Summary
Locking up a psychiatric patient in a seclusion room is controversial in the Netherlands as well as in other countries in and outside Europe. Since the beginning of this century, the Dutch government has urged mental health care institutions to reduce seclusion. In 2006, the Dutch branch organization for mental health care (GGZ Nederland) formulated a goal of reducing seclusion by 10% yearly. With financial support of the government, mental health care institutions in the Netherlands developed programs to achieve this goal. Mental health care institutions set up projects with a supervision group and a project leader, and developed and implemented various interventions to reduce coercion. These interventions were partly inspired by ethical considerations, especially notions from care ethics, stressing the importance of relationship, attentiveness and responsiveness. This thesis focuses on the effects of these interventions and the role of ethical concerns in attempts to reduce seclusion.

The general introduction (chapter 1) starts with a poem of a former patient, which shows that seclusion is a traumatic and emotional experience with a major impact on patients with psychiatric symptoms. Psychiatric patients describe feelings of helplessness, anxiety, distress, shame and loss. For mental health care workers, seclusion is also a negative experience. They describe feelings of shame, failure, stress, distrust and powerlessness. Moreover, there is no evidence for supposed therapeutic effects. From a care ethical perspective seclusion is problematic because relationship, attentiveness and responsiveness are at stake.

Over the years, the use of seclusion in mental health care institutions in the Netherlands met with critique. Since 1960, locking up seriously ill patients was no longer regarded as good care. In 1998, commentators from abroad described the Dutch coercion practice as inhumane and medieval. As a response to this, a project was developed to formulate criteria for professionals in order to improve the quality of care around seclusion in psychiatric practice. In 2001 these quality criteria were implemented in 12 mental health care institutions. In 2006, the Dutch branch organization for mental health care (GGZ Nederland) formulated the aim to reduce seclusion and other coercive measures by ten percent yearly. With financial support of the government, mental health care institutions in the Netherlands developed projects and programs to achieve this goal. In 2008 the government decided to make more funding available. Reduction of seclusion proved not easy, and various incidents took place in seclusion rooms. Moreover, self-advocates continued to protest against coercion in psychiatry. To create a measuring system with reliable data, six mental health care institutions took the initiative to develop a new registration method, called Argus. In 2011 three major reports were published: a report of the health care inspectorate (Health Care Inspectorate, 2011), a report of the Argus data set and a report on best practices with regard to the reduction of seclusion. The conclusions of these reports were critical; many strategies to reduce seclusion had been developed, but the reduction of seclusion still had a long way to go. In recent years, the focus of the projects has been on developing and implementing practical interventions, methods and instruments to reduce and prevent coercion and to enhance the quality of care for psychiatric patients. Yet, it is not clear which interventions have been effective, and how the effects can be explained. The central aim of this thesis is to get insight in the working of interventions developed in the Netherlands to reduce seclusion, and to understand the effects of these interventions from an ethical perspective.

The main research question of this thesis is: ‘Which are the effects of the projects to reduce seclusion, and how can these effects be explained using the theoretical framework of care ethics?’

This thesis consists of three parts. Part A addresses the state of the art regarding the reduction of seclusion in mental health care in the Netherlands. It examines the trends in reduction of seclusion and provides an overview of interventions which have been developed in Dutch health care institutions. Part B studies some specific interventions more in-depth. Part C describes my own experience and provides a reflection on the reduction of coercion in mental health care.

Part A: state of the art

Part A begins with a description of quantitative findings on the reduction of seclusion. The study in chapter 2 focuses on the trends in the number and duration of seclusions between 2007 and 2012. Based on the Argus data, this article evaluates whether the objective of a reduction of 10% yearly is achieved. It also assesses whether seclusion is being replaced by other interventions such as forced medication and moreover it examines to what extent the number of seclusions depends on the type of institution and on specific patient profiles.

Between 2008 and 2012, institutions registering in Argus showed a decrease between 13% and 45% in the rate of seclusion per 1000 admission hours. The percentage of patients involved was also reduced with 45% (11.8% in 2007; 6.5% in 2012). Substitution of seclusion with other intervention measures was not found. The decline in duration and number of seclusion was accompanied by an even larger decline occurred in the duration and number of isolations. Moreover, in most institutions where the use of seclusion decreased, no increase in forced medication was seen. In a small number of institutions, reduction of seclusion was accompanied by an increase in forced medication. Differences between mental health care institutions and patients have an impact on the number and duration of seclusions. A younger age, male gender, bipolar disorder, staying on an admissions ward or a forensic ward, as well as a smaller institutional size, are associated
Chapter 3 presents a study aimed at providing 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. In the literature, many interventions aiming to reduce seclusion are described. Yet, a systematic overview of interventions to reduce seclusion in the Netherlands is absent, and on an international level a little is known about the conditions for implementation of interventions to reduce seclusion in mental health care hospitals.

