Experiences with QualityRights audits and efforts to reduce restraints

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Mental health care in the Czech Republic

For decades mental health care in the Czech Republic was characterized by concentration of care in big psychiatric hospitals, lack of efficient connection with outpatient clinics and with social services sector. Influenced by best practices in the Netherlands, the UK and Italy changes were initiated by NGOs in the 90ties of the 20th century mainly with the effort to establish services in community. Since 2013 the reform of mental health care became part of the governmental agenda and Psychiatric Care Reform Strategy was launched. In the first phase until 2022 the Strategy is implemented in the form of projects supported by European Structural Funds in the amount of approximately 1 billion CZK. One of the main outcomes is piloting a network of Community Mental Health teams. Also, strategic steps were made to improve multidisciplinary cooperation and planning of services in regions based on the needs of people with mental health problems started having visible outcomes. Anti-stigma activities are part of the reform as well. In this article we would like to offer our experiences with implementing Quality Rights concept in psychiatric hospitals in the Czech Republic and have a closer look at actions focused on reducing seclusion and restraint measures.

QualityRights audits

The WHO QualityRights Toolkit is divided into five basic themes, each focused on specific articles of the Convention of Rights of Persons with Disabilities (CRPD): (1) articles 12 and 14 (the right to exercise legal capacity and the right to personal liberty and the security of person); (2) articles 15 and 16 (freedom from torture and cruel, inhuman, or degrading treatment or punishment and freedom from exploitation, violence, and abuse); (3) article 19 (the right to live independently and be included in the community); (4) article 25 (the right to enjoyment of the highest attainable standard of physical and mental health); and (5) article 28 (the right to an adequate standard of living).

QualityRights (QR) was chosen as a framework for quality improvement in Czech psychiatric hospitals within a larger scope of the psychiatric reform. In 2017 - 2018 the Ministry of Health (MoH) conducted QR audits in 17 psychiatric hospitals in its purview. Audit teams consisted of five evaluators: a psychiatrist, a social worker, a human rights lawyer, a service user, and a researcher. All of them were trained in the use of the WHO QualityRights Toolkit by WHO experts. Outcomes were published elsewhere (Winkler et al. 2020) with the conclusion that:

> *"...assessment of the quality of care and adherence to the CRPD in Czech psychiatric hospitals revealed serious shortages in almost all themes within the WHO QualityRights Toolkit. The majority of shortcomings are linked to the unsatisfactory state of buildings, the lack of qualified and thoroughly trained staff, insufficient support for service users' decisions and preferences, and insufficient emphasis on service users' integration into society."*

After audits – challenges and successes while implementing changes

The 2018 QR hospital audits were perceived negatively by most staff. They felt being checked by people with limited clinical experience and/or with different professional background. The perspective of human rights faced a considerable backlash.

The Ministry of Health (MoH) employed a team of part-time quality managers to initiate changes to address the audit findings. See more here: https://qualityrights.org/in-countries/czechia/ In typically change resistant hierarchical organizations that hospitals are and given the above-described context, their role was extremely difficult and achieving sustainable changes loomed to become a challenge.

In those hospitals where the quality manager succeeded to establish working relationships with members of line management, the initial focus was to raise at least some motivation in key medical staff. The institutional pressure on hospital management (from the MoH) seemed half-hearted and the medical staff is usually shielded from pressure by other external institutions involved in adherence to respect for human rights in health facilities (Czech ombudsman, CPT). The needed compliance could therefore only arise from applying persuasion by the quality managers to those staff open to change empathizing with patients and sensitive to human rights issues.

Building on fragile relationships and motivations, it was also necessary to mitigate the negative perception of the QR project and create a constructive and creative spirit in the change efforts. Education and development seemed to be a more promising overall approach than control, especially in the long-term perspective. The online QR education provided by the MoH team helped to give some legitimacy to the topic of human rights, but the half-hearted MoH stance and Covid limitations weakened its change potential. However, quality managers were not limited in their own internal change initiatives, and they could use whatever strategies they saw fit in their specific circumstances. In the following examples, we proceed from easier change efforts to more challenging ones.

