

An Experiential report and Critical appraisal of the WHO QualityRights e-Training on Mental Health, Recovery and Community Inclusion

Akhila Kallanja¹, N Vyjayanthi Venkataramu², and Murali Thyloth³

¹Junior Resident, Department of Psychiatry, Ramaiah Medical college, ²Assistant Professor, Department of Psychiatry, Ramaiah Medical College, ³Professor, Department of Psychiatry, Ramaiah Medical College, India; Immediate Past President WAPR (muralithyloth@gmail.com)

Psychiatry is no stranger to coercion and “treatments” so ghastly and terrifying that even reading about their descriptions sends chills down our spines. It’s a relief that the era of lobotomies and unmodified electroconvulsive therapies are only a part of the textbooks, and current psychiatric practices are much more advanced and humane. However, we cannot ignore that involuntary admissions, restraints, and forceful sedation are still a part of our modern psychiatric practice in many parts of the world. It’s the need of the hour that mental health professionals identify, address, and enforce the need for a person-centric and rights-based approach.

Along those lines, the World Health Organization (WHO) has recognized and prioritized the importance of protecting human rights globally to prevent individuals from experiencing inequality, injustice, and cruelty. In particular, WHO has identified various marginalized populations where the principles of human rights are of utmost significance, and among them are people living with mental illness. As all are aware, individuals with mental illness face a higher risk of abuse, violence, and inhuman treatment. The rights of people with mental illness are often neglected or compromised by caregivers and teams of mental health professionals. Given the existing lapses in protecting the rights of those living with mental illness, the WHO has initiated a globally accessible course aimed at enhancing the understanding of the quality rights of people with mental illness. This course is available free of charge, can be accessed by anyone, and covers various aspects related to the rights of people with mental illness.

The course is available on the website and is titled “WHO QualityRights E-training on Mental Health, Recovery, and Community Inclusion.” It is an asynchronous online course available in 11 languages. The course aims to change the attitudes and practices of all stakeholders involved in the care of persons with mental illnesses, including the persons themselves. It addresses issues related to discrimination and stigma, and promotes a person-centric and rights-based approach. Additionally, the course talks about normalization and reintegration into the community and empowers people with mental illness. The course takes approximately 8 to 15 hours to complete. After completing the course, participants receive a digital certificate as an acknowledgment from the WHO.

The course was launched in April 2022 and targets 5 million people to have completed this course by 2024. As mentioned in the recent flyer, around 60,000 people have completed this course in the last year. In this article, we aim to highlight the positive aspects and identify some of areas that could benefit from further improvement based on the experiences of authors who themselves have undergone the course. The training program has several positive aspects to it. The course content is comprehensive and easily comprehensible. The course covers all aspects of the rights of persons with mental illness. The training encourages the participants to reflect on the existing practices and rights violations occurring in mental health services and provide guidance to more humane approaches. It also strongly emphasizes the advantages of a rights-based approach and how this positively affects the prognosis, compliance, and overall quality of life of the individual. The majority of the questions in the course are based on case vignettes that represent various real-life scenarios that require a conceptual understanding and interpretation of the course material. The questions have detailed explanations and key points regarding the concepts relevant to the question.

The training successfully impresses upon the participants that people with mental illness or any disability are to have the same dignity, respect, and opportunities just as any other individual in the community.

There is no literature published on the effectiveness of the module, ground-level changes in care providers and policymakers, or the impact of the rights-based approach. The below mentioned are the after-thoughts the authors had on the course. The course is purely online and makes it easily accessible, flexible, and choice of the individual, however, we have observed over time that online training programs do not have the same level of impact as face-to-face training (1). Also, the effectiveness of online training programs greatly depends on the interest and motivation of the participant (2).

There are various factors to understand why the number of registrations/completions might be low, and further people who have registered and initiated the training but have not completed the entire course.

Firstly, we would like to focus on the length of the course, the course overall takes 8 to 15 hours long which might be difficult to most people to complete in one sitting, and may eventually forget when they are engrossed in their busy lives. One solution for this could be that the course has a basic and advanced level. The basic level could touch upon various topics briefly within 60-90 minutes and those interested to learn further can take up the advanced level course.

Secondly, some of the topics covered are relevant to mental health professionals and policymakers, the same content might not appeal to persons with mental illness and their loved ones. The course content creators can focus on dividing the topics based on relevance to the above-mentioned categories.

Thirdly, some questions asked at the end of modules are based on factual and historical aspects, this requires memorizing. The questions could instead focus more on a conceptual understanding of Quality rights.

Fourthly, the current training format is predominantly animation with background narration, this might be difficult for people to stay focused throughout. The content creators can work on, having an expert explain the concepts which will make it more engaging and also have a component of “face-to-face” interaction.

The fifth point the authors would like to discuss is the level of difficulty of the English language used for the questions. Some questions rely heavily on semantics and minor differences in meaning, for instance one question in the second module asks if a man in the given vignette is “respecting” or “protecting” or “fulfilling” the rights of the disabled person. While these words might seem reasonably distinct to a native English speaker, they appear quite similar to a person with average English proficiency. It could be helpful to reframe the questions in a simpler manner, considering the varying levels of English proficiency among people in developing countries.

In the next section, we would like to explore the cultural aspects of psychiatric care. The course content is based predominantly on the culture of the West/developed countries. Here the need for autonomy, and decision-making rights for treatment and legal decisions is based purely on a rights-based approach and the nominated representative has a role only in cases where the individual has diminished capacity. However, the culture in the East and developing countries seem to be greatly different. Here the families play a huge role in identifying those with mental health issues, bringing them for appropriate care, staying as caregivers in the hospital, and also playing a huge role in ensuring compliance to medications and reintegration into society. The rights-based approach here is very ambiguous and usually more collaborative than individualistic. We urge the team to focus on these nuances and focus on some core cultural factors which enhance care, develop better rapport, and still uphold the rights of an individual. As families' involvement in making decisions is expected and generally accepted, the affected individuals do not view this as a traumatic assault on their autonomy. Research indicates that outcomes of psychotic illnesses are better in developing nations like India as compared to developed nations (3). One of the factors contributing is the close involvement of family(4). Additionally, some cultures have a paternalistic doctor-patient relationship, not providing direction/advice

usually is not construed positively. We hence urge the World Health Organization to consider these subtle but significant cultural differences while formulating the curriculum for their universal rights training program.

The training program also emphasizes the need for idealistic institutional practices that are rights oriented, providing an adequately spaced physical environment, the food and water supply, need for freedom, and also emphasizes the need for social interaction and a sense of belonging to the community. These are important and need to be enforced to the maximum extent possible. However, certain situations necessitate physical or chemical restraint, usually when the individual's capacity diminishes and judgment is impaired. It would be more apt if this could be incorporated into the training program as a last resort to prevent harm to self or others and promote early recovery. The training program provides a negative attitude towards having specific fixed schedules and reinforcing techniques. However, through decades of learning, providing an activity schedule acceptable to the individual and using positive/negative reinforcement has been found to improve functionality, recovery, and integration into the community a seamless journey. Additionally, these techniques have a positive correlation with cognitive outcomes in persons with mental illness (7, 8). Therefore, the authors opine that shared decision-making and enforcement of structured activity is justified.

Finally, we greatly appreciate the initiative and acknowledge that the quality rights training program has an immense impact on educating and empowering the rights of people living with mental illness. The only large-scale Indian study based on the WHO rights training 2013 done by S Pathare (9) in the Indian state of Gujarat shows positive results. The authors urge the WHO QualityRights team to consider the feedback by the authors to make the program more successful.

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