

Article

Promoting Rights-Based Mental Health Care: Impact of the WHO QualityRights Training on Health Professionals in Brazil

Ana Beatriz Zanardo Mion ^{1,2}, Emanuele Seicenti de Brito ^{3,*}, Igor de Oliveira Reis ^{1,2}
and Carla Aparecida Arena Ventura ^{1,2,*}

¹ Department of Psychiatric Nursing and Human Sciences, Ribeirão Preto College of Nursing, University of São Paulo, Ribeirão Preto 14040-902, SP, Brazil; ana.zanardo@usp.br (A.B.Z.M.); igordeoliveirareis@usp.br (I.d.O.R.)

² PAHO/WHO Collaborating Centre for Nursing Research Development, Ribeirão Preto College of Nursing, University of São Paulo, Ribeirão Preto 14040-902, SP, Brazil

³ School of Economics, Administration, and Accounting, University of São Paulo (FEA-RP/USP), Ribeirão Preto 14040-905, SP, Brazil

* Correspondence: emanuele600@usp.br (E.S.d.B.); caaventu@erp.usp.br (C.A.A.V.)

Abstract

The protection and promotion of the human rights of individuals with mental disorders is a critical global priority, and initiatives such as the WHO QualityRights program aim to strengthen rights-based mental health care. We aimed to investigate the impact of the QualityRights core training on promoting knowledge and practices among healthcare professionals regarding the human rights of individuals with mental disorders, and to assess whether this training can reduce the stigma associated with mental disorders among these professionals. A quasiexperimental pre–post study was conducted with 26 primary healthcare professionals. Of these, 14 provided complete paired data, enabling direct comparison before and after the intervention. Participants completed standardized questionnaires assessing attitudes toward people with mental health conditions and psychosocial disabilities. Data were analyzed using paired statistical tests for pre–post comparisons, followed by multiple linear regression to examine factors associated with changes in scores. The training produced meaningful improvements in several items related to autonomy, legal capacity, coercion, and rights-based practices. Higher educational level was associated with greater attitudinal change. The WHO QualityRights training positively influenced healthcare professionals' attitudes toward human rights in mental health. Future research should include larger samples and long-term follow-up to strengthen the evidence base and evaluate the sustainability of these changes across diverse care settings.

Keywords: QualityRights; human rights; mental disorders; rights-based mental health care; health worker training



Academic Editor: Firas Kobeissy

Received: 7 October 2025

Revised: 5 February 2026

Accepted: 9 February 2026

Published: 12 February 2026

Copyright: © 2026 by the authors.

Licensee MDPI, Basel, Switzerland.

This article is an open access article distributed under the terms and conditions of the [Creative Commons Attribution \(CC BY\)](https://creativecommons.org/licenses/by/4.0/) license.

1. Introduction

Initially, the understanding of global mental health was shaped by distinct approaches. One of these was advocated by social anthropologists and cultural psychiatrists, who interpreted mental disorders as products of social and cultural forces (culturais) [1]. Despite shifts in these perspectives over time, the lack of equity in the treatment of mental disorders compared with physical illnesses persists globally. People affected by mental disorders, as well as the services designed for them, are often undervalued [2]. Treatment rates for these conditions remain remarkably low [3].

The challenges faced by mental health services in low- and middle-income countries are multifaceted, encompassing issues such as legislation, policies, financial resources, organization, and planning, in addition to the availability of evidence-based interventions and adequately tailored training. In Brazil, there has been a transformation in mental health services, marked by a slowdown in the expansion of Psychosocial Care Centers and Primary Care services after 2017, with a greater focus on outpatient and hospital-based services [4]. In countries like Mexico, the scarcity and unequal distribution of psychiatrists—with only 1.1 professionals per 100,000 inhabitants in the public sector, well below the minimum recommended by the World Health Organization (WHO)—leaves around 80% of people without access to appropriate care [5]. These challenges are intrinsically linked to the worldview and cultural belief systems of each population, which can serve as both advantages and limitations, but undoubtedly influence service utilization [3].

The integration of mental health into primary care has been identified as an effective strategy to ensure early and continuous access to care, promoting positive outcomes and greater social inclusion [6]. This approach underscores the essential role of human rights in advancing accessible and quality mental health care, which is fundamental for achieving better outcomes and protecting the most vulnerable members of society [7].

Mental disorders are fundamentally linked to human rights issues, including stigma, discrimination, and violations of rights faced by affected individuals and their families. These issues are widespread and severe, making initiatives to combat stigma and promote human rights indispensable in public mental health [2]. Despite the shift in attention to the mental health and illness process, reflected in new mental health policies, significant challenges remain. The perspective of professionals toward people with mental disorders should align with the psychosocial care model. However, some professionals still adhere to a biological and medical-centered view, possibly due to a lack of knowledge, ongoing health education, or social stigma [8].

Although healthcare providers often have broader biomedical knowledge of mental illnesses, this does not immunize them against stigmatizing attitudes and behaviors. A common narrative is that the social status associated with the healer's role and the self-image of being capable of alleviating suffering are threatened when confronted with a patient with a mental disorder, particularly if they lack psychiatric training or tools to provide effective care [9]. In this context, there are already instruments that identify key dimensions of stigma related to psychotropic medications, parenting styles, disruptive behavior, and discriminatory intent [10,11]. The results of these instruments can support the development of anti-stigma interventions, helping to prevent professionals from underestimating or dismissing symptoms, delaying diagnosis, and hindering access to treatment.

