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Defining Seclusion: A Qualitative Multiphase Study Based on the Perspectives of Youth and Professionals in Secure Residential Youth Care in the Netherlands

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ABSTRACT

Using seclusion in youth mental health care is controversial, as it can have physical and psychological consequences for youth and professionals. Notably, there is a wide disparity in how seclusion is defined in literature and practice. This leads to a diffuse image of what seclusion comprises, complicates measuring its prevalence, and hampers initiatives to reduce its use. Therefore, the objective of this study was to establish an unambiguous and measurable definition of seclusion supported by youth and professionals in secure residential youth care in the Netherlands. A qualitative multiphase approach was used to examine which elements of the definition are essential and receive consensus among youth and professionals. After a brief literature review, a Delphi survey and focus groups were performed. In total, 11 (ex-)clients and 33 professionals with extensive experience in secure residential youth care participated. Youth and professionals arrived at the following definition: "an involuntary placement in a room or area the client is not allowed or able to leave". During the implementation process, observations showed broad support for the definition by youth and professionals. With this, a foundation has been provided to monitor and reduce the use of seclusion in secure residential youth care in the Netherlands.

KEYWORDS

Seclusion; residential youth care; perspectives of youth and professionals

Introduction

In the past decades, the use of seclusion has been the subject of much controversy. The rationale that seclusion can prevent injury and reduce agitation has long been the primary justification for its use (Gerlock & Solomons, 1983). Over the years, however, studies have indicated little evidence regarding the efficacy of seclusion (e.g., Day, 2002; Sailas & Fenton, 2000) and have challenged the supposed therapeutic value of seclusion (e.g., Day, 2002; Finke, 2001; Prinsen & Van Delden, 2009). More specifically, studies have reported

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that seclusion can have harmful physical and psychological consequences for both youth and professionals (e.g., Fisher, 1994; Haugom et al., 2019; LeBel et al., 2010). Also, qualitative studies have shown that, according to youth, professionals sometimes use seclusion for practical reasons or as punishment (Engström et al., 2020; De Valk et al., 2019).

More awareness of the detrimental effects of seclusion have led to efforts to reduce and prevent the use of seclusion in youth care facilities worldwide (e.g., Greene et al., 2006; LeBel et al., 2014; Roy et al., 2020; Wisdom et al., 2015). One of the most renown examples of such efforts are the six core strategies developed by the National Association of State Mental Health Program Directors (Huckshorn, 2004; NASMHPD, 2008). These specific core strategies are (a) leadership toward organizational change, (b) use of data to inform practice, (c) workforce development, (d) use of prevention tools, (e) improve consumer's role in inpatient settings, and (f) debriefing techniques (NASMHPD, 2008). Research by Azeem et al. (2011) showed a significant reduction in seclusion rates after the implementation of the six core strategies in a youth care setting. Other studies found similar results in youth care settings (e.g., Caldwell et al., 2014; Wisdom et al., 2015).

In the Netherlands, concerns regarding the use of seclusion have been raised as well by youth and professionals of secure residential youth care organizations and policymakers. In a recent report, Defence for Children (2018) described the regular use of seclusion in secure residential youth care in the Netherlands as disturbing. According to Defence for Children (2018), it is well known that seclusion is still commonly used in secure residential youth care organizations in the Netherlands, although its use is harmful. Also, seclusion prevalence rates are not monitored on a national scale. This lack of oversight hampers monitoring the process of seclusion reduction. At the same time, the Dutch Ministry of Health, Welfare and Sport (2018) published a statement in which they declared the ambition to reduce the use of seclusion in secure residential youth care to zero by 2022. In addition, all secure residential youth care organizations in the Netherlands have also expressed the ambition to reduce the use of seclusion (Jeugdzorg Nederland, 2018). Given the importance of reducing the use of seclusion in secure residential youth care in the Netherlands and monitoring this progress, it is necessary that all secure residential youth care organizations use the same definition of seclusion.

To date, however, definitions of seclusion vary largely. Earlier, a review by Mason (1992) led to the discovery of seven recurring themes to define seclusion: "place", "social isolation", "egress" (i.e., lack of choice in leaving the room or area used for seclusion), "compulsion" (i.e., the action or state of forcing or being forced to do something), "time", "rationale", and "establishment" (i.e., the formulation of the definition differs between organizations). However, the author concluded that there was little consensus in the literature regarding the definition of seclusion (Mason, 1992). Nowadays, there still is a wide disparity

in how studies define seclusion (e.g., Green-Hennessy & Hennessy, 2015; De Hert et al., 2011; Larue et al., 2009; Roy et al., 2019). This lack of a clear definition of seclusion is also noticeable in secure residential youth care organizations in the Netherlands. The Dutch Youth Act (Youth Act §6.3), which applies to secure residential youth care, does not provide a definition of seclusion: it only states that seclusion should be temporary. This allows secure residential youth care organizations to freely interpret the definition of seclusion and its use in practice. In addition, every secure residential youth care organization has created their own protocols and guidelines for the use of seclusion in practice. However, the Dutch Youth Act lacks a legal framework to verify the application of these different protocols and guidelines. Therefore, seclusion and its use can have a different meaning in each organization which hampers a joint strategy and learning process that is necessary to reduce the use of seclusion on a national scale. In that regard, it is of importance that the professionals of various secure residential youth care organizations, who will put this process into practice, have a voice and reach consensus in what defines seclusion. Youth will also be involved in this process, since they are the ones receiving care in the secure residential youth care organizations and thus have personal experience with and personal interest in the matter. Hence, an unambiguous and measurable definition of seclusion supported by both youth and professionals in secure residential youth care is warranted.

