Chapter 3

Reduction of seclusion in Dutch mental health care: interventions and conditions

“Progress is impossible without change, and those who cannot change their minds cannot change anything.”

- George Bernard Shaw -

Abstract

Aim
This article aims to provide a systematic overview of interventions used in an attempt to reduce seclusion in Dutch mental health care institutions, as well as the conditions for the implementation of these interventions.

Background
Recently, many interventions have been developed in Dutch mental health care institution in order to reduce seclusion. Little is known about the principles underlying these interventions and the factors influencing their use in practice.

Design
This study follows the principles of naturalistic inquiry.

Method
Twenty-six mental health care institutions in the Netherlands were included. Data were collected during the years 2010 and 2011 through document analysis, group interviews with stakeholders (including nurses), and participant observation. Data collection and analysis were set up in an iterative way. Data analysis occurred concurrently with data collection.

Results
The interventions were clustered in five main categories: contact, prevention, learning from experience, participation, and cooperation. The findings show that a reduction of seclusion requires changes in patterns of action, structure and culture.

Conclusions
Reduction of seclusion in mental health care facilities requires interventions that focus on contact, prevention, learning from experience, participation, and cooperation. Interventions to reduce seclusion are only effective and sustainable when accompanied and supported by a change in organisational structure and ward culture.

Summary Statement

Why is this research needed?
• Systematic overview of interventions to reduce seclusion in the Netherlands is absent.
• Little is known about the conditions for implementation of interventions to reduce seclusion in mental health care institutions.

What are the key findings?
• Interventions to reduce seclusion in Dutch mental health care institution focus on contact, prevention, learning from experience, participation and cooperation: compared to international literature, contact stands out as a new intervention.
• Interventions to reduce seclusion are only effective and sustainable when accompanied and supported by a change in organisational structure and ward culture.

How should the findings be used to influence policy/practice/research/education?
• To reduce seclusion successfully, more attention should be paid to organisational structure and ward culture.
• More research is needed on the role of structural and cultural aspects in individual interventions.
Introduction

Locking a psychiatric patient in a seclusion room is a controversial practice in the Netherlands, as well as in other countries in and outside of Europe. Seclusion is a traumatic and emotional experience that has a major impact on patients with psychiatric symptoms (Hoekstra et al., 2004). It can have a major impact on staff as well (VanDerNagel, Tuts, Hoekstra & Noorthoorn, 2009). Psychiatric patients describe seclusion as a form of punishment. Patients frequently cite feelings of helplessness, anxiety and shame (Brown & Tooke, 1992; Hoekstra, Lendemeijer & Jansen, 2004; Martinez, Grimm & Adamson, 1999; Tooke & Brown, 1992). Nurses often play a key role in the seclusion of patients, and report feelings of shame, failure (Steele, 1993), stress, distrust and powerlessness (Vander Nagel et al., 2009). In addition, evidence for supposed therapeutic effects is lacking (Fisher, 1994; Prinsen & Van Delden, 2009).

Since 2000, the Dutch government has urged mental health care institution to reduce seclusion. In 2006, the Dutch branch organisation for mental health care (GGZ Nederland) formulated a goal of reducing seclusion and other coercive measures by 10% yearly. With the financial support of the government, mental health care institution in the Netherlands started projects within the context of a nationwide programme to achieve this goal. The projects vary from paying extra attention to the “first five minutes” of contact with a patient to the screening of risks. In these projects nurses play a key role; they are often the initiators, project leaders, and change agents. Many interventions were developed to accomplish this goal; some were evidence-based and most were experience-based. The principles underlying these interventions have thus far not been studied in a systematic way. Moreover, it is not known which conditions are needed to make these interventions work in practice.

