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ORIGINAL RESEARCH

Professionals' Attitudes Toward Reducing Restraint: The Case of Seclusion in The Netherlands

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Abstract
Introduction Despite public opinion and policy interventions, restraint remains a common practice. This is also the case in the Netherlands, where projects aimed to reduce seclusion, have not lead to a decreased use of restraint. Is this lack of effectiveness related to attitudes of the professionals? The aim of this study was to explore the attitudes of professionals working in mental health care toward restraint.
Method A questionnaire with eight scales was constructed for measuring attitudes of professionals. Scores of 540 professionals were studied, using analysis of variance and cluster analysis and related to several personnel and organizational characteristics.
Results The more professionals were personally involved in seclusion, the more they believed in it. Three types of professionals were identified: Transformers, Doubters and Maintainers. More than half of the psychiatrists (56%) belonged to the type of maintainers. Nurses were more divided.
Conclusion Professionals working in clinical settings are not really opposed to restraint. This could explain the limited effects of innovation projects.

Keywords Restraint · Seclusion · Attitudes · Psychiatrists · Nurses

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Introduction

Restraint is frequently used in mental health care, despite it remains controversial [1–3]. As in many other western countries, also in the Netherlands we see a strong tendency to reduce restraint. Although there is a 'grey zone' concerning the numbers of restraints [4, 5], it appears seclusion in the Netherlands dominates practice [6] and because of this its use is higher than in other western countries [7]. In this study restraint is defined as containment methods which restrict the patient's freedom, and seclusion is defined as placement and retention of an inpatient in a locked bare room. During the last 5 years, a number of projects that are mainly directed at the reduction of seclusion have been developed and executed in Dutch mental health institutions. Even if the majority of these projects seem to be successful in reducing restraint [8], the total number of restraints in Dutch health care sector has yearly increased rather than decreased [9]. This disappointing result is not just a Dutch phenomenon, but seems to be typical for most western countries [10, 11]. One obvious explanation is the willingness of professionals to change their own practice. If they are not convinced of the desirability and necessity of reducing restraint, the current practice of constraint remains [12]. Systematic research into what professionals think about restraint is lacking [13]. The present study tries to fill this gap by investigating the attitudes professionals have toward and their experiences with constraints as well as their participation in projects aimed at reducing seclusion.

Method

Sample and Procedure

The study was focused on professionals in mental health care who were involved in seclusion of psychiatric inpatients, concerning a sub population of the total of mental health care workers. Between 2003 and 2006, 750 of the included professionals were invited to fill in the questionnaire 'Professionals' attitudes toward seclusion'. The questionnaires were not randomly distributed, as there was no readily available sample. Instead, we used three different strategies. The professionals were approached at various working environments, inside as well as outside their practices and institutes: during two national conferences on restraint and coercion (n = 259), on twenty-one wards with rooms for seclusion at ten psychiatric institutes at four regions (n = 198), and during two local meetings concerning restraint and aggression (n = 83). A total of 540 respondents (response = 73%) completed the questionnaire. This sample strategy was considered a large part of the population to represent.

One-third of the respondents (32%) were aged between 40 and 50 years, while respondents aged 50 and over were the smallest group (18%). A total of 46% of the respondents were male and 52% female. Nearly 70% of respondents were nurses, 11% psychiatrists, 5% psychologists or psychotherapists, and 8% non-verbal therapists or social workers. Ninety-one percent of respondents had working experience of seclusion of psychiatric patients, and approximately half (47%) had had more than 5 years of experience of seclusion. Almost 80% of respondents were actively involved in seclusion, 15% 2–7 times a week and 5% often than once a day.

Thirty-one percent of respondents indicated that they had taken part in a project directed at the reduction of seclusion and 10% indicated that they were starting a restraint and coercion project in the near future.