The current study is a first step in establishing a durable decrease of seclusion in secure residential youth care in the Netherlands. By developing a shared definition of seclusion supported by both youth and professionals it will become possible to monitor the use of seclusion in secure residential youth care on both a national and an organizational level. As such, the purpose of this study was to (a) develop an unambiguous and measurable definition of seclusion supported by youth and professionals in secure residential youth care; (b) examine to what extent consensus on a definition of seclusion can be reached; and finally (c) examine on which elements of the definition of seclusion consensus can be reached.

Method

Procedure

In this study, a qualitative data-based, four-phase approach was applied: 1) brief literature review; 2) Delphi survey; 3) focus groups; and 4) implementation (described below). The study as described in this article was part of a larger research project examining the development of a definition and a registration system of seclusion in secure residential youth care in the Netherlands. The development of a registration system for seclusion in secure residential youth care is beyond the scope of this article and will be described

elsewhere. Institutional Review Board approval for this research project was obtained through the Amsterdam University Medical Center, location VUmc (reference number: 2020.148).

Participants

Throughout this study, purposive sampling methods were used to recruit participants. At the start of this research project, the directors of all 11 organizations for secure residential youth care in the Netherlands were contacted and asked to nominate a professional of their organization to participate as an ambassador for this research project within their organization. Since some organizations had several locations and decided to nominate a professional of each location, this led to a total of 18 ambassadors. At the start of this research project (the group composition changed somewhat during the research project, e.g., due to resignation or maternity leave), this group consisted of 83.3% female (n = 15) participants. Of the 18 participating professionals, 27.8% were identified as a treatment supervisor (n = 5), 22.2% as a head of department (n = 4), 5.6% as a psychiatric nurse practitioner (n = 1), 5.6% as a teacher (n = 1), 5.6% as a researcher (n = 1), 5.6% as a social worker (n = 1), 5.6% as a project manager (n = 2), and 16.7% as a psychologist (n = 3). All nominated professionals agreed to participate as ambassador. During the entire research project, ambassadors were responsible for the implementation of the research project in practice and served as a contact person for the researchers. To support this process and exchange experiences, ambassadors got together every 6 weeks. Two members of Experienced Experts (ExpEx: an organization for youth who have recent personal experience with treatment in secure residential youth care) were asked to join these meetings.

To recruit participants for phase 2, the Delphi survey, all ambassadors of the 11 organizations for secure residential youth care received an e-mail with information about the Delphi survey and the aim of the study. In this e-mail, they were requested to nominate two to three professionals of different positions within the organization (to ensure representation of various professions within secure residential youth care) or youth receiving treatment in the organization to participate in the Delphi survey. After nomination, 29 potential participants were contacted via e-mail and requested to participate, of which 22 agreed (75.8%). Participants of the Delphi survey included 20 professionals and 2 clients of organizations for secure residential youth care. The sample consisted of 54.5% female (n = 12) participants. Of the 20 participating professionals, 5% were identified as a psychiatric nurse practitioner (n = 1), 15% as a treatment supervisor (n = 3), 15% as a head of department (n = 3), 15% as a managing director (n = 3), 25% as a social worker (n = 5), and 25% as a psychologist (n = 5).

To recruit participants for the focus groups, all ambassadors of the 11 organizations for secure residential youth care received an e-mail with information about the focus groups and the aim of the study. In this e-mail, they were requested to nominate two to three professionals of different positions within the organization (to ensure representation of various professions within secure residential youth care) or youth receiving treatment at the organization to participate in the focus groups. In addition, ExpEx was asked to recruit participants. This resulted in the nomination of 23 potential participants which were contacted via e-mail and requested to participate. One of the potential participants was not able to travel to the location where the focus group was held. Therefore, this participant was excluded. This resulted in a total of 22 participants (95.6%). Participants in the focus groups consisted of 13 professionals, 7 clients of secure residential youth care organizations in the Netherlands, and 2 young persons of ExpEx. The sample consisted of 54.5% female (n = 12) participants. Of the 13 participating professionals, 7.7% were identified as a psychomotor therapist (n = 1), 23.1% as a treatment supervisor (n = 3), 30.7% as a social worker (n = 4), and 38.4% as a psychologist (n = 5).

In total, 44 participants with experience regarding seclusion in secure residential youth care (i.e., for youth and ExpEx, having experienced a seclusion; for professionals, having performed a seclusion or being involved in the process) were included in the Delphi method and focus groups. Beforehand, all participants were provided with information about the study and were asked to give oral and/or written consent to participate. Both youth and professionals participating in the focus groups were given the possibility to declare their travel expenses. Furthermore, youth participating in the focus groups received a €10 gift card.

Four-phase Approach

Phase 1: Literature Review

In the first phase, elements of seclusion were identified via a brief literature review (e.g., Day, 2002; Green-Hennessy & Hennessy, 2015; De Hert et al., 2011; Larue et al., 2009; Mason, 1992; Roy et al., 2019). Then, the elements of seclusion that resulted from the literature review were discussed in a meeting with the ambassadors of all 11 organizations for secure residential youth care. In this meeting, a skillful moderator (i.e. multiple years of experience with moderating group meetings, not the same moderator as the one for the focus groups) encouraged the ambassadors to discuss the elements and, if necessary, include any additional elements. During this meeting, the first author was present as note-taker, observing and writing down verbal interactions between the ambassadors. These observations were used to identify the elements that should be considered for inclusion in the definition of seclusion.

Phase 2: Delphi Survey

In phase 2, a Delphi survey was used to develop a concept definition of seclusion. A Delphi survey is a group communication technique featuring an iterative, multistage process which is widely used to build consensus (Hsu & Sandford, 2007). A concept definition of seclusion was reached through an online survey with two consecutive rounds of questions to a group of participants, while building consensus among participants regarding important elements of the concept definition. The questions in the Delphi survey were based on the elements retrieved in phase 1.