Primary care health professionals often report not having a solid theoretical foundation to support the care they provide to people with mental disorders in basic health units. They tend to consider referrals to psychosocial care centers or hospitals as the most appropriate course of action to ensure mental health care in primary settings [12]. Furthermore, acknowledging stigma as an influence on the actions of these professionals, education should focus on overcoming this issue. The analysis of stigma signals in concepts and skills appears to converge toward elements related to cultural competence, especially in the attitudinal aspect (feeling and being), suggesting that stigma-combatting strategies should address this competence [13].

Given the severity of the challenges faced by people with mental disorders due to stigma, discrimination, and a lack of respect for human rights, concerted and proportional efforts must be made to support methodologically robust research [14]. Effective mental health promotion also depends on intersectoral collaboration with areas not directly related

to health, such as education, housing, employment, industry, transportation, arts, sports, urban planning, and justice [2].

The World Health Organization's QualityRights Initiative represents a transformative approach to mental health care, grounded in a rights-based, recovery-oriented framework. It was designed to promote a structural transformation of mental health services, grounded in the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and in principles of rights-based and recovery-oriented care. The QualityRights training modules constitute the main educational component of the initiative and systematically address, using an evidence-based approach, the core themes necessary to advance human rights. These include: understanding the rights guaranteed by the CRPD; preventing coercive practices; strengthening legal capacity and supported decision-making; promoting alternatives to institutionalization; empowering and ensuring the active participation of people with lived experience; and fostering safe, inclusive, and respectful therapeutic environments. International studies have shown that these modules increase participants' awareness of rights violations, improve their understanding of coercive practices, and strengthen the adoption of autonomy-centered strategies, such as supported decision-making, advance planning, and recovery-oriented interventions. This training, structured around participatory activities, discussions, and case-based learning, has proven effective in different countries in sensitizing professionals, service users, and families to CRPD principles and in fostering clinical and organizational practices aligned with human rights [15]. Additionally, the training encourages the development of advocacy networks and peer-led groups to reinforce community-based services, while offering practical strategies—such as improved communication and specialized response teams—to reduce coercive practices in mental health settings [16].

The Initiative offers a suite of training tools, including in-person modules and an interactive e-training platform, designed to empower a wide range of stakeholders, from healthcare professionals to individuals with lived experiences and policymakers. These tools cover critical topics such as human rights, recovery, legal capacity, and the elimination of coercive practices [15]. The training employs diverse educational approaches, including skills teaching, myth deconstruction, and case vignettes, to foster sustainable changes in mindset and practice.

Although several countries have already implemented the QualityRights Initiative in different contexts, no study had previously applied the WHO training modules in Brazil, making this investigation the first of its kind in the country. Existing literature has focused primarily on international evaluations of the service assessment tool and on training implementations conducted in countries such as Chile, Egypt, Tunisia, India, and Finland. Thus, this study offers an original contribution by examining the effects of the QualityRights training among Primary Health Care professionals in the Brazilian context, expanding the understanding of the applicability and outcomes of this approach within health systems that have distinct organizational, cultural, and historical characteristics [17].

In this context, the aim of this study is to investigate the impact of the QualityRights core training on promoting knowledge and practices among healthcare professionals regarding the human rights of individuals with mental disorders, and to assess whether this training can reduce the stigma associated with mental disorders among these professionals.

2. Materials and Methods

2.1. Study Design

This is a quasiexperimental, nonrandomized study based on pre- and postintervention data. A quasiexperimental study differs from an experimental study in that it does not

include a control group and does not randomize the sample, where a single group serves as its own control before and after the intervention [18,19].

2.2. Participants

This study targeted professionals working in Primary Health Care (PHC) linked to the Family Health Strategy (FHS) in Brazil, who are directly involved in the care of health service users. The FHS constitutes the main organizational model of PHC in the country and is responsible for care coordination, continuity of care, and the provision of comprehensive health care to the population. Currently, Brazil has a large number of Family Health teams distributed throughout the national territory, composed of multidisciplinary teams that include physicians, nurses, nursing technicians or assistants, community health workers, and, in many contexts, other support professionals. This configuration represents a large, diverse, and strategic workforce for the implementation of public policies in mental health and human rights.

The study adopted a pre- and post-intervention design with repeated measures, in which participants served as their own controls, allowing for intra-individual comparisons before and after the intervention [20]. To assess the impact of the QualityRights Training—Core Modules on knowledge of human rights and its effectiveness as an anti-stigma intervention, data were collected at two time points: immediately before and after completion of the training. The QualityRights training was delivered as a capacity-building course for health professionals working in a Family Health Unit (FHU) located in the interior of the state of São Paulo. It is noteworthy that the modules used had been previously translated, culturally adapted, and validated for Brazilian Portuguese in a prior study [21].

The selection of the unit was based on convenience, considering institutional availability to participate in the study. The selected FHU presents a configuration typical of the Family Health Strategy, with a multidisciplinary team composed of physicians, nurses, pharmacists, and community health workers, reflecting the organization and work dynamics commonly found in Brazilian PHC. Thus, although derived from a single service, the sample shares structural and functional characteristics similar to those of other FHS teams in the country, reinforcing its suitability as a setting to evaluate the applicability of the QualityRights training under real-world practice conditions.

