QualityRights

Implementing improvement plans for service change

WHO QualityRights training to act, unite and empower for mental health

(PILOT VERSION)

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What is the WHO QualityRights initiative?

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

1. Build capacity to understand and promote human rights, recovery and independent living in the community.
2. Create community based and recovery oriented services that respect and promote human rights.
3. Improve the quality of care and human rights conditions in inpatient, outpatient and community based mental health and related services.
4. Develop a civil society movement to conduct advocacy and influence policy-making to promote human rights.
5. Reform national policies and legislation in line with best practice, the CRPD and other international human rights standards.

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

WHO QualityRights - Guidance and training tools

The following guidance and training tools are available as part of the WHO QualityRights initiative:

Service assessment and improvement tools

- **The WHO QualityRights Assessment Tool Kit**
- **Implementing improvement plans for service change** ←

Training tools

Core modules

- **Understanding human rights**
- **Promoting human rights in mental health**
- **Improving mental health and related service environments and promoting community inclusion**
- **Realising recovery and the right to health in mental health and related services**
- **Protecting the right to legal capacity in mental health and related services**
- **Creating mental health and related services free from coercion, violence and abuse**

Advanced modules

- **Realising supported decision making and advance planning**
- **Strategies to end the use of seclusion, restraint and other coercive practices**
- **Promoting recovery in mental health and related services**
- **Promoting recovery in mental health and related services: handbook for personal use and teaching**

Guidance tools

- **Providing individualized peer support in mental health and related areas**
- **Creating peer support groups in mental health and related areas**
- **Setting up and operating a civil society organization in mental health and related areas**
- **Advocacy actions to promote human rights in mental health and related areas**
- **Putting in place policy and procedures for mental health and related services (in preparation)**
- **Developing national and state-level policy and legislation in mental health and related areas (in preparation)**
- **Guidance on CRPD compliant community-based services and supports in mental health and related areas (in preparation)**

About this training and guidance

This module has been developed to provide training and guidance to improve the quality of care and human rights conditions in inpatient, outpatient and community based mental health and related services, following the conduct of a comprehensive assessment using the WHO QualityRights assessment toolkit.

Who is this training workshop 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 related services**
- **Managers of general health, mental health and related services**
- **Mental health and other practitioners** (e.g. doctors, nurses, psychiatrists, psychiatric nurses, neurologists, geriatricians, psychologists, occupational therapists, social workers, peers supporters and volunteers)
- **Other staff working in or delivering mental health and related services** (e.g. attendants, cleaning, cooking, maintenance staff)
- **Non-Governmental Organizations (NGOs), associations and faith-based organizations working in the area of mental health, human rights or other relevant areas** (e.g. Organizations of Persons with Disabilities (DPOs); Organization of users/survivors of psychiatry, Advocacy Organizations)
- **Families, care partners and others support people**
- **Other government institutions and services** (e.g. the police, the judiciary, prison staff, law reform commissions, disability councils and national human rights institutions)
- **Other relevant organizations and stakeholders** (e.g. advocates, lawyers and legal aid organizations)

Who should deliver the training?

Training should be delivered by a multi-disciplinary team including people with psychosocial, intellectual and cognitive disabilities, DPOs, professionals working in the area of mental health and related services, families and others with lived and/or professional experience in the area of mental health

The team conducting the training may differ depending on focus. For example, if the training is about addressing the rights of people with a psychosocial disability, it would be more important to have representatives from that group as leads to delivering the training rather than people with dementia, intellectual disabilities, autism or others and vice versa. However, nothing precludes the possibility of having multiple groups leading the training.

Guidance for facilitators

Principles for running the training programme

Participation and interaction

Participation and interaction are crucial to the success of the training. By providing sufficient space and time, the facilitator must first and foremost make sure that the people who are using mental health and related services are being listened to and included. Certain power dynamics within services might make some people reluctant to express their views. In general, the facilitator must emphasize the importance of including the views of all participants.

Some people may feel quite shy and not express themselves. Facilitators should make sure to encourage and engage everyone. Usually, after people have expressed themselves once, they are more able and willing to speak and engage in ongoing discussions. The training is a shared learning experience.

Facilitators are expected to engage participants in a way that draws on the experience and knowledge already existing within the group participating in the training. They will need to supervise and monitor the dynamics and discussions among participants.

Cultural sensitivity

Facilitators should be mindful of using culturally sensitive language and providing examples relevant to people living in the country or region where the training is taking place. In addition, facilitators should make sure that the specific 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 when carrying out the training.

Open, non-judgmental 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 the situation within the service, organisation or association, not to name and blame individuals for their particular conduct in the past. Facilitators should ensure that during the training, no-one is targeted in a way that makes them feel uncomfortable (e.g. attributing the blame to staff or families, etc.). Facilitators should avoid interrupting participants. It is not necessary to agree with people to effectively communicate with them. It may be necessary to withhold criticisms in order to fully understand a person's perspective.

Use of language

In addition, facilitators should be mindful of the diversity of the audience. People participating 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. avoiding the use of highly specialised medical, legalistic and technical terms, acronyms, etc.) and to ensure that all participants understand the key concepts and messages. With this in mind, facilitators should pause, take the time to ask and discuss questions with participants to ensure that concepts and messages are properly understood.

Operating in the current legislature and policy context

During the training, some participants may express concerns about the legislative or policy context in their countries. Indeed, some of the content may contradict national legislation or policy. For example, the topic on supported decision making may appear to conflict with existing national guardianship laws. Similarly, laws that provide for involuntary detention and treatment contradict

the overall approach of these modules. This can raise issues and concerns, particularly around professional liability.

First, facilitators should reassure participants that the modules are not intended to encourage practices which conflict with the requirements of the law. When the law and policy contradict the standards of the CRPD it is important to advocate for policy change and law reform. In this context it is also necessary to acknowledge that it will not happen immediately. However, 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. For example, even if guardians are officially mandated to make decisions on people's behalf based on a countries law, this does not prevent them from supporting people in reaching their own decisions and from ultimately respecting their choices. In this way, they will be making important strides towards implementing a supported decision making approach.

Throughout the training, facilitators should encourage participants to discuss how the new paradigms, actions and strategies promoted in the training materials can be implemented within the parameters of existing policy and law frameworks. Hopefully, the shift in attitudes and practices, along with effective advocacy, will lead to change in policy and law reform.

Being positive and inspiring

Facilitators should emphasise that the training is not about lecturing people or telling people what to do but to give them the basic knowledge and tools to find solutions for themselves. Most likely many participants already carry out many positives actions. It is possible to build on these to demonstrate that everybody can be an actor for change.

Group work

Throughout the exercises of the training, the facilitator needs to assess carefully whether participants will benefit from being placed in separate groups or in mixed groups that include both people who are using the service, staff, and family and care partners. As noted earlier, feelings of disempowerment, hesitation and fear, which can arise in mixed groups if participants do not feel comfortable in that setting, should be taken into account. Exercises are based on participation and discussion and should allow participants to reach solutions by themselves. The facilitators' role is to guide plenary discussions and when appropriate, prompt with specific ideas or challenges to facilitate the discussion.

Facilitator notes

The training modules incorporate 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 intended to be read out to participants are written in **black.**

Preliminary note on language

We acknowledge that language and terminology reflects the evolving conceptualisation of disability and that different terms will be used by different people across contexts over time. People must be able to decide on the words that others use to describe them. It is an individual choice to self-identify or not, but human rights still apply to everyone, everywhere.

Above all, a diagnosis or disability should never define a person because we are all individuals, with a unique personality, autonomy, dreams, goals and aspirations and relationships to others.

The choice of terminology adopted in this document has been selected for the sake of inclusiveness.

The term psychosocial disability includes 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 people's full and effective participation in society.

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

In relation to mental health, some people prefer using expressions 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 stigmatising.

In addition, the use of the term "mental health and related services" in these modules refers to a wide range of services including for example, community mental health centres, primary care clinics, outpatient care provided by general hospitals, psychiatric hospitals, psychiatric wards in general hospitals, rehabilitation centres, day care centres, orphanages, homes for older people, memory clinics, homes for children and other 'group' homes, as well as home-based services and supports provided by a wide range of health and social care providers within public, private and non-governmental sectors.

Learning objectives, topics and resources

Learning objectives

Participants will:

- Gain an in-depth knowledge of the results from the QualityRights assessment that has taken place in the mental health or related service;
- Understand how the results of the QualityRights assessment apply to all 5 themes within the QualityRights tool kit that have been covered in previous modules;
- Have space to discuss the results of the QualityRights assessment, the reasons for the results as well as their implications for the future of the service;
- As a group identify priority areas for action based on the QualityRights assessment results;
- Develop the skills needed to collaboratively develop and implement an improvement plan.

Topics

Topic 1: Understanding the quality and human rights conditions of mental health and related services

Topic 2: Defining a shared vision for the service

Topic 3: Service culture and change

Topic 4: Specific priorities for change in the service based on the QualityRights assessment tool kit

Topic 5: From problems to solutions and from action to impact

Topic 6: Moving forward

Resources required

To optimise 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 intimate environment conducive to free and open discussions
- Flexible, in terms of enabling the change of seating arrangements (for example movable seats so that people can get into groups for group discussions)

Additional resources needed include:

- Internet access in the room, in order to show videos
- Loud speakers for the video audio
- Projector screen and projector equipment
- 1 or more microphones for facilitator(s) and at least 3 additional wireless microphones for participants
- At least 2 flip charts or similar and paper and pens
- Presentation slides, **prepared in advance by the facilitator**, outlining the QualityRights assessment report for the service (See QualityRights assessment tool kit for further details about the assessment)
- Copies of the QualityRights assessment report
- Hard copies of the presentation *Moving from problems to solutions* in Topic 5 for each participant
- Copies of Annexes 1-7 and extra copies of Annex 7 for all participants

Time

16 hours

Number of participants

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

Actions required before training

Prior to conducting the training, it is important that the following actions have been taken:

- Directly involve senior management and make sure to have their endorsement and support
- Discuss QualityRights assessment findings with service management and the next steps to be taken
- Emphasize the importance of their support and how improvements will benefit everyone
- Emphasize that the assessment, improvement plans and follow-up actions are not being conducted to blame people, but to allow everyone to work together to improve the situation
- Ensure that all relevant stakeholders are invited for the training and actively involved in the implementation process and various working groups

Welcome and Introduction

Give participants an opportunity to explain their own background and their expectations for the day (if relevant). **(10 min)**

⚠ **Trigger warning**: It is important to highlight at the start of the training that this module may provoke difficult emotions for people who may have been through traumatic experiences of non-recovery approaches. Moreover, mental health and other practitioners may feel that they have been responsible for preventing recovery despite good intentions.

