Course Guide

Strategies to end seclusion and restraint

WHO QualityRights specialized training

QualityRights

World Health Organization

Transforming services and promoting the rights of people with psychosocial, intellectual and cognitive disabilities

The accompanying course slides are available here: https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools

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Acknowledgements

Conceptualization

Michelle Funk (Coordinator) and Natalie Drew Bold (Technical Officer) Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse (WHO, Geneva)

Writing and editorial team

Dr Michelle Funk, (WHO, Geneva), Natalie Drew Bold (WHO, Geneva); Marie Baudel, Université de Nantes, France

Key international experts

Celia Brown, MindFreedom International, (United States of America); Mauro Giovanni Carta, Università degli studi di Cagliari (Italy); Yeni Rosa Damayanti, Indonesia Mental Health Association (Indonesia); Sera Davidow, Western Mass Recovery Learning Community (United Sates of America); Catalina Devandas Aguilar, UN Special Rapporteur on the rights of persons with disabilities (Switzerland); Julian Eaton, CBM International and London School of Hygiene and Tropical Medicine (United Kingdom); Salam Gómez, World Network of Users and Survivors of Psychiatry (Colombia); Gemma Hunting, International Consultant (Germany); Diane Kingston, International HIV/AIDS Alliance (United Kingdom); Itzhak Levav, Department of Community Mental Health, University of Haifa (Israel); Peter McGovern, Modum Bad (Norway); David McGrath, International consultant (Australia); Tina Minkowitz, Center for the Human Rights of Users and Survivors of Psychiatry (United Sates of America); Peter Mittler, Dementia Alliance International (United Kingdom); Maria Francesca Moro, Columbia University (United Sates of America), ; Fiona Morrissey, Disability Law Research Consultant (Ireland); Michael Njenga, Users and Survivors of Psychiatry in Kenya (Kenya); David W. Oaks, Aciu Insitute, LLC (United States of America); Soumitra Pathare, Centre for Mental Health Law and Policy, Indian Law Society (India); Dainius Pūras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health (Switzerland); Jolijn Santegoeds, World Network of Users and Survivors of Psychiatry (the Netherlands); Sashi Sashidharan, University of Glasgow (United Kingdom); Gregory Smith, International consultant, (United States of America); Kate Swaffer, Dementia International Alliance(Australia); Carmen Valle, CBM International (Thailand); Alberto Vásquez Encalada, Office of the UN Special Rapporteur on the rights of persons with disabilities (Switzerland)

Contributions

Technical reviewers

Abu Bakar Abdul Kadir, Hospital Permai (Malaysia); Robinah Nakanwagi Alambuya, Pan African Network of People with Psychosocial Disabilities. (Uganda); Anna Arstein-Kerslake, Melbourne Law School, University of Melbourne (Australia); Lori Ashcraft, Resilience Inc. (United States of America); Rod Astbury, Western Australia Association for Mental Health (Australia); Joseph Atukunda, Heartsounds, Uganda (Uganda); David Axworthy, Western Australian Mental Health Commission (Australia); Simon Vasseur Bacle, EPSM Lille Metropole, WHO Collaborating Centre, Lille (France); Sam Badege, National Organization of Users and Survivors of Psychiatry in Rwanda (Rwanda); Amrit Bakhshy, Schizophrenia Awareness Association (India); Anja Baumann, Action Mental Health Germany (Germany); Jerome Bickenbach, University of Lucerne (Switzerland); Jean-Sébastien Blanc, Association for the Prevention of Torture (Switzerland); Pat Bracken, Independent Consultant Psychiatrist (Ireland); Simon Bradstreet, University of Glasgow (United Kingdom); Claudia Pellegrini Braga,

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Foreword

Ensuring mental health and well-being has become a worldwide imperative and an important target of the Sustainable Development Goals.

But in all countries around the world, our response has been woefully insufficient, and we have made little progress to advance mental health as a fundamental human right.

One in ten people are affected by a mental health condition, up to 200 million people have an intellectual disability and an estimated 50 million people have dementia. Many persons with mental health conditions, or psychosocial, intellectual, or cognitive disabilities lack access to quality mental health services that respond to their needs and respect their rights and dignity.

Even today, people are locked up in institutions where they are isolated from society and marginalized in their communities. Many are subjected to physical, sexual, and emotional abuse and neglect in health services, prisons, and the community. They are also deprived of the right to make decisions for themselves, about their care and treatment, where they want to live, and their personal and financial affairs. They are often denied access to health care, education and employment opportunities, and are prevented from full inclusion and participation in community life. As a result, people with mental health conditions and intellectual disabilities die 10 to 20 years younger than the general population in low-, middle- and high-income countries alike.

The right to health is fundamental to the World Health Organization's (WHO's) mission and vision, and underpins our efforts to achieve universal health coverage (UHC). The foundation of UHC is strong health systems, based on primary care, that deliver evidence based, person-centred services that respect people's values and preferences.

Fourteen new WHO QualityRights training and guidance modules are now available to achieve this vision. They will enable countries to translate international human rights standards into practice by influencing policy and building the knowledge and skills to implement person-centered and recovery-based approaches. This is what is required to provide quality care and support and to promote mental health and well-being.

Our conviction is that everyone—whether a service provider or member of the community, needs to have the knowledge and skills to support someone who has a mental health condition, psychosocial, intellectual, or cognitive disability.

We hope that these QualityRights training and guidance modules will be used widely and that the approach they offer will become the norm rather than the exception in mental health and social services worldwide.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

Supporting statements

Dévora Kestel, Director, Department of Mental Health and Substance Use, World Health Organization, Geneva

Around the world, there is increasing awareness of the importance of mental health and providing services and supports that are person-centred and promote a recovery oriented and human rights-based approach. This awareness comes alongside a recognition that mental health systems in high, middle and low-income countries are failing many individuals and communities due to limited access, poor quality services and human rights violations.

It is unacceptable that people using mental health services can be exposed to inhuman living conditions, harmful treatment practices, violence, neglect and abuse. There are many reports of services not responding to people's needs or failing to support them to live the independent lives in their community - instead their interactions with services often leaves them feeling hopeless and disempowered.

In the wider community context, people with mental health conditions, psychosocial, intellectual or cognitive disabilities are subjected to stigma, discrimination and extensive inequalities that permeate all aspects of their lives. They are denied opportunities to live where they choose, marry, have families, attend school, seek employment and enjoy leisure activities.

Adopting recovery and human rights approaches is essential if we are going to change this situation. A recovery approach ensures that services place people themselves at the centre of care. It focuses on supporting people to define what recovery looks like and means for them. This approach is about helping people to regain control of their identity and life, have hope for the future, and to live a life that has meaning for them, whether that be through work, relationships, community engagement, spirituality or some or all of these.

Recovery and human rights approaches are very much aligned. Both approaches promote key rights such as equality, non-discrimination, legal capacity, informed consent and community inclusion (all enshrined in the Convention on the Rights of Persons with Disabilities). However, the human rights approach imposes obligations on countries to promote these rights.

Through these training and guidance modules developed as part of the QualityRights initiative, the World Health Organization has taken decisive action to address these challenges and to support countries to meet their international human rights obligations. These tools enable several key actions to be realized around: promoting participation and community inclusion for people with lived experience; capacity building in order to end stigma and discrimination and promote rights and recovery; and strengthening peer support and civil society organisations to create mutually supportive relationships and empower people to advocate for a human rights and person-centred approach in mental health and social services.

I look forward to seeing these World Health Organization tools used in countries to provide a comprehensive response to the challenges faced by people with mental health conditions, psychosocial, intellectual or cognitive disabilities.

Dainius Puras, Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest attainable Standard of Physical and Mental Health.

QualityRights offers a new approach to mental health care which is rights-based and recovery-oriented.

This initiative of the World Health Organization is very timely. There is increasing understanding that mental health care policies and services worldwide need to change. Too often services for people with psychosocial disabilities and other mental health conditions are reliant on coercion, overmedicalization and institutionalization. This status quo is not acceptable, as it may continue to reinforce stigma and helplessness among both users and providers of mental health services.

All stakeholders – including policy-makers, mental health professionals and people using mental health services – need to be equipped with knowledge and skills in effective ways to manage change and to develop sustainable rights-based mental health services.

The QualityRights initiative, through specific well-designed modules, provides the necessary knowledge and skills, convincingly demonstrating that change is possible and that this change will lead to a win-win situation. Firstly, persons with disabilities and other mental health conditions, who may need mental health services, will be motivated to use services that empower them and respect their views. Secondly, providers of services will be competent and confident in applying measures that prevent coercion. As a result, power asymmetries will be reduced, and mutual trust and therapeutic alliance will be strengthened.

To abandon the legacy of outdated approaches in mental health care – based on power asymmetries, coercion and discrimination – may not be an easy direction to take. But there is growing understanding that the change towards rights-based and evidence-based mental health services is needed around the globe – in high-, middle- and low-income countries. WHO's QualityRights initiative and its training and guidance materials are extremely useful tools that will support and empower all stakeholders willing to go in this direction. I strongly recommend all countries to take QualityRights on board.

Catalina Devandas Aguilar, Special Rapporteur on the Rights of Persons with Disabilities

Persons with disabilities, particularly those with psychosocial and intellectual disabilities, often experience human rights violations in the context of mental health services. In most countries, mental health legislation allows involuntary hospitalization and treatment of persons with disabilities on grounds of their actual or perceived impairment, plus factors such as "medical necessity" and "dangerousness". Seclusion and restraints are regularly used during emotional crisis and severe distress in many mental health services, but also as form of punishment. Women and girls with psychosocial and intellectual disabilities are regularly exposed to violence and harmful practices in mental health settings, including forced contraception, forced abortion and forced sterilization.

Against this background, the WHO QualityRights initiative can provide essential guidance on the implementation of mental health services and on community-based responses from a human rights perspective, offering a path towards ending institutionalization and involuntary hospitalization and treatment of persons with disabilities. This initiative calls for training health-care professionals to provide health care and psychosocial support to persons with disabilities in a way that is respectful of their rights. By promoting compliance with the CRPD and the 2030 Agenda frameworks, the WHO QualityRights modules bring us closer to realizing the rights of persons with disabilities.

Julian Eaton Director, Mental Health, CBM International

The increase in interest in mental health as a development priority offers the opportunity to close the huge gap in care and support, enabling people to realize their right to good health care where this has previously been lacking. Historically, mental health services have often been of very poor quality and have ignored the priorities and perspectives of people who were using them.

The WHO QualityRights programme has been instrumental in putting in place the means for measuring mental health services according to the standards of the Convention on the Rights of Persons with Disabilities. This often marks a paradigm shift from the way that services have historically worked. The new training and guidance modules are an excellent resource, facilitating better practice in supporting people with mental conditions and psychosocial disabilities, enabling their voices to be heard, and promoting healthier environments that foster recovery. There is a long way to go, but QualityRights is a crucial resource for service providers and users, guiding practical reform for services that value dignity and respect, wherever they may be in the world.

Charlene Sunkel, CEO, Global Mental Health Peer Network

The World Health Organization's QualityRights training and guidance package promotes a strong participatory approach. It recognizes and values the importance of the lived experience of people with psychosocial, intellectual or cognitive disabilities in promoting recovery, undertaking advocacy, conducting research and reducing stigma and discrimination. The QualityRights tools ensure compliance with human rights standards, implementing strategies to end coercive practices. They show how persons with lived experience can provide peer support and can also contribute to the development, design, implementation, monitoring and evaluation of mental health and social services. Lived experience is much more than just knowledge and skills. Expertise emanates from people's in-depth understanding of the social and human rights impact of living with a psychosocial, intellectual or cognitive disability and the adversities of being shunned, segregated and discriminated against. It emanates from having to struggle to navigate a mental health system that often fails to provide services or support that would be beneficial to the person as an unique individual and that speaks to their specific recovery needs.

The mental health system is not the only societal system that presents barriers through which the person must navigate; access to other life opportunities such as education, employment, housing and overall health and well-being can be equally challenging. The unique and in-depth perspectives of people with lived experience can be the catalyst for change and transformation of all societal systems in order to protect human rights, encourage inclusion in the community, improve quality of life, and promote empowerment – all of which can contribute towards improved mental health and well-being.

Kate Swaffer, Chair, CEO Dementia International Alliance

It has been an honour and pleasure for Dementia Alliance International (DAI) to work with the WHO QualityRights initiative and its collaborators on this very important project. Human rights have generally been ignored in practice for people with dementia. However, these modules introduce a new approach to mental health, and also to dementia which is a neurodegenerative condition that causes cognitive disabilities. In contrast to the current post-diagnostic pathway for dementia, which is a pathway focused only on deficits and leading only to disability and dependence, this new approach and these unique and enabling modules promote rights and encourage and support people with dementia to live more positively.

By promoting the need for clear access to rights, the modules are practical tools that can be used by everyone, regardless of who they are. The modules, which take key human rights principles and make them actionable in practice, are as applicable and effective for health professionals as they are for people with dementia and their family members. For example, highlighting the need and benefits of peer-to-peer support – which is a free service DAI has been offering people with dementia since 2013, even before it was officially launched – and focusing on the issue of legal capacity and its relevance in terms of Article 12 of the CRPD provide tangible ways to better inform professionals and families to ensure that the rights of people with dementia will no longer be denied. I personally have every confidence that these modules will support all people experiencing mental health problems and psychosocial, intellectual or cognitive disabilities to live with a better quality of life.

Ana Lucia Arellano, Chair, International Disability Alliance

The United Nations Convention on the Rights of Persons with Disabilities, or CRPD, is the groundbreaking human rights treaty that promotes the paradigm shift from considering persons with disabilities as objects of charity or medical treatment to fully recognizing them as subjects of rights. This paradigm shift is particularly significant for persons with intellectual, psychosocial and multiple disabilities, or for persons with more intense support needs. Article 12 of the CRPD is key in promoting this shift in that it recognizes that persons with disabilities can exercise full legal capacity. This is the core human right that establishes the foundation on which all the others can be exercised.

QualityRights is a superb tool for enabling professionals and health practitioners to better understand and embrace the CRPD. The tool creates a bridge between persons with psychosocial disabilities, users and survivors of psychiatry and mental health services and the health sector, respecting the principles and values of the CRPD. The QualityRights modules have been developed in close consultation with users and survivors of mental health services, linking their voices to messages conveyed to States Parties of the CRPD. The International Disability Alliance (IDA) and its member organizations offer congratulations for the work developed under the QualityRights initiative. We strongly encourage WHO to continue efforts to transform mental health laws, policies and systems until they are CRPD-compliant, echoing the strong voices that call out for "Nothing about us, without us!"

Connie Laurin-Bowie, Executive Director, Inclusion International

WHO QualityRights aims to empower individuals and Disabled Persons Organizations to know their human rights and to advocate for change to enable people to live independently in the community and receive appropriate supports. Inclusion International welcomes this initiative which seeks to promote rights that are often denied to people with intellectual disabilities – namely the right to access appropriate mental health services in the community, the right to choose, the right to have a family life, the right to live in the community, and the right to be active citizens. QualityRights is a valuable contribution to our collective efforts to shape and influence policies and practice which enable everyone to be included in their communities.

Alan Rosen, Professor, Illawarra Institute of Mental Health, University of Wollongong, and Brain & Mind Centre, University of Sydney, Australia.

Freedom is therapeutic. Facilitating human rights in our mental health services can bring healing. It can ensure that, whenever possible, the person who is living with a mental health condition: a) retains choice and control over the assistance and care provided and b) is offered good-quality clinical and home support, if needed, to live in the community without disruption and "on their own turf and terms".

Following a long history of human rights advocacy in psychiatry, these modules show how the right to adequate care and all human rights and fundamental freedoms can be met without contradiction. Coercion in care – such as restraints, seclusion, forced medications, locked inpatient units, being cooped up in restrictive spaces, and institutional warehousing – must be curtailed. The optimal attainment of liberty in care entails immense change. This includes the widespread systematizing of practical evidence-based alternatives to avoid coercion – i.e. open doors, open respite facilities, open and free access, open communities, open minds, open conversations between equals, supported community living, enhancement of individual and family communication, problem-solving skills and support, advance directives, training in soothing and de-escalation, supported decision-making, the recovery orientation of all services and peer workers, and the co-production of policy with all stakeholders.

The WHO QualityRights programme, based on the United Nations CRPD, has been transformed here into a highly practical set of modules. For our professions, these modules offer a trajectory and a horizon to work towards rather than a finite answer or deadline. As well as optimizing clinical and support services, our political, legal and social actions with service users and their families have to be combined with our own emancipation as professionals from institutional thinking and from being yoked to habitual practices in mental health care. Only then and together can we vastly improve the prospects for an empowered, purposeful, contributing life, with full citizenship and full rights, for persons living with severe, persistent or recurrent mental health problems.

