A qualitative exploration of professional and patient experiences of release from seclusion

Haley Jackson

Submitted in accordance with the requirements for the degree of
Doctor of Philosophy (PhD)

The University of Leeds
Faculty of Medicine and Health
School of Healthcare

September 2020

The candidate confirms that the work submitted is her own, except where work which has formed part of jointly-authored publications has been provided. The contribution of the candidate and the other authors to this work has been explicitly indicated below. Appropriate credit has been given within the thesis where reference has been made to the work of others.

> Jackson., H. Baker, J. and Berzins, K. 2018. What factors influence the decisions of mental health professionals to release service users from seclusion? *International Journal of Mental Health Nursing*. **27**(6), pp.1618-1633.
>
> Jackson., H. Baker, J. and Berzins, K. 2019. Factors influencing decisions of mental health professionals to release service users from seclusion: A qualitative study. *Journal of Advanced Nursing*. **75**(10), pp.2178-2188.

Acknowledgements

I would like to say a big thank you to my PhD supervisors, Professor John Baker and Dr Kathryn Berzins without whose advice, guidance and perseverance I could not have completed this thesis. I am also grateful to Tracy Flanagan, Paul Johnson, Cathryn Hart, Jenni Jordan and Humber Teaching NHS Foundation Trust for their ongoing support over the 5 years it took me to complete the work. Thank you also to Leila Shard-Amit for her motivating words and to Jon Thacker for proof reading a draft. I would like to thank my family, Mum, Clare, Jess and James for being patient and listening to me complain incessantly.

I dedicate this thesis to my father who would be proud.

Preface

Back in 2014 and 2015 there were growing national concerns about the use of restraint and seclusion in mental health (MH) settings. A number of publications were released including the Transforming care: A national response to *Winterbourne View Hospital Department of Health Review Final Report* (Department of Health (DoH), 2012), the *Mind Mental Health: Crisis in Care Report* (MIND, 2013), *Positive and Proactive Care* (DoH, 2014), the updated Mental Health Code of Practice (DoH, 2015), and the NICE Guideline: Violence and aggression: short-term management in mental health, health and community settings (National Institute of Clinical Excellence (NICE), 2015).

I am a mental health nurse employed in an NHS Mental Health and Learning Disability Trust. Around that time, as part of a work stream aimed at reducing the use of restrictive interventions I was involved in an audit of seclusion practices. When completing the report, I thought patients seemed to remain secluded despite their records indicating they were settled. I wondered why this might be. In mid-2015, I was given the opportunity to undertake a PhD. There appeared to be little known about how decisions to release patients from seclusion were made, therefore I decided this would be a worthy topic.

Abstract

Background: Mental health policy stipulates seclusion should only be a last resort and used for the shortest time possible. Little was known about factors influencing or experiences of release from seclusion from a professional or patient perspective. Previous evidence focussed upon decisions to initiate episodes and was mainly from nurses despite policy requiring multi-disciplinary team involvement in release.

Aim: The aim of the study was to explore the experience of involvement in release from both the professional and patient perspective.

Design: Pragmatic nursing research using qualitative framework analysis.

Method: Two integrative literature reviews and thirty-six exploratory semi-structured interviews with professionals and patients were conducted. Data was summarised and interpreted to supported rigour, credibility and authenticity. Findings were collectively discussed and synthesised.

Literature reviews: Professional literature generated six themes: maintaining safety, risk assessment, interaction and control, factors external to the patient, compliance, release and reflection. Patient literature highlighted communication was inadequate, patients felt controlled and were unclear what they needed to do to be released.

Findings: Release was gradual and tested, informed by safety and subjective assessment. Shared implicit and explicit indicators of readiness for release were: calmness, compliance, control, co-operation, capacity, communication and commitment. However, multi-level factors relating to patients, professionals, teams, organisations and policy acted as barriers or facilitators to release. Patients had little say over what happened, thought were secluded too long and frustrated by delays. Experienced professionals were more likely to release but felt constrained by policy, whilst allied health professionals questioned their involvement.

Conclusion: Professionals continue to condone seclusion use and do not know how they could increase patient involvement. Factors hindering and facilitating release should be acknowledged to ensure patients are included in decisions, released at the earliest opportunity and to support reduction strategies.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

AHP Allied Health Professional

APNA American Psychiatric Nurses Association

BNI British Nursing Index

CASP Critical Appraisal and Skills Programme

CAQDAS Computer Assisted Qualitative Data Analysis Software package

CINAHL Cumulative Index to Nursing and Allied Health Literature

CQC Care Quality Commission

DoH Department of Health

DHEW Department of Health Education and Welfare

ECHR European Convention on Human Rights

GCP Good Clinical Practice

HCA Healthcare Assistant

HRA Health Research Authority

MDT Multi-disciplinary Team

MH Mental Health

NHS National Health Service

NICE National Institute for Health and Care Excellence

NMC Nursing and Midwifery Council

PATS-Q Professionals Attitude towards Seclusion Questionnaire

PDSA Plan-do-study-act

PICU Psychiatric Intensive Care Unit

PPI Public and Patient Involvement

PRISMA Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PRN Pro re nata

R&D Research and Development

REC Research Ethics Committee

SAMHSA Substance Abuse and Mental Health Services Administration

UK United Kingdom

UN United Nations

US United States

WHO World Health Organisation

Chapter one: Introduction

1.1 Thesis overview

The thesis is a qualitative exploratory study. It is a piece of nursing research that takes a pragmatic approach to provide knowledge on an area of clinical practice which little is known about. The thesis comprises four studies (see figure 1.1)

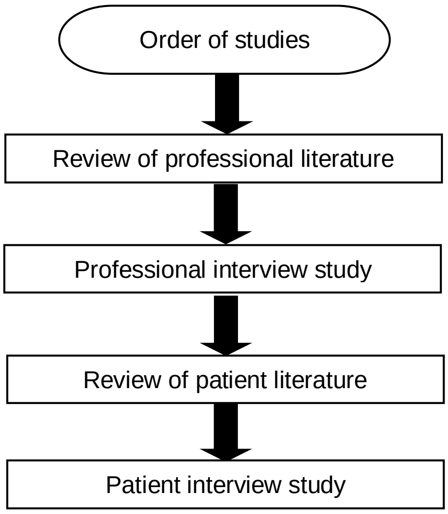


Figure 1.1 Order of studies

The findings of the studies are discussed individually and then synthesised to provide:

- An outline of ways patients believe the decision to release them from seclusion could be more inclusive and improve their experience;
- A trajectory describing the process of release;
- Indicators of patients readiness to be released from seclusion;
- A review of the barriers and facilitators to release;
- Implications for clinical practice; and,
- Recommendations for further research.

The thesis is organised into eight chapters (see figure 1.2). Chapter two is a background providing the history, definition and overview of statutory guidance for seclusion. It contains a review of current seclusion practices, plus highlights the differing ways in which professionals and patients view seclusion use. Chapter three sets out the philosophical, theoretical and methodological decisions which informed the design and methods selected. Chapter four describes the search strategies and findings of the two integrative literature reviews. Next, chapter five outlines the working methods used in the two qualitative interview studies, the findings of which are both given in chapter six. Chapter seven is a discussion of findings of both the literature reviews and interview studies. It has a section specifically focussed on the influences of nurses on decisions to release, as well as listing a number of recommendations made by patients for increasing their involvement. The chapter then presents a synthesis of the findings. Finally, chapter eight provides an overview of the thesis. It discusses the strengths and limitations of the thesis, a summary of implications for clinical practice and, finally makes recommendations for future research.

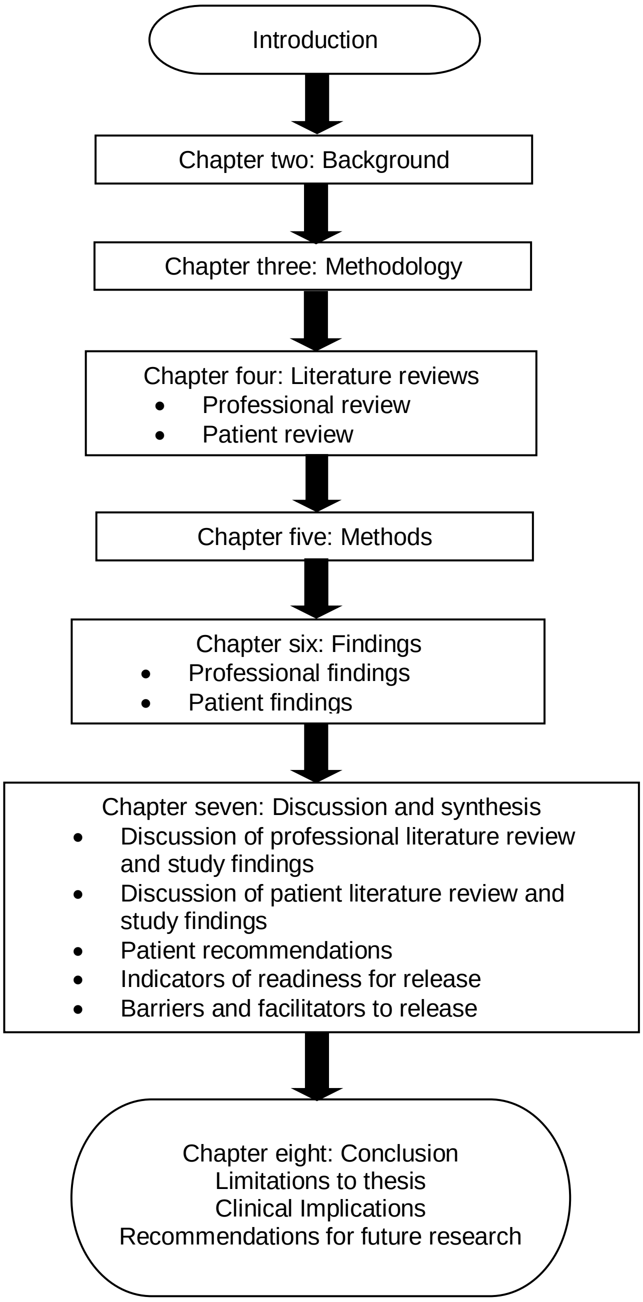


Figure 1.2 Order of chapters

1.2 Aims and objectives

The aim of the study was to explore the experience of involvement in release from both the professionals and patient perspective.

The objectives of the research were to understand:

- What factors influence mental health professionals to release patients from seclusion?
- What are patients' experiences of being involved in release from an episode of seclusion?

1.3 The contribution to knowledge made by this thesis

This thesis contributes new knowledge as these were the first literature and interview studies to focus upon decisions to release from seclusion from either the professional or patient perspective. The findings have been used to make recommendations for practice, policy and future research.

Chapter two: Background

2.1 Introduction

The purpose of the background chapter is to provide an overview of the use of seclusion and evidence into seclusion practices in mental health inpatient settings. The chapter traces how the methods of treatment and control established in asylums in the late 1700s continued through to the institutions of the mid twentieth century, and now form the basis and legitimacy for seclusion use today. The chapter provides the current working definition for seclusion in England and Wales, plus gives an overview of statutory and best practice governing use. The following sections, firstly review why professionals opt to seclude patients, which patients are likely to be secluded, how often seclusion is used and for how long. Next, the attitudes and feelings towards seclusion use are explored from the perspectives of both patients and professionals. The chapter then examines the ethical debates regarding human rights, moral arguments related to seclusion use and current initiatives aiming to eliminate it from healthcare settings. Finally, the background concludes evidence to date is focussed upon how decisions to seclude are made, and that this evidence is mostly from a nursing perspective. It identifies how little is known about the influence of the wider multi-disciplinary team (MDT) or how decisions to release patients from seclusion are made and experienced.

2.2 The nature of inpatient mental health care

In the United Kingdom (UK) in 2016/17 there were 56,435 reported physical assaults on National Health Service (NHS) professionals, a rise of 9.7 per cent on the previous year (Health Services Journal, 2018). 70% of these assaults occurred in mental health settings (Renwick et al., 2016) with mental health nurses three times more likely to be physically assaulted than nurses working in general healthcare (Edward et al., 2016). In addition to treatment decisions, mental health professionals contend with the unpredictability and uncertainty associated with psychiatric wards as patients may have mental or behavioural disorders, be legally detained against their will, and present with high rates of alcohol or illicit substance misuse (Reilly et al., 2019). Yet, evidence is lacking in regards to the most effective way to manage violence and aggression in inpatient settings (Georgieva et al., 2012).

2.3 The history of seclusion use in psychiatry

The use of seclusion is tied to prevailing cultural beliefs about the morality of treatments and the acceptance of physical restraint in the care of the mentally ill. Alty (1994) identified texts dating back to the 2nd century AD which referred to seclusion as, '…a method of calming a mentally ill patient by placing him in a room especially designated for that purpose' (Alty, p17, 1994), and talk of massage and soothing interventions. However, historians suggest through the ages seclusion has been associated with coercion and punishment, with people being incarcerate in basic cells with poor sanitary and living conditions. Up until the latter years of the Middle Ages religious orders tended to provide care and refuge, but it was the arrival of mental asylums which shaped modern psychiatric hospital services.

From their conception asylums held powers constituted outside of the police and the courts (Rainbow, 1984). Foucault's text *Madness and Civilisation* (1961) traced the advent of confining the poor, unemployed and insane back to the monarchical and bourgeois reforms of European economic and social orders in the mid-1600s. In the late 1700s the separation of those deemed *mad* began with the establishment of asylums and attempts were made to outlaw physical punishments and the use of shackling. In 1796, William Tuke established *The Retrea*t in the north of England at York delivering treatments based upon moral and religious Quaker principles rather than restriction. Around the same time, Philippe Pinel, in his *A Treatise on Insanity* (1801), introduced institutional care to Paris. Pinel rejected religion and talking believing science was the cure. He first proposed the idea medics should have sovereign power to oversee treatment of the insane (Foucault, 1961). The separation from society and control over people with mental illness continues today.

The legitimacy to control disturbed, violent or aggressive patients has long provided cause for concern. There was a clear shift in attitudes and practices in England and Wales towards the use of restraint around the mid-nineteenth century. Around this time, a number of leading psychiatrists claimed it was possible to treat people without the use of restraints. According to Topp (2018), debate also centred upon whether or not seclusion constituted restraint and should also be stopped. However, influential figures such as Dr Conolly from the Hanwell asylum in Middlesex, did not agree as in his text *Treatment of the Insane without Mechanical Restraint* he wrote, '…the patient cannot be at large with benefit to himself or with safety to others', (Conoolly, 1856, p42). As a consequence of the non-restraint movement, rates of seclusion increased with forcible confinement in solitude being viewed as calming and restorative. In 1858, seclusion use was supported and legitimised by the Lunacy Commission who described it as being when a patient is confined and separated from others. In their *Thirteenth Annual Report of the Commissioners in Lunacy (1859)*, the requirement to record where and when seclusion was used was introduced. Accounts in the latter part of the 1800s described how concerns about protection and safety saw rooms used to seclude patients evolve into padded cells. Furthermore in the 1880s seclusion was reported to be used, not only for safety, but for the observation and management of suicidal patients, especially at night when there was not enough staff (York, 2009). By the early 1900s the mental asylums began to be recognised as hospitals. Mental health care and treatments began to change with views towards the mentally ill being altered as shell shocked soldiers returned from World War One and new medications and treatments were introduced in the 1930s.

In the 1950s, the sociologist Ervin Goffman studied institutions using an ethnographic observational study as the basis for his publication *Asylums* (1961). His anti-psychiatry critique examined the social structures, interactions and rules operating in an American psychiatric hospital in order to explain how inmates became subservient to their wardens. Similar to Foucault (1961), Goffman (1961) reported practices in which mental illnesses were seen as a violation and threat to the social order, subsequently people could legitimately be contained and controlled. He found services led by staff members who viewed themselves as experts. Patients were depersonalised into adopting institutionally defined roles guided by moral expectations and implicit coercion. Goffman reported how staff members reacted when the social order and environment were challenged. He witnessed first-hand enforced isolation as a means of control writing:

> *…a self-destructive mental patient who is stripped naked for what is felt to be his own protection and placed in a constantly lit seclusion room, into whose Judas window any person passing on the ward can peer* (Goffman, 1961, p.23).

Plutchik et al. (1978) applied Goffman’s findings to two theories explaining why the practice of seclusion might be used. The first, a behaviourist model suggested seclusion was used to remove reinforcing stimuli, interrupt undesirable situations and provide feedback to aggressors. This supported Gutheil’s theory of seclusion (1978) that suggested when professionals felt threatened, they used seclusion to contain, isolate and decrease sensory input to manage out of control behaviours. The model is still applicable today as patients are secluded to combat actual or threatened violence, with decisions to seclude relating to behaviour management rather than any medical or therapeutic treatment. Plutchik et al.'s (1978) second theory had an ethological base that viewed the psychiatric ward as a naturalistic social subgroup with rules to be obeyed. This again remains relevant as Duxbury (2015) stated professionals continue to support the use of restrictive practices, including seclusion, to manage violence and aggression to promote the safety of all.

2.4 The use of restrictive practices

The reasons for and types of restrictive practices are subject to regional variation. Low-to-middle income countries may use interventions such as *pasung*, the physical restraint or shackling of a mentally ill person by care services or relatives as a method of containment (Wijayanti, 2019). Whereas, services in the developed world with healthcare systems which have greater resources only support physical restriction by professionals as a least restrictive option to manage disturbed behaviour (Substance Abuse and Mental Health Services Administration (SAMHSA), 2010; Australian National MH Commission, 2015; National Institute for Clinical Excellence (NICE), 2015). Restrictive interventions in England and Wales are described as:

> *…deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken* (Department of Health (DoH), 2014, p14).

A restrictive intervention should only be used to take immediate control of a dangerous situation if there is a possibility of harm. Restriction must not inflict pain, suffering or humiliation, nor be used as a punishment. Dack et al. (2012) outlined eleven restrictive interventions used by healthcare professionals (see figure 2.1), although not all of these are mandated in every country. Internationally practice varies as Scandinavian countries and Germany use mechanical restraint rather than seclusion (Nielsen et al., 2018), Australian, UK and United States (US) professionals administer higher levels of enforced medication, whereas the Dutch are more likely to seclude.

PRN (pro re nata) medications
Physical restraint
Intermittent observation
Seclusion
Time out
Compulsory intramuscular medication
Psychiatric intensive care
Mechanical restraint
Constant observation
Net beds
Open area seclusion

Figure 2.1 Containment methods (adapted from Dack et al. (2012))

2.5 Seclusion: a last resort or a preventative measure?

NICE guidance (2015) for England and Wales states seclusion should only be used as a last resort intervention. However this principle is difficult to evidence in clinical practice as what constitutes a last resort is a subjective decision. According to Deveau and McDonnell (2009, p175) the last resort, '…has a major drawback in that it is an easily voiced rhetorical device and very difficult to observe or challenge'. Inconsistencies have also been observed in the ways professionals manage aggressive incidents (Renwick et al., 2016). Whilst actual physical aggression is generally identified as the primary reason for initiating a seclusion (Larue et al., 2009; Bowers et al., 2010), evidence is contradictory. Agitation and disorientation (Keski-Valkama et al., 2007), or therapeutic-limit setting in response to disruptive or aggressive incidents (Vatne and Holmes, 2006), are also cited as indications. Kuivalainen et al. (2017) undertook four year retrospective analysis of Finnish incident seclusion and restraint reports from two hospitals. Using descriptive statistics they reported the threat of aggression (n=51, 25.4% of n=144) and the presence of other behaviours (n=50, 34.7%) were more significant predictors of seclusion use than the occurrence of actual aggression (n=43, 29.9%). Similarly, other findings reported seclusion was used for:

> *…behaviour connected with abuse, agitation, arousal, assault, hitting, restraint, shouting (among women), threatening, throwing and violence* (Bowers et al., 2017, p22).

This implies professionals may pre-empt actual assault, intervening when they suspect aggressive behaviours may increase and use seclusion to prevent further escalation.

2.6 Definition and legal basis for seclusion

2.6.1 Defining seclusion

Seclusion in inpatient mental health settings involves a patient being placed in a locked room or place of safety by the staff team (see appendix one). The definition for seclusion in England and Wales was updated in the Mental Health Code of Practice (DoH, 2015). It outlines the criteria under which seclusion can be used and described it as:

> *…the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others* (DoH, 2015, p.300).

A more recent definition from the World Health Organisation (WHO) reflects the negative connotations of seclusion stating it is the act of:

> *…isolating an individual away from others by physically restricting their ability to leave a defined space. It may be by locking someone in a defined space (e.g. room, cell) or containing them in a specific area by locking access doors or by telling them they are not allowed to move from a defined space and threatening or implying negative consequences if they do* (WHO, 2017, p.15).

2.6.2 Statutory guidance

In England and Wales all forms of physical restriction, physical intervention and imminent threat of force are governed by criminal and civil law. Healthcare organisations must ensure their policies and procedures comply with current standards, that employees understand the legal authority for any proposed actions, and patients are provided with information about their rights. The following legislation is relevant to seclusion use:

- The Human Rights Act (1998) and European Convention on Human Rights (ECHR) (1950) prohibit torture, inhuman or degrading treatment and uphold the right to liberty, freedom and dignity. They state there should be no punishment without the law, there should be respect for private and family life, freedom of thought, religion and belief, plus individuals should not face discrimination.
- The Equality Act (2010) outlines the Public Sector Equality Duty that healthcare organisations must take due regard to eliminate unlawful discrimination, meet individual need, minimise disadvantage and foster good relations. The Act covers equality of age, disability, gender, sexual orientation, race, religion or belief, marital status. Organisations should not directly discriminate, disadvantage, violate, harass, victimise or compromise a person's dignity by intimidating, hostile, degrading, humiliating behaviours or by providing offensive environments.
- The Mental Capacity Act (2005) provides statutory guidance on issues around care and treatment which includes seclusion. It protects the rights of those who lack the mental capacity to make specific decisions at particular times setting out a legal framework for when others may act in the best interests of people who lack capacity, or when Court authorisation for decisions or deprivations of liberty are warranted.
- The Mental Health Act (1983) covers the reception, care and treatment of patients. It is the legislation by which people with a mental disorder can be detained in hospital or police custody, and be assessed or treated against their wishes.
- The Mental Health Act Code of Practice (DoH, 2015) requires seclusion episodes to be managed and regularly reviewed by an MDT. It requires any decision to release a patient must involve or be sanctioned by a medical practitioner (see figure 2.2).

If a patient not detained under the MH Act (1983) is secluded, then an assessment for an emergency application for detention under the Act should be undertaken immediately. The principles of the Mental Capacity Act should also be considered at this time (DoH, 2015, p26). Policy in the research setting requires patients who are secluded but not detained become immediately subject to a holding power, either a Section 5(4) which is a 6 hour nursing power, or a Section 5(2) under which medics can detain patients for 72 hours pending further assessment.

A series of review processes should be instigated when a patient is secluded. These include MDT, nursing, medical and independent MDT reviews. All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient’s mental and physical state (DoH 2015, p304).

Seclusion should immediately end when an MDT review, a medical review or an independent MDT review determines it is no longer warranted. Alternatively where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the responsible clinician or duty doctor (DoH, 2015, p306).

The Code requires:

- If seclusion was not authorised by a psychiatrist, there must be a medical review within one hour or without delay if the patient is not known or there is a significant change from their usual presentation;
- The seclusion area to be within constant sight and sound of staff member;
- A documented report by the person monitoring is made every 15 minutes;
- Nursing reviews by two nurses every two hours throughout seclusion are maintained;
- Continuing medical reviews every four hours until the first (internal) MDT are undertaken;
- The first (internal) MDT is conducted as soon as is practicable;
- Independent MDT take place after eight hours consecutive or 12 hours intermittent seclusion (within a 48 hour period); and,
- Following first (internal) MDT continuing medical reviews are carried out at least twice daily (one by the responsible clinician) (DoH, 2015, p302).

Figure 2.2 Seclusion review guidance (DoH, 2015).

2.7 The use of seclusion

2.7.1 Which patients are likely to be secluded?

Evidence has suggested seclusions mostly occurred within the first seven days of admission (Bowers et al., 2017). Being younger, male, experiencing psychotic symptoms (Happell and Koehn, 2011), having a history of substance misuse or violence (Renwick et al., 2016), all carried a greater risk of being secluded. *The Count Me In Census* (2010) for England and Wales (Care Quality Commission (CQC, 2011)) found higher than average seclusion rates for the White/Black Caribbean Mixed, White/Black African Mixed, Black Caribbean and Black African groups. Plus, those perceived as unresponsive to de-escalation attempts or refusing PRN medication were also at increased risk of being secluded (Loi and Marlowe, 2017). Yet, findings are contradictory and patient demographics or characteristics, clinical indicators or acuity do not fully explain patterns of use (Janssen et al., 2013). Studies indicated the attitudes of professionals (Laiho et al., 2014), local cultures (Soininen et al., 2013b), environmental, and contextual factors (Janssen et al., 2013), also impacted upon seclusion rates. Furthermore, even when individual patient and professional variables were accounted for, groups of hospitals and individual wards working under the same organisational policies differed in their approaches, further affecting the likelihood patients may be secluded (Cleary et al., 2010).

2.7.2 How many patients are secluded?

It was estimated globally one in five psychiatric patients were secluded at least once during a period of hospitalisation (Bullock et al., 2014). In England and Wales, the *Mental Health Bulletin 2017/18 Annual Report* indicated a total of 8,805 people were secluded in 10,028 episodes. This equated to around 7.2% of all those admitted for inpatient care in mental health, learning disability and autism services (https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2017-18-annual-report accessed 4/7/20). Assessment of use varied greatly in the way data was presented and meaningful comparisons were complicated by the:

> *…different definitions, inconsistent methods of registration, different methods of data collection and an inconsistent expression of the seclusion* (Janssen et al., 2008, p.67).

Whereas Scandinavian countries have detailed national records regarding coercion, Dutch services used the Argus scale, a standardised collection tool for monitoring seclusion data (Van de Sande et al., 2013). Whilst in the UK, NHS Benchmarking did not start collecting figures until 2015. To some extent variance in rates could be explained not only by the variability in recording practices, but also by local historical and cultural influences. Seclusion practices have included monitored use in seclusion suites, segregation in isolated areas, through to incidents in which patients are locked in non-designated rooms such as bedrooms or quiet rooms. There were also locally derived terms such as time out, special observation, extra care suites or low stimulus environments. Furthermore, seclusion took place in countries with differing legislation, under a range of clinical specialities, ward sizes and staff groups (Boumans et al., 2015).

2.7.3 How long are people kept in seclusion?

Patients frequently complained they were kept in seclusion for too long (Allen et al., 2003) although professionals disputed this (Korkeila et al., 2016). The length of time patients spent secluded differed between countries, regions and institutional settings, with mean durations estimated to range from 9 minutes to 49 days 6 hours (Steinert et al., 2010). Again, regional variations in data collection standards made it difficult to compare figures with any certainty. The effect local practices have upon durations has been examined in a number studies. Training (Nagayama and Hasegawa, 2014), and changes to nursing practice (Sullivan et al., 2004) were all used to successfully reduce the length of time a patient remained secluded. However, one UK project reported despite managing to reduce durations of seclusions through care planning, it resulted in a four-fold increase in the time patients spent isolated in a less restrictive long-term care suite, meaning they were still technically secluded (Elzubeir and Dye, 2017). This implied patients may remain secluded in an attempt to prevent future escalations of aggression rather than for the imminent threat of violence or aggression.

Literature discussing the use of mechanical restraint suggested factors influencing use and decisions about management are comparable to those of seclusion (Keski-Valkama et al., 2010; Bergk et al., 2011). Research in Scandinavia found the length of time patients remained restricted in mechanical restraints related to the quality of the patient-professional relationship (Nielsen et al., 2018). Although untested to date, this might be of relevance to durations spent in seclusion and supports the argument that seclusion durations are likely influenced by relational aspects.

2.7.4 Does seclusion have a therapeutic value?

Despite seclusion having the propensity to reduce agitation, aggression and uncooperativeness (Georgieva et al., 2012), plus prevent re-escalation of violence (Gaskin et al., 2007; Kuosmanen et al., 2007), it was increasingly thought to be anti-therapeutic (Brophy et al., 2016). Seclusion was considered by some to be a treatment failure (Huckshorn, 2006). There was a lack of clarity regarding the effect upon clinical outcomes such as symptom reduction, recovery and discharge (Mellow et al., 2017). Moreover, the impact of being secluded appeared to vary with diagnosis (Stolker et al., 2006). Eguchi et al. (2018) found patients who had been secluded with lower functioning and greater impairment showed greater improvements and benefits to symptomology, whilst those with lower mood scores tended to become more depressed. They concluded seclusion could be effective in certain situations but cautioned this may be due to the concurrent use of medication. Other studies found seclusion negatively impacted upon outcomes or did not contribute to clinical improvement (Huf et al., 2012). Furthermore, seclusion was an indicator of an increased length of stay in hospital regardless of symptoms (McLaughlin et al., 2016), although did not appear to significantly affect quality of life at discharge (Soininen et al., 2013a).

2.7.5 Efforts to reduce the use of seclusion

Seclusion as a method of restraint in healthcare is contentious, subjective (Lindsey, 2009), and the focus of moral and ethical debate (Laiho et al., 2014). It has been described as '…*cruel, inhuman or degrading'* (United Nations (UN), 2013, p6), and there is international agreement it should be an intervention of last resort (SAMSHA, 2010; DoH, 2014; Australian MH Commission, 2015). It should be undertaken in accordance with the United Nations Principles for the Protection of People with Mental Illness (UN, 1991), and used by professionals only when faced with actual or threatened violence (DoH, 2014). In response to concerns, increasing emphasis has been placed on preventing the escalation of incidents (Steinert et al., 2010; LeBel et al., 2014; WHO, 2017) and efforts are underway to eliminate seclusion use (LeBel et al., 2014; Wieman et al., 2014; Duxbury et al., 2019). To date, this movement is focussed upon reducing rather than banning the practice (Kinner et al., 2017). Organisations are required to ensure patients only remain isolated or behind a locked door for the shortest possible time (NICE, 2015). According to Staggs (2015) the average time spent in seclusion was decreasing. Shorter durations could be attributable to changes in national policy (DOH, 2014; American Psychiatric Nurses Association (APNA), 2018; Australian National MH Commission 2015), the growing number of international and local restraint reduction programs, or changes in professionals attitudes towards restrictive practices (LeBel et al., 2014; Kinner et al., 2017). However, neither policy or reduction programs have offered specific guidance on how decisions to release patients should be made.

Nationally driven initiatives to reduce the use of seclusion and restraint include the Six Core Strategies from the US (Huckshorn, 2004), the Beacon Project in Australia, Positive and Proactive Care in the UK, the Dutch Restraint Reduction Programme and the Finnish/Japanese Sakura project. They all incorporate a number of interventions which, when used together, have been able to demonstrate variable rates of reduction. It is not yet clear which individual intervention or what combination of interventions are the most effective (Baker et al., 2019). Despite several successes in reducing seclusion use (Ching et al., 2010), achieving sustainability has proved difficult (Mann-Poll et al., 2011). As such, the total eradication called for in the Ashworth Inquiry (Fallon, 1999) may not be realistic as there will always be times when patients lack insight, do not understand consequence or cannot control their violence (Tamminen and Green, 2014). Therefore, services are advised to use a number of alternative restrictive practices to seclusion such as increased nursing interventions (WHO, 2017), strong ward leadership and multi-professional planning which involves patients in decisions about their care (Kontio et al., 2010). Yet, Elzubeir and Dye (2017) argued in certain environments, such as psychiatric intensive care units (PICUs), seclusion is not always avoidable and likely be used for the foreseeable future.

2.8 Patient perceptions and experiences of seclusion

2.8.1 Patients thoughts about seclusion

Patients thought professionals benefitted most from the use of seclusion (Ezeobele et al., 2014) describing it as punitive and a means of control (Soliday, 1985; Frueh et al., 2005; Adams et al., 2007; Mayers et al., 2010). Wilson et al. (2018) reported those who had been secluded likened staff members to prison guards. Under certain conditions, patients preferred it to other forms of restriction for the management of aggression (Bowers et al., 2004; Brady et al., 2017). This contradicted other research which found patients would rather be medicated than secluded (Veltkamp et al., 2008; Mayers et al., 2010; Georgieva et al., 2012), or that no significant difference existed between the preference for seclusion versus mechanical restraint (Bergk et al., 2011).

Patient views appeared to relate to the way in which a seclusion was conducted and their personal experience of the episode. They were more positive if they understood why they had been secluded (Veltkamp et al., 2008), although many reported being unclear why (Veltkamp et al., 2008; Kontio et al., 2012), and lacked clarity about what had happened (Meehan et al., 2000). For those residing in multi-bed communal wards, seclusion could potentially offer psychological space (Stolker et al., 2006). Whilst, for patients with prior experience of being secluded, approval rates for future seclusions were linked to the length of previous episodes, particularly if episodes had not lasted long or had not impacted upon their care (Georgieva et al., 2012).

2.8.2 What it feels like to be secluded

The review of patient experiences by Mellow et al. (2017) found evidence, albeit limited, related to the environmental experience, plus patient’s cognitive and behavioural response. However they reported most literature focussed upon their emotional response. A minority of patients have said seclusion was helpful, in that it provided relief and offered a less stimulating environment in which they felt safe and secure (Laiho et al., 2014), plus they were grateful for the constant support and supervision of professionals (Meehan et al., 2000; Chien et al., 2005). Yet despite the presence of professionals, the majority of patients still experienced abandonment, mistreatment and neglect (Ezeobele et al., 2014). Most seclusion experiences were negative (Keski-Valkama et al., 2010; Mayers et al., 2010; Larue et al., 2013; Eguchi et al., 2018), and these negatives outweighed any positives (Holmes et al., 2015). Patients complained seclusion rooms felt claustrophobic or cold (El-Badri and Mellsop, 2008), and they experienced a fear of becoming ill or dying, anger, embarrassment, humiliation, depression, sadness, panic, anxiety, distress, isolation, boredom or loneliness (Sheehan and Burns, 2011; Dack et al., 2012). Some viewed seclusion as a punishment in which they were helpless or powerless (Dack et al., 2012; Ezeobele et al., 2014; Sambrano and Cox, 2013), and subjected to unnecessary or excessive force (Lorem et al., 2015). Whilst others reported feeling dehumanised (Verbeke et al., 2019), undignified or disrespected, ‘…*like an animal in a zoo’* (El-Badri and Mellsop, 2008, p251).

2.8.3 The influence of previous trauma(s)

Studies found people with serious mental illness had high prevalence rates of historical trauma (Cusack et al., 2004; Frueh et al., 2005), and for those who did the experience of being secluded enhanced the negativity they felt both whilst locked in, and after the event (Frueh et al., 2005; Steinert et al., 2007; Hammer et al., 2011). Little appears to have been done to address this, as to date there remains a lack of evidence that structured debrief or post-seclusion follow-up regularly takes place (Needham and Sands, 2010). This was despite evidence which demonstrated debrief supported trauma-informed and recovery-oriented care (Larue et al., 2013; Te Pou, 2014), and having a single session of post-seclusion debrief offset the need for future counselling (Whitecross et al., 2013). Therefore, when possible, professionals should discuss with patients what their feelings and preferences are prior to, or during a seclusion, to ensure further distress or damage is minimised.

2.9 Professional thoughts and influence upon seclusion

2.9.1 Professional thoughts about seclusion

Professional views about seclusion differed (Roberts et al., 2009; Dack et al., 2012; Lorem et al., 2015). Whilst professionals acknowledged it could be harmful for patients (Kinner et al., 2017) and rated it as the least acceptable restrictive measure (Pettit et al., 2017), according to Kontio et al. (2012), they gave little thought to the patient perspective. Professionals often assumed they were acting in the patient’s best interest and perceived seclusion to be therapeutic (Mayers et al., 2010). Professional views were likely influenced by prevailing legal, moral and ethical discourses (Frueh et al., 2005; Norvoll and Pedersen, 2018). In addition, they were shaped by international statutory guidance, explicit hospital protocols and procedures, and local implicit ward cultures (Stolker et al., 2006; Goulet and Larue, 2018; Mellow et al., 2017). Furthermore, the workforce is diverse with differing training and registration requirements.

2.9.2 Team and individual characteristics

As outlined above (see section 2.7.1), variability in the use of seclusion was not only informed by individual patient presentation. Larue et al. (2009) and Laiho et al. (2013) identified a further number of interrelated variables which impacted upon seclusion use and included environmental factors, organisational factors, the effect of individual practitioners and nurse-patient therapeutic relationships. Research indicated team philosophies and working practices were also influential (Mason, 1997; Keski-Valkama et al., 2007; De Benedictis et al., 2011).

The effect of team size, composition or experience was unclear. Again, findings from research into mechanical restraint may be relevant. Nielsen et al. (2018) reported teams with higher levels of education and more years of experience consistently demonstrated a negative correlation with use of mechanical restraint. They found teams worked together to facilitate release. Surprisingly, two seclusion studies demonstrated a positive relationship existed between the number of qualified professionals on a shift and seclusion use (Bowers and Crowder, 2012; Staggs, 2013), although both were not clear if this was due to other variables such as increased patients acuity or that registered professionals set more boundaries, enforced rules or refused more requests. Whereas, other studies implied the presence of fewer professionals on a ward made it more likely (Morrison and Lehane, 1995; Van der Merwe et al., 2009). Bowers et al. (2010) identified use was greater when there were more males on duty, potentially contradicting research which identified female professionals were more likely to initiate an episode of seclusion (Janssen et al., 2007; Kalisova et al., 2014; Doedens et al., 2017). Interestingly, Doedens et al. (2017) reported the presence of nurses with a large physical stature was associated with a statistically significantly lower chance of seclusion use ($p=0.01$).

As with other aspects of seclusion use, the impact individual characteristics have on release has not been explored. Individual professional differences are thought to override the effect of the team (Husum et al., 2010; Georgieva et al., 2012; Laiho et al., 2014), and were shown to be as, if not more, important than the effect of the team or presentation of the patient in seclusion (Mann-Poll et al., 2011). Dutch and Australian research suggested professionals tendency to use seclusion was affected by levels of burnout, job satisfaction and therapeutic optimism (VanDerNagel et al., 2009; Happell et al., 2012), in addition to their propensity to be empathic (Owen et al., 1998; Yang et al., 2014). Further to this, previous experience and preferences (Mann-Poll et al., 2011), personality traits (Happell and Koehn, 2011), individual levels of tolerance (Renwick et al., 2016), peer pressure (Mason, 1997) and emotional influences (Etzioni, 1992), all affected the likelihood a clinician would opt to seclude. However, nurses disputed this with one stating decisions were, '*…based upon the clinical picture and* *environment, made on professionals judgment, not on emotion',* (Roberts et al., 2009, p.29).

2.9.3 Professionals' attitudes towards seclusion

According to Van Doeselaar et al. (2008), the more professionals used seclusion the more they valued it. Using the Professionals Attitude towards Seclusion Questionnaire (PATS-Q) (Van Doeselaar et al., 2008), they identified three groups of professionals: maintainers, doubters and transformers. Whilst transformers questioned the practice and attempted to find alternatives, the first two groups did not openly challenge seclusion use. They believed it helped establish boundaries and enforce acceptable standards of behaviour to create safer environments which enabled patients to engage in treatment (Marangos-Frost and Wells, 2000; Hall, 2004; Maguire et al., 2014; Korkeila et al., 2016). Further to this, Roberts et al. (2009) reported nurses described a sense of relief once violent patients had been secluded which suggested seclusion was a reactive measure and rationale for use might be applied later at a later date.

Similar to patients, professionals also reported negative feelings which included guilt (Roberts et al., 2009), shame, fear, distress (Goulet and Larue, 2016), anger and frustration (Maier, 1999), although some admitted they suppressed unpleasant emotions (Moran et al., 2009). Professionals faced moral and ethical dilemmas connected to seclusion (Landeweer et al., 2011). As on the one hand their actions infringed human rights (Goulet and Larue, 2016), whilst on the other hand, in certain circumstances if they failed to initiate a seclusion and someone was injured it might constitute negligence or impinge upon the human rights of others (Simon and Shuman, 2007; Slemon et al., 2017).

2.9.4 The responsibility to maintain safety

Safety was identified as the prime concern in mental health settings (Moylan, 2015). Decisions to seclude were generally seen to be influenced by safety and then by ethically driven factors (Goethals et al., 2012). For nurses, maintaining safety was seen as a priority required by their professional code (APNA 2018, Nursing and Midwifery Council (NMC) 2015). Healthcare organisations and colleagues, as well as patients, had an expectation inpatient nurses would ensure environments remained safe (Delaney and Johnson, 2008; Happell and Koehn, 2010). Moreover, the majority of nurses thought the availability of seclusion was necessary for them to maintain safety

(Martin and Daffern, 2006; Happell et al., 2012; Wilson et al., 2017; Muir-Cochrane et al., 2018). Nurses expressed concerns the removal of seclusion facilities might lead to an increase in the use of other methods of restriction such as physical restraint (Maguire et al., 2012), and result in more injuries (Moylan and Cullinan, 2011). However, in the commentary by Duxbury (2015) this was disputed and she argued it was unsupported by evidence.

2.9.5 Preventing injury

O'Rourke et al. (2018) reported injury rates for professionals in mental health services were rising. Other authors found no evidence for this (Smith et al., 2015; Goulet and Larue, 2016), but figures have indicated professionals were more likely to be injured when attempting to seclude a patient rather than from direct violence (Daffern et al., 2003; Donat, 2002; Smith et al., 2005; Renwick et al., 2016). Secluding a patient often involves a physical restraint, in which professionals hold and move them to a seclusion room. Therefore, it may be difficult to identify at what point an injury might be avoided or sustained. Similar to seclusion practices, there were wide variations in the incidence and recording of physical restraints across mental health settings. In the UK, NHS Trusts reported numbers between 38 and 3000 inpatients in their services were restrained per year (MIND, 2013). Agenda (2018) reported it to be as high as one in five patients. It was not clear how many patient related injuries occurred following physical restraint, although one report suggested in the UK between 2012 and 2017 thirty-two women died after experiencing restraint (Agenda, 2018). Renwick et al. (2016) found reports of patient injuries were not detailed and few included the patient view. High profile physical restraint deaths have included David *Rocky* Bennett who died in 1998 at a medium secure mental health unit as a direct result of face down restraint and, Seni Lewis who died in 2010 following a prolonged police restraint. To date, there is no literature outlining which methods are safer and for which circumstances (Pratt et al., 2014). However, it could be argued for patients who need longer periods to de-escalate, seclusion may be a safer and less restrictive option.

2.9.6 An appetite for change?

Under the principals of least restriction and recovery, professionals have stated they are being encouraged to relinquish the right to seclude (Holmes et al., 2015). As it remains a legitimate practice, it is still viewed as acceptable (Lemonidou et al., 2002; Happell and Koehn, 2011) and they feel justified in using it (Paterson and Duxbury, 2007; Larue et al., 2009; VanDerNagel et al., 2009; Happell and Harrow, 2010). However, a growing number of professionals are committed to reducing use (Whittington et al., 2009). Attitudes may be beginning to change due to increasing pressures from patients, carers, professional bodies and policymakers upon clinicians (Maguire et al., 2012; Kinner et al., 2017), and as discussed above, through reduction initiatives (see section 2.7.5).

2.10 Seclusion decision-making

2.10.1 An absence of guidance and tools to inform release

Professionals are faced with the dilemma that if they agree to release prematurely, it may result in further violence or aggression and patients might end up being re-secluded. In England and Wales, current clinical guidelines state seclusions should only last for, *'… the shortest time possible*' (NICE, 2015, p69), and that patients be released as soon as seclusion, '…*is no longer warranted*' (DoH, 2015, p306). Yet the guidance is not clear what a patient's readiness for release should look like, nor does it outline how release can be achieved. The influence individual nurses have upon seclusion decision-making and durations was recognised by the APNA who stated:

> *…skilled assessments of individuals who are restrained or secluded will not only ensure the safety of individuals in these vulnerable conditions, but also will ensure that the measures are discontinued as soon as the individual is able to be safely released (*APNA, 2018, p.3)

Similar to policy, their report failed to outline what these assessments or measures should be. Furthermore, despite structured assessments having demonstrated effectiveness in supporting the reduction of aggression (Van de Sande et al 2011), they have not been used to inform whether a seclusion was warranted (Abderhalden et al., 2008; Van de Sande et al., 2017) or that it should continue.

2.10.2 Seclusion decision-making models

Clinical decision making regarding seclusion was criticised as being subjective and inconsistent (Huckshorn, 2004; Lindsey, 2009). According to Crook (2001), *on-the-spot* decisions by mental health clinicians were influenced by experience and skill, yet made tenuous through the conflicted tensions of supporting patient choice whilst working within policy. Several studies have explored seclusion decision-making processes.

Whilst all concluded safety was the primary consideration (Whittington and Mason, 1995; Moylan, 2015), they also outlined how decisions to use seclusion were shaped by a multifactorial complex mix of personal, professional and organisational discourses and practices (see table 2.1). To date, models explaining decisions to seclude (Whittington and Mason, 1995; Holzworth and Wills, 1999; Laiho et al., 2013) have failed to provide robust supporting evidence (Allen et al., 2003; Hyde et al., 2009; Knox and Holloman, 2012). Their value has been questioned as they are nurse specific (Kuosmanen et al., 2015) and their transferability across settings is limited. No existing models were identified by the thesis which exclusively informed or explored decisions to release.

Author	Overview of model
Whittington and Mason (1995)	A cognitive model outlining stress-coping strategies.
Mason (1997)	Decision-makers use 1st/2nd level reasoning balancing reasonable and rationale choices.
Larue et al. (2009)	Patient-staff bi-directional relationships, organisational and environmental factors impact upon decisions.
Mann-Poll et al. (2011)	46% of decisions to seclude can be explained by individual characteristics.
Laiho et al. (2013)	Decisions are based upon observed behaviour and the previous experiences of the professionals.
Jarrin (2013)	Influences upon judgement to use seclusion include patient, unit and nurse factors.