Facilitators should be mindful of this and let participants know that they should feel free to step out of the training session if they need to until they feel able to participate again (please refer to *Guidance for facilitators* for more information).

Topic 1: Understanding the quality and human rights conditions of mental health and related services

Presentation: Recap the 5 themes within the QualityRights assessment tool kit (30 min.)

Remind the group that the QualityRights assessment has measured service performance against these themes. The first presentation introduces the 5 themes within the QualityRights assessment tool kit (1).

The five themes in QualityRights are:

1. The right to an adequate standard of living
2. The right to the enjoyment of the highest attainable standard of physical and mental health
3. The right to exercise legal capacity and the right to personal liberty and security of person
4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse
5. The right to live independently and be included in the community

What is the purpose of the QualityRights assessment tool kit?

- The QualityRights assessment tool kit is designed to support countries (and services) in assessing and improving the quality of mental health and related services and their compliance with international human rights standards.

- The assessment is a means through which services can identify and end poor quality care and human rights violations.

- The themes in the tool kit are based on the Convention on the Rights of Persons with Disabilities (CRPD) which is a legally binding treaty that outlines the rights that should be respected, protected and fulfilled for all people with disabilities, including people with psychosocial, intellectual and cognitive disabilities.

- The QualityRights assessment tool kit is not about promoting institutions or fixing them. Large mental health and related services, institutions or hospitals which are isolated and unconnected to the community should be closed and replaced with a network of services based in the community. At the same time, we should never abandon people in institutions during the transition to community based services – in other words, we need to make sure that *their* rights are not being violated during this transition phase.

So what do the themes of the QualityRights assessment tool kit cover?

<u>Theme 1: Adequate standard of living and social protection</u>

Theme 1 looks at the degree to which:

- People in acute or longer term care services have appropriate and comfortable living conditions.
- People have the fundamental necessities required to live a good life, such as clean water, food, heating, clothes, as well as privacy and appropriate bedding.

- People have opportunities to communicate and be engaged with the outside world during their period of stay.

    - The CRPD requires that people with psychosocial, intellectual and cognitive disabilities are provided with an adequate standard of living and protection of their social wellbeing.

Theme 2: Enjoyment of the highest attainable standard of physical and mental health

Theme 2 looks at the degree to which:

- People have access to the mental health care they require.
- People have access to physical health care (especially physical health care as this is often disregarded by health/mental health staff).
- There is a focus on supporting people to recover their life and be included in their community.

    - The CRPD requires that people with psychosocial, intellectual and cognitive disabilities be provided with the health services they may need and that they have access to the same range, quality and standard of free or affordable health care.

Theme 3: The right to exercise legal capacity and the right to personal liberty and security of person

Theme 3 looks at the degree to which:

- People with psychosocial, intellectual and cognitive disabilities are supported to make decisions about their own lives, such as where to live or which medical treatment to seek (as they have legal capacity).
- These decisions are not made by their families or health/mental health staff.

    - The CRPD requires that people with psychosocial, intellectual and cognitive disabilities be recognized as a person before the law who have the right to exercise their legal capacity and remain at the centre when making decisions which affect their lives.

    - In order to do this, they must be given access to supported decision making processes, including the right to involve trusted people who can support them in this process.

    - Legal capacity cannot be denied on the basis of a psychosocial, intellectual disability or cognitive disability. This means that people with psychosocial, intellectual and cognitive disabilities all around the world must be allowed to exercise this right on an equal basis with all others in every aspect of their life.

Theme 4: Freedom from torture or cruel, inhumane or degrading treatment or punishment and from exploitation, violence and abuse

Theme 4 looks at the degree to which:

- People are protected from physical, sexual and mental abuse.
- Practices of seclusion, physical, mechanical or chemical restraint are stopped, since these practices are not consistent with the prohibition of torture according to the CRPD.

    - The CRPD requires that all appropriate measures be taken to prevent violence, coercion and abuse from happening.

Theme 5: The right to live independently and be included in the community

Theme 5 looks at the degree to which:

- People with psychosocial, intellectual and cognitive disabilities are supported to live independently and to be full members of their community.
- Mental health and related services facilitate access to community groups, income-generating activities, housing, eligible pensions, leisure activities, and social services.

    - The CRPD states that people with psychosocial, intellectual and cognitive disabilities have the right to decide where they live and to be included in their community to prevent isolation or segregation.

Exercise 1.1: Reflecting on areas for improvement (30 min.)

The purpose of this exercise is to encourage participants in advance to identify the key challenges that will be outlined in this report.

Ask participants to split into groups of five. Each group will be asked to consider this reflective question for one of the five themes in QualityRights assessment tool kit.

This may facilitate a more positive attitude to the report when it is delivered, as it is not just a "lecture from an outsider" but a set of recommendations that they too identify with. Additional recommendations that evolve from discussions, not contained within the QualityRights assessment tool kit, may be included at the facilitator's discretion.

The rationale for splitting into groups that deal with each of the themes is to ensure that all 5 themes are given consideration from the very beginning.

Hand out to each participant the full list of themes and standards of the QualityRights assessment tool kit which were used to undertake the service assessment (Appendix 1) and copies of Appendix 2 – Reflecting on areas for improvement. This should be filled out after reflecting on the following question.

Think back to a health service that you have used and identify what was helpful, useful and made a positive difference to your life. Also consider what was neither helpful, nor useful and what would have made your experience a better one.

Based on your own experiences and knowledge of the theme within the QualityRights assessment tool kit, which areas for improvement do you think will be recommended in the assessment report of this service?

If the number of participants is 15 or less, it might be possible for each group to work on more than one theme each.

Presentation: QualityRights assessment for the service (60 min.)

At this point go through your pre-prepared presentation of the QualityRights assessment that was undertaken at the service. All participants should now be provided with a copy of the report summary as part of this session.

- The presentation should outline how the assessment was conducted, with some focus on the constructive preparations made by the service in advance of the assessment.
- It should provide an overview of the content of the assessment report dealing with all 5 thematic areas of the QualityRights assessment.
- It should highlight both positive areas of performance highlighted by the assessment, as well as areas that require improvement. In other words, the presentation should include:
    - One slide with POSITIVE HEADLINES from the assessment.
    - Another with the MOST IMPORTANT AREAS FOR IMPROVEMENT.
- In addition, the presentation should include a slide on POSITIVE STEPS ALREADY TAKEN IN RESPONSE to the assessment.
    - We are aware that these will include smaller actions such as conversations with managers or the preparations made for these training sessions.
- The aim is to create a sense that this assessment can generate a service of pride as well as an opportunity for areas to be improved.

Exercise 1.2: Discussion on the opportunities for improvement (40 min.)

This session is designed to be an open and inclusive space for "initial reactions". This allows for participants to share their own reactions (including negative reactions) to the report prior to being asked to work with the information in a constructive manner.

In plenary, invite participants to discuss their initial reactions to the contents of the report. Make sure to include comments and views from all participants – people using the service, staff, family, care partners and others.

What are your perspectives and feelings about the QualityRights assessment report?

This should be followed by a structured discussion led by the facilitator. Invite general comments from the group and encourage conversations between members of the training workshop.

Now ask the group the following questions:

- How do you feel about the positive areas discussed in the report?
- How do you feel about the negative aspects?
- Do you agree or disagree with the identified areas for improvement?
- Can this information be used to make improvements to how the service supports people?

As facilitator you need to be prepared to potentially answer certain questions at this point on the process of the QualityRights assessment. Any grievances on the process or content of the assessment

can be aired at this stage. Reassurance must be given that there will be space to discuss these further.

Please note that the presence of participants who strongly disagree with the identified areas of improvement might be indicative of a service culture that is reluctant to change. The importance of changing the service culture will be discussed in topic 3. However, if relevant and appropriate, these views can be addressed by the facilitator at this point in time.

Topic 2: Defining core values and a shared vision for the service

Presentation: The importance of having a vision based on core values (10 min.)

- An important part of the service change process is to define a vision based on a set of shared core values for the service that everyone can identify with and commit to.

- The vision should reflect how the service functions and what it aims to achieve, i.e. the overall outcome that the service is working towards. The vision usually sets high expectations for the service and is based upon a set of core values.

- The vision must be understood and shared by all members of the service. It must be broad enough to encompass a variety of perspectives from people who are using the service, staff, managers, family and care partners.

- The vision must be easy to communicate and be inspiring and uplifting in order to motivate all stakeholders within the service, impelling everyone to make their best effort in order to achieve a higher level of mental health and well-being for people.
    - For example, a vision could be "To become a service of excellence that provides holistic, recovery-oriented and high-quality services in the community in order to improve mental health and well-being for everyone".

- Core values should underlie the vision and drive all actions within the service.
    - For example, essential values include: Equality, respect, dignity, trust, confidentiality, well-being, connectedness, community care, shared understanding, participation, recovery, empowerment, hope, protection, compassion, inclusion, open-mindedness, reliability, strengths-focused, person-centred, person-driven, high quality etc.

- The key notion is that everyone in the service agrees about the importance of these core values and actively seeks to uphold these values.

Exercise 2.1: Defining a vision and core values for the service (1 hour and 30 min.)

Defining a vision and a set of core values for the service will create a shared foundation for any future actions within the service and community.

Divide participants into groups of five and explain that they will have 45 minutes to identify a core set of values and vision for their services and write this down in the handout from Appendix 3. Emphasize that there are no right or wrong answers.

Questions to consider when formulating a vision and values include:

- What are the outcomes that you would want for people who visit the service?
- What does this mean for what your service provides?
- What does this mean for how we deliver services?

When considering these questions it can be useful to refer to your completed copy of Appendix 2 in which you identified your own experiences about what makes a good service.

- Let us start with core values which will help also stimulate thinking about the vision.

- What core values do you believe are important for your mental health or related service? Try and describe what these values mean to you and why they are important. Consider the values presented earlier and think of other essential values. Write these down in Appendix 3.

- After writing your group's core values try to formulate a vision statement which describes how you would like to see your service function in the most ideal possible way. This should be in line with all the core values that you have identified. Also document this in Appendix 3.

After the group work, ask each group to present in plenary their 1) set of core values and 2) vision statement or any relevant phrases or themes that can help to build a shared vision statement

The facilitator should list on a flip chart 1) core values and 2) visions statements for the service or any relevant phrases, themes and statements that can be used.

The facilitator then supports the group to collectively define a shared set of values and a shared vision for the service that everyone agrees to uphold and commit to.

Examples of potential responses include:

- **Core values:** Equality, respect, dignity, trust, confidentiality, well-being, connectedness, community care, shared understanding, participation, recovery, empowerment, hope, protection, compassion, inclusion, open-mindedness, reliability, strengths-focused, person-centred, person-driven, high quality etc.
- **Vision statement:** Promoting mental health and well-being for everyone, recovery, reflecting compliance with human rights, upholding the notions of equality, respect and dignity, providing high-quality services etc.

