QUALITYRIGHTS TRAINING FOR STRENGTHENING MENTAL HEALTH SERVICES

25–28 March 2019
Majuro, Marshall Islands
QualityRights Training for Strengthening Mental Health Services
25–28 March 2019
Majuro, Marshall Islands
MEETING REPORT

QUALITY RIGHTS TRAINING
FOR STRENGTHENING MENTAL HEALTH SERVICES

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Majuro, Marshall Islands
25–28 March 2019

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NOTE

The views expressed in this report are those of the participants of the QualityRights (QR) Training for Strengthening Mental Health Services and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the QualityRights (QR) Training for Strengthening Mental Health Services in Majuro, Marshall Islands from 25 to 28 March 2019.
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Keywords

Mental health - standards / Mental health services – organization and administration / Community mental health services – standards / Human rights
SUMMARY

Following consultation with the two participating Member States, four modules were chosen for the training – two core modules and two advanced modules:

- Promoting human rights in mental health (Core)
- Realizing recovery and the right to health in mental health and related services (Core)
- Protecting the right to legal capacity (Advanced)
- Ending coercion, violence and abuse (Advanced).

Each module was nominally scheduled to utilize one of the available training days. They were delivered in a manner consistent with the updated and most current facilitator manuals available via the World Health Organization (WHO) QualityRights (QR) website. The training was presented by three co-facilitators from different countries. The training was well-received by participants, with proactive and concrete feedback provided on next steps.

In particular, the recovery concepts were easily understood and easily assimilated into the cultural context of the two participating countries. The concept of “legal capacity” and the need to avoid involuntary detention garnered the most interest among all participants. They revisited the concept during three of the four modules with questions arising as to when it was appropriate to detain someone and what to do if someone threatens violence against staff.

At the end of the training, participants worked in separate country groups to develop an action plan to progress QR within their jurisdiction. The details of these action plans are included in the Recommendations section below.
1. INTRODUCTION

1.1 Meeting organization

The QualityRights (QR) training was held at the Marshall Islands Resort in Majuro, Marshall Islands from 25 to 28 March 2019. Participants included senior health policy and clinical staff from the Marshall Islands and Federated States of Micronesia.

The training delivered four modules from the World Health Organization (WHO) QR training package designed to assist with understanding and implementing the Universal Declaration of Human Rights and the international Convention on the Rights of Persons with Disabilities (CRPD) in mental health service delivery. The training was organized by the WHO Regional Office for the Western Pacific and was delivered by Mr Martin Vandendyck, Dr Seongsu Kim and Mr David McGrath.

1.2 Meeting objectives

The objectives of the meeting were:

1) to understand how to improve the quality of care and human rights in inpatient and outpatient mental health services;
2) to identify how to create community-based and recovery-oriented services that respect and promote human rights; and
3) to develop an approach to promoting human rights, recovery and independent living in the community for people with mental health conditions, cognitive impairment and psychosocial disability.

2. PROCEEDINGS

Four QR training modules were delivered, with each module nominally scheduled to utilize one of the available training days. However, given the requirement for appropriate formalities on day one with available senior staff, the first module continued into the second day and required a short extension for completion.

The training was officially opened by the Secretary of Health for the Marshall Islands, with the opening ceremony coordinated by the Director of Health Promotion for the Marshall Islands. An opening address on behalf of WHO was made by Mr Martin Vandendyck.

Following consultation with the two participating Member States, the four modules chosen for presentation were two core modules and two advanced modules as follows:

- **Promoting human rights in mental health:** This module takes a close look at the CRPD and how it promotes and protects the rights of persons with psychosocial, intellectual or cognitive disabilities. The Convention was adopted by the United Nations General Assembly at the end of 2006 and entered into force in May 2008 – 60 years after the adoption of the Universal Declaration on Human Rights. As of November 2018, there were 177 States Parties to the Convention.
• **Realizing recovery and the right to health in mental health and related services:** This module provided comprehensive guidance on practical ways to introduce a person-centred recovery approach to services providing mental health care and support. The training included a detailed introduction to the recovery approach, explaining what it is and how this approach differs from traditional service approaches. Traditional treatments, care and support have tended to focus on diagnosis, the use of medication and, occasionally, psychotherapy, with an emphasis on removing or reducing symptoms. However, recovery is not just about symptoms but is also about a person’s life and identity.

• **Protecting the right to legal capacity:** This module focused on the right to legal capacity. This right, enshrined in the CRPD, means that persons with disabilities have the same right as anyone else to make their own decisions. The Convention also states that States Parties should provide persons with disabilities with the support they need to exercise their right to legal capacity. It is often supposed by many in society that persons with psychosocial, intellectual or cognitive disabilities are not able to reach their own decisions about every issue that concerns them. The Convention, as reflected in this training module, makes clear that, since all persons have equal rights, it is up to society to enable them to exercise those rights, and not to ignore them on the basis of outdated prejudices.

