

Freedom from coercion, violence and abuse

WHO QualityRights core training: mental health
& social services

QualityRights



World Health
Organization

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

Freedom from coercion, violence and abuse. WHO QualityRights Core training: mental health and social services. Course guide

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

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Foreword

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

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

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

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

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

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

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

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



Dr Tedros Adhanom Ghebreyesus

Director-General

World Health Organization

Supporting statements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Julian Eaton Director, Mental Health, CBM International

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

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

Charlene Sunkel, CEO, Global Mental Health Peer Network

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

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

Kate Swaffer, Chair, CEO Dementia International Alliance

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

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

Ana Lucia Arellano, Chair, International Disability Alliance

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

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

Connie Laurin-Bowie, Executive Director, Inclusion International

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

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

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

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

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

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

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

Peter Yaro, Executive director, Basic Needs Ghana

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

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

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

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

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

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

What is the WHO QualityRights initiative?



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

1

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

2

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

3

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

4

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

5

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

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

WHO QualityRights – Training and guidance tools


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

Service transformation tools

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

Training tools

Core modules

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

Specialized modules

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

Evaluation tools

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

Guidance tools

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

Self-help tools

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

About this training and guidance

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

Who is this training and guidance for?

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

Who should deliver the training?

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

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

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

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

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

How should the training be delivered?

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

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

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

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

- For example, if participants do not yet have any expertise in the areas of mental health, human rights and recovery, it would be important to conduct a 4–5-day workshop using the five core training modules. A 5 day sample agenda available at the following link: <https://qualityrights.org/wp-content/uploads/Sample-program-QR-training.pdf>
- If participants already have a basic understanding of the human rights of people with psychosocial, intellectual and cognitive disabilities but require more advanced knowledge about how specifically to promote the right to legal capacity in practice, then a workshop could be organized to focus on the module *Legal capacity and the right to decide* on day 1 and on the specialized module on *Supported decision-making and advance planning* (or selected parts of that module) on days 2, 3 and 4.

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

- For example, if a training is planned, covering all the core modules, then it will not be necessary to cover topic 5 (zooming in on article 12) or topic 6 (zooming in on article 16) since these issues will be covered in much greater depth in the subsequent modules (module on *Legal capacity and the right to decide* and on *Freedom from coercion, violence and abuse* respectively).
- However if an introductory training is planned based solely on module 2, then it is essential to cover topics 5 and 6 of this module, since this will be the only exposure that the participants will receive on these issues and articles.

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

Guidance for facilitators

Principles for running the training programme

Participation and interaction

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

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

Cultural sensitivity

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

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

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

Open, nonjudgemental environment

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

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

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

Use of language

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

Accommodations

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

Operating in the current legislative and policy context

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

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

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

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

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

Being positive and inspiring

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

Group work

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

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

Facilitator notes

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

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

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

Evaluation of the QualityRights training

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

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

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

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

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

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

- *Evaluation of the WHO QualityRights training on mental health, human rights and recovery: PRE-training questionnaire:*
<https://qualityrights.org/wp-content/uploads/20190405.PreEvaluationQuestionnaireF2F.pdf>
- *Evaluation of the WHO QualityRights training on mental health, human rights and recovery: POST-training questionnaire:*
<https://qualityrights.org/wp-content/uploads/20190405.PostEvaluationQuestionnaireF2F.pdf>

Training videos

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

Preliminary note on language

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

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

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

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

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

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

Learning objectives, topics and resources

Learning objectives

At the end of the training, participants will be able to:

- understand how and why violence, coercion and abuse occur in mental health and social care settings;
- understand the impact of violence, coercion and abuse;
- apply knowledge of the CRPD to understand how it protects people with disabilities from violence, coercion and abuse;
- understand and address attitudes, power relations and dynamics in mental health and social care settings;
- understand and apply different approaches and strategies for diffusing conflictual and tense situations.

Topics

Topic 1: What are violence, coercion and abuse? (30 minutes)

Topic 2: What does the CRPD say about violence, coercion and abuse? (20 minutes)

Topic 3: What are the impacts of violence, coercion and abuse? (Option 1: Approximately 1 hour and 50 minutes; Option 2: Approximately 45 minutes ; Option 3: Approximately 20 minutes)

Topic 4: Why are these practices happening? (30 minutes)

Topic 5: Understanding attitudes and power relations (55 minutes)

Topic 6: Key strategies to avoid and defuse conflictual situations (30 minutes)

Topic 7: Communication techniques (40 minutes)

Topic 8: Supportive environments and the use of comfort rooms (5 minutes)

Topic 9: Creating a “saying yes” and “can do” culture (10 minutes)

Topic 10: Individualized plans to explore and respond to sensitivities and signs of distress (55 minutes)

Topic 11: Response teams (1 hour)

Topic 12: Complaints and reporting procedures (35 minutes)

Topic 13: Stopping violence, coercion and abuse in my mental health or social service (25 minutes)

Note: The issue of seclusion and restraint will be addressed in depth in the module *Strategies to end seclusion and restraint*.

Resources required

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

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

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

Additional resources required for this training module include:

copies of Annex 1: CRPD original with associated simplified version for all participants
copies of Annex 2: Identifying sensitivities and signs of distress for all participants

Time

Approximately 8 hours.

Number of participants

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

For this module, it may be necessary to give people with psychosocial, intellectual or cognitive disabilities the opportunity to speak among themselves about the violence, coercion and abuse that they may have experienced, separate from mental health and other practitioners. The facilitator should therefore consider organizing a session prior to the training to allow for this discussion.

During the training, it may also be necessary to ensure the presence of one or more persons who have experience in dealing with trauma.

For topic 2, option 1:

The facilitator may want to invite one or more persons with a psychosocial, intellectual or cognitive disability to come and speak about violence, coercion and abuse that they have experienced and the impact it has had on their lives.

Introduction

Numerous publications and reports from countries, the UN, NGOs and the media show us that people with psychosocial, intellectual or cognitive disabilities in countries across the world are experiencing violence, abuse and coercive practices within mental health and social services.

Certain practices, such as physical, sexual, emotional, verbal violence and neglect are more overtly abusive, and understood as such by the health and social care sectors and the community at large. However other practices, such as involuntary admission and treatment, seclusion and restraint are in many instances not considered coercive at all, but rather, seen as a necessary part of care. Such practices are not only widely accepted by society, but also deeply entrenched within our mental health laws, policies and service culture. However, as this module highlights, they are perceived very differently by people who have experienced them, and can have devastating consequences on people's health and well-being.

Through this training module participants will explore how and why violence, coercion and abuse occur in mental health settings and gain a greater understanding of the significant impact that these practices have on people. The module also examines the role of power relations in exacerbating violence, coercion and abuse, and takes participants through the CRPD requirements in order to protect against these practices. Finally, participants will learn about some of the key strategies and approaches which have been shown to be effective in bringing about an end to abusive practices within services once and for all.

Topic 1: What are violence, coercion and abuse?

Time for this topic

Approximately 30 minutes.

The purpose of this section is for participants to explore the different types of violence, coercion and abuse that may be experienced in the mental health and social service setting.



Presentation: Introduction to this module (5 min.)

Although this module applies primarily to the context of mental health and social services, many of the topics and strategies discussed are also relevant for community settings. In particular, people may experience violence, coercion and abuse even before they access the service (e.g. in their home, at the police station, in the emergency service of a general hospital).

The key purpose of mental health and social services is to promote mental health and well-being and to support people using the services. However, in services in countries across the world people are experiencing violence, abuse and coercive practices such as involuntary admission and treatment.

To address these failures in mental health and related systems it is essential to work towards fostering a culture of safety, openness and transparency in services and to have strategies in place to prevent violence, coercion and abuse. When such events do occur, it is also necessary to address them immediately and in an effective way.

An important way to stop these practices within services is to respect people's rights under the Convention on the Rights of Persons with Disabilities (CRPD), including the right to make their own choices. This right also encompasses deciding if they want to receive support and where they want to receive it.

This module provides the knowledge and tools to achieve these goals.

The need to address the issues of violence, coercion and abuse in mental health and social services does not imply that people with psychosocial, intellectual or cognitive disabilities are inherently violent. Nor does it mean that all types of services and all mental health and related practitioners are systematically abusive and violent.

In this module, "violence, coercion and abuse" are considered together as variations of general maltreatment of individuals within mental health and social settings. The training module will first explore what violence, coercion and abuse are, and how these practices are seen and experienced in the context of a mental health or social service.



Exercise 1.1: Forms of violence, coercion and abuse (10 min.)

For this exercise, use a flipchart to create a spider chart (see Figure 1 below as an example).

Start by writing “Violence, coercion and abuse” in the centre.

Then ask participants:

Can you give examples of violence, coercion and abuse that occur in service settings that you are familiar with?

If participants answer by giving a broad category of violence, coercion and abuse (e.g. physical abuse), connect that category to the central bubble and then ask others to provide examples of this category of abuse (e.g. hitting, pushing, etc.).

Link these examples to the relevant categories of violence, coercion and abuse in the spider chart. One example may be relevant to more than one category (e.g. inappropriate touching can be both sexual and physical abuse).

If participants first answer by directly providing an example of abuse (e.g. “hitting”), explain that this type of abuse belongs to the broad category of physical abuse (e.g. “hitting is an example of physical abuse”) and then write both the broad category (i.e. “physical abuse”) and the example (i.e. “hitting”) underneath it, in the spider chart.

In addition to contributions from participants, please be sure to include forced medication, electro-convulsive therapy (ECT) without informed consent, as well as seclusion and restraint, among other examples of coercive practices, violence and abuse. In addition, neglect is often overlooked as a form of abuse and so it is important that this should also be explored with participants.

It may be necessary to encourage participants to go beyond general words and categories to describe the actual experiences and feelings that these practices may provoke. For instance, forced treatment with medication may be felt by some as a violent and unwanted intrusion into someone’s body and mind.

If different groups of stakeholders are represented, disagreement may emerge during this exercise. The facilitator should facilitate the discussion and encourage everyone to speak openly.

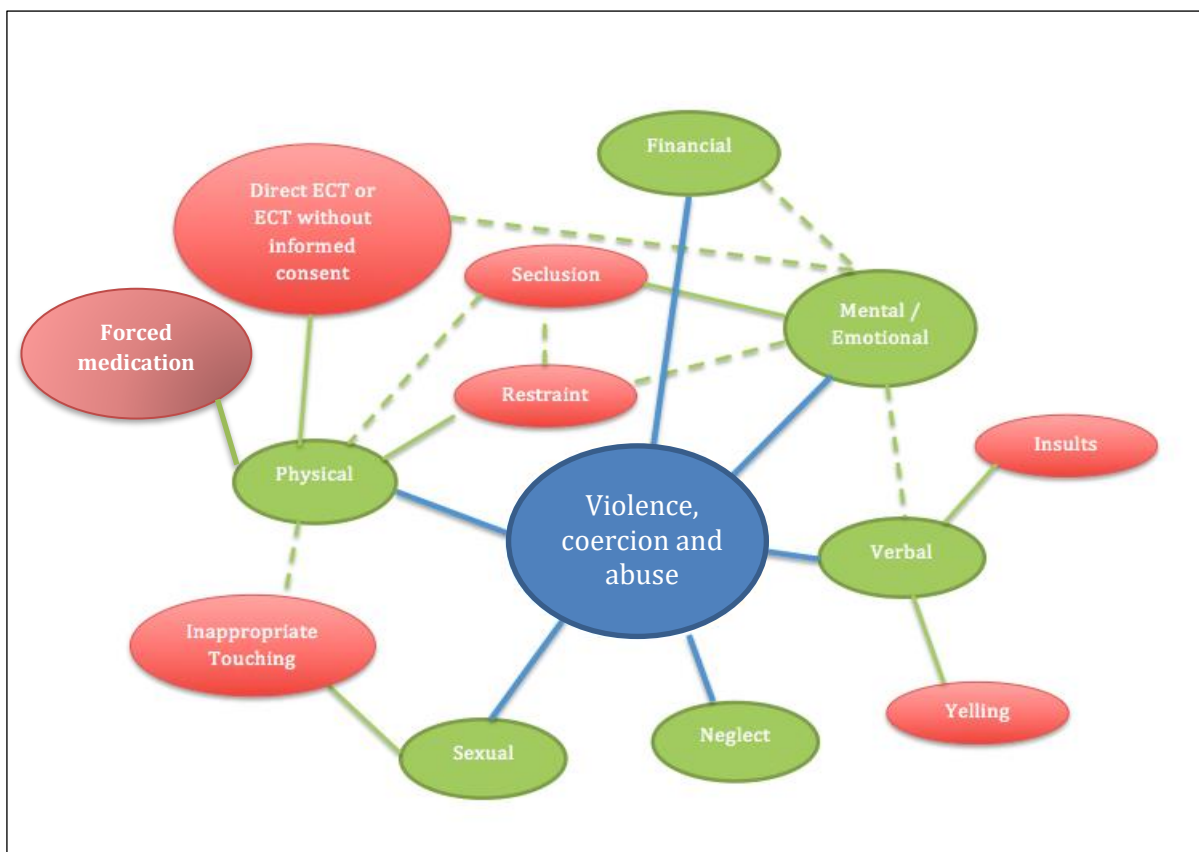


Figure 1. Example of a spider chart outlining various types of violence, coercion and abuse that may happen in a mental health setting. Dotted lines indicate implicit connection with another area of violence, coercion or abuse. This is just an example for the facilitator; the actual layout may vary during the session, depending on the facilitator's preference and contributions of participants.



