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850 DAYS NO SECLUSION

An exploration of the contributory factors to the successful reduction in use of seclusion within one regional Mental Health Service in the Netherlands

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WHAT

A qualitative inquiry into daily practice by interviewing all actors within the ward. We had a commission of the director to provide a report on stakeholder's opinions of the team approach .

WHY

To learn from what was achieved and translate these lessons into practical guidelines for further development of a methodic approach in the care at acute wards within our own and other acute wards.

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MEET OUR WARD, OUR TEAM AND OUR APPROACH.

- Who we are we
- Our team constitutes, nurses, social workers, doctors, psychiatrist, NP,
- Our ward has 20 beds (divided in IC and HC), one ICU, 3 seclusionrooms

- We apply the HIC guideline (Melle at al. 2019)
- The HIC scale (67 items) encompasses 11 domains including for example team structure, team processes, diagnostics and treatment, and building environment.
- The HIC model fidelity scores explained 27% of the variance in seclusion rates ($p < 0.001$). Adding patient characteristics to in the regression model showed an explained variance of 40%.

- van Melle AL, Voskes Y, de Vet HCW, van der Meijs J, Mulder CL, Widdershoven GAM. High and Intensive Care in Psychiatry: Validating the HIC Monitor as a Tool for Assessing the Quality of Psychiatric Intensive Care Units. Adm Policy Ment Health. 2019 Jan;46(1):34-43.
- Van Melle AL, Noorthoorn EO, Widdershoven GAM, Mulder CL, Voskes Y. Does high and intensive care reduce coercion? Association of HIC model fidelity to seclusion use in the Netherlands. BMC Psychiatry. 2020 Sep 29;20(1):469.

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BACKGROUND

- 2008
- Dolhuismanifest 2016
- The national objective was to stop seclusion use by January 1, 2020.

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CHIEZE ET AL.

Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review

Marie Chieze[1], Samia Hurst[2], Stefan Kaiser[1] and Othman Sentissi[1]*

[1] Adult Psychiatry Division, Department of Psychiatry, University Hospital of Geneva, Geneva, Switzerland, [2] Institute for Ethics, History and the Humanities, Faculty of Medicine, University of Geneva, Geneva, Switzerland

Background: Determining the clinical effects of coercion is a difficult challenge, raising ethical, legal, and methodological questions. Despite limited scientific evidence on effectiveness, coercive measures are frequently used, especially in psychiatry. This systematic review aims to search for effects of seclusion and restraint on psychiatric inpatients with wider inclusion of outcomes and study designs than former reviews.

Methods: A systematic search was conducted following PRISMA guidelines, primarily through Pubmed, Embase, and CENTRAL. Interventional and prospective observational studies on effects of seclusion and restraint on psychiatric inpatients were included. Main search keywords were *restraint*, *seclusion*, *psychiatry*, *effect*, *harm*, *efficiency*, *efficacy*, *effectiveness*, and *quality of life*.

Results: Thirty-five articles were included, out of 6,854 records. Studies on the effects of seclusion and restraint in adult psychiatry comprise a wide range of outcomes and designs. The identified literature provides some evidence that seclusion and restraint have deleterious physical or psychological consequences. Estimation of post-traumatic stress disorder incidence after intervention varies from 25% to 47% and, thus, is not negligible, especially for patients with past traumatic experiences. Subjective perception has high interindividual variability, mostly associated with negative emotions.

