Course Guide

Transforming services and promoting human rights

WHO QualityRights training and guidance: mental health & social services

QualityRights

World Health Organization

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

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

Contents

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Social networks, open dialogue and recovery from psychosis - Jaakko Seikkula, PhD
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Speech by Craig Mokhiber, Deputy to the Assistant Secretary-General for Human Rights, Office of the High Commissioner for Human Rights made during the event 'Time to Act on Global Mental Health - Building Momentum on Mental Health in the SDG Era' held on the occasion of the 73rd Session of the United Nations General Assembly.
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UNCRPD: What is Article 12 and Legal Capacity?
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Foreword

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

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

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

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

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

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

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

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

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

Supporting statements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Julian Eaton Director, Mental Health, CBM International

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

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

Charlene Sunkel, CEO, Global Mental Health Peer Network

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

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

Kate Swaffer, Chair, CEO Dementia International Alliance

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

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

Ana Lucia Arellano, Chair, International Disability Alliance

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

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

Connie Laurin-Bowie, Executive Director, Inclusion International

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

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

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

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

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

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

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

Peter Yaro, Executive director, Basic Needs Ghana

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

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

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

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

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

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

What is the WHO QualityRights initiative?

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

1 Build capacity to combat stigma and discrimination, and to promote human rights and recovery.

2 Improve the quality of care and human rights conditions in mental health and social services.

3 Create community-based and recovery-oriented services that respect and promote human rights.

4 Support the development of a civil society movement to conduct advocacy and influence policy-making.

5 Reform national policies and legislation in line with the Convention on the Rights of Persons with Disabilities and other international human rights standards.

For more information: http://www.who.int/mental_health/policy/quality_rights/en/

WHO QualityRights – Training and guidance tools

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

Service transformation tools

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

Training tools

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

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

Evaluation tools

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

Guidance tools

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

Self-help tools

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

About this training and guidance

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

Who is this training and guidance for?

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

Who should deliver the training?

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

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

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

Ideally, facilitators should be familiar with the culture and context of the location where the training is taking place. It may be necessary to conduct train-the-trainer sessions in order to build up a pool of

people who are able to carry out the training within a particular culture or context. These train-the-trainer sessions should include persons with psychosocial, intellectual or cognitive disabilities. They should also include other relevant local stakeholders who contribute to improving the quality of mental health and social services and the human rights of people with psychosocial, intellectual or cognitive disabilities.

How should the training be delivered?

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

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

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

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

- For example, if participants do not yet have any expertise in the areas of mental health, human rights and recovery, it would be important to conduct a 4–5-day workshop using the five core training modules. A 5 day sample agenda available at the following link: https://qualityrights.org/wp-content/uploads/Sample-program-QR-training.pdf

- If participants already have a basic understanding of the human rights of people with psychosocial, intellectual and cognitive disabilities but require more advanced knowledge about how specifically to promote the right to legal capacity in practice, then a workshop could be organized to focus on the module *Legal capacity and the right to decide* on day 1 and on the specialized module on *Supported decision-making and advance planning* (or selected parts of that module) on days 2, 3 and 4.

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

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

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

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

Guidance for facilitators

Principles for running the training programme

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

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

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

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

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

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

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

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

Use of language

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

Accommodations

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

Operating in the current legislative and policy context

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

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

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

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

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

Being positive and inspiring

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

Group work

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

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

Facilitator notes

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

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

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

Evaluation of the QualityRights training

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

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

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

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

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

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

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

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

Training videos

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

Preliminary note on language

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

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

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

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

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

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

Learning objectives, topics and resources

Learning objectives

This training will enable participants to:

- understand the importance of developing a shared vision of the service and the process for achieving this;
- understand the importance of the service culture for respecting the rights of people using the service;
- learn how to change the service culture and practices;
- gain an in-depth knowledge of the results from the QualityRights assessment that has taken place in the mental health or social service;
- have space to discuss the results of the QualityRights assessment, the reasons for the results and their implications for the future of the service;
- as a group, identify priority areas for action based on the QualityRights assessment results;
- develop the skills needed to collaboratively develop and implement an improvement plan.

Topics

Part 1. Service culture, vision and leadership
Topic 1: Defining a shared vision for the service (1 hour and 40 minutes)
Topic 2: Service culture and change (4 hours and 15 minutes)

For this part of the training, it is not essential that a QualityRights Assessment has been completed in the services)

Part 2. Developing and implementing a transformation/improvement plan for service change
Topic 1: Understanding the quality and human rights conditions of mental health and social services (2 hours and 40 minutes)
Topic 2: Specific priorities for change in the service based on the QualityRights assessment toolkit (2 hours and 30 minutes)
Topic 3: From problems to solutions and from action to impact (3 hours and 20 minutes)
Topic 4: Moving forward (25 minutes)

For this part of the training, it is essential that a QualityRights Assessment has been completed in the service

Resources required

- **Accompanying course slides, Transforming services and promoting human rights. WHO QualityRights Training and guidance: mental health & social services (Course Slides), are available here: https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools**
- **Room requirements: to optimize the learning experience for participants, the room in which the training takes place should be:**
  - ➢ large enough to accommodate everyone, but also small enough to create an environment conducive to free and open discussions;
  - ➢ seating arrangements that allow people to sit in groups (e.g. "banquet style" where several round tables are arranged around the room, allowing for several participants to sit together around each of the tables. This has the added benefit of encouraging

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interaction between participants and also of creating ready-made groups for group work exercises.)

- **reasonable accommodations, as required, ensuring inclusive access to the training for all persons.**
- **internet access in the room, in order to show videos**
- **loudspeakers for the video audio**
- **a projector screen and projector equipment**
- **1 or more microphones for facilitator(s) and at least 3 additional wireless microphones for participants (ideally one microphone per group table).**
- **at least 2 flipcharts or similar, plus paper and pens**

Additional resources required for this training module include:

- copies of the QualityRights assessment report
- hard copies of the presentation *Moving from problems to solutions* in Topic 3 for each participant
- copies of Annexes 1−8 for all participants. Please ensure that you make several copies of the template in Annex 8 since participants are required to complete it more than once.

Time

15 hours

Number of participants

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

Actions required before training

Prior to conducting the training, it is important that the following actions are taken:

- Directly involve senior management and make sure to have their endorsement and support.
- If an assessment has been conducted, discuss with the service management the QualityRights assessment findings and the next steps to be taken.
- Emphasize the importance of their support and how improvements will benefit everyone.
- Emphasize that the assessment, improvement plans and follow-up actions are not being conducted to blame people but to allow everyone to work together to improve the situation.
- Ensure that all relevant stakeholders are invited for the training and are actively involved in the implementation process and the various working groups.

Introduction

The purpose of this module is to assist participants to discuss and decide on actions that need to be taken to transform services in the direction of a recovery-oriented approach which respects human rights. Part 1 deals with the service culture, vision and leadership, while Part 2 deals with the development and implementation of an improvement plan for service change. While the training of Part 1 may be undertaken by all mental health and social services, Part 2 is based on the results of an assessment of quality of care and human rights that has been carried out in a service using the WHO QualityRights assessment toolkit and methodology, and focuses on areas of improvement that are specific to that service.

The purpose of this module is **not** to imply that psychiatric hospitals or other institutions can become good places to live or to stay in for a long time. Indeed, the message of the module – and of the whole QualityRights training – is that people should **never** be required to live in institutions. Large-scale mental health facilities which are isolated from, and unconnected to, the community should be phased out and replaced with community-based mental health and social services which promote recovery and respect human rights. QualityRights assessments may reveal bad conditions in certain institutions with substantial human rights violations, leading to the recommendation to close such facilities down.

The present module shows participants how to prepare an "improvement/transformation plan" for their mental health or social service in order to address the service's culture, power dynamics and the specific quality and human rights gaps identified. The notions of equality, respect and dignity between people using the service, staff and others must be included as core values and should be embedded in the service culture and practice. The QualityRights assessment helps in identifying areas for improvement which can be prioritized for immediate, medium-term and longer-term action.

Part 1. Service culture, vision and leadership

For this part of the training, it is not essential that a QualityRights Assessment has been completed in the service.

Topic 1: Defining core values and a shared vision for the service

Time for this topic
Approximately 1 hour and 40 minutes.

Presentation: The importance of having a vision based on core values (10 min.)

- An important part of the service change process is to define a vision for the service that everyone can identify with and commit to.

- The vision should direct how the service should function and what it aims to achieve – i.e. the overall outcome that the service is working towards. The vision usually sets high expectations for the service.

- The vision must be developed, understood and shared by members of the service – particularly people using the service, and their families, as opposed to staff only.

- The vision must be easy to communicate and must be inspiring and uplifting in order to motivate all stakeholders within the service to make their best efforts to achieve a higher level of mental health and well-being for people.
  - ➢ For example, a vision could be "To become a service of excellence that provides holistic, recovery-oriented and high-quality services in the community in order to improve mental health and well-being for everyone".

- Core values should be the basis for the vision and should drive all actions within the service.
  - ➢ For example, essential values could include: equality, respect, dignity, trust, confidentiality, well-being, connectedness, community care, shared understanding, participation, recovery, empowerment, hope, protection, compassion, inclusion, diversity, open-mindedness, non-discrimination, reliability, strengths-focused, person-centred, person-driven, and high quality.

- Both the vision and the core values must be in line with human rights standards, particularly the Convention on the Rights of Persons with Disabilities (CRPD). The vision and core values should reflect and respect the rights and dignity of people using the service, including the right to make their own choices and to be free from coercion, violence and abuse.

- The key point is that all stakeholders agree on the importance of these core values and actively seek to uphold them.

Exercise 1.1: Defining a vision and core values for the service (1 hour and 30 min.)

Divide participants into groups of five and explain that they will have 45 minutes to identify a core set of values and vision for their services and write this down in the handout from Annex 2. Emphasize that there are no right or wrong answers.

