

WHO QualityRights Programme in France: Implementation Strategy, Trends and Developments.

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Introduction

People living with psychosocial, intellectual or cognitive disabilities are still too commonly subject to discrimination, stigma and violence. Their fundamental human rights are often violated, including within mental health care and services (Drew et al., 2011). The Convention on the Rights of People with Disabilities (CRPD), aims to “promote, protect and ensure the rights of people with disabilities,” (United Nations, 2006). In mental health care, people living with psychosocial, intellectual or cognitive disabilities (hereafter “users” or “service users”) should see their rights to physical and mental health, freedom of movement, legal capacity and community inclusion respected. The human-rights model of disability promotes these rights by using recovery-oriented approaches and care organization that respects the dignity, rights and freedoms of those accessing care. This model considers people living with disabilities as equal and active participants of society capable of expressing and promoting their rights and choices. The World Health Organization’s (WHO) QualityRights (QR) programme concretely articulates service users’ rights in the context of mental health care through themes, norms and criteria based on the CRPD. This article will discuss the QR programme in France, the implementation strategy that distinguishes the initiative from control and accreditation procedures, and national trends stemming from observations completed since 2017. A brief introduction will contextualize the state of rights of people living with disabilities and mental health in France.

Mental health and psychiatric conditions are the first cause of invalidity in France (Fiat & Wonner, 2019). Close to a quarter of the population lives with depressive or anxiety disorders – the prevalence rises to 33% over a lifetime – while more severe conditions such as forms of schizophrenia and bipolar disorder have a lifetime prevalence of 8% (Cour des comptes, 2021 ; Coldefy & Gandré, 2020). Public psychiatry in France is organized by “sectors” – catchment areas used for administrative organization. Sectors offer and administer care to residents within their respective geographical boundaries, and their management, including care organisation and coordination, differs between sectors across France. The number of hospitalization beds reduced from 170 000 in 1970 to 50 000 beds in 1999 due to deinstitutionalization in mental health of psychiatry. This was, however, not supported by adequate development of ambulatory care, and combined with shortage in psychiatrists has resulted in increased difficulty in receiving patients in crises, insufficiently prepared discharge plans and more frequent rehospitalizations (Le Contrôleur général des lieux de privation de liberté, 2020). According to the French “Cour des Comptes” (2021), France has a re-hospitalization rate of 26.1% within two months of discharge, while long-term hospitalizations – defined as hospitalizations greater than or equal to 272 days in a year, continuous or not – represent 32.6% of psychiatric hospitalizations. In recent years, however, several measures have been developed to ease these issues. At regional levels, Territorial Mental Health Projects (PTSM, “Projets Territoriaux de Santé Mentale”) were developed to prioritize care coordination strategies, mental health promotion, and mental illness prevention actions based on territorial mental health diagnostics.

The Ministry of Health and Prevention, within the frameworks of the PTSM, mentions the QR initiative as a tool to “promote and respect the rights of people with mental disorders, and reinforce their power to decide and act, [as well as] fight against the stigmatization of mental disorders” (Ministère de la Santé et de la Prévention, 2022a). Moreover, the QR is included in the Mental Health and Psychiatry Roadmap carried by the Ministerial Delegation for Mental Health and Psychiatry (Ministère de la Santé et de la Prévention, 2022b). Mobile mental health care units have increasingly emerged in the last decade across France. They specialize their outreach to vulnerable populations, the elderly or children and adolescents, crisis management and care and perinatal mental health care. The implementation of mobile teams aims to increase access to care and improve the rights of people with mental health conditions.

Official accreditation and certification measures

France has independent monitoring authorities specialized in health care and human rights. The High Health Authority (HAS or “Haute Autorité de Santé”) is an independent public authority responsible for accreditation and certification procedures concerning quality of care offered by health care institutions in France (Haute Autorité de Santé, 2022). Every four years, institutions undergo a mandatory evaluation by the HAS and are certified, or are required to improve particular standards to receive accreditation. Accreditation is based on patient care, health care teams (multidisciplinary care coordination, patient outcomes and health and safety risks) and management (local and regional integration, leadership, risk management and patient involvement at institutional level).

From a human rights standpoint, the Contrôleur Général des Lieux de Privations de Liberté (CGLPL – the Controller General for Places of Deprivation of Liberty), also an independent entity, has the national mandate to visit institutions where citizens may be held against their will – including psychiatric hospitals or services – and to report any fundamental human rights violations. In 2020, the CGLPL published a report on involuntary treatment and fundamental rights, highlighting the current increase of involuntary treatment in psychiatric hospitals in France, and ongoing use of seclusion and restraint within mental health care settings. The report denounces the complex climate of mental health care: bed closures, higher demands of inpatient treatment, shortages in human resources and the “psychiatrization” of mental health conditions or normal life stressors. The report lists 67 recommendations to improve quality of care and the rights of mental health care users – from mental health care reforms and the inclusion of users in development of legislation, to the use of recovery-oriented practices in services and an increase in mental health care workforce. The report particularly denounces the predominant use of medical model within mental health care and strongly recommends a paradigm shift to social and human-rights models of care management for mental health conditions.

