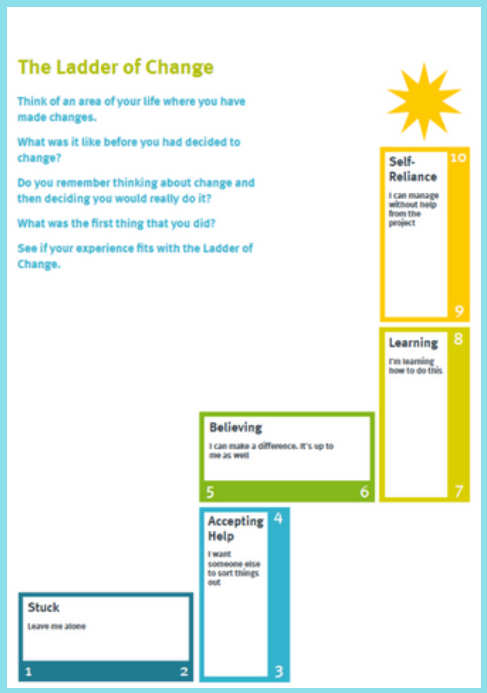
The majority had found purpose and an opportunity to prove themselves through their entrepreneurial venture. They talked about regaining a sense of dignity, feeling valued by their family members as they were able to support or contribute to their children and families, gain self-confidence and stability, and a few reported a reduction in their symptoms.*

We also shared an accountability checklist by which individuals in recovery together with their family / carer could take stock of key responsibilities related to their business and the person responsible for these tasks. The goal was to work towards supporting each other to balance the scales one small step at a time.

**As reported by their social workers*

Recognising the undulating nature of recovery

We used an excerpt the Outcomes Star (MacKeith & Burns, 2008) published by the Mental Health Providers Forum in the UK to talk about the process and milestones in the recovery journey which are illustrated in the 'Ladder of Change'. We used a translated version in our group discussion to talk about experiences that had helped them discover their strengths. Many individuals with lived experience shared deeply painful experiences which had eventually given way to their growth, while some continued to struggle with unresolved situations.



https://mnpmind.org.uk/wp-content/uploads/2021/09/Recovery-STAR-User-Guide.pdf

Chapter 4

Recovery Themes Discussed during the Sessions

Peer learning

A valuable outcome emerged from our group discussion. Individuals struggling with self-doubt, failure, rejection and interpersonal difficulties received acknowledgement, empathy and encouragement from peers who had lived through similar experiences and discovered possibilities and abilities previously inaccessible to them.

These exchanges offered hope and the possibility of an improved quality of life.

Social validation

The large majority of individuals with lived experience demonstrated a sense of responsibility, accountability, and appreciation for relational and resource support, while some expressed that the former imbued a sense of social validation and recognition.

They had been trusted with something important and they wanted to honour this gesture and prove they were worthy and capable.

Chapter 6

Business Development Workshop

A half-day workshop was organized to support persons in recovery and their carers in growing their home businesses, after the conclusion of the core support sessions. Twenty-two persons in recovery and thirteen carers attended this session. The event provided an opportunity to present their products, share their journeys, and receive tailored advice from resource persons across various industries.

The session began with a short workshop on leveraging digital platforms for marketing, followed by two experience-sharing sessions where two guest entrepreneurs recounted their journeys of building businesses despite personal and health-related challenges.

The Resource Persons Included:

- Directors of hotel chains
- Founders of local business product shops
- Sales, marketing, and customer relations experts
- Business advisors and entrepreneurs
- Directors of private sector export companies
- Women's entrepreneurship specialists
- Managing director of a construction company
- Executive officer of the Uva-Central Province Chamber of Commerce

Following the presentations, participants were divided into groups based on their product categories (e.g., food, agriculture, clothing). Each individual and their family member were given 15 minutes to present their business venture to a panel of experts, followed by individual feedback sessions. After everyone in the group had a turn to receive feedback, they were given the space to mingle freely, connect with the resource people from other groups, and exchange contact details for further opportunities.

Chapter 6

Business Development Workshop

Participants received diverse and practical insights, including:

- Enhancing product finishing to increase value and pricing potential.
- Exploring new marketplaces such as pop-up stores and community women's societies.
- Experimenting with organic cultivation to tap into niche markets.
- Identifying cost-effective sources for raw materials..
- Modifying products to capture market demands and increase sales.
- Considering business expansion by hiring support staff.
- Growing crops with fast harvest cycles or high demand in hotels and cafés during tourist seasons.
- Strengthening branding with labeled packaging and contact details.
- Consideration for sustainable pricing and profit margins.
- Participating in exhibitions to increase exposure.
- Links to available institutions and services that provide free resources and skills training.
- Actively building connections with new shops and retail platforms.

Beyond expert advice, peer learning was also a highlight. For instance, one participant involved in an agricultural venture and struggling with pest control found a solution from another attendee who had successfully managed the same problem. These exchanges reinforced the value of collaboration and knowledge-sharing within the community.
This session underscored the importance of mentorship, skill-building, and networking in fostering sustainable home businesses, especially for those navigating the challenges of recovery and caregiving.

