

Commentary

The World Health Organization's QualityRights initiative: rights and recovery-oriented services should be at the centre not the margins of psychiatry†

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Summary

The World Health Organization's QualityRights initiative represents an exciting shift towards creating mental health services that respect human rights and promote recovery. The initiative is the subject of a recent *BJPsych* editorial. In this article I challenge previously articulated criticism of QualityRights and suggest that psychiatry has much to gain from promoting rights-based practice.

Keywords

Human rights; QualityRights; coercion; recovery; lived experience

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The World Health Organization's QualityRights guidance and training materials were recently the subject of discussion in an editorial in the May edition of *BJPsych*. In the article 'The World Health Organization's QualityRights materials for training, guidance and transformation: preventing coercion but marginalising psychiatry' the authors make reference to the excellent work that the QualityRights initiative is doing in the arena of the reduction of coercive practices and supporting the transition toward mental health services that respect human rights standards and promote recovery-oriented and community-based practice.¹ As the title suggests the authors proceed to make the case that these materials are an attempt to marginalise psychiatry and in their essence are negative towards our discipline. As a psychiatrist who is proud of my profession as well as someone that was involved in the development of these materials, I feel it important to respectfully argue against this viewpoint and will argue that Hoare & Duffy display several fundamental misunderstandings about the nature of creating Convention on the Rights of Persons with Disabilities (CRPD) compliant services. I hope to make the case that psychiatry has nothing to fear but much to gain from embracing this progressive and forward-looking model for mental health services.

Background

The adoption of the CRPD in 2006 was a watershed moment for the disability movement internationally.² People with physical, psychosocial, intellectual and cognitive disabilities were to be viewed as rights holders, that must be provided with opportunities and services to live life to the fullest potential and on an equal basis with the rest of society. This United Nations CRPD was widely welcomed as a major step towards ending generations of discrimination and misperceptions around disability. Given that people with psychosocial disabilities and mental health conditions also face barriers and discrimination in everyday life, preventing full participation in society, they are also covered by the Convention. The WHO's QualityRights initiative

aims to put these rights into practice within mental health services. QualityRights imagines services that work alongside rather than coerce, services that are of high quality and based in the community rather than in institutions, services that place a focus on living a good life rather than merely symptom reduction. The guidance and transformation materials are truly inclusive and collaborative and were developed by people with lived experience, organisations of people with disabilities, and experts in the field of mental health and recovery, including psychiatrists from across the globe.

Rebuttal to the arguments outlined by Hoare & Duffy

The editorial does indeed highlight many of the strengths contained in the QualityRights materials including the promotion of recovery and supportive decision-making as well as practical tools for reduction and elimination of coercive practices. Rather than go into exhaustive details around the areas of agreement between myself and the authors I will focus on the areas the authors I feel have mistakenly outlined as limitations.

First, the authors erroneously depict the materials as negative toward the field of psychiatry and psychopharmacology. I could not disagree more strongly. The materials are indeed critical of current practice, in that they pose tough questions as to the reasons behind the widespread use of involuntary detention, forced medication, physical restraint and seclusion. Taking a critical view of current practice is a cornerstone of quality improvement. In my view, the QualityRights materials present a considered, yet critical challenge to the psychiatric orthodoxy that should not be disregarded as mere negativity or antipsychiatry. This is not in my view the sign of the thriving and self-assured profession we should be aiming to be and is a strategy that has failed us in the past.

QualityRights takes the view that coercive interventions are not in line with the rights afforded to people under the CRPD, and are in fact a direct violation of those rights. This naturally poses the question, how can we create services that respect rather than violate rights? In England, a doubling of involuntary detentions in psychiatric hospitals between 1983 and 2016 outlined in a recent *Lancet* article³ suggests that, although depicted as an intervention of last resort, coercion is fast becoming the modus operandi for dealing

† Commentary on...The World Health Organization's QualityRights materials for training, guidance and transformation: preventing coercion but marginalising psychiatry. *Br J Psychiatry* 218: 240–2.

with challenging clinical situations. This makes the case for alternatives all the more acute and pressing. Rather than being seen as a negative or an attempt to marginalise the profession it should in my view come as welcome relief and permission to steer away from this path of force and coercion.