Victor Limaza, Activist and facilitator of Justice for People with Disabilities, Documenta AC (Mexico)

Dignity and well-being are closely related concepts. Nowadays, those criteria by which we judge psychological suffering only in terms of neurochemical imbalances are being questioned, as is the view that certain manifestations of human diversity are pathologies that must be attacked to protect the person and society from supposed dangers, even though the interventions used may violate rights and cause irreversible damage. The interdisciplinary and holistic outlook in which subjective discomfort is addressed without undermining the dignity and ability of the person to make decisions, even in critical situations, should be the foundation on which the new mental health care models are constructed, respecting the principles of the CRPD. Understanding the experience of a person facing a critical state in their mental health is possible thanks to the bond generated through empathy, listening, open dialogue, accompaniment (especially among peers), support in decision-making, life in the community and the advance directives under strict safeguards. People with psychosocial disabilities are experts from experience and must be involved in developing the instruments that seek to lead to recovery. The QualityRights initiative of WHO is a good example of this paradigm shift providing tools and strategies for mental health care with the highest standards of respect for human rights. Undoubtedly, the full and equitable enjoyment of all human rights by every person promotes mental health.

Peter Yaro, Executive director, Basic Needs Ghana

The WHO package of training and guidance documents is a rich collection of material that aims to enhance work in mental health and rights-based inclusive development. The materials provide a significant step towards effective programming and mainstreaming of disabilities – especially psychosocial, intellectual and developmental disabilities – in interventions to address individuals' needs and rights as provided for in the CRPD. The QualityRights package marks a giant stride towards the longstanding recommendation that persons with lived experience be part and parcel of the conceptualization and implementation of interventions, together with the monitoring and evaluation of the project's achievements. With this guidance, the sustainability of initiatives can be assured and, for this reason, practitioners, service users, caregivers and all stakeholders are encouraged to utilize

the documents. In the approach presented here, there is no place for perpetrating violence and abuse on already vulnerable persons.

Michael Njenga, Chairperson of the Pan African Network of Persons with Psychosocial Disability, Executive Council Member, Africa Disability Forum and C.E.O. Users and Survivors of Psychiatry, Kenya

There is paradigm shift in the way we need to address mental health globally. The impetus for this shift has been created by the Convention on the Rights of Persons with Disabilities (CRPD) and by the adoption of the Sustainable Development Goals (SDGs) and the 2030 Agenda for Sustainable Development.

WHO's QualityRights tools and materials for training and guidance build on this key international human right as well as on international development instruments. The QualityRights initiative adopts a human rights-based approach to ensure that mental health services are provided within a human rights framework and are responsive to the needs of persons with psychosocial disabilities and mental health conditions. These materials also lay emphasis on the need to provide services as close as possible to where people live.

The QualityRights approach recognizes the importance of respecting each individual's inherent dignity and ensuring that all persons with psychosocial disabilities and mental health conditions have a voice, power and choice while accessing mental health services. This is an integral element in reforming mental health systems and services both globally and at local and national levels. It is essential, therefore, to make sure that these training tools and guidance materials are widely used so that they result in tangible outcomes at all levels for people with lived experience, their families, communities and entire societies.

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What is the WHO QualityRights initiative?

WHO QualityRights is an initiative which aims to improve the quality of care and support in mental health and social services and to promote the human rights of people with psychosocial, intellectual or cognitive disabilities throughout the world. QualityRights uses a participatory approach to achieve the following objectives:

1 Build capacity to combat stigma and discrimination, and to promote human rights and recovery.

2 Improve the quality of care and human rights conditions in mental health and social services.

3 Create community-based and recovery-oriented services that respect and promote human rights.

4 Support the development of a civil society movement to conduct advocacy and influence policy-making.

5 Reform national policies and legislation in line with the Convention on the Rights of Persons with Disabilities and other international human rights standards.

For more information: http://www.who.int/mental_health/policy/quality_rights/en/

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WHO QualityRights – Training and guidance tools

The following training and guidance modules and accompanying slide presentations available as part of the WHO QualityRights initiative, can be accessed at the following link:
https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools

Service transformation tools

- **The WHO QualityRights assessment toolkit**
- **Transforming services and promoting human rights**

Training tools

Core modules
- **Human rights**
- **Mental health, disability and human rights**
- **Recovery and the right to health**
- **Legal capacity and the right to decide**
- **Freedom from coercion, violence and abuse**

Specialized modules
- **Supported decision-making and advance planning**
- **Strategies to end seclusion and restraint** ⬅
- **Recovery practices for mental health and well-being**

Evaluation tools

- **Evaluation of the WHO QualityRights training on mental health, human rights and recovery: pre-training questionnaire**
- **Evaluation of the WHO QualityRights training on mental health, human rights and recovery: post-training questionnaire**

Guidance tools

- **One-to-one peer support by and for people with lived experience**
- **Peer support groups by and for people with lived experience**
- **Civil society organizations to promote human rights in mental health and related areas**
- **Advocacy for mental health, disability and human rights**

Self-help tools

- **Person-centred recovery planning for mental health and well-being – self-help tool**

About this training and guidance

The QualityRights training and guidance modules have been developed to enhance knowledge, skills and understanding among key stakeholders on how to promote the rights of persons with psychosocial, intellectual or cognitive disabilities and improve the quality of services and supports being provided in mental health and related areas, in line with international human rights standards, and in particular the United Nations Convention on the Rights of Persons with Disabilities and the recovery approach.

Who is this training and guidance for?
- **People with psychosocial disabilities**
- **People with intellectual disabilities**
- **People with cognitive disabilities, including dementia**
- **People who are using or who have previously used mental health and social services**
- **Managers of general health, mental health and social services**
- **Mental health and other practitioners** (e.g. doctors, nurses, psychiatrists, psychiatric and geriatric nurses, neurologists, geriatricians, psychologists, occupational therapists, social workers, community support workers, personal assistants, peer supporters and volunteers)
- **Other staff working in or delivering mental health and social services, including community and home-based services** (e.g. attendants, cleaning, cooking, maintenance staff, administrators)
- **Nongovernmental organizations (NGOs), associations and faith-based organizations working in the areas of mental health, human rights or other relevant areas** (e.g. organizations of persons with disabilities (DPOs); organizations of users/survivors of psychiatry, advocacy organizations)
- **Families, support persons and other care partners**
- **Relevant ministries (Health, Social Affairs, Education, etc.) and policymakers**
- **Relevant government institutions and services** (e.g. the police, the judiciary, prison staff, bodies that monitor or inspect places of detention including mental and social services, law reform commissions, disability councils and national human rights institutions)
- **Other relevant organizations and stakeholders** (e.g. advocates, lawyers and legal aid organizations, academics, university students, community or spiritual leaders, and traditional healers if appropriate)

Who should deliver the training?
Training should be designed and delivered by a multidisciplinary team, including people with lived experience, members of disabled persons' organizations (DPOs), professionals working in mental health, disability and related fields, families and others.

If the training is about addressing the rights of people with psychosocial disabilities specifically, it is important to have representatives from that group as leaders for the training. Likewise, if the purpose is to build capacity on the rights of persons with intellectual or cognitive disabilities, the leaders of the training should also be from these groups.

In order to liven up discussions, different options can be considered. For instance, facilitators with specific knowledge of a particular part of the training can be brought in for specific aspects of the training. Another option may be to have a panel of trainers for specific parts of the training.

Ideally, facilitators should be familiar with the culture and context of the location where the training is taking place. It may be necessary to conduct train-the-trainer sessions in order to build up a pool of

people who are able to carry out the training within a particular culture or context. These train-the-trainer sessions should include persons with psychosocial, intellectual or cognitive disabilities. They should also include other relevant local stakeholders who contribute to improving the quality of mental health and social services and the human rights of people with psychosocial, intellectual or cognitive disabilities.

How should the training be delivered?

Ideally, all the QualityRights training modules should be delivered, starting with the five core foundational modules. This can be followed by more in-depth training using the specialized modules (see above).

The whole training can be conducted through multiple workshops taking place over the course of several months. Each separate training module does not necessarily have to be completed in one day. It can be divided into topics and can be conducted over the course of several days, as required.

Since the training materials are quite comprehensive and time and resources may be limited, it may be useful to adapt the training according to the existing knowledge and background of the group, as well as the desired outcomes of the training.

Thus, the way these training materials are used and delivered can be adapted according to the context and requirements.

- For example, if participants do not yet have any expertise in the areas of mental health, human rights and recovery, it would be important to conduct a 4–5-day workshop using the five core training modules. A 5 day sample agenda available at the following link: https://qualityrights.org/wp-content/uploads/Sample-program-QR-training.pdf

- If participants already have a basic understanding of the human rights of people with psychosocial, intellectual and cognitive disabilities but require more advanced knowledge about how specifically to promote the right to legal capacity in practice, then a workshop could be organized to focus on the module *Legal capacity and the right to decide* on day 1 and on the specialized module on *Supported decision-making and advance planning* (or selected parts of that module) on days 2, 3 and 4.

When adapting the training materials according to specific training requirements it is also important, prior to the training, to go through all the modules to be covered in order to get rid of unnecessary repetition.

- For example, if a training is planned, covering all the core modules, then it will not be necessary to cover topic 5 (zooming in on article 12) or topic 6 (zooming in on article 16) since these issues will be covered in much greater depth in the subsequent modules (module on *Legal capacity and the right to decide* and on *Freedom from coercion, violence and abuse* respectively).

- However if an introductory training is planned based solely on module 2, then it is essential to cover topics 5 and 6 of this module, since this will be the only exposure that the participants will receive on these issues and articles.

These are examples of the different and varied ways in which the training materials can be used. Other variations and permutations are also possible on the basis of the needs and requirements of the training in a particular context.

Guidance for facilitators

Principles for running the training programme

Participation and interaction

Participation and interaction are crucial to the success of the training. All participants should be viewed as individuals who can contribute valuable knowledge and insights. By providing sufficient space and time, the facilitator(s) must first and foremost make sure that people with psychosocial, intellectual or cognitive disabilities are being listened to and included. Existing power dynamics in services and the broader society may make some people reluctant to express their views. In general, however, the facilitator must emphasize the importance of listening to the views of all participants.

Some people may feel shy or uncomfortable and not express themselves – which may be a sign of lack of inclusion or a feeling of insecurity in the group. Facilitators should make every effort to encourage and engage everyone in the training. Usually, after people have expressed themselves once and feel they have been heard, they are more able and willing to speak out and engage in discussions. The training is a shared learning experience. Facilitators should take time to acknowledge and as far possible answer all questions, so that nobody feels left out.

Cultural sensitivity

Facilitators should be mindful of participants' diversity, recognizing that multiple factors have shaped their experiences and knowledge, such as culture, gender, migrant status or sexual orientation.

Using culturally sensitive language and providing examples relevant to people living in the country or region where the training is taking place is encouraged. For example, depending on the country or the context, people may express or describe their emotions and feelings, or talk about their mental health, in different ways.

In addition, facilitators should make sure that some of the issues faced by particular groups in the country or region (e.g. indigenous people and other ethnic minorities, religious minorities, women, etc.) are not overlooked during the training. Feelings of shame or taboo about the issues being discussed will need to be taken into consideration.

Open, nonjudgemental environment

Open discussions are essential and everyone's views deserve to be listened to. The purpose of the training is to work together to find ways to improve respect for the rights of people using mental health and social services and of people with psychosocial, intellectual and cognitive disabilities within the broader community. During this training, some people may express strong reactions and feelings. It is important that the facilitator provides space during the training for people to express opinions and feelings. This means allowing people time to talk about their experiences without interruption and ensuring that others listen and respond to them in a sensitive and respectful manner.

It is not necessary to agree with people in order to communicate with them effectively. When discussion arises, it may be useful to remind all participants that they all share the same goal: to achieve respect for human rights in mental health and social services and in the community, and that all voices need to be heard in order to learn together. It may be helpful to share some basic ground

rules with the group (e.g. respect, confidentiality, critical reflection, non-discrimination) to refer back to when needed.

Note that some people may never before have had the opportunity to speak out freely and safely (e.g. people with lived experience, family members, and also practitioners). Therefore creating a safe space to enable all voices to be heard is essential.

Use of language

Facilitators should be mindful of the diversity of the participants. People taking part in the training will have different backgrounds and levels of education. It is important to use language that all participants are able to understand (e.g. by avoiding the use of/explaining highly specialized medical, legal and technical terms, acronyms, etc.) and to ensure that all participants understand the key concepts and messages. The language and the complexity of the training should be adapted to the specific needs of the group. With this in mind, facilitators should pause, provide examples when necessary, and take time to ask and discuss questions with participants to ensure that concepts and messages are properly understood. As far as possible, facilitators should use language that allows for nonmedical and/or culturally-specific models of distress to be part of the discussion (e.g. emotional distress, unusual experiences, etc.) *(1)*.

Accommodations

Accommodating different means of communication – such as by using visual and audio materials, easy-to-read adaptations, signing, providing assistance with writing for some of the exercises, or enabling people to come with their personal assistant – may be necessary at times to ensure that all people are included in the training.

Operating in the current legislative and policy context

During the training, some participants may express concerns about the legislative or policy context in their countries which may not be in line with international human rights standards, including the Convention on the Rights of Persons with Disabilities (CRPD). Similarly, some of the content of the training may contradict current national legislation or policy. For instance, laws that provide for involuntary detention and treatment contradict the overall approach of these training modules. Moreover, the topic on supported decision-making may appear to conflict with existing national guardianship laws. Another concern may be that national resources for implementing new approaches may be scarce or not available. These preoccupations can lead to questions from the participants about liability, safety, funding and about the larger political and societal context in which they live and work.

First, facilitators should reassure participants that the modules are not intended to encourage practices which conflict with the requirements of national law or policy, or which could put anyone in danger of being outside the law. In contexts where the law and policy contradict the standards of the CRPD it is important to advocate for policy change and law reform. Even though States Parties to the CRPD have an *immediate* obligation to cease violations of this Convention and other international human rights instruments, it is important to acknowledge that achieving full respect for the rights in the CRPD takes time and requires a variety of actions at all levels of society.

Consequently, an outdated legal and policy framework should not prevent individuals from taking action. A lot can be done at the individual level on a day-to-day basis to change the attitudes and practices within the boundaries of the law and to start implementing the CRPD. For example, even if

guardians are officially mandated on the basis of a country's law to make decisions on behalf of other persons, this does not prevent them from supporting those persons in reaching their own decisions and from ultimately respecting their choices.

This training provides guidance on dealing with various topics which are key to fostering the human rights-based approach in mental health and social services. Throughout the training, facilitators should encourage participants to discuss how the actions and strategies promoted in the training materials affect them and how they can be implemented within the parameters of existing policy and law frameworks. Shifts in attitudes and practices, along with effective advocacy, can lead to positive change in policy and law.

Being positive and inspiring

Facilitators should emphasize that the training is intended to share basic knowledge and tools, and to stimulate reflection in order to find solutions that are useful in participants' own context. It is likely that some positive actions already exist and that participants themselves, or other people or services, are already carrying them out. It is possible to build on these positive examples to create unity and to demonstrate that everybody can be an actor for change.

Group work

Throughout the exercises, the facilitator will ask participants to work in groups, which may be flexibly composed, by choice or randomly, depending on the preferences of participants. If participants do not feel comfortable in certain groups, this should be taken into account.

Exercises throughout the training are meant to foster participation and discussion. These exercises are designed to allow participants to come up with ideas and to identify solutions by themselves. The facilitators' role is to guide discussions and, when appropriate, to stimulate debate with specific ideas or challenges. If participants do not want to take part in some of the activities of the training, their wishes should be respected.

Facilitator notes

The training modules have facilitator notes which are in **blue**. The facilitator notes include examples of answers or other instructions for facilitators, which are not intended to be read out to participants.

The content of the presentation, questions and statements that are intended to be read out to participants are written in **black.**

Separate course slides accompanying the training modules to deliver the content of the modules are available at the following link: https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools

Evaluation of the QualityRights training

The QualityRights pre/post-evaluation questionnaires that come as part of this training package have been designed to measure the impact of the training and to improve it for future training workshops.

Participants are required to complete the pre-training evaluation questionnaire before the training starts. 30 minutes should be set aside for this.

At the end of the training, participants should complete the post-training evaluation questionnaire. Again, 30 minutes should be allowed for this.