Chapter 4

Why did we do what we did?

- Individuals with lived experience tend to internalize narratives that others use to describe them. “The sick person”, “the trouble maker”, “the dependent one”, “the failure”, “the burden”, “the one we are ashamed to acknowledge as ours”. In this context, they could find it daunting to take risks, accept responsibility, and make commitments to goals due to the cyclic and unpredictable nature of their illness. Failure would confirm the labels and narratives.

- The Recovery movement suggests the following as essential ingredients in a person’s journey from illness to a state of functional recovery[*1];
  - The emergence and sustenance of hope;
  - reclaiming a personal identity through the activation of agency and sense of self;
  - finding meaningful and purposeful activities and goals;
  - the discovery of one’s own “personal medicine”[*2] and the exploration of what contributes to one’s illness and wellness, and
  - finding a sense of belonging within their community as valued members.

- It is also recognized that this process would be an ongoing, uneven, and evolving one in which the individual living with a mental illness must remain an active agent.[*3]

- The initiative to support an entrepreneurial venture was intended to act as a catalyst to activate at least one of these features of recovery, which in turn (we hoped) would have a ripple effect on other aspects of their lives. The outcome we desired was not to produce successful entrepreneurs. It was to offer people the dignity of taking a risk, and venture beyond the limits of dependence, to test out their ideas and aspirations to learn ‘by doing’, and (re)gain valued roles as contributors.

**1 Slade 2009, Glover 2012, Commonwealth of Australia, 2013, Deegan 2003.*
**2 Deegan (2005): what one does to promote and maintain wellness in addition to what one takes in the form of treatment for the same;*
**3 (Davidson & Roe, 2007)*

Chapter 4

What did we learn?

Power sharing and risk tolerance.

As a funding organization, our resource persons respected the ideas and objectives that people with lived experience proposed for their business venture. While some were savvy, others were amateurs learning from mistakes. We shared knowledge and skills and offered feedback, but we did not attempt to rescue anyone.

Accountability grew out of trustworthy relationships.

All except one individual invested the funds in their business with a clear intention of establishing or expanding it. The majority, along with their families, expressed gratitude for the emotional support they received from their social workers and the facilitated group discussions which they found validating.

Peer interactions were inspiring but also confronting.

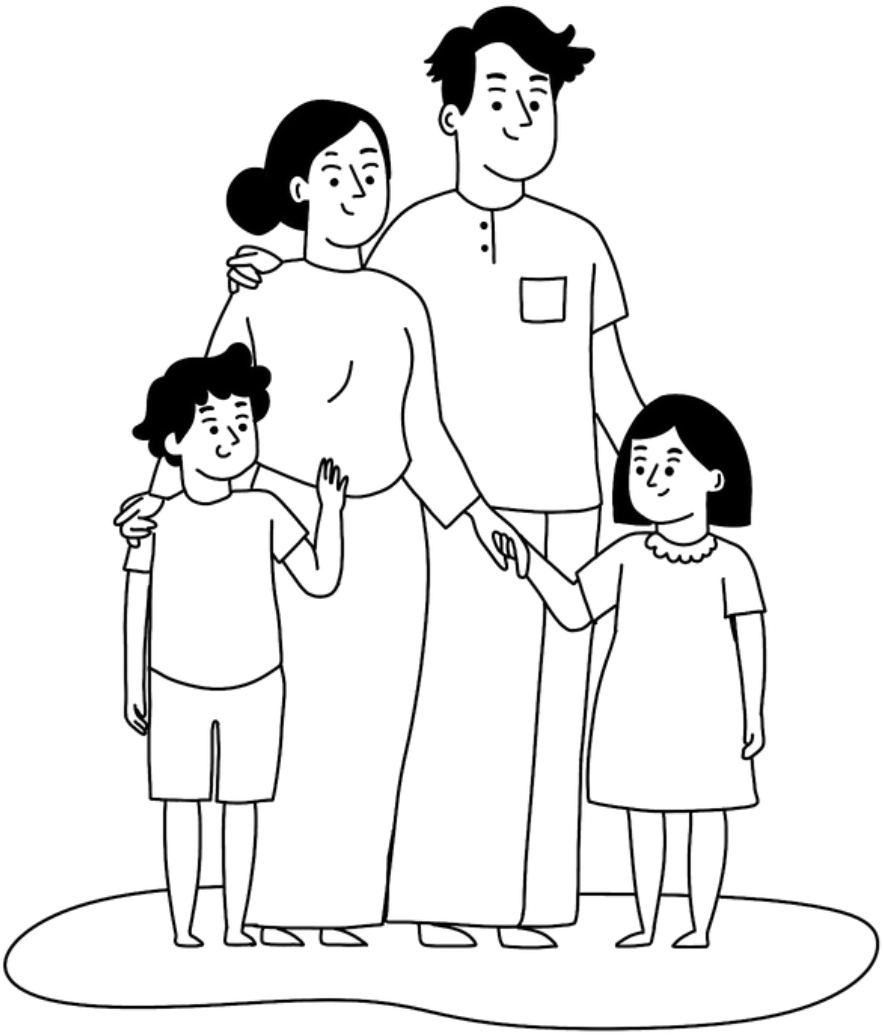
Each person's journey had been different and their approach to dealing with illness varied. Yet together they attested to the possibility of being identified by their abilities rather than their diagnosis.

