“I always pay attention how I close the door of the seclusion room. I want to do that gently. If you go into the seclusion room and listen, you will hear that the sounds are very loud and hollow. Closing the door can be very frightening for patients.”

- Quote from a nurse on my first internship -
Seclusion is a traumatic experience with feelings of confusion, fear, loneliness and powerlessness, as expressed in the poem quoted above. Over the past decades, seclusion has become a controversial issue in daily practice of Dutch mental health care. After much debate and criticism, the government, the sector organization of mental health care (GGZ Nederland) and the mental health care institutions in the Netherlands formulated a very clear message: Seclusion should be reduced! During the last ten years, most mental health care institutions have invested a lot of energy in projects to achieve this. This thesis examines what has been achieved as a result of these efforts, focusing on interventions to reduce seclusion which were developed. The interventions were partly inspired by ethical considerations, especially in line with care ethics, which stresses the importance of contact, attentiveness and responsiveness. This thesis focuses on the effects of the interventions and the role of ethical concerns in attempts to reduce seclusion. This introduction provides background information on (the reduction of) seclusion in mental health care. Also a description of the methodology will be given. The chapter ends with an outline of the thesis.

Seclusion in mental health care: ethical issues

During an involuntary admission in mental health care institutions, patients frequently undergo coercive measures. The notion of coercion implies that a patient is compelled to do something and has no freedom to choose an alternative option. There are different forms of coercive measures. Seclusion is defined as ‘locking up a patient alone in a specially designed locked room, with or without consent. Once in the room, the patient has no contact apart from the moments nurses attend for drinks or food and take away excrements and urine’ (Janssen, Van de Sande & Noorthoorn, 2011; Steinert & Lepping, 2009). Next to seclusion, three types of restraint can be distinguished. Mechanical restraint involves the use of belts or straps to restrict the patient’s movements. Manual restraint means the immobilization 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).

Seclusion is one of the most used coercive measures, especially in The Netherlands, and has always been part of practice in mental health care institutions. The last decades, excluding patients met with critique. Locking up a psychiatric patient in a seclusion room is controversial in the Netherlands as well as in other countries in and outside Europe. Seclusion is a traumatic and emotional experience with a major impact on
patients with psychiatric symptoms (Hoekstra, Lendemeijer & Jansen, 2004) as well as staff (Vo kes, 2007; Van Der Nagel, Tuts, Hoekstra & Noorthoorn, 2009). Psychiatric patients describe seclusion as a form of punishment. Feelings of helplessness, anxiety, distress, shame and loss are frequently cited by patients (Brown & Tooke, 1992; Tooke & Brown, 1992; Hoekstra et al., 2004; Martinez et al., 1999). Staff experience feelings of shame and failure (Steele, 1993), stress, distrust and powerlessness (Van Der Nagel et al., 2009). The contact and communication with the health care professionals has an effect on the perception of seclusion (Hoekstra et al., 2004; Meehan, Vermeer, Windsor, 2000). Seclusion is used primarily to control agitated, aggressive or dangerous patients (Fisher, 1994; Kaltiala-Heino, et al., 2000; Mohr, Petti & Mohr, 2003; Oflofsson & Norberg, 2001; Sailas & Wahlbeck, 2005; Steinert & Lepping, 2009) but there is no evidence for supposed therapeutic effects like a decrease of agitation and aggression (Fisher, 1994; Lendemeijer & Shortridge-Baggett, 1997; Prinsen & Van Delden, 2009; Sailas & Fenton, 2000).

From an ethical perspective coercion is a problematic issue. Until the 1960s coercion was regarded as acceptable and patients were considered incompetent to decide (Prinsen & Van Delden, 2009; Valimaki, Taipale & Kaltiala-Heino, 2001). In the last 40 years patient autonomy has become more important and consequently the question ‘when is coercion justified?’ is asked more and more (Verkerk, 1999). On the one hand, respect for the autonomy of the patient, human dignity and the traumatic and harmful experiences caused by seclusion provide a strong argument against seclusion (Prinsen & Van Delden, 2009). On the other hand, seclusion provides effective means for preventing injury and reducing agitation (Fisher, 1994). Prinsen and Van Delden (2009, p.72) argue that respect for autonomy and the violation of human dignity are not sufficient reasons to eliminate seclusion. They emphasize that long term promotion of autonomy and human dignity can also be used as arguments to support seclusion (Cleary, Hunt & Walter, 2010; Prinsen & Van Delden, 2009).