The number of participants should also be considered in light of the operational recommendations of the QualityRights Initiative itself. According to practical guidance from the World Health Organization, training sessions are more effective when conducted in small groups, preferably with up to 25 participants, as this format fosters active participation, professional interaction, critical debate, and balanced expression of ideas [15]. The international literature on QualityRights implementation supports this recommendation, with studies conducted in diverse contexts reporting similar sample sizes, such as the training carried out in Tunisia with 19 participants [22] and the study conducted in Iceland with 29 health professionals [23].

Prior to the start of the intervention, a meeting was held with the FHU coordination and all unit staff, during which the objectives, procedures, and stages of the study were presented. All professionals who had direct contact with service users were invited to participate. Participation was entirely voluntary, with no obligation to adhere to or remain in all stages of the study. Professionals aged 18 years or older who were engaged in care-related activities at the FHU were included, while those on vacation or leave during the intervention period were excluded.

In total, 26 health professionals initially agreed to participate in the study, including physicians, nurses, pharmacists, and community health workers, representing both sexes, different levels of education, and varying lengths of experience in Primary Health Care.

All 26 participants completed the pre-test and attended the initial training sessions. However, according to the study protocol, a minimum attendance criterion was established, allowing for only one absence. As a result, some professionals did not meet the attendance requirement and did not proceed to the subsequent stage.

After completion of the five core modules of the QualityRights ToolKit, 20 professionals met the attendance criteria and were invited to complete the post-test. Of these, 14 participants fully completed both the pre- and post-tests, generating complete paired data as required by the pre–post design. These 14 professionals constituted the final sample used in the comparative statistical analyses between the two assessment time points.

2.3. Measurements

The study used the WHO QualityRights pre-training and post-training questionnaires, which constitute the official evaluation instruments developed specifically by the World Health Organization's Policy, Law and Human Rights Team to measure changes in attitudes resulting from the training. The quantitative assessment focused on Item 4 of both questionnaires, composed of 17 subitems that evaluate attitudes toward people with mental health conditions and psychosocial disabilities. These 17 subitems were designed to reflect the core themes addressed in the QualityRights modules—including coercion, legal capacity, community inclusion, service environment, treatment choice, and hope—and were developed through an informal expert-consensus process. The instrument demonstrates good internal consistency, with a Cronbach's alpha of 0.75, as reported in international validation studies. Each subitem is rated on a 5-point Likert scale (from "strongly disagree" to "strongly agree"), in which higher scores indicate negative or coercive attitudes that are not aligned with international human rights standards, while lower scores reflect attitudes consistent with rights-based and recovery-oriented care. The overall questionnaire score ranges from 0 to 68 points, with lower values indicating greater alignment with the human rights principles promoted by the QualityRights Initiative. In addition to attitudes, the questionnaires also included sociodemographic data (such as age, gender, profession, educational background, and years of experience) and general perceptions related to mental health. The post-training questionnaire further contained additional items aimed at evaluating the usefulness of the modules, the clarity of the content, and any perceived changes in practice.

2.4. Procedures

Stage 1: Application of the QualityRights PRE-training questionnaire

To assess the effectiveness of the training in relation to its objectives, the QualityRights PRE-training questionnaire was applied. Both the pretest and the posttest (administered after the completion of the modules) are part of the QualityRights training evaluation tools used to assess the effectiveness of the modules and changes in attitudes. This allows for a comparison of results before and after the intervention. The tests include questions on sociodemographic data and opinions on mental health, such as the hiring of people with psychosocial disabilities.

Stage 2: Offering the QualityRights core training modules in a course format (training):

Each QualityRights core training module was conducted on specific dates previously agreed upon with the health unit manager. Six sessions were needed, as module 2 had to be divided into two days.

The sessions were conducted by a multidisciplinary team per the Initiative's recommendations. Generally, each session had three facilitators: two nurses, holding master's and doctoral degrees, and one law graduate, with a PhD and postdoctoral experience, all with proven expertise in the topics addressed and prior work with the QualityRights

Initiative. Additionally, a support team consisting of nurses, psychologists, lawyers, and nursing students assisted in the preparation and execution of each module.

Not all professionals who participated in the first step were able to attend all the training days. Therefore, not all of the initial 26 professionals progressed to the next step (Stage 3) because of the maximum allowance of one absence. This stage will be explained further below.

The material used was the Portuguese version, translated and culturally validated by [21]. Adaptations were made to adjust the duration of the sessions, ensuring that the training could be delivered within the time available to healthcare professionals at the facility. The modules' content and core essence remain unchanged, preserving the Initiative's concepts and methodology. Each session lasted between 1.5 and 2 h, in accordance with the Initiative's recommendations. The training materials are in the public domain on the WHO website, and the research project was authorized to use them.

Stage 3: Application of the QualityRights POSTtraining questionnaire

After the completion of the five core training modules, healthcare professionals who participated in most of the training days were invited to respond to the QualityRights posttraining questionnaire. A total of 20 healthcare professionals participated in this stage.

The posttraining questionnaire includes additional questions to evaluate the modules and the changes in participants' practices [24].