Instruments

Data from respondents were collected by means of the questionnaire 'Professionals' attitudes toward seclusion', which was especially developed for this purpose. Aside from a few questions on personal data (gender and age) and professional background (discipline, working experience of seclusion and personal involvement in seclusion), the questionnaire was divided into three parts [14]. Part 1 consisted of 14 statements on the different functions of seclusion [15]: as a form of treatment, as a necessary evil and as having an unjustifiable impact on patients. Sample of items include the following: 'seclusions that last longer than 24 h defeat the object of the exercise' and 'the seclusion room should provide a non-stimulating environment'. In part II, the respondents were asked about 17 possible causes of seclusion, including threat and violence, the prevailing culture on the ward also [16]. Two of the items were: 'nurse feels unsafe' and 'approach to the patient'. Part III contained a list of 12 alternatives to seclusion assessed by items such as 'improving protocols', 'make ward rules more flexible' and 'more nurses' [17].

Exploratory factor analyses using principal components (PC) extraction with varimax rotation were conducted on each of the three parts of the questionnaire to examine the construct validity. The number of components was obtained by using the criterion eigenvalue >1 and the scree test as an extraction rule combined with interpretability of the factors [18]. PC analysis of the items in part I (function of seclusion) resulted in two interpretable components: ethics and confidence in seclusion. The results of the factor analysis of the items in part II (reasons for seclusion) showed three components, each of which represents different reasons: culture, treatment and threat. PC analysis of the items in part III (alternatives to seclusion) resulted also in three components: better care, other care and more care. Based on these analyses, scales were constructed for each of the variables. Scores on these variables consisted of the average sum scores of the original items.

In Table 1, we present the reliability estimates (Cronbach's alpha) of the scales. From this table we can see that the reliability of the variables ranged from good (better care) to satisfying (ethics). The reliability of the variables confidence in seclusion and other care was low and that of more care was very low. This will be taken into account when the results are interpreted.

Data Analysis

Descriptive statistical analyses (frequencies, means, standard deviations) were performed first, followed by univariate analyses of variance (ANOVA) to examine the relationship

Table 1 Number of items, alpha-values and explained variances of the factors according to seclusion

Seclusion	Factors	Number of items	α	R^2 (%)	Total R^2 (%)
Nature and function	Ethics	8	0.68	18	35
	Confidence	6	0.58	17	
Reasons	Culture	7	0.82	23	52
	Treatment	6	0.69	15	
	Threat	4	0.70	14	
Alternatives	Better care	7	0.84	28	55
	Other care	2	0.51	16	
	More care	3	0.30	11	

between personal and professional characteristics and attitudes toward seclusion. Differences between the groups were investigated using post hoc tests (Bonferroni). Furthermore, two-step cluster analysis with likelihood as distance measure was conducted to identify types of mental health care professionals on the basis of the scores of the eight variables. The relationship between the found three clusters and the personal and professional characteristics was examined by means of χ^2 tests. Finally, the relationship between the three clusters and degree of participation in a restraint and coercion project was investigated using one-way analysis of variance (ANOVA).

Results

Descriptive Statistics

Table 2 shows the mean scores of professionals on the eight variables of seclusion (range 1–4). Where the nature and function of seclusion was concerned, the professionals valued ethical considerations over confidence in seclusion (GLM RM: $F(1,449) = 37.38$; $P < 0.001$). In other words, professionals were shown to have numerous questions about the necessity and desirability of seclusion. Questions concerning the consequences of seclusion were also raised. However confidence in the use of seclusion was also expressed. The professionals recognized that the reasons for seclusion often originated in the concrete work setting in particular: threat being the foremost reason ($F(2,483) = 478.12$; $P < 0.001$). Seclusion was seen as a means of coping with threatening situations. Where the alternatives of seclusion were concerned, the preference of the professionals was unambiguous: ($F(2,491) = 686.78$; $P < 0.001$) the use of seclusion will only decrease if current levels of care are increased, i.e. when bedside staffing levels are increased.