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Questions to consider when formulating a vision and values include:

- What are the core values you believe are important for your mental health or social service?
- What are the outcomes that you would want for the people who visit the service?
- What does this mean for what your service provides?
- What does this mean for how your services are delivered?
- What does all of this mean for the service's vision?

Start first by writing down the core values you believe are important for the service, using the document titled *Defining core values and a vision for the service* (Annex 2).

After writing your group's core values, try to formulate a vision statement which describes how you would like to see your service function in the most ideal way possible. This should be in line with all the core values that you have identified. Also write this in the document.

After the group work, ask each group to present in plenary (i.e. to the full group of participants) their set of core values and their vision statement or any relevant phrases or themes that can help to build a shared vision statement.

The facilitator should list these core values and vision statements (or phrases or themes) on a flipchart.

The facilitator should then work with the group to develop a collective set of values and a shared vision for the service that everyone agrees to uphold and commit to.

Examples of potential responses include:
- **Core values:** Equality, respect, dignity, trust, confidentiality, well-being, connectedness, community care, shared understanding, participation, recovery, empowerment, hope, protection, compassion, inclusion, open-mindedness, reliability, strengths-focused, person-centred, person-driven, high quality etc.
- **Vision statement:** Promoting mental health and well-being for everyone, recovery, reflecting compliance with human rights, upholding the notions of equality, respect and dignity, providing high-quality services etc.

Topic 2: Service culture and change

Time for this topic
Approximately 4 hours and 15 minutes.

Presentation: Understanding service culture (40 min.)

This topic is an opportunity to explain how the service culture of a mental health or social service influences the daily practices and routines of people using the service, as well as the staff and management. Changing the service culture is fundamental to any service reform, and for this reason it is dealt with in depth in the early part of this module.

The aim is to highlight that an unhealthy and degrading service culture leads to unhealthy and degrading actions and vice versa. This can negatively impact the mental health and well-being both of the people using the service and the service providers. Strategies are required to change certain cultures that are characterized by the use of seclusion, restraint, violence and coercion that violate human rights.

Refer to the module on *Freedom from coercion, violence and abuse* and the module on *Strategies to end seclusion and restraint* for more detailed information on these topics.

Definition of service culture

Service culture refers to the pattern of shared values, beliefs, rules and practices of the different members of a service *(2)*. It results from the dynamics between the different groups within the service, including people using the service, mental health and other practitioners, management and other relevant people such as family members and care partners.

The service culture can take on a life of its own that directly influences the daily practices of staff, people using the service and even of new members entering the service. Unfortunately, the culture is often accepted without reflection by the majority of the service members since the culture operates instinctively. The culture defines "the way we do things around here" *(2)*.

What influences service culture?

Service culture is influenced by visible factors, declared service values and basic underlying assumptions *(3)*. These factors are linked in an onion-like structure, as Figure 1 illustrates.

Figure 1. How factors, values and assumptions are linked
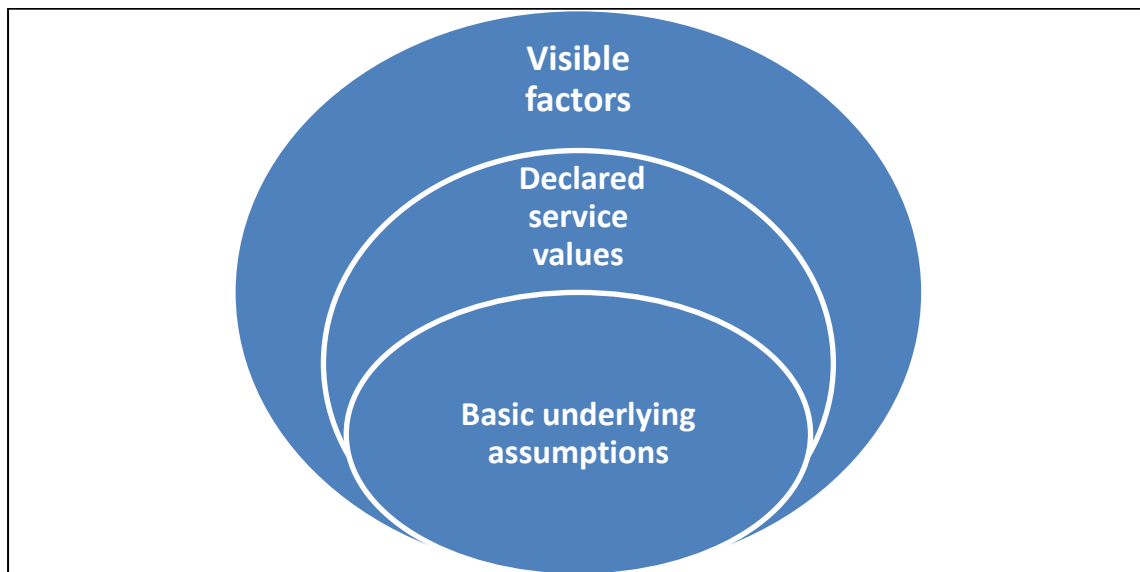
Visible factors are structures and signs of the physical, psychological or social environment. Examples include the design of the physical space, observed behaviour and interactions between people (i.e. daily practices and routines), the clothing that is worn, modes of communication between people, the language used, the spaces accessible, as well as any statement concerning the values of the service – including charters, mission statements and formal descriptions of how the service works. Visible factors can be easy to observe, but sometimes their meaning or what they represent is difficult to interpret.

Declared service values are what the service thinks "ought to be". They may be positively aligned with international human rights standards (e.g. no-one should be subject to the use of restraint), or they can contradict these standards (e.g. the use of restraints is acceptable under certain conditions). Values are often not seen directly – they are semi-visible and often expressed in writing or verbally through policy documents or documented procedures for the service. Often there are no declared service values to guide practice, which means that people can act in very contradictory ways due to the basic underlying assumptions that they hold *(4)*.

Basic underlying assumptions are often unconscious, taken-for-granted beliefs, ideas and attitudes which determine behaviour, perceptions, thoughts and feelings. They contribute strongly to the service's culture through influencing the thinking and behaviour of all its members *(3)*.

Having a set of positive values for the service will lead to an improved culture only if negative underlying assumptions are challenges and addressed. For instance, the belief that people with psychosocial, intellectual or cognitive disabilities are incapable of making decisions is a negative underlying assumption that will lead to practitioners making treatment and other decisions for people using the service (*visible factor*). This would then conflict with any declared value statement that the service may have concerning recovery and the autonomy of people using the service.

Basic underlying assumptions are usually invisible, in that they are not written down anywhere or questioned, which makes them difficult to identify and sometimes to understand. For instance, staff members may not allow people who are using the service to have lunch in the same room as the staff.

However, the staff's reasoning for this practice can be difficult to identify since a number of different scenarios may be governing their decision:

- The practice could be based on a rule of the service about how things should be done (declared values which are negative and not aligned with human rights approaches).
- The practice could be an informal practice initiated by staff members that reflects negative underlying basic assumptions of inequality between people using the service and staff.
- The practice may not reflect any rule based on formally declared values of the service. Instead it can simply be an expression of an automatic basic assumption regarding "the way we do things around here" or "the way things have always been" without further critical reflection.

In all three scenarios, no matter what the reason for this practice is, staff may be unaware of the impact of their decision-making on people using the service.

However, it is possible to change rules and practices that are not in alignment with declared service values by questioning the *values* (or lack of them) and *basic underlying assumptions* of both the service and of all stakeholders.

Changing all these areas – namely 1) negative underlying assumptions held by people in the service, 2) declared values held by the service that contribute to stigma and discrimination, and 3) visible factors, including those leading to negative automatic and habitual practices – is required in order to move towards a positive service culture.

It is important to note that within an overarching service culture are diverse staff and service providers whose experiences, power, advantages, social contexts and social positions can differ in many ways.

It is important for all service staff to question visible factors, values and basic underlying assumptions within their own practice. Critical self-reflection is essential.

Questions to ask oneself can include:

- What are my basic underlying assumptions about this service and the people who use this service? How has my social position, education or training shaped these assumptions?
- How might this affect how I see myself, and how others perceive me?
- How might this affect how I work (e.g. how I speak or behave with my peers and people using the service)?
- What can I do better to promote dignity, equality and respect (e.g. learn more about how different groups might experience discrimination; encourage participatory processes for change, etc.)?

From a service culture to a "culture of service"

The concept of "service" has important implications and should influence the service culture. It should mean that people are there because they are requesting, choosing, using and accepting services. As such, a system where involuntary interventions are permitted cannot be considered a "service".

All efforts should be invested in fostering a culture in which staff understand that people are coming to the service because they have needs (e.g. for respite from a difficult circumstance they are facing in their lives), they feel they could benefit from human connection, comfort and support during a particularly difficult time, or because they want to work on their recovery outside of their usual space

and routine. The service needs to shift from a culture of "managing" and "controlling" people, to a recovery-oriented approach in which the aim is to support people to meet their needs, when they need support to do so. In order to achieve such a cultural shift, it is essential for staff to work with people to meet their needs, rather than fail to respond to their needs or refuse to meet those needs.

At the same time, it is important to acknowledge that sometimes services may not be able to meet certain needs or may not be able to meet them immediately. This should be discussed with the person concerned. In addition, service managers should make sure that service staff have the working conditions necessary to enable and empower them to engage effectively with and meet the needs of people using the service.

Exercise 2.1: Understanding visible factors, values and basic underlying assumptions in this service culture (60 min.)

Ask participants to stay in the same groups as they were in for the last exercise and find their copies of Annex 4 – *Analysing visible factors, values and basic underlying assumptions in this service culture.* Complete this form when answering the following question and save it for later:

1.   Think back to Exercise 1.1 and to the declared values that you agreed on for the service. Write the values in the first column of the table.

2.   For each value, identify visible factors in the service that either reflect or conflict with the value. Visible factors could include rooms, clothing, furniture, food, communication styles and anything that you can observe.

