“If you really want to understand something, try to change it.”

-Kurt Lewin-
Main findings

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

The studies in this thesis show that 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.

In chapter 2, quantitative data on the reduction of seclusion were presented. Between 2007 and 2012, the number of hours of seclusion per 1000 admission hours was reduced with 45%. The percentage of patients involved was also reduced with 45% (11.8% in 2007; 6.5% in 2012). Thus, over the last six years a considerable reduction was achieved, albeit not as large as was aimed for by GGZ Nederland. Moreover, not all mental health care institutions showed a constant positive development. In many institutions, the reduction was more modest. Between 2011 and 2012, the number of hours in seclusion in proportion to the number of hours of admission was reduced in 11 institutions. In 7 institutions, the reduction was larger than 10%. In 6 institutions, the mean duration in seclusion remained the same. 4 Institutions showed an increase in number of hours in seclusion. In general, institutions which started early with projects, and with registration of coercion, show better results than those who have started more recently.

In chapter 3, interventions, instruments and methods aimed at creating conditions for the reduction of seclusion were described. Interventions were classified in five categories: (1) contact, (2) prevention, (3) learning from experience, (4) participation and (5) cooperation. From four of five categories, we examined an example in more detail in the subsequent chapters, in order to get better insight in these interventions.

In chapter 4, an example of an intervention in the category ‘contact’ is ‘the first five minutes at admission’ which was investigated. This intervention 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 interaction. Several actions are needed in order to realize a good first encounter: preparing the admission, welcoming the patient, providing comfort to the patient, introducing the patient to the ward, and finally asking the patient about personal issues that need to be addressed. The chapter showed that nurses experience this intervention as useful in the reduction of seclusion. The intervention enables them to approach the patient in an open and honest way. This makes the patient at ease and creates trust, which prevents tensions and conflicts. Moreover, nurses experience...
more freedom and responsibility to provide good care. This makes them more motivated for their daily work and to prevent seclusion.

An example of an intervention in the category ‘prevention’ is the crisis card (chapter 5). This is a small personal document that gives patients of mental health services the opportunity to arrange in advance the steps to be followed in the event of a psychiatric crisis. The card describes the signs of the patient’s psychiatric crisis and gives guidance as to 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 passersby, relatives, and carers instructions on how to act. The chapter showed that, according to the stakeholders, the crisis card is an important intervention to prevent seclusion. The crisis card helps to take the right actions. Care workers will know how to approach the patient to calm him or her down. They will also know which approach will have a detrimental effect on the person. Adequate actions during a crisis can help prevent the crisis from worsening and will reduce the risk of seclusion.

An example of an intervention in the category ‘learning from experience’ is registration of coercive measures (Argus), enabling feedback to practitioners on the results of efforts to reduce seclusion (see chapter 2). Chapter 6 presented 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 (Dauwe et al., 2013; Molewijk et al., 2008). The chapter showed that, according to the stakeholders, MCD creates room and time for caregivers to stop acting and think about a case. MCD helps structuring the discussion, energizes individual caregivers, and induces more dialogue outside the meetings. Moreover, the perspective of the patient is explicitly included in the investigation during an MCD, which raises caregivers’ awareness of the patient’s point of view and helps ensuring that the care provided is more in line with the patient’s views and needs. Finally, MCD results in a better cooperation and more equality in the decision process. According to caregivers, reflection, dialogue, improved cooperation, and the awareness of the perspective of the patient contribute to the reduction of coercive measures like seclusion in future situations.

The category ‘participation’ covers both participation of patients and of family. Chapter 7 investigated the value of patient participation, in the form of peer providers working at a ward. Peer providers are persons with a mental health condition who are employed as a counsellor, educator or companion to meet the needs of daily living, and as advocates to empower people with psychiatric disorders (Gates & Akbas, 2007). The chapter showed that peer providers and professionals experience that peer providers can improve the contact between patients and professionals. Moreover, they can foster understanding between the patient and the professional care provider and they can enhance the quality of care by giving feedback and playing a more active role on the ward. A better understanding can help to de-escalate situations and prevent seclusion. A better quality of care improves the livability on the ward which prevents conflicts.