Processes of change

Standard of living (part of Theme 1 of the QR toolkit) seemed easier to grasp. Unless rigid insensitivity is there, it is intuitive for medical staff to pursue improvements in living conditions for patients. However, ward managers often seem to delegate responsibility for this issue to operations management. These are persons responsible for construction, repairs, and maintenance of buildings, not exerting pressure for improvements or not presenting their needs altogether. Operations have a hard time prioritizing between departments and both groups lack a benchmark for grasping the human rights issue with respect to patient groups and medical services. QR offers a solution here. It provides a framework for assessing the living standard and setting a benchmark for types of psychiatric wards based on patient needs, duration of hospitalization etc. In Psychiatric Hospital Horní Beřkovice the MoH quality manager asked the nursing top management to participate in a hospital wide QR Theme 1 ward audit aided by an external expert (member of the 2018 QR audit team). The head nurses conducted mutual audits under expert supervision resulting in a complex rating of all hospital wards on QR Theme 1 standard of living criteria. Operations managers also participated in the audit and were provided with the results. These now serve as a guidance for decision making related to construction and repair planning, and also to building prioritization in the process of institutional care reductions related to nation-wide reform. Even when safety issues were raised, solutions often could be found, for instance safety locks were installed on patient toilettes to improve comfort.

The daily regime and ward rules (also mostly in Theme 1 of the QR toolkit) was a much tougher challenge. The operation of a typical psychiatric ward is a source of many human rights limitations with considerable impact on the living conditions of patients. Though often unnecessary, the various rules and limitations are strongly held in place by established processes and customs, reflected in documentation, and related to staff skills. Operational blindness dulls the felt need for suggested changes. Change efforts in this area were hard to sustain and tended to circle back to established practice.

Centre for Mental Health Care Development conducted a research study financed by MoH (Lukasová et al. 2020) focused on mapping the regimen practices used in psychiatric wards. It found a surprising diversity in problematic topics like locking bedrooms and bathrooms, access to fresh air, use of mobile phones and

devices, coffee and smoking regulations, visits of family etc. Describing the overall colourful picture including some good practices offered an opportunity to circumvent many sources of resistance. It also helped to support the change initiatives with professional ethos.

In Psychiatric Hospital Horní Beřkovice a workshop was conducted with authors of this study, simply discussing the good and bad practices in this area with head nurses and some voluntary psychiatrists. When changes were implemented in some departments, the "spell was broken" and dissemination ensued. This was particularly important with safety related issues such as unlocking bathrooms in acute departments for longer periods during the day. A personal example of an acute department head nurse who "loosened" many rules and regulations provided a strong impulse.

Seclusion and restraint (part of Theme 4 of the QR toolkit) was a particularly challenging, controversial, and highly safety-loaded subject. Inadequate acute department staffing, unsuitable department premises, unavailable conflict management training – such factors were making the issue even more fragile and opposition to changes was resolute. Pervasiveness of the problem can be seen on the fact that MoH itself rather chooses to overlook the issue. It issued an official guidance on restraint and seclusion in 2018. Though not widely implemented in many respects, no pressure or follow up was visible. The "unrest injection" was considered a restrain only here and there, debriefing after restraint is still uncommon etc.

MoH online QR workshops raised awareness of the issue a little, but one could hardly expect this to bridge the gap between human rights theory and established restraint practice. Also, Safewards toolbox was translated into Czech during Covid by Centre for Mental Health Care Development, offering some practical tools of conflict prevention and de-escalation. Though not actively promoted by the MoH, it was disseminated on its quality management platform providing a framework for addressing the QR Theme 4 tough restraint benchmark. Practical Safewards implementation in acute departments was attempted by some, but it showed to be surprisingly difficult and is only partially implemented in a few departments today.