3.   Finally, think back to the underlying assumption(s) that need to be challenged in order to uphold the values.

Underlying assumption 1: Staff need to "control" and "manage" people using the service.
Underlying assumption 2: People using the service cannot recover.

In plenary, ask each group to present its views on the questions and share personal experiences.

Values	Visible factors	Underlying assumptions to be challenged
E.g. Recovery approach	**Reflect the value:** *Modes of communication: respectful and recovery-oriented person-first language is being used and staff and people using the service regularly talk about this issue.*	*E.g. People cannot recover if they have been diagnosed with a mental health condition – it is a lifelong permanent condition.*
E.g. Nonviolent approach	**Conflict with the value:** *Seclusion is used in the service.*	*Using coercion is necessary at times for the good of the person to keep them safe.*

Remind participants to save the completed Annex 4 for later.

Presentation: Power dynamics in the service culture (20 min.)

The purpose of this presentation is to help participants understand the role and impact of power dynamics within the context of service culture. Power dynamics shape the nature of the relationships between staff, people using the service and others. Understanding and addressing these dynamics are important steps towards improving the service culture.

The culture in a service both leads to and reflects the existing power dynamics within that service. Focused attention is needed to understand these dynamics, the reasons behind them and their impact in order to improve or change the culture.

What are power dynamics?

Power operates in everyone's day-to-day life, creating advantages and disadvantages that change over time and place. Power is exerted and resisted at multiple levels, from the structural level (e.g. discriminatory policy), to individual interaction (e.g. racial slurs). Power relations include "power over" others but also "power with" others (when people work together as a collective) *(5)*. In other words, this often means being able to control or decide what someone can or cannot do – i.e. having a certain authority over something.

The term "power dynamics" refers to the different amounts of power people have in a given place or situation. Power dynamics influence access to, as well as the delivery and experiences of, mental health and social services. Within a mental health or social service, staff have more power than people using the service *(6)*. This is often referred to as a "power imbalance".

Power imbalance can be a significant barrier to the well-being of the people within the service – both those using the service and the staff. People using services often believe that mental health and other practitioners can do what they want because of their position, while the users themselves believe that they have little influence over their care *(7)*. Abuse of power can lead to violence, exploitation, coercion, abuse and cruel and degrading treatments.

As a result, people using the service may feel reluctant to resist or voice complaints of violence, coercion and abuse because of the intimidation and the power dynamics currently in place.

An example of how power imbalances occur

Power imbalances within the service culture are influenced by basic underlying assumptions which in turn have an impact on all aspects of the functioning of the service (including values and visible factors) *(3)*.

For instance, in many services the practices and routines of the staff are influenced by underlying basic assumptions of being in charge of the people using the service, resulting in a power imbalance. As a result, staff members in the service may prioritise order, control and procedures over communication, empathy and treating people with equality, respect and dignity even if these are the declared values of the service.

Staff inherently have power because they are given responsibility for providing and implementing services, rules and procedures. When the basic underlying assumptions of staff are not characterized by equality, dignity and respect, this both leads to and reflects a power imbalance in the service. This

can be seen in the daily practices (visible factors) when staff use disrespectful language or forcibly treat people, and when they use seclusion and restraint.

An unhealthy service culture with a power imbalance is further reinforced when the people using the service are dependent on the staff for their well-being and all basic needs. They often have no control over their situation, particularly when they are involuntarily detained.

It is important to note that a power imbalance can be reinforced or reduced/modified almost unconsciously by staff, management and others such as care partners and family. This is linked to the fact that the service culture can influence the individual's thinking and behaviour.

Refer to the modules Freedom from coercion, violence and abuse and Strategies to end seclusion and restraint for more information on the impact of power dynamics in mental health and social services.

Exercise 2.2: Real-life example of institutional culture (30 min.)

Show the participants the following video:

⚠️ **Warning:** This video may provoke strong emotional responses from some people.

Facilitators should be mindful of this. Prior to showing the video, let participants know that they should feel free to step out of the training session until the video has finished. The facilitator should also be mindful of any sign of distress shown by participants (please refer to *Guidance for facilitators* for more information).

Show participants the video only from the start until minute 4:11. This is sufficiently long to give participants an idea of the facilities in the video for the purposes of this exercise.

Forgotten People – Witness. Disability Rights International [9:42 min.]
https://www.youtube.com/watch?v=VVj1LCnO0OY&feature=youtu.be
(accessed 9 April 2019).

After having shown the video, ask participants the following questions in plenary:

- Think back to the discussion about visible factors and service values. In this video,
  - What kind of institutional culture did you see?
  - What were some of the visible factors?
  - Do you think the service had any declared values that it was following?
  - What do you think were some of the underlying assumptions?

Potential answers include:

Institutional culture:
- Terrible living conditions and environment, inhuman treatment, coercion, abuse, neglect, no respect for peoples' dignity

Visible factors:
- Poor living conditions (e.g. urine on the floor, filthy bathrooms, overcrowding, 5 cups for 99 people living in the facility).
- Inhuman and degrading treatment practices (e.g. people being tied to chairs, being locked up, no privacy, no respect for dignity).
- Neglect (e.g. nothing stimulating for people to do, people are left naked to roam the corridors, children are deprived of human contact).
- Clothes worn (e.g. staff wear clean uniforms, people using the service wear dirty clothes, pyjamas or nothing).
- Medical attention is inadequate or inappropriate.

Declared service values:
- No positive service values are discernible from the video.

Basic underlying assumptions:
- That people in the service do not need to be treated with dignity and respect.
- That it is acceptable to tie people up in order to prevent self-abuse.
- That the squalor in which people are required to live, the abuse and neglect they experience is acceptable given the lack of staff.

After the discussion, show the following:

What can we learn from this exercise?

The video demonstrates what an unhealthy institutional culture can look like. This is something we see a lot in psychiatric and social care institutions. A culture of inequality, discrimination, violence and coercion can escalate, causing vital damage to people's mental and physical health.

A culture that allows people to be treated without dignity or respect and that allows for coercion, violence, abuse and neglect is likely to cause profound damage to people's mental health and well-being.

Sometimes, the service culture in which people are placed (e.g. the institutional culture) can influence their behaviour as individuals more than they think and may even outweigh all their positive individual characteristics and values.

People's usual moral reasoning and thinking can be altered when the culture in which they are placed interacts with their underlying beliefs, decision-making and how they behave towards each other.

It is therefore important to assess the service culture critically in order to identify whether people are acting in accordance with the culture and whether the culture on a daily basis is consistent with the core values of equality, respect and dignity that should be embedded in any service.

Such assessment must consider the different levels that shape service culture – from individuals and groups (e.g. beliefs and assumptions) to the visible factors that influence behaviours even without noticing (e.g. staff behaviours), to the values and vision of the service and through to broader structures (e.g. other sectoral policies, social barriers to equal care in society at large etc.).

Presentation: What challenges do we need to overcome? (8) (40 min.)

Power imbalances in an unhealthy service culture often lead to resistance to change. Strategies for culture change need to take account of barriers that can block purposeful change.

Some of these barriers include:

- level of ownership
- change fatigue
- compassion fatigue
- complexity of the service
- leadership style
- multiple subcultures
- external influence.

Degree of ownership

Reactions to change by individuals or groups within the service can be negative, unpredictable and characterized by reluctance since change often evokes a sense of loss and the need for change is often unrecognized.

Even a few persons who are unhappy with the idea of change can cause disruption, and a group of people reluctant to change can be a significant barrier to positive change in the service.

Consequently, it is important to obtain the commitment of persons in leadership roles, or other individuals in the service, who are key to bringing about a change in the service culture. The leadership has a key role in promoting transparency and explaining the need for culture change to service staff and others.

Critically, the views of people using the service should orient the direction of culture change. It is important to hear individuals' concerns and to be mindful that the purpose of the service is to support and respond to their needs.

In order to implement culture change, a critical mass of people in the service needs to be involved. All stakeholders need to feel a sense of ownership over the process. People using the service often have no ownership at all. It is essential that they have an equal opportunity to be part of the process.

- People using the service, people working in the service and other stakeholders may work together to define a set of core values and a shared vision for the service (as was seen in Exercise 1.1) in order to promote ownership of the change process.

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- It is also necessary collectively to agree on and build the capacity of all stakeholders to understand and promote human rights within the service.

(Refer to the modules Human rights and Mental health, disability and human rights which provide information on human rights and seek to build capacity to understand and promote human rights and recovery.)

Change fatigue

Many services are involved in concurrent, and sometimes competing, change or transformation initiatives. Change initiatives may be the response to new standards of how a service should operate, to a new policy or new legislation, or in response to an internal review. Change initiatives may also take place in resource-constrained work environments (mental health and well-being are strong examples of areas where resources are often limited) which can mean staff feel they have limited time to engage with ongoing change initiatives *(9)*.

Change fatigue can lead to a sense of apathy and disengagement from change initiatives and can be a significant contributing factor to why a change initiative may fail. It is important to understand if your organization is affected by change fatigue and to invest in appropriate planning, consultation and communication throughout the change process to make sure that change is successful *(10),(11)*.

Compassion fatigue

Compassion fatigue is the stress that can occur in persons who have formal or informal caring roles for individuals with a chronic condition. It is a psychological response to the emotional strain that can develop from caring and supporting someone – particularly if there are no other supports.

Compassion fatigue may manifest itself in many ways – including a sense of hopelessness and anxiety, feelings of incompetency and negative attitudes but also a reduced sense of compassion for others *(12),(13)*. It is important to be aware of the potential for compassion fatigue among stakeholders involved in the change process so that they can be provided with the appropriate support for their own well-being and for their future engagement with the change process.

Complexity of the service

Services can be complex with multiple units or departments, management layers, supervisory styles and policies. All these elements need to be aligned to promote a unified cultural change. It can be helpful to review and map the organizational structure of the service so that all stakeholders can be identified and approached to participate in the culture change process. In addition, it will help everyone to understand their own and each other's roles and responsibilities in the service.

