

Regulation as an Obstacle to Care? A Care-Ethical Evaluation of the Regulation on the Use of Seclusion Cells in Psychiatric Care in Flanders (Belgium)

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Introduction

They came. Too late. They were angry. [...] I was not the only one on this unit. They cannot wait on me hand and foot. They left me there just like that. And no, I could not get a slice of bread. Breakfast is at 7:30. [...] I looked upwards, to a dimmed spotlight, to the red light of the camera, and to the two sprinklers. Would they spray water in case of fire? Or gas? (Froyen 2014, p. 37)

In her diary, Brenda Froyen—who was treated for a postpartum psychosis—describes her experiences in a seclusion cell shortly after being admitted to a psychiatric hospital. She compares the practice of solitary confinement in seclusion cells with the depersonalizing techniques used in concentration camps. This is an implicit reference to Tzvetan Todorov,

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who described the deprivation of clothing, the reduction of the victims to their animal-like basic needs, the loss of names, the large scale and the avoidance of direct communication as means to neutralize the call for help visible on the face of the other (Froyen 2014, pp. 37–39; Todorov 1999, pp. 158–177).¹

From a care-ethical perspective, however, recognizing and responding to this call is vital. Care ethics stresses the fragile aspects of life and focuses on the interdependence and relations between the actors, thereby aiming to improve the moral integrity within these relationships (Bowden 2000, p. 39; Engster 2004, p. 114; Herring 2013, p. 14; Sander-Staudt and Hamington 2011, p. IX; Slote 2007, pp. 10–12; Tjong Tjin Tai 2007, pp. 15–26). According to Tronto, care is an ongoing process of interconnected phases. The first is to notice that care is necessary, which is to care about. Ethically, this requires attentiveness. Second, one must assume responsibility for the identified need, and thus take care of. Therefore, care requires responsibility. The third phase requires the caregiver to actually respond to the need, which means he should give care. Ethically, this calls for competence. Fourth, an observation of, and a judgement on, the response of the object of care is demanded. This is what Tronto calls care-receiving, an act for which responsiveness is needed. Recently, Tronto added a fifth phase, caring with, which requires consistency between the previous phases and the democratic commitments to justice, equality and freedom (Edwards 2009, pp. 234 f.; Tronto 1993, pp. 100–126; Tronto 2013, pp. 22–24).²

From this perspective, depersonalized “care” is thus no care at all. According to Froyen, the obscuring nature of institutions and regulations distracts nurses from assessing and responding to needs. Therewith, she experienced in practice what care ethicists often claim: principles and rules of action are not always the right manual for human(e) and caring behaviour (Koehn 1998, p. 26; Noddings 1984, pp. 5 f.).

This is where the legal scholar turns up. From a care perspective, his hunger for equality, universality, objectivity and positivistic rationality has a suspicious undertone.³ Via a rephrased version of Todorov’s depersonalization thesis, this contribution tests whether the current Flemish regulation on the use of seclusion cells as a coercive measure is an obstacle for care and verifies what could be a supporting role for regulation on

solitary confinement. Regulation is interpreted broadly and does not only include rules issued by the Flemish (Belgian) government (“external regulation”) but also written rules issued by psychiatric hospitals (“internal regulation”). For the internal regulations, we rely on quality manuals of Flemish psychiatric hospitals and inspection reports of the Flemish Care Inspectorate (Zorginspectie 2015). When preparing this contribution, the nine inpatient psychiatric hospitals in the province of Flemish Brabant were asked to send their internal regulations on the use of seclusion cells. Five hospitals sent sufficient information. This contribution therefore does not give a comprehensive overview of all regulation(s), but points out some trends.

Depersonalizing Regulation?

In a first step, I slightly adapt and generalize the above-described characteristics of depersonalization to make it a touchstone for regulation on seclusion in inpatient psychiatric hospital care. Seclusion is defined as a type of solitary confinement whereby a patient resides in a specially designed locked room without his consent (Broeders van Liefde 1995; Steinert and Lepping 2009, p. 136; Voskes et al. 2014, p. 766). This contribution starts from the premise that seclusion might be executed in a caring way (Van Den Hooff and Goossensen 2013; Verkerk 1999; Voskes et al. 2014).⁴ Care is proposed as the counterpart to depersonalization. Thereby, the definition for care in health care as set out in this volume is applied: “Care in health care is a set of relational actions that take place in an institutional context with the aim to create, maintain, improve or restore well-being”.⁵ Consequently, if one cares about care when using seclusion cells, this definition should be met.