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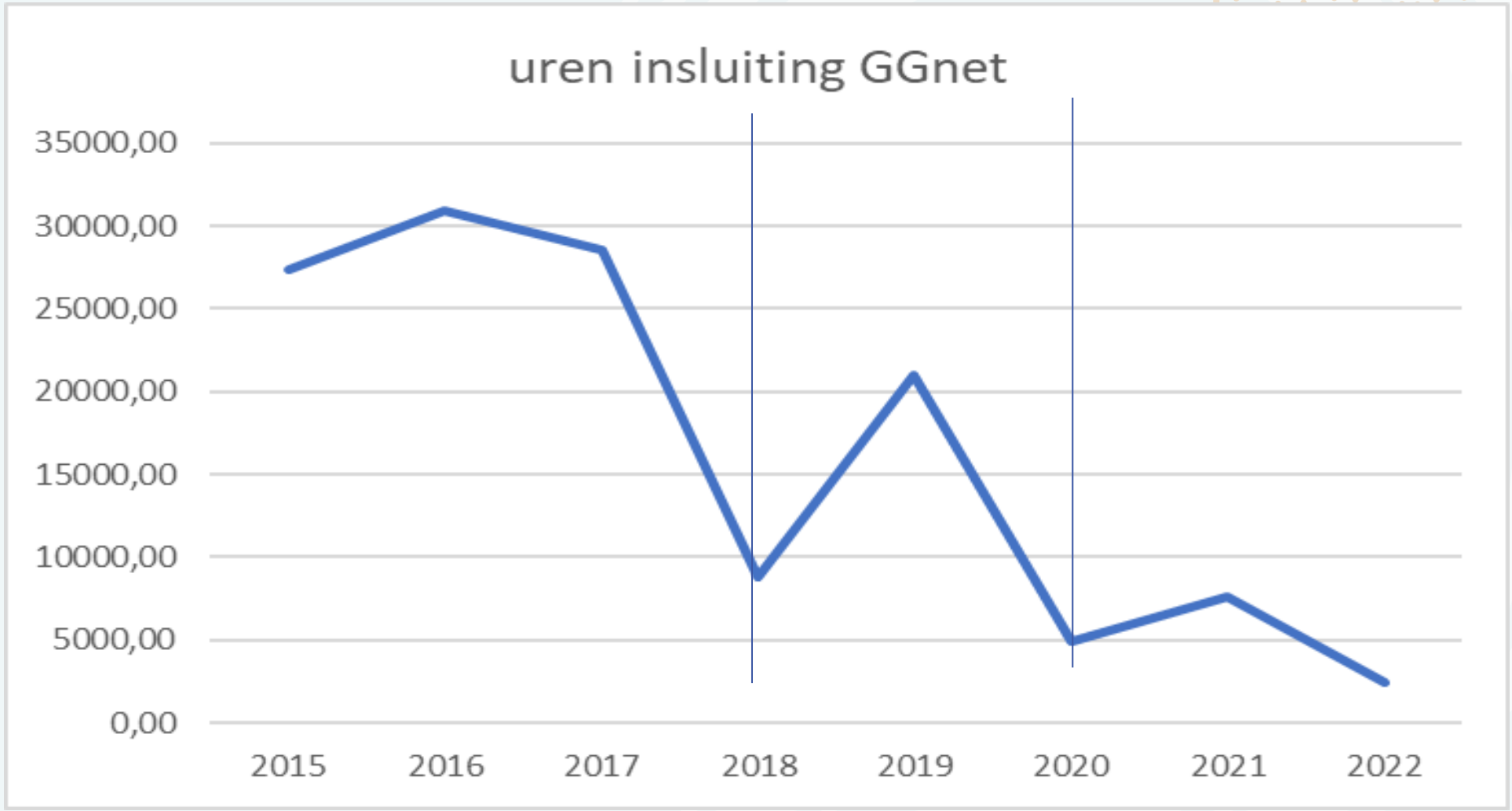
Trend figures Compulsion and Restraint GGNet

85% reduction
Across GGNet.