Since its adoption in 2006, there has been considerable debate around the application of key interpretations of provisions within the Convention from the United Nations Committee on the CRPD, specifically regarding the right to equal recognition before the law and legal capacity (article 12), as well as the right to 'liberty and security of person' (article 14).² QualityRights strives to highlight the wide variety of rights violations experienced by people with mental health conditions, some perhaps more shocking than others. They range from forced medication and involuntary detention to the provision of invasive and potentially irreversible procedures or treatment without free and informed consent.² QualityRights highlights these violations not to imply equivalence between them but to demonstrate the traumatic practices that can flow from the denial of legal capacity (article 12) and the 'liberty and security of person' (article 14) under the auspices of mental health laws. That the WHO is calling for an end to traumatic practices endorsed by psychiatrists in many jurisdictions around the world is a welcome shift. In my view if we are to truly strive to build inclusive societies that promote and respect the rights of all members then these violations of rights need to be urgently relegated to the history books of the psychiatric profession.

This leads me to another key fundamental misunderstanding the authors arrive at. That the QualityRights materials deny or do not acknowledge the evidence base for psychopharmacological interventions.¹ QualityRights and the recovery orientation it depicts welcomes all potential forms of support that can be used as a tool to promote recovery, including medications and the support of psychiatry.⁴ It is unequivocal, however, as to whom should decide what supportive interventions and strategies should be deployed – the person themselves. Nothing in either the CRPD or QualityRights is antipsychiatry or ideologically opposed to the use of medications. There is an acknowledgement and acceptance that medications and the wider therapeutic toolkit of psychiatry play an important part in the recovery of many people.⁴

The central aspect of article 12 of the CRPD is a person's right to legal capacity, which can be understood as the right to make their own decisions on an equal basis with others.² QualityRights and the CRPD recognise and promote the use of 'supportive decision-making' as an alternative to guardianship or substitute decision-making, that denies a person their right to make their own decision, be that about medication or anything else. People may require different levels of support based on their needs but the model represents a paradigm shift from best-interests decision-making to decisions based on a person's will and preference.⁴ Recovery is a fundamentally unique experience and although medications may be a potentially important tool in a person's recovery, they should not be depicted as the only tools of relevance or import. Nor should they be forced upon people who have been clear in their opposition to their use. The use of medications should be voluntary and given in the context of free and informed consent. It is important to acknowledge that incorrect use of medications, overmedication, documented side-effects or direct negative effects can, in itself, lead to suffering⁵ and a person must have all the information in order to make an informed decision about their treatment. This should not be revolutionary or controversial but a basic tenant of good practice. Too often the consent process can be rushed or insufficient. The indication for use of medications, side-effects or the long-term health impact of usage, may not be fully discussed.

To comply with the CRPD, in particular articles 12 and 14, society needs to reimagine the way in which we think about and provide treatment and support for people living with mental health conditions, as rights holders who should always retain their legal right to make decisions. The modules detail how alongside supported decision-making; advanced planning, de-escalation strategies and Ulysses clauses can in the vast majority of cases avoid the use of coercion. There is also a pragmatic and realistic acknowledgement that even in the best of CRPD compliant services conflict may be unavoidable and coercive practices may emerge. QualityRights also gives guidance on how to learn from these incidents and ensure they do not occur in the future.⁴

The call from the service-user movement is not for an end to psychiatry, but an end to the misallocation and misuse of power afforded to psychiatrists. The mantra of the disability rights movement is 'Nothing about us without us'. It is the culture of substitute decision-making, paternalism and discrimination within psychiatry that the movement is calling to end, not psychiatry itself. I see that not as an existential threat but a group of people rightly reclaiming power in their own lives. The authors are wrong to suggest that anything in the CRPD or QualityRights promotes the criminalisation of people with mental health conditions.¹ Instead it calls for the creation of non-discriminatory laws that apply to all of society not just one group or based on discriminatory attitudes, in addition to the provision of support and accommodations in situations where people's decision-making has been affected.

This shift to a new model of understanding within mental health services will not marginalise psychiatry but rather place the service user in the centre of all decisions about their lives. I feel strongly that psychiatry will thrive best as an important tool, among many others, in the armoury of a person navigating the complexities of a mental health condition or psychosocial disability. It is for the person themselves to decide which of these tools are helpful for their recovery journey and when they should be deployed. We must move away from societies and services that coerce people into complying with treatments or interventions they do not find helpful. Particularly when they may recreate the trauma of violence or control that many of our service users have already been victims of. Freedom, the right to make your own decisions, and taking back control of one's own narrative is therapeutic and should be the cornerstone of all modern and progressive mental health services.

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Declaration of interest

Since 2014 P.M. has been involved in the WHO QualityRights initiative and was involved in both the development and international rollout of the materials.

References

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