2.5. Statistical Analysis

Each participant was assigned a unique identification code for the study, and the data were analyzed via SPSS 21 software (IBM: Armonk, NY, USA). A descriptive analysis was initially conducted to understand the sample and explore important variables, such as demographic data.

The pre- and posttraining results included quantitative data, focusing on item 4 of the questionnaires, which consisted of 17 subitems related to attitudes toward people with mental health issues and psychosocial disabilities. These subitems address topics such as coercion, legal capacity, community inclusion, the service environment, treatment choice, and hope and are evaluated via a 5-point Likert scale, where higher scores indicate more negative attitudes. The total scores ranged from 0 to 68, with lower scores indicating greater alignment with human rights [24].

The pre- and post-training measurements were compared using paired data, assuming that the corresponding test statistic followed a standard normal distribution. To examine factors associated with changes in the QualityRights scale scores between the two time points, multiple linear regression models with normally distributed outcomes were fitted. In the deterministic component of the models, we included only variables that showed $p < 0.20$ in the bivariate analysis and that allowed for clinically plausible parameter estimates. In the final models, associations were considered statistically significant when $p < 0.05$.

2.6. Ethical Considerations

The research was approved by the Ethics Committee of the University of São Paulo at Ribeirão Preto School of Nursing (Approval No: 6.257.303). The free and informed consent term was read and signed by the participants in two copies, with one kept by them and the other by the research team. The study followed the recommendations of Brazilian Resolution No. 466, of 2012, on research involving human beings.

2.7. Declaration of Generative AI and AI-Assisted Technologies in the Writing Process

During the preparation of this work the authors used ChatGPT-5.2 (OpenAI, San Francisco, CA, USA) specifically for the purpose of translation. Following its use, the

authors carefully reviewed and edited the content as needed and take full responsibility for the content of the published article.

3. Results

Among the 26 initial participants in this study, the majority (80.8%) were female. Additionally, most of the participants (57.7%) were classified as community health agents (ACs). Approximately 30.8% of the participants had some specialization. Notably, the majority of the participants (80%) expressed their willingness to recommend training to others, as shown in Table 1.

Table 1. Profile of study participants by characteristics.

Variable	<i>n</i>	%
Gender Identity		
Female	21	80.8
Male	5	19.2
Profession		
Pharmacy Assistant	1	3.8
Community Health Agent (ACS)	15	57.7
Nursing Assistant	1	3.8
Nursing Technician	2	7.7
Nurse	5	19.2
Physician	2	7.7
Has a degree in health		
No	4	15.4
Yes	9	34.6
No response	13	50.0
Postgraduate Level		
No postgraduate degree	3	11.5
Specialist	8	30.8
Master's	1	3.8
Doctorate	1	3.8
No response	13	50.0
Would you recommend this course to others?		
Yes	20	80.0
No response	6	20.0

Note: Data expressed as absolute (*n*) and relative (%) frequencies.

Although 20 healthcare professionals responded to the pre- and posttraining questionnaires and were included in the study, only the responses of 14 professionals on the QualityRights training evaluation tools could be compared and paired because some professionals failed to answer certain questions, which could affect the results if included in the specific analysis.

Regarding the effect of the training on the pre- and posttraining questions of the QualityRights training evaluation tools, a statistically significant reduction was observed in the following items: “People with dementia should always live in group homes where staff can care for them” (Pre: 2.92 × Post: 1.71; $p = 0.006$), “People using mental health services should be empowered to make their own decisions about their treatment” (Pre: 3.21 × Post: 2.49; $p = 0.042$), “Healthcare professionals’ opinions about care and treatment should carry more weight than those of a person with an intellectual disability” (Pre: 3.07 × Post: 2.28; $p = 0.016$), “People with intellectual disabilities have the right to make their own decisions, even if I disagree with them” (Pre: 2.93 × Post: 2.21; $p = 0.026$), and “It is necessary to control people using mental health services to maintain order” (Pre: 3.50 × Post: 2.64; $p = 0.028$), as shown in Table 2.

Table 2. Evaluation of the impact of QualityRights core training on question 4 items in pre- and post-training questionnaires.

Item	Pretest Mean	Posttest Mean	z	p	95% CI
a	Nothing can be improved in mental health services without additional resources.	1.92	2.14	0.83	0.406
b	The service environment has little to do with people's mental health and well-being.	1.85	1.93	0.27	0.788
c	People with dementia should always live in group homes where staff can care for them.	2.92	1.71	−2.79	0.006
d	People with psychosocial disabilities/mental health issues should not be employed in jobs that require direct contact with the public.	1.71	1.78	0.37	0.712
e	Taking medication is the most important factor in helping people with mental health issues.	2.14	2.00	−0.44	0.666
f	You can only inspire hope when a person is no longer showing symptoms.	2.35	2.00	−1.00	0.318
g	People using mental health services should be empowered to make their own decisions about their treatment.	3.21	2.49	−2.04	0.042
h	Following the advice of others who have experienced mental health issues is very. . .	2.93	2.43	−1.40	0.162
i	Healthcare professionals' opinions on care and treatment should carry more weight than those of a person with an intellectual disability.	3.07	2.28	−2.40	0.016
j	It is acceptable to pressure people using mental health services to undergo treatments they do not want.	2.71	2.07	−1.87	0.062
k	People with mental health issues should not be given important responsibilities.	2.35	1.93	−1.89	0.058
l	When people go through a crisis, healthcare professionals or family members should take control.	2.85	2.85	0.00	1.000
m	People with intellectual disabilities have the right to make their own decisions, even if I disagree with them.	2.93	2.21	−2.23	0.026

Table 2. Cont.