The analysis of Prinsen and Van Delden (2009) is an example of the four principles approach (Beauchamp & Childress, 1994). This approach is based on four ethical principles: respect for autonomy, beneficence, non-maleficence and fidelity (Beauchamp & Childress, 1994). It is assumed that by considering these principles, a proper way of acting can be determined. However, the four principles approach has limitations in situations of coercion. The focus is on whether or not seclusion is justified at a certain moment. Little attention is paid to everyday ethical issues in contact with patients and the dilemmas involved, which may in the end result in recourse to coercive measures. Moreover, the morality of care relationships and the mutual expectations and moral obligations between the patient, the professional and other stakeholders are not addressed. Finally, the focus is on seclusion as an intervention which overrules a patient’s freedom, and can be justified in case of serious danger, and not to types of interference which may stimulate patients to take responsibility and behave in such a way that more intrusive interventions can be prevented. An ethics of care pays more attention to these aspects.

According to Tronto (1993, p.103) caring can be viewed as ‘a species activity that includes everything that we do to maintain, continue, and repair our world so that we can live in it as well as possible’. People give meaning to their life and identity in relation and interaction with others (Tronto, 1993).

Tronto (2013) defines care as a mutual activity and a structured process, which consists of five phases. The first phase is ‘caring about’. Someone has to be sensitive for the need of care and they have to recognize that care is necessary. The second phase is ‘taking care of’. Recognizing that there is a need of care is not enough. Someone has to take responsibility for meeting those needs and has to determine how to respond to it. ‘Care-giving’ is the next step of the caring process and involves the direct meeting of the needs of care. It involves the concrete actions. The fourth phase is ‘care-receiving’. The object of care will respond to the care it receives. It is an important phase because it is the only way to know if the care was adequate, so if the caring needs have been met. If the response to the caring activity is not what was expected, the need is not really met. The fifth and last phase is ‘caring with’. Care requires that caring needs and the ways in which they are met, are consistent with democratic commitments to justice, equality, and freedom for all (Tronto, 2013, p.23).

Tronto (2013) distinguishes five ethical qualities related to these phases. The first quality is attentiveness. It is important to be open for the need of others. If not, it is not possible to address the needs. The second quality is responsibility. Someone has to feel responsible to meet the needs of others. The third quality is competence. It is important that someone is competent to give care. If not, the situation will not be improved. The fourth quality is responsiveness. The care giver and the care receiver have to reflect upon the care given and make sure that it was adequate. The last quality is solidarity. In the process of care it is necessary to give a voice to all stakeholders in the allocation of caring responsibilities (Tronto, 2013).

The elements of ethics of care differ from those of principle ethics. The importance of care ethical aspects is reflected in stories of (former) patients. Patricia Deegan (1993, p.14), a peer provider, wrote:
The stories of patients about seclusion show the absence of attitudes and virtues emphasized by care ethics. Patients have the feeling that others do not listen (Abma, 2005; Van der Meijde, Abma & Van der Zee, 2005). Moreover, recognition of the despair and pain in situations of a seclusion, and loving attention are missing (Abma, 2005). Because of the lack of attentiveness, patients experience feelings of loneliness. This is especially the case in seclusion. If relations are drastically restricted, feelings of loneliness will occur (Hoekstra et al., 2004).

From a care ethics perspective, seclusion is problematic and inhuman. Contact, relationships and attentiveness are at stake. Moreover, in case of coercion, care givers must take difficult decisions like “Do we have to seclude this patient or not?” or “Do we have to give forced medication or not?” According to Nussbaum (1986) such decisions are examples of tragic situations. In tragic situations a choice has to be made. Sometimes there is just one course to follow. Nevertheless, one should be aware of the options that are left out, emotions that are appropriate, like vulnerability and powerlessness should not be pushed aside (Widdershoven & Berghmans, 2007). As Deegan (1993) states, one has to show that the negative consequences for patients are not ignored but recognized even when one cannot change them. From a care ethics perspective it is important to understand the concerns and issues of the different stakeholders in a moral dilemma. Moral dilemmas have a specific context (time, place, culture). One should acknowledge that not one outcome is the most appropriate. This approach differs from one in which abstract principles such as autonomy and beneficence, are applied in order to determine what is decisive for the situation (Sevenhuijsen, 1996; Tronto, 1993; Widdershoven, 2000).