This chapter describes the interventions to reduce seclusion developed in the Netherlands. The interventions are classified in five categories: (1) contact, (2) prevention, (3) learning from experience, (4) participation and (5) cooperation. This classification is largely in line with the classification found in three international systematic reviews. The results of this study show that conditions for implementation are important for ensuring long-lasting results. Changes in structure, such as comfort rooms, open nursing desks and rooms for family members, can contribute to the success of interventions and the reduction of seclusion. Moreover, changes in culture are needed, including 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 a closed culture to an open culture). Interventions to reduce seclusion are only effective and sustainable when accompanied and supported by a change in organisational structure and ward culture.

Part B: Interventions: four case studies

In this part four interventions are explored more in-depth. We focused on examples from various categories of interventions, distinguished in Chapter 3.

The first intervention, ‘the first five minutes at admission’, is presented in Chapter 4.

It is based on the assumption that the first encounter with the patient determines the quality of the relationship. The first contact with the patient is a crucial moment in the process of care. This entails both verbal and non-verbal contact. In this chapter the intervention is analysed from a care ethics perspective. Two cases are presented from an evaluation study in a mental health care institution. In both cases, the nurses follow the intervention protocol, but the outcome is different. In the first case, the patient ends up in the seclusion room. In the second case, this does not happen. Analysing the cases from a care ethics perspective, we conclude that applying the intervention in the right way implies more than following the steps laid down in the protocol. It requires a new way of thinking and acting, resulting in new relationships between nurses and patients. Care ethics theory can help to clarify what good care is actually about and to keep in mind what is needed to apply the intervention. Thus, care ethical theory can be highly practical and helpful in changing and improving health care practice.

Chapter 5 focuses on a study aimed at describing the effects and implementation of the crisis card (Crisiskaart©). This is a small personal document that gives patients of mental health services the opportunity to arrange in advance the process to be followed in the event of a psychiatric crisis. The card describes characteristics of the patient’s psychiatric crisis and explains what should happen in this eventuality, taking into account the patient’s treatment preferences. In case of severe confusion or anxiety, the crisis card provides passers-by, relatives and carers with instructions on how to act. The study consists of ten semi-structured interviews with health care professionals, patients, crisis card counsellors, a partner of a patient, a representative of the police and a representative of the emergency general practitioner post. The crisis card has multiple effects which can be divided into psychosocial effects, effects on crisis situations, and effects on hospital admissions. Moreover, the results highlight a number of issues regarding the implementation of the crisis card like preparation, the role of the counsellor, the use in crisis situations and bottlenecks and possibilities for improvement.

Chapter 6 presents Moral Case Deliberation (MCD) as an intervention to reflect on dilemmas and difficult situations regarding coercive measures. Moral Case Deliberation is a form of clinical ethics support, in which a trained facilitator uses a specific conversation method to support a group of health care professionals in reflecting on and analysing a concrete case. The study took place at an Medical Psychiatric Unit (MPU) of a university hospital and methods included interviews, participant observation and a focus group. The introduction of Moral Case Deliberation contributed to changes on the level of the individual health care professional, the team, and the quality of care. MCD creates room and time for caregivers to stop and think about a case, helps structuring the discussion, energizes individual caregivers, and induces more dialogue outside the meetings. The implementation of Moral Case Deliberation requires taking into account a number of conditions like ensuring continuity, participation of all disciplines and an active role of the local coordinator and the facilitator.

Chapter 7 aims to provide insight into the role of peer providers working in mental health care teams, by investigating effects and bottlenecks. Peer providers are persons with a mental health condition who are employed as a counsellor, educator or com-
The projects to reduce seclusion have resulted in improvements in mental health care. The study shows that the introduction of peer providers in the context of reduction of seclusion gives rise to new roles. Next to the traditional role of buddy, the roles of mediator, coach and co-worker can be seen. The combination of roles may create ambiguities and tensions. To deal with these tensions it is important to create an open learning process in which stakeholders become aware of each other’s issues and underlying values. This requires joint reflection and dialogue between peer providers and professional care workers with attention for vulnerability, strength and mutual dependencies.

Part C: Reflection

In the third part (chapter 8) of this thesis my own story is presented, first as a nurse in mental health care and later as a researcher of these practices, and a reflection on the reduction of seclusion in mental health care is provided. The aim of the chapter is to investigate the challenges and lessons concerning the reduction of seclusion in mental health care. The story shows the power of a dominant story in nursing practice. It also shows that a counter story can be developed. It expresses the ambivalences which come along with the development of the counter story and the doubts about its effectiveness in practice. Finally, it shows how a counter story can be put to the test and can gain credibility for a larger audience. We conclude that stories are not just a matter of words. Stories contain guidelines for action and are embodied in practices. To create a basis for developing a new practice, a story has to be enacted in practice.