Deprivation of Personal Belongings (“Deprivation of Clothing”)

I was wearing a deep blue, shapeless apron on my naked body. (Froyen 2014, p. 34)

Clothing and personal belongings are an expression of humanity. In the event of seclusion, however, patients must often hand them over for safety reasons (Kontio et al. 2012). In Flanders, Belgium, there are no external rules on patients' rights during seclusion (see Put et al. 2003), and the inspection authority rarely looks into the content of hospital procedures. Consequently, whether clothing and personal belongings have to be turned in is up to the psychiatric hospitals themselves. They internally regulate the issue in quality manuals. In the five different manuals, four provisions can be distinguished: (1) clothing and personal belongings must be handed over, (2) they must be handed over, unless there is no risk involved, (3) they need not be handed over, unless risk is involved; or (4) whether they are handed over is decided in the individual treatment plan.

The perspective of care does not object to safety rules, though it opposes the possibly categorical character of these rules, requiring unconditional obedience in every single case (Tjong Tjin Tai 2007, pp. 258–259). Categorical rules should be avoided for at least two reasons: First, they gloss over the complexity of care (Koehn 1998, p. 40; Sevenhuijsen 1998, p. 115). While in many specific situations, depriving a patient of clothing and personal belongings might be desirable or even necessary, it is imaginable that in some cases, this might have a counterproductive effect. Second, and more importantly, a categorical rule skips the role of nursing staff. The road to answering the question how to meet one's caring responsibilities in the best possible way—and thus to “care”—is closed down by categorical rules (Noddings 1984, p. 51, p. 56; Fisher 1995, p. 200). Consequently, a quality manual not drawing upon the responsibility and engagement of the caregiver is not a caring manual (Voskes et al. 2014, p. 771). For care ethics, a manual must offer guidance, but may not overrule the responsibility aspect of the patient-caregiver relationship (Edwards 2009, p. 234; Tronto 1993, p. 137).

Alienation (“Reducing the Victims to Their Animal-Like Basic Needs”)

I resisted like a threatened animal, a lioness, a beast. That's the way they have treated me.

It was a dark room, a room of only a few square meters. (Froyen 2014, p. 34)

The content of regulation or a wrongful dealing with it might lead to alienation (Jeandarme 2010, p. 149); the patient is not, in the first place, perceived as a human being but, for example, as a problem. In the regulations, danger is inherently linked to seclusion (Sabbe and Bervoets 2010, p. 197). For example, in the external regulation, there is no specific rule on involuntary treatment or involuntary measures in psychiatry (Rotthier 2012, p. 295). Therefore, open norms not specifically linked to psychiatry have to be applied. These norms justify seclusion if there is a serious risk (when a patient's life or health is seriously endangered or if there is a serious risk for the integrity of third parties) (Veys 2008, pp. 132–138).⁶ In Flemish external regulation, risk aversion is the only legally valid goal (Omzendbrief 1991). The reason for it is fairly straightforward and well-intended: as a consequence of the client-centred concept of autonomy underlying the Belgian patients' rights act, seclusion is one of the most far-reaching invasions on the freedom of choice, with a direct influence on a person's privacy and integrity. Therefore, seclusion must be the last resort (Veys 2008, p. 137; Omzendbrief 1991).