Table 2.1 Seclusion decision-making models

2.10.3 Lack of evidence about the involvement of the MDT

Although nurses have traditionally managed seclusion episodes (Kuosmanen et al., 2015), policy requires medics to be part of any decision to release patients. Medical literature to date has focussed upon review guidelines and patient assessment, but has failed to consider the external influences discussed above. Further to this, MDTs in England and Wales increasingly incorporate allied health professionals (AHPs), which include psychologists, occupational therapists, and social workers. It is not clear how prepared AHPs are to be involved in seclusion decision-making, nor is there evidence exploring their attitude towards the management of safety or use of seclusion.

2.10.4 Lack of patient involvement in decisions

Literature indicated professionals made decisions for, rather than with, patients who were secluded. Professionals sometimes questioned a patient's capacity to engage, arguing they as professionals had a moral duty to manage care (Georgieva et al., 2012). Patients stated their opinions were not valued (Soininen et al., 2013b) and tensions dominated their attempts to be involved in decisions regarding seclusion (Felton et al., 2018). Patients wanted to be given a greater voice about their treatment options (Veltkamp et al., 2008; Dack et al., 2012; Soininen et al., 2013b; Aguilera-Serrano et al., 2018). Policy requires they are given the opportunity to be active partners in deciding their own needs (NICE, 2011), whilst professionals should involve families more to promote collaboration and diminish conflict (DoH, 2010, Aguilera-Serrano et al., 2018).

The introduction of the Recovery model and recovery principles should have seen services do more to encourage patients to participate and negotiate shared decisions (McCabe, 2005). The model emerged in the mid-1990s and was defined as the:

> *…personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles…a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness* (Anthony, 1993, p12).

Recovery outcomes are distinct from traditional clinical domains and focused upon personal wellbeing and social inclusion (Bonney and Stickley, 2008; Walsh et al., 2008). Despite evidence patients with serious mental illness, can and should participate in shared decision-making (Hellerstein et al., 2007; Hamann and Heres, 2014), with regards to seclusion, this is still not the case as traditional paternalistic practices still dominate (Goulet and Larue, 2018).

There have been moves to encourage patients who have been secluded to contribute to choices about the management of their care and to share in decision-making. Swanson et al. (2008) examined the use of advance directives to reduce the use of restrictive practices and inform professionals of patient preferences. They reported benefits, but admitted these were not legally binding. *Positive and Proactive Care*

(DoH, 2014) and *the Brief guide [2]: positive behaviour support for people with behaviours that challenge* (CQC, 2015) recommended inpatient settings use behavioural support plans which take a bio-psycho-pharma-social approach and was shown to help professionals identify the best way to involve patients and make informed decisions about seclusion (Clarke and Clarke, 2014). Further to this, shared planning and decision-making increased patients willingness to co-operate, promoted their autonomy (Lorem et al., 2015), improved treatment outcomes (Ambrosini and Crocker, 2007) and boosted their satisfaction with treatment (Duncan et al., 2010). Although, as stated above (see section 2.7.3), caution is needed as goal-specific seclusion care plans could increase the durations patients remain isolated. Thus, care should be taken to ensure plans do not replace seclusion with enforced segregation. Overall, there is an absence of available evidence examining the way professionals interact with patients during episodes of seclusion and an absence of literature in regards to their release.

2.11 Conclusion

To conclude, this chapter acknowledged there are concerns associated with seclusion use in inpatient mental health settings. Overwhelmingly, patients report seclusion as negative, and that when secluded their autonomy and any involvement in decisions about their care is removed. Professionals are conflicted between acting in the patients best interest against ensuring the safety of all. Seclusion is an example where decision-making is unclear and is subject to wide variation in how it is described, the way it used and how long it is used for. This made it difficult to evaluate and make meaningful comparisons. Although the management of seclusions in England and Wales is tightly regulated and closely monitored, there appeared to be no clinical guidance or evidence-based practice to support clinicians taking decisions to release patients. Furthermore, despite medical and AHP involvement, there was no research evidence examining the influence or experience of the wider MDT upon decision-making in regards to seclusion. Understanding how release is facilitated may support the development of strategies to ensure clinical practice is consistent and patients are released at the safest and earliest opportunity.

The thesis addressed the absence of knowledge regarding release from seclusion through the development of two questions. Research questions should be tightly-focussed and can arise out of the experiences of the researcher relating to a clinical problem or be identified from the literature (Meadows, 2003). In this case, the questions were informed by the clinical experience of the researcher, background reading and discussion with the thesis supervisors. The questions were:

- What factors influence mental health professionals to release patients from seclusion?
- What are patients’ experiences of being involved in release from an episode of seclusion

They were used to review both the existing literature plus gather evidence from professionals and patients with recent involvement in a release from seclusion. According to Streubert and Carpenter (2011), research questions lead to the choice of methods chosen. The thesis is a qualitative exploration of professional and patient experiences of release from seclusion. The next chapter outlines the philosophical and methodological decisions and approaches which guided the planning and completion of the work.

Chapter three: Methodology

3.1 Introduction

Chapter three presents a critical evaluation of decisions taken to guide the design and completion of the thesis. It starts with an overview of the philosophical, theoretical and methodological debates surrounding knowledge and research. I am a nurse and social researcher with a clinically focussed question, and the chapter describes how the emphasis of the thesis was upon outcome rather than philosophical adherence. The decision to be pragmatic rather than strictly methodologically aligned was supported by the adoption of the framework analysis approach. The chapter outlines the quality criteria against which qualitative study and the thesis can be evaluated. Next, the strengths and limitations of the methods selected to conduct the studies are discussed. Finally, a conceptual overview of the thesis is presented and a summary of the content of the remaining chapters is given. Excerpts from the author's reflective journal are included to increase credibility and trustworthiness in the findings.

3.2 Research paradigms, perspectives and ethics

> *Understanding does not exist in a vacuum, like the individual it is embedded in experience, the context and the world* (Munhall, 2012, p.24).

Research is guided by the beliefs and philosophical assumptions of the researcher regarding the creation and nature of knowledge (Kuhn and Hacking, 2012). These beliefs constitute a researcher's worldview (Guba and Lincoln, 1989) and determine the way they identify a topic, gather and analyse data, and present their findings. Beliefs can be grouped into paradigms defined by their respective philosophical, theoretical and methodological differences.

3.2.1 Philosophical influences: Understanding the world

Philosophical consideration can strengthen research design and improve the quality of research outcomes (Halcomb, 2018). According to Cohen et al. (2000), philosophical standpoints are not right or wrong, but offer a language through which to communicate and understand knowledge.

3.2.1.1 Epistemology: The creation of knowledge

Epistemology explains how knowledge is created and understood. Knowledge can be generated, observed or tested, value free and independent of influence from the researcher. Conversely, it can be subjectively known, interactive and value mediated by the researcher, the reader, their language or geography. Knowledge and ways of knowing specific to nursing care, plus the research approaches which influence nursing study are discussed below (see section 3.2.2.4). Research knowledge is traditionally judged for its appropriateness and adherence to an epistemological position (Lincoln et al., 2018). However, Hammersley (2007a) and Ormston et al. (2014) argued social research need not be *epistemologically determined*. This reflects a shift in emphasis of nursing research towards the stance in which evidence carries precedence over philosophical paradigm (Streubert and Carpenter, 2011).

The creation and understanding of social knowledge are influenced by and connected to the researcher (Ormston et al., 2014). My influence was made visible throughout the design, completion and presentation of the thesis to ensure transparency and enhance rigour (see author's reflective journal 3.1). Further discussion about the insider role and potential biases to the thesis findings are presented below (see section 3.2.4).

I am a mental health nurse with sixteen years' experience. I have worked mainly in adult inpatient settings. I have initiated seclusions and managed patients secluded by colleagues. Secluding a patient in a locked room felt wrong, as if we had given up trying to manage a situation. I recall feeling pity, embarrassment and sadness for patients, balanced against doing what I thought was in their best interest, keeping everybody safe, upholding rights of other patients and remaining supportive of my team. It is difficult to admit with current drives to reduce use and the negativity towards seclusion expressed by patients but my feelings reflect those of colleagues and the literature as I do not what else could be done when faced with aggression Experience tells me releasing patients from seclusion is not just related to the patient and potential for violence, but the acuity of the ward, other patients, the reaction of the team, what can be put in place to mitigate risks, what happened…the list seems endless...

Author's reflective journal 3.1

3.2.1.2 Ontology: The nature of knowledge

Ontology is the study of the nature and reality of our world. The existence of a social reality can be explained by two overarching ideas which sit at opposite ends of the objective-subjective continuum:

- Realism views reality as independent of our beliefs but can be known and observed; and,
- Relativism supports the existence of multiple realities and perspectives, whereby individuals use their personal histories, values and cultural experiences to inform and share understanding (Streubert and Carpenter, 2011).

According to Andrews (2016) both positions fail to represent the truth about social phenomena or satisfy the intricacies of the world within which clinical research is conducted.

3.2.1.3 Critical realism

Although not strictly epistemologically or ontologically aligned, the thesis was structured upon the principles of critical realism. Critical realism claims the social world can be known through understanding the processes and structures which generate events (Bhaskar, 1979), as unobservable mechanisms result in observable events (Williams et al., 2017). It adopts a mid-way position between what is real and what is observed. Whilst critical realism views reality as separate from description, it remains tied to the social and historical world, generated through discourses of power and social injustice (Angus and Clark, 2012). Hammersley (2007b) stated the philosophy is able to bridge the theory-clinical practice gap. It was suited to this inquiry as it is not only able to transcend methodologies, it can both acknowledge the, '…complexity of healthcare practice and help to better understand the nature of nursing work and decision-making' (Williams et al., 2017, p6), whilst challenge practice and illuminate the opposing views and activities of patients and caregivers (Stickley, 2006). A critical realist approach supported the thesis to develop interpretative, rather than descriptive findings from differing perspectives.

Critical realism is fundamental to the framework analysis approach developed in the 1980s by Jane Ritchie and Liz Spencer at the National Centre for Social Research to support the management and qualitative analysis of data for social policy and practice. Ontologically, framework analysis sees reality:

> *…as something that exists independently of those who observe it but is only accessible through the perceptions and interpretations of individuals* (Ormston et al, 2014, p21).

Framework analysis enabled findings to be, *'…systematically generated and analysed with interpretations that are well founded and defensible*' (Ritchie et al, 2014b, p21). Whilst eclecticism in the approach can bring challenges, it also provided significant strengths (see section 3.2.2.2, 3.3.3 and 8.3).

3.2.2 Theoretical ideologies: Explaining the world

Theoretical assumptions influence the ways in which research should be conducted, and interpreted (Lincoln et al., 2018). There are a number of theoretical approaches which explain how the social world can be understood. Similar to philosophical paradigms, they exist on a sliding scale rather than as well-defined ideas (Crotty, 1998), and have blurred boundaries (Lincoln et al., 2018). When designing the thesis alternate theoretical approaches were considered and included:

- Humanism in which absolute objectivity is unrealistic and truth can only be observed through social interaction and observation;
- Constructionism whereby knowledge is generated and known via dialogical processes;
- Interpretivist thinking is based on individuals having differing views which can only be described subjectively;
- Critical theory views knowledge as contextual, underpinned by cultural, ideological and political beliefs; whereas,
- Pragmatism is an approach that, '…*transcends philosophical affiliations and defined epistemological and ontological positions'* (Durham et al., 2015, p10).

3.2.2.1 Pragmatism

The thesis took a pragmatic approach to define the focus and complete the research in a manner that best answered the question rather than following a distinct methodological strategy (Patton, 2002). Benner (2001) promoted pragmatism as the ideal philosophical basis to support nursing research (see section 3.2.2.4), as it reflected the multidimensionality and complexity of practical nursing knowledge. In social research, pragmatism permits researchers to focus their attention on the research problem and use pluralistic approaches to derive knowledge (Tashakkori and Teddlie, 2016). According to Mackey and Bassendowski (2017) the gathering of knowledge for healthcare treatments and interventions can be traced back to the 1840s with Florence Nightingale. It was not until the 1970s, with the growing belief that clinical knowledge and practices should be evidence-based to ensure optimum use of resources and best decisions were being taken, that Cochrane proposed the most reliable form of evidence should come from scientifically based randomised controlled trials. This view was subsequently supported by Sackett et al. (1996) who proposed a hierarchy of evidence in which randomised controlled trials (RCTs) sat at the top, however they also ranked other forms of evidence which carried less credence but could also considered. The model for evidence-based medicine continues to identify RCTs as the best evidence and demands a systematic approach to finding, appraising and using contemporaneous research findings as a basis for making clinical decisions (Rosenberg and Donald, 1995). Scott and McSherry (2009) argued evidence-based nursing had begun to move beyond a reliance on RCTs and systematic reviews to be practice-based as it included and placed equal value upon evidence drawn from clinical experience, patients, clients and carers, local context and the environment (Barkham and Margison, 2007). Although, despite the push for nursing knowledge to be practice-based, Nowell (2015) suggested theoretical knowledge and practice were inseparable.

Benner (2001) and Doyle et al. (2009) promoted pragmatism as the ideal philosophical basis to support nursing research (see section 3.2.2.4), as it reflects the multidimensionality and complexity of practical nursing knowledge. The thesis took a pragmatic approach to define the focus and complete the research in a manner that best answered the question rather than following a distinct methodological strategy (Patton, 2002). Pragmatists have traditionally used mixed methods, both quantitative and qualitative approaches to triangulate data and give support to findings (Morgan, 2014). However, Ritchie et al. (2014b) stated their methodology was pragmatic in that it supported the selection of the most, '*…appropriate method or methods to address specific research questions*' (Ormston et al,, 2014, p22).

Pragmatic decisions which give greater value to evidence rather than philosophical allegiance can attract criticism (Streubert and Carpenter, 2011), but Seale (2004) cautioned researchers not take an approach that *anything goes* or be uncritically attached to theory. Therefore, although the research question should define the form research takes and how the knowledge is produced (Peplau, 1988), practice-based studies should still be appraised against strict methodological criteria and clarify all their conceptual, theoretical and methodological decisions (Silverman, 2016).

3.2.2.2 The argument for framework analysis

Framework analysis offered not only a pragmatic but an evidenced-based approach to guide the thesis. It is an emerging and increasingly popular methodology (Gale et al., 2013; Smith and Firth, 2011), plus it lends itself to the complexities and uncertainties of research in nursing and healthcare (Swallow et al., 2003). The method has been successfully used to complement a range of theoretical and epistemological approaches to explore or test ideas (Braun and Clarke, 2006). Although framework analysis has been criticised for its inability to manage widely heterogeneous data (Gale et al., 2013) and subject to wider debates around the subjectivity of qualitative research (Hammersley, 2007b), it addresses criticisms of subjectivity through its ability to increase transparency, demonstrate rigour and enhance credibility (Ritchie et al., 2014b). Literature warns against researchers viewing the framework approach as an easy option, stressing it requires the same rigour, reflexivity and level of analytical skill as other qualitative methods (Gale et al., 2013).

3.2.2.3 Interpretivist research

Framework analysis sits, *'…within a broadly interpretivist frame…'*, (Ormston et al,, 2014, p22). Interpretivists interpret knowledge within human and social contexts. Attempts to explain interactional experiences at the point of release from seclusion could only ever be interpretive. Therefore, the use of framework analysis is further supported as it enabled the thesis to go,

> *'…beyond the explicit descriptions and accounts provided by the individual participants - drawing on the researchers' interpretations or on wider theories*' (Ormston et al., 2014, p22).

Interpretivists are criticised for their potential to introduce bias, however transparency and reflexivity within the methodology allow biases to be evident and discussed. Therefore, outlining the position of the researcher interpreting the data was fundamental to the credibility of the thesis (see section 3.2.4).

Ontologically, interpretivists suppose there are multiple realities and individuals have their own lived experience which can be used to understand social situations (Lincoln et al., 2018). Interpretivists often align with phenomenological philosophies which aim to understand the experience of others. The position of the researcher is key in phenomenology, as:

- On the one hand, Husserl (1913) suggested to a certain extent it was possible to bracket, or put aside, pre-existing knowledge to intentionally step out of the life-world to observe and use an analytic ego to discover the essential components of a situation (Caputo, 2000). Whereas,
- Heidegger (1927), argued understanding can only be known by being present in the knowledge, '*Essentially, the person exists only in the performance of intentional acts, and is therefore essentially not an object'*, (Heidegger, 1927/1962, p. 73).

Epistemologically, interpretivists are grounded in subjectivity and inter-subjectivity (Weaver and Olson, 2006). Kelly et al. (2017) stated interpretivists either follow processes of *hermeneutics* which were described by Gadamer as an interpretation of the meanings of language and communication (Ambrosio, 1987) or, *verstehen* which see the experience in the context of social processes and cultures. According to Cohen et al. (2000), phenomenology is well suited to nursing research seeking to understand the experience of delivering and receiving care. However, it was rejected by the thesis due the requirement for strict methodological rigour. Moreover, it may have also limited the ability of the thesis to develop practical implications for nursing practice (see section 3.1).

3.2.2.4 Nursing inquiry and knowledge

Nursing knowledge, and in particular mental health nursing knowledge, is seen as a blend of art and science:

> *The art of nursing is concerned with therapeutic relationships, with a person's internal world and sense of self… The science of nursing in contrast, is concerned with a person's bio physiological profile and their observable behaviour* (Norman and Ryrie, 2013, p80).

The knowledge’s used by nurses to inform clinical practice were outlined by Carper (1978) in her *Ways of knowing* model. This was revisited and updated by Chinn and Kramer (2018) who said nurses use knowledge’s which are:

- Empirical, quantifiable, verifiable and can be tested;
- Aesthetic to represent the individual and unique ability of nurses to understand and appreciate contextual and situational factors;
- Personal and require self-awareness, authenticity plus, the ability to understand interactions and relationships;
- Moral and ethical knowledge to judge the rights, duties and their obligations in situations; and involve,
- Praxis, which reflects the tradition of nursing to social justice and the need to support change within nursing and healthcare.

The acceptance that different kinds of knowledge can have equal validity supported the establishment of a body of nursing evidence (Munhall, 2012). Empirical knowledge, in particular knowledge generated in randomised controlled trials, was historically viewed as the best evidence upon which to base healthcare interventions (Sackett et al., 1996). Whereas, the number of clinical practice and health-related articles using qualitative methods informed by naturalism, reflecting the art of nursing, has risen significantly and now forms a large proportion of nursing knowledge (Daly et al., 2007).

3.2.3 Methodological approaches: Research strategy

There are three main strategies for conducting research which are tied to philosophical and theoretical decisions. Research can be quantitative or qualitative, or take a mixed methods approach. Framework analysis uses qualitative research methods.

3.2.3.1 Quantitative research

Quantitative research aligns with positivism and claims to take an objective stance towards knowledge, although there are challenges to this (Perez, 2020). It uses samples of the total population to represent, summarise or analyse statistical data. Quantitative studies have:

> *…questions and/or hypotheses that describe phenomena, test relationships, assess differences, and seek to explain cause and effect*

> *variables and tests for intervention effectiveness* (Lobiondo-Wood et al., 2017, p28).

Quantitative data are often numerical or pre-determined variables and not able to establish meaning at a level that justifies understanding (Franzosi, 2010). Therefore it was not appropriate for the thesis.

3.2.3.2 Qualitative research

Qualitative studies are naturalistic. Generally they have smaller samples, and use subjective data to explore and understand the experiences, processes, and meanings people assign to things (Kalof et al., 2008). Qualitative research is an umbrella term used to cover a number of approaches (Flick, 2007) which are discussed in greater detail below (see section 3.3). When carried out with rigour, the approaches can overcome criticisms they can be biased, anecdotal, not valid or unreliable (Anderson, 2010).

Despite the differences in qualitative approaches, there is consensus among qualitative researchers regarding what it means and how it is undertaken. Denzin and Lincoln (2018) defined qualitative research as:

> *…multimethod in focus, involving an interpretative, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical, interactional, and visual texts – that describe routine and problematic moments and meanings in individuals' lives* (Denzin and Lincoln, 2018, p3).

The varied focus of qualitative methods raised contradictions and tensions making it difficult to provide a single definition (Jovanović, 2011). A review of qualitative definitions by Aspers and Corte (2019) suggested four elements are necessary for a comprehensive description: distinction, process, closeness, and improved understanding. Therefore, it could be argued a statement regarding proximity be added to Denzin and Lincoln's (2018) definition.

Ontologically, qualitative inquiry acknowledges the co-existence of multiple truths contextualised by historical, experiential or cultural knowledge. Qualitative methods support explanation and understanding rather than predicting and verifying cause and effect. Broadly speaking it, *'…produces findings not arrived at by means of statistical procedures or other means of quantification*' (Strauss and Corbin, 1990, p17). It should not be seen as a *grab-bag* containing all things that are not quantitative, but one that can clearly identify socially located phenomena (Kirk and Miller, 1986). Qualitative study is both suitable for gathering information about topics upon which little is known (Morse and Field, 1995), and producing knowledge relating to nursing practice as it can be shaped by what is important to discover (Munhall, 2012).

Denzin and Lincoln (2018) stated there are three epistemological stances in qualitative research: how people interpret their experiences, how they construct their worlds, and what meanings they attribute to those experiences. Moreover, Ritchie and Ormston (2014), in their text on social research, described qualitative knowledge generation could be classified as:

- Contextual – describing the nature or form of what exists;
- Explanatory – to examine reasons for and associations between what exists;
- Evaluative – appraising the effectiveness of what exists; or,
- Generative – aiding the development of theories, strategies or actions.

The thesis uses an explanatory frame to examine factors affecting and experiences of release from seclusion.

Qualitative study is popular with nurses who generally recognise and embrace subjectivity in the research process. They use qualitative methods to identify, describe and explain concepts, experiences and phenomena to further nursing knowledge (Streubert and Carpenter, 2011). It provides a structure which offers sensitivity to explore the lived experiences of individuals from different perspectives. The methods are able to support and produce the knowledges which evidence the *art* of nursing described earlier (see section 3.2.2.4).

The early design for the thesis was a mixed methods study using qualitative methods to gather experiential data from professionals and quantify their data. However, during the first literature review it became apparent the patient voice was missing. A decision was taken, that rather than pursue further collection and examination of data from professionals, gathering the experiences of patients would be more valuable. The decision to switch to a purely qualitative thesis is defended as, in the early stages of the framework approach, researchers gather existing theory and evidence before finalising the study design, sampling and fieldwork tools (Ormston et al., 2014). Moreover, Kalof et al. (2008) stated qualitative researchers routinely make adjustments to the focus and design as their study progresses, sometimes at the very end of the project.

3.2.3.3 Mixed methods research

Mixed methods research grew out of pragmatism and involves:

> *…collecting and analysing intentional combinations of qualitative and quantitative data for a broader, deeper understanding of complex phenomena and conformed results* (Reed, 2016, p38).

By combining and triangulating methods, theory and data, mixed method studies offer a, *'…more complete understanding of the issue being studied*' (Cohen, 2017, p142). The approach can measure, test or verify the impact of phenomena, adding depth and breadth plus a holistic understanding to complex nursing practices. A mixed methods approach to quantify interview data for the thesis, would have offered further validity and confirmability to the findings but was not achievable in the time available.

3.2.4 Researcher perspective and positioning

> *We, as researchers, bring our own histories, values, assumptions, perspectives, politics and mannerisms into the research – and we cannot leave them at the door* (Braun and Clarke, 2013, p.36).

To highlight potential biases, researcher influence upon inquiry should be clearly stated throughout the conception, design, data collection, data interpretation and the way the research is presented. Influence differs according to the nature of the study, context of the setting and a researcher's familiarity with their participants (Taylor, 2011; Rogers, 2012; Paechter, 2013). Researchers taking an objective stance remain separate, minimise any influence they may have upon the collection and analysis of their data to increase its validity. Whereas, those seeking experiential data operate closer to their participants and data. Insider research is popular with nurse researchers as they often identify and research topics of interest to their practice. Studies by insider nurse researchers in the field of seclusion have included Johnson (1997), Meehan et al. (2000) and Larue et al. (2013).

3.2.4.1 Advantages of being an insider researcher

Being an insider researcher offered advantages and disadvantages. As an insider researcher, I had a connection to the research setting, an awareness of seclusion practices and a shared body of knowledge with participants which reduced the time needed to orientate to the setting (Raheim et al., 2016).

3.2.4.2 Disadvantages of being an insider researcher

However I was also aware there was potential for:

- Introducing bias that may have compromised the credibility and trustworthiness of findings;
- Prior knowledge of the topic might have impacted upon my ability to be objective and side line prejudices or pre-existing assumptions (see section 3.3.3);
- Difficulties may have arisen when establishing trusting and truthful relationships with participants I knew (see 5.4.2); and finally,
- As an insider researcher for role confusion may arise during both the stages of data collection and analysis (Asselin, 2003) (see section 3.2.5.5).

Framework analysis acknowledged the potential for bias and subjectivity, but encouraged researchers to provide a clear description of their position in regards to the research process and their effect upon data (Ormston et al., 2014). Therefore, to counter potential bias, my role, experience and pre-existing knowledge were clearly stated throughout the thesis. Moreover, the support and neutrality of the supervision team gave further opportunities for discussion and reflection (Kanuha, 2000).

3.2.5 Research ethics

High standards of ethical conduct and strict adherence to ethical standards were maintained in all stages of the thesis to demonstrate moral worth.

3.2.5.1 The philosophy of morality

Research ethics are the:

> *…moral problems encountered in connection with scientific or other academic research, by the researcher, their subjects or their social environment* (Berg & Tranøy , 1983, p. XIII).

According to Aita and Richer (2005), the two most common ethical constructs in research are described as:

- The teleological approach concerning rights, wrongs or consequences and balance the risks and benefits to the population: and,
- The deontological approach that relate to judgements about the decision-making process and remind researchers to consistently evaluate their actions.

Ethics were intrinsic to the thesis as participant realities were part of the inquiry (Lincoln et al., 2018). Qualitative designs present complex ethical challenges (Cutcliffe and Ramcharan, 2002), and Dubois (2008) added mental health research raised particular difficulty due to the nature of the population and requirement to safeguard healthcare information.

3.2.5.2 Ethical principles

Four core principles guide medical and social research:

- Autonomy: participants have the freedom to decide what they want to do;
- Beneficence: participants should be shown respect to meet their needs;
- Non-maleficence: vulnerabilities to physical, psychological or social harm should be considered; and,
- Justice: all people are equal and should receive equal treatment under the law.

Bergum (2004) argued the principle of *relationality* should be added to the above. *Relationality* positions consent and respect as a function of our relationships and cultural needs. These principles were translated into standards against which proposed and completed research should be judged.

3.2.5.3 Research ethics legislation

Guidance informing and regulating research can be traced back to the post-second world war Nazi trials and the publication of the Nuremberg Code (1948) (Shuster, 1997). The code introduced the idea of informed consent (see section 3.2.5.4) and was a precursor to the Declaration of Helsinki (1964) (https://www.wma.net/what-we-do/medical-ethics/declaration-of-helsinki/) which set out principles for the conduct of medical research on human beings, material and data. The Declaration has been updated on a number of occasions (https://www.wma.net/policy/) and the European Commission (2013) combined its research ethics framework to human rights.

UK guidance is supplemented by professional and academic bodies such as the Medical Research Council (https://mrc.ukri.org/research/) and the Royal College of Nursing (https://www.rcn.org.uk/professional-development/research-and-innovation). Permission to undertake research with health professionals or NHS patients is brokered though local NHS Trust clinical governance or local research and development departments (R&D). Approval is required via the Health Research Authority (HRA) (https://www.hra.nhs.uk/) and the NHS Research Ethics Committee (REC) processes.

3.2.5.4 Ethical standards

The practical steps taken by the thesis to ensure compliance with ethical principles and guidance were outlined in detail in section 5.2.2. Relevant ethical issues included informed consent, anonymity, confidentiality, plus my impact upon potential and actual participants.

Informed consent is the process by which researchers ensure participants understand the risks, benefits, and alternatives of a procedure or intervention. It is one of the most important ethical principles when collecting data from human participants (Gupta, 2013). The Belmont Report (Department of Health Education and Welfare (DHEW), 1978), stated informed consent should be guided by autonomy and beneficence, plus subject to three further principles: information, comprehension and voluntariness. It states, potential or actual research participants have the right:

- Not to be harmed;
- To be given full disclosure about the research;
- Of self-determination (to participate or withdraw); plus,
- Privacy, anonymity and confidentiality.

When gaining approval for studies, researchers are required to outline how they will protect the safety and privacy of participants. Strategies to mitigate for trauma and safeguarding issues were included in the design of the thesis (see section 5.2.2). Data protection, anonymity and confidentiality were also incorporated (see section 5.2.2).

Saunders et al. (2015) stated the terms anonymity and confidentiality are used interchangeably, whereas they argued anonymity is just one form of confidentiality.

Anonymity sits on a continuum stretching from a position where participants are completely anonymous to one where they are almost identifiable (Scott, 2005). Total anonymity was unachievable as I had contact with the participants (Van den Hoonaard, 2003). Ensuring anonymity in small samples can be difficult (Webster et al., 2014), whilst safeguarding research identities within local communities presents further challenges. However, I was able to protect their identities whilst maintain the value and integrity of their data (Saunders et al., 2015), by only revealing limited identifiable information.

Professional participants were known not only to the researcher, but to each other (see entry 1 author's reflective journal 3.2). Care and diligence was taken to ensure identities remained hidden, to both insiders and outsiders to the research. The researcher did not discuss or divulge who agreed to be interviewed, and quotes included in the thesis were only identified by profession and grade. Connolly (2003) stated ethics is not only about methodological implications of a study but also about the researcher's behaviour and their effect upon the research process.

The principles of confidentiality were applied to all the personal information. I not only withheld participants' names and the ward the seclusion occurred, but certain facts of what was discussed. There was a danger stripping relevant information may have de-contextualised or diluted the meaning of data therefore, some context was retained (see entry 2 author's reflective journal 3.2).

Entry 1: *I needed to be careful when recruiting colleagues who were known to each other both to protect their confidentiality and anonymity in their data but also to ensure they would trust me when deciding to participate. Although I promoted the study to groups of professionals via poster, emails and reminders at business meetings, I made sure when I spoke to anyone directly about discussing their potential participation, it was always in one to one private conversation. Should colleagues wish to tell anyone they had participated, then they were free to do that.* ***Entry 2:*** *I deliberated about leaving her details in as it didn't really make sense not to say where she worked at the time of the incident because she was discussing a patient who had just been admitted and was not known to* *the service. I read and read the text and decided to take the ward name out so it was not obvious to outsiders where the incident might have taken place. Plus, by removing her name and some details of the incident, I was able to keep her quotes without her colleagues being able to identify what seclusion event she was talking about*

Author's reflective journal 3.2

3.2.5.5 Ethics of dual role researching

The dual roles of researcher-colleague and researcher-clinician raised ethical dilemmas for the thesis. Researcher-colleague relationships can be challenging (Braun and Clarke, 2013). I was known to many of the professionals some of whom were senior, others were junior or from non-nursing disciplines. Care was taken not to coerce colleagues into participating, gloss over the impact of hierarchical relationships or compromise the confidentiality of individuals from the small community (Braun and Clarke, 2013). Colleagues may have been reluctant to open their thoughts and actions to scrutiny, or fear being critical of the organisation or healthcare team (Rubin and Rubin, 2005). Furthermore, as controversies regarding seclusion continue (see chapter two), colleagues may have responded in a socially desirable manner saying what they thought I wanted to hear (Denzin and Lincoln, 2018). Care was taken to be transparent regarding the researcher-participant relationships both during recruitment and the interviews to promote trustworthiness in the findings (see entries 1 to 6 author's reflective journal 3.3).

Entry 1: *Having worked on the wards which use seclusion it is likely I will know many staff I interview and possibly have knowledge or have nursed some of the patients. I do not intend to interview colleagues with whom I mix with socially but I am aware those who agree to participate may know my background, interests and role within the Trust. They may be lower or higher grade, may worry about disclosing their thoughts, say what they think I want to hear or want to appear politically correct. Despite me promising confidentiality and anonymity colleagues may have felt threatened as I was exploring their beliefs, clinical practice and professional competence.* ***Entry 2:*** *There is no doubt my position as a researcher made a difference to my ability to recruit staff members.*

> *Almost all the staff I approached agreed to participate. I would like to think I did not push anyone to be interviewed but acknowledge some may have had misgivings about participating.* **Entry 3:** *Nobody told me no outright but I could sense that *** was reluctant as she failed to agree an interview time.* **Entry 4:** *I didn't pursue him as he had not responded and when I did speak to him he seemed to be putting it off participating politely.* **Entry 5:** *Some I approached were keen to talk to me as seclusion practices are under the spotlight in the service. I had to stop them telling me things outside the interview and I remember saying wait until we start the interview this is really useful stuff!* **Entry 6:** *Visiting a ward this morning I spoke to a nurse about her feelings regarding the potential the seclusion facility might be removed from the unit. She said, 'Oh we have to be careful what we say when you are around, we know you don't agree with seclusion'. I reflected upon how my work must appear to colleagues and although no one expressed it openly, some may have been reluctant, hesitant to discuss seclusion or might be defensive about the way they described their experiences to me. I tried to be mindful not to express any views upon their practice but acknowledge the staff interviewed may not have felt comfortable describing their involvement.*
>
> Author's reflective journal 3.3

Clinician researcher-patient relationships can also pose difficulties if researchers have close connections to the research setting. Patients may confuse the role of insider healthcare researchers with that of their caregivers. However, if the well-being of patients is compromised by participation, the researcher's clinical duty of care takes precedence over the role of researcher.

Patient perceptions of the researcher may influence interactions and the quality of what is revealed (Richards and Emslie, 2000). Asymmetric power differences can impact upon the authenticity, credibility and truthfulness of the data (Brinkman, 2018). This effect may be greater still for inpatients in receipt of treatment as they may be guarded in their responses or concerned about being truthful so as not to affect their care. This was reflected upon in the thesis (see author's reflective journal 3.4).

I need to be mindful patients may be angry, distrustful or think participation may somehow benefit them or their care. He (patient) called me 'Miss' when he referred to me. We (nursing staff) tend to describe that as a 'prison mentality' and although he didn't express it outright I guess he might have been guarded in what he was saying to me.

Author's reflective journal 3.4

There was the potential patients may have brought their own agenda to their interview (Karnieli-Miller et al., 2009), that they might have moved away from the topic or discussed stories of their illness (Raheim et al., 2016) (see author's reflective journal 3.5). Whilst, it was recognised divergence took time away from exploring release, at times deviations added to contextual insight to support understanding of patient's experience and involvement in decisions.

Once the interview got underway he wanted to talk about why he had been admitted, about staff and other patients rather than seclusion. I think he thought I might be able to get him some leave or influence his care. I went through the informed consent again and reminded him what the research was about and he decided to leave so I destroyed his data.

Author's reflective journal 3.5

3.2.6 Public and patient involvement (PPI)

Public and Patient Involvement (PPI) supported the design of the questions and methods used by the thesis to ensure the focus and approach to the topic was relevant to the needs of people involved. PPI is a process whereby researchers actively involve members of the public or stakeholders in research. It enhances the quality, appropriateness, development of relevant research questions, strategies and methods used, PPI in the thesis helped produce user-friendly research materials (Brett et al., 2014) (see section 5.2.1). The values and principals of respect, support, transparency, responsiveness, fairness of opportunity and accountability were incorporated in the

PPI framework published by INVOLVE (2015), who are the national advisory group supporting public involvement in the NHS, public health and social care research.

3.3 The choice for qualitative inquiry

Aspers and Corte (2019) stated the gold standard of qualitative research are field studies, but added other qualitative methods are available which enable in-depth examination. The method selected should be in keeping with the researcher’s philosophical and theoretical choices and provide answers to questions with the right kind of knowledge. When little is known about a topic a qualitative exploratory study was recommended (LoBiondo-Wood et al., 2017). For the purposes of the thesis, the researcher’s beliefs, the aims and objectives of the study were taken into account when selecting the methods. Alternative methods used in comparable seclusion decision-making literature were considered (see table 3.1). The design selected took an interview and analysis approach, which was consistent with, and recommended by, framework analysis (Ormston et al., 2014). Qualitative research methods should be allowed to standalone, as over adherence to traditional *pure* research methodologies could undermine the contribution studies make to evidence-based health care (Fawcett, 2005). An interview and analysis design ensured this research remained true to the question to produce answers relevant to clinical practice.

The next section of this chapter defends the decision taken to use the integrative literature review method. The thesis comprised two literature reviews undertaken sequentially, one focussed on professional evidence and the other on patient evidence. Following this, the chapter discusses the decision to use semi-structured face-to-face interviewing, and then offers more insight into the data analysis processes of the framework analysis approach. Finally, the chapter outlines the quality criteria against which the thesis can be evaluated, and concludes with an overview of how the findings were presented.

Table 3.1 Qualitative methods considered

Method and focus	Reason for rejection by this thesis
Ethnography: Researcher is immersed in the setting and aims to gain understandings from a cultural, social and contextual perspective. Used by Fish (2018) in her study of the experiences of women secluded on locked wards. An ethnographic approach provides a way to gather data and develop concepts.	Seclusion episodes are not frequent events. Ethnography requires intensive episodes of fieldwork. Commitment to undefined period of observation to guarantee one or more episodes of seclusion would take place was not possible in this part-time study; Opportunity to be present when decisions are taken may be limited: ethical issues regarding informed consent and researching with vulnerable populations are difficult to navigate, professionals may be reluctant to permit the researcher to be present in the seclusion suite, decisions may be discussed when the researcher was not present; Researcher presence may affect way in which decisions are taken or experienced; Insider researchers with preconceived knowledge can affect the likelihood new unimagined or unchartered insights into the processes might be identified.
Grounded theory: Provides deep and interpretive insights into social processes and nursing practice, It offers a means to generate and test theory (Melia, 1982). Used by Muir-Cochrane (1995a, 1995b and 1996) to develop seclusion decision-making theory.	The thesis was a practical piece of clinical research aimed at exploration of experience in the hope it would offer evidence to support reductions both in the use of seclusion and the time patients spend secluded. The aim was not to develop a theory.
Phenomenology: Gets below surface of simple perceptions to discover and identify how phenomena are experienced and what are the shared essence of those experiences. Used by Askew et al. (2019) to research patient experience of being in seclusion.	The thesis aimed to develop strategies to improve a clinical practice and make recommendations for similar services. Thus, phenomenology was discounted as whilst it may have produced information rich data giving insight into to release, it would have limited potential for the development practical strategies and lack the ability for transferability of the findings to other settings. Furthermore, phenomenology did not fit with the preferred choice of framework methodology.
Case study design focus is on individual or groups of cases. Goulet and Larue (2018) used case study to gain an understanding of the context in which seclusion and restraint practices were used on one psychiatric ward.	Case study supports in-depth study to gather multiple perspectives from different sites. The aim of the thesis was not to focus on specific events or phenomena but to gather the views of individual professionals and patients across an inpatient service.

Action research aims to research and test change. It was used by Hyde et al. (2009) to improve seclusion practices via processes of evaluation and change.	The thesis did not intend to implement change .

3.3.1 Reviewing the literature

Literature reviews summarise specific topics of knowledge. When rigorously undertaken, they provide robust information sources for further research, plus support practitioners to identify evidenced based information to guide clinical practice and decision-making (Paré et al., 2015). Noble and Smith (2018) named seven types of literature review (see table 3.2).

Table 3.2 Types of literature review

Review Type	Methodology/purpose
Systematic reviews	Address focussed questions using a reproducible strategy to systematically search, critique, summarise and synthesise a range of evidence. Historically, systematic reviews reviewed randomized control trials (RCTs). However, the approach grew to incorporate research from a wider range of quantitative methods and more recently systematic reviews of qualitative research are produced.
Rapid evidence reviews	Less methodical than systematic reviews but attempt to be as comprehensive and rigorous within a given time-frame.
Scoping reviews	Identify and map evidence from relevant databases, hand searching, grey or unpublished literature but do not synthesise findings. They are used to identify relevant evidence and assess feasibility for undertaking a systematic review.
Integrative reviews	Use a systematic approach and detailed search strategy to identify evidence from a range of research methodologies and other relevant articles to answer a targeted clinical question. Findings are critically appraised, summarised and a thematic analysis of findings presented.
Realist reviews	Aim to understand why, how and the impact of phenomena plus under what conditions they are used. Realist reviews have a clear aim, use mixed sources of evidence, extract and synthesise evidence to produce explanations. They often recruit and involve stakeholders.
Narrative reviews	Provide an overview or broad perspective in a user friendly format. They do not outline how they identify or select evidence but describe and appraise it to provide a synthesised user friendly format.
Reviews of reviews	When review questions are broad and systematic reviews have already been completed, a systematic review of existing review or syntheses may be completed. Care should be taken as inclusion criteria in reviews may differ.

Systematic reviews, such as those produced by the Cochrane library (https://www.cochranelibrary.com/) are considered to be the most authoritative and credible sources of evidence, and sit at the pinnacle of hierarchies of evidence (Davies, 2019). There are two kinds of systematic review. Meta-analysis takes a quantitative approach to systematically identify and assess previous quantitative research. Meta-synthesis is a coherent method to analyse data from qualitative studies. As with study design, the type of review selected should relate to the question being asked. Steinert et al. (2010) used meta-analysis to compare and contrast international trends in the use of seclusion. Whereas, the review of experiences of secluded patients by Askew et al. (2019) was a meta-synthesis. Systematic reviews can include both quantitative and qualitative evidence, and was used by Van der Merwe et al. (2009) to combine the results of several empirical and naturalistic studies. The approach enabled them to present complex statistical data along with explanatory evidence.

3.3.1.1 Integrative literature reviews

For the purposes of the thesis, existing literature was identified and synthesised using an integrative review methodology. The method enabled the identification and appraisal of articles of varying methodologies (see tables 4.4 and 4.13), and the inclusion of grey literature (see section 4.2.1.1). Integrative reviewing is a, '..*comprehensive study and interpretation of the literature that relates to a particular topic'* (Aveyard, 2010, p.5). Two reviews were completed (see chapter four). The method was chosen as:

- No relevant reviews had been completed before;
- A scoping review would not have provided a synthesis of the evidence;
- Rapid, narrative or realist reviews were deemed to be not robust enough; and,
- Background reading suggested there was little evidence available on the topic which suggested the reviews should include a range of methodologies of primary data and expert opinion articles.

The method offered a systematic approach to gather and synthesise literature from a range of methodological and theoretical sources (Whittemore and Knafl, 2005). Integrative reviews see similar data extrapolated, reduced and categorised for analysis into themes (Doody et al., 2017). They have been criticised for their potential to lack rigour and introduce bias. Although, Whittemore and Knafl (2005) argued they can directly address clinical practice and policy enquiries, Dixon-Woods (2011) stated they can support claims of generalisability across settings. Furthermore, when little is known about a topic, integrative reviews can provide an initial conceptualisation, supporting searching and incorporating evidence from diverse sources.

To provide structure and enhance rigour, the reviews followed Cooper's (1988) five stage framework:

- Problem identification to outline the reviews main objectives;
- A literature search setting out what forms of evidence would be included and where evidence would be located;
- Data evaluation appraising the rigour of the design and methods of the evidence retrieved;
- Data analysis to collate and synthesise relevant data; and finally,
- Presentation of data in the form of a synthesis.

(Cooper, 1998)

In keeping with the framework analysis methodology described below (see section 3.3.4), themes were drawn through from the reviews to inform the interview schedules, which in turn formed the basis of the categories used in initial coding frameworks for the interview data.

3.3.2 Data collection

Qualitative data can be collected by a variety of means and methods. Table 3.3 presents an overview of methods of qualitative data collection and reasons why they were not used in the thesis. This list is not exhaustive as qualitative research can also use various forms of visual, auditory or multi-media-based source materials.

Table 3.3 Alternate methods of data collection

Method and rationale	Reason for rejection by this thesis
Descriptive or exploratory surveys collect data on characteristics or frequency about opinion, attitudes or facts (LoBiondo-Wood and Haber, 2017). Surveys were used by Steele (1993) and Johnson (1997).	Discounted as this work required information rich data (Patton, 2002).
Vignettes are short hypothetical accounts in which participants are asked to provide a response to an event and allow insight from several participants commenting on similar situations (Keane et al., 2012). Have been used in healthcare and clinical decision-making research (Bennell et al., 2007), and by (Mason, 1997) and (Mann-Poll et al., 2011).	Although vignettes might have allowed participants to feel comfortable to make sensitive disclosures, their validity and generalisability to real life has been questioned (Treece and Treece, 1986), as actual responses to violence and aggression may differ. Moreover, the perceptions of, or attitudes towards risk, do not always predict the actual actions which might be taken (Breakwell, 2007).
Written documentation is generally used by qualitative researchers to triangulate findings in mixed methods methodologies (Bowen, 2009).	Review of nursing records or debrief documentation may have introduced bias as the purpose and detail of the material might not have provided the depth of reasoning or understanding required for the thesis.
Observational data is collected by researchers observing and recording events as they occur naturally.	It could not be guaranteed a seclusion would take place during the observation period; It is difficult to observe thoughts and experiences, thus findings would be biased towards the perceptions and interpretations of the researcher rather than those of patients or professionals.
Focus groups are best for abstract topics, problem solving, examining social attitudes and refining concepts (Silverman, 2016). Authenticity of data collected in group interviews can be subject to social norms and participant honesty, and there can be issues associated with maintaining confidentiality and discussing sensitive issues (Lewis and McNaughton Nicholls, 2014).	Methodologically focus groups were not the best option as seclusion is a sensitive and emotive topic. Participants may struggle to be open and honest fearing they or their practice was being judged or scrutinised by fellow participants; Running focus groups with patients or professionals would have been difficult as it would not have been practical/achievable to undertake interviews directly after incidents as time would have passed before an appropriate number and mix of participants could be gathered together. Patients may have be discharged making them more difficult to recruit and less able to support should they become distressed. Heavy workloads and unpredictable clinical activities make it difficult for professionals to plan availability.

3.3.2.1 Interviews

> *Interviewing is a powerful way of helping people to make explicit things that have hitherto been implicit, to articulate their tacit perceptions, feelings and understandings* (Gray, 2009, p32).