Background

Seclusion is a coercive measure that is widely used in the field of psychiatry. It entails locking a patient in a closed room, without allowing the patient to have contact with the outside environment. Next to seclusion, three other types of restraint can be distinguished: mechanical, manual and chemical. Mechanical restraint involves the use of belts or straps to restrict the patient’s movements. Manual restraint means the immobilisation of a patient through holding techniques (Steinert & Lepping, 2009). Chemical restraint is a synonym for involuntary or forced medication (Kaltiala-Heino, Korkeila, Tuohimäki, Tuori, & Lehtinen, 2000). In most European countries, chemical restraint is the primary coercive measure of choice (Raboch et al., 2010). In the Netherlands, seclusion is most often used. This explains why seclusion is high in the Netherlands and why reduction of seclusion is an important goal (Janssen et al., 2008).

Reduction of seclusion in mental health care institution worldwide is an important issue. Recently, three systematic reviews on interventions to reduce seclusion and/or restraint were published (Gaskin, Elsom & Happell, 2007; Scanlan 2010; Stewart, van der Merwe, Bowers, Simpson & Jones, 2010). In these reviews, the interventions are clustered into six categories. The first intervention concerns staffing policies (Donat, 2003). Some wards manage a crisis situation with staff from other wards (D’Orio, Purselle, Stevens & Garlow, 2004; Witte, 2008). Also, crisis response teams are used (Smith et al., 2005).

A second group of interventions concerns the participation of patients and family members. They can be involved in the treatment planning and the evaluation of the treatment and care in the institution (Delenay, 2001; Fralick, 2007), in the development of crisis management plans and in designing coercion prevention interventions (Hellerstein, Staub & Lequesne, 2007; Jonikas, Cook, Rosen, Laris & Kim, 2004; Pollard, Yanasakm, Rogers & Tapp, 2007).

Identifying aggression-prone behaviour is a third major preventive intervention. Often, a crisis plan is used to identify aggression prone behaviour (D’Orio et al., 2004; Morrison et al., 2002). A crisis plan, based on discussions with the patient regarding how to manage in case of a possible crisis, can help patients to feel more in control of their mental illness (Sutherby et al., 1999). Risk assessment can improve clinical alertness, as well as decision-making, and can result in the timely application of de-escalation actions (Abderhalden et al., 2008; Van de Sande et al., 2011).

Registration of data on coercive measures is the fourth element of many programmes (Janssen et al., 2008; Steinert et al., 2006). Feedback of data may lead to informed reflection on outcomes.

Post-incident debriefing is the fifth intervention that is used. Debriefing focuses on describing the situational context of the patient-staff interaction that led to seclusion, as well as identifying prevention activities that can be utilised in the future. (Delaney, 2001; Jonikas et al., 2004; Khadivi, Patel, Atkinson & Levine, 2004).

Finally, changes in physical and environmental conditions can help to reduce seclusion. Examples include sensory approaches (Champagne & Stromberg, 2004; Visalli & McNasser, 2000) and modifying the environment (Taxis, 2002).

The reviews describe the importance of broad based programmes (Gaskin et al., 2007; Scanlan, 2010; Stewart et al., 2010). Reduction of seclusion requires systematic use of a
combination of interventions (Lebel, 2008). Little is known, however, about the conditions necessary for effective implementation of the interventions.

The study

Aim
This article aims to provide a systematic overview of interventions designed to reduce seclusion in Dutch mental health care institutions, as well as the conditions that are necessary for implementation of these interventions.

Design
This study uses a naturalistic inquiry methodology (Lincoln & Guba, 1985). The aim of naturalistic inquiry is to understand the particularities of a phenomenon in its naturalistic setting from the perspectives of the participants. We chose to interview participants in the institution and invited them to show us their work environment. This provides insight into the situation from the participant’s point of view and gives researchers access to their experiences (both positive and negative).

The study consisted of two phases:
1. Making an inventory (first 13 institutions)
   This phase provided an initial overview of interventions aimed at reducing seclusion and the conditions necessary for the implementation of those interventions. Data were collected through document analysis, group interviews and participant observation.

2. Further exploration (last 13 institutions)
   In this phase, the categories of interventions found were validated and condensed. Data were collected through document analysis, semi-structured group interviews and participant observation. This resulted in five main categories of interventions.