Care ethicists have often criticized this biomedical concept of autonomy for its wrongful overlap with an independently made decision (Cardol et al. 2002; Gilligan 1982, p. 71; Noddings 1984, pp. 359–362, 2002, pp. 109–117). Through this interpretation, care becomes a sign of dependency—opposed to autonomy (Tjong Tjin Tai 2007, p. 67; Tronto 1993, p. 140). This negative concept of autonomy overlooks the essence of personhood as defined by relationships and interdependence. For care ethics, care is not opposed to autonomy, but leads to it (Janssens et al. 2004, p. 454; Tjong Tjin Tai 2007, p. 365; Verkerk 1999, 2001). Not autonomy itself, but the capacity to attain it must be the focus (Noddings 2002, p. 110; Slote 2007, p. 62; Tjong Tjin Tai 2007, p. 68). This viewpoint on autonomy is expressed in Driessen's contribution (Chapter “*Sociomaterial Will-Work. Aligning Daily Wanting in Dutch Dementia Care*”) in this volume, where she describes the process of socio-material will-work. As Verkerk notes, coercion that aims at restoring autonomy might be care. Non-interference does not necessarily respect a patient's autonomy (Herring 2013, p. 174; Verkerk 1999, p. 366; Voskes et al. 2014⁷). Although a care perspective would come to the same conclusion as regulation—seclusion will always go with a certain degree of danger

and will be a last resort—it perceives the patient radically different. It is not in the first place about risk aversion but about restoring a person's capacity to act autonomously.

As a consequence, care as a set of relational actions—a central aspect of the *care in health care* definition—might be obscured by a regulatory discourse based on danger (Fisher 1995, p. 194; Gregory 2010, p. 2276). The patient might be reduced to, and objectified via, the danger he causes (see, e.g. Desai 2010, p. 89; Du Plessis 2013, p. 426; Fisher 1995, p. 200).⁸ Internally, this is clear in most of the manuals that contain step-by-step analyses of the risk for both patients and personnel during seclusion. Although in a manual these aspects are of major importance, the care perspective is not about a patient's dangerousness, but about his well-being. The goal of risk aversion is part of this well-being, though subordinate to the goal postulated by care ethics: the restoration of the self (Koehn 1998, p. 456). Only one manual states that the prior goal is restoration, which comprises risk aversion. All other manuals as well as inspection reports merely focus on risk and may thereby result in alienation.

Reduction to Procedure (“Loss of Name”)

No, I could not get a piece of bread. Breakfast was at seven thirty. I had had nothing to eat for over 18 hours. I was hungry, I was thirsty. (Froyen 2014, p. 37)

Procedural rules might detract a caregiver's attention from the actual patient. This is an often heard statement linked to the so-called rising role of regulation in the domain of care (Put and Van Assche 2013). Although it is not substantiated that the role of regulation in Flanders has increased over the past decades (Put and Van Assche 2013), it is worth to cast a glance at the procedural burden of seclusion. The registration burden imposed by Flemish external regulation is rather low (Janssen et al. 2014⁹; Rotthier 2012, pp. 311 f.). Although hospitals must register the duration of and reason for seclusion, there is no central register (Sabbe and Bervoets 2010, p. 198; Omzendbrief 1991).¹⁰ From a legal perspective, this implies

a low level of protection: the inspection agency is not aware of individual cases, nor is there a specific complaints procedure (see Rotthier 2012, pp. 342–352, for the general complaint procedures). Internally, manuals often require a higher burden for registration, especially during seclusion. Every observation must be put down in writing, though one quality manual explicitly warns not to use subjective terms—which care-ethically is questionable (Voskes et al. 2014, p. 771).

In addition, external regulation prescribes that the role of the institution and its nursing staff is to correctly execute the decision to seclude made by the physician. In liability law, the physician might be held liable for a bad decision on seclusion, the nursing staff for a bad execution of this decision (e.g. Swennen 2003, pp. 57 f.; Van Noppen 2013/2014; Veys 2005/2006; Omzendbrief 1991).¹¹ This implies a fragmentation of the procedure and a division of responsibilities based on liability law. This is translated into quality manuals, in which nurses are not allowed to decide on the modalities of seclusion. Therefore, especially when a clear division of responsibilities is combined with strict manuals prescribing a caregiver's behaviour, care might be reduced to the implementation of orders, which is also demonstrated in the contribution of Pei-Yi Liu in this volume.

Despite of this fragmentation in external regulation, manuals stress that the physician consults other team members prior to making a decision. This is preferable from the viewpoint of care, as a rupture in the phases of care is potentially prevented (Tjong Tjin Tai 2007, p. 326). In this context, Tronto incites institutions to develop a rhetorical space where conflicts on the interpretation of needs might be discussed (Tronto 2010, p. 168). For her, dealing with conflicts through dialogue is essential for caring institutions.