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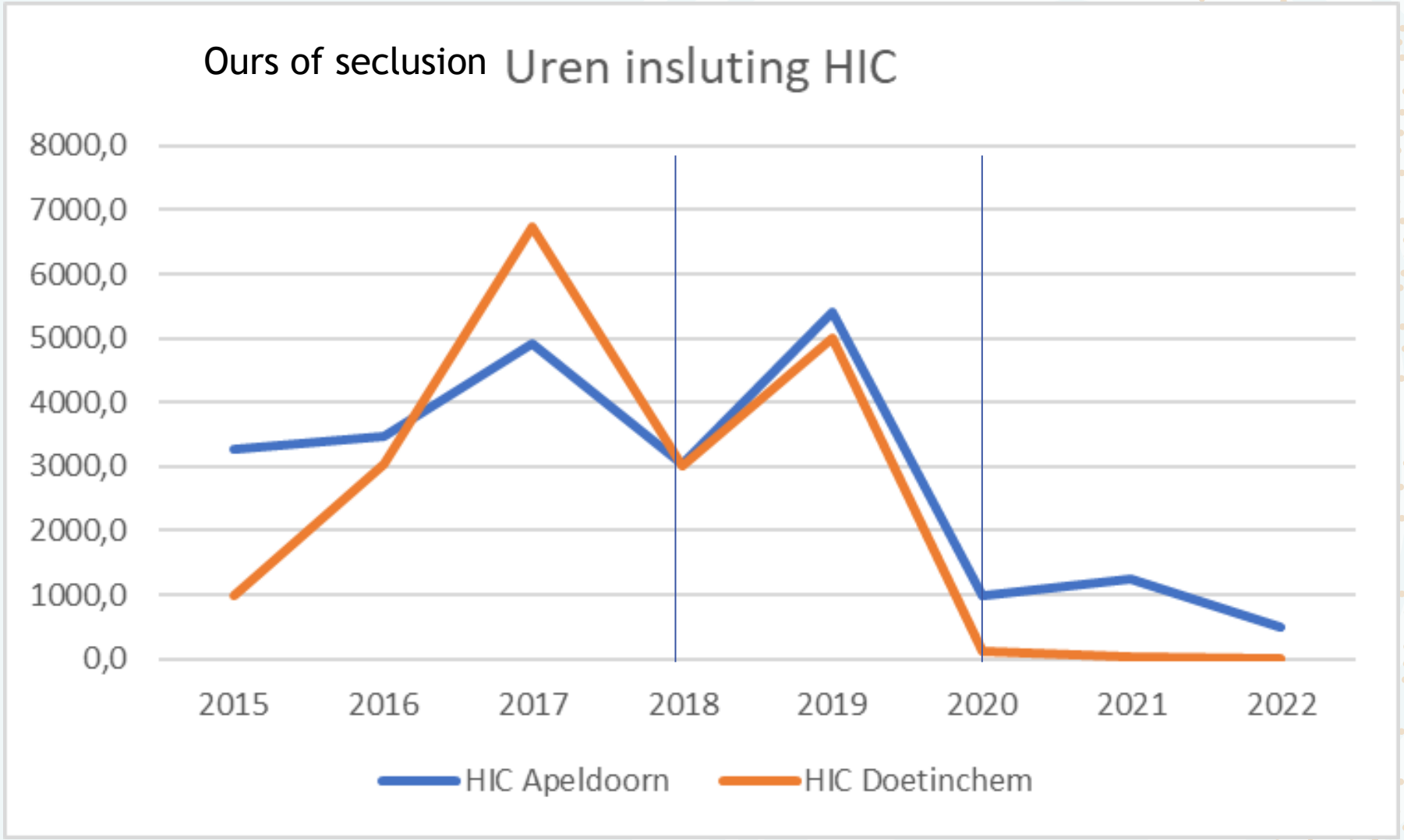
Both HIC wards



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THE EVALUATION STUDY

Goal: To identify factors that have contributed to the reduction of seclusion hours.

Method: Qualitative research, narrative approach, through a retrospective evaluation involving relevant stakeholders. We used a structured interview along a number of topics, within the next domains: engagement model, 6 domains of the safewards model, and the extent to which stakeholder could related with these items in there daily practice, the interview concluded with a open question on what the stakeholders felt contributed to reductions of seclusion use.

The interviews where transcribed (under construction), and main domains where filtered from the findings.