Relationship to Individual Characteristics

Table 3 shows the results of the univariate analyses of variance with regard to the relation between personal and professional characteristics and the eight seclusion variables. The section dealing with ethics showed significant differences by age (the number of ethical questions increased with age), by discipline (psychiatrists and nurses raised fewer ethical concerns) and by personal involvement in seclusion (the greater the distance from the primary process, the more ethical questions were raised). Confidence in seclusion was

Table 2 Mean and SD of the eight variables according to seclusion

Seclusion	Variables	Mean	SD
Nature and function	Ethics	2.74	0.38
	Confidence	2.56	0.42
Reasons	Culture	2.91	0.53
	Treatment	2.47	0.48
	Threat	3.23	0.45
Alternatives	Better care	2.90	0.52
	Other care	1.79	0.73
	More care	3.09	0.46

Table 3 Comparison between mean values of characteristics of professionals from mental health care according to variables of seclusion

Characteristics of professionals	N	Seclusion	Nature and function		Reasons			Alternatives		
		Variables	Ethics	Confidence	Culture	Treatment	Threat	Better care	Other care	More care
Gender	250	Man	2.70	2.52	2.86	2.40	3.20	2.81	1.83	3.06
	279	Woman	2.77	2.59	2.94	2.55	3.25	2.96	1.74	3.10
			F(1,420) = 3.31	F(1,426) = 0.90	F(1,446) = 1.95	F(1,440) = 12.45**	F(1,457) = 2.86	F(1,446) = 8.61*	F(1,450) = 0.60	F(1,456) = 2.89
Age in years	118	<30	2.67 ⓪	2.63	2.98	2.51	3.25	2.89	1.60	3.10
	153	30–40	2.70	2.61	2.91	2.49	3.23	2.86	1.71	3.12
	173	40–50	2.75	2.48	2.91	2.48	3.24	2.90	1.89	3.11
	96	50>	2.87 ⓪	2.51	2.81	2.40	3.17	2.96	1.98	2.97
			F(3,420) = 3.20*	F(3,426) = 1.93	F(3,446) = 1.64	F(3,440) = 0.30	F(3,457) = 0.63	F(3,446) = 1.65	F(3,450) = 0.88	F(3,456) = 1.68
Discipline	368	Nurse	2.71 ⓪	2.61 ⓪	2.89	2.48	3.20	2.89	1.76	3.12
	60	Psychiatrist	2.60 ①	2.44	2.90	2.44	3.37	2.68	1.60 ⓪	3.11
	26	Psychologist	2.95	2.21 ⓪①	3.03	2.52	3.36	2.93	1.92	2.92
	6	Non-verbal ther.	2.78	2.46	2.87	2.27	3.31	3.03	1.75	2.89
	36	Social worker	2.78	2.69 ①	3.00	2.50	3.22	3.05	1.69	2.98
	44	Other	3.05 ⓪①	2.35	2.90	2.42	3.20	3.03	2.42 ⓪	3.01
			F(5,420) = 2.29*	F(5,426) = 3.62*	F(5,446) = 0.82	F(5,440) = 0.80	F(5,457) = 2.76*	F(5,446) = 2.05	F(5,450) = 2.42*	F(5,456) = 0.92