Normalization of Seclusion (“Large Scale”)

Many psychiatric hospitals apply rules which state that patients who arrive at night automatically end up in the seclusion cell. It is some kind of a security measure due to the limited number of personnel. That is what happened to me. (Froyen 2014, p. 121)

Within a care trajectory, seclusion might seem a necessary step. The quality manual of one of the hospitals seems to suggest an automatic equation of urgency with danger, which in case of an emergency admission might lead to a low burden for seclusion. Moreover, the decision on urgency is made elsewhere and is possibly not reassessed. Overall, however, quality manuals suggest the last resort character of the measure (Omzendbrief 1991). Despite of this last resort character, seclusion seems to be applied quite frequently. Although there is no central record in Belgium, when inspection reports call a prevalence of 15% of the admitted patients relatively low, this might give an indication.¹²

Moreover, Belgium is one of the only countries in the world where seclusion in psychiatric care is at the same time combined with other coercive measures, for example, fixation (Bowers 2015). It is unclear whether and to what degree regulation has an influence on seclusion and fixation rates. Nevertheless, there is an ambiguity in Flemish external regulation. On the one hand, the technical aspects of seclusion are regulated: the presence of seclusion cells is a criterion for recognition (Rotthier 2012, p. 308),¹³ possible coercive measures must be mentioned in the hospital rules,¹⁴ registration is obligatory (Omzendbrief 1991),¹⁵ those who are responsible are appointed (Rotthier 2012, p. 312),¹⁶ and so on. On the other hand, it is not specifically regulated who may be secluded (Rotthier 2012, p. 295). Consequently, regulation determines that cells must be present, but not in which cases these cells could or should be used.

From a care-ethical perspective, the absence of concrete and strict rules regulating caregivers' behaviour may be applauded. Norms create a rational and objective framework, wherein care may be reduced to solving "a problem" (Noddings 1984, p. 24). There are two arguments, however, for why in this case the presence of a clear legal outlook or vision—and thus at least a minimum level of regulation specifically on seclusion—is necessary to enhance care. First, as demonstrated above, open and alienating norms based on risk dominate the decision nowadays.¹⁷ These open norms do not only aim at problem-solving actions, they also problematize the patient himself. Open norms, without a clear perspective on the patient's well-being, might make things worse. Second, the absence of a

clear perspective on seclusion, combined with the obligatory presence of seclusion cells, might lead to “defensive care” (Ankaert 2007, p. 9; Rom et al. 2006, p. 163). The psychological impact of liability law on caring practice must not be underestimated. Although care is a combination of an orientation and an action, liability law focuses on the latter (Tjong Tjin Tai 2007, p. 264). Psychiatric hospitals have a duty to protect residents from harming themselves or others. Jurisprudence accepts that a hospital can only commit itself to do everything that can be reasonably expected, but cannot be bound to the result (Veys 2005/2006).¹⁸ Since, in case of involuntary admissions, danger is a requirement for admission, judges reasonably expect more.¹⁹ Nursing staff—who are often unfamiliar with liability law (e.g. Scheepmans et al. 2011, p. 59)—might believe that in these cases, seclusion is what judges reasonably expect. An “if something happens” train of thought might lower the barrier to turn to seclusion (see, e.g. Van der Zwan et al. 2011, p. 125).²⁰

I do not maintain that Belgian judges prefer seclusion. They do not have an *a priori* preference for it, nor do they reject it.²¹ For judges, the criterion is that whatever is chosen has to be well considered. Noddings remarks that “when we care, we should, ideally, be able to present reasons for our action/inaction which would persuade a reasonable, disinterested observer that we have acted on behalf of the cared-for” (Noddings 1984, p. 23). The judge as a reasonable, disinterested observer tests whether the caregiver has acted as a good housefather. If a hospital aims to reduce coercion in a reasonable and well-considered way, judges take this into account.²² Seclusion is, moreover, not necessarily a way to limit liability (Van Noppen 2013/2014). On the contrary, badly executed seclusion might lead to liability as well (Directoraat-generaal Basisgezondheidszorg en Crisisbeheer 2007, p. 7).²³ Defensive care is thus a wrongful argument for seclusion.

