Institution, coercion and trauma: Freedom is a daily exercise.

Can relationship-oriented intensive care reduce coercion in psychiatry?

Thomas Emmenegger

Canton Ticino

- Southern region of Switzerland
- 350.000 inhabitants
- 1 pubblic psychiatric hospital with 147 acute beds, 4 mental health centers, 4 daily centers ecc.
- 3 private psychiatric hospitals with 140 beds

Situation we found: 2005 – 2009

in the public psychiatric hospital in Canton Ticino

(147 beds: acute psychiatric wards)

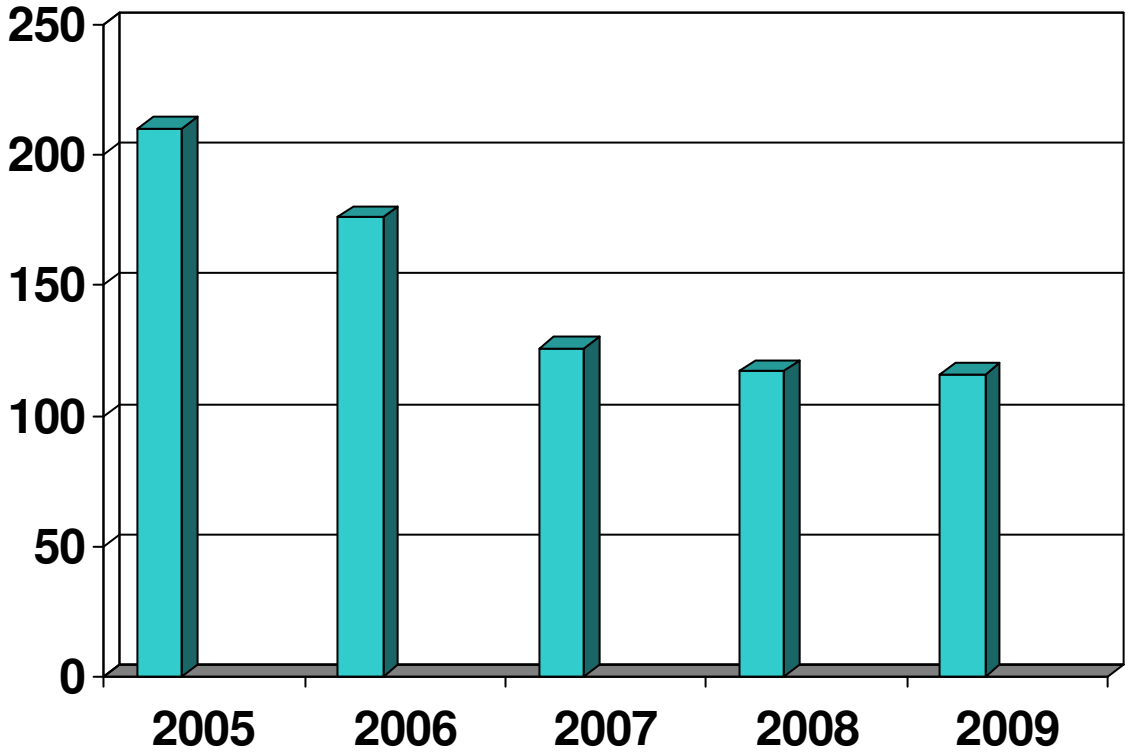
- Main "problem": high number of physical restraint within a open treatment concept (open wards and no seclusion rooms).