A unique ID needs to be created for each participant, whether they are completing the form by hand or online. This ID will be the same for both the pre-evaluation and the post-evaluation questionnaire. Unique IDs can be created, for example, by using the name of the country where the training is taking place followed by numbers 1 to 25 (or however many participants there are in the group). For instance, a participant could receive the unique ID of Jakarta12. It could be useful to include the pre and post questionnaires with unique IDs in the participants' folders before the training starts to ensure that the unique IDs are given to the correct participants. There is no need to track who gets which unique ID since the questionnaires are anonymous, but it is important to ensure that each person has same ID on both questionnaires.

Once the post-training evaluation questionnaire has been completed, the facilitator should open the discussion to all participants to express their views about the training, what parts they enjoyed and found useful and what parts they did not enjoy or find useful, as well as any other views they wish to share. This is also an opportunity to discuss what actions and strategies discussed during the training the participants intend to implement.

The pre and post questionnaires should be printed for each participant prior to the training. The versions for printing and distributing are available here:

- *Evaluation of the WHO QualityRights training on mental health, human rights and recovery: PRE-training questionnaire*:
  https://qualityrights.org/wp-content/uploads/20190405.PreEvaluationQuestionnaireF2F.pdf

- *Evaluation of the WHO QualityRights training on mental health, human rights and recovery: POST-training questionnaire:*
  https://qualityrights.org/wp-content/uploads/20190405.PostEvaluationQuestionnaireF2F.pdf

Training videos

Facilitators should review all the videos available in the module and chose the most appropriate ones to show during the training. The video links may change over time. It is therefore important to check that the links work prior to the training. If a link is not working an appropriate alternative link to a comparable video should be found.

Preliminary note on language

We acknowledge that language and terminology reflects the evolving conceptualization of disability and that different terms will be used by different people across different contexts over time. People must be able to decide on the vocabulary, idioms and descriptions of their experience, situation or distress. For example, in relation to the field of mental health, some people use terms such as "people with a psychiatric diagnosis", "people with mental disorders" or "mental illnesses", "people with mental health conditions", "consumers", "service users" or "psychiatric survivors". Others find some or all these terms stigmatizing or use different expressions to refer to their emotions, experiences or distress. Similarly, intellectual disability is referred to using different terms in different contexts including, for example, "learning disabilities" or "disorders of intellectual development" or "learning difficulties".

The term "psychosocial disability" has been adopted to include people who have received a mental health-related diagnosis or who self-identify with this term. The terms "cognitive disability" and "intellectual disability" are designed to cover people who have received a diagnosis specifically related to their cognitive or intellectual function including, but not limited to, dementia and autism.

The use of the term "disability" is important in this context because it highlights the significant barriers that hinder the full and effective participation in society of people with *actual* or *perceived* impairments and the fact that they are protected under the CRPD. The use of the term "disability" in this context does not imply that people have an impairment or a disorder.

We also use the terms "people who are using" or "who have previously used" mental health and social services to refer to people who do not necessarily identify as having a disability but who have a variety of experiences applicable to this training.

In addition, the use of the term "mental health and social services" in these modules refers to a wide range of services currently being provided by countries including, for example, community mental health centres, primary care clinics, outpatient services, psychiatric hospitals, psychiatric wards in general hospitals, rehabilitation centres, traditional healers, day care centres, homes for older people, and other "group" homes, as well as home-based services and services and supports offering alternatives to traditional mental health or social services, provided by a wide range of health and social care providers within public, private and nongovernmental sectors.

The terminology adopted in this document has been selected for the sake of inclusiveness. It is an individual choice to self-identify with certain expressions or concepts, but human rights still apply to everyone, everywhere. Above all, a diagnosis or disability should never define a person. We are all individuals, with a unique social context, personality, autonomy, dreams, goals and aspirations and relationships with others.

Learning objectives, topics and resources

Learning objectives

At the end of the training, participants will be able to:

- define practices in health-care services that constitute seclusion and restraint;
- discuss the physical and psychological impact of seclusion and restraint on people using services and on mental health and social service practitioners ;
- understand how seclusion and restraint violate human rights
- understand and challenge the reasons behind the use of seclusion and restraint in mental health and social services;
- build knowledge and skills on the different strategies that can be implemented in mental health and social services in order to end seclusion and restraint.

Topics

Topic 1: What is recovery? (10 minutes)
Topic 2: Defining seclusion and restraint (2 hours and 40 minutes)
Topic 3: The personal experience and impact of seclusion and restraint (3 hours and 30 minutes)
Topic 4: Challenging assumptions about seclusion and restraint (1 hour and 25 minutes)
Topic 5: Identifying tense situations and elements of a successful response (1 hour and 35 minutes)
Topic 6: Individualized plans to explore and respond to sensitivies and signs of distress (1 hour)
Topic 7: Creating a "saying yes" and "can do" culture (40 minutes)
Topic 8: Supportive environments and the use of comfort rooms (55 minutes)
Topic 9: De-escalation of tense and conflictual situations (15 minutes)
Topic 10: Response teams (1 hour)
Topic 11: Action to take to eliminate seclusion and restraint (2 hours and 10 minutes)

Note: The core module on *Freedom from coercion, violence and abuse* addresses a whole range of coercive practices happening in mental health and social services. This present module builds on many of the strategies discussed in the aforementioned core module. Similarly the strategies discussed in this present module are relevant to end coercive practices in general.

Resources required

- **Accompanying course slides, Strategies to end seclusion and restraing. WHO QualityRights Specialized training (Course Slides), are available here: https://www.who.int/publications-detail/who-qualityrights-guidance-and-training-tools**
- **Room requirements: to optimize the learning experience for participants, the room in which the training takes place should be:**
  - large enough to accommodate everyone, but also small enough to create an environment conducive to free and open discussions;
  - seating arrangements that allow people to sit in groups (e.g. "banquet style" where several round tables are arranged around the room, allowing for several participants to sit together around each of the tables. This has the added benefit of encouraging interaction between participants and also of creating ready-made groups for group work exercises.)
- **reasonable accommodations, as required, ensuring inclusive access to the training for all persons.**
- **internet access in the room, in order to show videos**
- **loudspeakers for the video audio**

- **a projector screen and projector equipment**
- **1 or more microphones for facilitator(s) and at least 3 additional wireless microphones for participants (ideally one microphone per group table).**
- **at least 2 flipcharts or similar, plus paper and pens**

Additional resources to print for this training module include:
- copies of *Annex 1: Scenarios*
- Optional: copies of *Annex 2: Quotes from people with lived experience of seclusion and restraint for all participants*
- copies of *Annex 3: Make an individualized plan*
- copies of *Annex 4: Personal actions to eliminate seclusion and restraint for all participants*
- copies of *Annex 5*: *Service-level change to eliminate seclusion and restraint for all participants.*

Time
Approx. 15 hours.

Number of participants
Based on experience to date, the workshop works best with a maximum of 25 people. This allows sufficient opportunities for everyone to interact and express their ideas.

Important reminder:

For this module, it may be necessary to give people with psychosocial, intellectual or cognitive disabilities the opportunity to speak among themselves about the violence, coercion and abuse that they may have experienced, separately from mental health and other practitioners. The facilitator should therefore consider organising a session prior to the training to allow for this discussion.

During the training, it may also be necessary to ensure the presence of one or more persons who have experience in dealing with trauma.

For exercise 3.1, Option 1: If this option is selected, prior to the session the facilitator will need to identify and invite one or two speakers who can speak about their own personal experience of being secluded or restrained (see below for more details on the topics for speakers to discuss).
For exercise 3.6, Option 1: If this option is selected, prior to the session the facilitator will need to identify and invite a practitioner or a member of the health staff who has had negative experiences in administering seclusion or restraint and wishes to share his/her experience.

Strategies to end seclusion and restraint
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Seclusion and restraint are widely prevalent practices in mental health and social services in countries everywhere which lead to physical and mental harm. Many staff resort to the use of these practices in the name of protecting people from perceived harm or danger. Contributing to the wide-scale implementation of these practices are national laws or policies allowing for their use, along with a service cultures that dehumanize people using services and desensitize staff to the impact of their coercive actions on individuals.

The purpose of this training on *Strategies to end seclusion and restraint* is not to imply that tense and conflictual situations do not arise within services – it is acknowledged that these types of situations do arise. However, as this module demonstrates, the use seclusion and restraints is wholly inadequate, inappropriate, unacceptable and harmful response to such situations.

By examining how negative attitudes and service cultures actively contribute to creating challenging situations, the module provides participants with opportunities to question the "conventional wisdom" around seclusion and restraint, and to understand the urgent need to change service practices in order to ensure that people are receiving the care and support they find acceptable, helpful and effective.

This module takes participants through the physical and psychological impact of seclusion and restraint, and outlines how these practices violate human rights. Participants will learn to challenge some of the assumptions used to justify these practices, and acquire knowledge and skills about key strategies and approaches that can be implemented to eliminate seclusion and restraint altogether.

Topic 1: What is recovery?

Time for this topic
Approximately 10 minutes.

Presentation 1.1: What is recovery? (10 min.)

This presentation gives a brief overview of recovery in order to set the scene for this module on seclusion and restraint.

This presentation aims to define the recovery-based approach in order to ensure that all participants share the same idea of recovery at the start of the module. The presentation also briefly examines the implication of a recovery-based approach in relation to the practices of seclusion and restraint. For more information, see the module on *Recovery practices for mental health and well-being.*

Recovery means different things to different people. It is generally understood to be about a person regaining control of his or her identity and life, having hope for the future and living a life that has meaning for that person. Below are some quotations and definitions regarding recovery:

* "Recovery is a <u>self-determined and holistic journey</u> that people undertake to heal and grow. <u>Recovery is facilitated by relationships</u> and environments that provide hope, empowerment, choices and opportunities that promote <u>people reaching their potential</u> as individuals and community members." *(2)*
* "What matters in recovery is not whether we're using services or not using services, using medications or not using medications. What matters in terms of a recovery orientation is, are we living the life we want to be living? Are we achieving our personal goals? Do we have friends? Do we have connections with the community?" *(3)*
* "Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them." *(4)*

A recovery approach is relevant to all people overcoming challenges in their life, including people with psychosocial, intellectual or cognitive disabilities. Recovery-oriented mental health and social services provide messages of hope and support to overcome barriers and to foster empowerment, personal growth, inclusion and independence. Such services respect people's choices, allowing them to drive their own care and recovery journey and to live the life they want.

A key point to understand is that recovery-oriented services are not based on coercion.

Coercive service environments, including services where involuntary admission and treatment are practised, create tension and conflict. People may often react to their situation, the way they are being treated, and to the environment of the service in a way that is perceived by the service staff, for example, as "threatening", "challenging" and "noncompliant". The response of the service to this is often to impose more coercion on people, including the use of seclusion and/or restraint (See module on *Freedom from coercion, violence and abuse*).

The use of seclusion and restraint is not therapeutic, is incompatible with a recovery approach and is contrary to the purpose of care. In addition, adopting a recovery approach and respecting people's choices regarding their care, treatment, supports and all other aspects of their lives reduces the potential for tense and conflictual situations to arise.

Topic 2: Defining seclusion and restraint

Time for this topic

Approximately 2 hours and 40 minutes.

Exercise 2.1: Meaning of seclusion and restraint (10 min.)

Begin with a brief, general discussion of participants' initial ideas about what the terms "seclusion" and "restraint" mean. The purpose of this exercise is to encourage participants to start thinking creatively and critically about seclusion and restraint – practices which, for many, may constitute acceptable, commonplace and unavoidable standard procedures within services. Ask participants the following question and invite them to share their thoughts.

What do you understand by the words: "seclusion" and "restraint"?

Write down ideas on a flipchart. Do not worry at this point about coming up with complete definitions as these terms will be defined in the next presentation.

Exercise 2.2: Identifying seclusion and restraint (15 min.)

The aim of this exercise is to discuss various explicit and subtle forms of seclusion and restraint that are commonly used in mental health and social services.

Some of these examples may initially seem ambiguous. Through discussion with participants, the idea is to clarify what constitutes seclusion and restraint (including its more subtle forms) and what does not. Note that this set of examples can be changed and tailored according to the context in which the training is delivered.

Show the following to participants:

Do the following constitute seclusion, restraint, both or neither?

1. Holding down a person in bed using a belt or chains.
2. Keeping a person in a caged bed.
3. Tying a person to a tree, bed or a fixed object.
4. Holding down a person.
5. Forcefully grasping someone's arms to put their clothes on.
6. Compelling a person to go to their room.
7. Keeping a person in their room with a door open, but the person is not allowed to leave.
8. Holding someone's hands down in order to feed them because they are undernourished.
9. Strapping a person down in order to feed them with a tube when the person has been refusing to eat for some time.
10. Having doors of a service locked for "safety" or other reasons, even if people are officially free to come and go as they wish.

- All these situations represent forms of seclusion and restraint. Some are more subtle than others, but all need to be eliminated from mental health and social services in order to ensure recovery and compliance with the CRPD.

- Some examples (examples 1-4) are obvious cases of seclusion and restraint – such as using caged beds, tying a person to a tree, bed or a fixed object, and holding a person down using belts or chains – and participants may not dispute this.

- However, participants may argue that some of these examples can be considered noncoercive or that some of these practices are better than others. Some practices may be justified, from participants' perspectives, as being for the benefit of the person concerned and therefore should not be considered seclusion and restraint (e.g. forcefully holding someone's hands down in order to feed them because they are undernourished).

- As the session proceeds, participants will understand that these practices are human rights violations and are harmful, do not benefit the person concerned and impede recovery. In fact, they all constitute seclusion and restraint.

Presentation: Forms of seclusion and restraint (15 min.)

This presentation aims to define seclusion and restraint and explore the various forms that these may take. It highlights what does and what does not constitute seclusion and restraint.

Seclusion:

- Seclusion is broadly defined as isolating an individual away from others by physically restricting the individual's ability to leave a defined space (confinement). It may be done by locking someone in a specific space (e.g. room, shed, cell) or containing them in an area by locking access doors, telling them they are not allowed to move from that area or threatening or implying negative consequences if they do.

Manual restraint:

- Manual restraint refers to interventions done with hands or bodies without the use of any device. It is sometimes called "holding".
- Manual restraint imposes a manual limitation on a person's movement (whole body or certain body parts) often using force.
- It also refers to any "hands-on" control of a person which may involve physical struggles such as dragging a person on the floor or holding a person against the floor. Sometimes it includes painful positions in order to execute control, such as twisting arms to the back or pressing pain points.
- "Prone" or "face-down" restraint is a common form of manual restraint. This is when a person is held face-down (or prone) on the floor and is physically prevented from moving out of this position. It is a particularly dangerous form of restraint due the risk of positional suffocation and sudden death *(5), (6, 7)*.

Physical (or mechanical) restraint:

- Physical (or mechanical) restraint commonly refers to interventions undertaken with the use of devices to immobilize the person or restrict a person's ability to freely move part of their body.
- Restrictive devices generally include belts, ropes, chains, shackles and tightened cloth. Physical restraints also comprise disabling clothing such as straightjackets, disabling gloves, disabling furniture such as cage-beds, net-beds or immobilization chairs.
- Tying someone to a tree or to another object is also a form physical restraint.

Chemical restraint:

- Chemical restraint is broadly defined as the use of medication administered against the person's will, which is claimed to be a "necessary treatment" or an "emergency measure" in order to control a person's movement and/or behaviour.
- It involves involuntary use of a sedating or psychotropic drug. It can include oral administration or injection of the medication without the person's consent.
- It is often administered in response to a perceived danger, such as a violent or aggressive act against one's self or others, or to control people or make them "easier to manage".
- Chemical restraint is frequently used as an alternative to, or alongside, manual restraint, physical restraint or seclusion. However, chemical restraint *is* a form of restraint itself, and it is *not* an acceptable alternative to other forms of restraint or seclusion although it is often thought to be a more positive alternative.

Seclusion and restraints are often accompanied by humiliating and degrading practices such as stripping people of their clothes, conducting body searches, and so on.

Combined coercive practices in health-care services:

- Seclusion and restraint are often used together; e.g. in many instances people are manually or physically restrained in order to be taken to a seclusion cell or room.
- Physical and mechanical restraints are often used in conjunction with chemical restraint; e.g. in many instances, people are forcibly held down (manual restraint) so that they can then be sedated.

Many practices that do not strictly constitute seclusion and restraint may be used to isolate people from the outside of the service (e.g. confiscating mobile phones, limiting or forbidding visits, limiting access to the Internet or other means of communication). This may prevent people using the service from reporting abuses.