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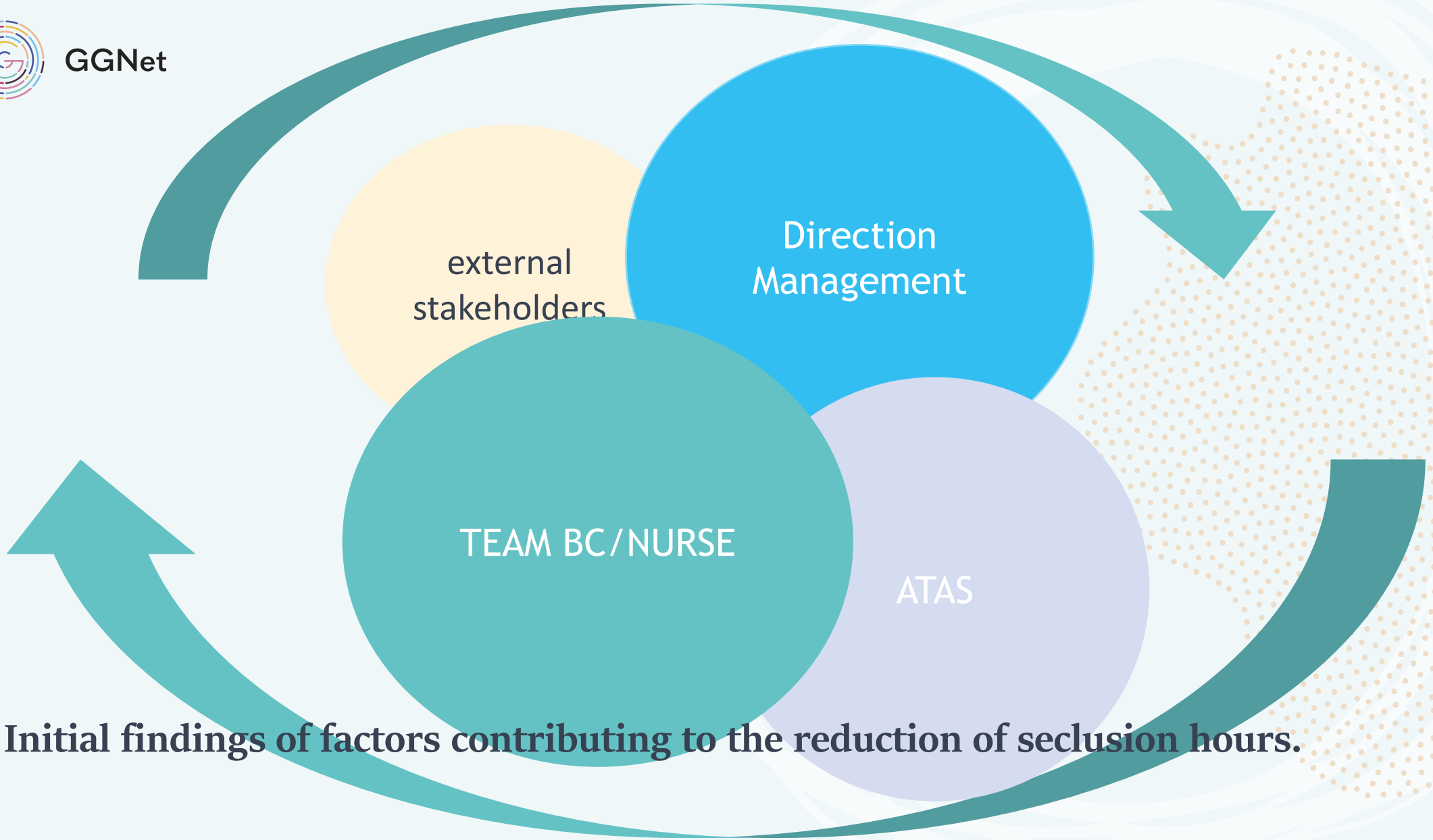

Initial findings of factors contributing to the reduction of seclusion hours.

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BOARD EN MANAGEMENT.

- Vision and Backup. Creating a flexible framework (ensuring it)
- Establishing conditions/prerequisites and maintaining approachability at a low level.
- Especially up front, support was pivotal because of resistance from on-duty nurses and psychiatrists

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TEAM NURSE EN STAFF

- Communication
- Mutual trust Scaling up and scaling down Reflection
- Autonomy/responsibility
- Early intervention Predicting aggression (BVC) De-escalation interventions
- With the principle of "You don't leave a patient alone."

