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Developing of Tool for Quality Assurance of Mental Health Inpatient Services in Azerbaijan

By

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Summary

The quality of care in mental health institutions is a serious concern in modern psychiatry. People with mental disabilities often face violation of their human rights. They often expose physical and sexual abuse, neglect, stigma, discrimination. Despite implementing the Mental Health Strategy adopted in 2011 in Azerbaijan, there is a lack of monitoring and evaluation of the provided services. The main goal of the study is to develop an instrument to monitor and evaluate the quality of mental health services in the context of human rights in Azerbaijan and to determine the reference intervals associated with good quality.

The study utilized observational cross-sectional design to examine the human rights, quality of life of inpatients and their satisfaction with the services in the Psychiatric Hospital N#1. A total number of 160 participants entered the study (100 inpatients, 30 family members and 30 staff members). The WHO Quality Rights Toolkit, the Schizophrenia Quality of Life Scale-Revision 4 and the Client Satisfaction Questionnaire were used as the main tools.

The results showed that the quality of services and the human rights the hospital were not fully met, precluding the provision of comprehensive and high-quality services for the persons with severe mental disorders. Unmet needs were higher in areas such as the right to exercise legal capacity, the right to personal liberty and security, and the right to live independently and to be part of the community. Some improvements were also necessary to meet needs concerning the right to an adequate standard of living, to enjoyment of the highest attainable standard of health and freedom from torture or cruel, inhuman or degrading treatment or punishment are protected and respected. Despite the level of the quality of life and satisfaction with services are average, there was a positive improvement in comparison with previous studies. The findings can be used for further improvement of the psychiatric services at Azerbeijan.

Key words: quality, human rights, violation, monitoring, Azerbaijan.

Resumo

A qualidade dos cuidados prestados nas instituições de saúde mental é uma preocupação relevante na psiquiatria moderna. As pessoas com perturbações psiquiátricas muitas vezes enfrentam violações a nível dos seus direitos humanos, incluindo abuso físico e sexual, negligência, estigma e descriminação. Apesar da implementação da Estratégia de Saúde Mental adoptada em 2011 no Azerbaijão, existe uma falta de acompanhamento e avaliação dos serviços prestados.

O principal objetivo deste estudo é desenvolver um instrumento para monitorizar e avaliar a qualidade dos serviços de saúde mental no contexto dos direitos humanos no Azerbaijão e determinar os intervalos de referência associados com a boa qualidade.

Foi elaborado um estudo com desenho transversal e observacional, centrado na avaliação do cumprimento dos direitos humanos e da qualidade de vida dos pacientes internados, assim como a sua satisfação com os serviços prestado no Hospital Psiquiátrico N#1. A amostra estudada foi de 160 (100 pacientes internados + 30 familiares + 30 membros do staff). Os instrumentos de avaliação foram o WHO Quality Rights Toolkit, a Schizophrenia Quality of Life Scale-Revision 4 e o Client Satisfaction Questionnaire.

Os resultados mostraram que a qualidade dos serviços e os direitos humanos no hospital não estavam plenamente atendidos, impedindo por isso a prestação de serviços integrados e de alta qualidade para as pessoas com transtornos mentais graves. As necessidades não satisfeitas eram mais elevadas em áreas como o direito ao exercício da capacidade jurídica, o direito à liberdade e segurança pessoal e o direito de viver de forma independente e fazer parte da comunidade. Também se evidenciaram necessidades não-totalmente satisfeitas em áreas relativas ao direito a um nível de vida adequado, ao gozo do mais alto nível possível de estado de saúde e à ausência de tortura ou de tratamentos ou penas cruéis, desumanos ou degradantes. Apesar do nível de qualidade de vida e da satisfação com os serviços serem apenas medianos, houve uma melhora positiva em relação aos estudos anteriores. Os resultados podem ser utilizados para a melhoria dos serviços de psiquiatria no Azerbaijão.

Resumen

La calidad de la atención en las instituciones de salud mental es un aspecto de gran relevancia en la psiquiatría moderna. Las personas con trastornos psiquiátricos a menudo se enfrentan a violaciones de sus derechos humanos, incluyendo abuso físico y sexual, la negligencia, el estigma y la discriminación. A pesar de la aplicación de la Estrategia de Salud Mental aprobada en 2011 en Azerbaiyán, hay una falta de seguimiento y evaluación de los servicios.

El objetivo de este estudio es desarrollar una herramienta para monitorear y evaluar la calidad de los servicios de salud mental en el contexto de los derechos humanos en Azerbaiyán y determinar los valores de referencia asociados con buena calidad.

Fue desarrollado un estudio de diseño transversal y observacional, para evaluar el cumplimiento de los derechos humanos y de la calidad de vida de los pacientes hospitalizados, así como su satisfacción con los servicios prestados en el Hospital Psiquiátrico N°1. La muestra fue de 160 pacientes hospitalizados (100 ingresados + 30 miembros de la familia + 30 profesionales). Los instrumentos de evaluación fueron el WHO Quality Rights Toolkit, el Schizophrenia Quality of Life Scale-Revision 4 y el Client Satisfaction Questionnaire.

Los resultados mostraron que la calidad de los servicios y los derechos humanos en el hospital no se cumplieron totalmente, impidiendo de este modo la prestación de servicios integrados y de alta calidad para las personas con trastornos mentales graves. Las necesidades insatisfechas fueron mayores en áreas tales como el derecho a ejercer la capacidad jurídica, el derecho a la libertad ya la seguridad personal y el derecho a vivir de forma independiente y ser parte de la comunidad. También mostró necesidades no-cubiertos en su totalidad en las áreas relacionadas con el derecho a un nivel de vida adecuado, al disfrute del más alto nivel posible de la salud y la ausencia de tortura o tratos o penas crueles, inhumanos o degradantes. A pesar del nivel de calidad de vida y satisfacción con los servicios de ser sólo mediano, hubo una mejora positiva en comparación con los estudios anteriores. Los resultados se pueden utilizar para mejorar los servicios psiquiátricos en Azerbaiyán.

Declaration:

This thesis is submitted in partial fulfillment for the award of the International Masters in Mental Health Policy and Services at the Faculty of Medical Sciences, the NOVA University of Lisbon.

This thesis is a presentation of my original research work. Wherever contributions of others are involved, every effort is made to indicate this clearly, with due reference to the literature, and acknowledgement of collaborative research and discussions.

The work has not been presented in part or whole to any other university or research institution, nor has it been submitted elsewhere for publication.

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Table of contents

List of Acronyms

WHO – World Health Organization

EPA – European Psychiatric Association

CRPD – Convention on the Rights of the Persons with Disabilities

UN – United Nations

CPT – European Committee for Prevention of Torture

SQLS - R4 – Schizophrenia Quality of Life Scale – Revision 4

CSQ-8 – Client Satisfaction Questionnaire -8

ECT – Electroconvulsive therapy

WPA – World Psychiatric Association

WHO - AIMS – World Health Organization Assessment Instrument for Mental health Systems

CHAPTER 1

INTRODUCTION

1.1. Brief summary of the problem

Mental health is an essential element of the healthcare. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community (1). Poor mental health is related to low living conditions, socio-economic status, hard work conditions, physical illnesses, discrimination, violence, human rights violations, etc. Hence the fundamental principle of promotion of mental health is respect and protects basic civil, political, socio-economic and cultural rights. It is vital to provide security and freedom by these rights to maintain a high level of mental health (2).

The burden of mental disorders has significant impact on health, human rights and economic consequences worldwide. Mental disorders are common in all regions of the world. One out of four people are affected by mental disorders in the world (3). In addition neuropsychiatric disorders have significant impact on the leading causes of worldwide disability. Almost 12% of the global burden of disease is counted on mental illnesses (4).

At the same time there is a huge gap between the need for treatment and its provision in most of countries. Between 76% and 85% of people with mental illness receive no treatment for their disorder in low and middle-income countries, while in high-income countries these percentages range between 35% and 50%. Another problem is the poor quality of care for many of those who get treatment. People with mental disabilities often face violation of their human rights which includes restrictions on the right to work and to education, unhygienic and inhuman living conditions, physical and sexual abuse, neglect, disregard civil and political rights, rights of citizenship. In addition harmful and degrading treatment practices such as physical restraint, seclusion and denial of basic needs and privacy in mental hospitals are reported in many countries (5). Thus lack of quality of services and human rights' violation are the actual problems nowadays.

The evidences point out that quality of care in metal health institutions remains a serious concern. In this regard expected outcomes are not predictably achieved even in health systems well-developed and resourced places. It is important to sustain a focus on the delivery of the improved outcomes and sought benefits, because if results are not as expected, early decisions should be made about necessity of modifying the strategy and selected interventions could be maintained to achieve better results. In addition, seeing the progress, achievements and the delivery of the quality goals to which they have subscribed will be helpful to maintain the motivation of stakeholders in the change process (6). WHO stands on the necessity of availability of valid, reliable, feasible and widely accepted quality assurance instruments such as guidelines and quality indicators. Such instruments should be developed by professional organizations and health services researchers (7).

Monitoring of mental health services is really an actual problem in Azerbaijan. Although Mental Health Strategy was adopted in 2011 (8) and the new mental health system was implemented, there is still lack of monitoring and evaluation of services. Monitoring instruments and procedures to assess the quality of mental health facilities are almost not available. Despite a lot of references about quality assurance in mental health worldwide, in Azerbaijan these issues are not addressed. At the same time lack of monitoring leads to poor quality of services and insufficient therapeutic outcomes, which prevent people from enjoying the highest standards of healthcare and human rights' protection (3). Thus, there is a real need to select a valid and easy-to-implement instrument, translate into Azerbaijani language and make it available for routine use.

1.2. State of the art and innovative aspects of study

On 2005 in Helsinki, representatives of 52 countries of the European Region (including the Republic of Azerbaijan) adopted a Declaration and a European Action Plan for the Protection of Mental Health, focused on tackling the negative consequences of mental disorders (9).

The National Mental Health Strategy adopted in 2011 in Azerbaijan points out the necessity of implement quality assurance procedures in public mental health services (8). In addition international documents such as Mental Health Declaration for Europe (9), WHO Mental Health Action Plan for 2013-2020 (10), WHO and EPA Quality Assurance in Mental Health Care (11), The International Declaration on Youth Mental Health (12) and the United Nations Convention on the Rights of the Persons with Disabilities CRPD (13) also stress the importance of monitoring and quality assurance procedures. According to aforesaid Declaration for Europe "the main priorities for

the next decade should be to foster awareness of the importance of mental well-being, to tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process, to design and implement comprehensive, integrated and efficient mental health systems, to address the need for a competent workforce, effective in all these areas, to recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services"(9).

The universal goals of the Action Plan are to promote mental well being, prevent mental disorders, promote human rights and reduce the mortality, morbidity and disability. Moreover, implementation of the Action Plan intended to ensure persons with mental illnesses to participate in the reorganization, delivery and evaluation of services (10).

EPA Quality Assurance in Mental Healthcare stresses the shortage of controlled trials for optimizing quality assurance in mental health systems, as well as the need to take into consideration the patients' perspectives for evaluation of services (eg, studies focused on the satisfaction with the services (7).

In 2006 the UN General Assembly adopted the CRPD (13). This document includes 7 articles such as the right to an adequate standard of living and social protection, the right to enjoyment of the highest attainable standard of physical and mental health, the right to exercise legal capacity, the right to personal liberty, the right to security, right to freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse, the right to live independently and to be included in the community. These articales from CRPD are the primary standards of quality in facilities in this study.

As far as we know, this study is the first research focusing on human rights and quality of services of psychiatric inpatient facilities in Azerbaijan. Until now neither patients satisfaction with the services, nor quality of life of inpatients have been evaluated in the Country. The study emphasizes the importance of improving both the quality of services and human rights protection in psychiatric hospitals. It also aims to detect essential quality problems and prepare recommendations for developing better approaches and better services for people with severe mental illness. Finally, the results obtained hereby might be compared with results of the similar studies implemented in other countires.

1.3. Objectives and expected achievements

The main purpose of the study is to develop a monitoring instrument for evaluation of the quality of inpatient mental health services in the context of human rights in Azerbaijan.

The specific objectives are:

- To select and adapt standards and indicators for quality assessment in inpatient facilities.
- To define reference intervals associated with good quality for selected indicators.
- To establish the procedures for monitoring of quality indicators.
- To pilot the instrument in real inpatient practice.
- To validate the tool for further implementation in mental health system of Azerbaijan.

1.4. Structure of the thesis

The thesis is divided into five chapters: Chapter 1 gives an introduction of the main subject; chapter 2 includes a non-systematic review of the literature on legislation, human rights observance and quality issues in psychiatric hospitals. Chapter 3 outlines the methodology carried out in the project, while chapter 4 describes the results of study. Finally, chapter 5 provides a discussion of the results given the results obtained in the other countries.

CHAPTER 2

CONCEPTUAL BACKGROUND

2.1. Human rights issues in psychiatric hospitals

Under the sponsorship of the United Nations, the human rights movement has become a genuinely international phenomenon (3). Nevertheless, worldwide people with mental health problems continue to suffer from human rights violation, stigma and discrimination (14). There are several regional instruments ensuring safety of the rights of individuals with mental disorders, enclosing the European Convention for Protection of Human Rights and Fundamental Freedoms, supported by the European Court of Human Rights (15),; Recommendation 1235 on Psychiatry and Human Rights accepted by the Parliamentary Assembly of the Council of Europe in 1994 (16); Nations General Assembly Resolution 46/119 on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, adopted in 1991 (17), the American Convention on Human Rights in 1978 (18); the Declaration of Caracas adopted by the Regional Conference on Restructuring Psychiatric Care in Latin America in 1990 (19).

In June 2016, the UN-Human Rights Council adopted a Resolution about mental health and human rights (20). Fundamental human rights were restated, and the specific human rights protections that need to be put in place for individuals with mental illness were underlined. The Council admitted the leading role of WHO in the field of health and the pivotal role of human rights in the implementation of the Mental Health Action Plan 2013-2020 and affirmed once again the responsibility and commitment of member states "to promote and protect all human rights and fundamental freedoms and to ensure that policies and services related to mental health comply with international human rights norms". The UN High Commissioner for Human Rights was requested by the Council to prepare a report "on the integration of a human rights perspective in mental health and the realization of the human rights and fundamental freedoms of persons with mental health conditions or psychosocial disabilities, including persons using mental health and community services" (20).

In addition to the International Covenant on Civil and Political Rights (21) and the International Covenant on Economic, Social and Cultural Rights (22), which are used to protect the human rights of those suffering from mental and behavioural disorders, the World Health Report 2001 (3) is the

most essential and critical international effort to protect the rights of the people with mental disorders.

The main agreement that protects and promotes the rights of people with disabilities, including those with mental disabilities, is the CRPD (13). States that signed the Convention have the liability to respect, protect, and fulfil internationally approved standards guaranteed to all people included in the convention. The signatory states acknowledge that the principles of the UN-CRPD should be integrated into their national legislations (23). Key principles of the convention reiterate respect for inherent dignity, individual autonomy covering the freedom to make one's own choices, full and productive participation and inclusion in the community, non-discrimination, equality of opportunity, and accessibility. The ratifying states should develop policies, legislation, and programs designed both to prevent abuse and, where it occurs, to guarantee appropriate support. The embracing principles of the UN-CRPD are an inclusion of disabled people into the society and communities rather than creating special rules and institutions (24). The UN-CRPD's general human rights are totally applicable to the situation of people with mental illnesses equally to people with other types of disabilities.

The UN-CRPD clearly states the right to health for all individuals with disabilities (Article 25) as well as the importance of health-related rehabilitation in building human and social potential, including the removal of barriers persons with severe disability face in attending individualized rehabilitation programs. The Convention contains particular provisions related to rehabilitation (Article 26), an essential but unnoticed aspect of the rights to health. Ratifying countries should accept appropriate mental health policies, laws and services that promote the rights of people with mental disabilities and encourage and allow them to make choices about their own lives, provide them with legal protections, and guarantee their full inclusion into the society. Mental health policy should promote human rights and provide the monitoring of different aspects of human rights in signatory countries (25).

The people in Europe are guided by the core human rights and experiences of service users and their families and carers, and there are three integral aspects of this action plan. (a) Fairness: individuals are given an opportunity to achieve the highest possible level of mental wellbeing, avoiding any form of discrimination, prejudice and neglect. (b) Empowerment: giving autonomy, independence to all people with mental health problems and giving them the opportunity to take responsibility authority and to make decisions about their lives, health and mental well-being. (c) Safety and effectiveness: developing trust by providing safe and effective activities and interventions, and

showing benefits to communities mental health and the wellbeing of people with mental disorders (26).

Although not legally compulsory, the resolution binds a number of fundamental rights which the international community considers as unbreakable either in the community or when persons with mental health problems receive treatment from healthcare institutions. There are two general categories for the 25 most important principles of the resolution: civil rights and procedures, and access to and quality of care. Principles state the essential freedoms and fundamental rights of mentally ill persons, criteria for the detection of mental disorders, protection of confidentiality, standards of care and treatment, especially involuntary admission and consent to treatment, rights of individuals with mental illness in mental health care facilities, supply of resources for mental health care facilities, provision of safeguards of the rights of mentally ill offenders, and procedural protection of the rights of the people with mental disorders (25)

According to international and national human rights documents, all measures should be taken to support voluntary admission and treatment and to avoid coercion. If involuntary admission and treatment are presumed necessary, strong safeguards have to be provided (27). Besides, examination of the conditions of detainement, access to grievance procedures, free legal consultation and other relevant assistance also should be ensured.

Over the past half a century, in the Europe and the USA, several mental health institutions with bad conditions have been closed down. To make a significant improvement in the lives of people with severe mental disorders, it is necessary to develop in LAMIC high-quality community mental health and primary care mental health services, in conjunction with general hospital acute care (28). Human rights violations can be reduced by deinstitutionalization and replacement of hospital-based care by community-based mental health service (29).

Violation of human rights among people with mental disabilities in psychiatric hospitals.

During their visits to different psychiatric hospitals in India and Central America, the Human Rights Commissions have revealed awful and unacceptable conditions for patients (30, 31). Many other psychiatric hospitals have the same problems, both in developed and developing countries. Many patients were in pyjamas or naked, living in filthy living conditions with leaking roofs, eroded and broken doors, broken windows, overflowing toilets (32). In some facilities, these conditions also involve lacking proper clothes, clean water for drink, fresh food, heating system, suitable bedding or hygiene facilities (33).

Besides this picture, service users are often subjected to inhuman and degrading treatment (34). Hospital staff sometimes put them in isolation rooms or restraints for a prolonged time (40). To make them docile and compliant, patients are often over-medicated (35). People with mental health problems, especially with mental disabilities, are often accepted as having the lack of the capacity to make decisions about their health in their interest. Many inpatients are improperly admitted to psychiatric facilities against their will and are treated without informed consent.

All over the world, the conditions in many psychiatric facilities are insufficient and jeopardize the patients' human rights, thus increasing chronicity (36). It is controversial that the living conditions and quality of psychiatric hospitals in developed countries are better than in developing ones.

According to Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez (37) ill-treatment in a health-care system was underestimated by the Special Rapporteur's mandates because only the denial of healthcare is generally considered as an obstacle to “right to health”. When several aspects of mistreatment and torture in healthcare setting identified by the Rapporteurship and United Nations mechanisms, there occurred a requirement to highlight the definite intensity and dimension of this problem, to detect abuses in the field of violations of the rights to health and to freedom from torture or cruel, inhuman, degrading treatment or punishment. The Special Rapporteur admits that there are unique obstacles to prevent torture and mistreatment in the healthcare system, such as, although never justified, authority defends particular experiences in healthcare on account of administrative benefits, modification of patients’ behaviour or medical necessity. The Committee against Torture deciphers State responsibility to stop torture as solid and interrelated with the urgency to prevent inhuman, cruel or degrading treatment or punishment, as these conditions increase the frequency of mistreatment that facilitates torture. In fact, the State have to prevent the torture in public officials, such as law enforcement agents, as well as physicians, other healthcare providers and social workers, including all of the working people in private psychiatric facilities, other institutions and detention centres.

Committee against Torture emphasizes that the prevention of torture must be applied in all types of institutions. The mandate of mentioned committee acknowledges that if treatments of an unalterable and obtrusive nature are enforced without a therapeutic purpose and the free and informed consent, it can be considered as torture or ill-treatment. This is especially the situation when intrusive and irreversible, non-consensual treatments are provided for vulnerable groups, for example, people with disabilities, in spite of the good intentions or medical needs. For instance, the discriminatory nature

of constrained psychiatric interventions, when perpetrated towards individuals with psychosocial disabilities, meets both intent and aim required under the Convention against Torture, Article 1 (38) despite arguments of "good intentions" by medical workers.