Sample
A purposive sampling approach was used to select institutions and, within the institutions, wards. In order to be included, institutions needed to have at least one project aimed at reducing seclusion that has been operating for two years. After this two-year period, institutions were considered to have enough experience in the reduction of seclusion. Twenty-six mental health care institutions were included. In each institution, two wards were visited. In total, 52 wards were included. At least 26 wards were closed admission wards, since these wards generally have the highest number of seclusion rooms. Various other wards were included: seven child and adolescent wards, seven wards for long-term care, five geriatric psychiatry wards, five special care units and two wards for forensic psychiatry.

Data collection
The data were collected in the years 2010 and 2011 through document analysis, interviews and participant observation.

Document analysis - Before the visit to the institution, the project leader of the institution provided the project plan, policy documents, protocols and other written documents concerning the reduction of seclusion. These documents were analysed by the first and third authors, producing an inventory of the activities in the project. The document analysis resulted in basic facts regarding the interventions used in the institution and the process of implementation. These data formed the background material for the interviews.

Interviews - In each mental health care institution, three group interviews were conducted: one with the project leader and institution management and the other two with a selection of staff, such as nurses, psychiatrists, managers and peer providers (former patients) of the wards. Respondents were selected on the basis of experience with the project. On average, seven persons participated in the group interviews. A total of approximately 360 (52 wards, approximately seven respondents per ward) persons participated in the group interviews.

In the first 13 institutions, open-ended questions were used. Attention was not only paid to successes, but also to bottlenecks of the interventions that were inventoried in the document analysis. In the next 13 institutions, the interviews were semi-structured, using 11 topics arising from the first round of open-ended interviews.

The interviews lasted for approximately one hour and took place in the institution. The first and third authors, both educated as psychiatric nurses, conducted the interviews. Answers to the questions were written out during the interviews, and subsequently a report of the interviews was made. This report was sent to the project leader and to the respondents for member-check.

Participant observation - The first and third authors observed the two wards in every institution for approximately 30–60 minutes (30 hours in total). The observer’s role consisted of watching, listening and having short conversations with staff. Field notes were written after each observation. The researchers also took photographs of the facilities in order to visualise conditions, such as the presence of a comfort room. The participant observation gave insight into the presence of facilities and into the behaviour of the professionals.
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Moreover, the principles of triangulation were applied. Document analysis, participant observation, and interviews were used to validate information. This is one of the quality procedures in naturalistic evaluation (Barbour, 2001). Finally, the analysis and coding processes were discussed repeatedly among the team of authors (multiple coding) (Barbour, 2001).

Results

The following categories of interventions were found: contact, prevention, learning from experience, participation, and cooperation. In this section, we will elaborate on these categories. For each category, the conditions for implementation are described. In the description of the categories, we focus on the interventions that the respondents regarded as being successful. However, these are not applied in all institutions in an effective way. Challenges will be addressed under the heading of ‘conditions’.

1. Contact

Interventions

Remaining in contact with the patient, even in a crisis situation, is one of the main ways to reduce seclusion. “By staying in contact with a patient in crisis, we can often prevent worse.” (Nurse)

Therefore, several institutions use “the first five minutes at admission.” This method is based on the viewpoint that the first contact with the patient determines the quality of future contact, and in this way, staff can prevent seclusion. Attention is paid to preparing the admission and welcoming the patient onto the ward.

Institutions also use “the first five minutes of the shift”. This method involves utilising an active and personal way of making contact at the start of the shift, the continuous presence of a nurse on the ward and assigning a patient to one nurse (allocation of the tasks). Professionals also mention that general rules on the ward may lead to tensions and conflicts. In a lot of institutions, these general rules have been abolished, and instead, a more individual approach is used. There are fewer conflicts and tensions, causing nurses to experience a higher level of safety.