- **Is physical restraint the price we have to pay for open doors?**

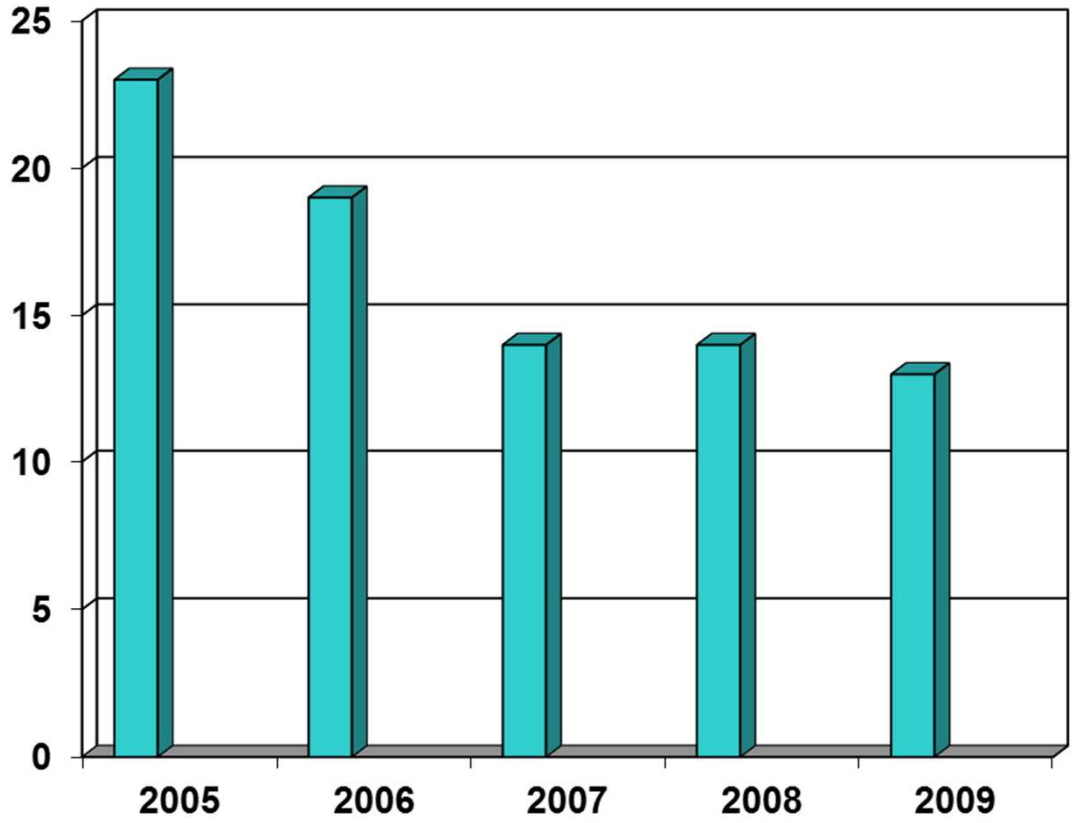
Monitoring data

- 2005: start of continuous surveillance and monitoring of data and key factors of physical restraint.
- taking into account the number of admissions 2006 – 2010, increased regulation of restraint is associated with a reduction in its use, but not its elimination.

People subject to restraint 2005 - 2009



Percent of people restrained 2005 - 2009 related to general admissions



Systemic correlation between formal and informal coercion

- Formal coercion as tip of the iceberg:
  - Visible, formal coercion just as physical restraint

    versus
  - Invisible, informal coercion

    (out of habit, situationally,

    no longer perceived)

Is Coercion as second nature of psychiatric institutions?

Who are the users who become objects of coercion?

- Adverse Childhood Experiences (ACE)
- The Relationship Between Seclusion and Restraint Use and Childhood Abuse Among Psychiatric Inpatients. (J. Hammer et al. 2011)
- ***Coercion as re-traumatization (thesis).***

high energy, high demand group

- Bachrach L. (1982). **Young Adult Cronic Patients**: an Analytical Review of Literature. Hospital and Community Psychiatry: 33, 189-197.
- Bassuk E. & Hopper K. (1980). **Chronic Crisis Patients**. A discrete Clinical Group. Am. Journal of Psychiatry: 137, 1513-1517.
- Pepper B. & Ryglewicz H. eds. (1982). **The Young Adult Chronic Patient**. Jossey-Bass Inc., San Francisco.
- Schwartz S. & Goldfinger S. (1981). **The New Chronic Patient**: Clinical Characteristics of an Emerging Subgroup. Hospital and Community Psychiatry: 32, 470-474.
- Sheets JL, Prevost JA., Reihman J. (1982). **Young Adult Chronic Patients**: Three Hypothesized Subgroups. Hospital and Community Psychiatry: 33, 197-203.