Exercise 2.3: Forms of seclusion and restraint (30 min.)

Participants will have different ideas about the various forms of seclusion and restraint so it is useful to encourage them to identify different examples of seclusion and restraint that are used at their own service. For instance, it may be the case that some participants have never considered the overuse of medication, medication administered outside agreed treatment plans, or administration of medication against a person's will as forms of restraint).

Ask participants the following questions:

1. What examples of seclusion and restraint are used in your mental health or social service?
2. What are the different terms that you use to describe seclusion and restraint in your service?

Draw a graph similar to the example below and write participant's examples in the relevant boxes.
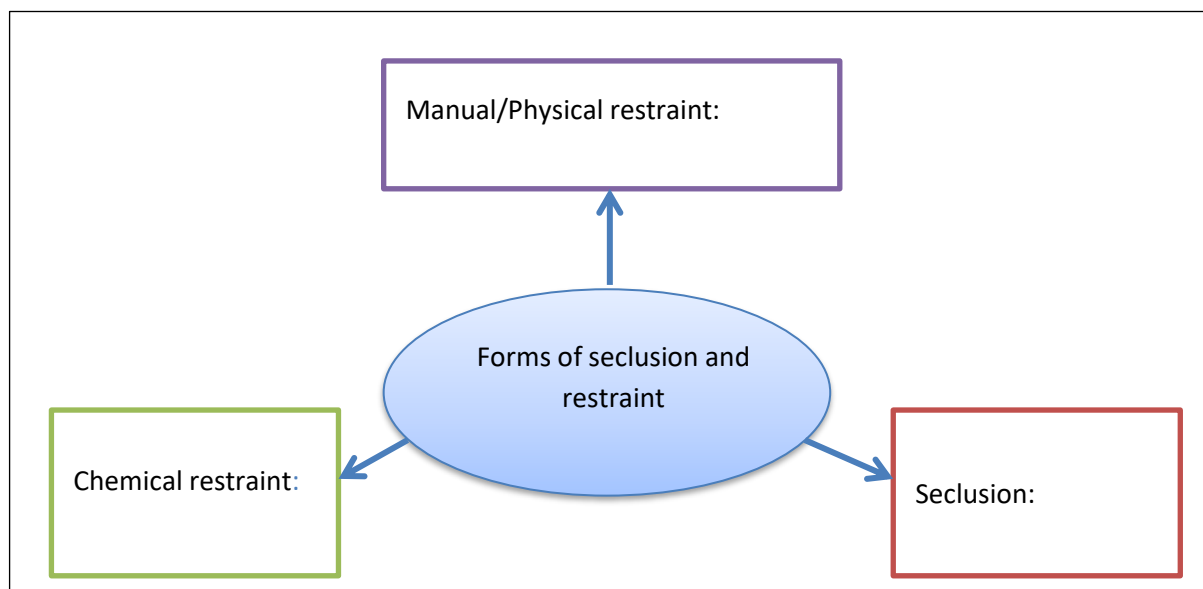
Some possible answers include (but are not limited to):

Seclusion:

- Placing a person in a locked room.
- Placing a person in a room with the door held shut.
- Requiring a person to stay in their room, even with the door open, in order to prevent them from moving about freely outside of the room.
- Separation of a person from other parts of the service and/or other service users, family and staff.

Restraint:

  Manual/Physical:

- Any manual method of limiting someone's movement (e.g. holding the person down).
- Applying any device to a person that limits their movement (e.g. hand and wrist straps).

  Chemical:
- Sedating a person to control or overpower them.
- Giving a person medication (which is thought to affect the person's thoughts, movement and behaviour) without the person's consent.

Note: Participants may highlight certain forms of seclusion and restraint specific to their own cultural or national contexts and with specific names: for example the act of physically restraining someone in

Indonesia is known as 'Pasung'. In the African context, chemical restraints are often called "stoppers".

⚠️**Warning:** Remind participants these images may be upsetting to some people.

Exercise 2.4: Images of seclusion and restraint (10 min.)

This exercise is designed to enable participants to view and discuss images of the various seclusion and restraint practices around the world.

Go through each of these images with the group and ask them to describe what the pictures display.

Do you see seclusion or restraint in this picture? What kind?

Presentation: The practice of seclusion and restraint constitutes a human rights violation (50 min.)

The statement that seclusion and restraint constitute human rights violations may provoke strong reactions from mental health and other practitioners participating in the training. Some may be of the opinion that these practices are necessary and justified to protect the person or others from harm. It may be important to acknowledge that seclusion and restraint may be carried out by staff with good intentions. However, it is also important to stress that these practices cause harm and that, during this training, non-harmful and noncoercive alternatives will be explored to support people in a way which is not damaging to them.

Secluding or restraining people violates many human rights. For example:

- the right to liberty and security
- the right to health
- the right to legal capacity
- the right to be free from violence and abuse
- the right to be free from torture and cruel, inhuman and degrading treatments or punishments
- the right to integrity of the person
- the right to privacy.

These rights are protected by many human rights instruments, including:

- the Universal Declaration on Human Rights
- the International Covenant on Civil and Political Rights
- the International Covenant on Economic, Social and Cultural Rights
- the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- the UN Convention on the Rights of the Child (CRC)
- the UN Convention on the Elimination of all Forms of Discrimination Against Women
- the UN Convention on the Rights of Persons with Disabilities (CRPD).

- The United Nations Special Rapporteur on Torture has called for "an absolute ban on restraints and seclusion" (8). He has stated that the imposition of solitary confinement "of any duration to persons with mental disabilities constitute cruel, inhuman and degrading treatment" (9).

To illustrate the previous presentations, show participants the following video about a man who has been living in a seclusion room for the past 5 years.

Attitude Live: Seclusion (29:10)
https://youtu.be/OjOXo9W68qQ (accessed 9 April 2019).

At the end of the video, give participants the opportunity to have an open discussion about what they have seen. After this discussion, the facilitator may wish to give participants the opportunity to take a break.

Presentation: When and why are seclusion and restraint used? (30 min.)

Mental health and other practitioners may resort to seclusion and restraint for various reasons. Many do not intend to be abusive or violent but different factors lead them to use these practices. For instance, national laws or policies may allow the use of seclusion and restraint to protect people from perceived harm or danger, and unhealthy service cultures (more information on service culture can be found in *Guidance on improving and transforming services*) or a lack of knowledge, training and resources may also contribute their use.

Ask participants:

Why do you think that seclusion and restraint are widely practised?

Possible answers may include:

- to stop someone from harming or endangering themselves or others;
- there are not enough other methods, or no time or resources to carry them out;
- because of stigma and prejudice towards people with psychosocial, intellectual or cognitive disabilities;
- because of a lack of education and training for staff;
- because mental health laws tell us to use them.

Inform participants that these factors will be explored in this presentation.

Mental health and social care professionals report using seclusion and restraint for many different reasons:

- **To stop harm or danger (real or perceived)**
- To stop people from hurting themselves or to keep them safe (e.g. in response to attempts to self-harm, or to end their life).
- To prevent people hurting others: service staff generally perceive potentially harmful or dangerous situations as creating a dilemma between the need to intervene by force or else do nothing. They generally do not see a third option.

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➢ Eliminating the practices of seclusion and restraint does not imply that people should not take steps to stop someone from hurting themselves or others. There may be situations that require an immediate response to save someone from harm or to save their life. However, any such response should be taken in the same way as it would be taken with a person who does not have a psychosocial, intellectual or cognitive disability.

At this point the facilitator may want to discuss some examples (e.g. preventing someone from jumping off a bridge, holding someone to prevent them from beating someone else) with participants. The aim is to make a clear distinction between these situations and seclusion and restraint.

➢ In addition, it is important for service staff to acknowledge that they cannot control everything. They may sometimes be so concerned for the well-being of people using the service that they will act in a way which is extremely restrictive and coercive and ultimately harmful and counterproductive.

- **Because of inadequate service policies, practices and resources**

  ➢ Service-level policies often allow for the use of seclusion and restraint. These practices may be considered standard procedures because they have never been challenged or because people feel powerless to change them in their practice.
  ➢ Insufficient staffing and resources in some mental health and social services means that staff resort to seclusion and/or restraint in an attempt to manage their service.
  ➢ Service staff feel compelled to use seclusion and restraints in order to implement the very rigid rules, procedures and schedules of the service.
  ➢ There may be inadequate resources to support the people using the service and to provide oversight of the running of the service.
  ➢ A negative service culture can dehumanize people using the service and desensitizes staff from seeing people as human beings who deserve respect.

- **Because of inadequate staff knowledge and skills**

  ➢ Sometimes these practices are used as an automatic response to a tense or conflictual situation.
  ➢ Staff may not have been trained on alternative strategies for responding to tense situations or for providing support to very distressed persons. In consequence, they do not have the necessary skills and tools that would enable them to use noncoercive techniques and creative alternatives when providing care and support to people using the service.
  ➢ Some people have mistaken beliefs that seclusion or restraint function as therapeutic treatment.

- **Because of misconceptions and assumptions about psychosocial, intellectual or cognitive disabilities**

  ➢ As an automatic reaction to someone who has a perceived or diagnosed condition due to assumptions and perceptions that the person may cause harm to themselves or others, or that they are unmanageable.
  ➢ Prejudice and discriminatory attitudes towards certain groups of people who use services who may be assumed to be "problem" groups (such as young people,

people from minority groups, males, people who uses substances, etc.) and presumption of violent or dangerous intent.

- **Because of fear of risk and staff/service liability**

  - ➢ Seclusion and restraint methods are often used as a first resort because their outcomes are perceived as being "certain" compared with other approaches.
  - ➢ Sometimes staff are concerned about being held liable or responsible if an incident occurs (e.g. if someone gets injured) when seclusion and restraint have not been used. This encourages staff to use these coercive practices.

- **To control**

  - ➢ To control or maintain order in the service environment by firmly handling nonconforming actions or behaviours. Indeed, many services tend to overemphasize the need to maintain an orderly environment, to the detriment of personalized care. In many such services, people are routinely overmedicated, sedated or restrained to ensure that they are "easier to manage" and "under control".
  - ➢ To coerce or oblige people using services to follow a particular course of action or to behave in a particular way.
  - ➢ Some service staff see the use of seclusion and restraint as a necessary means of setting limits in order to establish their authority and to "manage behaviour" early in their interactions with people using the service.

- **For convenience**

  - ➢ Service staff feel, in many cases, that it is easier and quicker to use coercive methods, such as seclusion and restraint, than to use other noncoercive methods to respond to tense situations or to support people who are very distressed. This may be particularly the case when there is a shortage of staff in services.

- **To punish**

  - ➢ As a form of punishment for those unwilling to follow instructions.
  - ➢ Sometimes staff do not perceive the use of seclusion and restraint as punishment but instead perceive it as a necessary consequence of certain actions or behaviours of persons using services.

Topic 3: The personal experience and impact of seclusion and restraint

Time for this topic
Approximately 3 hours and 32 minutes.

Exercise 3.1: The personal experience of seclusion and restraint (1 hour)

This exercise is designed to help participants understand that seclusion and restraint are violent adverse events that can contribute to mental, emotional and physical harm. It is important to encourage people who have not personally experienced these practices to try and understand the perspectives of the persons who have.

The facilitator may choose between one of the following options or combine them for a more comprehensive exercise.

Please note: The most powerful way to understand the personal experience of seclusion and restraint is to hear directly from people who have had this experience. Therefore Option 1 is the preferred option for this exercise.

Option 1: The facilitator should identify one or two speakers with lived experience of seclusion and restraint in mental health and social services and invite them to share their stories with the group. The facilitator should guide the speaker to describe not only what happened to them, but also how it happened. They should discuss how their experience negatively affected them, both emotionally and physically, as well as giving their ideas about what would have prevented the use of seclusion and restraint in their situation. **Ahead of this session, the facilitator will need to organize for such speakers to take part** (Additional instructions are provided at the beginning of this module).

Option 2: The facilitator should distribute a handout of quotes from people with lived experience of seclusion and restraints (see **Annex 2**) and should ask participants to discuss people's feelings and experiences relating to the practice of seclusion and restraint.

After hearing about or reading people's experiences of seclusion and restraint, ask participants:

- What are your thoughts and feelings about what you have heard and/or read?
- How might people be feeling when they are secluded or restrained? What can you say about the emotional and physical impact of seclusion and restraint?
- Would anyone like to comment on what could have been done differently in these situations?

Presentation: The psychological impact of seclusion and restraint on people using services (20 min.)

Evidence has linked the use of seclusion and restraint to many adverse impacts and outcomes *(10),(11),(12):*

Impact on psychological and emotional well-being

- The forceful assertion of another person's will over one's own, along with the loss of control over one's body and environment, generates very negative emotions and has deep psychological and traumatic impacts on people.
- Many people experience feelings of loss of dignity and respect, degradation, demoralization, dismissal, humiliation, fear, distress, anxiety, disempowerment, decreased self-esteem and self-confidence, powerlessness, hopelessness, helplessness, loneliness, despair, frustration, grief, anger, struggle, destructiveness, distrust, rejection and resistance.
- People can also experience dissociation from self and a feeling of being outside of one's own body.
- Seclusion and restraint can create trauma and may have long-term impacts on a person's life (relationships, work, etc.).
- When people are secluded and restrained, their lack of power, control and privacy may lead them to adopt behaviours that are further interpreted by mental health practitioners as symptoms of a mental health condition.
- Seclusion and restraint can retraumatize people who have a past history of sexual or physical abuse, or past psychological trauma *(13)*. People using services who witness the practice of seclusion or restraint on others may also suffer psychological impacts such as fear, anxiety, powerlessness, trauma, retraumatization, etc.
- They can increase self-harm and self-directed aggression, including self-mutilation and suicide attempts.
- In addition, family members and other care partners who learn that their relative has been secluded or restrained may experience feelings of guilt and powerlessness to help.

Impact on recovery (14)

- Seclusion and restraint are countertherapeutic and impede people's recovery. Some studies have shown that coercion, and particularly the use of seclusion, is associated with increased length of stay in services *(15).*
- They damage therapeutic alliances and are responsible for the breakdown of the relationship between people using services and health-care staff.

It is important to acknowledge that involuntary admission in mental health and social services can also cause the same type of psychological harm as seclusion and restraint, as described above. (For more information on this, see the training module on *Freedom from violence, coercion and abuse*).

At this point, show one of or both the following videos to participants:

1. Video: "I couldn't move. I couldn't breathe" (52 seconds): http://www.bbc.com/news/uk-england-37427665 (accessed 19 January 2017). This video is about the use of face-down restraint.

2. Uganda: "Stop the abuse" https://youtu.be/slr_SvB1uyU (5:07). accessed 9 April 2019. This video shows the practice of seclusion, restraint and associated abuses in Uganda.

Exercise 3.2: Psychological impact of the use of seclusion and restraint (30 min.)

The aim of this exercise is to highlight the grave psychological impact that the use of coercion has on people experiencing these practices.

Explain to participants that:

This video narrates the experience of Naomi Jones who has used services in the United Kingdom. Although this video was recorded in the United Kingdom, it is important to understand that seclusion and restraint practices take place across the globe, in high-, middle- and low-income countries. However, whatever the context, the psychological trauma and impact on people are significant.

The video should start at minute 10.27**:**
Video – 'Road so far': https://youtu.be/j405vpdjeUU?t=627 (accessed 9 April 2019).
(A later video will be shown during exercise 3.6 in order to explore the impact from the point of view of the staff of the service.

Ask participants the following question:

What do you think of Naomi's experience? What are some of the terms, emotions and feelings that Naomi describes as part of her experience?

Participants should be encouraged to discuss Naomi's testimony.

Use the flipchart to write down the various terms Naomi used to describe her experience.

- Terms describing Naomi's experience of restraint include: fear, confusion, disorientation, trauma, humiliation, anger, frustration, increased distress, punished, and loneliness.
- She did not feel helped, comforted or supported, and felt that her recovery was hindered.
- Naomi also describes feelings of trauma and fear that continued for weeks following the incident.

Presentation: The physical impact of seclusion and restraint on service users (7, 14, 16-22) (20 min.)

Manual restraints involve physical struggle which may lead to physical injuries such as:

- *bruises*
- *broken bones*
- *muscle wasting*
- *missing teeth*
- *head injuries*
- *coma*
- *choking* (people placed in restraints where they must remain on their back are at risk of choking on vomited food, liquid or saliva).