What I do assert, however, is that for mostly not-legally educated nursing staff, the presence of seclusion cells combined with a vague, danger-based legal criterion and a falsely perceived liability-sword might lead to normalization. Therefore (knowledge of) a clear regulatory outlook would enhance care.

Avoidance of Direct Communication (“Avoidance of Direct Communication”)

It was dark, except for the red flickering light of the camera. *Smile, you’re on candid camera.* (Froyen 2014, p. 122)

Over the last decades, surveillance technologies have found acceptance in care, even to the extent that all quality manuals refer to the use of visual and audio surveillance technologies. Externally, the use of these technologies in seclusion cells is not regulated—one could even ask oneself whether their usage does not go against general privacy laws. For the inspection organ, their presence is neither required nor advised against. In the risk-based regulatory framework, the use of surveillance technology is justified for reasons of safety (interestingly, the issue of privacy is not even raised) (Desai 2010; Stolovy et al. 2015, p. 276). Empirical literature, however, warns of the danger related to applying surveillance technology in a discourse of risk and safety, since technology might shift the already fragile balance between care and safety in inpatient psychiatric care (Desai 2010, p. 89) and lead to a Foucaultian surveillance climate (Du Plessis 2013, p. 430; Holmes 2001). Moreover, cameras might reinforce the previously mentioned alienating effects by creating a culture of fear (Jacob and Holmes 2011, p. 110).

However, inspection reports state very clearly that these technologies cannot function as a substitute for direct communication between the patient and the caregiver. Direct observation and communication remain essential. Nonetheless, for inspection, the reason for that is, again, safety, as cameras do not register everything. Consequently, again, not the patient, but danger and safety is focused upon.

Direct communication is not necessarily ruled out by the presence of surveillance technology. All quality manuals state that caregivers should regularly—the minimum intervals are internally regulated—visit the patient. On this point, external regulation requires intensified supervision.²⁴ Three manuals consider visual and verbal contact to be supportive of the caregiver’s surveillance task. The two other manuals see communication as a way to contribute to the well-being of the patient. One of the manuals even stresses the importance of follow-up care and a dialogue with the patient.

Towards a Supporting Role for Regulation

In the analysis above, I introduced care via a back door: when testing regulation on possibly depersonalizing effects, care—as opposed to depersonalization—automatically pops up. However—except for categorical manuals and top down internal regulation—most of the depersonalizing effects are not due to regulation itself, but due to a type of institutional care where regulation wrongfully takes the first place. In this part, I aim to reconcile care and regulation, first by pointing at how—from a care perspective—regulation might create obstacles for care and second, by elaborating on how these obstacles might be overcome.

Depersonalization Versus Care

As demonstrated, there are a number of depersonalizing aspects stemming from regulation that should worry a caregiver. With this, I do not want to assert that regulation is intentionally drafted to generate depersonalizing effects. I do not want to claim either that seclusion leads to depersonalization in the sense that caregivers necessarily act in an inhumane way. What I do maintain, however, is that (wrongfully dealing with) certain aspects of regulation might unintentionally obscure care and that this might *at least* give the patient a feeling of being depersonalized (see, e.g. Meehan et al. 2004).

The possibly depersonalizing effect of regulation stands out against the background of Tronto's phased practice of care (Tronto 1993, pp. 100–126). First, care requires noticing the need to care [Caring About]. Regulation might distract caregivers from this need. A focus on danger—the patient must be undressed, observed and guarded—implies deviating from the reason for a patient's presence in the hospital, restoring the self. Legally, the moral element of attentiveness (needs) is reduced to alertness (danger) (Bowden 1997, pp. 113–114; Jacob and Holmes 2011; Tronto 1993, pp. 134–135). Second, caregivers must assume responsibility for the needs they have noticed [Taking Care Of]. If a caregiver believes there is nothing to do about it, the patient is not taken care of. Regulation might arouse the feeling that seclusion is the only pos-

sible option, for example, because of categorical quality manuals, the distance between the caregiver and the patient or a fear for liability. Legally, the moral element of responsibility is reduced to the obligation to control the damage.

