

**World Health Organization QualityRights Training on Mental Health, Human Rights and Recovery**

**Report - February 2019**

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# Introduction

This document was produced by researchers from the Institute of Mental Health, University of Nottingham. The data presented are part of a survey used to assess the knowledge and attitudes of individuals who received the World Health Organisation (WHO) QualityRights Training on Mental Health, Human Rights and Recovery. This training was provided by WHO staff and consultants. This current report explores individuals’ differences in attitudes and knowledge in human rights in mental health pre- and post-training.

# Methods

* 1. **Sample**

The ‘World Health Organisation (WHO) QualityRights Training on Mental Health, Human Rights and Recovery’ was delivered through an online platform to ministry of health representatives, academics, service providers, NGO and DPO representatives (see appendix table 3 for full list) from across the world (countries listed in appendix table 4).

Materials: The questionnaires participants completed prior to training contained demographic information (e.g. age, gender, location, background) and 26 items in 5-point Likert scales (1-strongly agree to 5-strongly disagree) to measure individuals’ attitudes towards human rights in mental health. The post-training questionnaires contained the same questions, plus two additional sections with two open questions regarding their perceptions of how much their attitudes had changed due to the training, plus four open questions to evaluate the quality and relevance of the course.

# Procedure

Participants received the World Health Organisation (WHO) QualityRights Training on Mental Health, Human Rights and Recovery to improve their knowledge and attitudes on this subject. Training was provided through an online platform (e-training) run by the WHO. Individuals who participated in the e-training sessions were asked to complete anonymous questionnaires containing qualitative and quantitative questions twice; prior and post-training. Not all individuals completed the training, and some did not complete both pre- and post-training measurements. After completion, pre- and post- training questionnaires were paired using SPSS to match data using the unique identifiers such as ‘first initial of your mother’s first name’; ‘first initial of your father’s first name’; first name; family name etc. prior to data analysis.

Some participants completed the questionnaires multiple times. Where individuals had provided their name, duplicates were identified and removed prior to analysis leaving only their first completed questionnaire (even if only partially completed, unless no data was given on this version). However, there is a risk that duplicates may still exist in the data if participants did not provide their name and this could have affected the results.

# Data analysis

We analysed the pre- and post-training data separately and we compared the pre- and post-training measurements. The data was first uploaded into SPSS® (quantitative data) and Excel® (qualitative data) and the following analyses were then carried out:

*Quantitative data analysis*

Statistical analysis was done using SPSS 19. Pre-training and post-training data were merged to facilitate comparison between the two datasets. Data was paired in the merge using answers to questions in the questionnaire that specifically stated they would be used to match their data from pre and post training. It was not a requirement to answer these questions. Data was also merged from the questionnaires and the e-training. There were 733 respondents that completed/partially completed the pre-training questionnaire, while 181 respondents completed/partially completed the post-training questionnaire. Paired t-tests were run on all the statements to see if there was a change in the responses from before the training to after training. Only those who had completed both a pre and post training questionnaire were included in this analysis. Descriptive analysis was also done using all baseline data. Descriptive analysis was also done on the e-training data.

*Qualitative data analysis*

We conducted a thematic analysis of qualitative findings (Braun and Clarke, 2006). We have summarised relevant themes and quotes identified in the questionnaires to validate our interpretations.

# Results

* 1. **Sample characteristics** (see appendix tables 1-4)

The majority of respondents identified as ‘female’ at baseline (61.8%). Ages ranged from 20-76, with the majority being between the ages of 30 to 34 (23.0%). Most respondents were either affiliated with the Ministry of Health (27.4%) or a Service Provider in mental health or related areas (23.6%). Ghana and Indonesia were the two countries the majority of respondents said they were currently residing in (35.9% and 31.6%, respectively).

# Attitudes to human rights in mental health (see appendix table 5)

For all but one of the statements, the responses showed an improvement in attitudes towards human rights after the training. The statement that had a worse mean at follow-up was ‘Mental health services should support and encourage people to access education and employment opportunities in the community’, though this change was not significant. Apart from this, all but three statements demonstrated a statistically significant improvement. The statements that did not demonstrate a significant improvement were ‘Knowledge and understanding of human rights can improve the quality of care in mental health related services’, ‘There is a lot that mental health and other practitioners can do to promote the rights of people with mental health conditions’, and ‘You can only inspire hope once a person has recovered’. The statement that had the largest improvement based on percent change was ‘Controlling people using mental health services is necessary to maintain order’, where the mean score was 2.72 at baseline and 1.54 at follow-up.