Topic 3: Service culture and change

Presentation: Understanding service culture (40 min.)

This is an opportunity to explain how the service culture of a mental health or related service influences the daily practices and routines of people using the service, the staff and management. Changing service culture is fundamental to any other service reform, and for this reason it is dealt with in depth and at early on in this module.

The aim is to highlight that an unhealthy and degrading service culture leads to unhealthy and degrading actions and vice versa and that strategies are required to change certain cultures that are characterized by the use of seclusion, restraint, violence and coercion that violate human rights.

Refer to the modules *Creating mental health and related services free from coercion, violence and abuse* and *implementing strategies to end seclusion, restraint and other coercive practices in mental health and related services* for more detailed information on this topic.

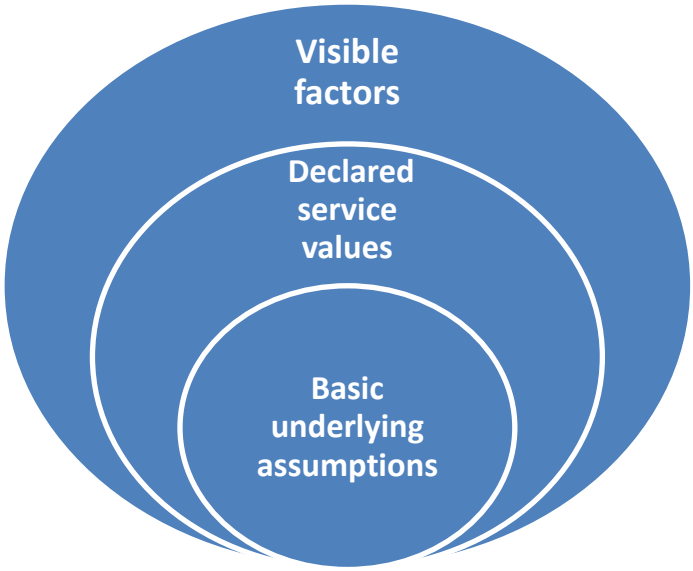
Definition of service culture

Service culture refers to the pattern of shared values, beliefs, rules and practices of the different members of a service.(2) It results from the dynamics between the different groups within the service including people using the service, mental health and other practitioners, management and other relevant people such as family and care partners.

The service culture can take on a life of its own to directly influence the daily practices of staff, people using the service and even of new members entering the service. Unfortunately, the culture is often accepted without reflection by the majority of its members as it is operated instinctively. It defines “the way we do things around here”.(2)

What influences service culture?

Service culture is influenced by artifacts (here referred to as visible factors), espoused beliefs and values (here referred to as declared service values) and basic underlying assumptions.(3) These factors are linked in an “onion” like structure as the figure below illustrates.



Visible factors are structures and signs of the physical, psychological or social environment. Examples include the design of the physical space, observed behaviour and interactions between people (i.e. daily practices and routines), clothing worn, modes of communication between people and the language used, as well as any statement concerning the values of the service including charters, mission statements and formal descriptions of how the service works. Visible factors can be easy to observe, but sometimes their meaning or what they represent is difficult to interpret.

Declared service values are what the service thinks ought to be and can for example equate with a set of core values for the service like the ones that were defined in exercise 2.1. Values are semi-visible and often expressed through written or verbal modes of communication. Declared core values, for example the notion of equality, should influence the daily practices in services, but often this does not necessarily happen in practice. This contradiction occurs when the values held by people in the service are not aligned with the declared service values. Instead practices of people in the service are governed by underlying basic assumptions, for example, of inequality.(4)

Basic underlying assumptions are the foundation of a service's culture and strongly influence the thinking and behaviour of all its members. Often basic underlying assumptions are unconscious, taken-for-granted beliefs, ideas and attitudes which determine behaviour, perceptions, thoughts and feelings.(3) They may be positive and align well with any declared service values or they may be negative and conflict with these. For example, an underlying assumption that people with psychosocial disabilities are incapable of making decisions is a negative underlying assumption that will lead to mental health and other practitioners making all treatment and other decisions for people using the service (*visible factor*). This would then conflict with any declared value statement that the service may have around recovery and the autonomy of people using the services.

Basic underlying assumptions are usually invisible, in that they are not written down anywhere, which makes them difficult to identify and sometimes to understand. For example, staff members may not allow people who are using the service to have lunch in the same room as the staff. Service staff have administrative power and they can implement this practice (*visible factor*). However, the

staff's reasoning for this practice can be difficult to identify, since a number of different scenarios may be governing their decision:

- The practice could be a rule based on the declared values of the service about how things should be done.
- The practice could be an informal practice initiated by staff members that reflects negative underlying basic assumptions of staff members characterized by a notion of inequality between people using the service and staff.
- The practice could be an automatic one which does not reflect any rule based on formally declared values of service nor any basic underlying notions about inequality, but could be an expression of "the way we do things around here" without further critical reflection.

In all three scenarios, no matter what the reason for this practice is, staff may be unaware of the impact of their decision-making in relation to people using the service. However, it is possible to change this rule and similar practices that are not in alignment with declared service values by questioning the *values* and *basic underlying assumptions* of both the service and of all stakeholders.

As this example shows, the culture can be accepted without reflection by the majority of its members as often it is operated instinctively. It defines "the way we do things around here". Changing negative underlying assumptions held by people in the service, declared values held by the service that contribute to stigma and discrimination, and visible factors, including those leading to negative automatic and habitual practices, are required in order to move towards a positive service culture.

As already discussed the culture in the service both leads to and reflects the existing power dynamics within the service. Focused attention is needed to understand these dynamics, the reasons behind and their impact in order to improve or change the culture.

Presentation: Power dynamics in the service culture (30 min.)

The purpose of this presentation is to help participants understand the role and impact of power dynamics within the context of service culture. Power dynamics refer to the nature of the relationships between staff, people using the service and others. Understanding and addressing these dynamics are important steps towards improving the service culture.

What are power dynamics?

Power is the ability to influence the thoughts and behaviour of others. This often means being able to control or decide what someone can or cannot do. Power can lead to violence, exploitation, coercion, abuse and cruel and degrading treatments.
The term "power dynamics" refers to the different amounts of power people have in a given place or situation. In a mental health or related service, the staff often have more power than people using the service.(5) This is often referred to as power imbalance.

A power imbalance can be a significant barrier to the well-being of the people within the service, both for the people using the service and staff. Often people using services believe that mental

health and other practitioners can do what they want because of their position, while they themselves believe that they have little influence in their care.(6)

As a result, people using the service may feel reluctant to voice complaints of violence, coercion and abuse because of the intimidation and the power dynamics currently in place.

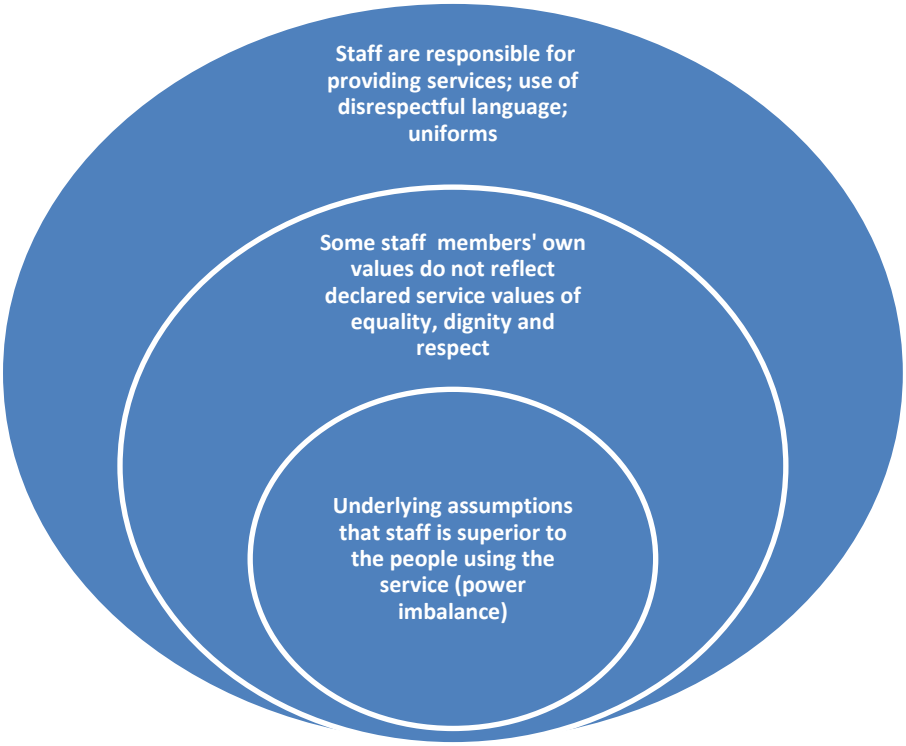
An example of how power imbalances are facilitated:

Power imbalances within the service culture are facilitated through basic underlying assumptions that influence the declared values and visible factors of the service.(3) For example, in many services:

- The practices and routines of the staff are influenced by *underlying basic assumptions* of being superior to the people using the service, resulting in a power imbalance.

- As a result, staff members in the service do not have a true understanding of and commitment to treating people with equality, respect and dignity (*declared service values)*.

- Staff inherently have power because they are given responsibility for providing and implementing services, rules and procedures. When the basic underlying assumptions of staff are not characterized by the notion of equality, dignity and respect, it both leads to and reflects a power imbalance in the service. This is seen in the daily practices (*visible factors*), e.g. physical division, the use of disrespectful language, seclusion and restraint. The use of uniforms and other practices carried out can reinforce the distance of staff from the people using the service unconsciously.



An unhealthy service culture with a power imbalance is further reinforced when the people using services are dependent on the staff for their wellbeing and all basic needs. Often they have no control over their situation, particularly when they are involuntarily detained.

It is important to note that a power imbalance can be reinforced or reduced/modified more or less unconsciously by people using the service, staff, management and others such as care partners and family. This is linked to the fact that the service culture influences the individual's thinking and behaviour by defining "the way we do things around here" without further reflection.

Refer to the modules *Creating mental health and related services free from coercion, violence and abuse* and *Implementing strategies to end seclusion, restraint and other coercive practices in mental health and related services* for more information on the impact of power dynamics in mental health and related services.

Exercise 3.1: Power dynamics at play (40 min.)

Show the participants the following video:

Stanford Prison Experiment with Dr. Steve Taylor (7) (8:23 min.)

https://www.youtube.com/watch?v=oAX9b7agT9o
Date accessed 04/08/2016

The Stanford Prison Experiment serves as an example of the impact of power imbalances and how an unhealthy service culture can affect how people interact and behave towards one another. A culture of violence and coercion can escalate, causing vital damage to people's mental and physical health.