Assertive Community Treatment

- **Alternative to Mental Hospital Treatment: I. Conceptual Model, Treatment Program, and Clinical Evaluation**
  Leonard I. Stein, MD; Mary Ann Test, PhD
  Arch Gen Psychiatry. 1980;37(4):392-397

  Mendota Mental Health Institute: a state psychiatric hospital in Madison, Wisconsin

  Community based treatment programs: **Assertive community treatment**, or **ACT**, is an **intensive** and highly integrated approach for community mental health service delivery. ACT programs serve outpatients whose symptoms of mental illness result in serious functioning difficulties in several major areas of life, often including work, social relationships, residential independence, money management, and physical health and wellness.

- **Programmi con persone di alta priorità a Trieste:** personenzentrierte Intensivprogramme in den 80° Jahren.

Heavy use

- *heavy service user*

Montgomery P., Kirkpatrick H. (2002). **Understanding** those who seek frequent psychiatric hospitalizations. Arch. Psychiatr. Nurs.: 16, 16-24

- *Heavy use*

Junghan U.M. & Brenner H.D. (2006). Heavy use of acute in-patients services: the challenge to translate a utilization pattern into service provision. Acta Psychiatr Scand 2006 :113 (Suppl. 429): 24-32

*«**persistent** and severe impairment in their psychological and social functioning»* (Rössler et al. 2006, p.7).

Intensive community treatment

- Junghan e Brenner (2006) unterstreichen, dass

"an early identification of potential heavy service users, which was a premise to offer treatment alternatives made-to-measure for these individuals, seems to be an unrealistic goal for the moment. Nevertheless there is evidence that different types of ***intensive community treatment*** *may help to reduce heavy service use in a considerable number of these patients"* (p.32).

A 5 year innovation program 2010 – 2015 in the public psychiatric hospital in Canton Ticino, Switzerland.

- **Challenge**: Is it possible to ***reduce/abolish*** physical restraint maintaining open wards without seclusion rooms?

- **Work hypothesis :** interdependence between restraint and severe mental illness.

- **Goals:** new synergies between intensive inpatient care and intensive community treatment: **intensive care.**

5 year innovation program 2010 – 2015

- 2010 public policy support to reduce restraint
- Higher staff-to-user ratios
- Conversion of existing teams
- Staff training and education
- Exploration with pilot projects
- **Work focus on: intensive care on crisis and heavy use on the same time.**

Intensive care on crisis intervention and on heavy use

2010 we started **into** the psychiatric hospital with two new teams with a *complementary effect*:

- **Emergency response team**

  ready for use 24 hours on call from the wards,

  1 psychiatrist and 10 nurses

- **Intensive case management team**

  Flexible, assertive and intensive care with user with complex clinical and social problematic,

  2010 1 psychiatrist and 5 nurses inside

  2016 2 psychiatrist and 10 nurses outside

Modular therapeutic crisis intervention: intensive relationship

- **1 to 1 relationship**
  - User is never alone
  - Every 2 hours evaluation
- **Intensive relationship assistance**
  - Every 4 hours evaluation
- **Individual weekly plan**
  - Elaborated with user

- *These forms of relationships are prescribed individually, but also discussed as a decision made by the team.*

Modular therapeutic crisis intervention

- average time of a crisis intervention is 2/3 hours.
- 1 to 1 relationship can be arranged across the wards. Help each other.
- 1 to 1 relationship should have a therapeutic function and not a control function

Dialogical approach on crisis, recovery-oriented

- Understanding and not adjudicating
  - To suspend the judgment
  - Do not act immediately closing the discourse
- Negotiate and not only treat
- Taking time for the relational work: active listening, co-experience, emotion-sharing
- Tolerate conditions of uncertainty:
  - Credit of confidence

2. Radical learning

- Radical vs incremental learning
  - Radical learning processes: we do something we have never done before. “I have not thaught that I am able to do this”.
  - Exploration actions

    versus random walk.
  - Develop new work processes.

3. Teambased work

- **Teamquality**

  to help each other, speaking about anxieties, develop goals together: cooperation
- **Workquality**

  Person-oriented, resource-oriented, goal-oriented
- **Leadership**

  Team-leader, team-building
- **Priorities versus «as usual»**

  developing priorities, new configurations of human resources.