Physical restraints can cause people to panic and choke on saliva or/and strangulate in the restraint. Due to their highly dependent situation, people are also at increased risk of:

- *Dehydration:* People can become severely dehydrated while in restraints or during a struggle when restraints are being applied.
- *Circulatory and skin problems: Pressure on the skin caused by tight restraints and immobilization may interfere with blood circulation. It can lead to skin deterioration and pressure sores. It can also lead to gangrene, which is the death of soft tissue due to lack of oxygen, when severe disruption to circulation takes place on the upper or lower limbs.*
- *Muscle atrophy.*

Chemical restraint can cause pain through the injection of medication.

In addition, people can be forced to experience the negative effects of medication which, depending on the drug prescribed, can include:

- Muscular problems, including spasms, rigidity, slowed or jerking movements, tremors and uncontrollable restlessness (akathisia).
- Cardiac effects, low blood pressure, dizziness, fainting.
- Dry mouth, blurry vision, constipation, hallucinations, memory impairment, difficulty in urinating.
- Lowering of the threshold for seizures.
- Neuroleptic malignant syndrome: a life-threatening condition characterized by rigidity, fever, increased heart rate, significant drop or rise in blood pressure *(23)*.
- Slowing and dulling of thought processes, apathy, loss of motivation to undertake any actions, emotional detachment *(24).*

Seclusion can cause people to panic and become injured. They may need immediate medical attention and may not be heard or seen on time, which can lead to permanent impairments. They are also at risk of dehydration and cardiovascular collapse.

When different forms of seclusion and/or restraint are combined, this multiplies the risks for the person's health.

All forms of seclusion and restraint can lead to death *(25), (17), (7)*:

- Investigations have shown that the causes of restraint- or seclusion-related death include suffocation, heart complications, drug overdoses or interactions, blunt trauma, strangulation or choking, fire or smoke inhalation, and aspiration.
- Restraint or seclusion also places persons at risk because it impedes their ability to escape during emergencies (e.g. fire).
- A review of the scientific literature on the adverse impact of physical restraint showed that the use of certain manual or physical restraints is particularly dangerous as they impose a restrictive effect on respiratory functioning *(26)*.
- Chemical restraint may clash or interfere with other medications, risking overmedication and sudden death *(27)*.
- Very little recent data exist on numbers of deaths related to seclusion or restraint. However, one national investigation across 50 states in the USA estimated that between 50 and 150 people die each year in mental health services and group homes as a direct result of restraint practices *(28)*.

Presentation: Drastic impact of the use of seclusion and restraint (5 min.)

The use of seclusion and restraint has been associated with wide-scale deaths of people using services in emergencies. The inability of people to move or leave the building during a fire means that they are trapped and cannot escape.

Below are two examples of the massive death toll that could have been avoided if people had not been restrained in mental health services.

Participants should be invited to share other examples that they may be aware of.

- Erwadi fire incident (29)
  - ➢ 6 August 2001
  - ➢ Ramanathapuram, Tamil Nadu, India
  - ➢ At least 25 people killed
  - ➢ When a fire broke out, all service users were burned alive because they were fastened in chains.

- Moscow Ramensky fire (30)
  - ➢ 26 April 2013
  - ➢ Ramensky, Russia
  - ➢ 38 people killed
  - ➢ A fire in the middle of the night killed service users who are thought to have been physically and chemically restrained in a locked facility.

 Exercise 3.3: Psychological impact of the use of seclusion and restraint on service staff (40 min.)

The aim of this exercise is to encourage participants to think about the negative impact of using seclusion and restraint.

There are two options for this exercise. Option 1 is the preferred option.

<u>Option 1:</u>

Prior to the session, the facilitator should identify a practitioner who is comfortable sharing negative experiences associated with using seclusion and restraint (including being chained, forced to take medication, etc.). The person should be invited to share his or her stories with the group.

After the speaker's presentation of negative experiences of administering seclusion and/or restraints, the facilitator may, through a series of question and answers, guide the speaker to discuss:

- the context of the situation that led to the use of seclusion and/or restraint;
- the impact of administering seclusion and restraints, including emotions and discomfort;
- the negative impact this may have had on the therapeutic relationship with people using services;
- what could have been done differently to change the course of events and prevent the use of seclusion and restraint.

Allow the participants the opportunity to ask the speaker questions related to the talk.

<u>Option 2:</u>

If it was not possible to organize a speaker prior to the session, share this 11-minute video about the experience of a psychiatrist who was attacked by a person who feared that coercive practices would be used against him.

Finger prints and foot prints (11:07): https://youtu.be/X8T2NEfUb3s (accessed 9 April 2019)

Next, invite participants to share their opinions about this video. Ask participants:

- What do you think of this experience?
- What are some of the terms, emotions and feelings that are used by the speaker when describing his experience?
- What are some of impacts on the person who experienced the coercion as well as on the therapeutic relationship?
- What could have been done differently to change the course of events and prevent this situation from happening?

Presentation: The impact of seclusion and restraint on mental health and related practitioners and services (10 min.)

The use of restraint or seclusion can also have a negative impact on practitioners.

- Evidence indicates that the use of coercive methods is linked to physical injuries of the staff. For example, one study attributed at least 50% of mental health staff injuries to the use of seclusion and restraint *(31), (14)*.
- Mental health and other practitioners who employ coercive measures such as seclusion and restraint can also experience trauma *(32),(10).*
- The use of force and coercion breeds resentment, guilt, frustration and loss of trust between the service users and staff which has a negative impact on therapeutic relationships *(33)*.
- Service staff may face a moral conflict between their desire on the one hand to provide good care and support to people (which in many cases is the reason why they entered the profession in the first place) and, on the other, being forced to act in coercive and abusive ways towards people they are seeking to help.
- The use of these practices can also lead to civil and criminal lawsuits against services and/or staff – for instance, on the grounds of excessive use of force, medical malpractice, failure to protect, assault and battery and failure to maintain a safe environment for people using the service *(34)*.
- Despite a common misconception that the use of seclusion and restraint is cost-effective, this claim is not substantiated by research data.
- The use of seclusion and restraint increases costs such as staff time, increased supervision, sedatives and tranquilizers, insurance, investigations, disruption of services, litigation and injuries *(14),(35)*.

Topic 4: Challenging assumptions about seclusion and restraint

Time for this topic
Approximately 1 hour and 25 minutes.

Presentation: Challenging assumptions about seclusion and restraint (32) (20 min.)

What are the <u>assumptions</u> that need to be challenged with regard to seclusion and restraint?

1. **Assumption 1: Seclusion and restraints can be used for the therapeutic benefit of people using mental health and social services**
    ➢   There is no evidence-based research that supports the idea that seclusion or restraints are therapeutic. On the contrary, as seen previously, evidence points to the fact that these practices can be damaging to a person's physical and mental well-being.

2. **Assumption 2: Seclusion and restraints keep people safe**
    ➢   Seclusion and restraints cause physical, emotional and mental harm.
    ➢   As we have seen, restraints sometimes cause physical harm such as broken bones and even death. Also, the psychological impact and trauma of seclusion and restraint is profound and long-lasting.
    ➢   Research evaluating the impact of a seclusion and restraint reduction programme in Pennsylvania (USA) showed that significantly reducing the use of seclusion and restraint in state and forensic psychiatric hospitals did not result in an increase in assaults on staff and, in some cases, the number of assaults on staff actually decreased *(36), (37)*. Other reports also indicate that reductions in coercive measures are associated with reduced staff injuries (38).

3. **Assumption 3: Seclusion and restraints prevent violent behaviour**
    ➢   Evidence shows that seclusion and restraints can make feelings of frustration and anger worse, resulting in more harmful behaviour.
    ➢   Indeed, people who have already experienced coercive practices such as seclusion and restraint and the associated feelings of loss of control, fear and humiliation, may feel that they have very little choice but to defend themselves, even violently, against a renewed coercive intervention. "If we want people to stop acting violently, perhaps we need to stop treating them violently" *(39)*.
    ➢   People using services tend to view seclusion and restraint as disciplinary punishment (e.g. for not doing what they are told, including failing to follow instructions to take their medication) and this can increase feelings of frustration towards mental health and related staff or others. The use of these practices also entrenches a culture of "them and us" *(14).*

4. **Assumption 4: Staff can accurately recognize potentially violent situations**
    ➢   The belief that it is possible to predict potentially violent behaviour and situations accurately is also a reason why practitioners resort to seclusion and restraint.
    ➢   However, predicting future violence and harm accurately is extremely

difficult.
- ➢ Often staff are not able to differentiate between unpredictable/unexpected behaviour and risky/dangerous behaviour. Staff also often correlate distress with aggression.
- ➢ The uncertainty with which risk of harm or violence to self or others can be anticipated by practitioners has resulted in a culture of overly defensive practices and increased use of coercive practices *(40),(41)*.

5. **Assumption 5: People with psychosocial, intellectual or cognitive disabilities are often irrational, violent and unpredictable**
- ➢ There is a common misconception that people with psychosocial disabilities are governed by their psychosis and/or hallucinations, which makes them violent, unpredictable and irrational.
- ➢ Substantial evidence exists to show that they are no more violent than the rest of the population and, in fact ,are more likely to be the victims of violence rather than perpetrators *(42), (43), (44), (45).*

6. **Assumption 6: There are circumstances in which the use of seclusion and restraint cannot be avoided.**
- ➢ This is one of the key assumptions about seclusion and restraints. We will explore this assumption in detail in the next exercise.

Exercise 4.1: Challenging the assumption that exceptional circumstances are valid reasons for using seclusion and restraint (25 min.)

The assumption that there are exceptional circumstances in which seclusion and restraints need to be used is one of the most challenging issues in relation to efforts to end the use of seclusion and restraint in mental health and social services. The facilitator should be prepared to discuss this exhaustively with the group.

Some participants may express the view that, sometimes, seclusion and restraint cannot be avoided. For instance, some participants may argue that, if someone is acting dangerously and violently, seclusion and restraint may be inevitable to avoid harm to the person and to others. The exercise below is intended to dispel this misconception.

Now show the following statement/misconception:

There are circumstances when the use of seclusion and restraints cannot be avoided.

Ask participants the following questions and encourage them to discuss their answers directly with each other:

1. Do you agree or disagree with this statement? Why?
2. Under which circumstances do you think seclusion and restraint <u>cannot</u> be avoided?

Ideas can be written down on a flipchart.

Some of the circumstances participants agreeing with the above statements could bring up include (but are not limited to):

- When people using services are acting aggressively or threatening violence towards staff or other people in the service.
- When people using the service need immediate hospital care and treatment because their life is at risk (e.g. to inject insulin into a person urgently needing treatment for diabetes, to protect a person at high risk of suicide).
- When people using the service are resisting medication even though mental health and social care practitioners believe that they need it.

After the discussion, take participants through the following:

Seclusion and restraint for people with psychosocial, intellectual or cognitive disabilities should be avoided even in extreme circumstances.

- Seclusion and restraints are not interventions of last resort.
- Alternatives to seclusion and restraints should <u>always</u> be sought in order to protect people's well-being.
- However, when someone is acting in a way which is very dangerous to others, this person should be stopped in the same manner as you would stop anyone, with or without a disability – such as by involving a specially trained group who are equipped with the skills to manage the situation (e.g. a response team, see topic 10) or alternatively in some instances law enforcement bodies (e.g. the police force) to guarantee the security of all. Law enforcement bodies who respond to such crises should be trained to understand the needs and specificities of people with disabilities, including people with psychosocial, intellectual or cognitive disabilities.

Staff believe that in some cases it is impossible to find alternatives to seclusion and restraint and this is why seclusion and restraint are used in the service.

- We should always consider the use of seclusion and restraints as a failure, a bad outcome and a human rights violation, even when it seems that all the alternatives to these practices were implemented before resorting to them.
- There are always alternatives to seclusion and restraint.
- Some of those alternatives will be discussed in the next topic.

The use of seclusion and restraints is also a service failure, the failure of a whole system and it could also be a failure of individual staff members.

The statement "The use of seclusion and restraints is always a service failure" could be seen as an accusation towards staff members. It is important to highlight that:

- A reflective space needs to be made for each individual member of staff to think through whether they themselves might have played a part in the events which resulted in the use of restraint or seclusion.
- Consideration also needs to be given as to whether the use of seclusion or restraint was a criminal act. In this case, appropriate actions should be taken within the criminal justice system.

Each failure should be considered an adverse event.

- It should be seen as an opportunity to understand and correct what went wrong.

- It should also allow for critical reflection on how individuals may inadvertently contribute to seclusion and restraint (e.g. "What factors about myself, the individual and the situation led me to believe this response was appropriate?")
- It should push staff to review and improve all the strategies that have been put in place to end seclusion and restraint.

A report should be written on the specific incident.

- In this report, the person who experienced the seclusion or restraint should be offered the opportunity to communicate their perspective (with the support of a trusted person, if they wish) on:
  - ➢ the events that led to the use of seclusion and/or restraint;
  - ➢ the use of seclusion and/or restraint itself and its impacts;
  - ➢ what they believe needs to be done to prevent these practices from being used again.
- The situation should also be reviewed by bodies and mechanisms independent from the service.
- In cases of serious legal concern, criminal investigation and prosecution should take place.

A general report should periodically be written on the use of seclusion and restraint within the service.

- A report should be written periodically (e.g. annually) to document all cases of seclusion and restraint in the service during the period. It should also describe and analyse strategies in place to eliminate seclusion and restraint.
- The information contained in the report should be anonymised/de-identified – i.e. it should not include the identity of the people concerned.
- These reports on the use of seclusion and restraint should be made publicly available. This will allow people to make more informed choices concerning their health-care provider, it will enable organizations or individuals to challenge the use of these practices (including through the legal process in court) and it will also encourage governments to investigate services that have particularly high rates of seclusion and restraint.
- Fostering a culture of transparency through regular reporting is likely to motivate management and staff to change and improve their practices.

Exercise 4.2: Is it possible to change the course of events leading up to the use of seclusion and restraints? (30 min.)

This exercise focuses on what can be done to prevent situations from escalating and explores lost opportunities to intervene along the way.

Participants may come up with their own examples and scenarios. Encourage them to reflect on these scenarios in a similar way to the exercise below.

Show and read the following scenario to participants:

Scenario 1 - Tom's experience

Tom is staying in a social care home for people with dementia. He wants to make a phone call to his sister and needs to obtain a phone card from the nurse to be able to place his call. The nurse says that she will handle his request in a minute because she is very busy.

Because the nurse is stretched and overloaded with various tasks, Tom has to wait for over an hour.
He becomes increasingly agitated and angrily bangs on the door of the nursing office. The nurse asks him to "calm down" which results in a deepening sense of frustration for Tom.

The nurse then responds by saying: "if you are in this frame of mind I will not allow you to make your phone call."

Tom starts pacing up and down in the corridor and becomes more and more agitated, kicking the door and being verbally abusive to staff walking past him.

Tom's agitation results in his being physically and chemically restrained. This was justified by the service staff as necessary for his own and others' safety.

Ask participants to answer the following questions:

1. **What do you think of this case?**
2. **How common is it in your service?**
3. **Was the use of restraint inevitable in Tom's case? What could have been done to prevent it?**
4. **Whose responsibility was it? Was it only the nurse's responsibility?**
5. **What impact do you think this incident had on Tom's well-being?**

After the discussion, show participants the following:

Reflections on Tom's scenario:

- The outcome of this scenario is quite common in many mental health and social care services, yet it could have been avoided.
- The level of dependency on the service and staff experienced by Tom, and the fact that he does not have control over his communication which is important aspect of life, leads him to react to this situation.
- The fact that the routine of the staff takes priority over Tom's needs, despite the fact that the primary reason for the service is to provide people with care and support, indicates that staff have dehumanizing attitudes towards people using the service. This is also reflected in the nurse's response to Tom which is demeaning and verbally abusive.
- In this case, the nurse should have prioritized Tom's needs above other tasks that could have been delayed for a few minutes, to provide Tom with the telephone card. The crisis could have then been avoided.
- Other doctors, nurses and other staff probably walked past Tom perhaps knowing he was waiting to make a telephone call and would have noticed early signs of distress due to the unnecessary wait. It would have taken a few minutes of their working day to help Tom, yet

no staff member assisted him. In the end, the course of events cost the staff significantly more time.

- The use of physical and chemical restraints is likely to have adversely affected Tom (e.g. powerlessness, traumatization, loss of control, fear, dehumanization), had a negative effect on his well-being, increased the costs of the service, and increased time demands on service staff.
- Each person who looked away when they could have taken action to help Tom could be considered to have been personally responsible for escalating the situation.
- One factor that may have contributed to the outcome could also be the failure of the service management to hire sufficient numbers of staff to avoid overloading existing staff members in order to allow them to respond adequately to the needs of people using the service. People can and should proactively take steps to influence the course of events whenever possible in order to avoid the escalation of a situation. Everyone has a role to play in preventing the use of seclusion and restraint and to demonstrate they are avoidable practices.
- Tom was let down – by the service which allowed seclusion and restraint and also by the service staff who ignored his request and basic human rights.