Conditions

On many wards, the physical environment has been changed. Walls are painted, couches replace chairs and there is more attention given to providing places where a
patient can relax or retreat, such as a "comfort room." A comfort room is a comfortably furnished room with relaxing light and sound and is meant to provide means of stress reduction. Patients, when feeling anxious or agitated may use the room. This room is used on a voluntary basis. Patients have the opportunity to relax and isolate themselves from the bustle on the ward.

To stay in touch with patients, professionals need to be present on the ward. Often, professionals are absent as they stay in the nursing office for administrative tasks as well as for consultation. This results in poor accessibility for patients and little insight into the situation on the ward. Several institutions have transformed the nursing offices into open counters. As a result, the nurses are more easily accessible to patients and the nurses can identify tensions early.

Respondents also reported changes in how they think about contact. Increasingly, nurses are aware that seclusion means that the contact with the patient is broken. Nurses have also become aware that this practice is harmful to the patient. They are motivated to find new ways of taking care of patients during a crisis. The change can be characterised as a movement ‘from control to contact’. Instead of controlling the patient, nurses pay more attention to the basic needs of the patient, trying to better listen to patients that are in crisis.

"Previously we always did the admission interview immediately at entrance. Nowadays, we pay more attention to the basic needs. Often, that is not an admission interview but rather a cup of coffee.” (Nurse)

Patients were often secluded immediately upon admission, without any attempt to make contact. The professionals at the ward tended to follow the advice of the ambulatory crisis team. An ambulatory crisis team is an outpatient team that visits a patient in crisis and decides if a patient has to be admitted (voluntarily or involuntarily). Following the advice of the crisis team often resulted in immediate seclusion in order to protect the safety of the patient and others. This policy has been changed; nurses at the ward currently make their own assessment of the potential danger. A basic assumption in this policy is that aggression outside the ward (for example, at the police office) does not necessarily mean that someone should be secluded in the institution.

"We will not follow the advice of the ambulatory crisis team blindly. We will first make contact with the patient and assess if seclusion is still necessary. Most of the time, this is not the case.” (Nurse)

2. Prevention

Interventions

Institutions have developed preventive interventions and methods for risk assessment. To identify a crisis at an early stage and to start directly providing adequate care, "crisis intervention plans" are used. The plan is made with the patient and helps to identify signals that the patient is not doing well. In the plan, ways that the nurses or psychiatrist can support the patient are described. Many patients benefit from knowing the steps the professionals will take in a crisis situation. A specific kind of crisis plan is the ‘crisis card’. This is a small personal card containing practical information about preferences for future crisis care and a contact person nominated by the patient.

Finally, risk assessment is an intervention designed to prevent a crisis and related adverse outcomes according to professionals. Some institutions use a (violence) risk assessment tool, the Crisis Monitor (Van de Sande et al., 2011). This is a set of observation instruments for symptom evaluation and to recognize the potential for danger to self and others. Nurses indicated that they observe better and more directly because of the Crisis Monitor. Therefore, they can signal the crisis earlier and can prevent seclusion.

Conditions

All institutions have training programmes for prevention, risk assessment or de-escalation. Prevention and de-escalation not only require nurses to have a particular set of skills, but facilities should also be adequate to utilize prevention and de-escalation techniques appropriately.

"I am well-trained in prevention and de-escalation, but success depends on facilities, like single bedrooms and a comfort room.” (Nurse)

In some institutions, nurses fill in the risk assessment scales, but they do not know what to do with a specific score in practice. In other institutions, they do not discuss the scores in the multidisciplinary team meetings. In these cases, risk assessment remains a goal in itself, rather than a way to prevent a crisis.

According to the professionals, the focus of attention used to be on “the top of the iceberg” (seclusion). Nowadays the phases before seclusion get more attention. Professionals are more focused on the prevention of a crisis instead of the prevention of seclusion.

"If a patient is in crisis, you’re too late. Then you’ve missed some signals.” (Nurse).
The former reactive way of working is changed into a more proactive approach. In the case of an escalation, professionals try to de-escalate using verbal techniques instead of physical techniques.

