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EDITORIAL

Can the World Health Organisation's 'QualityRights' initiative help reduce coercive practices in psychiatry in Ireland?

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The treatment of mental illness is undergoing a paradigm shift, moving away from involuntary treatments towards rights-based, patient-centred care. However, rates of seclusion and restraint in Ireland are on the rise. The World Health Organisation's QualityRights initiative aims to remove coercion from the practice of mental health care, in order to concord with the Convention on the Rights of Persons with Disabilities. The QualityRights initiative has recently published a training programme, with eight modules designed to be delivered as workshops. Conducting these workshops may reduce coercive practices, and four of the modules may be of particular relevance for Ireland. The 'Supported decision-making and advance planning' and the 'Legal capacity and the right to decide' modules highlight the need to implement the Assisted Decision-Making (Capacity) Act, 2015, while the 'Freedom from coercion, violence and abuse' and 'Strategies to end seclusion and restraint' modules describe practical alternatives to some current involuntary treatments.

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Introduction

Mental health law is being reshaped by the United Nations' (UN) Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006). Updated legislation often aims to provide mental healthcare to all on a voluntary basis rather than focusing on provisions for involuntary treatment. Rights-based, patient-centred practice is increasingly being adopted; supported decision-making is replacing substitute decision-making; and individual autonomy and capacity are becoming the defining ethic of 21st century psychiatry (Duffy and Kelly, 2020). The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has called for 'an absolute ban on restraints and seclusion' (UN Human Rights Council, 2013).

Despite ratifying the CRPD, Ireland has seen an increase in restrictive practices over the last decade (Mental Health Commission, 2019). The Health Information and Quality Authority (2019) has attempted to address this with a recent publication on rights-based approaches in health and social services. Many other countries have explicitly stated their desire to stop seclusion and restraint and have seen reductions in these practices (Allan *et al.* 2017). Some countries, such as India, have totally prohibited seclusion (Duffy and Kelly, 2019).

Mental Health Commission's review of coercive practices

In December 2019, Ireland's Mental Health Commission released a report on the use of restrictive practices in approved centres (Mental Health Commission, 2019). This, the Commission's ninth such report, found that the use of physical restraint and the duration of seclusion are increasing. In 2018, there were 7,464 episodes of seclusion or restraint in Ireland's mental health services, representing a 56% increase since 2008. There was also a 47% increase in the total number of seclusion hours in 2018 compared to 2017.

The Mental Health Commission report highlighted heterogeneity in the use of coercive practices across different approved centres, although it acknowledged that this can occur for a variety of reasons. Different approved centres and different community health organisations are often not directly comparable, due to the demographics of the populations they serve, staffing levels and access to seclusion rooms. Other countries also see large variations in the use of coercive practices across different services and regions (Lai *et al.* 2019).

The Mental Health Commission stated 'that there is no evidence of a therapeutic benefit associated with the

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use of restrictive practices such as seclusion and physical restraint. There is also limited evidence of restrictive practices reducing behaviours of violence and aggression. However, most approved centres do not have access to a psychiatric intensive care unit, and in a situation where de-escalation techniques are not effective, can be left with last resort options of seclusion, physical restraint or rapid tranquilisation' (p. 27).

The commission seeks to ensure that restrictive interventions are used only where 'strictly necessary, and that any interventions are undertaken safely, and in line with specified Rules and Codes of Practice' (p. 6). It also seeks to ensure that the safest and least restrictive measures are utilised.

'QualityRights' and the CRPD

After signing the CRPD in 2007, Ireland finally ratified it in 2018. This places a legal obligation on Ireland to comply with its provisions. The definition of disability in the CRPD explicitly includes individuals with long-term mental, intellectual or sensory impairments. Article 12 of the convention relates to 'equal recognition before the law'; this has be interpreted to be incompatible with the involuntary treatment of those with mental disorders. It should be noted that, in common with many other countries, Ireland made reservations in relation to articles 12, 14 and 27, meaning that they did not agree to fully comply with those articles.

In 2012, the World Health Organisation (WHO) *produced the QualityRights toolkit* through its 'Quality Rights' initiative. This toolkit comprises 116 criteria divided across five main themes. It aimed to assess and improve quality and human rights in mental health and social care facilities. It was developed to translate international human right standards, in particular the CRPD, into practice by influencing policy and building the knowledge and skills to implement person-centred and recovery-based approaches (Funk and Drew, 2017). These criteria have been used extensively throughout Europe to evaluate mental health practice, although Ireland was not included in the initial evaluation (WHO Regional Office for Europe, 2018). One of the objectives of this initiative is to end all coercive practices in mental healthcare, including seclusion and restraint (WHO, 2019*a*).

This absolutist stance on coercive measures has, however, been called into question and the arguments against it merit careful examination. Total prohibition may lead to criminalisation, stigmatisation and a widening of the treatment gap for individuals with mental illness (Freeman *et al.* 2015; Appelbaum, 2019). It is also unclear if such a ban is evidence based or ideologically driven (Szmukler, 2019).