• **Ending coercion, violence and abuse:** Through this training module, participants explored how and why violence, coercion and abuse occur in mental health settings; they gained a greater understanding of the significant impact these practices have on people. The module also examined the role of power relations in exacerbating violence, coercion and abuse, and took participants through the CRPD requirements in order to protect against these practices. Finally, participants learned about some of the key strategies and approaches that have been shown to be effective in bringing about an end to abusive practices within services once and for all.

These modules were delivered in a manner consistent with the updated and most current facilitator manuals available via the WHO QR website.¹ As such, details about the training content are not reproduced here. A small amount of additional material drawn from the experience of Dr Kim and his work at the WHO collaborating centre in the Republic of Korea was presented as part of the “Realizing Recovery” module. This was well-received by the participants.

A co-facilitation model was used, with facilitators rotating between topics to maintain energy and allow for continuous interaction. The style of facilitation allowed for interrogation of issues as they arose, and concepts were contextualized within the experiences of the two participating countries.

The concepts contained in the training were positively received by participants. In particular, the recovery concepts were easily understood and were easily assimilated into the cultural context of the two participating countries. The CRPD preference for a community-based intervention modality and lack of reliance on inpatient models of care was consistent with current practice in both countries; however, a new inpatient treatment facility is planned for the Federated States of Micronesia, and the use of a prison setting in the Marshall Islands was noted.

The concept that created the greatest conjecture in both sets of participants was “legal capacity” and the need to avoid involuntary detention. This concept was revisited during three of the four modules,

with questions arising as to “when is it appropriate to detain someone?” and “what should we do if someone is threatening violence against our staff?” While the training manuals provide initial answers to these questions, they do not address the threshold for the use of detention when staff safety is at risk. Given that training can potentially be provided by numerous trainers, a clear answer to the question “is it ever appropriate to involuntarily detain someone?” that resolves staff safety concerns is warranted in the training manuals.

The other noteworthy issue in the training was the concentration of health service staff in the training group and the concomitant absence of disabled people’s organizations or other consumer groups. This made a number of the exercises designed to elicit discrepancy redundant; for example, during the exercises where participants were asked to occupy different parts of the room depending upon their agreement or otherwise with particular statements, the service providers showed little differences in opinion. Therefore, follow-up questioning about whether minds had changed subsequent to alternative views being expressed did not yield significant results.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

The training was well-received by participants, with proactive and concrete feedback provided on next steps. At the end of the training, each country separated into working groups and developed an action plan to progress QR within their jurisdiction. The details of these action plans are included in the Recommendations section below.

3.2 Recommendations

3.2.1 Recommendations for Member States

1) Participants to provide immediate feedback on the results of the training session – including the planning of country activities – to their supervisors and relevant institutions in the country.

2) Participants to initiate and lead the implementation of the action plans as designed at the end of the training course.

3) Participants from the Federated States of Micronesia recommended an approach that recognized the federated nature of their jurisdiction:
   • Locate and review the national law for mental health and equivalent state laws or policies for consistency with the principles of the CRPD.
   • Incorporate capacity-building strategies into state plans and implementation frameworks, linking existing services, practice and policy.
   • Establish a task force, following consultation on appropriate membership, with representation from each state to develop a plan for implementation.
   • The task force to meet with stakeholders and policy-makers 10 weeks after it is initiated to agree on next steps.
   • Implement staff improvement training across each state.

4) Participants from the Marshall Islands recommended the following approach:
   • Arrange access to the e-learning modules for QR, with an appropriate certification pathway.
   • Implement training and awareness-raising initiatives with nongovernmental organizations (NGOs), health services, the private sector and policy representatives from key agencies such as the police and attorneys general.
• Incorporate QR principles and practices into complaints or grievance processes within health services.
• Set up a survey to better understand consumer needs and establish a baseline for monitoring.
• Ensure research ethics processes capture QR principles.
• Revise standard operating procedures to approach domestic violence, suicide and substance abuse.
• Establish a partnership arrangement to improve practice in the holding cells.
• Focus on outreach service models for hiring and training staff.
• Reconsider the role of the family in policies associated with consent, including culture change and legal change.
• Apply hospital-wide consent and refusal forms equally to all specialities.
• Integrate peer workers and NGOs into outreach.
• Allocate responsibility for implementation and oversight to the Human Rights Committee for the Marshall Islands.