In the Delphi survey (Hsu & Sandford, 2007), participants were asked to answer an online survey consisting of two consecutive rounds with open-ended questions. The first round focused on two main topics: i) "What is considered seclusion?"; and ii) "When is seclusion considered forced?" These topics were presented in eight open-ended questions (e.g., "What does the organization consider as seclusion?"; "In what type of rooms or areas does seclusion take place?"; "In which situations is seclusion needed?"; "Are there types of seclusion in which coercion is not needed?"). Following the first round, participants received a summary of the results of the first round and a new survey, based on the questions and answers of the first round, which consisted of four more in-depth, open-ended questions (e.g., "Which situations or what type of behavior can lead to the use of seclusion?"; "What is your opinion on seclusion of youth in their bedroom?") and one multiple choice question enabling participants to select which elements should be included in the concept definition of seclusion ("Alone"; "Involuntary"; "Locked room"; "Bedroom"; "Room specifically designed for the use of seclusion"). Subsequently, participants received a summary of the results of the second round of the Delphi survey, including a concept definition of seclusion. Participants were given the opportunity to share any suggestions regarding the concept definition. The complete surveys can be requested at the first author.

Phase 3: Focus Groups

Phase 3 consisted of focus groups. A focus group is a technique involving the use of in-depth group interviews, enabling richer data than one-on-one interviews due to the social interaction within the group (Rabiee, 2004). Individuals get to share their ideas and feelings about a topic with others in the group, allowing to shed a light on the similarities and differences in perspectives between and within groups of individuals (Rabiee, 2004). In the focus groups, participants provided feedback on the concept definition of seclusion, its elements and its operationalization in daily practice. The aim of the focus groups was to reach consensus on (the elements of) an unambiguous and measurable definition of seclusion that could be implemented in practice.

Participants of the focus groups were divided into four groups: two focus groups with professionals and two focus groups with youth. Professionals and youth were separated to ensure a safe environment in which they could speak openly. This way, youth did not have to take into account the effect of their opinions on professionals and vice versa. All 13 participating professionals were randomly divided over the two focus groups, resulting in one focus group with six professionals and one focus group with seven professionals. The two focus groups with youth were divided in one focus group with two participants of ExpEx and one focus group with seven participants of a secure residential youth care organization. All focus groups lasted two and a half hours with a fifteen-minute break. A skillful moderator (i.e., multiple years of experience with organizing and moderating focus groups) initiated the semi-structured discussion. By asking specific questions (e.g., "What is your opinion on the concept definition of seclusion?"; "Can the concept definition potentially be used in practice?"; "What is needed to reduce the use of seclusion in practice?") and facilitating interaction between participants, for example, by running a values walk (i.e., participants physically walked to different corners of the room to indicate whether they agreed or disagreed with the statements) and holding small group discussions, the moderator created an environment in which participants were encouraged to engage and exchange feelings, views and ideas about the concept definition of seclusion, its elements and its operationalization within practice. Furthermore, the first author was present as note-taker during all focus groups, observing and writing down both verbal and non-verbal interactions between participants.

Phase 4: Implementation

Lastly, phase 4 covered the implementation phase. The aim of this phase was to both implement and reassess the definition of seclusion. During a 6-month period, all 11 organizations for secure residential youth care implemented the definition of seclusion by using it to register seclusion in the electronic patient registration system. The implementation of the definition was discussed in meetings with the ambassadors of all 11 organizations for secure residential youth care and two members of ExpEx that took place every 6 weeks. In these meetings, a skillful moderator (i.e. multiple years of experience with moderating group meetings, not the same moderator as the one for the focus groups) encouraged attendees to exchange experiences with using and implementing the definition in practice. During all meetings, the first author was present as note-taker, observing and writing down verbal interactions between the attendees. These observations were used to reassess the definition of seclusion after the 6-month period.

Data Analysis

All data (i.e., responses to both rounds of the Delphi survey, notes of the focus groups by participants and the note-taker, observations during the

implementation process) were uploaded into the data analysis program MAXQDA. The first author analyzed all qualitative data, reading the responses and notes word by word. The first author then sorted, interrelated and grouped open codes through an inductive analysis (Thomas, 2006). Then thematic analysis (Braun & Clarke, 2012) was applied based on the elements of the definition of seclusion as identified in the literature review and meeting with the ambassadors. Each step of the analysis and reflection were carefully noted in a logbook by the first author and discussed with two senior researchers via peer debriefing (Creswell & Miller, 2000) to increase the reliability of the study. To ensure and further increase reliability, a member check was conducted (Creswell & Miller, 2000): after each round of the Delphi survey and after each focus group the findings were sent to each participant for verification.

Results

Phase 1: Literature Review and Meeting with Ambassadors

The results of the literature review and meeting with the ambassadors of all organizations for secure residential youth care showed that no clear definition of seclusion is used in both the scientific literature and in practice. Every study and every secure residential youth care organization uses a different combination of a wide range of elements to describe seclusion (e.g., involuntary placement in a room, solitary placement in a locked room, involuntary confinement of a client alone in a room or area from which he or she is physically prevented from leaving). As a consequence, multiple elements overlapped and recurred when defining seclusion. This led to the identification of the following elements for the definition of seclusion in secure residential youth care: types of rooms or areas used for seclusion, a solitary placement, the motivation for the use of seclusion, a description of the forced character of seclusion, the maximum duration of seclusion, and the consideration of the use of alternatives to seclusion.

Phase 2: Delphi Survey

First Round

The results of the first Delphi round showed that no clear definition is used to describe seclusion in secure residential youth care in the Netherlands. Some organizations provide a detailed description of seclusion (e.g., due to safety reasons the professionals decide to an involuntary placement in a locked seclusion room, placing youth in their bedroom with an open door for a period of 60 minutes or longer) whilst others give a more abstract description (e.g., involuntary placement in a room). Furthermore, there are organizations

that do not use the term seclusion. Instead, these organizations make a distinction between a pedagogical technique (i.e., telling a client to go to his or her bedroom) and an involuntary placement (i.e., placement in a locked room).

