



**QualityRights**

# WHO QualityRights Tool Kit

Assessing and improving quality  
and human rights in mental  
health and social care facilities



**World Health  
Organization**





QualityRights

# WHO QualityRights Tool Kit

**Assessing and improving quality and human  
rights in mental health and social care facilities**

WHO Library Cataloguing-in-Publication Data

WHO qualityrights tool kit: assessing and improving quality and human rights in mental health and social care facilities.

1.Mental health. 2.Mental health services - standards. 3.Human rights. 4.Quality of health care. 5.National health programs I.World Health Organization.

ISBN 978 92 4 154841 0

(NLM classification: WM 30)

© World Health Organization 2012

All rights reserved. Publications of the World Health Organization are available on the WHO web site ([www.who.int](http://www.who.int)) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: [bookorders@who.int](mailto:bookorders@who.int)). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press through the WHO web site ([http://www.who.int/about/licensing/copyright\\_form/en/index.html](http://www.who.int/about/licensing/copyright_form/en/index.html)).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Printed in Malta

Preferred citation:

*WHO QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities*. Geneva, World Health Organization, 2012.

# Contents

Acknowledgements . . . . .	v
1. Introduction . . . . .	1
2. WHO QualityRights tool kit . . . . .	3
3. Who can use the tool kit? . . . . .	9
4. Establish a project management team and objectives . . . . .	14
5. Establish an assessment framework . . . . .	15
6. Establish the assessment committee(s) and their working method . . . . .	22
7. Train the members of the assessment committee(s) . . . . .	24
8. Establish the authority of the committee(s) . . . . .	25
9. Prepare consent forms and seek ethical approval . . . . .	26
10. Schedule and conduct the assessment . . . . .	27
11. Observe the facilities . . . . .	28
12. Review facility documentation . . . . .	30
13. Interview service users, family members (or friends or carers) and staff . . . . .	33
14. Report the results of the assessment . . . . .	37
15. Use the results of the assessment . . . . .	39
Annex 1. Principles of recovery-oriented mental health practice . . . . .	41
Annex 2. Legal capacity and supported decision-making . . . . .	44
Annex 3. Convention on the Rights of Persons with Disabilities . . . . .	46
Annex 4. Themes, standards and criteria of the WHO QualityRights tool kit . . . . .	75
Annex 5. Examples of sample sizes for different types of facilities, according to number of staff and service users . . . . .	87
Annex 6. Sample consent forms for interviewees participating in an assessment . . . . .	90





# Acknowledgements

The principal authors of the tool kit were Michelle Funk and Natalie Drew, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, World Health Organization (WHO), Geneva, Switzerland.

Technical guidance and reviews were provided by:

- Melvyn Freeman, National Department of Health, South Africa
- Achmat Moosa Salie, World Network of Users and Survivors of Psychiatry, Ubuntu Centre South Africa, Cape Town, South Africa
- Anne Marie Robb, Ubuntu Centre South Africa, South Africa
- Judith Cohen, South African Human Rights Commission, South Africa
- Christine Ogaranko, Canada
- J. Ramón Quirós, Ministry of Health and Health Care, Principality of Asturias' Government, Spain
- Japheth Ogamba Makana, MindFreedom, Kenya
- Sawsan Najjir, MindFreedom, Kenya
- Charlene Sunkel, Gauteng Consumer Advocacy Movement; Chairperson, South African Mental Health Advocacy Movement, South Africa
- Sylvester Katontoka, Mental Health Users Network of Zambia
- Tomás Lopéz Corominas, Hierbabuena, Oviedo Association for Mental Health, Spain
- Helena Nygren Krug, WHO, Geneva, Switzerland
- Gemma Griffin, Mental Health and Addiction, Southern District Health Board, New Zealand
- Shekhar Saxena, WHO, Geneva, Switzerland
- David Crepaz-Keay, Mental Health Foundation, United Kingdom
- Javier Vasquez, WHO Regional Office for the Americas, Washington DC, United States
- Jose Miguel Caldas de Almeida, Faculty of Medical Sciences, New University of Lisbon, Portugal
- Soumitra Pathare, Ruby Hall Clinic, Pune, India
- Benedetto Saraceno, University Nova of Lisbon, Portugal; Global Initiative on Psychiatry, The Netherlands

We also wish to thank the following people for their expert opinion and technical input:

- Victor Aparicio, WHO Subregional Office, Panama
- Gunilla Backman, London School of Hygiene and Tropical Medicine, United Kingdom
- Laurent Benedetti, University of Massachusetts Medical School, United States
- Laura Bennett, Severn Deanery School of Psychiatry, United Kingdom
- Benjamin E. Berkman, Department of Bioethics, National Institutes of Health, United States
- Mrs Barbara Bernath, Association for the Prevention of Torture, Switzerland
- Andrea Bruni, WHO Country Office, Ethiopia
- Judith Bueno de Mesquita, University of Essex Law School, Colchester, United Kingdom
- Vijay Chandra, WHO Regional Office for South-East Asia, New Delhi, India



- Hugo Cohen, WHO Subregional Office, Argentina
- Sebastiana Da Gama Nkomo, WHO Regional Office for Africa, Brazzaville, Democratic Republic of the Congo
- Julian Eaton, CBM West Africa Regional Office, Togo
- Marta Ferraz, National Programme for Mental Health, Ministry of Health, Portugal
- Lance Gable, Wayne State University Law School, Detroit, Michigan, United States
- Amelia Concepción González López, Public Health and Participation, Principality of Asturias, Spain
- Lawrence Gostin, O'Neill Institute for National and Global Health Law, Georgetown University, Washington DC, United States
- Paul Hunt, University of Essex Human Rights Centre, Colchester, United Kingdom
- Shadi Jaber, Mental Health Families and Friends Society, West Bank and Gaza Strip
- Jan Paul Kwasik, Orygen Youth Health, Melbourne, Australia
- Caroline Fei-Yeng Kwok, Canada
- Oliver Lewis, Mental Disability Advocacy Centre, Budapest, Hungary
- Aiysha Malik, University of Oxford, United Kingdom
- Angélica Monreal, National Commission for the Protection of People with Mental Illnesses, Chile
- Maristela Monteiro, WHO Regional Office for the Americas, Washington DC, United States
- Matthijs Muijen, WHO Regional Office for Europe, Copenhagen, Denmark
- Jamil Nassif, Salfit Community Mental Health Center, Ministry of Health, West Bank and Gaza Strip
- Alana Officer, WHO, Geneva, Switzerland
- Ionela Petrea, Trimbos Institute WHO Collaborating Centre, The Netherlands
- Matt Pollard, Association for the Prevention of Torture, Geneva, Switzerland
- Jorge Rodriguez, WHO Regional Office for the Americas, Washington DC, United States
- Diana Rose, Institute of Psychiatry, King's College London, United Kingdom
- Khalid Saeed, WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt
- Tom Shakespeare, WHO, Geneva, Switzerland
- Jessica Sinclair, Maxwell Stamp PLC, United Kingdom
- Sarah Skeen, WHO, Geneva, Switzerland
- Peter Stastny, Global Mental Health Program/RedeAmericas, Columbia University, New York City, United States
- Kanna Sugiura, WHO, Geneva, Switzerland
- Ezra Susser, Mailman School of Public Health, Columbia University, New York City, United States
- Stephen Tang, Australian National University, Canberra, Australia
- Graham Thornicroft, Institute of Psychiatry, King's College London, United Kingdom
- Anil Vartak, Schizophrenia Awareness Association, Pune, India
- Henrik Wahlberg, Stockholm County Council, Centre for Transcultural Psychiatry, Stockholm, Sweden
- Simon Walker, Office of the High Commissioner for Human Rights, Geneva, Switzerland
- Xiangdong Wang, WHO Regional Office for the Western Pacific, Manila, Philippines
- Narelle Wickham, Justice Health, Canberra, Australia
- Moody Zaky, Comet General Hospital, Egypt

Administrative and secretarial support: Patricia Robertson

Graphic design and layout: Inis Communication, [www.iniscommunication.com](http://www.iniscommunication.com)

**Financial support from the Government of Spain and Portugal is gratefully acknowledged.**





# 1 Introduction

All over the world, people with mental disabilities, intellectual disabilities and substance abuse problems are subject to poor-quality care and violations of their human rights. Mental health services fail to integrate evidence-based treatment and practices, resulting in poor recovery outcomes. The stigma associated with these conditions means that people experience exclusion, rejection and marginalization by society. Misconceptions about people with such disabilities – that they are incapable of making decisions or taking care of themselves, that they are dangerous or objects of pity and welfare – mean they face discrimination in all aspects of life. They are denied opportunities to work, to get an education and to live fulfilling, independent lives in the community.

Ironically, some of the worst human rights violations and discrimination experienced by people with mental disabilities, intellectual disabilities and substance abuse problems is in health-care settings. In many countries, the quality of care in both inpatient and outpatient facilities is poor or even harmful and can actively hinder recovery. The treatment provided is often intended to keep people and their conditions ‘under control’ rather than to enhance their autonomy and improve their quality of life. People are seen as ‘objects of treatment’ rather than human beings with the same rights and entitlements as everybody else. They are not consulted on their care or recovery plans, in many cases receiving treatment against their wishes. The situation in inpatient facilities is often far worse: people may be locked away for weeks, months and sometimes years in psychiatric hospitals or social care homes, where they experience terrible living conditions and are subject to dehumanizing, degrading treatment, including violence and abuse.

It is critical to assess and improve quality and the observance of human rights in both outpatient and inpatient facilities in order to change this situation. A comprehensive assessment of facilities can help to identify problems in existing health care practices and to plan effective means to ensure that the services are of good quality, respectful of human rights, responsive to the users’ requirements and promote the users’ autonomy, dignity and right to self-determination. Assessment is important not only for reforming past neglect and abuses but also for ensuring effective, efficient services

in the future.<sup>1,2</sup> In addition, the results and recommendations from an assessment of quality and human rights can ensure that future policy, planning and legislative reform respect and promote human rights.

---

<sup>1</sup> *Quality improvement for mental health. WHO mental health policy and service guidance package.* Geneva, World Health Organization, 2003.

<sup>2</sup> A complementary resource in countries facing humanitarian crises is: World Health Organization & United Nations High Commissioner for Refugees. Checklist for site visits at institutions in humanitarian settings. In: *Assessing mental health and psychosocial needs and resources: tool kit for major humanitarian crises.* Geneva, World Health Organization, 2012.

# 2 WHO QualityRights tool kit

## Aim

The aim of the *WHO QualityRights tool kit* is to support countries in assessing and improving the quality and human rights of their mental health and social care facilities.

The tool kit is based on an extensive international review by people with mental disabilities and their organizations. It has been pilot-tested in low-, middle- and high-income countries and is designed to be applied in all of these resource settings.

In this tool kit, the term ‘people with mental disabilities’ can include those with mental, neurological or intellectual impairments and those with substance use disorders.

The term ‘facility’ refers to any place where people with mental disabilities live or receive care, treatment and/or rehabilitation. These include: psychiatric hospitals; psychiatric wards in general hospitals; outpatient services (including community mental health or substance abuse centres, primary care clinics and outpatient care provided by general hospitals); day-care centres for people with mental disabilities and social care homes (including orphanages, homes for elderly people, homes for children with intellectual and other disabilities and other ‘group’ homes).

Psychiatric and other long-stay inpatient facilities have long been associated with poor-quality care and human rights violations. People living in these facilities are isolated from society and have little or no opportunity to lead normal, fulfilling lives in the community. For this reason, the World Health Organization (WHO) recommends that countries progressively close down this type of facility and instead establish community-based services and integrate mental health into primary care services and the services offered by general hospitals. While this tool does not endorse long-stay facilities as an appropriate setting for treatment and care, as long as this type of facility continues to exist in countries all over the world, there is a need to prevent violations and promote the rights of those residing in them.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) is the basis for human rights standards that must be respected, protected and fulfilled in facilities.

## Themes

Five themes, drawn from the CRPD, are covered by the tool kit:

- 1. *The right to an adequate standard of living and social protection (Article 28 of the CRPD).*** Many people staying in residential facilities have inhuman living conditions, including overcrowding and poor sanitation and hygiene. Residents lack proper clothing, clean water, food, heating, decent bedding and privacy. The social environment is often no better: people are denied the opportunity to communicate with the outside world, their privacy is not respected, they experience excruciating boredom and neglect and little or no intellectual, social, cultural, physical or other form of stimulation. Article 28 of the CRPD requires, among other things, that people with disabilities are provided with an adequate standard of living, including adequate food, clothing, clean water, devices and other assistance for disabilities and continuous improvement of their living conditions.
- 2. *The right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD).*** In many countries, people do not have access to the basic mental health care and treatment that they require. Services are often too far from their homes or unaffordable. In other cases, the services themselves are of poor quality: ineffective or harmful treatments are applied, and comorbid general health problems are ignored. Institutional services are emphasized to the detriment of outpatient community-based facilities, and the focus of many services is on detaining people rather than helping them to develop their abilities in order to recover and (re)integrate into the community (See Annex 1 for the principles related to recovery). Furthermore, people living in residential facilities are often unable to access services for general and sexual and reproductive health. Article 25 of the CRPD requires that people with disabilities be given the health services they need, as close as possible to their communities. It also requires that they be given the same range, quality and standard of free or affordable health care, including sexual and reproductive health, as all other people.
- 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).*** People with mental and intellectual disabilities routinely experience violations of their right to exercise their legal capacity. They are often considered incapable of making decisions about their own lives, and key choices that concern them (e.g. about their place of residence, their medical treatment, their personal and financial affairs) are made by families, carers, guardians or health professionals. Furthermore, people in countries all over the world are given medical treatment or admitted to residential facilities without their express informed consent.

Article 12 of the CRPD states that people with disabilities have the right to recognition everywhere as persons before the law. It also re-asserts the rights of people

with disabilities to exercise their legal capacity on an equal basis with others in all aspects of life. They must therefore remain central to all decisions that affect them, including about their treatment, where they live and their personal and financial matters. Article 12 also states that, when needed, people should be given support in exercising their legal capacity. This means that they should have access to a trusted person or group of people, who can explain issues related to their rights, treatment and other relevant matters and who can help them to interpret and communicate their choices and preferences. The people providing support could include advocates, a personal ombudsperson, community services, personal assistants and peers (see Annex 2 for further information on supported decision-making).

Article 14 of the CRPD (the right to liberty and security of person) is an important provision in relation to admission without informed consent. It states that people with disabilities must not be deprived of their liberty unlawfully or arbitrarily, that any deprivation of liberty must be in conformity with the law and that the existence of a disability shall in no case justify deprivation of liberty.

**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).** People in inpatient facilities and social care homes in many countries are exposed to physical, sexual and mental abuse. Many spend days, months and even years living aimless, inactive lives in excruciating boredom and total social isolation. They are often secluded (for example in isolation cells) or placed in restraints (such as chains, shackles and caged beds). In addition they are often over-medicated, so that they remain docile and ‘easy to manage’. In many instances and according to international human rights law, this treatment amounts to ill-treatment and in some cases even torture.

Article 15 requires that all appropriate measures be taken to prevent people with disabilities from being subjected to torture or cruel, inhuman or degrading treatment or punishment. This Article also states that no one must be subjected to medical or scientific experimentation without his or her free consent. Article 16 requires that all measures be taken to protect people against and prevent all forms of exploitation, violence and abuse. This Article also requires that all appropriate measures be taken to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of people with disabilities who become victims of any form of exploitation, violence or abuse, including by the provision of protection services. In addition, recovery and reintegration must take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs. Importantly also, Article 16 requires that all facilities and programmes designed to serve people with disabilities be effectively monitored by independent authorities.