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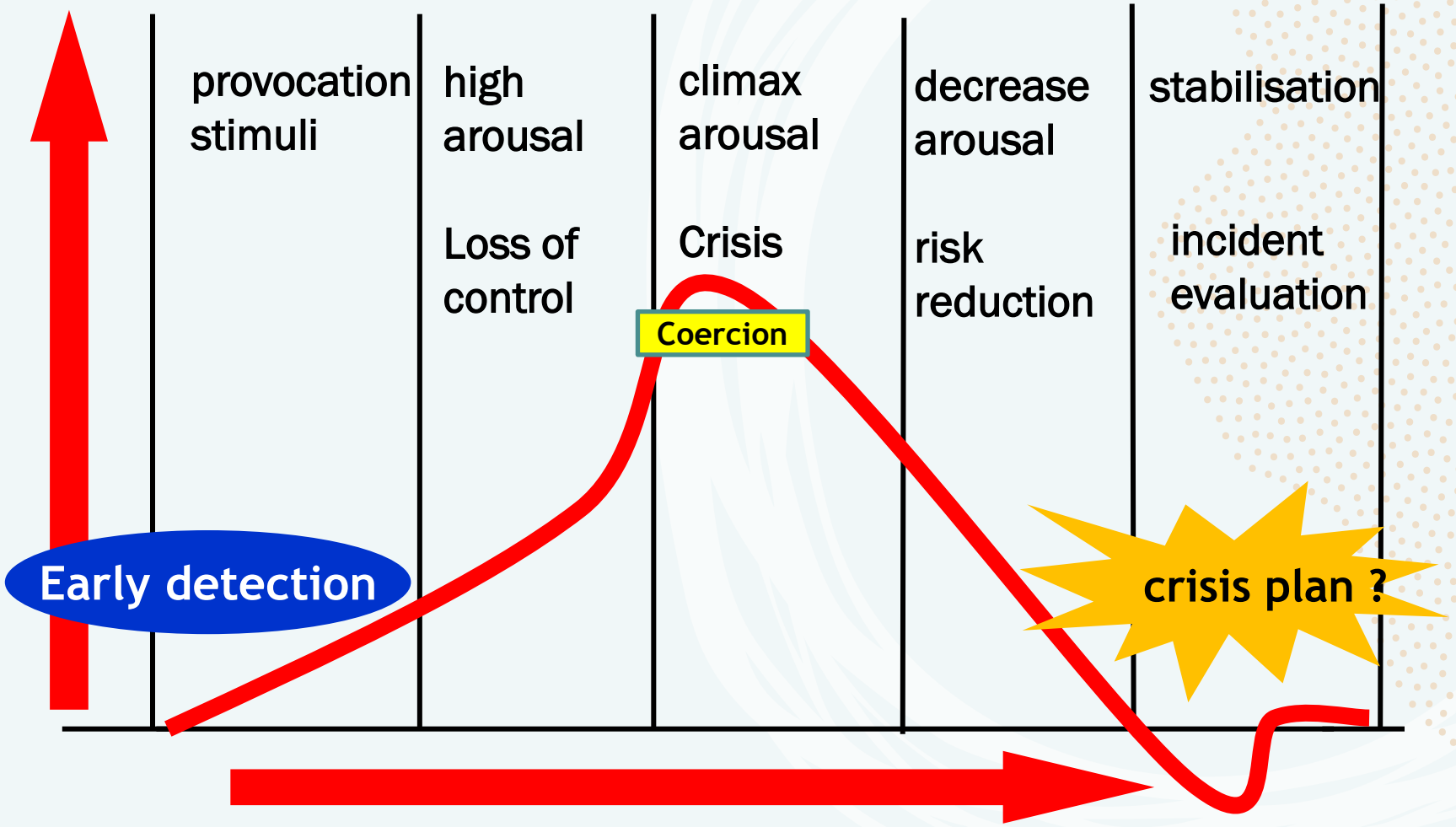
Affective dysregulation

(Kaplan &Wheeler, 1983, Scarpa & Raine,1997, Lobbestael, Cima & Arntz, 2013)



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MEDICAL INTERVENTION PLAN DETERMINED BY TEAM.

- Progressive medication administration.
- Clear protocol
- On duty personnel follows the protocol
- Transitioning from emergency to intervention and giving the nursing team control over choice and monitoring.
- It involves predicting crises and determining appropriate actions.

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PREFERENCE FOR INTERVENTION

- Why is there a "preference" for intervention medication over other forms of coercion, considering that administering emergency medication under coercion can be intrusive?
- The use of seclusion is not regarded as a treatment. The Mental Health Act (WVGGZ) provides us with the flexibility to choose earlier interventions. Initiating treatment is a priority.
- Please let me know when you are ready for the translation of the remaining parts of your presentation.