Next to the lack of a clear definition, organizations use a wide range of rooms (e.g., bedroom, time-out room, comfort room, seclusion room) for seclusion. According to professionals and youth, seclusion can take place in either the bedroom with a locked or open door, or in a room specifically designed for the use of seclusion. Professionals state that the different types of rooms for seclusion are used in an ascending order, with placement of youth in their bedroom being the first option, followed by placement in a time-out room or comfort room, and placement in a seclusion room being the last resort.

The extent of voluntariness also has a broad range. The treatment plan of the client – composed by a psychologist, the client and his or her parents or guardians – describes if and why the use of seclusion is allowed during treatment, the motivation for its use, the alternatives that should be used before proceeding to the use of seclusion, and the maximum duration of seclusion. If alternatives are insufficient and the client shows behavior that can be classified as an incident or emergency situation, the professional can decide to use seclusion according to the treatment plan. If seclusion is not included in the treatment plan and the client shows behavior that can be classified as an incident or emergency situation, the professional can decide to use seclusion according to the protocol used in the organization. In the latter case, a psychologist or treatment supervisor has to review the justification of the use of seclusion within 24 hours. According to youth and professionals an incident or emergency situation is best described as a situation in which the safety of the client or others cannot be guaranteed and earlier attempts to de-escalate the situation were insufficient. *Client: "It is an incident if you are a danger to yourself or others."* Professionals and youth state, however, that youth can also be secluded upon request, which professionals refer to as "voluntary seclusion". For most youth "voluntary seclusion" is described in their treatment plan and can, for example, be used in case of anxiety, psychosis, self-injurious behavior, and suicidal thoughts. "Voluntary seclusion" can take place in different types of rooms or areas, such as the bedroom, a time-out room, a seclusion room or the patio. Usually, the room or area is not locked in case of a "voluntary seclusion". *Professional: "Some youth choose to have a time-out in their room. Also, I have seen youth that requested to sleep in a seclusion room, because they were afraid they might harm themselves while spending the night in their bedroom."*

Second Round

Overall, respondents agreed with the summary of the first Delphi round. The respondents emphasized the large overlap in the way organizations perceive

seclusion. However, the summary also highlighted differences between organizations. For example, three professionals disagreed with using a minimal time limit as a way to describe seclusion. *Professional: "According to me, there is no minimal time limit to seclusion. A seclusion that lasts 10 minutes can have just as much impact on youth as a seclusion that lasts for over 60 minutes."* Furthermore, seclusion of youth in their bedroom created ambivalent feelings among professionals and youth. According to some of the professionals and youth, positive aspects of using a bedroom for seclusion is that a bedroom is a more humane environment and less invasive compared to a seclusion room. *Professional: "According to youth, their bedroom is a familiar and safe environment in which they have more opportunities to distract themselves and to calm down and connect with the professionals in a quicker way."* On the other hand, secluding youth in their bedroom detracts the bedroom from its familiar and safe environment. *Client: "The only private room we have in secure residential youth care is our bedroom. If seclusion can also take place in our bedroom, then this private space is gone."* Also, professionals state that the bedroom, other than a seclusion room, contains furniture and personal belongings which can complicate guaranteeing safety in case of potentially dangerous situations (e.g., aggression, self-injurious behavior, suicidal thoughts). In addition to the results of the first Delphi round, professionals and youth describe that seclusion is typically used in case of aggressive behavior, self-injurious behavior, suicidal behavior, psychotic behavior, and substance use.

The results of the second Delphi round also provide insight in which elements of the definition of seclusion are important to professionals and youth. Of all respondents, 73% ($n = 16$) state that "involuntary" should be included in the definition. Some professionals explicitly mention that they do not perceive and register "voluntary seclusion" as seclusion. *Professional: "In such cases we do not use coercion. Instead, it is a placement based on collaboration."* According to 64% ($n = 14$) of the respondents, "locked room" is an important element. Most professionals state that seclusion takes place in a locked room, regardless of the type of room. *Professional: "To me, 'locked room' is an important element of the definition of seclusion. In fact, telling youth to go to their bedroom and locking the door, is also seclusion. There is too little attention to this type of seclusion, they [professionals] should be more aware of that."* Other professionals point out that seclusion can also take place in a room that is not locked. *Professional: "It is seclusion if a client is placed alone, in a room (regardless of the room being locked or open) on an involuntary basis."* The element "alone" (i.e., without a professional or other youth) received support for inclusion in the definition by 50% ($n = 11$) of the respondents. Some professionals state that youth are always alone during seclusion. If a professional decides to stay with the client during seclusion, professionals do not perceive it as seclusion but as an intervention to support the client in regulating his or her tension and to prevent further escalation.

Professional: "When defining seclusion, I believe 'being alone' is a key element. To reduce the amount of seclusion, we [professionals] need to support the client in good and in bad times. We do not leave him or her alone. Instead, we help him or her through this difficult period in life." Lastly, 36% ($n = 8$) of the respondents marked "specifically designed room" as an element that should be included in the definition and "youth's bedroom" received 1% ($n = 1$) support for inclusion in the definition of seclusion. In conclusion, the abovementioned results and indicated elements of seclusion led to the following concept definition of seclusion: "the temporary and involuntary confinement of youth, alone and in a locked room".