Third, the caregiver must actually respond to the need [Care-giving]. Even if a caregiver cares about and takes care of a patient, the risk of not being able to meet a patient's needs is inherent. For example, a nurse might see a patient's needs and might feel responsible for them, but in the end, he has to implement a physician's decisions or has to follow strict quality manuals (Tronto 1993, p. 109). Moral competence is then reduced to legal incompetence. Fourth, care requires an observation of, and a judgement on, the response of the object of care [Care-receiving]. As regulation might obscure the prior phases, adequate responsiveness is under pressure, since the vulnerability of the patient is looked at from the perspective of danger rather than well-being. The actual needs of the patient are obscured in the first place. Moral responsiveness is turned into legal insusceptibility.

Immanent Care, Transcendent Regulation

Despite the risk that concepts such as danger and liability might overshadow care, no single care ethicist claims we should get rid of regulation. Even Noddings states that regulation is not bad, as long as it does not oblige caregivers to prematurely switch to a "rational-objective mode" (Noddings 1984, p. 26). Recently, Tronto added the requirement that "needs and the way they are met are consistent with democratic commitments to justice, equality, and freedom for all", as a fifth phase of care [Caring With] (Tronto 1993, p. 171, 2013, p. 23). This is not only a clear message for caregivers to act in line with democratic commitments but also for democracy—and thus regulation—to be "caring". How, then, should the relationship between regulation and care be perceived in the case of seclusion?

In his doctoral thesis, I believe Tjong Tjin Tai gives a clue when he demonstrates that acting out of disposition and acting out of duty are not opposing, but alternating viewpoints at two different moments in time: duty is what comes afterwards, at the level of justification, but has no

influence on the prior disposition for care itself (Tjong Tjin Tai 2007, p. 249). I maintain that the same is true for regulation: while regulation is (and should be) omnipresent in the domain of care, it should be invisible during the act of caring itself (Koehn 1998, pp. 6–7; Noddings 1984, p. 26; Robertson and Walter 2007, p. 210). Where care is immanent, regulation should be transcendent. Therewith I do not mean to say that caregivers should be unconscious of regulation: caregivers should certainly be aware of, and capable of dealing with, the regulatory framework (in advance). The act of caring itself, however, must not be subject to constant regulatory concern. This involves an appeal to both regulation and care.

An Appeal to Regulation

There should be a smooth overlap between the way care is provided and the regulation dealing with it, as implied by Tronto's caring democracy. This viewpoint has clear implications for the content and form of the regulatory framework on seclusion. Thereby, the functions of regulation serve as a stepping stone.²⁵

First, regulation coordinates human behaviour [regulatory function], including in the domain of care. In the event of seclusion, this function is nowadays translated into quality manuals. Coordination, however, is not necessarily the same as determination. As demonstrated in Section “[Deprivation of Personal Belongings \(“Deprivation of Clothing”\)](#)” and Section “[Avoidance of Direct Communication \(“Avoidance of Direct Communication”\)](#)”, manuals can be drafted in a categorical way—passing over the caring disposition and thus turning care into a problem-solving action—or in an open way, pointing at what should minimally be done, but leaving room for more (Noddings 1984, p. 55; Voskes et al. 2014). For good care, these quality manuals are nothing more than helpful guidelines—good practices—that do not stand in the way of a caring disposition and that in exceptional circumstances could be set aside or at least be discussed (see Section “[Reduction to Procedure \(“Loss of Name”\)](#)”) (Tjong Tjin Tai 2007, p. 259; Voskes et al. 2014).

Second, regulation provides for legal guarantees and legal protection [protective function]. For the moment, external regulation offers little or no protection to secluded patients: the legal position of psychiatric

patients is not regulated. Even though they may draw certain rights from general norms—for example, general privacy rights—it is difficult to challenge a seclusion. Consequently, from a regulative perspective, seclusion is not over-, but rather under-regulated. A care perspective would not oppose more protective regulation, as long as this does not lead to an excessive procedural burden. In fact, care as a practice stemming from a caring disposition should not even notice the existence of a protection system. As long as there is a caring disposition and care is provided according to the five phases, the protective function of regulation stays in the background. Once care as a relational and dialogical type of protection goes awry, regulatory protection is brought into the open (Koehn 1998, p. 40).