Item	Pretest Mean	Posttest Mean	z	p	95% CI
n	It is necessary to control people using mental health services to maintain order.	3.50	2.64	−2.20	0.028
o	The use of seclusion and restraint is necessary if people using mental health services become a threat.	3.14	3.28	0.37	0.712
p	People at risk of harming themselves or others should be isolated in a locked room.	2.00	1.71	−1.26	0.208
q	Involuntary admission does more harm than good.	2.85	2.93	0.24	0.810

Note: z values refer to the paired comparison. CI = confidence interval. Bold values indicate statistical significance ($p < 0.05$).

A statistically significant reduction was observed in the total score of the QualityRights scale, with pre- and posttraining values of 27.3 ± 8.2 and 21.3 ± 10.8 , respectively ($p = 0.022$), as shown in Table 3.

Table 3. Comparison of overall QualityRights Scale scores before and after intervention.

Mean	Preintervention SD	Median	Postintervention Q1	Q3	Mean
QualityRights Scale Overall score	27.3	8.2	29	20.5	32.2

Abbreviation: SD = standard deviation; Q1 = first quartile; Q3 = third quartile.

More years of schooling is related to a more pronounced reduction in the score for item 4 of the pre- and postquestionnaire of the QualityRights training evaluation tools ($\beta = -0.55$; 95% CI = $(-0.99; -0.10)$; $p = 0.015$), as detailed in Table 4.

Table 4. Factors associated with change in score for item 4 between pre- and post-training questionnaires.

Bivariate Association Variable	Multiple Regression b	95% CI	p	b	95% CI
Age (years)	0.07	−0.31, 0.45	0.713		
Gender identity (male) (Ref.: Female)	0.33	−9.49, 10.15	0.947		
Time working in current service (years)	0.28	−0.17, 0.73	0.215		
Degree in health Years of school	−6.40 −0.58	−20.16, 7.36 −1.01, −0.15	0.362 0.008	−0.55	−0.99, −0.10
Participation in a course or training on human rights and/or mental health	8.60	−1.93, 19.13	0.110	2.80	−7.40, 13.00

Notes: b = unstandardized regression coefficient; CI = confidence interval; Ref. = reference category. Bold values indicate statistical significance ($p < 0.05$).

4. Discussion

The present study investigated the effectiveness of QualityRights core training in increasing healthcare professionals' knowledge about the human rights of people with mental disorders and reducing associated stigma. More specifically, this investigation addresses a critical gap in the literature by applying the WHO training modules within the Brazilian Primary Health Care context for the first time. Unlike previous studies conducted in distinct cultural and organizational settings, this research assesses the applicability and impact of a rights-based approach within the Unified Health System (SUS), offering original evidence on its effectiveness in a scenario of high demand and limited resources.

The Family Health Strategy is a strategic point for the restructuring of the Unified Health System (SUS), serving as a fundamental gateway to integrate the system's principles. The inclusion of mental health actions in primary care aims to disrupt the traditional care model and advance the field of mental health. To achieve this goal, it is essential to provide training for primary care (PC) teams in psychosocial care. Integrated actions between primary care and mental health services are crucial to building processes that result in changes to healthcare practices, creating a network of attentive and individualized care [25]. Moreover, disease prevention and health promotion are cost-effective strategies that improve quality of life over time [25].

Several studies have conducted mental health education interventions in the context of primary care. Ayano et al. [26] evaluated the knowledge, attitudes, and practices of primary healthcare workers regarding mental, neurological, and substance use disorders. Their findings indicated that these aspects were relatively low before training but improved significantly afterward. These findings suggest that mental health training is essential for successful integration into primary care. Continuous education is critical for enhancing professionals' knowledge, attitudes, and practices, thereby facilitating the effective treatment of disorders within general health services.

Another study, conducted by Tilahun et al. [27], offered mental health training to primary care professionals and demonstrated that, despite being brief, the training had a significant effect on the motivation of community health professionals and the delivery of mental health services. By overcoming major barriers to care and providing adequate policy support, these professionals can substantially contribute to reducing the treatment gap for individuals with mental health needs. Similarly, a study in Malaysia evaluated a short video-based contact intervention as an antistigma measure among healthcare professionals. Ng et al. [28] reported that stigmatizing attitudes were common among these professionals and that a brief intervention could effectively improve these attitudes in the short term. However, long-term follow-up is recommended to ensure the intervention's sustained effectiveness.

Our findings reinforce the potential of the QualityRights Initiative to foster a structural shift towards rights-based and recovery-oriented care. The results obtained demonstrate that the training effectively promotes the understanding of human rights in mental health, moving beyond a purely biomedical perspective. The results of the pre- and postquestionnaires from QualityRights reflect findings that are consistent with those of previous studies. Significant changes were observed in themes such as involuntary treatment and autonomy. These changes align with the literature, highlighting the importance of the right to independence and self-determination for individuals in mental health services. These findings corroborate prior research, such as that of Morrissey [23], who also utilized QualityRights training tools and identified similar changes in attitudes and perceptions following training.