Validation through listening.

Listening to their individual experiences conveyed validation, recognition and respect. (as indicated by the group).

Guiding questions to support reflecting on adopting Recovery-Oriented approaches and practices.

- How do the stakeholders identify and perceive people with lived experiences of mental illness? What is the language used to describe them? Does it create 'otherness'?
- What do people with lived experience state as their most valued goals (what they want in life)?
- What are their strengths and difficulties? Does the intervention or service enable them to discover and work with/ work through these?
- Does the intervention or service walk the talk? Do the objectives, timelines, relationships, and communication reflect an understanding of the cyclic nature of some mental illnesses yet recognize and engage individuals with lived experiences through their strengths, goals, and aspirations.
- In what manner does the intervention or service enable equality?
- Can the intervention or service be supportive without becoming sympathetic (sympathy diminishes dignity)?



Carers and families play an indispensable role in the recovery process. Supporting them in navigating the challenges of their role and validating their losses and achievements is a crucial component of the recovery journey. It is equally important to help carers feel that their role is not just a burden, but a shared and meaningful partnership that contributes to healing and growth.

Chapter 5

Families and Carers

Contributed by Kanthi Hettigoda and Niluka Wickremesinghe

In the Sri Lankan context, where familial bonds are integral to social and cultural frameworks, carers play a central role in mental health recovery. Their involvement can significantly influence the trajectory of recovery, either by fostering progress or being the stumbling block that hinders the recovery process (Girdhar et al, 2024; Wang et al, 2017; Cham et al, 2022).

Recognizing the indispensable role of carers in the recovery process, this component of the initiative was thoughtfully crafted to empower them as active partners in their journey toward wellness. It provided carers with the tools and insights needed to embrace their role as enablers of recovery, emphasizing the importance of fostering autonomy and independence over practices of overprotection or control.

The program consisted of five structured sessions which were one and half hours long, aimed at engaging both persons in recovery and their primary carers. The majority of persons in recovery attended the session with one carer. These sessions were not merely informational but interactive, providing the space for the persons in recovery and carers to express themselves and also learn through each other's experiences. The space was one where they learned and also found comfort in shared experiences.

Chapter 5

What did we do?

A series of workshops and group discussions were organized with the selected persons in recovery and their carers.

Tree of Life and Introduction to Entrepreneurship

The journey commenced with the "Tree of Life" activity, an introspective exercise that encouraged participants to reflect on their strengths, connections, and aspirations. carers and persons in recovery collaboratively identified their roots (values), trunk (strengths), and branches (goals), creating a holistic view of their potential.

Following this activity, participants were introduced to the concept of entrepreneurship, sparking conversations about financial independence and resilience. Many participants had already begun small projects of their own, but these had come to a standstill due to the economic crisis or other challenges.

Developing Business Plans

Building on the entrepreneurial introduction, participants worked on creating practical and personalized business plans. Guided exercises offered clarity and structure, helping carers align their personal growth with economic ambitions. To balance the intensity of planning, relaxing activities such as mandala coloring were integrated into the session. This also gave them some space to relax as many expressed that coloring was not something they had done in a long time.

Financial Management

Financial literacy is a focal point in running small businesses. Hence this session was introduced to teach participants about budgeting, saving, and managing resources. Templates were introduced to simplify complex concepts, making them accessible to everyone.

A symbolic exercise at the beginning invited participants to visualize their business and their lives as a boat, prompting them to consider potential challenges and strategies for success.

Impact of Expressed Emotions

Emotions and their expression can profoundly impact recovery dynamics. “Expressed emotion” refers to a global index of particular emotions, attitudes, and behaviors expressed by relatives about a family member diagnosed with psychiatric illness (Satyakam and Rath, 2013).

This session used role-playing and group discussions to explore how five key emotional expressions impact the relationship and dynamics when expressed—three negatives (critical comments, hostility, emotional over-involvement)) and two positives (Positive remarks/regard, warmth) (Girdhar, Patil, Bezalwar 2024).

To foster open and honest dialogue, carers and persons in recovery were separated at key points, allowing for independent discussions that minimized potential conflicts or emotional discomfort. This separation provided a safe space for each group to express themselves freely and share their experiences without fear of judgment. Two clinical psychologists facilitated the sessions, ensuring that the carers received professional support to navigate any triggered emotions that might have hindered their ability to participate fully. Carers identified counterproductive patterns and practiced healthier ways of responding. This session was almost cathartic in a sense. The experience was intentionally structured to be reflective and emotionally relieving.

Recovery and Balancing Relationships

The final session emphasized self-care and equitable relationships within families. Carers and persons in recovery discussed strategies to promote autonomy while sharing responsibilities.

Facilitators highlighted the importance of setting boundaries and fostering mutual respect, ensuring that caregiving did not become overwhelming. To ensure open dialogue and authentic expression, the session was divided into separate discussions for carers and service users at specific points. As in the previous session, this approach provided a safe space for honest conversations. Two clinical psychologists facilitated the session, offering professional support to address any emotional triggers and ensure active participation.

