QualityRights e-training on mental health, human rights and recovery

Pre and Post Training Evaluation, June 2017

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Background

WHO QualityRights aims to improve the quality and human rights conditions in inpatient and outpatient mental health and social care services and to promote, more generally, the rights of ALL people with psychosocial, intellectual and cognitive disabilities.

The care available in mental health facilities around the world is not only of poor quality but in many instances actually hinders recovery. It is common for people to be locked away in small, prison-like cells with no human contact or to be chained to their beds, unable to move. Violations are not restricted to inpatient and residential facilities however; many people seeking care from outpatient and community care services are disempowered and also experience extensive restrictions to their basic human rights.

The QualityRights E-Training

This E-training was developed as part of the World Health Organization’s QualityRights initiative. Through providing an engaging and applied learning platform, it strives to promote good quality care and the rights of people with psychosocial, intellectual and cognitive disabilities. The training consists of six core modules.

- Human rights
- Human rights in mental health
- Protecting the right to legal capacity in services
- Creating services free from coercion, violence and abuse
- Improving the service environment
- Ensuring the right to health and recovery in services

The training was developed with important contributions from many experts including people with lived experience, mental health practitioners, human rights experts, Non-Governmental Organisations (NGOs), disabled people organizations and other advocates. This diversity enabled a training platform to be developed that could be applied across services and be accessible to a large number of people, including people with psychosocial, intellectual and cognitive disabilities, as well as people who are using services or working in services. It is also applicable to families and friends of individuals accessing services, as well as relevant organizations and other stakeholders.
What do the early pilot results tell us?

At the time of this analysis, a total of 24 individuals had completed baseline and follow-up questionnaires as part of the pilot evaluation. An overview of the regions represented by the pilot sample is illustrated in Figure 1, with an overview of the countries involved provided in Figure 2. An overview of participating individual’s organization /affiliation and background/experience is provided in Figures 3 and 4.

![Regions of responses analysed.](image)

Countries involved in pre-post evaluation:

- Armenia
- Bosnia and Herzegovina
- Brazil
- Germany
- Ghana
- Ireland
- Italy
- Lebanon
- Liberia
- Nigeria
- Sierra Leone
- Spain
- The Gambia
- United Kingdom
The questionnaire administered to participants asked about their attitudes towards some key issues relevant to human rights and mental health. Responses were measured using a 5-item Likert Scale ranging from Strongly Disagree – Strongly Agree. Analysing these pre and post questionnaires, we observed that after completion of the e-training, participants’ attitudes had changed towards a more human rights based approach to mental health. For 17 of the 26 items, this change of attitude was statistically significant ($p < 0.05; n=24$). An overview of the results is given below.
Overview of findings per question

The figures below present the mean ratings per attitudinal item. Due to the non-parametric asymmetrical nature of the data, the analysis was conducted using sign tests on responses to each of the individual questions and the questionnaire total. In addition, a selection of qualitative responses that most accurately represented the overall feedback is presented.

**Question 1: Knowledge and understanding of human rights can improve the quality of care in mental health related services**

Significance \( p = 0.38 \)

**Question 2: There is little mental health and other practitioners can do to promote the rights of people with mental health conditions.**

Significance \( p = 0.73 \)

**Question 3: Persons with severe mental health conditions should seek advice from their doctor before getting married.**

Significance \( p = 0.04 \)
Question 4: Nothing can be improved within mental health services without additional resources.

Significance ($p = 0.02$)

Question 5: The service environment has little to do with people’s mental health and well-being.

Significance ($p = 0.004$)

Question 6: People with dementia should always live in group homes where staff can take care of them.

Significance ($p = 0.18$)
Question 7: People with psychosocial disabilities should not be hired in work requiring direct contact with the public.

Significance ($p = 1$)

Question 8: Mental health services should support and encourage people to access education and employment opportunities in the community.

Significance ($p = 1$)

Question 9: I believe that taking medications is the most important factor to help people with mental health conditions get better.

Significance ($p = 0.006$)
**Question 10:** You can only inspire hope once a person has recovered.

Significance ($\rho = 0.003$)

**Question 11:** People using mental health services should be empowered to make their own decisions about their treatment.

Significance ($\rho = 0.13$)

**Question 12:** Following advice of other people who have experienced mental health issues is too risky.

Significance ($\rho = 0.004$)
Question 13: It is important to appear tough with people using mental health services in order to be respected.

Significance ($p = 0.18$)

Question 14: People with psychosocial disabilities need someone to plan activities for them.

Significance ($p = 0.02$)

Question 15: The opinions of health practitioners about care and treatment should carry more weight than those of a person with an intellectual disability.