**5. The right to live independently and be included in the community (Article 19 of the CRPD).** People with disabilities experience wide-ranging violations and discrimination, which prevent them from living and being included in the community. They are denied opportunities to work and get an education and access to the social and financial support they require to live in the community. They are also restricted in the exercise of their right to vote and to join and participate in political, religious, social and self-help or advocacy organizations. They are unable to exercise their religious or cultural practices and are denied opportunities for leisure, fitness and sports activities. Part of the problem is that both inpatient and outpatient services for people with mental disabilities are focused on treatment and care rather than on providing or facilitating access to the full range of support to allow these people to live independently in the community and participate fully in society.

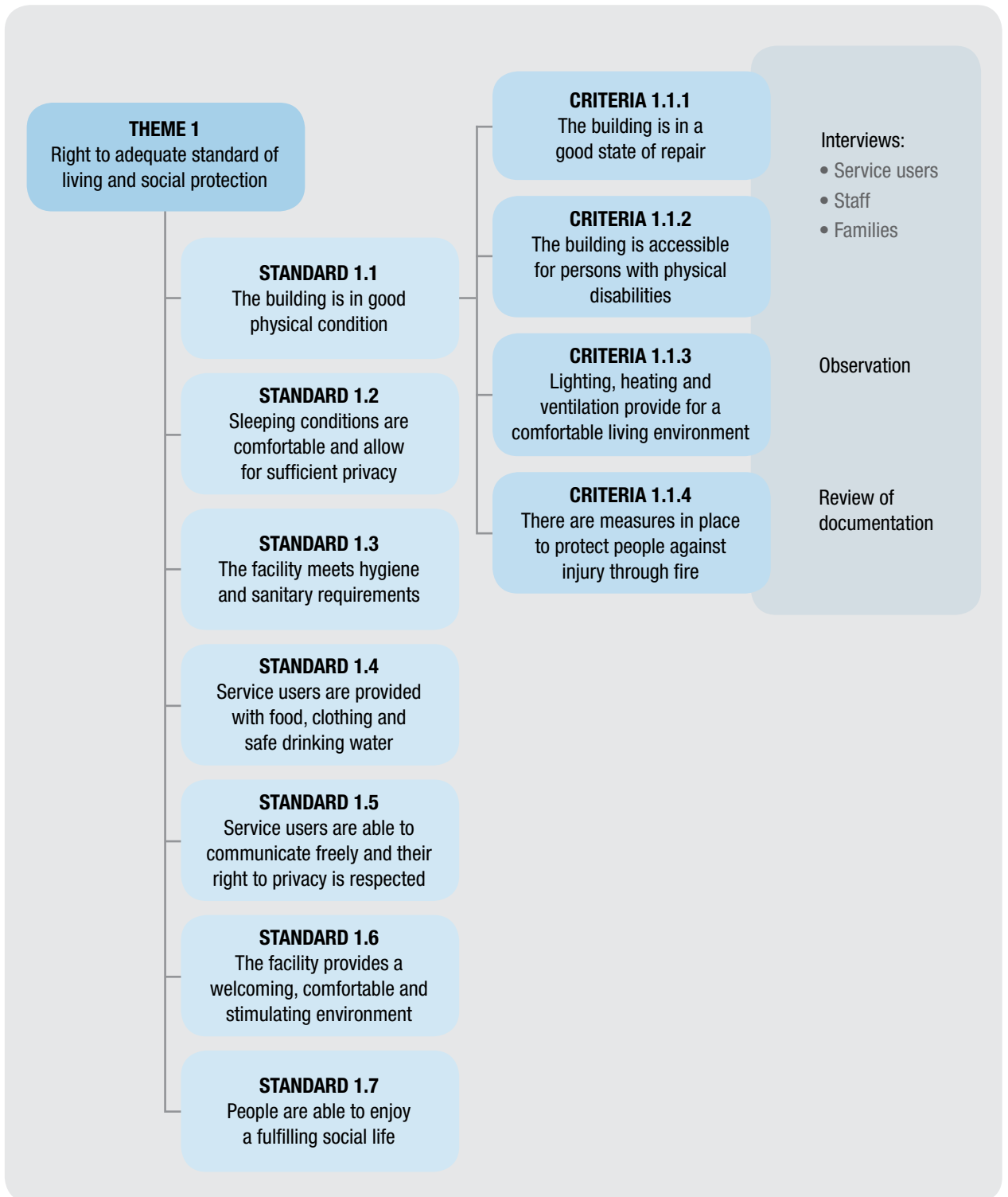
Article 19 states that people with disabilities have the right to live in the community and that governments must take effective, appropriate measures to facilitate their full inclusion and participation in society. It further states that people have the right to decide where and with whom they live; they must not be obliged to live in a particular living arrangement. Significantly also, Article 19 states that people must be given access to a range of in-home, residential and other community support services, including the personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community. The concepts of inclusion and participation outlined in Article 19 are further articulated in other articles of the Convention, including those on the rights to education, to work and employment and to participation in political, public and cultural life and in recreation, leisure and sport.

(See Annex 3 for the complete Convention on the Rights of Persons with Disabilities.)

## Standards and criteria used in the WHO QualityRights tool kit

Each of the ‘themes’ or ‘rights’ outlined above is broken down into a series of ‘standards’, which are further broken down into a series of ‘criteria’. The criteria form the basis of the quality and human rights assessment. It is against the criteria that the situation in facilities will be assessed, through interviews, observation and reviews of documentation. Assessment of each criterion enables the people doing the assessment to determine whether a particular standard has been met. The standards, in turn, help to determine whether the overarching theme has been met (Figure 1).

**Figure 1. Example of division of each theme into standards and criteria to be met in a quality and human rights assessment of mental health and social care facilities**



## Relevance of themes, standards and criteria to inpatient and outpatient facilities

As shown in Table 1, themes 2, 3 (with the exception of criterion 3.1.4), 4 and 5 and their respective standards and criteria apply to both inpatient and outpatient facilities. Theme 1 specifically addresses living conditions in residential facilities and thus does not apply to outpatient services; it does, however, apply to day-care centres. The full list of themes, standards and criteria is shown in Annex 4.

**Table 1. Applicability of themes to inpatient and outpatient facilities**

Theme	Inpatient	Outpatient
1	✓	✗
2	✓	✓
3	✓	Criterion 3.1.4 in standard 3.1 is not relevant for outpatient facilities
4	✓	✓
5	✓	✓

## Components of the WHO QualityRights tool kit

The *WHO QualityRights tool kit* provides detailed instructions on how to conduct an assessment and report and use the findings. It also includes several tools:

- **Assessment tools:**

- *The WHO QualityRights interview tool:* This tool provides guidance on conducting interviews with service users, family members (or friends or carers) and staff of the facility.
- *The WHO QualityRights review of documents and observation tool:* This tool provides guidance on reviewing documentation and making observations at the facility.

- **Reporting forms:**

- *Facility-based assessment report:* This document is designed to assist assessment teams in collating and presenting their findings, conclusions and recommendations for individual facilities.
- *Country-wide assessment report:* This document is designed to assist assessment teams in collating and presenting their findings, conclusions and recommendations for countries.



# 3 Who can use the tool kit?

The tool kit can be used by various national and international groups and organizations. It can be used for a single assessment or as part of a country-wide programme to improve facilities.

## International human rights bodies and nongovernmental organizations

A number of international and regional bodies have the mandate to monitor human rights in places of detention and other facilities. The United Nations Subcommittee on the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, for example, which was established under the United Nations Optional Protocol of the Convention against Torture and became operational in 2007, has the mandate to visit places of detention, including mental health and social care institutions in countries that have ratified the Convention. Similarly, in Europe, the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, set up under the Council of Europe's European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2007), also visits places of detention, including psychiatric hospitals and social care homes, to assess how people deprived of their liberty are being treated. Both the United Nations Subcommittee and the European Committee are made up of independent experts, and both provide recommendations to the countries concerned on effective measures to prevent torture and ill-treatment.

International nongovernmental organizations, such as Disability Rights International, the Mental Disability Advocacy Centre and the Global Initiative on Psychiatry, have all monitored and issued reports on human rights conditions in mental health and social care facilities.

While international human rights bodies and nongovernmental organizations can play a critical role in bringing about change in facilities, they cannot take sole responsibility for this function. The primary responsibility lies with national bodies or mechanisms.

## National bodies and mechanisms

Various national bodies and mechanisms can assess quality and human rights in mental health and social care facilities.

## National bodies and mechanisms established under international human rights standards

Certain international human rights instruments require that countries set up national mechanisms to promote human rights. Article 33 of the CRPD, for example, requires that governments establish one or more independent mechanisms, with the full involvement and participation of people with disabilities, in order to promote, protect and monitor implementation of the Convention.

Article 17 of the United Nations Optional Protocol of the Convention against Torture (see Table 2 for a link to the instrument) requires the establishment of one or several independent national mechanisms for the prevention of torture. These mechanisms have the power to examine regularly how people in places of detention are being treated, conduct interviews with detainees and make recommendations to the relevant authorities about improving treatment and conditions and preventing torture and other cruel, inhuman or degrading treatment or punishment.

## National human rights institutions

National human rights institutions are set up to promote and protect human rights. The Paris Principles adopted by the United Nations General Assembly in 1992 contain comprehensive recommendations on the role, composition, status and functions of these national institutions. They can be grouped into two broad categories: human rights commissions and ombudsperson agencies.

The functions of *national human rights commissions* include ensuring that laws and regulations comply with international human rights standards and investigating complaints of human rights abuses. Specialized commissions exist in certain countries to protect the rights of groups that are exposed in particular to violations of human rights, including women, children, refugees and minority groups. Many national commissions are required by law to report regularly directly to the legislature.

*Ombudspersons* are charged with representing the interests and addressing the concerns of the public by investigating complaints. In some cases, they may conduct investigations when no specific complaint has been lodged, for example when an entire group's rights are being violated.

Both national human rights commissions and ombudspersons should function independently of the government in order to carry out their investigations impartially. Both may rely on conciliation or arbitration to resolve complaints, although these bodies are sometimes given quasi-judicial status and granted authority to impose a legally binding outcome.

**Table 2. Important human rights instruments**

<b>United Nations instruments</b>	
Convention on the Rights of Persons with Disabilities	<a href="http://www2.ohchr.org/english/law/disabilities-convention.htm">http://www2.ohchr.org/english/law/disabilities-convention.htm</a>
Optional Protocol to the Convention on the Rights of Persons with Disabilities	<a href="http://www2.ohchr.org/english/law/disabilities-op.htm">http://www2.ohchr.org/english/law/disabilities-op.htm</a>
International Covenant on Economic, Social and Cultural Rights	<a href="http://www2.ohchr.org/english/law/cescr.htm">http://www2.ohchr.org/english/law/cescr.htm</a>
International Covenant on Civil and Political Rights	<a href="http://www2.ohchr.org/english/law/ccpr.htm">http://www2.ohchr.org/english/law/ccpr.htm</a>
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	<a href="http://www2.ohchr.org/english/law/cat.htm">http://www2.ohchr.org/english/law/cat.htm</a>
Optional Protocol to the Convention against Torture	<a href="http://www2.ohchr.org/english/law/cat-one.htm">http://www2.ohchr.org/english/law/cat-one.htm</a>
<b>Regional instruments</b>	
African Charter on Human and Peoples' Rights	<a href="http://www.africa-union.org/official_documents/treaties_%20conventions_%20protocols/banjul%20charter.pdf">http://www.africa-union.org/official_documents/treaties_%20conventions_%20protocols/banjul%20charter.pdf</a>
American Convention on Human Rights	<a href="http://www.oas.org/juridico/english/treaties/b-32.html">http://www.oas.org/juridico/english/treaties/b-32.html</a>
Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights	<a href="http://www.oas.org/juridico/english/treaties/a-52.html">http://www.oas.org/juridico/english/treaties/a-52.html</a>
Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities	<a href="http://www.oas.org/juridico/english/sigs/a-65.html">http://www.oas.org/juridico/english/sigs/a-65.html</a>
European Convention for the Protection of Human Rights and Fundamental Freedom	<a href="http://conventions.coe.int/treaty/en/Treaties/Html/005.htm">http://conventions.coe.int/treaty/en/Treaties/Html/005.htm</a>
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment	<a href="http://www.cpt.coe.int/en/documents/ecpt.htm">http://www.cpt.coe.int/en/documents/ecpt.htm</a>
<b>Other useful documents</b>	
United Nations handbook for parliamentarians on the Convention on the Rights of Persons with Disabilities	<a href="http://www.un.org/disabilities/default.asp?id=212">http://www.un.org/disabilities/default.asp?id=212</a>
Monitoring the Convention on the Rights of Persons with Disabilities. Guidance for human rights monitors	<a href="http://www.ohchr.org/Documents/Publications/Disabilities_training_17EN.pdf">http://www.ohchr.org/Documents/Publications/Disabilities_training_17EN.pdf</a>
Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. (A/63/175)	<a href="http://www.unhcr.org/refworld/pdfid/48db99e82.pdf">http://www.unhcr.org/refworld/pdfid/48db99e82.pdf</a>
Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (E/CN.4/2005/51)	<a href="http://www.essex.ac.uk/human_rights_centre/research/rth/docs/CHR2005.pdf">http://www.essex.ac.uk/human_rights_centre/research/rth/docs/CHR2005.pdf</a>

## National health or mental health commissions

Certain countries have established national health commissions, and some have established mental health commissions. These bodies are independent of the government and health facilities. Their purpose is to promote high standards and good practice in health care. In certain countries, such commissions have developed standards for ensuring good-quality services, often on the basis of extensive consultation with service users and staff at facilities. In some countries, such commissions are mandated to visit health facilities to undertake independent assessments of the standards of service, either on the basis of complaints they have received or as part of an ongoing assessment. On the basis of their assessments, national health commissions provide guidance on how the facility can improve the standard of care it provides.

## Health service accreditation bodies

Many countries have health service accreditation bodies or agencies. Like health commissions, these are independent bodies, which are responsible for assessing how well health-care services comply with recognized standards of care. On the basis of their assessment, however, accreditation bodies have the additional function of determining whether to accredit health facilities. When a facility is accredited it means that the service meets the required quality standards. This process helps to ensure that quality is the cornerstone of the official licensing of health and mental health services and facilities.

## National nongovernmental organizations

National nongovernmental organizations, in particular organizations of people with mental or intellectual disabilities or with substance abuse problems, as well as those focusing on human rights, disability or mental health and substance abuse issues, may also play a central role in assessing quality and human rights in mental health and social care facilities. Most nongovernmental organizations enjoy autonomy from the government and from the health system; they are in a strong position to make impartial assessments, as they do not fear that their resources will be cut if they expose deficiencies in facilities. For some nongovernmental organizations, the purpose of an assessment might be to highlight the conditions in facilities publicly in order to galvanize the government to take measures to improve them. Other organizations might undertake an assessment with the goal of subsequently working with the facility, health sector or government to improve quality and human rights conditions.

## A 'dedicated' assessment committee or body

A body or committee might also be established specifically for assessing quality and human rights in facilities and social care homes used by people with mental or

intellectual disabilities and substance abuse problems. In some countries, such bodies (and their composition and powers) are established by mental health or other legislation; the advantage is that this creates a legal obligation to assess facilities regularly and to report the findings and recommendations to the government. Another advantage is that such assessment committees cannot simply be disbanded because of a lack of resources or because they have revealed information that may be embarrassing to the government. The work of a legally appointed assessment committee is facilitated by the obligatory cooperation of service providers and full access to all parts of facilities.

A legally established committee is not, however, a requirement for effective assessment, and such bodies can be established outside a legal framework. These may be more flexible than a legally constituted body, for example with respect to their composition and terms of reference. In many countries, such bodies have been established by ministries of health or other government structures in order to improve conditions in facilities. A critical feature of such bodies, whether legally appointed or not, is that they retain independence from the government and the facilities that are being assessed.