Scenario 2 - Fatima's experience

Fatima is a first-year undergraduate student at university who is sharing a house with other students. She is sleep-deprived because she has been studying long hours to pass her exams. She is increasingly anxious that she might fail.

She goes to the doctor in the local primary health care centre to discuss her sleep problems. She also explains that she is experiencing stomach pain and panic attacks and that she is finding it more and more difficult to get out of bed in the morning.

The doctor refers her to a psychologist but, because her situation is not seen as a priority compared to other people, she has to wait three weeks for an appointment.

By this time she has become very unwell and is increasingly anxious and distressed. She misses her appointment with the psychologist, but nobody follows up with her.

One day her concerned housemates call the police because she is not letting them come into the house and she is not answering their phone calls. They fear that Fatima may be having thoughts of suicide and may hurt herself if nobody enters the house.

The police arrive and break down the door. A scuffle between Fatima and the police officers ensues, and Fatima is then put in restraints and involuntarily admitted to an inpatient mental health service.

After reading this scenario, ask participants the following questions:

1. **What do you think of this scenario?**
2. **How common do you think this scenario is?**
3. **Was the use of restraints inevitable in Fatima's situation?**
4. **What could have been done to prevent it?**

Once participants have had the opportunity to share their thoughts, explain to participants the following:

Reflections on Fatima's experience:

- The lack of human resources meant that Fatima was not provided with care and support when she requested it and before her situation deteriorated.
- There were opportunities throughout Fatima's experience in which she could have been provided with support.
- Because the police were called, the situation became coercive for Fatima. The police let Fatima down by restraining her. Their use of coercion increased her distress and agitation.
- The police, in their intervention, should have shown genuine concern towards Fatima and used noncoercive techniques to help her (e.g. talking to her calmly through the door, explaining that they were there to make sure she was OK, asking her if there was anything they could do for her, asking if she would allow them to come in, etc.).
- The restraints are likely to result in adverse effects for Fatima.
- Finally, the mental health service further let her down by involuntarily admitting her.

Presentation: Spectrum of lost opportunities (10 min.)

- Resorting to seclusion and restraint is a human rights violation.
- Everyone has a role to play to change the course of events. It is important to recognize the lost opportunities along the way that could have avoided the use of these practices.
- Staff in services should act in ways that respect the human rights and dignity of the people to whom they provide services, at all times.
- Conflictual or tense situations can often be avoided by being responsive to people's needs.
- Mental health and other practitioners within services need to examine whether their practices contribute to coercion and escalating violence. They need to recognize their personal responsibility in being responsive, compassionate and in providing support when people need it based on the person's free and informed consent.
- Each failure should be considered an opportunity to understand what went wrong and what can be done better next time.

Topic 5: Identifying tense situations and elements of a successful response

Time for this topic
Approximately 1 hour and 35 minutes.

Reflection from the previous topics: (15 min.)

Invite participants to share their thoughts and reflections from the previous topics.

Ask the group:

Has your opinion about seclusion and restraint changed? If yes, how?
How can we stop people resorting to seclusion and restraint?

After the discussion, play the following video which shows one perspective and experience of seclusion and restraint. It is a powerful summary of the use of seclusion and restraints and their impact on individuals and families.

Chained and locked up in Somaliland
https://youtu.be/mbjxRgRFb88 (3:05) (Accessed 9 April 2019)

At the end of the video, ask participants to share their thoughts. This is an opportunity to revisit some of the issues discussed previously and to set the scene for strategies to end seclusion and restraint.

Presentation: Identifying tense situations, and elements of a successful response (10 min.)

Introducing strategies to prevent and avoid seclusion and restraints

There are some key strategies to effectively respond to tense or conflictual situations and end the use of seclusion and restraint. They include:

- individualized plans to explore sensitivities and signs of distress;
- de-escalation;
- creating a "saying yes" and "can-do" culture;
- comfort rooms;
- response teams.

Each of these strategies will be discussed in more detail later in this training.

Before exploring these, it is important to look at how we can recognize sensitivities and signs of distress in order to be able to adopt an appropriate response and avoid escalating a situation.

Recognizing and responding to sensitivities and signs of distress

- Service staff often use seclusion and restraint in response to tense and conflictual situations.
- Tense and conflictual situations result from many causes, including miscommunications, misunderstandings or people "playing their roles" (e.g. the staff role of keeping control and maintaining order in the service). These situations often arise when someone feels they are not being listened to or that their wishes are not being respected.
- Identifying and responding to people's needs and distress early, in a noncoercive way, avoids escalating the situation.

- **Sensitivities:** We all have sensitivities, which are situations or stimuli that can lead to a range of emotions – including distress, frustration or anger – depending on the person. We may notice patterns in ourselves, in others, or in certain relationships, which cause reactions and counter-reactions.
- Everyone's sensitivities are different; something that can provoke strong emotions in one person may not have the same impact on someone else.
- Sensitivities and patterns of reactions can begin with a person's internal thoughts and feelings. They can also be prompted by external events and the behaviour of others.
- It is difficult for anyone to anticipate when someone else might experience a reaction to their own internal thoughts and feelings.
- Multiple sensitivities being activated within a short space of time can cause a person to experience great distress. Furthermore, multiple people's sensitivities being activated with high levels of distress can quite quickly lead to a tense and conflictual situation.

Examples of factors that can activate people's sensitivities include:

- hearing shouts or yells, or being shouted/yelled at
- not being listened to
- people getting too close
- people talking disrespectfully to you
- feeling pressured to do something you don't want to do
- people interfering with your personal belongings
- noise
- agitation around you
- people speaking too quickly
- not understanding what is happening around you or to you
- being isolated
- feeling lonely
- feeling disconnected from family and friends
- recalling bad memories
- lack of privacy
- darkness
- not having choice, control or input
- arguments
- being stared at.

Many of these factors can, in fact, be found in the mental health and social services environment.

How to recognize distress

Physical signs of distress require a thoughtful and supportive response, with the aim of identifying and removing the cause of the distress, providing comfort or otherwise assisting the person. Some common examples of signs of distress include *(46):*

- restlessness
- agitation
- pacing
- shortness of breath or rapid breathing
- sweating
- clenched teeth
- crying
- wringing hands
- rocking
- withdrawal
- prolonged eye contact
- increased volume of speech
- aggression,
- threatening harm.

Exercise 5.1: Discussion: understanding sensitivities and patterns of reactions (30 min.)

This exercise will help participants to realize that many people have similar sensitivities regardless of their mental health, and that it is important to respond to each other's sensitivities with patience and empathy.

Begin by inviting participants to think about what makes *them* feel scared, upset, angry, anxious or stressed.

Ask the group the following question and make a list of ideas on the flipchart.

What makes you feel scared, upset, angry, anxious or distressed, which could cause you to act in a way that might be upsetting to others (e.g. losing your temper, crying, becoming confrontational, etc.)?

After 1 or 2 minutes of individual reflection, invite participants to share their ideas. Make a list of responses on the flipchart.

Participants may give examples which are similar to those of the previous presentation.

Once participants have provided answers, explain that all people have sensitivities. Understanding these sensitivities is key to dealing with or avoiding the development of tense or conflictual situations, particularly since people have sought out services in order to work on their recovery or in order to have respite from already difficult situations in their lives.

Exercise 5.2: Calming actions (15 min.)

Begin this exercise by inviting participants to think on their own about how they deal with their sensitivities or distress and whether there are specific actions that help them. Ask the participants the following question:

What do you do when you are frustrated or upset? Are there any actions that you like to take, or that you like others to take, to help you in these moments?

After 1 or 2 minutes of individual reflection, invite participants to share their ideas. Make a list of responses on the flipchart. Some ideas may include (but are not limited to) the following:

- going for a walk
- listening to music
- talking to someone who will listen.

Once participants have had the opportunity to provide answers, emphasize that taking the time to understand what helps us or others is a key way to respond appropriately when sensitivities are activated.

Exercise 5.3: Responding to sensitivities and distress (20 min.)

This exercise gives participants a chance to apply the concepts covered in the previous presentation.

Scenario - Susan

1.   Read through the following scenario

Susan is a young woman with a diagnosis of bipolar disorder who has a history of being abused. She was brought by an ambulance to an inpatient service where you work as a mental health practitioner because she has not been sleeping for several days, feeling excessively energetic, restless and irritated by everyone around her. During the admission process she agreed to stay for a few days. She tells you that when she feels like this she becomes frightened of enclosed spaces. From previous times when Susan has used the service, it is clear that she often becomes distressed before going to bed. She covers her ears with her hands, stops listening and sometimes talks aggressively to staff and others in the service. The service has a policy that requires people to be in their rooms at 9.00 pm and people using the service do not have access to the common outside spaces (e.g. the television room) after that time.

2.   After reading the scenario discuss the following questions with participants.

Based on this description, what information is helpful to you in thinking about how to plan for Susan's support needs?

Is there anything else that you think might be useful to explore with Susan?

If Susan again expresses distress before going to bed, how might you respond?

Explain to participants that the purpose of this exercise is *not* to find a way to get Susan to go to bed without a fuss or to make sure she does not disturb others. Encourage participants to view the situation from a standpoint of empathy and accept that Susan is using the service for her recovery. If she is interfering with other people's sleep, participants should think about how she could be supported while also ensuring that others are supported.

3.   After the discussion, read the strategies that were identified and used:

After discussion with staff, Susan identified the following strategies for accommodating her personal preferences for a daily routine and responding to her needs:

- She will be offered support regarding the trauma caused by the abuse she suffered and to help her overcome her fear of enclosed spaces.
- She is not required to go to bed; she decides when the right time is for her. This resulted in a complete rethink of the service policy concerning going to bed in order to allow for accommodation of personal preferences.
- She can watch television in the common room until she feels tired, relaxed and ready to go to bed.
- If she wishes, she has the possibility to take a walk outside by herself or with a staff member.

Repeat the exercise with Abdu's story.

Scenario - Abdu

1.   Read through the following scenario:

Abdu is a 68-year-old man who has a diagnosis of dementia. He is unsteady on his feet and is prone to falling down. He enjoys walking around the halls and the grounds of the care home, and does not like to be told it is unsafe for him to wander around freely. When this occurs, he starts yelling and hits the person who stops him from going where he wants. He also yells at staff and walks around in a frustrated manner.

2.   Discuss the following questions with participants:

- What bothers Abdu the most?
- What can the service staff do to accommodate his needs?

3.   After the discussion, read the strategies that were identified and used:

Abdu and staff members at the home were able to identify the following strategies to support and accommodate Abdu and avoid distressing him.

- He is given a walking frame so that he can walk around freely and unassisted within the care home and its grounds.
- The staff also organize for volunteers from a local peer support group to go out with him on walks around town once or twice a week.

Topic 6: Individualized plans to explore and respond to sensitivities and signs of distress

Time for this topic
Approximately 1 hour.

 Presentation: Individualized plans to explore sensitivities and signs of distress (20 min.)

This presentation builds on the previous introductory session which highlighted the need to identify and understand sensitivities and signs of distress.

In the previous topic we examined how to recognize sensitivities and patterns of reactions. One potentially useful strategy which can contribute to ending seclusion and restraint is the development of individualized plans to explore sensitivities and signs of distress.

What is an individualized plan?

- It is a plan outlining actions that can help a person to calm down and relax in times of escalating anxiety, distress, frustration or anger depending on the person's sensitivities and common patterns of reaction.
- The plan is unique to each person.
- The plan focuses on the needs of the individual above the needs of the service.
- These plans include strategies to identify signs of distress and to respond to sensitivities before the situation escalates.
- Developing a plan with a person is an opportunity for others to understand what the emotions and feelings of the person are in certain situations and to discuss effective ways to meet the person's needs when this situation occurs and in the longer term.

Who are individualized plans for?

- It may not be relevant to develop individualized plans for all people. Not all people will want or need them. However, for some persons, developing individualized plans may be useful for understanding what makes the person feel distressed, anxious or angry, and how others can respond in these situations in a way that is respectful of the person and of their wishes and preferences. It is up to the individuals to decide whether such a plan is useful to them or not.
- Individualized plans are not only for people with psychosocial, intellectual or cognitive disabilities. The use of individualized plans applies equally to staff members, families and care partners. Everyone has sensitivities than can affect their behaviour in certain situations. Everyone should try to learn about and understand their own sensitivities and calming strategies.

How should an individualized plan be developed and used?

- The plan should be developed by the person concerned and, if they wish, with the support of other people they want to involve. These may include family members, mental health and related practitioners, peers, etc.
- The person for whom the plan is developed decides what goes into the plan – not other people.

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- The plan should be developed when the person is in a calm or relaxed frame of mind.
- Where useful, the plan can be integrated into a person's overall recovery plan (see module on *Recovery practices for mental health and well-being*).
- If the person wishes, plans should be made easily accessible to health staff, response teams, and other relevant people (e.g. kept in the medical records of the service or included in an online registry).
- Individualized plans should be updated and reviewed on a regular basis, as persons learn more about their sensitivities and causes of distress.

Making an individualized plan:

The person identifies and makes a list of what makes them feel frustrated, angry or distressed. The person can be assisted by others if he or she wishes. Persons also list how they express their distress (or how their distress manifests itself in them) and what they want others to pay attention to – i.e. as a signal for others to respond supportively.

The person then identifies potential strategies to address the underlying cause(s) of distress in order to remove it or else acknowledge it and seek comfort and support. These strategies will be different for everyone, but some examples include:

- going for a walk
- having someone acknowledge your feelings
- taking slow, deep breaths
- squeezing a ball or blanket
- being able to yell or cry
- spending time in a comfort room
- calling a friend or family member
- doing exercise
- taking a shower.

The steps taken to help people to remove the cause of distress, anger, frustration or anxiety or to overcome it must always be taken on a voluntary basis and should never be forced on anyone.

Calming actions and other ways to address distress should be tailored to each individual and each situation: something that works for one person at one time might not work for another person or for the same person at a different time. Creativity is important in finding solutions that are tailored to individual needs.

The use of individualized plans to deal with problems that arise from conflictual or tense situations can also be a good opportunity for service staff and people using the service to build trust and mutual respect for one another.

Exercise 6.1: Make an individualized plan (40 min.)

Everyone – including mental health and other practitioners, families and care partners – may benefit from identifying their own sensitivities. Remind participants that they don't have to disclose anything they don't want to.

Have the participants divide into pairs. Then distribute to participants copies of Annex 3 (Making an individualized plan). Participants can do this exercise by themselves if they prefer.

Invite each pair of participants to complete the table represented below for each person.

1. Begin the exercise with one person in each pair interviewing the other **about what makes them feel frustrated, anxious, angry or distressed.**
2. Then both partners should discuss **what helps the person calm down** during tense, stressful or conflictual situations.
3. Finally, the pair should identify **concrete steps to help the person who has shared their sensitivities to calm down or address the situation**.

After this first round, have the partners switch roles and repeat the exercise.

My plan to manage my sensitivities		
What are my sensitivities?	**What helps me to calm down?**	**What concrete steps can be taken?**
e.g. Feeling overwhelmed by noise and people around me	*e.g. Slowing down my breathing and taking some time to be by myself*	*e.g. Practice slow breathing: find a quiet place where I can be by myself until I feel calmer*

Topic 7: Creating a "saying yes" and "can do" culture

Time for this topic
Approximately 40 minutes.

Presentation: Creating a "saying yes" and "can do" culture (15 min.)

On admission to a service, people using the service (particularly those characterized by an institutional culture) and those brought into the service against their will are required to surrender considerable control to the service and staff.

They are away from their day-to-day life, their home, their familiar things and comforts, their food, their usual surroundings, their books and computers, television programmes, their family, friends, social networks, belongings, etc. They may be prevented from going outside, taking walks, keeping up their usual routines and habits, bringing and working on their art or writing or reading material. Being placed in a situation of loss of control and dependency on staff for their comfort, security, safety and well-being can cause distress, fear, anxiety and frustration.

Health-care staff often say "no" to people's requests or delay meeting these requests. This may be due to heavy workloads, staff shortages, poor training, service regulations or a culture of unresponsiveness in the service more generally.

The frustration, distress and dependency felt by the person concerned can be misperceived by staff as challenging behaviour and may ultimately lead to a conflictual situation in which staff resort to coercive measures such as seclusion and restraint.