Significance ($p = 0.002$)
**Question 16:** It is acceptable to pressure people using mental health services to take treatment that they don’t want.

Significance ($p = 0.0005$)

**Question 17:** Persons with mental health conditions should not be given important responsibilities while they are recovering.

Significance ($p = 0.003$)

**Question 18:** When people are unable to communicate you need to make decisions based on what you think is good for them.

Significance ($p = 0.01$)
**Question 19:** Health practitioners are in the best position to know what people with dementia are capable of achieving in their lives.

Significance ($p = 0.0002$)

**Question 20:** I believe that people with intellectual disabilities have the right to make their own decisions, even if I don’t agree with them.

Significance ($p = 0.003$)

**Question 21:** Controlling people using mental health services is necessary to maintain order.

Significance ($p = 0.11$)
**Question 22:** The use of seclusion and restraint are needed when people using mental health services become threatening.

Significance ($p = 0.05$)

**Question 23:** Often people using mental health services over-react to the use of seclusion.

Significance ($p = 0.06$)

**Question 24:** The use of seclusion and restraint does not change the therapeutic relationship between people using mental health services and staff.

Significance ($p = 0.02$)
**Question 25:** Isolating someone in a room is acceptable when it is done to prevent a person using mental health services from harming themselves or others.

Significance ($p = 0.01$)

**Question 26:** Most people do not mind if they are sedated to de-escalate a tense situation.

Significance ($p = 0.02$)

**Questionnaire Total Pre and Post**

Significance ($p = 0.0001$)
What are people saying about the training?
On completing the training, people were asked a series of questions as part of the evaluation.

Thinking back on the training, which activities/parts of the training had the biggest impact on you?

“The videos were excellent! They were short, simple, and precise. I enjoyed watching them because they were presented in an interesting manner which was very engaging.”

“Answer completion and getting things wrong then having to repeat. Helped to clarify thinking and focus attention on written materials.”

“Meaning of recovery”

“...I came to understand how to promote the rights to legal capacity through supported decision making, recovery plans and advance planning and how to avoid involuntary detention and treatment."

“..lastly is the fact that i came to know interesting information about the fact that even yelling to a patient and involuntary detention of a person against their will is coercion.”

“Creating services free from coercion, violence and abuse: The reason been is that most of the concept and Ideas had never occurred to me that way and so it really served as an eye opening session for me.”

“The videos where people with lived experience told their stories.”

“Case studies in each part, they are very practical and help in transforming theory into practice”

What did you like best about this training? What didn’t you like?

“The training itself challenges you - not only at an ideological level but also at a practice level. The training builds up as the modules progress. The best part about the training is that it allows you to understand HOW to apply rights in daily life and practice - ideas and concepts that may seem vague and absurd to others. The training goes into details of what each stakeholder can do to uphold rights.”

“...I found the variety and structure of the training to consider all styles of learning...”

Based on the training, do you believe your attitude towards people with psychosocial, intellectual and cognitive disabilities has changed? If yes, in what way? If no, why?

“Yes it has changed. I have learned that its not only about the treatment/medications provided in our mental facilities that helps in the recovery of our patients, but also that their should be social orientation and interaction, involving them in decision making, letting them make their decisions and tell us what are their preferences/choices instead of forcefully admitting them into a mental facility and making decisions on their behalf. That communication is key and their should be a proper flow of information from the service providers to the service users and family and their need to be a
team work between the mental health care providers, the patient and the family of the patient in order to provide the best of care to the patient.”

“Yes, in particular around current debates around decision making being made in the best interest of individuals as opposed to respecting and supporting legal capacity of the individual.”

“Yes. I now affirm that they (MH Service Users) can take valid decisions, contribute to societal development, as well as participate in political and public life. In short, “they are more of an Asset to the community than Liability”

“Yes, the training changed my attitude. It made me question and doubt the effectiveness of common psychiatric practices and reinforced my opinion that people with psychosocial, intellectual and cognitive disabilities should be the ones making decisions about their treatment and about how they want to live their lives.”

**Do you think your practices have/will change? If yes, in what way? If no, why?**

“I will suggest the materials from the training to be taken into account when discussing Law on Psychiatric care in my country.”

“Introducing more human rights based interventions and principles in practice and policy. Ensuring that other colleagues are aware and trained.”

“Yes. With more knowledge and understanding on the issues now, it means strength and confident in my advocacy work”

“Yes, because I will listen to them more this time for them to determine what they want”

“The training helps me in becoming more reflective of my actions with service users and attempt to re-think interactions which do not violate their rights.”

**I would recommend this training to others**

![Fig.3 Overview of responses to recommend training to others](image.png)

Yes = 23, No = 1