For the questions and statements from the post-training questionnaire relating to feedback about the online training the responses show that the training was well-received. The majority of respondents said that the training met their learning needs, the content was just right for their skills and knowledge, they were aware of all the features on the platform (though other than module discussions, the majority of respondents did not use these features), and several other positive feedback statements about the training.

Most users had completed the e-training (83.37% - see table 7). When looking at completion rates by course (see table 8) ‘Legal capacity and the right to decide’ had the highest percentage of users that had completed the course (95.81%), while the lowest percentage of course completion by users was ‘How to play on the platform?’ (58.26%). For completion rates by country (see table 9) Latvia had the highest (100%) and France had the lowest (33.33%), though for both countries there were very low numbers of users from the country. Those who identified as female had a slightly higher percentage of completion of the e-training than males (75.72% vs. 70.68% - see table 14) and users who were affiliated with Non-Governmental Organizations had the highest completion rate at 84.09%, while users affiliated with professional organizations/associations had the lowest completion rate at 58.82% (see table 11).

The total mean score for the e-training was 85.72%. Looking at mean scores (see table 12) by ‘Quality services and community inclusion’ had the highest mean score at 96.38% and ‘How to play on the platform?’ had the lowest at 64.25%, which is expected as it is set up so all users get a certain question wrong as part of the training. For mean scores by country Latvia had the highest (100%), while France had the lowest (34.33%), but again there are a very low number of users from these countries (see table 13). Those who identified as female had a higher mean score than those who identified as male (79.35% vs 75.15% - see table 14) and users who were affiliated with Non-Governmental Organizations had the highest mean score (85.23%), while users affiliated with professional organizations/associations had the lowest mean score (67.29%) (see table 15).

# Qualitative data analysis

Responses were largely similar between participants and minimal in length and so are described collectively to provide an overall picture of what was said.

**i) Overall Impact**

Overall, the training was overwhelmingly well received by participants and they discussed the ways in which the training had an impact on them. The most common impact discussed was gaining general knowledge of human rights and disabilities, and recognising that people with disabilities have the same rights as anybody else.

“I now understand that people with psychosocial disabilities have rights just like anyone else and these rights have to be respected despite personal bias or perception of severity of the disability.”

This in particular included advocating people with disabilities making decisions for themselves. The training increased participants’ confidence that people with disabilities have the capacity to make decisions and should be respected.

“Let them make decisions about their health and we should provide them necessary support, including encouragement and exploring right social interaction and engagement.”

The increased awareness of rights, equality and in turn inclusion in society accompanied a greater understanding of how to apply such knowledge in practice, through learning about recovery and holistic approaches and their application, providing a higher quality service.

 “It will be more positive paying more attention and focusing on active communication and listening… moreover responding positively to their rights.”

Many participants valued learning about the Convention on the Rights of Persons with Disabilities (CRPD). It informed their knowledge and practice and through this empowered them to protect individuals by recognising and rectifying infringements on their rights.

“I believe I have more confidence in implementing advocacy objectives, and I can quote the supporting legislation like the CRPD or the constitution.”

Reflecting on their own behavior, participants noted the training would change their practice, advocating people with disabilities to make their own decisions rather than thinking professionals know best. They mentioned gaining an understanding of how to provide dignified care for people with disabilities, committing to improving their lives. Participants felt compelled to share the knowledge they had gained through the training with their colleagues.

“I will share this lesson to everyone which I can… so I hope that everyone [can] understand about human right[s] for people with mental disability, and can change their attitude towards people with mental illness and mental disability, and help them to reach recovery and meaningful life in community”

Also, participants reported to have enjoyed meeting and collaborating with allied professionals. Participants enjoyed the group module discussions, the sharing of ideas, and the ability to collectively develop solutions to problems using case studies. Participants also felt a sense of hope in realising that others were fighting for the same cause, to improve the lives of people with disabilities, which bestowed a feeling of value to their work.

“I think the platform is really didactic and help us to understand better the information and to exchange opinions.”

“The discussion page was an active way of engaging with the larger community, and helpful to see what everyone thought of challenges and possible solutions.”

# Impact on Attitudes

Perceived attitude change after the training was split. Some participants felt their attitudes towards people with disabilities were already inclusive, respectful and dignified, whereas other participants noted ways in which their attitudes had definitely shifted towards being more focused on human rights and patient autonomy.