The study also shows how ordinary people can engage in violent acts or behaviours when placed in unhealthy cultural environments or situations.

After having shown the video, ask participants the following questions in plenary:

- What kind of service culture did you see manifest through visible factors and declared service values?
- What basic underlying assumptions did you identify?

There are no right or wrong answers. It is difficult to identify values and basic underlying assumptions, since these are not explicitly expressed or visible.

Potential answers include:

Visible factors:

- Clothing worn: the guards wear uniforms, sunglasses, nightsticks etc.
- Modes of communication: labelling of 'guards' and 'prisoners', threats, aggressive and abusive language towards the 'prisoners' etc.
- Physical space: prison cells, solitary confinement etc.
- Psychological environment: mental and physical abuse, coercion, force etc.

Declared service values:

- No healthy core values for the prison were defined when the prison was inaugurated.
- Declared values of the service related to control ('guards' were told that they are in charge – "It is your prison) and an "us versus them" distinction
- The 'prisoners' were regarded as bad and deserved to be punished.

Basic underlying assumptions:

- Prisoners were thought to be inferior and dangerous
- The 'guards' believed that the 'prisoners' deserved degrading treatment because they were inferior (e.g. washing the toilets).
- The 'guards' believed that "We have to treat force with force". The 'guards' justified their behaviour by the following statement: "You are dangerous, and we have to treat you as such".
- Guards came with their own understanding of the prison as an institution and associated underlying assumptions about what happens in a prison institution empowered the 'guards' and legitimized their use of violence and abuse towards the 'prisoners'.

After the discussion, show the following:

What does the study teach us?

The Stanford Prison Experiment teaches us an important lesson in relation to power dynamics and the impact of service culture on how we behave towards one another.

The study serves as an example of the impact of an imbalance in power and how an unhealthy service culture can affect how people interact and behave towards one another. A culture of violence and coercion can escalate, causing vital damage to people's mental and physical health.

It important to note, that the study also shows how ordinary people can engage in violent acts or behaviours in certain environments or situations.

- Sometimes, the situations in which people are placed (i.e. the service culture) can influence their behaviour as individuals more than they think and even outweigh all their positive individual characteristics and values.
  - Basic underlying assumptions e.g. that prisoners are bad and inferior that manifest in values and visible factors facilitate this

- This is the case for everyone, whether they are staff, people using the service, managers or other relevant people, such as family and care givers.
  - e.g. the college students who were ordinary, well-functioning men transformed into new roles as 'prisoners' and 'guards' without questioning this transformation

- People's usual moral reasoning and thinking can be suspended when the culture, in which they are placed, influences their decision-making and how they behave towards each other.

- It is therefore important to assess the service culture in order to identify whether people are acting in accordance with the culture and whether the culture is consistent with the core values of equality, respect and dignity that should be embedded in any service on a daily basis.

Exercise 3.2: What about this current service culture? (10 min.)

The aim of this plenary exercise is to encourage participants to think about how the culture in their service impacts the daily practices and routines.

By asking the following questions, the aim is to understand the degree to which the current service culture aligns with the core values and vision for the service which participants defined in exercise 2.1. In addition, it will highlight what the service culture does well and what challenges it faces.

- Think about the core values and vision for the service that were just formulated
- Do you think that the current service culture supports this ideal? If yes, why? If no, why not?

Presentation: What challenges do we need to overcome? (8) (60 min.)

Power imbalances in an unhealthy service culture often lead to a culture which is resistant to change. Strategies for culture change need to take into account barriers that can block purposeful change:

Some of these barriers include:

- Lack of ownership
- Complexity of the service
- Lack of appropriate leadership
- Cultural diversity
- External influence

Lack of ownership

Reactions to change by individuals or groups within the service can be negative, unpredictable and characterized by reluctance, since change often evokes a sense of loss.

Even a few individuals who are not happy with the idea of change can cause disruption, and a grouping of people reluctant to change can be very harmful to the service in any attempt to improve or change the situation.

Therefore, it is important to obtain leadership's commitment to implementing culture change, promote transparency and explain the need for culture change throughout the entire service.

In order to implement culture change, a critical mass of people in the service needs to be involved and all stakeholders need to feel a sense of ownership over the process.

- For example, defining a set of core values and a vision that is shared by all stakeholders (as was carried out in exercise 1.2) in the service is a key way of promoting ownership.
- It is necessary to collectively agree on promoting human rights. (Refer to the modules *Understanding human rights* and *Promoting human rights in mental health* that provide information on human rights and seek to build capacity to understand and promote human rights, recovery and independent living in the community).

Complexity of the service

The service culture which is strongly influenced by basic underlying assumptions, is created, reproduced and embedded in many ways that manifest through values and visible factors, e.g. different practices across the physical, psychological and social environment of the service.

Therefore, it takes time to change the existing culture throughout the entire service. As part of the change process it can be helpful to discuss how to address the complexity of the service in order to making sure that planned activities for change are undertaken across the entire service.

In relation to this, the exercise of collaboratively identifying visible factors, declared service values and basic underlying assumptions can trigger new insights for everyone in the service about different aspects of the current service culture. This will be explored in exercise 3.3.

Also by *reviewing and mapping the organizational structure* of the service, everyone in the service will be able to identify the different stakeholders. This will help to ensure that all stakeholders are approached to participate in the culture change process. In addition everyone will know their own and each other's roles in the service and understand personal responsibilities.

Also setting realistic target dates and allocating responsibility for planned activities is necessary to implement the changes that are needed.

Lack of appropriate leadership

Promoting leadership plays a key factor in culture change. Leadership can be defined as the process in which one engages others around them and works to achieve a common goal that is defined by a set of declared values and a vision for the service.

Two main styles of leadership are widely recognized:

- Transactional leadership: focused on securing people's compliance and by using material motivational factors (e.g. reward systems).

- Transformational leadership: focused on raising people's interest in engaging in the well-being of the service and inspire change in how people think. The end goal is to develop followers into leaders who are individual agents of positive change. This can happen by connecting people's sense of identity to the collective identity of the service; being a role model for people; challenging people to take greater ownership for their work and understanding their strengths and weaknesses in order to support them.

The two styles of leadership need to be integrated in a way that changes how people think and behave in the service, achieving a healthy power balance. For example, it can be valuable to reward staff for their compliance with new practices *(transactional*). However, for this strategy to be effective in the long run, people need to be engaged at a personal level and feel a connection between their individual identity and the collective identity of the service (*transformational*). This can be done by explaining how the practice of each staff member is crucial to how the service runs and the practices of everyone around them in the service. Highlighting the importance of how the staffs' own values of equality, respect and dignity will also influence the service and therefore should be reflected in the day-to-day running of the service. In relation to this, staff will feel a sense of ownership and commitment towards securing these core values in the service. (Refer to the modules *Understanding human rights* and *Promoting human rights in mental health* for more information on the importance of human rights in mental health and related services.

Cultural diversity

A service may consist of several different subcultures. That means that there may be competing and overlapping groups of people in the service that have different basic underlying assumptions, values and behaviours. These subcultures are sometimes linked to professional identity e.g. doctors, nurses and managers, but not necessarily so, and may simply reflect differences in culture, training, experience and background.

In practice, it means that staff members might have opposing ideas about how to support people who are using the service; hence people do not receive the same and equal treatment. It is important to be open about these differences within the service and understand how people can work together in a synergistic way in order to promote a shared understanding of core values.

Both the people using services, staff, managers and other relevant people who are related to the service must be open and actively work towards a synergistic service culture. For example, in order to find a shared way of undertaking daily practices and routines, it is important to communicate with all stakeholders in order to understand how different individuals or groups of people in the service think differently about how daily practices and routines should be undertaken. In regards to this, it can be helpful to discuss the modes of communication and the language used within the service.

External influence

Outside interests can sometimes work against efforts towards internal reform. For example, local or national legislation may not enforce laws to stop the use of seclusion and restraints or external stakeholders, such as organizations, may oppose the culture change.

For culture change to be successful, people in the service must view themselves as *agents of change* and be confident in the fact that they can initiate a movement of positive change.

Scenario: Transforming service culture through peer support (9),(10)

The Institute of Mental Health in partnership with the Nottinghamshire Healthcare NHS Trust launched a project to promote a culture of recovery-focused practice through the recruitment of individuals with lived experience as peer supporters.

One of the main challenges to changing the service culture was a practical one: people using the service were completely unaware that this service existed and was available should they be interested in receiving peer support.

In addition, peer supporters had to overcome resistance to change within the service. Some staff members had anxieties that their roles would be threatened and others misunderstood the role of peer supporters. Sometimes peer supporters were seen as being “an extra pair of hands” and at other times they were seen only as being responsible for those people using the service who were the most challenging for staff.

To address these challenges, a new system was set in place requiring staff to inform people using the service about peer support and to provide them with the opportunity to meet a peer supporter. Peer supporters built strong relationships with people using the service, who said that they felt more supported and experienced a better quality of relationship with peer supporters than with other staff. Eventually, peer supporters were able to influence the team by changing underlying negative assumptions and beliefs about people using the service and the day to day practices of staff.

Peer supporters were able to overcome the initial resistance from staff to develop positive and transformative relationships and staff reported being more hopeful and willing to try new approaches in their daily work. Self-assessments completed by the executive team showed a positive shift towards a recovery-based culture. A staff member commented: "*I think the benefit of having a peer supporter in the team, it reminds of why you're doing the job first and foremost. It reminds you people can get better, it almost provides you with some hope*."

Overall, peer support contributed to a significant reduction in inpatient stays and a transformation of the service culture towards integrating a recovery approach at all levels of the service. One peer supporter commented: "*I think what has surprised me is the fact that in this role you can influence things more than I thought you probably could*".

Exercise 3.2: Identifying challenges to overcome in this service culture (40 min.)

At this point in the training, it is possible that participants might be feeling overwhelmed by the importance of changing unhealthy power dynamics and service culture. It might feel beyond their individual control. Thus, explain to participants:

- Being aware of the factors in the service that influence the culture is the first step towards changing the service culture.
- You can influence the service culture by becoming an individual agent of change through knowledge sharing, critical reflection and self-evaluation.
- A service culture can have both strengths and weaknesses that need to be discussed. It is helpful to identify both cultural factors that facilitate and factors that hinder the desired culture change.

Divide participants into groups of five. Ask participants to take their copies of Appendix 4 – *Challenges to overcome in the service culture.* They should fill this out and save for later when answering:

1) What challenges do we need to overcome in this service culture? Consider strengths and weaknesses in relation to the common challenges presented earlier:
   a) Lack of ownership
   b) Complexity of the service
   c) Lack of appropriate leadership
   d) Cultural diversity
   e) External influence

Encourage participants to both identify positive and negative factors in relation to each factor and think of additional challenges in the service. Emphasize that there are no right or wrong answers.