We did not study examples of interventions in the category ‘cooperation’ in detail. Several interventions are, however, worthwhile mentioning. A first example of an intervention fostering cooperation is an exchange program for nurses. By working at another ward, nurses get insight into the routines on their own ward. Another intervention in this category is working with consultation teams. In a consultation team, various disciplines work together to analyse the crisis and facilitate reflection among the professionals at the ward. They support the ward and increase knowledge. A third example is participation of institutions in a community of practice (Abma et al., 2009b). A community of practice is a platform in which professionals of various institutions can share knowledge and experiences. Professionals work together and learn from each other how to further reduce seclusion in their own institution.

The interventions which we examined are accompanied by changes in attitudes and core values of professionals. An example is the change from control to contact, which can be seen in the intervention ‘the first five minutes at admission’. In institutions in which this intervention is successful, professionals are increasingly aware of the importance of understanding the patient and communicating with the patient. They also become more responsive to the needs of the individual patient instead of providing standard care. Thus, they develop new views on what is crucial in the care process, and new patterns of action, embodying new core values. Other interventions also require the development of new values. The importance of values can be seen in the names of the categories which we found; contact, participation, and cooperation are normative concepts, indicating necessary attitudes and values of professionals. Some interventions specifically focus on developing new values through fostering processes of moral learning. Chapter 6 showed how professionals learn how to deal with dilemmas and to better understand each other’s perspectives. By participating in MCD, they got more insight in crucial values in their work and in caring for patients in crisis. This enabled them to be more attentive to the needs of patients and colleagues.

Values like contact and care are also materialized in concrete and tangible changes in practice, for example in new arrangements such as comfort rooms. A comfort room is a nicely furnished room with relaxing light and sound, sometimes together with aromatherapy and is meant to provide stress reduction. The room can be used by patients when feeling anxious, agitated or angry. Contrary to seclusion rooms, a comfort room is
used on a voluntary basis. Patients have the opportunity to relax and isolate themselves from the hustle on the ward. In the study of the participation of peer providers (chapter 7), the peer providers contributed to the development of the comfort rooms to give meaning to concepts like comfort, patient friendliness and good care. Contact is fostered by building open counters instead of nursing offices. Other changes representing new values are possibilities for family to stay at the ward (rooming-in) and intensive care units in which the patient is not left alone.

In conclusion, our studies show that the projects to reduce seclusion have contributed to a decline in number and duration of seclusion in mental health care institutions, and the development of innovative interventions, which, according to the stakeholders, have fostered better ways of dealing with crises, embodying new attitudes and values.

Successes depended on contextual factors
Despite the attention to the reduction of seclusion during the last ten years and the development of many interventions, the overall aims set by the Dutch government and the branch organization for mental health care (GGZ Nederland), a yearly reduction of 10% in both number an duration of seclusion, has not been fully achieved. Some mental health care institutions did achieve a reduction in line with the aims. Others did not. Our studies show that the success of attempts to reduce seclusion can be explained by contextual factors, which determine the effectiveness of projects in various institutions.

The success of attempts to reduce seclusion is dependent on the presence of a long-term policy. Mental health care institutions which are successful tend to have a longer history of attention for the problems around seclusion. From the start of the debate in the nineties, they actively participated and experimented with new ways of organizing care in situations of crisis. They started projects aimed at furthering reflection of professionals and cooperation with clients and family. Thus, they were already working on the issue of reduction of seclusion when the government provided funding for projects in 2006 (chapter 2). This meant that projects could be developed, based on prior experiences, and that projects could be integrated in an existing structure (for instance a project group with participants of various disciplines, patient and family representatives).

