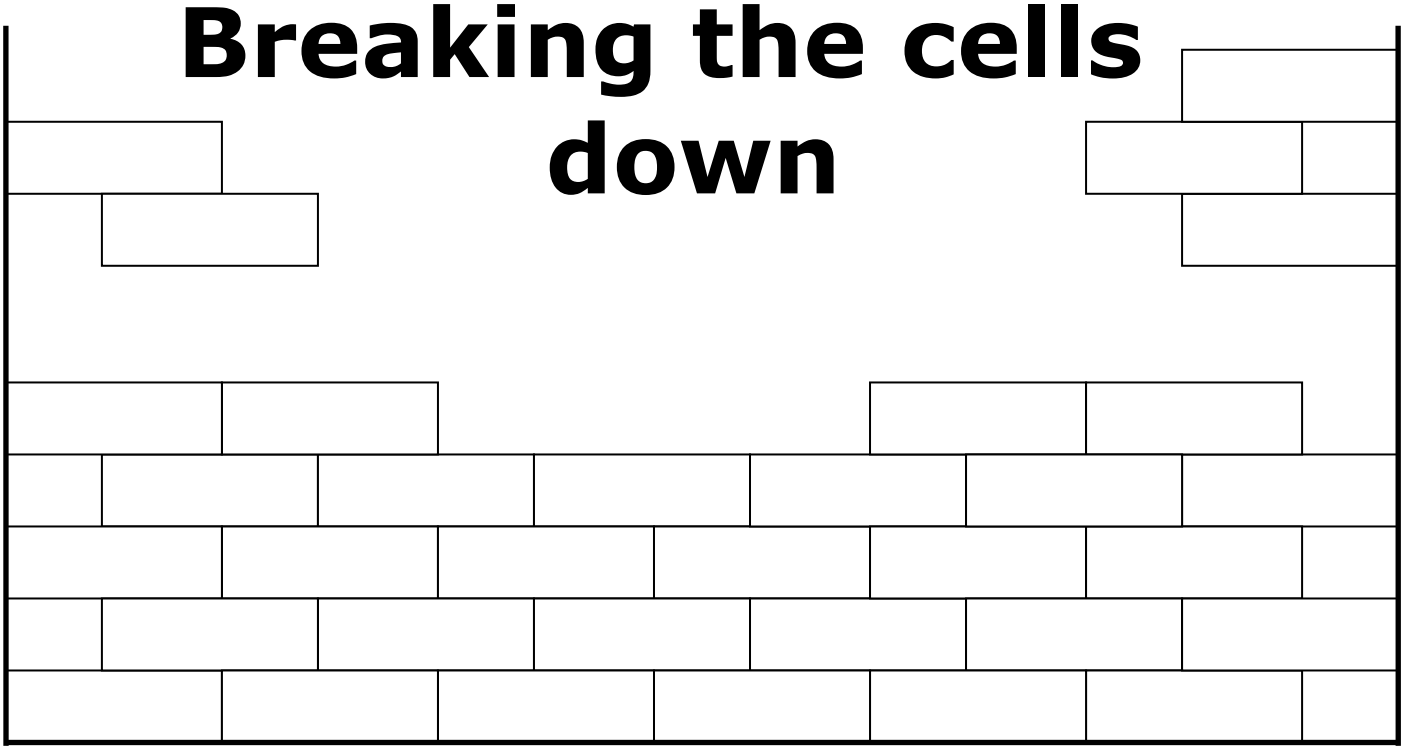
Report for Global Forum on Community Mental Health – 2007

Breaking the cells down



A First step towards de-institutionalization of Mental Health Care

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1. Introduction

This report **"Breaking the cells down"** is written by Jolijn Santegoeds from Actiegroep Tekeer tegen de isoleer! (activist group against isolation cells and coercion in psychiatry), which is the core part of the overall organization Stichting Mind Rights - the Netherlands, also initiated by Jolijn Santegoeds.

This report describes how to avoid coercion, and is made available within the context of the **Global Forum on Community Mental Health**, which was organized for the first time at 30/31 May 2007 at WHO, Geneva, Switzerland. Prominent initiators and facilitators of this Global Forum were Basic Needs, CristoffelBlindenMission (CBM), World Association for Psychosocial Rehabilitation (WAPR) and World Health Organization (WHO Mental Health and Substance Abuse and UK department of Health).

The objectives of the Forum meeting at Geneva were as follows:

- To provide a supportive network for all those interested in promoting community mental health services and care for people with severe mental disorders, including the involvement of consumer and advocacy groups.
- To share selected experiences of regional and country activities on community mental health services and to derive some lessons.
- To identify barriers and discuss ways to overcome them in strengthening community mental health services in low- and middle-income countries.

The Forum brought together mental health service leaders, consumers and family members involved with services and organizations involved in community mental health. It was the first time that consumer groups and family members were invited by WHO to contribute on mental health services and their strengthening in low- and middle-income countries.

1.1 Linking up with the Global Forum on Community Mental Health (GFCMH)

The GFCMH network is by invitation only, to secure the ideals of this new initiative. The participants of the Global Forum have all become members, who are ought to spread the global message of the Forum, eg. by organizing national or regional conferences. There is also a possibility to upload information, which may possibly be of use to other participants from all over the world. More information on www.gfcmh.com

The core activity of the author: Banning the use of isolation cells in psychiatry, fits within the targets of Community Mental Health (CMH) and Community Mental Health Care (CMHC), where socialization is needed. **Socialization** means to be part of society, by inclusion, which is opposite to exclusion. To break the walls down is one of the first things to do for enabling inclusion. This document may provide some useful tools and methods to avoid the use of isolation cells, and therefore this report is uploaded to the GFCMH.

This report was put together by collecting experiences, knowledge and expertise from different stakeholders at different meetings in the past few years by the author Jolijn Santegoeds, actively involved in users advocacy on banning isolation cells.

Breaking the cells down is part of de-institutionalization as well as socialization of mental health care. It is about changing attitude towards the people who need anything, and about treatment.

2 Starting point - the Netherlands

The Netherlands is an industrialized and developed country in the Northwest of Europe. With 16 million people it is a rather crowded urban country, with a variety of towns and cities on a flat landscape, with big farms (lots of cows) and the famous mills. Politically it is a rare country with ordinary democratic elections for a prime minister and the Cabinet (parliament), but it traditionally still has a queen and a royal family. The culture of the Netherlands (or Dutch culture) is known as "enjoying freedom" with almost unlimited possibilities. The Netherlands is for example open towards homosexuality, prostitution, abortion, euthanasia and smoking marihuana. Education, housing and health care are generally available * Commercial business and media promote that anything can look perfect (like America).