Leadership style

Promoting leadership is a key factor for culture change. Leadership can be defined as the process in which one person engages others around them and works to achieve a common goal that is defined by a set of declared values and a vision for the service.

Two main styles of leadership are widely recognized:

- Transactional leadership: focused on securing people's compliance by using material motivational factors (e.g. setting performance measures, reward systems).

- <u>Transformational leadership</u>: focused on raising people's interest in engaging in the well-being of the service and inspiring change in how people think. The end goal is to transform "followers" into leaders who are individual agents of positive change. This can happen by connecting people's sense of identity to the collective identity of the service; being a role model for others; challenging people to take greater ownership of their work; and understanding their strengths and weaknesses in order to support them.

The two styles of leadership need to be integrated in a way that changes how people think and behave in the service. For example, it can be valuable to reward staff for their promotion of positive new practices *(transactional)*.

However, for this strategy to be effective in the long term, people need to see the value-added benefits, be engaged at a personal level and feel a connection between their individual identity and the collective identity of the service (*transformational*). This can be done by explaining how the practice of each staff member is crucial to how the service runs and the practices of everyone around them in the service. It is also important to highlight how the staff's own values influence the service and therefore should be reflected in the day-to-day running of the service. In relation to this, staff will feel a sense of ownership and commitment towards securing these core values in the service. (Refer to the modules *Human rights* and *Mental health, disability and human right* for more information on the importance of human rights in mental health and social services).

Multiple subcultures

A service may consist of several different subcultures and subgroups with individuals who may not share similar social positions, beliefs and contexts. These subgroups may have different or competing interests, understanding, values and practices. Such groups are sometimes linked to professional identity (e.g. doctors, nurses and managers) but by no means always. These groups may simply reflect differences in social positions, education/training, experience and background. The existence of subcultures can lead to power struggles and inconsistencies in approaches within the service and can negatively affect its functioning and the quality of care it provides.

In practice, this means that staff members might have opposing ideas about how to support people who are using the service; hence, people may not receive equal treatment. It is important to examine these differences, be open about them, and understand how people can work together in a synergistic way in order to promote a shared understanding of core values. For instance, in order to find a shared way of undertaking daily practices and routines, it is important to communicate with all stakeholders and understand how different people or groups in the service think differently about how daily practices and routines should be carried out.

External influence

Resistance to change within services is also shaped by broader power dynamics and outside interests. For instance, local or national legislators may not enforce laws to stop the use of seclusion and restraints. External stakeholders, such as organizations or private entities, may also oppose the culture change required.

For culture change to be successful, people in the service must understand and discuss these external influences, view themselves as *agents of change* and be prepared to initiate a movement of positive change.

Scenario - Transforming service culture through peer support *(14), (15)*

The Institute of Mental Health, in partnership with the Nottinghamshire Healthcare NHS Trust, launched a project to promote a culture of recovery-focused practice through the recruitment of persons with lived experience as peer supporters.

One of the main challenges to changing the service culture was a practical one: people were completely unaware of the availability of peer support workers within the service.

In addition, peer supporters had to overcome resistance to change within the service. Some staff members were anxious that their roles would be threatened and some misunderstood the role of peer supporters. Sometimes peer supporters were seen as being "an extra pair of hands" and at other times they were seen as being responsible only for those people using the service who were the most challenging for staff.

To address these challenges, a new system was set in place requiring staff to inform people using the service about peer support and to provide them with the opportunity to meet a peer supporter.

Peer supporters built strong relationships with people using the service, who said that they felt more supported and experienced a better quality of relationship with peer supporters than with other staff. Eventually, peer supporters were able to influence the team by changing underlying negative assumptions and beliefs about people using the service as well as changing the day-to-day practices of staff.

Peer supporters were able to overcome the initial resistance from staff to develop positive and transformative relationships; staff reported being more hopeful and willing to try new approaches in their daily work. Self-assessments completed by the executive team showed a positive shift towards a recovery-based culture. A staff member commented: "I think the benefit of having a peer supporter in the team, it reminds of why you're doing the job first and foremost. It reminds you people can get better, it almost provides you with some hope."

Overall, peer support contributed to a significant reduction in inpatient stays and a transformation of the service culture towards integrating a recovery approach at all levels of the service. One peer supporter commented: "I think what has surprised me is the fact that in this role you can influence things more than I thought you probably could".

Exercise 2.3: Identifying challenges to overcome in the service culture (40 min.)

Divide participants into groups of five. Ask participants to take their copies of Annex 5 – Challenges to overcome in the service culture. They should fill this out and save for later when answering:

What challenges do we need to overcome in the culture of this service? Consider strengths and weaknesses in relation to the common challenges presented earlier. Many of these will overlap – e.g. degree of ownership, change fatigue, compassion fatigue, complexity of the service, leadership style, multiple subcultures, external influence.

Encourage participants to identify both positive and negative factors where these exist and think of additional challenges in the service. Emphasize that there are no right or wrong answers.

Potential answers include:

Degree of ownership
Strengths:
- Regular meetings are held with staff and people using the service in order to obtain feedback on what aspects of the service can be improved.

Weaknesses:
- Most of the staff do not invest themselves beyond the minimum necessary.
- Some people are reluctant and do not see the point of changing practices.
- There has been no process for managers, staff, people using the service and other key stakeholders to define a collective vision and values for the services.

Change fatigue
Strengths:
- The majority of people in the service understand the need for change and support these efforts

Weaknesses:
- Numerous previous attempts to bring about change have not had a positive impact on the service functioning and outcomes.

Compassion fatigue
Strengths:
- The overwhelming experience of compassion fatigue sends a strong signal that things need to be organized and implemented differently.

Weaknesses:
- Compassion fatigue is felt so strongly that clinical staff report not having the energy required to invest in management issues and a quality improvement process.

Complexity of the service
Strengths:
- A clearly defined management structure exists.
- People know who to go to when they need support.

Weaknesses:
- It can be difficult to know what one's individual role is with regard to taking the lead in initiating new activities.
- It is difficult to know who to ask for support when you need it in your team.
- Sometimes people do things in a certain way without questioning why.
- There are unstated rules that govern communication and behaviour between different professional groups and which have a negative impact on practices.

Leadership
Strengths:
- Management is open and flexible.
- Some staff members and representatives of people using the service serve as excellent role models.
- Most people feel a commitment to the shared vision and declared values of the service.

Weaknesses:
- Managers avoid taking difficult but important decisions that are required for the proper functioning of the service.
- Some staff members do not connect their own sense of identity to the collective identity of the service, thus resulting in practices which are not consistent with the values of the service.

Multiple subcultures
Strengths:
- The service is characterized by a high degree of diversity, with people from many different backgrounds who have a wide range of expertise and experience.

Weaknesses:
- Different subgroups among the practitioners of the service do not agree on care and support plans.
- A lack of effective communication about different views and roles result in inconsistencies in the provision of support.

External influence
Strengths:
- The service has close collaboration with external stakeholders in the community.
- The service has a good reputation and support in the community.

Weaknesses:
- Local or national legislation works against efforts to change.
- The service constantly has to justify its existence and basic funding requirements.

Concluding Part 1 of the training (15 min.)

Every staff member, person using the service, family member and other care partner needs to be aware of and willing to challenge the visible factors, values and basic underlying assumptions of the service.

Being an individual agent of change may be extremely difficult in some services. People may sometimes face repercussions when they try to promote change. That is why a commitment at the leadership level of the service – and the creation of a culture that allows for positive ownership and responsibility between individuals – is necessary for sustainable change to be achieved. Individuals can initiate change but ultimately the whole service needs to be willing and motivated to change.

Culture change is difficult and takes time. The process of culture change can face many different barriers, including people who are reluctant to change.

Individuals may feel alone with their worries and may find it difficult to navigate and know what to do. Joining up with others who have similar points of view, or who also challenge practices, may be very helpful.

Quote:

"Sometimes I'm skeptical about how much I'm impacting the organizational culture. There's so much that needs changing! But then I'll take a step back and see that the language is changing. The way people are talking about hearing voices and self-harm is changing. I think I'm really making a difference here. It's what keeps me going." – Peer supporter, USA *(16)*

Part 2. Developing and implementing a transformation/improvement plan for service change

*For this part of the training, it is **<u>essential</u>** that a QualityRights Assessment has been completed in the service.*

Topic 1: Understanding the quality and human rights conditions of mental health and social services

Time for this topic
Approximately 2 hours and 40 minutes.

 Presentation: The 5 themes of the WHO QualityRights assessment toolkit (30 min.)

Remind the group that the QualityRights assessment has measured service performance against these themes. The first presentation introduces the 5 themes within the QualityRights assessment toolkit (17).

The complete WHO QualityRights assessment toolkit is available at the following link: https://www.who.int/publications/i/item/who-qualityrights-tool-kit

The five themes of WHO QualityRights assessment toolkit are:
1. The right to an adequate standard of living.
2. The right to the enjoyment of the highest attainable standard of physical and mental health.
3. The right to exercise legal capacity and the right to personal liberty and security of person.
4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse.
5. The right to live independently and be included in the community.

What is the purpose of the QualityRights assessment toolkit?
- The QualityRights assessment toolkit is designed to support countries (and services) in assessing and improving the quality of mental health and social services and their compliance with international human rights standards.
- The assessment is a means by which services can identify and end poor-quality care and human rights violations.
- The themes in the toolkit are based on the UN Convention on the Rights of Persons with Disabilities (CRPD) which is a legally binding treaty that outlines the rights that should be respected, protected and fulfilled for all people with disabilities, including people with psychosocial, intellectual or cognitive disabilities. For more information on the implications of the CRPD in mental health, see the module *Mental health, disability and human rights*.
- The QualityRights assessment toolkit is not about promoting institutions or fixing them. Large mental health and social services, institutions or hospitals which are isolated or unconnected to the community should be closed and replaced with a network of services based in the community. At the same time, we should never abandon people in institutions during the transition to community-based services; in other words, we need to make sure that their rights are not violated during this transition phase.