In the last chapter (chapter 9) the research question of this thesis is addressed by presenting three main findings, and reflecting on these findings from a care ethics perspective. The following main findings are presented:

Projects aimed to reduce seclusion have resulted in positive developments both from a quantitative and a qualitative perspective

The projects to reduce seclusion have resulted in improvements in mental health care institutions in the Netherlands. Positive developments can be seen both in quantitative outcomes, that is the reduction of the number and duration of seclusions, and in qualitative developments, for instance in the quality of care in general, and the quality of care regarding coercion and seclusion. Our research shows a decline in number and duration of coercive measures, and the development of a set of interventions, with new underlying values and tangible changes.

Successes depended on contextual factors

Institutions which were more successful in reducing seclusion did not embrace ad hoc policies, but developed a long-term program, including all stakeholders, and had a structural cooperation with external parties. This created conditions for fundamental changes which are needed to develop new ways of dealing with crises, going beyond habitual practices leading to proliferation of violence.

Reduction of coercion requires a transition in practice, culture and structure

Reduction of seclusion is not only a matter of developing and implementing interventions. It requires a combination of changes in patterns of action (practice), changes in values and perceptions (culture), and changes in physical and organizational structures (structure). Reduction of seclusion is a transition of a complex system. Interventions are not effective, if no attention is paid to cultural and structural conditions. Without changes in culture and structure, interventions are tricks that are not effective.

The main findings show that working routines, values, attitudes and structures play a crucial role in reducing coercion. The interventions we studied both fostered and required a change in the relationship between professional and patient. These changes have an ethical dimension. This can be clarified by reflecting on the interventions from a care ethics perspective. In the projects to reduce seclusion, stakeholders have learned that interactions between patients and professionals should not be regarded as instantaneous, but as a process in which participants try to find adequate answers to needs. All phases of care (caring about, taking care of, care-giving, care receiving and caring with) are important to make interventions work.

Moreover, the concept of autonomy plays an important role in the reduction of seclusion. Seclusion is an infringement of autonomy, and therefore it is highly problematic. Seclusion interferes with the patient’s right to self-determination. Therefore, professionals are often hesitant to intervene. On the one hand, this can serve as a barrier against unnecessary interventions in the patient’s freedom. On the other hand, the hesitation of professionals to intervene may result in further deterioration of the situation, with a greater risk of seclusion later. Against the approach of respecting patient autonomy by adopting an attitude of non-interference, care ethicists have argued for a more active and committed role. In order to prevent a crisis. From this perspective, autonomy is not fostered by providing freedom as such, but by working together with the patient in order to create a situation in which the patient is enabled to deal with first signals of a coming crisis. People are not independent from others, but live in relationships of dependency and need these relationships to be autonomous. This
implies the need for 'compassionate interference', influencing a patient to make his or her life more bearable.

Moral behaviour is not so much letting the other free to decide, but organizing life by taking care for each other and defining mutual relationships of responsibility. This implies that the professional, the patient and the family are jointly responsible for helping to prevent a crisis, and dealing with difficult situations in the best possible way. It is important to find new balances between professionals, patients and relatives. This requires learning processes and negotiations.

In conclusion, care ethics theory not only can help to explain the (lack of) effects of interventions, and to foster insight in the problems involved in the reduction of seclusion. It can also provide input for the development of interventions, and stimulate stakeholders to change their practices, develop new values, and take up new responsibilities. Care ethics can help stakeholders to understand values which are crucial in reducing seclusion, and learn to see their practice from a new perspective. Thus, care ethical theory can be highly practical and helpful and is relevant both in a descriptive and a normative sense for reducing seclusion in a structural way.

After reflecting on methodological issues, the final chapter ends with some future directions and challenges for research and practice. The recommendations for research entail that indicators of success should not only focus on quantitative criteria, but also entail process variables related to cultural change and the realization of care ethical notions in practice. Next to quantitative research, qualitative data are needed to get insight in experiences, processes and lessons learned. Moreover, patients and relatives should be involved. We also recommend more research on evidence of interventions.

The recommendations for practice focus on the importance of revisiting the quality criteria which were formulated in 2001, and to pay more attention to care ethical principles in the reduction of seclusion. Next to making use of the theory of (care) ethics it is important "to do ethics". Moral Case Deliberation can be helpful in this respect.

A further recommendation concerns the role of outpatient care in successfully preventing seclusion. Professionals in outpatient care should work in a more proactive way, focusing on prevention and cooperation with the clinic. The new development towards High and Intensive Care in mental health care in the Netherlands provides opportunities for a more proactive way of working and a better cooperation between outpatient care and the clinic. Therefore, this new approach should be elaborated further, with support of mental health care institutions, professional and patient organisations.