* There is also an other side of Dutch society, where life is based on survival, with primary needs like: daily food, rent of the housing, electricity-bills, decent clothes, a bike, a laundry machine etc. Help is hardly available for them. Full participation in the wide offers of society is very limited with a lack of primary needs. Another obstruction is a kind of "social competition for success" due to the "neoliberal view on perfection". It has become an own responsibility to become assimilated and successful, and those who are not successful are generally dropped at the so-called bottom of society (which means unemployed with a low social income, and stigmatized as irresponsible, incapable or worse: as "parasites"). Therefore poverty is often hidden very well. In fact everyone has to look as shiny as possible.

2.1 Political trends and health care relations

The number of (governmental) psychiatric institutions nationwide is big, about 49 mental health care hospitals for clinical psychiatric (APZ) in total with 22.450 beds. There are hundreds of other mental health care facilities (eg. outpatient). The users total is about 210.000. Psychiatric hospitals often have single rooms, and services may vary at every location. Private clinics for mental health are not very commonly used or well known.

Bureaucracy is growing, and a growing number of desks, specializations (territories), managements and management models is designed and implemented (which are further and further away from the field practices, sometimes with impersonal and inhumane policies). Also the number of formats of registrations, applications, legislations etc. for acts and situations is still increasing. This does not lead to efficiency, but on contrary this bureaucracy is putting an awful pressure on society, which is endlessly demotivating for carers and users and other stakeholders. The discrepancy between governmental and management views and top down legislations (bureaucracy), and the field's needs seem to be huge in almost all sectors of society.

Criminalization of psychiatry is the circle of more aggression and a more repressive approach. Criminalization is experienced by the users, who's rights are violated by structural social exclusion, marginalization and repression combined with the wish to participate fully in society. These injustices feed anger and aggression.
Criminalization is also present at the cultural fact that outsiders will often just stigmatize users as being "not good enough". This creates a kind of split up in the society of the Netherlands, which has bad effects on the community and mental health care eg by more neglect and aggression (incl repressive treatments).

2.2 Common spread view on mental health treatment

There are some exceptional laws on mental health care in the Netherlands, which are defining the construction of hospitals and involuntary treatment.

- The construction law for mental hospitals implies that every psychiatric hospital must have at least 2 isolation cells, (and more per certain amount of beds), otherwise the construction can not be accredited for mental health care. (*Fortunately it is not obliged to use these cells*)

- Another law is called: Wet BOPZ, Wet Bijzondere Opnamen in Psychiatrische Ziekenhuizen ("law on Special Admissions in Psychiatric Hospitals"). This law gives **legal possibilities to treat someone against his/her will, which is called "involuntary treatment".** This may consist of involuntary admission, or involuntary treatment such as coercive measures and means (eg administering food or drugs, seclusion, fixation etc.). The view on involuntary treatment is exceptional in the Netherlands. Others countries do not consider coercion as a part of the treatment, but use coercion only for overcoming temporarily crisis situations when treatment is not possible. But in the Netherlands coercion can be considered legally as a part of the mental health care treatment.

This "official" view, that coercion may be good for people who suffer from mental health, disturbs the field of practice of delivering good mental health care.

A possible explanation for this false perceptions can be found in history. The Netherlands were conquered and involved in World War 2 (1940-1945). In this period all of the psychiatric patients, disabled, Jews, gays, Roma's etc. were killed due to theories of eugenetics (calling certain people inferior). After this genocidal war the country was rebuild (until the 80's) and today, the Netherlands could be positioned between the USA and the rest of Europe: wealthy, politically democratic and in a way aiming for material perfectionism.
In history (before and after the Holocaust) the psychiatric hospitals were mainly used to separate the users from society, to create a homogenous society. Group activity schemes (including drill instructions and punishment with isolation cells) were used to train the users to behave in accordance to a designed daily life schedule and to "be normal". (eg get up at 8, breakfast at 9, be creative at 10 etc.). The group activity scheduling does not have any regards for the patients individual feelings and it is in fact just an easy way to claim the rules, and keeping the people restricted.
It seems that some of the above perceptions are still slightly seated in policy making eg visible by structural poverty and forceful treatments (criminalization).

Mental health care gets little priority from politics, and mental health is easily associated with nuisances and criminality, so the official focus from policymakers is mainly on the side of repression and forceful interventions to the elimination of these nuisances.
This implies that psychosocial problems are misjudged at large in Dutch society, which leads to eg **inadequate practices and inadequate education of carers and others, and inadequate legislations and inadequate priorities on investments etcetera.**

2.3 Coercion in psychiatry in the Netherlands

Official investigations point out that coercion (coercive treatment) is more used in Netherlands, compared to the countries surrounding the Netherlands. Eg the use of isolation cells in psychiatry in the Netherlands is the highest within Europe (RTL news, 19th of March 2006), followed by Ireland and Finland. In some other countries more coercive medication is used. In the Netherlands, the numbers on seclusion, coercive medication and fixation, as well as the combinations of these are growing.

2.4 Privatizing health care

Also in the Netherlands there is a trend of privatizing the public services, mainly with commercial and wild business taking over the market and aiming for profits. (neoliberalism). After privatizing the psycho pharmaceutical industry (unfortunately), nowadays also the hospitals and insurances are being privatized. Officials plead that freedom of choices and concurrence will increase the quality of the services, but in practice often the opposite occurs and the services get marginalized while the contributions peak, to gain profits (market oriented). This corresponds with the cultural tendency of the split up between "winners and losers" in the Dutch society. Besides all of this, a lot of people are worried about the availability, and the ability to make a good choice in a period of sufferance from mental problems, because one may eg. be chaotic in distress, which could possibly lead to tremendous problems in the bureaucratic and split up society (where every service has to be paid).

2.5 Author's perspective: against coercion

It may be good to emphasize the perspective of the Author explicitly: which is against coercion and forced treatments on mental health care, and pro negotiation and equality. The author is actively advocating on banning coercion from psychiatry, also due to personal experiences with psychiatry as a user, a family member and nowadays also as an expert on alternatives for coercive interventions. The grassroots activities to improve psychiatry have started in 2002 and have grown to a official foundation called Stichting Mind Rights, consisting of mainly young people, users and supporters. The activities will be described in detail further on in this report. (see attachment 1).

2.6 Other users initiatives and activities against coercion

A lot of user movements are locally or regionally anticipating. Some national organizations are promoting mental health issues more generally, others are active on a local community basis.

By starting a specified discussion on banning seclusion (and exclusion) we gained a certain coherence with other groups, because seclusion is a well-known problem, which certainly needs attention of all stakeholders. A lot of movements have started to discuss on this topic.

The following text is a translated part of a press release of the "Landelijk Platform van clienten- en familieorganisaties in de GGZ" (national platform of clients and family organisations of mental health care) on Decembre 2nd 2005.

> When psychiatric patients get into a crisis, they often get isolated, separated, sometimes even fixated (tied) or drugged. These kind of coercive measures and means are used frequently in mental health care. But even when there is no crisis situation the assistance uses the isolation cell. E.g. unacceptable behaviour can be a reason. Patients as well as the assistance get in a negative downward spiral of aggression and impotence.
> The government considers to expand the legal possibilities of coercive treats. But there are alternatives. In the past years fine alternatives for isolation cells have been developed, this was highly stimulated by the national project "Dwang en Drang" (Project Coercion and Urge) This was concluded on the 2nd of decembre, 2005 in Amersfoort, during a workconference of the Landelijk Platform van clienten- en familieorganisaties in de GGZ (national platform of user and family organisations of mental health care).
> Full text at paragraph 4.3 National projects to avoid coercion.