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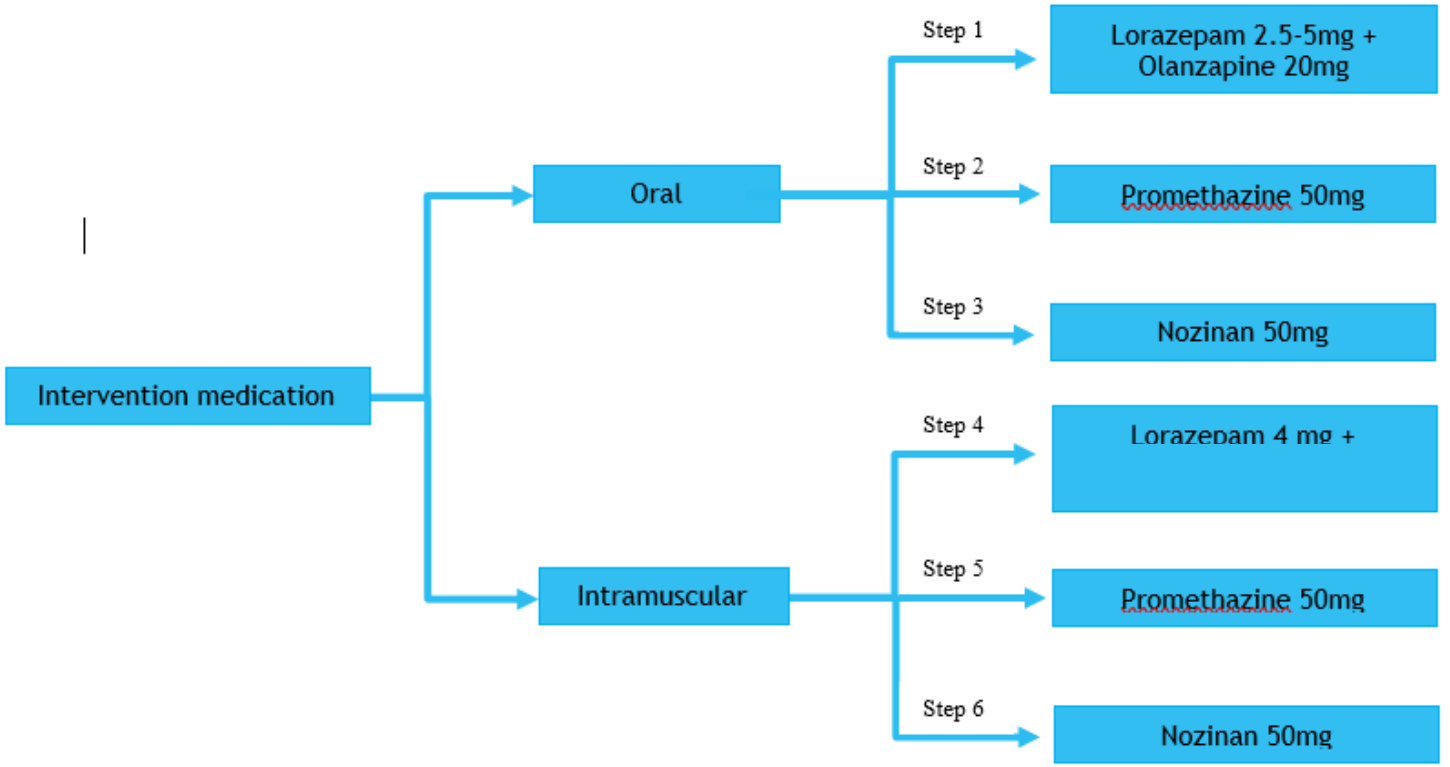
THE PROTCOL

Figure 1



Hagashima et al, 2004
Paris et al 2021

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ATAS

- Ward officers Compulsion and Restraint. Coaching (Nico Oud).
- Monitoring.
- PDCA > Triade XL, evaluation of incidents. Training and education.
- Now also focusing on outpatient care.
- De-escalation interventions.

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EXTERNAL STAKEHOLDERS

- Crisis service.
- On-duty personnel.
- Vulnerability due to policies implemented during the night and evening.
- Police (Mutual understanding agreement established). (Evaluation of case coordination)
- Resorting to criminal offenses at an earlier stage.

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OUR ISSUE

- In the Netherlands, differences in seclusion use are vast
- Hospital figures vary from 40000 hours to 1000 hours in Trusts of comparable size
- Our approach is effective and in line with Dutch policy and guidelines
- What contributes to this effect?
- Is our approach possible in comparable wards elsewhere?
- We are planning interviews in comparable wards to understand differences

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THE MAIN QUESTIONS FOR THE GROUP

We are interested in your tips and advice how to move forward

Up to now, we used a topic list (for the directors evaluation of the past) followed by open ended questions into the contributing factors With the experience of the last 5 months, we are struggling with the next issues:

1. Where to put the focus on and how to extract our experience from interviews, in a way others could learn from it. (why did we managed? What is the x factor)

1. How can we study this?

2. Which methodological techniques should we use?