Interviews were selected as they allowed the researcher to explore delicate, complex and personal experiences (Rubin and Rubin, 2005). They can elicit depth to aid the understanding of motivations, as interviewers can probe answers and clarify details (Ritchie and Ormston, 2014). According to Adams (2015) interviews are useful for researchers who:

- Want to know the independent thoughts of individuals in groups;
- Need to ask questions which may be difficult to answer in group settings; and,
- Are exploring uncharted territory and want latitude to spot useful leads and pursue them.

There are examples of interview being used to gather data in other seclusion research, both as a standalone method or as part of a defined qualitative approach (see table 3.3). Qualitative interviews tend to favour face-to-face personal contact and were the preferred option in the thesis. Vogl (2013) argued telephone communications were less personal and more anonymous, but acknowledged they could prevent distortion and address power imbalances towards participants.

3.3.2.2 Semi-structured interviewing

There are three main types of qualitative interview: structured, un-structured and semi-structured (Howell, 2013). According to Pope and Mays (2006), structured interviews involve trained interviewers asking a standard set of questions to which they expect a fixed or focussed response. Whereas unstructured, often referred to as in-depth interviews, may use only one or two questions to elicit greater detail. Unstructured interviewers take a more casual approach, clarifying and probing responses. Sitting on a sliding scale between the two are semi-structured interviews. They are pre-prepared, but more contextual allowing interviewers to maintain order whilst give flexibility (Braun and Clarke, 2013). They were selected for use in the thesis as they allowed direct examination of real life experiences, and at the same time supported me to maintain consistency and control over what was discussed. This meant new ideas and themes could be introduced, plus participants had the freedom to explore issues and talk about what was important to them (Rubin and Rubin, 2005).

Initial analysis was carried out concurrently with data collection which allowed emergent concepts to be clarified and explored in later interviews.

Rigorous development of the interview questions contributed to trustworthiness and credibility in the data. The questions for this study (see section 5.4.1) were devised following a five-stage model:

- Review pre-requisites for using semi-structured interviews;
- Retrieve previous knowledge;
- Formulate preliminary interlay guides;
- Pilot the guides; and,
- Present the guides in the final written report.

Kallio et al. (2016).

As stated in 3.3.1, the interview questions were developed from the themes identified in the two integrative reviews. They were further refined in discussions with the supervisory team and the Patient and Public Involvement group (PPI) (see section 5.2.1), and subject to ethical approval (see section 5.2.2). The questions were piloted in two interviews (see section 5.4.1.2). Within qualitative study, piloting questionnaires can identify flaws or limitations within the interview design (Kvale, 2007), although piloting is useful preparation regardless of paradigm (Tashakkori and Teddlie, 2016).

3.3.2.3 Study samples

Sample composition and size were subject to epistemological and methodological decisions. The sample compositions were guided by the:

- Aim of the study;
- Sample specificity;
- Use of established theory;
- Quality of dialogue; and,
- Strategy for analysis.

Malterud et al. (2016).

Ethics committees may require researchers to submit sample sizes and data collection plans on applications. This may present difficulties for qualitative researchers as, quantitative samples are determined by estimated power calculations based on the nature of their analysis. Whereas, in the early stages of qualitative projects it is difficult to state with certainty how many participants will be required.

Whilst it is possible to mathematically calculate adequate sample sizes for qualitative research (Galvin, 2015), practically there are challenges to determining exactly how many they should include.

The thesis involved populations which are characteristically niche or hard to reach (Guest et al., 2006; Ritchie et al., 2014a). There are wide variations in suggested sizes, and lack of agreement regarding minimum and maximum numbers (Bryman, 2012). Size in qualitative studies should be related to the ability of the data collected to provide adequate depth and understanding into the topic under investigation. This concept was defined by Malterud et al. (2016) as the *information power*. Denzin and Lincoln (2018) stated in certain cases one interview may be enough, whereas others have suggested around ten (Gerson and Horowitz, 2002), with an extra two or three on top to ensure saturation (Bowen, 2008). Adler and Adler (2012) believed it could be as many as 60. A review of qualitative PhD projects by Mason (2010) reported sample sizes ranged between 1 and 95, with a mean of 31. However, Brannen and Nilsen (2011) suggested it was more about finding the right people to involve rather than the size of the sample as one person's data could make all the difference. In the face of such debate, it seems interviewing enough participants to give a convincing understanding should be the guide, so the main indicator might not be sample size but data saturation.

Data saturation is generally a standard by which rigour within qualitative inquiry is measured. Although, Saunders et al. (2018) argued transparency of the sample fit and analytical processes together with the research aims are of greater relevance. Saturation signifies the end of data collection and the point at which additional data is not found, new codes do not emerge or pre-established conceptual categories appear to have been populated. It is not always clear if data saturation has been achieved (Saunders et al., 2018), or if it is achievable. Some qualitative studies generalise and state saturation was reached, yet evidence for this is often scant. Other researchers are equally as vague in stating they, '…*know their data*' (Morse , 2015, p588). For this thesis, data saturation was not expected in the professional sample. The sample was identified and defined before data collection commenced using a sample matrix to ensure a range of professionals and mixed levels of experience were included. Decisions relating to the patient group were more pragmatic (see section 5.3.2.2).

3.3.3 Data analysis

Qualitative data analysis sees categories taken for granted at the beginning of the study undergo qualitative changes from first to second order constructs. As with all methodological decisions, the method of analysis selected should be appropriate to the design and incorporated into the planning of a project. There are a number of methods available for analysing qualitative data (see table 3.4).

Table 3.4 Methods of qualitative analysis

Method of analysis	**Aim/Process**
Thematic analysis	The researcher closely examines their data to identify common themes, topics, ideas and patterns of meaning which are repeated.
Framework analysis	Analysts summarise categories, illustrate data linkages and analytic strategies within a frame.
Content analysis	The researcher establishes rules and makes deductive inferences by observing certain characteristics in the data.
Constant comparative analysis	Each interpretation and finding is compared with existing findings emerging from analysis. Used in grounded theory it is iterative and can be deductive, inductive or abductive. It can be used to develop abstract theories and concepts.
Narrative analysis	Personal stories, oral histories are viewed in their entirety rather than being contextualised or fragmented.
Conversational analysis	Focussed upon how participants express themselves and how social orders are constructed.
Discourse analysis	Analyses language and the way it is embedded in social and cultural situations.

Framework analysis was selected for the thesis to guide the management of data and qualitative interpretation treating them as sequential tasks (Spencer et al., 2014b). The method is flexible as it can be deductive using predefined structured guides, but can also be inductive allowing topics to emerge from the data or pragmatic in that agreed topics are explored whilst thought is given to new insights and inconsistencies which warrant further study (Gale et al., 2013). It was suitable for use as it was my first attempt at data analysis. It enabled more than one analyst to be involved, plus the generation of a clear audit trail of the analytic decisions and how the themes emerged.

> *Researcher expectations, past experiences, beliefs, and emotions can prevent the researcher from achieving a detachment necessary*

> *for analysing data objectively. Also, awareness of current issues in the organisation may lead the researcher to identify a problem prematurely without delving deeper to examine all data or fail to recognise a problem that exists* (Asselin, 2003, pp.99-100).

Therefore auditability was also important as there was potential for bias as insider researchers risk imposing their own beliefs upon the analysis (see section 3.2.4).

3.3.3.1 Undertaking a framework approach

Framework analysis has five stages:

- Familiarisation with data;
- Construction of a thematic framework;
- Indexing and sorting of data;
- Summarising data in analytical framework; and finally,
- Synthesising by mapping and interpreting.

(Spencer et al., 2014, p297)

It is similar to thematic analysis in that the focus is upon immersion in and reduction of data, followed by a comparison of emergent themes. Where it differs is in the way in which analysts demonstrate how themes emerged. Thematic analysts develop explanatory categories and themes (Braun and Clarke, 2006; Pope and Mays, 2006). Whereas, framework analysts summarise categories, plus illustrate data linkages and analytic strategies within a matrix (Ritchie and Ormston, 2014). Whilst care should be taken to ensure summaries retain both the context of the data and the language of the participant, summarisation allows the reduction of large datasets into more manageable accounts (Furber, 2010). Summaries in the thesis were interpreted into themes (Braun and Clarke, 2006; Pope and Mays, 2006). A detailed description of framework analysis is provided in the methods chapter (see section 5.5).

The framework approach supports both case-based and theme-based analysis, enabling researchers to explore, compare views of predefined groups and explain the relationships between them (Gale et al., 2013), whilst allowing the data to remain true to the participant’s voice (Smith and Firth, 2011). The case-based approach was more useful for analysing data from professionals to compare and contrast the experiences of members of the MDT, whereas the theme-based was more appropriate for supporting analysis of patient data by concepts (see section 5.5.1.4).

3.3.4 Data synthesis and relevance to theory

3.3.4.1 Synthesis of the findings

Finally, findings from the two literature reviews and two interview studies were brought together in a discussion and synthesis chapter which made links to existing evidence and theories about seclusion (see chapter seven). Discussion chapters are a synthesis and interpretation of findings which describe,

> *…what was already known about the research problem being investigated, and to explain any new understanding or fresh insights…'* (University of South Carolina (USC), 2014).

Qualitative synthesis is an interpretive process and particularly useful to inform evidence for use in practical healthcare interventions and settings (Lockwood et al., 2015). Framework synthesis is one form of qualitative synthesis and was developed by (Barnett-Page and Thomas, 2009). It uses processes similar to the way framework analysis manages data although,

> *'…a framework may not simply be an instrument for analysis but may also represent a scaffold against which findings from the different components may be brought together and organised'* (Carroll et al., 2011, p1).

Framework synthesis offered a highly structured approach by which *a priori* insights and themes from the findings of the two literature reviews and interview studies were organised and analysed. This involved building a frame with the findings, then summarising, comparing and contrasting the data, the results of which supported the generation of two models, highlighted a trajectory for release and produced a list of recommendations made by patients for improving practice (see section 7.8).

3.3.4.2 Presentation of the findings

Presenting the findings of qualitative research is,

> *…not simply recording the outcomes of the analysis but also an active construction and re-presentation of the form and nature of the topics being explored* (White et al., 2014, p368).

During the period of study a number of outputs for specific audiences were produced. These included posters, professional forums, presentations and peer reviewed journal articles, all of which supported discussion and engagement with the data.

The next section of this chapter outlines the quality criteria against which the thesis can be evaluated.

3.4 Quality criteria

Cutcliffe and McKenna (1999) argued the quality and rigour of qualitative research should be measured against different criteria to quantitative research. Quantitative research is judged by reliability, validity and generalisability. Opinion differs in which criteria should be used to evaluate qualitative studies. More than one hundred criteria for evaluating qualitative research were identified by Stige et al. (2009) which included transferability, generalisability, ontological authenticity, reciprocity, dependability, confirmability, reflexivity, fittingness, vitality, sacredness and goodness. For the purposes of the thesis, consideration was given to the Consolidated criteria for reporting qualitative research: a 32-item checklist for interviews and focus groups, (COREQ) (Tong et al., 2007) (available from https://academic.oup.com/view-large/27217733), and the five quality criteria suggested by Denzin and Lincoln (2018): credibility, dependability, confirmability, transferability and reflexivity (see table 3.5).

Table 3.5 Qualitative research quality criteria (Denzin and Lincoln, 2018)

Criteria	Definition
Credibility	Confidence can be placed in the truth of the findings. Findings represent original data and a correct interpretation of participants' views.
Dependability	The appropriateness of the design and processes used to answer the question, plus measurement of the stability of findings over time.
Confirmability	The data and interpretations of the findings are clearly derived from the data and can be confirmed by other researchers.
Transferability	The degree to which findings can be transferred to other contexts, settings and populations.
Reflexivity	The researcher undertakes critical self-reflection upon own biases, preferences, preconceptions, and their relationship with the participant.

3.4.1 Credibility

The design of the thesis supported the role of an insider researcher to collect in-depth interview data from people with lived experience of seclusion. Aspers and Corte (2019) stated that to demonstrate credibility, qualitative researchers should be close to their participants in order to display understanding and interpretation. Framework analysis further supported credibility and authenticity as verbatim participant quotes were used to inform and illustrate the categories and themes.

3.4.2 Dependability

This appropriateness of fit of the method of analysis is one of the criteria by which the dependability of the study is evaluated. To demonstrate rigour and enhance the dependability of the findings, the thesis stayed true to the ontological, epistemological and theoretical of the framework analysis approach and those of the methods selected (see section 3.2). Accounts were gathered from multiple perspectives. Healthcare professionals represented a range of roles, grades and experiences, plus patients with differing demographics, diagnoses and experiences of seclusion, all with recent involvement in an episode of seclusion. In addition, the findings of the professional study were discussed at professional forums. The patient themes were not fed back to the patients as there was not time within the PhD timeframe.

3.4.3 Transferability

Detailed description of the study context was included to ensure readers can make judgements regarding the transferability of the findings to other settings (Korstjens and Moser, 2018). Chapter two outlined the legal basis for seclusion, whilst section 5.3.1 and appendix one provide insight into the local setting in which the study was conducted. Transferability of the findings to other services is difficult due to the cultural and contextual nature of seclusion practices. However, it is hoped the findings will be of interest to organisations and individuals in similar circumstances.

3.4.4 Confirmability

The confirmability and trustworthiness of qualitative research findings is dependent upon the transparency of the subjectivity or neutrality of the data (Lincoln and Guba, 1985). A clear audit trail is essential. Transparency in data analysis was supported through the use of framework analysis, together excepts from the author’s reflective journal and worked examples from the author’s coding notes (see section 5.5). Findings should not be based on the researcher’s preferences or viewpoints but grounded in the data (Korstjens and Moser, 2018). Therefore supervision, which included discussion and reflection with both supervisors, acted as an independent check to strengthen the research process. Supervision sessions covered topics such as the researcher’s interview technique, possible areas of interest to pursue when collecting data, methods of transcription, coding, analysis and interpretation decisions.

3.4.5 Reflexivity

Reflexivity is when researchers:

> *…examine one's own conceptual lens, explicit and implicit assumptions, preconceptions and values, and how these affect research decisions in all phases of qualitative studies* (Korstjens and Moser, 2018, p121).

It is the responsibility of the researcher to engage in reflexivity to examine their influence upon the processes of qualitative inquiry (Streubert and Carpenter, 2011). Reflexivity is an integral element in demonstrating quality in qualitative research and throughout the PhD a reflective journal was kept to support this process. It incorporated:

- *Functional reflexivity* outlining how the researcher produced and affected the knowledge (Wilkinson, 1988); and
- *Theoretical sensitivity* demonstrating insight and reflectivity regarding the actions taken (Strauss and Corbin, 2010).

According to Jasper (2005), reflective journaling is not only valuable in mitigating issues of bias or subjectivity, but central to the development of a qualitative researcher's ability to think critically, support identification of connections between disparate information, and create new perspectives.

3.5 Conceptual framework

An overview of the conceptual framework outlined in table 3.6. Conceptual frameworks provide a coherent, unified and orderly way of seeing related events or processes relevant to a research study (Fawcett, 2005). Fawcett (2008) stated clarity regarding conceptual and theoretical links to nursing research studies are essential if the discipline and credible practice knowledge are to advance.

Table 3.6 Conceptual framework for thesis

Personal worldview	I am a woman in my mid-fifties, who is a mental health nurse with experience of listening to people and helping them explore their thoughts and feelings. I am aware of the importance of self-reflection, and that my experience both differs from and affects the way I interpret those of others. I am interested in strategies to support staff teams to end episodes of seclusion appropriately and believe greater understanding of the effect upon patients could improve care.
Problem	In 2014 I completed an audit of seclusion practices in my organisation that included the durations of episodes. I could not benchmark results against comparable services as at the time data was not collected nationally. Literature suggested differences in durations may be explained by a complex mix of factors.
Philosophical Framework	Critical realism: Knowledge exists independently and is accessible through the perceptions and interpretations of individuals (Hammersley, 2007a; Ormston et al., 2014).
Theoretical Framework	Clinical nursing research is pragmatic as its focus and guiding principles should seek to answer a healthcare problems (Benner, 2001); Qualitative research is appropriate to explore phenomena little is known about (LoBiondo-Wood and Haber, 2017).
Methodological Framework	Framework analysis is not aligned to any a particular epistemological, philosophical, or theoretical approach but offered is a flexible tool adaptable for use with qualitative approaches that aim to generate themes.(Spencer et al., 2014b).
Research Questions:	What factors influence mental health professionals to release patients from seclusion? What are patients' experiences of being involved in release from seclusion?
Methods	Integrative literature reviewing (Dixon-Woods, 2011); Face to face semi-structured interviews (Rubin and Rubin, 2005); Framework analysis (Ritchie et al., 2014b).
Nursing Theory	Nursing knowledges (Chinn and Kramer, 2018); Novice to Expert (Benner, 2001).

3.6 Conclusion

To provide a clear audit trail and demonstrate rigour in the thesis, chapter three discussed the philosophical, theoretical and methodological influences upon research and their relevance to the creation of new knowledge. The chapter argued why a pragmatic approach was selected. As a piece of nursing research the identification of strategies for improving clinical practices were given precedence over the research methodology, although the studies and overall plan retained structure. There was an explanation of the benefits that face-to-face interviewing of participants with first-hand experience brought to the inquiry. Plus, a discussion was presented regarding how framework analysis supported the data management and analytical processes to enable summarisation and interpretation of the findings. The chapter outlined the methodological choices and ethical challenges faced by insider nurse researchers. It clearly stated the researcher had prior knowledge and an understanding of the topic which could not be separated from the collection, analysis or interpretation of the data. The chapter stressed reflexivity to support transparency was incorporated throughout the completion of the thesis. Finally, a conceptual overview was included.

Four studies were conducted for this thesis which are presented and discussed in the following chapters;

- Chapter four details the methods used to produce findings for two integrative reviews;
- Chapter five outlines the methods taken to complete two interview studies and analyse their data; followed by,
- Chapter six which presents the findings of the interviews; and,
- Chapter seven contains the discussion and synthesis of all four studies.

Chapter four: Literature reviews

4.1 Introduction

> *Integrative literature review is a form of research that reviews, critiques, and synthesises representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic are generated* (Torraco, 2005, p.356).

Chapter four outlines the methods used to conduct two separate literature reviews and their findings. These were titled:

- What factors influence the decisions of professionals to release patients from seclusion? and,
- What are the experiences and involvement of patients in release from seclusion?

Both followed Cooper's (1988) five stage framework for integrative reviews outlined in chapter three (see section 3.3.2). Seclusion literature is sometimes found in evidence detailing the wider issues of physical restraint and reducing restrictive practices in mental health care. However, these reviews searched for and considered evidence which related primarily to adults who had been secluded. This decision is discussed and defended in the concluding chapter of the thesis (see section 8.3). Some of the evidence included in the reviews was found embedded in articles relating to both seclusion and restraint as well as mixed age groups, although only relevant data was extracted.

The chapter is divided into three parts. Part one presents the review of professional literature (see section 4.2). Part two is the review of patient literature (see section 4.3). The limitations of both reviews are outlined in part three (see section 4.5). Following this the chapter concludes, as little was known about the experience of release from seclusion, further study was warranted.

Part one: Professional literature review

4.2 What factors influence the decisions of professionals to release patients from seclusion?

4.2.1 Stage 1: Problem identification

The review aimed to identify and synthesise existing evidence detailing factors influencing professional decisions to release patients from seclusion.

4.2.2 Stage 2: Literature search

4.2.2.1 Search strategy

Schardt et al. (2007) recommended the first and most important step of the search process was to formulate a well-focused question. The question, 'What factors influence mental health professionals when releasing a patient from seclusion' was developed by defining the population, concepts and processes involved. This was broken down into discrete facets (see table 4.1).

Table 4.1 Professional review: Search terms

Search Terms	
Population	mental health OR psychiatr* OR learning disabilit* OR forensic OR PICU AND
Concept	seclu* OR isolat* OR confine* OR segr* OR separ* OR time out OR quarantine* AND
Processes	assess* OR decision* OR judge* OR consider* OR protocol* OR process* OR outcome* OR review*

The use of a structured approach to searching offered greater precision when compared to searches using standard database search tools. A comprehensive systematic search of Electronic databases: Medline, CINAHL (Cumulative Index to Nursing and Allied Health Literature), EMBASE, PsychInfo, BNI (British Nursing Index) and the Cochrane database was completed. The search parameters chosen extended from January 1991 to September 2017 to capture changes in policy and practice and to meet the standards set out in the United Nations Principles for the

Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UN, 1991) (see table 4.2). The searches were re-run in March 2020 (see section 4.2.2.3).

Table 4.2 Professional review: Sources selected

Date		**Search strategy used, including any limits**	**Hits**
CINAHL	3.9.17	Abstracts/1991/English/Peer Reviewed	1,494
Medline	3.9.17	Abstracts/1991/English/Human OVID Medline 1946 to September Week 1 2017	6,323
Embase	5.9.17	Abstracts/1991/English/Journal/Human/ not including medline journals Embase Classic+Embase 1947-2017 September	1,254
PsychInfo	3.9.17	Abstracts/1991/English/Peer Reviewed/Human 1806-September 2017 Week 1	4,762
BNI	5.9.17	Abstracts/1991/Peer Reviewed	174
Cochrane	6.9.17	MeSH descriptor: [Decision-making] AND MeSH descriptor: [Psychiatry] AND seclusion (2790, 471, 57)	2
		Total Minus Duplicates	14,009 5,040
		TOTAL	8,969

In the initial search, 14,009 articles were retrieved and downloaded to Endnote© Version X9. These were supplemented by a further three articles making a total of 14,012. The three articles were found by:

- A hand search of reference lists of relevant articles covering a range of topics relating to decision-making, influences and attitudes towards seclusion that identified one further article by Muir-Cochrane (1995); and,
- A systematic search of grey literature which located a survey project undertaken as part of an MSc (Johnson, 1997) and a book chapter in a medical textbook.

Grey literature describes material often difficult to find, not peer reviewed and hard to organise (Tillett and Newbold, 2006). It incorporates review and editorial articles, book chapters, theses, dissertations, guidelines, policies plus other material, and is located by browsing search engines, websites, university repositories or magazines. The inclusion of such evidence can broaden reviews, but finding relevant articles is subject to chance as search methods lack specific guidance (Mahood et al., 2013) and inclusion risks bias (Hopewell et al., 2007).

A total of 5,040 duplicates were removed. Using the online software package Covidence (https://www.covidence.org/home accessed 15.9.17) 8,972 articles were screened by title. Of these, 8,723 were discounted. The 249 remaining abstracts were screened by the researcher and checked by a supervisor using inclusion and exclusion criteria (see table 4.3). Twenty-eight of these were selected for full review. Sixteen were removed as they did not refer to releasing patients. Twelve were identified as relevant. Of these ten were primary research articles and two expert opinion. The search process has been summarised in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses diagram (PRISMA) (Moher et al., 2009) (see appendix two).

Table 4.3 Professional review: Inclusion exclusion criteria

Inclusion criteria	Exclusion criteria
• Mental health professionals or psychiatric nurses, doctors; • Inpatient settings; and, • Primary research from studies relating to decisions about seclusion.	• Reviews of other literature; • Studies primarily about physical restraint; • Demographic or diagnostic indicators of seclusion not related to decision-making processes; • Children and adolescents only; • Research exploring or describing professionals or patient characteristics; • Predictors of seclusion; • Patient experience/views/perceptions of being secluded; and, • Family experience/views/perceptions of seclusion.

4.2.2.2 Search findings

A summary of the methodological features of the articles are presented below (see table 4.4). The table includes the two articles of expert opinion (in light grey), plus a further three articles identified in an updated search (in dark grey) (see section 4.2.2.3). The ten research articles from the first search were from five countries: the UK (2), Netherlands (1), US (1), Canada (1) and Australia (5). Three Australian studies reported on one dataset (Muir-Cochrane, 1995; Muir-Cochrane and Harrison, 1996a; Muir-Cochrane, 1996b). This was a qualitative study using grounded theory which used semi-structure interviews to explore perceptions of nurses and ethical processes relating to seclusion. Two other qualitative studies, Wynaden et al. (2002) and Larue et al. (2010), also used semi-structured interviews researching seclusion decision making processes and nursing interventions. Hyde et al. (2009), described a PDSA (plan-do-study-act) action research project which aimed to implement change in seclusion practices.

Four studies were quantitative. Steele (1993) used a structured survey with an open-ended component requiring respondents to rate and comment on their attitudes towards seclusion. As part of an evaluation of seclusion use, Mason and Whitehead (2001) asked nurses who had recently initiated a seclusion episode to complete a structured questionnaire to rate their rationale for continuing or terminating an episode of seclusion. Likewise Johnson (1997) used a survey tool developed from literature to weight and rate factors relevant to the continuation and discontinuation of seclusions. Finally, Boumans et al. (2015) asked respondents to rate the necessity and appropriateness of hypothetical decisions they might make using vignettes. They also evaluated the impact of an innovation project upon changing attitudes towards seclusion and/or decision-making at two time points.

The two articles of expert opinion Bhavsar et al. (2014) and Beck (2015) outlined good practice for medics undertaking seclusion reviews.

Table 4.4 Professional review: Methodological features

Citation	Aim	Method	Setting/ Sample	Data Collection	Method of analysis
Steele (1993)	To determine attitudes, opinions and factors that influence decision to remove restriction.	Quantitative Descriptive	US Inpatient 28 mixed MDT Professionals	Survey	Basic statistical analysis
Muir-Cochrane (1995) (1996a) / (1996b)	To investigate nurse perceptions of secluding psychiatric patients on closed wards/ provide conceptual framework for nursing practice.	Qualitative Grounded Theory	Australia Inpatient 7 MH nurses	Semi-structured interviews	Constant comparative analysis
Johnson (1997)	To formulate a checklist to support review decisions to continue seclusion.	Quantitative	UK High security 87 MH nurses	Postal survey	Statistical analysis
Mason & Whitehead (2001)	A study of secluded female patients in a special hospital.	Quantitative	UK High security 16 Nurses	Face-to-face questionnaire	Descriptive analysis
Wynaden et al., (2002)	To explore decision-making process surrounding use of seclusion.	Qualitative Descriptive/ exploratory	Australia PICU 7 MH nurses 1 Medic	Semi-structured Interviews	Content analysis
Hyde et al., (2009)	Devise frameworks for decision to seclude and release.	Qualitative Action Research	Australia District hospital MDT	PDSA cycles	Practice development
Larue et al., (2010)	To explore and describe nursing interventions in episodes of seclusion in a psychiatric facility.	Qualitative Descriptive/ exploratory	Canada Short-stay 24 MH nurses	Semi-structured Interviews	Content analysis
Boumans et al., (2015)	Did innovation change attitudes towards seclusion and/or decisions?	Quantitative	Netherlands High security 14 MHNs experimental vs control wards	Survey	Statistical analysis
Bhavsar et al., (2014)	To examine and outline the process of undertaking medical reviews of secluded patients.	Expert opinion	UK PICU 3 Medics	Discussion	n/a
Beck (2015)	Seclusion reviews for Junior Medics.	Expert opinion	UK	Problem based example	n/a
Fish (2018)	To propose a theory of the experiences of people with learning disability in seclusion.	Qualitative Ethnography	UK 3 LD forensic wards 10 Professionals	Interviews and observation	Thematic analysis
Goulet and Larue (2018)	To understand the context in which seclusion and practices are used.	Qualitative/ Participatory case study	Canada MH hospital 14 MH Professionals	Semi-structured interviews and observation	Content analysis QDA Miner software
Haugom et al., (2019)	What are the ethical challenges of using seclusion?	Qualitative Exploratory	Norway 57 MH wards 149 inpatient cases	Case reflections Semi-structured written questionnaire	Content analysis

4.2.2.3 Updated search results

The review was updated on the 21st March 2020 (see table 4.5).

Table 4.5 Professional review: Updated search findings

Search activity	Results
Date range searched	1.9.17 to 21.3.20
Articles identified (minus duplicates)	3,752
Screened by abstract/title	58
Screened by inclusion/exclusion criteria	14
Articles identified for inclusion	3

The search provided three further research articles (see table 4.4). They were from the UK (1), Canada (1) and Norway (1). All three were qualitative. Fish (2018) used ethnography and interviewing, placing herself in a learning disability setting to undertake in-depth exploration of the experience of both using and being subject to seclusion. Steele (1993) (see original search above), had also included learning disability wards. Goulet and Larue (2018) used a participatory case study with interviews and an observational design, again speaking to both professionals and patients. Finally, the Norwegian study (Haugom et al., 2019), took a descriptive exploratory approach examining written ethical reflective accounts. It was included as the findings were relevant to the review question. Although Norway has a slightly different definition for seclusion with no locked or closed door between the patient and professionals (Haugom et al., 2019), it is often used alongside mechanical restraint (Steinert et al., 2013).

4.2.3 Stage 3: Data evaluation

4.2.3.1 Quality appraisal

The thirteen research studies, ten from the initial search and three from the updated search, were assessed using Critical Appraisal Skills Programme (CASP) lists (https://casp-uk.net/casp-tools-checklists/ accessed 12.9.17). CASP offered a range of tools suitable for use with differing qualitative and quantitative methods. A condensed version of an excel file created to record the quality appraisal for inclusion in this review is presented in appendix three.

An assessment of quality was made for each article. The following criteria were used to evaluate the research studies (Baker et al., 2010):

Q1 Are the research question/aims and design clearly stated?
Q2 Is research design appropriate for aims and objectives of the research?
Q3 Are the methods clearly described?
Q4 Is the data adequate to support the author's interpretations/conclusions?
Q5 Are the results generalisable/transferable?

The following scores were given: 0 = not met, 1 = partly met and 2 = fully met. Poor quality studies scored three or less, medium quality between four and six, whilst high quality studies scored seven or above (see table 4.6). Due to the small number of articles identified, none were discounted on methodological grounds and inclusion was dependent upon relevance to the research question. This decision was consistent with the pragmatic approach of the thesis and the aim to produce clinically relevant findings.

Table 4.6 Professional review: Quality appraisal

	Q1	Q2	Q3	Q4	Q5	Total	Grade
Steele (1993)	1	1	1	0	0	3	Low-quality
Muir-Cochrane (1995,1996a, 1996b)	2	2	2	2	0	8	High-quality
Johnson (1997)	2	1	2	1	0	6	Medium-quality
Mason & Whitehead (2001)	1	1	1	1	0	4	Medium-quality
Hyde et al., (2009)	2	2	2	2	0	8	High-quality
Larue et al., (2010)	2	2	2	2	0	8	High-quality
Boumans et al., (2015)	2	2	2	2	0	8	High-quality
Fish (2018)	2	2	2	2	0	8	High-quality
Goulet & Larue (2018)	2	2	2	2	0	8	High-quality
Haugom et al., (2019)	2	2	2	2	0	8	High-quality

The two articles of expert opinion were appraised using a checklist developed by Burrows and Walker (2012) (see figure 4.1) to support judgements regarding their quality and reliability (see table 4.7). The inclusion of expert opinion is justified if it supports evidenced-based practice and is an information source used by practitioners. However, it should only supplement research findings, not replace them (Herman and Raybould, 2014). Expert opinion is regarded as low down the hierarchy of evidence

(Sackett et al., 1996). Although not evidenced based, the appraisal tool draws on a framework by Crombie (1996) and a delphi study by Mayer (2009) examining factors academics thought relevant.

Q1 Is the author an expert?
Q2 Is the opinion published within a credible source?
Q3 Is their opinion evidence-based?
Q4 Are the authors personal statements clearly presented as such?
Q5 Is the opinion in response to a practical concern?
Q6 What are their findings?
Q7 Does the author provide arguments for and against the position?
Q8 Does the author identify any limitations of their statement?

Figure 4.1 Critiquing tool for expert opinion (Burrows and Walker (2012)

Table 4.7 Professional review: Appraisal of grey literature

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Bhavsar et al., (2014)	Yes	Yes	No	Yes	Yes	Advice for reviews	No	Yes
Beck (2016)	Yes	Yes	No	Yes	Yes	Advice for reviews	No	No

4.2.3.2 Critical appraisal

The total sample size of the studies was 388, with individual samples ranging between 7 and 149. This excluded Hyde et al. (2009) who worked with nursing teams from two wards. The validity and representativeness of the samples varied as the articles included a range of ages, professions, experience and genders. Generally there was an over representation of nursing views as, five of the studies included only nurses, whilst the others had a pre-dominance of nurse participants. Although as stated by Muir-Cochrane (1995), nurses were the professional group most likely to initiate and manage seclusion.

Reliability of the quantitative studies could be questioned as Johnson’s (1997) postal survey reported a high response rate of 54.87% (n=87), although it was not clear how potential participants were randomised. Mason and Whitehead (2001) also randomised participants, but stated the low number of incidents made it unfeasible to establish a control group for comparison. Whereas, Boumans et al. (2015) identified one ward as an intervention (n=14) and another three as control wards (n=30), but admitted as they were not identical they were not true controls.

Haugom et al. (2019) collected 149 written cases from 57 wards from across Norway. Whilst, the other qualitative studies used smaller locally recruited samples to gain in-depth information rich data or explore local practices. Larue et al. (2010) reflected upon potential bias in their sample but were unable to explain why one site in their study was able to recruit more participants. Potential biases were discussed in other studies which admitted participants may have felt coerced into taking part. For example, Wynaden et al. (2002) reported everyone they approached agreed to participate. Conversely, samples may have been affected if professionals declined to participate because of personal views about seclusion or fears that their practice may be scrutinised.

Time since involvement in a seclusion was seen as important in that it could affect recall. Studies differed in their requirements regarding the length of time they allowed since the episode. Larue et al. (2010) recruited professionals within forty-eight hours of the seclusion ending but admitted the logistics of this resulted in fewer participants. Whereas, Mason and Whitehead (2001) stated participants need only have first-hand recent knowledge of making decisions about seclusion. Other studies did not require recent involvement, just that participants must be working in a setting with seclusion (Muir-Cochrane, 1995; Johnson, 1997; Steele, 1993; Wynaden et al., 2002; Hyde et al., 2009; Boumans et al., 2015).

Studies were conducted in settings of varied size and clinical purpose, again limiting the generalisability and transferability of the review findings. Haugom et al. (2019) gathered cases from professionals working with adults, adolescents and elderly patients in acute/sub-acute urban and rural hospitals. Whilst others were adult only inpatient facilities, which included wards in metropolitan (Muir-Cochrane, 1995; Muir-Cochrane and Harrison, 1996a; Muir-Cochrane, 1996b; Hyde et al., 2009; Larue et al., 2010; Goulet and Larue, 2018) and semi-rural hospitals (Steele, 1993). Two were from PICUs (Wynaden et al., 2002; Bhavsar et al., 2014), the other four from forensic settings. Johnson (1997) used a male high security ward, Fish (2018) three forensic women's learning disability wards (two low secure and one medium secure), and Mason and Whitehead (2001) one female medium secure ward. Finally, Boumans et al. (2015) conducted an experiment upon high security wards in a larger hospital, but did not make the gender mix or clinical speciality evident.

Five studies did not refer to ethical consideration in their planning or completion. Boumans et al. (2015) did but failed to make it clear whether agreement to participate was gained from the manager or team members. Wynaden et al. (2002) considered participant anonymity stating comments and situations would be unrecognisable to the wider readership. In two studies researchers were based within the setting, however neither were present when a seclusion event took place reducing the credibility of their findings. Of these, Fish (2018) gained verbal and written consent from those on the wards who wished to participate and omitted data for those who declined. Goulet and Larue (2018) did not clarify if all ward healthcare professionals, patients or ward visitors agreed to be observed.

The studies used an array of methods for data collection and analysis. Validity and reliability were compromised by Steele (1993) and Mason and Whitehead (2001) who both used non-validated tools. Whereas, Johnson (1997) piloted his survey tool with colleagues, and Boumans et al. (2015) used validated tools and vignettes developed by expert clinicians. Credibility in the qualitative studies was enhanced through the collection of in-depth exploratory data which provided detail and understanding (Muir-Cochrane, 1995; Muir-Cochrane and Harrison, 1996a; Muir-Cochrane, 1996b; Goulet and Larue, 2018; Fish, 2018).

Boumans et al. (2015) collected quantitative data in an anonymised web survey making it less susceptible to influence by the researchers, whereas Johnson (1997) admitted his position as hospital manager may have created power over his respondent's data. Similarly, studies using face-to-face interviews were unable guarantee participants did not offer socially desirable answers or attempt to portray their attitude and practice in a positive light. Both Muir-Cochrane (1995) and Wynaden et al. (2002) failed to state their position as researchers or their effect on the data, although other qualitative articles were clearer (Larue et al., 2010; Fish, 2018; Goulet and Larue, 2018).

The authenticity and trustworthiness of the qualitative studies were evaluated by the level of description of adherence to processes of analysis and use of original participant quotes. Wynaden et al. (2002) were experienced nurses who coded, categorised and clustered data, seeking clarification from participants and using field notes. Larue et al. (2010) also used team coding, although the use of more than one coder does not guarantee rigour as analysts may disagree and interpretations are only as good as the level of critical dialogue (Greenhalgh, 2010). The validity and reliability of the quantitative studies was limited by the basic level of statistical analysis

(Steele, 1993; Johnson, 1997), whilst the analysis in Boumans et al. (2015) was used to demonstrate that improvements to the use of seclusion regressed at a later date.

The main findings of the thirteen research and two expert opinion articles, are presented in table 4.8

4.2.4 Stage 4: Data analysis

The fourth stage of Cooper's framework is data analysis. According Riahi et al. (2016) it is the least developed stage of the integrative review process. For both the professional and patient reviews in the thesis an inductive thematic analysis was completed. Braun and Clarke (2013) described thematic analysis as a method to support the identification, analysis, organisation, description, and reporting of themes within a data set. Critics have suggested it does not support higher level interpretative analysis but it:

> *…can produce insights that go beyond the obvious or surface level to see patterns or meanings that link to broader psychological, social or theoretical concerns* (Braun and Clarke, 2013, p204).

Nowell et al. (2017) described how the principles of thematic analysis can be applied to review findings which they termed thematic synthesis under which relevant data is extracted from articles and key concepts identified, analysed and interpreted. They argued although thematic analysis is generally linked to qualitative methods, it could be used across a range of epistemologies and research questions. Whilst they acknowledged the difficulties often arose when bringing research findings together from differing contexts and methodologies, they stated the results could be useful to inform healthcare practice and policy. The process of analysis for the reviews in this thesis followed Nowell et al's., (2017) guidance in that:

- Relevant text was extracted from each paper and coded. Details regarding the method of coding used in the thesis are given in section 5.5.1.1.
- Coded data was arranged by descriptively into a thematic matrix arranged so it could be viewed by topic or by article. Kuckartz and McWhertor (2014) stated the use of a matrix permits coders to select, separate and develop abstract concepts without losing sight of the original context. It is a useful tool for novice researchers as it supports collaborative analysis.

- Patterns and relationships were identified via an inductive and iterative process moving the data from descriptive to interpretative. Themes were verified by a supervisor.
- Conclusions were drawn from each theme and integrated into interpretative summary statements (Whittemore and Knafl, 2005). Throughout the process, steps were discussed and verified with project supervisors.

Table 4.8 Professional review: Findings

Author	Findings
Steele (1993)	Professionals encouraged patients to be calm and be able to discuss rationally inappropriate behaviour and alternatives. Patients were released when they could demonstrate they had regained control. Professionals assessed reaction to release and then assisted in re-entry to ward. Patient requests did not affect decision and 70% of professionals were not at all swayed by client requests to come out. Professionals felt they made good decisions when to terminate episodes.
Muir-Cochrane (1995)	Core category of, ‘controlling’ was identified in which nurses were concerned for individuals but saw their own role as a controller to maintain therapeutic milieu and preserve safety for good of all. Professionals negotiated, re-assessed and gave control back to the patient. The decision to terminate an episode was based upon a the patients ability to reason, to express how they are feeling and to behave with some personal control. Practice was bounded by unequal power, staffing levels, environmental and organisational practices, legalities and protocols.
Muir-Cochrane and Harrison (1996a)	Professionals looked for conforming behaviours. They wanted to be convinced patients had regained self-control. Control was perceived if the patient could reason with clinicians, talk about what had happened, cease unwanted behaviours and accept the limits placed upon them. Seclusion was legitimatised for safety reasons, the reduction of stimulus, supporting low staffing, poor environments and fitting with organisational requirements. On termination, patients most frequently returned to their rooms or were accompanied outside for a cigarette before returning to the ward.
Muir-Cochrane (1996b)	Termination was a gradual and systematic process of assessment and re-integration. Assessment of readiness was a team decision. Nurses set strong clear limits and assessed compliance via conversation and observation of behaviour. Patients needed to be in control of self and accept behavioural limits. Initially patients were nursed in a low stimulus environment, went to their bedroom to relax or went into the garden.
Johnson (1997)	Suggested factors involved in decisions to discontinue are significantly similar to those for initiating episodes. The threat of violence/fear behaviours were most important, followed by a history of violence, agitation then active symptoms of mental illness. External factors were of lesser importance. The duration of episodes related to the severity of the incident. Decisions were complicated by professionals ability to risk assess and the accuracy of risk assessments.
Mason and Whitehead (2001)	Findings suggested despite majority of patients symptoms reducing within one hour it did not affect decisions to terminate. Professionals acclimatised to certain patients behaviour and anticipated they would be secluded longer. No significant relationship was found between type of assault, target of assault and duration of episode. Decisions were shaped by external pressures to terminate seclusion prematurely followed by the level of risk, paperwork, problems of secluding female patients and unpleasant behaviours.

Wynaden et al., (2002)	A step-wise process used knowledge, experience, pattern recognition and consideration of alternatives to make decisions. Safety was paramount and influences decisions. Decisions were affected by professional experience, expertise and number of regular team members, plus increased number and acuity of patients. Termination occurred if patient 'manageable', no longer a risk to self, other patients or professionals and showed commitment to plan.
Hyde et al. (2009)	Safety was most important factor. There should be enough professionals to assess safely. Purpose was to assess if patient was safe enough to leave secluded environment and not a risk to self or others. Considerations included patient history (past, current, history of seclusion), current presentation (behavioural, verbal cues) and risk assessment data.
Larue et al., (2010)	Patient condition was assessed by their behaviour and expectation of risk via observation and knowledge of history. Decisions were affected by local culture. 50% of nurses found the environment stressful and felt overworked which affected their decision -making. Nurses set expectations to patient to end seclusion and looked for pre-crisis behaviours to return. Criteria for bringing episode to an end were related to the circumstances that led to the seclusion.
Bhavsar et al., (2014)	Medical guidelines for PICU seclusion reviews which split process into: Information gathering, mental state review, physical examination, risk assessment and debrief documentation. Authors found despite existence of local and NICE guidance, there was no risk assessment or specific guidance on what practitioners should be doing during reviews.
Boumans et al., (2015)	Demonstrated nurse decision-making was affected by team confidence, staffing levels and the ability of the patient to communicate. During periods of organizational instability work engagement decreased whilst professionals insecurities increased and they were more hesitant when ending episodes and reintegrating patients back to the ward.
Beck (2015)	Text book to support learning of junior medics undertaking seclusion reviews
Goulet and Larue (2018)	Explicit and implicit factors influenced use of seclusion and decision-making. Professionals and patients internalised rules and both should be educated in ways to address power imbalances. Professionals tolerated different levels of risk and set limits on for acceptable behaviour. Sense of safety was influenced by support of peers and management but did not affect work. Patient debrief did not have clear objectives and was not undertaken systematically. Professional team debrief was not always feasible and only took place if difficulties were established with the decision-making.
Haugom et al., (2019)	Safety must be prioritised over patient self-determination. Professionals face ethical challenges for decisions of treatment or control over patients, and stressful not to be able to find an optimal solution. Professionals were aware they had power but taking control puts strain on them and they became physical and mentally exhausted, and afraid of the necessary follow-up required by the organisation. Patient insecurities arose from lack of unified team approach
Fish (2018)	Professionals faced a care versus control dilemma. Seclusion was used as a way to manage the wider ward environment. Professionals looked for patients to be calm, not shouting, not be red in the face, be able to talk to staff and accept medication. Professionals stated they got to know triggers and signs of individual patients. Sometimes if patients were released and were not calm they need to be re-secluded.

4.2.5 Stage 5: Presentation of findings

The findings generated seven themes (see figure 4.2). There was one overarching theme, maintaining safety. The sub-theme of risk assessment as a process also emerged. Risk assessment incorporated the further sub-themes of: interaction, control, and external factors peripheral to the patient secluded. External factors included the influence of professionals and the acuity of wider environment. Once professionals were satisfied the patient was safe to release, two further sub-themes, the requirement for patient compliance, and ultimately releasing and reflecting were considered. Each theme is discussed in more detail below.

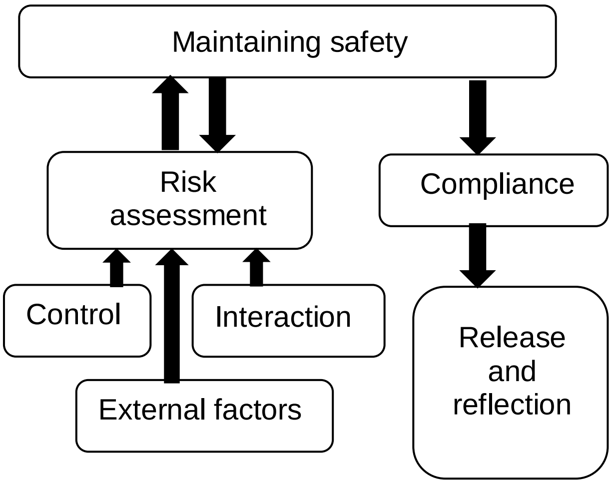


Figure 4.2 Professional study: Model for releasing patients from seclusion

4.2.5.1 Themes

Safety

Safety was the major factor considered by professionals when deciding to release a patient from seclusion (Wynaden et al., 2002; Hyde et al., 2009). Perceptions of safety (Boumans et al., 2015) were discussed in terms of being or feeling safe, such as when faced with the threat or fear of violence (Steele, 1993; Johnson, 1997; Mason and Whitehead, 2001). A positive sense of safety was related to an individual's work experience, their relationship of trust with the team, the training they received, plus the quality of the communication and level of preventative methods used on the ward (Goulet and Larue, 2018). Those who perceived insufficient support by peers and management felt greater insecurities. Professionals did not feel overwhelmed by fear or think their work was affected by their sense of safety (Goulet and Larue, 2018), but wanted to feel it was safe enough to go in the seclusion room (Steele, 1993; Muir-Cochrane and Harrison, 1996a; Larue et al., 2010), or safe enough to allow patients to leave the environment (Hyde et al., 2009; Boumans et al., 2015), '*We let him out as soon as it was safe to do so'* (Wynaden et al., 2002, p264).