Potential answers include:

Lack of ownership:

Strengths:

- Many staff members and managers wish to take responsibility and empower each other on a daily basis to provide high-quality services

- Representatives of the people using the service are enabled to take part in and have direct influence on daily practices
- Some people feel ready and are committed to step into a leadership role

Weaknesses:
- Some people are reluctant and do not see the point of changing practices
- There is no declared set of core values or vision for the service

Complexity of the service:

Strengths:
- Some people are committed to follow target dates and engage in planned activities
- People know who to go to when they need support

Weaknesses:
- It can be difficult to know what one's individual role is in regards to taking the lead of initiating new activities
- Difficult to know who to ask for support when you need it in your team
- Sometimes people do things in a certain way without questioning why

Lack of appropriate leadership:

Strengths:
- Some representatives for people using the service and some staff members easily take on an informal leadership role and seek to support others
- Some staff members and representatives of people using the service serve as excellent role models
- Most people feel a commitment to the shared vision and declared values of the service

Weaknesses:
- The daily manager(s) do not set a good example as role models
- Difficult to navigate in accordance with best practice and be an individual agent of positive change
- Some staff members do not connect their own sense of identity to the collective identity of the service resulting in incongruence between the declared and non-declared service values.

Cultural diversity:

Strengths:
- The service is characterized by a high degree of diversity with people from many different backgrounds who have a wide range of expertise and experience

Weaknesses:
- The different subgroups of mental health and other practitioners do not agree on care and support plans
- A lack of effective communication about these different views result in inconsistencies in the provision of support

External influence:

Strengths:
- The service has close collaboration with external stakeholders in the community
- The service has a good reputation and support in the community

Weaknesses:

- Local or national legislation working against efforts to change
- The service needs to convince key stakeholders about the necessity of changing practices

Exercise 3.3: Understanding visible factors, values and basic underlying assumptions in this service culture (60 min.)

Ask participants to stay in the same groups as they were in for the last exercise and find their copies of Appendix 5 – *Analysing visible factors, values and basic underlying assumptions in this service culture. Complete* this form when answering the following question and save for later:

1) Within the service culture, identify strengths and weaknesses in relation to visible factors

Question to consider:

- How are we doing things in the service? Think of strengths and weaknesses in relation to physical space, clothing worn, modes of communication, role hierarchy etc.

Potential examples of strengths and weaknesses in relation to visible factors include:

Strengths:

- Physical space: the physical division between people using the service and staff is structured in a way so that people using the service and staff are together in a common room when having lunch.
- Clothing worn: staff and people using the service do not wear different clothing, except when necessary for sanitary or other reasons.
- Modes of communication: respectful and recovery-oriented person-first language is being used and staff and people using the service regularly talk about this issue.
- Role hierarchy: representatives for people using the service promote equality by collaborating closely with the staff and management and give their advice on the daily practices and routines.

Weaknesses:

- Physical space: the physical division between people using the service and staff is structured in a way, so people using the service and staff do not spend time together, e.g. solitary confinement, divided dining halls etc.
- Clothing worn: staff and people using the service wear different clothing, and people using the service all have to wear the same clothes
- Modes of communication: degrading and stigmatizing language by staff and managers when talking to and about the people using the service and vice versa
- Role hierarchy: there are no representatives of people using the service; hence the people using the service have little influence on the daily practices and routines.

2) Discuss whether the declared core values of the service align with basic underlying assumptions of the different members of the service culture

Questions to consider:

- Recall exercise 2.1: What are the declared values of the service?

- Think about how these core values are actively demonstrated in the daily practices and routines of the service that were just described (visible factors). For example, the use of a respectful and recovery-oriented language promotes equality, respect and dignity.
- Are these declared values in alignment with the service members' basic underlying assumptions and ultimately peoples' actions towards each other?
- Must something about "the way we do things around here" be addressed?

Potential answers:

- The list of declared service values and the vision of the service are well-known in the service and people seek to adhere to these in the daily practices, e.g.:
    - The staff has a high sense of commitment to treating each other and people using the service with respect and dignity and supporting in their recovery
    - The staff do not want to use seclusion, restraint and coercion because these practices are degrading and constitute human rights violations

- List of declared values of how the service should work are not always practiced. Many practices are in conflict with the values of the service that were formulated in exercise 1.2 and are influenced instead by negative underlying assumptions held by many people in the service.
    - Subgroups in the team of mental health and other practitioners differ in their views on how to support the people using the service resulting in inconsistent practices in the service, e.g. nurses and psychiatrists have diverse views on how to best manage challenging situations, i.e. through active listening and dialogue or using the seclusion room
    - Notions of inequality between people who are using the service and staff, e.g. people using the service and staff cannot stay in the same room, people should wear different clothing or degrading and stigmatizing language
    - Notions that the people using the service cannot recover, e.g. staff do not seek to support people using the service in connecting with services in the community such as education and job training opportunities that can help them in their recovery
    - Notions about the use of seclusion, restraint and coercion being legitimate

In plenary, ask each group to present their views in relation to the questions and share personal experiences. Remind participants to save the completed appendix 5 for later.

Presentation: How to be an individual agent of change (10 min.)

In continuation of the previous exercise, the aim of this presentation is to show participants that action can be taken collaboratively in the service and also as an individual agent of change on a daily basis.

Quote:
"*Sometimes I'm skeptical about how much I'm impacting the organizational culture. There's so much that needs changing! But then I'll take a step back and see that the language is changing. The way people are talking about hearing voices and self-harm is changing. I think I'm really making a difference here. It's what keeps me going*." – Peer supporter, US (11)

- On a daily basis, we can influence the service culture by questioning visible factors, values and basic underlying assumptions and encourage each other towards taking ownership and responsibility for everyone's well-being.

- The following steps can be taken by every person in the service:
  - Share your knowledge and experiences, critically reflect and self-evaluate
  - Try and question visible factors, values and basic underlying assumptions
    - E.g. consider how people talk to each other (refer to the *Preliminary note on language* in the introduction of this module for examples)
    - E.g. does the service live up to its declared values?
    - E.g. are there any unhealthy basic underlying assumptions about the way to do things that are not in alignment with the core declared service values?
  - Do something about it when you feel that something is not right

- It is important to remember that culture change and quality improvement takes time.

Emphasize that culture change is difficult and takes time. The process of culture change can face many different barriers, including people who are reluctant to change.

Explain to participants that, in particular, if you as an individual feel alone with your worries, whether you are a person who are using or have previously used the service, a staff member, a manager, a care giver or a family member, it can be difficult to navigate and know what to do. Try to join up with others who have similar points of views or challenge the views of others.

Topic 4: Specific priorities for change in the service based on the QualityRights assessment tool kit

Presentation: Priorities for change (10 min.)

In the previous topic, we discussed service culture and the importance of changing the service culture to promote well-being for everyone in the service. This is an immediate priority and a prerequisite for any other change.

In this topic, we will now look at other specific changes or areas of improvement that can be made based on the QualityRights assessment. First, it is important to distinguish between immediate and mid- and longer term priorities. Not everything can be done at once.

This is an opportunity to discuss what standards from the QualityRights assessment are priorities to act on immediately and what standards require mid- and longer-term action. Ask participants to fill out their copies of Appendix 6 – *Priorities for change*.

In particular, draw attention to the perspectives of people using the service.

Qualities of an immediate priority:

- Poor performance on the standard can be dangerous for people using the service
- Poor performance on the standard can lead to the deterioration of physical and mental health
- Poor performance on the standard can have a negative impact on the majority of people using the service
- Poor performance on the standard results in people wanting to leave and stops others from using the service

Qualities of a mid- or longer term priority:

- Improvement on the standard will be an important change to the service, but does not impact the safety of people using the service
- Improvement on the standard will affect a minority of the people we serve
- Improvement on the standard can only be acted on when priority standards have been addressed
- Improvement on the standard may help to reach more people, but is not a barrier stopping them from using the service

Exercise 4.1: Priorities for change (90 min.)

During this exercise, participants will discuss priority areas for action for the service based on the assessment report.

Before the group discussion, emphasize that what participants identify as priorities will feed into the improvement plan and therefore directly influence the process. By informing them of this, participants will realize how important their role is in improving the service.

The question for now is what are the priorities – what needs to be improved? At a later stage when the key priority issues have been identified, the question will become *how can we address these priorities given the resources that we have or likely to obtain.*

Ask participants to break up into several small discussion groups of five people. Once they have settled into their groups, ask them to complete the following:

In your groups, use the summary report of the QualityRights assessment to:

- Identify the standards within each theme that you consider to be immediate priority areas requiring action (please identify a minimum of 3 per theme)
- Identify other standards within each theme which you consider to be mid- and longer term priorities

It is important to understand that the aim of the exercise is to identify priorities on what is "right" and appropriate according to QualityRights standards. Avoid letting issues of resource availability influence your priority setting. This is a separate issue that needs to be considered later.

Use the guidance for selecting immediate and longer term priorities (Appendix 6 – *Priorities for change*).

After the discussions, the groups will come together and one member from each group will present the standards identified as priorities for each theme and explain why they chose these.

After each group presents, you should encourage discussion in plenary as to whether people agree or disagree with these immediate and mid- or longer term priorities.

Exercise 4.2: Compiling a list of priorities (1 hour)

After the plenary discussion, work with participants to prepare a list of priority areas for change focusing on the immediate priorities only. Using the flip chart, compile the following in plenary:

- A master list of DEFINITIVE PRIORITIES of standards requiring improvement (priorities all groups agree with)

- POTENTIAL PRIORITIES of standards for improvement (that may warrant further discussion).

If the participants do not reach a consensus on the definitive priorities, it is possible to conduct a majority vote on what the definitive priorities should be.

This initial priority list of standards for improvement that has been collaboratively compiled by the group can provide the foundation for the action areas of the improvement plan. This list should be recorded and stored somewhere safe and accessible for future use in meetings as part of the improvement plan process.

It is important to emphasize to participants that the list of priority standards for improvement will be actively used in their daily work of the service. Therefore, highlighting the input from all participants and stakeholders is crucial in order for the improvement plan to be successful.

Topic 5: From problems to solutions and from action to impact

Exercise 5.1: How can this service improve? (50 min.)

Ask participants the following:

Think about what this service can do to improve on the QualityRights standards.

On the basis of their experiences, participants will come up with great ideas. Write the ideas on a flipchart. In the following, the key is to put these ideas into a structured framework for improvement.

Presentation: Moving from problems to solutions (60 min.)

At this point there will be a session on moving from the problems identified to the solutions generated. The process we are describing is summarized by the flow chart below.