A second factor influencing the success of attempts to reduce seclusion concerns the project management. The project leader played an important role in this respect. An ambitious project leader who sets goals and evaluates the goals will contribute to the project’s success. Moreover, the project should be firmly grounded in the organization, supported by the board of directors, but also by middle management and team managers. It should actively include professionals on the work floor, and invite them to develop creative solutions. In institutions in which top down and bottom up approaches are integrated, reduction of seclusion has more chance of being a success (Voskes, Theunissen & Widdershoven, 2011).

A further factor is the collaboration with outsiders. Outsiders can stimulate reflection on taken-for-granted ideas and contribute new rationalities and perspectives (Abma, 2007; Gergen, 1992). Collaboration with other mental health care institutions was an important factor in the success of projects aimed at reducing seclusion. Some institutions participated in a ‘community of practice’, in which a group shares knowledge and experience with a practice, resulting in a collective and situated learning process (Abma, 2007; Abma et al. 2009b; Wenger et al., 2002). The aim is to develop and improve a shared practice. Because of a real concern, an intriguing question or an urgent issue, members are willing to meet and share knowledge and experience (Abma, 2007; Abma et al. 2009b; Wenger et al., 2002). As researchers we facilitated two communities of practice: one in the south and one in the middle of the Netherlands. Both communities consisted of around eight members, all project leaders of various institutions. In the first years of the community the members exchanged views on and experiences of how to create support within the institutions and how to respond to an increase in the number of seclusions rather than a decrease. Later they choose one topic to elaborate. In the south the focus was on Intensive Care in mental health care, in the middle on consultation teams to prevent seclusion. In these communities of practice, participants experienced their companionship as inspiring and stimulating. Over time, the members developed common knowledge and shared approaches. As such, the communities of practice provided opportunities for involvement of outsiders in the participating institutions.

In the projects to reduce seclusion, researchers were also important outsiders. In evaluation studies, the projects were monitored and the researchers reflected together with the stakeholders on the quantitative data, their goals, the (expected) problems or barriers, the interventions and the successes. In this way, the professionals on the wards were able to interpret the data and they received periodical information about the results of their efforts. Moreover, through the input of the research, they were able to make adjustments to the project to reach their goals or to be more successful.

In conclusion, our studies show that institutions which are more successful in reducing seclusion did not embrace ad hoc policies, but developed a long-term program, including all stakeholders, and cooperated with external parties on a structural basis. 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**

Chapter 3 showed that reduction of seclusion is not only a matter of implementing interventions. Reduction of coercion 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, a system innovation (Abma et al., 2009b; Van Raak, 2010).

An example of the importance of the combination of changes in practice, culture and structure can be seen in our study of the intervention ‘The first five minutes at admission’ (Chapter 4). To make this intervention work, changes in culture were needed. The traditional culture in mental health care institutions is characterized by a focus on control of the patient and on safety. This implies a reactive attitude, working from routine, regarding the patient as an object of care, and a closed attitude and culture. In the projects to reduce seclusion, mental health care institutions focused on changing these characteristics. Chapter 4 showed the importance of contact with the patient and a more individual approach. Values changed from control to contact and, instead of safety, care workers found it important to take (responsible) risks. Chapter 5 showed that a crisis card gives patients a voice in their own care around a crisis. They know best how to act in case of a crisis. In this way they became partners in care instead of just object of care. Moreover, due to the crisis card there is more attention for preventing a crisis instead of solving the crisis (from reactive to proactive). Chapter 6 showed that care workers can develop a learning and responsive attitude instead of routine. Care workers became more creative in dealing with a patient in crisis. Finally, chapter 7 showed the importance of contact and feedback. Peer providers can play an important role in this. The examination of the implementation of peer providers at a ward showed the need for developing new views on roles, relationships and responsibilities. Professionals should be open to patients becoming actually co-workers; and peer providers should adopt an attitude of cooperation, rather than one of being an advocate of the patient.