What do the themes of the WHO QualityRights assessment toolkit cover?

Theme 1: Adequate standard of living and social protection
Theme 1 looks at the degree to which:
- People in acute or longer-term care services have appropriate and comfortable living conditions.
- People have the fundamental necessities required to live a good life – such as clean water, food, heating and clothes, as well as privacy and appropriate bedding.

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- People have opportunities to communicate and to be engaged with the outside world during their period of stay.
  - ➢ (**Note that:** The CRPD requires that people with psychosocial, intellectual or cognitive disabilities are provided with an adequate standard of living and protection of their social well-being.)

Theme 2: Enjoyment of the highest attainable standard of physical and mental health

Theme 2 looks at the degree to which:
- People have access to the mental health care they require, on the basis of the person's free and informed consent.
- People have access to physical health care (especially as this is often disregarded by health/mental health staff).
- There is a focus on recovery and community inclusion.
  - ➢ (**Note that:** The CRPD requires that people with psychosocial, intellectual or cognitive disabilities are provided with the health services they may need and that they have access to the same range, quality and standard of free or affordable health care as others.)

Theme 3: The right to exercise legal capacity and the right to personal liberty and security of person

Theme 3 looks at the degree to which:
- People with psychosocial, intellectual or cognitive disabilities have a right to make decisions about their own lives, such as where to live or which medical treatment to seek and can receive support to do so.
- These decisions are not made by their families or health/mental health staff.
  - ➢ **Note that:** The CRPD requires that people with psychosocial, intellectual or cognitive disabilities be recognized as persons before the law who have the right to exercise their legal capacity and make decisions which affect their lives, on an equal basis with all others, in every aspect of their life;
  - ➢ Legal capacity cannot be denied on the basis of a psychosocial, intellectual disability or cognitive disability.
  - ➢ People with disabilities must be given access to supported decision-making processes, including the right to involve trusted people who can support them.
  - ➢ People with psychosocial, intellectual or cognitive disabilities cannot be admitted, detained or treated in services against their will. Non-institutional options should be made available and they should be able to receive support in their own homes and other settings.

Theme 4: Freedom from torture or cruel, inhumane or degrading treatment or punishment and from exploitation, violence and abuse

Theme 4 looks at the degree to which:
- People are protected from physical, sexual and emotional abuse.
- Practices of forced treatment, seclusion, physical, mechanical or chemical restraint are stopped, since these practices are not consistent with the prohibition of torture according to the CRPD.
  - ➢ **Note that:** The CRPD requires that all appropriate measures be taken to prevent violence, coercion and abuse from happening.

Theme 5: The right to live independently and be included in the community

Theme 5 looks at the degree to which:
- People with psychosocial, intellectual or cognitive disabilities are supported to live independently and to be full members of their community.
- Mental health and social services facilitate access to community groups, income-generating activities, housing, eligible pensions, leisure activities and social services.
  - **Note that:** The CRPD states that people with psychosocial, intellectual or cognitive disabilities have the right to decide where they live, to be included in their community to prevent isolation or segregation and to access services and supports that enable them to live independently and be included in the community.

Exercise 1.1: Reflecting on areas for improvement (30 min.)

The purpose of this exercise is to encourage participants to identify in advance the key challenges that are outlined in the QualityRights assessment report.

Ask participants to sit in groups of approximately five people. Each group will be asked to consider this reflective question for one of the five themes in the QualityRights assessment toolkit.

This may facilitate a more positive attitude to the report when it is delivered, as it is not just a "lecture from an outsider" but a set of recommendations with which they identify. Additional recommendations that evolve from discussions, not contained within the QualityRights assessment toolkit, may be included at the facilitator's discretion.

The rationale for dividing into groups that each deal with one of the themes is to ensure that all five themes are given consideration from the very beginning.

Hand out to each participant the full list of themes and standards of the QualityRights assessment toolkit which were used to undertake the service assessment (Annex 6) and copies of Annex 3 (*Reflecting on areas for improvement*). This should be filled out after reflecting on the following question.

Think back to a health, mental health or social service that you have used and identify what was helpful, useful and made a positive difference to your life. Also consider what was neither helpful nor useful and what would have made your experience a better one. In your brainstorming, think of barriers to accessing the service and factors for facilitating access.

Based on your own experiences and knowledge of the themes within the QualityRights assessment toolkit, which areas for improvement do you think will be recommended in the assessment report of this service?

If the number of participants is 15 or fewer, it might be possible for each group to work on more than one theme each.

Presentation: WHO QualityRights assessment for the service (60 min.)

At this point go through your pre-prepared presentation of the QualityRights assessment that was undertaken at the service. All participants should now be provided with a copy of the report, or a summary, as part of this session. If appropriate, depending on the context and the anticipated reaction of participants, copies of the reports could be made available prior to the training.

- The presentation should outline how the assessment was conducted, with some focus on the constructive preparations made by the service in advance of the assessment.
- It should give some elements of context (national law and policy and their compliance with the CRPD, etc.).
- It should provide an overview of the content of the assessment report dealing with all 5 thematic areas of the QualityRights assessment.
- It should highlight both positive areas of performance highlighted by the assessment, as well as areas that require improvement. In other words, the presentation should include:
  - ➢ One slide with POSITIVE HEADLINES from the assessment.
  - ➢ Another slide with the MOST IMPORTANT AREAS FOR IMPROVEMENT.
- In addition, the presentation should include a slide on POSITIVE STEPS ALREADY TAKEN IN RESPONSE to the assessment. This may include actions such as conversations with managers or the preparations made for these training sessions.
- The aim is to create a sense that this assessment can generate a service of pride as well as an opportunity for areas to be improved.

Exercise 1.2: Discussion on the opportunities for improvement (40 min.)

This session is designed to be an open and inclusive space for "initial reactions". This allows for participants to share their own reactions (including negative reactions) to the report prior to being asked to work with the information constructively.

In plenary, invite participants to discuss their initial reactions to the contents of the report. Make sure to include comments and views from all participants – people using the service, staff, family, care partners and others.

What are your views about the QualityRights assessment report?

This should be followed by a structured discussion led by the facilitator. Invite general comments from the group and encourage conversations between participants in the training workshop. All voices and perspectives should be heard in the discussion.

Now ask the participants the following questions:

- How do you feel about the positive areas discussed in the report?
- How do you feel about the negative aspects?
- Do you agree or disagree with the identified areas for improvement? Why?
- Do you feel there are important information gaps in the report?
- Can the report information be used to make improvements to how the service supports people?

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- Would the current law and policy in your country be a barrier to implementing these improvements?

As facilitator, you should be prepared to allow grievances about the process or content of the assessment to be aired at this stage and to respond to participants' questions on these. Reassurance should be given that there will be time and space to discuss these further.

Please note that the presence of participants who strongly disagree with the identified areas for improvement might be indicative of a service culture that is resistant to change. The importance of changing the service culture has been discussed in Part 1 of this training. If relevant and appropriate, these views can be addressed by the facilitator at this point in the training.

In addition, the last question is likely to create concern from participants that the law and policy in their country, particularly laws around involuntary detention and treatment and guardianship laws, may be barriers to improvements. A response from the facilitator may include that advocacy will be necessary to change the law or policy and that such a change may take time. In the meantime, there is a lot that can be done at the individual and service level to bring practices more in line with the CRPD.

Topic 2: Specific priorities for change in the service based on the WHO QualityRights assessment toolkit

Time for this topic
Approximately 2 hours and 30 minutes.

Presentation: Priorities for change (10 min.)

In Part 1 of the training, we discussed service culture and the importance of changing the service culture in order to promote the well-being of people using the service. This is an immediate priority and a prerequisite for any other changes. This will also contribute to creating a better working environment for staff.

In this topic, we look at other specific changes or areas of improvement that can be made based on the QualityRights assessment. First, it is important to distinguish between 1) immediate and 2) mid-term and longer-term priorities. Not everything can be done at once.

<u>Qualities of an immediate priority</u>

* Poor performance on the standard can be dangerous for people using the service.
* Poor performance on the standard can lead to the deterioration of physical and mental health.
* Poor performance on the standard can have a negative impact on the majority of people using the service.
* Poor performance on the standard results in people wanting to leave and stops others from using the service.

<u>Qualities of a mid-term or longer-term priority</u>

* Improvement on the standard will be an important change to the service but does not have an impact on the safety of people using the service.
* Improvement on the standard will affect a minority of the people we serve.
* Improvement on the standard can be acted on only when priority standards have been addressed.
* Improvement on the standard may help to reach more people but is not a barrier preventing them from using the service.

Exercise 2.1: Priorities for change (80 min.)

During this exercise, participants will discuss priority areas for action for the service on the basis of the assessment report.

Emphasize that priorities identified by participants will feed into the improvement plan and therefore directly influence the process. By informing them of this, participants will realize how important their role is in improving the service.

The question for now is what are the priorities – "What needs to be improved?" At a later stage when the key priority issues have been identified, the question will become "How can we address these priorities given the resources that we have or are likely to obtain?"

Distribute to participants copies of the guidance for selecting immediate and longer-term priorities (Annex 7 – *Priorities for change*).

Ask participants to divide into several small discussion groups of five people. Once they have settled into their groups, ask them to complete the following:

In your groups, use the summary report of the WHO QualityRights assessment to:

- Identify the standards within each theme that you consider to be immediate priority areas requiring action (please identify a minimum of 3 per theme).
- Identify other standards within each theme which you consider to be mid-term and longer-term priorities.

It is important to understand that the aim of the exercise is to identify priorities for what is "right" and appropriate according to QualityRights standards. Avoid letting issues of resource availability influence your priority-setting. Availability of resources is a separate issue that needs to be considered later.