Professionals adopted utilitarian principals regarding safety, striving to maintain the safety of the patient secluded, plus viewed safety as a right of other patients and the team:

> Nurse: *We have to ensure the safety of the other patients and staff. The danger aspect is always there and I think once you can isolate that danger away from others everyone breathes a sigh of relief* (Muir-Cochrane, 1995, p17).

Professionals prioritised safety over patient's self-determination (Haugom et al., 2019). They saw themselves as responsible for maintaining safety, bound by ethical and legal considerations and obliged under their duty of care to provide a safe environment (Muir-Cochrane and Harrison, 1996a). The premise of safety was informed by perceived risk.

Risk assessment

Risk assessment was integral to professional decisions. No clear link was expressed between the risk relating to type or target of assault preceding the incident upon and the willingness of the professional to release a patient (Mason and Whitehead, 2001). Although no specific risk assessment tool was available to support professionals releasing patients from seclusion (Bhavsar et al., 2014), there was a general consensus among the articles of issues which were relevant. These included historical factors of previous recorded aggression, prior use of seclusion and professionals own knowledge of the patient (Steele, 1993; Hyde et al., 2009; Larue et al., 2010). Current physical health status was also considered (Bhavsar et al., 2014; Beck, 2015), as were immediate risks of harm (Muir-Cochrane, 1995; Mason and Whitehead, 2001; Hyde et al., 2009). Risks were assessed by patient approachability (Boumans et al., 2015) and observations of their behaviour:

> Nurse: *Has he slept? Is he agitated? Is he still walking around with clenched fists? The nature of his speech, the tone, the loudness, his face? What sort of impression does he give?* (Larue et al., 2010, p212).

Nurses implied they assessed behaviours associated with anger or frustration rather than symptomatic indicators of mental illness when considering release. In contrast, articles by medics suggested they undertook a more holistic assessment including a mental state examination (Bhavsar et al., 2014; Beck, 2015). At the point of release, there was consensus the patient should no longer be deemed an imminent risk of causing harm to self or others (Beck, 2015). Yet, it was acknowledged elevated risk indicators may still be present or fluctuating:

> *Nurse: He was still unpredictable and for the rest of the shift he has been reasonably okay. There are still periods of [high] arousal but he can still be talked down* (Wynaden et al., 2002, p264).

The process of risk assessment was ongoing, being undertaken by individuals and discussed within teams. However, professionals expressed different levels of tolerance towards risk (Goulet and Larue, 2018). They struggled to make accurate predictions regarding levels of risk especially for violent individuals (Mason and Whitehead, 2001) or those secluded under the influence of illicit substances (Wynaden et al., 2002). Furthermore, it was unclear why, even if a patient stabilised within the first hour, it had no bearing on their release (Mason and Whitehead, 2001). This suggested the threat or fear of continued violence was not the only factor impacting upon release from seclusion.

Interaction

Risk assessment incorporated three further sub-themes. The first related to a patient’s ability and willingness to interact with professionals. Interacting also encompassed the quality of communication, engagement and relationships which took place. Initially, communication was one directional with professionals explaining to patients why they were secluded, giving them clear and persistent instructions as to what would happen next, and what was expected of them (Steele, 1993; Muir-Cochrane, 1995; Muir-Cochrane, 1996b; Muir-Cochrane and Harrison, 1996a; Wynaden et al., 2002; Larue et al., 2010):

> *Nurse: You explain the reasons to them why their behaviour is unacceptable, explain the choices and that this or that will happen, even if they don't appear to understand* (Muir-Cochrane, 1995, p17).

Patients were expected to move to a state where they were appropriately engaging with professionals who placed great emphasis upon verbal and sometimes non-verbal communication (Hyde et al., 2009). Although cognitive impairments, language barriers and medication were mediated for, communication was seen as a key test of functioning (Bhavsar et al., 2014). Diminished communication (Boumans et al., 2015) or ongoing abuse directed at professionals (Mason and Whitehead, 2001) adversely affected the duration patients spent in seclusion. There was a consensus across the articles that professionals continually reassessed the ability of the patient to engage in a reasoned negotiation, which entailed working to connect with them (Muir-Cochrane, 1995; Larue et al., 2010), whilst gaining their feedback (Wynaden et al., 2002). When patients were able to express their feelings and demonstrate increased insight, they were viewed as moving towards release:

> Nurse: *If they can step back and allow me to come in and talk about what's happened and can engage in some form of conversation, you know you are getting somewhere* (Muir-Cochrane, 1996b, p.323).

Communication was also seen as essential for giving information and offering reassurance both to the patient in seclusion by telling them, '*You're safe, you're here, we're with you…*' (Fish, 2018, p147), and to others:

> Nurse: *There's other sick patients and they don't know what's going on and they need to be told what's happening and that they are safe, and keep things normal* (Muir-Cochrane, 1996b, p322).

Professionals reported using themselves as a therapeutic tool to move patients towards the point of release. This they did by meeting basic needs (Larue et al., 2010), plus by providing emotional care such as supporting reflection (Wynaden et al., 2002), counselling, parenting (Muir-Cochrane, 1996b), praising and problem solving (Muir-Cochrane and Harrison, 1996a). Professionals stated they strove to maintain any therapeutic previous or existing relationship:

> Nurse: *When they see me, sometimes we can circumvent the whole situation... because they say, 'Hi XXX ', and they know what I'm like and what my limits are* (Muir-Cochrane, 1996a, p322).

Professionals felt justified in their decision to seclude but accepted their involvement in the management of an episode of seclusion may damage any therapeutic relationship they had with the patient. Although they held concerns regarding what the patients thought, many admitted to not being swayed by their requests (Steele, 1993). However, concerns were expressed regarding the way the episode was perceived by patients who had been secluded:

> Nurse: *I'm always concerned about how the clients perceived the experience. Did they come away thinking they were helped or harmed by the experience?* (Muir-Cochrane, 1995, p26).

Control

A further sub-theme of risk assessment was control. Despite professionals believing they worked to maintain partnerships (Larue et al., 2010), at times they admitted seclusion was used to take control and exert power as opposed to it being a therapeutic intervention (Steele, 1993; Muir-Cochrane, 1995). The relationship between taking control and delivering treatment posed ethical challenges and put strain on workers (Fish, 2018; Haugom et al., 2019). It was accepted seclusion is an environment where control was removed from the patient (Bhavsar et al., 2014), with professionals initially acting as a controller, protecting others against the patient exhibiting aggression or distress:

> Nurse: *When they don't have a clue and are disrobing, defecating, etc., if they are so out of control that you have to control them* (Muir-Cochrane, 1995, p17).

Control was also seen to flow back and forth between professionals and patients. Professionals described this process differently. On the one hand, some stated they handed or allowed patients to take control (Muir-Cochrane, 1995), whereas on the other, patients were said to have regained or took it themselves (Wynaden et al., 2002). The assessment that patients had control was integral to the risk assessment process. Although not an essential prerequisite to release, patients were expected to demonstrate they had some control over their actions and behaviours. The return of control occurred as part of a cool down phase and was indicated when patients were calmer, reasonable, were more manageable and had ceased unwanted behaviours (Steele, 1993; Muir-Cochrane, 1995; Fish, 2018). Likewise, professionals reported they would be prepared to end an episode when comfortable with the degree of calmness (Johnson, 1997):

> Nurse: *Before seclusion is terminated we [staff] go through the process with the patient just to see how she feels in herself, and if she is calm and settled?* (Wynaden et al., 2002, p264).

External influences

A third sub-theme of risk assessment was that release was not made without consideration of risk factors external to the patient. Such factors not only affected the chance a patient might remain secluded, but also the length of time their seclusion may last. External factors included the acuity of the wider population (Johnson, 1997; Wynaden et al., 2002) and the local ward culture (Johnson, 1997; Wynaden et al., 2002; Larue et al., 2010). The attributes of individual professionals also influenced release. This included attitudes towards the patient (Muir-Cochrane, 1995; Johnson, 1997; Mason and Whitehead, 2001), or the number of professionals on shift (Muir-Cochrane, 1996b; Johnson, 1997; Wynaden et al., 2002; Boumans et al., 2015). There was a strong consensus in the articles regarding the impact of professionals upon release and was summed up by one:

> *Nurse: My own experience gives me a degree of confidence. As far as the infrastructure [staff on unit], it is becoming more problematic. We are more frequently moving into a scenario of where there is one male on [duty] and the male thing is only a part of the issue. The other side of the issue is that the other staff on duty are agency staff or new to the service. There is a problem when staff are not confident, and able to react quickly. There is an increasing potential for risk because of the loss of experience and gender [male staff] in this area. Intervening in a team where people are not capable also carries risks. Feeling confident to manage violence is not totally a gender issue but it is exaggerated. We are losing more and more staff and it is getting more dangerous. We work with reduced staff and with much more violence* (Wynaden et al., 2002, p262).

Further to this, Haugom et al. (2019) stated it was important professionals were able to take breaks and be supported whilst managing seclusion episodes to counter findings individuals experienced mental exhaustion, or were afraid of what would happen when the patient was released and what follow-up actions they would be required to take.

Professionals reported thinking they made good decisions regarding seclusion (Steele, 1993), but agreed experience and expert knowledge was essential (Steele, 1993; Muir-Cochrane, 1995; Johnson, 1997; Wynaden et al., 2002). Release was also shown to be influenced by organisational factors. For example, Boumans et al. (2015) demonstrated during periods of turmoil that restrictions placed upon patients increased up to five times on wards which had previously managed to reduce the use of seclusion. Furthermore, political influences such as the 1991 national enquiry into the improper care and treatment of patients in UK Special Hospitals (DoH, 1999), left professionals feeling pressured to terminate episodes of seclusion early (Mason and Whitehead, 2001).

Compliance

The review found there were explicit and implicit rules to which patients were expected to adhere (Goulet and Larue, 2018). Once professionals were satisfied the risk of further violence or aggression had reduced to a manageable level, the release of the patient from seclusion was determined by the likelihood they would be compliant. A clear power imbalance was evident as professionals set conditions regarding what patients should be, or not be doing, before they would agree release. For some this involved gentle guidance towards compliance:

> Nurse: *As a little prompt, we will try to give some feedback that is positive in that these are the behaviours we are trying to target* (Wynaden et al., 2002, p264).

Whereas, at times this was more overt with professionals requiring patients to have ceased all offending behaviours (Muir-Cochrane, 1995) and shown remorse (Beck, 2015):

> Nurse*: …can you give me the commitment that you've got control, if they say, 'No I don't want to talk to you', in no uncertain terms then I'd say 'I think you need a little more time* (Muir-Cochrane, 1996b, p323).

Compliance was also judged by the reaction or willingness of patients to accept medication (Muir-Cochrane and Harrison, 1996a). Whilst some professionals linked levels of compliance and commitment with exit plans to release (Wynaden et al., 2002; Larue et al., 2010) others reported exit conditions should reflect pre-crisis behaviours (Larue et al., 2010).

> Nurse: *I suppose because you get to know them, you know the signs and you know the triggers and you can see in general presentation, physical presentation. They're not anxious anymore, they're not red in the face, they're not shouting or screaming, they're very calm, they're talking to you, they've had some medication. You just get to know the signs really* (Fish, 2018, p145).

Releasing and Reflecting

Finally, exiting was usually a stepped or graded process to allow professionals and patients to build trust, test out and re-integrate back on to the ward in a controlled and safe manner (Bhavsar et al., 2014; Beck, 2015). Actual re-entry to the ward was usually an assisted process (Muir-Cochrane, 1996b) as on occasion a patient may need to be re-secluded (Fish, 2018). Some patients were initially transferred to a low stimulus environment, taken to their bedroom to relax or accompanied outside to a garden area before returning to the ward:

> Nurse: *I would like you to come to the day room to have a drink and smoke, talk about what's happened* (Muir-Cochrane, 1996b, p323).

Conversely, if a patient asked to remain in seclusion their request maybe granted, with the door left open so that they could emerge when they felt ready (Muir-Cochrane, 1995). As part of being released, professionals thought patients should be encouraged to reflect and talk about their experience of the event (Steele, 1993; Wynaden et al., 2002). However, in reality this was often lacking (Fish, 2018; Goulet and Larue, 2018). Professionals were also advised to reflect to identify learning to support the management of future episodes:

> Nurse*: I try to look and see if our outcomes have been successful. Is there any other ways we could have done this [managed the patient] and how could we have done it better*? (Wynaden et al., 2002, p265).

Similarly, de-brief for professionals was not undertaken systematically but more likely to occur if there were difficulties during the process of release or for newly qualified team members (Goulet and Larue 2018).

The limitations of the review are listed in part three at the end of this chapter (see section 4.5). A discussion of the findings of the review are presented in chapter seven.

Part two: Patient literature review

4.3 What are the experiences and involvement of patients in release from seclusion?

The second review was of patient literature and followed similar processes to the professional review above (see section 4.2).

4.3.1 Stage 1: Problem identification

The review aimed to identify and review existing evidence detailing the experience of patient involvement in release from seclusion.

4.3.2 Stage 2: Literature search

4.3.2.1 Search strategy

The research question was developed using the population, concept and processes framework. The question was broken down into component parts (see table 4.9).

Table 4.9 Patient review: Search terms

Search Terms	
Population	mental health OR psychiatr* AND service user* OR patient* OR inpatient* OR consumer* OR client* AND
Intervention	secl* OR isolat* OR confine* OR segr* OR timeout OR quarantine* OR separ* OR contain* OR restrict*OR coerc* AND
Outcome	experience* OR view* OR involve* OR subject* OR suffer* OR perception OR attitude* OR impact OR feel*

A comprehensive systematic search of Electronic databases: Medline, CINAHL, EMBASE, PsychInfo and the ProQuest (including the British Nursing Index) was carried out. The search parameters were 1st January 1991 to 11th December 2018 (see table 4.10). The search was re-run on 18th March 2020 (see section 4.3.2.2).

Table 4.10 Patient review: Sources selected

	Date	**Search strategy used, including any limits**	**Hits**
CINAHL	11.12.18	Abstracts/2008/English/Human/Adult/Peer Reviewed	1,545
Medline	11.12.18	Abstracts/2008/English/Human/Adult/Peer Reviewed	1,563
Embase	11.12.18	Abstracts/2008/English/Human/Adult/exclude medline journals/Peer Reviewed	172
PsychInfo	11.12.18	Abstracts/2008/English/Human/Adult/Peer Reviewed	1,270
BNI	11.12.18	Abstracts/2008/Abstracts/Peer Reviewed	483
		Total Minus Duplicates	5,033 2,152
		TOTAL	2,881

A total of 5,033 articles were retrieved and downloaded to Endnote© Version X9. These were supplemented by two articles identified via hand searching of reference lists. A systematic search of grey literature did not identify further relevant articles. 2,152 duplicates were removed. A total of 2,881 articles were screened by title. Of these, 2,759 were discounted. One hundred and twenty-two abstracts were screened using inclusion and exclusion criteria (See table 4.11). Forty-six of these were selected for full review. Nine were identified as relevant. The review process has been summarised in a PRISMA diagram (Moher et al., 2009) (see appendix two).

Table 4.11 Patients review: Inclusion exclusion criteria

Inclusion criteria	Exclusion criteria
• Mental health or psychiatric; • Adults; • Patients with experience of being secluded; and, • Primary research or articles referencing patient involvement in decisions about seclusion.	• Reviews of other literature; • Articles about patient characteristics, demographic and diagnostic indicators of seclusion; • Articles with a primary focus on physical restraint; • Predictors of seclusion; • Children or adolescents; • Nurse or professionals experience/views/perceptions of being secluded.

4.3.2.2 Updated search results

The searches were re-run using the same terms and databases on 18th March 2020 (see table 4.12). The articles were screened by title and abstracts were scrutinised using the same inclusion and exclusion criteria. Of those retrieved, five were read in full and two were identified as relevant. Therefore, eleven articles in total were included in the review.

Table 4.12 Patient review: Updated search findings

Search activity	**Results**
Date range searched	1.9.17 to 21.3.20
Articles identified (minus duplicates)	3,752
Screened by abstract/title	58
Screened by inclusion/exclusion criteria	14
Articles identified for inclusion	2
Total (with 9 from initial search)	11

4.3.2.3 Search Findings

The main methodological features of the articles are presented in table 4.13. The research studies were conducted in seven countries: US (3), Canada (2), Finland (2), Australia (1), Netherlands (1), New Zealand (1) and England (1). One was quantitative and used a survey regarding perceptions of being restrained or secluded (Soininen et al., 2013b). Six were qualitative, all of which used face-to-face semi-structured or open-ended interviews. They employed various methodologies including: an exploratory approach (Meehan et al., 2000; Kontio et al., 2012), grounded theory (Hoekstra et al., 2004), phenomenology (Faschingbauer et al., 2013; Askew et al., 2019) and a participatory case study design which included an observational element (Goulet and Larue, 2018). The other four took a mixed-methods approach. Kennedy et al. (1994) undertook a descriptive study which explored the relationship between length of time in seclusion in relation to frequency of visits by professionals and incidence of hallucinations, matching this data with that gathered from open-ended questions. Martinez et al. (1999) used a survey and focus groups, whereas El-Badri and Mellsop (2008) and Larue et al. (2013) both used mixed-methods questionnaires.

Table 4.13 Patient review: Methodological features

Citation	Aim	Method	Sample/sample	Time since secluded	Data Collection	Method of analysis
Kennedy et al., (1994)	Exploration of seclusion experiences of seriously ill patients.	Mixed Methods	25 Inpatients psychotic illness Acute MH Unit United States	Secluded <5 days	Open-ended interviews, rating scales. Record analysis	Descriptive Statistics and text analysis
Martinez et al., (1999)	Learning about seclusion experience from patients perspective.	Mixed Methods	69 Patients MH hospital United States	Secluded and non-secluded	Survey and focus groups	Content analysis
Meehan et al., (2000)	How do patients describe and construct meanings of seclusion experience.	Qualitative/ Exploratory	12 inpatients 2 Acute MH units Australia	Secluded <7days	Semi-structured Interviews	Meaning categorisation (Kvale 1996)
Hoekstra et al., (2004)	How patients secluded cope effect on relationship with services.	Qualitative/ Grounded Theory	7 Patients Community care Netherlands	Experience of being secluded	Semi-structured Interviews	CAQDAS (Computer assisted qualitative data analysis software)
El-Badri and Mellsop (2008)	Investigating patient and professionals beliefs on the use of seclusion.	Mixed Methods	111 Patients Outpatient clinic New Zealand	56 experienced seclusion	Survey	Descriptive statistics and content analysis
Kontio et al., (2012)	To explore patient experience and perception of seclusion and restraint.	Qualitative	30 Inpatients 6 Acute Units in 2 Hospitals Finland	2-7 days post-seclusion	Open-ended interviews	Inductive content analysis
Faschingbauer et al., (2013)	Investigation the experience of seclusion patient perspective.	Qualitative/ Phenomenology	12 Inpatients MH Hospital United States	Secluded 24hrs+ and <7 days	Semi-structured interviews	Text analysis (Van Manen 1990)
Larue et al., (2013)	Identify/describe patients perceptions of a seclusion/ restraint protocol.	Mixed Methods	50 Inpatients 5 Acute wards in 1 hospital Canada	7-30 days post-seclusion	Interview and Survey	Descriptive Statistics. Text analysis
Soinnen et al., (2013)	To describe perceptions of care of patients experiencing seclusion or restraint.	Quantitative	90 inpatients 7 wards/3 hospitals Finland	<5 days secluded or restrained	Survey	Analysed differences & associations among variables vs perceptions
Goulet & Larue (2018)	To understand the context in which seclusion and practices are used.	Qualitative/ Participatory case study	3 inpatients with psychotic illness MH hospital Canada	8-30 days post-seclusion	Semi-structured interviews and observation	Content analysis QDA Miner software
Askew et al., (2019)	Being in a Seclusion Room: The Forensic Inpatients Perspective.	Qualitative/ Phenomenology	7 inpatients 1 medium secure hospital England	>28 days since secluded	Semi-structured interviews	Interpretative Phenomenological Analysis

4.3.3 Stage 3: Data evaluation

4.3.3.1 Quality appraisal

The articles were appraised using CASP. A mixed methods studies evaluation tool by Long (2005) was also used as no appropriate CASP tool was identified. A condensed version of the appraisal is presented in appendix three. Quality was graded using the same criteria as the professional study (see section 4.2.3.1 and table 4.14). As in the professional review, just a small number of articles were relevant and each article only contained occasional references to release. Therefore again no articles were discounted on methodological grounds.

Table 4.14 Patient review: Quality appraisal

	Q1	Q2	Q3	Q4	Q5	Total	Grade
Kennedy et al., (1994)	1	2	2	1	0	6	Medium-quality
Martinez et al., (1999)	1	1	0	0	0	2	Low-quality
Meehan et al., (2000)	1	2	1	1	1	6	Medium-quality
Hoekstra et al., (2004)	2	2	2	2	0	8	High-quality
El-Badri & Mellsop (2008)	1	1	1	0	0	3	Medium-quality
Kontio et al., (2012)	2	2	2	2	1	9	High-quality
Faschingbauer et al., (2013)	1	2	2	2	1	8	High-quality
Larue et al., (2013)	2	2	2	2	0	8	High-quality
Soinnen et al., (2013)	2	2	2	2	1	9	High-quality
Goulet & Larue (2018)	2	2	2	2	1	9	High-quality
Askew et al., (2019)	2	2	2	2	1	9	High-quality

4.3.3.2 Critical appraisal

The studies ranged in size and recruitment methods. Attempts were made to exclude data if they did not clearly relate to the seclusion of adult patients. However, samples included patients who had been secluded and/or restrained (Soininen et al., 2013b), plus patients who had, or had not, experienced seclusion (Martinez et al., 1999; El-Badri and Mellsop, 2008), and all age groups (Martinez et al., 1999). Therefore the amount of data relevant in the articles was further reduced. In addition, Goulet and Larue (2018), expressed caution as they only interviewed three patients and did not reach data saturation.

The settings included inpatient and outpatient settings, plus a forensic hospital (Askew et al., 2019). Wards were described as acute, acute admission, mental health or long-stay wards. They were of differing sizes, staffed by dissimilar professional groups and set in both urban and rural areas. Furthermore, two studies recruited participants from community settings. One was described as an outpatient clinic (El-Badri and Mellsop, 2008) and the other a long term community setting (Hoekstra et al., 2004). This variability affected the generalisability and transferability of any findings, but it is possible the experience of being secluded may be similar across all settings. Therefore, data was viewed as useful for inclusion in this review.

Most studies considered ethical factors relevant to research with vulnerable populations and acknowledged discussion of a seclusion experience may cause distress. Consequently, nine out of eleven studies recruited inpatients with access to twenty-four hour care and support. Support for outpatients was more variable. El-Badri and Mellsop (2008) randomly approached patients giving them a questionnaire but did not consider providing support. In contrast, Hoekstra et al. (2004) required patients to be undergoing treatment by a community team to ensure help was available if needed.

Not all outlined processes of informed consent. Martinez et al. (1999) failed to explain how they ensured confidentiality and anonymity despite conducting focus groups which need ground rules and group agreements to allow participants to discuss experiences in safety. Kontio et al. (2012) described capacity and the ability to communicate as having been assessed by professionals. They suggested staffing workload, shortages and inattentiveness meant the opportunity patients had to participate was dependent upon the willingness of professionals to support the research. Similarly, Soininen et al. (2013b) stated an ambivalence by professionals meant only half of potential participants where given the chance to take part. Finally, the importance of maintaining confidentiality was addressed in some but not all articles. Goulet and Larue (2018) stated they maintained confidentiality and anonymity despite participants in small local samples being more easily identifiable.

The majority of studies allowed participants to be interviewed up to seven days after their seclusion ended (Kennedy et al., 1994; Meehan et al., 2000; Kontio et al., 2012; Faschingbauer et al., 2013; Soininen et al., 2013b). This supported more accurate recall and allowed researchers to capture recent experience (Kontio et al., 2012), with participants having chance to recover (Meehan et al., 2004) and process their emotions (Faschingbauer et al., 2013). Two studies, Larue et al. (2013) and Goulet and Larue (2018) opted for a seven to thirty day period since the seclusion. They argued this followed recommendations suggesting patients should be interviewed when they have returned to a pre-crisis state but not too long after as they might reconstruct events incorrectly (Holmes et al., 2004; Soininen et al., 2014). Whereas, Askew et al. (2019) recruited patients whose most recent episode of seclusion had been more than twenty-eight days prior to interview to ensure they were not put at risk of being re-traumatised. A further three studies (Martinez et al., 1999; Hoekstra et al., 2004; El-Badri and Mellsop, 2008) did not specify a time period therefore their findings might be affected by recall or could be reflections on more than one incident.

Validity and reliability was enhanced through the use of validated tools. Soininen et al. (2013b) used a Finnish version of the Secluded and Restrained Patients Perceptions of their Treatment (SR-PPT) (Noda et al., 2012), and Larue et al. (2013) developed their tool using experts in a delphi study. Kennedy et al. (1994) administered a semi-structured interview scale based upon a previously validated scale (Richardson, 1987), and Askew et al. (2019) an interview guide developed in conjunction with patients. Credibility was demonstrated in qualitative studies such as Meehan et al. (2000), El-Badri and Mellsop (2008) and Faschingbauer et al. (2013) who used open-ended probing questions. The grounded theory study by Hoekstra et al. (2004) described a cyclical process that built upon previous participant responses. Qualitative face-to-face interviewing allowed studies to gather deep experiential data, offering patients the opportunity to provide subjective accounts and raise issues they felt important (Soininen et al., 2013b). Larue et al. (2013) suggested interviewing face-to-face was also ethically preferable as it could identify distress. Authenticity and credibility was demonstrated by the use of patient data.

Description and openness about the participant-researcher relationships supported trustworthiness and reliability in the data. However, only four articles did this clearly. Meehan et al. (2000) used interviewers known to patients, making use of existing relationships to produce richer meaningful responses. Whereas, El-Badri and Mellsop (2008) and Soininen et al. (2013b) argued if researchers were known to patients it could compromise data, as they may have given socially desirable answers or worried that making critical comments may affect their care. In Askew et al. (2019), the researcher was an outsider, the relational and power imbalances were considered and used to, *'…enhance the interpretative nature of the analysis'*, (p3).

Qualitative data was analysed using methods including content analysis, meaning categorisation, thematic analysis, hermeneutic analysis and interpretative phenomenological analysis. The reliability and trustworthiness was difficult to assess if the analysis was poorly described (Martinez et al., 1999; Meehan et al., 2000; El-

Badri and Mellsop, 2008). Alternatively when clear descriptions were given, the processes were auditable (Kontio et al., 2012; Faschingbauer et al., 2013; Larue et al., 2013; Goulet and Larue, 2018; Askew et al., 2019), or replicable and reliable (Soininen et al., 2013b).

4.3.4 Stage 4: Data analysis

The main findings of the eleven articles are presented in table 4.15. Data was analysed using the same processes as the professional review (see section 4.2.4). None of the studies had a primary focus of patient experience of involvement in release from seclusion.

Table 4.15 Patient review: Findings

Table 5: Main findings	
Kennedy et al., (1994)	Six patients had no interactions with professionals but other data suggested professionals talked to patients about their feelings, attended to their personal needs, gave them PRN medication, talked about criteria for release and negotiated a contract with them. Patients who were experiencing hallucinations in seclusion spent longer (but not statistically significant) periods as they were more likely to receive medication or a therapeutic intervention.
Martinez et al., (1999)	Many patients stated they were not told what was expected them to be released, although some said they were. Seclusion was seen by patients as a form of punishment and a means of staff teams maintaining control. At this time patients felt there was a need for therapeutic intervention not just containment.
Meehan et al., (2000)	There were unspoken rules of seclusion so patients thought it was important they complied, remained calm and did not display aggressive behaviour in order to be released. Patients did not know how long they would be secluded or what they needed to do to be released. Decisions were subjective and more for the benefit of professionals. Patients wanted to be given the opportunity to gain control and be given extra support on release. Communication was seen as especially important at this time but patients stated it depends which professional is there as that made a difference.
Hoekstra et al., (2004)	Patients suggested they were not able to make choices regarding release and that care during seclusion was inequitable. One stated despite an advance directive to have medication in seclusion this was ignored. Patients felt professionals should support them to maintain autonomy through communication, finding a meaningful timetable and allow them to gain trust (in each other) to facilitate release.
El-Badri and Mellsop (2008)	A significant number of patients did not know reason for seclusion or what they needed to do to be released. They wanted more information about their situation. The presence of a family member may be helpful to support their decisions.
Kontio et al., (2012)	Seclusion was a seen as a longitudinal process. Patients experienced seclusion as negative complaining professionals failed to give them information about what would happen about why and how long, were impolite and disrespectful, plus there was a lack of activity offered. Patients said their perspective did not receive sufficient attention.
Faschingbauer et al., (2013)	Communication was seen as essence of all seclusion experiences. The negative effects outweighed the positive effects. Patients felt powerless and unfairly treated. They wanted more respect, to be told what was happening and to be given the opportunity to calm down. Professionals should be aware of patients history and preferences.
Larue et al., (2013)	Patients said decisions were of a relational nature. Patients said even if they were unreceptive, professionals should offer comfort, show respect, be courteous and share their own thoughts about the situation. Patients needed to be given the chance to prove themselves by undertaking personal care or doing an activity. They want additional support after release as their time/space perceptions can be distorted. Post incident reviews should focus on decisions, emotions and future prevention.
Soininnen et al., (2013)	Patients who received adequate attention from professionals reported they were more able to voice opinions, although these were not taken into account. Older patients expected more involvement in decisions.
Goulet & Larue (2018)	Explicit and implicit factors influenced use and practice of seclusion. Patients reported injustice and suffered loss of autonomy. Their initial trigger was replaced by frustration at being secluded. They adopted acceptable behaviour and advised peers to remain calm. Debrief was informal and not systematic. Returning to the unit felt uncomfortable when returning. Patients and professionals should be educated in ways to address power imbalances.
Askew et al., (2019)	Patients felt professionals had control over of their seclusion experience and the duration. Patients behaved passively in the hope they would get what they wanted. They chose not to argue for fear of consequences such as staying in longer or being restrained. One refused to leave to show he was in control. Another assessed the differences in professionals capabilities, qualifications and salaries of in response to them assessing his risk - he thought lack of training explained the long duration of his seclusion. Suggests power dynamic as influential which is not picked up in other studies, plus patients engaged in behaviour to be released which was not reflective of how they felt.

4.3.5 Stage 5: Presentation of findings

Four themes were generated: inadequate communication, control and compliance, secluded too long and lastly, increasing patient involvement.

4.3.5.1 Themes

Inadequate communication

> *Patients perceived communication as the central issue or essence of their experience of seclusion either positive or negative* (Faschingbauer et al., 2013, p37).

Communication with professionals was seen by patients as influential to their overall experience of being secluded. Yet, findings as to whether constructive communication took place leading up to release were contradictory. One study which spoke directly to patients reported 30 out of 50 (60%) *somewhat* or *strongly* agreed professionals communicated with them during their seclusion (Larue et al., 2013). Whereas, another found meaningful therapeutic interaction took place for only 6 out of 25 (24%) patients (Kennedy et al., 1994). A number of other studies found communication during this period was poor or non-existent (Martinez et al., 1999; El-Badri and Mellsop, 2008; Kontio et al., 2012), a major source of dissatisfaction and a barrier to their involvement (Meehan et al., 2000). Patients complained they were not given the opportunity to talk (Kontio et al., 2012), felt ignored (Hoekstra et al., 2004; Faschingbauer et al., 2013) or that nurses were harsh, unfriendly and unprofessional:

> *I did not like it that that two nurses stood indifferently near me in the seclusion room and talked by themselves* (Kontio et al., 2012, p20).

Furthermore, those who stated they spoke to professionals or tried to be involved did not always feel listened too, and that their opinions or wishes were not valued (Martinez et al., 1999; Hoekstra et al., 2004; Larue et al., 2013; Soininen et al., 2013b):

> *They refused to come and talk to me. They refused to give me a blanket. They refused to let me go to the bathroom. They refused to give me a pillow. They refused everything. All my rights were gone* (Faschingbauer et al., 2013, p36).

Patients felt it was not only important professionals communicated with them, but they also placed importance on which professional it was and what they said (Kontio et al., 2012). This was highlighted by Askew et al. (2019) who stated patients overall experience of seclusion centred upon their experience of the staff team. If communication took place, it helped patients understand the professional point of view, they felt less isolated, more calmed and engaged in the process of release. The findings suggested the focus of communication leading up to release differed dependent upon the professional present. In some cases patients were given an explanation why they had been secluded (Kennedy et al., 1994; Hoekstra et al., 2004). This was appreciated, as if they understood why, they would be more supportive of the decisions by professionals (Kontio et al., 2012; Soininen et al., 2013b). Martinez et al. (1999) suggested younger patients had a better understanding of what was required, although were not clear why this may be. In some studies, patients recalled conversations being about their current situation, feelings and medication, or arrangements regarding personal care rather than being given information or an explanation of what would happen next, or what they needed to do to be released (Meehan et al., 2000; El-Badri and Mellsop, 2008; Kontio et al., 2012; Faschingbauer et al., 2013; Larue et al., 2013). Not knowing what to do left patients wondering who could help them (Kennedy et al., 1994; El-Badri and Mellsop, 2008):

> *I didn't understand why they put me into the seclusion room and I never got information on this. The staff was reluctant to provide information on why and how long, what next* (Kontio et al., 2012, p19).

Control and compliance

Despite thinking they were not routinely told what they needed to do to be released, patients thought professionals wanted them to be calm (Martinez et al., 1999; Meehan et al., 2000; Hoekstra et al., 2004; Faschingbauer et al., 2013; Goulet and Larue, 2018) and demonstrate self-control (Martinez et al., 1999; Larue et al., 2013; Soininen et al., 2013b). They believed seclusion was used as a means to control their behaviour (El-Badri and Mellsop, 2008) as well as control their access to the external environment (Kennedy et al., 1994). Askew et al. (2019) found patients experienced immense feelings of powerlessness at the loss of control. Studies described control as being felt both in a physical sense, as patients were kept in isolation, and in a psychological sense, as they were told what to think or forced to comply (Martinez et al., 1999; Meehan et al., 2000; Hoekstra et al., 2004; Kontio et al., 2012; Larue et al., 2013; Goulet and Larue, 2018). This was summed up in one comment that reported language during a seclusion episode was, *'…replete with deontic expressions (e.g. we have to, you must)'* (Goulet and Larue, 2018, p860). A number of the articles suggested patients took a subordinate role seeing them comply with the demands of professionals (Meehan et al., 2000; Hoekstra et al., 2004; Goulet and Larue, 2018). Askew et al. (2019) found patients might display disruptive behaviour in an attempt to regain control. Whereas, non-compliance was seen by others as an indicator of an adverse mental condition and used by professionals to further justify their actions.

Decisions were seen as arbitrary. Goulet and Larue (2018) found release was more dependent upon implicit rules within the treatment team rather than explicit hospital protocols or standards. There were the, *'…unspoken rules of seclusion'* (Meehan et al., 2000, p374), which carried consequences for those displaying inappropriate behaviour, '…*both sides had internalised the standards to which patients and staff should adhere'* (Goulet and Larue, 2018, p860). Therefore, patients adopted acceptable behaviours or might *play the game* to appear compliant. Engaging in such behaviours and misleading professionals were seen as strategies by patients who were attempting to shift back the balance of control and capacity to influence decisions (Meehan et al., 2000; Askew et al., 2019).

Secluded for too long

The qualitative study by Meehan et al. (2000) suggested the length of time patients could expect to remain secluded did not appear to be related to the attainment of any set goals or exit criteria. Askew et al. (2019) reported the duration of a seclusion was controlled and determined and by professionals. Whilst Larue et al. (2010) found only 16 out of 50 (32%) of patients *somewhat* or *strongly* agreed with the length of time they remained secluded, meaning 68% thought they were secluded too long. The majority of the other studies agreed (Martinez et al., 1999; Hoekstra et al., 2004; El-Badri and Mellsop, 2008; Kontio et al., 2012; Faschingbauer et al., 2013; Goulet and Larue, 2018). Being secluded longer than necessary led to feelings of injustice (Meehan et al., 2000; Faschingbauer et al., 2013; Goulet and Larue, 2018). Lengthy seclusions made matters worse and could exacerbate symptoms (El-Badri and Mellsop, 2008). Patients felt bored which caused them to, *'…act out even more*' (El-Badri and Mellsop, 2008, p250) or provide their own stimulation. This might include singing, banging on door, talking, yelling. Such actions could be viewed by professionals as agitation resulting in them being secluded longer (Martinez et al., 1999; Meehan et al., 2000; El-Badri and Mellsop, 2008; Kontio et al., 2012).

Once release had been agreed, the worries and fears of patients did not dissipate (Meehan et al., 2000). Patients suggested they needed more support at that point as they felt uncomfortable returning to the ward to face peers and possible repercussions (Meehan et al., 2000) or grudges from professionals (Hoekstra et al., 2004).

Increasing patient involvement

The articles reviewed contained ways in which patients thought they could be more involved:

- Even if patients were unreceptive (Larue et al., 2013) professionals should work to improve the relational aspects of seclusion such as building trust and respect to minimise the negative experiences and encourage joint decision-making (Kennedy et al., 1994; Martinez et al., 1999; Hoekstra et al., 2004; El-Badri and Mellsop, 2008; Kontio et al., 2012; Faschingbauer et al., 2013; Larue et al., 2013; Soininen et al., 2013b);
- Appointing a nurse in charge of communication could ensure patients received attention (Kontio et al., 2012) plus, had the opportunity to talk, discuss their point of view and be heard (Goulet and Larue, 2018). Patients did not want to be told what to do or be given false promises by professionals, but instead required clear information about what they could expect (Meehan et al., 2000; Kontio et al., 2012; Faschingbauer et al., 2013; Soininen et al., 2013b);
- Professionals and teams should have an awareness of the patient's background and history of any trauma or preferences (Faschingbauer et al., 2013);
- There should be an independent or external evaluator available to ensure decisions to release are objective and there is no conflict of interest with professionals involved in prior incidents (Martinez et al., 1999; Kontio et al., 2012);
- Families should be told about the seclusion:

  > *…because seclusion is such a frightening experience, the patient's family should be called immediately and the family who knows the patient best should be given the option of coming in to help calm the person. She expressed her family's involvement would help her exit seclusion more quickly* (Martinez, 1999, p16).

- The environment should be comfortable (Goulet and Larue, 2018) to enable patients to calm down (Faschingbauer et al., 2013), relieve stress and boredom (Meehan et al., 2000; El-Badri and Mellsop, 2008);
- Patients want to talk, off-load immediately (Meehan et al., 2000), or be involved in debrief to be given opportunities to learn ways to cope with crisis,

avoid or allow quicker exit from seclusion in the future (Martinez et al., 1999; Faschingbauer et al., 2013); and finally,

- Goulet and Larue (2018) believed training should not only be given to professionals to enable them to better support patients who were secluded, but also to patients who find it difficult to not to become subordinate and give up their autonomy when secluded.

Next, part three outlines the strengths and limitations of the two literature reviews.

Part three: Conclusion

4.5 Strengths and limitations of the reviews

These were the first reviews focussed upon the release of patients from seclusion. There were a number of strengths and limitations in the reviews listed below:

Weaknesses included:

- Only English language articles published after 1991 were included;
- Evidence may have been missed as the articles reviewed were required to have a primary focus of seclusion however seclusion use is sometimes included in literature about physical restraint;
- The definition and use of seclusion is subject to wide variation, although for the purposes of this work only comments relevant to release were extracted and synthesised;
- The research studies were conducted within a range of care settings, influenced by local policy and practices, and included diverse professional staff teams. Professionals working in high security and learning disability services may face and manage risk differently to those working in adult inpatient wards. Furthermore, seclusion use is affected by staff teams and individual professional differences;
- Evidence may have included findings from children and adolescents. Attempts were made to only include data which was clearly relevant to adults and to release. This was challenging as much of the literature found did not separate the seclusion process into distinct stages. Furthermore, not all participants in one article had been secluded. therefore it cannot be guaranteed comments related solely to release;
- The time between the seclusion and participation in a research differed between the articles, thus some comments may be subject to recall bias. Patient comments may have been biased to safeguard their ongoing care,

subject to poor recollection or to offer social desirability. Professional comments could have been subject to bias as they may have been protecting their practice or again responding as they thought the researcher wanted to hear. Nevertheless, findings may be of general interest to patient experience groups, mental health professionals working in inpatient environments or services implementing restraint reduction programmes.

However attempts were made to mitigate against these and the thesis had a number of strengths including:

- Both professional and patient literature was reviewed;
- The integrative review process searched for and allowed the inclusion of a wide range of literature upon a topic little was known. Therefore, the research articles had a range of methodologies and were of mixed quality, although none were discounted for methodological weakness; and finally,
- My background reading, the knowledge of the supervisors and attendance at reducing restrictive interventions events, added to confidence relevant articles were not omitted;
- The reviews provided a robust and transparent explanation of the methods and processes used which added to the credibility and authenticity of the findings.

4.6 Conclusion

To conclude, these reviews found little evidence relating to the experience of release from seclusion either from a professional or patient perspective. That which was found, resonated and overlapped with the wider literature about seclusion discussed in chapter two. The professional review was published in a peer review journal (Jackson et al., 2018) (provided separately). The majority of the research with professionals focussed on reduction initiatives, de-escalation and factors influencing the initiation of a seclusion, little was evident about how they influenced, communicated and how, or indeed if, they involved patients in release. Despite England and Wales requiring seclusions to be managed by the MDT, the influence of MDT working at this point remains to be understood. Similarly, patient research centred upon views about seclusion and the impact of seclusion upon their well-being, not about their experience of involvement or influence upon release. The patient review identified ways in which patients said their experience could be improved. A clearer understanding of how these views relate to release may be useful to inform strategies to reduce the durations those secluded need to remain in seclusion.

Overall, the findings were strengthened by the use of an integrative review methodology which enabled the inclusion of a greater depth and breadth of material (Riahi et al., 2016). Despite there being little previous research regarding release, when synthesised the findings produced concerns that release could be better understood to support discussion and initiatives to improve clinical practice. The reviews identified the need for further understanding. Chapter five now describes the methods used to conduct two individual exploratory studies.

Chapter five: Methods

5.1 Introduction

Chapter five describes the methods used to complete the two interview studies. It starts with an outline of the design of both studies, then discusses the effect the PPI advisors and ethics approval processes had upon the studies' structure. The chapter explains the decisions taken which informed the sampling, recruitment, development of questions and interview stages in detail. It then gives an account of the use of framework analysis and the analytical steps taken to code, categorise and summarise the data to enable development and interpretation of themes. Reflective journal entries and author's coding notes are used to support the decisions and offer reflexivity.

5.2 Planning and management

> *Design in qualitative research is not a discrete stage at the outset of a study but a continuing process of review and adjustment throughout* (Lewis and McNaughton Nicholls, 2014, p.48).

The objectives of the research were to explore:

- What factors influence mental health professionals to release patients from seclusion?
- What are patient experiences of being involved in release from an episode of seclusion?

A Gantt chart (see appendix four) was produced to monitor progress. It was revised periodically to reflect the methodological change made to the thesis and the practicalities of managing the project. Each of the two studies followed the same design and ran sequentially (see figure 5.1). The findings from both studies are presented in chapter six. Chapter seven then provides a discussion of both the interviews and literature reviews, and a synthesis of the findings.

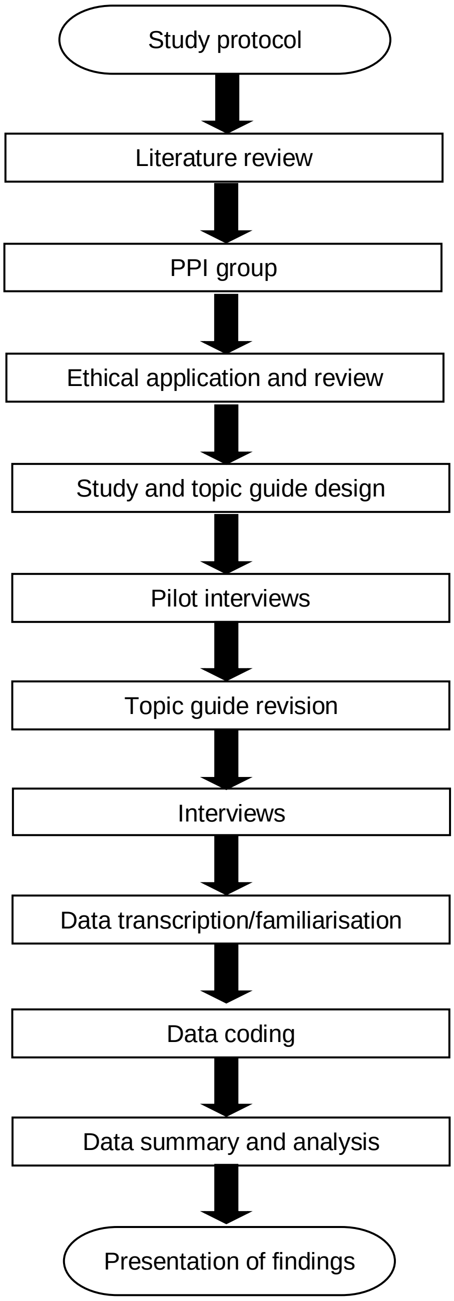


Figure 5.1 Study design

5.2.1 Patient and Public Involvement (PPI)

Professionals and patients not included in the study were invited to review the studies' design, topic guide and tentative professional themes.