Convention on the Rights of Persons with Disabilities in France

The United Nations adopted the Convention on the Rights of Persons with disabilities (CRPD) in 2006. France ratified the CRPD in 2010, and the first reports of its implementation were published in 2020. The United Nations, in its Concluding Observations on the Initial report of France (2021), welcomes French legislation protecting persons with disabilities, the creation of an inter-ministerial committee on disability in 2009 (Le Comité Interministériel du Handicap (CIH) | Handicap, n. d.), the appointment of the Defender of Rights as “the independent monitoring mechanism”, and national dialogue surrounding disability due to national conferences. In 2021, the Defender of Rights published its first report on the implementation of the CRPD in France, denouncing the over-representation of people living with psychosocial disabilities in detention and incarceration centres – a condemnation also made by the European Court of Human Rights to France in 2012 (Le Contrôleur général des lieux de privation de liberté, 2020). The United Nations reiterates the predominance of the medical model of disability in France recommending the need to shift to a human rights model within policy, law and legislation.

Implementation of QualityRights in France

The French World Health Organization Collaboration Centre for research and training in mental health (WHOCC) is a service of Lille Métropole's public mental health establishment (EPSM LM) in northern France. The WHOCC supports the WHO for the development and recognition of good practices in community mental health, e-mental health, and the inclusion of people living with psychosocial disabilities, carers and concerned citizens in research, training and care organization. Lastly, the WHOCC supports the WHO in the development and implementation of the QualityRights (QR) programme in France and French-speaking countries since 2017. It has since deployed 25 QR interventions, representing 35 units visited in 13 establishments across France. These include private and public establishments, ambulatory care and inpatient services. Three interventions have been implemented internationally in Belgium (2016), Tunisia (2018), Burkina Faso (2020), and an upcoming intervention is planned in Côte d'Ivoire in 2023.

All QR assessments in France are done on voluntary basis. The assessments are referred to as « observations », as they do not hold particular political or accreditation stakes for establishments. This distinguishes QR observations to already existing mandatory certification and control procedures by the HAS and CGLPL, and characterizes QR observations as a complementary mechanism. The observations provide external and multidisciplinary perspectives on users' rights, care organization and the use of recovery-oriented practices. They offer, at all levels, areas for reflection, recommendations for improvements and tools and/or examples of good practices from other French services. Establishments must formulate their interest in the QR initiative by establishing the first point of contact with the WHOCC-Lille. This sets an unprecedented tool for institutions, services, units and professionals at all levels to take ownership of the objectives and improve their practices and quality of care.

Each observation project is co-constructed with the professionals or establishment requesting an observation. Various contexts have arisen: certain establishments completed observations to prepare accreditation or certification visits from the HAS or the CGLPL; others utilized the QR as a tool in continuation of improvement efforts following accreditation visits; some initiatives for QR observations emanate from Quality of Care Directors to create an institutional action plan on common areas of improvement following results of multi-unit observations, while various initiatives have come directly from Heads of Mental Health services, service managers and Head Doctors. Ideally, all levels establishments are involved. Meetings are arranged to present QR values and methodology to staff and users of units visited. An objective of these meetings is to reassure mental health professionals that QR observations are not part of control measures and that no certification is given. The QR initiative delivers an observation report that becomes theirs to use as a tool to prioritize change, discuss service culture and reflect on care organization.

The following step is to create an observation team, which must include one mental health service user or peer-support worker, one family member, one psychiatrist and one observation coordinator. The last four observers may be any mental health related professional – paramedical mental health professionals, lawyers, researchers, establishment directors or management staff, etc, and teams are composed with a mix of experienced and first-time observers. There are currently 140 observers nationally, with 11% psychiatrists, 12% carers, 19% users, and the remaining 58% mental health professionals. Before the observation, a team meeting is organized to review the QR ToolKit first presented during the training session and to prepare logistics and on-site coordination.

Observations take place over two days, with a third day devoted to rating criteria, norms and themes from the QT ToolKit (WHO, 2012). The number of reports does not always reflect the number of units visited. The team of observers makes a collective decision to write a joint report if they agree service culture, care organization and user rights are coherent across units. The report is written as a team, and centralizes verbatim citations from interviews as well as observation and documentation analysis notes justifying all rating choices. Recommendations are given with tools to implement them.

The report is sent prior to the final feedback meeting, in which 3 members of the observation team discuss the results. A public meeting is proposed, with at least services users and professionals, to encourage broad discussion. An additional meeting with management and the Board of Directors is proposed to discuss institutional issues.

Trends in National Results

Since the implementation of QR in France, all ratings have been centralized. Common trends have emerged through the 35 units visited since 2017.

Person-centred Recovery Practices

Results reflect the UN's and CGLPL's comments on the predominant medical model of mental health, with many services organized with a classical inpatient/outpatient distinction. Some services have undertaken steps towards developing human rights based approaches to care by developing individual recovery plans. These plans, however, are yet to be systematically user-driven. The intention to respect service users' choices and preferences in treatment is seen and services could benefit from formalized implementation policies for individualized recovery plans and advanced directives. This would increase users' legal capacity, improve therapeutic alliance and ease care pathways as de-escalation tools.