After the discussions, the groups will come together and one participant from each group will present the standards identified as priorities for each theme and explain why these were chosen.

After each group gives its presentation, the facilitator should encourage discussion in plenary as to whether people agree or disagree with these immediate and mid-term or longer-term priorities.

Exercise 2.2: Compiling a list of immediate priorities (60 mins)

After the plenary discussion, work with participants to prepare a list of priority areas for change, focusing on the immediate priorities only. Using the flipchart, compile the following in plenary:

- A master list of AGREED-UPON PRIORITIES of standards requiring improvement (priorities all groups agree with).
- OTHER IDENTIFIED PRIORITIES of standards for improvement (that may warrant further discussion).

If there are priorities for which participants do not reach a consensus, it is possible to decide by majority vote as to which should be included as agreed-upon priorities.

This initial list of priority standards for improvement that has been collaboratively compiled by the group can provide the foundation for the action areas of the improvement plan. The list should be recorded and stored safely; it should be accessible for future use in meetings as part of the improvement plan process.

It is important to emphasize to participants that the list of priority standards for improvement will be used in the daily work of the service. Therefore, highlighting the input from all participants and stakeholders is crucial in order for the improvement plan to be successful.

Topic 3: From problems to solutions and from action to impact

Time for this topic
Approximately 3 hours and 20 minutes.

Exercise 3.1: How can this service improve? (40 min.)

Ask participants the following:

Think about what this service can do to improve on the QualityRights standards.

On the basis of their experiences, participants will come up with great ideas. Write the ideas on a flipchart. In the following, the key is to put these ideas into a structured framework for improvement.

Presentation: Moving from problems to solutions (40 min.)

At this point there will be a session on moving from the problems identified to the solutions generated. The process is summarized in the flowchart below.

The facilitator should explore with the participants each step that is included in the flowchart.

Note that concerns about blame and institutional barriers to change – including political will, power dynamics and lack of funds and resources – need to be acknowledged and discussed openly. However, this discussion should be contained and should focus on how people can move forward in positive ways that take account of existing resources and creativity.

FLOWCHART

The flowchart (**Figure 2, below**) shows each step in the process of developing improvement/transformation plans for the service following the QualityRights assessment. An improvement/transformation plan should be developed on the basis of the discussions and decisions made. See the improvement/ transformation plan template and examples in Annex 8.

PREPARATION

- Prior to initiating the QualityRights improvement plan, ensure that all stakeholders have been invited to participate. Stakeholders include people who are using or have previously used the service, staff, management and other relevant persons such as care-givers and family members. Directly involve senior management and make sure that the implementation process is overseen by an oversight committee that includes representatives of people who are using or have previously used the service.
- It is important to make sure that people who feel they have been harmed by the services are **not** excluded from this process and that their views and opinions are heard.

IDENTIFICATION AND PRIORITIZATION OF PROBLEMS

- The first step of the improvement process is discussion to identify and prioritize the areas for change and problems that need to be addressed. Distinctions will need to be made between those areas for change and problems that need to be addressed immediately and those that can be implemented in the medium and longer term. Criteria that can help make these judgements are presented in Topic 2.
- Through the prioritization process, it is important to understand whether others in the service agree that identified areas/problems are priority areas. If they do not agree, then it is important to understand why and to better communicate why they are priorities.

DEVELOPING STRATEGIES

- The next step is to develop a strategy in order to address the area for improvement that has been prioritized. This should reflect the vision and core values of the service. The qualitative information from the QualityRights assessment report is helpful for developing strategies.
- It is important to think broadly about potential strategies. Not all areas for change/problems can be solved by training. Many will require multiple solutions – including policy and legislation, attitude and culture change, development of new skills, financial investment, additional human resources, self-reflection and support from senior management.

Questions to consider when formulating strategies
- What is the source(s) of the problem/challenge?
- What needs to be done to solve this problem/challenge?
- What resources are available?
- Who needs to be involved in dealing with this problem/challenge? (Consider whether this is something for which staff take primary responsibility, or whether it will require the leadership of people using the service or other groups.) How can they best be meaningfully involved?
- Are some people resisting the change? It may be necessary to identify, listen to and understand the reasons behind any resistance to change.
- Are the diversity and diverse needs of those affected by the "problem" being considered?
- Is a working group required to help define strategies?

ACTIVITIES, BUDGET DATES, RESPONSIBILITIES

- For each strategy it is important to decide on the activities that will be initiated.
- A planned activity is a specific response to a problem that can help achieve the strategy that the team believes will be most effective in generating positive results.
- Again, this is an occasion to draw upon the qualitative information from the QualityRights assessment report in order to consider which actions would be appropriate.
- All activities should:
  - include target dates
  - be costed
  - include the names of people who will be responsible for implementing and completing the activity
- By carefully allocating responsibility for each planned activity to an individual or group of people (including people who are using or have previously used the service or others), everyone knows who is in charge of making sure that the activity or activities are completed.
- Planning these activities, rather than simply responding immediately, gives structure to how the team approaches the challenge. In this way, the team understands that there is a clear

plan of action that will be followed in order to implement the strategy and produce an impact.

- With the specific activities, target dates, and related responsible persons, the working group and service management team can more easily monitor progress on the implementation of the strategy.

The table below provides an example of different strategies, activities, targets, indicators, time frames, responsible persons and budget identified to address *QualityRights **Standard 4.2**. Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises.*

Area of improvement 1 (illustrative example). Date of preparation: 20 May 2020 Standard 4.2. Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	Target 50% reduction in use of seclusion and restraint	Indicator Number of episodes of seclusion and restraint	Time frame including dates July–December 2020	Responsible person(s) Head of mental health service	Budget
Strategy 1: Putting in place measures to end the practice of seclusion and restraint					
Activity 1 **Provide a series of training workshops:** Arrange workshops to train people in the service (service users, staff and management) about techniques to eliminate the use of seclusion and restraint.	5 x 4-day training workshops for 100 participants (total)	Number of people trained	July –December 2020	Dr A and peer supporter A	Workshop and trainer expenses to come from regular service budget for training
Activity 2 **Create templates for individual plans for managing sensitivities, triggers and crises for people using the service and for staff:** The templates should include space to document sensitivities and triggers as well as actions to address these. The templates should be completed with the person for whom they are being developed (staff or service user).	Templates completed	Percentage of staff and service users with completed templates	July 2020: Preparation of template August 2020: Introduce routine use of template	Service manager, clinical lead and representative for people using the service	0
Activity 3 **Setting up a procedure for monitoring the use of seclusion and restraint in the service:** Monitor each time seclusion or restraint is used, the reason given for its use, and the length of time it was used for.	Procedure established	Record book completed with key information on use of seclusion or restraints	June 2020: Procedure documented June July 2020: Training in procedure as part of Activity 1	Chair of working group	0

Activity 4	**Development of comfort room and closing of seclusion room**	3 comfort rooms established	Number of times comfort rooms used, and evaluation after each use	August−September 2020	Service manager, clinical lead and representatives of service users	Cost of materials and design expert
Activity 5	**Convening senior management and leadership after each episode of seclusion and restraint,** in order to discuss what went wrong and how the response can be improved next time.	100% meetings held following use of seclusion and restraint	Percentage of meetings held following use of seclusion or restraint	After each incident	Senior management and leadership	0
Activity 6	**Making publicly available a yearly anonymized report** documenting cases of seclusion and restraint throughout the year.	Yearly report available	Yearly report published and publicly available	Yearly	Senior management	0
Activity 7	**Developing a zero seclusion and restraint policy for the service:** This policy should address the procedures that staff need to follow to ensure that seclusion and restraint are not used, including 1) development and implementation of individualized plans, 2) de-escalation techniques, 3) comfort rooms, 4) response teams, 5) post-crisis reviews, and 6) monitoring procedures for any use of seclusion or restraint.	Comprehensive policy available	All staff receive training on the policy	July−August 2020	Service manager and service user representative	Small budget
Activity 8	**Inter-service information events: A schedule and place for** inter-service information events where staff and people using the service can share knowledge and experience on de-escalation techniques, critically reflect, self-evaluate, and share best practices and experiences on what does and what does not work.	A written schedule of meetings available	100% of meetings implemented according to plan Evaluation of meetings	Every 6 months	Service managers across the region	Refreshment and transport expenses

EVALUATION OF IMPACT

- When making an improvement/transformation plan, the team should consider what positive impact they are hoping to achieve and should consider ways of monitoring this. Impact should be monitored both on people using the service and on staff.
- Central to this process is the selection of indicators to monitor performance.
- Impact may occur immediately after the planned activities have started or at a later point in time.
- In addition to monitoring indicators of performance, an important way to assess impact is to repeat the QualityRights assessment after a period of time.
- This will allow the evaluation of change to occur in a strategic and planned way.

It is also important to consider that improvement plans may have negative impacts.

FOLLOW-UP ON STRATEGIC ACTION

- It is important to ensure that the quality improvement process is embedded in the daily work of the service and that all stakeholders have a sense of ownership and responsibility.
- The outcomes of the implementation process should be presented to the appointed oversight committee of the service.
- A briefing note/memo could be prepared describing the initial situation in the service, the process for identifying solutions and the impact of implementation. The briefing note/memo should be presented to relevant stakeholders, including government institutions, in order to disseminate the findings and promote policy and legislative action for further sustainable change.
- Finally, a follow-up review session should take place to inform changes to the improvement strategy where required.