Next to changes in practice and culture, structural changes are needed in order to make interventions work. In many institutions, facilities were improved, for instance comfort rooms, open counters instead of closed nursing offices and one person bed rooms. Change in structure is not only a matter of facilities. A protocol, which for instance was developed in ‘the first five minutes at admission’, can be helpful to minimize uncertainties (Chapter 4). A crisis card provides a material basis which supports professionals and patients to discuss what should be done in case of a crisis, and to actually do this if a crisis occurs (Chapter 5). Moral Case Deliberation requires support by the manager, both political (putting it on the agenda) and practical (providing time for professionals to participate).

In conclusion, our studies show that interventions aimed at reducing seclusion require a change in practice, culture and structure. 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.

**Reflection on the main findings from a care ethics perspective**

Our main findings show that working routine, values, attitudes and structures play a crucial role in reducing seclusion. The interventions we studied both fostered and required a change in the relationship between professional and patient, a change from control to contact. These changes have an ethical dimension. This can be clarified by reflecting on the interventions from a care ethics perspective. This will show that care ethical theory can both help to explain changes required in reduction of seclusion, and provide input for such changes.

**Care as a process**

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. Tronto (2013) distinguishes five phases in the process of care: caring about, taking care of, care giving, care receiving and caring with. Chapter 4 showed the importance of the first phase of care: ‘caring about’. Being attentive to the needs of patients is crucial in the intervention ‘The first five minutes at admission’. Not being attentive means that care does not start well and is misdirected. Also the case of the crisis card showed that being aware of the needs is important. The description of the needs on the card ensures that care is in line with the wishes and values of the patient.

The crisis card is also a good example of the importance of the second phase of care, ‘taking care’. The card not only describes the signs of a crisis, but also the responsibilities of all parties involved in case of a coming crisis. In preventing seclusion, it is crucial not to wait until things get out of hand, but to take responsibility when signs of a coming crisis are present. The intervention ‘the first five minutes at admission’ shows that responsibility can take various forms. From a care ethics perspective, responsibility should address crucial needs. Although safety is often a relevant need, contact may be even more important. Thus, the responsibility of the staff at admission is not merely to ensure safety, but also to welcome the patient.

The third phase, care giving, is also a crucial element in the care process. It is not enough to be aware of a need and to take responsibility, action is also needed. This requires...
competence on the side of the care-giver. Competence can be fostered by protocols. Yet, protocols also require competence in applying the rules. Chapter 4 showed that the intervention ‘the first five minutes at admission’ implies more than strictly following the protocol. The application of a rule implies a ‘loving conversation’ between the rule and the characteristics of the situation (Nussbaum, 1986). It requires a context of mutual engagement and responsibility (Pettersen & Hem, 2011).

‘Care receiving’ is the fourth phase. In this phase the care giving is evaluated. Without and adequate response of the care receiver, the care process is not complete. One of the interventions to evaluate care is Moral Case Deliberation. By reflecting on a case retrospectively, a better view is generated on what went well and what did not. Moreover, in Moral Case Deliberation there is attention on how care can be improved in a next situation. Also the crisis card pays attention to evaluation of the care given in case of a crisis. If the needs are not met, the crisis card is modified.

The crisis card and Moral Case Deliberation can also be regarded as crucial elements in the fifth and last phase, ‘caring with’. In this phase democracy is pursued. In the process of care it is necessary to give a voice to all stakeholders in the allocation of caring responsibilities (Tronto, 2013). Vice versa, democracy needs care to solve problems of inclusion. In the crisis card responsibilities are made explicit. By the use of the crisis card, also the patient gets a voice in the allocation of responsibilities. In this way, the crisis card reinforces the empowerment of patients and creates more equality.

In Moral Case Deliberation a communicative climate is sustained in which all voices are heard and acknowledged which are important normative notions concerning dialogue (Weidema, 2014). In this process of dialogue responsibilities Americare get attention and are negotiable and are made transparent. Moreover, Moral Case Deliberation is a way to take care for a democratic environment.