Under article 1 of the CRPD (13) individuals with disabilities include those who have long-term intellectual impairments, which, in interaction with various barriers, may inhibit their total and efficient participation in the community on an equal basis with others. They have been either ignored or confined in psychiatric and social care institutions, the psychiatric wards. Besides, the CRPD presents executive guidance on the rights of persons with disabilities and forbids involuntary treatment and involuntary confinement on the grounds of disability, replacing earlier standards such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (17). Critical abuses, such as negligence, mental and physical abuse and sexual violence, are still committed against persons with mental and intellectual disabilities in health-care settings. There can be no therapeutic rationale for the use of solitary confinement and extended restraint of people with mental disabilities in psychiatric facilities; both prolonged isolation and restraint may constitute torture and ill-treatment (37). There is well-documented evidence of people living their whole lives in such psychiatric or social care facilities. The Committee on the Rights of Persons with Disabilities has been very clear in calling for the prohibition of disability-based detention. The women living with disabilities, especially with psychiatric labels are at risk of various forms of discrimination and abuse in healthcare settings. (39). Forced sterilisation of girls and women with disabilities has been widely reported (41). National law in Spain, among other countries, permits for the sterilisation of minors who are determined to have severe intellectual disabilities (42). In 15 states of the USA have the laws that fail to defend women with disabilities from involuntary sterilisation (43).

Human rights of people with mental disorders in Azerbaijan

Provision for human rights protection of people affected by mental disorders is regulated by relevant legislation including the Constitution of the Republic of Azerbaijan (44), the Law on 'Health Protection' (45), the Law on 'Psychiatric Care' (46), other legal acts and international treaties adopted by Azerbaijani government. Lack of awareness and recognition of these norms often results in serious violations of patients' rights. For instance, some judges are reluctant to accept cases related to involuntary hospitalisation while mental health administrations are not interested in submitting such cases to courts. In recent years, this malpractice met sharp criticism from relevant

international bodies.

In 2006, the delegation of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) visited several mental health facilities in Azerbaijan. During the visit, the delegation assessed progress towards implementing the CPT's recommendations. It examined the situation in psychiatric establishments and evaluated the legal safeguards applicable to involuntary psychiatric patients under the Law on 'Psychiatric Care'. The visit revealed significant shortcomings related to conditions in the hospitals as well as to the observance of existing legislation. The CPT critical report resulted in a closure of the City Psychiatric Hospital #1 and refurbishment in the mental hospital in Sheki. Also, it promoted the actions on a development of procedures for implementing the Law.

During the follow-up visits in 2008, CPT delegation noticed "unlike during the 2006 visit, hardly any accusations of ill-treatment by staff were received at the mental hospital in Sheki where the vast majority of the inpatients now expressed positive feedback about the workers. Further, inter-patient violence did not appear to be a significant problem at the establishment (47)". At the same time, the delegation observed some signs of inter-patient violence in the largest mental hospital in Mashtaga, Baku, which often stemmed from the stressful living conditions and the scarce staff presence on the wards. Many of the patients' rooms offered no privacy (with beds often placed close together and in some cases touching), and lacked visual stimulation and personalization. As for involuntary admissions, the CPT delegation pointed out at both the №1 Psychiatric Hospital in Mashtaga and the regional mental hospital in Sheki, almost all civil patients were formally admitted as "voluntary". On admission to the facility, patients were requested to sign a recently-introduced form entitled "Application for voluntary hospitalisation". However, patients were kept in locked wards and the overwhelming majority of those with whom the delegation spoke declared that they had been held in the institution against their will and wanted to be released. It also became evident from the information collected by the mandate that during some of these patients admission they were in such a mental state that they were neither able nor assisted in giving a free and informed consent to their hospitalisation.

It is important to mention that an absence of clear procedures for the discharge of patients who have lost family and social relations is a substantial barrier regarding human rights protections. There are many examples when family members reject to accept their mentally ill patients back home after termination of their treatment in hospital. In such situation both doctors and hospital administration experience undecidable problem to discharge a patient regardless a high possibility that she or he

will stay on the streets or to keep a patient in the mental hospital without medical indications. In both cases, it is a violation of patients' human rights and medical ethics. Unfortunately, although there is legislation regarding sheltered housing and discrimination of people with mental disorders, the law is not enforced. Yet, psychiatric in-patients have a lack of adequate and free access to legal assistance.

Many of the problems related to patients' rights protection are due to inadequate coordination between various governmental bodies. For example, there is a lack of cooperation between mental health facilities and medical-social commissions within the Ministry of Labor and Social Security. Despite the legislation requires conformity of diagnoses with international standards adopted in the country, the named medical-social commissions use obsolete classification to assess disability, and they do not accept medical records made by mental health facilities.

In 2011, the mandate of CPT evaluated the improvement in providing legal safeguards of inpatients in psychiatric institutions after their previous visits and the extent to which the Committee's proposals have been achieved. As a positive fact, the mandate noted the progress associated with reconstructions in mental health facilities and better services. It was also mentioned that the director of the №1 Psychiatric Hospital in Mashtaga released directions to workers regarding the application of physical restraint and seclusion, allowing its use only after doctor's authorization and registration. At the same time, new recommendations were included into the CPT report published at the end of 2012.

The CPT visits, as well as the regular monitoring by the representatives of the Ombudsman Office, has been promoting positive changes in the field of human rights protection of persons with mental disorders. At the same time, it is important to have a monitoring mechanism carried out by civil society. The Article 42 of the Law on Psychiatric Care ('Public surveillance on the observance of human rights protection during psychiatric care provision') stipulates that mental health organisations could be eligible to monitor the human rights of persons receiving care at psychiatric services.

With this regard, the users' organisations may become an essential part of a process of human rights protection. Along with their official involvement in consultations on mental health policy and legislation, they may take part in direct advocacy for combating stigma, discrimination and human rights violation. Users and family organisations are able to influence governments on human rights protection and to increase public awareness on social integration of individuals with mental disorders. Organisations of users can also raise awareness about barriers to mental health, need for

mental health services, inadequate quality of care, scarce information about treatments, abuse and other violations (48).

2.2. Legislation, policy and services in Azerbaijan

The well-being of the population is a principal focus for governments. Policies across government can improve mental well-being and decrease vulnerability to risk factors. Mental illnesses are one of the significant global health challenges in the European Region due to its high prevalence, the burden of disease and associated disability. Mental disorders, including schizophrenia, depression and anxiety are major causes of disability, early retirement and economic burden in many countries, thus demanding policy action (26).

The legislation is necessary to assure that the essential human rights of people with mental disorders are protected. Policies and laws should provide the respect of human rights and meet the obligations set out by international and European human rights documents, taking into consideration the needs of vulnerable groups. The greater majority of European countries have already signed the International Bill of Human Rights (49) (the Universal Declaration of Human Rights (50), the International Covenant on Economic, Social and Cultural Rights (22) and the International Covenant on Civil and Political Rights (21)) and the Council of Europe Convention for the Protection of Human Rights and Fundamental Freedoms (15). These instruments created legally bound duty on governments to respect, secure and fulfil the human rights within them. Additionally, both the United Nations and European human rights systems have various internationally accepted standards related to the rights of individuals with mental health problems (9). The central purpose of mental health policies and legislation is being redirected towards developing opportunities that enable people with mental disorders to make use of their own decisions and to take part fully in community and family life which they are entitled. The mental health policies require combining a reform of services with particular attention to quality, guaranteeing the delivery of reliable, effective and appropriate treatment by the qualified workforce (26). Also, the policies and programmes must promote the right to privacy, individual autonomy, the right to equality and non-discrimination, the right to information and participation and freedom of religion, assembly and movement.

In Azerbaijan, provision for human rights protection of people affected by mental disorders is regulated by relevant legislation including the Constitution of the Republic of Azerbaijan, the Law on ‘Health Protection”, the Law on ‘Psychiatric Care’, other legal acts and international treaties

adopted by Azerbaijani government (44, 45, 46). The Law on 'Psychiatric Care' is to administer relations in the course of mental health care provision as well as to determine rights and responsibilities of physical and judicial bodies in this respect.

In 1996, WHO developed the Mental Health Care Law: Ten Basic Principles (51) as a further interpretation of the UN General Assembly Resolutions such as Principles for the Protection of Persons with Mental Illness (17) and as a guide to assist countries in developing mental health laws. The principles include promotion of mental health and prevention of mental disorders, access to basic mental health care, mental health assessments in accordance with internationally accepted principles, provision of least restrictive type of mental health care, self-determination, right to be assisted in the exercise of self-determination, availability of review procedure, automatic periodic review mechanism, qualified decision-maker, respect of the rule of law (51). All these principles have been reflected in the Law on 'Psychiatric Care', and mental health care of persons with mental disorders should be based on legitimacy, humanity, and observance of human and civil rights and freedoms (see Art.3)

According to the legislation, people with mental disorders have the same rights and benefits as patients receiving care in other health facilities. These rights are listed in the Article 6 and include the followings:

- Respectful attitude and prohibition of degrading treatment;
- Access to free mental health care meeting adopted standards for governmental health facilities;
- Access to information about patients' rights as well as about the mental disorder and methods of treatment;
- Admission to psychiatric facility for a period necessary for assessment and treatment only;
- Receiving all available treatment in accordance with medical indications;
- Choice of any professional eligible to provide psychiatric care (after obtaining his or her consent);
- Choice of any mental health facility;
- Access to consultations with other medical professionals;
- Access to lawyer;
- Legal representative and other persons.

In addition according to the Article 15 the government guarantees:

- Psychiatric care in case of emergency; inpatient and outpatient assessment, counselling,

treatment, prevention, and rehabilitation;

- All kinds of psychiatric examination including forensic, psychosocial (disability), and conscript (fitness for military service);
- Social care and disability pension; determination of guardianship and trusteeship; psychosocial support for natural and human-made disasters' survivors;
- General and professional education for non-adult persons with mental disability;
- Occupational therapy and special provisions for employment of people with severe mental illness;
- Sheltered accommodation for social withdrawn and homeless people with mental illness;
- General health care for people with mental illness;
- Other provisions necessary to maintain the social security of people with mental disorders.

The Article 5 considers the issues of voluntary mental health care. Mental health care is provided on the basis of free and informed consent. The consent must be obtained in written form freely, without threats or improper inducements and signed by a patient (or his/her legal representative) and a mental health professional responsible for the case. No treatment should be given to a patient without his or her informed consent, except as provided for involuntary admission. A patient or his/her legal representative has a right to refuse from suggested care or to stop it at any moment. In this case, they should be informed about possible consequences of this decision (Article 10).

Mental health legislation also protects confidentiality by providing for sanctions and penalties for breaches of confidentiality, either by professionals or mental health facilities. The Article 7 points out persons with mental disorders have the right to confidentiality of information about their mental state and treatment; such information should not be disclosed to third parties without their consent excluding certain exceptional cases stipulated by the legislation. Professionals and mental health facilities and other official authorities are responsible for keeping in secret the information related to patients.

Persons receiving (or have been receiving) mental health care have a statutory right to free and full access to their clinical information maintained by mental health facilities. These persons should be provided with the information within two days after their written application. Access to information may be restricted in exceptional situations when clinical records of a person put at risk the safety of the patient or others. The family members may get the information necessary to be better able to look after their relatives only, and they have no access to information that may cause serious harm to him or her.

The Article 8 recognises the principle of care delivered in the least restrictive alternative. Mental health care is given no longer than is necessary without restriction of patients' rights and freedoms and with the use of treatments meeting criteria of good clinical practice.

Although the legislation emphasises that every effort shall be made to avoid involuntary admission in exceptional cases people with mental disorders may be admitted and treated involuntarily. The Article 11 of the Law on 'Psychiatric Care' includes clear criteria for involuntary admission which include the followings:

- Serious immediate danger of a patient with mental disorder for self or others (examples suicide attempts, aggressive behaviour)
- Helplessness i.e. inability to meet essential life needs due to mental illness (e.g. catatonic stupor, severe dementia)
- If a person whose mental illness is severe and likely to lead to a serious deterioration in his or her condition and will prevent the giving of proper treatment that can only be provided by admission to a mental health facility.

The Article 25 describes the procedures related to involuntary admission in the case of emergency. A person involuntary admitted to mental health facility should be evaluated within 48 hours, and discharged immediately after if his/her hospitalisation is considered as unfounded. In a case of valid reasons for involuntary admission (confirmed by a commission of three psychiatrists), a clinical report should be submitted to a local court no later than 48 hours after hospitalisation. The court checks the adequacy of the reasons indicated in the report against the criteria listed in the Article 11 and then take an appropriate decision regarding involuntary admission and treatment.

Regardless voluntariness of admission, all patients treated in mental hospital are eligible to apply at any time to the hospital administration, as well as to require observance of their rights and interests. They also are eligible to apply freely to the Head Psychiatrist of the Ministry of Health, the executive authorities, the office of the Prosecutor, the Ombudsman Office, the courts and his/her legal representative (lawyer). Although legislation provides many rights to persons with mental disorders, they may be unaware of their rights and thus unable to exercise them (WHO Resource Book). Therefore the legislation includes a provision for informing patients about the reasons and goals for hospitalisation, their rights, and hospital regulations as soon as possible after admission as the patient's condition permits (article 23).

Besides this legislation, The Republic of Azerbaijan has also signed the Declaration of Helsinki, accepting its obligations on the realisation of an Action Plan based on the Declaration principles,

and adopted a new National Mental Health Strategy in 2011.

The National Mental Health Strategy aims to protect and prevent the impairment of mental disorders, to arrange the conditions for providing accessible, effective and comprehensive care for population, to protect the human rights and interests of people with mental illnesses and to counter stigma and discrimination, and to improve the social support for people suffering from mental disorders and their families. There are five priority areas, including the followings: improvement of governance and intersectoral coordination in mental health and human rights protection, improvement of mental health resources (human resources, physical capital, and investment), extending measures to prevent mental disorders among population, integration of mental health services into primary health care and development of mental health and social welfare services for people with mental health problems. The strategy covers a 5-years strategic action plan between 2011 and 2015, emphasising the evaluation of outcomes. Unfortunately, there is a lack of monitoring instruments for assessment the outcomes of the strategy, creating an obstacle to the full implementation of the mental health plan.

Mental health care in Azerbaijan contains an institutional approach based on the old Soviet model. The total number of mental health outpatient facilities in Azerbaijan is 8, while of mental hospitals is 11. 2 general hospitals have the psychiatric departments. There are 5-day treatment facilities and seven community residential facilities. The number of beds in psychiatric hospitals is 3076, 60 of them are reserved for children and adolescents, while general hospitals contain only 70 beds for all. Mental health expenditures cover around 2-3% of the total health care budget. Approximately 85% of this expenditure is allocated to mental hospitals (52). The main mental health services are provided at the psychiatrists' offices in out-patient clinics, out-patient psychiatric facilities, psychiatric hospitals and offices in several private centres. Day-care units are available in some of the psychiatric hospitals. Psychiatric outpatient facilities and hospitals are located in urban areas. Two psychiatric hospitals, one psychiatric unit in general hospital and one out-patient mental health centre are located in the capital city, while the others are available in the other cities. All state health facilities are free of charge and accessible to all service users, however, some additional services may have charges (53).

The number of mental health professionals such as psychiatrists, psychiatric nurses is insufficient. Their training does not meet international requirements for professional education at both undergraduate and post-graduate levels. There is no special educational programs in child and adolescent psychiatry, geriatric and forensic psychiatry. Special psychotherapy programs are absent.

Lack of clinical psychologists, social workers, occupational therapists also has a negative effect on the provision of mental health care. Despite the existence of psychosocial interventions, services in inpatient facilities are mostly focused on psychotropic medication (54). For last five years, the mental health services are in the process of important development, shifting institutional services to modern integrative community-based mental health care. During this reform, psycho-neurological dispensaries (PND) transformed into mental health centres and most of older workers of PND were sent to district primary healthcare settings. The newly set up centres not only employed the psychiatrists, but also created a multidisciplinary team with clinical psychologists, social workers, and occupational therapists. (53).

2.3. WHO QualityRight Toolkit

The WHO QualityRights tool kit - a tool to assess the quality and human rights in mental health and social care facilities was developed based on the CRPD by the WHO. The tool kit covers the large-scale review of people with mental disabilities and related organizations. The primary purpose of this instrument is to ensure the assessment, improvement of the quality and promotion of human rights in mental health facilities and social care homes in various countries. The instrument can be used by different international, as well as national organizations, such as stakeholders, NGOS, human right institutions, national health commissions, etc. All inpatient and outpatient facilities providing care, treatment and rehabilitation for those suffering mental health problems can be assessed within instrument in order to identify problems and to guarantee that the facilities provide services with high quality, respectful of human rights and sensitive to the users' requirements. (55).

CHAPTER 3

METHODOLOGY

3.1. Study design and subjects

The study utilizes an observational cross-sectional design to examine the human rights, quality of provided services and satisfaction with services.

The study was carried out in five departments of Psychiatric Hospital №1. The total number of participants were n=100 inpatients and n=30 family members who were admitted to the hospital and n=30 staff members of the facility. 20 inpatients and 6 staff members were randomly selected from each department. Participants represented the population from both genders. All participants were interviewed by professionals trained in using relevant assessment tools. Consent form were obtained from all participants and they were given information about the purpose of the study and their right to cancel attendance.

Group	**Planned number**	**Conducted number**
Service users	100	100
Family members /caregivers	50	30
Staff	30	30
Total	**180**	**160**

Research team included 3 psychiatrists and a clinical psychologist from National Mental Health Centre who trained on using the "WHO Quality Rights Toolkit - Assessing and improving quality and human rights in mental health and social care facilities" and Human Rights.

3.2. Study setting

The study took place at Psychiatric Hospital №1 of the Ministry of Health which is the largest psychiatric facility in South Caucasus. The hospital is intended for 1890 in-patients suffering from severe mental disorders while people with less serious mental conditions may get an out-patient treatment. This hospital is the only inpatient facility in our country utilizing modern services. The

hospital has ten male wards and six female wards, as well as specialized wards for patients with drug addiction, tuberculosis, and other infectious diseases. In addition there are wards for children and adolescents, elderly persons and forensic patients. Each ward has from 50 to 70 beds. The total number of staff members is approximately 800, including psychiatrists, other physicians, clinical psychologists, occupational therapists, nurses, orderlies and auxiliary personnel. The hospital was repaired and supplied with new equipment meeting necessary standards.

3.3. Sampling recruitment plan, inclusion criteria

Study participants included inpatients, their family members, and medical staff. The five wards (three male, two female wards) were selected randomly by use of a special software (56). The same approach was utilized in selecting 20 inpatients in each ward. The 5 participants from nursing were randomly chosen and a psychiatrist working in each ward was invited as a sixth participant. Randomization of family members or caregivers was not possible because of their insufficient number of people consenting to take part in the survey.

The inclusion criteria for patients were the followings:

- informed consent to participate in the study;
- minimal age of 18 and maximal age of 60;
- length of treatment in the hospital no less than one month;
- absence of intellectual disability, acute psychoses or substance abuse

The inclusion criteria for family members or caregivers were the followings:

- consent to participate in the study;
- age of 18 or more
- caring of patients

The inclusion criteria for staff were the followings:

- consent to participate in the study;
- length of employment in the hospital no less than six months;

3.4. Overall method

The study was conducted in five stages. At the first stage we discussed with the mental health authorities. The instrument was selected for evaluation of the facility, in addition to other instruments to assess the quality of life of patients and their satisfaction with provided services.

They were translated into Azerbaijani language. The discussion also included creation and selection of a trained assessment team consisting of three psychiatrists and a clinical psychologist.

The second stage covered the selection of wards and participants. Training was provided for interviewers. Before research, pilot interviews were conducted with ten patients, two family members and one mental health worker, in order to detect whether or not questions were clear for them (these patients were not included in the main study). According to the feedback from interviewers and interviewees regarding its utility, the toolkit was refined and the necessary changes were made in the research protocol.

At the third stage the study was carried out. The interviews were conducted with patients, family members and staff. Taking into consideration that the study was conducted in inpatient services, visits were arranged according spare time of patients. The first visit to each department was unannounced. Interviewers visited the facility until all interviews were conducted. Interview was provided face-to-face and in privacy. Socio-demographic and other variables (eg, duration of hospitalization, diagnosis) obtained from the patients were cross-checked with hospital data. Each interview lasted between 40-90 minutes (average 45) with patients and 20-30 minutes with staff and family members. At the same time, observation of the conditions in facilities was conducted and a review of service users' files was recorded.

