



Original article

Long-term reduction of seclusion and forced medication on a hospital-wide level: Implementation of an open-door policy over 6 years



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ABSTRACT

Background: Psychiatric inpatient treatment is increasingly performed in settings with locked doors. However, locked wards have well-known disadvantages and are ethically problematic. In addition, recent data challenges the hypothesis that locked wards provide improved safety over open-door settings regarding suicide, absconding and aggression. Furthermore, there is evidence that the introduction of an open-door policy may lead to short-term reductions in involuntary measures. The aim of this study was to assess if the introduction of an open-door policy is associated with a long-term reduction of the frequency of seclusion and forced medication.

Method: In this 6-year, hospital-wide, longitudinal, observational study, we examined the frequency of seclusion and forced medication in 17,359 inpatient cases admitted to the Department of Adult Psychiatry, Universitäre Psychiatrische Kliniken (UPK) Basel, University of Basel, Switzerland. In an approach to enable a less restrictive policy, six previously closed psychiatric wards were permanently opened beginning from August 2011. During this process, a systematic change towards a more patient-centered and recovery-oriented care was applied. Statistical analysis consisted of generalized estimating equations (GEE) models.

Results: In multivariate analyses controlling for potential confounders, the implementation of an open-door policy was associated with a continuous reduction of seclusion (from 8.2 to 3.5%; $\eta_p^2 = 0.82$; odds ratio: 0.88) and forced medication (from 2.4 to 1.2%; $\eta_p^2 = 0.70$; odds ratio: 0.90).

Conclusion: This underlines the potential of the introduction of an open-door policy to attain a long-term reduction in involuntary measures.

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1. Introduction

Psychiatric inpatient treatment is increasingly performed in settings with locked doors [1,2]. Legal status does not seem to be the crucial factor for admission to a locked ward [3] and locking policies are mainly determined by local tradition and highly variable between countries, hospitals and wards [4]. The decision to admit a patient to a locked ward is primarily driven by safety concerns, as locked doors are regarded as an effective measure for protection against the outside, control over patients, secure and

efficient care and relief for relatives [2]. Following the medical-ethical guidelines of the Swiss Academy of Medical Sciences, the application of a coercive measure is indicated in cases where a risk of harm to the patient or others cannot otherwise be averted [5]. The constraints to personal freedom these treatment settings impose is ethically problematic and is acceptable from an ethical point of view only under certain conditions: the least restrictive alternative is used and its duration is kept to a minimum, the patient's rights are granted, patient's relatives or guardians are informed and the procedure follows established national and local protocols [6–8]. Locked door settings could also be justified if they would prevent the necessity of safety measures interfering further with personal freedom such as seclusion, restraint and forced medication.

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However, locked wards have well-known disadvantages [9,10]. Among others, patients' satisfaction with treatment and care may be lower than on open wards [11], the therapeutic atmosphere may be worse [12] and patients may feel confined and dependent [13]. In addition, recent data challenges the hypothesis that locked wards provide improved safety over open-door settings regarding suicide, absconding and aggression [14,15]. Furthermore, locked door settings might even increase the incidence of seclusion, restraint and forced medication, as increased rates of aggressive incidents have been connected to a punitive or threatening atmosphere on locked inpatient units [16]. In addition, closed doors are often used to replace the staff-patient contact, which again might lead to increased safety measures and involuntary treatment. On the contrary, the change to an open-door policy has shown the potential to reduce the incidence of these safety measures. This effect has been found in studies examining individual wards [17–21] and in a large observational data set from 21 German hospitals [22]. In addition, there is evidence that these effects cannot be fully attributed to shifts from recently opened to still closed wards [21]. Following this line of thought, the official statement of the ethics committee of the German Medical Association recommended the reduction of compulsory treatment and the reduction of closed wards in psychiatric settings [23].

However, several open questions that cannot be answered from the current literature remain: it is unsure whether the hospital-wide introduction of an open-door policy is associated with an enduring positive effect on seclusion and forced medication, or if there is a limited effect with return to previous levels. Furthermore, it is unclear what amount of reduction regarding safety measures is possible and how large the effect size of the complex intervention "introduction of an open-door policy" might be.