5.2.1.1 Patient advisory sessions

Two patient advisory groups were held at the host organisation. Remuneration for time and effort was offered in the form of a £10 gift voucher for each attendee. The group initially consisted of three patients with experience of seclusion in a forensic service. The meetings took place prior to the commencement of data collection and discussed the aims of the research, the proposed design and study information. The patients were supportive of the project. The first group reviewed the lay summary and the participant information leaflet before it was given to professionals. The second group approved a patient information leaflet, a poster to advertise the study and discussed the topic guide. The NHS Research Ethics Committee (REC) subsequently requested the poster be re-drafted (see 5.2.2.2).

5.2.1.2 Professional advisors

A professional with experience of using seclusion reviewed the interview questions for the professional study but suggested no changes. Findings from the professional interview study were presented back to two professional forums. These enabled the initial themes to be discussed and commented on. Feedback was positive and enhanced the dependability of the findings as clinicians stated they recognised seclusion practices within the themes.

5.2.2 Ethical review

Good Clinical Practice (GCP) training (https://www.nihr.ac.uk/health-and-care-professionals/learning-and-support/good-clinical-practice.htm) and the University of Leeds Research Ethics training were completed as preparation for undertaking the study. Two separate applications for ethical review and approval were made.

5.2.2.1 Professional study

Favourable ethical opinion was given by the Leeds University School of Healthcare Ethics Committee (IRAS 217447, HREC 16-006), the Health Research Authority (HRA) (17/HRA/0545) plus the local R&D (Research and Development) department of the sponsor (27/02/2017) (see appendix five). As discussed earlier (see section 3.2.5.4), key ethical issues for this study included data protection, informed consent, confidentiality and anonymity for participants. Data protection was guided by a data management plan in line with University of Leeds requirements and HRA standards.

Informed consent was taken prior to each interview and recorded on the Participant Consent Form. Participation was voluntary and a period of forty-eight hours was given to allow professionals to consider participation (see appendix six).

Confidentiality and anonymity were outlined and maintained as per the professional Participant Information Sheet.

The benefits and risks of participation were discussed. Professionals were advised findings might inform a reduction in the use and length of seclusion within the local service. Participation could also be useful for professional development and re-validation purposes. Risks included professionals may become distressed or disclose issues of bad practice. The measures incorporated in the study protocol to address this included:

- The main researcher was a qualified mental health professional with experience in supporting people in distress and supervising clinical practice;
- All professional participants had access to support and supervision via the host organisation; and,
- If the researcher uncovered harmful practice it would have been discussed with the research supervisor and the participant. If necessary, a referral would have been made with full knowledge of the participant to the patient safety lead in the host organisation.

None of the above measures arose and no concerns were raised.

5.2.2.2 Patient study

Further favourable ethical opinion was gained from University of Leeds School of Healthcare Ethics Committee (IRAS 244043), the Health Research Authority (18/HRA/0180) plus the local R&D department of the host organisation (27/02/2017) (see appendix five). The study involved NHS patients therefore it required full Research Ethics Committee (REC) review (favourable opinion gained 20/7/18). A non-substantial amendment was agreed (17/07/19) to extend the data recruitment period for thirty-five days (see appendix five). The key ethical issues included data protection, confidentiality, participant anonymity, informed consent, plus researching with vulnerable adults who may not have had capacity to participate in research (see author's reflective journal 5.1)

The committee were supportive of the proposal but suggested should patients agree to participate, rather than wait forty-eight hours, they should be offered the opportunity to be interviewed straightaway. REC members suggested enforcing a minimum time period may deter people keen to participate, and valuable contributions may be lost. I am aware of how helpful this was as waiting impacts upon

> *participation rates and it meant I could capture data from patients whilst the event was still fresh in their mind, at a time when they were willing to speak to me and before they left the ward*
>
> Author's reflective journal 5.1

Potential patient participants were vulnerable adults, many detained under the Mental Health Act (DoH, 2015). Despite the views of vulnerable groups being valuable to the development of healthcare services, they are often excluded from participation in research.

In the first instance, the patients' capacity to participate was assessed by their direct care team (see appendix six). If the patient agreed to be approached by the researcher, the study was explained and they were offered a patient Participant Information Sheet. Patients were advised this was an educational project, there would be no benefit to them personally, however findings would contribute to local understanding and literature about the experience of being secluded. The researcher considered and assessed the capacity, consent, understanding and willingness to participate prior to, and during all patient contact and interviews.

Informed consent was obtained and followed the same principles as the professional study (see section 3.2.5.4). Patients were reassured participation was voluntary and involvement would not affect their care, treatment or recovery. They were told they could withdraw from the study and any data they provided would be deleted up to commencement of the analysis. As patients might discuss sensitive and potentially traumatic issues, processes for support were available. The researcher was experienced in assisting people in distress and they were current inpatients in hospital with twenty-four hour support. It was acknowledged the researcher was in an unusual position of dual-researcher in holding both a clinical and research role (see section 3.2.5.5) (see entry 1 and 2 author's reflective journal 5.2).

> ***Entry 1:*** *She became upset saying she wanted to be with her children who had died. She said the whole experience of being secluded was stressful and embarrassing, she had never experienced anything like it. She remembered been stood at the seclusion door with no clothes on her bottom half after wetting herself, then stuffing the clothes through the*

> *hatch [in the door]. She said she was a health professional, and in all her years of being in and out of mental health units she had never been so humiliated. I gave her the opportunity to end the interview or take a break but she wanted to carry on. Before I left the ward I went to the office and discussed she had expressed suicidal thoughts but had not disclosed specific plans or intent. I told staff she may want extra support over the next few days. A nurse stated somebody else had heard her say this but they didn't seem overly concerned. I documented in her notes and raised it with the charge nurse.* ***Entry 2:*** *Staff at PICU said she had capacity and agreed to be interviewed but when I spoke to her I suspected she agreed to talk to me because she wanted to know when she would be moving to ** (female treatment unit). I knew her [the patient] from an admission about a year ago. I explained I had no influence or knowledge about her current care. She accepted that and agreed to still be interviewed. We established a level of trust quickly and she engaged really well being open about her seclusion experience. I wondered if our previous contact influenced this but I took care to present as a researcher and not fall into the role of a nurse so as not to confuse her about the purpose of my visit…*
>
> Author's reflective journal 5.2

5.3 Study design

5.3.1 Setting

Both studies were conducted on adult mental health inpatient wards in Humber Teaching NHS Foundation Trust, an organisation delivering mental health, learning disability and community services in the North of England. When selecting the research setting several factors were considered. The setting:

- Provided professional and patient populations with experience of seclusion;
- Offered an environment in which the lead researcher had prior knowledge and practical access to; and,
- Was part of the acute mental health inpatient service delivered by the sponsoring organisation.

Charge nurses of five adult acute or treatment wards with seclusion facilities were asked for permission to approach potential participants for both studies. The wards were on four separate geographical locations, but all subject to the same policies and procedures (see table 5.1). The admission ward and PICU were in the same building, and the treatment wards on separate sites in residential districts in a city. Wards were selected as they were for adult patients, had access to seclusion facilities and operated in similar environments. Professionals worked in MDTs and had close ties. On occasion they were required to work on or support seclusion reviews on the other wards. Patients were transferred between the wards dependent upon gender and clinical need.

Table 5.1 Study setting

Ward	Purpose
1	14 bedded mixed sex adult mental health admission ward
2	10 bedded mixed sex adult mental health admission/treatment ward
3	18 bedded male adult mental health treatment ward
4	18 bedded female adult mental health treatment ward
5	14 bedded mixed sex adult mental health PICU

5.3.2 Sample

Samples were a subset of the total eligible populations. Sample compositions for this thesis were subject to theoretical and pragmatic influences (Braun and Clarke, 2013) (see section 3.3.2.3).

5.3.2.1 Professional sample

A purposive sample was selected for the professionals study to achieve a detailed exploration and understanding of the topic (Bryman, 2012). The inclusion criteria of the professional sample were they should be:

- A professionally registered medic, nurse, psychologist, occupational therapist or social worker, or a healthcare assistant;
- Working on a ward with seclusion facilities in the host organisation; and,
- Have recent involvement in a review or subsequent discussions regarding ending a seclusion episode.

It was important to ensure a range of professional MDT members were included as the Mental Health Code of Practice (DoH, 2015) requires, and NICE guidance (NICE, 2015) states, medical and associated professionals must be involved in seclusion reviews and any decision to end an episode should include a medic (see figure 2.2). A sample matrix was developed to guide recruitment (see table 5.2). Healthcare assistants were included, as although not being professionally registered or part of formal review procedures, they were first hand observers of seclusion episodes.

Furthermore, their opinion was often sought by registered professionals during the review process.

Table 5.2 Professional study: sample matrix

	Profession	Male (actual)	Female (actual)
Role	Nurse (5/6)	1 to 2 (1)	1 to 2 (4)
	Senior nurse 7+	1 to 2 (1)	1 to 2 (4)
	Medics (Junior & Staff grade)	1 to 2 (1)	1 to 2 (2)
	Consultant	0 to 1 (1)	0 to 1
	AHP	0 to 1	0 to 1 (5)
Area	Admission Unit	3 to 4 (2)	3 to 4 (3)
	Treatment Unit	3 to 4 (2)	3 to 4 (10)
	PICU	3 to 4	3 to 4 (2)
Additional	HCA	0 to 1 (1)	0 to 1 (1)
	Total Target (actual)	16 to 20 projected 21 (actual sample recruited)	

Previous seclusion research set differing requirements regarding the length of time permitted between a professional's involvement in managing a seclusion to their participation in a study (see section 4.2.3.2). The decision was taken not to set a rigid time frame for this thesis. This would ensure recruitment was feasible and could meet the criteria set out in the sample matrix.

5.3.2.2 Patient sample

The patient study used a convenience sample (Haber, 2017). Convenience samples risk bias and may reduce representativeness. However, rather than set a strict sampling strategy this approach would ensure the sample would be achievable in the timeframe (see entry 1 and 2 author's reflective journal 5.3). The sample aimed to include a broad range of patients with differing diagnosis, demographic profiles and reasons for the seclusion.

It was recognised patient recruitment may be difficult as the:

- Number of potential patients to include would be limited by the infrequency of seclusion episodes;
- Mental capacity may fluctuate and their participation would be subject to their stage of recovery as they may be unwell, chaotic or distressed for some time;
- There are barriers to patient recruitment and participation in mental health research (see section 5.4.2.2), and

- My ability to recruit systematically would be reduced as the PhD was part-time study.

Previous patient seclusion research identified clear parameters regarding the length of time since being secluded and interview (see table 4.13). The patient literature review (see section 4.3.2.2) included samples which ranged between seventy-two hours up to non-specific time frames in which patients were only required to having had an historic experience. Researchers based decisions on recall ability or the potential to be re-traumatised but evidence was conflicting. This study did not set a specific cut-off to allow patients who wished to participate time to regain capacity or recover from acute illness.

The inclusion criteria were patients who:

- Were an inpatient aged 18 or over who had been recently secluded in the patient study period;
- Had the capacity to consent to take part in an interview.

The patient study planned to interview between twelve and twenty patients (for discussion regarding qualitative sample sizes see section 3.3.2.3).

Entry 1: *I thought about how I could recruit patients to represent a range of illnesses and experiences. I listed things such as gender, age, diagnosis, ward they were secluded on, was this the first time they had been secluded. I also thought about how long they might have been secluded. The sample matrix was getting complex. It was discussed in supervision that the number of potential patients would be limited and applying strict criteria might restrict the pool further. I decided to attempt to recruit from all those who were secluded and review the number of interviews plus evaluate the quality and content of the data as the study progressed.* ***Entry 2:*** *I had interviewed twelve patients by the end of the initial data collection period. Work on the remainder of the PhD was going well. I was aware that some interviews were short, as although patients wanted to participate, some soon tired, were on high doses of medication, or lost focus. They struggled to recall what had happened in the lead up to and at the point of release. The supervisors suggested applying for an extension as although I had reached the lower sample threshold, I had time to collect more data to increase the credibility of the work*

Author’s reflective journal 5.3

5.4 Data collection

Data were collected in semi-structured face-to-face interviews.

5.4.1 Interview questions

5.4.1.1 Interview guides

Two interview guides with questions and prompts were developed from the background reading and findings of the literature reviews (see section 3.3.2.2), and are presented below (see figures 5.2 and 5.3). The main questions are in bold, with researcher prompts in italics.

Question: Can you tell me about your experience of working in mental health services?

Prompts: Profession, length of service, work history

Question: You were recently part of an MDT seclusion review team. Will you talk me through what happened?

Prompts: How you became involved, your role in the review, your knowledge of patient / incident prior to review, what did team say to the patient, how did patient respond, what did staff members do, what did the patient do, patient awareness, understanding, engagement

Question: What things did the team consider import when making their decision?

Prompts: Patient presentation, risk assessment, safety, other factors

Question: Can you describe what happened during the release?

Prompts: What expectations were set, what did staff members do, what did patient do

Question: What involvement did the patient have?

Prompts: Patient awareness, understanding, engagement

Question: What involvement did the patient's family or advocacy have?

Prompts: Awareness of seclusion, involvement in decision

Question: Do you have anything else you want to say about seclusion?

Prompts: Was this episode typical/atypical, thoughts about seclusion in general

Figure 5.2 Professional interview questions

Question: I understand you have been secluded recently. I would like to ask you a bit more about your experience especially in relation to what happened during the process of your release. I want to start off by asking what was your experience of being secluded?

Prompts: Was this the first time? Can you tell me about the last time? What happened? Who took the decision? What did you understand about why they secluded you?

Question: Can you tell me what the staff members were doing?

Prompts: What did staff say to you? Did they ask you anything? Did they tell you to do anything? What did you say to staff? Do you think they listened to you? Did they ask you to take medication?

Question: How well did you know the staff involved?

Prompts: Does knowing or not knowing staff make a difference? Did you behave differently towards different members of staff? Why?

Question: What did you have to do to be released from seclusion?

Prompts: Did you understand what staff wanted to happen? What did they tell you about their plans? How were you involved in deciding when you could come out?

Question: What was happening when you were being released from seclusion?

Prompts: What did you know about the plan? How did staff tell you what would happen? Did you go straight back on the ward?

Question: What happened after you were released?

Prompts: did you get a debrief? What about the other patients on the ward? What support do you get from staff?

Question: Did your family or partner know you had been secluded?

Prompts: Who told them? Did you want them to know?

Question: Have you anything else you would like to say about the process of being released from seclusion?

Figure 5.3 Patient interview questions

5.4.1.2 Pilot interviews

The first two interviews of each study were treated as pilots (Kvale, 2007). Piloting strengthened the quality of later interviews, as questions were tested and feedback was gained from supervisors on interviewing technique (see entry 1 and 2 author's reflective journal 5.4). Further minor amendments were made to the questions to make them less structured to improve their flow and permit topics of interest to be explored.

Entry 1: *During supervision we discussed the first two interviews transcripts and the interview questions [professionals]. The supervisors suggested I should try to probe answers a bit deeper to get to the root of experience rather than concentrating on factual events. We agreed the schedule was too structured and would be better if less structured**. Entry 2:** The interview guide had been changed and it felt as if it worked better, the flow seemed more conversational and natural. I used it this morning and was able to get a deeper insight, better quality data and allowed the interviewee to explore her thoughts around something I had not predicted. **** (Assistant Psychologist) spoke about how uncomfortable she felt being included in a review team. She said she had not had training about seclusion and that she was there to 'tick a box' rather than there to give a valued opinion. I thought this was interesting and intended to explore this in other interviews with AHPs*

Author's reflective journal 5.4

5.4.2 Recruitment and interviewing

5.4.2.1 Recruitment of professionals

Potential participants were identified via an electronic dashboard which recorded seclusion episodes in real-time in the host organisation. When a seclusion was marked as complete the researcher contacted the ward to identify which professionals had been involved. If they were eligible and fitted the sample requirements, they were invited to participate in an interview (see appendix six).

Recruitment of healthcare professionals willing to participate in research is notoriously difficult (Broyles et al., 2011). Braun and Clarke (2013) stated studies focussed on topics of interest and relevance manage this better. Despite this study being publicised on wards via communications with charge nurses, posters and newsletters, no professional volunteered themselves or responded to an invitation to participate by email. Therefore, the researcher physically attended wards and spoke directly to potential participants. Professionals reported they had not heard about the research or had not thought about participating, although many were keen to talk about their experience. This approach appeared more successful and recruitment was completed within the planned time period (see entry 1 and 2 author's reflective journal 5.5). Figures relating to seclusion episodes and patient recruitment are provided in section 6.2.1.

> ***Entry 1:*** **** didn't reply to my email or ring me back but when I went to the ward she said she was happy to be interviewed. She started to tell me what had happened over the weekend. I stopped her and said wait until I do the interview.* ***Entry 2:*** *I was mindful to be careful to make sure I did not coerce anyone. Over the course of the recruitment period I can think of three people who initially agreed to speak to me but then didn't take part. One moved to *** (different team) but I think the other two didn't really want to be interviewed as although they agreed, they never committed to arrange a time and place, so I didn't push it with them.*
>
> Author's reflective journal 5.5

5.4.2.2 Recruitment of patients

Similar to the professional study the researcher identified potential patient participants via an electronic dashboard (see appendix six). Recruitment can be problematic for a number of reasons and barriers to recruiting mental health patients are well documented (Ulrich et al., 2012; Gray, 2017). As stated previously, capacity was assessed by the direct team and the researcher (see section 5.2.2.2). The researcher assessed capacity both prior to and during each interview. When capacity was doubted, interviews were terminated and the data destroyed. Professionals act as gate keepers using clinical diagnosis as a reason why patients might not want to participate (Carmichael et al., 2016), or feel they need to protect patients from being approached (Howard et al., 2009). Pressures of time and resource were also reasons given by professionals as preventing them from being able to recruit patients to studies (Jackson et al., 2019b). Furthermore, Carmichael et al. (2016) suggested many lack the confidence to approach patients about involvement in research feeling that it is somehow separate from their role and outside the realms of clinical practice. (see author's reflective journal 5.6).

> *The dashboard showed four patients had been secluded in the last few days at *** and ***. When I visited the first ward the nurse said she would speak to all three patients (three were from her ward and one next door) and ask if any would be willing to speak to me. This surprised me as it is*

> *proving difficult to get staff to ask for me. They often say I don’t think they [the patient] is ready or I don’t think they will talk to you. I was even more surprised when they came back to say that all four of them would as patients to date have declined. Staff told me if I sat in the interview room at the front of the building they would bring them to me one at a time. I consented and interviewed the first two. The first patient was quite psychotic and at times expressed fleeting delusional thoughts about her life, but I did check out during the interview on a couple of occasions if she knew why I had asked to talk to her and she understood and could tell me what my role and reason was for being there so I continued. The second patient cut the interview short as she said she was tired and struggling to think straight as she was on a lot of medication. She said I could keep her data and we agreed if she wanted to talk to me again I could go back. The third patient was a young man in his early twenties. He went through the consent process but when I started to ask about seclusion it became apparent that he did not want to talk about his experience but had agreed to meet me because he seemed to think I might be able to do something to help him get out of hospital. When I reminded him that taking part was nothing to do with his care he got up and left. It made me wonder if recruiting participants too soon was advisable. The fourth went better.*
>
> Author’s reflective journal 5.6

Initially, the data collection for this study was for July 2018 to June 2019. Twelve interviews were completed. As stated earlier in the thesis (see section 5.2.2.2), this was extended and a further three interviews conducted (see section 5.3.2.2 and entry 1 and 2 author’s reflective journal 5.3). An overview of the fifteen patients interviewed is provided in table 6.2.

5.4.3 Interviewing participants

The principal researcher undertook all the interviews. Thought was given to where and when each interview would take place. All were completed in private rooms. Care was taken to create a calm atmosphere and put participants at ease. My safety whilst in the setting was considered, as I carried a personal alarm and ward staff knew my whereabouts at all times.

All recorded interviews were transcribed by the researcher (see entry 1 author's reflective journal 5.7), anonymised and stored as outlined in the ethics approval procedures in the data management plan stored on the University of Leeds password protected server. The task of transcribing was time consuming as each interview took around five to six hours to fully complete. Transcribing interviews has benefits for novice researchers and it fitted well with the framework analysis method as the process supported:

- Ongoing reflection of interviewer performance;
- Identification of topics of interest to explore;
- Familiarisation with the data;
- Formulation of initial concepts and themes in the data.

Spencer et al. (2014b).

Entry 1: *Transcribing took a long time but was useful as it helped to improve my interviewing technique and supported ideas and themes to explore in future interviews. However in hindsight I am not sure I would have opted to transcribe all the interviews as time might have been better spent on other tasks.* ***Entry 2:*** *This was the first time I had transcribed an interview recording and I began by including every emm, mmm, pauses, stress on words and other utterances. This was quite distracting when I began to analyse the data but to promote consistency I carried on. This was discussed and reflected upon in supervision. During later analysis I began to edit these out to make the sentences more legible as they did not appear to be adding anything of value to either the summaries or the quotes*

Author's reflective journal 5.7

5.5 Data Analysis

Interview data for both studies were analysed using framework method of analysis to guide the management, summary, mapping of the data, plus thematic analysis to interpret and identify themes. A clear and transparent auditable trail is provided in the thesis. Extracts from the author's coding notes are included below.

5.5.1 Framework analysis

Chapter three outlined the five stages of framework analysis (see section 3.3.3.1).

5.5.1.1 (Stage 1) Familiarisation with the data

In-depth analysis for either study did not commence until all the interviews were completed. However, immersion in the data began during the collection periods, interviews were transcribed verbatim and checked as soon as practicable after taking place. Transcription is the first step in data analysis. Accuracy at this stage can affect the dependability of the findings. Transcripts included all utterances, stresses and pauses:

> Researcher: *How did you feel when you were put in seclusion?*
>
> Patient C: *A bit pissed off really (laughs)… why have they done it, it's not **fair**, emm… it's not nice* (Transcript Patient C page 1).

According to Oliver et al. (2005), naturalistic transcription is generally used in conversational analysis and can cause analysts to lose focus. This level of detail was not analysed for the purposes of this thesis, therefore during the processes of analysis and summary data was cleansed (see entry 2 author's reflective journal 5.7).

The content of each interview was summarised to initiate comparison, contrasting and the development of later analytical categories (Kuckartz and McWhertor, 2014). A short reflective piece was also written after each interview to support personal development (Rubin and Rubin, 2005) (see appendix seven). Familiarisation with the data provided contextual understanding (Furber, 2010), plus gave preliminary thoughts and impressions about content of the transcripts (Gale et al., 2013). The process of knowing and being immersed in the data during the data collection period informed exploration of issues of interest in the later interviews.

Research texts differ in the way they describe qualitative data coding. For the purposes of the thesis, the following were used:

- Codes represented:

  > *…most often a word or a short phrase that symbolically assigns a summative salient, essence-capturing, and/or evocative attribute for a portion or passage of language based or visual data* (Saldana, 2013, p3);

- Categories were labels, '…*for the initial organisation of the data'* (Spencer et al., 2014, p278). Coding frameworks often contain about seven process categories, which in turn can have several more detailed subcategories (Saldaña, 2013);
- Data summaries represented groups of data about the same thing. According to Spencer et al. (2014a) summaries retain the original essence of the data, contain minimal interpretation and do not discount data deemed to be irrelevant.
- Concepts and interpretations reflected broader ideas as opposed to codes and categories which represented one idea; and lastly,
- Themes were patterns of data with shared meaning underpinned by one central concept, or idea. Themes in the thesis were an interpretative account of the summary of experiences of involvement release from seclusion.

5.5.1.2 (Stage 2) Construction of initial thematic frameworks

Two tentative coding frameworks were developed one for professional data and the other for patient data. Categories in the frameworks were informed by the literature review, reading and re-reading interview transcripts and discussion with the supervisors. They were entered into NVivo 11, a Computer Assisted Qualitative Data Analysis Software package (CAQDAS). In comparison to pen and paper coding and sorting, NVivo was quicker and allowed coded data to maintain links with the original transcripts.

Two interviews from each study were selected at random and coded against the initial frameworks in NVivo to ensure they were fit for purpose. Codes were developed by considering each line, phrase and paragraph in the original data. A supervisor coded the same data independently and minor adjustments were agreed upon. Revisions were made to the framework during the processes of indexing and sorting (see Stage 3 below). A fluid approach to the construction of frameworks enhanced conceptual clarity and reduced the chance that data overlapped or were left out as the themes were developed and re-ordered:

> *Devising and refining a thematic framework is not an automatic or mechanical process, but involves both logical and intuitive thinking. It involves making judgements about meaning, about the relevance and importance of issues, and about implicit connection between ideas* (Srivastava and Thomson, 2009, p.76).

The two category frameworks devised for coding the data are presented in appendix eight.

5.5.1.3 (Stage 3) Indexing and sorting of the data

The next stage involved coding all the interview data, termed by Spencer et al. (2014b) as indexing and sorting. These are cyclical processes and entailed the recording, reorganisation and grouping of similar data which share characteristics to predict patterns and commonalities (Saldaña, 2013).

Indexing involved taking each transcript in turn. Every phrase, sentence and paragraph was read and assigned as a code to an appropriate category (see appendix eight). Primarily codes were descriptive. Saldaña (2013) proposed two coding methods, *splitting* by which coders break data down into small bits, versus *lumping* in which coders capture the essence of larger passages. Initial attempts at coding were discussed in supervision sessions and suggestions made to code larger segments of data to support contextual understanding whilst retain authenticity. Thus codes were of mixed length and, if appropriate, assigned to one or several differing categories (see table 5.3). Spencer et al. (2014b) stated assigning codes to multiple categories helps illustrate interconnections or linkages in the data. This was useful for the deeper analytical processes used later in the framework method.

Table 5.3 Coding example in NVivo

NVivo Categories	Coded text from professional interview 12
Codes\\3 Control\3.3 Planning	So obviously somebodies going to go into to seclusion and you know immediately we are going to make sure that their comfort needs, everything else are met and we are going to be looking at how we are going to get them out. Emm so sitting down… and what that usually would entail particularly for me is that I would be sitting down emm and putting the bones of a management plan together before the official hour review before the medic. I would say it's largely that management plan is led by nursing staff. It's very rarely that the medics would come up with the plan. It's more likely that they would just sign they'll agree to it. If there is anything they want to add then they'll add it and… but it is mostly the nurses you know that would complete paperwork that's required.
Codes\\4 Interaction\4.4 Relationship\Support	… you know immediately we are going to make sure that their comfort needs are met.
Codes\\4 Interaction\4.1 Communication\Staff \MDT	…largely that management plan is led by nursing staff. It's very rarely that the medics would come up with the plan. It's more likely that they would just sign they'll agree to it. If there is anything they want to add then they'll add it and… but it is mostly the nurses you know that would complete paperwork that's required.

Debate has centred upon how much text to code. Kuckartz and McWhertor (2014) argued irrelevant data need not be considered, whereas Saldana advised novice researchers to code all their data. Blair (2016) was more pragmatic suggesting either method was acceptable, but stressed rigour and reflexivity to be more important. Indexing was a lengthy process. On occasion, during the interviews, participants went off topic, therefore only relevant data was coded. Other irrelevancies were removed at the next stage of analysis (see author's reflective journal 5.8).

> ***Entry 3:*** *Initially I transcribed full interviews but nearer the end of the interviewing I was able to distinguish what was irrelevant such as, times when patients deviated from the topic and wanted to talk about other aspects of their care. *** [patient] seemed more interested in telling me about what had happened earlier that day when his girlfriend had visited. It sounded important to him so I let him talk and when appropriate I brought the focus back to what had happened when he was talking to the HCA outside the seclusion room. I didn't transcribe this part but skipped forward*
>
> Author's reflective journal 5.7

Sorting data, '…*enables the analyst to engage with data that are judged to be about the same thing'* (Spencer et al., 2014, p303). Codes and categories were reviewed and split, combined, re-labelled or disregarded. Framework analysis allowed indexed data to be linked back to the original data source. This retained coherence and meaning, plus supported the identification of topics and insights across the full data set and coding frames. NVivo, did this automatically permitting data extracts to be viewed by transcript, codes or categories.

5.5.1.4 (Stage 4) Data summary and display

Once indexed, categories, codes and data were exported into Microsoft Excel. Each category was stored on a separate excel page with a column for each sub-category and a row for each participant. Data in each cell was summarised in a manner meaningful to the research question. Summaries:

> *…should include enough detail and context so that the analyst is not required to go back to the transcribed data to understand the point being made, but not to include so much to leave the analyst 'bogged down' in the raw data* (Spencer et al., 2014, p309).

Novice researchers tend to produce too detailed summaries (Li and Seale, 2007). Ward et al. (2013) stated this could be mitigated when links were made back to the back to the original data. Final summaries for patient and professional data differed:

- Patient data was organised using a category-based approach whereby a summary of each category was produced for each individual. These were further summarised to provide an overall summary for each category (see appendix nine).
- Professional data used a case-based approach. Data were summarised for each professional for each category, then further summarised to produce a summary for each professional staff group (nurses, medics, AHPs, HCAs) for each category. This enabled data to be compared and contrasted not only between individual participants, but also between professions (see appendix nine).

The summaries were refined, re-summarised and collated to develop concepts and interpreted into themes. NVivo enabled changes to be tracked back and forth through the summaries to the raw data, to check and re-check concepts and identify verbatim quotes (Whittemore, 2005; Spencer et al., 2014b). Remaining true to participant's data is fundamental to the approach and central in development of abstract concepts and themes whilst minimising likelihood of misinterpretation (Ward et al., 2013).

5.5.1.5 (Stage 5) Synthesising by mapping and interpretation

During this final stage data was read and re-read iteratively. The frameworks helped make sense of the entire data set as descriptive summaries and concepts were developed into explanatory themes (Furber, 2010). Supervision sessions provided a forum to discuss abstraction and interpretation as data moved from the descriptive, to one containing deeper analytical insight (see author's reflective journal 5.8). The team approach to coding and analysing data enhanced rigour in the findings, although Morse (1997) cautioned when coding in groups ideas may get over-ruled or lost. Explanatory themes stood alone as distinctive ideas, but also fitted together to provide an overall analysis (Braun and Clarke, 2013). The themes are the researchers own interpretation of the data and aimed to provide an understanding into what was going on when release was being decided, whilst make links to existing concepts and evidence (Braun and Clarke, 2013).

We had discussed the [professionals'] themes. I thought I had come up with final themes – they told a story about what professionals said happened in a release. I had mapped it as a process: planning (or setting exit criteria?), pinpointing the readiness to be released, opening the door, testing out, support after release. We discussed how this was not deep analytical interpretation but description. I needed to find deeper meaning, conceptual or theoretical insights in the data. Although analysis should tell a story, themes did not need to be linear, so I returned to the transcripts, codes, categories and concepts identified earlier .

Author's reflective journal 5.8

5.6 Conclusion

Chapter five, provided clear and auditable details of the methods used to conduct the interview studies and data analysis. The chapter described the strategies of PPI, ethics and recruitment which were used when designing the interview studies. The pragmatic nature of the thesis allowed the methods selected to be adaptable to the practicalities and clinical pressures of healthcare research, whilst ensured the thesis retained rigour. Evidenced based qualitative approaches to the development of the question, sampling, interviewing and data analysis were incorporated into the design. Plus, reflective journal entries and author's coding notes illustrated the decisions and steps taken to enhance trustworthiness in the findings. Findings of the studies are now outlined in chapter six, then discussed and synthesised in chapter seven.

Chapter six: Findings

6.1 Introduction

Chapter six presents the findings of the two interview studies. Part one is the professional study, and part two is the patient study. As outlined in the previous chapter, the interview questions were developed from background reading and the literature reviews, plus refined through pilot interviews and researcher reflexivity on the interview techniques. An overview of the participants details are provided, however care was given to ensure the confidentiality and anonymity of participants was maintained (see sections 3.2.5.4 and 5.2.2). Interview lengths are given as well as the role and NHS banding of the professionals, plus the time between seclusion and interview is provided for patients. The data were categorised, summarised and interpreted using framework analysis (see sections 3.3.3 and 5.5).

Part one: Professional study

6.2 What factors influence mental health professionals to release patients from seclusion?

6.2.1 Interview details

Between May 2017 and January 2018, twenty-four professionals were invited to participate in an interview. Twenty-one accepted and three declined (see table 6.1). Interviews for the professional study ranged between 19 minutes 52 seconds to 53 minutes 52 seconds with a mean duration of 37 minutes 44 seconds. Nineteen professionals chose to be interviewed at their work base, two opted to attend on different sites. All interviews were digitally recorded. Professionals were given an option of a telephone interview to fit in with their busy clinical schedules, however all chose to meet face to face.

Demographic data collected from professional participants was kept to a minimum: profession, grade, career length, gender, and current place of work. It was decided not to collect ethnicity and age to protect their anonymity, as doing so may have made them more identifiable to colleagues and it was not clear it would enhance or impact upon the findings. The gender of participants was collected but not displayed in this thesis to ensure professionals they were not easily identifiable. Sixteen participants were females and five were males. The overrepresentation of females in the sample was a reflection of the gender imbalance in the population of health care professionals working in the research setting.

Table 6.1 Professional study: interview details

No	Role/Grade	Time in mental health care	Length of interview
1	Nurse Band 6	20 years	33 mins
2	AHP Assistant Psychologist Band 4	4 years	25 mins
3	AHP Occupational Therapist Band 6	9 years	32 mins
4	Nurse Band 5	7 months	33 mins
5	Nurse Band 6	16 years	20 mins
6	Nurse Band 7	17 years	36 mins
7	Nurse Band 5	3 years	34 mins
8	Nurse Band 6	5 years	38 mins
9	Nurse Band 7	12 years	38 mins
10	Nurse Band 7	34 years	39 mins
11	AHP Occupational Therapist Band 6	5 years	38 mins
12	Nurse Band 7	11 years	54 mins
13	Nurse Modern Matron Band 8	15 years	32 mins
14	AHP Psychologist Band 8	16 years	43 mins
15	AHP Social Worker Band 7	7 years - 1 year MH	44 mins
16	Healthcare Assistant Band 3	21 years	54 mins
17	Healthcare Assistant Band 3	7 years	39 mins
18	Medic (GP Trainee Year 1)	8 years <6 months MH	43 mins
19	Medic (GP Trainee Year 2)	9 years - 8 months MH	41 mins
20	Medic (Consultant Psychiatrist)	25 years +	43 mins
21	Medic (Core Trainee Year 2)	9yrs - 2yrs MH	28 mins

The following section explores the factors influencing professional decisions to release patients from seclusion. The profession and interview number for data discussed in the findings can be cross-referenced with details above (see table 6.1). The professionals described release as a gradual and tested process. Six themes were identified in the data: do as you're told, do I believe you?, in the end it's your choice, can we cope?, do I don't I? and covering your back. The findings of the professional study were published in a peer review journal (Jackson et al., 2019a), a copy of which is supplied separately.

6.2.2 Professional themes

6.2.2.1 Do as you're told

Professionals indicated that patients needed to calm down, and do as they were told. One AHP (14) said the patient was, *'…placed in a room and told to stop there until they behave, we have decided that you can, if you do, then we will, if not you will not be released'*. Professionals questioned their approach, but where unsure of how else to manage the situation:

> Nurse (4): *It's horrible isn't it, because you have got to say these things, but it's also a case of if you don't, you are not going to get anywhere. You don't really have much choice*.

Such actions were rationalised as necessary:

> Medic (20): *It is important they do as they are asked but how else could we do it? Come out when you're ready? Here are the keys. It's part of the engagement. I am looking that a patient understands that we cannot allow them to be violent, we have a ward full of vulnerable patients, and colleagues are not here to be assaulted. If you are reasonable with us you can come out.*

Despite taking an authoritarian stance professionals stated they listened to and respected the views of patients. However, ultimately patients were required to follow direction, being seen as, '…*not in a position to be dictating terms'* (HCA 17). One professional reflected:

> AHP (11)*: To some extent I think we set the rules and they [the patient] have to do what we ask because we are controlling their access. So no I don't think we negotiate as such. We ask and see what they think but we do talk to them as much as possible, offer reassurance and tell them what we are planning.*

Patients need not necessarily agree with reasons for being secluded but they were expected to acknowledge why they had been, plus demonstrate co-operation and compliance. If not, professionals thought they were not ready to be released and so would be reluctant to the open door.

Knowledge of, or *knowing* the patient was seen to be helpful. '*It informs decision-making, how they might be, how they have been before*' (Nurse 6). It helped professionals balance their expectations of how the patient should behave against what the patient might realistically be able to manage. Professionals thought knowing the patient might hasten release, although for patients with previous histories of violence it might have the opposite effect. Plus, if the patient was unknown to the service, professionals would be more likely to, '…*err on side of caution'* (Nurse 7).

6.2.2.2 Do I believe you?

Professionals looked for a guarantee from the patient they would control their behaviour, remain stable and not be aggressive if they were released. They wanted to trust the patient but did not want to be taken for fools. *'We took care not to be played'* (HCA 17). For, as stated by one nurse, patients were not always honest, '…*they may throw you a curve ball'* (Nurse 1). Or another that:

> Nurse (12)*: We have all seen patients who say the right things to get out, can hold it together for so long then it all spills out*. *I've come across patients who to all intents and purposes tick the box for perhaps coming out of seclusion but there is that gut feeling that they are holding something back, trying to get one over on you. It's whole raft of things that I personally prefer to see met before I am satisfied that person will come out*.

Trust was linked to diagnosis, although professionals stated it should not make a difference, it did:

> Nurse (12)*: People with a personality disorder, who are sat there all sweetness and light and they're very, very sorry and they'll never happen again, and you know full well it's different. You can't always take everything at face value*.

Decisions were seen as more difficult if the patient was under the influence of illicit substances as they were seen as unpredictable. Potential for future violence was considered, although professionals felt greater emphasis should be given to the patient's current presentation and emotional state. Calmness, tolerance, control over emotions and temper were viewed as indicators of their readiness for release. These were rated higher than expressions of remorse which could sometimes be seen as insincere or temporary:

> Nurse (12): *After having smashed ten windows, thrown furniture, smashed the place up, assaulted staff, within an hour, I'm very sorry I'll never do it again with a smile on her face. That's a situation where you think potentially we are going to be back in the same situation half an*

> *hour after we let you out and on occasions that is exactly what happened*.

In some instances, professionals' willingness to trust was broken as the patient might exploit the power imbalances which exist within MDTs:

> Nurse (8)*: He was all, you deserved what you got. I'll get you again when I come out. 5 minutes later when doctor walked in, he was pleasant and appropriate*.

6.2.2.3 In the end it's your choice

Patients were not viewed as passive recipients. Professionals thought in the end release was, '…*in their* [*the patient's*] *hands*, *… they have a certain amount of power to manage their own behaviour'* (AHP 14), the choice to take control, choose whether or not to engage, accept the consequences of their actions and offer a guarantee they will not be aggressive. As stated by one HCA (17), *'…they know the game, they know how it goes'*.

A willingness to engage and communicate indicated the patient was, '…*moving in the right direction*', (Nurse 10). '*If they can't talk to you about it then I don't think they should be coming out and that's that*' (HCA 16) and, '*In the longer-term patients are positive towards staff, it is in their interest to be'* (Nurse 7). Furthermore, '*No matter how distressed they are, they can process at least enough of it to know what's expected of them*' (Nurse 8). The quality and level of engagement set the timescale for re-entry to the ward, thus patients with poor communication skills might end up being secluded longer.

Professionals thought not releasing a patient sometimes felt punitive, but argued patients needed to take responsibility for their actions. Patients should realise they may have raised anxieties of others on the ward who witnessed the preceding event, plus understand professionals have other things to manage:

> Nurse (12)*: It's all too easy to forget that you have got someone in there… It depends what kind of shift you are having. I was the only qualified on, been ten days off. I didn't know a single patient on the unit. I was trying to do meds, keep everybody safe, decide who should go out, if they should have this that or the other and I hadn't got the best of teams on around me… Out of sight out of mind.*

6.2.2.4 Do I, don't I?

Release was guided by subjective judgments: '*Generally you know, you get a feeling it is coming to an end*' (Nurse 1). Things started to level out, there were fewer negatives, more positives and the periods of stability got longer. Professionals described having, '…*the luxury of time'* (Nurse 10) and release as being gradual and tested. Initially, patients accessed a controlled area outside the lockable room under supervision, although technically they were still secluded. For professionals, opening the inner locked door was a test of approachability allowing them to gauge the patient's response to stimuli:

> Medic (18)*: …so maybe the door should stay open to see how he managed, and if he managed okay and was settled and he was talking and had his medication then he would be able to go back to ward*.

Professionals were conflicted describing a climate of political correctness in the organisation which discouraged seclusion and wanted release to be as quick as possible, against their professional responsibility to maintain safety:

> Nurse (12)*: Once the patient goes back on the ward, the team on have to deal with the consequences of your decision, if that is wrong you're not going to keep their trust in you. There goes your credibility*.

One reflected it was difficult to get the patient back in if they are released too early. '*This might involve a scuffle'* (HCA 16), cause further distress or risk of injury to those involved.

Reviews were sometimes undertaken jointly by two or more professionals who may hold differing perspectives. Nurses talked about being guided by gut feelings and intuition. Did the patient show understanding, were they communicating, had their behaviour peaked and anger resolved? Medics undertook a brief mental state and physical health assessment. Whereas, psychologists considered formulation (a conceptualised view of the patients past and present), occupational therapists set goals, and the social worker considered the wider social support of the patient. Rather than influencing decisions, AHPs thought they offered independence and safeguards but felt detached from the decisions being made by the nurses and medics. They questioned their role:

> AHP (3):… *sometimes you're only there to dot the i's and cross the t's. It's because you need to have an MDT review that you are there rather than because your opinion is valued*.

Similarly, a junior medic stated when on-call, *'Decisions are made by ward team. I am there to monitor physical health and support nurses who are keen to tell you what they want*' (Medic 19).

Getting two professionals or an MDT together out of hours might inadvertently prolong the duration of the seclusion episode. Furthermore, one senior nurse reflected changes to practice meant the process had become onerous and counterproductive:

> Nurse (13)*: I suppose there is always that danger, but on only a few occasions can I ever recall that we used a bedroom or another room, a lounge to seclude somebody who was disturbed. I say seclude, but it wasn't really seclusion or at least not for long periods as can happen when you put someone in a seclusion suite and start the whole rigmarole of the policy. Yes, the policy does provide safeguards, but I can recall years ago it was different, we once used a low stimulus room, put the man in and just held the door. Told him to sit down, to calm down and after around 20 minutes went in. We de-escalated through the door, got him to move back, put his weapon down, I just think that now it would be more formal, get a doctor, start the paperwork, it would probably have turned out different and lasted longer and affected our relationship with him. So I get it, that if that is the only way to prevent your staff being assaulted is to put something between yourselves and the aggressor, then that's what is going to happen.*

Confidence in agreeing to release a patient came with experience. Less experienced professionals where more cautious, found it difficult to challenge senior professionals and relied on colleagues:

> Nurse (9): *Inexperienced nurses who may lack confidence, trying to maintain safety of everybody, sometimes it is safer in their eyes to place person in seclusion and keep them there rather than risk injuries, but with more experience, skills and knowledge they learn to deal with people*.

One junior nurse (5) stated, '*I would never want to bring them out without having discussion, see a good couple of hours minimum settled presentation*'. Less experienced professionals had raised anxieties, especially on a night and a weekend. Seniors understood this as junior medics were told, '*…make sure you do not make the decision on your own*' (Medic 20).

Senior professionals had greater ability to move resources which could reduce seclusion durations. Moreover, one experienced nurse thought they would be more likely to take positive risks resulting in a quicker release, even breaking policy:

> Nurse (12): *I'll be very honest and say that if I want to bring somebody out then I'll do that and I'll let a medic know then that is what I have done*.

6.2.2.5 Can we cope?

Professionals wanted to be certain they would cope post release. The number and skills of professionals on shift was strongly connected to their perceptions of coping or managing safety:

> Nurse (1): *I would be horrified if I thought for any moment that I made the decision to keep a person secluded longer than needs be on the back of external factors* [*staffing*].

Whilst one nurse felt, '*Staffing was often stated as the biggest issue*' (Nurse 8), another added:

> HCA (17)*: We didn't have enough staff so he wasn't released at that time. We needed to wait until next shift arrived. The plan was to bring him out when more of us [staff] were around. Later that morning he came out*.

If there were not enough staff members on shift, professionals would attempt to bolster numbers, *'…what I don't want to do is to try and keep a patient in seclusion unnecessarily because we don't have staff'* (Medic 20). Facilitating release might take '…*six [professionals] at least but it depends on activity, difficult to do on a night shift but we plan ahead'* (Nurse 4). Ultimately:

> Nurse (8)*: You have to manage, go with what you've got. You could ring other units, everyone is in the same boat, the on-call manager might offer suggestions, but nothing you haven't thought of already, get on with it and release them when you think their ready*.

HCAs thought despite it being qualified professionals who sanctioned release, the responsibility to cope was more likely to fall upon them. '*They say what's what and it's us HCAs who have to manage it… we get the backlash*' (HCA 16).

In addition to enough professionals, the permanency and skills of the team were also relevant.

> HCA (16): *This is a difficult ward to work on, some days you have got two bank nurses, you have just got to get on but it's difficult for a nurse to trust judgement of somebody who has never worked here before… then you probably get somebody [Nurse] who has got five long term elderly geriatrics like me [HCAs], they know verbally we would handle it, they would be comfortable to let that individual out because they know we would be able to diffuse it*.

Furthermore, coping was influenced by environmental and clinical pressures. Professionals aimed to manage patients in the safest and least restrictive environment but acknowledged if safety could not be met on an open unit, a transfer to a PICU might be arranged.