Participants who did not change their attitude believed they could not change if they already agreed with the principles of the training and treated disabled people with respect.

“My attitude remained the same as before - human rights based and person centred approach.”

Most of those participants who felt their attitudes had changed noted a changed view towards people with disabilities making their own decisions. They felt the training enlightened their views from a best interests approach to facilitating patient autonomy in decision making.

“I now have more trust and confidence that they are in capacity to make extremely sound and fruitful decisions.”

“I now understand that people with psychosocial disabilities have rights just like anyone else and these rights have to be respected despite personal bias or perception of severity of the disability.”

Participants mentioned changing their attitudes towards seclusion, becoming strongly opposed to seclusion after the training. They mentioned behavioral changes to accommodate and support disabled patients’ needs, wishes and opinions through supported decision making.

“My attitude changed especially with respect to seclusion, before I thought it is appropriate to some extent.”

This centered on a decisive shift of attitudes in favour of equality and human rights. Encouragingly, several participants felt compelled to share the training with others and engage in advocacy work from local to policy level.

“I will share this lesson to everyone which I can.”

“I am convinced that the psychiatric care should solve its problems on governmental and international level, too.”

Responses therefore demonstrated a willingness to spread CRPD principles both in participants’ individual practices, but also to share practices learnt from the training up to policy level.

 “I will promote this training and its practice up to the decision maker level.”

# Impact on Practices

Answers to this question reflected participants change in attitudes in understanding the importance of human rights. Participants mentioned they would respect disabled people’s right to make decisions for themselves. This entailed treating them as equal human beings. They described how they would engage more with patients, involving them when creating treatment plans, as well as their families.

“Informed consent is key in every treatment and allowing patients to make their own treatment or recovery plan

“In the event I need to deal with a family member with declining cognitive function, I understand the importance of adhering to their own wishes.”

In turn, participants felt this would “improve the quality of my work”.

In addition, many participants mentioned they will no longer use seclusion, even in a crisis situation.

“Clients/patients choice first, not to use seclusion as a means of calming a disturbed patient”

Participants felt the legal knowledge the training provided gave them more confidence in implementing advocacy objectives. They felt they were better equipped to uphold the human rights of patients with disabilities, and as one participant reported the training has “motivated me a lot to continue [to] go further” to do so.

“I will be able to improve and engage better on human rights with the knowledge I have gained from the course”

However, some participants worried that there is still considerable stigmatisation attached to patients with disabilities. Others felt financial constraints limited the reach of the training.

“Stigmatization still going on in this community and even health workers”

“All the efforts we make in my country are unfortunately largely dependent and bounded by finances”

“At least I individually will try to respect the patients more. But the whole practices in my institution may not be changed in a short time. We need more health workers that have insight [into] human rights. And some complicated circumstances also include the health worker's burdens due to the massive amount of service user[s], another overload works, and the underpayment systems.”

Nevertheless, many participants mentioned the training motivated them to increase activism of CRPD principles, and pass on what they have learned to colleagues, implement the practices in their workplace, and lobby higher authority with the hope of spreading the impact of this training.

“I will talk to my colleagues to build… supported decision making, for this is the fundamental change that I need to make at my workplace.”

“I will try to fight against discrimination of people with psychosocial disability but I would like to do it on the national level, because I see how important it is.”

# Additional comments and feedback

Feedback on the format of the training was very positive; participants particularly liked the videos and cases studies. Participants felt engaged by the interactive structure of the training. Most participants mentioned the case studies as one of the things they liked best about the training, being helpful to understand the impact in practice.

 “I liked case studies, because I face such cases in my everyday practice.”

Many participants praised the modules on recovery and ending coercion as having a big impact on them.

Several candidates requested further case studies to engage in more ‘challenging’ dilemmas such as handling a crisis situation. Some felt this could be encouraged through the module discussions.

“I would like to learn more on other mental health practitioners' experiences in copying crisis situations.”

“Continuing to include invitations for participants to offer personal, professional, and life experience throughout the modules.”

Following the positive feedback, there was a demand from some participants for further training for those who “wish to advance with the training to another level”.

Not all participants used the additional features of the platform and fewer participants answered this question, but most of those who did praised the module discussions and coaching to clarify any points of confusion. Some participants suggested incentivising the module discussions and peer and personal coaching page by awarding points for participation.