Figure 2. Development of QualityRights improvement/transformation plan
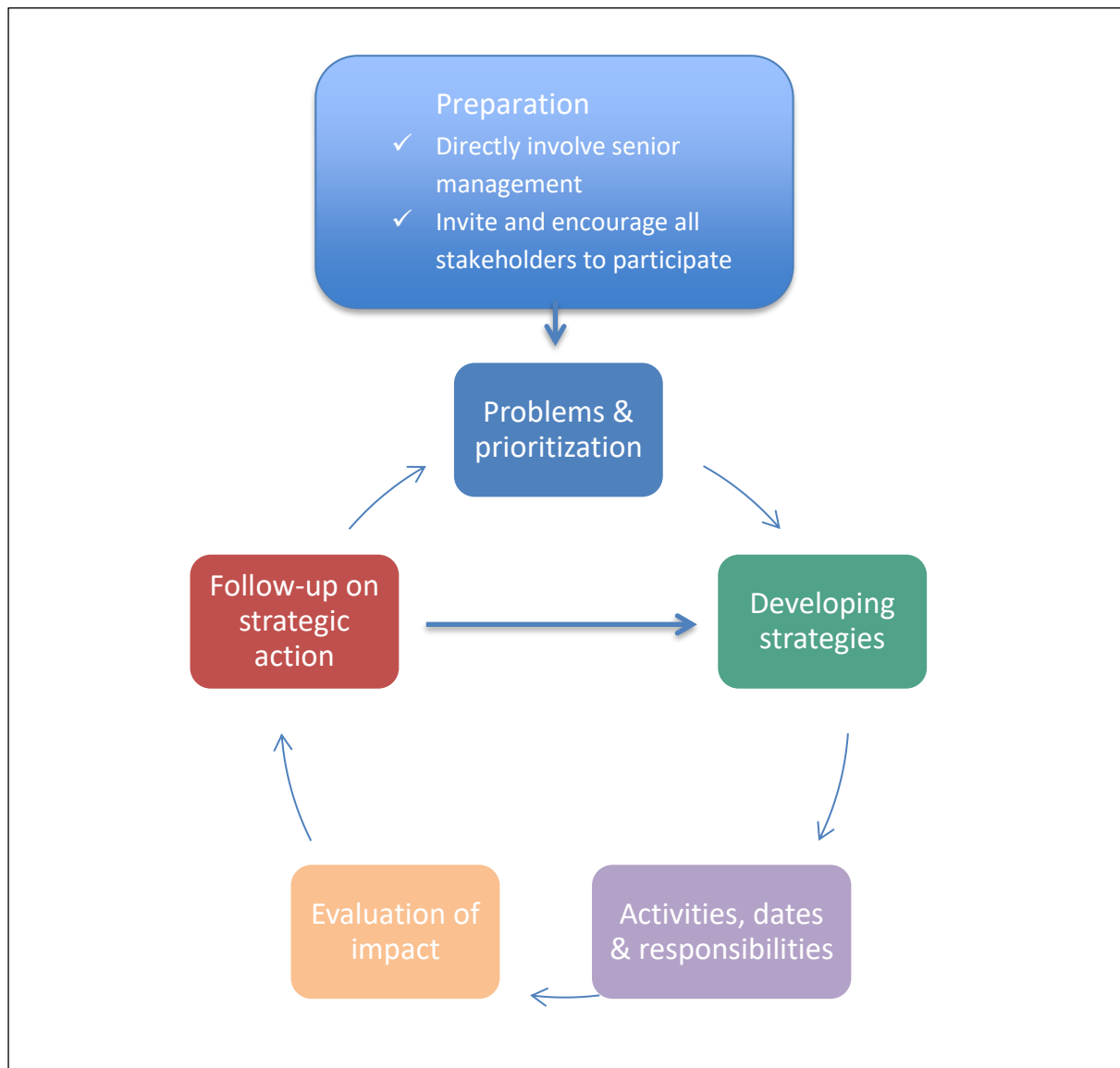
Exercise 3.2: Our own examples (2 hours)

At this stage it is time for participants to work in small groups of five persons to develop a strategy and to plan activities for two areas of improvement identified in the QualityRights assessment. For this, participants should use the template provided in Annex 8 Improvement/transformation plan template for each priority strategy identified. Participants will require several copies of the template for each of the areas of improvement that they will be required to work on.

One area of improvement that participants should work on in this exercise concerns changing the service culture since this is an inevitable part of improvement/transformation plans for all services.

The second area for improvement for participants to work on should be identified from the list of immediate priorities generated as a result of Exercise 2.2.

The purpose is to highlight how these two identified areas of improvement can be implemented in their own service by using the flowchart presented earlier.

Hard copies of the presentation on moving from problems to solutions should be handed out to each of the groups. Each group will be allocated an area for improvement that that was identified in exercise 2.2.

- Inform the groups that they will now be completing the improvement/transformation plan template for (at least) two areas:
  1. Culture change.
  2. Any additional priority area identified from Exercise 2.2 using the flowchart process.

- The groups will then present their plans in plenary for the whole group to comment on and engage in discussion.

- It is important to challenge the ideas that are brought forward. Ask the groups:
  ➢ Do you think that the planned activities and target dates are realistic?
  ➢ What challenges do you foresee when dealing with this issue?

This process can repeated for as many areas of improvement as it is possible to complete during the workshop session(s).

Topic 4: Moving forward

Time for this topic
Approximately 25 minutes.

Presentation: Working groups and QualityRights champions (15 min.)

- Finally, the scene should be set for the future work that is required of the service. This includes completing the work on the improvement plan if this has not yet been completed through the workshops (see Annex 8 below) and monitoring the implementation of the improvement plan for each theme.

- Participants will have an opportunity to form working groups on each theme. Membership of each group can be allocated by the service manager or – preferably – participants can themselves decide which working group they are most interested in.

- Working groups should be encouraged to be mixed groups when possible and appropriate. This will not always be the case (see *Guidance for facilitators*). They should involve a diversity of people using the service, staff (including mental health and other practitioners in addition to attendants and cleaning, cooking and maintenance staff), management and also family members and care partners where possible. Setting clear target dates for the establishment of the working group and for carrying out its work can also ensure that the improvement/transformation plan moves forward according to a realistic time frame.

- QualityRights champion(s) can be appointed to oversee the progress of each working group. QualityRights champions are people identified in the service – including people using the service, peer supporters and/or staff – who have demonstrated their willingness, interest, motivation and commitment to quality and human rights improvements. QualityRights champions are selected on the basis of their capacity to influence others and should have a long-term commitment to the service. Note that: People who are using or have previously used the service should be remunerated for extra time or resources incurred as a result of taking up this role.

- The organization of inter-service informational events should be encouraged in order to facilitate ongoing knowledge-sharing, critical reflection and self-evaluation of the improvement process (**See box on Inter-service informational events**).

Inter-service informational events

- The management should create a safe space for knowledge-sharing, critical reflection and self-evaluation which strengthens the awareness of appropriate and less appropriate practices and routines in the daily work of the service.
- The inputs of people who are using, or have previously used, the service are particularly important. Facilitating access and participation to these events is key.
- This will provide people who are using or have previously used the service, as well as staff, with an opportunity to express their personal views about the ongoing process and enable them to exchange both positive and negative experiences during the process.
- Sharing/broadening of knowledge, critical reflection and self-evaluation will support a service culture of empathy and ethical behaviour based on the notions of equality and respect and with an overall aim to end all human rights violations.
- This can lead to a restructuring of the strategies currently in place. The idea behind this is that motivation tends to be higher when everyone views the process as enriching and gains a sense of ownership as well as commitment to being agents of change.

Concluding the training (10 min.)

Ask participants the following questions in plenary and make sure you obtain as many different views from various stakeholders as possible:

- What are the 3 key points that you have learned from this training?
- Do you feel that you have the tools required to further develop the service improvement plan?

Then show the following take-home points:

Initiating an improvement plan

- The QualityRights assessment toolkit, which is based on five themes, has been designed to support services in assessing and improving the quality of care and compliance with the CRPD and other international human rights standards.
- An improvement plan is a way to address problems and challenges identified through the QualityRights assessment.
- Prior to initiating an improvement plan, it is necessary to involve senior management and to establish an oversight committee. The meaningful participation of all stakeholders is crucial.
- When initiating an improvement plan, the culture and power dynamics of the service must be addressed. The service culture influences the dynamics between the people using the service, staff, management and other relevant people such as family and care-givers.
- Problems, or areas for improvement, need to be identified and prioritized for immediate, medium-term and longer-term action. The QualityRights assessment will be helpful for this.
- An improvement plan requires strategies that assess and respond to challenges in a critical way.
- Positive impacts can be achieved with planned activities. There must be clear time frames and target dates for actions and clear designation of individuals or groups who have responsibility for the implementation of actions.

- Indicators of performance can be used to monitor and evaluate the impact of the plan.
- In a follow-up session, the preliminary and expected outcomes are shared – including with external stakeholders. It is possible that the strategy may need to be restructured when moving forward.
- The notions of equality, respect and dignity between people using the service, staff and others must be included as the core values and should be embedded in the service culture and practice.
- Collaboratively and individually, we can all be agents for creating daily and long-term positive change within the service.

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Annexes

Annex 1: Scenario

Topic 2: *Presentation – What challenges do we need to overcome?* **Transforming service culture through peer support**

The Institute of Mental Health, in partnership with the Nottinghamshire Healthcare NHS Trust, launched a project to promote a culture of recovery-focused practice through the recruitment of persons with lived experience as peer supporters.

One of the main challenges to changing the service culture was a practical one: people were completely unaware of the availability of peer support workers within the service.

In addition, peer supporters had to overcome resistance to change within the service. Some staff members were anxious that their roles would be threatened and some misunderstood the role of peer supporters. Sometimes peer supporters were seen as being "an extra pair of hands" and at other times they were seen as being responsible only for those people using the service who were the most challenging for staff.

To address these challenges, a new system was set in place requiring staff to inform people using the service about peer support and to provide them with the opportunity to meet a peer supporter.

Peer supporters built strong relationships with people using the service, who said that they felt more supported and experienced a better quality of relationship with peer supporters than with other staff. Eventually, peer supporters were able to influence the team by changing underlying negative assumptions and beliefs about people using the service as well as changing the day-to-day practices of staff.