Similarly, a study conducted in Tunisia that also used QualityRights training tools and assessed knowledge and attitudes before and after training reported a general im-

provement in participants' attitudes toward human rights in mental health. While only a few items showed statistically significant differences, such as patients' decision-making power over their treatments, most questions exhibited positive changes [22]. These results are comparable to those of the present study, where significant improvements were also observed in items related to patient empowerment and reduced control over mental health service users. Additionally, a study in India implemented the QualityRights program with an intervention group, whereas a control group did not receive the intervention. The program's impact was assessed through attitude scales applied at the beginning and during follow-up. Staff turnover posed a challenge, with only 58% of initially enrolled staff remaining until the study's conclusion—a challenge also observed in our study. The results indicated more favorable attitudes toward reducing coercion among the intervention group staff, with significant changes in areas related to autonomy and the avoidance of coercion, which is consistent with the findings of our study [29].

In a study conducted in Ghana, the impact of QualityRights e-training on attitudes toward people with mental health conditions and disabilities was evaluated. The online course covered human rights, recovery, legal capacity, the end of coercion, and community inclusion and was completed by more than 17,000 participants between February 2019 and December 2021. The participants completed pre- and postcourse questionnaires, with the analysis including 417 paired and 4299 unpaired responses. Significant posttraining improvements were observed, particularly in items related to treatment choice, legal capacity, and coercion, aligning with our findings on the effectiveness of QualityRights in fostering positive changes in attitudes toward human rights [24]. This accumulated evidence suggests that the WHO modules are robust tools capable of producing positive outcomes across diverse health systems and cultural backgrounds.

Thus, delivering training online can be an effective strategy to increase healthcare professionals' participation, especially among younger professionals and those with fewer years of experience, who may be more inclined to participate in online courses than in-person ones. This aspect is reflected in our results, in which professionals with more years of experience demonstrated more significant attitude changes when comparing pre- and posttest results.

Regarding the limitations of this study, the small sample size ($n = 14$ for paired analysis) must be acknowledged as a primary constraint. Although 26 professionals were initially recruited, the methodological requirement for complete pre- and post-test data resulted in a reduced final analytical sample. Furthermore, as this was a convenience sample drawn from a single FHU, the findings cannot be extrapolated to all PHC professionals, the totality of FHS teams in Brazil, or distinct clinical contexts, such as specialized secondary or hospital services.

Nevertheless, the sample reflects the typical multiprofessional composition of the FHS, the predominant organizational model of PHC in Brazil, which is directly involved in community-based mental health demands. Consequently, these results are directly applicable to FHS teams and similar PHC environments with comparable professional structures. The study thus offers relevant evidence on the feasibility, acceptability, and preliminary impact of the QualityRights training within real-world PHC settings. We argue that focusing on this representative gateway of the Unified Health System (SUS) provides valuable insights, as specialized professionals in secondary or tertiary services might exhibit different baseline stigma levels due to more frequent contact with mental health disorders. While statistical generalizability remains limited, these findings provide essential groundwork for future multicenter investigations with expanded, representative samples across different Brazilian regions.

Finally, regarding future directions, our observations align with the literature recommending that anti-stigma interventions include long-term follow-up. Most studies assess the impact of such interventions only over a brief period [30]. Therefore, we suggest that a reevaluation of participants in future research could yield improved outcomes, confirming the consolidation of attitude changes. Additionally, expanding the implementation of QualityRights training across diverse healthcare settings and audiences, including policymakers and informal caregivers, could further amplify the observed positive outcomes.

5. Conclusions

The results of this study demonstrate that the WHO QualityRights training had a positive effect on the knowledge and practices of Brazilian healthcare professionals regarding mental health. Significant changes were observed in key items of the pre- and posttraining questionnaires, particularly concerning autonomy, legal capacity, and the reduction in coercive practices. The findings suggest that the training successfully improved the understanding of rights-based mental health care, reduced stigma, and fostered more empathetic attitudes among healthcare workers.

Demographic characteristics, such as age and gender, did not significantly affect the test scores, but years of schooling were associated with more pronounced reductions in stigma, indicating that the training had a greater impact on professionals with higher educational levels. The study underscores the importance of integrating continuous education in primary care to foster a compassionate and inclusive care network. Despite the sample size limitation, the evidence highlights the significant potential of the QualityRights program as a transformative tool for the Brazilian Unified Health System (SUS), promoting a shift from a biomedical model to one grounded in human rights.

Author Contributions: Conceptualization, A.B.Z.M. and E.S.d.B.; methodology, A.B.Z.M.; validation, E.S.d.B. and C.A.A.V.; formal analysis, A.B.Z.M.; investigation, A.B.Z.M. and E.S.d.B.; resources, C.A.A.V.; data curation, A.B.Z.M., E.S.d.B. and I.d.O.R.; writing—original draft preparation, A.B.Z.M.; writing—review and editing, E.S.d.B. and I.d.O.R.; visualization, E.S.d.B. and I.d.O.R.; supervision, C.A.A.V. and E.S.d.B.; project administration, C.A.A.V.; funding acquisition, C.A.A.V. All authors have read and agreed to the published version of the manuscript.