Which body undertakes quality and human rights assessments will depend in part on the bodies and structures that already exist in a country. For example, if there is a national human rights commission with the requisite independence, mandate and expertise to assess facilities, it may make good sense to take advantage of this structure. Where no appropriate body exists, it may be necessary to establish a 'dedicated' assessment committee. The choice of body or mechanism also depends on the purpose of the assessment and how the results will be used.

# 4 Establish a project management team and objectives

The first step in implementing *WHO QualityRights* is to establish a core team of people who will be responsible for overseeing the project, providing guidance to the committee who will carry out the assessment (see section 6), managing and coordinating the assessment, reporting the results and following up with action.

The project management team might comprise representatives from the ministry of health, other appropriate ministries (e.g. of social welfare), representatives of organizations of people with mental disabilities, family organizations, national human rights or health commissions or bodies and health, mental health and legal professionals.

The management team must be given sufficient authority to execute the assessment project effectively. In some contexts, for example, this may require official recognition of the authority of the team in overseeing assessments of mental health and social care facilities in the country by the ministry of health, the ministry of social welfare or another government body. Appointing high-level representatives to the management team may be an effective means of securing the necessary authority.

Another means of ensuring sufficient authority for the management team is to appoint an advisory board comprising high-level government representatives (for example, parliamentarians or senior staff of national health commissions or human rights institutions) and the heads of organizations of people with disabilities and family and professional organizations. A high-level advisory board can serve the dual purpose of advising the management team on running the project and giving it the necessary political ‘clout’ to undertake its work unimpeded.

The management team should determine the objectives of the assessment. Is the main objective to assess and improve all inpatient and outpatient facilities in the country, or will the project be limited to inpatient facilities? Is its purpose to inform policy and legislation or, when these are already in place, to strengthen their implementation? Determining the objectives of the assessment will clarify the framework and how the results will be reported.

# 5 Establish an assessment framework

Once the purpose of the assessment has been determined, a number of issues must be considered by the management team before starting the assessment.

## Determine the scope of the assessment.

Early on in the project, the management team should determine and agree upon the scope of the assessment.

First, what type of facility or service will be assessed? For example, will the assessment focus on services for a specific group of people: people with mental disabilities, people with intellectual disabilities, people with neurological disabilities, people with substance use disorders, adults, children or elderly people? Will the focus be on residential facilities (e.g. psychiatric hospitals, psychiatric wards in general hospitals, social care homes) or outpatient facilities (e.g. day-care centres, community-based services, primary care clinics, outpatient care provided by general hospitals, rehabilitation centres)? Or will both inpatient and outpatient facilities be assessed? Table 3 outlines some types of services that could be considered for assessment.

**Table 3. Types of services to consider for assessment**

Type of facility:	Facility providing services for:
Psychiatric hospital	Adults
Psychiatric ward in general hospital	Children
Outpatient services (including community mental health or substance abuse centres, primary care clinics, or outpatient care provided by general hospitals)	The elderly
Rehabilitation centres	Alcohol use disorders
Day Care Centres	Substance use disorders
Social care home (including orphanages, homes for elderly people, homes for children with intellectual and other disabilities and other 'group' homes)	Mental disorders
	Intellectual disabilities
	Neurological disorders

In addition, the geographical scope of the assessment should be determined. Will it be nationwide? Will it focus on one or two regions or districts of the country? Or perhaps only one or two facilities will be assessed? If it is a national or district level assessment, will all facilities in the country or district be assessed? Alternatively, is the aim to obtain an overall picture of conditions in facilities in the country or district on the basis of assessments in a number of selected facilities (which are representative enough to reflect conditions in nationwide)?

## Understand the organization of services in the country.

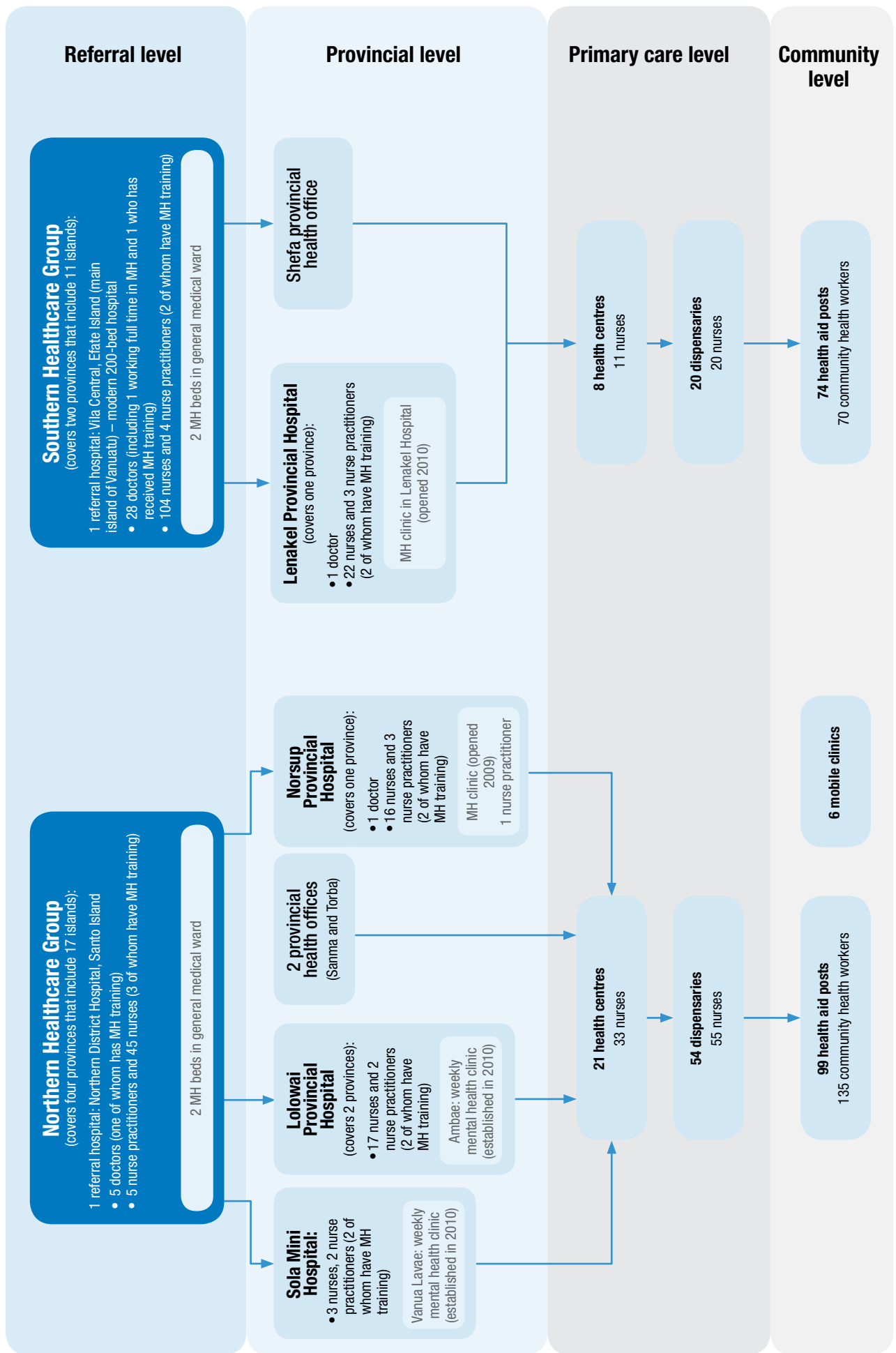
In order to determine the scope of the assessment, it is important to understand how both mental health and general health facilities or services in the country are organized. The management team should therefore map all relevant services throughout the country, with information on the body responsible for each service. As different sectors may be responsible for different services, it may be necessary to map not only mental health services but also substance abuse services (if they are separate from mental health) and relevant services provided by the social services sector (for example, in some countries, social care and other group homes). Figure 2 gives an example of how mental health and general health services can be mapped in a country.

Mapping is important for several reasons:

- It will help to determine which sector(s) must be approached for the assessment. For example, in addition to the ministry of health, it may be necessary to approach the ministry of social welfare to obtain its approval to conduct the assessment in the facilities for which it is responsible.
- Mapping can also help to ensure that no facilities are overlooked for assessment. For example, if the purpose of the project is to assess all inpatient and outpatient mental health and social care facilities throughout the country, mapping will help to ensure that all such facilities have been identified and avoid overlooking a certain category of facility (e.g. military mental health services or services in the private sector).
- Mapping also helps to determine the scale of the assessment and what is realistically achievable. For example, after mapping all facilities, the management team might decide that it is not feasible to assess inpatient and outpatient facilities at the same time and that, as a first step, the assessment should concentrate on conditions in outpatient facilities only.
- Mapping of services can also help to ensure that the assessment will reflect conditions in facilities in the country as a whole. For example, if the purpose is to assess only some facilities in order to obtain a picture of conditions throughout the country, mapping will help to identify a sufficiently diverse number and range of facilities and ensure that they are situated in all parts of the country, including both urban and rural areas.



**Figure 2. Organizational structure of mental health (MH) services in the general health system of Vanuatu (2011)**



## Select facilities for assessment.

Having defined the scope and mapped the relevant services or facilities in the country, the management team must select the facilities to be assessed. As mentioned above, all facilities in the country might be assessed, or a random selection of facilities could be assessed to obtain a picture of quality and human rights in these services.

To help in making this decision, it might be useful to consider the number of facilities in each category. For example, if there are only three mental health units in general hospitals, all of them could be sampled. If there are 10 mental health units in general hospitals, at least five might be sampled to obtain a representative sample.

It is important to ensure that all parts of a facility are assessed. For example, many large psychiatric hospitals have several different units or services (e.g. acute care unit, chronic care unit, forensic unit, outpatient services), and each should be assessed.

It is worth bearing in mind that the units in a facility might differ drastically. For example, the conditions in a female chronic care unit in a psychiatric hospital might be found to be good, while those in the male acute unit in the same hospital might be very poor. In this situation, it might be difficult to assess the facility as a single entity, as the conditions are so variable; averaging the assessments would dilute both the good and the bad parts of the facility. In such cases, therefore, it may be necessary to assess, score and report on each unit separately.

### **Assessing general health facilities as a comparison**

In order to conduct an effective assessment of conditions in mental health and social care facilities, it is important to have a comparison. A useful comparison is with general health care facilities in the same country. A comparison between mental health and social care facilities in two different countries is unlikely to be useful, as the national context (e.g. resources devoted to health and other factors) will differ. Assessing mental health and social care facilities against general health facilities in the same country allows a more valid comparison, as the national context is the same.

It is essential, therefore, that the committee (or committees, depending on the scale of the assessment) also visit general health care facilities. Such visits allow the committee to determine whether people using mental health and social care facilities really receive the same standards of health care and respect for their rights as people using general health care services.

Ideally, one general health care facility should be visited for each category of mental health and substance abuse facility being assessed. For example, if inpatient mental health facilities are being assessed, an inpatient facility for a 'general' health problem (e.g. a cancer unit in a general hospital) should

also be visited. If outpatient mental health facilities are being assessed, the committee should also visit a general health outpatient facility.

When more than one committee is involved in conducting assessments (e.g. for district-level or national assessments), each committee should visit the same general health care facility or facilities in order to reduce subjectivity in the findings of different committees, as everyone will have the same comparison.

Assessment of general health facilities need not be lengthy, but it should be as detailed as the committee decides is necessary. For example, it may involve all three assessment activities – observation of the facility, review of documentation and interviews with users – or only one or two of those activities. In assessing inpatient facilities, the committee should undertake at least the observation component. When outpatient facilities are being assessed, at a minimum, interviews should be conducted with the users. In all cases, the committee should record its findings on the *WHO QualityRights* reporting forms and discuss any differences in findings between mental health and general health facilities in its final report.

## Select themes for the assessment.

As stated above, the *WHO QualityRights Tool Kit* comprises five themes:

- the right to an adequate standard of living (Article 28 of the CRPD);
- the right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD);
- the right to exercise legal capacity and the right to personal liberty and the security of person (Articles 12 and 14 of the CRPD);
- freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD); and
- the right to live independently and be included in the community (Article 19 of the CRPD).

The management team will decide whether to assess all five themes or whether to select a few specific ones. It is recommended that all five themes be assessed, to ensure that the assessment is thorough and comprehensive, although fewer can be selected in a specific country context. There is a degree of overlap between the standards and criteria under the different themes, as many of the issues are interconnected. For example, standards 2.3 and 3.1 both address recovery plans that reflect the preferences and choices of service users, as this issue is relevant to both the right to health (covered in theme 2) and the right to exercise legal capacity (covered in theme 3).

## Determine which and how many people from each facility to interview.

The management team will determine the number of service users, family members<sup>3</sup> and staff to be interviewed in each facility. The *WHO QualityRights interview tool* includes questions directed at all three groups, and it is important to sample them all, as each has a different perspective and can add vital, complementary information to the assessment. Interviews should be undertaken with a wide selection of people associated with the facility, for example with service users of different ages, different genders, different diagnoses and different ethnic origins and receiving services from different units or sections of the facility, people who have recently been admitted as well as those who have been there for some time, and (in the case of inpatient facilities) users who are in the facility voluntarily as well as those who are there without their consent. Family members of a broad range of categories of service users should be identified for interview. In some contexts, it may also be appropriate to interview friends or members of the service user's support network.

Different categories of staff should be interviewed, including the head of the facility, assistant nurses, registered nurses, social workers, psychologists, psychiatrists and other health professionals. Staff who have been at the facility for some time should be interviewed as well as those who are new to the facility. It may also be useful to interview cleaners, kitchen staff, security personnel, janitors and other relevant staff.

The numbers of people interviewed depends on the number of service users and staff associated with the facility, the size of the facility and the number of units it comprises. The management team's approach for determining the number of service users, family members and staff is similar to the approach for selecting the number of facilities to be assessed. Annex 5 gives guidance on determining sample sizes for interviews; for example:

- If only six users are receiving services from a facility, all of them should be interviewed (100%).
- If there are 16 service users, about eight should be interviewed (50%) at a minimum.
- If there are 40 service users or more, at least 12 should be interviewed (approximately 30%).
- The number of interviews to be conducted with family members can be determined by halving the number of interviews planned with service users. In each of the scenarios above, therefore, the number of family members to be interviewed would be three (50% of number of service users), four (50%) and six (50%).
- The numbers of staff can be selected on the basis of the same proportions used for service users.

---

<sup>3</sup> Throughout this document, the term 'family members' is used to include friends and carers.

Although the numbers and categories of staff and service users to be interviewed can be determined before the assessment, the people to be interviewed should be selected randomly by the assessment committee at the time of the visit to the facility. Consideration must be given to the health status of individuals before interviewing them.

The figures above are just examples, and each management team will determine how many interviews should be conducted in the context of each facility. The guiding principle is to obtain enough information from the review of documentation, observation and interviews for an accurate view of conditions in the facility. The sample of people interviewed must be large enough to ensure their anonymity. If too few staff and service users are interviewed, for example, individuals might be identifiable from the report, perhaps leading to negative repercussions for them. The more people interviewed, the more difficult it is for specific responses to be linked to particular individuals.

Once a clear picture of the establishment has been obtained from review of documentation, observation and interviews, there may be no need to conduct further lengthy interviews. This may be the case for large institutions. For example, the committee may decide to interview 100 of the 300 service users (i.e. 30%) of a large facility; however, if a clear picture of conditions in the facility has emerged after 30 interviews with service users, there may be no need to interview a further 70.

# 6 Establish the assessment committee(s) and their working method

Once the scope of the assessment and the number of facilities to be assessed have been decided, the management team should determine how many assessment committees will be needed. In some contexts (e.g. small countries or when only one or two facilities are being assessed), only one committee may be necessary. In other contexts (e.g. for national or district-wide assessments), several committees will be needed.

The management team will also determine the working method of the assessment committees. When several committees are needed, a country may decide to have a central committee, with subsidiary committees to conduct assessments in regions or districts. The subsidiary committees would report to the management team, which would be responsible for standardizing the inputs and reporting to the relevant authority. This activity should, as far as possible, involve the independent members of the management team.