Table 3 continued

Characteristics of professionals	N	Seclusion	Nature and function		Reasons			Alternatives		
		Variables	Ethics	Confidence	Culture	Treatment	Threat	Better care	Other care	More care
Working experience of seclusion	44	None	2.99	2.46	2.97	2.52	3.27	2.99	2.00	2.94 ⓪
	98	<1 year	2.74	2.58	2.91	2.42	3.15	2.87	1.68	3.00
	41	1–2 years	2.67	2.67	2.91	2.46	3.22	2.90	1.71	3.15
	99	2–5 years	2.70	2.57	2.96	2.50	3.24	2.94	1.71	3.16 ⓪
	105	5–10 years	2.74	2.59	2.86	2.48	3.27	2.85	1.68	3.08
	148	>10 years	2.71	2.52	2.88	2.48	3.23	2.89	1.95	3.12
			F(5,420) = 0.44	F(5,426) = 1.00	F(5,446) = 0.30	F(5,440) = 0.71	F(5,457) = 1.20	F(5,446) = 0.82	F(5,450) = 1.36	F(5,456) = 2.73*
Personal involvement in seclusion	79	Never	2.93 ⓪①②③	2.35 ⓪①②③	3.02	2.47	3.26	2.99	2.16 ⓪①②③	2.97
	137	<1 per month	2.73 ⓪	2.55 ⓪④	2.90	2.47	3.18	2.88	1.73 ⓪	3.07
	174	1–4 per month	2.71 ①	2.57 ①⑤	2.83	2.39 ⓪	3.21	2.84	1.76 ①	3.12
	81	2–7 per week	2.62 ②	2.73 ②④⑤	2.96	2.66 ⓪	3.32	2.90	1.68 ②	3.15
	29	>1 per day	2.56 ③	2.73 ③	2.95	2.51	3.32	2.96	1.41 ③	3.27
			F(4,420) = 4.30*	F(4,426) = 6.18**	F(4,446) = 2.44*	F(4,440) = 3.57*	F(4,457) = 2.23	F(4,446) = 0.70	F(4,450) = 4.61**	F(4,456) = 1.20

GLM Univariate ANOVA: * $P < 0.05$; ** $P < 0.001$

Post hoc tests Bonferroni: ⓪①②③④⑤ = $P < 0.05$ within a characteristic of professionals for a variable of seclusion, e.g. the characteristic personal involvement in seclusion has for the variable ethics a significant difference between never and <1 × per month (see ⓪)

related to discipline (direct care staff scored higher in this than treating professionals) and personal involvement in seclusion (confidence increased with more personal involvement). Where the reasons for seclusion are concerned, it was notable that culture and threat were hardly connected to personal and professional characteristics. In relation to the variable treatment, women scored higher on this variable than professionals who were personally involved in seclusion. Finally, the alternatives: no relation between personal and professional characteristics and better and more care was found. Other care however was related to discipline (psychiatrists had the least faith in other care) and personal involvement in seclusion (the more seclusion was frequently used the less faith in other care).

Types of Professionals

Cluster analysis was performed on the basis of the scores of the eight variables to distinguish different types of professionals. A three cluster solution was chosen as that seemed to give the clearest picture. Figure 1 shows the differences in means per cluster type. Types were described as follows.

Type I (N = 90), 'Transformers'. This was a group of professionals who had little faith in seclusion (mean = 2.06) and in whom ethical thinking was strongly prevalent (mean = 3.11), unlike the other types. This group indicated that the causes threat (mean = 3.40) and culture (mean = 3.19) certainly played a part in seclusion and in this fell between the other two types. Unlike the other two types, these professionals were strongly in favor of alternatives, as well as of the non-standard solution of other care (mean = 2.78). This type of professional wanted to change the seclusion practices.

Type II (N = 184), 'Maintainers'. This was the group with predominantly low averages. These professionals thought ethical considerations just slightly more important (mean = 2.67) than confidence in seclusion (mean = 2.64). This group reported far fewer reasons than the other types; this was particularly true for culture (mean = 2.53). Furthermore the professionals accorded less value to alternatives than the other types; they were not in favor of other care (mean = 1.59). This type of professional saw no reason to reduce seclusion, despite their ethical objections.

Type III (N = 119), 'Doubters'. In contrast to the other two types, the professionals in this group accorded more value to seclusion as an intervention (mean = 2.75) than to the ethical side of the matter (mean = 2.60). In this group the averages for reasons were highest. This group indicated that the causes such as threat (mean = 3.53) and culture (mean = 3.26) played a large part in seclusion. This group was the most in favor of the alternative more care (mean = 3.34) but not at all in favor of other care (mean = 1.54). This type of professional actually had a problem: despite the fact that they indicated reasons and were interested in common alternatives, they also saw the use and the point of seclusion.