Our studies showed that all phases of care are important in making interventions work. We noticed that professionals tend to emphasize care giving. This is especially the case for nurses, who are trained in providing care. For them, it is important to become sensitive to the other phases of care too. An intervention which can be helpful in this respect is Moral Case Deliberation (Chapter 6). It underlines the need to reflect before acting, and to take into consideration the perspectives of all parties involved. This provides a good basis for fostering attentiveness and responsiveness. Peer providers can also play a role fostering sensitivity for other phases, especially the phase of ‘caring about’. They can play a role in bridging the gap between patient and professional, creating mutual understanding and respect.

Relational autonomy

The concept of autonomy plays an important role in the ethical debate around 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. Thus, respect for autonomy may have the paradoxical consequence that by leaving the patient free to do as he or she likes, intervention is merely postponed. An attitude of non-interference then means that the patient is free to decide for him- or herself, until a situation of danger occurs, resulting in intervention.

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 (Verkerk, 1999). 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. The crisis card, presented in Chapter 5, is an example of an intervention which helps the patient to regain autonomy in case of a crisis. The crisis card describes the signs of a crisis and clarifies what should happen in this situation. The patient is supported by the crisis card counsellor and together they prepare a comprehensive crisis card plan. Via the crisis card, patients develop insight in their own crisis, its early signs, and actions that professionals should take in order to deal with the situation. Moreover the crisis card offers professionals new insight in the perspective of the patient.

The crisis card may be viewed as a means to foster patient’s responsibility in formulating their caring needs for future situations of crisis, helping them to entrust care for their well being in these situations to others (Gremmen, Widdershoven, Beekman, Zuijerhoudt & Sevenhuijsen, 2008). Other persons involved also have to clarify their responsibilities and competencies. By drafting a crisis card, patients recognize their vulnerability and accept that they need the help of others to prevent a crisis. According to Tronto (1993), acceptance of vulnerability is a precondition for autonomy. People are not independent from others, but live in relationships of dependency and need these relationships to be autonomous. Based on the notion of relational autonomy, Verkerk (1999) argues for ‘compassionate interference’, influencing a patient to make his or her life more bearable.
Moral responsibilities

From a relational perspective, 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. In an ethical approach based on autonomy as self-determination, the patient is responsible for his or her behaviour, and the responsibility of the professional is to intervene if the situation gets out of hand. In a care ethics approach, professionals, patients and family are both responsible for creating a situation in which crises can be prevented. The professional is not the only one responsible for averting danger; the patient has a role in that too.

From a care ethics perspective, moral life pivots around the distribution of responsibilities (Landweer, 2013; Walker, 2007). Projects aimed to reduce seclusion imply the need for a change in distribution of responsibilities. This study showed several changes in responsibilities.

One of the changes is described in chapters 3 and 4. Professionals at the ward now take responsibility themselves for deciding whether in an emergency admittance, the patient will be put in seclusion. Before, they acted on the advice of the ambulatory crisis team, which often resulted in immediate seclusion to prevent the safety of the patient and others. Professionals at the ward now regard themselves responsible for the assessment, and make their own judgement. They do not only look at safety, but also feel responsible for making contact, creating trust. Thus, responsibilities have changed, and new values have become dominant. Safety is no longer regarded as a condition for contact, but seen as a possible outcome of contact.

The introduction of the crisis card (Chapter 5) also leads to and requires changes in responsibilities. Patients take responsibility for formulating their caring needs. Moreover, the patient distributes the responsibilities for care giving among different stakeholders like professionals and family members. In this way also family members get responsibilities in case of a crisis.

The implementation of peer providers, described in Chapter 7, clearly resulted in changes in roles, relationships and responsibilities. An important issue for both care workers and peer providers was to clarify the tasks and responsibilities of a peer provider. Care workers doubted whether peer providers can perform tasks in the domain of the professionals, and had questions about the expertise of peer providers. They also thought that peer providers were too vulnerable themselves for working at an acute admission ward. Thus, the introduction of peer providers raised issues of responsibility, which needed serious attention. The peer provider intervention depended on finding new balances between professionals and patients, involving new definitions of identity and relationships.