Data was included into Statistical Package for the Social Sciences (SPSS 16.0), and analyzed at the fourth stage. The fifth stage included the writing of the thesis.

3.5. Selection of instruments

1. ***WHO Quality Rights Toolkit to assess and improve quality and human rights in mental health and social care facilities,*** translated and adapted into Azerbaijani. This tool was designed for collecting essential information and improving the quality of services and human rights issues in the facilities. This toolkit has 5 main themes based on CRPD which each one contains standards with 3 to 7 criteria. The themes included the followings:

   - The right to an adequate standard of living (Article 28 of the CRPD) ;
   - The right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD);

- The right to exercise legal capacity and the right to personal liberty and the security of person (Articles 12 and 14 of the CRPD) ;
- Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD);
- The right to live independently and be included in the community (52).

The criteria rated as “Met fully” - if entrant completely pleases, “Met partially” - if entrant a little bit pleases, “Unmet” - if entrant does not please, “Not applicable” - if the criteria is not applicable for the facility, “Don't know” - if entrant has no idea about emphasized situation.

2. ***Schizophrenia Quality of Life Scale Revision 4 (SQLS-R4)*** – This is a tool designed to measure the quality of life of schizophrenic patients. This scale, created by Wilkinson et al., covers the main life areas highly relevant to people with schizophrenia (57). It has 33 items, with two sub-scales: 13 items for cognition and vitality and 20 items for psychosocial feelings. Items are scored with a Likert scale (never=1, rarely=2, sometimes=3, often=4, sometimes=5). The scores have been standardized by an algorithm, from 0 to 100, with higher score meaning lower quality of life. The scale has been translated and adapted into Azerbaijani.

3. ***Client Satisfaction Questionnaire (CSQ-8)*** – This is an 8-item self-report scale designed to measure patients' satisfaction with services (58). The items cover areas such as quality of service, kindness of service, extent of program, amount of service, outcome of service, general satisfaction and support of staff. The CSQ-8 is unidimensional, yielding a homogeneous estimate of general satisfaction with services. Each item scores 1-4. Total satisfaction score ranges from 8 to 32, with higher score indicating higher levels of satisfaction. It was translated and adapted into Azerbaijani.

Translation and back-translation was done by professional translators and professional mental health workers together.

3.6. Trainings for interviewers

Two first-year residents of Psychiatry and one clinical psychologist from the National Mental Health

Centre were selected as interviewers. Their training included human rights, quality assurance, survey-conducting, data management, interview scoring, etc. To ensure their interviewing skills they conducted a initial assessment of ten patients, two family members and a special mental health professional. The feedback from pilot trial participants was deeply discussed before acceptation

3.7. Statistical analysis.

The data was analysed with SPSS-16®. Analysis of outcomes was carried out by using descriptive statistics. Frequency distribution of criteria of all standards was determined separately for patients, staff and family members. Spearman's rank correlation was applied to determine relationship between client satisfaction score and quality of life scores. Cronbach's alpha and Spearman's rank correlation was used for describe internal consistency of the SQLS-R4. The correlation was assessed for the SQLS-R4 subscales. The correlation sets for small $r = 0.1 - 0.3$; medium $r = 0.4 - 0.6$; strong $r = 0.7$ and more. 0 indicates no relation. The internal consistency for Cronbach's alpha sets as for excellent $\alpha > 0.9$; good $\alpha > 0.8$; acceptable $\alpha > 0.7$; questionable $\alpha > 0.6$; poor $\alpha > 0.5$; and unacceptable $\alpha < 0.5$. The significance level for all tests was established at $p < 0.05$.
The results calculated as following: achieved fully >70% responses of totally met, not initiatied > 70% responses of totally unmet, the other results was considered as partially met. In case of the question is not suitable for participant, or they do not know the answers the result indicated as don't know/not available. These numbers are given artificially because there is no exact formula for calculating the results.

3.8. Ethical considerations

Ethical approval for carrying out study was obtained from Ethical Committee of the Azerbaijan Psychiatric Association. To prevent damage to life, health, welfare, dignity of participants the research was studied according to Legislation of Mental Health (Mental Health Legislation, 2011). During the study all investigators are responsible for the protection of anonymity and confidentiality of each participant. Informed consent was obtained from all participants at the beginning of the study. An informed consent form providing information for the assessment, confidentiality, right to cancel attendance was read and signed by all participants.

CHAPTER 4

RESULTS

4.1. Socio-demographic characteristics.

100 inpatients, 30 family members and 30 staff members were involved in the study.

Patients: The sample population was 60% male. The age range was 18 to 60 (female: 21 to 60, male: 19 to 57). There was a predominance of single (51%) and divorced (23.4%) patients. Middle-income group was predominant with 56%, followed by 40% low income group. Majority of patients (81%) were unemployed. Number of hospitalization varied between 1 to 45 times while duration of hospitalization ranges between 1 to 276 months (23 years). Most of patients were diagnosed with schizophrenia (68%).

Table 1. Socio-demographic characteristics of the patients

Variable		Patient
Gender:	Male	60 (60%)
	Female	40 (40%)
Age M (SD):	Total	42.19 (11,031)
	Male	39.98 (1,418)
	Female	45.50 (1,640)
Marital status:	Single	51 (51%)
	Married	13 (13%)
	Divorced	32 (32%)
	Widow(er)	4 (4%)
Educational level:	Primary	7 (7%)
	Secondary	59 (59%)
	High	16 (16%)
	Vocational	18 (18%)
Social status:	Low	40 (40%)
	Middle	56 (56%)
	High	4 (4%)
Employment status:	Yes	19 (19%)
	No	81 (81%)
Diagnosis:	Schizophrenia	68 (68%)
	Schizoaffective disorder	7 (7%)
	Bipolar disorder	3 (3%)
	Depressive episode	4 (4%)
	Personality disorders	15 (15%)
	Dissociative disorders	3 (3%)
Number of hospitalizations M (SD):		4,47 (5,458)
Length of stay (months) M(SD):		45,06 (62,806)

Staff: The number of female staff participants (90%) was higher than the male (10%). The workers' age ranged from 23 to 56. The length of service changes from 1 year to 22 years. The proportion of nurses was 26.7%, following by 46.7% of other workers including occupational therapists, cook and maid.

Table 2. Socio-demographic characteristics of the staff members

Variable		Staff
Gender:	Male	3 (10%)
	Female	27 (90%)
Age M (SD):	Total	37.90 (10.930)
	Male	43.67 (5.897)
	Female	37.26 (2.117)
Marital status:	Single	10 (33.3%)
	Married	18 (60%))
	Divorced	1 (3.3%)
	Widow(er)	1 (3.3%)
Educational level:	Primary	1 (3.3%)
	Secondary	10 (33.3%)
	High	8 (26.7%)
	Vocational	11 (36.7%)
Social status:	Low	11 (36.7%)
	Middle	18 (60.0%)
	High	1 (3.3%)
Profession:	Psychiatrist	5 (16.7%)
	Psychologist	3 (10.0%)
	Nurse	8 (26.7%)
	Others	14 (46.7%)
Length of service (year) M (SD):		6.43 (6.345)

Family members: There were more female family members (63.3%) than male (36.7%). The age range was 25 to 68. Married family members were dominant with 56.7%. Parents were the most frequent visitors (33.3 %), followed by patients' children (23.3%).

Table 3. Socio-demographic characteristics of the family members

Variable		Family member
Gender:	Male	11 (36.7 %)
	Female	19 (63.3%)
Age M (SD):	Total	45.43 (12.437)
	Male	43.55 (4.328)
	Female	46.53 (2.628)
Marital status:	Single	6 (20%)
	Married	17 (56.7 %)
	Divorced	4 (13.3%)
	Widow(er)	3 (10%)
Educational level:	Primary	0 (0%)
	Secondary	9 (30%)
	High	16 (53.3%)
	Vocational	5 (16.7%)
Social status:	Low	2 (6.7%)
	Middle	26 (86.7%)
	High	2 (6.7%)
Employment status:	Yes	23 (76.7%)
	No	7 (23.3%)
Relationship with patients:	Parents	10 (33.3%)
	Husband/wife	5 (16.7%)
	Siblings	6 (20%)
	Children	7 (23.3%)
	Others	2 (6.7%)

Kruskal-Wallis test revealed significant difference due to *educational level* between the 3 groups ($\chi2$=12.517; df=2; p=0.002). Oneway ANOVA test showed significant differences between *age* of participants (f=3.328; df=2; p=0.036). The Pearson Chi-square showed statistically significant difference in *marital status* between participant groups ($\chi2$=43.282; df=6; p=0.000).

There was also statistically significance in *gender* ($\chi2$ =24.572; df=2; p=0.000). The rate of male on inpatient group and the rate of female on staff and family member group were higher. The *employment status* of family members was statistically significant higher than the patients status ($\chi2$=35.090; df=1, p=0.000).

4.2. Usage of WHO QR Toolkit

The tables of results from Table4 to Table18 are given as Annex I (results of patients), Annec II (results of family members) and Annex III (results of staff).

4.3. Schizophrenia Quality of Life Scale Revision - 4 and Client Satisfaction Questionnaire – 8

After analyzing data with descriptive statistics, the Table19 demonstrated that the minimum and maximum scores of total SQLS-R8 were 27.27 and 74.55 (M=49.43; SD = 12.04). Mean of subscale 'Cognition and vitality' was M=51.37; SD=11.96 and of subscale 'Psychosocial feelings' was M=48.17; SD=14.35. SQLS-R4 showed good internal consistency (Chronbach's Alpha = 0.870). The higher score indicates lower quality of life.

Table19. Minimum, maximum, mean number of SQLS-R4

	Minimum	Maximum	Mean
Total score	27.27	74.55	49.43 (37.39-61.47)
Cognition and vitality	30.77	78.46	51.37 (39.41-63.33)
Psychosocial feelings	24.00	81.00	48.17 (33.82-62.52)

The Spearman's rank correlation revealed that there was a significant correlation between cognition and vitality subscale and psychosocial feeling subscale. (r=0.564, p=0.000)

In accordance with the table 21, the descriptive statistics showed that the minimum score of CSQ-8 was 8, while the maximum score was 32. (M=21.11; SD=5.980). At the same time, higher values indicates higher satisfaction.

Table20. Minimum, maximum, mean number of CSQ-8

	Minimum	Maximum	Mean
The score of CSQ-8	8	32	21.11 (15.13–27.09)

4.4. The correlation between quality of life and satisfaction with services provided

According to Spearman's rank correlation test there was statistically significant negative correlation

between the CSQ-8 and total score of SQLS-R4, subscale cognition and vitality, subscale psychosocial feelings.

Table21. Correlation between Total SQLS and subscales

Correlation		Total SQLS	Cognition and vitality	Psychosocial feelings
CSQ-8:	Pearson correlation	-0.459	-0.370	-.435
	Sig. (2-tailed)	0.000	0.000	0.000
	N	100	100	100

There was no correlation between CSQ-8 score and number of hospitalization or duration of illness. In addition, the correlation between SQLS scores and number of hospitalizations or duration of illness also was not found. However, there is correlation between marital status and number of hospitalization (r=0.252; Sig.=0.012).

CHAPTER 5

DISCUSSION

5.1. Discussion of the results.

The current study is the first initiative to evaluate the quality of psychiatric hospitals regarding human rights in Azerbeijan. For this study, I developed an instrument to assess the quality of services in the hospital using CRPD articles, yet considering patient perspective *(55)*. The study demonstrated that the toolkit is valid and culturally appropriate for this kind of assessment in Azerbaijan. Within the pilot trial the questions were cleared and in the study all questions were understandable to all participants. In addition, this study was the first to use the SQLS-R4 and CSQ-8 tools to assess client satisfaction and quality of life.

A major strength of the research is that the study allowed us to understand both the achievements and the weaknesses occurred in the psychiatric hospital since policy has been implemented. The hospital's good performance was displayed with the relatively high score by providing the right to an adequate standard of living and social protection (A 28) and the right to enjoyment of the highest attainable standards of physical and mental health (A 25). The hospital's weakness was shown in two important areas: the right to exercise legal capacity and the right to personal liberty and the security of person (A 12 and 14), and the right to live independently and be included in the community (A 19).

Although there are many studies conducted about the quality of psychiatric hospitals, only two studies were found with the application of the WHO Quality Rights Toolkit- one in Chile and one in Greece. The study in Chile was carried out in ambulatory psychiatry care services which demonstrated that the level of respect for rights of user were lower in inpatient services than in outpatient ones (66**).** The Greek researchers studied both the psychiatric clinic and the urologic clinic to examine the difference human right issues between the service users. Their study showed a disparity between the two departments in treatment and sustainment of human rights. The clients in the urology clinic have better recognition of the right to an adequate standard of living than the patients in the psychiatric one. The psychiatric patients were not considered to have legal capacity and equality before the law. They face stigmas and barriers that prevent full participation in society. There is the violation of fundamental human rights such as the right to liberty and security of the person, the right to equal enjoyment of all human rights and fundamental freedoms and to respect of

patients' inherent dignity, the right to give free and informed consent to medical treatment in Greece (64).

Table 22. Overall conclusion of the theme 1.

Theme 1. The right to an adequate standard of living (Article 28).	**Patients**	**Family**	**StaFF**
Standard 1.1: The building is in good physical condition.	AF	AF	AF
Standard 1.2: The sleeping conditions of service users are comfortable and allow sufficient privacy.	AP	AF	AF
Standard 1.3: The facility meets hygiene and sanitary requirements.	AF	AF	AF
Standard 1.4: Service users are given food, safe drinking-water and clothing that meet their needs and preferences.	AF	AF	AF
Standard 1.5: Service users can communicate freely, and their right to privacy is respected.	AP	AP	AP
Standard 1.6: The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.	AP	AP	AF
Standard 1.7: Service users enjoy a fulfilling social and personal life and remain engaged in community life and activities	AP	AP	AP

In the **first** theme, there were no big differences between the opinion of the service users, family members and staff. The achievement was attained in compliance with the standards the good physical condition of the building, the hygiene and sanitary requirements of the facility, the food, drink and clothing that meet the patients' needs. The study carried out in Portugal has showed that the level of disability of patients is positively associated with living environment (69). In this regard, the patients, family members and staff totally satisfied with these standards in the facility. However, all these groups were partially pleased with an enjoyment of fulfilling social and personal life and

remaining engaged in community life and activities. In the perception of the service users and caregivers, the standards of sleeping conditions, communicate freely and the respect to their right to privacy, the welcoming, comfortable environment conducive to active participation and interaction were met partially, while the staff commented on the same only the standard of freely communication and respect to the right to privacy.

The observation of the interviewers displayed that the building condition is repaired in good condition and is provided necessary tools to protect inpatients against fire. Although participants stated that the facility is accessible for people with physical disability, there were no elevators or alternatives to stairways available in the setting. Two wards had a specific light unpleasant smell. There are separate wards with shared rooms for women, men and children in the hospital. The sleeping conditions are comfortable and sufficient. Some rooms are overcrowded. Killaspy et al. (70) revealed that the quality of care for patients with a defined expected maximum length of stay is higher in smaller units than larger units, which have poorer quality. Patients in smaller hospital unites (2-6 beds) were free to go to bed when they want and lay in bed during the day. However, the patient's had no privacy. Furthermore, patients were able to store their personal belongs, but the wardrobes were not private, lockable spaces. The bathing and toilet facilities are generally clean. However, there was a dropping in the bathroom in one ward. Eating areas are clean and culturally appropriate. The food given is in a good quality, but some patients were not satisfied with the dietary options. All patients are provided with appropriate clothing if they need. Patients were not allowed to use personal phones and did not have access to the internet while in the wards. Calls were only allowed to be made through staff phones with the doctor's permission. Service users can receive visits only from their close relatives during the day and they are then able to hold private conversations. Patients can move and communicate freely inside of the ward. The access to outdoor areas is given only to some patients who are not aggressive. Their communication with opposite sex was limited. The furniture in good quality is provided in wards. However, they are insufficient. All patients easily communicate with staff and with each other in any language. Facilities provide few leisure opportunities, including books, TV, some table games, knitting, and painting. Nevertheless many patients do not spend time with these opportunities.

Table23. Overall conclusion of the theme 2.

Theme 2. The right to enjoyment of the highest attainable standard of physical and mental health (Article 25).	**Patients**	**Family**	**Staff**
Standard 2.1: Facilities are available to everyone who requires treatment and support.	AF	AF	AF
Standard 2.2: The facility has skilled staff and provides good quality mental health services.	AP	AF	AF
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.	AP	AP	AP
Standard 2.4: Psychotropic medication is available, affordable and used appropriately	AP	AP	AF
Standard 2.5: Adequate services are available for general and reproductive health.	AP	AP	AF

In the **second** theme, the standard of availability of facility to everyone who requires treatment is achieved fully as a result of the interviewees' response. The patients consider that the skill of the staff and provision of mental health services in the hospital met their needs partially while considering the family members and staff's opinion. This standard was met fully. According to the conclusion of the analysis of all interviews, the standard of "treatment, psychosocial rehabilitation and links to support network are an essential parts of the service user-driven recovery plan and contribute their ability to live independently" is achieved to a limited extent. However, satisfaction with availability of the psychotropic medications and adequate services for general and reproductive health was partially reached for the patients and the family members, while staff considered these standards as achieved fully.

According to the researcher's observation, no person who requests treatment for severe mental health problems is denied for admittance to the hospital. All patients are examined for physical health on admission to the hospital. The blood analyses, tests to check specific infections, X-ray are the essential part of the first physical examination. According to Choi SK et al (71), there is a gap in

delivering mental health services to depressed HIV-positive patients in Ontario. They suffer from unequal access to these services.

The staff is skilled with sufficient professional skills to provide necessary counseling. Whereas, training about human rights, especially rights of the persons with disabilities is necessary. In addition, there is a lack of clinical psychologists and social workers. Staff refer patients to general health care system, community-based mental health services if necessary. They help patients to be in touch with their close family members. The patients can consult with staff when they want. However, they generally insist on giving cigarette rather than gaining information about their treatment which sometimes causes a controversy. Users can express their complaint, however their complaints are not always taken into consideration.

Services users that are involuntarily admitted do not always have their preference consider for their care. In some cases, the user's preference for psychotherapy is not supported.

Majority of participants reported that the facility has comprehensive, individualized recovery plan with social, medical goals. However, that finding differs from what was observed in reality. The hospital generally provides treatment with few medications, which include typical neuroleptics, TSAs, only a few atypical antipsychotics. This also limits appropriate treatment of different type of mental disorders. Staff provides the patients with the information about their illness, medications, general health issues when they ask for. Some patients have incomplete information from their experiences, while others are not interested in getting any ones. In some cases, this is related to the negative consequences of the illness. On the other hand, according to the patients' reports, the prescription of medication is a doctor's responsibility and they should not query as long as they are satisfied with the treatment.

Although rehabilitation services exist in the hospital, they are not well-organized. There is no systematic recovery plan for rehabilitation of patients. Alternative services, such as occupational therapy are used as "rehabilitation services". It consists of painting, wood carving, making handmade objects with clay, knitting etc. The patients are selected according to their abilities and talents, which means the minority of patients can benefit from these services. Sometimes handmade artifacts created by patients are present in exhibitions provided by hospital administration.

Different studies have found that almost all kind of mental disorders are linked to the increased risk of chronic physical diseases. Thus the interventions should aim at the prevention of chronic physical conditions with integration of treatment of mental illnesses (59, 60). At the same time, it was revealed that the increased rate of physical diseases in patients with schizophrenia can be related not

only with its nature and treatment, but also with unsatisfactory managed of health services, medical staff's attitudes and social stigma (61).

A previous study showed that psychosocial rehabilitation service has significant effect on clinical improvement of patients in Azerbaijan (62). The study carried out in England also emphasized that the inpatient mental health rehabilitation services effectively achieved discharge of more than half patients receiving services within the 12 month follow-up period (63).

Table24. Overall conclusion of the theme 3.

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

In the **third** theme, patients evaluated the level of the procedures and safeguards to prevent detention and treatment without free informed consent, as well as the right to confidentiality and access to their personal health information as not satisfying. Their perception of the level of their preferences for the place and form of treatment and the given support and their exercise for their legal capacity was partly satisfied.