## Select members of the assessment committees.

The management team should decide on the members of the assessment committees. A key principle in establishing a committee is that the people selected must be independent from government and from the facilities being assessed. The committee should also be multidisciplinary, bringing together people with a variety of skills and experience.

Assessments of facilities used by people with mental disabilities, intellectual disabilities and substance abuse problems must involve people with those disabilities. Their expertise and perspective are essential and help to ensure that the concerns of service users are identified and addressed.

The committee should also include health professionals with expertise in mental health and/or substance abuse who can assess the quality of care and treatment in facilities. Ideally, one or more of the health professionals will have experience in a variety of health settings, so that they can compare conditions and parity between facilities for people with mental health or substance abuse problems and facilities for general health care.

Lawyers and human rights defenders are also important members of the committee, because they can provide expertise on issues related to legislation and the rights of

people with disabilities. Representatives of families and carers and social workers also bring useful knowledge and experience to an assessment.

Depending on the country, it may be appropriate to include other people on the committee, such as community or religious leaders or laypeople with a commitment to improving the rights of people with disabilities.

Members of the management team can also be part of an assessment committee, as long as they are independent from government and the facilities and they have no conflict of interest in conducting the actual assessment.

The gender, ethnic group, race, disability and cultural balance of the committee should be considered in selecting members. Other desirable characteristics for members of the committee area include: an interest in promoting the rights of people with disabilities; respect for the capacity of people with disabilities to make decisions and choices for themselves; sensitivity to national ethnic, political, religious, cultural, social and economic diversity; good communication skills; and an ability to be empathetic and to exercise impartiality.

## **Determine the different functions of the members of the committee.**

The management team should decide who will be responsible for different aspects of the assessment, including:

- coordination, such as coordinating the meetings of the committee, visits to facilities and follow-up work;
- observation of conditions in facilities;
- review of documentation;
- conducting interviews;
- drafting the report(s) of the assessment, including collating results and drafting reports after visits; and
- addressing questions, concerns or complaints after a facility visit, by liaising with service users and staff.

Certain members of the assessment committee will have skills, knowledge and experience that may suit them for a particular role. For example, some may have experience in conducting interviews. Members who have experienced disability themselves may play a useful role in conducting interviews with service users, as they may have a deeper understanding some of the issues and can gain the trust of the users. Members of the committee should not be limited to specific roles, and they will probably undertake diverse activities during the assessment. Rather, the different strengths of members of the committee should guide decisions on the allocation of roles and responsibilities.

# 7 Train the members of the assessment committee(s)

Members of the assessment committee will need training on using the *WHO Quality-Rights tool kit on assessing and improving quality and human rights in mental health and social care facilities*, as well as on human rights and quality issues. The management team is likely to be well equipped to provide training. In addition or alternatively, external trainers with relevant expertise might provide some of the training. These might include representatives of organizations of people with mental disabilities, of national human rights institutions or of nongovernmental human rights organizations. Similarly, representatives of the national health commission or another relevant body might be enlisted to provide training on quality issues.

In preparation for the training, the management team should become familiar with each component of the *WHO QualityRights tool kit*: this overview; the tools, which consist of the interview tool and the tool for observation and reviewing documentation; and the reporting forms for facility-level and country-level reporting.

The assessment committee must understand the rights of people with mental disabilities, intellectual disabilities and substance abuse problems specifically. In particular, the committee should be aware of the international instruments that the country has ratified, which set legal obligations on the government. Members should be familiar with the CRPD, which outlines the rights of people with disabilities. Other international standards with which they should be familiar are the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and regional African, inter-American and European human rights instruments, as well as a number of (non-binding) documents that provide useful guidance on the rights of people with disabilities (see Table 2 on page 11).

Members of the committee should also be familiar with relevant national policies, plans and laws related to mental health, substance use and disability and with anti-discrimination legislation and the national constitution. This will enable them to determine whether those policies, plans and laws are being adhered to. In many countries, policies, plans and laws are outdated, and this can prevent good-quality services and violate human rights. The assessment may identify problems and gaps in existing national documents, and committee members can include recommendations to fill those gaps in their report.

Familiarization with international and national journal articles, media articles and reports of nongovernmental and other organizations on the conditions in facilities and on the rights of people with disabilities is also useful.





# Establish the authority of the committee(s)

A committee is most effective when it has official authority to conduct the assessment. Such authority may be conferred by the leader of the country (president or prime minister) or by the ministry of health or other relevant ministry. Alternatively, such authority might be established in legislation (for example in a law on mental health that contains provisions for the inspection of facilities) or in the mandate of the body responsible for the assessment (e.g. a national human rights commission).

Such authority allows committee members to work without interference or outside influence and without fear of negative repercussions for themselves or those who provide them with information, irrespective of the assessment findings. It also allows the committee to visit and observe any facility without obstruction, obtain unrestricted access to all parts of those facilities and conduct interviews with any people it deems relevant, while guaranteeing their anonymity and confidentiality.

In some cases, the government (e.g. the ministry of health) or the facility itself may 'commission' an assessment, for example to improve quality. While this may require the involvement of government representatives or people linked to the facility (for example in coordinating the assessment or facilitating access), the assessment itself (i.e. the visits and interviews with informants) and the analysis and reporting of findings must be undertaken by people who are wholly independent and have no conflict of interest.

The management committee must also organize access to facilities. When an assessment has been 'commissioned' by a government body (e.g. the ministry of health or the ministry of social welfare) or by the facility itself, access should be straightforward. When this is not the case, the management team might have to seek approval to conduct the assessment from the relevant government body. That body must recognize the authority of the committee to undertake the assessment, including its authority to make unannounced visits, and should advise facilities that they may be assessed.

# 9 Prepare consent forms and seek ethical approval

Consent must be obtained from the staff, service users and family members participating in the assessment before interviews are conducted. Therefore, a consent form must be prepared, to be signed by interviewees, which provides information about the assessment and about the confidentiality of the interview. Consent must also be sought if the interview is to be tape- or video-recorded, and the wishes of the interviewees must be respected if they refuse. If interviewers wish to take photographs of any apparent signs of physical abuse (e.g. bruising, cuts) on service users, they also require the informed consent of the user. Annex 6 gives an example of a consent form, which can be adapted and translated for national use.

Protecting the confidentiality and anonymity of the people being interviewed is crucial to ensure that no negative repercussions result from the assessment. It is therefore important that all consent forms, tape- and video-recordings, photographs and other documentation that might reveal the identity of interviewees be kept in a secure place, which can be accessed only by members of the assessment committee.

Some countries require clearance from a national ethics committee before an assessment project. When ethical approval is required, the management team must follow the procedures required by their national ethics body to obtain the necessary clearance.

# 10 Schedule and conduct the assessment

## Announced versus unannounced visits

When possible, the assessment committee should make unannounced visits to facilities. If staff at a facility know the date and time of a visit, they might prepare for the visit by 'cleaning up' the facility, so that committee members will see a 'sanitized' version of the facility rather than the actual conditions. Unannounced visits ensure that committee members see conditions as they are experienced by people in the facility every day.

## Visits at different times of the day

If possible, several visits should be made to the same facility at different times of the day, so that members of the committee can observe conditions in the morning, afternoon and night.

## Introduce the committee and explain the assessment project

Before starting the visit, the committee should meet with facility staff and service users and, when possible, family members to explain the purpose of the assessment and their visit and to outline what they will be doing and what they hope to achieve.

The committee should try to establish a sense of partnership and cooperation with the staff, service users and family members. Staff may feel uneasy about the assessment, fearing that their work is being monitored and judged. Service users and family members may also be wary of the assessment and fear repercussions if they take part in interviews. The committee should therefore endeavour to promote a spirit of collaboration, emphasizing that all those involved have a common goal – to improve conditions at the facility – and that this can be achieved only with the input and active participation of all. The assessment team must not, however, raise unrealistic expectations about what the assessment will achieve, and they should make it clear that conditions are unlikely to improve immediately but only over time.

The assessment committee might prepare a flyer to disseminate among staff, service users and families, outlining the above information.

# 11

## Observe the facilities

Observation is central to assessing conditions in mental health and social care facilities. The *WHO QualityRights review of documentation and observation tool* provides a guide for committee members on what they should observe during their visits to facilities, with space to record their findings.

Committee members should conduct observations in all parts of a facility. In the case of inpatient services, for example, observations should be made in acute and chronic units, the sleeping quarters in both male and female wards, seclusion rooms, rooms in which electroconvulsive therapy is administered, occupational therapy rooms, the kitchen, eating area, toilets and bathrooms.

Observation should not be restricted to an examination of physical conditions; it should also include what happens at the facility. For example, when visiting inpatient and outpatient services, the assessment committee should observe the interactions between staff and service users in order to determine whether the users are being treated with dignity and respect and whether their rights and their legal capacity are respected. Therefore, as part of the observation, committee members should sit in on sessions involving staff and service users, including:

- consultations between service users and staff: Are service users participating in preparation of their recovery plan? Can they voice their opinions and choices concerning their treatment, and are these respected? Or are these decisions made for them?
- rehabilitation sessions: Are staff merely lecturing service users in these sessions, or are service users actively participating in gaining skills?

### **Tips for observation**

Observations should be made with all five senses.

**See** – In inpatient facilities, carefully observe the physical conditions and assess whether they are acceptable. For example, are the washing amenities and toilets clean? Do service users' sleeping quarters offer enough privacy? Is there overcrowding? In both inpatient and outpatient facilities, observe the interactions and relationships between staff and service users. Are service users spoken to and treated with dignity and respect?

**Smell** – Be aware of the different smells in inpatient facilities. For example, do the toilets smell? Bad smells may indicate that the toilets are not working or are not cleaned regularly and are thus unhygienic and possibly hazardous.

**Feel** – Touch the bedding to determine whether it is of adequate quality and appropriate for the climate. Feel for yourself whether the ambient temperature in different parts of the facility is comfortable or too hot or too cold. Turn on the taps to determine whether there is running hot water. It is not enough to ask whether there is adequate bedding, heaters or ventilators in the bedrooms or hot running water. You must check these for yourself.

**Hear** – Sounds in a facility, or sometimes their lack, can also be revealing. Are there shouts or screams from service users? If so, try to determine why and what is being done about them. Is the volume of music or a television inconsiderate of service users? Is there silence in the facility, and, if so, does this indicate a repressive atmosphere in which service users are reluctant to communicate with each other, visitors or members of staff?

**Taste** – Sometimes the food given to service users in facilities is not fit for consumption. Therefore, taste the food to judge whether it tastes good and is edible.

# 12 Review facility documentation

Reviewing documentation is an important part of the assessment. The *WHO Quality-Rights documentation and observation tool* is a guide to committee members on the types of documentation to be reviewed in the assessment. Documentation can be divided into four broad categories:

- facility policies, guidelines, standards and other official directives;
- administrative records (e.g. number and categories of staff, number, age and gender of service users, admission and discharge records);
- records of specific events (e.g. complaints, appeals against involuntary admission and treatment, incidents of theft, abuse, deaths); and
- service users' personal records or files.

**Facility policies, guidelines, standards and other official directives** are an important source of information on issues related to the quality of service, conditions in facilities and the human rights of service users. The absence of facility policy for a specific area is often an indication that the relevant standards are not being met; it is therefore important to carefully assess that area. For example, if there is no facility directive concerning the administration of electroconvulsive therapy, there is a good chance that informed consent for this procedure is not obtained from service users. This aspect should be examined further during interviews and observation.

Facility policies, guidelines, standards and other official directives may either promote or violate human rights and quality standards. In analysing these documents, members of the committee should draw on their knowledge of international and national human rights standards to assess whether the documents are consistent with those standards.

Even if facility policies are in line with quality and human rights standards, there is no guarantee that they are respected, and it is the responsibility of the assessment committee, during interviews and observation, to assess the extent to which the policies are adhered to in practice. When a facility policy is not implemented, the reasons must be determined. For example, lack of implementation of policies might indicate poor management or lack of staff training. Good policies are useful only if they are implemented; good policies that are not implemented have little value.

Members of the committee should also review **administrative records** and document information relevant to the assessment, including:

- numbers of staff, by profession (e.g. psychiatrists, psychologists, occupational therapists);
- number of users receiving services from the facility;
- numbers of female and male service users;
- the age range of service users; and
- number of service users under guardianship.

Additional information to be reviewed and documented in relation to inpatient facilities includes:

- the number of beds in use,
- the number of service users under voluntary status,
- the number of service users under involuntary status (admission and treatment) and
- the average length of stay of all service users.

The review of administrative documents can provide important information about human rights and quality issues. For example, the review might reveal that the facility lacks adequate human resources in relation to the number of service users. It might indicate that a large number of people are being admitted and treated on an involuntary basis, indicating that the legal capacity of service users is systematically ignored. Or it might reveal that children are being kept in inpatient facilities meant for adults.

**Records of specific events**, such as service user complaints, appeals against involuntary admission and treatment, incidents of theft and abuse and deaths, are also useful sources of information. Examining complaints by service users, for example, can reveal problems and violations or even patterns of abuse at the facility, which should be examined further during the assessment. A lack of complaints should also be documented, as it may indicate that no mechanism for complaints exists or that it is inaccessible to service users. A disproportionately high incidence of deaths among service users might indicate abuse or neglect, poor-quality health care or poor living conditions at the facility.

**Service user personal files and records** can also reveal important information. A review of such files can might indicate, for example, whether they are up to date, when medicine schedules were last reviewed and changed, if informed consent for treatment is being obtained, whether recovery plans and advance directives<sup>4</sup> are being designed in collaboration with service users and whether service users can add information to their files. It can also reveal whether people are receiving the correct medication and dosage for their condition or whether they are being overmedicated, incorrectly medicated or given too many medications simultaneously.

---

<sup>4</sup> Users can specify in advance their choices about health care, treatment and recovery in the event that they become unable to communicate their choices at some future time. Advance directives can also include treatment and recovery options that people do *not* want to have, and as such can help to ensure that they do not receive any intervention against their wishes.

The assessment committee should be given access to all service user records and select a number of these at random for detailed examination. They might decide to examine the records of the service users who are to be interviewed, with their consent. The files examined should cover the full range of service users by e.g. age, ethnic origin, gender and diagnosis. The assessment committee should determine whether consent is required to examine service users' files.

In order to review documentation effectively, a senior member of the staff of the facility should be available to assist in finding the documentation to be reviewed, as it is unlikely that all will be in a single place. A list of the documents to be reviewed might be given to staff at the facility before the visit.



# 13 Interview service users, family members (or friends or carers) and staff

Interviews with service users, family members and staff at a facility and listening to their views and perspectives are critical to the assessment. The *WHO QualityRights interview tool* outlines the themes, standards and criteria against which conditions in facilities should be assessed. The tool also contains questions associated with each criterion to assist the interviewer.

A number of issues should be considered in relation to the interview.

## Selecting interviewees

In selecting people to interview, the committee should be guided by the range of service users and staff and the sample size determined by the management committee (see Annex 5). The committee, and not the staff of the facility, must select the service users and staff to be interviewed to ensure that the process remains impartial.

The committee may decide which family members to interview or may be guided in their selection by service users. The committee should decide whether to interview family members during the visit to the facility or whether to organize such interviews outside the visit.

Staff, service users and family members have the right to decline to be interviewed, and the assessment committee must respect their decisions.

## The interview

A room or a space must be found to conduct interviews that ensures the privacy of the interviewees and allows them to talk freely. The interview should involve one interviewer (or a maximum of two: one to conduct the interview and the other to take notes for example) and the person being interviewed. Some service users might ask to have a person they trust (but not a staff member) with them during the interview, and this wish should be facilitated.

