

A "NO-RESTRAINT" PSYCHIATRIC DEPARTMENT: OPERATIVE PROTOCOLS AND OUTCOME DATA FROM THE "OPENED-DOORS EXPERIENCE" IN TRENTO

Wilma Di Napoli & Olaf Andreatta

Mental Health Department, Trento, Italy

SUMMARY

The "Open Doors" and no restraint project in the psychiatric department of Trento originated from de-institutionalization and empowerment practices, amply extended in the Mental Health Service of Trento over the past years.

This paper aims to present the authorized operative protocols of no restraint methods and data from the first four years experience of no restraint management in the psychiatric Department of Trento.

Avoiding physical restraint and confinement force every member of the ward staff to look for innovative solutions and means a deeper and strenuous engagement of the staff in the therapeutic relationship. We are aware that this is basically a small thing, and that certainly it will create many contradictions. We chose to stay on the other hand in these contradictions, and to witness that it is possible, and indeed useful. The great lesson we learnt over past years in Community Psychiatry was that only the hard experience of these contradictions can allow people to regain health, not just as assimilation to stereotyped models, but as adhibition of resources and self-determination, normally stolen by psychiatric illness.

Key words: no restraint - community psychiatry – empowerment - UFE

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INTRODUCTION

The "Open Doors" and no restraint project in the psychiatric department of Trento originated from de-institutionalization and empowerment practices, amply extended in the Mental Health Service of Trento over the past years (De Stefani 2011). It was indeed inspired by the strong belief in the efficacy of every means that returns dignity and self-determination to the patient.

Psychiatric wards are often characterized by two elements: passivity and/or symmetric conflict.

The first aspect is a psychological attitude, often associated with hospitalization in a broad sense, even in non-psychiatric settings, and is modulated by all those attitudes that grant a major decision-making power to the health staff.

The second element is more representative of psychiatric settings and it is certainly burdened by a typical culture, which for many years has been confusing care with custody. The power gap between patients and health staff easily triggers conflicts that have also a symbolic value, to reaffirm a denied right of self determination. The doors of psychiatric wards and the restraint methods have always been a symbol of this gap, fostering conflicts and violence that may be more easily prevented by enforcing relational and dialectical strategies (Toresini 2004).

The no restraint and open doors resolution of the psychiatric department of Trento, took place after a long path, consisting of many meetings and discussions involving doctors and staff, patients, their families, forensic experts, volunteers and citizens cooperating with our mental health service: this path led to the development of a shared and reasoned choice, through

the clarification of the thorniest issues in terms of safety, responsibility, engagement and relational power within the care relationship, leading to a rich discussion about psychiatric models and routine.

OBJECTIVES

This paper aims to present:

- the authorized operative protocols performed in the psychiatric Department of Trento, developed in order to establish approved and detailed procedures for the management of "open doors" and no restraint methods;
- data from the first four years experience of no restraint management in the psychiatric Department of Trento.

METHODS

Physical restraint is often qualified in literature as a strategy to front and solve the problem of psychiatric inpatient aggressiveness: basically, the context to which it is related always involves some degree of confinement (Van der Merwe 2009).

Actually we consider the isolation in which ward staff and inpatients may live within the ward walls as a severe risk factor leading to application of physical restraint. The ward is usually perceived and experienced as something outside the community itself, with different rules and praxis, despite the fact that the extreme mental distress, which can lead to aggressive behaviour, originated anyway in the community.

The proper way to prevent restraint is the effort of the whole staff of the mental health service, that means hospital staffs as well as community staff, to maintain the

therapeutic continuity, sharing each patient's care, trying to reduce patient's feeling of being abandoned in a separate environment, where they are to be controlled and segregated rather than helped and restored (Toresini 2004).

In this way relational and communication skills combined with the patient's confidence in staff can promote alternative ways of treatment based upon dealing and dialogue.

Avoiding physical restraint and confinement forces every member of the ward staff to be keen, to look for innovative solutions, new organizational models, and of course means a deeper and strenuous engagement of the staff in the therapeutic relationship (Toresini 2004).