As a facilitator you should explore each stage included in the flow chart with participants. The ideas behind each stage (noted on the PowerPoint) will be explained and then followed by examples to reinforce how a change and improvement plan works.

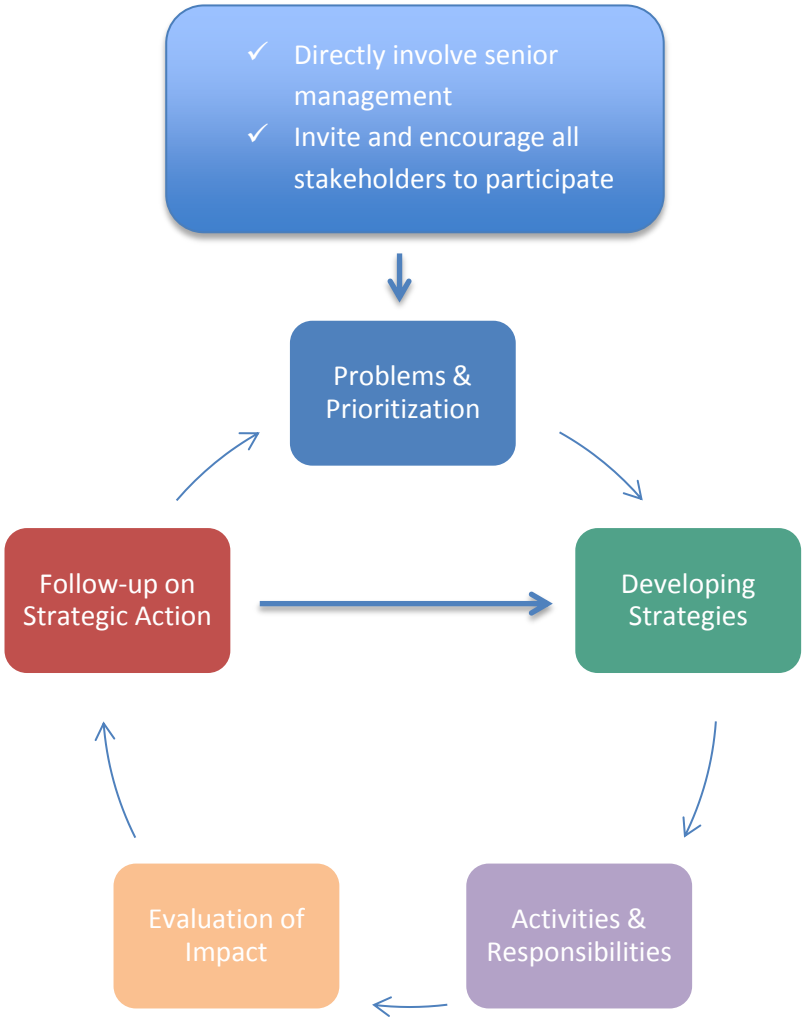
Please note that issues around blame and institutional barriers to change including political will, lack of funds and resources need to be acknowledged and openly discussed. However, this discussion should be contained and focused on how people can move forward in a positive way. Ways that take account of existing resources and require creativity and becoming agents of change.

FLOW CHART

This flow chart (below) shows each step in the process of solving the areas of improvement identified during the QualityRights assessment:

- Prior to initiating the QualityRights improvement plan, ensure that all stakeholders participate. This includes people who are using or have previously used the service, staff, management and other relevant people such as care givers and family. Directly involve senior management and make sure than an oversight committee oversees the implementation process, including representatives of people who are using or have previously used the service.
- In the first step of the improvement process, it is important to identify the problems and prioritize the areas of improvement.
- The next step is to develop a strategy in order to address the areas of improvement. These should reflect the vision and core values of the service.

- For each strategy it is important to decide on the activities that will be initiated, set target dates and assign responsibility to various people for completing these in order to implement the strategy.
- After this the impact of the strategy in addressing the problems or gaps should be evaluated.
- Finally, a follow-up review session should use the results of the evaluation to inform changes to the strategies for improvement currently in place.



ROBLEMS & PRIORITIZATION:

- The first stage for improving services is the identification of problems – based on performance on the standards of the QualityRights assessment.
- These problems must be prioritized and then addressed in order of the most pressing issues first. Having said that, sometimes there is an argument to be made for changing something that is easier rather than most pressing, simply because it might be what leads people to having more credibility, power and reach to be able to make future substantial changes.
- This process of prioritization starts today.

Illustrative example

PROBLEMS & PRIORITIZATION:

Seclusion and restraint are used on a regular basis in the inpatient service

- In their QualityRights assessment, this service identified that they were not fulfilling standard 4.2 regarding seclusion and restraint.
- People who are using or have previously used the service and the staff met in plenary (like us today) and decided this was an immediate priority that needed to be improved.

DEVELOPING STRATEGIES:

- Forming a strategy will help everyone think about problems in a critical way.
- As a group, and with the participation of all relevant stakeholders, it is possible to get to the core of the area of improvement and find potential solutions.
- This makes the planned activities more effective. It is important to think broadly about potential solutions.
- Not all problems can be solved by training. Many problems will require multiple solutions including policy and legislation, protocols, attitude and culture change, developing new skills, financial investment, additional human resources and training and support from senior management.

Questions to consider:

- What is the source of the challenge?
- What needs to be done to solve this challenge?
- What resources do we have?
- Who needs to be involved in dealing with this challenge? (Need to consider whether this is something that staff take primary responsibility for or will it require the leadership of people using the service or other groups?)
- Do others in the service agree that this is a priority challenge? If they do not, then we need to better communicate why this is an important area to address.
- Do we need to create a working group that will be dedicated to finding solutions?

Illustrative example

DEVELOPING STRATEGIES

Train all staff in methods of de-escalation to end the practice of seclusion and restraint

- The practices of seclusion and restraint constitute human rights violations and contradict the vision and core values of the service. Thus, it was decided to eliminate seclusion and restraint in the inpatient service.

- Lack of knowledge and skills for de-escalation was cited as important reasons for the practice of seclusion and restraint continuing.
- All service staff are involved in the practice of seclusion and restraint and therefore need to be trained.
- A budget to run a series of training workshops with external trainers was identified
- When the issue of seclusion and restraints was discussed, it became clear that the majority of staff felt ambivalent and distressed when they used restraints on others or put people into seclusion. They were under the belief that this was the only option in challenging situations.
- The staff reported many occasions when these practices resulted in a breakdown of trust between staff and people using the services.
- There was widespread agreement that ending this practice would be beneficial for people using the services and staff.
- The head of nursing was concerned that without seclusion and restraint her staff would be more at risk. She met with management and attended extra training on de-escalation techniques. She is now supportive of the plan.
- A working group was set up to monitor how often seclusion and restraint was used. After each incident, they met with the staff involved to discuss use of de-escalation techniques.

The modules *Creating mental health and related services free from coercion, violence and abuse* and *Implementing strategies to end seclusion, restraint and other coercive practices in mental health and related services* provide more information on seclusion, restraint and other coercive practices within mental health and related services and how to change these practices.

ACTIVITIES & RESPONSIBILITIES

- A planned activity is a specific response to a problem that can help achieve the strategy that the team believes will be most effective to get positive results.
- Planning these activities, rather than just simply responding immediately, gives structure to how the team approaches the challenge.
- This way the team understands that there is a clear plan of action that will be followed in order to implement the strategy and have impact.
- By carefully allocating responsibility for each planned activity to an individual or group of people, which also includes people who are using or have previously used the service or others, everyone knows who is in charge of making sure that the activity or activities are completed.
- All activities should have target dates for completion.
- With the specific activities and related responsible persons, the working group and service management team can more easily monitor progress on the implementation of the strategy.

Illustrative example

ACTIVITIES & RESPONSIBILITIES to end seclusion & restraint were planned and conducted including inter-service informational events

(solution)

- The working group met and decided on their response to the area of improvement.
- All activities planned were aligned with the strategy agreed to by the people using the service, staff and the management.
- All activities were listed, in the following template, with named individuals and target dates.

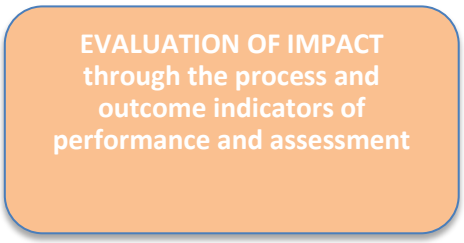
Standard for improvement 1 (illustrative example) **Standard 4.2**. Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises		**Timeframe including target dates**	**Responsible person(s)**	**Budget**
Strategy 1 **Train all staff on methods of de-escalation and end the practice of seclusion and restraint**				
Activity 1	**Provide training workshop:** Arrange workshop to train people who are using the service and staff about the recovery approach and techniques to eliminate the use of seclusion and restraint. Explain that seclusion and restraint constitute human rights violations and must be eliminated. (Refer to the modules *Understanding human rights* and *Promoting human rights in mental health*)	2 weeks	Dr A. and peer supporter A	Part of regular service budget for training
Activity 2	**Create personal templates for people using the service:** Creation of templates for people using the service on how to manage triggers that may lead to challenging behaviour or crises. The templates are developed with the person and can be used as part of a recovery plan.	4 weeks	Service manager, clinical lead and representative for people using the service	0
Activity 3	**Develop policy for responding to crisis situations:** This policy should include immediate follow-up meetings with the people experiencing the crisis in order to evaluate how the crisis was handled and potentially restructure the template.	1 week	Service manager and clinical lead	0
Activity 4	**Develop individualized plans for staff:** Staff develop individualized plans for managing their own triggers for frustration and tension in order to avoid using seclusion and restraint.	3 weeks	QualityRights Champion and each staff member	0
Activity 5	**Monitoring and evaluation:** Monitor number of times seclusion/restraint is used immediately and then on an ongoing basis (indicators of performance). Staff also asked to report on the reasons for each and to explore alternative methods.	Immediate and ongoing	Chair of working group	0
Activity 6	**Development of 'open door' comfort room and closing of seclusion room**	3 weeks	Dr B (Dept. Health) and peer supporter B	Small budget
Activity 7	**Inter-service informational events:** Planning a schedule and place for these where staff and people using the service can share knowledge and experiences on de-escalation techniques, critically reflect and self-evaluate. This will sharpen people's understanding of how to deal with ethical and value-based challenges that arise on a daily basis.	Regularly	Manager	0

EVALUATION OF IMPACT

- When making an improvement plan the team should consider what positive impact they are hoping to achieve and to think about ways of monitoring this. Impact for people using the service as well as staff should be monitored.
- Central to this process is the selection of indicators of performance.
- Impact may occur immediately after the planned activities have started or at a later point in time.
- In addition to monitoring indicators of performance, an important way to assess impact is to repeat the QualityRights assessment after a period of time.
- This will allow the evaluation of change to occur in a strategic and planned way.