Chapter 5

Why did we do what we did?

Recovery from mental health challenges is not an individual journey; it requires a collective and holistic approach that involves both the individual and their immediate support system. In Sri Lanka, where a collectivist culture prevails and many persons in recovery live within extended family systems, carers often shoulder the dual responsibility of providing emotional, financial, and logistical support.

While this caregiving structure can be a significant source of strength, in the absence of a community mental health care system, clinical services rely on families for extended care once the patient is discharged. Medication regimens are entrusted to carers, along with risk mitigation. While this caregiving structure can be a significant source of strength, it can also inadvertently hinder the recovery process. Regardless of the methods of care employed, the role of a carer remains profoundly demanding and is frequently underappreciated or misunderstood within formal mental health interventions.

Carers often face the added challenge of balancing their responsibilities with the need to secure a sustainable income generation method to support their families. The demands of caregiving, however, often consume much of their time and energy, limiting their ability to engage in formal, in-person employment. This dynamic leaves carers struggling to find work that accommodates their responsibilities or relying on alternative arrangements to ensure the safety and care of the persons in recovery. Entrusting the care of persons in recovery to someone else is often not a viable option due to safety concerns, both for the person in recovery and the individual tasked with caregiving.

While carers strive to support the journey of the persons in recovery toward independence, the inherent risks associated with granting autonomy can be overwhelming, often compelling them to maintain control over the situation. This dynamic, though well-intentioned, can inadvertently create a tense and strained living environment, heightening stress levels and diminishing the overall quality of life for everyone involved.

Chapter 5

Why did we do what we did?

The initiative was driven by several core objectives:

01. Acknowledging carers' Contributions

Carers' efforts are crucial yet often go unrecognized. By highlighting their indispensable role, the program aimed to validate their struggles and celebrate their contributions.

02. Addressing Emotional Awareness

Negative emotional expressions, such as criticism or frustration, can lead to relapses or stagnation in recovery. By introducing carers to healthier emotional expressions, the program laid a foundation for more constructive relationships.

03. Fostering Independence

Teaching entrepreneurial and financial skills was designed to empower both carers and service users, fostering resilience and reducing dependency within families. The initiative created an opportunity to explore and adopt a collaborative approach to recovery, alleviating the carers' perception that they must shoulder the entire burden alone. Carer burden is considered as a factor that impedes the recovery process (Cham et al, 2022). Engaging in income-generating activities can activate interest, renew skills, enhance self-esteem, and help individuals overcome the perception of being a burden to their families and the community. This, in turn, fosters a positive mindset, contributing to breaking the negative cycle associated with mental health challenges.

03. Strengthening Family Dynamics

The initiative addressed relational imbalances and promoted healthier communication patterns. Families were encouraged to build tolerance for risk, recognise its role in recovery which in turn will reduce conflict and foster environments where each member felt valued and supported. Generating additional income for the family can enhance their quality of life while reducing social stigma. It can also elevate the family's standing within the community, fostering respect and recognition. Furthermore, the new business has the potential to benefit the neighborhood by providing goods, services, or employment opportunities, creating a ripple effect of positive impact.

Chapter 5

Why did we observe?

- Carers Felt Validated - Many carers shared that this program marked the first time their experiences and struggles were acknowledged. This validation uplifted them emotionally and motivated active participation.

- Heightened Emotional Awareness - Through psychoeducation, carers learned to recognize and alter negative behaviors. They expressed renewed commitment to creating supportive home environments.

- Improved Communication - Families reported more meaningful exchanges. Persons in recovery felt seen and valued, while carers developed better coping mechanisms for their emotional triggers. A WhatsApp group was created to sustain dialogue and provide ongoing peer support, with members sharing resources and encouraging one another.

- Strengthened Peer Support - Both carers and persons in recovery found solidarity in shared experiences. Group discussions and the WhatsApp platform became avenues for communication and exchange. A carer mentioned feeling less isolated after hearing about the similar struggles of others.

- Behavioral Transformations - Observable changes included carers exhibiting greater patience and compassion. Persons in recovery became more engaged in daily activities, reflecting the positive influence of these changes.

Chapter 5

What did we learn?

- Overall, the experience of these sessions reemphasized the fact that recovery is more than symptom management; it involves equipping families with tools and strategies for navigating mental health challenges collaboratively.

- Training sessions that address emotions and personal experiences require adequate time and space, as certain activities and lessons may evoke deeper emotional responses and related experiences. Sufficient time should be allocated to process these emotions, reflect on the experiences, and engage in meaningful discussions.

- Empathy can be learned through relevant techniques. Carers who practiced empathy observed noticeable improvements in the interactions of the persons in recovery.

