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Seclusion and the importance of contextual factors: An innovation project revisited

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ABSTRACT

Variation in seclusion rates between psychiatric facilities cannot be adequately explained by patient characteristics alone and there is a growing awareness of the influence of 'cultural' and staff factors on the use of seclusion. In this study, staff variables as well as seclusion parameters were investigated during the implementation of an innovation project, against the background of an institutional program to reduce the use of coercive measures. The results demonstrate the impact of confidence within the team, staffing level and communication with the patient on nurses' decisions on seclusion. The importance of the organizational context is further illustrated by the negative effects of organizational instability on nurses' attitudes and decision making with respect to seclusion, and on seclusion rates. A reduction in the use of seclusion was achieved after the implementation of the innovation project; however, during a period of organizational turmoil, the work engagement scores of staff decreased and the use of seclusion increased. The results of this study show the vulnerability of innovations within the continuously changing organizational context of mental health care.

1. Introduction

1.1. Seclusion and facility effects

In mental health care, the ongoing use of seclusion and the slow pace of change is a source of concern (Keski-Valkama et al., 2007; Vruwink, Mulder, Noorthoorn, Uitenbroek & Nijman, 2012). Seclusion is defined as the enclosure of a patient in a special bare room, which has been approved for this purpose by the government, with the door locked (GGZ Nederland, 2012). Since the years 1990s, a wide variation in seclusion rates between psychiatric facilities has been identified (Betemps, Somoza & Buncher, 1993; Forquer, Earle, Way & Banks, 1996; Korkeila, Tuohimäki, Kaltiala-Heino, Lehtinen & Joukamaa, 2002; Way & Banks, 1990). Although international differences could be explained partly by methodological issues and differences in legal provisions (Janssen et al., 2008; Muir-Cochrane & Holmes, 2001; Steinert & Lepping, 2009; Steinert et al., 2010), on the national level facility effects still are an important source of variability, even if patient factors are accounted for (Husum, Bjørngaard, Finset & Ruud, 2010; Janssen et al., 2013). Whereas 'objective' ward characteristics, such as ward size, bed occupancy rate, turn-over rate, census, shift and staffing level, do not have straightforward effects on the use of seclusion (Fisher, 1994; Janssen, Noorthoorn, van Linge & Lendemeijer, 2007; Lay, Nordt & Rössler, 2011; Morrison & Lehane, 1995; Way, Braff, Hafemeister & Banks, 1992), contextual factors, such as staff morale, staffing change, staff–staff conflict, positive teamwork, communication, team climate, ward culture and the provision of an effective, well-organized structure of rules and daily routines, have proved to be important determinants of conflict and the use of seclusion (Bowers, 2009; De Benedictis et al., 2011; Moran et al., 2009; Papadopoulos, Bowers, Quirk & Khanom, 2012; Paterson, McIntosh, Wilkinson, McComish & Smith, 2013). In a vignette study of decision making on seclusion, the effects of 'pure' patient characteristics on nurses' decisions to seclude were rather small, as compared to the impact of communication, confidence within the team and staffing level (Boumans, Egger, Souren, Mann-Poll & Hutschemaekers, 2012). Several authors emphasize the need for further study to understand the effect of different treatment cultures on the use of coercion (Kaltiala-Heino, Korkeila, Tuohimäki, Tuori & Lehtinen, 2000; Larue, Dumais, Ahern, Bernheim & Mailhot, 2009).

1.2. Staff training and attitudes toward seclusion

Emotional exhaustion and staff burn out are associated with justifications for the use of seclusion and higher containment rates (Bowers, Nijman, Simpson & Jones, 2011; Happell & Koehn, 2011). Strategies to improve staff morale, for example educational interventions designed

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to enhance the skill and competency of staff, tend to show a positive impact on job satisfaction, reduced stress, burnout and/or staff turnover (Gilbody et al., 2006), but also negative effects of staff training on these parameters are described (Jones, 2009). The effect of training on professionals' attitudes toward containment procedures has not been established: whereas some authors did not find any change (Bowers, Alexander, Simpson, Ryan & Carr-Walker, 2004; Hahn, Needham, Abderhalden, Duxbury & Halfens, 2006; Kontio et al., 2013), Mann-Poll, Smit, van Doeselaar and Hutschemaekers (2013) demonstrated that, after a seclusion reduction program, professionals scored significantly higher on ethical concerns about using seclusion and on the option of 'more care' as an alternative to seclusion.

1.3. Present study

Changes in staff factors in relation to the use of seclusion were the focus of the current research. In addition to a large institutional program to reduce the use of seclusion and other coercive measures in a psychiatric hospital, an innovative way of working, called 'the methodical work approach', was introduced at one ward; this ward, the experimental ward, was compared with a control group of three other wards within the same hospital. The background and a detailed description of this innovation project, as well as the reduction in the use of seclusion achieved after implementation of the methodical work approach, are reported elsewhere (Boumans, Egger, Souren & Hutschemaekers, 2014). In the present, explorative study, we investigated whether changes in staff variables at the experimental ward explain the reduction in the use of seclusion; therefore, we compared the experimental ward with the control wards with respect to staff variables as well as seclusion parameters: the incidence and duration of seclusion. The primary aim of the study was to investigate, with respect to staff variables, the additional effect of the innovation project at the experimental ward vs. the effects of the institutional program introduced at all wards. The research question was whether the innovation project contributed to a change in attitudes toward seclusion and/or decision making on seclusion and/or an increase in work engagement of the nurses of the experimental ward, as compared with the nurses of the control wards.