These results show that the three types differed the most in their attitudes toward the function of seclusion—where one type scored higher on ethics, the other scored lower—the reverse was true of confidence in seclusion. Ethics and confidence in seclusion were shown to be more or less opposed to each other (see Fig. 1). With regard to reasons for seclusion and alternatives, the three types did not differ that much.

Relationship Between Types and Characteristics

The relationship between the three types and personal and professional characteristics was tested by χ^2 tests (see Table 4). The results show a significant correlation between the three

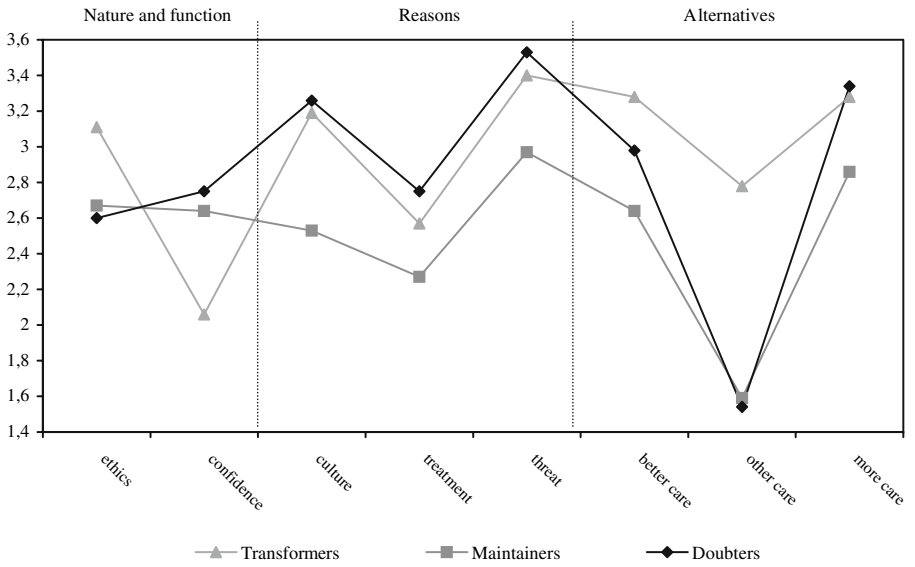

Fig. 1 Comparison between mean values of types of professionals according to variables of seclusion

types of professionals and three of the five characteristics of professionals: age, discipline and personal involvement.

Age: of those professionals aged 30–39, more than half (51.8%) were maintainers, while professionals up to the age of 30 were both maintainers and doubters (both 42.4%). Of those professionals aged 40–49, approximately a quarter were doubters (25.2%) and transformers (28.2%). Of the professionals over the age of 50, approximately one-third (31.3%) were transformers, while in the groups aged up to 30 and from 30 to 39 years this was less than one-fifth (15.3 and 17.3% respectively).

Discipline: more than half of the psychiatrists (55.8%) proved to be maintainers, 25.6% doubters and 18.6% transformers. The nurses were more spread over the three types: 45.2% were maintainers, 34.8% were doubters and 20.1% were classified as transformers. Social workers were mainly maintainers (60%), while psychologists (52.9%) and other staff (46.7%) were typed as transformers.

Personal involvement in seclusion: more than half the professionals (52.5%) who actively used seclusion lesser than once a month were classified as maintainers, as were professionals who used seclusion 1–4 times a month (51.6%). Conversely, professionals who actively used seclusion 2–7 times a week and more often than once a day, were principally doubters (52.4 and 44.4% respectively). Of those who never used seclusion, the majority were transformers or maintainers (both 42.1%).

Relationship of Types to Participation in a Project

There proved to be a significant correlation between types of professionals and participation in a project directed at the reduction of seclusion ($F(2,248) = 7.04$; $P < 0.05$). Transformers took part in a project more often, maintainers took part in a project less often and doubters were more often about to embark on a project or had just started.