Phase 3: Focus Groups

Professionals

Professionals stress that by using the concept definition of seclusion in practice, involuntary placing youth in their bedroom with a locked door would also be perceived as seclusion. According to this view, seclusion does not only take place in cases in which youth show behavior that indicates an incident or emergency situation but also at moments when professionals tell youth to go to their bedroom and lock the door behind them. For instance, as part of the daily program at moments when youth are being placed in their bedroom with a locked door (e.g., scheduled rest during shift change of professionals, scheduled rest during the night), and when a protocol demands locking in youth in their bedroom before handling an alarm situation at another group. Perceiving the placement of youth in their bedroom as seclusion led to divided opinions among participants. Supervisors, heads of departments and managing directors were critical of describing the placement of youth in their bedroom as seclusion. Instead, they perceive such placements as a pedagogical technique, enabling youth to calm themselves. Placement of youth in their bedroom, a time-out room or comfort room are not perceived as seclusion by them. According to supervisors, heads of departments and managing directors only the placement of youth in a seclusion room should be registered as seclusion. *Treatment supervisor: "It is important to decrease the use of the seclusion room, not the placements of youth in their bedroom."* This opinion led supervisors, heads of departments and managing directors to emphasize the need for a more specific description of the element "room or area" in the definition of seclusion.

Social workers and most psychologists were less critical compared to supervisors, heads of departments and managing directors. The concept definition and the discussion in the focus group led them to believe that placement of the youth in their bedroom is a type of seclusion instead of a pedagogical technique. In practice, social workers scale the rooms used for seclusion. The first step is trying to let the client calm him or herself in his or her bedroom (if

necessary the bedroom is stripped from all furniture and personal belongings). If placement in the bedroom is not perceived safe or is not effective in calming the client, placement in a time-out room or comfort room is considered. As a last resort, professionals can consider placing the client in a seclusion room. Therefore, social workers and psychologists emphasize describing seclusion as the placement of a client in a room, irrespective of the type of room. Another aspect social workers and psychologists point out are the policy differences between secure residential youth care organizations regarding leaving the bedroom door open or closed during scheduled rest moments. In some organizations the door of the bedroom is open during scheduled rest moments, whilst in others the door is locked. Yet in other organizations, the policy is to personalize the scheduled rest moments, enabling some youth to leave their bedroom during these moments, whilst others are not able to do so. According to some of the professionals having an "open door policy" during scheduled rest moments is nothing more than a sham. *Professional: "Youth are expected to stay in their bedroom during a scheduled rest moment, even if the door of their room is open. Also, it is part of their daily program, which is mandatory. So, to what extent is this seclusion voluntary or involuntary?"*

Next to the discussion about placement of the youth in their bedroom as a type of seclusion, opinions were also divided about whether "alone" should be included in the definition of seclusion. A minority of the professionals agreed with including this element in the definition of seclusion. However, most professionals state that seclusion can also take place while a professional is present (e.g., when the professional sits next to the client in a seclusion room). What is more important according to these professionals, is whether the client is involuntary secluded from other youth.

Lastly, some professionals mentioned the absence of the motivation and the aim for the use of seclusion in the concept definition. This way, the concept definition leaves room for seclusion without the necessity to be preceded by an incident or emergency situation. However, other professionals state that, in practice, seclusion is not always preceded by an incident or emergency situation. According to them, seclusion also takes place as a consequence of undesirable behavior (e.g., running away, not abiding the rules). *Professional: "It has become routine. If youth return late from leave, we have to impose sanctions."*

Youth

According to youth, seclusion is used in a broad range of situations. Examples of situations include an emergency situation, aggressive or suicidal behavior, not abiding by the rules of the organization, and a scheduled rest moment. Youth stress that in most situations, the use of seclusion can and should be avoided. Often, seclusion is used as a punishment if youth do not abide by the rules of the organization.

Moreover, choosing seclusion as a way to cope with aggressive or suicidal behavior can aggravate the behavior and possibly deteriorate the treatment relationship between the client and the professional. Rather than secluding youth in such situations, which gives them the feeling of being punished for their behavior, it is of importance for youth to have the opportunity to interact with someone. On the other hand, some youth state that in some situations it can be helpful to use seclusion. If a client, for example, shows self-injurious behavior in the presence of others, secluding that person from the group can be a way to restore the feeling of safety in the group. In conclusion, youth emphasize that the use of seclusion should always have a clear goal.

Youth also point out that the type of rooms and areas used for seclusion, and whether these rooms or areas can be locked, differ between organizations. In some organizations only the seclusion room can be locked, whilst in other organizations all rooms can be locked. Being locked in is an important aspect of seclusion for youth. Therefore, youth perceive a scheduled rest moment in their bedroom with a locked door as seclusion as well, although less invasive. *Client: "Being locked in during a scheduled rest moment is not because of something youth have done. We are not the problem, it is mandatory for all youth and part of the policy."* Youth highlight degrees in the use of seclusion. From least to most invasive, these are: bedroom, chill-out room, time-out room or comfort room, and seclusion room.

Regarding the concept definition, youth state that three of its elements are redundant. First of all, "temporary" is an element that is hard to grasp. *Client: "How long does 'temporary' last for? How do you decide how long a seclusion should last?"* Most youth think "temporary" refers to a short stay in a seclusion room, but that does not mean that the seclusion is over. Instead, it can continue in a different manner. For instance, if seclusion in a seclusion room is over, youth still have to go their bedroom earlier in the night than others during a period of seven days. Next, "voluntary" is something that does not exist in secure residential youth care according to youth. Instead, treatment in secure residential youth care in general is perceived as involuntary by youth. Youth also point out that "voluntary" seclusion can easily become involuntary if one does not abide by the rules (e.g., not wanting to be physically examined due to past traumatic events, which is in conflict with the policy of the organization). Usually, seclusion is not perceived as involuntary by the professionals, since at the start of treatment, youth agree with what is stated in their treatment plan regarding seclusion. In practice however, seclusion based upon what is mentioned in the treatment plan, can still feel involuntary to youth. Lastly, "alone" is something youth perceive as evident. A professional comes and checks upon you every 15 minutes during seclusion, but, essentially, you are there by yourself.