To summarize this: It is nowadays officially and widely admitted that lot of bad practices occur inside psychiatric hospitals in the Netherlands. And Project "Dwang en Drang" ("Coercion and Urge") has concluded that **the results of treatments are better when carers talk and listen to the users**, instead of forcing users to behave in a certain way. (more information on this Project see paragraph 4.3)

So nowadays in 2007, the 4 main different dynamics on psychiatry in the Netherlands are:

1) **criminalization and marginalization of users by policies.**
2) **exclusion and rejection of the users by the overall community (stigma)**
3) **fear of psychiatry by the users (forceful treatments and repression)**
4) **joint efforts to improve the quality of mental health care**

The following part of this report will focus on the joint efforts to improve the quality of mental health care and to avoid coercive treatments.

2.7 Some existing core initiatives on Community Mental Health (CMH), or Community Mental Health Care (CMHC) in the Netherlands

Some relevant Dutch social initiatives on socialization of mental health care:

- Kwartier-maken : "Quarter making", Mrs. Doortje Kal, www.kwartiermaken.nl
Quarter Making is based on the idea that 1 out of 4 people has a psychic/psychiatric problem during his or her life, and this equals to one quarter of society, which is a very visible and workable statement. The annual Kwartiermakers-festival (festival on Quarter Making) aims to spread this quarter (in time and space etc.).

- User groups, Self helping groups, meeting places, different types of social networks for sharing and coping with certain experiences, such as Anonymous Alcoholics or Stg. Time Out for women with a history of abuse, or for advocacy and promotion of rights, or sharing hobbies, sports, festivities etc. (eg sessions, courses or clubs or buddy projects) or work or may be anything else requested. These projects mainly offer joy or meaning to life, friendship and companionship.

Some main Dutch professional initiatives on socialization of mental health care are:

- Mantelzorg: "Mantle Care", which is care provided by a person (non professional carer) within the ordinary social network (eg family, neighbours, friends etc.). Different financial arrangements can be made for this "Mantle Care".

- Ambulante zorg: "Outpatient Care", which is available in a variety at/from different support centres, also including Social Work, Centres for Addictions, Child Care, including regular home visit by a social worker for support etc. This outpatient care can be related with user groups (eg a professionally supervised talking group for Children of Parents with Mental Health Problems).

- Reclassering: "Probation Care", for re-integrating people after their sentence back to society, including housing and work, to avoid relapses.

It is often said that Reclassering (Probation Care) has better results for users than mental health care, probably because of bigger investments, due to the social urgency.

3. Targets and Aims against coercion (by Stg. Mind Rights)

Our main aim is: Satisfaction of the clients (or users) and their surroundings in all relations with mental health care

Translated to the following main sub goals (not numbered or following each other, and no complete overview of all our wishes):

- No coercion related to mental health care (equality)
- Agreement and partnership on treatments
- Meeting individual needs by the availability of flexible choices on treatments
- Respect for identity of users (and carers)
- Effective Mental Health Care (Best Practices)
- and much more

Some more information on the views of Stg Mind Rights can be obtained from:
- the Red Paper (2006) – a patient declaration on improving mental health care throughout European member states.
- WSF Report (2007): the high needs of social inclusion and support of users and survivors of psychiatry.

Both documents are available at the website of stg. Mind Rights: www.mindrights.org

3.1 Guidelines and Principles

- In our efforts on banning seclusion we agreed with all stakeholders to emphasize: we want **no shifting** from one form of force to another, so seclusion should not be replaced by coercive medication etc. **The efforts should be focussed on how to reach agreement and partnership between carers and users. Communication, equality, respect and negotiation are key words.**

- The use of isolation cells is very visible and outsiders do easily understand the misconceptions on seclusion (abandonment is not High Care, and imprisonment, rejection, fear and loneliness can be very traumatizing (not low-stimulus at all), which is not increasing wellbeing). **Recognition of the misconceptions on seclusion causes more understanding for the users and their needs (a condition for CMHC)**.

- Also, after having the misconceptions on seclusion clear, the discussion on pharmaceutical drugs can be started more equally, because the aspect "chemical repression" is often understood better in coherence to isolation cells.

- All have good intentions and aim for the future.

4. Strategy of Change (by Stg. Mind Rights)

I have come a long way and I have many experiences. By telling my personal story, I have appealed to human feelings. This way of communication should not be underestimated. My personal (bad) experiences with psychiatry are readable at attachment 1 or at www.mindrights.org (at "From psychiatric patient to activist").

4.1 View and mission (Stg. Mind Rights)

Due to mine and other users bad experience, I decided to stand up for improvement of psychiatry. Successes are made by **aiming at the future**, by showing respect towards the (initially) **good intentions** of the carers (and users). We always say the bad practices of the carers are due to lack of personnel, and not to bad intentions. Carers have chosen to care for others, so their inability is merely due to bad investments (e.g. lack of personnel, heavy workload, leading to inability to pay personal attention to everyone, combined with bad infrastructure, legislations, habits, bureaucracy and poor facilities). We need co-operation and non-offensive communication, joint efforts for true discussions (which can be so painful) and feedback and **support on both sides.** We share the same goals, and we all believe **we can improve psychiatry, but we can only do it together** with carers and users and family etc., in all honesty. We need the carers on our side to make the change with us. In the Netherlands we have succeeded in **challenging the carers to care, and to start joint efforts to change the coercion practices**. The carers are not happy with coercion as well. They notice the resistance and want to make efforts.

In my opinion, it is important to talk about **personal feelings**, because mental health is about feelings and wellbeing, which should not be oppressed but dealt with. Do not fear the discussions, although some things may feel offensive, just tell about your true feelings and aim for constructive cooperation and deliberating on good compromises, or new ideas, which are agreeable for all stakeholders. It is important to start with feelings, to be honest and to be open. Users often become emotional on this subject and fear the excitement, because it may lead to rejection, relapses etc. (history of exclusion). The carers often have a hard time in admitting and pointing at their own **fears, limitations, ignorances and powerlessness** (main reasons for coercion).
Aim for this true reflection and use **common sense** to work on a social solution.

The user always has a certain centralized position in the discussion, as a consumer and touch stone of the quality of care. When the user tells about feelings and communicates his/her experience, the carers are able to understand it on a **human basis** (empathy with their field of interest). Cling on to this human basis, and extend the discussion to this direction. What can be improved regarding the experiences of all stakeholders?
It is also important to **allow people to feel different at these things**. Eg seclusion is said to be a last resort, but in reality it is a frequent bad habit, and more efforts on alternatives have to be made. Unfortunately not everyone agrees yet on the possibility of alternatives ("blinded by the workload and traditional violence"). Sometimes we advice such carers to appeal to colleagues in crisis situations, to show them the alternatives in practice. We have to stimulate every improvement, step by step. All stakeholders have to find **an agreeable solution**, so we need to include and consider all the different stakeholders with different views and negotiate to a good compromise. This requests patience, but it is definitely worth it. (information on alternatives in chapter 5).