Every effort must be made to overcome any barriers in communication between the interviewer and the interviewee. For example, if the interviewee and the interviewer speak different languages or the interviewee has an impairment that hinders his or her ability to communicate (e.g. difficulty in speech or hearing), appropriate language or sign language interpreters should be brought in.

Before beginning an interview, the interviewers should introduce themselves, explain the purpose of the interview and answer any questions that the interviewee may have. Interviewers should also ask questions to derive information about the interviewees (e.g. where they are from, how long they have been in the facility). This type of introduction builds a rapport between the interviewee and interviewer and puts people at ease. It may also be useful to discuss any fears the interviewees may have about possible repercussions resulting from their participation in the interview and outline the measures that have been taken to protect their anonymity and confidentiality. Interviewers should also go through the informed consent form with interviewees to ensure that they have fully understood its content before they sign it.

The interview can be long and tiring, and interviewees should be allowed breaks when they require them. Furthermore, service users on certain medication may find it difficult to concentrate for long periods and might need regular breaks. The interviewer must be sensitive to any difficulty service users might have in relating their experiences and allow them to break off the interview and return to it later if necessary.

An element that has already been ascertained by the assessment committee, either in previous interviews or by observation, need not be addressed in subsequent interviews. For example, if the committee has observed that the toilets at the facility are dirty, there is no need to ask interviewees about the cleanliness of toilets. The reverse is not true, however. For example, if the toilets appear to be clean upon inspection, questions about the cleanliness and hygiene of toilets should be posed during interviews, as the toilets might have been cleaned especially for the visit of the assessment committee and are usually dirty and not cleaned regularly enough. Interviewers can also ask additional questions not covered in the *WHO QualityRights interview tool*.

At the end of the interview, interviewers should thank service users for their time. They should be told how to contact the assessment team if they wish to provide additional information after the visit, report any new problems or abuses or voice any concerns about repercussions against them after the interview. Interviewers should also tell the interviewees about the next steps in the assessment and tell them that they will be notified of the results once the report has been finalized.

Interviewers must not discuss the content of interviews with anyone except other committee members. One way of promoting confidentiality is for each member of the committee to sign an agreement that they will respect the confidentiality of the assessment and of the people who have been interviewed.

## Interviewing tips

**Interviewers should conduct interviews in a manner that is respectful and courteous.** Interviewees should not be made to feel that they are being cross-examined but rather that they are providing valuable input into the assessment.

**The perspectives of all those being interviewed are important.** Very often, the views of service users are considered invalid or are overlooked. Interviews should be conducted in a manner that acknowledges and respects the views and perspectives of service users.

**Allow for silence to give the interviewee time to think, and do not interrupt.** Silence may be needed for longer than feels usual or comfortable.

**Avoid interruptions.** Allow people to speak without interrupting them. If you have a question about what they are saying, wait until they have finished their sentence.

**Avoid excessive note-taking.** Note-taking can be distracting for interviewees. It is important to listen to responses. One possibility is to have two people at interviews: one asking questions and listening to the responses and the other taking notes.

**Short summaries, repeating what you have heard in your own words,** may be a useful technique to indicate that you are listening and to check that you have understood what the person is saying correctly.

**Avoid leading interviewees in their answers.** Interviewers often tend to lead interviewees to the answer they are expecting to hear. It is important to be aware of this tendency and make efforts to avoid it.

**Use open-ended questions.** Open-ended questions (e.g. “Can you comment on the physical state of the property?”) allow interviewees to share information they consider important. Avoid closed questions (e.g. “Do you think the physical state of the facility is bad?”) as far as possible, as these can prevent interviewees from expressing their views in their own way.

**Be flexible.** People may not answer the questions in the order presented in the *WHO QualityRights interview tool*. Interviewees’ answers to one question might also provide information relevant to a question planned for later in the interview. Do not stop them by saying that you plan to ask that question later on, but allow them to answer the question at hand fully.

**Try to ascertain whether issues highlighted by the interviewees are unique events or practices or whether they are commonplace and common practice in the facility.** For example, if someone says that a member of staff spoke to them disrespectfully, try to ascertain whether this happened only once with one member of staff or whether it is a common occurrence, with one or several staff.

**Volume, speed, tone.** Be aware of the volume of your voice and also your tone and speed. You should not speak too loudly, too quietly or too quickly. Allow the interviewee to set the pace of the interview.

**Practice, practice, practice.** Conducting interviews is a real skill. Learning interview techniques takes practice. It is therefore important to practice them, for example with committee colleagues or with your family and friends at home, before your visit to the facility.

## Reporting cases of abuse

Committee members may become aware during interviews, observation or review of service user complaints that one or several service users are being exposed to abuse or neglect that puts their health and well-being at immediate risk for harm. Before the assessment therefore, the committee should decide how such situations will be handled, perhaps by speaking with the head of the facility or another relevant authority, so that the situation can be addressed quickly. The agreement of the service users concerned might have to be sought before the abuse is reported. When there are specific national guidelines or legal provisions on the reporting of abuse, these must be followed. The committee should identify legal or social channels and the names of legal representatives or advocates who can assist victims of abuse. In addition, committee members might decide to give service users a telephone number at which they can be contacted should the users wish to report any incidents of abuse or neglect after the visit.

# 14 Report the results of the assessment

## Reporting findings for individual facilities

The *WHO QualityRights reporting form for individual facilities* provides a framework for the assessment committee to document systematically the extent to which each of the five themes of the *WHO QualityRights* tool has been realized in a specific mental health or social care facility. All sections of the report should be completed:

- executive summary,
- method used for the assessment,
- results of the assessment (including quantitative scoring and qualitative findings),
- discussion and
- conclusions and recommendations.

All members of the committee should meet as soon as possible after completion of the assessment (because impressions and information fade quickly) to discuss, integrate and compile their results from interviews, observation and review of documentation into a final report on the facility. The committee will then score each of the criteria, standards and themes of the *WHO QualityRights tool kit* as follows: 'achieved in full', 'achieved partially', 'achievement initiated', 'not initiated' or 'not applicable'.

The facility-level reporting form has space for scoring each criterion within a standard and then each standard within each theme. It also includes space to score the general health facility that was assessed, so that the two kinds of facility can be compared.

These quantitative scores are on their own meaningless, and qualitative information is necessary to give substance, detail and a comprehensive picture of the situation in the facility. The *WHO QualityRights reporting form* is a template for integrating quantitative and qualitative findings into a single report.

## Reporting findings for more than one facility

If more than one facility has been assessed (e.g. a national or district assessment), all the committees conducting assessments must meet to discuss, integrate and compile their results for each facility and prepare an overall national or district-wide assessment. The *WHO QualityRights reporting form for country-wide assessments* provides a framework.

The reporting form has the same sections as those for individual facilities, provides the same ratings for scoring (although the scores for each facility are listed and presented by theme on the country or district-level reporting form) and includes a template for integrating quantitative and qualitative findings into a single country or district-wide report.

### **Reaching consensus on assessment findings**

One of the most challenging aspects of assessments is reaching consensus among committee members and among committees in the case of district and national assessments. The standards and criteria in the instrument should guide committee members in determining what is expected of a facility to meet quality and human rights benchmarks. There is, however, much subjectivity in making assessments, and scores may differ. For example, one committee member might consider an acceptable level of achievement of a certain criterion, while another may find it unacceptable. In order to reduce such subjectivity, committee members should have detailed discussions about how they scored their findings and reach a consensus on the rating of the overall theme, standard or criterion. When a consensus cannot be reached, it is advisable to choose the lowest score.

Inclusion of the results of assessments of general health facilities also helps to reduce subjectivity in scoring both within and among assessment committees, as they provide a common point of comparison for standardizing or adjusting ratings.

Discussion of findings, standardizing or adjusting ratings and drafting a report (for a single facility or at national or district level) take time, and several meetings may be required before a report can be produced that represents consensus about conditions in the facilities.

# 15

## Use the results of the assessment

Assessments of quality and human rights in mental health and social care facilities can serve several purposes, and the results can be used in many different ways. Everyone involved in an assessment should clearly understand and agree on its purpose and how the results will be used.

### Informing policy, planning and law reform

At the macro-level, the results of an assessment can be used to inform policies, plans and legislation on mental health and substance abuse. For example, the results might reveal a need for more intensive, focused training of health or mental health workers with regard to best practice in treatment and to the rights of people with disabilities. This can subsequently be incorporated into mental health policies and plans. The results of an assessment might indicate that an existing law (e.g. legislation on mental health and substance abuse) requires revision. For example, if the assessment reveals that many people are being treated involuntarily, provisions on informed consent should be incorporated or strengthened. An assessment might reveal the need to establish a 'patient charter' that outlines the rights of users of mental health, substance abuse and other services.

### Understanding human rights violations and advocating for change

The results of an assessment can also be used to understand the extent and type of human rights violations occurring in facilities and to raise awareness about these issues among the relevant authorities and stakeholders, where appropriate. A number of international and national nongovernmental organizations have investigated conditions in mental health and social care facilities and disseminated their findings and recommendations widely to governments, the media, the public and other relevant authorities and groups. Highlighting deficiencies and violations can persuade authorities and civil society groups to address these problems. In determining whether and how to use this approach, the probable result must be taken into account. In certain contexts, such as use of the media to highlight and expose violations, this approach can be an important means of stimulating improvements in human rights conditions; in others, however, it can generate mistrust, so that facilities close themselves off to scrutiny, thereby driving violations further underground.

## Quality improvement

The results and recommendations from the assessment should be used as the basis for formulating a quality improvement plan, which should be integrated into the management and delivery of services at the facility. The ideal situation is one in which staff, service users and families work together in a participatory approach to prepare a plan that includes concrete actions and targets to prevent violations, promote human rights and improve the quality of treatment and care in the facility. Implementation of the improvement plan can be assessed continually as part of the facility's management, with periodic reviews following the *QualityRights assessment tool*. This approach can achieve better care and greater enjoyment of human rights, particularly as it involves the participation of service providers in bringing about positive change, rather than an external body. People become part of the process and make changes not because they have to (although the standards to be achieved are set) but because they are partners in the process and want to improve the service. A limitation of this approach is that it is rarely truly independent from the health authorities. This can be overcome by periodically bringing in an independent body to undertake an assessment. Therefore, a combined approach of ongoing internal assessment and improvement with periodic external assessment is useful.

## Capacity-building in human rights

The results of an assessment can also be used to identify gaps in knowledge in relation to human rights and quality issues. Tailored training and education can be conducted with staff, service users and families to ensure that each stakeholder understands the rights of people with mental disabilities and the quality standards that must be respected and promoted to improve conditions in the service.



# Annex 1. Principles of recovery-oriented mental health practice

Australian Government. *National standards for mental health services*. Canberra, 2010. Reprinted by permission of the Australian Government. <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10>

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connection – and external conditions that facilitate recovery – implementation of human rights, a positive culture of healing, and recovery-oriented services<sup>5</sup>.

The purpose of principles of recovery oriented mental health practice is to ensure that mental health services are being delivered in a way that supports the recovery of mental health consumers.

## 1. Uniqueness of the individual

Recovery oriented mental health practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
- accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive.

---

<sup>5</sup> Jacobson N, Greenley D, What Is Recovery? A Conceptual Model and Explication. *Psychiatric Services* 52:482–485, 2001

## 2. Real choices

Recovery oriented mental health practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

## 3. Attitudes and rights

Recovery oriented mental health practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to each individual
- promotes and protects individual's legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual
- instils hope in an individual's future and ability to live a meaningful life.

## 4. Dignity and respect

Recovery oriented mental health practice:

- consists of being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, particularly for their values, beliefs and culture
- challenges discrimination and stigma wherever it exists within our own services or the broader community.

## 5. Partnership and communication

Recovery oriented mental health practice:

- acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement
- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

## 6. Evaluating recovery

Recovery oriented mental health practice:

- ensures and enables continuous evaluation of recovery based practice at several levels
- individuals and their carers can track their own progress
- services demonstrate that they use the individual's experiences of care to inform quality improvement activities
- the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and well being measures.

These Recovery Principles have been adapted from the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the United Kingdom.

# Annex 2. Legal capacity and supported decision-making

People with mental disabilities are routinely denied the right to exercise their legal capacity. Through guardianship and other substitute decision-making measures, they are often prevented from making decisions and choices about their lives, including on issues related to their living arrangements, their medical care, their personal and financial affairs and other matters. Instead, these decisions are often made by families, carers, guardians or health professionals.

The aim of the United Nations *Convention on the Rights of Persons with Disabilities* (see Annex 3) is to end this situation. Article 12 of the Convention recognizes that people with disabilities, including mental disabilities, have the right to exercise their legal capacity, i.e. to make decisions and choices on all aspects of their lives, on an equal basis with others.

The Convention also recognizes that some people may on occasion require assistance in making decisions about their lives and promotes a supported decision-making model as the means for providing this assistance.

Supported decision-making involves the nomination by people with mental disabilities of a trusted person or a network of people with whom they can consult and discuss issues affecting them. Such people may assist service users in understanding the choices and options available to them in relation to their mental health treatment (e.g. whether to get treatment, where to get treatment, what type of treatment) and in communicating their choices and preferences to others when necessary. They may help others to realize that a person with significant disabilities is also a person with a history, interests and aims in life and is someone capable of exercising his or her legal capacity. In supported decision-making, the presumption is always in favour of the person with a disability who will be affected by the decision.<sup>6</sup>

Staff at mental health and social care facilities can play a vital role in promoting supported decision-making by:

- encouraging service users to nominate support people or networks of people,
- facilitating contacts between service users and their support people and

---

<sup>6</sup> *From exclusion to equality: realizing the rights of persons with disabilities. Handbook for parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol.* New York, United Nations, 2007. <http://www.un.org/disabilities/default.asp?id=212>.

- ensuring that service users and their support people are given the space and time to discuss issues related to mental health treatment and care.

Forms of supported decision-making include support networks, personal ombudspeople, peer support, advocates and personal assistants. Canada and Sweden offer models of supported decision-making, which are currently being implemented:

- Canadian Association for Community Living: <http://www.cacl.ca/>
- Nidus Personal Planning Resource Centre and Registry (British Columbia, Canada): <http://www.rarc.ca/textual/home.htm>
- Sweden Personal Ombudsman Model – PO-Skane: <http://www.po-skane.org/>

# Annex 3. Convention on the Rights of Persons with Disabilities

(adopted by the United Nations General Assembly in December 2006)

## Preamble

*The States Parties to the present Convention,*

- (a) *Recalling* the principles proclaimed in the Charter of the United Nations which recognize the inherent dignity and worth and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world,
- (b) *Recognizing* that the United Nations, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, has proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind,
- (c) *Reaffirming* the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms and the need for persons with disabilities to be guaranteed their full enjoyment without discrimination,
- (d) *Recalling* the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Rights of the Child, and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families,
- (e) *Recognizing* that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others,
- (f) *Recognizing* the importance of the principles and policy guidelines contained in the World Programme of Action concerning Disabled Persons and in the Standard Rules on the Equalization of Opportunities for Persons with Disabilities in influencing the promotion, formulation and evaluation of the policies, plans, programmes and actions at the national, regional and international levels to further equalize opportunities for persons with disabilities,

- (g) *Emphasizing* the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development,
- (h) *Recognizing also* that discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person,
- (i) *Recognizing further* the diversity of persons with disabilities,
- (j) *Recognizing* the need to promote and protect the human rights of all persons with disabilities, including those who require more intensive support,
- (k) *Concerned* that, despite these various instruments and undertakings, persons with disabilities continue to face barriers in their participation as equal members of society and violations of their human rights in all parts of the world,
- (l) *Recognizing* the importance of international cooperation for improving the living conditions of persons with disabilities in every country, particularly in developing countries,
- (m) *Recognizing* the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities, and that the promotion of the full enjoyment by persons with disabilities of their human rights and fundamental freedoms and of full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty,
- (n) *Recognizing* the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices,
- (o) *Considering* that persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them,
- (p) *Concerned* about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status,
- (q) *Recognizing* that women and girls with disabilities are often at greater risk, both within and outside the home of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation,
- (r) *Recognizing* that children with disabilities should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children, and recalling obligations to that end undertaken by States Parties to the Convention on the Rights of the Child,
- (s) *Emphasizing* the need to incorporate a gender perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by persons with disabilities,

- (t) *Highlighting* the fact that the majority of persons with disabilities live in conditions of poverty, and in this regard recognizing the critical need to address the negative impact of poverty on persons with disabilities,
- (u) *Bearing in mind* that conditions of peace and security based on full respect for the purposes and principles contained in the Charter of the United Nations and observance of applicable human rights instruments are indispensable for the full protection of persons with disabilities, in particular during armed conflicts and foreign occupation,
- (v) *Recognizing* the importance of accessibility to the physical, social, economic and cultural environment, to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms,
- (w) *Realizing* that the individual, having duties to other individuals and to the community to which he or she belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the International Bill of Human Rights,
- (x) *Convinced* that the family is the natural and fundamental group unit of society and is entitled to protection by society and the State, and that persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities,
- (y) *Convinced* that a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities will make a significant contribution to redressing the profound social disadvantage of persons with disabilities and promote their participation in the civil, political, economic, social and cultural spheres with equal opportunities, in both developing and developed countries,

*Have agreed as follows:*

## ARTICLE 1

### Purpose

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.