Third, regulation resolves conflicts [dispute solving function]. Under Section “[Normalization of Seclusion \(“Large Scale”\)](#)”, we have already demonstrated that a sole focus on this function might lead to distortions and even more seclusion. Nevertheless, in parallel with the protective function, conflict resolution should be invisible and superfluous for care. Within (the five phases of) care, disputes are dealt with dialogically and outside of the regulatory framework. Tronto’s rhetorical space in institutional care is a textbook example (Tronto 2010, p. 168). Besides, the shift towards alternative dispute resolution in law might contribute to the preservation and restoration of a caring relationship (Sevenhuijsen 1998, p. 116; Tronto 2010, pp. 166–169). Only when there is a rupture in care itself and care is, as a consequence, out of reach, classical regulatory dispute resolution turns up (Koehn 1998, p. 40, pp. 51–52).

Fourth, regulation expresses cultural meaning and societal values [symbolic function] and consequently enters into Tronto’s caring democracy, where justice is reframed as *caring with* for the common good (Tronto 2013, p. 182). The protective values currently underlying the regulation on seclusion—autonomy, integrity and safety—should be subordinate to and assessed from the perspective of care as a central value in a democracy or a democratic institution (Koehn 1998, pp. 34–35; Sevenhuijsen 1998, p. 110–113; Slote 2007, pp. 94–96; Tronto 2013, p. 159, p. 164). The current rupture between danger and autonomy obscures the perspective of care (see Section “[Normalization of Seclusion \(“Large Scale”\)](#)”).²⁶ It would be better to explicitly regulate seclusion, whereby its role as a protective measure should be exceeded and turned into the goal of restoring the self

in a context of interdependency. Legally, this implies that seclusion should be categorized and regulated as “forced treatment”, rather than as a “safety measure”. This requires a turnover of the concept of autonomy.

An Appeal to Care

On the side of care, caregivers should not be overwhelmed or blinded by regulation. Many potentially depersonalizing consequences of regulation—the concepts of danger and protection, the fragmentation of responsibility, the level of abstraction, the stress on actions rather than dispositions and so on—cannot be shove aside. These aspects may, however, not paralyse care. Depersonalization is not a feature of regulation, but a feature of an institutional care setting where regulation wrongfully takes the first place. Although not all aspects of regulation are supportive of care, even in its present form, regulation is mostly not opposite to care. On the contrary, some quality manuals even support and fuel a care-ethical reflection. Moreover, regulation might have a supportive function for care, for example, via the creation of a forum for interpersonal dialogue or via a turnover of the safety perception in psychiatric care (De Benedictis et al. 2011).

Conclusion

Through the concept of depersonalization, this contribution has demonstrated that regulation might be an obstacle to care for secluded patients. Especially when rules are categorical or have a vague outlook, are fragmentizing or aimed at problems rather than persons, care might be endangered. However, we should not abolish all regulation or perceive it all sceptically. Nor should we turn care ethics into rules, since the disposition for care can, essentially, not be regulated.

This contribution maintains that, in the domain of seclusion, regulation and care can fruitfully co-exist if, on the regulatory side, the functions of the regulation are tailored to the needs of care and, on the side of care, regulation is not wrongfully perceived as *the* benchmark. For seclusion in Flanders, Belgium, this requires a mental shift in attitudes towards

care. Regulation is not at the centre, but at the outskirts of care. At these edges, regulation aims to (1) support—not obstruct—care via references to good practices. There, the role of an open, dialogical and well-thought-out internal regulation is essential. Furthermore, regulation aims to (2) intervene when care goes awry. Even today, in most cases, care should not worry about regulation: the legal requirement of risk aversion, for example, does not contradict the caring requirement to restore the self.

The possibly depersonalizing effects of regulation on seclusion are unfolded in the way care and regulation deal with one another, not in regulation as such. Nonetheless, rethinking regulation, especially at the external level, would be supportive to care. In a regulatory framework that cares about care, seclusion should be turned into a well-regulated type of forced treatment—rather than a protective measure—with an outlook towards more autonomy and a clear—though not overburdening—protective framework, by which conflicts can be resolved when things go awry. This type of regulation would not be an obstacle but an added value for care.