The family members expressed the fact that, their relatives which receive treatment in the hospital can fully exercise their legal capacity and are completely given the support they may require to exercise their legal capacity. The results also showed that patient's preferences for the place and form of treatment can be a priority in some situations (AP); procedures and safeguards are partially

provided to stop detention and treatment without free and informed consent; and the right to confidentiality and access to their private health information are partially ensured for service users. According to the staff's opinion, the patients' confidentiality is completely achieved and they can get all information about their health condition without any obstacles. Involuntary admitted patients cannot choose the place or treatment form, while some patients receive the inpatient treatment with their written consent. In addition, the result of interviews with staff shows that the implementation of the legal capacity of inpatients and the given support that may require exercising their legal capacity are not achieved fully yet. The facility did have a lawyer, but most patients were unaware of this service.

The researchers observed that majority of admitted patients were involuntary. All involuntary admissions are notified to a legal authority during 48 hours. Workers are eager to discharge patients as soon as possible, yet some stay for a long time. Although users have the right to refuse treatment, most of them they are kept against their will. They are detained until treatment shows any positive effect. At the same time, close relatives' agreement is important in discharge process. This is related to the fact that, if patient's family does not want him/her at home at that time, there is no place patient to go.

Unfortunately, the majority of the staff and patients do not have enough information about their rights. For instance, the law supports the patients' right to appealing procedures, in this case, to litigate about their detention against their will. In fact, they are unaware about this right. There is a lawyer of the facility. According to the report of the staff, he makes regular visits of the wards. If the patients have any requests, they can contact him. But patients' perception reveals opposite condition. Patients declared that, during their stay they are not able to go to the court or can not contact any legal authority.

The majority of the staff treats the service users friendly. However, sometimes there are arguments. As it was observed and confirmed by the patients, the common reason for the argument are the following, patients do not comply with the orders, they insist on asking for cigarettes, or more medications. Patients are able to consult with a support person from their family members or staff member they choose, which are recognized and respected by the staff in making decisions about admission, treatment and personal, legal and other issues. If they do not have any support person, so staff helps them in making decision.

The personal medical files for each patient are kept in the doctor's room. No service user has any access to these files. They can have information written in the files only by asking doctor. Taking

into consideration that, many patients admitted involuntarily, it is forbidden to give medical files to them in the hospital. The patients are not trusted to add any written information to their files.

Researchers in many other countries show the similar problem in point of legal capacity. The result of a similar study carried out in Greece is almost identical to our result. The patients' right to exercise their legal capacity, to personal liberty and security, right to the enjoyment of the highest attainable standard of physical and mental health the right to rehabilitation are not respected (64). People with mental health problems continue to be denied legal capacity to make a decision about their healthcare, housing and etc. in Canada (65). The study in Chili also presented a low level of achievement on the same topic, especially on the given priority to preferences of the users to choose the place and treatment form (66). The substantial consequences related to involuntary admission affects not only individuals, but also their relatives and professionals. This causes the significant deficits in the quality of documentation and it requires to be addressed in advanced training, education and in daily routines (67).

Table25. Overall conclusion of the theme 4.

Theme 4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16).	**Patients**	**Family**	**Staff**
Standard 4.1: Service users have the right to be free from verbal, mental, physical or sexual abuse and physical or emotional neglect.	AP	AF	AF
Standard 4.2: Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	AP	AP	AF
Standard 4.3: Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with free and informed consent.	NA/DK	NA/DK	AP
Standard 4.4: No service user is subjected to medical	AP	DK	AF

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 or other forms of ill-treatment and abuse.	AP	AF	AF

The **fourth** theme, covering the right to freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse, was achieved partially. The main issue about the theme was related to ECT, psychosurgery and other medical procedures that may have permanent effects on patients. Most of the participants were unaware of existence ECT in the facility. Psychosurgery and other harmful medical procedures are not applicable at the hospital.

At the same time, the weaknesses are concentrated mainly on the issue of the right to exercise legal capacity and the personal liberty and the security of a person, and the right to live independently and to be included in the community.

The researchers comment that the majority of the staff treat patients with respect and dignity. To use physical, verbal or any other form of abuse is forbidden in all wards. However, some patients reported about being subjected to verbal abuse. As mentioned above, only the minority of the staff members argues with, or shouts to patients. According to the responses of participants, the administration fires those who punish patients or treat them inhumanely.

In most of the wards seclusion is prohibited and they do not possess seclusion room, while in some wards the patients are rarely subjected to isolation. According to the participants' statements, physical restraint is used for offensive patients only with doctor's permission for a short time period. No seclusion or restraint procedures were observed during interviews in the hospital. The aggressive patients are given medication to make them docile. The staff is not trained in de-escalation techniques, nevertheless they can prevent crisis and the harm to the users and the staff. Not only patients, but also the majority of staff and family members are not informed about having access to legal procedures, such as file appeals and complaints. Ombudsman, delegation of the European Committee for the Prevention of Torture and other legal representatives sporadically visit and monitor the human rights in the facility. Indeed, during the interviews, an ombudsman had visited the facility and talked to some of the patients confidentially.

The hospital has an ECT unit which is the only one in the country. It is provided for patients 18+ only free informed consent. There is no place for psychosurgery, thus such irreversible treatments

are not applicable for the hospital. Abortion or sterilizations also not carried out in the hospital. All medical or scientific experimentations are carried out only with the free and informed consent. Potentially dangerous experiments are not allowed to conduct in the facility.

According to Martin V et al, (72) in German hospitals patients were exposed to mechanical restraint more than seclusion, however in Swiss hospitals more patients were secluded than restrained. In addition, German psychiatric care providers kept the time on the coercive measure as short as possible. Flammer E and Steinert T (73) indicated that involuntary medication is applied rarely.

The study in Chili shows that the mental health services relatively achieved high levels on the right protection against torture and cruel, inhuman or degrading treatment (66), while in Greece evidence states that the treatment condition in psychiatric clinics is a negative and discriminatory. The patients are exposed to restraints which constitute torture (64). In fact, the studies show that the assessment and monitoring of the compliance with human rights in psychiatric facilities decelerates the incidence of coercive measures such as forced medication, isolation and mechanical restraint (74).

Table26. Overall conclusion of the theme 5.

Theme 5. The Right to live independently and be included in the community (Article 19 of the CRPD).	**Patients**	**Family**	**Staff**
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	NI	AP	NI
Standard 5.2: Service users can access education and employment opportunities.	NI	NI	NI
Standard 5.3: The right of service users to participate in political and public life and to exercise freedom of association is supported.	NI	NI	NI
Standard 5.4: Service users are supported in taking part in social, cultural, religious and leisure activities.	AP	AP	AP

The lowest performance was revealed in the **fifth** theme. This topic requires special consideration since it has a low level of achievement. The right to live independently and be included in the community is unmet. In spite of supporting the patients in taking active part in social, cultural, religious and other leisure activities, the patients are not supported in gaining access to living places or necessary financial resources to live in the community. Their access to education or employment is very limited. They cannot take a part in the political and public life during their stay at the facility. They do not have any information about their political right, even though they do not use the right to vote.

It has been observed that in some cases, patients that do not have any suitable community accommodation after their discharge from the hospital are kept in the facility. All patients are given necessary information and supported about financial resource – social pension. The children and adolescents with intellectual disabilities are educated in special primary and secondary schools. The staff is not able to provide any information about employment and support the right to vote and taking a part in political life. Stigma and discrimination have strong effect in these life areas for people with mental disorders. People with the severe mental illnesses face barriers in their job search.

They face many difficulties in accessing and maintaining employment *(53).* They are not accepted in most workplaces. Not only the service users, but also the he staff are unaware about the patients' right to vote. They do not participate in election during their stay in the facility. Religious and many social organizations don't have any access to the mental institutions. At the same time, the workers support the users in participating in the social activities. All users are permitted to fulfill their religious activities.

It is necessary to emphasize that, the facility administration provides a few activities for some patients, including walking tour in the city, to take a part in some social activities (theatre, pantomime, and exhibition). In June, 2013 the exhibition "European City Days" was organized in Baku "Old City". The representative group of patients were invited to present their handicrafts for the first time in public. In August, 2013 patients were played in theatre on the 200th anniversary of the publication of the brothers Grimm's fairy tales (68).

The problems faced in fifth theme are common in Greece and Chili. The right to full inclusion of patients in the community, to live independently the right to education, employment, participation in political, public, and cultural life, and in recreation and leisure are restricted in psychiatric facilities. (64, 66).

Ebrahimi H et al (75) stress that the majority of nurses are favor of applying social isolation and restriction and they have medium level of stigma toward the people with mental illness in the neighboring country - Iran. While in European countries (Finland, Lithuania, Ireland, Italy and Portugal) nurses' opinions and attitudes toward patients are mostly positive, despite it varies across countries. Portuguese nurses' attitudes are significantly more positive, while Lithuanian ones' are more negative than the others (76).

The result of SQLS-R4 demonstrated that, the instrument is valid and reliable for use in Azerbaijan. According to the data analysis, the level of the quality of life among inpatients ranges widely. The result shows that most of patients' quality of life is average. The level of satisfaction with the provided services were low, however the CSQ-8 presented that, now the satisfaction level has increased, but patients are not totally satisfied yet.

The clinical characteristics such as duration of illness and number of hospitalizations are not correlated with the level of satisfaction and quality of life. The negative correlation was found between the CSQ-8 and total score of SQLS-R4, so subscale cognition and vitality and subscale psychosocial feelings. This indicates that the patients with higher level of quality of life are more satisfied with the services. Small correlation was found between the marital status of the patients and the number of their hospitalizations.

5.2. Limitations of the study

The main limitation of the study refers to the sample. The number of the selected wards and entrants was small in proportion to the general number of facility's wards, staff, service users and their family members. Besides, the randomization of wards left out most of wards including gerontology, infectious, forensic etc. At the same time, the family members could not be randomized and the number of family members/caregivers was not conducted exactly as planned. The rationale for this is that most of families do not visit their relatives in the hospital because of stigma and work. Even many who visited, did not give consent to take a part in the study because of "having no time". In addition, the time for conducting interviews was not sufficient since most of family members made their hospital visits generally at the weekends.

The other problem is about the sincerity of the participants. Most of the patients felt pressure as a result they were saying the opposite (social desirability). They might have hid their real opinion

because of avoiding punishment. The staff also felt under pressure, they did not wish to say anything wrong that might have discredited the hospital and their work.

One of the critical issues faced during the study was the analyzing and scoring the result. There is no clear guidance about calculating the achievement level.

5.3. Conclusions and recommendations

The results have broad effects on mental health service monitoring, planning and improvement of mental health services in Azerbaijan. The study is an important step in fulfilling the responsibility of National Mental Health Strategy in the matter of evaluation of the services in the psychiatric hospitals. The WHO Quality Rigth Toolkit for quality assessment of inpatient facilities was adapted. Reference intervals of good quality for selected indicators were defined. The instrument was validated for further implementation in the mental health system.

Evidence presented indicates that the quality of services and human rights in psychiatric hospital are not sufficient enough to provide comprehensive, high-quality services for people with the severe mental illnesses. The patients face several human rights violations in the hospital. The violation covers the significant norms articulated in CRPD, the right to exercise legal capacity, the right to personal liberty and security of person, right to live independently and be included in the community. The right to an adequate standard of living, right to enjoyment of the highest attainable standard of physical and mental health and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment are protected and respected, however there is a need to improve services in these spheres. The development is also necessary to increase the quality of life of the patients and the level of client satisfaction.

The study showed that the detention of patients and treatment without their consent is one of the main problems. There is a great need to provide residential care facilities, shelters for homeless patients. The patients are not supported to have access to education, to get employment, to take a part in the political and public life. The stigma and discrimination make a barrier not only in enjoying fully participation in society, but also among the family members.

All these findings can help to detect fundamental quality concerns and to formulate **recommendations** for further improvement of psychiatric services at the level of the country which will give an opportunity to provide comprehensive recovery of people with mental health problems.

First, the study should be conducted in all psychiatric hospitals in the Azerbaijan. In addition, it should be carried out in out-patient facilities which offer mental health care in order to understand the weaknesses of the services in the country. The major recommendations are following:

- Make strict amendments in National Mental Health Strategy for next 5-years action plan to ensure the human rights;
- To create a team for monitoring the mental health services and evaluate the quality of services with developed tool regularly;
- Increase the level of awareness about mental health and mental disorders in order to reduce stigma and discrimination;
- Train the staff of the psychiatric facilities on human rights and inspire them to support patients to exercise their legal capacity;
- Improve psychosocial rehabilitation and leisure activities inside and outside of the facilities;
- Provide facilities with newly-developed medications;
- Provide safeguards to avoid of unnecessary involuntary admission, decrease the number of beds in psychiatric hospitals which are mostly associated with human rights violations. Shifting care to general hospitals.
- Create residential care facilities, home care support and job opportunities for patients with SMI.

The study should be carried out once a year to examine the changes in the facility and to ensure that the facility administration improves the services regularly.

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ANNEX I

The results of patients:

Table 4. Theme 1. The right to an adequate standard of living and social protection (patients)

Standards:	Criteria:	AF %	AP %	NI %	NA/ DK%
Standard 1.1.The building is in good physical condition.	1.1.1 The building is in a good state of repair.	83	12	5	-
	1.1.2 The building is accessible for people with physical disabilities.	44	32	24	-
	1.1.3 The building's lighting (artificial and natural), heating and ventilation provide a comfortable living environment.	70	24	5	-
	1.1.4 Measures are in place to protect people against injury through fire.	74	7	13	6
Standard 1.2: The sleeping conditions of service users are comfortable and allow sufficient privacy.	1.2.1 The sleeping quarters provide sufficient living space per service user and are not overcrowded.	87	12	1	-
	1.2.2 Men and women as well as children and older persons have separate sleeping quarters.	99	-	1	-
	1.2.3 Service users are free to choose when to get up and when to go to bed.	60	5	35	-
	1.2.4 The sleeping quarters allow for the privacy of service users.	36	45	19	-
	1.2.5 Sufficient numbers of clean blankets and bedding are available to service users.	93	7	-	-
	1.2.6 Service users can keep personal belongings and have adequate lockable space to store them.	40	40	20	-
Standard 1.3: The facility meets hygiene and sanitary requirements	1.3.1 The bathing and toilet facilities are clean and working properly	90	7	3	-
	1.3.2 The bathing and toilet facilities allow privacy, and there are separate facilities for men and women.	100	-	-	-
	1.3.3 Service users have regular access to bathing and toilet facilities.	71	1	28	-
	1.3.4 The bathing and toileting needs of service users who are bedridden or who have impaired mobility or other physical disabilities are accommodated.	78	13	5	4
Standard 1.4: Service users are given food, safe drinking-water and clothing that meet their needs and preferences.	1.4.1 Food and safe drinking-water are available in sufficient quantities, are of good quality and meet with the service users' cultural preferences and physical health requirements.	67	28	5	-
	1.4.2 Food is prepared and served under satisfactory conditions, and eating areas are culturally appropriate and reflect the eating arrangements in the community.	93	6	1	-
	1.4.3 Service users can wear their own clothing and shoes (day wear and night wear).	79	14	7	-
	1.4.4 When service users do not have their own clothing, good-quality clothing is provided that meets their cultural preferences and is suitable for the climate.	90	7	3	-
Standard 1.5: Service users can communicate freely, and their right to privacy is respected.	1.5.1 Telephones, letters, e-mails and the Internet are freely available to service users, without censorship.	2	3	95	-
	1.5.2 Service users' privacy in communications is respected.	55	19	25	1

	1.5.3 Service users can communicate in the language of their choice, and the facility provides support (e.g. translators) to ensure that the service users can express their needs.	94	2	4	-
	1.5.4 Service users can receive visitors, choose who they want to see and participate in visits at any reasonable time.	57	9	34	-
	1.5.5 Service users can move freely around the facility.	24	33	43	-
Standard 1.6: The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.	1.6.1 There are ample furnishings, and they are comfortable and in good condition.	91	5	4	-
	1.6.2 The layout of the facility is conducive to interaction between and among service users, staff and visitors.	94	5	1	-
	1.6.3 The necessary resources, including equipment, are provided by the facility to ensure that service users have opportunities to interact and participate in leisure activities.	53	22	25	-
	1.6.4 Rooms within the facility are specifically designated as leisure areas for service users.	55	1	44	-
Standard 1.7: Service users enjoy a fulfilling social and personal life and remain engaged in community life and activities.	1.7.1 Service users can interact with other service users, including members of the opposite sex.	44	39	17	-
	1.7.2 Personal requests, such as to attend weddings or funerals, are facilitated by staff.	37	6	54	3
	1.7.3 A range of regularly scheduled, organized activities are offered in both the facility and the community that are relevant and age-appropriate.	31	25	44	-
	1.7.4 Staff provide information to service users about activities in the community and facilitate their access to those activities.	19	17	64	-
	1.7.5 Staff facilitate service users' access to entertainment outside the facility, and entertainment from the community is brought into the facility.	24	11	65	-

Table 5. Theme 2.The right to enjoyment of the highest attainable Standard of physical and mental health (patients)

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
Standard 2.1: Facilities are available to everyone who requires treatment and support	2.1.1 No person is denied access to facilities or treatment on the basis of economic factors or of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	88	-	11	1
	2.1.2 Everyone who requests mental health treatment receives care in this facility or is referred to another facility where care can be provided	80	-	18	2
	2.1.3 No service user is admitted, treated or kept in the facility on the basis of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	30	1	63	6
Standard 2.2: The facility has skilled staff and provides good quality mental health services	2.2.1 The facility has staff with sufficiently diverse skills to provide counselling, psychosocial rehabilitation, information, education and support to service users and their families, friends or carers, in order to promote independent living and inclusion in the community.	76	18	6	-
	2.2.2 Staff are knowledgeable about the availability and role of community services and resources to promote independent living and inclusion in the community.	24	23	53	-
	2.2.3 Service users can consult with a psychiatrist or other specialized mental health staff when they wish to do so.	65	14	21	-
	2.2.4 Staff in the facility are trained and licensed to prescribe and review psychotropic medication.	87	1	11	1
	2.2.5 Staff are given training and written information on the rights of persons with mental disabilities and are familiar with international human rights Standards, including the CRPD.	58	22	18	2
	2.2.6 Service users are informed of and have access to mechanisms for expressing their opinions on service provision and improvement.	53	17	30	-
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	2.3.1 Each service user has a comprehensive, individualized recovery plan that includes his or her social, medical, employment and education goals and objectives for recovery.	33	41	25	1
	2.3.2 Recovery plans are driven by the service user, reflect his or her choices and preferences for care, are put into effect and are reviewed and updated regularly by the service user and a staff member.	42	25	32	1
	2.3.3 As part of their recovery plans, service users are encouraged to develop advance directives which specify the treatment and recovery options they wish to have as well as those that they don't, to be used if they are unable to communicate their choices at some point in the future.	13	17	70	-
	2.3.4 Each service user has access to psychosocial programmes for fulfilling the social roles of his or her choice by developing the skills necessary for	16	30	54	-

	employment, education or other areas. Skill development is tailored to the person's recovery preferences and may include enhancement of life and self-care skills.				
	2.3.5 Service users are encouraged to establish a social support network and/or maintain contact with members of their network to facilitate independent living in the community. The facility provides assistance in connecting service users with family and friends, in line with their wishes.	40	27	33	-
	2.3.6 Facilities link service users with the general health care system, other levels of mental health services, such as secondary care, and services in the community such as grants, housing, employment agencies, day-care centres and assisted residential care.	42	19	39	-
Standard 2.4: Psychotropic medication is available, affordable and used appropriately	2.4.1 The appropriate psychotropic medication (specified in the national essential medicines list) is available at the facility or can be prescribed.	92	7	-	1
	2.4.2 A constant supply of essential psychotropic medication is available, in sufficient quantities to meet the needs of service users.	84	13	3	-
	2.4.3 Medication type and dosage are always appropriate for the clinical diagnoses of service users and are reviewed regularly.	80	9	11	-
	2.4.4 Service users are informed about the purpose of the medications being offered and any potential side effects.	19	30	51	-
	2.4.5 Service users are informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy.	17	4	79	-
Standard 2.5: Adequate services are available for general and reproductive health	2.5.1 Service users are offered physical health examinations and/or screening for particular illnesses on entry to the facility and regularly thereafter.	72	21	7	-
	2.5.2 Treatment for general health problems, including vaccinations, is available to service users at the facility or by referral.	68	12	19	1
	2.5.3 When surgical or medical procedures are needed that cannot be provided at the facility, there are referral mechanisms to ensure that the service users receive these health services in a timely manner.	68	16	16	-
	2.5.4 Regular health education and promotion are conducted at the facility.	30	22	48	-
	2.5.5 Service users are informed of and advised about reproductive health and family planning matters.	22	-	78	-
	2.5.6 General and reproductive health services are provided to service users with free and informed consent.	65	5	30	-