It is necessary to understand that people are coming to the service because they have needs, whether for respite from difficulties they are experiencing in their life, for human connection and comfort in difficult times, or in order to work on their recovery outside of their usual life and routine.

In order to be truly effective, it is necessary for the service to shift from a culture of "managing" and "controlling" people to one which is recovery-oriented and supportive of people using services. This necessarily requires staff to acknowledge and be responsive to people's needs and requirements rather than denying and refusing them.

A useful strategy is to create a **"saying yes"** and "can do" culture within a service. This involves creating a nonjudgemental space to think through the way decisions are reached and whether it is possible to say "yes" rather than "no" in response to a request from people using the service. This will help service staff put people first, along with their needs and requirements.

Before saying "no" to requests from a person using the service, staff practitioners should first R.E.F.L.E.C.T on the request. Think about (47):

> **R** – Reframe: What would it take to say "yes"?
> **E** – Easy: Is "no" the easy option?
> **F** – Feeling: What would it feel like for the person if I say "no"?
> **L** – Listen: Have I really listened to the person concerned and what they are asking?
> **E** – Explain: Can I explain to the person concerned why I am unable to meet their request?
> **C** – Creative: Are there creative ways I could meet the request of the person?
> **T** – Time: Am I giving enough time to consider the request?

Even in situations where practitioners have already said "no" to a request, it is useful to R.E.F.L.E.C.T on the motivations for having said "no":

> **R** – Reframe: What would it have taken to say "yes"?
> **E** – Easy: Was "no" the easy option?
> **F** – Feeling: What would it have felt like?
> **L** – Listen: Did staff listen to the person concerned?
> **E** – Explain: Was an explanation given to the person concerned?
> **C** – Creative: Was creativity used to try and find a way to meet the person's request?
> **T** – Time: Was enough time taken to consider the request?

Reflecting on these questions encourages participants who are practitioners and care partners to think in more depth about their practices and how they can reverse the situation to develop a culture of "First say yes".

Another important question to be considered by staff is:

Can I give resources to people using the service so that they do not need to make this request and can become more autonomous?

For this last question, it is important to note that:

The purpose is not to provide the person with the information or resources they ask for in order to "get rid of the person". Staff should listen to the person and try to really understand what they need. They should be honest about the resources and information they can provide and be careful not to overwhelm the person with too many or irrelevant resources. This may sometimes involve directly linking the person with someone who is able to fulfil their request.

At the same time, it is important to acknowledge that not all needs can always be met; sometimes the service cannot meet those needs, or meeting them may take time. However, in situations where a person's request or need cannot be met, this should be discussed with the person. In addition, the service management should make sure that service staff are able to care for their own needs in the process, so they can be fully attentive and willing to be engaged.

Exercise 7.1: Creating a "saying yes" and "can do" culture in our mental health and social service (25 min.)

This exercise is designed to help the participants to come up with a list of steps that can be taken to create a "saying yes" and "can do" culture in a mental health or social service.

Ask mental health and social care practitioners, people using services, and care partners/families each the following questions.

- **Question for mental health and related practitioners:** Think about the last time you said "no" to the request of a person using the service? What could you have done differently?

- **Question for care partners/families:** Think about the last time you said "no" to the request of your relative with a psychosocial, intellectual or cognitive disability. What could you have done differently?

- **Question for people using services:** Think about the last time a staff member or care partner/relative said "no" to your request. What could been have done differently?

After writing on the flipchart the various responses from participants, ask them the following question, and then record their ideas on the flipchart.

- What is needed to create a culture of "saying yes" in a mental health or social service?
- How could practitioners, people using the service, families and care partners or others be involved in this process?
- Which skills would be needed to create or improve a "saying yes" culture?

Topic 8: Supportive environments and the use of comfort rooms

Time for this topic
Approximately 55 minutes.

Presentation: Supportive environments and comfort rooms (15 min.)

The environment of a service may play a role in increasing or reducing tensions. A coercive or oppressive environment may increase conflicts and escalation while a comfortable and supportive environment may foster and support recovery, wellness, inclusion, hope, resilience, social interaction and so on.

While the overall environment should be supportive, a practical illustration may be to create a comfort room in the service. A comfort room provides a sanctuary from stress and allows people to experience their feelings and relieve discomforts in privacy. It can be offered at any time, and can help to prevent escalation.

Comfort rooms *(48-50)*

A comfort room provides a sanctuary from stress and allows people to experience their feelings and relieve discomforts in privacy.

- A comfort room is not a seclusion room. It is a preventive tool that can help someone in distress to calm down and relax.
- These rooms should always be used on a voluntary basis and with the informed consent of the person concerned.
- It is useful to respect the use of comfort rooms as a place of sanctuary and healing so that they are not perceived as being only for people using the service or used as seclusion rooms. One way to do this is to make them available to people using the service as well as to staff for the purpose of any activities involving relaxation and rest.
- Before suggesting that another person use the comfort room, it is important to check one's own emotions and reactions and make sure that the suggestion to use the room is not being made in order to relieve one's own discomfort in a situation. It is also important to recognize that this suggestion may be unwelcome.

Setting up a comfort room

- Staff and people using the service should work together to develop a plan for the creation of a comfort room. It is essential that people using the service are welcome to participate actively in the planning, creation and design of the comfort room.
- Discuss and decide:
  - ➢ what the comfort room is for, how it is envisioned to be used, what kind of environment should be created;
  - ➢ which room (or rooms) will be used;
  - ➢ how it will be furnished and decorated;
  - ➢ how it will be paid for;
  - ➢ who will be in charge of maintaining the room.

When designing the room, the safety of people using the room should be an important consideration. It may be useful to think about the room in term of universal design to make it safe and accessible to everybody. It may also be necessary to remove glass items, flammable objects, lightweight objects that can easily be thrown around or fixtures that could be used to harm oneself or others (e.g. doorknobs).

For some people it can be useful to include calming and soothing sensory stimulation in comfort rooms in order to move the focus of attention away from distress and onto something else. Sensory approaches must always be voluntary.

Examples of sensory approaches that can be integrated into a comfort room may include warm water, soft blankets, carpets or pillows, calming colours, low lighting, rocking chairs, quiet, calming music or sounds, aromatherapy, etc.

Sensory approaches should be individualized. Service staff should work with the person if the person wishes to try different sensory approaches to see what works for them. Persons can also explore available sensory approaches for themselves.

It is important to keep in mind that what is calming for one person might be stressful for another. For instance, some people might prefer to sit quietly with little or no sensory stimulation. Others might need to wail, scream, drum, dance, pray or use other strategies as a means of calming down.

Exercise 8.1: Sensory approaches (15 min.)

Begin this exercise by inviting participants to think individually about some sensory approaches that could be used in a comfort room within their service. Ask participants the following:

Try to think of some specific sensory approaches that can be used in a mental health or social service setting.

After 5-10 minutes of individual thinking time, invite participants to share their ideas with the group. Make a list of ideas on the flipchart.

Presentation: Comfort rooms in emergency departments in general hospitals or in other places of acute care (10 min.)

- Emergency departments in general hospitals or in other places of acute care are often the first places that people go to when experiencing very serious distress.
- In such places, the conditions can be busy and chaotic, with abundant factors and stimuli such as noisiness, overcrowding and long waiting times that can exacerbate people's distress and anxiety *(51)*.
- Also, emergency department staff are rarely trained in noncoercive strategies to support people experiencing distress. As a result, in many cases staff resort to the use of seclusion and restraint.
- Surveys have shown that the use of seclusion and restraint in emergency departments is very common *(52, 53)*.

- Creating a comfort room within an emergency department is a useful means of ensuring that people do not have to wait in noisy, overcrowded and sometimes chaotic waiting rooms; instead, they can wait in a calming environment away from negative stimuli.

Exercise 8.2: Comfort rooms in your service (15 min.)

This exercise is meant to help participants come up with a list of steps that could be taken to create a comfort room in their service.

Ask the following questions and record ideas on the flipchart:

What must be done to create a comfort room in a mental health or social service?

- Which room will be used?
- What kind of space do people want to create?
- Who will be responsible for creating it?
- What can be included in the room?
- How can one gather and incorporate suggestions from people using the service and staff when creating the room?
- How will it be funded?

Topic 9: De-escalation of tense and conflictual situations

Time for this topic
Approximately 15 minutes.

Presentation: Introduction to de-escalation (15 min.)

De-escalation is a technique for managing situations in which people are feeling extremely distressed or upset, leading them to act in ways that may negatively affect them and others either emotionally or physically. This can lead to very challenging situations that may sometimes even threaten the safety of the persons involved.

De-escalation is an approach which engages and establishes a collaborative relationship with the key people involved in a conflict in order to resolve or diffuse the situation. De-escalation applies effective communication techniques to these situations (for more information on communication techniques see the module on *Freedom from coercion, violence and abuse*).
For example, de-escalation involves practising active listening. Active listening is a structured form of listening and responding that focuses the attention on the person.

Active listening is about being attentive to what someone else is saying in order to be able to understand their views and feelings.

Active listening requires full attention to be paid to the person and checking to make sure that one has understood the true meaning of what is being said.

Active listening also requires being mindful not to place one's own meaning on what the person is saying. It is about having a dialogue (rather than a monologue) with the person concerned and valuing their feelings, thoughts and ideas. (For more information on active listening, refer to the module on *Recovery practices for mental health and well-being*).

When interacting with a person who is expressing distress in ways that others find to be disturbing or threatening, everyone concerned needs to make the effort to remain engaged and to acknowledge their emotional reactions.

Some people naturally possess the skills to de-escalate conflictual or tense situations using these techniques. However, de-escalation is something that <u>everyone</u> can learn and practice. It requires training to be performed effectively in order to produce safe and satisfying outcomes. Service staff may therefore benefit from further training on this topic.

Tips to avoid escalating a situation *(54)*

- Respect the person's personal space.
- Avoid enclosed spaces (e.g. small rooms) to make sure that the person does not feel trapped, cornered or confined.
- Try to engage with the person. Inform the person that you wish to support them and will not do anything against their will or anything to harm them.
- Do not use language that can be perceived as provocative, humiliating and condescending. Be polite and respectful at all times.
- Talk to the person with the appropriate degree of formality, depending on your knowledge of the person.
- Do not rush the person. Give them time and space to process what is being said and to respond.
- Try to understand the reason behind the person's distress and try to understand what the person needs and wants. Ask the person directly what they expect and what you can do.
- Ask the person what they would find helpful and try to offer some options and choices.
- Do not dismiss what the person is saying just because you disagree. Even of you do not agree, try to find areas on which you can agree. If you are unable to agree on anything, then agree to disagree.
- Facilitate access to people that the person knows and trusts.
- Once the difficult moment has passed, try to explore with the person what has happened.

De-escalation techniques may differ across contexts and cultures and need to be adapted accordingly.

Time for this topic
Approximately 1 hour.

 *Presentation: The creation of a response team (36, 37, 55-57) **(30 min.)***

This presentation provides an overview of how response teams can be used to intervene during tense or conflictual situations without using coercive measures.

What is a response team?

- A response team is a core group of experienced and committed people who embrace a noncoercive approach and who are responsible for intervening/responding when there is likely to be an emergency situation that is considered to be difficult or "unmanageable" by those present.
- A response team may have different names in different countries and services – e.g. Crisis Response Team or Psychiatric Emergency Response Team.
- Response teams can be effective managing a crisis by using good communication, de-escalation and violence-prevention skills to defuse and safely resolve a tense or conflictual situation *(58)*.
- Team members help and assist during a conflictual situation but can also perform proactive prevention in services.
- It is important to note, however, that the intervention of a response team is not necessary or appropriate when people are simply expressing distress. The response team is appropriate only when one person's or several people's distress has a cumulative impact on each other and becomes a tense and conflictual situation that the they are not able to resolve by themselves.
- The team should be available at all times, especially when the risk of an incident may be higher (e.g. at night).

The purpose of the response team is <u>always</u> to respond to tense and conflictual situations in a nonviolent and noncoercive way. It is important to ensure that the response team does not evolve over time into a team that itself uses coercive and violent measures to manage tense and conflictual situations.

Objectives:

- To provide a safe resolution to conflictual or tense situations that have safety implications or which have the potential to harm people.
- To develop and implement noncoercive and nonconfrontational approaches that are designed to help and support the persons involved rather than to control them.
- To reduce the potential for injury or harm during such situations.
- To provide an organized team approach and leadership to the most difficult conflictual situations.
- To train and share experiences and knowledge with others on noncoercive skills and strategies.

- To contribute to discussion and review of the situation once it has been resolved with a view to continually improving the way in which such situations are responded to.

Composition and role

The response team should include:
- Mental health and social care practitioners (aides, nurses, doctors and others) who are committed to noncoercive approaches in services and care. There is a risk of escalation if the persons involved in the conflictual situation are unfamiliar with the team members.
- Teams should also include other members (e.g. peer supporters, community advocates, family members).
- The composition of the response team is tailored to the needs of the person(s) (e.g. sensitive to age, gender, culture, particular needs). Therefore, it is important to make sure that the composition of the team respects gender, ethnic and age balance as far as possible.

Role of various members:
- Team members should have clear and specific roles to avoid confusion and duplication under stress.
- At least one core group should be assigned to the mental health or social service on a day-to-day basis.
- There can also be team members outside the service who are "on call" when needed:
  - These members do not stay permanently at the mental health or social service.
  - They are called to assist on the basis of need.
  - They can be called on at short notice and report to the location in a short period of time.
  - Team members should receive remuneration for the time when they are "on-call".

Team leaders

- Response Teams should have a team leader. This should be an individual with effective leadership and de-escalation skills and experience in supporting people in distress. Team leaders should be screened by the management of the service prior to their engagement on the team.
- An effective team leader:
  - promotes a nonviolent approach to the resolution of a situation;
  - promotes the safety of all the persons involved in the conflictual or tense situation;
  - takes a leadership role in the situation and delegates roles and responsibilities to other team members (e.g. clearing the area, ensuring there are no potential harmful or dangerous objects, etc.);
  - keeps up to date with, and shares new research on, noncoercive approaches;
  - is competent with verbal and nonverbal communication skills;
  - listens to advice and coaches others on safety issues and noncoercive practices;
  - questions unsafe decisions and practices;
  - is responsible for the response and all post-event debriefing.

Training on noncoercive responses

- Team members (both professional and non-professional) should be trained on how to avoid and manage crises.
- Mental health and social services should upgrade the quality and quantity of their training, making it an annual requirement for all team members.

- The members should be trained together and have working relationships so that they can respond together as a team and prevent any miscommunication or lack of coordination in the situations in which they intervene.
- Training should include how to support people with special needs and requirements (e.g. pregnant women, people with physical impairments, etc.).
- Training should simulate the stress of real-life situations that have in the past resulted in the use of seclusion and restraint, thus enabling members to practise keeping calm under stress.
- As response teams gain more practical experience, their effectiveness in diffusing conflictual situations increases over time.
- All staff at the service (not just members of the response team) should also receive training in noncoercive responses to conflictual situations.

The response team in action:

1. Prior to a potential conflictual situation

- When a conflictual situation occurs, the staff member at the scene alerts the response team by calling its members to the location of the situation by radio, pagers or other methods.
- When members are alerted, they stop what they are doing and report to the area.
- The response team needs to come to the area in a short period of time (less than 5 min.).

2. Responding to a crisis or an emergency

- As team members arrive they are met by the team leader who identifies which measures to take in the particular situation, based on dialogue with the persons involved, past experience of effective measures, personal observation, advance plans or individualized plans (where these are available), etc.

- Health staff on the response team should determine whether there are underlying medical reasons making a person behave or react in a certain way and whether that person has any pre-existing conditions (e.g. cardiac problems, history of trauma, drug use, etc.) of which the team should be aware.

- The team leader designates one person to take charge of the response. This should be a team member who knows, and has the best relationship with, the person concerned.

- Team members work with all the persons concerned to understand the immediate circumstances and relevant background that precipitated the situation and to identify means of overcoming it. This will lead to a relationship based on shared knowledge that will, in turn, enable members to understand people's positions.

- When necessary, one or more members should lead people not involved in the situation (e.g. non-essential staff or people using the service) away from the area.

  Members of the response team should ensure that other staff members are providing the necessary support to other people using the service.
- Response teams should take action to calm the environment (e.g. reduce harsh lighting, reduce any noise pollution/loud noises, etc.) and remove any potentially harmful objects (e.g. furniture, medical equipment).

- Response teams should not overwhelm the persons involved and contribute to chaos by, for instance, all talking at the same time or rushing to act at the same time. Doing so may increase the potential for injury and trauma.