By coincidence, an unexpected freeze on recruitment and a period of organizational turmoil offered us the opportunity to investigate the interfering effect of organizational factors on the institutional program and the innovation project. Thus, the secondary aim of the study became to evaluate the changes in nurses' attitudes toward seclusion and/or decision making on seclusion and/or work engagement, as well as the changes in the actual use of seclusion during the period of organizational turmoil. The secondary research questions were whether the organizational event had any effect on staff variables and/or the use of seclusion, and whether such an effect differed between the experimental and control wards.

2. Methods

2.1. Study site and participants

2.1.1. The Vincent van Gogh hospital

The data on which the study is based were collected in the psychiatric hospital Vincent van Gogh in Venray, the Netherlands. This public psychiatric hospital with over 900 beds offers outpatient and semirural services as well as inpatient treatment, to adolescent, adult and elderly patients with a broad spectrum of psychiatric disorders and/or substance abuse disorders. Eighteen beds are reserved for forensic psychiatric treatment with a medium security level. Crisis management, short term treatment, long-term treatment and (training for) sheltered housing are available; the average length of stay during the study period was 901–1269 days for the long stay departments and 49–57 days for the short term wards. For its assigned geographic region, the hospital has a commitment to receive and treat all patients referred for an involuntary admission under the Netherlands Mental Health Act. Inpatient treatment is continued until adequate risk reduction has been achieved. Patients transferred from a high security forensic hospital to the forensic psychiatric ward for rehabilitation can be referred to the high security forensic hospital in case of non-compliance; otherwise, transfer of a patient with a non-forensic legal status to a high security forensic hospital following an extreme violent incident is very exceptional.

The four wards selected for this study constituted the section of the hospital with the highest level of security. At these closed wards with seclusion facilities, intensive treatment was offered to adult patients with very severe behavior disturbances, resulting from (a combination of) bipolar or psychotic disorders, emotional disorders, substance use disorders, personality disorders and intellectual disabilities. In this study, the experimental ward (21 beds) was compared with a control group consisting of the three other wards (together 45 beds). All nurses working with a permanent contract on one of the four wards were invited to participate in the study. At the start in 2008 and during two years after, the nurses were invited to answer a survey every half year, yielding measurements at five time points. Anonymity was guaranteed, but participants were asked to note their age, gender, years of experience in secluding patients, frequency of participation in the seclusion process and the ward at which they worked. The study was conducted in accordance with the declaration of Helsinki and was approved by the Institutional Review Board. All four ward teams consented to participate in the study.

2.1.2. Legislation and policy on coercive measures

In the Netherlands, under the Dutch Mental Health Act of 1994, the use of specific measures is permitted in an emergency situation or as part of enforced treatment of patients suffering from a psychiatric disorder who endanger themselves and/or other persons. These measures include seclusion (the enclosure of a patient in a special bare room, which has been approved for this purpose by the government, with the door locked), mechanical restraint (the restriction of movement of a patient by mechanical means), enforced medication (the administration of medication to a resisting patient) and enforced feeding (the administration of fluids and/of food to a resisting patient); as an alternative to seclusion, a further measure can be used: the enclosure in a special 'low stimulus' room, which is not the own bedroom (GGZ Nederland, 2012). In the Vincent van Gogh hospital, such a 'low stimulus room', also called 'the quiet room' had an adjacent private bathroom, and a few personal possessions were allowed to bring in, according to the level of self control of the patient. Although the enclosure of a patient in a 'quiet room' may be a somewhat milder coercive measure, it is not very different from seclusion.

Coercive measures can be used exclusively as a last resort to prevent imminent harm to self or others, when there are no alternative options left to ensure the safety of the patient and other persons. The use of all coercive interventions have to be registered and reported to the Dutch Inspectorate. A local protocol for the use of these measures is obligatory for all psychiatric facilities. In the Vincent van Gogh hospital, the version of this protocol dating from 1996 was renewed in 2006, after the National Mental Health Organization formulated the ambition to reduce the use of seclusion with 10% each year. The protocol was adjusted again in January 2010 to facilitate more stringent reporting obligations. The criteria for the use of coercive measures were unchanged. A committee within the hospital supervises the use of the coercive measures.

2.1.3. The institutional program to reduce the use of coercive measures

In 2006, the hospital started to participate in a nationwide program aimed at the reduction of the use of seclusion and restraint in psychiatric facilities. Grants were allocated by the Dutch government to hospitals, provided that they had a specific plan how to reduce the use of coercive measures; other criteria were developing psychiatric intensive care, gathering reliable data on coercive measures, and enhancing expertise

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