“I appreciated the module discussions where I was able to also see the thoughts and insights of other peers.”

Some participants felt that whilst the language was clear, it was difficult to keep up with the training if English was not their first language. Others felt it prevented them from engaging fully in the module discussions. Many participants requested both the course and peer discussions to be translated into national languages and felt this would encourage greater use.

“English is not my language, so it´s more complicated for me to discuss in English”

Finally, some participants mentioned they would like to be able to download the videos and PDFs, which would further enable them to share the knowledge with colleagues and organisations.

# Course evaluation (see appendix table 6)

This course received mostly positive feedback from the attendees. More than 90% of attendees that provided feedback found that the course met their learning needs and 98% of participants thought the content presented was relevant. In addition, over 98% found that the content was clearly communicated and the course was engaging. The flow of content and activities worked well for 94% of participants and 95% found the case scenarios helpful. Finally, the training expectations were met for 92%, was considered to be useful in the work or life of 99% of the attendees, helped change the attitude towards people with psychosocial, intellectual and cognitive disabilities for 75% and will probably alter the practice/aspects of life of 79% of them. As discussed under section 4ii, it is likely that participants who felt their attitudes did not change already agreed with the principles in the training.

# Conclusions

This evaluation report showed that there was major improvements in attitudes and knowledge in human rights in mental health in people who completed the World Health Organisation (WHO) QualityRights Training on Mental Health, Human Rights and Recovery. Some specific concept areas of knowledge and attitudes could be further reinforced in future courses (e.g. human rights of people with dementia, taking informed consent) and these were highlighted in the report. Attendees valued very much this opportunity and they expect this to have a positive impact on their day-to-day practice.

# Reference

BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77-101.

**Appendix**

**Table 1.** Gender at baseline

|  |  |  |
| --- | --- | --- |
| Gender | Frequency | Percent (%) |
| Female | 339 | 61.8 |
| Male | 208 | 37.9 |
| Other  | 2 | 0.4 |

n=549

**Table 2.** Age at baseline

|  |  |  |
| --- | --- | --- |
| Age | Frequency | Percent (%) |
| 20-24 | 17 | 3.1 |
| 25-29 | 107 | 19.4 |
| 30-34 | 127 | 23.0 |
| 35-39 | 103 | 18.7 |
| 40-44 | 73 | 13.2 |
| 45-49 | 48 | 8.7 |
| 50-54 | 28 | 5.1 |
| 55-59 | 30 | 5.4 |
| 60-64 | 12 | 2.2 |
| 65+ | 7 | 1.3 |

n=552

**Table 3.** Affiliation at baseline

|  |  |  |
| --- | --- | --- |
| Affiliation | Frequency | Percent (%) |
| Academia | 76 | 13.7 |
| Disabled People’s Organizations | 20 | 3.6 |
| Ministry of Health | 152 | 27.4 |
| Non-Governmental Organizations | 59 | 10.6 |
| Other Government Ministry/Department/Commission | 23 | 4.2 |
| Professional organizations/associations | 22 | 4.0 |
| Service Provider (general health) | 5 | 0.9 |
| Service Provider (mental health or related areas) | 131 | 23.6 |
| UN organizations and agencies | 28 | 5.1 |
| World Health Organization | 18 | 3.2 |
| Other | 20 | 3.6 |