Table 6. Theme 3.The right to exercise legal capacity and the right to personal liberty and the security of person (patients).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
Standard 3.1: Service users' preferences for the place and form of treatment are always a priority	3.1.1 Service users' preferences are the priority in all decisions on where they will access services.	45	3	52	-
	3.1.2 All efforts are made to facilitate discharge so that service users can live in their communities.	41	26	33	-
	3.1.3 Service users' preferences are the priority for all decisions on their treatment and recovery plan.	19	26	55	-
Standard 3.2: Procedures and safeguards are in place to prevent detention and treatment without free and informed consent	3.2.1 Admission and treatment are based on the free and informed consent of service users.	52	1	47	-
	3.2.2 Staff respect the advance directives of service users when providing treatment.	21	18	61	-
	3.2.3 Service users have the right to refuse treatment.	15	6	78	1
	3.2.4 Any case of treatment or detention in a facility without free and informed consent is documented and reported rapidly to a legal authority.	48	2	46	4
	3.2.5 People being treated or detained by a facility without their informed consent are informed about procedures for appealing their treatment or detention.	13	2	84	1
	3.2.6 Facilities support people being treated or detained without their informed consent in accessing appeals procedures and legal representation.	20	2	78	-
Standard 3.3: Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity	3.3.1 At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices.	62	21	16	1
	3.3.2 Clear, comprehensive information about the rights of service users is provided in both written and verbal form.	14	2	84	-
	3.3.3 Clear, comprehensive information about assessment, diagnosis, treatment and recovery options is given to service users in a form that they understand and which allows them to make free and informed decisions.	13	9	78	-
	3.3.4 Service users can nominate and consult with a support person or network of people of their own free choice in making decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected will be recognized by the staff.	40	15	45	-
	3.3.5 Staff respect the authority of a nominated support person or network of people to communicate the decisions of the service user being supported.	56	16	28	-
	3.3.6 Supported decision-making is the predominant model, and substitute decision-making is avoided.	17	82	1	-
	3.3.7 When a service user has no support person or network of people and wishes to appoint one, the facility will help the user to access appropriate support.	14	14	70	2
Standard 3.4: Service users have the right to confidentiality and access to their personal health information	3.4.1 A personal, confidential medical file is created for each service user.	61	1	33	5
	3.4.2 Service users have access to the information contained in their medical files.	7	-	88	5
	3.4.3 Information about service users is kept confidential.	68	-	26	6

	3.4.4 Service users can add written information, opinions and comments to their medical files without censorship.	7	-	89	4

Table 7. Theme 4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (patients).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
Standard 4.1: Service users have the right to be free from verbal, mental, physical or sexual abuse and physical or emotional neglect	4.1.1 Staff members treat service users with humanity, dignity and respect.	70	23	7	-
	4.1.2 No service user is subjected to verbal, physical, sexual or mental abuse.	16	49	35	-
	4.1.3 No service user is subjected to physical or emotional neglect.	60	11	28	1
	4.1.4 Appropriate steps are taken to prevent all instances of abuse.	55	14	31	-
	4.1.5 Staff support service users who have been subjected to abuse in accessing the support they may want.	65	8	27	-
Standard 4.2: Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	4.2.1 Service users are not subjected to seclusion or restraint.	14	10	75	1
	4.2.2 Alternatives to seclusion and restraint are in place at the facility, and staff are trained in de-escalation techniques for intervening in crises and preventing harm to service users or staff.	45	1	53	1
	4.2.3 A de-escalation assessment is conducted in consultation with the service user concerned in order to identify the triggers and factors he or she finds helpful in diffusing crises and to determine the preferred methods of intervention in crises.	36	11	52	1
	4.2.4 The preferred methods of intervention identified by the service user concerned are readily available in a crisis and are integrated into the user's individual recovery plan.	41	2	54	3
	4.2.5 Any instances of seclusion or restraint are recorded (e.g. type, duration) and reported to the head of the facility and to a relevant external body.	41	-	50	9
Standard 4.3: Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with free and informed consent	4.3.1 No electroconvulsive therapy is given without the free and informed consent of service users.	10	-	34	56
	4.3.2 Clear evidence-based clinical guidelines on when and how electroconvulsive therapy can or cannot be administered are available and adhered to.	3	-	10	87
	4.3.3 Electroconvulsive therapy is never used in its unmodified form (i.e. without an anaesthetic and a muscle relaxant).	7	-	1	92
	4.3.4 No minor is given electroconvulsive therapy.	6	-	-	94
	4.3.5 Psychosurgery and other irreversible treatments are not conducted without both the service users' free and informed consent and the independent approval of a board.	-	-	-	100
	4.3.6 Abortions and sterilizations are not carried out on service users without their consent.	86	-	2	12
Standard 4.4: No service	4.4.1 Medical or scientific experimentation is	78	-	4	18

user is subjected to medical or scientific experimentation without his or her informed consent	conducted only with the free and informed consent of service users.				
	4.4.2 Staff do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting service users to participate in medical or scientific experimentation.	65	-	1	34
	4.4.3 Medical or scientific experimentation is not undertaken if it is potentially harmful or dangerous to the service user.	68	-	2	30
	4.4.4 Any medical or scientific experimentation is approved by an independent ethics committee.	-	-	-	100
Standard 4.5: Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment or other forms of ill-treatment and abuse	4.5.1 Service users are informed of and have access to procedures to file appeals and complaints, on a confidential basis, to an outside, independent legal body on issues related to neglect, abuse, seclusion or restraint, admission or treatment without informed consent and other relevant matters.	22	7	71	-
	4.5.2 Service users are safe from negative repercussions resulting from complaints they may file.	63	8	28	1
	4.5.3 Service users have access to legal representatives and can meet with them confidentially.	59	7	32	2
	4.5.4 Service users have access to advocates to inform them of their rights, discuss problems and support them in exercising their human rights and filing appeals and complaints.	33	4	61	2
	4.5.5 Disciplinary and/or legal action is taken against any person found to be abusing or neglecting service users.	29	2	68	1
	4.5.6 The facility is monitored by an independent authority to prevent the occurrence of ill-treatment.	73	-	27	-

Table 8. Theme 5. The right to live independently and be included in the community (patients).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
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	5.1.1 Staff inform service users about options for housing and financial resources.	15	12	73	-
	5.1.2 Staff support service users in accessing and maintaining safe, affordable, decent housing.	19	7	70	4
	5.1.3 Staff support service users in accessing the financial resources necessary to live in the community.	21	4	72	3
Standard 5.2: Service users can access education and employment opportunities	5.2.1 Staff give service users information about education and employment opportunities in the community.	13	2	83	2
	5.2.2 Staff support service users in accessing education opportunities, including primary, secondary and post-secondary education.	12	4	81	3
	5.2.3 Staff support service users in career development and in accessing paid employment opportunities.	15	5	77	3
Standard 5.3: The right of service users to participate in political and public life and to exercise freedom of association is supported.	5.3.1 Staff give service users the information necessary for them to participate fully in political and public life and to enjoy the benefits of freedom of association.	23	5	72	-
	5.3.2 Staff support service users in exercising their right to vote.	15	3	79	3
	5.3.3 Staff support service users in joining and participating in the activities of political, religious, social, disability and mental disability organizations and other groups.	3	1	96	-
Standard 5.4: Service users are supported in taking part in social, cultural, religious and leisure activities	5.4.1 Staff give service users information on the social, cultural, religious and leisure activity options available.	34	14	52	-
	5.4.2 Staff support service users in participating in the social and leisure activities of their choice.	27	16	56	1
	5.4.3 Staff support service users in participating in the cultural and religious activities of their choice	26	15	58	1

ANNEX II

The results of family members:

Table 9. Theme 1. The right to an adequate Standard of living and social protection (family members).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DK%
Standard 1.1.The building is in good physical condition.	1.1.1 The building is in a good state of repair	86.7	6.7	6.7	-
	1.1.2 The building is accessible for people with physical disabilities	26.7	36.7	36.7	
	1.1.3 The building's lighting (artificial and natural), heating and ventilation provide a comfortable living environment	70	16.7	6.7	6.7
	1.1.4 Measures are in place to protect people against injury through fire	93.3	6.7	-	-
Standard 1.2: The sleeping conditions of service users are comfortable and allow sufficient privacy.	1.2.1 The sleeping quarters provide sufficient living space per service user and are not overcrowded.	70	30	-	-
	1.2.2 Men and women as well as children and older persons have separate sleeping quarters.	100	-	-	-
	1.2.3 Service users are free to choose when to get up and when to go to bed.	66.7	13.3	20	-
	1.2.4 The sleeping quarters allow for the privacy of service users.	20	80	-	-
	1.2.5 Sufficient numbers of clean blankets and bedding are available to service users.	93.3	6.7	-	-
	1.2.6 Service users can keep personal belongings and have adequate lockable space to store them.	66.7	26.7	6.7	-
Standard 1.3: The facility meets hygiene and sanitary requirements	1.3.1 The bathing and toilet facilities are clean and working properly	73.3	20	-	6.7
	1.3.2 The bathing and toilet facilities allow privacy, and there are separate facilities for men and women.	100	-	-	-
	1.3.3 Service users have regular access to bathing and toilet facilities.	70	-	30	-
	1.3.4 The bathing and toileting needs of service users who are bedridden or who have impaired mobility or other physical disabilities are accommodated.	86.6	6.7	-	6.7
Standard 1.4: Service users are given food, safe drinking-water and clothing that meet their needs and preferences.	1.4.1 Food and safe drinking-water are available in sufficient quantities, are of good quality and meet with the service users' cultural preferences and physical health requirements.	80.0	13.3	-	6.7
	1.4.2 Food is prepared and served under satisfactory conditions, and eating areas are culturally appropriate and reflect the eating arrangements in the community.	93.3	6.7	-	-
	1.4.3 Service users can wear their own clothing and shoes (day wear and night wear).	86.7	13.3	-	-
	1.4.4 When service users do not have their own clothing, good-quality clothing is provided that meets their cultural preferences and is suitable for the climate.	70	30	-	-
Standard 1.5: Service users can communicate freely, and their right to	1.5.1 Telephones, letters, e-mails and the Internet are freely available to service users, without censorship.	13.3	33.3	53.3	-
	1.5.2 Service users' privacy in communications is	76.7	23.3	-	-

privacy is respected.	respected.				
	1.5.3 Service users can communicate in the language of their choice, and the facility provides support (e.g. translators) to ensure that the service users can express their needs.	100	-	-	-
	1.5.4 Service users can receive visitors, choose who they want to see and participate in visits at any reasonable time.	56.7	30.0	13.3	-
	1.5.5 Service users can move freely around the facility.	13.3	53.3	33.3	-
Standard 1.6: The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.	1.6.1 There are ample furnishings, and they are comfortable and in good condition.	80.0	20.0	-	-
	1.6.2 The layout of the facility is conducive to interaction between and among service users, staff and visitors.	100	-	-	-
	1.6.3 The necessary resources, including equipment, are provided by the facility to ensure that service users have opportunities to interact and participate in leisure activities.	63.3	36.7	-	-
	1.6.4 Rooms within the facility are specifically designated as leisure areas for service users.	66.7	-	26.7	6.7
Standard 1.7: Service users enjoy a fulfilling social and personal life and remain engaged in community life and activities.	1.7.1 Service users can interact with other service users, including members of the opposite sex.	73.3	6.7	20.0	-
	1.7.2 Personal requests, such as to attend weddings or funerals, are facilitated by staff.	43.3	16.7	40	-
	1.7.3 A range of regularly scheduled, organized activities are offered in both the facility and the community that are relevant and age-appropriate.	40.0	50.0	10.0	-
	1.7.4 Staff provide information to service users about activities in the community and facilitate their access to those activities.	20.0	30.0	50.0	-
	1.7.5 Staff facilitate service users' access to entertainment outside the facility, and entertainment from the community is brought into the facility.	20.0	16.7	63.3	-

Table 10. Theme 2. The right to enjoyment of the highest attainable Standard of physical and mental health (family members).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
Standard 2.1: Facilities are available to everyone who requires treatment and support	2.1.1 No person is denied access to facilities or treatment on the basis of economic factors or of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	100	-	-	-
	2.1.2 Everyone who requests mental health treatment receives care in this facility or is referred to another facility where care can be provided	86.7	-	13.3	-
	2.1.3 No service user is admitted, treated or kept in the facility on the basis of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	26.7	-	66.7	6.7
Standard 2.2: The facility has skilled staff and provides good quality mental health services	2.2.1 The facility has staff with sufficiently diverse skills to provide counselling, psychosocial rehabilitation, information, education and support to service users and their families, friends or carers, in order to promote independent living and inclusion in the community.	70	23.3	6.7	-
	2.2.2 Staff are knowledgeable about the availability and role of community services and resources to promote independent living and inclusion in the community.	16.7	46.7	36.7	-
	2.2.3 Service users can consult with a psychiatrist or other specialized mental health staff when they wish to do so.	83.3	16.7	-	-
	2.2.4 Staff in the facility are trained and licensed to prescribe and review psychotropic medication.	100.0	-	-	-
	2.2.5 Staff are given training and written information on the rights of persons with mental disabilities and are familiar with international human rights Standards, including the CRPD.	70.0	30.0	-	-
	2.2.6 Service users are informed of and have access to mechanisms for expressing their opinions on service provision and improvement.	43.3	50.0	-	6.7
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	2.3.1 Each service user has a comprehensive, individualized recovery plan that includes his or her social, medical, employment and education goals and objectives for recovery.	50.0	30.0	20.0	-
	2.3.2 Recovery plans are driven by the service user, reflect his or her choices and preferences for care, are put into effect and are reviewed and updated regularly by the service user and a staff member.	53.3	33.3	6.7	6.7
	2.3.3 As part of their recovery plans, service users are encouraged to develop advance directives10 which specify the treatment and recovery options they wish to have as well as those that they don't, to be used if they are unable to communicate their choices at some point in the future.	20.0	43.3	36.7	-
	2.3.4 Each service user has access to psychosocial	20.0	30.0	43.3	6.7

	programmes for fulfilling the social roles of his or her choice by developing the skills necessary for employment, education or other areas. Skill development is tailored to the person's recovery preferences and may include enhancement of life and self-care skills.				
	2.3.5 Service users are encouraged to establish a social support network and/or maintain contact with members of their network to facilitate independent living in the community. The facility provides assistance in connecting service users with family and friends, in line with their wishes.	70.0	30.0	-	-
	2.3.6 Facilities link service users with the general health care system, other levels of mental health services, such as secondary care, and services in the community such as grants, housing, employment agencies, day-care centres and assisted residential care.	33.3	50.0	10.0	6.7
Standard 2.4: Psychotropic medication is available, affordable and used appropriately	2.4.1 The appropriate psychotropic medication (specified in the national essential medicines list) is available at the facility or can be prescribed.	80.0	13.3	-	6.7
	2.4.2 A constant supply of essential psychotropic medication is available, in sufficient quantities to meet the needs of service users.	63.3	16.7	-	20.0
	2.4.3 Medication type and dosage are always appropriate for the clinical diagnoses of service users and are reviewed regularly.	70.0	10.0	6.7	13.3
	2.4.4 Service users are informed about the purpose of the medications being offered and any potential side effects.	66.7	26.7	6.7	-
	2.4.5 Service users are informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy.	33.3	10.0	56.7	-
Standard 2.5: Adequate services are available for general and reproductive health	2.5.1 Service users are offered physical health examinations and/or screening for particular illnesses on entry to the facility and regularly thereafter.	93.3	6.7	-	-
	2.5.2 Treatment for general health problems, including vaccinations, is available to service users at the facility or by referral.	73.3	20.0	-	6.7
	2.5.3 When surgical or medical procedures are needed that cannot be provided at the facility, there are referral mechanisms to ensure that the service users receive these health services in a timely manner.	86.7	6.7	-	6.7
	2.5.4 Regular health education and promotion are conducted at the facility.	56.7	23.3	20.0	-
	2.5.5 Service users are informed of and advised about reproductive health and family planning matters.	56.7	-	43.3	-
	2.5.6 General and reproductive health services are provided to service users with free and informed consent.	66.7	33.3	-	-

Table 11. Theme 3.The right to exercise legal capacity and the right to personal liberty and the security of person (family members).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
Standard 3.1: Service users' preferences for the place and form of treatment are always a priority	3.1.1 Service users' preferences are the priority in all decisions on where they will access services.	-	-	-	100
	3.1.2 All efforts are made to facilitate discharge so that service users can live in their communities.	56.7	43.3	-	-
	3.1.3 Service users' preferences are the priority for all decisions on their treatment and recovery plan.	63.3	26.7	10.0	-
Standard 3.2: Procedures and safeguards are in place to prevent detention and treatment without free and informed consent	3.2.1 Admission and treatment are based on the free and informed consent of service users.	50	10	40	-
	3.2.2 Staff respect the advance directives of service users when providing treatment.	46.7	26.7	26.7	-
	3.2.3 Service users have the right to refuse treatment.	60.0	10.0	30.0	-
	3.2.4 Any case of treatment or detention in a facility without free and informed consent is documented and reported rapidly to a legal authority.	46.7	6.7	23.3	23.3
	3.2.5 People being treated or detained by a facility without their informed consent are informed about procedures for appealing their treatment or detention.	20.0	-	80.0	-
	3.2.6 Facilities support people being treated or detained without their informed consent in accessing appeals procedures and legal representation	43.3	36.7	20.0	-
Standard 3.3: Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity	3.3.1 At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices.	70.0	30.0	-	-
	3.3.2 Clear, comprehensive information about the rights of service users is provided in both written and verbal form.	60.0	-	40.0	-
	3.3.3 Clear, comprehensive information about assessment, diagnosis, treatment and recovery options is given to service users in a form that they understand and which allows them to make free and informed decisions.	76.7	23.3	-	-
	3.3.4 Service users can nominate and consult with a support person or network of people of their own free choice in making decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected will be recognized by the staff.	93.3	6.7	-	-
	3.3.5 Staff respect the authority of a nominated support person or network of people to communicate the decisions of the service user being supported.	80.0	20.0	-	-
	3.3.6 Supported decision-making is the predominant model, and substitute decision-making is avoided.	46.7	-	46.7	6.7
	3.3.7 When a service user has no support person or network of people and wishes to appoint one, the facility will help the user to access appropriate support.	43.3	20.0	30.0	6.7
Standard 3.4: Service users have the right to confidentiality and access to their personal	3.4.1 A personal, confidential medical file is created for each service user.	26.7	-	6.7	66.7
	3.4.2 Service users have access to the information contained in their medical files.	40.0	13.3	26.7	20.0

health information	3.4.3 Information about service users is kept confidential.	36.7	6.7	46.7	10.0
	3.4.4 Service users can add written information, opinions and comments to their medical files without censorship.	6.7	-	86.7	6.7

Table 12. Theme 4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (family members).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
Standard 4.1: Service users have the right to be free from verbal, mental, physical or sexual abuse and physical or emotional neglect	4.1.1 Staff members treat service users with humanity, dignity and respect.	53.3	46.7	-	-
	4.1.2 No service user is subjected to verbal, physical, sexual or mental abuse.	70.0	23.3	6.7	-
	4.1.3 No service user is subjected to physical or emotional neglect.	80.0	6.7	6.7	6.7
	4.1.4 Appropriate steps are taken to prevent all instances of abuse.	80.0	6.7	13.3	-
	4.1.5 Staff support service users who have been subjected to abuse in accessing the support they may want.	86.7	-	-	13.3
Standard 4.2: Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	4.2.1 Service users are not subjected to seclusion or restraint.	80.0	20.0	-	-
	4.2.2 Alternatives to seclusion and restraint are in place at the facility, and staff are trained in de-escalation techniques for intervening in crises and preventing harm to service users or staff.	66.7	-	13.3	20.0
	4.2.3 A de-escalation assessment is conducted in consultation with the service user concerned in order to identify the triggers and factors he or she finds helpful in diffusing crises and to determine the preferred methods of intervention in crises.	46.7	46.7	-	6.7
	4.2.4 The preferred methods of intervention identified by the service user concerned are readily available in a crisis and are integrated into the user's individual recovery plan.	36.7	-	10.0	53.3
	4.2.5 Any instances of seclusion or restraint are recorded (e.g. type, duration) and reported to the head of the facility and to a relevant external body.	-	20.0	6.7	73.3
Standard 4.3: Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with free and informed consent	4.3.1 No electroconvulsive therapy is given without the free and informed consent of service users.	10.0	-	33.3	56.7
	4.3.2 Clear evidence-based clinical guidelines on when and how electroconvulsive therapy can or cannot be administered are available and adhered to.	-	-	-	100
	4.3.3 Electroconvulsive therapy is never used in its unmodified form (i.e. without an anaesthetic and a muscle relaxant).	-	-	-	100
	4.3.4 No minor is given electroconvulsive therapy.	-	-	-	100
	4.3.5 Psychosurgery and other irreversible treatments are not conducted without both the service users' free and informed consent and the independent approval of a board.	-	-	-	100
	4.3.6 Abortions and sterilizations are not carried out on service users without their consent.	70.0	-	-	30.0