The acuity or emotional tone of the ward was also factored in as professionals were reluctant to return the patient to chaos, balancing the likelihood the patient could remain settled. Other patients may have witnessed the preceding incident or there may have been an altercation which was important to resolve. Lastly, seclusion might represent a safe place for the patient, '…*if you suddenly take it all away and put them back out on ward then they can be overwhelmed and end up back in quite quickly'* (AHP 14).

6.2.2.6 Covering your back

Finally, professionals felt they needed to cover their backs. They felt exposed, that their practice was under scrutiny when they initiated or managed a seclusion episode. Nurses feared getting it wrong, being judged incompetent, and having to protect their self:

> Nurse (7): *If you make the decision [for the patient] to remain in there and someone says you shouldn't have you think to yourself, Oh God I am now in a whole barrel load of trouble*.

One junior nurse stated they felt criticised by management if procedures were not followed correctly, and they would be, '…*taken down a formal capability route'* (Nurse 4)*'*. Whilst another thought It difficult to keep up with policy changes and '*feared not being up to date*' (Nurse 5).

Professionals accepted seclusion had the potential to be misused, could be too lengthy and have a detrimental effect upon patients, but perceived their responsibility to maintain safety negated concerns. They also considered the moral and ethical basis of using seclusion. Although all those interviewed disliked using seclusion, all felt there to be no other option and were unable to come up with any acceptable alternative actions, '*It's not that it gets more comfortable, but I suppose if you can justify your decision…'* (Nurse 9).

As stated by one senior nurse:

> *(Nurse 10): In the end all you can do is tell your professionals to make sure the patient is all right, adhere to policy and get them out as soon as possible*.

Part two: Patient study

6.3 What are patient experiences of being involved in release from an episode of seclusion?

6.3.1 Details of interviews

A total of ninety-one seclusion episodes took place in the four wards of the research setting during the period July 2018 to September 2019. There were fifty-two potential participants of which:

- Eleven patients were not approached as their care team stated they did not consider them to have capacity or felt they were not appropriate to ask at that time. Three of these patients were approached a later date, one of whom agreed to interview;
- Sixteen patients declined to take part;
- Eight patients were not approached as they had been discharged prior to the researcher being able to attend the ward;
- Seventeen patients agreed to be interviewed. Of these, one did not appear to have capacity when the interview commenced. Another chose not to continue once the consent process had been completed. Their interviews were stopped and data was deleted.

The study recruited a convenient sample of patients which was not representative of all those secluded in the organisation in the study period. Fifteen patients participated (see table 6.2).

- Seclusion durations ranged from 1 hour 45 minutes to 9 days 13 hours and 10 minutes (mean time in seclusion 1 day 11 hours and 20 minutes, median of 4 hours and 38 minutes).
- The duration of interviews ranged from 12 minutes to 42 minutes.

- The age range of the patients was 24 years old to 62 years old, with a mean age of 32 years and a median of 29 years.
- The mean interview length was 27 minutes 30 seconds, with a median of 25 minutes.
- The time between release from seclusion and interview was about seven days, with one outlier of 97 days. As discussed in chapter five (see section 5.3.2.2), this study required patients to have been secluded in the study period but did not limit the time between seclusion and interview. The outlier, Patient G, had been secluded, transferred out of area and returned to the local service within the data collection period. The patient could recall details of her seclusion and wished to be heard. Therefore her data was included.

Patients were interviewed by the researcher on the ward they were resident in on the date of their interview. For eight patients this was the ward on which they had been secluded. For the other seven, it was on a different ward in the host organisation.

All patients were asked at the start of the interview if they consented to be digitally recorded. Six patients preferred the researcher to take notes (see Table 6.2). The responses of the patients who declined to be digitally recorded were handwritten in note form by the researcher. To support re-call and accuracy, these were re-written by the researcher as soon as possible, four immediately after the interview and a further two within 24 hours. One transcript was presented back to the patient who had asked if could approve the content before permitting it to be included in the research. The verbatim transcripts tended to be more detailed and longer than the hand written scripts. However, this appeared to be because the recorded interviews contained more data that was unrelated to the topic.

Table 6.2 Patient study: interview details

	Age	M/F	Time in seclusion	Length of interview	Time since secluded
A	24	F	4hrs	17 mins	7 days
B	26	F	2hrs 5mins	24 mins	1 day
C	32	F	27hrs 5mins	15 mins	17 days
D	29	F	46hrs 10mins	25 mins (Not recorded)	8 days
E	35	M	9 days 13hrs 10mins (229 hrs 10 mins)	27 mins (Not recorded)	12 days
F	62	F	6hrs 20 min	42 mins (Not recorded)	16 days
G	29	F	84hrs	25 mins (Not recorded)	97 days
H	41	F	30hrs 7mins	38 mins	8 days
J	41	M	20hrs 46min	19 mins (Not recorded)	1 day
K	26	M	8hrs 50mins	12 mins	9 days
L	32	F	8hrs 10mins	22 mins (Not recorded)	5 days
M	27	F	1hrs 45mins	31 mins	3 days
N	27	F	6hrs 10min	32 mins	4 days
P	26	M	30hrs 5 mins	41 mins	5 days
Q	30	M	31 hrs 25 mins	36 mins	3 days

According to Seale (1997), rigour and validity in qualitative research data is enhanced if data is recorded. Audio recording can also increase the reliability of findings as interviews can be listened to repeatedly and re-visited to verify during data analysis. Furthermore, the COREQ guidelines Tong et al. (2007) (see section 3.4) stated that qualitative interviews with audio recorded data provide a more accurate reflection of participants' views. Whereas Rutakumwa et al. (2019) argued, although the majority of literature takes for granted recorded interviews result in greater accuracy and more complete accounts, the quality of audio-recorded data and hand written transcripts which are produced directly after interviews can be comparable in detail. In addition, (Al-Yateem, 2012) stated whilst handwritten note taking requires interviewers to fully engage with participants, it can also encourage researcher reflexivity and maintain interactive participant-researcher relationships.

The reasons for patients not wanting to be recorded were not explored during the interview so as not to pressurise or dissuade them from participation. There was potential audio recording patients who were not comfortable may have impacted the openness, truthfulness and therefore credibility of their data. Rutakumwa et al. (2019) suggested the choice to record should be a contextual decision. For some patients, recording may have raised fears there might be personal consequences or impacts upon their treatment. Therefore, the health status, vulnerability and unequal power position of patients was considered.

The duration of each interview was dependent on the ability and willingness of each patient to engage in meaningful discussion about their understanding and involvement in being released from seclusion. The in-depth nature of the interview aimed to uncover details of the patient's experience that would not be evident in questionnaire or less probing research methods. Ongoing assessment was conducted with each patient to assess the appropriateness of ending or continuing their interview. As, not only did some patients quickly tire, in many cases they found difficult to separate their release from the full experience of being seclusion.

The following findings explore the patient's experience of involvement in release from seclusion. Patient interviews were labelled alphabetically and quotes can be cross-referenced with details above (see Table 6.2). Not all patients could recall every detail of what happened to them whilst being secluded, during their time in seclusion or upon release, '*I can't remember…*' (Patient D) or, '*It was all a blur*' *(*Patient B). Recollection appeared to be affected by shock, as they had not been expecting to be physically held and locked in a cell. Some described the experience as chaotic, traumatic and undeserved. Three patients acknowledged they had the potential to be violent or aggressive, but all denied they were danger to others stating they would never hurt anybody. Only one patient requested to be secluded, she said it gave her a '…*calmness and peace and tranquillity'* (Patient H), a place to be on her own. Patients described having little involvement in deciding their release but reflected on ways they may have influenced the decision and offered suggestions for improving the experience.

Five themes were identified in the data: the initial crisis, what do I need to do to get out?, what was I waiting for?, being released, and lastly, doing things differently.

6.3.2 Themes

6.3.2.1 The initial crisis

This first theme outlined the initial crisis and represented a period between being secluded and the patients feeling they were ready for release. Patients talked about this time as being one in which they recognised a change in both their selves and in their relationship with the professionals.

Immediately after being secluded, patients did not always understand why it had occurred or know what would happen to them next:

> Patient (E): *At the time I didn't really understand why I was put into the cell, I thought it was part of mental health, the system here determining whether or not you could go on the ward.*

Patients wondered how long they might be kept secluded. Not knowing this left them feeling angry, frightened or unsafe. '*I was angry because I did not know how long I would have to stay in that room'* (Patient J). Patients who had been secluded previously had more awareness of what might happen. Whereas, those experiencing their first episode of psychiatric care or seclusion did not:

> Patient (N): *It was horrible, I couldn't get my breath. At first I was that angry I couldn't even scream. I thought they were going to keep me in forever or for ages anyhow. I was frightened about how long it would last.*

Initially, some patients wanted to be left alone until they felt like talking or became more composed. '*I needed some space, to regroup in my head*' (Patient M). However, others thought it was professionals who distanced themselves and held back from engaging. One described them as, '…*standoffish, they were just watching me, observing me'* (Patient D). Another recalled how, at first professionals did not answer her when she spoke to them, so she ended up talking to herself to make herself feel better.

Four people reported during the early part of their seclusion they were hearing voices or still under the influence of illicit substances. One of these thought the effects of illegal drugs caused him to mistrust professionals. He believed he would be poisoned and not get out alive:

> Patient (P): *To start with I felt they were trying to use medication to poison me… I am not sure exactly but I think they may have tried sedating me by putting something in the food I was eating.*

Whilst another remembered struggling with his thoughts until the effects of the substances had worked out of his system:

> Patient (Q): *When I went in I was off my face. They said I'd been trying to pull things off the wall and I had tried to head butt one of the coppers. I was grabbing the keys. I was thinking if I had the keys I could open*

> *everything everywhere and get whatever I wanted in the world. I was totally out of it... You can't get out and it's scary as you can't get away from stuff going on in your head.*

Then, things began to change. Some patients recognised this as a personal change. One patient reached a realisation he had not been well when he first went in but that later he was more aware of his situation. This was corroborated by another who reflected:

> Patient (P): I *needed to be of a certain state of mind in order for them to be able to let me out but at the start of that I was unaware of being able to see that. Towards the end I was able to stand at the door and actually engage with them in a conversation, so there was actually a two-way conversation towards the end. Whereas at the start of it, it was more of me trying to avoid what they were saying and me trying to fight against them.*

Other patients thought it was professionals who altered their attitudes and actions towards them. Professionals started to loosen restrictions, they would fetch food and drink and permit them to use the bathroom. Two described how at first professionals opened a flap in the seclusion room door and passed food through, but that later they opened the door, brought it in and put it down on the floor. Another said:

> Patient (E): *I had been going [to the toilet] in the corner and it stank terrible, then I later went to the shower room toilet. There were loads of them there and somebody must have tidied round the room whilst I was out of it, cleaned up that kind of thing and I had a shower, put some clean stuff on. I had something thing to eat and [HCA] brought me hot chocolate.*

Once this change had occurred, many patients thought release should soon follow. Yet, this was not always the case.

6.3.2.2 What do I need to do to get out?

Patients were not sure what professionals wanted to see in order to be released. Some doubted professionals had a clear plan or, '*If they had any [plans] I can't remember them telling me any*' *(*Patient D). Not having or knowing the plan for release was seen as failure of care by patients. They thought it prolonged the time they were kept locked in seclusion:

> Patient (P): *They [the professionals] should have a plan and stick to it, not just make it up as they go along, it could have been shorter if they were prepared differently.*

For those patients who were aware of a plan, they complained plans were vague, '…*the doctor told me the plan was to do as the nurse said*' (Patient J). Despite not clearly understanding what they had to do to be released, some patients were able to identify implicit expectations in regards to how they should be:

> Patient (K): *I don't think they really said how I needed to be out aloud, it was just more something that they wanted, something that goes without saying, settle down and then you can come out*.

Patients suggested they were left to guess how professionals expected them to act in order to be released. These expectations included:

- Being calm;
- Saying sorry;
- Showing a willingness to communicate; and,
- Co-operating.

Being calm was something cited by all patients. One was clear in that she was told she would be released if she remained calm. Examples of what was understood by being calm included not arguing, shouting, head-butting, tying ligatures, threatening or being loud. *'It's when you've calmed down, it's if you stop being loud, not shouting or carrying on arguing, that's it really, just being calmer' (*Patient C). Likewise:

> Patient (M): *They said I had to sit on the chair for so long and talk to them to see if I was calm. I suppose it was up to [nurse] who wanted to make sure I was calm and not going to smash anything else or try and get out.*

Patients associated not being calm enough with having to remain in seclusion longer. However, the duration patients were expected to remain calm was not consistently applied. One patient told me, '*He [the doctor] said an hour of settled behaviour*' (Patient B). Whereas another that, '*Someone said I would probably come out in the morning when the day nurses got there and I did*' (Patient J). For a further patient this duration was undefined, having been told she would remain in seclusion until arrangements could be made for her to be moved to another hospital.

Patients thought it was easier to become calmer if the professionals were supportive or if they knew the professionals who were with them. Once they were calm, patients experienced professionals as more positive towards them, but thought it did not necessarily mean they would be released:

> Patient (L): *Even if you say I've calmed down, look am I shouting? It makes no difference, none at all. I was stood at the door saying why won't you open up, I've told you I'm sorry. I won't do it again, what's wrong with you all. I showed them I could act calm, took their tablets. Once your locked in there it's outta your hands. They're in charge, like in a prison.*

In addition to being calm, patients suggested professionals expected them to demonstrate remorse. Patient N believed professionals were angry with her because she would not say sorry, whilst Patient L questioned why she should be sorry claiming she was unwell. Six of those interviewed admitted they had been derogatory, rude and insulting towards professionals, four of whom later apologised:

> Patient (M): *I couldn't believe what I had done. I'm quite embarrassed really and I said I was really sorry to [nurse] and the other nurses. The whole thing made me think about how I behaved and realised I missed my kids, that I needed to make things work and to change. I didn't feel as they were angry with me, which probably made it worse. It made me feel more guilty.*

In order to appear calm and remorseful, patients disclosed they often hid their true feelings saying what they thought professionals wanted to hear, '*I wanted out and so I was smiling and saying it's okay now, but I wasn't really'* (Patient L). It was as if pretending things had changed might speed up release as*, 'The more you protest the longer you will be in so I just had to keep calm and carry on pretending to them' (Patient F).*

Patients agreed that in order to be released they also needed to show they were willing to communicate. They recalled being told they should speak to professionals appropriately, not be loud or threatening. Some patients consciously avoided interacting until they felt ready, '*I pretended to be asleep so I didn't have to talk to them'* (Patient F), or '*I didn't speak to staff. I didn't choose to be involved with them'* (Patient D). This was confirmed by another who said:

> Patient (B*): I can't be bothered usually to talk to them but when I want to come out I have to make an effort. It depends who it is and how I am feeling, if I want to talk I will'.*

Not knowing the professionals supporting the seclusion was experienced as a barrier to communication. Patients found it harder to talk and more difficult to trust professionals they did not know. They were critical of certain professionals whom they said had poor communication skills. Plus, they thought their involvement in release was impeded if the communication offered by professionals was inadequate. One patient said, '*Staff don't speak to me enough'* (Patient C), whilst another that:

> Patient (F*): She didn't say anything to me, she should have brought the chair closer and introduced herself. It wasn't until I put the mattress up against the door she actually did something.*

Patients complained professionals laughed at them, did not explain their legal rights, nor listened to what they had to say in regards to their release. '*Once the 'phet was out of my system I should have been let out as I was okay and I did say that to them' (*Patient Q). If their opinion was not accounted for, they felt vulnerable and powerless*:*

> Patient (C*): It wasn't right… It's all out of your control, they [professionals] put you in and say what's what, you've got no voice. You only get let out when they are ready to let you out*.

More positive experiences had occurred with other professionals. Some notable valued and therapeutic conversations disclosed during the interviews had taken place with HCAs:

> Patient (N*): We talked about all sorts. She [healthcare assistant] was asking me about the dogs and was talking about going back to college. We got on to what I like to do and she suggested I go to boxing to get rid of my energy which is something I might think about when I get out... A nurse let me out to go to the toilet and told me what I should do if I got wound up again.*

Although communication should be two-way, not all patients felt professionals listened to them. Some described feeling invisible,' *It's as if I'm not there'* Patient (H). One recalled:

> Patient G: *They [professionals] would talk among themselves about me… they thought I couldn't hear them but I could, it felt as though I didn't even exist.*

Patients said they reminded professionals they had feelings and should be respected. They told the professionals *this is not me* and attempted to distance themselves from the type of person they thought might be secluded, perhaps to elicit more compassionate care. *'I am a mother'* (Patient M), *'I was a health professional…'*

(Patient F) *'I'm an educated person'* (Patient P) or, '*I don't feel as though I am insane person, I just feel as though I lost my way a little bit'* (Patient K).

In addition, some patients described being expected to co-operate and thought they were able to influence release by demonstrating a willingness to do so, '*He told me I had to prove I would co-operate… he might not have said prove, I can't really remember but it was something like that'* (Patient L). Some made a conscious effort to follow or play by the rules, '…*it was about keeping my head down, doing as I was told, I could have kicked off but I didn't'* (Patient K). Similarly:

> Patient (J*): The manager was saying a few things and taking medicine because I was refusing it then I started taking it. I have refused anti-psychotic medication and it was used to bargain to say you can come out if you take this. I thought if it keeps them happy.*

Furthermore, others said they were expected to offer a guarantee they would continue to co-operate both during and after release:

> Patient (G): *They wanted me to agree that I wouldn't try to do anything stupid, not try to push past them and get out, that I would just go to the bathroom and then go back in*.

Plus, '*She [the nurse] said I could go back to the ward if I promised to be quiet as the other patients were in bed*' (Patient L).

Overall, patients seemed to describe similar expectations. However, patients thought professionals were not always clear in the way they communicated what they expected.

6.3.2.4 What was I waiting for?

Despite thinking they met expectations, patients complained they might still remain secluded but were not always clear why. Release seemed to be a waiting game. **'***I was telling them I should not be in here but they said I had to wait. I was not sure what I was waiting for?'* (Patient J). In certain instances, waiting caused patients to re-escalate as it increased their distress and anger, plus overrode the initial shock at being secluded. One patient described how he was made to stay in:

> Patient (P): *…maybe for a twenty-four hour period and it made me actually want to kill myself. I did actually, that's why I have got the bloodshot eyes because I tried to strangle myself because I didn't want to be in there any longer.*

One patient was told by professionals she needed to stay in seclusion until she was safe to release, whilst others complained they remained secluded at the convenience of professionals. Patients linked waiting, not only to there being enough professionals available to support their release, but also to the reluctance or inability of certain professionals to make decisions. '*It was about waiting for Dr [Psychiatrist] as no one else would make any decisions'* (Patient F). Another recalled:

> Patient (N): *I wanted the doctor to come as the nurses had been arguing with me and because they said I had to stay there until he did, so I kept asking is he here yet? I want to get out? But no, you'll have to wait until [the psychiatrist] comes, you'll have to wait until [Charge Nurse] comes.*

There was an acknowledgment by some patients they were possibly kept waiting as part of an assessment process. As, although one remembered being told he could just leave seclusion and go back to his room, others recalled a period in which they felt they were being tested for readiness for release:

> Patient (P*): They waited until I could engage. It was a combination of them being resilient, sticking by me and just constantly trying to calm and relax me, also using drugs to relax me, sweat the substances out my system that were influencing my behaviour and then ease me out of the situation. It wasn't like 'oh we will open the door and here you go', it was a smooth and calming process, open the door, sit down, calm down, relax, medication. Then it was engaging in conversation, them making sure I was clear about their intentions and my intentions before they put me back in a situation where I was around other people.*

The length of time this took differed. One person said she, '…*spent about half an hour tops [sat next to staff member] and then they let me back on to the ward*' (Patient L), but for others it was longer:

> Patient (B*): They come in and ask me how am I feeling, am I calm, do I still want to hit people? Sometimes I sit with the door open and they talk to me, or they might say go and chill on your bed, let's go for a cig. Once the nurse said I could come out, use the toilet, then sit with the door open. I slept with the door open and came out the next day. We played Frustration [board game] all night long which was fun.*

Patients' understanding of why they were waiting appeared to be influenced by their knowledge of the seclusion procedures and knowledge of the professionals managing their care. They did not always know who the professionals were nor what they were doing. According to Patient A, '*They [professionals] don't always introduce themselves, you might not see the same staff twice, they're strangers'*. Another recalled how professionals:

> Patient (E): …*kept going in and out, in and out, going out to get the doctor or somebody else changing who was out there*. *No one explained what was happening, why they were there and then they weren't'.*

Others alluded to times when two or three, or even groups of professionals, would appear at the seclusion room door. Three of those interviewed recognised there were set review procedures taking place at these points, but had not felt included. One of these had previous service user involvement experience with the CQC (Care Quality Commission), whilst the other two had been secluded before.

Waiting was also linked to the clinical skill, the role and the authority of the professionals within the team. Patients stated HCAs tended to sit, observe and type notes. Nurses co-ordinated their needs such as letting them use the bathroom or bringing medication. Whereas, medics were more willing to open the door, enter the seclusion room and ask questions about how they felt. One patient reflected, '*They [professionals] do what they can within their power and level of skill'* (Patient P). Whereas another said:

> Patient (L*): The care assistant said I would have to wait until the nurse came back then we could ask her. Then a doctor who I had never seen before turned up, he said I had to do what the nurse said and then they should let me out.*

Patients noticed decisions were often referred to qualified or senior professionals. This was summed up by one who had experienced multiple admissions:

> Patient (H*): …qualified staff made the rules. I specifically ask to speak to a nurse if I have got a problem in order to get what I want as I have been in mental health for years. It's the nurses who make the decisions and say what's what so I ask them*.

Similarly the value of non-permanent ward staff members, was also questioned, '…*bank and agency staff why bother talking to them, what's the point, they can't do anything*' (Patient G). Again, those without previous seclusion experience were less aware of this:

> Patient (K*): She [HCA] said she couldn't do anything to get me out that it wasn't her decision as she didn't really work here, which I thought was confusing cos' if she was staff and she knew I was okay why she didn't just let me out.*

6.3.2.4 Being released

Mostly patients reported not being directly asked if, or how, they should be released. Two were released despite not feeling ready. One recalled, '*I was still angry and agitated when they took me back to my bedroom*' (Patient K), Whilst the other protested against release but felt ignored. Generally, patients reported being told release would happen:

> Patient (C): *He [the psychiatrist] asked if I felt okay but I don't think I was involved no, it was up to them …If you don't agree, you don't come out, simple as. Will you do this 'yes', will you do that 'yes'…*

Less frequently patients thought they and the professionals made the decision together:

> Patient (H): *I think they involve me as much as they can… it's when I'm ready and when they're ready. It's difficult to put into words. We are talking so it's something we decide together… I can't think of a time they have asked me to leave seclusion before I was ready.*

Some patients wondered if the decision even could be shared, '*I am not sure how it could be?*' (Patient C). Although not directly involved, patients discussed ways in which they exerted influence over decisions. For one this was possible when he, '*…developed an understanding of how I should act'* (Patient P*).* Whilst others tried to make professionals see their point of view that the seclusion was undeserved and unfair.

At the point of release most patients wanted to go to their bedroom to sleep or to withdraw away from the other patients on the ward, although two said they had preferred to go into the garden. Initially professionals stayed with them on a one-to-one basis which patients thought was to offer support and ensure they remained calm, plus deter retaliation from others:

> Patient (L*): [HCA] followed me upstairs and sat outside my room and they followed me round for days even though I said I was sorry and I wouldn't go in anybody else's bedroom. They kept going on that people would retaliate… but I just wanted to go to bed.*

Generally patients did not have concerns about being on the ward or around peers, '*You think I would be worried about other patients but wasn't. I just fit back in with who was there'* (Patient E). Although some were more hesitant:

> Patient (G*): It makes me anxious when I go back on to the ward as everyone knows where you have been so it feels a bit weird that being around people again*.

Very few reported being offered a dedicated opportunity to discuss or to reflect on their experience of the seclusion. One stated he talked over his admission experience, which included seclusion, in depth at a meeting conducted by the psychiatrist with another medic and a nurse in attendance. Another recalled a meeting in which a junior medic briefly mentioned seclusion, *'…but only to ask how am I now, it was more about my alcohol and drug use'* (Patient K). Others reported being interviewed for this research as their first opportunity to discuss their experience. However, not all wanted to think too deeply about it, *'I would rather not think about it… it's too difficult' (Patient D),* or, '…*what was the point as it would not change anything'* (Patient L).

6.3.2.5 Doing things differently

Finally, patients suggested a number of ways in which their experience of involvement in release from seclusion could be improved. These involved avoiding being secluded in the first place, wanting family or someone else to help get them out, professionals being better prepared and trained to deal with patients who have been secluded and, wanting to be both heard and involved in the decision to be released.

Firstly, they stated seclusion might be avoided in the first place if professionals spent longer de-escalating difficult situations, offered time out or the use of a low stimulus environment. Patients wanted somewhere to calm down but did not think seclusion was the answer:

> Patient (C*): I think they could have taken me away from there and say right what you've done is wrong… I'd rather they'd watch me for a bit longer rather than seclude me. Maybe sit and talk to you, help you to relax and talk more… not behind a locked door so you can just go out and come back.*

Three suggested the proactive use of medication may have helped prevent seclusion being used:

> Patient (N*): The meds they gave me made me feel a bit better. They could have done that instead before, give me them in the bedroom, left me to chill there.*

However, if patients were secluded, they wanted assurance their views would be listened to, the episode would be short and they would be released at the earliest opportunity:

> Patient (G*): It would be better if it was just for a couple of hours to help you calm down. It feels like a punishment if you are kept in for a long time*.

Secondly, patients wanted their family or a significant other to be aware they had been secluded. One asked for her GP to be told but this was not done. Being able to contact potential support or receive visits would help patients not only feel safer, but they thought others could advocate for their release. One patient believed her parents had been informed, but most were doubtful their family were made aware:

> Patient (N*): I wanted my mum to come and tell them to let me out... I couldn't ring her as they had gone through my pockets, taken my mobile and my money, so I had to get through it on my own which was hard. I rang her when I came here (treatment unit) so it was not the next day but the day after that she found out.*

Not all patients believed their family or friends could help. One told me his girlfriend had visited the ward and brought belongings but had not been permitted to see him. Another that her family avoided visiting when she was secluded. Whilst others suggested even if families were aware they might not necessarily understand what seclusion actually meant:

> Patient (Q): *I don't know if she knew I had been secluded. I don't know what the point of telling her would be, what could she have done, nothing really?*

Thirdly, patients thought professionals needed better training and tools to better prepare them to manage distressing or difficult situations. According to one,

> Patient (P): *It's the fault of the system not staff. A lot of elements of the system are fragmented, broken and need looking at. I nearly lost myself due to things not being structured properly*.

Patients suggested professionals should have more understanding about the impact of what it feels like to be secluded and how it affects those who are. They thought professionals supporting seclusion and deciding upon release should use a psychological perspective, which meant understanding their personal histories and why they were secluded. Patients believed this knowledge would lead to a quicker release.

Fourth and finally, patients not only wanted to be heard and involved in decisions about their release, but wanted consistent and clear information regarding how this would happen. It was suggested the ability of professionals to communicate adequately and facilitate difficult conversations was essential if they were to relate and connect with patients in a manner that was approachable and understandable. However, despite some patients reporting professionals did their best, for many, the experience had little therapeutic value and did little to convince them professionals were working to get them released.

> Patient (P): *They were just trying to be polite, kind, and nice, tried to relax me, it would be just like nice gestures. For someone who has just spent nearly three weeks in a psychotic episode, these are loose words, they don't hold much meaning. So it's hard for me to just hear do you want a sandwich, calm down, do you need a drink? It's hard for someone who has gone through so much trauma to just look at someone who is just saying things like that and say, Oh yeah that's fine give me a sandwich and I'll calm down and I'll come out. It's not enough. They could do better, say something along the lines of we're here to help, not hurt you, we're trying to do what's best for you, but you need to realise we can't let you out of this room until we know your safe and not going to put us in danger. There are certain words, phrases, ways of putting things across, maybe tools and methods which could be used to make that process smoother, make seclusion periods shorter.*

6.4 Strengths and limitations of interview studies

Similar strengths and limitations applied to both studies:

- These were the first in-depth exploratory studies of professional and patient experiences of release from seclusion;
- The transferability of the studies to other findings is limited as seclusion use is subject to local contextual and cultural influences, however the insights and experiences could be of interest to service providers, professionals and patient groups in similar services;

- The views expressed are individual experiences and may not be representative of the wider mental health workforce or patients;
- It is possible both samples were affected by recruitment biases although the professional sample included a range of professionals and the patient sample was increased as time permitted;
- Insider researchers may introduce bias upon data collection and analysis, although reflexivity was integral throughout the processes of both studies;
- The researcher was known to many of the professional participants as a colleague. Interviewing colleagues enabled the researcher to use existing relationships to establish trust and rapport. However, they may have given socially desirable answers or ones which protected their credibility;
- Likewise patient participants may have responded in ways so as not to affect their care or treatment;
- Time periods between seclusion and interview required only recent experience. This ensured support was available for participants but may have meant recall was affected; and finally,
- Patient recollections may have been affected by medications or cognitive impairment at the time of seclusion or during their interview. Yet as stated earlier, as long as adequate safeguards are in place, it is important to offer vulnerable patients a voice if practices are to be improved.

The strength and limitations of the thesis are discussed further in chapter eight (see section 8.3).

6.5 Conclusion

Chapter six presented the findings from two interview studies. Initially, the professional study described how they experienced release as a gradual process in which they tested out the readiness of patients to be released, but that they also thought about safety and protecting their self from criticism. Professionals admitted they told patients to calm down and directed them whilst in seclusion, reflecting on their need to trust what they were hearing and seeing. They thought patients had some responsibility in securing their release. The patient study explored the ways in which patients experienced being involved in release. Patients recognised a change took place over the course of the seclusion, but stated they lacked an understanding in regards to what professionals were doing, what they as patients should be doing and why they were kept waiting to be released. Patients did not feel involved but described ways in which they tried to influence release and made recommendations for professionals and services which they thought could improve their experiences of seclusion.

Chapter seven is a discussion of the findings of the literature reviews in chapter four and the interview studies presented above. It examines the findings and makes comparisons with the wider literature about seclusion practices. The chapter concludes with a synthesis of the findings and proposes knowledges that may be useful for professionals supporting patients in seclusion.

Chapter seven: Discussion and synthesis

7.1 Introduction

Chapter seven is divided in to two parts. Part one is a discussion of the findings from the literature reviews and interview studies (see chapters four and six). Part two is a synthesis of these discussions. The synthesis outlines a common trajectory of release, a number of indicators which suggest a patient might be ready for release and finally, further factors which act as barriers or facilitators and impact upon the decisions by professionals to release patients from seclusion.

Part one: Discussion of findings

Part one contains six sections. The first two sections are a discussion of the findings from the professional literature review and interview study (see sections 7.2 and 7.3). The thesis is nursing research, therefore the third section discusses the factors influencing release specifically from a nursing perspective (see section 7.4). The next two sections are a discussion of the findings of the patient review and interviews (see sections 7.5 and 7.6). Following those, at the end of part one is a summary of recommendations made by patients. It lists the ways in which patients believe their experience of seclusion and opportunities to be involved in decisions to be release could be improved.

7.2 Discussion of findings from the professional review

This was the first integrative literature review to focus solely upon factors considered by mental health professionals releasing patients from seclusion within inpatient settings. It found there to be very little evidence to guide professionals and that which was available was embedded within literature relating to perceptions, experience and decisions to initiate seclusion episodes. Evidence mainly came from nurses who were seen as the group most likely to oversee the initiation and management of seclusion episodes (Muir-Cochrane, 1995). Policy and guidance in England and Wales (DoH, 2015; NICE, 2015) require MDTs to be included in monitoring and reviewing the progress of patients who are secluded. However, the experiences, impact or potential benefits of their involvement, and specifically that of medics, upon release was not evident and warranted further study.

As discussed in chapter two, when professionals were faced with actual or threatened violence, they believed they used seclusion to maintain safety rather than for any therapeutic value (Chambers et al., 2015). Similarly, the review found safety was the dominant value when considering release. Professionals felt it was their duty to manage ward safety as they could be held personally, morally or legally responsible for not doing so (Simon and Shuman, 2007). Decision-making regarding safety and the use of restraint in general has been shown to be the result of a number of complex and interrelated factors (Riahi et al., 2016). However, safety decisions regarding release appeared to differ from decisions to seclude as factors other than imminent violence were considered. This was possibly because decisions to initiate a seclusion were made in a time of crisis so likely distorted by stress (Morrison, 1990). Whereas, release was experienced as less pressured, so there was time for discussion, consideration and planning.

The review suggested professionals conducted a risk assessment as part of their decision-making. However, it found there to be no best practice guidance, no specific risk assessment for the violent and aggressive behaviours of patients who were secluded, or no assessment tool to support decisions to release from seclusion. There are evidence-based risk assessments available which include the Staff Observation Aggression Scale–Revised (SOARS) (Nijman et al., 1999) to assess demographic and diagnostic risk factors, the Dynamic Appraisal of Situational Aggression (DASA) (Ogloff and Daffern, 2006) that predicts imminent aggression, and the East London Modified Brøset (ELM-B) (Loi and Marlowe, 2017) to indicate the need to seclude in PICUs. Although the tools have successfully demonstrated they could reduce the frequency of seclusion (Van de Sande et al., 2013), they have not been tested to guide the release of patients, nor do they take into account the wider environmental and interactional factors described by the professionals in the thesis. Therefore, the development and validation of an appropriate risk assessment with a broad range of domains could support professionals to reduce durations of seclusion in a safe and consistent manner.

The findings implied decisions to release patients were not only concerned with safety and risk assessment, but a complex mix of professional, team, organisational and environmental cues (Mann-Poll et al., 2011). The review indicated that to some extent, influences upon release mirrored those used by professionals defending the use of seclusion (Larue et al., 2009; Mann-Poll et al., 2011; Laiho et al., 2013). Yet, it was unclear how these influences impacted upon release or why some patients were quickly returned to seclusion.

Similar to Hernandez et al. (2017), the review found regular team discussion and the involvement of senior experienced professionals reduced the number of hours patients remained secluded. This indicated the presence of senior leadership and organisational support should be available to assist less experienced professionals in learning the skills necessary to enable them to proactively plan release in a safe manner. The strength of effect or the ways in which individual professional characteristics influenced decisions to release would be difficult to identify and measure with any accuracy. However, further exploration and understanding of what these factors are might contribute to reducing the length of time patients spent secluded, prevent re-seclusion and reduce the frequency of seclusions.

Professionals believed they involved patients in decisions to release them, whereas the review found they took control and directed seclusion episodes leaving patients with little choice but to comply. Goulet and Larue (2016) stated paternalism and control continued to dominate psychiatric care, but they thought it was both professionals and patients whom internalised standards relating to how such processes operated. Langan et al. (2004) warned professionals not to expect patients to agree with the act or the maintenance of their seclusion, but ensure they understand the personal situation of the patient and take great care not to confuse patient insight with disagreement.

To conclude, the review implied it was more than the potential risk to safety posed by patients in seclusion which influenced release. Release was also dependent upon wider multi-level influencing factors. The review findings indicated further exploration and understanding about which, and how, these factors influenced release was needed especially as the impact of involvement of medics and AHPs was not evident. Such knowledge could support the development of best practice guidance for nurses, medics and AHPs in ensuring patients only remain secluded for the shortest time possible. From the evidence reviewed, it was not clear if patients were encouraged or given the opportunity to be part of decisions to be released. Therefore, the original plan for the thesis to explore factors influencing professionals was broadened to include the views of patients

7.3 Discussion of the professional study findings

Similar to existing evidence, the interview study found professionals working in mental health settings did not like secluding patients, but they justified it by stating they believed there were occasions when they had no alternative (Roberts et al., 2009; Duxbury, 2015). Decisions to seclude were often reactive to actual or threatened violence (Gutheil, 1978; Riahi et al., 2016). However, as in the professional literature review above (see section 7.2) and findings detailing other forms of restraint (Hernandez et al., 2017; Nielsen et al., 2018), professionals making the decision to release patients from seclusion said they had *the luxury of time.* Decisions to release were described as multi-disciplinary, and a gradual considered process of assessing, testing and reintegration. This allowed professionals to plan and prepare patients for their return to communal ward areas.

The clinical experience of the nurse in charge of seclusion reviews appeared to have a major influence on release, and is discussed later in the thesis (see section 7.4.3). It was unclear if the influence of senior professionals was related to their practice experience, greater self-confidence, developed communication skills, experience in forming relationships, higher tolerance for risk or knowledge of management strategies (Nagayama and Hasegawa, 2014). However, the findings implied it was not only their personal attributes, but that senior professionals had greater authority to source extra support resources. Access to resources was seen as important as decisions were influenced by a number of factors beyond the behavioural presentation of the patient. These included the physical layout and acuity of the ward, plus the size and skill of the staff team. Release may be delayed unless there were enough staff members with the right skills present. What constituted *enough staff* and *the right skills* was not clear. Release could involve a *show of force* to communicate to patients professionals were willing to take action to ensure compliance. A show of force in psychiatry is when:

> *…a number of staff are assembled within view of the patient, with the implicit or explicit threat that the patient knowing will be manually restrained or forced to undergo treatment, unless they comply voluntarily*
>
> (Bowers et al., 2012, p31).

Bowers (2007) reported seclusion use was not only affected by the number of professionals, but by the permanency and skills of the team. Too many registered nurses or non-regular professionals were adversely correlated to containment decisions and high ward acuity (Bowers, 2009; Staggs, 2013). In addition, Staggs (2015) argued skill mix and experience were as, if not more, important than numbers. Although the effect of individual differences (Laiho et al., 2014), or team cultures on seclusion practices cannot be understated (De Benedictis et al., 2011), the qualities, skills and attributes of professionals required to ensure a quick and safe release from seclusion remain to be evidenced.

Seclusion decisions should always involve a nurse and a medic. However, junior nurses expressed anxieties about managing seclusion episodes (see section 7.4.3) and Bhavsar et al. (2014) raised concerns about medical support for seclusion reviews which took place on nights and weekends. They described how seclusion was sometimes the first experience junior medics or psychiatric trainees had of mental health inpatient care. Junior medics interviewed for the thesis who had been on-call outside normal working hours said they, only felt confident to monitor physical health and support the nurses, not to lead the decision-making process. Therefore, patients secluded outside of normal working hours may remain secluded longer than necessary if skilled professionals are not available.

Decisions to release not only include nurses and medics but, when possible or as a minimum for seclusion episodes of eight hours or longer, involved the wider MDT. The study identified there were both advantages and disadvantages to this. MDT involvement was supported as it encouraged a range of opinions and options. AHPs were seen to bring independence, safeguards, plus their varied professional views and perspectives to the conversation. Despite the benefits of MDT collaboration, their inclusion in decisions could introduce tension around ethical issues (Wiles et al., 2016) and highlight moral differences within teams (Barnao et al., 2012). Whereas, these findings uncovered differences in the power and influence the professions had over seclusion decisions. Again, the experience of an AHP was influential upon their ability to engage fully in the seclusion decision-making process. Less experienced AHPs felt disempowered, that their opinions were overlooked as seclusion reviews where led by senior medics or nurses whose primary focus was to monitor the patient’s physical health, the patient’s ability to follow direction and the capacity of the team to manage the safety of the ward. AHPs raised concerns that at times they felt undervalued by their medical and nursing colleagues. Furthermore, they felt unprepared for their role in review procedures, and at times were unclear what they brought to the reviews. This suggests there is an imbalance of power despite MDT working being encouraged and required by policy. The benefit of their inclusion, impact upon decisions and potential are still not clearly understood. Ensuring non-nursing professionals are adequately prepared for their role in seclusion reviews is imperative, and further study is recommended.

Similar to existing literature, the management of safety and risk underpinned seclusion decisions (Moylan, 2015; Riahi et al., 2016), and were the biggest considerations when deciding if to release patients. Although professionals wanted to ensure ward environments were safe, both physically and emotionally, they did not want to prolong a seclusion unnecessarily. Yang et al. (2014) identified perceptions of safety and seclusion use were linked, and professional perceptions in the study of feeling safe and being able to cope once the patient was released were connected to the professional’s knowledge of the patient and trust in colleagues (Goulet et al., 2017). Professionals’ prior knowledge of the patient supported assessment, enabling them to not only to risk assess, but to make more accurate predictions of the patient’s honesty and intent. At times, professionals thought it difficult to trust what patients told them, as some patients were dishonest or *played the game.* Furthermore, they thought even patients with honest intent might not be able to maintain a settled presentation. It appeared professionals looked for certainty that aggression had peaked and they were making the right decision, but questioned the certainty of this.

No professional interviewed in the study referred to using a validated risk assessment, nor is it clear if risk assessments are used systematically across other similar services. The assessment of ongoing or imminent violence or aggression appeared to be based upon gut feeling or instinct, rather than guided by structured professional, clinical or actuarial tools (Lewis and Webster, 2004). This is concerning as Nielsen et al. (2017) demonstrated unstructured risk assessment by nurses and psychiatrists prolonged episodes of mechanical restraint. Therefore, unstructured judgments and an over reliance on the willingness of professionals to end seclusions may result in episodes lasting longer than is necessary. Furthermore, this study found inexperienced and junior professionals were more cautious when agreeing release. So, if healthcare services are to meet policy requirements and ensure seclusion is only used for the shortest time possible, inconsistent and subjective decision-making within the release process needs to be challenged. Additionally, professionals should be encouraged to make greater use of evidence-based assessment tools to manage ongoing risk as per standard clinical practice.

To conclude, despite the MH Code of Practice (DoH, 2015) stating patients should be involved in decisions about their care and treatment, the study found little evidence shared decision-making took place in regards to release from seclusion (Kontio et al., 2012; Larue et al., 2013). Furthermore, professionals were unclear how it could achieved. Similar to findings of the professional literature review (see section 7.2), release was influenced, not only by the presence of ongoing aggressive behaviour, but by the willingness of patients to cooperate, the effect their release may have on the ward milieu and the availability of skilled professionals with access to resources to manage safety. The review and the interview study both raised implications for clinical practice (see section 8.4), and highlighted areas recommended by the thesis for further study (see section 8.5).

As the thesis was nursing research, specific thought was given to the role of nurses involved in making decisions to release patients from seclusion. The following section discusses findings which related specifically to nursing practices and perspectives.

7.4 Nurses experience of involvement in release

Chapter three (see section 3.2.2), described how nursing knowledge could be categorised into differing ways of knowing (Chinn and Kramer, 2018). These ways of knowing were recognisable in the nursing literature about seclusion and findings of the professional interview study above. Nurses demonstrated praxis as there was evidence they wanted to improve clinical practices and patient care. The knowledges they described as guiding their decisions to release patients included critical thinking, professional judgement, practice experience, self-reflection, plus personal, moral and ethical principles. These are explored in detail below.

7.4.1 Personal beliefs

The findings indicated nurses in particular struggled with the moral dilemmas surrounding the acceptability of seclusion balanced against an expectation they would maintain safety (Muir-Cochrane, 1995; VanDerNagel et al., 2009; Zheng et al., 2019). Moreover, they faced the challenge of prioritising the care and what they perceived to be the best interests of the patient in seclusion, against those of their other patients and colleagues. Nurses feared not being supported (Ezeobele et al., 2014) and, as suggested by Silver (2007), contradicted their own values to maintain solidarity with their team and ensure they could call on colleagues to protect them if needed. Furthermore, similar to Muir-Cochrane et al. (2018), findings were their involvement in a seclusion left them fearing their professional competency and skills would be judged, and their clinical practice would be scrutinised. Therefore, nurse leaders should be aware both of the concerns and pressures faced by frontline nurses, and ensure supervision and support is provided in order to retain and develop their workforce.

7.4.2 The influence of nurse characteristics

As discussed in chapter two, previous research demonstrated the individual characteristics and attitudes of nurses influenced how they either viewed seclusion (Mann-Poll et al., 2011; Boumans et al., 2012; Laiho et al., 2012; Van der Merwe et al., 2013; Riahi et al., 2016), or the likelihood they would be involved in initiating a seclusion episode (Happell and Harrow, 2010; Boumans et al., 2012; Green et al., 2018). Nurse levels of burnout, job satisfaction and therapeutic optimism (Happell and Koehn, 2011) plus, gender and stature have also demonstrated relevance towards the likelihood they would use seclusion (Janssen et al., 2007; Doedens et al., 2020). Although, the significance of these characteristics was inconsistent (Staggs, 2013), it is likely some may adversely affect the willingness of a nurse to release a patient. Further study to identify the impact of nurse characteristics may raise awareness, plus identify which characteristics might contradict or support safe and timely decisions.

7.4.3 Nursing experience, seniority and leadership

Nurses in the study did not refer to gender or size, but implied nursing skills and clinical experience influenced decisions. After safety, as stated above (see section 7.3), the experience of the nurse leading the review was arguably one of the most influential factors affecting release (Nagayama and Hasegawa, 2014). Further to this, senior nurses were more likely to be able to access resources to facilitate release (Boumans et al., 2015). Access to resources was seen as beneficial for managing seclusions and included being able to transfer patients to more appropriate or secure environments, or increase staffing levels if required. Restraint teams may take time to assemble and staffing on wards during nights and weekends is often limited by the numbers on shift, therefore at these times release may be deferred.

The findings suggested experienced senior nurses were also more confident in their ability and decisions. Whereas, junior nurses would be more likely wait for the next planned review rather than suggest releasing before one took place. Thus, there appeared to be a marked difference in the decisions to release made by experienced nurses. Benner’s (2001) Novice to Expert model described how practitioners progress through the five stages of novice, advanced beginner, competent, proficient, and expert nurses to achieve the ability to perform skilfully. Hesitancy among junior nurses appeared to be linked to fears over safety and how their clinical practice would be viewed if situations deteriorated or were deemed to be managed ineffectively. This may also explain why nurses with lesser experience were more likely to use and support seclusion use (Green et al., 2018).