Table 4 Coherence between characteristics and types of professionals: N, χ^2 and eta's

Characteristics of professionals	Types of professionals	Transformers	Maintainers	Doubters	Total N	χ^2	df	eta
Gender	Man	44	102	53	199	3.64	2	0.097
	Woman	45	78	63	186			
Age in years	<30	13	36	36	85	14.53*	6	0.175
	30–40	19	57	34	110			
	40–50	37	61	33	131			
	50>	21	30	16	67			
Discipline	Nurse	56	126	97	279	29.19*	10	0.165
	Psychiatrist	8	24	11	43			
	Psychologist	9	7	1	17			
	Non-verbal therapist	1	3	0	4			
	Social worker	2	12	6	20			
	Other	14	12	4	30			
Working experience of seclusion	None	12	16	3	31	16.71	10	0.093
	<1 year	16	33	16	65			
	1–2 years	2	13	11	26			
	2–5 years	15	34	27	76			
	5–10 years	14	40	27	81			
	>10 years	30	47	35	112			
Personal involvement in seclusion	Never	24	24	9	57	32.90**	8	0.225
	<1 per month	18	53	30	101			
	1–4 per month	27	66	35	128			
	2–7 per week	8	22	33	63			
	>1 per day	3	7	8	18			

χ^2-tests: * $P < 0.05$; ** $P < 0.001$

Discussion

The results of this study show that while professionals have many ethical questions they are predominantly in favor of the practice of seclusion. In their opinion, seclusion is a solution in threatening situations and is strongly linked to departmental culture. Although most professionals see seclusion as an appropriate form of treatment, they see more care as a suitable alternative. Furthermore, three different types of professionals were found: transformers, maintainers and doubters. The transformers were more often older than younger professionals (those over the age of 40 were overrepresented), were more often psychologists or belonged to one of the other professions, and were more often than not, not involved in seclusion. The maintainers were usually in their thirties (professionals aged 30–39 were overrepresented) and most of them were regularly involved in seclusion (monthly). The overrepresentation of psychiatrists was noticeable. In the group of doubters, the younger professionals were in the majority (professionals under the age of 30 were overrepresented). Discipline appeared to be less important, although nurses were slightly overrepresented. These professionals were more frequently involved in seclusion

on a daily basis. Maintainers are shown to be the least convinced of the necessity and desirability of changing current practice. Of all the respondents in this study, they are the group, who to date, have participated least in a project aimed at a reduction in the use of seclusion.

Professionals' Attitudes: Relationships and Interpretations

A clear picture has emerged from the results of this study: the more often professionals use seclusion the more positive they are about its use. While it is true to say professionals have doubts about its use at the beginning of their careers, over the course of time their belief in seclusion grows. After the age of forty, and often at some distance from the primary process, criticism of seclusion once again emerges. How can this change in attitude toward seclusion be explained? The most obvious explanation for this is habituation. Habituation to restraint and coercion brings with it acknowledgement of the necessity and desirability of the use of seclusion and it becomes a legitimate and justifiable practice [19]. Frequent use of this intervention blinds people to its negative effects as it were, and strengthens their own belief that what they are doing is good and acceptable practice [20–22]. It is even possible that this development reinforces the views of the professional on the positive aspects of seclusion [23]. Seclusion then becomes part of the culture.

However, the results show that those professionals who do not have (or no longer have) direct contact with restraint and coercion, such as managers, are the ones with a negative opinion of seclusion. They point out the influence of departmental culture and are in favor of alternatives to seclusion. As these professionals are no longer bound by the limitations imposed by working with patients in the ward setting in daily practice, they are able to distance themselves from departmental culture [24]. This enables them to think of possible alternatives that go further than just increase the number of staff on the ward. This could be a possible explanation for the critical views encountered in this group of professionals.