Standard 4.4: No service user is subjected to medical or scientific experimentation without his or her informed consent	4.4.1 Medical or scientific experimentation is conducted only with the free and informed consent of service users.	30.0	-	20.0	50.0
	4.4.2 Staff do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting service users to participate in medical or scientific experimentation.	6.7	-	13.3	80.0
	4.4.3 Medical or scientific experimentation is not undertaken if it is potentially harmful or dangerous to the service user.	20.0	-	-	80.0
	4.4.4 Any medical or scientific experimentation is approved by an independent ethics committee.	30.0	13.3	16.7	40.0
Standard 4.5: Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment or other forms of illtreatment and abuse	4.5.1 Service users are informed of and have access to procedures to file appeals and complaints, on a confidential basis, to an outside, independent legal body on issues related to neglect, abuse, seclusion or restraint, admission or treatment without informed consent and other relevant matters.	26.7	36.7	36.7	-
	4.5.2 Service users are safe from negative repercussions resulting from complaints they may file.	83.3	6.7	10.0	-
	4.5.3 Service users have access to legal representatives and can meet with them confidentially.	100	-	-	-
	4.5.4 Service users have access to advocates to inform them of their rights, discuss problems and support them in exercising their human rights and filing appeals and complaints.	86.7	6.7	6.7	-
	4.5.5 Disciplinary and/or legal action is taken against any person found to be abusing or neglecting service users.	53.3	-	46.7	-
	4.5.6 The facility is monitored by an independent authority to prevent the occurrence of ill-treatment.	93.3	-	6.7	-

Table 13. Theme 5. The right to live independently and be included in the community (family members).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
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	5.1.1 Staff inform service users about options for housing and financial resources.	13.3	56.7	30	-
	5.1.2 Staff support service users in accessing and maintaining safe, affordable, decent housing.	36.7	20	43.3	-
	5.1.3 Staff support service users in accessing the financial resources necessary to live in the community.	50.0	20.0	30.0	-
Standard 5.2: Service users can access education and employment opportunities	5.2.1 Staff give service users information about education and employment opportunities in the community.	-	20.0	80.0	-
	5.2.2 Staff support service users in accessing education opportunities, including primary, secondary and post-secondary education.	-	-	100	-
	5.2.3 Staff support service users in career development and in accessing paid employment opportunities.	-	-	100	-
Standard 5.3: The right of service users to participate in political and public life and to exercise freedom of association is supported.	5.3.1 Staff give service users the information necessary for them to participate fully in political and public life and to enjoy the benefits of freedom of association.	-	20.0	80.0	-
	5.3.2 Staff support service users in exercising their right to vote.	-	-	93.3	6.7
	5.3.3 Staff support service users in joining and participating in the activities of political, religious, social, disability and mental disability organizations and other groups.	20.0	167	56.7	6.7
Standard 5.4: Service users are supported in taking part in social, cultural, religious and leisure activities	5.4.1 Staff give service users information on the social, cultural, religious and leisure activity options available.	26.7	36.7	36.7	-
	5.4.2 Staff support service users in participating in the social and leisure activities of their choice.	-	36.7	63.3	-
	5.4.3 Staff support service users in participating in the cultural and religious activities of their choice	6.7	43.3	50.0	-

ANNEX III

The results of staff:

Table14. Theme 1. The right to an adequate Standard of living and social protection (staff).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DK%
Standard 1.1.The building is in good physical condition.	1.1.1 The building is in a good state of repair	90.0	10.0	-	-
	1.1.2 The building is accessible for people with physical disabilities	43.3	26.7	30.0	-
	1.1.3 The building's lighting (artificial and natural), heating and ventilation provide a comfortable living environment	86.7	13.3	-	-
	1.1.4 Measures are in place to protect people against injury through fire	100	-	-	-
Standard 1.2: The sleeping conditions of service users are comfortable and allow sufficient privacy.	1.2.1 The sleeping quarters provide sufficient living space per service user and are not overcrowded.	83.3	16.7	-	-
	1.2.2 Men and women as well as children and older persons have separate sleeping quarters.	100	-	-	-
	1.2.3 Service users are free to choose when to get up and when to go to bed.	76.7	6.7	16.7	-
	1.2.4 The sleeping quarters allow for the privacy of service users.	60.0	33.3	6.7	-
	1.2.5 Sufficient numbers of clean blankets and bedding are available to service users.	96.7	3.3	-	-
	1.2.6 Service users can keep personal belongings and have adequate lockable space to store them.	60.0	33.3	6.7	-
Standard 1.3: The facility meets hygiene and sanitary requirements	1.3.1 The bathing and toilet facilities are clean and working properly	90.0	10.0	-	-
	1.3.2 The bathing and toilet facilities allow privacy, and there are separate facilities for men and women.	100	-	-	-
	1.3.3 Service users have regular access to bathing and toilet facilities.	96.7	-	3.3	-
	1.3.4 The bathing and toileting needs of service users who are bedridden or who have impaired mobility or other physical disabilities are accommodated.	93.3	-	6.7	-
Standard 1.4: Service users are given food, safe drinking-water and clothing that meet their needs and preferences.	1.4.1 Food and safe drinking-water are available in sufficient quantities, are of good quality and meet with the service users' cultural preferences and physical health requirements.	90	10	-	-
	1.4.2 Food is prepared and served under satisfactory conditions, and eating areas are culturally appropriate and reflect the eating arrangements in the community.	100	-	-	-
	1.4.3 Service users can wear their own clothing and shoes (day wear and night wear).	93.3	6.7	-	-
	1.4.4 When service users do not have their own clothing, good-quality clothing is provided that meets their cultural preferences and is suitable for the climate.	93.3	6.7	-	-
Standard 1.5: Service users can communicate freely, and their right to privacy is respected.	1.5.1 Telephones, letters, e-mails and the Internet are freely available to service users, without censorship.	3.3	13.3	83.3	-
	1.5.2 Service users' privacy in communications is respected.	30.0	33.3	36.7	-

	1.5.3 Service users can communicate in the language of their choice, and the facility provides support (e.g. translators) to ensure that the service users can express their needs.	96.7	3.3	-	-
	1.5.4 Service users can receive visitors, choose who they want to see and participate in visits at any reasonable time.	46.7	30.0	23.3	-
	1.5.5 Service users can move freely around the facility.	23.3	63.3	13.3	-
Standard 1.6: The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.	1.6.1 There are ample furnishings, and they are comfortable and in good condition.	86.7	10.0	3.3	-
	1.6.2 The layout of the facility is conducive to interaction between and among service users, staff and visitors.	90	6.7	3.3	-
	1.6.3 The necessary resources, including equipment, are provided by the facility to ensure that service users have opportunities to interact and participate in leisure activities.	93.3	6.7	-	-
	1.6.4 Rooms within the facility are specifically designated as leisure areas for service users.	90.0	10.0	-	-
Standard 1.7: Service users enjoy a fulfilling social and personal life and remain engaged in community life and activities.	1.7.1 Service users can interact with other service users, including members of the opposite sex.	26.7	60.0	13.3	-
	1.7.2 Personal requests, such as to attend weddings or funerals, are facilitated by staff.	76.7	13.3	10.0	-
	1.7.3 A range of regularly scheduled, organized activities are offered in both the facility and the community that are relevant and age-appropriate.	76.7	23.3	-	-
	1.7.4 Staff provide information to service users about activities in the community and facilitate their access to those activities.	53.3	23.3	23.3	-
	1.7.5 Staff facilitate service users' access to entertainment outside the facility, and entertainment from the community is brought into the facility.	53.3	30.0	16.7	-

Table15. Theme 2. The right to enjoyment of the highest attainable Standard of physical and mental health (staff).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
Standard 2.1: Facilities are available to everyone who requires treatment and support	2.1.1 No person is denied access to facilities or treatment on the basis of economic factors or of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	96.7	-	3.3	-
	2.1.2 Everyone who requests mental health treatment receives care in this facility or is referred to another facility where care can be provided	86.7	-	13.3	-
	2.1.3 No service user is admitted, treated or kept in the facility on the basis of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	33.3	-	66.7	-
Standard 2.2: The facility has skilled staff and provides good quality mental health services	2.2.1 The facility has staff with sufficiently diverse skills to provide counselling, psychosocial rehabilitation, information, education and support to service users and their families, friends or carers, in order to promote independent living and inclusion in the community.	83.3	16.7	-	-
	2.2.2 Staff are knowledgeable about the availability and role of community services and resources to promote independent living and inclusion in the community.	33.3	30.0	36.7	-
	2.2.3 Service users can consult with a psychiatrist or other specialized mental health staff when they wish to do so.	90.0	10.0	-	-
	2.2.4 Staff in the facility are trained and licensed to prescribe and review psychotropic medication.	96.7	-	3.3	-
	2.2.5 Staff are given training and written information on the rights of persons with mental disabilities and are familiar with international human rights Standards, including the CRPD.	83.3	16.7	-	-
	2.2.6 Service users are informed of and have access to mechanisms for expressing their opinions on service provision and improvement.	93.3	3.3	3.3	-
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	2.3.1 Each service user has a comprehensive, individualized recovery plan that includes his or her social, medical, employment and education goals and objectives for recovery.	33.3	46.7	16.7	3.3
	2.3.2 Recovery plans are driven by the service user, reflect his or her choices and preferences for care, are put into effect and are reviewed and updated regularly by the service user and a staff member.	60.0	16.7	20.0	3.3
	2.3.3 As part of their recovery plans, service users are encouraged to develop advance directives10 which specify the treatment and recovery options they wish to have as well as those that they don't, to be used if they are unable to communicate their choices at some point in the future.	20.0	13.3	66.7	-
	2.3.4 Each service user has access to psychosocial programmes for fulfilling the social roles of his or her choice by developing the skills necessary for	26.7	56.7	16.7	-

	employment, education or other areas. Skill development is tailored to the person's recovery preferences and may include enhancement of life and self-care skills.				
	2.3.5 Service users are encouraged to establish a social support network and/or maintain contact with members of their network to facilitate independent living in the community. The facility provides assistance in connecting service users with family and friends, in line with their wishes.	83.3	16.7	-	-
	2.3.6 Facilities link service users with the general health care system, other levels of mental health services, such as secondary care, and services in the community such as grants, housing, employment agencies, day-care centres and assisted residential care.	36.7	33.3	30.0	-
Standard 2.4: Psychotropic medication is available, affordable and used appropriately	2.4.1 The appropriate psychotropic medication (specified in the national essential medicines list) is available at the facility or can be prescribed.	93.3	6.7	-	-
	2.4.2 A constant supply of essential psychotropic medication is available, in sufficient quantities to meet the needs of service users.	96.7	3.3	-	-
	2.4.3 Medication type and dosage are always appropriate for the clinical diagnoses of service users and are reviewed regularly.	86.7	3.3	10.0	-
	2.4.4 Service users are informed about the purpose of the medications being offered and any potential side effects.	40.0	26.7	33.3	-
	2.4.5 Service users are informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy.	56.7	6.7	36.7	-
Standard 2.5: Adequate services are available for general and reproductive health	2.5.1 Service users are offered physical health examinations and/or screening for particular illnesses on entry to the facility and regularly thereafter.	96.7	3.3	-	-
	2.5.2 Treatment for general health problems, including vaccinations, is available to service users at the facility or by referral.	96.7	3.3	-	-
	2.5.3 When surgical or medical procedures are needed that cannot be provided at the facility, there are referral mechanisms to ensure that the service users receive these health services in a timely manner.	96.7	3.3	-	-
	2.5.4 Regular health education and promotion are conducted at the facility.	33.3	46.7	20.0	-
	2.5.5 Service users are informed of and advised about reproductive health and family planning matters.	33.3	-	66.7	-
	2.5.6 General and reproductive health services are provided to service users with free and informed consent.	80.0	6.7	13.3	-

Table16. Theme 3. The right to exercise legal capacity and the right to personal liberty and the security of person (staff).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
Standard 3.1: Service users' preferences for the place and form of treatment are always a priority	3.1.1 Service users' preferences are the priority in all decisions on where they will access services.	-	-	-	100
	3.1.2 All efforts are made to facilitate discharge so that service users can live in their communities.	83.3	16..7	-	-
	3.1.3 Service users' preferences are the priority for all decisions on their treatment and recovery plan.	50.0	36.7	13.3	-
Standard 3.2: Procedures and safeguards are in place to prevent detention and treatment without free and informed consent	3.2.1 Admission and treatment are based on the free and informed consent of service users.	-	-	-	100
	3.2.2 Staff respect the advance directives of service users when providing treatment.	40.0	6.7	53.3	-
	3.2.3 Service users have the right to refuse treatment.	23.3	26.7	50.0	-
	3.2.4 Any case of treatment or detention in a facility without free and informed consent is documented and reported rapidly to a legal authority.	86.7	3.3	3.3	6.7
	3.2.5 People being treated or detained by a facility without their informed consent are informed about procedures for appealing their treatment or detention.	16.7	3.3	80.0	-
	3.2.6 Facilities support people being treated or detained without their informed consent in accessing appeals procedures and legal representation	23.3	13.3	63.3	-
Standard 3.3: Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity	3.3.1 At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices.	76.7	23.3	-	-
	3.3.2 Clear, comprehensive information about the rights of service users is provided in both written and verbal form.	60.0	3.3	36.7	-
	3.3.3 Clear, comprehensive information about assessment, diagnosis, treatment and recovery options is given to service users in a form that they understand and which allows them to make free and informed decisions.	30.0	26.7	43.3	-
	3.3.4 Service users can nominate and consult with a support person or network of people of their own free choice in making decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected will be recognized by the staff.	86.7	10.0	3.3	-
	3.3.5 Staff respect the authority of a nominated support person or network of people to communicate the decisions of the service user being supported.	96.7	3.3	-	-
	3.3.6 Supported decision-making is the predominant model, and substitute decision-making is avoided.	33.3	3.3	63.3	-
	3.3.7 When a service user has no support person or network of people and wishes to appoint one, the facility will help the user to access appropriate support.	40.0	6.7	53.3	-
Standard 3.4: Service users have the right to confidentiality and access to their personal health information	3.4.1 A personal, confidential medical file is created for each service user.	93.3	-	6.7	-
	3.4.2 Service users have access to the information contained in their medical files.	6.7	-	93.3	-
	3.4.3 Information about service users is kept confidential.	100	-	-	-

	3.4.4 Service users can add written information, opinions and comments to their medical files without censorship.	100	-	-	-

Table17. Theme 4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (staff).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
Standard 4.1: Service users have the right to be free from verbal, mental, physical or sexual abuse and physical or emotional neglect	4.1.1 Staff members treat service users with humanity, dignity and respect.	83.3	16.7	-	-
	4.1.2 No service user is subjected to verbal, physical, sexual or mental abuse.	50.0	43.3	6.7	-
	4.1.3 No service user is subjected to physical or emotional neglect.	86.7	10.0	3.3	-
	4.1.4 Appropriate steps are taken to prevent all instances of abuse.	96.7	3.3	-	-
	4.1.5 Staff support service users who have been subjected to abuse in accessing the support they may want.	96.7	3.3	-	-
Standard 4.2: Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	4.2.1 Service users are not subjected to seclusion or restraint.	23.3	30.0	46.7	-
	4.2.2 Alternatives to seclusion and restraint are in place at the facility, and staff are trained in de-escalation techniques for intervening in crises and preventing harm to service users or staff.	90.0	-	10.0	-
	4.2.3 A de-escalation assessment is conducted in consultation with the service user concerned in order to identify the triggers and factors he or she finds helpful in diffusing crises and to determine the preferred methods of intervention in crises.	93.3	6.7	-	-
	4.2.4 The preferred methods of intervention identified by the service user concerned are readily available in a crisis and are integrated into the users' individual recovery plan.	96.7	-	3.3	-
	4.2.5 Any instances of seclusion or restraint are recorded (e.g. type, duration) and reported to the head of the facility and to a relevant external body.	86.7	3.3	-	10.
Standard 4.3: Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with free and informed consent	4.3.1 No electroconvulsive therapy is given without the free and informed consent of service users.	40.0	3.3	33.3	23.3
	4.3.2 Clear evidence-based clinical guidelines on when and how electroconvulsive therapy can or cannot be administered are available and adhered to.	40.0	-	-	60.0
	4.3.3 Electroconvulsive therapy is never used in its unmodified form (i.e. without an anaesthetic and a muscle relaxant).	36.7	-	-	63.3
	4.3.4 No minor is given electroconvulsive therapy.	36.7	-	-	63.7
	4.3.5 Psychosurgery and other irreversible treatments are not conducted without both the service users' free and informed consent and the independent approval of a board.	-	-	-	100
	4.3.6 Abortions and sterilizations are not carried out on service users without their consent.	96.7	-	-	3.3
Standard 4.4: No service	4.4.1 Medical or scientific experimentation is	96.7	-	3.3	-

user is subjected to medical or scientific experimentation without his or her informed consent	conducted only with the free and informed consent of service users.				
	4.4.2 Staff do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting service users to participate in medical or scientific experimentation.	73.3	-	13.3	13.3
	4.4.3 Medical or scientific experimentation is not undertaken if it is potentially harmful or dangerous to the service user.	86.7	-	-	13.3
	4.4.4 Any medical or scientific experimentation is approved by an independent ethics committee.	70.0	-	3.3	26.7
Standard 4.5: Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment or other forms of ill-treatment and abuse	4.5.1 Service users are informed of and have access to procedures to file appeals and complaints, on a confidential basis, to an outside, independent legal body on issues related to neglect, abuse, seclusion or restraint, admission or treatment without informed consent and other relevant matters.	53.3	3.3	43.3	-
	4.5.2 Service users are safe from negative repercussions resulting from complaints they may file.	90.0	6.7	3.3	-
	4.5.3 Service users have access to legal representatives and can meet with them confidentially.	86.7	3.3	10.0	-
	4.5.4 Service users have access to advocates to inform them of their rights, discuss problems and support them in exercising their human rights and filing appeals and complaints.	40.0	10.0	50.0	-
	4.5.5 Disciplinary and/or legal action is taken against any person found to be abusing or neglecting service users.	70.0	-	30.0	-
	4.5.6 The facility is monitored by an independent authority to prevent the occurrence of ill-treatment.	96.7	-	3.3	-

Table18. Theme 5. The right to live independently and be included in the community (staff).

Standards:	Criteria:	AF %	AP %	NI %	NA/ DN%
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	5.1.1 Staff inform service users about options for housing and financial resources.	23.3	3.3	73.3	-
	5.1.2 Staff support service users in accessing and maintaining safe, affordable, decent housing.	10.0	10.0	80.0	-
	5.1.3 Staff support service users in accessing the financial resources necessary to live in the community.	13.3	6.7	76.7	-
Standard 5.2: Service users can access education and employment opportunities	5.2.1 Staff give service users information about education and employment opportunities in the community.	20.0	3.3	76.7	-
	5.2.2 Staff support service users in accessing education opportunities, including primary, secondary and post-secondary education.	6.7	6.7	86.7	-
	5.2.3 Staff support service users in career development and in accessing paid employment opportunities.	6.7	13.3	80.0	-
Standard 5.3: The right of service users to participate in political and public life and to exercise freedom of association is supported.	5.3.1 Staff give service users the information necessary for them to participate fully in political and public life and to enjoy the benefits of freedom of association.	16.7	6.7	76.7	-
	5.3.2 Staff support service users in exercising their right to vote.	6.7	6.7	86.7	-
	5.3.3 Staff support service users in joining and participating in the activities of political, religious, social, disability and mental disability organizations and other groups.	16.7	13.3	70.0	-
Standard 5.4: Service users are supported in taking part in social, cultural, religious and leisure activities	5.4.1 Staff give service users information on the social, cultural, religious and leisure activity options available.	86.7	10.0	3.3	-
	5.4.2 Staff support service users in participating in the social and leisure activities of their choice.	66.7	26.7	6.7	-
	5.4.3 Staff support service users in participating in the cultural and religious activities of their choice	60.0	23.3	16.7	-

ANNEX IV

Sosio-Demoqrafik Göstəricilər

Cins	1. Kişi 2. Qadın
Yaş	
Ailə vəziyyət	1. Subay 2. Evli 3. Boşanmış 4. Dul
Təhsil	1. Ibtidai 2. Orta 3. İxtisaslaşmış orta 4. Ali
İş	1. İşləyir 2. İşsiz
Maddi-sosial statusu	1. Yüksək 2. Orta 3. Aşağı
Diaqnoz:	1. Sch 2. Sch-aff 3. BAP 4. Depres 5. Şəxs poz 6. DKP
Stasionarlaşmaların sayı:	
Stasionarlaşmanın müddəti:	
Vəzifəsi:(işçi)	1.Həkim 2.Psixoloq 3.Tibb bacısı 4.Digər
Iş stajı(işçi)	
Qohumluğu(qohum):	1. Valideyn 2. Övlad 3. Bacı/qardaş 4.H/yoldaşı 5. Digər

ANNEX V

Üst Keyfiyyət Və Hüquqlarin Qiymətləndirilməsi Cədvəli Psixi Sağlamliği Təmin Edən Sahələrdə Keyfiyyətin Və İnsan Hüquqlarinin Qiymətləndirilməsi.