3.2.2 Recommendations for WHO

WHO is requested to consider the following:

1) Provide rapid follow-up to discussions held in the training sessions and to the individual country action plans drafted.
2) Provide technical support to individual countries in the implementation of their action plans, including support for further translation and dissemination of key documents and for consultation missions by experts.
3) Consider the following technicalities in the design of the QR training package:
   • Add an “action planning” segment at the end of the training schedule as a regular part of the structured agenda. Ensuring continuity of action once the QR training is complete is a challenge. The training is resource intensive for participating countries and not designed for continued face-to-face presentation. For the most efficient response, individual Member States should continue with the rollout using their own available resources and skills. A facilitated plan to allow for this is recommended.
   • Consider creating adaptations to the training sessions for participants with uniform professional or life experiences. Although the training is specifically designed for diverse cohorts, some of the exercises are less useful when the groups are relatively similar.
ANNEXES

Annex 1: List of participants

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## Annex 2: Meeting timetable

### Quality Rights Training for Strengthening Mental Health Services

**Majuro, Marshall Islands**  
**25–28 March 2019**

### Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday, 25 March</th>
<th>Time</th>
<th>Tuesday, 26 March</th>
<th>Time</th>
<th>Wednesday, 27 March</th>
<th>Time</th>
<th>Thursday, 28 March</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30</td>
<td>Registration</td>
<td>08:30</td>
<td>Morning energizer</td>
<td>08:30</td>
<td>Morning energizer</td>
<td>08:30</td>
<td>Morning energizer</td>
</tr>
<tr>
<td>09:00</td>
<td>Opening remarks by Mr Martin Vandendyck Technical Lead, Mental Health and Substance Abuse, WHO/WPRO</td>
<td>09:00</td>
<td>Zooming in on article 16 – Freedom from exploitation, violence and abuse</td>
<td>09:45</td>
<td>Understanding the right to legal capacity</td>
<td>08:30</td>
<td>Recapitulation of Day 3</td>
</tr>
<tr>
<td>10:00</td>
<td>Understanding disability from a human rights perspective</td>
<td>10:30</td>
<td>Empowering people to defend the CRPD rights</td>
<td>10:30</td>
<td>Supported decision-making and advanced planning</td>
<td>10:30</td>
<td>Recapitulation of Day 3</td>
</tr>
<tr>
<td>11:30</td>
<td>The Convention on the Rights of Persons with Disabilities (CRPD)</td>
<td>11:30</td>
<td>What is mental health?</td>
<td>11:30</td>
<td>Key strategies to avoid and defuse conflictual situations</td>
<td>11:30</td>
<td>Recapitulation of Day 3</td>
</tr>
<tr>
<td>12:00</td>
<td>Lunch break</td>
<td>12:00</td>
<td>Lunch break</td>
<td>12:00</td>
<td>Lunch break</td>
<td>12:00</td>
<td>Lunch break</td>
</tr>
<tr>
<td>13:00</td>
<td>Applying the CRPD to real life scenarios</td>
<td>13:00</td>
<td>The role of mental health and related services in promoting the right to health</td>
<td>13:00</td>
<td>Informed consent and person-led treatment and recovery plans</td>
<td>13:00</td>
<td>Communication techniques</td>
</tr>
<tr>
<td>13:30</td>
<td>What is recovery?</td>
<td>14:00</td>
<td>Promoting recovery</td>
<td>14:00</td>
<td>Avoiding involuntary detention and treatment</td>
<td>13:30</td>
<td>Supportive environment and comfort rooms</td>
</tr>
<tr>
<td>15:00</td>
<td>Coffee and tea / Mobility break</td>
<td>15:00</td>
<td>Coffee and tea / Mobility break</td>
<td>15:00</td>
<td>Coffee and tea / Mobility break</td>
<td>15:00</td>
<td>Coffee and tea / Mobility break</td>
</tr>
<tr>
<td>15:30</td>
<td>Zooming in on article 12 - Equal recognition before the law</td>
<td>15:30</td>
<td>The role of practitioners and mental health and related services in promoting recovery</td>
<td>15:30</td>
<td>Avoiding involuntary detention and treatment (continued)</td>
<td>15:30</td>
<td>Stopping violence, coercion and abuse in my service</td>
</tr>
<tr>
<td>16:20</td>
<td>Conclusion of the day</td>
<td>16:00</td>
<td>Conclusion of the day</td>
<td>16:00</td>
<td>Conclusion of the day</td>
<td>16:20</td>
<td>Closing remarks by Mr Martin Vandendyck</td>
</tr>
</tbody>
</table>

**25 March**

- Morning energizer (Day 1)
- Recapitulation of Day 1

**26 March**

- Understanding disability from a human rights perspective
- Empowering people to defend the CRPD rights
- Supported decision-making and advanced planning

**27 March**

- What is mental health?
- Key strategies to avoid and defuse conflictual situations

**28 March**

- Coffee and tea / Mobility break