Presentation: What are violence, coercion and abuse? (15 min.)

Violence is the intentional use of physical force or power – threatened or actual – which either results in or has a high likelihood of resulting in injury, death, psychological harm or deprivation.

Coercion can be understood as any action or practice undertaken which is inconsistent with the wishes of the person in question (i.e. undertaken without the person's informed consent) to make the person behave or stop behaving in a certain way. In some cases, coercion may be authorized by national laws (e.g. a law allowing for involuntary admission and treatment of people in mental health services).

There is an important overlap between the notions of violence and coercion. Actions carried out coercively are often felt as violent. Similarly, enacting coercion generally requires a degree of violence.

Examples of violence and coercion against people with psychosocial, cognitive and intellectual disabilities may include:

- Seclusion and restraint, including hands-on physical restraint, mechanical restraint or using medication to control someone's behaviour (chemical restraint).
- Forced admission to, and treatment in, mental health and social services.
- Forced treatment in the community.
- Economic violence and coercion (i.e. controlling a person's resources to compel the person to do things he or she does not want to do).
- Involuntary sterilization, contraception or abortion.

Violence and coercion can be more subtle. For instance:

- Making people think that there may be negative repercussions or actions taken against them, or that certain things may be refused to them (e.g. access to food, newspapers, television) if they do not comply with a treatment.
 - Giving someone medication without their knowledge (e.g. hidden in their food).
- It is important to note that United Nations bodies and experts have said that coercive practices in the mental health context – such as forced treatment, seclusion and restraint, ECT and psychosurgery without informed consent – can be considered as a form of torture and ill-treatment (2),(3),(4),(5),(6). For example the United Nations Special Rapporteur on Torture has stated that solitary confinement “of any duration to a person with mental disabilities constitutes cruel, inhuman and a degrading treatment” and that any restraint for even a short period of time may constitute torture and ill-treatment. The Special Rapporteur has called for “an absolute ban on restraints and seclusion” (7, 8).
- In addition ECT should never be given without informed consent and never in its unmodified form (i.e. without anaesthetic and muscle relaxant).

The following are working definitions that are likely to cover issues and examples identified by participants in the previous exercise. These categories are only indicative. Acts of violence and abuse identified in exercise 1.1. may fall under more than one category.

- **Physical violence and abuse (9):** Any intentional and unwanted contact against any person that may or may not inflict injury or harm on the body, including hitting, pushing, pulling, kicking, scratching, slapping, grabbing at clothing or the face, throwing objects, and forcefully preventing movement.
- **Mental/emotional violence and abuse (10):** Behaviour that is designed to control and subjugate another person through fear, humiliation, intimidation, punishment, and emotional trauma; behaviour that wears away at the victim's sense of self-worth through, for example, berating and belittling, intimidation, threats, deception, misinformation, manipulation, privation of decision-making power, restricting access to family and friends, removing a ramp or assistive device (such as a white cane) or mobility devices (such as a wheelchair), removing or controlling communication aids or refusal of assistance to communicate. It is important to note that just because mental or emotional abuse does not involve physical contact or force, this does not mean it is not extremely harmful.

- **Verbal violence and abuse:** Demeaning, destructive, infantilizing, condescending and aggressive language, including name-calling, yelling, aggressive, discriminatory or disrespectful speech, using profanities or threats, deliberately triggering anger or fear in the person.
- **Sexual violence and abuse:** Any unwanted action involving a sexual element. For instance: rape (i.e. penetration with any body parts or objects), sexual assault, unwanted sexual touching of any part of the body (clothed or unclothed); harassment, encouraging a vulnerable individual to engage in sexual activity, including sexual acts with someone else; or intentionally engaging in sexual activity in front of a vulnerable individual. Other practices such as strip searches and forcing people to stand naked in front of others (e.g. for showers) may also constitute sexual violence.
- **Neglect:** The failure, whether deliberate or inadvertent, to provide for a person's basic needs, whether physical, emotional, social or medical – for instance ignoring a person, failing to assist with needs of daily living (hygiene, dressing, eating), failing to provide food, water or sanitation, failing to provide access to services and support.

Intersections of gender with violence, coercion and abuse

A number of social factors, including gender, can increase the risk of violence, coercion and abuse within and beyond mental health services.

- Women and girls can experience high rates of intimate partner violence and sexual assault, including in mental health facilities (11); and women and girls with psychosocial disabilities are at increased risk of violence both in community and domestic settings (12).
- Transgender populations can experience high rates of violence, harassment and abuse, including when accessing health services and within mental health service settings (13), (14).
- The use of coercive measure such as restraint can vary across gender within services (15).

As seen in the previous exercise, many of these forms of violence and abuse are happening in mental health and social services.

Topic 2: What does the CRPD say about violence, coercion and abuse?

Time for this topic

Approximately 20 minutes.

The purpose of this section is to encourage participants to recall the articles of the CRPD that relate to violence, coercion and abuse.



Exercise 2.1: Recalling the CRPD (5 min.)

Ask participants to take their copies of the CRPD (Annex 1). Then ask the group:

What does the CRPD say about violence, coercion and abuse?

This question is meant to re-introduce the content and relevance of the CRPD to the topic of violence, abuse and coercion in mental health and social services. Encourage participants to share their thoughts, or even guesses, as this will help them re-engage with the CRPD. After a few minutes of participants sharing ideas, continue with the following presentations.



Presentation: Articles of the United Nations Convention on the Rights of Persons with Disabilities (15 min.)

The CRPD protects people against violence, exploitation, abuse, neglect and coercion.

All the articles of the Convention are interrelated and are relevant to this topic. However, only the most directly relevant articles are presented here.

Article 10: The right to life

Article 10 requires countries to take measures to protect the right to life of people with disabilities.

Ending violence, coercion and abuse, which can lead to death, is an important measure for protecting the right to life.

Article 12: Equal recognition before the law

Article 12 recognizes that people with disabilities have the right to legal capacity – that is, the right to make their own decisions and to have their decisions respected by others. By recognizing this right, and ensuring that people's choices are respected, the CRPD protects people with disabilities against many forms of violence, coercion and abuse

Article 12 is particularly important in creating equality and protecting against any discrimination, exclusion or forced treatment or intervention against one's will by giving people the right to decide in any area of life.

The law may often allow coercive practices to be carried out against people with disabilities on the basis that the practices are considered "beneficial" to the person and/or that the person is seen as having poor decision-making skills.

Article 12 requires States Parties to ensure that service providers, family members and others respect the person's choices and refrain from carrying out interventions against the person's will.

The provisions of article 12 are explained in more depth in the modules on [Legal capacity and the right to decide](#) and [Supported decision-making and advance planning](#).

Article 14: Liberty and security of the person

The Committee on the Rights of Persons with Disabilities, which oversees the implementation of the CRPD by States Parties, has clearly established that article 14 prohibits involuntary detention in mental health and social services (16).

This is extremely important because detention in these services is often accompanied by – and is the setting for – violence, coercion and abuse (6).

Detention is harmful as it deprives people of their liberty and places them under the control of others, breaking their links with the community. Behind closed doors, violence and abuse can go unnoticed and unhindered. Prohibiting involuntary detention in mental health and related settings, therefore, prevents many forms of violence, coercion and abuse from occurring in mental health settings.

Article 15: Freedom from torture or cruel, inhuman or degrading treatment or punishment

Article 15 states that people with disabilities must not be treated cruelly or tortured (e.g. beaten, sexually abused or forcibly given medication or ECT).

People with disabilities must not be subjected to medical or scientific experimentation, unless they provide free and informed consent (e.g. in relation to a clinical trial where people are administered drugs that are being tested).

Article 16: Freedom from exploitation, violence and abuse

Exploitation, violence and abuse can take many forms and can occur in health-care settings as well as within the community. Article 16 recognizes that attention to gender, age and disability-related concerns needs to occur in order to provide protection from exploitation, violence and abuse and to provide services and supports that promote recovery for people who have experienced them.

Article 16 requires that:

- Countries implement laws and rules and take other necessary measures to protect people with disabilities from exploitation, violence and abuse in the home and in the community.
- Countries provide support and information to people with disabilities, their families and carers to enable them to recognize and report exploitation, violence and abuse.
- Countries ensure that services for people with disabilities are properly checked and monitored to make sure that abuses do not occur.
- Countries must put in place policies, laws and other measures to ensure that abuses are investigated and that abusers are brought before the courts.

Article 17: Protecting the integrity of the person

Article 17 states that people with disabilities have their physical and mental integrity respected on an equal basis with the physical and mental integrity of others.

This means that their body and mind must be respected.

- For example, they should not be beaten or raped, and they should not be subjected to treatment or intervention without their consent.

In any form, violence, coercion and abuse violate human rights and profoundly affect individual health and well-being.

Topic 3: What are the impacts of violence, coercion and abuse?

Time for this topic

Option 1: Approximately 1 hour and 50 minutes.

Option 2: Approximately 45 minutes.

Option 3: Approximately 20 minutes.



Warning: This activity may provoke strong emotional responses from some people.

Facilitators should be mindful of this. Prior to this activity, facilitators should let participants know that they should feel free to voice their emotions, or take a pause or step out of the training session until the end of the activity. The facilitator should also be mindful of any sign of distress shown by participants and should be prepared to provide support.



Exercise 3.1: Personal experiences of violence, coercion and abuse have impacts (50 min.)

The purpose of this section is to present participants with real examples of the negative impacts of violence, coercion and abuse in mental health and social services.

Highlight to participants that:

- As we saw, the CRPD has many articles which protect people against violence, abuse and coercive practices.
- The CRPD also explains what countries need to do to prevent and protect people from these practices.
- Very often, people undertake these practices without any real thought or idea about the actual consequences of their actions on the person concerned.
- In order to end these practices (and the attitudes and beliefs that facilitate them), it is important to consider, understand and internalize the impact that violence, coercion and abuse have on people.

Three options are given below, in order of preference, based on the potential for impact on participants that each option can have. One or more of the options will be followed by group exercise 3.1.

Exercise options:

Option 1: A person or panel of people who have experienced violence, coercion or abuse in mental health or social services to talk about their experience and the impact it had on their lives.

Option 2: Videos on violence, coercion and abuse and persons who have survived these experiences..

Option 3: Quotes from people who have experienced violence, coercion and abuse.