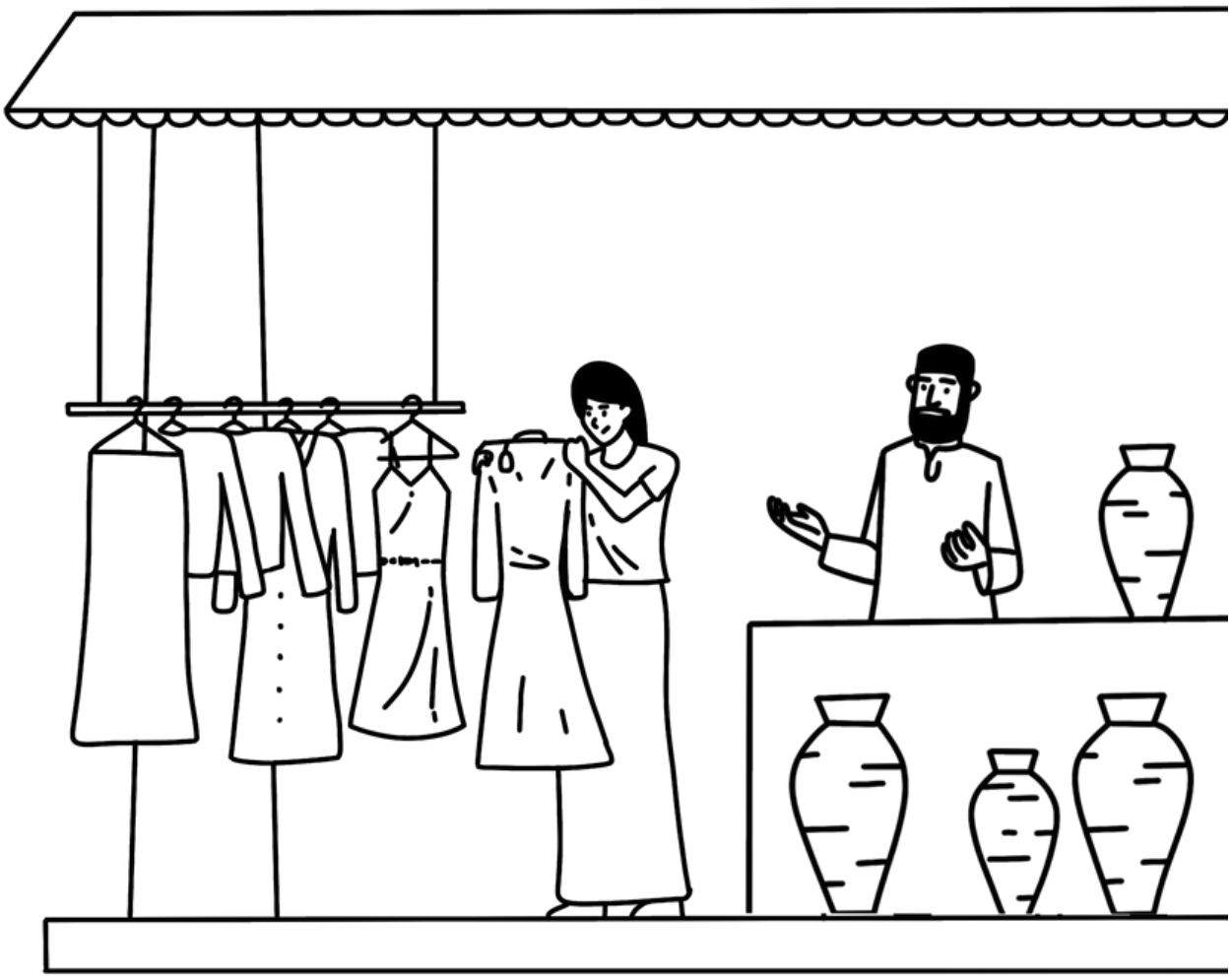
- It is extremely important to pay attention to and express empathy for the difficulties faced by carers before expecting them to be empathetic toward the person in recovery.

- The whole family should be made aware of the recovery process and their role in it. Carers felt pressured when the family did not understand the process. They said other family members provoked episodes without knowing how to handle situations, adding to the carer's burden.

- Carers felt a sense of belonging and relief by talking and sharing with other carers.

Guiding questions to support service providers and carers reflect on adopting Recovery-Oriented approaches and practices.

- How well do carers understand the connection between their emotional expressions and the recovery process of the person with lived experiences? What can be done to facilitate this learning?
- How can the carer be encouraged to take responsibility in their own capacity, building on their unique strengths?
- How can families, support people, and carers be proactively linked to other services and support systems that will assist them in their caring role?
- What unique challenges do carers face in balancing their roles within the family? How can they be supported to identify and address these?
- What can be done to ensure that carers are equipped to recognize signs of progress and setbacks in the journey of persons in recovery?
- How can carers be supported to maintain their own mental health and well-being while aiding the person in recovery?
- What specific skills or resources can help carers foster a more supportive environment at home?
- How can carers be encouraged to build peer networks for mutual learning and support?
- How can the healthcare system work better to engage carers in the recovery process?



Supporting income generation becomes a crucial component of recovery when illness intersects with financial insecurity.