n=554

**Table 4.** Country of residence at baseline

|  |  |  |
| --- | --- | --- |
| Country | Frequency | Percent (%) |
| Afghanistan | 1 | 0.2 |
| Albania | 1 | 0.2 |
| Argentina | 2 | 0.4 |
| Armenia | 3 | 0.5 |
| Australia | 5 | 0.9 |
| Bosnia and Herzegovina | 6 | 1.1 |
| Brazil | 1 | 0.2 |
| Bulgaria | 2 | 0.4 |
| Burkina Faso | 1 | 0.2 |
| Cambodia | 2 | 0.4 |
| Canada | 2 | 0.4 |
| Central African Republic | 1 | 0.2 |
| Croatia | 5 | 0.9 |
| Cyprus | 1 | 0.2 |
| Czech Republic | 2 | 0.4 |
| Denmark | 5 | 0.9 |
| Dominican Republic | 1 | 0.2 |
| Ecuador | 8 | 1.4 |
| Eritrea | 2 | 0.4 |
| Estonia | 3 | 0.5 |
| Ethiopia | 1 | 0.2 |
| Fiji | 1 | 0.2 |
| France | 4 | 0.7 |
| Georgia | 15 | 2.7 |
| Germany | 1 | 0.2 |
| Ghana | 200 | 35.9 |
| Greece | 1 | 0.2 |
| India | 4 | 0.7 |
| Indonesia | 176 | 31.6 |
| Iraq | 1 | 0.2 |
| Ireland | 2 | 0.4 |
| Italy | 8 | 1.4 |
| Kenya | 4 | 0.7 |
| Latvia | 4 | 0.7 |
| Lesotho | 1 | 0.2 |
| Liberia | 1 | 0.2 |
| Lithuania | 3 | 0.5 |
| Mexico | 6 | 1.1 |
| Montenegro | 3 | 0.5 |
| Mozambique | 1 | 0.2 |
| Namibia | 1 | 0.2 |
| Nepal | 2 | 0.4 |
| Netherlands | 1 | 0.2 |
| New Zealand | 1 | 0.2 |
| Nigeria | 1 | 0.2 |
| Norway | 1 | 0.2 |
| Pakistan | 2 | 0.4 |
| Philippines | 2 | 0.4 |
| Republic of Moldova | 2 | 0.4 |
| Romania | 1 | 0.2 |
| Serbia | 19 | 3.4 |
| Somalia | 1 | 0.2 |
| South Africa | 6 | 1.1 |
| Spain | 1 | 0.2 |
| Sudan | 1 | 0.2 |
| Switzerland | 1 | 0.2 |
| Syrian Arab Republic | 1 | 0.2 |
| Tajikistan | 1 | 0.2 |
| Turkmenistan | 1 | 0.2 |
| Uganda | 2 | 0.4 |
| Ukraine | 1 | 0.2 |
| United Kingdom | 7 | 1.3 |
| United States of America | 3 | 0.5 |
| Viet Nam | 3 | 0.5 |
| Zambia | 1 | 0.2 |

n=557

**Table 5.** Change in means from baseline to follow-up

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Statement | Mean (before) | Mean (after) | Percent change (%) | Direction of change | Sig. | Effect size (Cohen’s d) |
| [a. Knowledge and understanding of human rights can improve the quality of care in mental health related services.]1 | 4.77 | 4.78 | 0.2 | Positive | .916 | 0.011 |
| [b. There is a lot that mental health and other practitioners can do to promote the rights of people with mental health conditions.]1 | 4.57 | 4.73 | 3.5 | Positive | .095 | 0.159 |
| [c. Persons with severe mental health conditions should consult their doctor before marrying.]2 | 3.52 | 2.16 | 38.6 | Positive | .000 | 0.886 |
| [d. A lot can be improved within mental health services without additional resources.]2  | 2.68 | 3.36 | 25.4 | Positive | .000 | 0.389 |
| [e. People with dementia should always live in group homes where staff can take care of them.]2 | 2.77 | 1.67 | 39.7 | Positive | .000 | 0.845 |
| [f. People with psychosocial disabilities should not be hired in work requiring direct contact with the public.]3  | 1.74 | 1.38 | 20.7 | Positive | .002 | 0.298 |
| [g. Mental health services should support and encourage people to access education and employment opportunities in the community.]3 | 4.74 | 4.68 | 1.3 | Negative | .456 | 0.067 |
| [h. Medication is the most important factor to help people with mental health conditions get better.]3 | 2.79 | 1.74 | 37.6 | Positive | .000 | 0.715 |
| [i. You can only inspire hope once a person has recovered.]4 | 2.22 | 1.97 | 11.3 | Positive | .058 | 0.185 |
| [j. People using mental health services should be empowered to make their own decisions about their treatment.]4 | 4.31 | 4.60 | 6.7 | Positive | .015 | 0.240 |
| [k. Following the advice of other people who have experienced mental health issues is too risky.]4 | 2.07 | 1.73 | 16.4 | Positive | .001 | 0.326 |
| [l. It is important to appear tough with people using mental health services in order to avoid being manipulated.]5 | 2.47 | 1.58 | 36.0 | Positive | .000 | 0.638 |
| [m. People with psychosocial disabilities need someone to plan activities for them.]5 | 2.77 | 1.63 | 41.2 | Positive | .000 | 0.872 |
| [n. The opinions of a person with an intellectual disability about care and treatment should carry more weight than those of health practitioners.]6  | 3.12 | 3.94 | 26.3 | Positive | .000 | 0.582 |
| [o. It is acceptable to pressure people using mental health services to take treatment that they don't want.]6 | 2.00 | 1.34 | 33.0 | Positive | .000 | 0.571 |
| [p. Persons with mental health conditions should not be given important responsibilities.]6 | 1.95 | 1.51 | 22.6 | Positive | .000 | 0.372 |
| [q. When people are unable to communicate, you need to make decisions based on your ideas about what is best for them.]6 | 2.83 | 1.86 | 34.3 | Positive | .000 | 0.656 |
| [r. Health practitioners are in the best position to know what people with dementia are capable of achieving in their lives.]7 | 2.91 | 1.87 | 35.7 | Positive | .000 | 0.759 |
| [s. People with intellectual disabilities have the right to make their own decisions, even if I don’t agree with them.]7 | 3.92 | 4.43 | 13.0 | Positive | .000 | 0.417 |
| [t. Controlling people using mental health services is necessary to maintain order.]7 | 2.72 | 1.54 | 43.4 | Positive | .000 | 0.824 |
| [u. The use of seclusion and restraint is needed if people using mental health services become threatening.]7 | 2.83 | 1.76 | 37.8 | Positive | .000 | 0.683 |
| [v. Seclusion is not an appropriate way to manage a crisis.]7 | 3.75 | 4.41 | 17.6 | Positive | .000 | 0.523 |
| [w. The use of seclusion and restraint negatively affects the therapeutic relationship between people using mental health services and staff.]8 | 3.99 | 4.68 | 17.3 | Positive | .000 | 0.640 |
| [x. Locking people in a room is acceptable if they are at risk of harming themselves or others.]8 | 3.00 | 1.91 | 36.3 | Positive | .000 | 0.727 |
| [y. Most people do not mind if they are sedated to de-escalate a tense situation.]8 | 2.80 | 1.81 | 35.4 | Positive | .000 | 0.789 |
| [z. Involuntary admission does more harm than good.]8 | 3.20 | 4.22 | 31.9 | Positive | .000 | 0.674 |