All three options may create an opportunity for participants who have experienced coercion, violence and abuse to speak about it. If participants feel comfortable enough to share their experience with the rest of the participants they should be allowed and supported to do so. It may be necessary to adjust the time of the session to make sure that participants who wish to share their experience are given the appropriate time and space to do so. and the INTAR India video which are available at the end of this topic.

Option 1

Face-to-face discussion with people who have experienced coercion, violence and abuse

Option 1 is the preferred option. The facilitator should try to arrange for one or more people who have experienced coercion, violence and abuse in mental health and social services to tell their story during this training.

The careful selection of a speaker (or speakers) who can bring their perspective to the issue is key to this process. Some people may not be ready to speak publicly about their experience or may have a tendency to minimize or justify the abuse that they have suffered.

Invite people with experience of violence, coercion and abuse to attend the session and share their experiences with the participants.

If a person(s) who has experienced violence, coercion or abuse is identified and willing to speak, the following format may be used:

Introduction to the session and speaker(s) by the facilitator.

- The person(s) share their stories (as much or as little as they feel comfortable with). Encourage the person(s) to talk about the types of abuse they have experienced, as well as the impact it had on them.
- A period for questions, answers and discussion with the participants. The facilitator is encouraged to mediate questions to ensure that the speaker(s) feel comfortable and supported in sharing their story with the group. The speaker(s) should by no means be made to feel obliged to respond to uncomfortable, inappropriate or intrusive questions. Speakers should also not be made to feel that they are being interrogated by the group.

Option 2

Videos of violence, coercion and abuse in services (45 min.)

Show videos of interviews/testimonials of persons who have experienced violence, coercion or abuse in mental health settings. Examples include the following:

- Women institutionalized against their will in India. (4:15) December 2013. <https://youtu.be/NZBxl9pNYHw> (accessed 9 April 2019).
- I couldn't move. I couldn't breathe (52 seconds). BBC News. <http://www.bbc.com/news/uk-england-37427665> (accessed 4 December 2018).
- Open Paradigm Project – Dorothy Dundas (12:22). May 2013. <https://youtu.be/8kZMaUZ7wm0> (accessed 9 April 2019).
- Ghana: abuse of people with disabilities (3:45). Human Rights Watch, October 2012. <https://youtu.be/wTGV4s2fktQ> (accessed 9 April 2019).
- Uganda: people with psychosocial disabilities demand, “End the abuse!” (4:57). MDAC, April 2016. https://youtu.be/slr_SvB1uyU (accessed 9 April 2019).
- Bupa Adelaide nursing home accused of poor care following death of resident (7:28 min.). ABC Australia, 1 May 2017. <http://www.abc.net.au/news/2017-05-01/bupa-adelaide-nursing-home-accused-of-poor-care/8487694> (accessed 23 February 2017).

It is necessary to emphasize to participants that:

- The abuses shown in these videos are obvious and extreme. However, it is important to understand that violence and abuse can take many forms, including more subtle forms, and can happen anywhere.

Remind participants of the different forms of violence, coercion and abuse discussed in Topic 1.

Option 3

Show the following quotes about violence, coercion or abuse in services. This option may be combined with Option 1 and/or Option 2 for a more comprehensive session.

Quotes from people who have experienced violence, coercion or abuse (20 min.)

"I was on a very heavy amount of Valium, not to where I was unconscious, but add the sedative effect to my already defeated self and I was putty... I was like an abused dog that, if you went up to her and gave another kick she wouldn't have flinched. I was in a bad way, and therefore I was hugely open to abuse... There was no point me telling anybody. Who's going to believe a mental patient – a mental inpatient – over a longstanding member of staff who was seemingly highly respected and regarded by his colleagues? It is an open playing field for predators in that environment. Who is going to speak up when they have been in a mental health institution?" (17) *Catherine, ex-mental health service user.*

"The ECT was a violent and damaging assault on my brain and my very soul. It made me emotionally worse, not better. I became catatonic and desperately in fear for my life" (18) *Dorothy*

"After they unlocked the door and they dragged me in there, they said, 'well you can't keep your clothes for danger issues'. And they made strip me down. They kept a video on me the whole time. For a girl who is awkward and is in there for issues of abuse at home, all that did was extend my hate" (19) *A woman in seclusion and restraint as an adolescent*

"The nurses would make us have the medications in front of them. If I complained that there were too many tablets, the nurse would sometimes forcefully put the pills in my mouth and stroke my throat to send them down, the way I feed my dogs....I woke up one night and I couldn't move; my body was in intense physical pain. A nurse came and jabbed an injection into my body, without even taking off my clothes. You are treated worse than animals; it's an alternate reality." (20) *46-year-old woman with a perceived psychosocial disability, Delhi, 25 August 2013*

"I was locked up at...[the] hospital for one year, during which time I spent one month forcibly restrained to a chair facing the wall. Why? Because I was a 'danger' to myself. I was taken out of restraints for 20 minutes a day and led in circles around the chair on a leash. I was stripped of all personal effects, including my wedding band. I wore only a white sheet. The psychiatrist and staff mocked me, calling me... a 'dog'. I was broken eventually. I began babbling to myself. [The psychiatrist] placed me in the quiet room. There were faeces on the walls and floor so they gave me a mop and said clean it up. I tried to escape, but was tackled and put back in restraints... Eventually I learned the catch phrases and behaviour required for discharge. I faked my way out. That was 20 years ago. To this day, I am traumatized..." (21) *W. Martin*

"It was very difficult to be inside all day long," he said. "I was counting the days until I got out." "Sometimes if you refuse to take the medication or you become aggressive the guards beat you with a stick and slap you. I was so happy to leave, I felt like a prisoner there, I felt like I was getting my freedom back when I left."

"I have been wearing them [the chains] for 45 days. Someone escaped from the centre and they chained several of us after this as they said we might escape too. One patient is chained to the window now. They [the staff] said he tried to escape, so they chained him." (22) *Abdi, Somaliland.*



Exercise 3.2: Violence, coercion and abuse have impacts (15 min.)

After going through one or more of the previous exercise options, brainstorm with the group various impacts of violence, coercion and abuse in mental health and social services. Write down examples given by participants in a list. Where necessary, refer to previous exercises to stimulate discussion.

What do you think are some of the impacts of these violent, coercive or abusive practices? Within the discussion, highlight the impact, not only on people experiencing these practices, but also on mental health and other practitioners, care partners, family members and other people involved.

Some examples of impacts include, but are not limited to:

- Emotional trauma or re-traumatization and suffering.
- Physical health consequences such as injury and even death.
- Feeling bad from the effects of medication or ECT.
- Negative feeling such as a sense of grief, anger, loss, humiliation, sadness.
- Sense of separation from society and feeling like a second-class citizen.
- Loss of relationships because of friends or family members' involvement in coercive practices such as forced admission to mental health and social services and/or forced medication and difficulty in forming new relationships.
- Negative impact on mental health.
- Poor recovery outcomes, need for long-term support.
- Loss of trust/fear in the staff, the service and the system.
- Bad reputation/media exposure for staff and mental health and social services.
- Loss of respect for staff.
- Lack of job fulfilment for staff.
- Emotional scars, demoralization for people experiencing the abuse and also for staff and families.
- Funding for services is limited or withdrawn, leading to further deterioration of the service.
- Police enquiry.
- Lawsuits.

In addition, if this issue does not arise during the discussion, it is important to make the point that:

People who have already experienced violence and abuse in their lives – as well as coercive practices in services such as seclusion and restraint, and the associated feelings of loss of control, mistrust, fear and humiliation – may feel that they have very little choice but to defend themselves, even violently, against a renewed coercive intervention.

“If we want people to stop acting violently, perhaps we need to stop treating them violently”(23)

Sera Davidow, Director of Western Mass Recovery Learning Community, Massachusetts, USA

Topic 4: Why are these practices happening?

The purpose of this section is to help participants become aware of reasons why violence, coercion and abuse occur in mental health and social services.



Exercise 4.1: Reasons why violence, coercion and abuse occurs in services (15 min.)

Begin this topic with a brainstorming session with the group about reasons why these practices might occur in services.

Ask participants:

What are some of the reasons why violence, coercion and abuse occur?

Make a list of the reasons given by participants on the flip chart.

Participants may have difficulty identifying reasons why violence, coercion and abuse occur. If the group reaches a standstill, try encouraging participants to view the situation from different perspectives: from the perspective of a person with psychosocial, intellectual or cognitive disability, an individual staff member, a security member of the security staff, or a person from the administration, and encourage them to think about the service policies, culture, etc. (e.g. ask: “What might cause a staff member or a family member to act abusively towards a person?”)

The facilitator should introduce the issue of mental health legislation which allows - and even in some cases makes compulsory - staff to use coercive practices in mental health and social services if it does not come up in the discussion.

The facilitator should also be prepared for participants bringing up that the behaviour of people using the services is responsible for the use of coercion or violence by staff.

A response to this argument may include that it is considered legitimate to use physical force in self-defence or to defend another person when the use of force is proportionate to the attempted act of violence. However, in many services, responses to behaviour that is perceived as violent are not in self-defence and are out of proportion with the threat of harm.

Therefore it is important that alternatives to coercive or abusive practices are implemented in order to safeguard the wellbeing of people using the services. Mental health and other practitioners and security staff, who have the primary responsibility to ensure safety in the service, need to be well trained in de-escalation techniques, human rights and in showing sensitivity to the concerns of people using services. People with psychosocial, intellectual or cognitive disabilities should also participate as trainers and be hired in services to help change the culture around coercion, violence and abuse (e.g. as peer supporters). The fact that individuals may act in a way that is perceived as challenging should not be a reason to resort to coercion, violence and abuse.

Some reasons why violence, coercion and abusive practices occur include (but are not limited to):

- People feel that it is the only way to “manage” behaviours perceived as challenging, and a lack of awareness of alternative methods.
- People with psychosocial, intellectual or cognitive disabilities/users of mental health and social services are dehumanized in the eyes of practitioners and others.
- There may be staffing shortages and a lack of time to support people individually.
- People believe that it is justified/not a problem or that it is “therapeutic”.
- The use of these practices has gone unchallenged in the past.
- There is ingrained discrimination, or stereotypes, of people using services, including on the basis of their race, gender, age and other factors
- There is fear for the safety of the person or others.
- A lack of staff supervision and disciplinary action can lead to inappropriate behaviour or practices.
- Services may be isolated from the community, with a lack of interactions and linkages between the services and the community and a lack of monitoring of services.
- The practices are allowed by the service, by national law and policy or by courts.
- Practitioners are not properly screened before being accepted for employment in the service (i.e. some may have a prior history of abuse, bullying or criminal activity).
- People’s own experience of being mistreated in their lives,
- may lead the to believe that some violence or abusive behaviours are normal or acceptable.
- Staff feel overwhelmed at managing both their work and home life (extra jobs, financial stressors, family caregiving burden, etc.).
- Psychological defences may play a role (e.g. staff project their feelings onto others or see others as different, partly due to diagnosis or labelling).
- There may be a lack of contact, trust and communication between people using the service and staff.

Then show the slide below to participants and compare it with the answers written on the flipchart.



Presentation: Reasons why violence, coercion and abuse occur in services (15 min.)

Explain to participants that:

We will look at some of the reasons why violence, coercion and abuse occur. You will recognize some of your responses on this slide.

This slide lists some reasons why violence, coercion and abuse occur in mental health and social services. Some of the reasons are linked to attitudes, others are linked to knowledge and skills (or lack of) and yet others are linked to management practices.

ATTITUDE

- People believe that the use of violence, coercion or abuse is justified or necessary to control a behaviour perceived as challenging. This can be based on discriminatory beliefs about people with disabilities and other groups.
- People believe that sometimes practices such as seclusion and restraints are inevitable.
- Power dynamics (attitude and management).
- People believe that violence and coercion may be necessary to punish behaviours that are considered inappropriate.

- Misconception and discriminatory attitudes.