Moral Case Deliberation can be helpful for participants to get insight in roles, relations and responsibilities, and to redefine them. In Chapter 6 it was shown that, as a consequence of Moral Case Deliberation, nurses experienced more equality in decision making. In the past, nurses simply had to execute the treatment policy determined by the psychiatrist. Nowadays, dialogue plays a central role, and policy making is regarded as a joint endeavour of psychiatrist and nurses. As a result, nurses feel more responsible for decisions in patient care.

An analysis of the interventions described in the previous chapters in terms of Walker’s care ethical theory on distribution of responsibility shows the importance of changes in the moral landscape of the ward. Walker’s theory helps to explain that changes at an ethical level are needed in order to make complex interventions work. It also shows that moral arrangements in which professionals and patients play a more equal role require learning processes and ‘negotiations’ in which parties become more responsible for the process as a whole.

Conclusion: no effect without ethics

In conclusion, care ethics theory can help to explain the (lack of) effects of interventions aiming to reduce coercion in mental health care. It sheds light on what is needed in the reduction of seclusion. There has to be attention for all phases of care, for relational (aspects of) autonomy and for redistribution of responsibilities. 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 in attempts to reduce seclusion in a structural way.

Care ethics can also learn from practices in mental health care. Our study shows that important ethical qualities can be materialized in interventions which help stakeholders to reorient and reorganize their practice. Examples such as the crisis card or Moral Case Deliberation can help various parties involved in mental health care to find a way to put...
elements of care ethics in practice. Empirical research can help clarifying what is needed to make care ethics work. Both by its design and by its outcomes, our study shows that care ethics can only be effective if stakeholders in practice define core values and develop practices of responsibilities in a shared and democratic way.

Strengths and weaknesses of the study

The research on which this thesis is based has several strengths and weaknesses. One of the strengths is the personal background of the researcher (the author of this thesis) and the prolonged engagement. Because the researcher was first a nurse in mental health care and later a researcher she knew the research field very well and thereby it was relatively easy to build trust with the respondents. Moreover, by the prolonged engagement an in-depth understanding of the phenomenon under study could be ensured. The personal background could also be a weakness because the researcher is possibly less objective and neutral. By working together and reflecting on the data repeatedly with fellow-researchers (with another background) we tried to enhance the trustworthiness of the data. Moreover, the reports of the interviews were subjected to a member check with the respondents in order to ensure trustworthiness of the data, as well as to validate the analysis (Meadows & Morse, 2001).

A second strength is that this thesis consists of studies with several methods. The combination of studies on a national level (chapter 2 and 3) and the case studies in different mental health institutions (chapter 4, 5, 6 and 7) has resulted in a broad scope and a balance between breadth and depth. We used quantitative and qualitative separately but we did not combine the different methods in a mixed methods design. A weakness is therefore that a qualitative interpretation of the quantitative data was lacking.

A third strength is the involvement of different stakeholder, such as nurses, peer providers, psychiatrist and managers. We have been able to study the perspective of the professionals. However, a weak point is the absence of the perspective of the patient and the family. Next to involving patients and their relatives in data collection, patients might join more actively in the research process as advisors or research partners (Abma, Nierse & Widdershoven, 2009; Nierse, Schipper, Zadelhoff, van de Griendt & Abma, 2011).

Finally, our research is situated in regular mental health care for adults and most of the data were collected on acute admission wards because at these wards there are generally the most seclusions. This may limit the generalizability. However, by the use of detailed descriptions of context, stakeholders and meaning (thick descriptions), readers can judge whether or not the findings apply in other settings like children and youth psychiatry, elderly psychiatry or forensic psychiatry.

Recommendations for research and practice

The lessons we have learned and the limitations of this study provide recommendations for future research and practice.