It is also important to consider that there may be negative impacts from improvement plans.

Illustrative example



- Process indicators of performance included the number of staff trained and the number of activities successfully implemented. The main outcome indicator was the number of episodes of seclusion and restraint.
- The results showed that the strategy to end the use of seclusion and restraints was successful in reducing seclusion and restraint rates which was the main outcome indicator. Over 90 % of staff were trained and 80 % of the planned activities were implemented:
  - Service staff now feels more confident in using de-escalating techniques after the training they received. They also feel better able to manage their own triggers for frustration.
  - Identifying triggers for both people using the service and staff in addition to follow-up meetings after crisis episodes has reduced the overall number of crisis scenarios.
  - Even before the comfort room was opened, the number of occasions when seclusion and restraints were used had already decreased.
  - The trust that people using the service had in staff increased based on a survey undertaken.
  - At the inter-service informational events, everyone has been able to meet and share knowledge, critically reflect and self-evaluate on the improvement process.

FOLLOW-UP ON STRATEGIC ACTION

- It is important to ensure that the quality improvement process is embedded in the daily work of the service and that all stakeholders have a sense of ownership and responsibility.
- The outcomes of the implementation process should be presented to the appointed oversight committee of the service.
- A 2-page brief/memo should be prepared describing the initial situation in the service, the process of identifying solutions and the impact of implementation. The brief/memo should be presented to relevant stakeholders, including governmental institutions, in order to disseminate the findings and promote policy and legislative action to further create sustainable change.

Illustrative example

FOLLOW-UP ON STRATEGIC ACTION:

Use outcome of evaluation to improve strategic action in the service and at policy level

- People who are using or have previously used the service, staff and management were on board from the beginning and were assigned clear roles and responsibilities.
- The plan and preliminary outcome was presented to the appointed oversight committee which had closely followed the process and when necessary provided support and guidance.
- An approval brief/memo was created and (with the improvement plan attached) presented to external stakeholders, both non-governmental organizations and advocacy groups as well as governmental institutions, in order to push for policy and legislative action to end seclusion and restraint throughout the country.

Explain to participants that this concrete example of how to end seclusion, restraint and coercion also demonstrates that any change or improvement initiated, no matter what or how specific or concrete, will require a change in the service culture.

- This illustrative improvement plan serves as an example of how a change in service culture is an evitable part of any implementation plan process.

- In this case, many factors affecting service culture were addressed through the implementation of the strategy to reduce seclusion and restraint:
    - Visible factors: Training people in the recovery approach and new techniques to end the use of seclusion and restraint; opening of an open door comfort room for people using the service and staff in order to create an atmosphere of trust; developing personal templates for people using the service and for staff on how to manage triggers in addition to an official policy on how to respond to crisis with follow-up meetings etc.
    - Values: The vision and set of core values for the service were re-introduced to allow discussion, foster inclusion and trust and underline new practices. The inter-service informational events facilitated an open and non-judgmental space for everyone to share knowledge and experiences, critically reflect and self-evaluate on their own values in relation to the core values and vision of the service.
    - Basic underlying assumptions: More fundamentally, the view that the use of seclusion and restraint is necessary was challenged. It was discovered that the staff do not feel comfortable using seclusion and wish to end this practice. This realization generated a movement for change and introducing new practices such as the comfort room.

- Given that service culture is so fundamentally important to all services, this will now be addressed in the following exercise.

Exercise 5.2: Improvement plan for changing the service culture (90 min.)

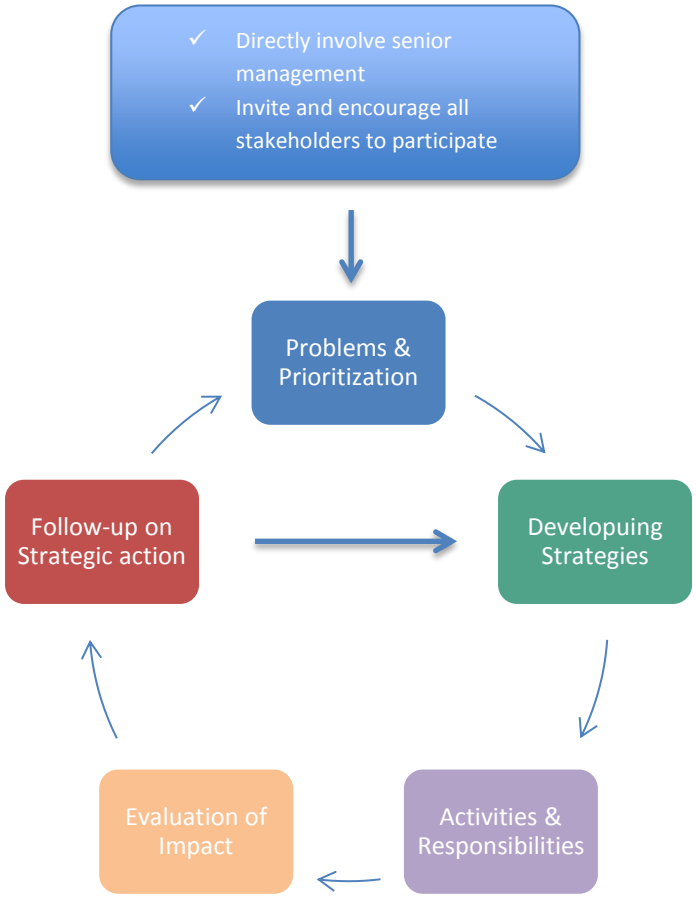
The purpose of this plenary exercise is to develop a comprehensive strategy for service culture change using the previously presented flow chart together with the information and discussions from Topic 3 on culture change (Appendix 4 and 5).

- Take a copy of annex 7 – *Improvement plan template for service culture change*. We will now fill out this template as we work through the flow chart steps in plenary.

Throughout the exercise, the facilitator writes down the answers in relation to each stage of the flow chart on a flipchart while participants are encouraged to fill out their own templates accordingly.

Show the following:

In order to plan the change in the service culture, we will work through the steps in the flowchart.



PROBLEMS AND PRIORITIZATION:

- As discussed earlier, it is important to ensure that all stakeholders are engaged in the process of changing the service culture. The working group should include senior management, people using the service, staff, care partners, family and other relevant stakeholders.
- First, it is important to understand the current service culture or the way things are now and also identify the main problems faced by the service.
- Next, we must prioritize what needs to change first and foremost. This may be the notion of inequality between people using the service and staff or something completely different.

Questions to consider:

Try and recall the service vision, and set of core values (exercise 2.1) that we established earlier. Take out your completed forms of appendix 3, 4 and 5 and recall identified challenges to overcome for this service including visible factors, values and basic underlying assumptions.

Based on these:

- What do you think are immediate and mid- and longer term priorities for change?
- Choose one immediate priority for change that you wish to carry out in this improvement plan for service culture change.

DEVELOPING STRATEGIES:

- Next, we need to identify a set of strategies to meet the challenge in the current service culture.

Questions to consider:

- What is the source of the challenge?
- Who needs to be involved in dealing with this challenge?
- Do others in the service agree that this is a priority challenge? If they do not, then we need to better communicate why this is an important area to address.
- What resources do we have?

ACTIVITIES & RESPONSIBILITIES:

- It can be difficult to create change when people need to unlearn old ways of doing things in order to learn new ones. It is important to collaboratively define a range of activities that can be carried out to create positive culture change, set clear target dates and allocate responsibility.

Questions to consider:

- What activities can be carried out to meet the prioritized challenge?
- What are target dates and should be allocated responsibility for carrying out the activities?
- How do we work through each challenge?

Give participants time to explain whether or not they think planned activities or target dates are realistic and how to overcome potential challenges. Encourage participants to be as concrete as possible when formulating suggestions for activities.

EVLUATION OF IMPACT:

- Changing the service culture takes time.
- The process of service culture change should be monitored on an on-going basis and evaluated by a set of pre-defined indicators of performance. The team should assess how the culture change is coming along by including both positive and potentially negative outcomes in the evaluation.

Questions to consider:

- How do we monitor the outcomes of change for this specific challenge?
- How do we make sure to address potential positive and negative outcomes?

Possible indicators of performance might include:

- Number of staff trained in core values promoting human rights and recovery
- Number of staff members who have received leadership training
- Qualitative outcomes from inter-service informational events
- Qualitative evaluation from surveys and/or interviews with stakeholders

FOLLOW-UP:

- In this final step of the process, it is important to ensure that the culture change is embedded in the daily practices and that all stakeholders have a sense of ownership and responsibility.
- The preliminary outcomes of the culture change could be presented to everyone in the service and external stakeholders in order to push for policy and legislative action in the community promoting human rights.

Questions to consider:

- How can we make sure that the culture change is embedded in the daily practices?
- How do we foster a sense of ownership and responsibility in all stakeholders?
- If necessary, on the basis of preliminary outcomes: How do we re-adapt our strategy?
- How do we promote policy and legislative action in the community?

By now, it should be clear how the flowchart can be applied when preparing and implementing a service change, respectively in an identified area of improvement and in the service culture.

Ask participants if they have any questions and move on to the next exercise.

Exercise 5.3: Our own examples (2 hours)

By now, it is time for the participants to work in small groups of five to develop a strategy and plan activities for an area of improvement identified in the QualityRights assessment.

By working on their own, the purpose is to highlight how an identified area of improvement in their own service can be implemented in practice by using the flow chart presented earlier.

Hard copies of presentation *Moving from problems to solutions* are handed out to each of the groups. Each group will be allocated an area for improvement that that was identified in exercise 4.2:

- Inform the groups that you will now be using the flow chart model to address another of the areas for improvement that has been identified in the QualityRights assessment of this service.
- Each group will have a copy of the template to complete (Appendix 7).
- The groups will then present in plenary for the whole group to comment and engage in discussion.
- The facilitator will guide the discussion in the room by going through the steps outlined under each section in the presentation *Moving from problems to solutions.*

- It is important to challenge the ideas that are brought forward.
    - Ask the group whether or not they think planned activities and target dates are realistic?
    - What challenges do they predict when dealing with this issue?

This process is repeated for one example of each of the 5 themes and then for as many areas for improvement as is possible to complete during the workshop session(s). Hand out copies of Annex 7 - *Improvement plan template for each priority strategy identified.*

Topic 6: Moving forward

Presentation: Working groups & QualityRights Champions (15 min.)

- Finally, the scene should be set for the future work that is required of the service. This includes:
  - Completing the work on the improvement plan if this has not yet been completed through the workshops. See in Appendix 7 below.
  - Monitoring the implementation of the improvement plan for each of the themes.
  - Planning inter-service informational events in order to create on-going knowledge sharing, critical reflection and self-evaluation of the improvement process (see box below)

- Participants will have an opportunity to form into working groups on each theme. These can be allocated by the service manager or preferably people elect themselves to participate in the working group which they are most interested in.