KNOWLEDGE AND SKILLS

- Insufficient understanding and education about the linkages between violence, trauma and mental health
- Belief that coercive practices are a form of treatment, that they prevent harm or create safety.
- Insufficient training on building meaningful contact and supportive relations and on alternative strategies for defusing violent and challenging situations.
- People are not being informed and educated about human rights.
- There is no active learning from mistakes and complaints based on feedback from the person concerned about how they experienced the coercive event.

POLICY AND MANAGEMENT

- There is a lack of supervision in the mental health or social service.
- Local/national legislation or policies permit these practices, and there is a lack of sanctions and remedies from courts.
- Service policy or protocols allow practices such as seclusion and restraint, involuntary admission and treatment etc.
- Abuses in services are not visible to the outside world due to lack of monitoring, services are isolated from the community, and there is a lack of interaction and linkages between the service and the community.
- There is a culture of violence, coercion and abuse in services.
- Prevention of violence, coercion or abuse within services is not a priority issue.
- There are not enough staff to manage tense, difficult or conflict situations adequately.
- Power imbalance between staff and people using services.
- People fear they may lose their job or face repercussions if they report abuses.
- The inappropriate design of the service (e.g. stressful, oppressive environment) is not suitable for fostering recovery and inclusion.
- The interests of service and providers (e.g. profit-making) are being prioritized over the interests and needs of people.

To pre-empt the following topic on “Understanding attitudes and power relations”, engage participants in thinking about how violence, coercion and abuse can be prevented:

As a group: think about instances of violence, coercion and abuse in mental health and social services that you have experienced, witnessed, heard or read about.

- What are the factors that led to this incident? Think about factors ranging from the individual to the system-level.
- How do you think it affected all the persons involved, including people using the service, family and service staff?
- How could these incidents have been prevented and what could be changed now to prevent similar incidents from happening in the future?
- Do you have any ideas about alternative strategies that can be used to avoid violence, abuse or coercive practices?

Topic 5: Understanding attitudes and power relations

Time for this topic

Approximately 55 minutes.

The purpose of this topic is to help participants to understand how some mental health and social services create an environment in which power imbalances exist and contribute to coercion, violence and abuse.



Exercise 5.1: The meaning of power (10 min.)

Explain to participants that:

In this exercise, we will discuss the power dynamics in mental health and social services.

Ask the group:

What do you understand by the word power?

Some of the answers may include, but are not limited to:

- Authority
- Force
- Control
- Hierarchy
- Unequal/unfair
- Repression
- Influence.



Presentation: Power dynamics in mental health and social services (10 min.)

In this presentation we shall explore what is meant by the “power dynamics” in mental health and social services.

What is power?

- Power operates in everyone’s day-to-day lives, creating advantages and disadvantages that change over time and place. Power is exerted and resisted at multiple levels, from the structural level (e.g. discriminatory policy) to individual interaction (e.g. racial slurs). Power relations include “power over” others, but also “power with” others (when people work together as a collective) (24). In other words, this often means being able to control or decide what someone can or cannot do and having a certain authority over something or someone. Power imbalance can lead to violence, exploitation, coercion, abuse and cruel and degrading treatments.

What are power dynamics?

- The term “power dynamics” refers to the different amounts of power that various people have in a given place.
- Power dynamics also influence access to the delivery and experiences of mental health and social services.
- In a mental health or social service, mental health and other practitioners have more power than people using the services. This is often referred to as a power imbalance.

Why are there differences in power?

Many differences in power are due to the various roles and responsibilities of people in mental health or social services:

- Staff provide services, are responsible for running the services, and implement the service rules and procedures. In this sense, they inherently have power.
- In addition, staff are legally permitted and often required by law to use coercion. This renders people subjected to coercive practices powerless to defend themselves and change their situation and allows the staff to regard their wishes (e.g. concerning leaving the service, choices about care and treatment) as invalid and ignore them.
- The mere threat or possibility of being involuntarily detained and treated can often exacerbate the power imbalance: people know they need to adhere to what staff members offer or prescribe in order to avoid being involuntarily admitted and treated.

Within the mental health or social service context, people using the services depend on staff for their well-being and to receive services. They require the expertise of staff for their treatment and care over which they often have no control. This dependence on staff and lack of control can put them at particularly high risk of coercion and violent and/or abusive treatment.

A number of factors can influence and exacerbate the power dynamics in mental health and social services:

- The type of clothing worn by staff (e.g. uniforms versus more casual clothing) and people using the services (service-issued/pyjamas versus personal clothing).
- The places where people eat meals (e.g. if staff have their own separate cafeteria or meal lounge); or separate staff toilets.
- The nature of communication between people (e.g. staff talk condescendingly to other people or ignore them/their views, wishes and opinions).
- Staff wear badges.
- Who is taking notes and/or keeping files?
- Who has authority and keys/swipe cards to lock certain areas (e.g. locked wards)?
- Who is expected to live their lives with written treatment plan, goals, etc. and who just gets to live their lives?
- Whose voice and opinion is heard and accepted with greater frequency?
- Whose needs are reflected in service policies, agendas and guidelines

Given the potential power dynamics in a service, the behaviour of staff towards people using the service has a huge impact on their rights as well as on their well-being and recovery.

Identifying and preventing violence, coercion and abuse can happen only when people acknowledge the unequal power dynamics in a service and change their behaviour accordingly.

While the power dynamic cannot be eliminated completely – especially as long as laws allow for involuntary admission and treatment and other forms of coercion – it can nevertheless be recognized and limited.

A respectful and supportive contact decreases chances of escalation and reduces the risk of violence, abuse and coercion. All people deserve to be treated on an equal basis with others, and with dignity and respect.



Exercise 5.2: What contributes to power dynamics? (35 min.)

Ask the group the following questions:

What contributes to power dynamics in a mental health or social service?

- Beliefs that a group or individual is “lesser than” another (e.g. less able, less intelligent, less deserving of rights, etc.).
- Social and structural exclusion of individuals and groups or segments of the population (e.g. discrimination based on gender as well as colonialism, sexism, racism, policies that do not address or worsen the experience of certain groups, etc.).
- Feeling powerless or resisting certain power dynamics.

How might differences in the clothing people wear influence power dynamics?

- Clothing sets people apart from one another.
- People wearing hospital clothes can increase the perception of being different (i.e. requiring treatment) and not of the same status as others.
- Clothing can distinguish and create hierarchy.

How might differences in the places where people eat lunch influence power dynamics?

- If people have separate dining facilities, it entrenches differences and helps create a “them and us” environment.

How might the way in which staff listen and talk to people using the services influence power dynamics?

- When people are not listened to or heard they can feel powerless and not valued. Conversely, active listening and empathy can change power dynamics for the better.
- Diagnosis and medical terms may make people feel dehumanized and imply that staff has the knowledge and power.

What other examples can you think of that might influence power dynamics within services?

- Lack of personal freedoms and choice.
- Lack of privacy (e.g. other people coming into one's personal space without permission).
- Needing to ask permission for everything.
- Curfews.
- Separate toilets.
- **What are the power dynamics at play in your service?**
- **Can you think of situations in your service where staff have power over people using the service or where people have little power to make their own decisions?**

Some answers might include:

- choices about treatment and care;
- visiting hours and access to family and friends;
- phone calls;
- when to go to sleep and to get up;
- going outside;
- going to occupational therapy;
- choice of food and when to eat;
- decisions about when to take a shower/bath etc;
- when to leave the service.
- **What repercussions may sometimes occur when people using the service do not comply with service rules or with instructions given to them?**
- physical or verbal abuse;
- seclusion and restraints or other punishments;
- forced detention and treatment;
- restrictions on leave;
- delayed discharge (some people may comply with what they are told only to get out sooner);
- withholding of access to television, means of communication etc.

It is important to communicate the message that:

- **Often, the reasons why people are not complying with service rules are not explored or taken seriously by staff. Instead, this noncompliance is seen as being due to the person's mental health condition or personality.**

Finally, ask participants:

- **What can be done to overcome this power imbalance?**

Encourage debate around this question as there may be a wide range of answers.

The message to get across to participants is that:

- It is essential to acknowledge that due to the power imbalances and dynamics, people using services are at higher risk of violence, coercion and abuse.
- Law that allows for involuntary admission and treatment in mental health and social services largely contributes to power imbalance and are not compliant with the CRPD.
- Changing practices within mental health and social services to end coercion, violence and abuse does not have to wait until such laws are repealed.
- Thinking about our own role, position or work is the first step towards addressing the power imbalance. For service staff, this involves asking oneself questions such as “What knowledge, values and experiences do I bring to my work?”, “How has my upbringing, education or training shaped the way I see things?”, “How have my experiences of advantage and disadvantage shaped how I work?”, “Do I know how others might think about me or perceive me?” (25)
- Reducing power imbalance also entails staff becoming mindful of their own limitations and needs so that they do not become overwhelmed by challenging situations and can help de-escalate them.

Here, it may be necessary to have a short debrief session on how participants are feeling about the issues covered so far, as the previous discussions may have been emotionally difficult for some people.

Topic 6: Key strategies to avoid and defuse conflictual situations

Time for this topic

Approximately 30 minutes.



Presentation: What is an effective and appropriate response to tense situations? (30 min.)

This presentation describes different ways in which people may react to tense situations. It distinguishes inappropriate and ineffective responses to tense situations from more appropriate and effective responses.

It then identifies five key strategies which can be used to respond to these situations and thereby avoid the use of coercive and abusive practices.

Tense situations often lead to conflict situations that are sometimes “resolved” using force (e.g. violence and coercion).

They typically result from miscommunications and misunderstandings. They may also result from people “playing their roles” (e.g. the staff role of keeping control and maintaining order in the service) or even “good intentions” (e.g. staff being convinced that a treatment will be beneficial to the person). They also often arise when people feel they are not being listened to or that their wishes are not being respected.

Both staff and people using the service can be at the origin of a tense situation. However, people using the service are much more likely to face a coercive or violent response.

When not handled appropriately, tense situations have the potential to evolve into a conflict.

Examples of situations that can escalate into violence include:

A person feels that he or she is not being listened to and becomes annoyed and distressed.
A staff member gets frustrated when the person refuses treatment.

Even issues that may appear unimportant may create conflict when not handled respectfully and supportively.

Inappropriate and ineffective responses or practices

Shouting

- Shouting is often used to assert control, to be heard or “to make things clear”.
- Shouting can increase tension and make people feel even more distressed.

Threats and intimidation ...

- ... are used to pressure and coerce people to do or not do something;
- ... but they can make people feel helpless, despondent, afraid and demeaned.

Forceful handling ...

- ... includes pushing, grabbing, pulling and other physical force.
- ... can cause injuries.
- ... can quickly escalate a situation to violence.

Forced medication:

- ... is often used to resolve a tense situation or to prevent people from behaving in a way that is perceived as challenging (e.g. sedation).
- ... can have negative impacts on people's health.
- ... can seriously damage the relationship between the individual and staff members.

Seclusion and restraint

- They often make the situation worse.
- There is no evidence that these practices help individuals improve their self-control.
- There is no therapeutic benefit or long-term positive impact on behaviour change.
- They can increase feelings of helplessness, fear, distress, frustration, anger and resentment.
- They can lead to deterioration of a person's mental health and seriously hinder recovery.
- The practices can result in suffering, injury or even death of people who are using the services.
- They can harm the therapeutic relationship between the individual and the staff member.
- They can also leave psychological wounds on staff members, family or others who witness or impose these measures.

Appropriate and effective responses

Many people using mental health services have experienced trauma in their lives. When violence, coercion and abuses occur in mental health services, not only do the service fail to help people but they compound the original difficulties, by retraumatizing people using the service (26).

It is very important that mental health and other practitioners learn how to react to tense situations in ways that are trauma-sensitive, not damaging or counter-productive. A good start may be to ask the person in distress first what could bring relief (e.g. if there is a preferred person who could be contacted, or if there is a specific need). Since most tension starts from discomfort and powerlessness, listening carefully and reducing powerlessness are key. In addition, responding early reduces the chances that the situation escalates into a conflict.