Funding: This study was funded by the National Council for Scientific and Technological Development (CNPq)-Brazil (process n° 408399/2021-0).

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Institutional Review Board (or Ethics Committee) of the University of São Paulo at Ribeirão Preto School of Nursing (protocol code 6.257.303 and date of approval: 23 August 2023).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study are available on request from the corresponding author. The data are not publicly available due to ethical/privacy issues.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

CI	Confidence Interval
CNPq	National Council for Scientific and Technological Development (Brazil)
CRPD	Convention on the Rights of Persons with Disabilities
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
SUS	Unified Health System (Brazil)

USF Family Health Unit
WHO World Health Organization

References

- Patel, V.; Saxena, S.; Lund, C.; Thornicroft, G.; Baingana, F.; Bolton, P.; Chisholm, D.; Collins, P.Y.; Cooper, J.L.; Eaton, J.; et al. The Lancet Commission on Global Mental Health and Sustainable Development. *Lancet* **2018**, *392*, 1553–1598. [CrossRef]
- Wahlbeck, K. Public Mental Health: The Time Is Ripe for Translation of Evidence into Practice. *World Psychiatry* **2015**, *14*, 36–42. [CrossRef]
- Rathod, S.; Pinninti, N.; Irfan, M.; Gorczynski, P.; Rathod, P.; Gega, L.; Naeem, F. Mental Health Service Provision in Low- and Middle-Income Countries. *Health Serv. Insights* **2017**, *10*, 1178632917694350. [CrossRef]
- Krefer, L.T.; de Oliveira, W.F. Reformulações na Política Nacional de Saúde Mental: Análise de Dados de Assistência no Período de 2012 a 2022. *Cien. Saude Colet.* **2025**, *30*, e13372023. [CrossRef]
- Barrón-Velázquez, E.; Mendoza-Velásquez, J.J.; Mercado-Lara, A.; Quijada-Gaytán, J.M.; Flores-Vázquez, J.F. The Mental Health Provider Shortage in the Mexican Public Sector: 2023 Estimates of Psychiatrists and Psychologists. *Salud Ment.* **2024**, *47*, 179–187. [CrossRef]
- Funk, M.; Saraceno, B.; Drew, N.; Faydi, E. Integrating Mental Health into Primary Healthcare. *Ment. Health Fam. Med.* **2008**, *5*, 5–8. [PubMed]
- Funk, M.; Drew, N.; Knapp, M. Mental Health, Poverty and Development. *J. Public Ment. Health* **2012**, *11*, 166–185. [CrossRef]
- Barros, S.; de Sousa Nóbrega, M.D.P.S.; dos Santos, J.C.; da Fonseca, L.M.; Floriano, L.S.M. Mental Health in Primary Health Care: Health-Disease According to Health Professionals. *Rev. Bras. Enferm.* **2019**, *72*, 1609–1617. [CrossRef]
- Kohrt, B.A.; Turner, E.L.; Rai, S.; Bhardwaj, A.; Sikkema, K.J.; Adekun, A.; Dhakal, M.; Luitel, N.P.; Lund, C.; Patel, V.; et al. Reducing Mental Illness Stigma in Healthcare Settings: Proof of Concept for a Social Contact Intervention to Address What Matters Most for Primary Care Providers. *Soc. Sci. Med.* **2020**, *250*, 112852. [CrossRef]
- Carrara, B.S.; Sanches, M.; Bobbili, S.J.; de Godoy Costa, S.; de Sousa, Á.F.L.; de Souza, J.; Ventura, C.A.A. Validation of the Opening Minds Scale for Health Care Providers (OMS-HC): Factor Structure and Psychometric Properties of the Brazilian Version. *Healthcare* **2023**, *11*, 1049. [CrossRef]
- Caraveo-Anduaga, J.J.; Martínez-Vélez, N.A.; Arroyo-Belmonte, M.; Gaytán-Flores, F.I. Adaptation and Validation of an Instrument for Measuring Stigma towards Mental Health Problems in Children among Health Professionals. *Salud Ment.* **2025**, *48*, 99–109. [CrossRef]
- Rotoli, A.; da Silva, M.R.S.; dos Santos, A.M.; Netto de Oliveira, A.M.; Calcagno Gomes, G. Mental Health in Primary Care: Challenges for the Resoluteness of Actions. *Anna Nery Sch. J. Nurs.* **2019**, *23*, e20180303. [CrossRef]
- Vieira, V.B.; Delgado, P.G.G. Estigma e Saúde Mental na Atenção Básica: Lacunas na Formação Médica Podem Interferir no Acesso à Saúde? *Physis Rev. Saúde Coletiva* **2021**, *31*, e310422. [CrossRef]
- Thornicroft, G.; Mehta, N.; Clement, S.; Evans-Lacko, S.; Doherty, M.; Rose, D.; Koschorke, M.; Shidhaye, R.; O'Reilly, C.; Henderson, C. Evidence for Effective Interventions to Reduce Mental-Health-Related Stigma and Discrimination. *Lancet* **2016**, *387*, 1123–1132. [CrossRef]
- World Health Organization (WHO). *QualityRights Materials for Training, Guidance and Transformation*; World Health Organization: Geneva, Switzerland, 2019. Available online: <https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools> (accessed on 21 June 2021).
- Hoare, F.; Duffy, R.M. The World Health Organization's QualityRights Materials for Training, Guidance and Transformation: Preventing Coercion but Marginalising Psychiatry. *Br. J. Psychiatry* **2021**, *218*, 240–242. [CrossRef] [PubMed]
- Mion, A.B.Z.; Ventura, C.A.A. The WHO QualityRights Initiative and Its Use Worldwide: A Literature Review. *Int. J. Soc. Psychiatry* **2023**, *70*, 424–436. [CrossRef]
- Dutra, H.S.; dos Reis, V.N. Desenhos de Estudos Experimentais e Quase-Experimentais: Definições e Desafios na Pesquisa em Enfermagem. *Rev. Enferm. UFPE Line* **2016**, *10*, 2230–2241. Available online: <https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/11238/12841> (accessed on 8 February 2026).
- Lobiondo-Wood, G.; Haber, J. Desenhos Não Experimentais. In *Pesquisa em Enfermagem: Métodos, Avaliação Crítica e Utilização*; Guanabara-Koogan: Rio de Janeiro, Brazil, 2001.
- Polit, D.F.; Beck, C.T. *Fundamentos da Pesquisa em Enfermagem: Avaliação de Evidências para a Prática de Enfermagem*, 7th ed.; Artmed: Porto Alegre, Brazil, 2011.
- de Brito, E.S.; Mion, A.B.Z.; de Oliveira Reis, I.; da Silva, A.M.; Ventura, C.A.A. Promoting Human Rights in Mental Health: Cultural Adaptation and Validation of the WHO QualityRights Training in Brazil. *Ment. Illn.* **2025**, *2025*, 9356669. [CrossRef]
- Carta, M.G.; Ghacem, R.; Milka, M.; Moula, O.; Staali, N.; Uali, U.; Bouakhari, G.; Mannu, M.; Refrafi, R.; Yaakoubi, S.; et al. Implementing WHO-QualityRights Project in Tunisia: Results of an Intervention at Razi Hospital. *Clin. Pract. Epidemiol. Ment. Health* **2020**, *16*, 125–133. [CrossRef]