## ARTICLE 2

### Definitions

For the purposes of the present Convention:

“Communication” includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology;

“Language” includes spoken and signed languages and other forms of non spoken languages;

“Discrimination on the basis of disability” means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;

“Reasonable accommodation” means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms;

“Universal design” means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. “Universal design” shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.

## ARTICLE 3

### General principles

The principles of the present Convention shall be:

- (a) Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;
- (b) Non-discrimination;
- (c) Full and effective participation and inclusion in society;
- (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- (e) Equality of opportunity;

- (f) Accessibility;
- (g) Equality between men and women;
- (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

## ARTICLE 4

### General obligations

1. States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, States Parties undertake:

- (a) To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention;
- (b) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;
- (c) To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes;
- (d) To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention;
- (e) To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise;
- (f) To undertake or promote research and development of universally designed goods, services, equipment and facilities, as defined in article 2 of the present Convention, which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design in the development of standards and guidelines;
- (g) To undertake or promote research and development of, and to promote the availability and use of new technologies, including information and communications technologies, mobility aids, devices and assistive technologies, suitable for persons with disabilities, giving priority to technologies at an affordable cost;
- (h) To provide accessible information to persons with disabilities about mobility aids, devices and assistive technologies, including new technologies, as well as other forms of assistance, support services and facilities;
- (i) To promote the training of professionals and staff working with persons with disabilities in the rights recognized in this Convention so as to better provide the assistance and services guaranteed by those rights.

2. With regard to economic, social and cultural rights, each State Party undertakes to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realization of these rights, without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law.

3. In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.

4. Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of persons with disabilities and which may be contained in the law of a State Party or international law in force for that State. There shall be no restriction upon or derogation from any of the human rights and fundamental freedoms recognized or existing in any State Party to the present Convention pursuant to law, conventions, regulation or custom on the pretext that the present Convention does not recognize such rights or freedoms or that it recognizes them to a lesser extent.

5. The provisions of the present Convention shall extend to all parts of federal states without any limitations or exceptions.

## ARTICLE 5

### Equality and non-discrimination

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

## ARTICLE 6

### Women with disabilities

1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.
2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

## ARTICLE 7

### Children with disabilities

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

## ARTICLE 8

### Awareness-raising

1. States Parties undertake to adopt immediate, effective and appropriate measures:
  - (a) To raise awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities;
  - (b) To combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
  - (c) To promote awareness of the capabilities and contributions of persons with disabilities.
2. Measures to this end include:
  - (a) Initiating and maintaining effective public awareness campaigns designed:

- (i) To nurture receptiveness to the rights of persons with disabilities;
- (ii) To promote positive perceptions and greater social awareness towards persons with disabilities;
- (iii) To promote recognition of the skills, merits and abilities of persons with disabilities, and of their contributions to the workplace and the labour market;
- (b) Fostering at all levels of the education system, including in all children from an early age, an attitude of respect for the rights of persons with disabilities;
- (c) Encouraging all organs of the media to portray persons with disabilities in a manner consistent with the purpose of the present Convention;
- (d) Promoting awareness-training programmes regarding persons with disabilities and the rights of persons with disabilities.

## ARTICLE 9

### Accessibility

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

- (a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
- (b) Information, communications and other services, including electronic services and emergency services.

2. States Parties shall also take appropriate measures to:

- (a) Develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
- (b) Ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;
- (c) Provide training for stakeholders on accessibility issues facing persons with disabilities;
- (d) Provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;

- (e) Provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;
- (f) Promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
- (g) Promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;
- (h) Promote the design, development, production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum cost.

## ARTICLE 10

### Right to life

States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

## ARTICLE 11

### Situations of risk and humanitarian emergencies

States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.

## ARTICLE 12

### Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance

with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

## ARTICLE 13

### Access to justice

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

## ARTICLE 14

### Liberty and security of the person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

- (a) Enjoy the right to liberty and security of person;
- (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

## ARTICLE 15

### Freedom from torture or cruel, inhuman or degrading treatment or punishment

1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.
2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

## ARTICLE 16

### Freedom from exploitation, violence and abuse

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.
3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.
4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.
5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.



## ARTICLE 17

### Protecting the integrity of the person

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

## ARTICLE 18

### Liberty of movement and nationality

1. States Parties shall recognize the rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others, including by ensuring that persons with disabilities:

- (a) Have the right to acquire and change a nationality and are not deprived of their nationality arbitrarily or on the basis of disability;
- (b) Are not deprived, on the basis of disability, of their ability to obtain, possess and utilize documentation of their nationality or other documentation of identification, or to utilize relevant processes such as immigration proceedings, that may be needed to facilitate exercise of the right to liberty of movement;
- (c) Are free to leave any country, including their own;
- (d) Are not deprived, arbitrarily or on the basis of disability, of the right to enter their own country.

2. Children with disabilities shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by their parents.

## ARTICLE 19

### Living independently and being included in the community

States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- (a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- (b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

- (c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

## ARTICLE 20

### Personal mobility

States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:

- (a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;
- (b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;
- (c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;
- (d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

## ARTICLE 21

### Freedom of expression and opinion, and access to information

States Parties shall take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice, as defined in article 2 of the present Convention, including by:

- (a) Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost;
- (b) Accepting and facilitating the use of sign languages, Braille, augmentative and alternative communication, and all other accessible means, modes and formats of communication of their choice by persons with disabilities in official interactions;
- (c) Urging private entities that provide services to the general public, including through the Internet, to provide information and services in accessible and usable formats for persons with disabilities;
- (d) Encouraging the mass media, including providers of information through the Internet, to make their services accessible to persons with disabilities;
- (e) Recognizing and promoting the use of sign languages.

## ARTICLE 22

### Respect for privacy

1. No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks.

2. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

## ARTICLE 23

### Respect for home and the family

1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

- (a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;
- (b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;
- (c) Persons with disabilities, including children, retain their fertility on an equal basis with others.

2. States Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, wardship, trusteeship, adoption of children or similar institutions, where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.

3. States Parties shall ensure that children with disabilities have equal rights with respect to family life. With a view to realizing these rights, and to prevent concealment, abandonment, neglect and segregation of children with disabilities, States Parties shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families.

4. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.

5. States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.

## ARTICLE 24

### Education

1. States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and life long learning directed to:

- (a) The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;
- (b) The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;
- (c) Enabling persons with disabilities to participate effectively in a free society.

2. In realizing this right, States Parties shall ensure that:

- (a) Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;
- (b) Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;
- (c) Reasonable accommodation of the individual's requirements is provided;
- (d) Persons with disabilities receive the support required, within the general education system, to facilitate their effective education;
- (e) Effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion.

3. States Parties shall enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. To this end, States Parties shall take appropriate measures, including:

- (a) Facilitating the learning of Braille, alternative script, augmentative and alternative modes, means and formats of communication and orientation and mobility skills, and facilitating peer support and mentoring;
- (b) Facilitating the learning of sign language and the promotion of the linguistic identity of the deaf community;
- (c) Ensuring that the education of persons, and in particular children, who are blind, deaf or deafblind, is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximize academic and social development.

4. In order to help ensure the realization of this right, States Parties shall take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities.

5. States Parties shall ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination and on an equal basis with others. To this end, States Parties shall ensure that reasonable accommodation is provided to persons with disabilities.

## ARTICLE 25

### Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- (b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
- (c) Provide these health services as close as possible to people's own communities, including in rural areas;

- (d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- (e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

## ARTICLE 26

### Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

- (a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
- (b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

## ARTICLE 27

### Work and employment

1. States Parties recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard

and promote the realization of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps, including through legislation, to, inter alia:

- (a) Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions;
- (b) Protect the rights of persons with disabilities, on an equal basis with others, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances;
- (c) Ensure that persons with disabilities are able to exercise their labour and trade union rights on an equal basis with others;
- (d) Enable persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training;
- (e) Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment;
- (f) Promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business;
- (g) Employ persons with disabilities in the public sector;
- (h) Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures;
- (i) Ensure that reasonable accommodation is provided to persons with disabilities in the workplace;
- (j) Promote the acquisition by persons with disabilities of work experience in the open labour market;
- (k) Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.

2. States Parties shall ensure that persons with disabilities are not held in slavery or in servitude, and are protected, on an equal basis with others, from forced or compulsory labour.

## ARTICLE 28

### Adequate standard of living and social protection

1. States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.

2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:

- (a) To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs;
- (b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes;
- (c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counselling, financial assistance and respite care;
- (d) To ensure access by persons with disabilities to public housing programmes;
- (e) To ensure equal access by persons with disabilities to retirement benefits and programmes.

## ARTICLE 29

### Participation in political and public life

States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, and shall undertake to:

- (a) Ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives, including the right and opportunity for persons with disabilities to vote and be elected, inter alia, by:
  - (i) Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use;
  - (ii) Protecting the right of persons with disabilities to vote by secret ballot in elections and public referendums without intimidation, and to stand for elections,



- to effectively hold office and perform all public functions at all levels of government, facilitating the use of assistive and new technologies where appropriate;
- (iii) Guaranteeing the free expression of the will of persons with disabilities as electors and to this end, where necessary, at their request, allowing assistance in voting by a person of their own choice;
- (b) Promote actively an environment in which persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others, and encourage their participation in public affairs, including:
- (i) Participation in non-governmental organizations and associations concerned with the public and political life of the country, and in the activities and administration of political parties;
  - (ii) Forming and joining organizations of persons with disabilities to represent persons with disabilities at international, national, regional and local levels.

## ARTICLE 30

### Participation in cultural life, recreation, leisure and sport

1. States Parties recognize the right of persons with disabilities to take part on an equal basis with others in cultural life, and shall take all appropriate measures to ensure that persons with disabilities:
  - (a) Enjoy access to cultural materials in accessible formats;
  - (b) Enjoy access to television programmes, films, theatre and other cultural activities, in accessible formats;
  - (c) Enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance.
2. States Parties shall take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society.
3. States Parties shall take all appropriate steps, in accordance with international law, to ensure that laws protecting intellectual property rights do not constitute an unreasonable or discriminatory barrier to access by persons with disabilities to cultural materials.
4. Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture.

5. With a view to enabling persons with disabilities to participate on an equal basis with others in recreational, leisure and sporting activities, States Parties shall take appropriate measures:

- (a) To encourage and promote the participation, to the fullest extent possible, of persons with disabilities in mainstream sporting activities at all levels;
- (b) To ensure that persons with disabilities have an opportunity to organize, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources;
- (c) To ensure that persons with disabilities have access to sporting, recreational and tourism venues;
- (d) To ensure that children with disabilities have equal access with other children to participation in play, recreation and leisure and sporting activities, including those activities in the school system;
- (e) To ensure that persons with disabilities have access to services from those involved in the organization of recreational, tourism, leisure and sporting activities.

## ARTICLE 31

### Statistics and data collection

1. States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall:

- (a) Comply with legally established safeguards, including legislation on data protection, to ensure confidentiality and respect for the privacy of persons with disabilities;
- (b) Comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics.

2. The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights.

3. States Parties shall assume responsibility for the dissemination of these statistics and ensure their accessibility to persons with disabilities and others.

## ARTICLE 32

### International cooperation

1. States Parties recognize the importance of international cooperation and its promotion, in support of national efforts for the realization of the purpose and objectives of the present Convention, and will undertake appropriate and effective measures in this regard, between and among States and, as appropriate, in partnership with relevant international and regional organizations and civil society, in particular organizations of persons with disabilities. Such measures could include, inter alia:

- (a) Ensuring that international cooperation, including international development programmes, is inclusive of and accessible to persons with disabilities;
- (b) Facilitating and supporting capacity-building, including through the exchange and sharing of information, experiences, training programmes and best practices;
- (c) Facilitating cooperation in research and access to scientific and technical knowledge;
- (d) Providing, as appropriate, technical and economic assistance, including by facilitating access to and sharing of accessible and assistive technologies, and through the transfer of technologies.

2. The provisions of this article are without prejudice to the obligations of each State Party to fulfil its obligations under the present Convention.

## ARTICLE 33

### National implementation and monitoring

1. States Parties, in accordance with their system of organization, shall designate one or more focal points within government for matters relating to the implementation of the present Convention, and shall give due consideration to the establishment or designation of a coordination mechanism within government to facilitate related action in different sectors and at different levels.

2. States Parties shall, in accordance with their legal and administrative systems, maintain, strengthen, designate or establish within the State Party, a framework, including one or more independent mechanisms, as appropriate, to promote, protect and monitor implementation of the present Convention. When designating or establishing such a mechanism, States Parties shall take into account the principles relating to the status and functioning of national institutions for protection and promotion of human rights.

3. Civil society, in particular persons with disabilities and their representative organizations, shall be involved and participate fully in the monitoring process.

## ARTICLE 34

### Committee on the Rights of Persons with Disabilities

1. There shall be established a Committee on the Rights of Persons with Disabilities (hereafter referred to as “the Committee”), which shall carry out the functions hereinafter provided.

2. The Committee shall consist, at the time of entry into force of the present Convention, of twelve experts. After an additional sixty ratifications or accessions to the Convention, the membership of the Committee shall increase by six members, attaining a maximum number of eighteen members.

3. The members of the Committee shall serve in their personal capacity and shall be of high moral standing and recognized competence and experience in the field covered by the present Convention. When nominating their candidates, States Parties are invited to give due consideration to the provision set out in article 4.3 of the present Convention.

4. The members of the Committee shall be elected by States Parties, consideration being given to equitable geographical distribution, representation of the different forms of civilization and of the principal legal systems, balanced gender representation and participation of experts with disabilities.

5. The members of the Committee shall be elected by secret ballot from a list of persons nominated by the States Parties from among their nationals at meetings of the Conference of States Parties. At those meetings, for which two thirds of States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

6. The initial election shall be held no later than six months after the date of entry into force of the present Convention. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit the nominations within two months. The Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating the State Parties which have nominated them, and shall submit it to the States Parties to the present Convention.

7. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election once. However, the term of six of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these six members shall be chosen by lot by the chairperson of the meeting referred to in paragraph 5 of this article.

8. The election of the six additional members of the Committee shall be held on the occasion of regular elections, in accordance with the relevant provisions of this article.

9. If a member of the Committee dies or resigns or declares that for any other cause she or he can no longer perform her or his duties, the State Party which nominated the member shall appoint another expert possessing the qualifications and meeting the requirements set out in the relevant provisions of this article, to serve for the remainder of the term.