Training in recovery approaches for all health care staff would increase ownership of the concepts, and contribute to de-compartmentalize responsibilities between staff, as all have a role in service users' recovery. The implementation of such paradigm changes, however, can be met with resistance from health care professionals. Additionally, many services are under-staffed and over-worked. Recovery-practices can be considered complex to implement in services where user to staff ratio is high. Training on recovery-oriented practices can nuance the human-rights model to mental health care – it is not about adding processes and procedures, but rather to take hold of the concepts and transfer them in daily work.

Community Inclusion

Most observations highlighted compartmentalization of resources and professionals outside hospital settings, thus hindering which hinders community inclusion. The responsibility of inclusion is often left solely to social workers or outside social services. This more often reiterates the separation between hospitalization and community, as service users also often lack information on community activities nor have access to social services or support outside hospital settings. Closed-door services, as well as involuntary treatment and hospitalization, are permitted and become obstacles to respect users' fundamental rights. This perpetuates not only the centralization of care but also the stigmatization of mental health care users. Mental health care sectors would benefit from reflections on care organization, both within services and within communities, to increase collaboration and improve care continuity. Including external social and community workers as members of mental health care organization could increase the possibility of community inclusion, empowerment, reduction of stigma and continuity in care pathways.

Access to Information

Results show service users tend to lack access to information on a variety of subjects. There is a shortage of information given on the rights of service users. Most services possess use welcome booklets and display the Charter of Patient Rights in Psychiatry. Still, many users report being uninformed on their rights and that efforts by professionals to ensure their comprehension would be appreciated. Results also highlight the need for users to receive comprehensive information on diagnosis and treatment options – including benefits, side effects and alternatives. Systematically seeking free and informed consent through supported decision-making in regards to treatment options is a precursor to empowering service users and consistently respecting their legal capacity and right to decide. Services could benefit on developing such policies in collaboration with service users in their units.

Access to information in regards to social, cultural, political and associative life as well as leisure activities outside the establishment is lacking. This perpetuates stigma and discrimination, and may impede a persons' ability to find meaning, connect to others and find hope, important elements to recovery. Access to information on community life is closely linked with community inclusion and the development of collaboration networks between mental health, social and community resources.

Training

It seems necessary for establishments to offer training on the Convention on the Rights of People with Disabilities as well as on recovery practices.

Service users and staff members should receive training on the rights of service users. It is imperative for service users to have access to this information, and for staff members to question their practices in relation to international norms and human rights standards for persons living with disabilities. In continuation, training on the implementation of these concepts in mental health care could be organized in a regular basis. For example, training on strategies to reduce the use of seclusion and restraints can be given to all staff members. Training on person-centred recovery-based approaches is necessary to improve empowerment and service-user led recovery. Specifically, training for the use of advance directives and individualized recovery plans is required to strengthen and support the use of recovery paradigms. Management staff have expressed the necessity of training on these topics, with many also reporting their disarray at the scarcity of training options on rights and recovery in France.

Current Developments

The WHOCC is constantly reflecting on the development of the QualityRights initiative in France and French-speaking countries.

The WHOCC QR team coordinated the translation of the 14 QR training modules, soon to be published. The translation was completed thanks to our national and international collaborators (ADESM, UNAFAM, WHO-PAHO Collaborating Centre in Montreal, Canada, AMPAQ, WHOCC Morocco, Humanity Inclusion Belgium, peer-support workers and experts by experience). The translation of the e-training platform into French was also under the WHOCC coordination. The QR team is currently implementing pilot training for the module Strategies to End Seclusion and Restraint (World Health Organization, 2019), which has been adapted to French context. The national launch of the training module is planned for 2023. The aim is to fill the gap in training in line with CRPD values.

Research projects are being developed to explore the effects of the QR programme on quality of life at work for professionals. Additionally, we aim to explore the prioritization of implemented recommendations by services, observe the effects of the programme on hospitalization length-of-stays, on the ratio of professionals assigned to inpatient and outpatient care, and the effects of the programme on the number and length of seclusion and restraint used. These projects are awaiting funding application responses.

Furthermore, the WHOCC will work on a process to simplify data collection and report writing, and facilitate potential research on data.

The WHOCC hopes to continue to develop and deepen the QR initiative in France and French-speaking countries. It hopes to continue to adapt its implementation strategy to have greater wide-reaching national implementation and increase the number of observations per year in France. The use of the QR initiative on a voluntary basis creates a dynamic in which establishments are welcomed to reflect on their practices, without stakes of accreditation. It leaves space for the improvement of the rights on people living with psychosocial, intellectual or cognitive disabilities based on CRPD values. The QR programme will continue to be a concrete lever for change in France and abroad as a support to translate complex international guidelines into daily practices respecting the rights, dignity and freedoms of service users.

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