23. Morrissey, F.E. An Evaluation of Attitudinal Change towards CRPD Rights Following Delivery of the WHO QualityRights Training Programme. *Ethics Med. Public Health* **2020**, *13*, 100410. [[CrossRef](#)]
24. Poynton-Smith, E.; Orrell, M.; Osei, A.; Ohene, S.-A.; Ansong, J.; Gyimah, L.; McKenzie, C.; Moro, M.F.; Drew-Bold, N.; Baingana, F.; et al. A Quantitative Analysis of Human Rights-Related Attitude Changes towards People with Mental Health Conditions and Psychosocial, Intellectual, or Cognitive Disabilities Following Completion of the WHO QualityRights e-Training in Ghana. *Int. J. Ment. Health Syst.* **2023**, *17*, 46. [[CrossRef](#)] [[PubMed](#)]
25. de Souza, Â.C.; Amarante, P.D.; Abrahão, A.L. Inclusion of Mental Health in Primary Health Care: Care Strategy in the Territory. *Rev. Bras. Enferm.* **2019**, *72*, 1677–1682. [[CrossRef](#)]
26. Ayano, G.; Assefa, D.; Haile, K.; Chaka, A.; Haile, K.; Solomon, M.; Yohannis, K.; Adane, A.A.; Jemal, K. Mental Health Training for Primary Health Care Workers and Implication for Success of Integration of Mental Health into Primary Care: Evaluation of Effect on Knowledge, Attitude and Practices (KAP). *Int. J. Ment. Health Syst.* **2017**, *11*, 63. [[CrossRef](#)] [[PubMed](#)]
27. Tilahun, D.; Hanlon, C.; Araya, M.; Davey, B.; Hoekstra, R.A.; Fekadu, A. Training Needs and Perspectives of Community Health Workers in Relation to Integrating Child Mental Health Care into Primary Health Care in a Rural Setting in Sub-Saharan Africa: A Mixed Methods Study. *Int. J. Ment. Health Syst.* **2017**, *11*, 15. [[CrossRef](#)]
28. Ng, Y.P.; Rashid, A.; O'Brien, F. Determining the Effectiveness of a Video-Based Contact Intervention in Improving Attitudes of Penang Primary Care Nurses towards People with Mental Illness. *PLoS ONE* **2017**, *12*, e0187861. [[CrossRef](#)]
29. Pathare, S.; Funk, M.; Drew Bold, N.; Chauhan, A.; Kalha, J.; Krishnamoorthy, S.; Sapag, J.C.; Bobbili, S.J.; Kawade, R.; Shah, S.; et al. Systematic Evaluation of the QualityRights Programme in Public Mental Health Facilities in Gujarat, India. *Br. J. Psychiatry* **2019**, *218*, 196–203. [[CrossRef](#)]
30. Carrara, B.S.; Fernandes, R.H.H.; Bobbili, S.J.; Ventura, C.A.A. Health Care Providers and People with Mental Illness: An Integrative Review on Anti-Stigma Interventions. *Int. J. Soc. Psychiatry* **2021**, *67*, 840–853. [[CrossRef](#)] [[PubMed](#)]

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.