Reduction of seclusion in the Netherlands

The study for this thesis started for me with research for my master thesis in 2006, but far earlier seclusion as a problematic issue in mental health care got attention in the Netherlands. To understand the actual developments it is important to know where we come from and what has happened in the last decades.

Protests from patient organizations (1960 - 1990)

Since 1960, various patient organizations were campaigning against the use of coercion. In 1982, a group of patients and others strapped themselves to the fence of the health care inspectorate (Van de Graaf, 2009) to campaign against seclusion. In 1983, the patient organization formulated a fairly radical criticism on the seclusion of patients (Dekker, 1983). These protests resulted in growing attention for the problematic situation in mental health care institutions and the importance of the reduction and prevention of seclusion and the improvement of the quality of care in mental health care institutions more in general. Locking up seriously ill patients was not considered good care anymore, but an expression of powerlessness of care workers and the unhealthy regime of mental health care institutions (Goffman, 1975).

The new psychiatry law (1994)

As a consequence of actions of patient organizations and wider social developments, a new law on psychiatry was drafted, which replaced the old 1884 law in 1994. The new law (The Psychiatric Hospitals (Compulsory Admissions) Act (Wet bijzondere opnemingen in psychiatrische ziekenhuizen, BOFZ) aimed to protect patient rights by specifying strict criteria for the use of coercion. The law states that coercive measures, including seclusion, can only be applied in case of danger to others or to oneself as a consequence of psychiatric illness. It also states that measures should be effective and proportionate. Moreover, seclusion is only allowed if less intrusive measures are not available. Although the law entailed strict conditions for coercion, it did not result in a decline of the use of seclusion. Despite the attention to the humanization of psychiatry in society and the strict regulation of coercion in the law, seclusion remained a structural part of daily care in mental health care institutions in the Netherlands.

Development of quality criteria (1998 - 2001)

Around the turn of the century, the debate on coercion flared up again. Commentators from abroad described the Dutch coercion practice as inhumane and mediaeval (Van der Werf, 2001; Vorselman, 2003). Although no reliable data about the number of seclusions was available, various authors stated that the situation in the Netherlands was worse than in other countries and required public attention (Vrijlandt, 1998). As a consequence of the debate, a project was started to develop normative guidelines for professionals in order to improve the quality of care around seclusion in psychiatric practice (Berghmans, Elfahmi, Goldsteen & Widdershoven, 2001). The aim of the project was to engender a dialogue about the seclusion and to develop normative guidelines for professionals in practice (Berghmans et al., 2001; Abma, Molewijk & Widdershoven, 2009).
The project was designed in a responsive way. The experiences of all stakeholders were the starting point of the research and the development of the project proceeded in continuous dialogue with practice. In the project, eight quality criteria were formulated:

1. Be aware that coercion as a part of psychiatric health care entails conflicting obligations.
2. Be aware that conflicting obligations lead to ambivalences in colleagues, patients and family. Pay attention to feelings of ambivalence and deal with in a creative manner.
3. Acknowledge that coercion is a part of care process and only justified in a context of engagement. It requires attentiveness, responsibility, competence and alignment between staff, patient and family.
4. Use of coercion requires proper communication. Pay attention to contact, openness and staying in touch.
5. Use of coercion requires reflection on objectives of the intervention, not only on the dangerousness but also on how interventions contribute to the ability of the patient’s control of his own life. Coercion should not be routine.
6. Be aware of the variety of measures. Do not use more restrictive measures than is necessary.
7. See coercion in a time perspective, anticipate its use. Be transparent about the interventions and the effects. Evaluate the use of the intervention with patient and family.
8. Foster adequate physical and social preconditions and act when these are lacking.

The quality criteria shifted the attention from the legal question when coercion is allowed to the question how care can prevent coercion. Concepts and normative principles from ethics of care (attentiveness, responsibility, competence, responsiveness, respect, openness, and dialogue) were used to theoretically underpin the quality criteria.


After the development and publication of the quality criteria, implementation was started in projects in 12 mental health care institutions. The aims of these projects were (1) ensure carefulness in situation of coercion, (2) development of alternatives for coercion and (3) the reduction of coercion. The project resulted in an overview of good practices regarding the quality criteria (communication, prevention, culture, implementation and registration) and was published in a book (Abma, Widdershoven & Lendemeijer, 2005).