An appropriate and effective response to a tense situation involves:

- asking the person how they want to be supported/treated;
- treating the person concerned with respect and empathy;
- paying attention to prior history of trauma or abuse;
- listening to their concerns and wishes;
- trying to understand how they are feeling and acknowledging their feelings;
- being patient and supportive;
- being reassuring;
- giving the person space and time;

- keeping calm;
- finding a nonviolent solution to problems.

When dealing with tense situations, it may be necessary to think about the safety of all the persons around (e.g. asking people whose presence is not necessary to leave the room or to stay at a safe distance).

Recognizing and responding to sensitivities and signs of distress

Sensitivities are situations or stimuli which can lead to a range of emotions depending on the person, including distress, frustration or anger. Identifying sensitivities and signs of distress should not be undertaken only in relation to people using the services. It should also be undertaken for staff, families and others because they too may have sensitivities and signs of distress that can be identified, in order to avoid the development of a conflict. Staff in mental health or social services may also benefit from additional training on how to manage their own stress levels or anger and on remaining calm in difficult situations.

It is important to try and identify a person's sensitivities and signs of distress, anger or frustration as soon as possible in order to prevent an escalation of the situation into a conflict. This needs to be done in a holistic and respectful way. It is important not to consider sensitivities and signs of distress or anger as stimuli or behaviours that should simply be eliminated or suppressed. They may have a deeper meaning and explanation for people which it is important to try to understand. In addition, sensitivities and signs of distress or anger are not necessarily the result of a specific situation but may be tied to deeper issues in the person's life situation. It may then be necessary to support the person to address these issues relating to the broader context.

Multiple sensitivities being activated within a short space of time can cause a person to experience great distress, and many people's sensitivities being activated with high levels of distress can lead to a tense and conflictual situation.

For example, some sensitivities might be:

- not feeling listened to
- people speaking disrespectfully to me
- other people using my things without permission
- loud noises
- being touched
- not having choice, control or input.

Signs of distress are physical or outward signs that someone may be experiencing distress. Physical signs of distress call for a sensitive and supportive response, with the aim of identifying and removing the cause of distress, providing comfort or otherwise assisting the person. Some common examples include (27):

- Restlessness
- Agitation
- Pacing
- Shortness of breath or rapid breathing
- Tightness in the chest
- Sweating
- Clenched teeth

- Crying
- Wringing hands
- Rocking
- Withdrawal, fear, irritation
- Prolonged eye contact
- Increased volume of speech
- Aggression
- Threatening harm.

When sensitivities and signs of distress have been identified, key strategies exist to respond to the situation and to avoid and defuse conflictual situations. They include:

1. Communication techniques
2. Supportive environments and comfort rooms
3. Creating a saying “yes” and “can do” culture
4. Individualised plans to explore sensitivities and signs of distress
5. Response teams.

Each of these strategies will be elaborated in topics that follow.

Topic 7: Communication techniques

Time for this topic

Approximately 30 minutes.



Presentation: Communication skills (15 min.)

Good communication skills are essential for the day-to-day running of an effective service that is responsive to people's needs. Staff should have time for communication and contact with the people using the service.

Good communication skills are also essential when approaching a tense situation. Using these skills is one of the most effective ways of managing tense and conflictual situations in a way that is respectful and avoids coercive practices.

These techniques seek to make the person feel respected, listened to, valued and supported.

When people feel that they are being listened to, they are more likely to communicate more openly and clearly, allowing a peaceful resolution to the situation. Communication is interpersonal by nature. Therefore, if efforts to meaningful communication do not seem to succeed with one person, it is advisable to ask another (a colleague, a peer or other supporter) to try to make a meaningful contact.

The nature of communication

Here is a quote about the importance of communication as a means of avoiding coercion:

*"I'm not sure it's the exact words that are most important, but rather, the **tone** of voice, **body language** and the physical **environment** of the verbalization..." (28)*

The quote highlights that there is a lot more to communication than the words that we use.

Good communication can help avoid and resolve tense situations.

Communication should be:

- **Respectful:** treating everyone in the situation with respect and dignity.
- **Attentive:** devoting full attention to the persons concerned.
- **Affirming:** supporting and encouraging people's ability to find ways to calm themselves and resolve the situation.
- **Positive:** encouraging people to be confident that their situation can change or that they can find ways to overcome it.
- **Empathetic:** putting in effort to understand the thoughts and feelings of everyone involved.
- **Patient:** taking as much time as necessary to hear the concerns of the persons involved and to reach a fair and peaceful resolution to the situation.

- **Culturally sensitive:** It is important to be mindful of a person's background and history, recognizing that multiple factors have shaped their experiences and knowledge, such as culture, gender, migrant status, sexual orientation or other status.

Communication may also be improved by attention being paid to the structural elements contributing to mental health and the broader context of the individual (e.g., racism, poverty, welfare policies, contemporary forms of segregation, etc.) (29),(30),(31). This can include inviting people to share information related to their identities, contexts and needs as they feel relevant

Good communication can be a skill that some people have naturally, while for others it takes more practice and training.

Active listening (32)

Active listening is an essential aspect of good communication and helps people feel heard and understood. Active listening is essential for people using mental health and social services to have their concerns, story and views heard. For active listening to work, the listener need to be genuinely interested in what the speaker is saying.

- Active listening is a structured form of listening that focuses the attention on the speaker.
- The listener gives full attention to the speaker. By paying full attention to the speaker, the listener will be able to ask relevant questions because they are actively engaged in the conversation. This is also important for building trust.
- Active listening can be demonstrated by non-verbal actions (nodding, looking in the eyes, open body language e.g. unfolded arms).
- Listener repeats in own words what they think the speaker has said (e.g., "It seems like you..."). This is important because very often we hear what we *expect* to hear rather than what has actually been said. So by paraphrasing what has been said, the listener can ensure that they have truly understood what the person has said. This is not about parroting what the person has said. It is about understanding the true or underlying meaning about what has been said.
- The listener does not agree or disagree, but reaffirms what the speaker has said.
- This kind of dialogue leads to greater understanding of the thoughts, feelings and motivations of the speaker.

Benefits of active listening

- It promotes attentiveness and shows interest and respect for the person.
- It avoids misunderstandings.
- It encourages people to open up and say more by conveying that what they have to say has value.
- It encourages the expression of emotions and feelings.
- It prevents escalation of a situation.
- It is more likely to help develop a person-centred solution to a situation or problem.



Exercise 7.1: Phrases for calming a tense situation (33) (25 min.)

This exercise is designed to help participants to think about the reactions that everyone has to certain phrases. The exercise shows how common phrases used by mental health and other practitioners can evoke powerful (and, at times, negative) emotional responses.

Read the following phrases:

1. Would it be helpful to you if we sit down and talk about the problem together?
2. If you don't calm down, I will have to restrain you.
3. You are going to be OK.
4. Calm down!
5. I am here to help you.
6. You are being unreasonable.
7. We can solve this problem together.
8. Do you want to talk about how you are feeling?
9. You are being childish.
10. What can I do to help?
11. You're doing well.
12. I know this is temporary and you will be feeling better soon.
13. Count on me.
14. You don't have to prove anything to anybody.
15. I know you will get through this.
16. You are a very valuable person.
17. Remember your achievements...not only your problems.
18. Tell me what you want/need?
19. I respect your views.
20. We can work together through this.
21. It's OK to feel like that.
22. Don't give up.
23. I can't promise, but I'll do my best to help.
24. You can have trust in yourself and your ability to recover

Go through each phrase with participants, asking the following:

- How do these words make you feel?
- Do you think this would be helpful in calming a tense situation? Why or why not?
- Is there some phrase that works for everyone?

After going through all the phrases, ask participants the following:

- Do you currently use any of these types of phrases when you are confronted with a difficult situation?
- Can you think of other things to say that might help calm tense situations?
- What are some things you have heard others say that are not helpful?
- Can you think of helpful words to say instead of these unhelpful things?
- How can your tone of voice, body language and posture communicate beyond words?

Finish this exercise telling participants the following:

- Even through these simple phrases we can see that the words that we use have power and make an important impact on how people feel. This is particularly true in tense situations.
- Simple phrases like this can either make us feel calmer/less threatened, or else can make us feel more tense and upset.
- It is important to note that what may seem to be a helpful phrase to some people may not be to others. The context, culture, who is saying the phrase and also the intention behind the phrase all determine how it is received by others.

Topic 8: Supportive environments and the use of comfort rooms

Time for this topic

Approximately 5 minutes.



Presentation: Supportive environments and comfort rooms (34) 5 min.):

The environment of a service may play a role in increasing or reducing tensions. A coercive or oppressive environment may increase conflicts and escalation while a comfortable and supportive environment may foster and support recovery, wellness, inclusion, hope, resilience, social interaction and so on.

While the overall environment should be supportive, a practical illustration may be to create a comfort room in the service. A comfort room provides a sanctuary from stress and allows people to experience their feelings and relieve discomforts in privacy. It can be offered at any time and can help to prevent escalation.

A comfort room should be used voluntarily, and must not be used as a place of seclusion. People should never be locked into the room or otherwise prevented from leaving.

Another example is the use of sensory approaches. Sensory approaches can sometimes be useful, depending on the person, to reduce anxiety and distress and to calm down. Sensory approaches are meant to stimulate different senses (touch, hearing, smell, sight, taste).

Sensory approaches should also be used only with the informed consent of the person and if identified by the person as helpful.

Some examples include:

- Music
- Massage
- Warm water
- Soft blankets, carpets or pillows
- Calming colours
- Low lighting
- Rocking chairs
- Aromatherapy
- Animals (if appropriate).

Topic 9: Creating a saying “yes” and “can do” culture

Time for this topic

Approximately 10 minutes.



Presentation: Creating a saying “yes” and “can do” culture (10 min.)

Mental health and social services need to shift from a culture of “managing” and “controlling” people, to a recovery-oriented approach in which the aim is to support people and meet their needs, when they want support to do so (e.g. need for respite from difficult circumstances, need for human connection and comfort, need to work on recovery outside of one’s usual space and routine). In order to achieve such a cultural shift, it is essential for staff to work with people to meet their needs.

Often, however, on admission to a service, people using services with an institutional culture and people brought in against their will are required to surrender considerable control to the service staff. Being placed in a situation of loss of control and “dependency” on staff for their comfort, security, safety and well-being can cause fear, distress, anxiety and frustration and may lead to conflictual situations.

These feelings can be further increased by the fact that mental health and other practitioners often say “no” to people’s requests or delay meeting these requests, many times without explanation. This may be due to heavy workloads, staff shortages, poor training or a belief that fulfilling a request is not in the “best interest” of the person. It may also be due to service regulations or a culture of unresponsiveness in the service more generally.

A useful strategy to make this cultural shift is to create a “saying yes” and “can do” culture within a service. This involves creating a non-judgemental space to think through how decisions are reached and whether it is possible to say “yes” rather than “no” in response to a request from people who are using the services.

Before saying “no” to requests from people who are using the services, staff members should first R.E.F.L.E.C.T (35) on the request. Think about:

R – Reframe: What would it take to say yes?

E – Easy: Is “no” the easy option?

F – Feeling: What would it feel like for the person if I say “no”?

L – Listen: Have I really listened to the person concerned and what they are asking?

E – Explain: Can I explain to the person concerned why I am unable to meet their request?

C – Creative: Are there creative ways in which I could meet the request of the person?

T – Time: Am I giving enough time to consider the request?

It is important to acknowledge that sometimes services may not be able to meet certain needs, or may not be able to meet them immediately. This should be discussed with the person.

In addition, service managers should make sure that service staff have the working conditions necessary to enable and empower them to engage effectively with, and meet the needs of, people using the service.

Topic 10: Individualized plans to explore and respond to sensitivities and signs of distress

Time for this topic

Approximately 55 minutes.



Presentation: Individualized plans to explore sensitivities and signs of distress (36) (15 min.)

What is an individualized plan?

An individualized plan is a document in which the person identifies their sensitivities and signs of distress as well as strategies and actions that they themselves or others can take to respond to the situation and alleviate distress, anxiety, frustration or anger.