MÖVZU 1

Qənaətbəxş həyat səviyyəsi hüququ (Maddə 28, ƏHHK)

Standard 1.1 Müəssisə texniki cəhətdən sazdır.

1.Sizcə, müəssisənin(binanın) ümumi vəziyyəti, təmiri standartlara uyğundurmu? (məs.pəncərələr qırıq deyil, divarın boyası/suvağı tökülmür və s.)

Tam Qismən Qətiyyən

2.Müəssisə fiziki qüsurlu şəxslərin(əlillərin) istifadəsi üçün münasibdirmi?

Tam Qismən Qətiyyən

3.Müəssisənin ilboyu işıqlandırılması, qızdırılması, havalandırılması orada qalmaq üçün rahat şəraiti təmin edirmi?

Tam Qismən Qətiyyən

4.Sizcə, bu müəssisədəki insanlar yanğın hadisələrinə qarşı nə dərəcədə qorunur? Lazımi təhlükəsizlik tədbirləri görülürmü? (yanğınsöndürən balonlar, yanğın siqnalları, yanğın zamanı yatılı xəstələrin təxliyəsi və s.)

Tam Qismən Qətiyyən

Standard 1.2 İstifadəçilərin yataq şəraitləri rahatdır və məxfilik təmin olunur.

1.Çarpayıların sayı otaqlarda kifayət qədərdirmi? Hər bir xəstəyə çatacaq qədər çarpayı varmı, və ya otaqda çarpayıların sayı həddindən çoxdurmu?

Tam Qismən Qətiyyən

2.Kişilər, qadınlar, uşaqlar və yaşlılar üçün yataq otaqları ayrıdırmı?

Bəli Xeyr

3.Siz yuxudan istədiyiniz vaxt oyanıb, istədiyiniz vaxt yatmağa getməyə özünüz qərar verə bilirsinizmi?

Bəli Bəzən Xeyr

4.Yataq otaqlarında sizin məxfiliyiniz qorunurmu? (Məsələn, paltar dəyişərkən başqaları sizi narahat edirmi?) Qapını özünüz kilidləyə bilirsinizmi?

Tam Qismən Qətiyyən

5.Yataq dəstləri kifayət sayda, rahat və istidirmi?

Tam Qismən Qətiyyən

6.Sizin hər birinizin öz şəxsi əşyalarınızı qoymaq üçün şəxsi şkaflarınız/çəkməcələriniz varmı? Onları açarla bağlaya bilirsinizmi?

Bəli Qismən Xeyr

Standart 1.3 Müəssisə gigiyenik və sanitar cəhətdən tələbatlara tam uyğundur.

1.Sanitar qovşaqları (hamam-tualet) nə dərəcədə təmiz və işlək vəziyyətdədir? (müntəzəm olaraq təmizlənirmi, kranlar, duşlar işləyirmi, daimi isti suyu olurmu, kifayət qədər tualet kağızları olurmu və s.)

Tam Qismən Qətiyyən

2.Qadın və kişilər üçün sanitar qovşaqları ayrıdırmı? Məxfilik(özəllik) təmin olunurmu?

Bəli Xeyr

3.Siz istədiyiniz vaxt tualet və hamamdan istifadə edə bilirsinizmi? (olurmu ki bəzən istifadənizə məhdudiyyətlər qoyulsun)

Bəli Xeyr

4.Ehtiyac olduqda, məsələn əlillərə, yataq xəstələrinə tualet və ya hamamdan istifadə etmək üçün işçilər köməklik göstərirlərmi? Kömək etdikləri zaman bunu necə edirlər, əsəbi olurlarmı)

Tam Qismən Qətiyyən

Standart 1.4 İstifadəçilərin ərzaq, təmiz su və geyimə olan tələbatları tam təmin olunur.

1.Sizə kifayət qədər keyfiyyətli ərzaq və su verilirmi? İstəmədiyiniz yeməklərdən imtina edə bilirsiniz, yoxsa məcbur yeyirsiniz?

Tam Qismən Qətiyyən

2.Mətbəx və yeməkxana rahat və təmiz olur? Yeməklər təmiz şəraitdə hazırlanıb verilir?

Tam Qismən Qətiyyən

3.Öz istədiyiniz geyimləri geyinə bilirsiniz? Sizə təmiz geyimlər verilir? (vaxtlı-vaxtında yuyulurlar?)

Bəli Bəzən Xeyr

4.Əgər kiminsə paltarı, geyimi yoxdursa, onlara xəstəxanadan keyfiyyətli paltarlar verilirmi?

Tam Qismən Qətiyyən

Standart 1.5 İstifadəçilər sərbəst şəkildə ünsiyyət qura bilirlər və onların məxfiliyinə hörmətlə yanaşılır.

1.Xəstəxanada telefon, məktub, e-mail və internetdən sərbəst şəkildə istifadə edə bilirsiniz?

Tam Qismən Qətiyyən

2.Yaxınlarınızla ünsiyyət zamanı(telefonla, məktubla və s.) məxfilik təmin olunurmu? İşçilər tərəfindən danışıqlarınız dinlənilir və ya məktublarınız oxunurmu?

Tam Qismən Qətiyyən

3.İstədiyiniz dildə sərbəst danışmağa icazə verilir?

Tam Qismən Qətiyən

4.İstədiyiniz şəxslə istədiyiniz zaman görüşə bilirsiniz? Bununla bağlı sizə məhdudiyyətlər qoyulurmu?

Bəli Bəzən Xeyr

5.Müəsisənin içində və ətrafında istədiyiniz kimi sərbəst gəzə bilirsiniz?

Tam Qismən Qətiyyən

Standart 1.6 Müəssisə aktiv iştiraketmə və qarşılıqlı əlaqələrin yaranması üçün qonaqpərvər, rahat və həvəsləndirici mühiti təmin edir.

1.Pasiyentlər üçün kifayət qədər yaxşı vəziyyətdə olan mebellər(oturacaqlar, stollar və s.) varmı?

Tam Qismən Qətiyyən

2.Binanın quruluşu, dizaynı, xüsusilə hər kəsin ortaq istifadə etdiyi zallar digər pasiyentlərlə, işçilərlə, gələn qonaqlarla qarşılıqlı əlaqələr qurmağa tam imkan verirmi?

Tam Qismən Qətiyyən

3.Boş vaxtlarınızı keçirtmək üçün sizə müstəlif vasitələrdən – qəzet, jurnal, kitab, musiqi, kompüter, TV və s. istifadə etməyə şərait yaradılır?

Tam Qismən Qətiyyən

4.Boş vaxtlarınızı keçirtmək üçün xüsusi otaqlar varmı? (TV zalı, oxu zalı və s.)

Bəli Xeyr

Standart 1.7 İstifadəçilər sosial və şəxsi həyatdan tamamən zövq ala bilir və icma həyatı və məşğuliyyətlərində iştirakına davam edir.

1.Digər qadın və kişi pasiyentlərlə sərbəst ünsiyyət qurmağınıza icazə verilirmi? Hər hansı qadağalar qoyulurmu?

Bəli Bəzən Xeyr

2.Sizin üçün xüsusi olan günlərdə – yaxınlarınızın toy və ya yas mərasimlərində – iştirak üçün getməyinizə xəstəxanadan icazə verilirmi?

Bəli Bəzən Xeyr

3.Müəyyən vaxtlarda burada sizin üçün hər hansı fəaliyyətlər təşkil olunurmu? Əgər olunursa, iştirak edib-etməməyi seçmə hüququnuz olurmu?

Bəli Bəzən Xeyr

4.Xəstəxanadan kənarda, cəmiyyətdə hər hansı fəaliyyətlərdə iştirak edə bilirsiniz? Bu fəaliyyətlər haqqında sizə işçilər məlumat verirmi?

Bəli Bəzən Xeyr

5.İşçilər xəstəxanadan xaric əyləncələrdə iştirak etməyiniz üçün icazə verirlərmi, və ya əyləncələrin xəstəxanada təşkil olunmasına şərait yaradırlarmı?

Bəli Bəzən Xeyr

MÖVZU 2

Fiziki və psixi sağlamlığın ən yüksək əlçatan səviyyəsindən istifadə hüququ (Maddə 25, ƏHHK)

Standart 2.1 Ehtiyacı olan hər bir kəs müəssisədə lazımi müalicə və dəstəkdən istifadə edə bilər.

1.Olurmu ki, maddi imkanı olmadığı üçün, başqa milliyyətdən, dindən olduğu üçün, və ya siyasi baxışlarına görə insanların xəstəxanaya qəbulu və müalicəsindən imtina edilir?

Xeyr Bəli

2.Ehtiyacı olan şəxs burada müalicə ala bilmədikdə, başqa xəstəxanalara, yardım mərkəzlərinə

yönləndirilirmi?

Bəli Xeyr

3.Sizcə xəstəxanada müalicə alıb stabilləşdiyi üçün evə yazılmalı olan xəstələrin burada başqa səbəblərdən xəstəxanada saxlanılmağı davam edilirmi? Nəyə görə (irq, cins, din, siyasi səbəblər, yoxsulluq, ailə istəmədiyi üçün və s.)

Xeyr Bəli

Standart 2.2 Müəssisədə tam bacarıqlı işçilər fəaliyyət göstərir və əhalini keyfiyyətli psixi sağlamlıq xidmətləri ilə təmin edir.

1.Sizcə, işçilərin pasiyentlərə tam hərtərəfli yardım göstərmək üçün kifayət qədər lazımi bacarıqları varmi? Hansı növ işçilər var burada, saya bilərsinizmi?

Tam Qismən Qətiyyən

2.İşçilər sizin sərbəst yaşamağınıza dəstək üçün müxtəlif icma xidmətləri/poliklinikalar və digər yardım mərkəzləri (məşğulluq, evlə təmin etmə, təhsil, sosial təminat) və s. haqda sizə nə dərəcədə məlumatlar verirlər?

Tam Qismən Qətiyyən

3.İşçilərlə (həkim, psixoloq, sosial işçi, tibb bacısı və s.) konsultasiya üçün istədiyiniz vaxt görüşə bilirsiniz?

Bəli Bəzən Xeyr

4.Burada sizə dərmanları kim təyin edir, dəyişdirir? Sizcə onun buna lisenziyası/səlahiyyəti varmı?

Bəli Xeyr

5.Sizcə, işçilər insan hüquqlarını, pasiyentlərin hüquqlarını tam bilirlər?

Tam Qismən Qətiyyəm

6.Pasiyentlər aldığı xidmətlərlə bağlı, onların daha da inkişaf etdirilməsi üçün öz fikirlərini, şikayətlərini bildirə bilirlər?

Bəli Bəzən Xeyr

Standart 2.3 Müalicə psixososial reabilitasiya və dəstək şəbəkələri və digər xidmətlərlə əlaqələr istifadəçi fokuslu bərpa planının bir hissəsidir və istifadəçilərin cəmiyyətdə/icmada müstəqil yaşamağına kömək edir.

1.Hər bir pasiyentin özünəuyğun, onun məqsədlərinə yönəlmiş bərpa planı varmı? Bu plana nələr daxildir? (iş, təhsil, sosial həyat, tibbi aspektlər və s.)

Tam Qismən Qətiyyəm

2.Bərpa planları Sizin öz müalicə seçimlərinizi əks etdirirmi, müntəzəm olaraq yenidən gözdən keçirilirmi?

Tam Qismən Qətiyyəm

3.Hər hansı bir xoşagəlməz hadisə zamanı (psixoz, xəstə özü qərar vermək iqtidarında olmadıqda) pasiyentlərin müalicə taktikaları işçilər tərəfindən onların istəkləri nəzərə alınmadan məcburi olaraq həyata keçirilir?

Qətiyyən Qismən Tam

4.Müəssisədə psixososial reabilitasiya, həyati bacarıqla və özünəqulluq proqramları varmı? Onlardan səmərəli istifadə olunurmu?

Tam Qismən Qətiyyən

5.İşçilər sizi, ailənizlə və digər sizə dəstək olan insanlarla əlaqələrinizin davam etməsi üçün həvəsləndirirlərmi/bu cəhətdən sizə kömək göstərirlərmi?

Tam Qismən Qətiyyəm

6.İşçilər sizin digər xəstəxanalarla, sağlamlıq mərkəzləri ilə və sosial xidmətlərlə əlaqələr qurmağınıza komək edirlərmi?

Tam Qismən Qətiyyən

Standart 2.4 Psixotrop dərmanlar mövcuddur, ucuzdur və müvafiq istifadə olunur.

1.Müəssisədə lazım olan bütün dərman vasitələri varmı?

Tam Qismən Qətiyyən

2.Dərmanların sayı hər kəsə davamlı olaraq çatmağa kifayət edirmi? Olur ki, hər hansı bir dərman vasitəsinə ehtiyac olduğu halda o dərman xəstəxanada olmasın?

Tam Qismən Qətiyyən

3.Dərmanlat hər kəsə öz diaqnozlarına, və ya vəziyyətlərinə uyğun olaraq verilir? Heç ele bir hal eşitmisinizmi ki, kiməsə səhv dərman verilsin?

Tam Qismən Qətiyyən

4.Sizə qəbul etdiyiniz dərmanlar və onların əlavə təsirləri haqqında məlumat verilirmi?

Tam Qismən Qətiyyən

5.Sizə mümkün ola biləcək başqa müalicə növləri haqqında, məsələn psixoterapiya, məlumat verilibmi?

Bəli Xeyr

Standart 2.5 Ümumi və reproduktiv sağlamlıq üçün müvafiq xidmətlər mövcuddur.

1.Xəstəxanada qəbul zamanı ümumi fiziki müayinədən(diş daxil olmaqla) keçmisiniz? Digər xəstəliklərin olub-olmadığı yoxlanılıbmı?

Tam Qismən Qətiyyəm

2.Ehtiyac yarandıqda, xəstələrin digər somatik xəstəlikləri müalicə olunurmu? Müalicə burada aparılır, yoxsa başqa xəstəxanalara yönləndirilirlər?

Tam Qismən Qətiyyəm

3.Cərrahi əməliyyatlar, və ya hər hansı digər tibbi prosedurlara ehtiyac yarandıqda, xəstələr müvafiq xidmətlərlə təmin olunurlar? (Burada, və ya başqa müəssisədə)

Tam Qismən Qətiyyəm

4.Sağlamlıq haqqında maarifləndirici və profilaktik(qoruyucu) tədbirlər təşkil olunurmu?

Bəli Çox az Xeyr

5.Sizə ailə planlaşdırılması haqqında məlumatlar verilirmi? Müstəqil olaraq ailə qurmaq, və ya uşaq sahibi olmaq qərarı verə bilirsinizmi?

Bəli Xeyr

6.Bütün ümumi tipli və reproduktiv sağlamlıqla bağlı xidmətlər sizin öz razılığınızla və pulsuz təmin olunur?

Tam Qismən Qətiyyən

MÖVZU 3

Qanun qarşısında bərabərlik və Azadlıq və şəxsi toxunulmazlıq hüququ(Maddə 12 və 14, ƏHHK)

Standart 3.1 Müalicə yeri və forması ilə bağlı Istifadəçilərin arzuları həmişə öncəliklidir.

1.Bu xəstəxanada müalicə almaq qərarını siz özünüz vermisiniz, yoxsa siz istəmədən gətirilmisiniz? Sizin müalicəni harada və necə almaq haqqında qərarınıza əhəmiyyət verilir?

Bəli Bəzən Xeyr

2.İşçilər sizin xəstəxanadan mümkün qədər tez evə buraxılmağınıza və cəmiyyətə qayıtmağınıza köməklik göstərirlərmi?(əgər yox, nəyə əsasən?)

Tam Qismən Qətiyyəm

3.Müalicə planı hazırlanan zaman sizin nəyə üstünlük verdiyinizi öyrənib, ona əsasən plan qəbul edirlərmi?(əgər yox, nəyə əsasən?)

Bəli Bəzən Xeyr

Standart 3.2 Şəxsin razılığı (və razılaşdırılmış məlumatı) olmadan saxlanılması və müalicəsinin q qarşısının alınması üçün lazımi prosedurlar və mühafizə tədbirləri görülür.

1.Xəstəxanaya qəbul olunan zaman burada müalicə almaq üçün razılıq vermisiniz?

Bəli Xeyr

2.Hər hansı bir xoşagəlməz hadisə baş verən zaman (məs.psixoz, şəxs özü qərar vermə iqtidarında olmadığı hallar), onun bu situasiyalar üçün əvvəldən verdiyi qərar ailəsi və işçilər tərəfindən anlayışla qarşılanıb yerinə yetirilirmi?

Bəli Bəzən Xeyr

3.Siz müalicədən imtina etmək istəsəniz, bu istəyiniz yerinə yetirilirmi? Müalicədən imtina edən şəxslər tanıyırsınızmı?Onlar xəstəxanadan azad olundularmı?

Bəli Bəzən Xeyr

4.Sizcə, şəxsin istəyi olmadan, qeyri-könüllü xəstəxanaya qəbul edildikdə bu haqda hər-hansı sənədləşdirilmə aparılırmı? Sizcə bu barədə sənədlər hara yazılıb göndərilir?

Bəli Bəzən Xeyr

5.Elə bir hal olubmu ki, qeyri-könüllü xəstəxanaya qəbul olunmuş şəxs bu qərardan məhkəməyə şikayət edib? Belə bir şeyin mümkünlüyü haqqında məlumatınız varmı?

Bəli Xeyr

6.İşçilər pasiyentlərin məhkəməyə müraciət etmək istədikləri hallarda onlara bununla bağlı köməklik göstərirlərmi?

Bəli Bəzən Xeyr

Standart 3.3 İstifadəçilər qanun qarşısında bərabərlik hüquqlarından istifadə edə bilir və ehtiyac yarandıqda onlara bu hüquqlarından istifadə etmək üçün dəstək verilir.

1.İşçilər sizin fikirlərinizi hörmətlə dinləyib, sizinlə seçimləriniz və qərarlarınız haqqında müzakirə aparırlar?

Bəli Bəzən Xeyr

2.Xəstəxanaya qəbul olarkən sizə buradakı hüquqlarınız haqqında yazılı, və ya şifahi məlumat verilib?

Bəli Xeyr

3.Xəstəxanaya qəbul olarkən sizə buradakı müayinələr, diaqnozunuz, müalicə üsulları haqqında aydın məlumat verilib? Əgər hə, Siz müayinə və müalicə üsullarını özünüz seçə bilirsiniz?

Bəli Qismən Xeyr

4.Siz öz şəxsi(maddi, qanuni və s.) işləriniz və müalicə seçiminizdə qərar vermək üçün sizə dəstək olacaq insanlar seçib onlarla məsləhətləşə bilirsini?

Bəli Bəzən Xeyr

5.Sizə dəstək olan insanlarla münasibətinizə və məsləhətləşməyinizə işçilər rahat şərait yaradırlarmı? Onlara hörmətlə yanaşırlarmı?

Bəli Bəzən Xeyr

6.Əgər burada kimsə sərbəst qərar verə bilmirsə, ona kömək edə biləcək yaxını ilə birlikdə qərar verməsinə çalışılır(yəni özü ilə söhbət edilir, qərar verməyə həvəsləndirilir), yoxsa onun yerinə başqa şəxslər(məsələn işçilər, ailəsi) qərar verir?