In Psychiatric Hospital Horní Beřkovice the MoH quality manager (also hospital employee) was granted management support to set up a continuous internal project focused on limiting the use of restraint and seclusion. Head nurses of relevant wards formed a team meeting on a semi-regular basis. The meeting agenda involved analysing monthly restraint and seclusion statistics, discussing reasons behind observed changes, exploring the rightfulness of indications and opportunities in the nursing care. Safe- wards tools were presented one by one, but not forced. The quality manager also ensured that all arising educational opportunities are offered to the nurses. In 2019 for example, MoH together with WHO organized a de-escalation training conducted by British trainers followed up by consulting on ward premises. Currently the acute ward staff participates in a Norway funded project focused on conflict prevention and de-escalation described below in more detail.

The strategy thus combined keeping continuous focus on the restraint and seclusion issue while providing opportunities for relevant education and development. Results are apparent in the statistics and visible progress was achieved. In 2020 the number of restraints applied in the hospital dropped by 48% compared to the previous year, time spent in restraint dropped by 36%. Number of seclusions dropped by 30% and time in seclusion dropped by 16% over the same period. The decline continued during 2021 and recently stabilized on much lower numbers. The use of pharmacological restraint is now recognized as a restraint method by psychiatrists and appears in the restraint statistics.

Recent developments and opportunities

QualityRights audits conducted in Czech psychiatric hospitals highlighted the topic of quality requirements inherent in CRPD. The report (Winkler et al. 2020) brought a complex overview of the many problematic aspects of care in these facilities. However, the audits were perceived as detached from clinical reality by majority of hospital staff. External assessment is a powerful tool to provide an overview and global

picture, but at the same time it may provoke resistance. Despite occasional local successes, a lot remains to be done. The emotionally loaded media debate flaring up now and then in the Czech Republic together with a more convincing stance of national healthcare authorities might provide a drive needed to further push the issue.

Several targeted activities were conducted by the Ministry of Health in collaboration with the WHO as a follow up to the QR audits (WHO 3-day training in de-escalation techniques, WHO online training on rights-based mental health services). These activities were accepted much better by the medical staff of acute wards. A new guideline on seclusion and restraint was elaborated in 2021 on the MoH quality management platform and is now available to MoH for official distribution. It translates many restraints related issues into guides and tools that should be perceived by most hospital staff as sensible and realistic. Since 2022 cage beds are not mentioned in the law among restraint methods. It effectively means, that cage beds are not considered to be legal, and their usage was stopped in all health facilities in the Czech Republic.

An in-depth qualitative study of using restraint measures in psychiatry was conducted in 2019 with MoH support (Říčan et al., 2019). The findings stressed negative experiences of patients. Many of them felt humiliated and traumatized. However, the research also highlighted the difficult situation of medical workers. They are often under-staffed, under pressure and with minimum external support, working according to the traditions of the ward. Based on these findings we want to highlight the necessity of multiple training and study visit opportunities to reduce conflicts on wards and the resulting need for restraint measures. We argue that the supportive approach towards people who are directly (doctors, psychologists, nurses) and indirectly (managers) involved in using seclusion and restraint measures can empower staff and be a powerful leverage to change.

As an example of this approach, we shortly describe a project by Centre for Mental Health Care Development supported by Norwegian grants financial scheme.

The project titled "Education for improving human rights situation of people with mental health issues" was submitted in cooperation with the Ministry of Health and is in line with the National Mental Health Action Plan 2020 – 2030. There are 6 psychiatric wards engaged voluntarily and the project is conducted in partnership with the University of South-Eastern Norway. The aim of the project is to reduce the frequency of restraint use by 6 % in participating wards. This will be achieved by provision of study visits in Norway, training in de-escalation skills and training in Safe-wards interventions. Following the trainings each facility will develop its own plan to reduce seclusion and restraint use. The idea is to strengthen the supportive and safe environment, focus on conflict prevention and management in psychiatric wards and create examples of good practice that would inspire other wards. The training program for de-escalation and Safe-wards will be piloted with support from Denmark and after accreditation it will be available to medical staff of acute wards elsewhere. Special support will also be provided to hospital managers to influence their attitudes and strengthen their competence to support necessary changes to reduce the rate of seclusion and restraint. This action is also an example of international cooperation on a highly important topic.

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