It may not be relevant to develop specific individualized plans to explore sensitivities and signs of distress for all people – not all people will want or need them.

However, for some people, developing individualized plans may be useful for understanding what makes them feel distressed, anxious or angry and how others can respond in these situations in a way that is respectful of the person and of their wishes and preferences. Some people may want to develop a plan on their own, while others may want to involve trusted persons in the process.

Developing a plan is an opportunity for others to understand what the emotions and feelings of the person are in certain situations and to discuss effective ways to meet their needs when this situation occurs and in the longer term.

Therefore individualized plans can help to resolve tense situations more effectively without the use of coercion, abuse or violence.

The person developing the plan should have the possibility to let all relevant people – including mental health and other practitioners, families and care partners – know about its existence so they know how to support the person in an effective and acceptable way.

Mental health and other practitioners, families and other supporters can also develop their own individualized plans; they too may have sensitivities that can affect their behaviour in conflictual situations. It is important that they understand their own sensitivities and identify calming methods that also work for them so that they do not contribute to creating a tense situation or making a situation worse.

When an individualized plan is made well, for a person who is comfortable receiving this type of support for dealing with typical sources of distress, it can be beneficial to everyone concerned and can provide for a better environment within the mental health or social service or at home.

Calming strategies should be introduced into the individualized plan

After sensitivities and signs of distress have been identified, people should be encouraged and supported to explore what helps them to feel better and regain control. List these options in their individualized plans.

Some examples might include:

- going for a walk/getting some fresh air
- having someone acknowledge my feelings
- taking slow, with deep breaths
- squeezing a ball or blanket
- being able to yell or cry
- spending time in the comfort room
- calling a friend or family member
- sports or exercise,
- music, art and creativity
- gardening
- pets and animals.

If individualized plans are shared with service providers, they should be accessible during tense situations (e.g. people should be allowed to keep their own copy, have it on record in the service, on the online registry, etc.).

They can be developed as stand-alone documents or as part of an overall recovery plan or of an advance plan/directive.

In summary:

- Individualized plans are unique to each person. They focus on the needs of the individual and not the needs of the service. Very often services are geared towards following procedures or doing things for ease. A plan requires adaptability, flexibility and also creativity.
- Individualized plans are developed by the person concerned and, if they wish, other people they want to involve. These may include family members and other care partners, friends, colleagues, peer supporters, mental health and other practitioners, etc.
- Individualized plans identify sensitivities and signs of distress.
- Individualized plans include strategies to respond to sensitivities before a situation escalates.

These issues are explored in more depth in the module on *Strategies to end seclusion and restraint*.



Exercise 10.1: Making individualized plans (40 min.)

For this exercise, ask participants to divide into pairs. Participants may do this exercise on their own if they prefer.

Distribute copies of Identifying sensitivities and signs of distress (Annex 2).

Ask each group to:

Begin the exercise with one person in each pair interviewing the other about what makes them feel distressed, frustrated, anxious or angry.

Then discuss what helps the other person calm down during stressful situations.

Interview your partner:

A. What makes you feel frustrated, anxious or angry?

E.g. People not addressing me by my full name, not making my own decisions, not being listened to, my views being ignored, a request being ignored or postponed, loud music, feeling crowded with too many people around.

B. What helps you to calm down in stressful situations?

To prompt the discussion, the following questions can also be asked: What do you like to hear from people in these situations? With whom do you want to be? What strategies do you use to calm down? E.g. Going into a quiet room to relax, talking with my sister, relaxing music and a cup of tea.

Finally, fill in the table provided in Annex 2.

After discussing strategies like the ones mentioned above, use Annex 2 to make an individualized plan with your partner.

- List the sensitivities and signs of distress.
- List the calming strategies.

After this first round, have the pairs switch roles and repeat the exercise.

Topic 11: Response teams

Time for this topic

Approximately 1 hour.



Presentation: Response teams (37) (15 min.)

Now we will explore response teams as a key strategy for managing tense situations. Response teams are being used in different countries – e.g. in Pennsylvania’s hospitals in the USA – where they have achieved a massive reduction in the use of coercive measures within psychiatric hospitals as well as forensic units (This example is described later in Topic 13 (38)).

What is a response team?

A response team is a core group of trained people responsible for intervening/responding when there is likely to be an emergency situation considered to be unmanageable by those present.

Response teams are trained to respond to conflictual situations by using communication and de-escalation skills to defuse and safely resolve the situation. As response teams gain more practical experience, their effectiveness in defusing conflictual situations increases over time.

The purpose of the teams is always to respond to conflictual situations in a nonviolent and non-coercive way. It is important to ensure that the response team does not evolve over time into a team that itself uses coercive and violent measures to manage tense and conflictual situations.

It is important to note, however, that the intervention of a response team is necessary only in certain crisis situations where other strategies are not appropriate or have not worked. In many instances, people may simply need some time and space to overcome their distress by themselves or with support from staff and others.

Who can be part of a response team?

The group can include:

- Mental health and other practitioners (aides, nurses, doctors, and others).
- Other members (including peer supporters, community advocates and family members/ care partners).
- One core group is assigned to the service on a day-to-day basis, covering days and nights.
- In addition, there are also on-call members:
 - these do not stay permanently at the service;
 - they are called in on a needs basis;
 - they can be called in at short notice and should be able to report to the emergency location quickly.

It is important to make sure that the composition of the response team is tailored to the needs of the person(s) (e.g. sensitive to age, gender, culture, particular needs).

How does a response team work?

Response teams come to the scene of the emergency situation in a short period of time.

Their core intervention is the development of a non-intrusive, non-controlling, non-confrontational and actively empathic relationship with the persons involved without the use of coercive measures (i.e. not using seclusion, restraints, forced medication, sedatives or tranquilizers).

The response team starts with a recovery approach immediately. The team demonstrates hope, calmness, positive affirmation and confidence in its ability to avert, prevent and de-escalate a crisis situation professionally without violence. Members of the team work towards building a relationship with the persons involved, working with them to understand the immediate circumstances and relevant background that precipitated the crisis.

Persons can choose to give the response team access to individualized plans, advance plans and/or recovery plans so they can determine what is the most effective response according to people's will and preferences. The response team should also ask if the person has advance plans, or if there is a preferred person who could be contacted.

Response teams should be allowed to take as much time as it is necessary to solve a particular situation.

Once the situation has been resolved:

- A debriefing session should be held between members of the Team to discuss the response, review the outcome and to determine what worked, what did not work and how things can be managed better if a similar situation emerges.
- A separate debriefing session should be offered to the person who is in crisis, when they are feeling ready, in order to better understand what the person went through, what provoked their distress, the reasons behind their reaction, how appropriately they think the team dealt with the situation and how they can improve.
 - The persons concerned should have the opportunity to write their own personal perspective of the incident and what should happen in similar situations in the future.
 - This is also an opportunity to develop or review individualized plans.
 - This presents a valuable opportunity for mutual learning.



Exercise 11.1: Creating a response team (45 min.)

This exercise is meant to help participants come up with a list of steps that can be taken to create a response team in their service.

Ask participants to split into groups of 3-4 members.

Allocate each group one or two of the following questions:

- Who can you involve (be sure to consider gender, ethnic and age balance)?
- How can people who are not staff members be included as part of the response? (e.g. can they be available at the service on a daily basis or they can be “on call” to come quickly to the service?)
- What skills do you think would be necessary for the members of the response team?
- How can you organize the training for this team?
- Are there costs involved in setting up a response team and, if so, how can it be funded?

Give each group 30 minutes to discuss the questions.

After the discussion, ask one person in each group to volunteer to share their answer with other participants.

Topic 12: Complaints and reporting procedures

Time for this topic

Approximately 35 minutes.

The purpose of this section is to introduce complaints and reporting policies and procedures as a way of preventing and responding to violence, coercion and abuse in mental health and social services. It is important to make sure that people have a way of speaking out against violence, coercion and abuse. Accountability is an essential part of a rights-based approach in mental health and social services.

The following presentation introduces key information about complaints and reporting procedures. The presentation is followed by prompts for discussion about how participants can implement these procedures in their service.



Presentation: Procedure for reporting complaints, coercion, violence and abuse (20 min.)

Establishing a procedure for reporting complaints, coercion, violence and abuse is central to preventing and stopping abuse from occurring. Complaints and reporting procedures should uphold the rights of the CRPD and ensure that practices such as involuntary admission and treatment, seclusion and restraints are prohibited.

Many complaints and reporting mechanisms in countries do not fully protect the rights of the CRPD. It is important to advocate for these bodies and mechanisms to fully embrace the principles of the CRPD in order to guarantee an effective protection of people's rights.

Elements of an effective reporting procedure

Any procedure should be independent of the mental health or social services and from government. People will be reluctant to make a complaint or to report abuse, no matter how minor or serious the incident, because of the potential negative repercussions on their treatment and care and concerns about retaliation.

Independent bodies could include ombudsperson offices (39), human rights institutions/commissions or other appropriate bodies. An independent body or person can also be effective when based within the mental health service itself. The key is that the body or person remains truly independent and is not pressured by staff or influenced by the surroundings to handle complaints in a certain way.

In addition to independence, other important features include:

- Accessibility to the complaints mechanism.
- Assistance by trusted persons (e.g. family, peer workers, independent advocacy services) to support someone, in line with their preferences and needs, to file a complaint or report violence or abusive practices.
- Real and effective investigation of the complaint.
- Timely processing and response to complaints.

In addition, the option to raise complaints directly with the service should also be available, as it enables improvement.

Cases of serious legal concern

These slides are designed to remind participants that, in serious cases of violence, coercion and abuse, complaints should be managed externally by the criminal justice system.

Some reports of violence, coercion and abuse are criminal (e.g. physical abuse, rape, torture and other ill-treatment) and require criminal investigations and proceedings. These should be reported directly to the police, in addition to being reported to the independent body dealing with violence, coercion and complaints.

Criminal and civil legislation within the country must also be applied to incidents occurring in mental health and social services in order to protect people who are using services from violence and abuse. Accountability is very important. Every person has the right to be free from violence and abuse, and all citizens must be protected equally.

Police, courts and other bodies should be trained in dealing with complaints from persons with psychosocial, intellectual or cognitive disabilities (e.g. raise awareness on the rights of these groups, on the barriers posed by substitute decision-making measures, involuntary hospitalization, social context or other factors).



Presentation: Complementary strategies for addressing complaints, coercion, violence and abuse (40) (5 min.)

In addition to having a body that receives and investigates complaints and reports of violence, coercion and abuse, it is useful to invite an independent body or service to conduct periodic but regular checks at which members of the investigative body talk to people who are using the service, as well as to families and staff members.

Mental health and social services can be creative in introducing other mechanisms to allow people to make complaints in a way that they feel safe, such as by placing a “Suggestion box” in an accessible, but relatively private area for people to place complaints anonymously.

Service culture

A reporting mechanism for complaints, violence, coercion and abuse must be supported by a culture of improvement in the mental health and social services.

A culture of quality improvement in the services means:

- Ensuring that persons are aware of their rights and of how and where they can complain.
- Proactively seeking and learning through feedback from people. Any review process should always include feedback from the person(s) who has experienced violence, coercion or abuse.
- Encouraging people to share their feedback, and providing them with assurances that their opinions are valued.

- Providing additional support to persons who have complaints or disagreements with the service they use, if they want this.
- Establishing complaints processes that are fair and transparent.
- Creating a service culture that values the safety and well-being of all people in the service.
- Instilling attitudes among mental health and other practitioners that consider complaints as opportunities for growth and improvement of services.
- Ensuring that people can access independent advocacy services.
- Providing appropriate and relevant education (e.g. education around preventing violence, recognizing the signs of abuse, active listening and so on).



Exercise 12.1: Access to external complaints mechanisms (10 min.)

Ask participants:

How can mental health and social services facilitate access to external complaints mechanisms?