3. Learning from experience

Interventions
A third way to prevent seclusion is learning from experience. This could be the experience of the patient, but it can also be the experience of the professionals themselves. First, the institutions now systematically evaluate the care after seclusion, and in some cases, after admission. The patient is asked about his or her experiences, often by a written questionnaire. The purpose of the evaluation is to better understand the experiences of the patient and to find better ways to deal with crises.

“Mirror meetings” are also effective in determining experiences and evaluating care. During these meetings, patients and family present experiences with care. A facilitator leads the discussion, and the role of the professionals is to listen.

Reflection is important in order to learn from the experiences of the professionals themselves. According to nurses, the reduction of seclusion requires insight into the experiences, successes and bottlenecks. Moreover, it requires less routine and more creativity. Less routine-guided behaviour implies active thinking, which means that interventions cannot be completely standardised. The professional must constantly reflect on the usefulness of the intervention for specific patients and contexts.

“Creativity is important, every patient is different. You must constantly check whether you are still on the right track.” (Nurse)

To get insight into their own actions, professionals organize peer review meetings or moral case deliberation meetings to jointly reflect on the care in a multidisciplinary group. Moral case deliberation is a meeting between stakeholders (professionals, managers, directors, patients and family) in which they systematically reflect on their moral questions from their own practice. A specifically trained, non-directive facilitator, following a methodical structure, facilitates the moral deliberation. A moral case deliberation can also be organised retrospectively; in this way, the professionals reflect on the care given and get feedback on their actions and attitude.

Conditions
Nurses experience a lack of time to evaluate and reflect on the care given. Moreover, psychiatrists are often absent in reflection meetings. Management should facilitate the activities. Not only should nurses be involved, but psychiatrists should also be present. Evaluation and reflection should not only be regarded as a source of inspiration and motivation, but also as interventions that affect the quality, effectiveness and efficiency of care.

“Reflection is not only fun. It actually improves cooperation and care.” (Nurse)

Nurses have become aware that seclusion can be experienced as traumatic. Also, they themselves have increasing difficulties with seclusion. For this reason, professionals find it important to talk about experiences in the seclusion room. Moreover, they realise that lessons can be learned from the experiences of the patient as well as from the nurses’ own experiences. Some institutions discuss all evaluations once a month; in this way, they gain insight into certain routines. In these institutions, a change is visible from evaluation to learning.

Finally, most institutions register seclusions, as well as other coercive measures, like physical restraint and chemical restraint, in a database. The data can give information about the number and duration of coercive measures. Most institutions adequately register coercive measures. However, feedback of these data gets less attention.

“We spend a lot of time on the registration. But actually, we do too little with the data.” (Manager)

4. Participation

Interventions
In many institutions, former patients with experiential knowledge (“peer providers”) participate in the process of care. They support patients on the ward, have conversations with them, and, for example, take them for a walk. Peer providers can easily make contact with patients.

“Patients feel understood more quickly by an experiential expert. They understand without needing many words.” (Nurse)

Peer providers can give feedback on the care given at the ward. In some institutions, they are involved in the implementation of interventions. For example they evaluate seclusions or prepare crisis cards with patients.

Increasingly, the family is seen as a relevant source of information about the patient. Participation in the treatment plan by members of the patients’ families is increasing. Also, more attention is paid by institution staff to the care needs within the family.
“Except that family can provide information, they often need care themselves. This is also a part of our job.” (Psychiatrist)

Conditions
The participation of patients and family can lead to tensions regarding tasks and responsibilities. This can be improved by making use of the “triad card.” This card assists professionals in identifying the role and wishes of the family. The card includes a list of potential tasks and can be used as an agenda for conversations between the staff and family members.

To foster the participation of family, many wards have abolished visiting hours. As a consequence, family members can easily visit the patient and be involved in the care for the patient. Also, opportunities for “rooming-in” and family rooms are being developed.