4.2 Tools and methods (Stg Mind Rights)

We use several ways to ask for feedback from society on coercion, which are put below to give an idea of the tools and methods we use in our user advocacy group, Stichting Mind Rights:

4.2.1 Draw attention to the subject (coercion/psychiatry) eg by general announcements and public actions:

- Spreading posters and leaflets
- Organizing street marches, demonstrations and manifestations, often using:

- Music and arts, which are symbolizing the existence of feelings and ways to cope with emotions, and are also generating a vibe of happiness and relief (as a good practice of wellbeing).

4.2.2 Promote our view and mission eg by:

- Handing out leaflets, business cards, posters etc.
- Maintaining a website
- Participating in interviews for magazines, papers, radio and television.
- Participating in discussions, workshops, meetings etc.
- Providing stalls at conferences, sometimes with the use of symbolic items, eg:
  - A small scaled isolation cell with a doll in it,
  - A similar doll in a cosy teenage sleeping room, with another doll (girl friend/carer) carrying a heart shaped little pillow.
  - An extremely big teddy bear
  - Sweet candy hearts
  - Rubber medical gloves (for signatures against strip searching of children with mental problems, who are put in jail[1])

4.2.3 Become an expert on alternatives on coercion

- Collecting and spreading knowledge, especially on alternatives
- Participate in progressive processes like discussions and work conferences

Another key activity of Stichting Mind Rights is the involvement of the initiator (the author) as a freelancer in activities of several client organizations, such as the client organization of the local psychiatric hospital in Eindhoven and other districts, and also the rather frequent participating in national conferences, meetings, discussions and workshops on several locations (eg at institutions, user groups, NGO meetings etc).

4.3 National Project Coercion and Urge

In 2004/2005 an official and scientific pilot project was started at 12 psychiatric hospitals to avoid coercion. This project is called Project Dwang en Drang (Project Coercion and Urge) and was initiated by professional carers.
The pilot project resulted in **8 quality guidelines for coercive interventions**, which are:

1. Realize that coercion and urge are an aspect of psychiatric practices, and that the psychiatric practices are characterized by contrary obligations.
2. Contrary obligations lead to ambivalent feelings and emotions from colleagues, from the client (user) and from the family. Pay attention to these feelings. Handle urge and tension creatively.
3. Consider coercion and urge within scope of the process of providing care. Interventions are only justified within the context of concern and nearness. This demands attention, responsibility, professionalism and tuning. Starting-point in the process of providing care is consultation between carers, user and family. Carers ought to take care of participation of all stakeholders within the care process.
4. Coercion and urge demand good communication. Pay attention to treatment and attitude, openness, making appointments, maintaining contact. Negotiation and convincing can prevent situations of coercion, but ought to be avoided during coercive interventions.
5. Reflect on the goal of the intervention. Do not only look at the elimination of risks and dangers, but question if and how this intervention will contribute to the users possibilities to have control on his/her own life, and to increase the self control. Reflections on the goals of forceful interventions also means that these interventions do not become routines.
6. Reflect on the means. Be aware of the variety of the range of interventions. Do not use more radical means than necessary. Aim for creative handling of situations. Be flexible, respectful and tactful.

[1] Imprisonment of children with mental health problems in regular youth prisons is done because of insufficient facilities to provide care to this group. These kids are in a virtual waiting line for mental health care, and are put under custody, because of the so-called "urgency of outplacement/separation from their normal surroundings".

7. Place coercion and urge in a time perspective. Aim for an anticipating approach. Make appointments in advance with the user, and if possible also with the family. Be transparent on the intervention and the effects of this. Evaluate every aspect of coercion and urge with the user and the family. Try in deliberations with all the stakeholders, to learn from each other for dealing with each other in the future. Provide institutional forms of evaluation.
8. Aim for adequate conditions (professionalism, availability, constructional facilities, educational guidance, protocolling) and start actions if these are lacking.

The main successful practical themes of the pilot project regarding to alternatives on Coercion and Urge are:

- **Avoiding panic** in crisis situations, eg by aggression coaches, and
- More efforts on prevention by more joint **focussing on detection** of individual problems and needs in an early stage, and **abolishment of excessive rules.** (every reaction has a cause, eg the maximum of 2 blocks of sugar in tea can lead to frustrations and arguments)
- Creating a sphere of openness, peacefulness and cosiness at the wards: where **joint efforts for general wellbeing and satisfaction** are central themes of the daily life, and aim for re-establishing trust (and overcoming the split up between carers and users) so that **anything can be discussed at any time.**

More information on project coercion and urge can be found in paragraph 4.4, and more information on alternatives in chapter 5.

4.3.1 Discussions

To change the practices in the field, a period of true discussion between carers and users is necessary. Also family and other stakeholders eg friends and colleagues, but also "outsiders", police, community leaders, general medical doctors and nurses, all should be involved.
Once we started to discuss on the use of coercion and isolation cells we learned a lot. When a discussion is based on true feelings and honesty it is often very interesting, but it can also be hard and emotional.

- **A good leader of the discussion is a great advantage.**

Some main arguments of carers, including users feedback are:

1. **"You have a very radical and extreme opinion. It is not possible".**
   *- We believe in a successful abolishment of isolation cells in mental health care. We really want to talk about your objections, and we can share our experiences and maybe we agree in the end, if we all are willing to **listen to each others truth**.*

2. **"Isolation is not bad, it's good for users. Users become peaceful by it"**
   - 1. Nobody gets out of the isolation cell before he/she has stopped agitating and is "quiet".[2]
   - 2. The effect of isolation is not a specific process (in time, effects) nor a coordinated process contributing to healing.
   *- 3. Isolation is **fighting symptoms**, disturbing trust and relations, obstructing communication and creating introvert "time-bombs".*

3. **"Isolation is only a last resort. We do whatever we can".**
   *- Is that true? Is it a last resort? **Do they try everything else?***

4. **"Safety of all is more important than individual needs".**
   - 1. You ought to be a carer! Make more efforts to provide care.
   *- 2. And every reaction has a cause. So why is there a crisis? What was the cause? **What does the user need?***

[2] *The average period of one isolation is approx. 11 days in the Netherlands 2005*

5. **"There are no alternatives for complex situations. I don't have time for it".** *- Do something about that!* ***Show some initiative!*** *Go to your boss or labour union etc.*

The main arguments of family and relatives are:

- "**Protect my relative. He/she is getting out of control/ out of reach. I can't handle it, because I don't know how".**
- **"Help my relative, cure him/her if possible".**
- "I rely on the professionals' knowledge on what's best".