Some answers may include:

- Post telephone numbers, contact addresses and websites of public agencies or NGOs that deal with violence, coercion and abuse next to a phone or computer that is accessible to people.
- Include relevant telephone numbers, websites and contact addresses in a leaflet provided to all persons in the service and to their supporters.
- Make sure that people have access to telephones that are reasonably private (e.g. not next to the nurse station or in the middle of a corridor).
- Partner with local agencies or NGOs who specialize in handling violence, coercion and abuse to have regular visits in the service during which people can meet with NGO or agency members anonymously.

Topic 13: Stopping violence, coercion and abuse in my mental health or social service

Time for this topic

Approximately 25 minutes.

The purpose of this section is for participants to apply the concepts and strategies discussed in this training module for preventing violence, coercion and abuse in their own service.



Ending abusive practices in services is possible! Example (10 min.)

The Pennsylvania example (38)

In the 1990s, the Pennsylvania Department of Public Welfare in the USA instituted an active programme to reduce, and ultimately eliminate, seclusion and restraints in mental health and forensic hospitals. All the hospitals have been seclusion-free for several years and are approaching zero use of restraints.

The programme was realized through a combination of training, monitoring, policy revisions, cultural change, data transparency, use of response teams and by adopting a recovery approach.

Research evaluating the impact of the programme from 2001 to 2010 (41), (42) showed significant reductions in the use of seclusion and restraint over this period across the state. During the span of the study, the use of unscheduled medication an indicator of the use of chemical restraint also declined. Furthermore, contrary to fears, there was no increase in assaults on staff; in some cases, the number of assaults on staff even decreased.

After this initial presentation, show the slide summarizing the topics covered so far in order to provide a reference point for the brainstorming session. Encourage participants to think of strategies, policies and procedures that can be used to stop violence, coercion and abuse in their service.



Presentation: Recap of strategies for understanding and stopping violence, coercion and abuse (5 min.)

Addressing power dynamics

Strategies to avoid coercion, violence and abuse:

1. Communication techniques
2. Supportive environment, including comfort rooms
3. Creating a saying yes” and “can do” culture
4. Individualized plans to explore sensitivities and signs of distress
5. Response teams.



Exercise 13.1: What can you do to prevent violence, coercion and abuse? (10 min.)

Ask the group to think about their service (that they are using, or that they are working in) or a service they know:

What can you do to prevent abuse in your service?

Brainstorm with participants a list of ways by which violence, coercion and abuse can be prevented within their mental health or related service.

Possible answers from participants may include, but are not limited to:

- We can adopt a clear policy of no coercion, violence and abuse and of systematic improvement of the service.
- We can report incidences of violence, coercion or abuse which we witness.
- We can become more aware of how we may create, contribute or exacerbate situations of violence, coercion or abuse and can encourage others to do the same.
- We can let people decide to try treatment options that work for them and we should not try to impose ones that they don't want.
- We can establish a response team.
- We can create/strengthen mechanisms by which people can report harmful practices.
- We can give staff the opportunity to have more training, including training on good communication techniques and understanding the intersections between violence and mental health for diverse people using services.
- We can start to implement individualized plans for staff and people using the service to prevent and respond to tense situations.
- We can have open discussions with all the people concerned about what constitutes coercion, abuse and violence and how best it can be addressed.
- We can lobby for repealing laws that allow for coercion, violence and abuse to occur in mental health and social services.
- We can help building a culture of trust between all the stakeholders.
- We can organize regular meetings to discuss the different strategies and make sure that they are implemented.



Presentation: Concluding the session (5 min.)

Ask participants:

What are 3 key points that you have learned from this session?

After the discussion, show the slide on take home messages.

- Every person deserves to be treated with respect and dignity at all times.
- Coercion, violence and abuse are a violation of the CRPD and should never occur in mental health and social services. Everyone should work creatively to end these practices.

- Unequal power dynamics exist in every mental health and social service. Mental health and other practitioners need to be mindful of this and should try to counter this imbalance when they interact with people using the services.
- Many things can be done to prevent violence, coercion and abuse in mental health or social services, such as giving people a way to safely report these abusive practices, and making sure that their complaints are effectively and appropriately managed and addressed.
- We can all play a role in preventing violence, coercion and abuse in mental health and social services. Doing so will help create an environment in which the rights, well-being and recovery of people are promoted, as well as a safer and better working environment for service staff. Everyone in the service will benefit!

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Annexes

Annex 1: The Convention on the Rights of Persons with Disabilities

(Original version **with associated simplified version**) ^{1,2}

Different language versions (including sign language) are accessible at the following link: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html> (accessed 5 March 2018).

Article 1 - Purpose of the Convention

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.

The goal of this Convention is to make sure that people with disabilities have the same rights as everybody else and that they are respected by 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;

¹ Convention on the Rights of Persons with Disabilities (CRPD). United Nations (UN) General Assembly Resolution A/RES/61/106, 24 January 2007. New York (NY): United Nations; 2007. (<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html>, accessed 20 November 2018).

² United Nations (UN) Enable. International agreement on the rights of disabled people (easy-read version) [online publication]. New York (NY): United Nations; 2012. (<https://resourcecentre.savethechildren.net/sites/default/files/documents/6761.pdf>, accessed 2 February 2017).

"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.

"Communication" means all the ways used by people with disabilities to talk and understand information, for example computers, easy-read or Braille.

"Discrimination" means being treated unfairly because you have a disability. It includes not getting reasonable accommodation.

"Language" means any way people talk to each other, including sign language.

"Reasonable accommodation" means modifications of the environment which allow people with disabilities to enjoy their rights (for example this includes making adjustments and accommodations in educational, employment, and other contexts to make sure that people with disabilities have the same opportunities as others).

"Universal design" means products and items made for and usable by everybody, including people with disabilities.

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.

The basic ideas of the convention are:

- a. People must be respected for who they are and are free to make their own choices;
- b. No one should be discriminated against (i.e. treated unfairly);
- c. People with disabilities have the right to be part of, and participate in, the life of the community and society;

- d. Everybody, including people with disabilities, is different and this is a good thing. People with disabilities must be respected and accepted like everybody else;
- e. Everyone should have the same chances in life;
- f. People with disabilities should have access to all the services and activities that others enjoy;
- g. Men and women are equal;
- h. The capacities of children with disabilities to make decisions and to do things for themselves will develop as they grow up and this needs to be respected.

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.

What do countries need to do?

1. All countries should make sure the rights of people with disabilities are respected and that they are treated equally. They do this by:
 - a. Making or changing laws and rules;
 - b. Changing law, rules or behaviours that cause people with disabilities to be treated unfairly;
 - c. Taking into account the human rights of people with disabilities anytime they put in place a policy or programme;
 - d. Not doing things that are against the Convention and making sure that the government and authorities respect this Convention;
 - e. Taking steps to make sure that people, organizations or companies treat people with disabilities equally and fairly.
 - f. Developing items and services that everybody can use;
 - g. Developing and using technology to help people with disabilities and making sure that they can access this technology without spending a lot of money;
 - h. Giving accessible information to people about things or services that can be useful and helpful;
 - i. Training people so they can respect the rights protected by this Convention.
2. All countries should do as much as they can afford to make sure people with disabilities are not discriminated against.
3. All countries should involve people with disabilities in making new laws and policies.

4. When countries have rules or laws which are even better than the Convention, they should not change them.
5. The Convention applies everywhere in countries.

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.
-
1. Countries agree that everyone is equal.
 2. Discrimination against people with disabilities is not allowed and the law protects people against discrimination.
 3. Countries should make sure that people get the reasonable accommodation they need (i.e. that modifications and adjustments are made within society so that people can access information, services, activities and opportunities like everybody else).
 4. When countries make specific laws or rules to make sure that people with disabilities are equal in practice, this is not discrimination.

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.
-
1. Women and girls with disabilities are often treated even more unfairly. They should also enjoy all their human rights.
 2. Countries should make sure that women and girls have enough chances in life and power and control over their lives to enjoy all the rights of the 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.
-
1. Children with disabilities should enjoy their human rights, like other children.
 2. When things are done for children, what is best for them is the most important thing to think about.
 3. Countries should make sure that children with disabilities have the right to give their opinion. Their point of view should be respected more and more as they grow up and mature. When necessary, help needs to be given to children to express their opinion.

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.

1. Countries should immediately:
 - a. Help everybody realize that people with disabilities have equal rights;
 - b. Combat false ideas about people with disabilities and practices which hurt them;
 - c. Show that persons with disabilities can and do contribute to society.
2. They should do this by:
 - a. Campaigning to make people think positively about disability.
 - b. Teaching children and adults the importance of respecting the rights of people with disabilities.
 - c. Encouraging the media to talk positively and in a respectful way about people with disabilities.
 - d. Supporting other awareness-raising programmes.

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.
- 1. To make it possible for people with disabilities to be with others in society and to do the same activities as others, countries should give them access to transport, information, buildings, services and any other service or item to allow this. Countries should also remove all the obstacles that make it difficult for people to be with others in society.
- 2. They should do this by:
 - a. Making rules to make public buildings and services accessible to people with disabilities;
 - b. Making sure that building and services offered by private companies (or other private organizations) are accessible to people with disabilities;
 - c. Training people on accessibility;
 - d. Writing signs in public buildings in Braille and in simple language or form so that everybody can understand;
 - e. Making persons available to guide people with disabilities in public buildings, for example guides, readers and people who can translate sign language;
 - f. Promoting other forms of assistance;
 - g. Making sure that people with disabilities have access to new technology like internet;
 - h. Supporting the creation of technology and tools which are already accessible to everybody so that people can buy them at a low price.

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.

Everybody has the right to life. Countries must make sure that people with disabilities enjoy this right like everybody else.

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.

Countries must make sure that people with disabilities are properly protected during dangerous situations like wars and natural disasters (for example, hurricanes, earthquakes, floods, etc.).

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.
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1. The law must recognize that people with disabilities are human beings with rights and responsibilities like anyone else.
 2. People with disabilities have the same rights as everybody else and must be able use them. People with disabilities must be able to act under the law which means they can engage in transactions and create, modify or end legal relationships. They can make their own decisions and others must respect their decisions.
 3. When it is hard for people with disabilities to make decisions on their own, they have the right to receive support to help them make decisions.
 4. When people receive support to make decisions, they must be protected possible against abuse. Also:
 - The support that the person receives should respect the rights of the person and what the person wants;
 - It should not be in the interests of or benefit others;
 - The persons providing support should not try to influence the person to make decisions they do not want to make.

- There should be enough support for what the person needs;
 - The support should be as short as possible;
 - It should be checked regularly by an authority which can be trusted.
5. Countries must protect the equal rights of people with disabilities:
- To have or be given property;
 - To control their money;
 - To borrow money; and
 - Not to have their homes or money taken away from them.

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.
1. People with disabilities have the same rights to go to court, take other people to court or take part in what happens in courts as anyone else. People with disabilities should have support to make sure they can access justice.
 2. Countries should train people working in courts and tribunals and also police and prison staff so they can help people with disabilities to access justice.

Article 14 - Liberty and security of 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.
1. People with disabilities have the right:
 - a. To be free like other people. The law must protect their freedom.
 - b. Not to be detained or imprisoned because they have a disability.

2. If people with disabilities are imprisoned, they must be protected by international human rights law and treated in a way that respects the objectives and principles of this Convention.

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.
-
1. People with disabilities must not be tortured or treated cruelly. They cannot be experimented on by doctors or scientists unless they freely agree.
 2. Countries should do everything possible to make sure that people with disabilities are not tortured or treated cruelly.

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 care partners, 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.

1. Countries must make laws and rules to make sure that people with disabilities are protected within and outside their home from violence, and from being exploited or abused.
2. Countries must prevent abuse by giving support, information and training to persons with disabilities, their families and care partners. Everybody should learn how to avoid, recognize and report violence and abuse. They should make sure that support for preventing abuse takes into account women, older persons, children and persons with different kinds of disabilities.
3. Countries must make sure that services that support people with disabilities are properly checked by an independent body.
4. Countries must make sure that people with disabilities who have been abused get the help and support they need to keep them safe and help them recover from the abuse.
5. Countries must make sure they create laws and policies (including ones that focus on women and children) to effectively find out if abuses are occurring, to investigate these and take abusers to court.