Participation requires that nurses are genuinely interested in the perspective of former patients and family members, and that experience is acknowledged as a valid of knowledge. Involvement of patients and family requires a new way of thinking about patients and family. Family members are not only a source of information but are also partners in the patient’s care.

5. Cooperation

Interventions
The reduction of seclusion requires cooperation on the ward, between wards within an institution and between different institutions. On the ward, active involvement of psychiatrists is considered to be important. Respondents believe that the psychiatrist has a role in coaching the nursing team.

“My job is to empower the nurses. I do this by giving the nurses a lot of responsibility and confidence. This enhances the collaboration and contributes to the reduction of seclusion and restraint.” (Psychiatrist)

To cooperate with other wards, nurses work for a short period of time on other wards and meet other nurses. An exchange programme gives the nurses insight into their own routines and the routines of the ward. This facilitates reflection on issues that were previously taken for granted. Moreover, some institutions work with a consultation team or a response team to prevent seclusion. In a consultation team, various disciplines work together to analyse the crisis and facilitate reflection among the professionals on the ward. They support the ward and increase knowledge.

One intervention to improve the cooperation between institutions is a community of practice. A community of practice is a platform between institutions in which professionals can share knowledge and experiences. Professionals work together and learn from each other about how to further reduce seclusion in their own institution.

Conditions
Respondents can find it difficult to give outsiders access to the unit. In recent years, however, respondents have realised that they could also learn from outsiders.

“We often open our doors to outsiders. This is helpful because they see things that can be improved.” (Manager)

Change requires an open culture. Nurses should be prepared to learn from colleagues and other outsiders. The management can play an important role in creating an open culture by being transparent to the employees. Moreover, the management should stress the importance of reducing seclusion and should set targets.

Table 2. Overview interventions and conditions

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<thead>
<tr>
<th>Category</th>
<th>Interventions</th>
<th>Conditions</th>
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<tbody>
<tr>
<td>Care and contact</td>
<td>• Remaining contact</td>
<td>• Physical environment</td>
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<td></td>
<td>• First five minutes at admission</td>
<td>• Comfort room</td>
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<td></td>
<td>• First five minutes of the shift</td>
<td>• Open counter</td>
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<td></td>
<td>• Abolishment of general rules in general</td>
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<tr>
<td>Prevention</td>
<td>• Crisis intervention plan</td>
<td>• Training programmes for</td>
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<td></td>
<td>• Crisis card</td>
<td>prevention, risk assessment</td>
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<td></td>
<td>• Crisis Monitor</td>
<td>and de-escalation</td>
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<td>Learning from</td>
<td>• Written evaluation/ debriefing</td>
<td>• Involvement and</td>
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<tr>
<td>experience</td>
<td>• Mirror discussions</td>
<td>facilitation of management</td>
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<td></td>
<td>• Peer review meetings</td>
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<td>• Moral case deliberation</td>
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<td></td>
<td>• Registration of coercive measures</td>
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<tr>
<td>Participation</td>
<td>• Experiential experts</td>
<td>• Triad card</td>
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<td></td>
<td>• Involvement of family and important others</td>
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<td>Cooperation</td>
<td>• Exchanging nurses</td>
<td>• Leadership</td>
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<td>• Community of practice</td>
<td>• Transparency of the management</td>
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<td>• Consultation team</td>
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<td></td>
<td>• Cooperation between nurses and psychiatrists</td>
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</tbody>
</table>
Discussion

In the Netherlands, a large variety of interventions aimed at reducing seclusion can be found. Carrying out the interventions is primarily the responsibility of the nurses on the ward. In recent years, much energy has been devoted in many projects, set up in the context of a national programme. Overall, this has resulted in a considerable reduction of seclusion, both in number and in duration (Janssen, 2013). Interventions designed to reduce seclusion can be classified into five categories: contact, prevention, learning from experience, participation, and cooperation. Our classification is largely in line with the classification found in the systematic reviews (Gaskin et al., 2007; Scanlan, 2010; Stewart et al., 2010). Several interventions, such as risk assessment, review of seclusion, training in de-escalation, and focusing on the attitude of nurses within the first five minutes of a patient–staff encounter, are used in the majority of institutions. Most of these interventions have some evidence backing their use (Donat, 2003, D’Orio et al., 2004; Hellerstein et al., 2007; Sullivan et al., 2005). Interventions that are less frequently used, such as consultation teams and staff rotation, can also be found in the literature (D’Orio et al., 2004, Sullivan et al., 2005).