Definition

The results of the focus groups led to adjustments of the concept definition. Two of the elements of the concept definition, "temporary" and "alone", are left out. Youth emphasize that these elements are not distinctive. According to them, seclusion is always temporary and solitary. Moreover, professionals add that seclusion can also take place whilst the professional is present. Next, the element "locked" is replaced by not being allowed to leave the room or area. Although being locked in is an important element of seclusion according to youth, some professionals state that seclusion can also take place without locking the door of the room or area. This element is associated with the degree of involuntariness. In the definition, "involuntary" is retained as an element of seclusion, since both professionals and youth state that seclusion is always involuntary. However, there are degrees in involuntariness (e.g., scheduled rest moment, seclusion after an incident, seclusion as described in the treatment plan) which should be taken into account in practice. Concluding, these adjustments to the concept definition of seclusion resulted in a definitive definition in which seclusion is "an involuntary placement in a room or area the client is not allowed or able to leave".

Phase 4: Implementation

At the start of the implementation process (i.e., using the definition to register seclusion in the electronic patient registration system), not all ambassadors agreed upon describing and registering the involuntary placement of a client in a room with an open door as seclusion. In their opinion, the definition of seclusion was too broad. During the six-month period, however, the broad and final definition of seclusion increasingly received support among all ambassadors. Youth of ExpEx that attended the meetings that took place every six weeks also supported the broad definition of seclusion. Both youth of ExpEx and ambassadors of all 11 organizations for secure residential youth care emphasized that the three main elements (i.e., "involuntary", "room or area", "not allowed or able to leave") were clear. Furthermore, ambassadors noticed that these elements were supportive in conversations about what seclusion means with professionals in their organization. By using a broad definition to register seclusion, awareness has been raised amongst professionals about what seclusion means. Before, seclusion of youth in their bedrooms remained unregistered and therefore unnoticed. Now, professionals have become more aware of the various types of seclusion that exist in practice. Thus, the implementation phase did not lead to a reassessment of the definition but to the embracement of a broad definition of seclusion and a greater awareness of various types of seclusion. Further, the implementation of a broad definition of seclusion has led to adjustments on different levels: from searching for alternatives (e.g.,

exercising, going for a walk with a professional, being able to call the parents at night in case of trouble falling asleep) to modifications in policies of organizations (e.g., eliminating a scheduled rest moment). In sum, the definition of seclusion, as developed by youth and professionals in secure residential youth care, receives support and appears to be a good base to gain insight in the patterns of (the use of) seclusion which in turn provides starting points to reduce the use of seclusion.

Discussion

In order to arrive at an unambiguous and measurable definition of seclusion supported by youth and professionals, the current study investigated the perspectives of youth and professionals in secure residential youth care. The results indicate that youth and professionals agreed upon including the following elements in the definition of seclusion: "involuntary" and "placement in a room or area". "Temporary" and "alone" were elements that were not perceived as distinctive, and were therefore not included in the definition. Another element, "locked", did not lead to full consensus. Instead, it was replaced by "not being allowed or able to leave the room or area". This led to the following definition of seclusion: "an involuntary placement in a room or area the client is not allowed or able to leave".

To our knowledge, no previous study has developed a definition of seclusion by identifying which elements of the definition receive consensus from youth and professionals in practice. Earlier, a review (Mason, 1992) did evaluate the way seclusion was defined in 166 articles and books on seclusion and found seven recurring elements: "place", "social isolation", "egress", "compulsion", "time", "rationale", and "establishment". All seven elements as described by Mason (1992) recurred in the responses and discussions of youth and professionals in the process of developing a definition of seclusion. For instance, with respect to "place" and "egress", youth and professionals that participated consistently made reference to a designated area in which seclusion takes place and the lack of choice of youth in leaving this designated area. Further, youth and professionals considered "social isolation" and "time" as important (the elements were included in the concept definition) but not as distinctive, and were therefore excluded. This demonstrates that, through time, not much has changed regarding which elements are seen as important in defining seclusion. In practice, however, not all elements received enough consensus to be included in the definition. Nonetheless, it is recommended to include such elements (e.g., "rationale", "time") in the registration of seclusion, since it enables the obtainment of more in-depth information about the process of seclusion in practice. Subsequently, analyzing this type of information can provide insights which can support the reduction of the use of seclusion and enable measuring its progress.

Further, close attention should be paid to the various types of seclusion that exist in practice. The process of defining seclusion was characterized by a diversity of opinions among participants. For instance, some participants stated that seclusion takes place in a locked room which prevents the client from leaving, whereas other participants described that seclusion can also take place in a room that is not locked which clients are not allowed to leave. This diversity of opinions is reflected in the broad definition of seclusion: it is a comprehensive concept which includes various types of seclusion that are used in practice. The large variety in types of seclusion can be demonstrated by dividing the definition of seclusion into three axes. On the first axis, the autonomy of youth is stated. There are two extremes on this axis. On the one hand, the client is in control and chooses to be secluded on a voluntary basis which is written down in the treatment plan. On the other hand, the client is secluded on an involuntary basis. Between these two extremes there are degrees of autonomy. For instance, seclusion does not always go hand in hand with physical resistance by youth. On the second axis, the room or area in which seclusion takes place is stated. This can either be the bedroom or a seclusion room, and anything in between. The third axis is related to egress (as described by Mason, 1992). On the one side of the axis, youth are secluded in a locked room or area which prevents them from leaving. On the other side of the axis, youth are secluded in an open room or area which they are not allowed to leave.

Registering seclusion by using a broad definition provides the opportunity to reveal the various types of seclusion that are used in practice. This also applies to the rationale for the use of seclusion in practice. For instance, some participants stated that seclusion is preceded by an incident or emergency situation, whereas other participants mentioned that seclusion is sometimes used for practical reasons (e.g., scheduled rest during shift change of professionals, when a protocol demands locking in youth in their bedroom before handling an alarm situation at another group) or as a consequence of undesirable behavior (e.g., running away, not abiding the rules). The use of seclusion for practical reasons or even as a consequence of undesirable behavior has also been described in recent research (Engström et al., 2020; De Valk et al., 2019) and confirms the need to make seclusion practices transparent. This can be done by using a broad definition to register and monitor the different aspects that are related to use of seclusion. In turn, such information can serve as a starting point for conversations about which types of seclusion one may want to decrease and which types one may want to entirely diminish. In order to track the progress of decreasing different types of seclusion, it may be helpful to divide the broad definition of seclusion in different categories in the future. This has been done before in an earlier study (Day, 2002), although this was not supported by qualitative or quantitative

research. Therefore, future research should focus on different types of seclusion and include both qualitative and quantitative measures to determine how the different types of seclusion can be reduced and monitor this process.