OPERATIVE PROTOCOLS

The management of a no restraint department cannot work without a proper and shared clinical evaluation of the complex situation of every patient, made by medical and nursing staff, upon detected risk factors (self-injury, aggressiveness, treatment adherence, substance abuse, confusion, falls). This is done daily, and then reported in the medical record and on a nurse monitor which can be easily viewed by the staff.

This assessment permits us to divide hospitalized patients into 3 categories: green (low-risk), yellow (medium risk), red (high risk); according to this distinction, the ward staff proceed in adopting the best suited strategies under specific operating instructions to lower and manage these risks, for example one to one attendance by a dedicated nurse, ongoing surveillance, relational strategies of de-escalation, pharmacotherapy.

Moreover in the Psychiatric department of Trento the main door is open from 9 to 20. At every turn, from 9 to 20, a selected nurse, cooperating with UFE (De Stefani et al. 2011), stays near the door, in order to look at the situation of the common areas, alternating observation and arrangement at the door, using this space to facilitate negotiation, collaboration and achievement of therapeutic agreements with patients.

Negotiation is indeed the key tool through which nurses search for the patients' cooperation, without adopting a paternalistic attitude or other disqualifying ways, but rather supporting an empathic attitude of listening to his needs: they use the "lounge-space" near the door as a

place where it is possible to talk and entertain, in order to promote an attitude of relational closeness and to reduce the restrictive impact felt by patients.

In the first 48 h after admission, there are no leave allowed, especially for unknown patients; this is done to permit a clinical observation and to decide more properly which kind of agreements should be done. Generally leave - either alone or accompanied, intra-or outside hospital - and their duration and frequency during the day, must be discussed with the ward staff beforehand, and then recorded.

This strong effort to search for agreement with patients brings everybody to consider treatment as something shared and not a simply doctor-centered matter, furthermore great effort is put into the involvement and empowerment of patients and their families, and much time is dedicated to inform patients and accompanying persons, family members and/or friends, about no restraint ward rules.

If a patient does not comply with hospitalization and it is absolutely necessary and urgent not to interrupt it, the hospital staff may also decide to close the door temporarily until the resolution of the "crisis", to have the possibility of lowering stress through dialogue and negotiation, and to accomplish a new therapeutic agreement. When it is not possible to draw up a new therapeutic agreement to inpatient treatment, the doctor evaluates whether to discharge, always trying to establish a therapeutic program of treatment at home, involving community resources and family, or to suggest a compulsory hospitalization (in Italy called TSO), always continuing to pursue a new therapeutic agreement.

RESULTS

As you can see from figure 1 below, after opening the ward doors in 2010, there was not a significant increase in overall absecongment from the psychiatric department, particularly if we consider their size in relation to the whole number of inpatients, which increased considerably in the last four years. On the other hand there was a remarkable decrease of the number of aggressive acts, despite the increasing number of hospitalizations, as an evident outcome of no restraint strategies (Haglund 2006).

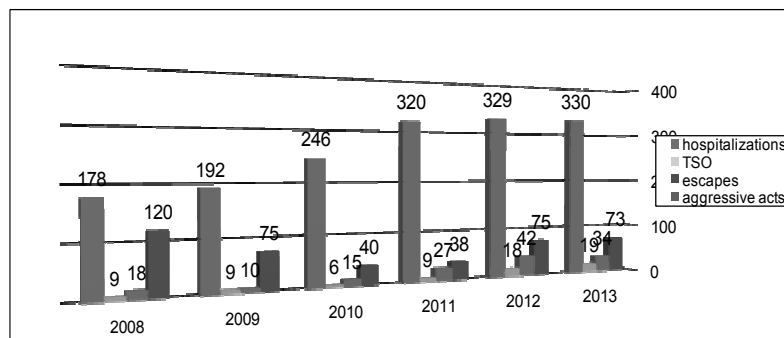


Figure 1. Absecongment from and aggressive acts within the psychiatric department after introduction of open ward door policy in 2010