Peer supporters were able to overcome the initial resistance from staff to develop positive and transformative relationships; staff reported being more hopeful and willing to try new approaches in their daily work. Self-assessments completed by the executive team showed a positive shift towards a recovery-based culture. A staff member commented: "I think the benefit of having a peer supporter in the team, it reminds of why you're doing the job first and foremost. It reminds you people can get better, it almost provides you with some hope."

Overall, peer support contributed to a significant reduction in inpatient stays and a transformation of the service culture towards integrating a recovery approach at all levels of the service. One peer supporter commented: "I think what has surprised me is the fact that in this role you can influence things more than I thought you probably could".

Annex 2: Defining core values and a vision for the service
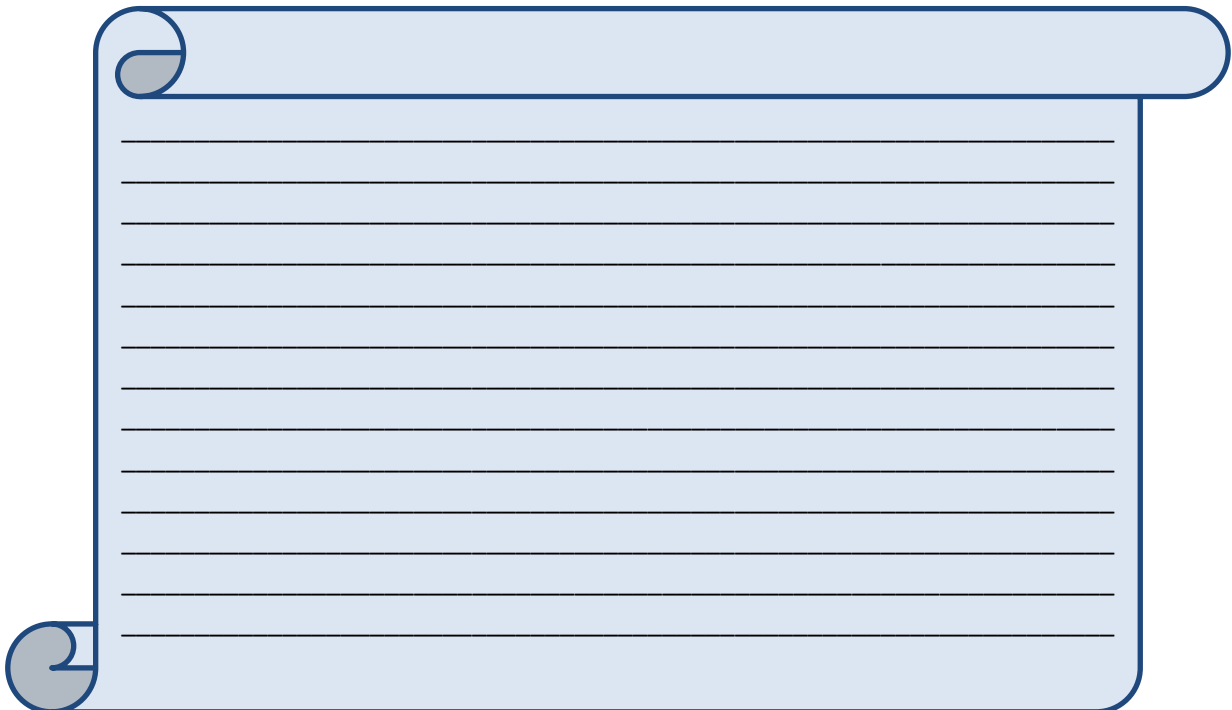
Questions to consider when formulating a set of core values and a vision statement:
- What are the core values you believe are important for your mental health or social service?
- What are the outcomes that you would want for people who visit the service?
- What does this mean for what your service provides?
- What does this mean for how your services are delivered?
- What does all of this mean for the service's vision?

When considering these questions, it can be useful to refer to your completed copy of Annex 3 in which you identified your own experiences about what makes a good service.

What values do you believe are important for a mental health or social service? *Consider the values presented earlier and think of other essential values:*

_____
_____
_____
_____
_____
_____
_____
_____

Try to formulate a vision which should eventually describe how you would like to see your service function in the most ideal possible way. This should be in line with all the core values that you have identified as the most important to be promoted.

Annex 3: Reflecting on areas for improvement

Think back to a health service that you have used….

Think back to a health service that you have used and identify what was helpful, what was useful and what made a positive difference. Also consider what was neither helpful nor useful and what would have made your experience a better one. In your brainstorming, also think about factors that either facilitated your access to the service or created barriers to your access.

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Based on your own experiences and knowledge of the theme within the QualityRights assessment toolkit, which areas for improvement do you think will be recommended in the assessment report of this service?

_____
_____
_____
_____
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_____
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_____

Annex 4: Analysis of visible factors, values and basic underlying assumptions in the service culture

1. Think back to Exercise 1.1 and to the declared values that you agreed on for the service. Write the values in the first column of the table.

2. For each value, identify visible factors in the service that either reflect or conflict with the value.
*   Visible factors could include rooms, clothing, furniture, food, communication styles and anything else that you can observe.

Values	Visible factors

3. Finally, think back about the underlying assumption(s) that need to be challenged in order to uphold the values.

*Underlying assumption 1:*_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Annex 5: Challenges to be overcome in the service culture

Challenges	Strengths	Weaknesses
Degree of ownership		
Change fatigue		
Compassion fatigue		
Complexity of the service		
Lack of appropriate leadership		
Multiple subcultures		
External influence		

Annex 6: Themes and standards of the WHO QualityRights toolkit

Theme 1. The right to an adequate standard of living (Article 28 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD))

Standard 1.1   The building is in good physical condition.

Standard 1.2   The sleeping conditions of service users are comfortable and allow sufficient privacy.

Standard 1.3   The service meets hygiene and sanitary requirements.

Standard 1.4   Service users are given food, safe drinking-water and clothing that meet their needs and preferences.

Standard 1.5   Service users can communicate freely, and their right to privacy is respected.

Standard 1.6   The service provides a welcoming, comfortable and stimulating environment that is conducive to active participation and interaction.

Standard 1.7   Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities.

Theme 2. The right to enjoyment of the highest attainable standards of physical and mental health (Article 25 of the CRPD)

Standard 2.1   Services are available to everyone who requires treatment and support.

Standard 2.2   The service has skilled staff and provides good-quality mental health services.

Standard 2.3   Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community.

Standard 2.4   Psychotropic medication is available, affordable and used appropriately.

Standard 2.5   Adequate services are available for general and reproductive health.

Theme 3. The right to exercise legal capacity and the right to personal liberty and the security of person (Articles 12 and 14 of the CRPD)

Standard 3.1   Service users' preferences regarding the place and form of treatment are always a priority.

Standard 3.2   Procedures and safeguards are in place to prevent detention and treatment without free and informed consent.

Standard 3.3   Service users can exercise their legal capacity and are given the support they may require to exercise this legal capacity.

Standard 3.4   Service users have the right to confidentiality and access to their personal health information.

Theme 4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD)

Standard 4.1   Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect.

Standard 4.2   Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises.

Standard 4.3   Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the service or by referral to another service, must not be abused and can be administered only with the free and informed consent of the service user.

Standard 4.4   No service user is subjected to medical or scientific experimentation without his or her informed consent.

Standard 4.5   Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse.

Theme 5. The right to live independently and be included in the community (Article 19 of the CRPD)

Standard 5.1   Service users are supported in gaining access to a place to live and to have the financial resources necessary to live in the community.

Standard 5.2   Service users can access education and employment opportunities.

Standard 5.3   The right of service users to participate in political and public life and to exercise freedom of association is supported.

Standard 5.4   Service users are supported in taking part in social, cultural, religious and leisure activities.

Annex 7: Priorities for change

Qualities of immediate priority:

- Poor performance on the standard can be dangerous for people using the service.
- Poor performance on the standard can lead to the deterioration of physical and mental health.
- Poor performance on the standard can have a negative impact on the majority of people using the service.
- Poor performance on the standard results in people wanting to leave and prevents others from using the service.

Standard	Themes				
	1 (Standard of living)	**2** (Physical and mental health)	**3** (Legal capacity and personal liberty)	**4** (Freedom from torture)	**5** (Right to live independently)
1					
2					
3					

Qualities of mid-term or longer-term priority:

- Improvement on the standard will be an important change to the service but does not have an impact on the safety of people using the service.
- Improvement on the standard will affect a minority of the people we serve.
- Improvement on the standard can be acted on only when priority standards have been addressed.
- Improvement on the standard may help to reach more people but is not a barrier preventing them from using the service

Standard	Themes				
	1	**2**	**3**	**4**	**5**
1					
2					
3					

Annex 8: Improvement/transformation plan template for each priority strategy identified

This template can be copied for each separate strategy of the improvement plan, including culture change. More columns can be added, as required, for additional activities.

Area of improvement 1 Date of preparation: QualityRights standard:		Target	Indicator	Time frame including dates	Responsible person(s)	Budget
Strategy 1 -						
Activity 1						
Activity 2						
Activity 3						
Activity 4						
Activity 5						

Transforming services and promoting human rights is a part of the series of training and guidance modules for the WHO QualityRights Initiative. The main goal of this module is to provide training and guidance for mental health and social services on how to transform and improve services towards a recovery-oriented approach which respects human rights.

This module contains two interrelated sections:

Part 1: Service culture, vision and leadership provides guidance to develop a shared vision and values for service delivery and address negative service cultures and power dynamics between staff and people using the services.

Part 2: Developing and implementing a transformation/improvement plan for service change helps people to understand the quality and human rights gaps within their service highlighted through the WHO QualityRights toolkit assessment, and then takes participants through a process of identifying priorities and actions for change in order to develop a comprehensive and concrete improvement/transformation plan.

This module used in conjunction with the WHO QualityRights assessment toolkit provides a comprehensive approach to improved service delivery in line with a person-centred, recovery and human rights-based approach.

World Health Organization