1n=113

2n=112

3n=109

4n=108

5n=103

6n=102

7n=99

8n=98

**Table 6.** Frequencies of post-training specific statements/questions

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question/Statement | Sub-Question | Responses | Frequency | Percentage (%) |
| Overall, this training met my learning needs.1 |  | Strongly Agree | 60 | 52.63 |
| Agree | 46 | 40.35 |
| Neutral | 3 | 2.63 |
| Disagree | 2 | 1.75 |
| Strongly disagree | 3 | 2.63 |
| For my skill level and knowledge, the content was:1 |  | Advanced | 20 | 17.54 |
| Just right | 73 | 64.04 |
| Basic | 21 | 18.42 |
| Were you aware of the following features on the platform?2 | Coaching | Yes | 99 | 88.39 |
| No | 13 | 11.61 |
| Module Discussions | Yes | 104 | 92.86 |
| No | 8 | 7.14 |
| Challenges | Yes | 98 | 87.50 |
| No | 14 | 12.50 |
| Peer & Personal Coaching Page | Yes | 87 | 77.68 |
| No | 25 | 22.32 |
| Did you use any of the following features on the platform?2 | Coaching | Yes | 26 | 23.21 |
| No | 86 | 76.79 |
| Module Discussions | Yes | 68 | 60.71 |
| No | 44 | 39.29 |
| Challenges | Yes | 45 | 40.18 |
| No | 67 | 59.82 |
| Peer & Personal Coaching Page | Yes | 28 | 25.00 |
| No | 84 | 75.00 |
| Please indicate your level of agreement with the following statements.2 | a. The content presented was relevant. | Strongly Agree | 71 | 63.39 |
| Agree | 39 | 34.82 |
| Neutral | 1 | 0.89 |
| Disagree | 1 | 0.89 |
| Strongly disagree | 0 | 0.00 |
| b. The flow of the content and activities worked well. | Strongly Agree | 62 | 55.36 |
| Agree | 43 | 38.39 |
| Neutral | 5 | 4.46 |
| Disagree | 2 | 1.79 |
| Strongly disagree | 0 | 0.00 |
| c. The content was clearly communicated. | Strongly Agree | 61 | 54.46 |
| Agree | 49 | 43.75 |
| Neutral | 0 | 0.00 |
| Disagree | 2 | 1.79 |
| Strongly disagree | 0 | 0.00 |
| d. The training engaged participants. | Strongly Agree | 56 | 50.00 |
| Agree | 50 | 44.64 |
| Neutral | 5 | 4.46 |
| Disagree | 0 | 0.00 |
| Strongly disagree | 1 | 0.89 |
| e. The case scenarios were helpful. | Strongly Agree | 71 | 63.39 |
| Agree | 35 | 31.25 |
| Neutral | 6 | 5.36 |
| Disagree | 0 | 0.00 |
| Strongly disagree | 0 | 0.00 |
| f. The amount of information was sufficient. | Strongly Agree | 52 | 46.43 |
| Agree | 51 | 45.54 |
| Neutral | 7 | 6.25 |
| Disagree | 2 | 1.79 |
| Strongly disagree | 0 | 0.00 |
| g. The training met my expectations. | Strongly Agree | 52 | 46.43 |
| Agree | 51 | 45.54 |
| Neutral | 8 | 7.14 |
| Disagree | 1 | 0.89 |
| Strongly disagree | 0 | 0.00 |
| h. The training experience will be useful in my work/life. | Strongly Agree | 73 | 65.18 |
| Agree | 38 | 33.93 |
| Neutral | 1 | 0.89 |
| Disagree | 0 | 0.00 |
| Strongly disagree | 0 | 0.00 |
| i. This course changed my attitude towards people with psychological, intellectual and cognitive disabilities. | Strongly Agree | 50 | 44.64 |
| Agree | 34 | 30.36 |
| Neutral | 15 | 13.39 |
| Disagree | 9 | 8.04 |
| Strongly disagree | 4 | 3.57 |
| j. This course will alter my practice/aspects of my life. | Strongly Agree | 51 | 45.54 |
| Agree | 37 | 33.04 |
| Neutral | 14 | 12.50 |
| Disagree | 8 | 7.14 |
| Strongly disagree | 2 | 1.79 |