Research

Combining quantitative and qualitative research

Evaluation research may help participants in practice to get feedback on the effect of their attempts to reduce seclusion. This research should not take the form of an external judgement, but should empower practitioners and give them a voice. As a consequence of the explicit goal of the Dutch government and the branch organization for mental health care (‘Seclusion has to be reduced with ten percent each year, both in number and in duration!’), mental health care institutions tended to focus on quantitative results, that is reduction in number and duration of seclusion. However, a reduction as such does not imply that the quality of care (regarding seclusion) is improved. We have noticed that in some institutions, forced medication increased, or patients were locked up in other rooms than a seclusion room (substitution). Therefore, 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. Moreover, it is important to reflect on effect measures, and determine which outcomes are relevant. This also requires discussing outcome measures from a normative point of view. Care ethical values, such as trust and relational autonomy might play a role in discussions on outcome measures. Next to quantitative research, qualitative data are needed to get insight in experiences, processes and lessons learned. Because of the involvement of different stakeholders and the enhancement of the mutual understanding and the mutual learning between stakeholders, responsive evaluation is a suitable method (Abma, 2006; Abma & Widdershoven, 2005). In this study patients and their relatives were not involved. In studies in the future it is important that also patients and their relatives are involved and get an equal voice.

Research on effectiveness of interventions

Due to the cutbacks in Dutch mental health care, efficiency and effectiveness of interventions become more important, resulting in a growing need for evidence based interventions. In this study we investigated quantitative effects of interventions in general and qualitative effects of specific interventions as experienced by the stakeholders. Yet,
Moral reflection
In case of seclusion, professionals experience moral dilemmas and conflicting obligations. The theory of (care) ethics can play an important role in these dilemmas and in the reduction of seclusion. However ethics and morality starts with actual experience, not with theories and concepts. What is morally good should get defined within concrete situations and by means of a dialogue (Abma, Molewijk & Widdershoven, 2009; Molewijk et al. 2008). It is important to make use of the theory of (care) ethics but also “to do ethics”. Moral Case Deliberation is an example how “to do ethics”. Moral Case Deliberation considers practice as a source of moral wisdom: without a practice and the experiences of the stakeholders, moral knowledge (both from theory as from stakeholders) has no meaning. Theories and concepts are useful, but they should be grounded in real-life practice (Abma et al., 2009a; Widdershoven, Abma & Molewijk, 2009). As described in chapter 6, Moral Case Deliberation can play an important role in the reduction of coercion. In MCD participants explore new dimensions and perspectives and develop a new way of thinking that may lead to a shift in practice, culture and structure.

A real change in culture requires the awareness of the importance of moral reflection of professionals at all levels of the organization. Reflection should be facilitated by the managers. Reflection should not be considered as a source of inspiration and motivation only. Reflection partly determine the quality, effectiveness and efficiency of care.

High and Intensive Care (HIC)
The focus of this study was on the clinic. A lot of professionals indicated that often a patient is already in crisis when he or she is admitted. In this situation it is difficult to prevent seclusion. To prevent a crisis and seclusion successfully it is very important that also the outpatient care will change their working routines. The outpatient care has to work more pro-actively, preventive and more in cooperation with the clinic.

High and Intensive Care in mental health care (Van Mierlo, Bovenberg, Voskes & Mulder, 2013) may contribute to a more proactive way of working and a better cooperation between outpatient care and the clinic. At a high and intensive care unit, use is made of the lessons learned in the projects to reduce seclusion. Nevertheless, also in the implementation of HIC, changes in working routine, structure and culture should be combined.

Practice
Quality criteria revisited
The attention for reduction of seclusion started with raising awareness and formulating quality criteria for dealing with coercion (Berghmans et al. 2001). In the following years, mental health care institutions have focused on the development of interventions. A change in working routines was supposed to result in a reduction of seclusion. During this process, the quality criteria were translated into concrete and practical interventions. At the moment we know what needs to be done to put the recommendations formulated in the quality criteria into practice. However, this study indicates that sometimes professional and other stakeholders tend to forget what is at stake in the quality criteria. The core of the quality criteria is providing care from a number of central values like contact, engagement, responsibility, cooperation and responsiveness. It is therefore important to revisit the quality criteria and to pay more attention to the underlying care ethical principles in the reduction of seclusion.
References