10. The Committee shall establish its own rules of procedure.

11. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention, and shall convene its initial meeting.

12. With the approval of the General Assembly, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide, having regard to the importance of the Committee's responsibilities.

13. The members of the Committee shall be entitled to the facilities, privileges and immunities of experts on mission for the United Nations as laid down in the relevant sections of the Convention on the Privileges and Immunities of the United Nations.

## ARTICLE 35

### Reports by States Parties

1. Each State Party shall submit to the Committee, through the Secretary-General of the United Nations, a comprehensive report on measures taken to give effect to its obligations under the present Convention and on the progress made in that regard, within two years after the entry into force of the present Convention for the State Party concerned.

2. Thereafter, States Parties shall submit subsequent reports at least every four years and further whenever the Committee so requests.

3. The Committee shall decide any guidelines applicable to the content of the reports.

4. A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports, repeat information previously provided. When preparing reports to the Committee, States Parties are invited to consider doing so in an open and transparent process and to give due consideration to the provision set out in article 4.3 of the present Convention.

5. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Convention.

## ARTICLE 36

### Consideration of reports

1. Each report shall be considered by the Committee, which shall make such suggestions and general recommendations on the report as it may consider appropriate and shall forward these to the State Party concerned. The State Party may respond with any information it chooses to the Committee. The Committee may request further information from States Parties relevant to the implementation of the present Convention.

2. If a State Party is significantly overdue in the submission of a report, the Committee may notify the State Party concerned of the need to examine the implementation of the present Convention in that State Party, on the basis of reliable information available to the Committee, if the relevant report is not submitted within three months following the notification. The Committee shall invite the State Party concerned to participate in such examination. Should the State Party respond by submitting the relevant report, the provisions of paragraph 1 of this article will apply.

3. The Secretary-General of the United Nations shall make available the reports to all States Parties.

4. States Parties shall make their reports widely available to the public in their own countries and facilitate access to the suggestions and general recommendations relating to these reports.

5. The Committee shall transmit, as it may consider appropriate, to the specialized agencies, funds and programmes of the United Nations, and other competent bodies, reports from States Parties in order to address a request or indication of a need for technical advice or assistance contained therein, along with the Committee's observations and recommendations, if any, on these requests or indications.

## ARTICLE 37

### Cooperation between States Parties and the Committee

1. Each State Party shall cooperate with the Committee and assist its members in the fulfilment of their mandate.

2. In its relationship with States Parties, the Committee shall give due consideration to ways and means of enhancing national capacities for the implementation of the present Convention, including through international cooperation.

## ARTICLE 38

### Relationship of the Committee with other bodies

In order to foster the effective implementation of the present Convention and to encourage international cooperation in the field covered by the present Convention:

- (a) The specialized agencies and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite specialized agencies and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;
- (b) The Committee, as it discharges its mandate, shall consult, as appropriate, other relevant bodies instituted by international human rights treaties, with a view to ensuring the consistency of their respective reporting guidelines, suggestions and general recommendations, and avoiding duplication and overlap in the performance of their functions.

## ARTICLE 39

### Report of the Committee

The Committee shall report every two years to the General Assembly and to the Economic and Social Council on its activities, and may make suggestions and general recommendations based on the examination of reports and information received from the States Parties. Such suggestions and general recommendations shall be included in the report of the Committee together with comments, if any, from States Parties.

## ARTICLE 40

### Conference of States Parties

1. The States Parties shall meet regularly in a Conference of States Parties in order to consider any matter with regard to the implementation of the present Convention.
2. No later than six months after the entry into force of the present Convention, the Conference of the States Parties shall be convened by the Secretary-General of the United Nations. The subsequent meetings shall be convened by the Secretary-General of the United Nations biennially or upon the decision of the Conference of States Parties.

## ARTICLE 41

### Depositary

The Secretary-General of the United Nations shall be the depositary of the present Convention.

## ARTICLE 42

### Signature

The present Convention shall be open for signature by all States and by regional integration organizations at United Nations Headquarters in New York as of 30 March 2007.

## ARTICLE 43

### Consent to be bound

The present Convention shall be subject to ratification by signatory States and to formal confirmation by signatory regional integration organizations. It shall be open for accession by any State or regional integration organization which has not signed the Convention.

## ARTICLE 44

### Regional integration organizations

1. "Regional integration organization" shall mean an organization constituted by sovereign States of a given region, to which its member States have transferred competence in respect of matters governed by this Convention. Such organizations shall declare, in their instruments of formal confirmation or accession, the extent of their competence with respect to matters governed by this Convention. Subsequently, they shall inform the depositary of any substantial modification in the extent of their competence.
2. References to "States Parties" in the present Convention shall apply to such organizations within the limits of their competence.
3. For the purposes of article 45, paragraph 1, and article 47, paragraphs 2 and 3, any instrument deposited by a regional integration organization shall not be counted.
4. Regional integration organizations, in matters within their competence, may exercise their right to vote in the Conference of States Parties, with a number of votes equal to the number of their member States that are Parties to this Convention. Such an organization shall not exercise its right to vote if any of its member States exercises its right, and vice versa.



## ARTICLE 45

### Entry into force

1. The present Convention shall enter into force on the thirtieth day after the deposit of the twentieth instrument of ratification or accession.
2. For each State or regional integration organization ratifying, formally confirming or acceding to the Convention after the deposit of the twentieth such instrument, the Convention shall enter into force on the thirtieth day after the deposit of its own such instrument.

## ARTICLE 46

### Reservations

1. Reservations incompatible with the object and purpose of the present Convention shall not be permitted.
2. Reservations may be withdrawn at any time.

## ARTICLE 47

### Amendments

1. Any State Party may propose an amendment to the present Convention and submit it to the Secretary-General of the United Nations. The Secretary-General shall communicate any proposed amendments to States Parties, with a request to be notified whether they favour a conference of States Parties for the purpose of considering and deciding upon the proposals. In the event that, within four months from the date of such communication, at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of two thirds of the States Parties present and voting shall be submitted by the Secretary-General to the General Assembly for approval and thereafter to all States Parties for acceptance.
2. An amendment adopted and approved in accordance with paragraph 1 of this article shall enter into force on the thirtieth day after the number of instruments of acceptance deposited reaches two thirds of the number of States Parties at the date of adoption of the amendment. Thereafter, the amendment shall enter into force for any State Party on the thirtieth day following the deposit of its own instrument of acceptance. An amendment shall be binding only on those States Parties which have accepted it.
3. If so decided by the Conference of States Parties by consensus, an amendment adopted and approved in accordance with paragraph 1 of this article which relates

exclusively to articles 34, 38, 39 and 40 shall enter into force for all States Parties on the thirtieth day after the number of instruments of acceptance deposited reaches two thirds of the number of States Parties at the date of adoption of the amendment.

## ARTICLE 48

### Denunciation

A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. The denunciation shall become effective one year after the date of receipt of the notification by the Secretary-General.

## ARTICLE 49

### Accessible format

The text of the present Convention shall be made available in accessible formats.

## ARTICLE 50

### Authentic texts

The Arabic, Chinese, English, French, Russian and Spanish texts of the present Convention shall be equally authentic. In witness thereof the undersigned plenipotentiaries, being duly authorized thereto by their respective Governments, have signed the present Convention.

# Annex 4. Themes, standards and criteria of the WHO QualityRights tool kit

## Theme 1. The right to an adequate standard of living (Article 28 of the CRPD)<sup>7</sup>

### Standard 1.1. The building is in good physical condition.

#### *Criteria*

- 1.1.1 The building is in a good state of repair (e.g. windows are not broken, paint is not peeling from the walls).
- 1.1.2 The building is accessible for people with physical disabilities.
- 1.1.3 The building's lighting (artificial and natural), heating and ventilation provide a comfortable living environment.
- 1.1.4 Measures are in place to protect people against injury through fire.

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

#### *Criteria*

- 1.2.1 The sleeping quarters provide sufficient living space per service user and are not overcrowded.
- 1.2.2 Men and women as well as children and older persons have separate sleeping quarters.
- 1.2.3 Service users are free to choose when to get up and when to go to bed.
- 1.2.4 The sleeping quarters allow for the privacy of service users.
- 1.2.5 Sufficient numbers of clean blankets and bedding are available to service users.
- 1.2.6 Service users can keep personal belongings and have adequate lockable space to store them.

---

<sup>7</sup> Theme 1 applies specifically to living conditions in residential facilities and thus does not apply to outpatient facilities; it does, however, apply to day-care centres.

### **Standard 1.3. The facility meets hygiene and sanitary requirements.**

#### ***Criteria***

- 1.3.1 The bathing and toilet facilities are clean and working properly.
- 1.3.2 The bathing and toilet facilities allow privacy, and there are separate facilities for men and women.
- 1.3.3 Service users have regular access to bathing and toilet facilities.
- 1.3.4 The bathing and toileting needs of service users who are bedridden or who have impaired mobility or other physical disabilities are accommodated.

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

#### ***Criteria***

- 1.4.1 Food and safe drinking-water are available in sufficient quantities, are of good quality and meet with the service user's cultural preferences and physical health requirements.
- 1.4.2 Food is prepared and served under satisfactory conditions, and eating areas are culturally appropriate and reflect the eating arrangements in the community.
- 1.4.3 Service users can wear their own clothing and shoes (day wear and night wear).
- 1.4.4 When service users do not have their own clothing, good-quality clothing is provided that meets their cultural preferences and is suitable for the climate.

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

#### ***Criteria***

- 1.5.1 Telephones, letters, e-mails and the Internet are freely available to service users, without censorship.
- 1.5.2 Service users' privacy in communications is respected.
- 1.5.3 Service users can communicate in the language of their choice, and the facility provides support (e.g. translators) to ensure that the service users can express their needs.
- 1.5.4 Service users can receive visitors, choose who they want to see and participate in visits at any reasonable time.
- 1.5.5 Service users can move freely around the facility.

## **Standard 1.6. The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.**

### ***Criteria***

- 1.6.1 There are ample furnishings, and they are comfortable and in good condition.
- 1.6.2 The layout of the facility is conducive to interaction between and among service users, staff and visitors.
- 1.6.3 The necessary resources, including equipment, are provided by the facility to ensure that service users have opportunities to interact and participate in leisure activities.
- 1.6.4 Rooms within the facility are specifically designated as leisure areas for service users.

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

### ***Criteria***

- 1.7.1 Service users can interact with other service users, including members of the opposite sex.
- 1.7.2 Personal requests, such as to attend weddings or funerals, are facilitated by staff.
- 1.7.3 A range of regularly scheduled, organized activities are offered in both the facility and the community that are relevant and age-appropriate.
- 1.7.4 Staff provide information to service users about activities in the community and facilitate their access to those activities.
- 1.7.5 Staff facilitate service users' access to entertainment outside the facility, and entertainment from the community is brought into the facility.

---

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

### **Standard 2.1. Facilities are available to everyone who requires treatment and support.**

#### ***Criteria***

- 2.1.1 No person is denied access to facilities or treatment on the basis of economic factors or of his or her race, colour, sex, language, religion, political or other

opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.

- 2.1.2 Everyone who requests mental health treatment receives care in this facility or is referred to another facility where care can be provided.
- 2.1.3 No service user is admitted, treated or kept in the facility on the basis of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.

## **Standard 2.2. The facility has skilled staff and provides good-quality mental health services.**

### ***Criteria***

- 2.2.1 The facility has staff with sufficiently diverse skills to provide counselling, psychosocial rehabilitation, information, education and support to service users and their families, friends or carers, in order to promote independent living and inclusion in the community.
- 2.2.2 Staff are knowledgeable about the availability and role of community services and resources to promote independent living and inclusion in the community.
- 2.2.3 Service users can consult with a psychiatrist or other specialized mental health staff when they wish to do so.
- 2.2.4 Staff in the facility are trained and licensed to prescribe and review psychotropic medication.
- 2.2.5 Staff are given training and written information on the rights of persons with mental disabilities and are familiar with international human rights standards, including the CRPD.
- 2.2.6 Service users are informed of and have access to mechanisms for expressing their opinions on service provision and improvement.

## **Standard 2.3.<sup>8</sup> Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan<sup>9</sup> and contribute to a service user's ability to live independently in the community.**

### ***Criteria***

- 2.3.1 Each service user has a comprehensive, individualized recovery plan that includes his or her social, medical, employment and education goals and objectives for recovery.

---

<sup>8</sup> See also standard 3.1.

<sup>9</sup> See Annex 1 for more information on recovery-oriented mental health care.

- 2.3.2 Recovery plans are driven by the service user, reflect his or her choices and preferences for care, are put into effect and are reviewed and updated regularly by the service user and a staff member.
- 2.3.3 As part of their recovery plans, service users are encouraged to develop advance directives<sup>10</sup> which specify the treatment and recovery options they wish to have as well as those that they don't, to be used if they are unable to communicate their choices at some point in the future.
- 2.3.4 Each service user has access to psychosocial programmes for fulfilling the social roles of his or her choice by developing the skills necessary for employment, education or other areas. Skill development is tailored to the person's recovery preferences and may include enhancement of life and self-care skills.
- 2.3.5 Service users are encouraged to establish a social support network and/or maintain contact with members of their network to facilitate independent living in the community. The facility provides assistance in connecting service users with family and friends, in line with their wishes.
- 2.3.6 Facilities link service users with the general health care system, other levels of mental health services, such as secondary care, and services in the community such as grants, housing, employment agencies, day-care centres and assisted residential care.<sup>11</sup>

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

### ***Criteria***

- 2.4.1 The appropriate psychotropic medication (specified in the national essential medicines list) is available at the facility or can be prescribed.
- 2.4.2 A constant supply of essential psychotropic medication is available, in sufficient quantities to meet the needs of service users.
- 2.4.3 Medication type and dosage are always appropriate for the clinical diagnoses of service users and are reviewed regularly.
- 2.4.4 Service users are informed about the purpose of the medications being offered and any potential side effects.
- 2.4.5 Service users are informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy.

---

<sup>10</sup> An advance directive is a written document in which a person can specify in advance choices about health care, treatment and recovery options in the event that they are unable to communicate their choices at some point in the future. Advance directives can also include treatment and recovery options that a person *does not* want to have, and as such can help to ensure that they do not receive any intervention against their wishes.

<sup>11</sup> See also Theme 5.

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

### ***Criteria***

- 2.5.1 Service users are offered physical health examinations and/or screening for particular illnesses on entry to the facility and regularly thereafter.
- 2.5.2 Treatment for general health problems, including vaccinations, is available to service users at the facility or by referral.
- 2.5.3 When surgical or medical procedures are needed that cannot be provided at the facility, there are referral mechanisms to ensure that the service users receive these health services in a timely manner.
- 2.5.4 Regular health education and promotion are conducted at the facility.
- 2.5.5 Service users are informed of and advised about reproductive health and family planning matters.
- 2.5.6 General and reproductive health services are provided to service users with free and informed consent.

## **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.<sup>12</sup> Service users' preferences regarding the place and form of treatment are always a priority.**

#### ***Criteria***

- 3.1.1 Service users' preferences are the priority in all decisions on where they will access services.
- 3.1.2 All efforts are made to facilitate discharge so that service users can live in their communities.<sup>13</sup>
- 3.1.3 Service users' preferences are the priority for all decisions on their treatment and recovery plan.

---

<sup>12</sup> See also standard 2.3.