Nationwide program (2004 – 2008)

From 2004, seclusion got more attention in the media. Incidents in seclusion rooms in mental health care institutions were reported (Abma & Van der Zee, 2004). 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. Mental health care institutions set up projects with a project supervision group and a project leader, and developed and implemented various interventions to reduce coercion. The Dutch branch organization facilitated a platform for the exchange of knowledge and experiences. In 2007, 34 mental health care institutions had started a project aimed at the reduction of seclusion.


In 2008 the government decided to make more funding available. The achievement of a reduction of seclusion proved not easy, and various incidents took place in seclusion rooms (Abma, Widdershoven, Vrijlandt & Hommes, 2008; Abma, Widdershoven, Landeweer & Voskes, 2009; Abma et al., 2009). Moreover, self-advocates continued to protest against coercion in psychiatry. Jolijn Santegoeds, for instance, strongly raised her voice against seclusion, and developed a ‘mind rights foundation’ and a ‘rage against the seclusion room’ (‘tekeer tegen de isoleer’).

The effects of the projects to reduce seclusion were initially difficult to measure because of the lack of complete and reliable data (Janssen, Hutchemaekers & Lendemeijer, 2005; Janssen et al., 2008). To create reliable figures, 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 (Noorthoorn et al., 2011) and a report on the best practices with regard to the reduction of seclusion (Voskes, Theunissen & Widdershoven, 2011). The conclusions of these reports were worrisome: 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. In this thesis, we will investigate the developments around seclusion, and examine what is needed to realize reduction of seclusion in mental health care institutions. We will analyse some interventions more...
in-depth, and focus on the requirements for making these interventions work. We will specifically focus on the ethical background of interventions, and investigate the role of moral attitudes and values in attempts to reduce seclusion in mental health care.

Aim and research question

In this study on the reduction of seclusion in mental health care, empirical research into the effects of the projects to reduce seclusion is combined with an ethical analysis. For the empirical research into effects, we used various methods. On a national level, trends in reduction of seclusion were investigated with quantitative methods, and characteristics of interventions to reduce seclusion were studied in a qualitative field study. Several interventions were studied in-depth, using a responsive evaluation approach. In this research approach, the effects of policies and interventions are interpreted from multiple perspectives and a dialogue is initiated between stakeholders. The combination of various methods is itself based on the view that each method provides a specific perspective, and that results always require further interpretation of and dialogue about the meaning of the outcomes. In this sense, our overall approach is interpretive and dialogical, acknowledging that insight into complex processes can only be fostered through critical assessment of various data, in interaction with participants in practice.

For our ethical analysis we used a care ethics perspective. As was explained above, care ethics provides a perspective on ethical issues in health care which focuses on the everyday experiences of and tensions between patients, professionals and other participants in the care process. It stresses the importance of relational virtues, such as attentiveness, responsibility, competence, responsiveness and trust. Moreover, it fits in with responsive evaluation, in that it recognizes the role of perspectives and relationships.

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?"

Studies and methodology

This thesis consists of three parts. The first part addresses the state of the art regarding the reduction of seclusion in mental health care. It describes trends in seclusion, and provides a systematic overview of the interventions which have been developed in order to reduce seclusion (chapter 2 & 3). The second part studies some specific interventions more in detail (chapter 4 to 7). The last part (chapter 8) is a reflection, based on my own experience.

Table 1. Overview chapters

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Chapter 2 focuses on the changes over the years in number and duration of seclusion in Dutch mental health care institutions. Quantitative methods were used to get insight in the reduction of coercion on a national level. Data were collected through the registration of all the coercive measures in the Argus data set (Janssen, 2012).

Chapter 3 provides a systematic overview of strategies to reduce seclusion in Dutch mental health care and conditions for implementation of these strategies. This study uses a naturalistic inquiry (Lincoln & Guba, 1985). The aim of naturalistic inquiry is to understand the particularities of a phenomenon in its natural setting from the perspectives of the participants. Twenty-six mental health care institutions were included and data were collected through document analysis, interviews and participant observation.