1n=114

2n=112

**Table 7.** Frequencies of progress in e-training

|  |  |  |
| --- | --- | --- |
| Progress | Frequency | Percent (%) |
| Completed | 3915 | 83.37 |
| In Progress | 455 | 9.69 |
| Not Started | 326 | 6.94 |

n=4696

**Table 8.** Progress in e-training by course

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Course Name | Completed (%) | In Progress (%) | Not Started (%) | N |
| How to play on the platform? | 58.26 | 14.81 | 26.92 | 702 |
| Ending coercion, violence and abuse | 94.25 | 4.26 | 1.50 | 869 |
| Human rights | 71.02 | 19.79 | 9.18 | 773 |
| Human rights, mental health and disability | 80.79 | 14.74 | 4.47 | 604 |
| Legal capacity and the right to decide | 95.81 | 2.98 | 1.21 | 907 |
| Mental health, well-being and recovery | 90.55 | 7.14 | 2.30 | 434 |
| Quality services and community inclusion | 95.33 | 3.44 | 1.23 | 407 |

**Table 9.** Progress in e-training by country

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Country/State | Completed (%) | In Progress (%) | Not Started (%) | N |
| Croatia | 87.50 | 12.50 | 0.00 | 8 |
| Czech Republic | 83.33 | 16.67 | 0.00 | 6 |
| Denmark | 71.43 | 14.29 | 14.29 | 7 |
| Ecuador | 60.00 | 20.00 | 20.00 | 5 |
| France | 33.33 | 33.33 | 33.33 | 6 |
| Ghana | 60.18 | 21.90 | 17.92 | 452 |
| India | 87.50 | 12.50 | 0.00 | 8 |
| Indonesia | 58.08 | 25.75 | 16.17 | 167 |
| Italy | 71.43 | 0.00 | 28.57 | 7 |
| Kenya | 83.33 | 16.67 | 0.00 | 6 |
| Latvia | 100.00 | 0.00 | 0.00 | 5 |
| Malawi | 80.00 | 0.00 | 20.00 | 5 |
| Mexico | 88.89 | 0.00 | 11.11 | 9 |
| Nepal | 40.00 | 40.00 | 20.00 | 5 |
| Philippines | 75.00 | 25.00 | 0.00 | 8 |
| Romania | 87.50 | 12.50 | 0.00 | 8 |
| Saudi Arabia | 77.78 | 22.22 | 0.00 | 9 |
| Serbia | 90.00 | 6.67 | 3.33 | 30 |
| South Africa | 71.43 | 0.00 | 28.57 | 7 |
| Switzerland | 37.50 | 31.25 | 31.25 | 16 |
| Uganda | 35.71 | 57.14 | 7.14 | 14 |
| United Kingdom | 42.86 | 21.43 | 35.71 | 14 |
| United States | 70.00 | 20.00 | 10.00 | 10 |