The purpose of the current study was to develop an unambiguous and measurable definition of seclusion supported by youth and professionals in secure residential youth care. This study has shown that it is possible to reach a broad and measurable definition of seclusion that receives support from both youth and professionals in secure residential youth care. In practice, the implementation and the registration of the broad definition of seclusion was supportive in conversations with professionals and helped creating more awareness among professionals of the various types of seclusion that exist in practice. However, the results have also shown that the broad definition of seclusion is not unambiguous. As previously stated, the definition of seclusion is a comprehensive concept which includes various types of seclusion that are used in practice. This was demonstrated by both the different motivations for the use of seclusion and the three axes of seclusion: 1) autonomy; 2) room or area; and 3) egress. Therefore, it is essential to develop a uniform registration system to monitor the use of seclusion and the different aspects that are related to it (e.g., rationale, room or area, egress) over time for all secure residential youth care organizations in the Netherlands. There are multiple benefits to the use of a uniform registration system. First, a uniform registration system of seclusion can provide detailed insight in several important areas, such as patterns related to the duration of seclusion, the rationale to use seclusion, the rooms or areas used for seclusion. This way, it might be possible to derive different types of seclusion from the data. Second, the data of such a registration system can be used to analyze the use of seclusion and the patterns that are related to it on an organizational level. This also includes monitoring the progress on decreasing the use of seclusion. The results of these analyses can then be used as valuable input to stimulate change in the use of seclusion on an organizational level. Thus, the patterns that can be derived from the data can be used as feedback and can serve as starting points to change the use of seclusion in secure residential youth care organizations. Lastly, a uniform registration system enables monitoring the (decreasing) use of seclusion and its different types and patterns over time on a national level.

Limitations

This study has some limitations. The most important limitation is the selection of participants: although maximum diversity in the sample of youth and professionals was aimed for and participation was voluntary, the study relied on those youth and professionals who had been nominated by the ambassadors of the organizations and whether the nominees were willing to participate.

Nominees who were not willing to participate could have had a different opinion on the topic addressed in this study. Further, the Delphi survey performed in this study consisted of only two rounds, whereas three rounds seems optimal to ensure meaningful results (Hsu & Sandford, 2007). However, due to time limitations, it was not possible to organize an additional round. Moreover, one of the focus groups consisted of only two participants whilst the optimum number lies between six and ten (Rabiee, 2004). Despite this limitation, it must be noted that the participants in this focus group appeared to state and discuss their opinions openly.

Conclusion

This study arrived at the following definition: "an involuntary placement in a room or area the client is not allowed or able to leave". This constitutes a broad and measurable definition of seclusion that is supported by both youth and professionals in secure residential youth care in the Netherlands. With this, a foundation has been laid to monitor the use of seclusion, learn from feedback on its use, and reduce seclusion in secure residential youth care in the Netherlands. This approach is in line with one of the six core strategies (i.e., use of data to inform practice) to reduce the use of seclusion (NASMHPD, 2008). Future research should focus on the prevalence and types of seclusion used in secure residential youth care. By developing a uniform registration system for all secure residential youth care organizations, it will become possible to monitor and provide feedback on the (decreasing) use of different types of seclusion on an organizational as well as on a national level.

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References

Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing*, *24* (1), 11–15. https://doi.org/10.1111/j.1744-6171.2010.00262.x

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper (Ed.), *The handbook of research methods in psychology* (pp. 57–71). American Psychological Association.

Caldwell, B., Albert, C., Azeem, M. W., Beck, S., Cocoros, D., Cocoros, T., Montes, R., & Reddy, B. (2014). Successful seclusion and restraint prevention efforts in child and adolescent programs. *Journal of Psychosocial Nursing and Mental Health Services*, *52*(11), 30–38. https://doi.org/10.3928/02793695-20140922-01

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, *39*(3), 124–130. https://doi.org/10.1207/s15430421tip3903_2

Day, D. M. (2002). Examining the therapeutic utility of restraints and seclusion with children and youth: The role of theory and research in practice. *American Journal of Orthopsychiatry*, *72*(2), 266–278. https://doi.org/10.1037/0002-9432.72.2.266

De Hert, M., Dirix, N., Demunter, H., & Correll, C. U. (2011). Prevalence and correlates of seclusion and restraint use in children and adolescents: A systematic review. *European Child & Adolescent Psychiatry*, *20*(5), 221–230. https://doi.org/10.1007/s00787-011-0160-x

De Valk, S., Kuiper, C., Van Der Helm, G. H. P., Maas, A. J. J. A., & Stams, G. J. J. M. (2019). Repression in residential youth care: a qualitative study examining the experiences of adolescents in open, secure and forensic institutions. *Journal of Adolescent Research*, *34*(6), 757–782. https://doi.org/10.1177/0743558417719188

Engström, I., Engström, K., & Sellin, T. (2020). Adolescents' experiences of the staff's different interaction styles in coercive youth care in Sweden: a qualitative study. *Issues in Mental Health Nursing*, *41* (11), 1027–1037. Advance online publication. https://doi.org/https://doi.org/10.1080/01612840.2020.1757794

Finke, L. M. (2001). The use of seclusion is not evidence-based practice. *Journal of Child and Adolescent Psychiatric Nursing*, *14*(4), 186–190. https://doi.org/10.1111/j.1744-6171.2001.tb00312.x