1.1. Aims and hypotheses of study

The aim of the present study was to examine if the introduction of an open-door policy in a hospital providing mental healthcare services is associated with the frequency of seclusion and forced medication and if yes, how enduring these associations might be. This led us to the following hypotheses:

- the introduction of an open-door policy is associated with a long-term reduction of the frequency of seclusion;
- the introduction of an open-door policy is associated with a long-term reduction of the frequency of forced medication.

2. Methods

2.1. General framework

The Department of Adult Psychiatry, Universitäre Psychiatrische Kliniken (UPK) Basel, University of Basel, Switzerland, provides psychiatric in and outpatient services for a population of about 190,000 people living in the city of Basel and the surrounding area. It has a health care mandate for psychiatric patients in the canton of Basel-City and basic healthcare insurance does not cover inpatient treatment in other cantons. During the 6-year study period (2010–2015), between 250 and 260 beds on 15 wards were available for inpatient treatment. In a clinic-wide approach to enable a less restrictive policy [12,21], six previously closed psychiatric wards were permanently opened beginning from August 2011. During this process, a systematic change towards a more patient-centered and recovery-oriented treatment standard including active family and caregivers involvement, the

implementation of a new concept in cognitive behavioral therapy (individual and group therapy), the implementation of a primary nursing care delivery model, improved availability of pharmaco- and psychotherapy, teambuilding measures and de-escalation training for the personnel, was implemented (compare [24,25]).

Processes for the prevention of critical incidents, seclusion and forced medication were continuously monitored to ensure maximum safety for patients and personnel while reducing involuntary treatment [26]. The primary interdisciplinary team consisted of psychiatrists, psychologists and nurses. Table S1 summarizes the number of full-time employees per profession and per examined year and is available as an online-only supplement to provide an overview on staff-to-case ratio and team composition. Team members were aware of clinical monitoring but were not informed that a scientific evaluation of the data would be performed.

2.2. Study population

Inclusion criteria for the current study were inpatient status at the Department of Adult Psychiatry, UPK Basel, at least 18 years of age, and admission to one of the 15 wards between 01/2010 and 12/2015. Patients whose inpatient treatment had not been completed within the analysis period were excluded from the current study. Of the 17,615 inpatient cases available from 01/2010 to 12/2015, 17,359 (98.6%) were entered in the current analyses. No further in or exclusion criteria were defined to ensure a naturalistic sample.

2.3. Documentation and management of clinical data

Clinical and treatment data were continuously documented using the Medfolio software (current version: 2.2.0.2085; NEXUS AG, Villingen-Schwenningen, Germany) and extracted using HCe[®] Analytics software (Business Intelligence Connector 3 (BIC 3) for patient controlling; TIP Management AG, Dübendorf, Switzerland). Data on age, gender, marital status, nationality, housing situation, occupational situation, diagnoses according to the International Classification of Diseases, 10th revision (ICD-10 [27]), legal status, type of admission, psychopharmacological treatment and type of discharge were documented by the psychiatrists responsible for the respective patient.

Due to legal requirements, a detailed documentation of coercive measures was available. A definition of coercive measures can be found in the medical-ethical guidelines of the Swiss Academy of medical Sciences [5] and two types of coercive measures were recorded as main outcome parameters:

- first, forced isolation with or without psychopharmacological treatment was documented as "seclusion" and defined as the involuntary placement of an individual locked in a room alone, which may be set up especially for this purpose;
- secondly, forced intake of oral or application of intramuscular medication without forced isolation was documented as "forced medication" and defined as administering medication against the patient's will using restraint or strong psychological pressure (involving at least three staff members) [28].

Data on physical restraint, defined as mechanical restraint using belts or straps, were not available for the current analyses as this coercive measure is not used at the UPK Basel. Involuntary hospitalization constitutes an additional coercive measure. However, only public health officers and local authorities are allowed to initiate an involuntary hospitalization in the canton of Basel-City—although longer-term changes in their decisions and guidelines

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