A second interesting finding is the relationship between the attitudes of the professionals and their participation in projects that are mainly directed to the reduction of restraint and coercion. Although these projects have not led to a reduction in its use, we see that the attitudes toward seclusion of those professionals who have taken part in these projects have become far more critical. These professionals have more time for alternatives and distance themselves from the limitations of departmental cultures. How this connection should be interpreted is, however, far from clear. One possible explanation is self-selection: teams that were dissatisfied with the current situation and wanted to implement change, took part in these projects. Interpreted in this way, participation is thus the consequence of a critical attitude toward restraint. An alternative explanation, which is not definitively explained by the results, is that as a consequence of participation in this type of project, professionals have become more critical of restraint and have learned to distance themselves from prevailing professional practice. This means that their criticism of current seclusion practice is not the *cause* of their participation but actually the *result* of their participation.

From the perspective of supporters of reduction of restraint, the second explanation offers more hope than the first. If participation in projects indeed results in professionals becoming more critical of seclusion, then it may also be expected that they will be prepared to actively implement change in current seclusion practice. This reasoning could also apply in the first interpretation, but in that case reduction of seclusion would be limited to teams or departments where there is already criticism of this practice. Large-scale reduction of

the use of seclusion in institutions throughout the Netherlands would then be a less realistic goal and may even prove to be an illusion.

Whichever of the interpretations is preferred, 'deep change' of current seclusion practices is proposed by Huckshorn [25] who calls for 'new ways of thinking and behaving'. No short-term effect has been shown. This means that in order to achieve real results, projects should be followed up and intensified. Research is particularly important for the presumption of relationships between deep change and a reduction in seclusion. Longitudinal studies into the functioning of professionals within various practices of restraint are necessary in order to examine the tenability of this proposal in the future and to arrive at conclusions on the possibilities and chances of a reduction in restraint in psychiatric institutions [11].

The results of our study have not only raised questions about the role of the professional in this. They also point to a gap between the attitudes and policy of managers and most of the professionals with direct patient contact. This is food for thought. Why is policy and practice so far apart on this question? It even appears that a reduction of seclusion is a bigger problem to the policy-makers situated at a distance, than it is to professionals involved in direct care. The managers have determined a policy that is not, or scarcely, accepted in practice. The problem for the managers is compounded by the fact that more than half of psychiatrists, the 'playing captains' of the departments where seclusion is used, belong to the group that has a positive attitude toward the practice. Those directly responsible for seclusion policy are, in other words, the main opponents of the national policy on reduction of restraint as formulated by the united group of managers in Dutch Mental Health Care.

However it is not only policy-makers who have a problem, but also psychiatrists. They play a key role in realizing a reduction in restraint. Why is it that of all the professional groups within mental health care, psychiatrists have the most positive attitude toward seclusion? Have they lost touch with what is happening at policy or ward level, or are there other factors at play? Their position could possibly be explained by the large number of roles that a psychiatrist is expected to fulfill [26, 27], including those of manager and expert, which are conflicting ones. Also the current emphasis in law and policy on risk reduction may make psychiatrists choose the surety of formal restraint. This is certainly true of psychiatrists in the Netherlands and may well apply to their colleagues elsewhere, e.g. Scandinavia, the UK and the USA. Differences in the law mean that countries vary in their use of formal restraint [7, 13, 28]. In the Netherlands, psychiatrists prefer seclusion to forced medication [26, 29]; while in some other countries psychiatrists regard seclusion as the most restrictive intervention [7, 30–33].

This study showed conclusively that many professionals who are directly involved in inpatient care still have a very long way to go before they come to regard a reduction in restraint as a priority. First, discussions between management and professionals should be implemented concerning the desirability and necessity of a reduction in the use of seclusion. Then it should be made clear if this reduction is actually feasible. Contrary to the views of most of the professionals themselves [12, 33], an increase in the number of staff will not necessarily contribute to a reduction in seclusion [34], while in the opinion of many professionals, an increase in the number of interactions between professional and patient will actually contribute, as well as an improvement of interpersonal approach and ongoing reviewing of seclusion events [3, 35, 36]. Taking into account the positive fundamental attitude to formal restraint and the dislike of alternative interventions, it can be predicted that reduction will not be realized by means of one standardized order from management. This situation requires differentiated strategies for change that take the

diversity of views of the professionals and the existing departmental cultures as their starting points.

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