Notes

1. Quotes from the work of Froyen are Translated by the author. Froyen referred to Todorov indirectly via the categorization made in Pollefeyt (1997, p. 99–101).
2. For a similar application to seclusion, see Voskes et al. (2014, p. 771).
3. See, for example, A-M. Mol, “The logic of care”, presentation at the workshop Caring about Care, Amsterdam, University of Amsterdam, 8 Feb. 2016.
4. *Contra* Driessen (Chapter “[Sociomaterial Will-Work. Aligning Daily Wanting in Dutch Dementia Care](#)”), in this volume.
5. Cf. chapter *Introduction* (Chapter “[Understanding Care. Introductory Remarks](#)”) of this volume.
6. Combination of Art. 8, §5 and Art. 15, §2 Patients’ rights law, Art. 416 and Art. 422*bis* Penal Law Code and legal necessity in legal doctrine and jurisprudence.
7. On how the five minutes before seclusion may defuse the situation.
8. See, for example, *Vragen en Antwoorden Vlaams Parlement 1995–1996*, 7 May 1996, 13 (vr. 47 J. Stassen).

9. The registration burden is low, especially when compared to, for example, the Netherlands.
10. See Art. 5, §2 Royal Order 8 July 1991 ter uitvoering van artikel 36 van de wet van 26 juni 1990 betreffende de bescherming van de persoon van de geesteszieke, *BS* 26 juli 1991. Further referred to as RO 8 July 1991.
11. For case law, see Rb. Tongeren 15 May 1995, *Rechtskundig Weekblad* (1996–97) 362; Kh. Brussels 31 May 2005, *Tijdschrift voor Gezondheidsrecht* 5 (2005–06) 39.
12. Compare to 11% in the Netherlands (Steinert et al. 2010) and a rise to almost 20% in case of psychosis (Janssen et al. 2014, p. 133).
13. Art. 5, §1 RO 8 July 1991.
14. Art. 3 RO 8 July 1991.
15. Art. 5, §2 RO 8 July 1991.
16. Attachement 1 of the Royal Order of 18 June 1990 houdende vaststelling van de lijst van de technische verpleegkundige verstrekkingen en de lijst van de handelingen die door een arts aan beoefenaars van de verpleegkunde kunnen worden toevertrouwd, alsmede de wijze van uitvoering van die verstrekkingen en handelingen en de kwalificatievereisten waaraan de beoefenaars van de verpleegkunde moeten voldoen, *BS* 27 July 1990.
17. Combination of Art. 8, §5 and Art. 15, §2 Patients' rights law, Art. 416 and Art. 422bis Penal Law Code and legal necessity in legal doctrine and jurisprudence.
18. For case law, see Ghent 10 March 2011, *Tijdschrift voor Gezondheidsrecht* 3 (2013–14)189; *contra* Rb. Tongeren 15 September 2004, *Limb. Rechtsl.* 2004, 283.
19. See case law: Antwerp 11 October 2005, *Limburgs Rechtsleven* 3 (2006) 179.
20. Also see Haeusermann (Chapter “[The Dementia Village—Between Community and Society](#)”) in this volume.
21. For case law, see Vred. Eeklo 12 January 1995, *Tijdschrift voor Gentse rechtspraak* (1995) 171–172; Antwerp 19 January 1998, *Tijdschrift voor Gezondheidsrecht* (1998–99) 312; See parallel for fixation Corr. Bruges 2 May 2005, *Tijdschrift voor Gezondheidsrecht* 3 (2007–08) 228 and case-law note Veys (2007–08), pp. 224–225.
22. For case law, see Antwerp 6 November 2003, *Tijdschrift voor Gezondheidsrecht* (2003–04) 40; Antwerp 11 October 2005, *Limburgs Rechtsleven* 3 (2006) 179.
23. For example in case law on fixation: Ghent 10 September 1997, *Tijdschrift voor Gezondheidsrecht* (1999–00) 130–131.

24. Art. 5, §2 RO 8 July 1991.
25. The four functions of regulation are derived from Claes et al. 2009, pp. 5–11.
26. See a similar debate in the Netherlands in, for example, Arends and Frederiks 2006.

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