Fisher, W. A. (1994). Restraint and seclusion: A review of the literature. *The American Journal of Psychiatry*, *151*(11), 1584–1591. https://doi.org/10.1176/ajp.151.11.1584

Gerlock, A., & Solomons, H. C. (1983). Factors associated with the seclusion of psychiatric patients. *Perspectives in Psychiatric Care, 21*(2), 46–53. https://doi.org/10.1111/j.1744-6163.1983.tb00173.x

Greene, R. W., Ablon, J. S., & Martin, A. (2006). Use of collaborative problem solving to reduce seclusion and restraint in child and adolescent inpatient units. *Psychiatric Services*, *57*(5), 610–612. https://doi.org/10.1176/ps.2006.57.5.610

Green-Hennessy, S., & Hennessy, K. D. (2015). Predictors of seclusion or restraint use within residential treatment centers for children and adolescents. *Psychiatric Quarterly*, *86*(4), 545–554. https://doi.org/10.1007/s11126-015-9352-8

Haugom, E. W., Ruud, T., & Hynnekleiv, T. (2019). Ethical challenges of seclusion in psychiatric inpatient wards: A qualitative study of the experiences of Norwegian mental health professionals. *BMC Health Services Research*, *19*(1), 879. https://doi.org/10.1186/s12913-019-4727-4

Hsu, -C.-C., & Sandford, B. A. (2007). The Delphi technique: Making sense of consensus. *Practical Assessment, Research, and Evaluation*, *12*(10), 1–8. https://doi.org/10.7275/pdz9-th90

Huckshorn, K. A. (2004). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services*, *42*(9), 22–33. https://doi.org/10.3928/02793695-20040901-05

Jeugdzorg Nederland. (2018). *Ambitie Jeugdzorg Nederland: Jeugdzorg(Plus) zonder gedwongen afzonderingen [Ambition Youth Care Netherlands: (secure residential) youth care without seclusion]*. Jeugdzorg Nederland. Retrieved June 18, 2020, from https://www.jeugdzorgnederland.nl/actueel/jeugdzorgplus-zonder-gedwongen-afzonderingen/

Larue, C., Dumais, A., Ahern, E., Bernheim, E., & Mailhot, M. P. (2009). Factors influencing decisions on seclusion and restraint. *Journal of Psychiatric and Mental Health Nursing*, *16*(5), 440–446. https://doi.org/10.1111/j.1365-2850.2009.01396.x

LeBel, J. L., Duxbury, J. A., Putkonen, A., Sprague, T., Rae, C., & Sharpe, J. (2014). Multinational experiences in reducing and preventing the use of restraint and seclusion. *Journal of Psychosocial Nursing and Mental Health Services*, *52*(11), 22–29. https://doi.org/10.3928/02793695-20140915-01

LeBel, J. L., Huckshorn, K. A., & Caldwell, B. (2010). Restraint use in residential programs: Why are best practices ignored? *Child Welfare*, *89*(2), 169–187.

Mason, T. (1992). Seclusion: Definitional interpretations. *The Journal of Forensic Psychiatry*, *3* (2), 261–270. https://doi.org/10.1080/09585189208407770

Ministry of Health, Welfare and Sport, and Ministry of Justice and Security (2018). *Actieprogramma Zorg voor de Jeugd [action program care for youth]*. Ministry of Health, Welfare and Sport, Ministry of Justice and Security. Retrieved June 18, 2020, from https://www.rijksoverheid.nl/documenten/rapporten/2018/04/01/actieprogramma-zorg-voor-de-jeugd

National Association of State Mental Health Program Directors [NASMHPD] (2008). *Six core strategies for reducing seclusion and restraint use©*. National Association of State MentalHealth Program Directors [NASMHPD]. Retrieved June 18, 2020, from https://www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use

Prinsen, E. J. D., & Van Delden, J. J. M. (2009). Can we justify eliminating coercive measures in psychiatry? *Journal of Medical Ethics*, *35*(1), 69–73. https://doi.org/10.1136/jme.2007.022780

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society*, *63*(4), 655–660. https://doi.org/10.1079/PNS2004399

Roy, C., Castonguay, A., Fortin, M., Drolet, C., Franche-Choquette, G., Dumais, A., Lafortune, D., Bernard, P., & Geoffrion, S. (2019). The use of restraint and seclusion in residential treatment care for youth: A systematic review of related factors and interventions. *Trauma, Violence & Abuse*, 1–21. https://doi.org/10.1177/1524838019843196

Roy, C., Morizot, J., Lamothe, J., & Geoffrion, S. (2020). The influence of residential workers social climate on the use of restraint and seclusion: A longitudinal study in a residential treatment center for youth. *Children and Youth Services Review*, *114*, 105035. https://doi.org/10.1016/j.childyouth.2020.105035

Sailas, E. E. S., & Fenton, M. (2000). Seclusion and restraint for people with serious mental illnesses. *Cochrane Database of Systematic Reviews*, (1), Article CD001163. https://doi.org/10.1002/14651858.CD001163

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237–246. https://doi.org/10.1177/1098214005283748

UNICEF Nederland and Defence for Children (2018). *Jaarbericht Kinderrechten 2018 [Annual report on children's rights 2018]*. UNICEF Nederland and Defence for Children. Retrieved June 18, 2020, from https://www.unicef.nl/files/DFC-18%20Jaarbericht_TOTAAL_WT_LR.pdf

Wisdom, J. P., Wenger, D., Robertson, D., Van Bramer, J., & Sederer, L. I. (2015). The New York state office of mental health positive alternatives to restraint and seclusion (PARS) project. *Psychiatric Services*, *66*(8), 851–856. https://doi.org/10.1176/appi.ps.201400279

Youth Act § 6.3 (2020). Retrieved June 18, 2020, from https://wetten.overheid.nl/BWBR0034925/2020-03-19