<sup>13</sup> Criterion 3.1.2 applies only to inpatient facilities; all other criteria under this standard apply to both inpatient and outpatient facilities



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

### ***Criteria***

- 3.2.1 Admission and treatment are based on the free and informed consent of service users.
- 3.2.2 Staff respect the advance directives of service users when providing treatment.<sup>14</sup>
- 3.2.3 Service users have the right to refuse treatment.
- 3.2.4 Any case of treatment or detention in a facility without free and informed consent is documented and reported rapidly to a legal authority.
- 3.2.5 People being treated or detained by a facility without their informed consent are informed about procedures for appealing their treatment or detention.
- 3.2.6 Facilities support people being treated or detained without their informed consent in accessing appeals procedures and legal representation.<sup>15</sup>

## **Standard 3.3. Service users can exercise their legal capacity and are given the support<sup>16</sup> they may require to exercise their legal capacity.**

### ***Criteria***

- 3.3.1 At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices.
- 3.3.2 Clear, comprehensive information about the rights of service users is provided in both written and verbal form.
- 3.3.3 Clear, comprehensive information about assessment, diagnosis, treatment and recovery options is given to service users in a form that they understand and which allows them to make free and informed decisions.
- 3.3.4 Service users can nominate and consult with a support person or network of people of their own free choice in making decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected will be recognized by the staff.<sup>17</sup>
- 3.3.5 Staff respect the authority of a nominated support person or network of people to communicate the decisions of the service user being supported.
- 3.3.6 Supported decision-making is the predominant model, and substitute decision-making is avoided.

---

<sup>14</sup> See standard 2.3.

<sup>15</sup> See also standard 4.5.

<sup>16</sup> See Annex 2 for further information on supported decision-making.

<sup>17</sup> See Annex 2 for further information on supported decision-making.

3.3.7 When a service user has no support person or network of people and wishes to appoint one, the facility will help the user to access appropriate support.

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

#### ***Criteria***

- 3.4.1 A personal, confidential medical file is created for each service user.
- 3.4.2 Service users have access to the information contained in their medical files.
- 3.4.3 Information about service users is kept confidential.
- 3.4.4 Service users can add written information, opinions and comments to their medical files without censorship.

## **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.**

#### ***Criteria***

- 4.1.1 Staff members treat service users with humanity, dignity and respect.
- 4.1.2 No service user is subjected to verbal, physical, sexual or mental abuse.
- 4.1.3 No service user is subjected to physical or emotional neglect.
- 4.1.4 Appropriate steps are taken to prevent all instances of abuse.
- 4.1.5 Staff support service users who have been subjected to abuse in accessing the support they may want.

### **Standard 4.2. Alternative methods are used in place of seclusion<sup>18</sup> and restraint<sup>19</sup> as means of de-escalating potential crises.**

#### ***Criteria***

- 4.2.1 Service users are not subjected to seclusion or restraint.

---

<sup>18</sup> 'Restraint' means the use of a mechanical device or medication to voluntarily prevent a person from moving his or her body.

<sup>19</sup> 'Seclusion' means the voluntary placement of an individual alone in a locked room or secured area from which he or she is physically prevented from leaving.

- 4.2.2 Alternatives to seclusion and restraint are in place at the facility, and staff are trained in de-escalation techniques<sup>20</sup> for intervening in crises and preventing harm to service users or staff.
- 4.2.3 A de-escalation assessment is conducted in consultation with the service user concerned in order to identify the triggers<sup>21</sup> and factors he or she finds helpful in diffusing crises and to determine the preferred methods of intervention in crises.
- 4.2.4 The preferred methods of intervention identified by the service user concerned are readily available in a crisis and are integrated into the user's individual recovery plan.
- 4.2.5 Any instances of seclusion or restraint are recorded (e.g. type, duration) and reported to the head of the facility and to a relevant external body.

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

***Criteria***

- 4.3.1 No electroconvulsive therapy is given without the free and informed consent of service users.
- 4.3.2 Clear evidence-based clinical guidelines on when and how electroconvulsive therapy can or cannot be administered are available and adhered to.
- 4.3.3 Electroconvulsive therapy is never used in its unmodified form (i.e. without an anaesthetic and a muscle relaxant).
- 4.3.4 No minor is given electroconvulsive therapy.
- 4.3.5 Psychosurgery and other irreversible treatments are not conducted without both the service user's free and informed consent and the independent approval of a board.
- 4.3.6 Abortions and sterilizations are not carried out on service users without their consent.

---

<sup>20</sup> De-escalation techniques can involve: prompt assessment and rapid intervention in potential crises; using problem-solving methods with the person concerned; being empathetic and reassuring; using stress management or relaxation techniques such as breathing exercises; giving the person space; offering choices; giving the person time to think.

<sup>21</sup> Triggers might include being pressured to do something, being asked certain questions or being in the presence of a person one is not comfortable with. Factors that help to diffuse a crisis might include being left alone for a while, talking to a person one trusts or listening to music.

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

##### ***Criteria***

- 4.4.1 Medical or scientific experimentation is conducted only with the free and informed consent of service users.
- 4.4.2 Staff do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting service users to participate in medical or scientific experimentation.
- 4.4.3 Medical or scientific experimentation is not undertaken if it is potentially harmful or dangerous to the service user.
- 4.4.4 Any medical or scientific experimentation is approved by an independent ethics committee.

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

##### ***Criteria***

- 4.5.1 Service users are informed of and have access to procedures to file appeals and complaints, on a confidential basis, to an outside, independent legal body on issues related to neglect, abuse, seclusion or restraint, admission or treatment without informed consent and other relevant matters.
- 4.5.2 Service users are safe from negative repercussions resulting from complaints they may file.
- 4.5.3 Service users have access to legal representatives and can meet with them confidentially.
- 4.5.4 Service users have access to advocates to inform them of their rights, discuss problems and support them in exercising their human rights and filing appeals and complaints.
- 4.5.5 Disciplinary and/or legal action is taken against any person found to be abusing or neglecting service users.
- 4.5.6 The facility is monitored by an independent authority to prevent the occurrence of ill-treatment.

## **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 have the financial resources necessary to live in the community.**

#### ***Criteria***

- 5.1.1 Staff inform service users about options for housing and financial resources.
- 5.1.2 Staff support service users in accessing and maintaining safe, affordable, decent housing.
- 5.1.3 Staff support service users in accessing the financial resources necessary to live in the community.

### **Standard 5.2. Service users can access education and employment opportunities.**

#### ***Criteria***

- 5.2.1 Staff give service users information about education and employment opportunities in the community.
- 5.2.2 Staff support service users in accessing education opportunities, including primary, secondary and post-secondary education.
- 5.2.3 Staff support service users in career development and in accessing paid 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.**

#### ***Criteria***

- 5.3.1 Staff give service users the information necessary for them to participate fully in political and public life and to enjoy the benefits of freedom of association.
- 5.3.2 Staff support service users in exercising their right to vote.
- 5.3.3 Staff support service users in joining and participating in the activities of political, religious, social, disability and mental disability organizations and other groups.

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

***Criteria***

- 5.4.1 Staff give service users information on the social, cultural, religious and leisure activity options available.
- 5.4.2 Staff support service users in participating in the social and leisure activities of their choice.
- 5.4.3 Staff support service users in participating in the cultural and religious activities of their choice.

# Annex 5. Examples of sample sizes for different types of facilities, according to number of staff and service users

## **Reminder (see section 5: Establish an assessment framework)**

The numbers of people interviewed depend on the number of service users and staff associated with the facility, the overall size of the facility and the number of units it comprises. For example:

- If only six service users receive services from a facility, all of them (100%) should be interviewed.
- If there are 16 service users, a minimum of eight (50%) should be interviewed.
- If there are 40 service users or more, at least 12 (approximately 30%) should be interviewed.
- The number of interviews to be conducted with family members can be determined by halving the number of interviews planned with service users. Thus, in the scenarios above, the number of family members to be interviewed would be three (50% of the number of service users), four (50%) and six (50%).
- The numbers of staff to be interviewed can be determined on the basis of the same proportions used for service users.

These proportions are only guides. It might be unnecessary to conduct the predetermined number of interviews if the assessment team considers that it has gathered sufficient information to ascertain the quality and human rights conditions of the facility. For example, there is no point in interviewing people if the interviews do not provide important additional information. Therefore, with probable dropouts and withholding of consent, there will often be a difference between the planned and the actual numbers of interviews conducted.

It is not mandatory to conduct interviews for general health facilities. Comparisons between mental health and general health facilities can be made based on observation. However, for a more in-depth comparison, interviews may also be conducted for general health facilities using the above proportions as a guide.

## Psychiatric hospitals

Facility	Total number of staff	Total number of users	Number of interviews planned		
			Users	Family members	Staff
H-1	17	70	23	12	9
H-2	18	120	40	20	9
H-3	14	65	22	11	7
H-4	22	110	37	19	11
H-5	20	125	42	21	10
General health facility (ideally tertiary)	40	140	–	–	–
<b>Total</b>	<b>131</b>	<b>630</b>	<b>164</b>	<b>83</b>	<b>46</b>

## Inpatient units

Facility	Total number of staff	Total number of users	Number of interviews planned		
			Users	Family members	Staff
N-1	2	12	12	6	2
N-2	3	4	4	2	3
N-3	4	6	6	3	4
N-4	3	8	8	4	3
N-5	2	13	13	6	2
General health facility (ideally inpatient ward)	6	12	–	–	–
<b>Total</b>	<b>20</b>	<b>55</b>	<b>43</b>	<b>21</b>	<b>14</b>



## Outpatient facilities

Facility	Total number of staff	Total number of users per week	Number of interviews planned		
			Users	Family members	Staff
P-1	2	120	40	20	2
P-2	3	90	30	15	3
P-3	4	60	20	10	4
P-4	3	80	26	13	3
P-5	2	130	44	22	2
General health facility (ideally outpatient)	4	60	–	–	–
<b>Total</b>	<b>18</b>	<b>540</b>	<b>160</b>	<b>80</b>	<b>14</b>

## Day treatment facilities

Facility	Total number of staff	Total number of users per week	Number of interviews planned		
			Users	Family members	Staff
D-1	2	12	12	6	2
D-2	3	4	4	2	3
D-3	4	6	6	3	4
General health facility (ideally day treatment)	4	12	–	–	–
<b>Total</b>	<b>13</b>	<b>34</b>	<b>22</b>	<b>11</b>	<b>9</b>

# Annex 6. Sample consent forms for interviewees participating in an assessment (to be adapted to the national context)

*[Instructions to the interviewer: Read the introduction and the purpose of the visit and interview to the interviewee. If you are even slightly concerned that he or she does not fully understand each clause, explain the meaning and implications in as simple and understandable terms as possible. Make sure that the person is truly giving his or her ‘informed consent’ to being interviewed. If you consider that the person is unable to sign this consent form because he or she does not understand the contents, even after you have explained the purpose carefully, he or she should not be interviewed. In some cases, a tape recording may be made of the interview. When this is the case, the interviewee must sign both consent to be interviewed and consent to be recorded.]*

## Introduction and purpose of the visit and interview

My name is *[Name of assessor and profession or background if appropriate]*

I am working as part of a team, which includes *[Names of other members of the assessment team and professions or background if appropriate]*

The purpose of the interviews I am conducting is to gather information and the perspectives of the staff, the users or residents and members of families (or friends or carers) about this facility.

If you agree to be interviewed, I will ask you questions about the facility itself, the care and treatment provided and the rights of people in the facility.

I am an ‘independent assessor’, which means that I do not have any ties or obligations towards any person or organization. I conduct my work independently and am not subject to any outside pressure in the way in which I conduct my work, nor can I be influenced to make inaccurate claims or withhold information about my findings or my report.

Being an ‘independent assessor’ also means that nobody other than me and the team I am working with will know what you say to me. While we will be sharing our final report with *[tick box below as appropriate]*, we will ensure your personal confidentiality in our report.

- The hospital management
- Other staff at this hospital
- Government
- The media
- Nongovernmental organizations
- Other (specify) \_\_\_\_\_

In order to ensure that your identity is not divulged, your name will not be written on my interview tool and will not appear in the final report.

If you inform me of a particular event or issue that you think will make it easy to identify you and with which you would rather not be linked, please let me know, and we will make every effort to ensure that your identify is protected.

I will ask you questions drawn from an instrument being prepared by the World Health Organization to assess and improve quality and human rights in mental health and social care facilities.

You do not have to go ahead with this interview with me, and you may refuse to participate if you wish. Your decision not to participate will be kept confidential. There will be no penalty, sanction or other negative repercussions should you refuse to participate in this interview.

If you agree to answer these questions, you may stop the interview at any time, and your decision to stop the interview will be kept confidential. Again, no penalty, sanction or repercussions will occur if you refuse to finish this interview. Some questions may be of a sensitive nature; if you do not wish to answer them, we can move on to the next question.

The team I am working with and I hope that the information we get from you and others and from visiting and assessing the facility will be used to identify areas that should be improved. While we hope that this assessment will lead to improvements, we cannot guarantee that areas you are unhappy with will be changed. We will nevertheless endeavour to use this information to bring about any positive changes that may be needed.

*[When the interview is to be tape-recorded]* I would like to tape this interview, but you are entitled not to have it taped. We will ensure that the tapes are not given to

anyone outside this monitoring team, and your name will not be linked to the recording. Again, no penalty, sanction or repercussions will occur if you decide you would rather not have the interview taped.

If you agree to the interview being taped, please sign both part A and part B of the consent form overleaf.

If you agree only to the interview but not to taping of the interview, please sign only part A of the consent form overleaf.

Please ask me any questions you have about this interview before signing the consent form. You may also stop me during the interview if you have any questions about it.

The interview will last approximately [... hours, ... minutes. *State approximate duration.*]

## Consent forms

### Part A. Consent to be interviewed

I agree to participate in an interview, the aim of which is to gather information and the perspectives of the staff, the users and residents and members of families (or friends or carers), about the facility itself, the care and treatment provided and about the rights of people in the facility.

I understand that I am participating freely in this interview, without being forced in any way to do so, and that I have the right to refuse to participate. If I decide not to participate, this will be kept confidential, and there will be no penalty, sanction or repercussions incurred by me should I refuse.

I understand that I can stop this interview at any time should I wish not to continue and that this will be kept confidential and no penalty, sanction or repercussions will be incurred by me should I put an end to the interview.

I understand that my identity will be kept strictly confidential.

I understand that this consent form will not be linked to the interview tool and that my answers will remain confidential.

The purpose of this interview has been explained to me, and I understand the contents of this form.

Name in block capitals: \_\_\_\_\_

Signature of participant: \_\_\_\_\_

Date: \_\_\_\_\_

### **Part B. Consent for the interview to be tape- or video-recorded**

I hereby agree to have this interview tape-recorded. I understand that my name will not be linked to the recording, and no one will be able to link me to the answers I give.

Name in block capitals: \_\_\_\_\_

Signature of participant: \_\_\_\_\_

Date: \_\_\_\_\_

### **Part C. Consent for photographs to be taken during the interview**

I hereby agree to having photographs taken. I understand that my name will not be linked to the photographs, and no one will be able to link me to the answers I give.

Name in block capitals: \_\_\_\_\_

Signature of participant: \_\_\_\_\_

Date: \_\_\_\_\_





The *WHO QualityRights tool kit* provides countries with practical information and tools for assessing and improving quality and human rights standards in mental health and social care facilities. The Toolkit is based on the United Nations *Convention on the Rights of Persons with Disabilities*. It provides practical guidance on:

- the human rights and quality standards that should be respected, protected and fulfilled in both inpatient and outpatient mental health and social care facilities;
- preparing for and conducting a comprehensive assessment of facilities; and
- reporting findings and making appropriate recommendations on the basis of the assessment.

The tool kit is designed for use in low-, middle- and high-income countries. It can be used by many different stakeholders, including dedicated assessment committees, nongovernmental organizations, national human rights institutions, national health or mental health commissions, health service accreditation bodies and national mechanisms established under international treaties to monitor implementation of human rights standards and others with an interest in promoting the rights of people with disabilities.

The *WHO QualityRights tool kit* is an essential resource, not only for putting an end to past neglect and abuses but also for ensuring high-quality services in the future.



**World Health  
Organization**

Mental Health Policy and Service Development  
Department of Mental Health and Substance Abuse  
World Health Organization  
Geneva, Switzerland

ISBN 978 92 4 154841 0