Some other arguments of users against coercion and seclusion are:

- **The very common users reaction: Agitation, "NO!" and resistance**, which means "I don't like it and I don't want it"
- Isolation cells are NOT low stimulus, but **fearful, horrific and traumatizing.**
- Seclusion is ending communication and obstruction to communication and no equality, instead of offering support and human empathy.
- Coercion means overruling someone in a violent or manipulative way, symbolizing **no equality, a lack of negotiation and no good arguments.**
- "Do you think an isolation cell could help anyone?"
- "When your computer breaks down, would you shut it off and walk away?..."
- Without the existence of cells, alternatives are obligatory, so throw away the key.

It is a long, creative and inspiring way. Sometimes you have to take some risks to start the **discussion**. Eg. some carers only start reflecting on seclusion, when you talk about "golden cells". So therefore a cynical holiday leaflet was made (at the client organization of the local psychiatrical clinic in Eindhoven) It consisted of a commercial for relaxing isolation cells, "Costa del Cell, very good for your wellbeing…" it was spread with a sweet biscuit attached, at the psychiatric hospital around Christmas. It resulted in a lot of divers reactions, and we had to **be able to take some criticism**. But nevertheless the reflection on seclusion started to come alive.

Within the professional health care sector some special tools are used to direct to a specific perspective. These perspectives makes carers reflect more on this topic, and it will start the discussion, like the leaflets with Costa del cell.
I am involved as a freelancer in activities of the client organization of the local psychiatric hospital in Eindhoven, which is the city where I live. Some of these activities are:

- **Debates, conferences and workshops**, eg during the national week of Psychiatry, with an annual theme (this years theme: Feeling safe..).
- Making **a playful handbook** to question and avoid the use of isolation cells, called "Open Doors.." (including the holiday leaflet and practical questions and alternative approaches on situations).
- "Redesigning the isolation cells" to generate new views. An artist involved gained the idea to play several movies of 5 seconds (like a newsflash) at the same time inside the cell to "stimulate adaptation to reality" or another artist suggested to take a teddy bear inside and put nice colours on the walls.
- **Workshops: Teaching skills for good practices etc.**:
    - Workshop on Hospitality by a famous Dutch hotel manager, on how to treat guests at best.
    - Multi-logue meetings (derived from dialogue): which consists of a multidisciplinary group of people, representing all stakeholders of the subject and including outsiders, all debating equally.

Stichting Mind Rights is also involved with the movement of **Social Forums**, such as the Dutch Social Forum 2004-2006-2007, the European Social Forum 2006 Athens-Greece, and the World Social Forum 2007 in Nairobi-Kenya.
Also a short international documentary on our campaign against seclusion is being made by Eric Scaltriti from Spain.

After the discussion period
At the end of the discussion period some choices have to be made (per institution or ward), in benefit towards the carers who are willing to change their practices. The "idealistic carers" need progressive surroundings. Sometimes the "old-fashioned carers" whom are not willing to change the practices, eventually have to be dismissed from their job as a carer (unsuitable).

To summarize this strategy of change:

- stimulate a true and honest reflection on seclusion and coercion (**discussion**)
- draw conclusions from the reflections (**"joint goal: try to stop coercion"**)
- start working on improvements (**eg by discussion, developing alternatives, launching pilot projects, capacity building etc.**)
- stimulate progress towards better practices and aim for a joint treatment (cooperation), with a constructive and positive approach, and **provide a just and appropriate attitude, networks, means and measures.**

4.4 National Projects to avoid coercion

The Pilot Project Dwang en Drang (Coercion and Urge) has developed itself to a national project. To illustrate this development, the following text is the official full translated press message of 2005 from the national platform of users and familiy organizations.

> the translation of the official press message- The summary of the conference on December 2nd 2005, Amersfoort about reduction of forced treatment/coercion
> (translation from Dutch into English by Jolijn Santegoeds)
>
> **Crisis in psychiatry: curing is better than isolation**
> **Careful care on demand, makes isolation superfluous.**
>
> When psychiatric patients get in a crisis, they often get isolated, separated, sometimes even fixated (tied) or drugged. These kind of coercive measures and means are used frequently in mental health care. But even when there is no crisis situation the assistance uses the isolation cell. E.g. unacceptable behaviour can be a reason. Patients as well as the assistance get in a negative downward spiral of aggression and impotence.
> The government considers to expand the legal possibilities of coercive treats. But there are alternatives. In the past years fine alternatives for isolation cells have been developed, this was highly stimulated by the national project Dwang en Drang (Project Coercion and Urge. This was concluded on the 2nd of December 2005 in Amersfoort, the Netherlands, during a work conference of the Landelijk Platform van clienten- en familieorganisaties in de GGZ (national platform of clients and family organisations of mental health care).
>
> **Reduction of coercion goes to slow**
> In the Netherlands a lot of coercive means and measures are used in comparison to the countries surrounding the Netherlands. Care providers and professionals are not preparing to make a big change. The line of business targets to reduce the number of isolations yearly by 10%. This is not a impressive aim and it will be questionable if even this target will be gained. The participants of the work conferences plea for more progressiveness. The institutions and assistance should be awakening to a necessary culture change: from coercion and repression to intensive caring. There are a very lot of examples that this approach is successful.
> Even though the view on coercion may vary between patients, assistance and family and other involved persons, our joint aim is to reduce coercion.
>
> **(Individual) Detection plan or Signal plans**
> At the Geestesgronden (a Dutch institute) they use signal plans. This plan is composed together with treating persons and patient. The plan gives information on how to detect and signalize an upcoming crisis, and what the patient can do to prevent the crisis, it also mentions what approach the assistance should choose on behalf of the patient (e.g. keep a certain distance from the patient in stressed situations). When the caring assistance consider a persons feelings, coercive matters can be avoided most of the times. The Geestesgronden

started to work with these individual signalization plans in 1992. Within 3 years the numbers on isolation had decreased from 230 a year to less than 10 a year, in spite of a decreasing number of assistance personnel. The absence due to sickness also showed a drastic decrease.

From ruling to co-operation
An increasing number of psychiatric patients is carrying a so called Crisis card. This crisis card gives brief information on how the patient wants to be receipted and treated when a crisis occurs, and how a further escalation can be prevented. It seems that coercion can be reduced significantly by the use of crisis cards, this was drawn from international investigations, publicized in the British Medical Journal.
On the TBS-department Roozenburg in Altrecht an aggression coach was introduced. (TBS means psychiatric with criminal records) These coaches train co-operators to handle aggression, to prevent the negative downward spiral between patients and staff. The approach of this has been shifted from ruling and domination to co-operation and negotiation. The result: from 500 aggression incidents a year to 100 a year, and isolation/separation from above 100 a year to about 5.
Another institute, de Gelderse Roos, targets to be completely free from isolation cells by 2010. On the department Siependaal this has already been realized due to the new approach, which also closely involves the family and relatives from the patients.
Action plan Platform GGZ (GGZ: Mental Health Care)

These and other successful new methods on prevention of coercive matters were put together at the 2nd of December. This will be summarized in a conference report. The Platform GGZ will make a Action plan, In the beginning of 2006 this action plan will be handed to government and politics and will be spread in the line of business.