**Part 2 Case studies: responsive evaluation**

Part 2 of this thesis explores four interventions that were developed or implemented in the programs to reduce seclusion more in-depth. These interventions cover various categories of interventions, distinguished in chapter 3. It was not possible to study an intervention from each category, because for one category no in-depth data were available. The investigation of each of the four interventions took the form of a case study. According to Thomas (2011, p.513) case studies are “analyses of persons, events, decisions, periods, projects, policies, institutions, or other systems that are studied holistically by one or more methods. The case that is the subject of the inquiry will be an instance of a class of phenomena that provides an analytical frame - an object- within which the study is conducted and which the case illuminates and explicates.”

In the case studies, a responsive evaluation approach was followed, based upon qualitative methods like document analysis, interviews, focus groups and participant observation.

Responsive evaluation was developed by Stake (1975) as an alternative for goal-oriented evaluation. According to Stake (1975) too little attention was paid to the context and processes of implementation in evaluation. Moreover, stakeholders were not sufficiently involved in evaluation and there was too much focus on goals and intentions of policymakers. Responsive evaluation was further developed by others. According to Guba & Lincoln (1989), it is important to do evaluation research with the active involvement of all stakeholders instead of only consulting stakeholders. Abma (2006) adjusted this interactive approach to the context of health research. Central to this approach is the exchange of experiences and perspectives between stakeholders through dialogue (Widdershoven & Abma, 2007). Values in dialogue are openness, attentiveness and respect (Abma, 2001). At the beginning of a study, the issues of stakeholder are often unknown, the design develops in dialogue with all stakeholders (emergent design). The aim is not to create consensus but to create mutual understanding and practice improvement. In responsive evaluation, the researcher is embedded within practice and follows a dialogical and interactive approach (Widdershoven, Abma & Molewijk, 2009).

In the case studies, responsive evaluation was chosen because this approach is suitable for gaining an insight into the multiple perspectives of those involved in an intervention (Guba & Lincoln, 1989; Stake, 2004). Moreover, this approach is suitable in contexts where power asymmetries exists (like mental health care) and the experiences of marginalized groups, like psychiatric patients, are taken into account (Abma, 2000; Abma, 2005; Abma, Molewijk & Widdershoven, 2009).

**Part 3 Reflection on the reduction of coercion: an auto-ethnography**

The third part of this thesis presents my own story, first as a nurse in mental health care and later as a researcher of these practices. In both roles I experienced what it means to care for psychiatric patients and how to act during moments of crisis. The article provides a reflection on the reduction of seclusion in mental health care. The aim of the article is to investigate the challenges and lessons concerning the reduction of seclusion in mental health care. The methodology used in the article is inspired by co-constructed auto-ethnography (Ellis & Bochner, 2000; Reed-Danahay, 1997). Auto-ethnography is an approach to research and writing that seeks to describe and systematically analyse (graphy) personal experience (auto) in order to understand cultural experience or practice (ethno) (Ellis, 2004). An auto ethnography combines characteristics of autobiography and ethnography. The author retroactively and selectively wrote about past experiences using a logbook and field notes. To analyse these experiences, data of research was used.

**Outline**

This thesis consist of three parts. The first part presents the state of the art regarding the reduction of seclusion. This part consists of chapter 2 and 3. Chapter 2 presents quantitative and qualitative data on the reduction of seclusion in the Netherlands. Chapter 3 provides a systematic overview of strategies to reduce seclusion in Dutch mental health care and conditions for implementation of these strategies.

The second part of this thesis consists of four chapters. In each chapter an intervention to reduce seclusion is discussed. In chapter 4, an intervention called ‘the first five minutes at admission’ is described and analysed using the theory of Tronto. Chapter five concerns the crisis card. This chapter discusses the experiences with the effects of and the bottlenecks in the implementation of the crisis card. Chapter 6 focuses on moral dilemmas and the implementation of Moral Case Deliberation on a Medical Psychiatric Unit in an academic hospital. The aim of the study was to identify moral
dilemmas regarding coercion in mental health care, and to investigate the value and implementation of Moral Case Deliberation. Chapter 7 focuses on the successes and bottlenecks surrounding implementation of peer providers on different wards of a mental health care institution. The aim of the study was to investigate the qualitative effects of the participation of peer providers at the wards, and to monitor the process and make recommendations for adjustments during the process.

Part 3 presents the story of the author of this thesis and provides a reflection on the reduction of coercion. The thesis ends with a general discussion (chapter 9). In this chapter we will discuss our main findings and provide an answer to the research question. We will also formulate a conclusion and recommendations for research and practice.

References


Chapter 1 General introduction