Bəli(özü ilə) Xeyr(onun yerinə)

7.Əgər burada kiminsə məsləhətləşib bir qərar verməsi üçün yaxını yoxdursa, ona işçilər tərəfindən belə bir şəxs tapmağa kömək edilirmi? Məsləhətləşmək üçün insanlarla əlaqə yaradırlarmı?

Bəli Bəzən Xeyr

Standart 3.4 İstifadəçilərin məxfilik və öz şəxsi sağlamlıqları haqqında məlumat alma hüquqları var.

1.Sizin xəstəliyiniz haqqında məlumatlar yazılan vərəqələr/kartalar(xəstəlik tarixləri) harada saxlanılır? Saxlanıldıqları yer kilidli olur?

Bəli Xeyr

2.Sizin öz şəxsi məlumatlarınız saxlanılan sənədlərlə tanış olmaq üçün istədəyiniz zaman sizə verirlərmi?

Bəli Bəzən Xeyr

3.Sizin şəxsi məlumatlarınız olan kartaları(xəstəlik tarixləri) başqa insanlar götürüb oxuya bilər? Siz digər xəstələrin kartalarını alıb oxuya bilirsinizmi? Sizin xəstəliyiniz haqqında bütün məlumatları sizin yaxınlarınıza deyirlərmi?

Xeyr Bəzən Bəli

4.Siz özünüz öz kartanıza hər hansı bir məlumat əlavə edə, yaza bilərsinizmi?

Bəli Xeyr

MÖVZU 4

İşgəncədən və qəddar, qeyri-insani və ya ləyaqət alçaldan rəftar və cəza növlərindən azadolma və İstismardan, zorakılıqdan və təhqirdən azadolma hüquqları (Maddə 15 və 16, ƏHHK)

Standart 4.1 Istifadəçilər şifahi, psixoloji, fiziki və seksual təhqirlərdən, fiziki və emosional laqeydlikdən azadolma hüququna malikdir.

1.İşçilər (həkim, tibb bacıları. Sanitarlar və s.) sizinlə necə rəftar edir? Sizinlə mərhəmətli, xoş rəftar göstərirlər? Hər zaman sizin güvənliyinizi düşünürlərmi?

Tam Qismən Qətiyyən

2.A.Olurmu ki, işçilər sizi təhqir etsin, qışqırsın, hədələsin? Və ya əl qaldırsın, döysünlər? Görmüsünüzmü ki, işçilər kimisə itələyib, vurub, onlara nəsə atıb? (Necə sözlər deyirlər, nə edirlər, nümunə deyə bilərsiniz?Pasiyentlər bu vəziyyətlərdən kiməsə şikayət ediblərmi?)

Xeyr Bəzən Bəli

2.B.Olurmu ki, Pasiyentlər sözə baxmadıqda, çox səs saldıqda ona dərman verib sakitləşdirsinlər ki, deyilənlərə əməl etsin? Cəza vermək üçün pasiyentlərə dərman verirlərmi? Və ya olurmu ki, işçilər hansısa xəstələrdən xoşları gəldiyi üçün onlara xüsusi davransınlar(öpmək, qucaqlamaq, sığallamaq və s.)

Xeyr Bəzən Bəli

3.Belə bir hadisənin şahidi olmusunuzmu ki, köməyə ehtiyacı olan pasiyent işçilərdən kömək istəsin, ancaq heç kim onu saymasın, yardım etməsin?

Xeyr Bəzən Bəli

4.Pasiyentlərin təhqir olunmasının, döyülməsinin qarşısını almaq üçün tədbirlər görülürmü? (Belə hallar baş verdikdə, pasiyentlər kimə şikayət edirlər? Nə tədbirlər görülür?)

Bəli Bəzən Xeyr

5.İşçilər təhqir olunan, döyülən xəstələrə köməklik göstərirlərmi? Belə halların olub-olmadığını yoxlamaq üçün müayinələr keçirilirmi?

Bəli Xeyr

Standart 4.2 Mümkün olan krizis hallarının həlli üçün məhdudiyyət və təcridetmə üsullarına alternativ üsullar tətbiq olunur.

1.Pasiyentlərdə kriz halları baş verdikdə (məsələn, təhlükəyə səbəb ola bilən kəskin stress halında, pasiyent digər xəstələrə və işçilərə təhlükə yaratdıqda) işçilər nə edirlər? Tək otağa salınıb bağlay;rlar, izolyasiya edirlər və ya çarpayıya bağlayırlar?

Xeyr Bəzən Bəli

2.Krizis halları üçün (pasiyent digərləri üçün təhlükəli olduqda) onun vəziyyətini həll etməyin təcriddən başqa yolları varmı? Sizcə işçilər bu vəziyyətləri həll etmək üçün təlimlər keçiblərmi?

Bəli Xeyr

3.İşçilər pasiyentləri nələrin krizə saldığını, onları özlərindən çıxartdığını aşkar edə bilirlərmi? Xəstələrin bu streslərdən azad olması üçün nəyə ehtiyacları olduqlarını aydınlaşdırmaq məqsədi ilə onlarla konsultasiya aparılırmı? (Onların özlərindən nəyə ehtiyacları olduğu soruşulurmu?)

Bəli Bəzən Xeyr

4.Daha əvvəl baş vermiş potensial krizis səbəbləri haqqında (məsələn, nələr pasiyentlərdə kriz halı yarada bilər, onları aqressiv edə bilər) məlumat qeydə alınıbmı? Bu halda buna qarşı görülməli olan hazır tədbirlər varmı? İşçilər bu vəziyyətlərdə nə edirlər?

Bəli (var) Xeyr (yoxdur)

5.Bütün təcrid edilmə(izolyasiya) və məhdudiyyət halları sənədləşdirilirmi? Bu haqda müdiriyyətə məlumat verilirmi?

Bəli Bəzən Xeyr

Standart 4.3 Elektrokonvulsiv terapiya, psixocərrahiyyə və digər üzünmüddətli, geridönməz təsirə malik tibbi prosedurlar ehtiyac olmadıqca tətbiq edilməməlidirlər və yalnız istifadəçinin məlumatlı razılığı ilə onlara müraciət edilə bilər.

1.Xəstəxanada EKT-Elektrokonvulziv Terapiyadan istifadə olunur? Ekt istifadəsi üçün pasiyentlərin razılığını alınır? Onlara prosedur haqqında məlumar verilirmi?

Bəli Bəzən Xeyr

2.EKT istifadəsi üçün dəqiq qaydalar varmı? Hansı hallarda EKT istifadə oluna bilər, və ya oluna bilməz? Məlumatınız varmı? Elə bir hal olubmu ki, EKT ehtiyac olmadığı halda pasiyentə tətbiq olunub?

Bəli(var) Xeyr(yoxdur)

3.Sizcə, hansısa xəstəyə anesteziyasız(keyləşdirmədən) EKT edilibmi? Və ya kiməsə cəza vermək üçün EKT tətbiq olunubmu? Bu haqda məlumatınız var?

Xeyr Bəzən Bəli

4.Xəstəxanada EKT-nın 18 yaşdan kiçiklərə tətbiq olunduğunu eşitmisiniz?(olunurmu)

Xeyr Bəli

5.Pasiyentlərə burada hər hansı cərrahi əməliyyət edildiyini eşitmisiniz? Burada psixocərrahiyyə (beynində, başda) əməliyyatlar aparılırmı? Və ya hər hansı geriyədönməz təsirləri olan müalicələr aparılırmı? Əgər hə, pasiyentlərə bu prosedurlar haqqında məlumat verilib, razılıq alınırmı?

Bəli(razılıq alınır) Xeyr(razılıq alınmır)

6.Bu və ya başqa xəstəxanada pasiyentlərə razılıqları olmadan abort və ya sterilizasiya edilibmi?

Xeyr Bəli

Standart 4.4 Heç bir İstifadəçi özünün məlumatlı razılığı olmadan tibbi və ya elmi təcrübəyə məruz qala bilməz.

1.Heç olubmu ki, burada pasiyentlər hansısa yeni elmi və ya tibbi eksperimentdə (məsələn, yeni bir dərman eksperimentində) öz razılığı olmadan iştirak etsin?

Xeyr Bəli

2.Pasiyentlərin elmi təcrübələrdə iştrak etməsinə görə işçilərə mükafat verilirmi?

Xeyr Bəli

3.Heç olubmu ki, belə bir eksperiment pasiyent üçün zərərli və təhlükəli olub? Təhlükəli olduğu halda davam etdirilibmi?

Xeyr Bəli

4.Tibbi və ya elmi təcrübə üçün razılıq prosedurları hansılardır? Müstəqil etik komitə tərəfindən bu təcrübələrə icazə alınırmı?

Bəli Bəzən Xeyr

Standart 4.5 İşgəncədən, qəddar, qeyri-insani ləyaqət alçaldan və digər xoş olmayan rəftarlardan qorunmaq üçün lazımi tədbirlər görülür.

1.Sizə aydın və anlaşılan şəkildə şikayət prosedurları (razılığınız olmadan müalicə, sizə qarşı olan

zorakılıqlar, təhqirlər) barəsində məlumat verilibmi? Şikayətlərinizi kimə, hara, necə bildirə bilərsiniz?

Bəli Qismən Xeyr

2.Olurmu ki, kimsə şikayət etdiyi üçün cəzalandırılsın? Pasiyentlər qorxudulduqları üçün şikayət etmədiyi hallar olurmu?

Xeyr Bəzən Bəli

3.Öz qanuni nümayəndəniz ilə təklikdə görüşmək imkanınız varmı? Onunla şikayətləriniz haqqında danışa bilirsiniz?

Bəli Bəzən Xeyr

4.İstənilən vaxt Öz hüquqlarınızı qorumaq üçün hansısa fərdi və ya təşkilatlarla (əlilləri cəmiyyəti,insan hüquqlarını qoruyan cəmiyyətlər, vəkillər) görüşüb dəstək ala bilirsiniz? Bu fərd və təşkilatlarla görüşmək imkanınız varmı?

Bəli Bəzən Xeyr

5.Bilirsinizmi ki, kobud rəftar və təhqirlərə görə həmin şəxslər məsuliyyətə cəlb oluna bilərlər? Xəstəxanada elə bir hadisə ilə(məsuliyyətə cəlb olunma) rastlaşmısınızmı?

Bəli Xeyr

6.Xəstəxana mütəmadi olaraq belə halların (kobud rəftar, təhqir və s.) aşkarlanması və qarşısının alınması üçün rəhbərlik və ya başqa orqanlar tərəfindən yoxlanılırmı?

Bəli Xeyr

MÖVZU 5

Müstəqil həyat tərzi və yerli icmaya cəlb olunma hüququ (Maddə 19, ƏHHK)

Standart 5.1 İstifadəçilərə evlə təmin olunmaq və yaşamaq üçün lazımi maddi vəsaitlərin əldə edilməsi üçün dəstək verilir.

1.,İşçilər Sizə xəstəxanadan çıxdıqdan sonra ehtiyac olarsa, evlə və ya maddi yardımla necə təmin

olunmaq haqqında məlumatlar verirmi? Belə bir xidmələrin olması haqqında məlumatınız varmı?

Bəli Qismən Xeyr

2.İşçilər Sizə qalmaq üçün yer tapmaqda köməklik göstərirlərmi?

Bəli Qismən Xeyr

3.İşçilər Sizə maddi yardımla təmin olunmağa köməklik göstərirlərmi?

Bəli Qismən Xeyr

Standart 5.2 İstifadəçilər təhsil və iş fürsətləri əldə edə bilirlər.

1.Sizə cəmiyyətdə təhsil almaq, kariyera qurmaq və iş fürsətləri əldə etmək haqqında məlumatlar verilirmi? Bu fürsətləri necə əldə etmək və ya dəyərləndirmək haqqında məlumatınız var?

Bəli Qismən Xeyr

2.Sizə, və ya sizin uşaqlarınıza məktəb və ya universitetlərdə təhsil almaq üçün köməklik göstərilirmi?

Bəli Qismən Xeyr

3.İşlə təmin olunmağınıza köməklik göstərilirmi?

Bəli Qismən Xeyr

Standart 5.3 İstifadəçilərin siyasi və ictimai həyatda iştiraketmə hüququ və öz üstünlük verdiyi birliklərə(ticarət birlikləti, siyasi partiyalar və s.) sərbəst daxil və xaricolma hüquqları dəstəklənir.

1.Siyasətdə necə iştirak edə biləcəyiniz haqda sizə məlumat verilirmi?Məsələn, səsvermə hüququnuz, psixi sağlamlıqla bağlı qərarların verilməsində iştiraketmə hüququnuz və s.?

Bəli Qismən Xeyr

2.Səsvermə zamanı iştirak etməklə bağlı sizə kömək göstərilirmi? Necə?

Bəli Qismən Xeyr

3.Sizə Psixi pozuntudan əziyyət çəkən insanlar birlikləti/təşkilatları, Əlillər Cəmiyyəti, və ya hər hansı bir digər siyasi, dini və ya sosial təşkilatlarda aktiv iştirak etməyiniz üçün yardım edilirmi?

Bəli Qismən Xeyr

Standart 5.4 İstifadəçilərin sosial, mədəni, dini və asudə fəaliyyətlərdə iştirakı dəstəklənir.

1.İşçilər sizə boş vaxtlarınızda məşğul ola biləcəyiniz fəaliyyətər haqqında, və ya sosial, mədəni, dini tədbirlər haqqında məlumatlar verir?

Bəli Qismən Xeyr

2.Sosial fəaliyyətlər, tədbirlərdə iştirak etmək üçün sizə hansı yardımlar edilir? Məsələn, transport və ya bilet təşkil edilirmi?

Bəli Qismən Xeyr

3.Mədəni və ya dini fəaliyyətlərdə, tədbirlərdə iştirak etmək üçün sizə hansı yardımlar göstərilir?

Bəli Qismən Xeyr

ANNEX VI

Həyat Keyfiyyəti Şkalası

1. İş görmək üçün enerjinizin çatmadığı anlar olurmu?

◯heç vaxt ◯nadir hallarda ◉bəzən ◯tez –tez ◯həmişə

2. İş görməyə özünüzü məcbur edə bilmədiyiniz hallarla üzləşmisinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

3. Gələcəyiniz üçün narahat olursunuzmu?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

4. Tənhalıq hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

5. Ümidsizlik hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

6. Təşviş, həyəcan hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

7. Gündəlik işlərinizi edə bilirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

8. İnsanların sözlərini yalnış anladığınız hallar olurmu?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

9. Fikrinizi cəmləmə problemi ilə qarşılaşırsınızmı?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

10. İnsanlarla münasibət qurmağa çətinlik çəkirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

11. Sıxıntı və ruh düşkünlüyü hiss etdiyiniz anlar olurmu?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

12. "Mən bacara bilərəm" hissi sizə nə dərəcə yaxındır?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

13. Çox qarışıqlıq və əminsizlik hiss etdiyiniz hallarla qarşılaşmısınızmı?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

14. Yuxu ilə bağlı narahatlığınız olurmu?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

15. Əhval dəyişkənliyi (gah yüksək, gah da enmiş) sizə nə dərəcə yaxın bir hissdir?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

16. "Daha yaxşı ola bilməyəcəm" düşüncəsi sizi narahat edirmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

17. "Nələrsə" haqqında narahat olursunuzmu?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

18. Sizə elə gəlirmi ki, insanlardan sizdən çəkinir və uzaq durmağa çalışır?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

19. Keçmiş haqqında düşündükdə məyusluq hissi keçirirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

20. Əşyaları xatırlamağa çətinlik çəkirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

21. Dünyadan təcrid olunduğunuzu hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

22. İnsanların yanında özünüzü narahat hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

23. Aydın düşünməkdə çətinlik çəkirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

24. Sizi məyus edən düşüncələriniz olurmu?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

25. Özünə zərər vermə haqqında fikirləriniz varmı?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

26. Özünüzü xoşbəxt hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

27. Əhval-ruhiyyəniz aşağı olurmu?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

28. Gün ərzində özünüzü yuxulu hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

29. Özünüzü narahat hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

30. Sosial həyatınızla bağlı narahat olursunuzmu?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

31. Yorğun hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

32. Fiziki olaraq özünüzü gücsüz hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

33. Normal həyat yaşamadığınızı hiss edirsinizmi?

◯heç vaxt ◯nadir hallarda ◯bəzən ◯tez –tez ◯həmişə

ANNEX VII

İstifadəçi Məmnunluğu Sorğusu

Zəhmət olmazsa, aldığınız xidmətlər haqqında bəzi suallara cavab verəsiniz. Bununla siz göstərdiyimiz xidmətlərin daha da yaxşılaşdırılmasına kömək edəcəksiniz. Bizim üçün müsbət və ya mənfi olmasından asılı olmayaraq sizin həqiqi fikirləriniz vacibdir. Sizdən bütün suallara cavab verməyinizi xahiş edirik. Həmçinin siz öz irad və təkliflərinizi də qeyd edə bilərsiniz. Biz sizin yardımınızı yüksək dəyərləndiririk. Təşəkkürlər.

Aldığınız xidmətlərin keyfiyyətini necə qiymətləndirirsiniz?

1	2	3	4
Pis	Orta	Yaxşı	Mükəmməl

İstədiyiniz növ yardımı aldınızmı?

1	2	3	4
Xeyr, qətiyyən	Xeyr, tam yox	Bəli, ümumən	Bəli, tamamilə

Bizim xidmətlər sizin ehtiyaclarınızı nə qədər qarşılayır?

1	2	3	4
Heç bir hissəsini	Yalnız az bir hissəsini	Əksər hissəsini	Demək olar ki hamısını

Əgər yaxınınız bənzər köməyə ehtiyac duyarsa, bizim xidmətləri ona məsləhət görərdinizmi?

1	2	3	4
Xeyr, heç bir ehtimalla	Xeyr, böyük ehtimalla	Bəli, böyük ehtimalla	Bəli, tamamilə

Aldığınız xidmətlərin həcmindən məmnunsunuzmu?

1	2	3	4

Xeyr, qətiyyən məmnun deyiləm	Çox az məmnunam	Demək olar ki məmnunam	Tamamilə məmnunam

Aldığınız xidmətlər sizə problemlərinizi daha yaxşı həll etməyə kömək etdimi?

1	2	3	4
Xeyr, daha da pisləşdirdi	Xeyr, heç bir kömək etmədi	Bəli, demək olar ki kömək etdi	Bəli, tamamilə kömək etdi

Ümumilikdə, aldığınız xidmətlərdən nə dərəcədə məmnunsunuz?

1	2	3	4
Qətiyyən məmnun deyiləm	Çox az və ya fərq etmir	Demək olar ki məmnunam	Tamamilə məmnunam

Əgər yenidən yardıma ehtiyacınız olsa, yenidən bizim xidmətlərdən istifadə edərdinizmi?

1	2	3	4
Xeyr, heç bir ehtimalla	Xeyr, böyük ehtimalla	Bəli, böyük ehtimalla	Bəli, tamamilə

Sorğuda iştirak etdiyiniz üçün təşəkkür edirik!

İrad və təkliflərriniz

ANNEX VIII

Məlumatlı Razılıq

Mən, müəssisənin fəaliyyəti, müalicə və orada göstərilən xidmətlərin qiymətləndirilməsi, eyni zamanda müəssisədə insan hüquqlarının nə dərəcə qorunmasını müəyyənləşdirmək məqsədi ilə işçilər, istifadəçilər və onların ailə üzvləri (yaxınları, qanuni nümayəndələri) ilə məlumatların toplanması məqsədilə aparılan müsahibədə iştirak etməyi qəbul edirəm

Mən bu müsahibədə öz istəyimlə, hər hansı güc tətbiq olunmadan iştirak etdiyimi və iştirak etməkdən imtina hüququm olduğunu anlayıram. Əgər iştirak etməkdən imtina etsəm, bu məlumat konfidensial (gizli) saxlanılacaq və buna görə mənə cəza, sanksiya, təzyiqlər tətbiq edilməyəcəkdir.

İstənilən vaxt bu müsahibədə iştirakımı dayandıra biləcəyimi və bu məlumatın konfidensial (gizli) saxlanılacağını, buna görə mənə cəza, sanksiya, təzyiqlər tətbiq edilməyəcəyini anlayıram.

Mənim kimliyimin tam gizli saxlanılacağını anlayıram.

Mən bu məlumatlı razılığın müsahibə vasitəsi olmadığını və verdiyim cavabların tam gizli saxlanılacağını anlayıram.

Bu müsahibənin məqsədi mənə tam izah edilib və mən bu formanın məzmununu anlayıram.

İştirakçının adı və soyadı: _____

İştirakçının imzası: _____

Tarix:_____