The interventions that we found in our study are often used in combination. The need for combining various interventions is stressed in the literature (LeBel, 2008; Murphy & Bennington-Davis, 2005). The interventions found in our study are in line with the six core strategies distinguished by Huckshorn (2004): using the data, using seclusion reduction tools (risk assessment and de-escalation techniques), participation of consumers and using debriefing techniques. The two strategies (leadership and workforce development) that we did not identify do still play a role as conditional factors (Huckshorn, 2004; LeBel, 2008).

Our categorisation also shows some differences, compared with the literature. Contact is not an important category in the international literature. One strategy frequently described in the literature is increased staffing. This strategy was addressed during the interviews, but according to our respondents, increasing staff is not a crucial intervention in reducing seclusion.

Conditions for the implementation of interventions aimed at reducing seclusion are hardly addressed in the literature. Yet, our results show that such conditions are important for ensuring long-lasting results. Comfort rooms, open nursing desks and rooms for family members can contribute to the success of interventions and the reduction of seclusion. Applying interventions in a structured way, with support of management, is also important. Finally, a change in culture is needed, resulting in new views on the relationships with patients (from control to contact), the management of a crisis (from reactive to proactive), the importance of learning from experience (from routine to learning), the role of participation (from object of care to partner in care), and the need for cooperation (from closed to open).

Reduction of seclusion can be seen as the transition of a complex system. According to Loorbach (2007) and Rotmans (2006) a transition requires a combination of structural or organisational innovations, changes in patterns of action, and changes in culture. These elements interact. For example, building a comfort room (organisational change) is not enough to prevent seclusion. In order for a comfort room to have an effect on seclusion, new working routines have to be developed, focusing on making the patient feel welcome. This in turn requires an open attitude of nurses (culture). Likewise, registration of seclusion data (as a working routine) has only added value by providing structural feedback (Janssen, 2012) and a shared belief that the data are useful for learning. When there is no change in culture and structure, the interventions appear as tricks and they will not be effective. To prevent and reduce seclusion, changes in culture, structure and patterns of action are necessary.

Limitations

Some limitations of this study must be considered. First, the large number of institutions included limited the possibilities of the researcher conducting in-depth qualitative research on the factors influencing implementation. Second, the data collection shows some limitations. Interviews took place in groups, which might have resulted in the respondents mutually influencing each other and answering less honestly about the situation on the ward. Moreover, participant observations were short, making it difficult to distinguish between habits and incidents. Third, institutions could choose both the wards visited and the respondents to be interviewed. These wards were probably more successful in the reduction of seclusion and respondents may have been intensely involved in the projects. Therefore, they may have other experiences and views than did the less engaged professionals. Finally, the respondents were primarily nurses and managers. Psychiatrists were often absent and most of the wards did not have a peer provider. Moreover, the perspectives of patients, as well as their experiences have not been addressed.
Conclusions

In order to reduce seclusion in mental health care institutions in the Netherlands, various interventions are used. Our study shows five main categories: contact, prevention, learning from experience, participation, and cooperation. Implementing these interventions are primarily the responsibility of the nurses that work in the ward. We found that the reduction of seclusion requires a combination of changes in patterns of action, structure and culture. Interventions are only effective and sustainable when accompanied and supported by a change in organisational structure and culture. Fostering changes in the organisation and the beliefs of the professionals in that organisation is important for the successful reduction of seclusion in mental health care institutions.

References