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.

People with disability should have their body and mind respected. Nobody should hurt their body and mind.

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.
1. People with disabilities have the right to move around, to choose where to live and to have a country. Countries should make sure that:
 - a. People with disabilities have a right to a nationality and they can decide to change their nationality if they want. They must not be refused to have a nationality for unjust reasons or because they have a disability;
 - b. People with disabilities have the right to have identity papers, like passports, and to use them. They must have access to procedures for immigration;
 - c. They must be able to leave any country including their own;
 - d. They must not be unjustly stopped from coming back to their own country.
2. Children with disabilities have the right to be registered at birth and to have a name, to have a nationality, and if possible, to know their parents and be cared for by them.

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.

People with disabilities have the right to live like other people and to have the same choices in life. Countries should make sure that people with disabilities:

- a. Can choose where to live and with who. They should not be forced to live somewhere if they do not want to;
- b. Have access to a lot of different community services so they can live with others in the community. They should not live in places that isolate them or keep them away from their community;
- c. Have access to the same community services as all other people.

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.

Countries should make sure that people with disabilities can get about as much as possible. They do this by:

- a. Helping people to get about when and how they want and for a low price;
- b. Helping people get good and cheap aids, tools and support for their mobility;
- c. Training people on mobility skills (e.g. how to get from place to place with ease, speed, safely and efficiently);
- d. Encouraging companies which make mobility aids to think about all different needs of people 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.

People with disabilities have the right to say and think what they want. They also have the right to receive and give information. To do this they can use different forms of communication. Countries must respect this right by:

- a. Making sure that information is given in a way that people with disabilities can understand;
- b. Making sure that people can communicate with officials, for example in sign languages, Braille and other ways;
- c. Telling people working in the private sector to make their information accessible to people with disabilities;
- d. Encouraging the media, including the Internet, to make their service accessible to persons with disabilities;
- e. Recognizing and encouraging 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.
- 1. People with disabilities have the right to have a private life, a family and a home. They also have the right to private correspondence like phone calls, letter or email. Nobody should attack their honour and reputation. This should be respected no matter where they live. The law should protect this right.
 - 2. Countries should make sure that personal information about people with disabilities is kept confidential as is done for other people.

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.
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1. People with disabilities have the right to marry, have a family, be parents and have relationships on an equal basis with others.
 - a. People with disabilities have equal rights to get married and start a family as long as both members of the couple want to.
 - b. People with disabilities have a right to decide how many and when to have children. They should receive information about having children.
 - c. People with disabilities should not be prevented from having children, for example by sterilization.
 2. People with disabilities have the same rights and responsibilities as others concerning adoption. Countries must support people with disabilities to bring up their children if they need support.
 3. Countries should protect children with disabilities from being concealed, abandoned, neglected or kept apart from society, by giving support and information to their families.
 4. Countries should make sure children are not taken away from their parents because they have, or their parents have a disability. When a child is taken away from its parents, the law must make sure this is fair and for the good of the child.
 5. When parents cannot take care of a child with a disability, the child should stay with other family members. When this is not possible, the child should live 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.

1. People with disabilities have the right to education like others. Countries should make sure the education system accept them and that they can learn all their lives so that:
 - a. They can develop their skills and abilities and be accepted and valued in the world;
 - b. They can develop their personality, creativity, talent and other abilities;
 - c. They can do activities with and for others.
2. Countries should make sure that:
 - a. They are not excluded from (kept out of) mainstream education. Children with disabilities must be allowed to go to mainstream primary and secondary schools;
 - b. They must be able to go to inclusive, good and free schools close to home, like other people;
 - c. Schools and universities must make changes to their environment so that children and adults with disabilities can access them;
 - d. People with disabilities must get the support they need to learn;
 - e. The support must be adapted to each person.
3. Countries need to make sure that people with disabilities are able to learn life and social development skills to make sure they can live and participate in society and the life of their community on the same basis as all other people. In order to achieve this, countries must encourage people to learn all the different ways that people with disabilities can use to communicate.
4. Countries must employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille. They must also train people who work in the area of education to learn skills and techniques which will help them to support people with disabilities in getting their education.
5. Countries must make sure that people with disabilities can have access to educational opportunities after they have completed primary and secondary school, including training that is needed in order to get jobs, to help them to improve their lives and to strengthen their knowledge and skills.

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.

People with disabilities should have the same chance as others to be in good health. Countries should make sure that people with disabilities access health services. In particular, they must:

- a. Give people with disabilities access, on an equal basis with everybody else, to all types of health services which are of good quality and not expensive;
- b. Make sure people with disabilities get the types of health services they need because of their disability;
- c. Make sure services are close to people's homes even if they live in the countryside;
- d. Make sure health professionals give the same quality of service to people with disabilities as to others. Health professionals must give enough information to people and must get the consent of people with disabilities before they treat. Countries should train doctors, nurses and others to make sure that they treat people with disability with respect;
- e. Make sure people with disabilities are not discriminated against in health and life insurance and that they have access to these insurances on an equal basis with other people;
- f. Make sure people are not refused care, treatment or food and fluids.

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.
-
1. Countries should make sure people with disabilities can lead an independent and good life. They must provide them with habilitation and rehabilitation in the areas of health, work, education and social services in order to make this happen.
 - a. Countries must make sure that they look at people with disabilities' needs and strengths at an early stage so that people with disabilities can get the supports and services they need.
 - b. These services must help people with disabilities to be included in society, to live with others and do the same activities as others. These services must be voluntary, and must be close to where people live even if they live in the countryside.
 2. Countries need to train habilitation and rehabilitation professionals to provide these services for people with disabilities.
 3. Countries need to make sure people with disabilities get different aids and equipment to live in the community.

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.
1. People with disabilities have a right to work, like other people. They have the right to earn money and choose their job. Countries must make sure that the right to work of people with disabilities is respected. This includes:
- a. Not allowing discrimination (i.e. making sure people with disabilities have equal job rights, rules, pay and opportunities);
 - b. Making sure people with disabilities have good and safe working conditions, that they have equal chances at getting jobs and equal pay and that they are not abused at work;
 - c. Making sure people with disabilities have a right to join a trade union like others;
 - d. Making sure people with disabilities can go on work programmes and work training;
 - e. Helping people with disabilities to find and keep jobs as well as get better jobs;
 - f. Helping people with disabilities set up their own businesses;

- g. Giving people with disabilities jobs in the public sector (public sector jobs for example, include government jobs in public schools and universities, in the police force, in public health services etc.);
 - h. Helping companies to give jobs to people with disabilities;
 - i. Making sure people with disabilities get reasonable accommodation in the workplace;
 - j. Helping people with disabilities to get work experience by spending a short period in a workplace to learn what it is like to do that kind of work;
 - k. Helping people with disabilities get a job, get back to work and retain their work through different programmes, supports and services.
2. Countries must make sure that people with disabilities are not forced to do unpaid work.

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.
-
- 1. People with disabilities have an equal right to a satisfactory and acceptable standard of living/living conditions for them and their families. This includes food, clothing, housing and clean water.
 - 2. People with disabilities have the right to be protected by the state from poverty and bad living conditions. Countries should:
 - a. Give people with disabilities access to clean water and services and aids for their disability, at a price they can afford.

- b. Make sure people with disabilities, especially girls and women and older people, get help to have better living conditions.
- c. Make sure people with disabilities who are poor get help from the state to buy the things they need because of their disability.
- d. Make sure people with disabilities have access to public housing programmes.
- e. Make sure people with disabilities get retirement pensions as other people.

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.

Countries must make sure that people with disabilities are able to take part in politics on the same basis as everybody else. In order to ensure this, countries must:

- a. Take action to make sure that people with disabilities are able to participate in political life, including to vote and to be elected.

This includes:

- i. Making sure voting is easy and understandable to people with disabilities.
 - ii. Making sure voting is secret and free. They must also make sure that people with disabilities can stand for election and become public officials.
 - iii. Allowing people with disabilities to choose someone to help them with voting if they want to.
- b. Encourage the participation of people with disabilities in public affairs. This means that:
- i. People with disabilities have the right to join nongovernmental organizations and associations.
 - ii. They have the right to create and join organizations of persons with disabilities.

Article 30 - Participation in cultural life, recreation, leisure and sports

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.
1. People with disabilities have the right to take part in cultural life like other people. This means that:
 - a. Cultural materials, like books, are accessible.
 - b. Television, films and theatres and other activities are made available in formats that are accessible to people with disabilities.
 - c. People with disabilities can access places like theaters, museums, cinemas, libraries and touristic sites.
 2. People with disabilities should be supported to express their creative, artistic and intellectual skills.
 3. Countries should make sure that the rights of authors on their work do not prevent people with disabilities to access material.
 4. The language and culture of people with disabilities should be respected; this includes sign language and deaf cultures.
 5. People with disabilities have the right to have fun and take part in sports and leisure activities. Countries must:
 - a. Encourage people with disabilities to access mainstream sporting activities;
 - b. Make sure people with disabilities can create and participate in sporting and recreational activities specific to their disabilities;
 - c. Make sure that persons with disabilities have access to sporting, recreational and tourist places and events;
 - d. Make sure children with disabilities have equal access to all these activities, including at school;
 - e. Make sure that people working in the areas of recreation, tourism, leisure and sport can help people with disabilities.

Annex 2: Identifying sensitivities and signs of distress

3,4,5,6

My sensitivities

To manage your ups and downs the first thing to do is to identify your sensitivities. Sensitivities are **things that happen – external events or circumstances – that may cause you to feel anxious, scared, miserable or discouraged**. The table below shows some examples of common triggers, and actions to be taken to stay well when those sensitivities occur:

My sensitivities
What to do

³ Personal recovery plan. Nottingham: Nottinghamshire National Health Service (NHS) Trust.

⁴ Taking back control: a guide to planning your own recovery. Nottingham: Nottinghamshire National Health Service (NHS) Trust; 2008.

⁵ Copeland ME. WRAP – Wellness Recovery Action Recovery Plan®. USA: US Peach Press; 2011.

⁶ Advance statement. Nottingham: Nottinghamshire National Health Service (NHS) Trust; 2008.
(<https://www.nottinghamshirehealthcare.nhs.uk/download.cfm?doc=docm93jjm4n1799.pdf&ver=1845>., accessed 9 February 2017).

My signs of distress

Signs of distress are **changes in your feelings, thoughts or behaviour that suggest things are not quite right**. These signs are important because, if you recognize them and take action early, you may be able to prevent a crisis occurring. List your signs of distress in the box below.

My signs of distress
What to do

The World Health Organization's QualityRights training and guidance modules focus on the knowledge and skills required to provide good quality mental health and social services and supports and to promote the rights of people with psychosocial, intellectual or cognitive disabilities.

Through exercises, presentations, case scenarios, extensive discussions and debates, the **QualityRights training modules** unpack some critical challenges that stakeholders are facing in countries everywhere. For instance:

- How do we respect people's will and preference, even in challenging situations?
- How do we ensure people's safety and at the same time respect each person's right to decide about their treatment, their life and their destiny?
- How do we end seclusion and restraint?
- How does a supported decision-making approach work if someone is unable to communicate their wishes?

The **QualityRights guidance modules** complement the training materials. The guidance modules on *Civil Society Organizations* and on *Advocacy* provide step-by-step guidance on how civil society movements in countries can take action to advocate for human rights-based approaches in the mental health and social sectors in order to achieve impactful and durable change. The guidance modules on *One-to-one peer support* and on *Peer support groups* provide concrete guidance on how to effectively set up and run these critical but often overlooked services.

The ultimate goal of the WHO QualityRights modules is to change mindsets and practices in a sustainable way and empower all stakeholders to promote rights and recovery in order to improve the lives of people with psychosocial, intellectual or cognitive disabilities everywhere.



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