4. New definition of our work

New protocols and new forms of collaboration with:

- Police
- Emergency wards of general hospitals
- ambulance

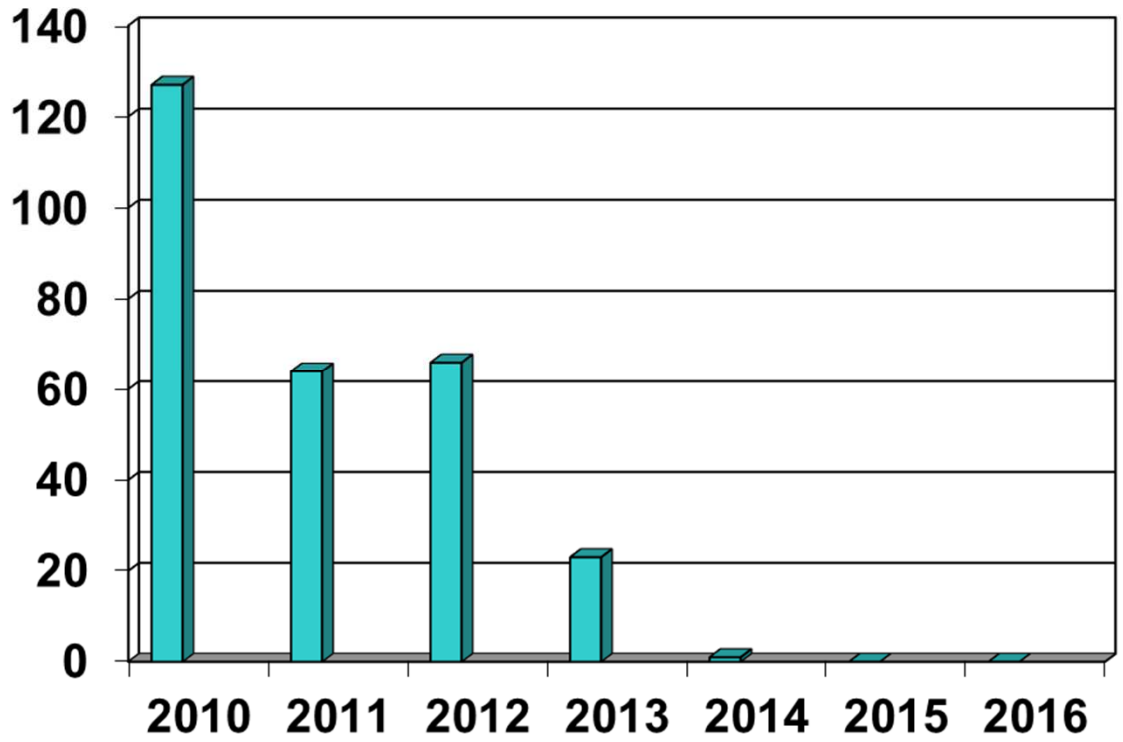
5. Out of the box: better work in the hospital needs better work on the territory

- Intensive care concepts on heavy use: tailor made, flexible, inside and outside.
- Intensive, assertive, long term treatment-plans outside of the hospital (home-treatment, apartments, communities, work opportunities).
- Focus on quality and quantity of therapeutic relationships. Involvement of motivated nurses and doctors with good work experience (leadership).