Chapter 6

Final Reflections: What We Take Forward

Contributed by Kaushi Jayawardena

While recovery-oriented practices may be familiar in theory, their practical implementation remains limited in Sri Lanka. Few have the opportunity to witness these approaches in action, learn from them, and integrate them into everyday practice. Systemic structures, cultural factors, inadequate funding, a shortage of service providers, and limited mental health literacy create significant barriers for both practitioners and individuals in recovery, making it difficult to fully understand and engage with such approaches.

This project attempted to bridge that gap. It brought together a diverse range of stakeholders—persons in recovery, community organizations, and mental health service providers—who facilitated different elements of living well. Through every training, discussion, shared moment, and exchange of feedback, the core elements of personal recovery gradually came to life: an active sense of self, hope, connectedness, personal control, and discovery (Glover, 2012).

As this compilation of reflections comes to an end, we ask:
What lessons do we carry forward,
and how do we continue to build on these foundations?

Chapter 6

Small, Low-Cost Interventions Can Drive Meaningful Change

The implementation of recovery-oriented practices does not always require large-scale investments. Often, small yet intentional actions can create a significant impact:

- A nurse who addressed service users by name and acknowledged their birthdays fostered stronger, more trusting relationships.
- Carers who felt heard during sharing sessions were better equipped to provide supportive home environments.
- A young service user, inspired by hearing a snippet of a English conversation between facilitators, started to work on improving her language skills by watching Youtube videos.
- Opportunities for social connection allowed individuals in recovery to share experiences, build relationships, and develop a sense of belonging. Peer support became a vital source of acceptance, understanding, and encouragement—not only during sessions but also in daily life. Many participants formed new friendships and reached out to one another in times of distress, offering comfort and solidarity beyond the structured program.

Even in a hospital setting, a Psychiatric Social Worker who visits the Social Services department to act as a bridge between service users and potential employment opportunities alone can support the journey of recovery without incurring additional costs in a way that will help a person rebuild their sense of self and life.

These examples highlight how simple, cost-effective changes can enhance the recovery journey.

"We had fallen apart (කඩාගෙන වැටිලා) because of the illness, and fallen to a place where we had no recognition (පිළිගැනීමක්) from others - at a time like that you all told us that we can improve, we can get to a better place (දියුණු වෙන්න පුළුවන්, තැනකට එන්න පුළුවන්), that we shouldn't just stay in the place of illness. When a part of society was telling us that we are patients, another part of society was telling us we can improve and come to a better place."

Person in recovery, 30 years

Chapter 6

Support for Income Generation Becomes a Crucial Component When Illness Intersects with Financial Insecurity

> Research highlights a bidirectional link between poverty and mental health, with financial insecurity increasing the risk of mental health struggles (March et al., 2023) and mental health conditions, in turn, limiting opportunities to engage in employment and income generation. Unemployment is strongly associated with poor mental health (The Health Foundation, 2021), and unemployed men face a two- to threefold higher risk of death by suicide (Great Britain Samaritans, 2012). Nearly one in every two individuals with mental health challenges are also in debt (Money and Mental Health Policy Institute, 2019), and debt-related stress, accompanied by feelings of shame and burdensomeness, also heightens the likelihood of anxiety, depression, and suicidal ideation (Amit et al., 2020). The impact of such socioeconomic disadvantage begins early, with children from the poorest 20 percent of households being four times more likely to experience mental health difficulties by the age of 11 compared to those from the wealthiest 20 percent of households (Centre for Mental Health, 2015).

When financial insecurity intersects with mental illness, it can create a cycle that is difficult to break without external support, making recovery even more challenging. Providing opportunities for income generation offers more than just financial relief—it supports developing hope, motivation, and a sense of agency in individuals who might otherwise feel discouraged or unable to move forward.

The livelihood component in this project was instrumental in fostering key aspects of recovery. Beyond financial stability, it contributed to a sense of purpose, autonomy, and self-worth. If direct livelihood support is not feasible, alternative pathways—such as vocational training, employment mentorship, or structured engagement in meaningful activities—should be integrated into recovery-oriented interventions. Enabling individuals not to be confined to a life of dependence and to see themselves as active, contributing members of society can be a turning point in their recovery process.

"There was this thought that we could do things like this, it gave our mind a strength (ශක්තියක් ආවා). This is good for our minds. Mentally - there was a happiness and a strength."

Person in recovery, 57 years

Chapter 6

It Takes a Whole Community…

Sustaining and expanding recovery-oriented practices requires **a collective effort** from a diverse group of stakeholders. Mental health professionals, support staff, community leaders, and professional associations all play a critical role in creating an environment where personal recovery is prioritized. Their advocacy and leadership—amplifying the voices of persons with lived experience and promoting systemic change—is essential for long-term progress.

However, facilitating recovery is not solely the responsibility of service providers and policymakers. It takes a village—not just to raise a child, but to support recovery as well. Every member of society has a role to play in helping others live well and enabling individuals in recovery to rebuild their lives.