The Landelijk Platform Clienten- en Familieorganisaties in de GGZ consists of:
Stichting LPR, belangenorganisatie clienten ggz * Vereniging Clientenbond in de geestelijke gezondheidszorg * Stichting Pandora * Nederlandse Vereniging voor Autisme * Vereniging Ypsilon * Vereniging voor Manisch-Depressieven en Betrokkenen * Stichting Labyrint/In Perspectief * Stichting Borderline * Stichting Anorexia en Boulimia Nervosa * VO!CE* Vereniging Balans*Vereniging Impuls * SLKF, Stichting Landelijke Koepel Familieraden in de GGZ .

After the nice results of this pilot project at 12 institutions on avoiding coercion, the Pilot Project Dwang en Drang (Coercion and Urge) has developed itself to a national project.

4.4.1 Development of project Coercion and Urge in time perspective

In 2003 some professional projects were started on decreasing the use of isolation cells within psychiatry. At the beginning 12 institutions were involved in a project to avoid forceful treatments (Project Dwang en Drang: Project Coercion and Urge). In this 2 year period some quality aspects on coercion and treatments were identified and published (about the legitimacy and other aspects of isolation cells (e.g. no punishment, as short period as possible, first try other things (less harmful), does the intervention have a role in the healing/recovery process?, evaluate the use of force, communicate, use early detection of signals, and most of all: within the professional health care; make a cosy sphere of openness where anything can be discussed and end the continuous struggle which gets worse and worse: BE PARTNERS in the healing process.

In the following year 2005, **the national branch organization GGZ Nederland ("Mental Health the Netherlands") has set the national targets on decreasing seclusion by 10% each year**.

To get these national targets, the government has given an incidental financial support of 7 million euros (to GGZ NL) in the first year (2006), and 5 million in the next year (2007), and it seems like there will be 5 million available for projects on decreasing coercion every year structurally.

This finance is meant to start projects on avoiding coercion, but it is only available for institutions, not for clients/user groups etc. But institutions only get financial funding when they include user movements in the process towards better mental health care and less coercion.

Since 2005-2006, when the governmental finances got available about 35 institutions started projects on avoiding coercion, especially on avoiding the use of isolation cells. Together with these projects, a lot of discussions have started on the use of force. The professional carers agree now that seclusion is not High Care (a popular new view). But then again the professionals have no experience on handling complex situations, while they were used to use isolation cells etc. Nowadays a lot of professionals give it a try to ban coercion, and these professionals are happy to have a new challenge on their field of interest. But others are feeling attacked while their behaviour is discussed, they don't want to admit that their old-fashioned knowledge is based on fear and powerlessness, they still see seclusion as a necessary tool for "safety of the society". These others feel misjudged, lost and abandoned and they are defensive, pleading that they do whatever they can, which should according to them be appreciated. This old-fashioned group is the hardest group to convince on new alternatives.

We are very happy to say there are more and more professional standing up, informing their colleagues that there are other ways, to provide better care.

5. Results: Alternatives for coercion

Wellbeing and mental health is always a personal issue, which should be treated with individual respect of human diversity and different views, perceptions etc.

The best alternative for coercion is to offer a flexible range of choices and to aim for satisfaction:

1. A lot of coercion can be avoided by offering a wide range of choices, because when someone is in a crisis it is **an individual matter what is helpful.** In practice often only one or two offers are being made.
2. A lot of coercion can be avoided (especially at admission) by spending more time and efforts on the process of convincing and negotiating on the right form of help. Coercion starts where negotiation ends. By carefully **extending the negotiation process** a lot of coercion can be avoided. Fair negotiation is about a flexible range of choices.
3. To prevent and to end a crisis a lot of **creativity** is requested from the carers and users. Sometimes it is e.g. a relative, who can **provide comfort** to the user, and play a significant role in **communication** and finding the right solution. Also music may comfort people, creativity, nature and sports etcetera. Coercion can be avoided by releasing the 'pressure or urge' in an earlier stage of the problem. This is about early detection (signalizing) and starting to provide care by offering **choices and possibilities to release the feelings and emotions.**

By asking for feedback, a lot of feelings and emotions are released, and to have experience with several ways of releasing feelings can be very useful. **By discussions at any level, a first step towards negotiation is made, because different views and feedback become transparent and manageable.**

It may take quite a lot of efforts to start moving towards better practices, but on the other hand, it is **beautiful to be challenged in this way**, and even small steps towards better practices (equal negotiation) are **very much appreciated by all stakeholders**. Even relatively small improvements may have **a great positive impact on someone's life**.

5.1 Capacity building:

All stakeholders, carers, users, family etc. are not happy with coercion. Discussions are a truly good tools to develop alternatives, especially Multi-logues, where valuable knowledge and common sense is combined by interdisciplinary participants.

With the start of several projects to avoid coercion the discussion on avoiding coercion and urge has become structured and in near future probably structural.

5.2 Alternatives on coercion in practice

As mentioned before: the best alternative on avoiding coercion is to **communicate and negotiate** on the best form of care, and to implement **an attitude change from offer-based towards user-based care.**
In execution this means a change of attitude towards users. The new attitude is closer to the heart, with true good intentions and real helpful care.

A range of successful implemented alternatives to avoid coercion is put below:

1. **Avoid panic in a crisis situation**
2. Deal with the cause of the panic and crisis. (eg frustration, fear or anger)
3. Have no fear, but have faith in your professionalism and in the user. Feel in control of the situation and **show confidence in a good ending**.
   - 3.1. Sit down, show the non-violence of the surroundings, (inspired by Nonviolent passive resistance and Satyagraha by M.K Ghandi).
   - 3.2. Aggression coaches, for handling aggression professionally and advanced education and knowledge on handling and avoiding panic and crisis (increasing feelings of capability and safety)

4. **Carefully extend negotiation**
5. Take plenty of time
6. Aim for true communication, with an eventual aim for a trustful relation (identification and equality).
7. Try to calm the desperate user by offering possibilities for comfort
8. Give non-offensive, clear, and fair feedback, offer possibilities, answer questions
9. Offering choices (good examples and advice etc.), but let the person decide on the best practices for that moment.
   - 9.1. Include family, friends or other close persons in communication, ideas and negotiation - to avoid misunderstanding, fear, loneliness and panic, and for more trust and comfort
   - 9.2. Aggression coaches, for handling aggression professionally.

10. **Negotiate as long as it takes,**
11. Resist criminalization and don't slide down in the negative spiral of violence, with forceful coercion and overruling, which is often answered by aggression and resistance, which is obstructing a constructive trustful relation, necessary for real mental health care with joint efforts for self-control, happiness, understanding and full equal participation in daily society.