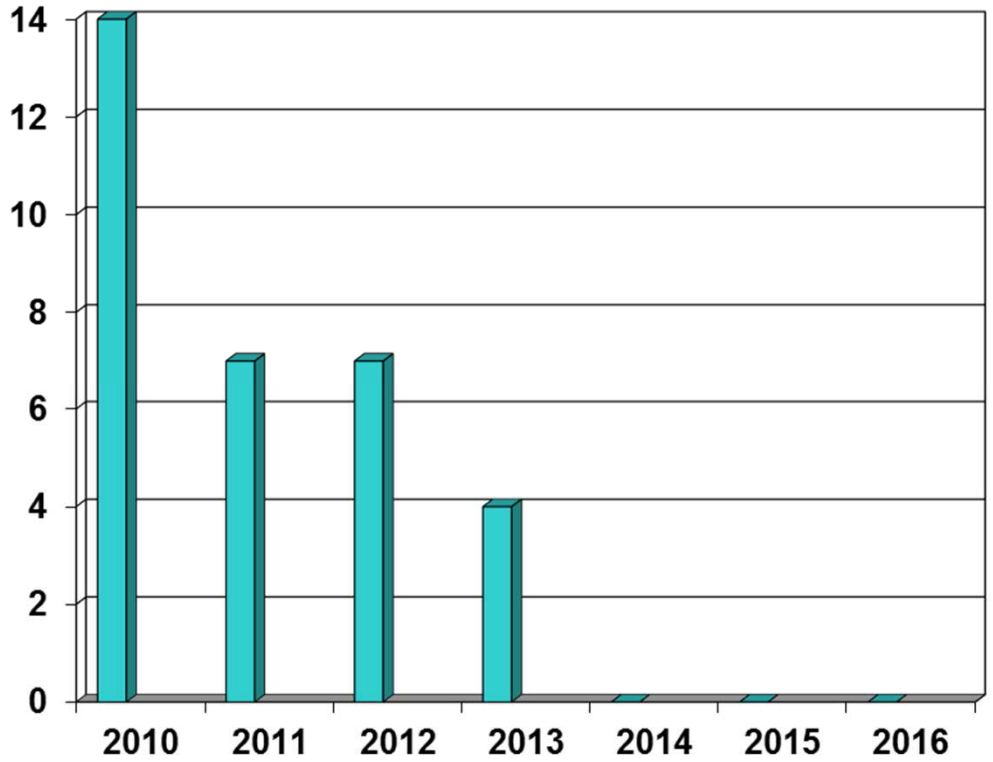
6 Impact factors (ex post)

- Intensive care as intensive relationship
- Radical learning
- Team based work
- Definition of our work
- Thinking and acting out of the box
- Leadership

People subject to restraint 2010 – 2016



Percent of people restrained 2010 - 2016 related to general admissions



Results achieved in 5 years

- Complete elimination of physical restraint
- Open wards
- No seclusion rooms
- Less severe work accidents
- Less forced medication
- Cooperation on work
- Focus on Quality of relationship and user's rights
- New treatment concepts of crisis and heavy use with relationship-oriented intensive care.

correspondence

Dr. med Thomas Emmenegger

emmen@fastwebnet.it

Improving staff safety

Work accidents during the last 10 years:

	severe acccident	moderate accident
2008:	6	7
2009:	3	6
2010:	3	3
2011:	3	10
2012:	2	6
2013:	2	2
2014:	1	5
2015:	1	6
2016	3	6
2017	2	7

Forced medication

	2017	2016	2015	2014
oral	8	16	18	53
i.m.	89	161	142	154
total	97	177	160	207

Suizide Patienten CPC

2010:	1
2011:	1
2012:	0
2013:	2
2014:	0
2015:	0
2016:	1
2017:	1

1. Contradiction between care time and control time

Intensive care means

- Intensive relationship with a therapeutic and safety function:

  Assertive and flexible

- And not only an observation function:

  Passive attitude

  Control

Recovery oriented relationships

- Care time

  Empathic oriented relationship:

  there is no therapy without sympathy.

  new forms of work-organization able to liberate time for relationship.

- Negotiate for treating

  Oriented for understanding, not decision oriented

Institutions remove that relations are just as water for the fish

There are these two young fish swimming along and they happen to meet an older fish swimming the other way, who nods at them and says "Morning, boys. How's the water?" And the two young fish swim on for a bit, and then eventually one of them looks over at the other and goes "What the hell is water?“

(David Foster Wallace)

Different, person-centered approach on heavy use

- Person- and resource oriented
- Assertive and flexible
- Continuative
- Integrated
- Intensive
- Networking
- New forms of sheltered living and supported employment

impact factors for **eliminating** restraint

- Clear ethical basic attitude
- both **intensive care** on crisis and heavy use implemented with new public policies:
  - Additional human resources and conversion of exsisting
- Radical learning, exploration, training
- Team based and integrated work
- Better definition of our work
- Convinced leadership
- Monitoring of all coercion measures
- Involvement of all employees, cooperation
- Improving staff safety

Therapeutische Kontinuität zur Selbstbefähigung: Zuversicht

"The capacity to aspire, like any complex cultural capacity, thrives and survives on practice, repetition, exploration, conjecture, and refutation. Where the opportunities for such conjecture and refutation in regard to the future are limited (and this may well be one way to define poverty), it follows, that the capacity itself remains relatively less developed." (Arjun Appadurai 2004)

Zuversichtlich zu werden kann man lernen.