Small acts of support can create ripple effects of impact. This support can take many forms, including:

- **A teacher** who offers extra lessons to help children catch up on missed learning.
- **A family member** who provides patience, encouragement, and stability.
- **A hospital** that creates opportunities for former service users to sell their products at the "Pay Day Fair".
- **A service provider, such as bank personnel,** who is patient and guides people through processes like learning how to use digital banking or opening a bank account.
- **A peer service user** who is a phone call away to share happiness and sorrow.
- **A business, market, or training center** that opens networks and selected markets to novice entrepreneurs.
- **A neighbor or a friend** who offers practical support, such as childcare or accompanying someone to reconnect with potential business partners.
- **A skills training program or a community mentor** who equips individuals with tools for financial independence.

When communities actively participate in recovery efforts, individuals are not only supported in regaining stability but are also empowered to contribute back to society. A truly recovery-oriented approach requires all of us to recognize the part we can play and take action, however small, to foster inclusion and opportunity.

"I still feel lonely a lot, but I try to manage that feeling. When there are a lot of people in these sessions and we are all talking, those feelings become less.... We talk on the phone. And then we also come to the hospital market ('pola') and we meet there."
Person in Recovery, 57 years.

We hope this documentation of our journey and reflections invites you to find your own way to support personal recovery within the communities you belong to.
Thank you.

Our Core Team

The Kandy National Hospital

Dr. Gihan Abeywardena
Consultant Psychiatrist
gihan_abey@yahoo.com

Dr. Jayantha Herath
Senior Registrar
jayanthaherath100@gmail.com

Dr. Himali Priyadarshika Jayasekara
Consultant Psychiatrist

Nalaka Ekanayake
Psychiatrist Social Worker
bekanayakanalaka@gmail.com

Lasanthika Thilakarathne
Psychiatrist Social Worker
lasanthikamilani@gmail.com

Lathika Ekanayake
Psychiatrist Social Worker
lathikaie@yahoo.com

A.W.Athukorala
Psychiatrist Social Worker
awathukorala@gmail.com

Community-Based Organizations

Champika Gayani and Team
Gampola Udapalatha Prajashakthi Development Foundation (GUPDF)
gupdf2020@gmail.com

Nisha Shareef and Team
"අයිතීන් වෙනුවෙන් අපි" We for Rights
shareefnisha22@gmail.com

Our Core Team

The Asia Foundation's MHPSS Unit & the Consultants to the Unit

Niluka Wickremesinghe
Program Manager
The Asia Foundation
niluka.wickremesinghe@asiafoundation.org

Rehan Meemaduma
Program officer
The Asia Foundation
rehan.meemaduma@asiafoundation.org

Omella Outschoorn
Program Associate
The Asia Foundation
omella.outschoorn@asiafoundation.org

Husna Shiraz
Program Associate
The Asia Foundation
husna.shiraz@asiafoundation.org

Roshan Dhammapala
Clinical Psychologist
rdhammapala@gmail.com

Dr. Kanthi Hettigoda
Clinical Psychologist
kanthihettigoda@gmail.com

Dr. Ganesan Mahesan
Consultant Psychiatrist
mahesanganesan2009@gmail.com

Kaushi Jayawardena
Psychologist & MHPSS Practitioner
kaushi.mhpss@gmail.com

References

Alwis, I., Baminiwatta, A., & Chandradasa, M. (2024). Prevalence and associated factors of depression in Sri Lanka: a systematic review and meta-analysis. Social psychiatry and psychiatric epidemiology, 59(2), 353–373. https://doi.org/10.1007/s00127-023-02495-z

Amaresha, A. C., & Venkatasubramanian, G. (2012). Expressed emotion in schizophrenia: an overview. Indian journal of psychological medicine, 34(1), 12–20. https://doi.org/10.4103/0253-7176.96149

Amit, N., Ismail, R., Zumrah, A. R., Mohd Nizah, M. A., Tengku Muda, T. E., Tat Meng, E. C., Ibrahim, N., & Che Din, N. (2020). Relationship between debt and depression, anxiety, stress, or suicide ideation in Asia: A systematic review. Frontiers in Psychology, 11. https://doi.org/10.3389/fpsyg.2020.01336

Bredski, J., Forsyth, K., Mountain, D., Harrison, M., Irvine, L., & Maciver, D. (2015). What in-patients want: A qualitative study of what's important to mental health service users in their recovery (Wayfinder partnership). Mental Health Review Journal, 20(1), 1-12. https://doi.org/10.1108/mhrj-02-2014-0003

Center for Mental Health. (2015). Children of the new century: Mental health findings from the millennium cohort study. https://www.centreformentalhealth.org.uk/wp-content/uploads/2018/09/newcentury.pdf

Cham, C. Q., Ibrahim, N., Siau, C. S., Kalaman, C. R., Ho, M. C., Yahya, A. N., Visvalingam, U., Roslan, S., Abd Rahman, F. N., & Lee, K. W. (2022). Caregiver Burden among Caregivers of Patients with Mental Illness: A Systematic Review and Meta-Analysis. Healthcare (Basel, Switzerland), 10(12), 2423. https://doi.org/10.3390/healthcare10122423

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. Journal of Mental Health, 16(4), 459-470. https://doi.org/10.1080/09638230701482394

Deegan, G. (2003). Discovering recovery. Psychiatric Rehabilitation Journal, 26(4), 368-376. https://doi.org/10.2975/26.2003.368.376
Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. Psychosocial Rehabilitation Journal, 11(4), 11-19. https://doi.org/10.1037/h0099565

Deegan, P. E. (2005). The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities. Scandinavian Journal of Public Health, 33(66_suppl), 29-35. https://doi.org/10.1080/14034950510033345

References

Deivanayagam, T. A., Ní Chobhthaigh, S., Devakumar, D., Patel, K., Rannan-Eliya, R. P., & SLHAS Collaborators. (2024). Mental health prevalence, healthcare use and access between 2018 and 2022 in Sri Lanka: an analysis of survey data. National Institute for Health and Care Research.