- Even during a conflictual situation it is important to be mindful of ways in which the relationship of the persons present can be enhanced and to avoid saying or doing things that hinder these relationships.

3.   Once the situation has been resolved

- A post-incident review should be conducted as soon as possible, and no later than 72 hours after the incident.

- A debriefing session should be held between members of the response team to discuss the response, review the outcome and determine what worked, what did not work and how things can be managed better in future if a similar situation emerges.

- The response team should discuss with all persons involved what they think led up to the situation, how it was handled, and what could be done to prevent a similar situation from occurring in the future.
  - ➢ The purpose of a review is to learn lessons, to support staff and people using the service, and to encourage positive relationships between people.

- For the person using the service who was involved in the situation, a separate debriefing session should be conducted when the person feels ready, in order to better understand what led up to the situation, what they went through, what provoked their distress, what happened that they were reacting to, and how appropriately they think the response team dealt with the situation.
  - ➢ This is also an opportunity to develop or review individualized plans.
  - ➢ The persons concerned should have the opportunity to write their own personal perspective of the incident and of what should happen in similar situations in the future.

- In addition, a post-incident review should be undertaken soon after the crisis (e.g. within 3 days). Recommendations should be made as part of the review, highlighting actions that could be taken in the future to improve the ability of the service to avoid and respond to conflictual situations. Results of this review should be shared with the service staff and service management as needed.

Exercise 10.1: Creating a response team (20 mins)

This exercise is meant to help participants to come up with a list of steps that can be taken to create a response team in their service.

Ask the following questions and record ideas on the flipchart.

What can be done to create a response team in your service?

- Who could you involve?
- How could people who are not staff members be included as part of the response team (e.g. can they be available at the service on a day-to-day basis or could they be "on call" to come quickly to the service)?
- How could you organize the training for this team?
- If funding is needed, how could it be funded?

Reflective exercise (10 min.)

The reflective exercise gives the participants an opportunity to further think about what has been learned in the training.

Below is a question to reflect on after the session. You can either write down your answer to discuss at the next topic or simply think about your answers.

What can you do as an individual to help eliminate the use of seclusion and restraint in your service?

Topic 11: Action to take to eliminate seclusion and restraint

Time for this topic
Approximately 2 hours and 12 minutes.

The purpose of this topic is to encourage participants to reflect on the strategies described in the previous topics and think about what concrete action they could implement in their own context.

Exercise 11.1: Current practices for responding to tense and conflictual situations in the service (15 min., slides)

This is a brief discussion exercise designed to encourage participants to talk about what currently happens in conflictual situations within their service (it may also be a service that they are familiar with).

Ask participants the following question:

- How does your service currently manage crisis situations?

Allow 15 minutes for participants to share their thoughts on this.

Exercise 11.2: Personal action to eliminate seclusion and restraint (20 min.)

This exercise is intended to encourage participants to discuss the implementation of alternative strategies outlined in the training. This is meant to encourage the group to commit to eliminating seclusion and restraint through personal action.

Begin by inviting participants to think on their own about some specific individual actions they can take to eliminate seclusion and restraint.

Ask the group:

What are some personal actions that can be taken to eliminate the use of seclusion and restraint in a mental health or social service?

After 5-10 minutes of individual reflection, invite participants to share their ideas with the group. Make a list of responses on the flipchart. Some examples may include (but are not limited to):

- Take a breath before approaching a tense situation in order to allow myself time to think before rushing to address it.
- If I see someone demonstrating a behaviour that upsets me, try to lower my voice and project calm, kindness and understanding.

- When approaching a tense situation, think about how the other person might be feeling and how I can respond to the situation, keeping in mind that person's sensitivities.
- When I see a staff member struggling with a tense situation, respectfully offer to help.
- Report the use of seclusion and restraint to supervisors.
- Talk with other staff members about the kinds of strategies that can be used to diffuse tense and conflictual situations peacefully.
- Work with people using the service to understand their needs, sensitivities and preferences in order to accommodate them.
- Work with people using the service as a group to understand how the environment and overall practices of the service setting can be improved in order to better meet everyone's needs.
- Question individual staff and service practices which are coercive and which do not align with the recovery approach in the service.
- After a conflictual situation has been resolved, talk with everyone involved about what was done well, what was not done well and what could be done better in future. I can also reflect on how my assumptions and behaviour influenced the situation and how this could be improved in the future.

After making the list, help the group select three actions from the list to which they can collectively commit (i.e. the whole group selects three or more personal-level actions that every person will commit to). Invite them to write these actions on the table hand-out **(see Annex 4).**

Exercise 11.3: _Service-level action to eliminate seclusion and restraint (1 hour)_

Next, have participants make a list together of four or five changes that need to be carried out at the service level to end the use of seclusion and restraint at their service. The list should include the specific actions that need to be taken in order to implement those changes. You can draw a table on the flipchart (see below) or invite participants to write these changes on the table titled _Service-level changes to eliminate the use of seclusion and restraints_ (Annex 5).

Ask participants the following questions:

What are some changes that can be implemented at the service level to eliminate the use of seclusion and restraint?

(Record these in the "Service-level change" column)

What actions need to be taken in order to implement these changes?

(Record these in the "What needs to be done" column)

Example table to draw on the flipchart:

Service-level change	What needs to be done
E.g. Develop a service policy aimed at eliminating the use of seclusion and restraint	*E.g. Action 1: Convene a meeting of staff and people using the service to start developing the service policy for eliminating seclusion and restraint* *Action 2: etc.*
E.g. Staff should all have skills in how to avoid and manage conflictual situations	*Action 1: Hold training sessions for all staff on strategies to avoid and manage crises* *Action 2: etc.*

Presentation: Service-level actions to eliminate the use of seclusion and restraint (20 min.)

To sum up the discussions of the previous exercise, show participants this short presentation.

As we have seen in the previous exercise, actions to eliminate the use of seclusion and restraint can be taken at the individual level and also at the service level through policy and cultural changes in services.

Examples of actions at the service level include:

- Develop a service policy aimed at eliminating the use of seclusion and restraint.
- Establish a service policy to ensure that staff are not held responsible or liable when accidents or incidents have occurred if they have followed all correct noncoercive strategies, procedures and protocols.
  - ➢ Very often staff resist finding alternatives to seclusion and restraint because they fear they will held accountable for damages or may lose their jobs. Removing this liability is key to eliminating seclusion and restraint.
- Train all staff on trauma-informed approaches and recovery-oriented practices.
- Train all staff on how to avoid and respond to tense and conflictual situations.
- Evaluate and debrief with staff on what is working and what is not working in the management of conflictual situations.
- Establish a comfort room within the service.
- Regularly review and discuss data collected on the use of seclusion and restraint.

The Pennsylvania State Hospital System's
Seclusion and Restraint Reduction Programme (36, 37, 55, 56)

In the 1990s, the Pennsylvania Department of Public Welfare instituted an active programme to reduce, and ultimately eliminate, seclusion and restraint in mental health and forensic hospitals. All the hospitals have been seclusion-free for several years and are approaching zero-use of restraint.

The programme was realized through a combination of training, monitoring, policy revisions, cultural change, data transparency, the use of response teams and by adopting a recovery approach to providing mental health and social services.

Research evaluating the impact of the programme from 2001 to 2010 showed significant reductions in the use of seclusion and restraint over this period across the state. During the span of the study, the use of unscheduled medication as an indicator of the use of chemical restraint also declined. Furthermore, contrary to fears, there was no increase in assaults on staff; in some cases, the number of assaults on staff even decreased.

At the end of the presentation show the following video to participants about "No force first", a restraint reduction programme implemented in the United Kingdom.
No force first, Mersey Care NHS Trust (7:15)
https://youtu.be/sCNdpDK3V3g (accessed 9 April 2019)

 Presentation: Wrapping up (10 min.)

Ask participants:

What are the 3 key points that you have learned from this training?

Follow this question with these key take-home messages.

- Seclusion and restraint are human rights violations and are harmful.
- There are many strategies to prevent or adequately respond to tense and conflictual situations without resorting to seclusion and restraint.
- Everyone has a role to play in ending seclusion and restraint.
- By ending these practices, everyone will benefit.

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Annexes

Annex 1: Scenarios

Topic 4: *Exercise 4.2 - Is it possible to change the course of events leading to the use of seclusion and restraint?*, **Tom**

Tom is staying in a social care home for people with dementia. He wants to make a phone call to his sister and needs to obtain a phone card from the nurse to be able to place his call. The nurse says that she will handle his request in a minute because she is very busy.

Because the nurse is stretched and overloaded with various tasks, Tom has to wait for over an hour. He becomes increasingly agitated and angrily bangs on the door of the nursing office. The nurse asks him to "calm down" which results in a deepening sense of frustration for Tom.

The nurse then responds by saying: "if you are in this frame of mind I will not allow you to make your phone call."

Tom starts pacing up and down in the corridor and becomes more and more agitated, kicking the door and being verbally abusive to staff walking past him.

Tom's agitation results in his being physically and chemically restrained. This was justified by the service staff as necessary for his own and others' safety.

Topic 4: *Exercise 4.2 - is it possible to change the course of events leading to the use of seclusion and restraint?*, **Fatima**

Fatima is a first-year undergraduate student at university who is sharing a house with other students. She is sleep-deprived because she has been studying long hours to pass her exams. She is increasingly anxious that she might fail.

She goes to the doctor in the local primary health care centre to discuss her sleep problems. She also explains that she is experiencing stomach pain and panic attacks and that she is finding it more and more difficult to get out of bed in the morning.

The doctor refers her to a psychologist but, because her situation is not seen as a priority compared to other people, she has to wait three weeks for an appointment.

By this time she has become very unwell and is increasingly anxious and distressed. She misses her appointment with the psychologist, but nobody follows up with her.

One day her concerned housemates call the police because she is not letting them come into the house and she is not answering their phone calls. They fear that Fatima may be having thoughts of suicide and may hurt herself if nobody enters the house.

The police arrive and break down the door. A scuffle between Fatima and the police officers ensues, and Fatima is then put in restraints and involuntarily admitted to an inpatient mental health service.

Topic 5: *Exercise 5.3 - Responding to sensitivities and distress*, **Susan**

Susan is a young woman with a diagnosis of bipolar disorder who has a history of being abused. She was brought by an ambulance to an inpatient service where you work as a mental health practitioner

because she has not been sleeping for several days, feeling excessively energetic, restless and irritated by everyone around her. During the admission process she agreed to stay for a few days. She tells you that when she feels like this she becomes frightened of enclosed spaces. From previous times when Susan has used the service, it is clear that she often becomes distressed before going to bed. She covers her ears with her hands, stops listening and sometimes talks aggressively to staff and others in the service. The service has a policy that requires people to be in their rooms at 9.00 pm and people using the service do not have access to the common outside spaces (e.g. the television room) after that time.

Topic 5: *Exercise 5.3 - Responding to sensitivities and distress*, **Abdu**

Abdu is a 68-year-old man who has a diagnosis of dementia. He is unsteady on his feet and is prone to falling down. He enjoys walking around the halls and the grounds of the care home, and does not like to be told it is unsafe for him to wander around freely. When this occurs, he starts yelling and hits the person who stops him from going where he wants. He also yells at staff and walks around in a frustrated manner.

Annex 2: Quotes from people with lived experience of seclusion and restraint
(1,2,3)

The big problem I have with restraints is that you start feeling vulnerable and you start thinking imaginary things like the people are going to hurt you, especially like the staff. Since they are required by law to always chart you, you are always seeing them staring at you through the window while you are lying there like, you know and it's scary. Very scary.
—*Male*

As an adolescent, age 12, I was put in a psychiatric unit for adolescents. I was there for abuse situations and the duration of my stay I was put into seclusion, which we called the padded room. I was put in there and stripped down to nothing, and I was forced to stay there for 5 hours because I refused to watch a sexual assault video. Instead of letting me stay in my room and talk to my nurse at that time, they said if I don't follow the rules this is where I have to go.
—*Female in seclusion and restraint as an adolescent*

I have been in seclusion about seven times. I've had experiences where I've had 7 or 8 people take me down and I've had experiences where I have had less. It's very degrading because when they put you there even as a girl or woman, all you're left is your underwear and a paper gown and a mattress that has nothing on it.
—*Female*

Fear basically is a big thing. You're vulnerable. The seclusion room is sometimes used as a punishment, not as a therapy. I don't think treating someone like an animal is really a therapy. I think a lot of the staff are scared of the patients. And they react to that fear by controlling the patients and not trying to treat the patients.
—*Male*

Then they have these restraints; they really are kind of sadistic in a way. You are spread-eagled so you really can't move. You can't have any circulation. You can't do anything. And when they do it on your stomach lying down, you really can't even breathe. And the human instinct when you are spread-eagled is to get up, so you are constantly fighting these things.
—*Male*

I've heard about people trying to pull their feet out of restraints and getting hurt. I've never tried that, my feet are too big and I was afraid I might lose them.
—*Male*

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[1] Roadmap to seclusion and restraint free mental health services. Rockville (MD): Substance Abuse and Mental Health Servies Administration (SAMHSA); 2005.
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[3] Living in hell: abuses against people with psychosocial disabilities in Indonesia. New York (NY): Human Rights Watch; 2016. (https://www.hrw.org/report/2016/03/20/living-hell-abuses-against-people-psychosocial-disabilities-indonesia, accessed 4 April 2019).

I usually would end up hurting myself more because of what they had done, instead of less.
—*Female*

They said as soon as I stopped being angry, they would let me out. Meanwhile you are naked on your bed, strapped down with your door open and they wondered why you weren't mellowing out.
—*Female as an adolescent in restraint and seclusion*

Seclusion room, same thing with the people viewing you. They are always looking at you with them beady eyes. It's very frightening; it's very frightening.
—*Male*

After they unlocked the door and they dragged me in there, they said, 'well you can't keep your clothes for danger issues'. And they made strip me down. They kept a video on me the whole time. For a girl who is awkward and is in there for issues of abuse at home, all that did was extend my hate.
—*Female in seclusion and restraint as an adolescent*

I know it deepened my fear. I was in there to get help so I wouldn't injure myself anymore and become a better person. It just made me more angry and didn't help
nothing.
—*Female*

 "I used to be tied up at home with a plastic rope. My heart broke when they chained me…. I was chained when I first came [to Galuh]. I get chained often—at least 10 times since I have come because I fought with the others. It can last for one day to a week. I had to go to the toilet on the spot, in the drain in the room. The staff slaps and hit me often, already three times because I peed and got angry. Tell the government, I want to go home."
—*Male from Indonesia.*

"They call my name, put medicine in my hand and ask me to drink it…. They don't allow me to refuse,"
—*Wuri, a woman with a psychosocial disability living in a rehabilitation centre, said. "They make me swallow the medicine and if I don't drink it, they put me in the isolation room."*
—*Female from Indonesia*

Annex 3: Make an individualized plan

My plan to manage my sensitivities		
What are my sensitivities?	**What helps me to calm down?**	**What concrete steps can be taken?**

Annex 4: Personal actions to eliminate seclusion and restraint

(More rows may be added to this table as necessary)

Personal actions to eliminate seclusion and restraint in my service
E.g. Work with service users to make individualized plans with them
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Annex 5: Service-level changes to eliminate seclusion and restraint

Service Level Change	Actions to be taken
E.g. Develop a service policy aimed at eliminating the use of seclusion and restraint.	*E.g. Action 1: Convene a meeting of staff and people using the service to start developing the service policy for eliminating seclusion and restraints* *Action 2: etc.*
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

The World Health Organization's QualityRights training and guidance modules focus on the knowledge and skills required to provide good quality mental health and social services and supports and to promote the rights of people with psychosocial, intellectual or cognitive disabilities.

Through exercises, presentations, case scenarios, extensive discussions and debates, the **QualityRights training modules** unpack some critical challenges that stakeholders are facing in countries everywhere. For instance:

- How do we respect people's will and preference, even in challenging situations?

- How do we ensure people's safety and at the same time respect each person's right to decide about their treatment, their life and their destiny?

- How do we end seclusion and restraint?

- How does a supported decision-making approach work if someone is unable to communicate their wishes?

The **QualityRights guidance modules** complement the training materials. The guidance modules on *Civil Society Organizations* and on *Advocacy* provide step-by-step guidance on how civil society movements in countries can take action to advocate for human rights-based approaches in the mental health and social sectors in order to achieve impactful and durable change. The guidance modules on *One-to-one peer support* and on *Peer support groups* provide concrete guidance on how to effectively set up and run these critical but often overlooked services.

World Health Organization