QualityRights training resources

In 2019, the WHO QualityRights group released detailed training and advocacy resources that seek to bring mental health practices in line with the CRPD (WHO, 2019*b*). As a consequence, these resources focus heavily on reducing coercive practices. They include five core training modules which cover human rights, mental health, disability, capacity, recovery and the right to freedom from coercion, violence and abuse. There are also three specialised training modules which address recovery practices, strategies to end seclusion and restraint, and supported decision-making and advance planning.

These modules are designed to be delivered in workshops with teaching provided by multidisciplinary teams, including people with lived experience of mental illness. They are aimed at all people involved in mental health services ranging from service users and family members to clinicians and managers. The modules are flexible and can be tailored to the needs of those attending the meetings.

Four modules are of particular relevance to Ireland's increasing use of seclusion and restraint. First, the module on 'Legal capacity and the right to decide' examines individual legal capacity, calls into question assessments of capacity, and attempts to shift the paradigm from substitute to supported decision-making (WHO, 2019*c*). From an Irish perspective, commencement of the Assisted Decision-Making (Capacity) Act, 2015 would partly address many of the topics in this module and would also likely help reduce the necessity for coercive practices.

Second, the module on 'Freedom from coercion, violence and abuse' highlights the impact of coercive measures on individuals and the negative perception of these practices in the international human rights community (WHO, 2019*d*). It proposes practical steps to reduce these practices, looking at the role of training and communication in avoiding such situations in the first place, greater use of comfort (low stimulus) rooms, empowering staff with greater flexibility, considering alternatives to coercive measures in individual care plans, and development of dedicated response teams.

In an Irish context, addressing many of these issues would require increased staffing levels and more training in de-escalation techniques. Staffing levels have been shown to be associated with coercive practices (Starace *et al.* 2018). The individual care plans discussed by the WHO mirror in many ways the integrated care plans currently in use in Ireland, although the latter do not automatically give consideration to potential triggers of disturbed behaviours or specify less restrictive responses when such behaviours occur. It might be useful to add this consideration to the integrated care plans

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of inpatients who have been restrained or secluded to try to reduce the requirements for further coercive practices in these cases.

The WHO also considers the role of response teams, who are groups of experienced and trained individuals who use non-coercive approaches to respond to situations that may lead to seclusion or restraint (Smith *et al*. 2005, 2015). Such teams may include peer supporters or community advocates. In parallel with this, enhanced levels of accommodation and flexibility across services may also help address any power imbalances and facilitate more collaborative working between all stakeholders.

Third, the module on 'Strategies to end seclusion and restraint' sees seclusion and restraint as 'wholly inadequate, inappropriate, unacceptable and harmful' (p. 1), 'incompatible with a recovery approach' and 'contrary to the purpose of care' (p. 3) (WHO, 2019*a*). This document uses a broader definition of restraint than is used in Ireland, describing practices such as 'compelling someone to go to their room' as coercive. A practice such as this would not be recorded in the numbers currently published by the Mental Health Commission in Ireland.

This WHO module expands further on the measures discussed earlier in the document and sets them in a context where seclusion or restraint would be considered. Some of the examples provided may be superficial or over-idealised, but they are, nonetheless, useful starting points for further discussion about how to reduce coercive practices. This module also highlights the importance of patient and carer education in the reduction of seclusion and restraint.

Fourth, the module on 'Supported decision-making and advance planning' provides a more detailed discussion of capacity and suggests that advance care plans should come into effect at a point of the individual's choosing, rather than at a point where they are deemed to lack capacity (WHO, 2019*e*). This module also discusses the role of a 'Ulysses' clause which would be needed in such a framework in order to protect an individual's right to health (Dresser, 1984). This is a mechanism of consenting, in advance, to treatment that an individual may not consent to, at the time. The individual binds them self to a course of action and waves their right to refuse treatment in a particular context. This module again highlights the need for assisted decision-making legislation, such as Ireland's Assisted Decision-Making (Capacity) Act, 2015, but also hints that such legislation may need to continue to evolve once it is implemented in order to maximise autonomy and protect rights over time.

Many challenges could arise implementing the QualityRights initiative in an Irish setting. The two largest obstacles are the current legislation and mental health resources. The Mental Health Act 2001 primarily relates to involuntary treatment and hence is highly discordant with the QualityRights principals. Current levels of resourcing in Irish mental healthcare limit the ability to provide the level of support and capacity building envisaged. Resource limitations may also inhibit the ability of services to deliver the training modules, although its cost in an Irish context is yet to be determined.

Conclusion

Both the CRPD and the WHO QualityRights initiative highlight Ireland's international legal obligation to address coercive practices in mental health care. The QualityRights training resources could be a useful tool in reducing coercive practices as they highlight a number of steps that could expedite reform. Coercive measures could be reduced by enhancing training and education for all involved in mental healthcare including service users, family members and service providers. The commencement of the Assisted Decision-Making (Capacity) Act, 2015 would also be a useful step in maximising individual capacity (Kelly, 2019). Finally, increased funding and staffing would allow for additional training, greater flexibility in delivery of care and provision of more person-centred services – all of which would hopefully reduce the use of coercive measures over the coming years.