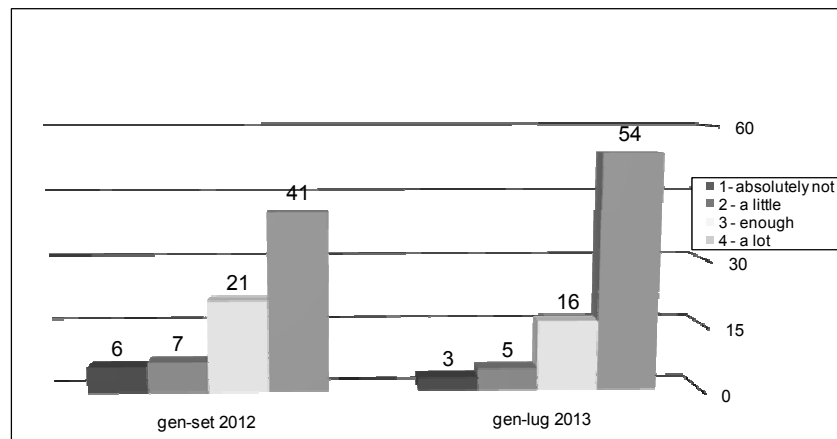


Figure 2. Satisfaction index expressed by the patients about their experience in the department after introduction of open ward door policy in 2010 (a lot= good satisfaction, absolutely not=poor satisfaction)

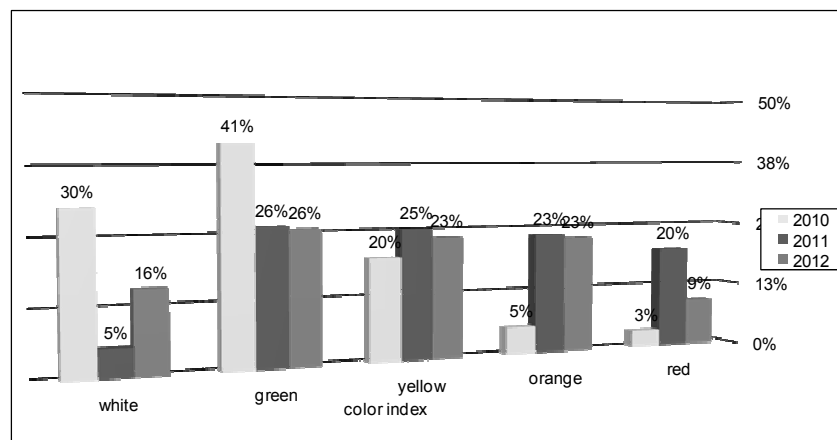


Figure 3. Emotional and wearing burden reported by the staff after introduction of open ward door policy in 2010

The strenuous work done by nurses in promoting a good therapeutic alliance, even with open doors, resulted in a good "holding" therapy, in a clear improvement of the satisfaction index expressed by the patients about their experience in the department (Figure 2), but on the other hand it resulted in an emotional and wearing burden reported by the staff (Figure 3) (Haglund 2006, Muller 2002).

In the last two years the whole department "climate" showed considerable enhancement, proving that this distress may be a necessary step in the adaptation process to new habits and practices, and that, without excluding critical phases, they never stopped a continuous progress in our ongoing experience (Davi 2011).

CONCLUDING REMARKS

The no restraint and open doors choice achieved in the psychiatric department of Trento, has meant to be an opportunity to lessen the gap between inside and outside, which frequently brought isolation, sorrow, regression and did not allow patients to regain social skills and rights. At the same time we decided to take a chance adopting new operational styles in the hospital

environment, which usually reveals a more authoritarian and forbidding attitude.

We are aware that this is basically a small thing, and this certainly will create many contradictions. We chose to stay on the other hand in these contradictions, and to witness that it is possible, and indeed useful (Davi 2011).

The great lesson we learnt over past years in Community Psychiatry was that only the real experience of these contradictions can allow people to regain health, not just as assimilation to stereotyped models, but as adhibition of resources and self-determination normally stolen by psychiatric illness.

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Conflict of interest: None to declare.

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Correspondence:

Dr. ssa Wilma Di Napoli, M.D., Psychiatrist
Mental Health Department
Via Garibaldi, 9, Erba (CO), Italy
E-mail: wilmaangela.dinapoli@apss.tn.it