Wilson et al. (2018) argued seclusion decisions presented a dilemma between what was practicable and what was achievable, and these findings implied nurses learned this from experienced colleagues. Both Wardhaugh and Wilding (1993) and Fish (2018) highlighted weak leadership had adverse effects upon seclusion practices. Therefore the presence of senior and experienced nurses to provide supervision, lead team discussions and be visible during seclusion situations is imperative.

Moreover, facilitating discussions is important as reflexive teams have been shown to be successful in countering minority dissent (De Dreu and Beersma, 2005) and in reducing seclusion use (Boumans et al., 2012). In contrast, poor or inadequate leadership with limited supervisory support and inadequate debrief or post discussion, reduced the opportunities nurses got to learn and reflect upon their own performance. Findings in the study indicated senior nurses undertaking seclusion support should not only be available, but be aware of the significance of their effect.

7.4.4 Education and training

Nagayama and Hasegawa (2014) reported, in addition to the presence of experienced nurses, there was a direct link between a nurse's education about seclusion and their willingness to agree a release. Education is a way to bridge the gap between novice and expert clinicians (Happell and Harrow, 2010; Bowers and Crowder, 2012). In relation to seclusion practices, it has been shown to assist professional development, build confidence and develop less risk-averse practices (Ramluggan et al., 2018). Bloom (2002) stated the impact of teams should be also considered when devising education, policy and guidance, as educating teams supports cultural change and reductions in use of seclusion (Ching et al., 2010; Mann-Poll et al., 2011; Boumans et al., 2014). Furthermore, organisations who delivered educational interventions showed they could reduce complacency and encourage enhanced practice (Newman et al., 2018). Education to use the policy correctly and training strategies aimed at reducing durations is necessary and should be addressed by all organisations with seclusion facilities. Yet it should be noted, whilst nurses in the study described educational sessions useful for learning about seclusion practices, they were critical of some aspects of policy and procedure.

7.4.5 Knowledge of policy and procedure

Nurses interviewed were critical of the current seclusion policy for three reasons.

- Firstly, although national seclusion policy and guidance (DoH, 2015, NICE, 2015) focused upon a rigorous process of review, it stopped short of outlining how release could be agreed and achieved;
- Secondly, they feared not being up to date with their knowledge and understanding of local policy, which they said changed frequently; and,
- Thirdly, nurses suggested, despite ensuring legal rights and safeguards for patients were upheld, policy and procedural requirements had the potential to curtail the autonomy of the nurse in charge to manage and de-escalate situations. Nurses described how once a seclusion was initiated, their focus

was diverted from the patient. As, at the very time more support and nursing skills were required to deal with situations, they were tasked with assembling review teams and completing paperwork.

Policy and procedure was therefore experienced as onerous and counterproductive to the aim of release at the earliest opportunity. The consequences of which, were not only damaging to nurse-patient therapeutic relationships, but contributed to delayed release.

The points raised in the discussion sections are revisited in chapter eight in the implications for nursing practice (see section 8.4), and recommendations for further study (see section 8.5). The next sections of this chapter contain firstly, a discussion of the patient literature (see section 4.3) and secondly, a discussion of the patient interview study findings (see section 6.3).

7.5 Discussion of findings from patient review

The second review was unique in that it focussed upon release from the patient perspective. Similar to the wider literature about seclusion, findings indicated most patients opposed the practice and reported it to be a negative, often distressing or traumatic experience. It was difficult to know to what extent patients agreed with the way in which they were released or felt involved in the decision. For, similar to the professional review, there appeared to be very little evidence related to their views or experiences of release. That which was found, suggested patients did not feel involved or that their views were not taken into account. This contravened policy which stated it is the responsibility of professionals to ensure information is given, and patient wishes are taken in consideration in line with recovery-based approaches and the principles of positive behavioural support (Australian Health Ministers' Advisory Council, 2013; DoH, 2014, DoH, 2015).

The review identified patients were clear about what they wanted professionals to do better. Patients wanted to be told what they needed to do to be released as, other than being calm, co-operative and compliant, they were not sure what else was expected. Patients wanted professionals to know their history, have an awareness of any previous trauma, plus be with them offering reassurance on an ongoing basis. Further to this, they wanted professionals to have skills to assess and monitor them, be responsive to their needs and release them as soon as possible.

Patient literature implied professionals misjudged their capacity or ability to be involved in decisions (Osborn and Stein, 2017). For those who lacked capacity, had poor cognitive functioning or were in disagreement with professionals, supported decision-making through the introduction of advocacy, involvement of family members and advance directives could ensure patient rights and wishes were upheld. Goulet and Larue (2018) believed both professionals and patients needed educating in these principles if change is to be achieved.

Whilst patients acknowledged the propensity professionals had to engage in communication might be restricted by their available time and workload (Cleary et al., 2018), the biggest barrier to release resulted from inadequate communication and sub-standard relational engagement by professionals. Patients consistently complained about the level and quality of communication before, during and after seclusion episodes (Norris and Kennedy, 1992; Mayers et al., 2010; Kontio et al., 2012; Larue et al., 2013; Ezeobele et al., 2014). Poor or impaired communication from patients was seen to delay release. Whereas, poor communication from professionals contributed to unsatisfactory nurse-patient relationships (Mellow et al., 2017), a loss of trust (Ling et al., 2015), negativity towards the institution (Robins et al., 2005), and resistance towards future admission (Bonner et al., 2002). On the other hand, being listened to or given information (Lorem et al., 2015) prevented future incidents (Wynaden et al., 2002) and diminished the negative impacts of episodes (Norris and Kennedy, 1992; Ezeobele et al., 2014).

For those patients who voiced a preference, they still felt unheard and critical of professionals whom they said failed to listen, or even discounted their views. To counter this, they want a dedicated nurse with the responsibility of communicating important information and promoting discussion. As, when collaborative practice was inconsistent or non-existent, the opportunity patients had to be involved in decisions about their care at this point was reduced. To ensure decisions are acceptable to both parties (Hoffman et al., 2014), will require a shift within seclusion practices towards the establishment of shared and decision-making between patients and professionals (Goulet and Larue, 2018).

Overall, the review found no articles which primarily focused on release, although the findings resonated with literature regarding their overall experience of seclusion. Patients disliked seclusion and were not routinely asked their views about release. Communication regarding their situation, options and preferences was inadequate as patients said they were not certain of what they needed to do to get out. The review concluded, a greater understanding of what happened when patients were released and ways in which they were involved, might support understanding into how durations could be kept to a minimum and their experience be less distressing.

7.6 Discussion of the patient study findings

Consistent with the literature review (see section 7.5), the quality of the communication and nurse-patient relationship figured prominently in the patient study findings. Patients complained communication was inadequate and inconsistent. They described a lack of openness and respectful dialogue (Bressington et al., 2011), plus thought professionals could be patronising and insulting (Mayers et al., 2010). As seclusion progressed, they felt professionals became more directive and superficial, and did not listen (Haw et al., 2011). According to Wilson et al. (2017), pre-existing rapport often vanished when patients were secluded. Likewise, the findings reflected how, in the early stages of a seclusion, patients either wanted time before they felt able to engage, or that professionals disengaged leaving them feeling ignored, invisible and non-existent (Mayers et al., 2010; Ezeobele et al., 2014; Fish, 2018). If patients knew the professionals before the seclusion, it allowed engagement to be established early in the episode and, as it progressed, they felt reassured, safer and thought they might get better care. Whereas not knowing professionals caused them anxiety. This was not always possible as in adult mental health services seclusions often occurred early in an admission, limiting the time patients and professionals had to be acquainted (El-Badri and Mellsop, 2008; Bowers et al., 2017). Patients might be admitted direct to seclusion from police custody, as was the case for six people in the study. Whereas, Maguire et al. (2014) found patients in forensic services had an advantage in that there were better opportunities for them to get to know each other as admissions were longer.

Patients recognised the benefits of having a positive relationship with professionals. The quality of relationships, not only affected the likelihood a patient might be secluded (Bowers et al., 2012), but durations were shorter if professional-patient empathic relationships were present (Sullivan et al., 2004). Patients in the study thought if they showed remorse it might restore good relations and get them released sooner. Some were genuinely sorry, whereas others admitted they feigned remorse. Patients acknowledged professionals attended to their physical needs, brought them food and drink, allowed them out from behind the locked door to use the bathroom and cleaned the seclusion room if necessary. However, they were more critical of the way in which professionals responded to their emotional needs. Literature reports seclusion as anti-therapeutic (Wilson et al., 2017; Tingleff et al., 2019; Hawsawi et al., 2020), therefore the notion therapeutic relationships can be maintained during seclusion must be questioned. However, as seclusion provides opportunity for one to one engagement (Hoekstra et al., 2004), and professionals should not only be able to offer skilled communication, but deliver positive relational interventions. They should make greater efforts to engage, holistically assess and maintain therapeutic relationships with patients to encourage them to share responsibility and ownership in decisions to be release them (Ramluggan et al., 2018).

Policy requires plans for release are written and shared with patients (DoH, 2015). They should contain what is, and is not, reasonable to expect patients to be able to comply with (Sullivan et al., 2004). Kontio et al. (2010) were more specific, outlining plans should be negotiated detailing what support in the seclusion room will be given, agreements for leaving the door open and the provision of post-seclusion care. Similar to findings by Kontio et al. (2012), patients in the study said professionals did not always have a clear plan, or at least did not tell them what it was. If they did, the plans were vague *don't fight, don't shout, keep calm, is that a plan?* Furthermore, plans seemed inconsistent in the way they were discussed or administered. Overall, patients disputed they were involved in formulating plans and said they were not explicitly told what professionals expected in order to release them.

Of the expectations patients could identify, being calm was the most important, but still *went without saying*. Meehan et al. (2004) reported 100% of professionals thought seclusion helped patients calm, whereas only one third of patients agreed. Wynaden et al. (2002) also questioned it, as only 47% of patients said they could calm in seclusion. The findings indicated patients who did not necessarily feel calm, might pretend to be calm in order to secure release. Whereas, other studies have suggested patients appeared calm because they felt powerless (Mason and Whitehead, 2001) or that, '…what constitutes calm in this environment could simply be a manifestation of defeat and immobility', (Fish, 2018, p145).

There was some consensus between professionals and patients about what the expectations for release might be (see section 7.9). Yet, even if these expectations were met, release was not necessarily granted as patients often remained secluded for a further period of time. Patients experienced it as waiting to be released, but were not clear why. For those who had not been secluded before, the review process, the *comings and goings* of the professionals and being told to wait, were experienced as confusing and, as described above caused frustration.

A minority of patients valued the peace seclusion offered, whilst others worried about the reaction of other patients on the main ward preferring to stay in where they were (Beer, 2008; Laiho et al., 2013). Most patients wished to be released at the earliest opportunity. As outlined in chapter two, patients thought they remained secluded for *too long* (Allen et al., 2003; El-Badri and Mellsop, 2008; Sambrano and Cox, 2013).

A consequence of this was that their anger at being secluded may be superseded by anger at remaining secluded. Gildberg et al. (2015) described that when episodes of mechanical restraint were prolonged, patients became trapped in spirals of frustration and protests, which further impacted negatively on assessment. In the study waiting to be released exacerbated not only anger, but anxiety and boredom. Waiting also encouraged patients to *act out*. This suggests professionals need to clearly inform patients what they are doing and why, plus facilitate release as soon as patients appear ready.

Overall, the findings of the patient study indicated patients did not have a voice, nor were they actively involved in planning or agreeing release. Patient involvement in decisions has been shown to be lacking, especially for those who were secluded (Kontio et al., 2012; Soininen et al., 2012; Van der Merwe et al., 2013). Involvement in treatment decisions supported recovery and helped patients achieve personal goals (Jennings et al., 2018), and was recommended as a standard for all adult mental health services in England and Wales (NICE, 2011). Yet, Kaminskiy (2015) stated a shift in the balance of the existing power arrangements to involve patients in shared decisions for seclusion would be difficult to achieve in institution-based mental health services. Plus, as seclusion is a behavioural rather than a therapeutic intervention, the ideal of full equality and involvement is perhaps not realistic.

The next section summarises suggestions made by patients in the literature review and interview study.

7.7 Recommendations made by patients

The thesis identified a number of recommendations made by patients to increase their involvement in decisions to be released and improve their overall experience of seclusion. These were:

- To be treated with respect and dignity;
- To know why they have been secluded;
- If possible professionals should know something about a patient’s history, circumstances and preferences for managing difficult situations;
- A dedicated nurse should be identified to have the responsibility of communicating important information and promoting discussion;
- An independent person should be available to help and advocate. It was not clear if patients would view professionals working in the same service as independent, and too many professionals outside the room who patients did not know was overwhelming;

- Families or significant others named by the patient in seclusion should be made aware in line with the patient's wishes; and,
- Professionals should have better training to communicate, de-brief, and prevent seclusions.

To conclude part one, neither literature review found much evidence detailing the experiences or factors impacting upon release. The interview studies were the first in-depth explorations and understanding of professional and patient views about the topic. The thesis raised a number of concerns regarding current clinical practices which are outlined fully in the final chapter (see section 8.4). It also highlighted a number of areas of practice and service provision which would benefit further study (see section 8.5). Part two of this chapter now presents a synthesis of the findings from all four studies.

Part two: Synthesis of findings

7.8 Trajectory of release

The findings of the two literature reviews and two interview studies were synthesised using a qualitative framework synthesis method (see section 3.3.4.1). The approach had pragmatic advantages as it supported translation of the findings into elements of release from seclusion which have relevance to clinical practice. The findings suggested the decision to release patients from seclusion followed a trajectory which was under the control of professionals, with patients having little say over what happened. Release was a gradual and tested process dependent upon a number of multi-level factors (see section 7.9). Professional decisions were guided initially by safety and asked, *is it safe enough*? This assessment of safety was often a subjective and unstructured judgement based upon perceptions of risk to self, professional colleagues and other patients. Running parallel to the risk assessment was an assessment of readiness for release. Readiness was indicated by a number of expectations patients should be able to meet (see section 7.9). However, even if patients demonstrated these, there were further factors which acted as barriers or facilitators which impacted upon and could potentially delay release (see section 7.10).

7.9 Indicators of readiness for release

There was a number of expectations professionals wanted patients to meet prior to their release (see figure 7.1). Some of these they clearly communicated, although as suggested earlier, others were unspoken or implicit. The relevance of each of the seven indicators remains to be presented back to professionals and patients for discussion and feedback.

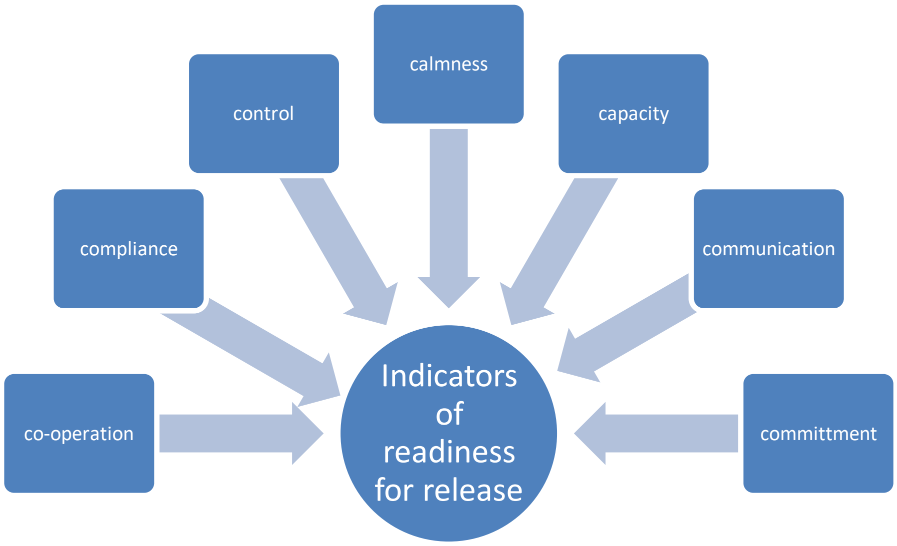


Figure 7.1 Seven indicators of readiness for release from seclusion

7.9.1 Calmness

- The patient is settled, not shouting, not threatening or not displaying anger;
- Professionals should be aware patients may act calm to secure release, although the insight to realise they should be calm and their ability to act calm, suggests they may have a degree of control over their actions.

7.9.2 Control

- The patient demonstrates control over their actions and interactions;
- Self-control is indicated when a patient is able to reason with professionals, talk about what had happened, have ceased unwanted behaviours and remains in control when limits are placed upon them.

7.9.3 Compliance

- Patients are able or willing to comply with requests;
- Compliance might be indicated by patients accepting medication against their wishes, communicating or following direction;
- Non-compliance may be a protest behaviour therefore professionals should consider if it might cease if the patient is released.

7.9.4 Co-operation

- Co-operation begins when patients have calmed, are willing to engage in discussion and not fighting against direction;
- Co-operation is interactional therefore professionals should engage the patient in meaningful dialogue and involve them in decisions when possible;
- The ability and likelihood patients will co-operate tends to increase as the seclusion progresses.

7.9.5 Capacity

- Capacity is affected by cognitive ability, diagnosis or the influence of illicit substances;
- Professionals should take care not to misjudge decisions or insist patient views and decisions align with their own, or those of their team;
- If patients lack capacity, have poor cognitive functioning or disagree with the MDT, the possibility of involving advocacy, family members or advance directives should be available to ensure patient rights and wishes are upheld.

7.9.6 Communication

- Efforts to encourage communication should be made throughout the seclusion episode;
- A lead professional should be identified to be responsible to ensure the exchange of information takes place;
- Communication may initially be limited but should increase as the episode moves towards release to allow a thorough assessment of mental state, risk and intent;
- Care should be taken release is not delayed for patients with poor or impaired communication.

7.9.7 Commitment

- Professionals should outline, negotiate a clear plan for release to which both patients and professionals should demonstrate intent to follow;
- Patients should show commitment to remaining calm, in control, compliant and co-operative on their release.

7.10 Barriers and facilitators to release

As stated above, even if the indicators of readiness for release are met, other multi-level factors impact upon and may further delay the decision (see figure 7.2).

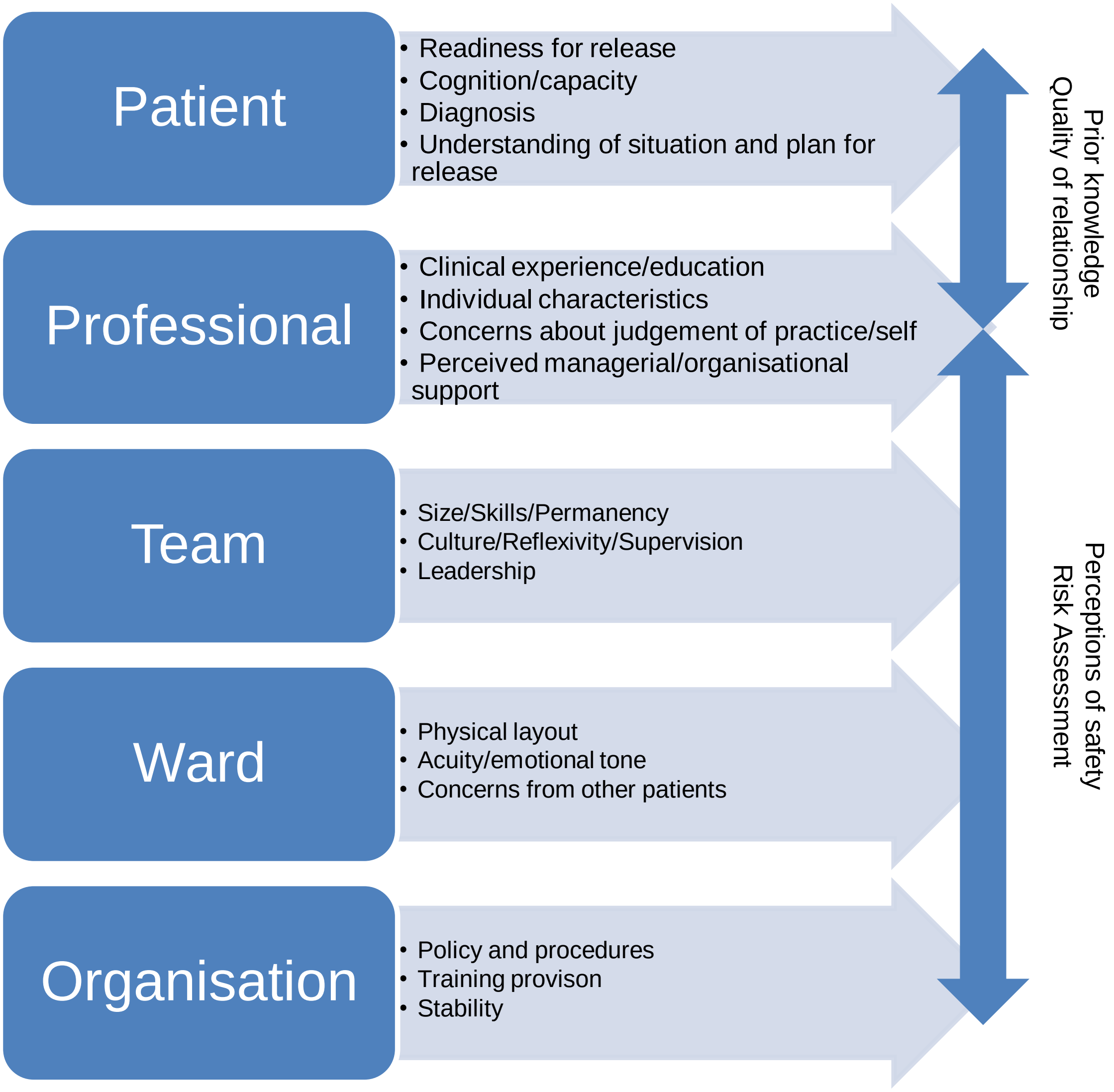


Figure 7.2 Multi-level barriers and facilitators to release

7.10.1 Patient - professional factors

- Efforts should be made where possible to ensure staff members previously acquainted with patients are used to support seclusion episodes;
- The quality of the relationship affects patient experience of being secluded and may be relevant to release from seclusion. Thus, professionals should have the skills to form and make efforts to establish positive relationships with patients in seclusion; and,
- Patients should be given information about why they were secluded and what they need to do to be released.

7.10.2 Professional characteristics

- The clinical experience, ability to lead and confidence in own practice is paramount for clinicians making decisions to release patients from seclusion to ensure release is safe and at the earliest opportunity;
- Professionals should be self-aware and reflect upon their impact on seclusion decisions;
- Professionals should ensure they understand the policy and facilitate release as soon as possible.

7.10.3 Influence of team

- Teams should have strong leadership;
- Teams should ensure permanent staff members with skills to interact and lead decisions to release patients from seclusion are available at all times;
- Teams should be engage in discussions about current and post-incident reflection on their performance; plus,
- Teams managing seclusion should be aware of the implicit cultural beliefs that operate locally and undertake team-based education with all MDT members.

7.10.4 Ward factors

- Wards should have facilities to be able to support patients post-seclusion to ensure least restrictive care can be delivered for their safety, privacy and dignity;
- Wards should maintain a safe and therapeutic milieu;
- Professionals should ensure other patients on the wards are reassured, supported and aware of what is happening within the bounds of confidentiality.

7.10.5 Organisational responsibilities

- Organisations should offer safe and stable environments in which care is delivered;
- Organisations should ensure policy and procedures are fit for purpose, disseminated and understood;
- Education about seclusion including representation from patients with lived experience should be delivered to all professionals involved in seclusion decision-making.

Many of these factors can be mitigated against. Moreover, awareness of their influence upon release could support professionals, teams and healthcare organisations to ensure release is safe, appropriate and patients remain secluded for the shortest time possible.

7.11 Discussion conclusion

To conclude, prior to the thesis little was known about the factors impacting upon or the experience of involvement in release from seclusion. Although professionals argued they negotiated, existing literature and the interview findings suggested patients disagreed and were not involved as much as they wanted. The chapter presents a list of recommendations from patients of ways in which they think their experience and involvement could be increased.

The thesis found safety as the overall consideration for release, and that some aspects of decisions to release were similar to those indicating seclusion would be used. However, it also identified release was a gradual tested process, giving time for other factors to be considered. The chapter summarises the findings and outlines a trajectory, indicators of readiness for release and notes further barriers and facilitators to release. It acknowledges, whilst further discussion is needed to evaluate the clinical relevance of the findings for professionals, an appreciation of the wider influences might support professionals to overcome the barriers to releasing patients at the earliest opportunity.

Finally, chapter eight provides a review of the thesis, an overall conclusion for the work and a discussion of the strengths and limitations of the study. It offers implications for practice and a list of recommendations for further study.

Chapter eight: Conclusion

8.1 Introduction

The thesis is a transparent and defensible account of PhD research exploring professional and patient experiences of release from an episode of seclusion in a mental health inpatient setting. Chapter eight provides an overview and conclusion for the thesis. Section 8.2 revisits the aims and objectives, the methodology and methods chosen to conduct the studies. Next, a summary of findings of the four studies and synthesis in chapter seven are presented. Section 8.3 outlines and discusses the strengths and limitations of the thesis. Chapter eight then lists implications for clinical practice highlighted by the thesis (see section 8.4) and makes a number of recommendations for future study (see section 8.5). Finally, the thesis ends with an overall conclusion to the PhD. A short reflective piece about my PhD journey and thoughts about the findings are presented in appendix ten.

8.2 Thesis overview

Chapter two outlined the current statutory guidance and evidence to explore why and how seclusion was used in clinical practice in England and Wales. It reported patients disliked seclusion, and overwhelmingly experienced it as difficult and distressing. Literature suggested professionals also disliked seclusion. They stated they only secluded patients as a last resort, but continued to support its use not knowing what else they could to manage violence and aggression. However, the chapter indicated there were signs the views of professionals were being challenged and beginning to change. Chapter two established:

- Little was known about the factors influencing or the experience of involvement in release from seclusion from either a professional or patient perspective; and,
- Existing evidence relating to seclusion decisions was focussed upon decisions to initiate episodes and was mainly from nurses.

The aim of the thesis was to explore professional and patient experiences of release from seclusion. It had two objectives which were to understand:

- What factors influence mental health professionals to release patients from seclusion?
- What are patients' experiences of being involved in release from an episode of seclusion?

Chapter three described the philosophical, theoretical and methodological knowledges used to conduct the thesis. An overview of a conceptual framework for the thesis was provided in table 3.6. As a piece of nursing research, the thesis aimed to answer a clinically focussed question, emphasising outcome over the adoption of a strict research methodology. However, the use of Spencer and Ritchie's (2014) framework analysis approach provided a structure to support the interpretation of experiential data. The pragmatic nature of the approach enabled the creation of tools and the selection of methods useful for exploring an area of nursing practice about which little was known. Chapter three explored the impact of my role as an insider nurse researcher. The potential for bias was examined further in chapter five (see sections 5.4 and 5.5), and discussed further below (see section 8.3). To give assurance my influence was both considered and visible, the processes of reflexivity and supervision were incorporated into the thesis to ensure methodological decisions and analytical processes were appropriate and transparent (see chapters three and five).

The design, methods and findings of studies in the thesis were presented in chapters four, five and six. Alternative approaches and methods used by other seclusion research studies were considered (see tables 3.1,3.2, 3.3 and 3.4), and a clear audit trail was provided in the thesis illustrating decisions taken at each stage of the design. Chapter four contained the search results and findings of two integrative literature reviews. Integrative reviews were selected for their appropriateness to identify literature from multiple sources (see sections 3.3.1 and 4.2.2), and complimented the pragmatic approach of the thesis.

- The review of professional literature (see section 4.2) included thirteen mixed primary research studies and two expert opinion articles. The articles were of mixed methodologies, variable quality and only contained brief references to release. The review generated seven themes. An overarching theme was maintaining safety, with the others being: risk assessment, control, interaction, external factors, compliance and lastly, release and reflection.
- The review of patient literature (see section 4.3) identified eleven research articles. Again they were of mixed methodologies, variable quality and only contained minimal references to release. The patient review generated four themes. These were: communication, control and compliance, delaying release and increasing patient involvement.

The reviews indicated further study was needed to understand the factors influencing release from seclusion, the impact of medics and the MDT on decisions, and professional and patient experiences of involvement in release.

Reading for the background chapter and the literature reviews failed to identify literature specifically related to the seclusion experiences in England and Wales of Black, Asian and Minority Ethnic (BAME) patients. Furthermore, only one international study was identified by the thesis that described the cultural and compounding factors seclusion had upon an indigenous population in Australia (Sambrano and Cox, 2013). Therefore, further study is urgently needed to address this imbalance to evidence and understand ways in which the BAME community may be unfairly prejudiced or discriminated against in regards to all aspect of seclusion use.

Chapter five described how the two qualitative interview studies were influenced both by PPI processes, ethical considerations and the use of framework analysis. Using semi-structured interviews, the studies collected and explored in-depth personal accounts, firstly from professionals and then from patients. The data was managed and analysed using the structured framework analysis method (see section 5.5). This enabled the coding, categorising, summary and development of explanatory themes, whilst retain authenticity as participant data could be drawn through, presented and interpreted to support the findings. The findings were given in chapter six.

- The professional interview study (see section 6.2) involved twenty-one professionals from MDTs working on four inpatient wards with seclusion facilities. The professionals all had recent experience of decision-making to release patients from seclusion. The study generated six themes which were: do as you're told, do I believe you, in the end it's your choice, can we cope?, do I don't I?, and covering your back.
- The patient interview study involved fifteen patients who had been secluded on one of the four wards during the study period. The five themes generated were: the initial crisis, what do I need to do to get out?, what was I waiting for? being released, and finally, doing things differently.

The findings of all four studies were then discussed in chapter seven. Specific attention was given to the impact of nurses upon release, plus to recommendations made by patients about how their experience could be improved and their involvement in decisions increased. The professional study found perceptions of safety, the experience of the professional leading the review and a number of multi-level factors appeared to be as influential as the presentation of the patient in seclusion. Patients were unclear what they needed to do be released and felt the communication offered by professionals was inadequate. Lastly, the experience of professionals and patients involved in release were synthesised to provide an understanding into an area of clinical healthcare practice upon which little was known (see section 7.8). The synthesis described a trajectory for decision-making that described release from seclusion, a list of seven indicators suggesting patients may be ready for release (see section 7,9), and finally barriers and facilitators which further impacted upon decisions to release (see section 7.10).

The following section outlines the limitations and strengths of the thesis.

8.3 Limitations and strengths of the thesis

The thesis had multiple strengths. It was developed and written in accordance with the quality criteria outlined by Denzin and Lincoln (2018) and the COREQ guidelines (Tong et al., 2007) (see section 3.4). Prior to the thesis, practice knowledge regarding release was limited to policy and procedural guidance, plus to minimal references in the wider literature regarding the use and experiences of seclusion. A major strength of the thesis was that the professional literature and interview study were both peer reviewed and published in nursing journals (Jackson et al., 2018; Jackson et al., 2019a). However, there were number of methodological limitations which must be considered when appraising the quality and relevance of the research which are discussed below.

The pragmatic choices made over the course of the PhD guided the methodological decisions and methods selected to provide rigour and produce a defendable thesis. The legitimacy of nursing research to replace strict philosophical allegiance with a focus upon outcome was supported by literature (Streubert and Carpenter, 2011) (see section 3.2.2.2). The thesis design developed, from the original idea which was to explore and quantify the factors which influenced professionals making decisions to release patients from seclusion, to one that was exploratory and incorporated the views of patients. Including the two perspectives strengthened the findings. According to Hawsawi et al. (2020), there is a shortage of literature regarding shared interventions. Furthermore, Goulet and Larue (2016) stated research into seclusion should include patients and professionals as they may share or have opposing views. The PhD was a time-bound, therefore the inclusion of patient views limited the thesis to an exploratory study, however there are plans to take the findings forward to evaluate their usefulness to clinical practice.

The choice to use an integrative review methodology was justified (see section 3.3.2 and table 3.2). It enabled the inclusion of material from wider sources, although it located little evidence of relevance outside peer reviewed journals (see sections 4.2 and 4.3). It is possible the reviews were limited by the search terms and screening criteria used to identify evidence (see tables 4.3 and 4.11). The choice not to include evidence relating to other forms of restraint may have meant relevant literature was omitted, although the decision can be defended. Muir-Cochrane et al. (2018) stated physical restraint is almost invariably used when seclusions are initiated. Furthermore, research evidence does not always deal with restraint and seclusion separately (Brophy et al., 2016; Riahi et al., 2016; Sethi et al., 2018; Tingleff et al., 2019). However, factors affecting release from a physical restraint hold may differ to those influencing release from a locked room. This view was supported as, professionals in the thesis suggested release from seclusion was gradual, considered and tested, with time for MDT review and discussion. Release from seclusion is therefore arguably more comparable to release from a mechanical restraint. Literature about the effect of the professional-patient relationship and release from mechanical restraint were referred to in the discussion sections, although not included in the review as mechanical restraint was not used by healthcare staff in the research setting.

Auditability and trustworthiness were supported in the thesis as it contained excerpts from the author's reflective and coding journals. Their inclusion demonstrated reflexivity and enhanced transparency in the design and decision-making process (see sections 3.2.4 and 5.4). There is the possibility biases were present in the thesis. I was an insider, the implications of which may have affected it in a number of ways. The thesis discussed the advantages and disadvantages that previous knowledge of the topic, knowing many of the participants and familiarity with the research setting might have had upon the research (see sections 3.2.4). The pitfalls of recruiting colleagues, plus undertaking the dual role of researcher-colleague were explored and reflected upon in detail (see sections 3.2.5, 5.2 and 5.4). However, my interest in the effect of the policies and processes for managing seclusion episodes, enabled the thesis to remain focussed upon the clinical decision and outcome rather than be distracted by moral and ethical debates about the rights and wrongs of secluding patients.

Professional colleagues and patients recognised the importance of the work and kindly agreed to participate. A strength of the study was that all the participants had been directly involved release, which also increased the credibility of the findings.

Although recruitment was not systematic due to the study being part-time, the design ensured all those interviewed had access to support at any time should it be required (see section 5.2.2.1). Comparable seclusion literature articles offered conflicting advice in regards to the time permitted between the seclusion and research interview to mitigate for issues around recall and the ability to participate effectively, many of which had a cut-off date (see section 4.2.3). Whereas, the patient study allowed patients time to recover and participate at any point until their discharge from inpatient care. This proved useful as patients were not always able or willing to participate within seven days of their seclusion ending. Furthermore, the professional study permitted interviews to be scheduled and re-scheduled to fit around clinical duties and shift working patterns. The practical nature of the decisions, encouraged participation but remained responsive to the demands and conditions of the research setting.

The pragmatic design also allowed the two samples used to differ in type, composition and size (see sections 5.3.2.1 and 5.3.2.2). Samples for each study were selected for their appropriateness, which further increased the credibility of findings. The samples were of sufficient diversity and size for qualitative studies. However, the transferability of research relating to seclusion is limited due to differences in local populations, plus influences from policy, practice and cultures (see sections 2.7 and 2.9). The findings could be of interest to people working in similar settings and service providers. Limited data were collected from participants to preserve anonymity and provide confidentiality.

Credibility was further supported as twenty-one members of the MDT working on the wards in the research setting participated and shared their experiences (see table 5.2). This research was the first to involve members of the MDT and was able to note some novel insights from the perspectives of both nurses and non-nurses. Biases may have been introduced as the researcher may not have captured all the views and practices of the professionals, those interviewed may have given social desirable responses to protect their professional credibility, and the views of professionals not interviewed were not represented. Furthermore, the inclusion of a range of professions may have compromised the depth of the data.

The impact of the MDT or AHPs upon seclusion decisions had not been researched before, and very little experiential evidence from medics was identified, which added to the value of the findings. Previous evidence was mainly from nurses (see section 5.2.3.2). The views of nurses may have been overrepresented, but the study sample included a range of skills and experiences. This was a further strength as, the findings identified nurses with more experience approached decisions to release in a different way to those with lesser experience. The transferability of the findings may be affected by the gender imbalance in the sample toward females, however it is representative of the wider healthcare workforce.

The thesis was also the first to explore patient involvement in seclusion decisions. As with most seclusion literature (see section 2.8), it found patient views about seclusion were mostly negative, but also that the length of their seclusion impacted upon their experience (Georgieva et al., 2012). The findings therefore have relevance, as they identified ways durations patients spend secluded could be reduced and potential improvements could be made to their experience. A possible limitation was that in the literature and interview study, patients found it difficult to separate the decision from their overall experience of seclusion, therefore their data may have not directly related to release. The convenient patient sample may not have captured the complete range of views of those who have been secluded, although arguably that would not be achievable.

Difficulties were encountered during recruitment which prevented all potential patient participants from being systematically approached. These included being a lone researcher, a part-time PhD student and needing to rely on the care team to agree to make the initial approach to the patient. The importance of, and barriers to, recruiting mental health patients into research were explored (see section 5.4.2.2). It is vital the voice of this group are heard, however they are often dismissed as not able to participate due to concerns over their vulnerability or capacity (Knaak et al., 2017). The ethical and clinical implications of researching with patients were discussed (see sections 3.2.5 and 5.2.2.2), with particular thought given to the clinician-researcher relationship (see section 3.2.5.4). The exclusion of families and carers from the study may be a limitation to the thesis, however they are not generally consulted or involved in decisions to release patients. Further to this, not all patients thought family members would understand what seclusion entailed. Although, attention should be given to their views and is an area for possible future study.

Pragmatic decision were taken to select the most appropriate tools and methods to answer the questions posed in the thesis. The use of ethnographic or observational methods to collect data for the thesis was ruled out for a number of reasons (see table 3.1). Semi-structured interviews permitted the collection of in-depth data, whilst enabled the researcher to explore topics of interest and participants to deviate or raise issues not thought of by the researcher. The limitations of interview studies were listed (see section 6.4), but they were preferred despite risking recall bias (see section 6.4). Further concerns about the accuracy and completeness of the data collected could be questioned as not all patients agreed to their interview being recorded (see table 6.2). Efforts were made to counter this by ensuring notes were transcribed as soon as possible after the interview. The interview guides were developed from the literature and integrative reviews. Although they were not validated, the questions were assessed by PPI advisors and piloted with participants to ensure they were fit for purpose. The data collected was rich, but the quality and depth may have been limited by skill of the researcher. The method was a suitable choice for a for novice researcher (Gale et al., 2013) (see section 3.3.4). Although, as I had not analysed qualitative data, or led a research project prior to the PhD, the methods and techniques may not have been used to their full potential. Performance and adjustment were discussed in supervision, and ongoing reflexivity saw the quality of later interviews and the level of analysis improve.

A further strength of the study was that framework analysis could handle the large amount of data using systematic and transparent processes (Yin, 2014; Gale et al., 2013), (see sections 5.5). Furthermore, it enabled the words of the participants to be drawn through to offer authenticity, to both illustrate and support the findings. The synthesis of the findings acknowledged the proposed indicators of readiness for release should be presented to professionals and patients for feedback and comments to support their credibility. The indicators could be useful to help patients understand what professionals are looking for, plus may guide professionals in their decision-making. However, it is not suggested they are a replacement for clinical practice experience, nor do they account for the other factors such as safety, the availability of resources or the acuity of the wider ward (see section 7.10).

The remaining sections of the thesis outline the clinical implications for mental health professionals and service providers developed from the findings, plus identifies recommendations for further study. Section 8.6 offers final concluding remarks.

8.4 Implications for practice

Professionals, organisations, commissioners and policy-makers should be aware of the recommendations made by patients in regards to their seclusion experience and potential for involvement in decisions about the care (see section 7.7). Mental health service providers who permit seclusion should:

- Be aware of the barriers and facilitators which influence patients release from seclusion;
- Deliver education and skills training to all professionals using seclusion about:

    - the effect of seclusion upon patients;
    - the importance of skilled communication and developing working relationships with patients;
    - policy and procedure;
    - encourage reductions in the use of seclusion and restraint; and,
- Ensure adequate resources are available to ensure release is safe, appropriate and at the earliest opportunity.

Senior leaders should:

- Ensure they are visible to support seclusion decisions;
- Have an awareness of the significance of their influence and experience when making decisions with junior professionals;
- Recognise the difficulties faced by frontline professionals managing violence and aggression and undertaking seclusion reviews;
- Challenge inconsistent and subjective seclusion decisions;
- Provide supervision, clinical and emotional support to junior professionals.

Team leaders should ensure:

- Regular team reflective sessions and development sessions in regards to seclusion practices are offered;
- Team cultures are considered when devising education, policy and guidance which should include nurses, senior and junior medics, AHPs and HCAs.

Healthcare professionals conducting seclusion reviews and making decisions to release patients should:

- Ensure their expectations for release are clear and reasonable;
- Proactively plan, involve, negotiate and share plans for release with patients. These plans should be detailed, specific and clear;
- Communicate, reassure and foster positive relationships with patients in seclusion;
- Use evidence-based assessment tools to manage risk as per standard clinical practice;
- Use policy to ensure patients are released at the earliest opportunity rather than wait for the next seclusion review;
- Not expect patients to agree with being secluded;
- Understand the personal situation of the patient and take great care not to confuse insight with disagreement.

8.5 Recommendations for future research

This thesis identified a number of areas for further research to identify ways of improving patient experience and understand how durations might be reduced. Recommendation for research includes:

- Further exploration and understanding of the experiences, impact and potential benefits of MDT involvement upon release;
- Identification and measurement of the characteristics, qualities, and skills of professionals which could support quick and safe release from seclusion;
- Development and testing of strategies aimed at increasing the involvement of patients in decisions to be released from seclusion;
- The creation and validation of an appropriate assessment tool which could offer support to professionals releasing patients from seclusion;
- Examination of the ways in which families, carers and advocacy could be involved in supporting the release of patients who have been seclusion; and
- An exploration and understanding of the experience of BAME patients who have been subjected to seclusion and professionals supporting their care.

8.6 Thesis conclusion

To conclude, the thesis was the first to specifically explore the factors influencing and the experience of being involved in release from an episode of seclusion in an inpatient mental health setting, either from the professional or patient perspective. Therefore, the findings provided original knowledge and insight into an area of clinical practice upon which little was known. The thesis found release from seclusion was a gradual and tested process, mainly informed by perceptions of safety, under the control of professionals. The experience of patients suggested they did not feel heard or involved, and were not clear what was expected of them. Patients felt they were secluded for too long and if even when they felt ready for release, they were kept waiting in seclusion which compounded their fear and frustration. There were a number of implicit and explicit indicators which suggested a patient was be ready for release. These indicators were calmness, compliance, control, co-operation, capacity, communication and commitment. Professionals acknowledged even when patients met these criteria, their decisions were further impacted by a complex interaction of multi-level influences which included individual, team, ward culture, environmental and organisational factors. In addition, national policy and drives to reduce the use of restrictive interventions in mental health services also affected the way in which seclusion were ended. Nurses in particular feared their credibility was being judged and their practice scrutinised. The thesis has provided information that can be used to support professionals to understand their impact upon decisions to release patients from seclusion and raise awareness of the patient voice. Although, it is still not clear how patients could be involved in decisions about their release and what that would look like.

List of References

Abderhalden, C., Needham, I., Dassen, T., Halfens, R., Haug, H. and Fischer, J. 2008. Structured risk assessment and violence in acute psychiatric wards: randomised controlled trial. *The British Journal of Psychiatry.* **193**(1), pp.44-50.

Adams, J., Drake, R. and Wolford, G. 2007. Shared Decision-Making Preferences of People With Severe Mental Illness. *Psychiatric Services.* **58**(9), pp.1219-1221.

Adams, W. 2015. *Conducting semi-structured interviews.* 4th ed. San Francisco: Jossey-Bass.

Adler, P. and Adler, P. 2012. *Expert voices.* National Centre for Research Methods Review Discussion Paper.

Agenda. 2018. *Agenda briefing on the use of restraint against women and girls.* London: Agenda.

Aguilera-Serrano, C., Guzman-Parra, J., Garcia-Sanchez, J.A., Moreno-Küstner, B. and Mayoral-Cleries, F. 2018. Variables Associated With the Subjective Experience of Coercive Measures in Psychiatric Inpatients: A Systematic Review. *The Canadian Journal of Psychiatry.* **63**(2), pp.129-144.

Aita, M. and Richer, M. 2005. Essentials of research ethics for healthcare professionals. *Nursing & Health Sciences.* **7**(2), pp.119-125.

Al-Yateem, N. 2012. The effect of interview recording on quality of data obtained: a methodological reflection. *Nurse researcher.* **19**(4), pp.31-35.

Allen, M., Carpenter, D., Sheets, J., Miccio, S. and Ross, R. 2003. What do consumers say that they want and need during a psychiatric emergency? *Journal of Psychiatric Practice.* **9**(1), pp.39-58.

Alty, A. 1994. *Seclusion and mental health : a break with the past.* London: Chapman & Hall.

Ambrosini, D. and Crocker, A. 2007. Psychiatric Advance Directives and the Right to Refuse Treatment in Canada. *The Canadian Journal of Psychiatry.* **52**(6), pp.397-402.

Ambrosio, F.J. 1987. Gadamer's Hermeneutics: A Reading of Truth and Method, by Joel C. Weinsheimer. *Journal of the British Society for Phenomenology.* **18**(2), pp.194-196.

American Psychiatric Nurses Association (APNA). 2018. *Position Statement: The Use of Seclusion and Restraint.*

Anderson, C. 2010. Presenting and evaluating qualitative research. *American journal of pharmaceutical education.* **74**(8), pp.141-141.

Andrews, T. 2016. Ontological Issues in Qualitative Research in Nursing. *Texto & Contexto - Enfermagem.* **25**.

Angus, J.E. and Clark, A.M. 2012. Using critical realism in nursing and health research: promise and challenges. *Nursing inquiry.* **19**(1), pp.1-3.

Askew, L., Fisher, P. and Beazley, P. 2019. Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective. *Journal of psychiatric and mental health nursing.* **26**(7-8), pp.274-285.

Aspers, P. and Corte, U. 2019. What is Qualitative in Qualitative Research. *Qualitative Sociology.* **42**(2), pp.139-160.

Asselin, E. 2003. Insider Research: Issues to Consider When Doing Qualitative Research in Your Own Setting. *Journal for Nurses in Staff Development.* **19**(2), pp.99-103.