**Table 10.** Progress in e-training by gender

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gender | Completed (%) | In Progress (%) | Not Started (%) | N |
| Female  | 75.72 | 14.81 | 9.47 | 243 |
| Male | 70.68 | 16.54 | 12.78 | 133 |

**Table 11.** Progress in e-training by affiliation

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Affiliation | Completed (%) | In Progress (%) | Not Started (%) | N |
| Academia | 77.19 | 14.04 | 8.77 | 57 |
| Disabled People’s Organizations | 69.23 | 23.08 | 7.69 | 13 |
| Ministry of Health | 70.65 | 16.30 | 13.04 | 92 |
| Non-Governmental Organizations | 84.09 | 6.82 | 9.09 | 44 |
| Other Government Ministry/Department/Commission | 69.23 | 23.08 | 7.69 | 13 |
| Professional organizations/association | 58.82 | 35.29 | 5.88 | 17 |
| Service Provider (mental health or related areas) | 75.00 | 13.04 | 11.96 | 92 |
| UN organizations and agencies | 68.42 | 15.79 | 15.79 | 19 |
| World Health Organization | 71.43 | 28.57 | 0.00 | 14 |
| Other | 80.00 | 6.67 | 13.33 | 15 |

**Table 12.** Mean scores in e-training by course

|  |  |  |
| --- | --- | --- |
| Course Name | Mean SCOs (%) | N |
| How to play on the platform? | 64.25 | 702 |
| Ending coercion, violence and abuse | 95.45 | 869 |
| Human rights | 74.32 | 773 |
| Human rights, mental health and disability | 83.85 | 604 |
| Legal capacity and the right to decide | 96.17 | 907 |
| Mental health, well-being and recovery | 92.07 | 434 |
| Quality services and community inclusion | 96.38 | 407 |
| Total | 85.72 | 4696 |

**Table 13.** Mean scores in e-training by country

|  |  |  |
| --- | --- | --- |
| Country/State | Mean SCOs (%) | N |
| Croatia | 87.50 | 8 |
| Czech Republic | 83.33 | 6 |
| Denmark | 75.86 | 7 |
| Ecuador | 75.00 | 5 |
| France | 34.33 | 6 |
| Georgia | 89.29 | 14 |
| Ghana | 67.02 | 452 |
| India | 87.50 | 8 |
| Indonesia | 64.78 | 167 |
| Italy | 71.43 | 7 |
| Kenya | 83.33 | 6 |
| Latvia | 100.00 | 5 |
| Malawi | 80.00 | 5 |
| Mexico | 88.89 | 9 |
| Nepal | 40.00 | 5 |
| Philippines | 75.00 | 8 |
| Romania | 87.50 | 8 |
| Saudi Arabia | 77.78 | 9 |
| Serbia | 90.00 | 30 |
| South Africa | 71.43 | 7 |
| Switzerland | 44.38 | 16 |
| Uganda | 35.71 | 14 |
| United Kingdom | 46.00 | 14 |
| United States | 83.80 | 10 |

**Table 14.** Mean scores for e-training by gender

|  |  |  |
| --- | --- | --- |
| Gender | Mean SCOs (%) | N |
| Female | 79.35 | 243 |
| Male | 75.17 | 133 |

**Table 15.** Mean scores for e-training by affiliation

|  |  |  |
| --- | --- | --- |
| Affiliation | Mean SCOs (%) | N |
| Academia | 80.39 | 57 |
| Disabled People’s Organizations | 71.62 | 13 |
| Ministry of Health | 74.53 | 92 |
| Non-Governmental Organizations | 85.23 | 44 |
| Other Government Ministry/Department/Commission | 82.23 | 13 |
| Professional organizations/association | 67.29 | 17 |
| Service Provider (mental health or related areas) | 78.42 | 92 |
| UN organizations and agencies | 73.63 | 19 |
| World Health Organization | 79.00 | 14 |
| Other | 81.67 | 15 |