12. **Early detection:**
13. Prevent a crisis by early anticipation on hard feelings, such as fear, anger, depression, confusion etc.
    - 13.1. Make efforts on individual detection, with individual signal plans, crisis cards and use your senses – collect information on how to signalize and handle situations in an early stage of the problem (eg keep distance or come close, offer comfort, cheer one up etc).
    - 13.2. Evaluate crisis, draw conclusions and learn from it, eg by composing a signal plan with the user, family and other stakeholders (if relevant).

14. **Flexible range of choices**
15. Offer a wide flexible range of choices, to give users possibilities to release urges, feelings and emotions under their own control in an early stage. Eg by availability of sports, music, nature, rest, creativity, social activities etc.
16. Flexibility, cooperation and creativity is needed for finding individual solutions,
    - 16.1. Be open towards ideas of the users and family, friends etc.
    - 16.2. Cooperate and negotiate, establish partnership on the recovery process: establishing full participation in society, if necessary tuned in to meet individual needs.

17. **Comfort the users**
18. Create a sphere of openness at the wards where anything can be discussed (prevention),
19. Show hospitality and provide a **home** where all the present identities are warmly welcome to show their true feelings.
20. Offer possibilities for releasing feelings and emotions such as communication with anyone (the user choice), or comfortable activities etc.

21. Education

22. Educate carers and future carers by involving them in the field already, more education and knowledge on handling situations is increasing feelings of self assurance, capability and safety.
    - 22.1. Involve future carers in the hot discussion on coercion.
    - 22.2. Organize workshops and meetings on field practices.
    - 22.3. Invite users and family and other stakeholders for giving feedback and information or guidance.
    - 22.4. Aim for the wildest dreams on improvement (e.g. psychiatry as a hotel) which gave us the idea of hotel management teaching hospitality to carers.

23. Multi-logue

24. Dare to look beyond your own imagination and knowledges
    - 24.1. Invite interested outsiders to discuss the practices.

25. Another option is to just throw away the key and oblige yourself to alternatives.

Do not leave all these alternatives at the design table, but start improving the practices and spread the knowledge.

For any further information, feedback, suggestions or questions email to tekeertegendeisoleer@hotmail.com

A full contact address is available at chapter 7 Information.

6. Future and Further development

We are proud to have the positive developments such as project Coercion and Urge on the field of mental health care in the Netherlands, but still there is a very long way to go towards full community mental health and community mental health care.

Breaking the cells down is part of de-institutionalization as well as socialization of mental health care. It is about a change of attitude towards the people who need anything, and about treatment.

The Dutch society is getting very complicated due to bureaucracy and its bodices and a change of attitude towards treating the needs of the people and the community seems inevitable, from offer-based to need-based.

Also in psychiatric settings such as mental health hospitals this attitude change has to be made. In regard of the users needs, isolation cells have to be banned from mental health care and maintaining contact and communication is the key challenge. Breaking the cells down demands an attitude of hospitality, flexible negotiation and equality, and all stakeholders should be feeling safe.

Mental health is about satisfaction of all stakeholders in a collective society. When professionals are able to deal right with crisis situations, then the society can be taught to do the same thing, and also deal with crisis situations.

In this way projects to avoid coercion can be practical tools for generating knowledge for community mental health care.

For any further information or questions email to tekeertegendeisoleer@hotmail.com
A full contact address is available on the next page.

7. Information

7.1 Contact addresses

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Website Dutch: www.mindrights.nl

Context:
Global Forum on Community Mental Health (GFCMH)
www.gfcmh.com

7.2 Other mentioned organizations

Eindhoven psychiatric hospital (users organization) :

	GGzE - users organization
Postal address:	Postbus 909, postvak 6103 5600 AX, Eindhoven
Telephone:	040 - 2970 618
Email:	clientenbelangenbureau@ggze.nl
Website GGzE:	www.ggze.nl

Stichting Time Out (self helping networks, also my travel partners for Social Forums)
www.stichting-time-ot.nl

GGZ Nederland (overall line of business organization, "Mental Health the Netherlands")
www.ggznederland.nl

Attachment 1 The Author's Personal relation with psychiatry

I myself became involved with psychiatry when I was young and my mother was experiencing mental problems. My parents got divorced and my oldest brother (with Down's Syndrome), my younger brother and myself were living with mother. She had a psychosis and she was taken away violently by a crisis team. I had never seen my mother screaming and resisting like that, only when she was caught and "arrested" by the crisis team and drugged and strapped on a stretcher. This was my first experience with psychiatry. We, the kids went to stay at the neighbours or friends. My oldest brother went to live with my dad for the rest of his youth. They explained us: "mother was very ill, but she would be better". Mother would come back after some weeks, completely drugged and strange, but every time she got along, recovered as far as possible and be stabilized for a few years while on the pharmaceutical drugs. This repeated a few times in my youth.

At age 16, I was having severe trouble due to adolescence and feeling lonely etcetera, but I was very scared of mental health and psychiatry related things, so I did a suicide attempt. I got rushed into a hospital, but the day after, I immediately tried it again, out of fear of being diagnosed as a mental patient.
I was immediately admitted into a mental health hospital, but due to a waiting list for youth centres, I was put into a closed adult admission ward (15 people, 2-3 carers). A strange empty place with lots of stupid rules (no TV before 7 o'clock, maximum 2 sugar in tea or coffee). Nothing was allowed, nothing was warm or familiar to me. I felt like I was lost and I felt really bad. I was very scared and tried to run away, but they caught me and locked me in my room. I tried to harm myself, and then I was put into the isolation cell for the first time of my life. My world changed from there.
I felt like I had lost it all and I did not understand justice anymore. I was too scared to make a sound and at that stage my suicidal feelings increased explosively. I began to think that the Netherlands were maybe still at a kind of secret war, maybe "happy childhood" is a fairy tale of the modern cruel world, like Santa Claus.., maybe my mother did not dare not tell me this part, because of her own experiences, was that the reason of her illness? It was confusing.
I was very scared and I did not really co-operate in the following dialogues. I became even more quiet, figuring out the ways to escape or kill myself. I was too scared to tell about my problems, and I only told them some simplified things. I was hoping to be released earlier by making them believe that I was cured from these simplified things (eg eating disorder etc.). I was too scared to show myself, I could only think of being somewhere else. My mother and family were allowed to visit me one hour a week or so.