- Working groups should be encouraged to be mixed groups when possible and appropriate. This will not always be the case (see *Guidance for facilitators*). They should involve people using the service, staff (including mental health and other practitioners in addition to attendants, cleaning, cooking, maintenance staff), management and also family members and care partners where possible.

- QualityRights Champion(s) can be appointed to oversee the progress of each working group. QualityRights Champions are people identified in the service, including people using the service, peer supporters and/or staff, who have demonstrated their willingness, interest, motivation and commitment to quality and human rights improvements. QualityRights Champions are selected on the basis of their capacity to influence others, have a long-term commitment to the service. NB: People who are using or have previously used the service should be remunerated for extra time or resources incurred as a function of taking up this role.

- Set clear target dates for establishment of the working group and for carrying out of their work.

Inter-service informational events

- ✓ The management needs to create a safe space for knowledge sharing, critical reflection and self-evaluation which strengthens the awareness of appropriate and less appropriate practices and routines in the daily work of the service.
- ✓ In relation to this, the inputs of people who are using or have previously used the service are of particular importance.
- ✓ This will provide people who are using or have previously used the service as well as staff with an opportunity to express their personal views about the on-going process and be able to exchange positive and negative experiences during the process.
- ✓ Sharing of knowledge, critical reflection and self-evaluation will support a service culture of empathy and ethical behaviour based on a notion of equality and respect.
- ✓ This can lead to a restructuring of the strategies currently in place.
- ✓ The idea behind this is that motivation tends to be higher when everyone views the process as enriching, and gains a sense of ownership and commitment to being agents of change.

Concluding the training (10 min.)

Ask participants the following questions in plenary and make sure to get as many different views from various stakeholders as possible:

- What are the 3 key points that you have learned from this training?
- Do you feel that you have the tools required to further develop the service improvement plan?

Then show the following take home points:

Initiating an improvement plan

- The QualityRights assessment tool kit has been designed to support services to assess and improve the quality of care and compliance with human rights standards and is based around 5 themes.
- An improvement plan is a way to address problems and challenges identified through the QualityRights assessment.
- Prior to initiating an improvement plan, involving senior management and an oversight committee is necessary. The participation of all stakeholders is crucial.
- Problems/areas of improvement need to be identified and prioritized.
- An improvement plan requires strategies that assess and respond to challenges in a critical way.
- Positive impacts can be achieved with planned activities facilitated by responsible people.
- Indicators of performance can be used to monitor and evaluate the impact of the plan.
- In a follow-up session, the preliminary and expected outcomes are shared – also with external stakeholders. Possibly, the strategy has to be restructured when moving forward.
- When initiating an improvement plan, the culture and power dynamics of the service must be addressed. The service culture influences the dynamics between the people using the service, staff, management and other relevant people such as family and care givers.
- The notion of equality, respect and dignity between people using the service, staff and others must be included as the core values and should be embedded in the service culture.
- In collaboration, an unhealthy service culture and the daily practices within the service can be changed.
- In relation to this, we can all be individual agents of positive change on a daily basis.

Annexes

Annex 1: Themes and standards of the WHO QualityRights Tool Kit

Theme 1. The right to an adequate standard of living (Article 28 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD))

Standard 1.1	The building is in good physical condition.
Standard 1.2	The sleeping conditions of service users are comfortable and allow sufficient privacy.
Standard 1.3	The service meets hygiene and sanitary requirements.
Standard 1.4	Service users are given food, safe drinking-water and clothing that meet their needs and preferences.
Standard 1.5	Service users can communicate freely, and their right to privacy is respected.
Standard 1.6	The service provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.
Standard 1.7	Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities.

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

Standard 2.1	Services are available to everyone who requires treatment and support.
Standard 2.2	The service has skilled staff and provides good-quality mental health services.
Standard 2.3	Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community.
Standard 2.4	Psychotropic medication is available, affordable and used appropriately.
Standard 2.5	Adequate services are available for general and reproductive health.

Theme 3. The right to exercise legal capacity and the right to personal liberty and the security of person (Articles 12 and 14 of the CRPD)

Standard 3.1	Service users' preferences regarding the place and form of treatment are always a priority.
Standard 3.2	Procedures and safeguards are in place to prevent detention and treatment without free and informed consent.
Standard 3.3	Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity.
Standard 3.4	Service users have the right to confidentiality and access to their personal health information.

Theme 4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD)

Standard 4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect.

Standard 4.2 Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises.

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

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

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

Theme 5. The right to live independently and be included in the community (Article 19 of the CRPD)

Standard 5.1 Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community.

Standard 5.2 Service users can access education and employment opportunities.

Standard 5.3 The right of service users to participate in political and public life and to exercise freedom of association is supported.

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

Annex 2: Reflecting on areas of improvement

Think back to a health service that you have used and identify what was helpful, useful and made a positive difference. Also consider what was neither helpful, nor useful and what would have made your experience a better one.

Based on your own experiences and knowledge of the theme within the QualityRights assessment tool kit, which areas for improvement do you think will be recommended in the assessment report of this service?

Annex 3: Defining core values and a vision for the service

Questions to consider when formulating a set of core values and a vision statement:

- What are the outcomes that you would want for people who visit the service?
- What does this mean for what our service provides?
- What does this mean for how we deliver the services?

When considering these questions it can be useful to refer to your completed copy of Appendix 2 in which you identified your own experiences about what makes a good service.

What values do you believe are important for a mental health or related service? *Consider the values presented earlier and think of other essential values*

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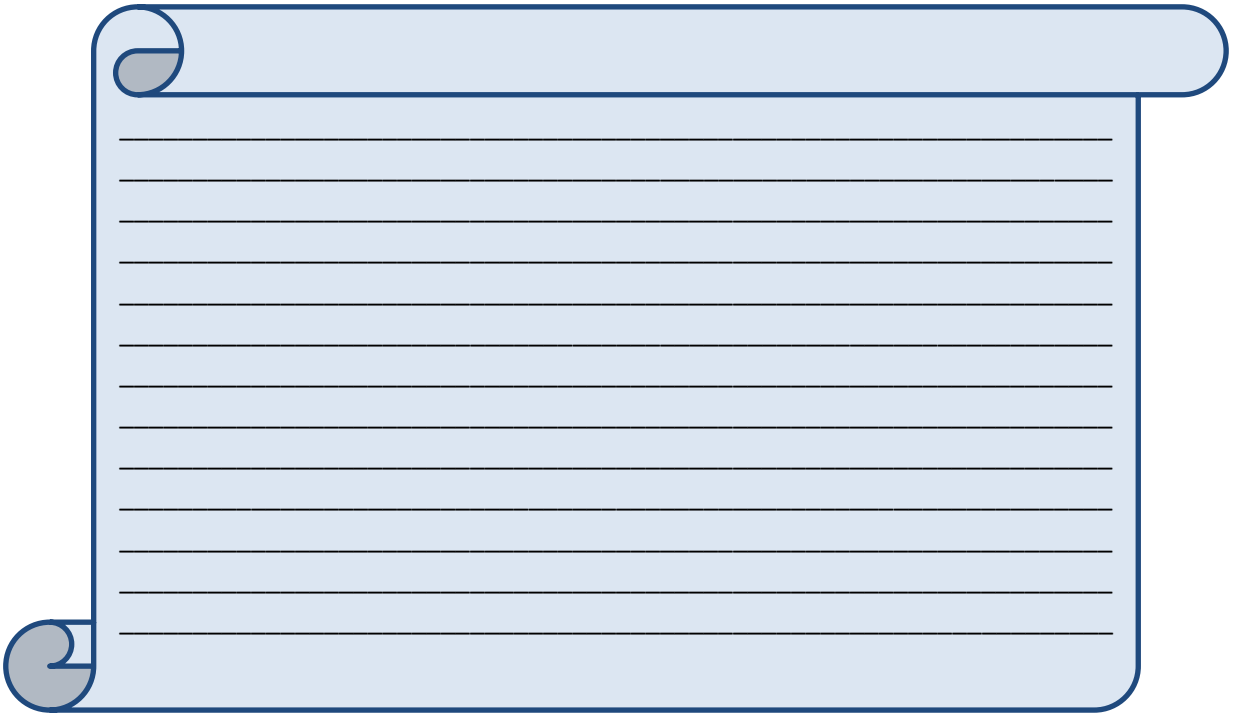
Try to formulate a vision which eventually should describe how you would like to see your service function in the most ideal possible way. This should be in line with all the core values that you have identified as the most important to promote.



Annex 4: Challenges to overcome in the service culture

Challenges	Strengths	Weaknesses
Lack of ownership		
Complexity of the service		
Lack of appropriate leadership		
Cultural diversity		
External influence		

Annex 5: Analysis of visible factors, values and basic underlying assumptions in the service culture

1) Within the service culture, identify strengths and weaknesses in relation to visible factors

Questions to consider:

- How are we doing things in the service? Think of strengths and weaknesses in relation to e.g. physical space, clothing worn, modes of communication, role hierarchy, official practices etc.

Strengths	Weaknesses

2) Discuss whether the declared values of the service are in alignment with the undeclared values/basic underlying assumptions of the different members of the service culture

Questions to consider:

- Recall exercise 2.1: What are the declared values of the service?
- Think about how these core values are actively demonstrated in the daily practices and routines of the service that were just described (visible factors). For example, the use of a respectful and recovery-oriented language promotes equality, respect and dignity.
- Are these declared service values in alignment with the service members' own non-declared values/basic underlying assumptions and ultimately peoples' actions towards each other?
- Must something about "the way we do things around here" be addressed?

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Appendix 6: Priorities for change

Qualities of an immediate priority:

- Poor performance on the standard can be dangerous for people using the service
- Poor performance on the standard can lead to the deterioration of physical and mental health
- Poor performance on the standard can have a negative impact on the majority of people using the service
- Poor performance on the standard results in people wanting to leave and stops others from using the service

Practice	Themes				
	1	2	3	4	5
1					
2					
3					

Qualities of a mid- or longer term priority:

- Improvement on the standard will be an important change to the service, but does not impact the safety of people using the service
- Improvement on the standard will affect a minority of the people we serve
- Improvement on the standard can only be acted on when priority standards have been addressed
- Improvement on the standard may help to reach more people, but is not a barrier stopping them from using the service

Practice	Themes				
	1	2	3	4	5
1					
2					
3					

Annex 7: Improvement plan template for each priority strategy identified

*this template can be copy/pasted for each separate strategy of the improvement plan incl. culture change

Area for improvement:		Timeframe including target dates	Responsible person(s)	Budget
Strategy 1				
Activity 1				
Activity 2				
Activity 3				
Activity 4				
Activity 5				

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