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Richard Duffy has no conflicts of interests.

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Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors confirm that this editorial did not require ethics committee approval.

References

Allan JA, Hanson GD, Schroder NL, O'Mahony AJ, Foster RMP, Sara GE (2017). Six years of national mental health seclusion data: the Australian experience. *Australasian Psychiatry* **25**, 277–281.

https://doi.org/10.1017/ipm.2020.81 Published online by Cambridge University Press

Appelbaum PS (2019). Saving the UN Convention on the Rights of Persons with Disabilities – from itself. *World Psychiatry* **18**, 1–2.

Dresser R (1984). Bound to treatment: the Ulysses contract. *Hastings Center Report* **14**, 13–16.

Duffy RM, Kelly BD (2019). India's mental healthcare act, 2017: content, context, controversy. *International Journal of Law and Psychiatry* **62**, 169–178.

Duffy RM, Kelly BD (2020). *Background to Mental Health Law. In India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights*. Springer: Cham.

Freeman MC, Kolappa K, de Almeida JM, Kleinman A, Makhashvili N, Phakathi S, *et al.* (2015). Reversing hard won victories in the name of human rights: a critique of the general comment on article 12 of the UN convention on the rights of persons with disabilities. *Lancet Psychiatry* **2**, 844–850.

Funk M, Drew N (2017). WHO QualityRights: transforming mental health services. *Lancet Psychiatry* **4**, 826–827.

Health Information and Quality Authority (2019). *Guidance on a Human Rights-Based Approach to Care and Support in Health and Social Care Services*. Health Information and Quality Authority: Dublin.

Kelly BD (2019) Irish medical organisation doolin memorial lecture 2019: rhetoric and reality in mental health – Ireland and the world. *Irish Journal of Medical Science*. doi: 10.1007/s11845-019-02163-9

Lai J, Jury A, Long J, Fergusson D, Smith M, Baxendine S, Gruar A (2019). Variation in seclusion rates across New Zealand's specialist mental health services: are sociodemographic and clinical factors influencing this? *International Journal of Mental Health Nursing* **28**, 288–296.

Mental Health Commission (2019). *The Use of Restrictive Practices in Approved Centres: Seclusion, Mechanical Restraint and Physical Restraint December 2019*. Mental Health Commission: Dublin.

Smith GM, Ashbridge DM, Davis RH, Steinmetz W (2015). Correlation between reduction of seclusion and restraint and assaults by patients in Pennsylvania's state hospitals. *Psychiatric Services* **66**, 303–309.

Smith GM, Davis RH, Bixler EO, Lin HM, Altenor A, Altenor RJ, *et al.* (2005). Pennsylvania State hospital system's seclusion and restraint reduction program. *Psychiatric Services* **56**, 1115–1122.

Starace F, Mungai F, Barbui C (2018). Does mental health staffing level affect antipsychotic prescribing? Analysis of Italian national statistics. *PLoS One* **13**, e0193216.

Szmukler G (2019). 'Capacity', 'best interests', 'will and preferences' and the UN convention on the rights of persons with disabilities. *World Psychiatry* **18**, 34–41.

United Nations (2006). *Convention on the Rights of Persons with Disabilities*. United Nations: New York.

United Nations Human Rights Council (2013). *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (document A/HRC/22/53)*. United Nations: Geneva.

World Health Organization (2012). *WHO QualityRights Tool Kit to Assess and Improve Quality and Human Rights in Mental Health and Social Care Facilities*. World Health Organization: Geneva.

World Health Organization (2019a). *Strategies to End Seclusion and Restraint. WHO QualityRights Specialized training. Course Guide*. World Health Organization: Geneva.

World Health Organization (2019b). QualityRights materials for training, guidance and transformation. World Health Organization (https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools). Accessed 1 January 2020.

World Health Organization (2019c). *Legal Capacity and the Right to Decide. WHO QualityRights Core Training: Mental Health and Social Services. Course Guide*. World Health Organization: Geneva.

World Health Organization (2019d). *Freedom from Coercion, Violence and Abuse. WHO QualityRights Core Training: Mental Health and Social Services. Course Guide*. World Health Organization: Geneva.

World Health Organization (2019e). *Supported Decision-Making and Advance Planning. WHO QualityRights Specialized Training. Course Guide*. World Health Organization: Geneva.

World Health Organization Regional Office for Europe (2018). *Mental Health, Human Rights and Standards of Care Assessment of the Quality of Institutional Care for Adults with Psychosocial and Intellectual Disabilities in the WHO European Region*. World Health Organization Regional Office for Europe: Copenhagen.

https://doi.org/10.1017/ipm.2020.81 Published online by Cambridge University Press