At the youth institution, already on the first day I was imprisoned for the night after drinking poisonous cleaning (after hospital treatment) and immediately after the release from this cell I did another attempt by eating batteries. Again in the hospital I discovered after a week that they were giving me psychiatric drugs without my permission (I was 16 and I was a bright student on the highest school level. I felt poisoned and scared.
In this way lost my dignity and my patience, I did not like to be there at all, and I tried so many harmful things. It resulted in a continuous struggle, and after several weeks I was locked up in an isolation cell with a daily schedule of contact moments, for toilet and showering (under supervision), eating, drinking etcetera. I was being called: *"a dangerous hazard to myself and they wanted to protect me from harming myself. They could not keep an eye on me 24 hours a day, so they had to lock me up for my own safety, because that would keep me from reaching knives and other dangerous means. It was for my own best"* they said to me. I did not agree, and I agitated by harming myself more and more. The struggle got worse and worse (with according to them: *"reasons to believe in a deadly ending for me").* I smuggled things into the isolation cell to harm myself, and the "carers" answered with more coercion such as a diversity of coercive medication, forced body searches (with rubber gloves into intimate parts of my body), fixation (with cotton straps, sometimes naked on the bed, with the blanket shoving off..) and long-term seclusion for months, with nothing but a daily schedule for supervised showering, toilet, eating etc. I did not attack the personnel, I only tried to escape and harmed myself. And I was always

asking them awkward critical questions such as: *"would you treat your own kid like this? Do you think this helps me to live on? And why do you take my life with the cell, if I am not allowed to finish my life myself?"* They had no answers for me, instead they made a new rule: *"no discussion, redirect her to the weekly contact with the psychiatrist"*.
I was diagnosed with a severe Borderline personality disorder, and I was referred as an untreatable nuisance who draws too much attention.

At age 17 and a half, I was transferred to an adult ward, because more force could be used legally in an adult setting (normally from age 18). The treatment was the same as the youth institution. While I was in the cell I heard the life outside of the cell continuing without me. I felt so lost, because I felt I did not belong anywhere. Harming myself had become a daily habit, it was about the only challenge I had left, and breaking out of the cell and the institution. In one of the numerous physical struggles towards the isolation cell, my thumb was injured (a complex situation). I could not stretch my thumb, but the carers said I was only drawing attention. I ran away with one of the users and we went to (several!) medical hospital, but although they diagnosed the injury and were willing to heal it, they were restricted by bureaucracy and policies: **any runaway who is involuntary admitted with a juridical measure (wet BOPZ) should be brought back to the institution (therefore I could not rely on family, friends etc.) and an involuntary user is only capable of legal acting under supervision and with permission of the psychiatric carers.** Therefore I was removed from the medical hospital by the police several times, while the medics had discovered and diagnosed the injury on my tendon, and were willing to do surgery immediately. But the psychiatric carers said I was acting theatre and I had misleaded the medics. It took me many weeks to officially prove that the tendon of my thumb was broken (with electric power at a physiotherapist, and intensive contact with the local person engaged on users rights), and only after this proof I was allowed to go to a medical hospital. Some months later, when I had *"earned some freedom-privileges"*, a similar misjudgement repeated when I had broken my Achilles Tendon with a friendly game of soccer in the internal yard. After a week I still could not walk, and I was put into the isolation cell because of crawling and shoving on chairs (due to inability to walk, but according to the carers: unwilling to walk and drawing attention in a negative way). After approx. 3 weeks I was allowed to go to a medical hospital, which healed my injury and also arranged the closing of this awful ward.

Then, I was transferred to an Intensive Care Clinic in another city (Eindhoven), with about 14 users and 5-8 carers during the day. The first day I ran away, because I had the opportunity. I had no place to go, and just hung around, after 2 days I came back, along with some user I knew. I got no punishment at all, but I was allowed to go outside if I wanted, because I had come back in good health (not harming myself). My world changed again.
I was in a ward full of possibilities. With free access to the music room, a creative studio, an internal yard, and even the TV and the phone. I got outside more and more, playing guitar with some friends, singing, laughing, hanging around. Once I went to the movies in the city (not in a big group-activity, but only with 1 carer, like normal friends). To me it was very impressive to be participating in the society by going to the movies on a normal basis (I still felt very much stigmatized). In the beginning I sometimes had some relapses, but I got along better and better. I was frequently staying outside for a couple of days. Eventually I stopped harming myself.
But then the carers insisted I should spend more time on the ward, for participating in the therapy processes etc. I told them I was not really interested in therapy, because I wanted to be outside, because I liked it there better. I said: "I am not suicidal anymore, I want to go back into the society, and I really think I am capable of returning to society, and it seems to me that returning to society is the main goal of psychiatry itself, so there is no way you can stop me."
They indeed could not stop me. I wrote a letter to the official judge to end my coercive admission, which was indeed stopped. Then I took my bag and left.
Unfortunately, I was in no position to have access to some social rehabilitation projects (for housing etc.) because I left the institution without agreement of the carers (bureaucracy again). I needed a certain note on recovery from them ,which they were

unable to give me, because I had withdrawn myself from my treatment. Due to a lack of housing and no support from any institution (other than re-entering psychiatry) I was homeless for about 2,5 years, and I was sleeping outside a lot, but it really gave me my freedom back. I slept at several places and learned a lot. I finally could decide freely what to do, and I kept everyone at a distance.
One thing that struck me was, one time on the streets, when a women said to me: "I wish I could do something for you, but I really don't know what I could do for you". This struck me, because she was so honest about her feelings. I felt warm by what she said, it was so humane, so pure. I did not feel bad anymore at that moment. It is still in my memory, because it touched me so much.
In my opinion, sometimes it is best just to admit it, when you don't know what to do.

In this homeless period I have used hard drugs, not to get blurred, but to feel strong and awake (speed, amphetamine), and also not to become enemies of the junks. I did not steal, I just managed else way. I was allowed to sleep at the shelter for addicted people (where I was the only girl). I quitted this scene when some people were murdered or died otherwise. I had no problem stopping with drugs, because I run away before, and I only needed my freedom. I was not allowed to stay in the shelter because I had stopped taking drugs (bureaucracy again). So I was outside on the streets again. Unfortunately I had the same incident with my thumb again. Again I was not believed, this time the general doctor rejected me (as a homeless girl of 20 years old), and it took me about 11 months to get surgery (after giving up, but some friends helped me to return to "the system" and ask for help). After surgery an acquaintance offered me a sleeping place to recover. I stayed there for a year and went back to school in the year 2000, followed by studying Environmental Sustainable Materials Technology (sustainable technical management). I graduated at the end of 2005, and in 2006 I have won a prize of 2,500 euros for sustainability, with my graduation report on measuring sustainability of energy supply (Eco-Energie-Index).

In the year 2002, when I was studying, I finally found a lawyer who would try to help me to get these practices judged (because I finally had a postal address, requested for bureaucracy). Due to the lawyer I gained some faith and confidence again. After receiving a text message on continuing bad practices in the institutions where I have been, I decided to start the protests against isolation cells. I started with hanging leaflets and posters in the neighbourhoods of the mental hospitals, which made it to the regional newspaper as "Anonymous protest against isolation cells" with a small picture and some lines of text.
After this small success I decided to do more of such protests and in 2003 I have initiated Actiegroep Tekeer tegen de isoleer! (Action group Beat isolation cells) which has grown to the overall organization Stichting Mind Rights, since 2006.

The results of the campaigns against isolation cells (so far) are described in the report: **Breaking the cells down.**

With best regards,

Jolijn Santegoeds
www.mindrights.org