Department of Health and Ageing Staff. (2013). A national framework for recovery-oriented mental health services: Policy and theory.
Girdhar, A., Patil, R., & Bezalwar, A. (2024). Understanding the Dynamics: A Comprehensive Review of Family Therapy's Impact on Expressed Emotions in Schizophrenia Patients. Cureus, 16(5), e59491. https://doi.org/10.7759/cureus.59491

Glover, H. (2012). Recovery, lifelong learning, empowerment and social inclusion: Is a new paradigm emerging? Empowerment, Lifelong Learning and Recovery in Mental Health, 15-35. https://doi.org/10.1007/978-0-230-39135-2_2

Great Britain Samaritans. (2012). Men and suicide: Why it's a social issue. https://media.samaritans.org/documents/Men-and-Suicide-Report-Samaritans.pdf

Guerrero, E., Barrios, M., Sampietro, H. M., Aza, A., Gómez-Benito, J., & Guilera, G. (2024). Let's talk about recovery in mental health: an international Delphi study of experts by experience. Epidemiology and psychiatric sciences, 33, e41. https://doi.org/10.1017/S2045796024000490

Jacob, K. S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. Indian Journal of Psychological Medicine, 37(2), 117-119. https://doi.org/10.4103/0253-7176.155605

Jordans, M. J., Komproe, I. H., Tol, W. A., & de Jong, J. T. (2018). Reintegration of child soldiers in war-affected regions: A review of psychosocial evidence and a framework for intervention. International Journal of Mental Health Systems, 12(1), 36. https://doi.org/10.1186/s13033-018-0211-4

Klevan, T., Bank, R. M., Borg, M., Karlsson, B., Krane, V., Ogundipe, E., Semb, R., Sommer, M., Sundet, R., Sælør, K. T., Tønnessen, S. H., & Kim, H. S. (2021). Part I: Dynamics of Recovery: A Meta-Synthesis Exploring the Nature of Mental Health and Substance Abuse Recovery. International journal of environmental research and public health, 18(15), 7761. https://doi.org/10.3390/ijerph18157761

Kohrt, B. A., Mendenhall, E., Brown, P. J., & Ukpong, D. I. (2018). Social determinants of mental health and recovery-oriented care in global mental health. Psychological Medicine, 48(3), 422-433. https://doi.org/10.1017/S0033291717002786

References

Kuek, J. H. L., Raeburn, T., & Wand, T. (2023). Asian perspectives on personal recovery in mental health: a scoping review. Journal of mental health (Abingdon, England), 32(2), 517–533. https://doi.org/10.1080/09638237.2020.1818709

Marchi, M., Alkema, A., Xia, C., Thio, C. H., Chen, L., Schalkwijk, W., Galeazzi, G. M., Ferrari, S., Pingani, L., Kweon, H., Evans-Lacko, S., Hill, W. D., & Boks, M. P. (2023). The impact of poverty on mental illness: Emerging evidence of a causal relationship. https://doi.org/10.1101/2023.05.19.23290215

Mohapatra, S., & Rath, N. M. (2021). Expressed emotion in psychiatric disorders. Eastern Journal of Psychiatry, 16(1-2), 17-22. https://doi.org/10.5005/ejp-16-1--2-17

MONEY AND MENTAL HEALTH:THE FACTS. (2019). Money and Mental Health Policy Institute. https://www.moneyandmentalhealth.org/wp-content/uploads/2019/03/debt-mental-health-facts-2019.pdf

Nettasinghe, R., & Abesekara, L. (2020, March). The prevalence and readmission of psychiatric patients in the National Institute of Mental Health Sri Lanka [Conference session]. Commonwealth Nurses and Midwives Conference, London, UK.

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., ... & Unützer, J. (2018). The Lancet Commission on global mental health and sustainable development. The Lancet, 392(10157), 1553-1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. Journal of Mental Health, 20(4), 392-411. https://doi.org/10.3109/09638237.2011.583947

Slade, M. (2009). Personal recovery and mental illness: A guide for mental health professionals. Cambridge University Press.

The Health Foundation. (2021). Unemployment and mental health. https://www.health.org.uk/reports-and-analysis/briefings/unemployment-and-mental-health

Wang, X., Chen, Q., & Yang, M. (2017). Effect of caregivers' expressed emotion on the care burden and rehospitalization rate of schizophrenia. Patient preference and adherence, 11, 1505–1511. https://doi.org/10.2147/PPA.S143873

World Health Organization. (2022). Community mental health: Evidence for action. Retrieved from https://www.who.int