Australian Health Ministers' Advisory Council. 2013. *The National framework for recovery-oriented mental health services.* Australia: Australian Government.

Australian National MH Commission. 2015. *A Case for Change: position paper on seclusion, restraint and restrictive practices in mental health services.* Sydney: National Mental Health Commission.

Aveyard, H. 2010. *Doing a literature review in health and social care : a practical guide.* Second edition. ed. Maidenhead: McGraw-Hill/Open University Press.

Baker, A., Young, K., Potter, J. and Madan, I. 2010. A review of grading systems for evidence-based guidelines produced by medical specialties. *Clinical medicine (London, England).* **10**(4), pp.358-363.

Baker, J., Berzins, K., Kellar, I. and Canvin, K. 2019. Reducing Restrictive Practices: Understanding Key Intervention Components. *Mental Health Research in Leeds.* [Online]. Available from: https://mentalhealthresearchleeds.co.uk/2019/06/13/reducing-restrictive-practices-understanding-key-intervention-components/

Barkham, M. and Margison, F. 2007. Practice-based evidence as a complement to evidence-based practice: From dichotomy to chiasmus. In: Freeman, C. and Power, M. eds. *Handbook of Evidence-Based Psychotherapies: A Guide for Research and Practice.* Chichester: Wiley, pp.443-476.

Barnao, M., Robertson, P. and Ward, T. 2012. Ethical decision making and forensic practice. *The British Journal of Forensic Practice.* **14**(2), pp.81-91.

Barnett-Page, E. and Thomas, J. 2009. Methods for the synthesis of qualitative research: a critical review.

Beck, K. 2015. Seclusion Reviews In: Stringer, S., et al. eds. *Psychiatry: Breaking the Ice Introductions, Common Tasks, Emergencies for Trainees.* Chichester: John Wiley and Sons Ltd, p.246.

Beer, D. 2008. Psychiatric intensive care. In: Beer, D., et al. eds. *Psychiatric Intensive Care.* Second edition. ed. Cambridge: Cambridge University Press.

Bennell, C., Jones, N. and Corey, S. 2007. Does use-of-force simulation training in Canadian police agencies incoroporate principles of effective training? *Psychology, Public, Policy, and Law.* **13**, pp.35-273.

Benner, P.E. 2001. *From novice to expert: excellence and power in clinical nursing practice.* Commemorative ed. Upper Saddle River, NJ: Prentice Hall.

Berg, K. and Tranøy, E. 1983. *Research Ethics.* New York: Alan Liss.

Bergk, J., Einsiedler, B., Flammer, E. and Steinert, T. 2011. A Randomized Controlled Comparison of Seclusion and Mechanical Restraint in Inpatient Settings. *Psychiatric Services.* **62**(11), pp.1310-1317.

Bergum, V. 2004. Relational ethics in nursing. In: Storch, J., et al. eds. *Toward a moral horizon: Nursing ethics for leadership and practice* Toronto: Pearson Education, pp.485-503.

Bhaskar, R. 1979. *Philosophy and the Human Sciences: the Possibility of Naturalism: a Philosophical Critique of the Contemporary Human Sciences.* 3rd ed. London: Routledge.

Bhavsar, V., Sethi, F. and Hillier, B. 2014. Medical guidelines for PICU seclusion reviews. *Journal of Psychiatric Intensive Care.* **10**(1), p40.

Blair, E. 2016. A reflexive exploration of two qualitative data coding techniques. *Journal of Methods and Measurement in the Social Sciences.* **6**(1), pp.14-29.

Bloom, S. 2002. Creating Sanctuary. *Violence and Coercion in Mental Health Settings: Eliminating the use of seclusion and restraint.* [Online]. pp.1-20. [Accessed 21/08/2020].

Bonner, G., Lowe, T., Rawcliffe, D. and Wellman, N. 2002. Trauma for all: A pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing.* **9**(4), pp.465-473.

Bonney, S. and Stickley, T. 2008. Recovery and mental health: a review of the British Literature. *Journal of Psychiatric and Mental Health Nursing.* **15**(2), pp.140-153.

Boumans, C., Egger, J., Bouts, R. and Hutschemaekers, G. 2015. Seclusion and the importance of contextual factors: An innovation project revisited. *International Journal of Law and Psychiatry.* **41**, pp.1-11.

Boumans, C., Egger, J., Souren, P. and Hutschemaekers, G. 2014. Reduction in the use of seclusion by the methodical work approach. *Journal of Psychiatric and Mental Health Nursing.* **23**, pp.161-170.

Boumans, C., Egger, J., Souren, P., Mann-Poll, P. and Hutschemaekers, G. 2012. Nurses' decision on seclusion: patient characteristics, contextual factors and reflexivity in teams. *Journal of Psychiatric and Mental Health Nursing.* **19**(3), pp.264-270.

Bowen, G. 2008. Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research.* **8**(1), pp.137-152.

Bowen, G. 2009. Document Analysis as a Qualitative Research Method. *Qualitative Research Journal.* **9**(2), pp.27-40.

Bowers, L. 2007. The City-128 study of observation and outcomes. *BMC Psychiatry.* **7**(Suppl 1), pp.S122-S122.

Bowers, L. 2009. Association Between Staff Factors and Levels of Conflict and Containment on Acute Psychiatric Wards in England. *Psychiatric Services.* **60**(2), pp.231-239.

Bowers, L., Alexander, J., Simpson, A., Ryan, C. and Carr-Walker, P. 2004. Cultures of psychiatry and the professional socialization process: the case of containment methods for disturbed patients. *Nurse Education Today.* **24**(6), pp.435-442.

Bowers, L. and Crowder, M. 2012. Nursing staff numbers and their relationship to conflict and containment rates on psychiatric wards-A cross sectional time series Poisson regression study. *International Journal of Nursing Studies.* **49**(1), pp.15-20.

Bowers, L., Cullen, A., Achilla, E., Baker, J., Khondoker, M., Koeser, L., Moylan, L., Pettit, S., Quirk, A., Sethi, F., Stewart, D., McCrone, P. and Tulloch, A. 2017. Seclusion and Psychiatric Intensive Care Evaluation Study (SPICES): combined qualitative and quantitative approaches to the uses and outcomes of coercive practices in mental health services. *Health Services and Delivery Research.* **5**(21), pp.1-116.

Bowers, L., Ross, J., Nijman, H., Muir-Cochrane, E., Noorthoorn, E. and Stewart, D. 2012. The scope for replacing seclusion with time out in acute inpatient psychiatry in England. *Journal of Advanced Nursing.* **68**(4), pp.826-835.

Bowers, L., Van Der Merwe, M., Nijman, H., Hamilton, B., Noorthorn, E., Stewart, D. and Muir-Cochrane, E. 2010. The Practice of Seclusion and Time-out on English Acute Psychiatric Wards: The City-128 Study. *Archives of Psychiatric Nursing.* **24**(4), pp.275-286.

Brady, N., Spittal, M., Brophy, L. and Harvey, C. 2017. Patients' Experiences of Restrictive Interventions in Australia: Findings From the 2010 Australian Survey of Psychosis. *Psychiatric Services.* **68**(9), pp.966-969.

Brannen, J. and Nilsen, A. 2011. Comparative Biographies in Case-based Cross-national Research: Methodological Considerations. *Sociology.* **45**(4), pp.603-618.

Braun, V. and Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology.* **3**(2), pp.77-101.

Braun, V. and Clarke, V. 2013. *Successful qualitative research: a practical guide for beginners.* Los Angeles, CA: Sage.

Breakwell, G. 2007. *The psychology of risk.* Cambridge: Cambridge University Press.

Bressington, D., Stewart, B., Beer, D. and MacInnes, D. 2011. Levels of service user satisfaction in secure settings - A survey of the association between perceived social climate, perceived therapeutic relationship and satisfaction with forensic services. *International journal of nursing studies.* **48**, pp.1349-1356.

Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughes, J., Tysall, C. and Suleman, R. 2014. Mapping the impact of patient and public involvement on health and social care research: a systematic review. **17**(5), pp.637-650.

Brinkman, G. 2018. The Interview. In: Denzin, N. and Lincoln, Y. eds. *The SAGE handbook of qualitative research* 5th ed. Thousand Oaks, California: Thousand Oaks, CaliforniaSAGE Publications, Inc.

Brophy, L., Roper, C., Hamilton, B., Tellez, J. and McSherry, B. 2016. Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings. *Australian health review : a publication of the Australian Hospital Association.* **40**(6), pp.599-604.

Broyles, L., Rodriguez, K., Price, P., Bayliss, N. and Sevick, M. 2011. Overcoming Barriers to the Recruitment of Nurses as Participants in Health Care Research. *Qualitative Health Research.* **21**(12), pp.1705-1718.

Brunswik, E., Hammond, K.R. and Stewart, T.R. 2001. *The essential Brunswik: beginnings, explications, applications.* Oxford: Oxford University Press.

Bryman, A. 2012. *Social Research Methods.* 4th ed. Oxford: Oxford University Press.

Bullock, R., McKenna, B., Kelly, T., Furness, T. and Tacey, M. 2014. When reduction strategies are put in place and mental health consumers are still secluded: An analysis of clinical and sociodemographic characteristics. *International Journal of Mental Health Nursing.* **23**(6), pp.506-512.

Burrows, E. and Walker, S. 2012. Developing a Critiquing Tool for Expert Opinion. *Working Papers in Health Sciences.* **1**(3).

Caputo, J. 2000. *More Radical Hermeneutics on not knowing who we are.* Bloomington: Indiana University Press.

Care Quality Commission (CQC). 2015. *Brief guide [2]: positive behaviour support for people with behaviours that challenge.*

Carmichael, J., Misselbrook, T., Marriner, L., Forrest, A. and Molodynski, A. 2016. Clinicians' attitudes towards patient involvement in mental health research. *Progress in Neurology and Psychiatry.* **20**(1), pp.22-25.

Carper, B. 1978. Fundamental Patterns of Knowing in Nursing. *Advances in Nursing Science.* **1**(1), pp.13-24.

Carroll, C., Booth, A. and Cooper, K. 2011. A worked example of "best fit" framework synthesis: A systematic review of views concerning the taking of some potential chemopreventive agents. *BMC medical research methodology.* **11**(1), pp.29-29.

Chambers, M., Kantaris, X., Guise, V. and Välimäki, M. 2015. Managing and caring for distressed and disturbed service users: the thoughts and feelings experienced by a sample of English mental health nurses. *Journal of Psychiatric and Mental Health Nursing.* **22**(5), pp.289-297.

Chien, W., Chan, C., Lam, L. and Kam, C. 2005. Psychiatric inpatients’ perceptions of positive and negative aspects of physical restraint. *Patient Education and Counseling.* **59**(1), pp.80-86.

Ching, H., Daffern, M., Martin, T. and Thomas, S. 2010. Reducing the use of seclusion in a forensic psychiatric hospital: assessing the impact on aggression, therapeutic climate and staff confidence. *The Journal of Forensic Psychiatry & Psychology.* **21**(5), pp.737-760.

Chinn, P. and Kramer, M. 2018. *Knowledge Development in Nursing: Theory and Process.* Elsevier.

Clarke, L. and Clarke, T. 2014. Realizing nursing: a multimodal biopsychopharmacosocial approach to psychiatric nursing: Biopsychopharmacosocial approach. *Journal of Psychiatric and Mental Health Nursing.* **21**(6), pp.564-571.

Cleary, M., Hunt, G. and Walter, G. 2010. Seclusion and its context in acute inpatient psychiatric care. *Journal of Medical Ethics.* **36**(8), pp.459-462.

Cleary, M., Lees, D. and Sayers, J. 2018. Friendship and Mental Health. *Issues in Mental Health Nursing.* **39**(3), pp.279-281.

Cohen, M., Kahn, D. and Steeves, D. 2000. Introduction. *Hermeneutic Phenomenological Research: A Practoce Guide for Nurse Researchers.* Thousand Oaks: Sage Publications, Inc.

Connolly, P. 2003. *Ethical principles for researching vulnerable groups* Ulster: Central Print Unit.

Conolly, J.. 1856. *The treatment of the insane without mechanical restraints / by John Conolly.* London.

Cooper, H. 1998. *Synthesizing research: a guide for literature reviews.* 3rd ed. Thousand Oaks, Calif;London;: Sage Publications.

Covidence Systematic Review Software. Melbourne, Australia: Veritas Health Innovation.

Crombie, J. 1996. *The Pocket Guide to Critical Appraisal.* London: BMJ Publishing Group.

Crook, J. 2001. How do expert mental health nurses make on-the-spot clinical decisions? A review of the literature. *Journal of Psychiatric and Mental Health Nursing.* **8**(1), pp.1-5.

Crotty, M. 1998. *The foundations of social research: meaning and perspective in the research process.* London: Sage Publications.

Cusack, K., Frueh, B. and Brady, K. 2004. Trauma History Screening in a Community Mental Health Center. *Psychiatric Services.* **55**(2), pp.157-162.

Cutcliffe, J. and McKenna, H. 1999. Establishing the credibility of qualitative research findings: the plot thickens. *Journal of Advanced Nursing.* **30**(2), pp.374-380.

Cutcliffe, J. and Ramcharan, P. 2002. Leveling the Playing Field? Exploring the Merits of the Ethics-as-Process Approach for Judging Qualitative Research Proposals. *Qualitative Health Research.* **12**(7), pp.1000-1010.

Dack, C., Ross, J. and Bowers, L. 2012. The relationship between attitudes towards different containment measures and their usage in a national sample of psychiatric inpatients. *Journal of Psychiatric & Mental Health Nursing (John Wiley & Sons, Inc.).* **19**(7), pp.577-586.

Daffern, M., Mayer, M. and Martin, T. 2003. A preliminary investigation into patterns of aggression in an Australian forensic psychiatric hospital. *The Journal of Forensic Psychiatry & Psychology.* **14**(1), pp.67-84.

Daly, J., Willis, K., Small, R., Green, J., Welch, N., Kealy, M. and Hughes, E. 2007. A hierarchy of evidence for assessing qualitative health research. *Journal of Clinical Epidemiology.* **60**(1), pp.43-49.

Davies, A. 2019. Carrying out systematic literature reviews: an introduction. *British journal of nursing* **28**(15), pp.1008-1014.

De Benedictis, L., Dumais, A., Sieu, N., Mailhot, M., Létourneau, G., Tran, M.A., Stikarovska, I., Bilodeau, M., Brunelle, S., Côté, G. and Lesage, A. 2011. Staff perceptions and organizational factors as predictors of seclusion and restraint on psychiatric wards. *Psychiatric Services.* **62**(5), pp.484-491.

De Dreu, C. and Beersma, B. 2005. Conflict in organizations: Beyond effectiveness and performance. *European Journal of Work and Organizational Psychology.* **14**(2), pp.105-117.

Delaney, K. and Johnson, M. 2008. Inpatient psychiatric nursing: why safety must be the key deliverable. *Archives of psychiatric nursing.* **22**(6), pp.386-388.

Denzin, N. and Lincoln, Y. 2018. *The SAGE handbook of qualitative research.* 5th ed. Thousand Oaks, CA: Sage Publications, Inc.

Department of Health (DoH). 1999. *Report of the committee of inquiry into the Personality Disorder Unit, Ashworth Special Hospital.* London: The Stationery Office.

Department of Health (DoH). 2010. *Recognised, valued and supported: next steps for the carers strategy.* London: HMSO.

Department of Health (DoH). 2012. *Transforming care: A national response to Winterbourne View Hospital: Department of Health Review Final Report.* London: Department of Health

Department of Health (DoH). 2014. *Positive and Proactive Care: reducing the need for restrictive interventions.* London: HM Government.

Department of Health (DoH). 2015. *Mental Health Act 1983: Code of Practice.* London: DH.

Department of Health Education and Welfare (DHEW). 1978. *The Belmont Report.* Washington DC: United States Government Printing Office.

Deveau, R. and McDonnell, A. 2009. As the last resort: reducing the use of restrictive physical interventions using organisational approaches. *British Journal of Learning Disabilities.* **37**(3), pp.172-177.

Dixon-Woods, M. 2011. Using framework-based synthesis for conducting reviews of qualitative studies. *BMC Medicine.* **9**(1), pp.39-39.

Doedens, P., Maaskant, J., Latour, C., van Meijel, B., Koeter, M., Storosum, J., Barkhof, E. and de Haan, L. 2017. Nursing Staff Factors Contributing to Seclusion in Acute Mental Health Care – An Explorative Cohort Study. *Issues in Mental Health Nursing.* **1**(6).

Doedens, P., Vermeulen, J., Boyette, L.-L., Latour, C. and de Haan, L. 2020. Influence of nursing staff attitudes and characteristics on the use of coercive measures in acute mental health services-A systematic review. *Journal of Psychiatric and Mental Health Nursing.* **27**(4), pp.446-459.

Donat, D. 2002. Employing behavioral methods to improve the context of care in a public psychiatric hospital: Reducing hospital reliance on seclusion/restraint and psychotropic PRN medication. *Cognitive and Behavioral Practice.* **9**(1), pp.28-37.

Doody, O., Butler, M., Lyons, R. and Newman, D. 2017. Families' experiences of involvement in care planning in mental health services: an integrative literature review. *Journal of Psychiatric and Mental Health Nursing.* **24**(6), pp.412-430.

Doyle, L., Brady, A.-M. and Byrne, G. 2009. An overview of mixed methods research. *Journal of research in nursing.* **14**(2), pp.175-185.

Dubois, J. 2008. *Ethics in Mental Health Research, Principles, Guidance and Cases* Oxford Oxford University Press.

Duncan, S., Van der Merwe, M., Bowers, L., Simpson, A. and Jones, J. 2010. A Review of Interventions to Reduce Mechanical Restraint and Seclusion among Adult Psychiatric Inpatients. *Issues in Mental Health Nursing.* **31**(6), pp.413-424.

Durham, W., Sykes, C., Piper, S. and Stokes, P. 2015. Conceptual frameworks and terminology in doctoral nursing research. *Nurse Researcher.* **23**(2), pp.8-12.

Duxbury, J. 2015. The Eileen Skellern Lecture 2014: Physical restraint: in defence of the indefensible? *Journal of Psychiatric and Mental Health Nursing.* **22**(2), pp.92-101.

Duxbury, J., Baker, J., Downe, S., Jones, F., Greenwood, P., Thygesen, H., McKeown, M., Price, O., Scholes, A., Thomson, G. and Whittington, R. 2019. Minimising the use of physical restraint in acute mental health services: The outcome of a restraint reduction programme ('REsTRAIN YOURSELF'). *International journal of nursing studies.* **95**, pp.40-48.

Edward, K., Stephenson, J., Ousey, K., Lui, S., Warelow, P. and Giandinoto, J. 2016. A systematic review and meta-analysis of factors that relate to aggression perpetrated against nurses by patients/relatives or staff. *Journal of Clinical Nursing.* **25**(3-4), pp.289-299.

Eguchi, R., Onozuka, D., Ikeda, K., Kuroda, K., Ieiri, I. and Hagihara, A. 2018. Psychological assessment of acute schizophrenia patients who experienced seclusion either alone or in combination with restraint. *International Journal of Psychiatry in Medicine.* **53**(3), pp.171-188.

El-Badri, S. and Mellsop, G. 2008. Patient and staff perspectives on the use of seclusion. *Australasian Psychiatry.* **16**(4), pp.248-252.

Elzubeir, K. and Dye, S. 2017. Can amount and duration of seclusion be reduced in psychiatric intensive care units by agreeing SMART goals with patients? *Journal of Psychiatric Intensive Care.* **13**.

Etzioni, A. 1992. Normative affective factors: Toward a new decision making model. In: Zey, M. ed. *Decision Making Alternatives to Rational Choice Models.* Newbury: Park: Sage Publications, pp.89-111.

European Commission. 2013. *Ethics for Researchers.* Luxembourg: Publications Office of the European Union.

European Convention on Human Rights. 1950. *European Convention on Human Right.* Council of Eurpoe.

Ezeobele, I., Malecha, A., Mock, A., Mackey-Godine, A. and Hughes, M. 2014. Patients' lived seclusion experience in acute psychiatric hospital in the United States: a qualitative study. *Journal of Psychiatric and Mental Health Nursing.* **21**(4), p303.

Fallon, P. 1999. *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital.* London: HMSO.

Faschingbauer, K., Tempel, W. and Peden-McAlpine, C. 2013. Use of Seclusion: Finding the Voice of the Patient to Influence Practice. *Journal of Psychosocial Nursing & Mental Health Services.* **51**(7), pp.32-38.

Fawcett, J. 2005. Criteria for Evaluation of Theory. *Nursing Science Quarterly.* **18**(2), pp.131-135.

Fawcett, J. 2008. The added value of nursing conceptual model-based research. *Journal of Advanced Nursing.* **61**(6), pp.583-583.

Felton, A., Repper, J. and Avis, M. 2018. The construction of people with mental health problems as risk objects: Findings of a case study inquiry. *Journal of Psychiatric and Mental Health Nursing.* **25**(9-10), pp.558-568.

Fish, R. 2018. ‘Behind This Wall’ – Experiences of Seclusion on Locked Wards for Women. *Scandinavian Journal of Disability Research.* **20**(1), pp.139-151.

Flick, U. 2007. *Designing qualitative research.* London: Sage Publications.

Foucault, M. 1961. *Madness and civilization: A history of insanity in an age of reason.* New York: Vintage.

Franzosi, R. 2010. Sociology, narrative, and the quality versus quantity debate (Goethe versus Newton): Can computer-assisted story grammars help us understand the rise of Italian fascism (1919–1922)? *Theory and Society.* **39**(6), pp.593-629.

Frueh, B., Knapp, R., Cusack, K., Grubaugh, A., Sauvageot, J., Cousins, V., Yim, E., Robins, C., Monnier, J. and Hiers, T. 2005. Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services.* **56**(9), pp.1123-1133.

Furber, C. 2010. Framework analysis: a method for analysing qualitative data. *African Journal of Midwifery and Women's Health.* **4**(2), pp.97-100.

Gale, N., Heath, G., Cameron, E., Rashid, S. and Redwood, S. 2013. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology.* **13**(1), p117.

Galvin, R. 2015. How many interviews are enough? Do qualitative interviews in building energy consumption research produce reliable knowledge? *Journal of Building Engineering.* **1**, pp.2-12.

Gaskin, C., Elsom, S. and Happell, B. 2007. Interventions for reducing the use of seclusion in psychiatric facilities: Review of the literature. *British Journal of Psychiatry.* **191**(4), pp.298-303.

Georgieva, I., Mulder, C.L. and Wierdsma, A. 2012. Patients' Preference and Experiences of Forced Medication and Seclusion. *Psychiatric Quarterly.* **83**(1), pp.1-13.

Gerson, K. and Horowitz, R. 2002. Observation and Interviewing: Options and Choices. In: May, T. ed. *Qualitative research in action.* London: Sage.

Gildberg, F.A., Fristed, P., Makransky, G., Moeller, E.H., Nielsen, L.D. and Bradley, S.K. 2015. As time goes by: reasons and characteristics of prolonged episodes of mechanical restraint in forensic psychiatry. *J Forensic Nurs.* **11**(1), pp.41-50.

Goethals, S., Dierckx de Casterle, B. and Gastmans, C. 2012. Nurses' decision making in cases of physical restraint: a synthesis of qualitative evidence. *Journal of Advanced Nursing.* **68**(6), pp.1198-1210.

Goffman, E. 1961. *Aslyums: Essays on the social situation of mental patients and other inmates.* Harmondsworth: Penguin.

Goulet, M.-H., Larue, C. and Dumais, A. 2017. Evaluation of seclusion and restraint reduction programs in mental health: A systematic review. *Aggression and Violent Behavior.* **34**, pp.139-146.

Goulet, M. and Larue, C. 2016. Post-Seclusion and/or Restraint Review in Psychiatry: A Scoping Review. *Archives of Psychiatric Nursing.* **30**(1), pp.120-128.

Goulet, M. and Larue, C. 2018. A Case Study: Seclusion and Restraint in Psychiatric Care. *Clinical Nursing Research.* **27**(7), pp.853-870.

Gray, D. 2009. *Doing Research in the Real World.* 2nd ed. Thousand Oaks, CA.: Sage Publication Ltd. .

Gray, D. 2017. *Doing research in the real world.* 4th ed. Los Angeles, CA: Sage.

Green, R., Shelly, C., Gibb, J. and Walker, T. 2018. Implementing seclusion in forensic mental health care: A qualitative study of staff decision making. *Archives of Psychiatric Nursing.* **32**(5), pp.764-768.

Greenhalgh, T. 2010. *How to read a paper: the basics of evidence-based medicine.* 4th ed. Chichester Hoboken, NJ: Wiley-Blackwell.

Guba, E. and Lincoln, Y. 1989. *Fourth generation evaluation.* Sage Publications.

Guest, G., Bunce, A. and Johnson, L. 2006. How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods.* **18**(1), pp.59-82.

Gupta, U. 2013. Informed consent in clinical research: Revisiting few concepts and areas. *Perspectives in clinical research.* **4**(1), pp.26-32.

Gutheil, T. 1978. Observations on the theoretical bases for seclusion of the psychiatric inpatient. *American Journal of Psychiatry.* **135**(3), pp.325-328.

Haber, J. 2017. Sampling. In: LoBiondo-Wood, G. and Haber, J. eds. *Nursing research : methods and critical appraisal for evidence-based practice.* 9th ed. St Louis: Elsevier Mosby, pp.46-77.

Halcomb, L. 2018. How an understanding of paradigms can improve the quality of nursing research. *Nurse Researcher.* **25**(4), pp.6-7.

Hall, J. 2004. Restriction and Control: The Perceptions of Mental Health Nurses in a UK Acute Inpatient Setting. *Issues in Mental Health Nursing.* **25**(5), pp.539-552.

Hamann, J. and Heres, S. 2014. Adapting Shared Decision Making for Individuals With Severe Mental Illness. *Psychiatric Services.* **65**(12), pp.1483-1486.

Hammer, J., Springer, J., Beck, N., Menditto, A. and Coleman, J. 2011. The relationship between seclusion and restraint use and childhood abuse among psychiatric inpatients. *Journal of Interpersonal Violence.* **26**(3), pp.567-579.

Hammersley, M. 2007a. *Ethnography : principles in practice.* Third edition. ed. London: Routledge.

Hammersley, M. 2007b. The issue of quality in qualitative research. *International Journal of Research & Method in Education.* **30**(3), pp.287-305.

Happell, B., Dares, G., Russell, A., Cokell, S., Platania-Phung, C. and Gaskin, C. 2012. The Relationships between Attitudes toward Seclusion and Levels of Burnout, Staff Satisfaction, and Therapeutic Optimism in a District Health Service. *Issues in Mental Health Nursing.* **33**(5), pp.329-336.

Happell , B., Dares, G., Russell, A., Platania-Phung, C. and Gaskin, C. 2012. The Relationships between Attitudes toward Seclusion and Levels of Burnout, Staff Satisfaction, and Therapeutic Optimism in a District Health Service. *Issues in Mental Health Nursing* **33**(5), pp.329-336.

Happell, B. and Harrow, A. 2010. Nurses' attitudes to the use of seclusion: A review of the literature. *International Journal of Mental Health Nursing.* **19**(3), pp.162-168.

Happell, B. and Koehn, S. 2010. Attitudes to the use of seclusion: has contemporary mental health policy made a difference? *Journal of Clinical Nursing.* **19**(21-22), pp.3208-3217.

Happell, B. and Koehn, S. 2011. Seclusion as a necessary intervention: the relationship between burnout, job satisfaction and therapeutic optimism and justification for the use of seclusion. *Journal of Advanced Nursing* **67**(6), pp.1222-1231.

Haugom, E.W., Torleif, R. and Torfinn, H. 2019. Ethical challenges of seclusion in psychiatric inpatient wards: a qualitative study of the experiences of Norwegian mental health professionals. **19**(1).

Haw, C., Stubbs, J., Bickle, A. and Stewart, I. 2011. Coercive treatments in forensic psychiatry: A study of patients' experiences and preferences. *Journal of Forensic Psychiatry & Psychology.* **22**(4), pp.564-585.

Hawsawi, T., Power, T., Zugai, J. and Jackson, D. 2020. Nurses' and consumers' shared experiences of seclusion and restraint: A qualitative literature review. *International journal of mental health nursing.*

Health Services Journal. 2018. *Violent attacks on NHS staff.* Basildon, Essex.: Health Services Journal.

Heidegger, M. 1927. *Being in Time.* New York: State University of New York Press.

Hellerstein, D., Staub, A. and Lequesne, E. 2007. Decreasing the Use of Restraint and Seclusion Among Psychiatric Inpatients. *Journal of Psychiatric Practice.* **13**(5), pp.308-317.

Herman, R. and Raybould, A. 2014. Expert opinion vs. empirical evidence: the precautionary principle applied to GM crops. *GM crops & food.* **5**(1), pp.8-10.

Hernandez, A., Riahi, S., Stuckey, M., Mildon, B. and Klassen, P. 2017. Multidimensional approach to restraint minimization: The journey of a specialized mental health organization. *International Journal of Mental Health Nursing.* **26**(5), pp.482-490.

Hoekstra, T., Lendemeijer, H. and Jansen, M. 2004. Seclusion: the inside story. *Journal of Psychiatric and Mental Health Nursing.* **11**(3), pp.276-283.

Hoffman, R., Elmore, J., Fairfield, K., Gerstein, B., Levin, C. and Pignone, M. 2014. Lack of Shared Decision Making in Cancer Screening Discussions. *American Journal of Preventive Medicine.* **47**(3), pp.251-259.

Holmes, D., Kennedy, S. and Perron, A. 2004. The mentall ill and social exclusion: A critical examination of the use of seclusion from the patient's perspective. *Issues in Mental Health Nursing.* **25**(6), pp.559-578.

Holmes, D., Murray, S. and Knack, N. 2015. Experiencing Seclusion in a Forensic Psychiatric Setting: A Phenomenological Study. *J Forensic Nurs.* **11**(4), pp.200-213.

Holzworth, R. and Wills, C. 1999. Nurses' judgments regarding seclusion and restraint of psychiatric patients: A social judgment analysis. *Research in Nursing & Health.* **22**(3), pp.189-201.

Hopewell, S., McDonald, S., Clarke, M. and Egger, M. 2007. Grey literature in meta-analyses of randomized trials of health care interventions. *Cochrane Database Systematic Review.* **18**(2).

Howard, L., de Salis, I., Tomlin, Z., Thornicroft, G. and Donovan, J. 2009. Why is recruitment to trials difficult? An investigation into recruitment difficulties in an RCT of supported employment in patients with severe mental illness. *Contemporary Clinical Trials.* **30**(1), pp.40-46.

Howell, K. 2013. *Methods of Data Collection.* London: Sage Publications Ltd.

Huckshorn, K. 2004. Reducing seclusion restraint in mental health use settings: core strategies for preventio. *Journal of Psychosocial Nursing and Mental Health Services.* **42**(9), pp.22-33.

Huckshorn, K. 2006. Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint. *Administration and Policy in Mental Health and Mental Health Services Research.* **33**(4), pp.482-491.

Huf, G., Coutinho, E. and Adams, C. 2012. Physical restraints versus seclusion room for management of people with acute aggression or agitation due to psychotic illness (TREC-SAVE): a randomized trial. *Psychological Medicine.* **42**(11), pp.2265-2273.

Human Rights Act, 1998. UK.

Husserl, E. 1913. *Ideas: General Introduction to Pure Phenomenology.* Taylor and Francis.

Husum, T., Bjorngaard, J., Finset, A. and Ruud, T. 2010. A cross-sectional prospective study of seclusion, restraint and involuntary medication in acute psychiatric wards: patient, staff and ward characteristics. *BMC Health Services Research.* **10**(1), pp.89-89.

Hyde, S., Fulbrook, P., Fenton, K. and Kilshaw, M. 2009. A clinical improvement project to develop and implement a decision-making framework for the use of seclusion. *International Journal of Mental Health Nursing.* **18**(6), pp.398-408.

INVOLVE. 2015. *INVOLVE: Public involvement in research: values and principles Framework.* Eastleigh: INVOLVE.

Jackson, H., Baker, J. and Berzins, K. 2018. What factors influence the decisions of mental health professionals to release service users from seclusion? *International Journal of Mental Health Nursing.* **27**(6), pp.1618-1633.

Jackson, H., Baker, J. and Berzins, K. 2019a. Factors influencing decisions of mental health professionals to release service users from seclusion: A qualitative study. *Journal of advanced nursing.* **75**(10), pp.2178-2188.

Jackson, H., Wray, J., Gardiner, E. and Flanagan, T. 2019b. Involving carers in risk assessment: a study of a structured dialogue between mental health nurses and carers. *Journal of Research in Nursing.* **24**(5), pp.330-341.

Janssen, W., Noorthoorn, E., de Vries, W., Hutschemeakers, G., Lendemeijer, H. and Widdershoven, G. 2008. The use of seclusion in the Netherlands compared to countries in and outside Europe. *International Journal of Law and Psychiatry.* **31**(6), pp.463-470.

Janssen, W., Noorthoorn, E., Van linge, R. and Lendemeijer, H. 2007. The influence of staffing levels on the use of seclusion. *International Journal of Law and Psychiatry* **30**(2), pp.118-126.

Janssen, W., Northoorn, E., Nijman, H., Bowers, L., Hoogendoorn, A. and Widdershoven, G. 2013. Differences in Seclusion Rates Between Admission Wards: Does Patient Compilation Explain? *Psychiatric Quarterly.* **84**(1), pp.39-52.

Jarrin, I. 2013. *The Place of Ethics in Mental Health Nurses' Clinical Judgment in the Use of Seclusion*. MSc thesis, University of Manitoba.

Jasper, M. 2005. Using reflective writing within research. *Journal of Research in Nursing.* **10**(3), pp.247-260.

Jennings, H., Slade, M., Bates, P., Munday, E. and Toney, R. 2018. Best practice framework for Patient and Public Involvement (PPI) in collaborative data analysis of qualitative mental health research: methodology development and refinement. *BMC Psychiatry.* **18**(1), p213.

Johnson, B. 1997. *Factors in the continuation and discontinuation of seclusion in a special hospital*. MSc thesis, Liverpool University.

Jovanović, G. 2011. Toward a social history of qualitative research. *History of the Human Sciences.* **24**(2), pp.1-27.

Kalisova, L., Raboch, J., Nawka, A., Sampogna, G., Cihal, L., Kallert, T.W., Onchev, G., Karastergiou, A., del Vecchio, V., Kiejna, A., Adamowski, T., Torres-Gonzales, F., Cervilla, J.A., Priebe, S., Giacco, D., Kjellin, L., Dembinskas, A. and Fiorillo, A. 2014. Do patient and ward-related characteristics influence the use of coercive measures? Results from the EUNOMIA international study. *Social Psychiatry and Psychiatric Epidemiology.* **49**(10), pp.1619-1629.

Kallio, H., Pietilä, A., Johnson, M. and Kangasniemi, M. 2016. Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing* **72**(12), pp.2954-2965.

Kalof, L., Dan, A. and Dietz, T. 2008. *Essentials of social research.* London: Open University Press.

Kaminskiy, E. 2015. The Elephant in the Room: A Theoretical Examination of Power for Shared Decision Making in Psychiatric Medication Management. *Intersectionalaties: A Global Journal of Social Work, Reserach, Polity and Practice.* **4**(2), pp.19-38.

Kanuha, V.K. 2000. "Being" Native versus "Going Native": Conducting Social Work Research as an Insider. *Social Work.* **45**(5), pp.439-447.

Karnieli-Miller, O., Strier, R. and Pessach, L. 2009. Power Relations in Qualitative Research. *Qualitative Health Research.* **19**(2), pp.279-289.

Keane, D., Lang, A., Craven, M. and Sharples, S. 2012. The use of vignettes for conducting healthcare research.

Kelly, M., Dowling, M. and Millar, M. 2017. The search for understanding: the role of paradigms. **25**(4).

Kennedy, B., Williams, C. and Pesut, D. 1994. Hallucinatory experiences of psychiatric patients in seclusion. *Archives of Psychiatric Nursing.* **8**(3), pp.169-176.

Keski-Valkama, A., Koivisto, A., Eronen, M. and Kaltiala-Heino, R. 2010. Forensic and general psychiatric patients' view of seclusion: a comparison study. *Journal of Forensic Psychiatry & Psychology.* **21**(3), pp.446-461.

Keski-Valkama, A., Sailas, E., Eronen, M., Lönnqvist, J. and Kaltiala-Heino, R. 2007. The use of seclusion and restraint during 15 years – a nationwide study in Finland. *BMC Psychiatry.* ((Suppl 1):S157).

Kinner, S., Harvey, C., Hamilton, B., Brophy, L., Roper, C., McSherry, B. and Young, J. 2017. Attitudes towards seclusion and restraint in mental health settings: findings from a large, community-based survey of consumers, carers and mental health professionals. *Epidemiology and Psychiatric Sciences.* pp.1-10.

Kirk, J. and Miller, M. 1986. *Reliability and validity in qualitative research.* Newbury Park: Sage.

Knaak, S., Mantler, E. and Szeto, A. 2017. Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare management forum.* **30**(2), pp.111-116.

Knox, D. and Holloman, G. 2012. Use and avoidance of seclusion and restraint: consensus statement of the american association for emergency psychiatry project Beta seclusion and restraint workgroup. *The western journal of emergency medicine.* **13**(1), pp.35-40.

Kontio, R., Joffe, G., Putkonen, H., Kuosmanen, L., Hane, K., Holi, M. and Valimaki, M. 2012. Seclusion and Restraint in Psychiatry: Patients' Experiences and Practical Suggestions on How to Improve Practices and Use Alternatives. *Perspectives in Psychiatric Care.* **48**(1), p16.

Kontio, R., Valimaki, M. and Putkonen, H. 2010. Patient restrictions: are there ethical alternatives to seclusion and restraint? *Nursing Ethics.* **17**(1), pp.65-76.

Korkeila, H., Koivisto, A.M., Paavilainen, E. and Kylma, J. 2016. Psychiatric Nurses' Emotional and Ethical Experiences Regarding Seclusion and Restraint. *Issues in Mental Health Nursing.* **37**(7), pp.464-475.

Korstjens, I. and Moser, A. 2018. Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice.* **24**(1), pp.120-124.

Kuckartz, U. and McWhertor, A. 2014. *Qualitative text analysis: a guide to methods, practice & using software.* Los Angeles, CA: Sage.

Kuhn, T. and Hacking, I. 2012. *The structure of scientific revolutions.* 4th ed. Chicago: The University of Chicago Press.

Kuivalainen, S., Vehviläinen Julkunen, K., Louheranta, O., Putkonen, A., Repo Tiihonen, E. and Tiihonen, J. 2017. Deescalation techniques used, and reasons for seclusion and restraint, in a forensic psychiatric hospital. *International Journal of Mental Health Nursing.* **26**(5), pp.513-524.

Kuosmanen, L., Hätönen, H., Malkavaara, H., Kylmä, J. and Välimäki, M. 2007. Deprivation of Liberty in Psychiatric Hospital Care: the Patient's Perspective. *Nursing Ethics.* **14**(5), pp.597-607.

Kuosmanen, L., Makkonen, P., Lehtila, H. and Salminen, H. 2015. Seclusion experienced by mental health professionals. *Journal of Psychiatric and Mental Health Nursing.* **22**(5), pp.333-336.

Kvale, S. 2007. *Doing interviews.* London: Sage.

Laiho, T., Kattainen, E., Astedt-Kurki, P., Putkonen, H., Lindberg, N. and Kylma, J. 2013. Clinical decision making involved in secluding and restraining an adult psychiatric patient: an integrative literature review. *Journal of Psychiatric and Mental Health Nursing.* **20**(9), p830.

Laiho, T., Kattainen, E., Astedt-Kurki, P., Putkonen, H., Lindberg, N. and Kylmä, J. 2012. Clinical decision making involved in secluding and restraining an adult psychiatric patient: An integrative literature review. *Journal of psychiatric and mental health nursing.* **20**.

Laiho, T., Lindberg, N., Joffe, G., Putkonen, H., Hottinen, A., Kontio, R. and Sailas, E. 2014. Psychiatric staff on the wards does not share attitudes on aggression *International Journal of Mental Health Systems* **8**(1), pp.14-14.

Landeweer, E., Abma, T. and Widdershoven, G. 2011. Moral margins concerning the use of coercion in psychiatry. *Nursing Ethics.* **18**(3), pp.304-316.

Langan, J., Lindow, V. and Joseph Rowntree, F. 2004. *Living with risk: mental health service user involvement in risk assessment and management.* Bristol, UK: Policy Press.

Larue, C., Dumais, A. and Ahern, E. 2009. Factors influencing decisions on seclusion and restraint. *Journal of Psychiatric and Mental Health Nursing.* **16**(5), pp.440-446.

Larue, C., Dumais, A., Boyer, R., Goulet , M., Bonin, J. and Baba, N. 2013. The Experience of Seclusion and Restraint in Psychiatric Settings: Perspectives of Patients. *Issues in Mental Health Nursing.* **34**(5).

Larue, C., Piat , M., Racine , H., Ménard , G. and Goulet , M. 2010. The Nursing Decision Making Process in Seclusion Episodes in a Psychiatric Facility *Issues in Mental Health Nursing.* **31**(3), pp.208-215.

LeBel, J., Duxbury, J., Putkonen, A., Sprague, T., Rae, C. and Sharpe, J. 2014. Multinational experiences in reducing and preventing the use of restraint and seclusion. *J Psychosoc Nurs Ment Health Serv.* **52**(11), pp.22-29.

Lemonidou, C., Priami, M., Merkouris, A., Kalafati, M., Tafas, C. and Plati, C. 2002. Nurses' perceptions toward seclusion and use of restraints for psychiatric patients in greece. *The European journal of psychiatry.* **16**(2), pp.81-90.

Lewis, A. and Webster, C. 2004. General instruments for risk assessment. *Current Opinion in Psychiatry.* **17**(5), pp.401-405.

Lewis, J. and McNaughton Nicholls, C. 2014. Design Issues. In: Ritchie, J., et al. eds. *Qualitative Research Practice.* 2nd ed. London: Sage, pp.47-76.

Li, S. and Seale, C. 2007. Learning to Do Qualitative Data Analysis: An Observational Study of Doctoral Work. *Qualitative Health Research.* **17**(10), pp.1442-1452.

Lincoln, Y. and Guba, E. 1985. *Naturalistic inquiry.* Beverly Hills, Calif: Sage Publications.

Lincoln, Y., Lynham, S. and Guba, E. 2018. Paradigms and perspectives in contention. Paradigmatic controversies, contradictions, and emerging confluences revisited. In: Denzin, N. and Lincoln, Y. eds. *The SAGE handbook of qualitative research.* 5th ed. Thousand Oaks, CA: Sage Publications, Inc.

Lindsey, P. 2009. Psychiatric nurses' decision to restrain. *Journal of Psychosocial Nursing and Mental Health Services.* **47**(9), pp.41-49.

Ling, S., Cleverley, K. and Perivolaris, A. 2015. Understanding Mental Health Service User Experiences of Restraint Through Debriefing: A Qualitative Analysis. *Canadian Journal of Psychiatry.* **60**(9), pp.386-392.

LoBiondo-Wood, G. and Haber, J. 2017. Nonexperimental Designs. In: LoBiondo-Wood, G. and Haber, J. eds. *Nursing research : methods and critical appraisal for evidence-based practice.* 9th edition. ed. St. Louis: Elsevier Mosby.

LoBiondo-Wood, G., Haber, J. and Krainovich-Miller, B. 2017. The Research Process: Integrating Evidence-Based Practice. In: LoBiondo-Wood, G. and Haber, J. eds. *Nursing research : methods and critical appraisal for evidence-based practice.* 9th ed. St Louis: Elsevier Mosby.

Lockwood, C., Munn, Z. and Porritt, K. 2015. Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. *International Journal of Evidence-Based Healthcare.* **13**(3).

Loi, F. and Marlowe, K. 2017. East London Modified-Broset as Decison-Making Tool to Predict Seclusion in Psychiatric Intensive Care Units. *Frontiers in Psychiatry.* **8**(Article 194), pp.1-11.

Long, A. 2005. *Evaluative Tool for Mixed Method Studies.* [Online]. [Accessed 20.12.2017]. Available from: https://usir.salford.ac.uk/id/eprint/13070/1/Evaluative_Tool_for_Mixed_Method_Studies.pdf

Lorem, G., Hem, M. and Molewijk, B. 2015. Good coercion: Patients' moral evaluation of coercion in mental health care. *International Journal of Mental Health Nursing.* **24**(3), pp.231-240.

Mackey, A. and Bassendowski, S. 2017. The History of Evidence-Based Practice in Nursing Education and Practice. *Journal of professional nursing.* **33**(1), pp.51-55.

Maguire, T., Daffern, M. and Martin, T. 2014. Exploring nurses' and patients' perspectives of limit setting in a forensic mental health setting.(Author abstract). *International Journal of Mental Health Nursing.* **23**(2), p153.

Maguire, T., Young, R. and Martin, T. 2012. Seclusion reduction in a forensic mental health setting. *Journal of Psychiatric and Mental Health Nursing.* **19**(2), pp.97-106.

Mahood, Q., Van Eerd, D. and Irvin, E. 2013. Searching for Grey Literature for Systematic Reviews: Challenges and Benefits. *Research Synthesis Methods.* **5**(3), pp.221-234.

Malterud, K., Siersma, V.D. and Guassora, A.D. 2016. Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research.* **26**(13), pp.1753-1760.

Mann-Poll, P., Smit, A., de Vries, W., Boumans, C. and Hutschemaekers, G. 2011. Factors contributing to mental health professionals' decision to use seclusion. *Psychiatric Services.* **62**(5), pp.498-503.

Marangos-Frost, S. and Wells, D. 2000. Psychiatric nurses' thoughts and feelings about restraint use: a decision dilemma. *Journal of Advanced Nursing.* **31**(2), pp.362-369.

Martin, T. and Daffern, M. 2006. Clinician perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric setting. *Journal of Psychiatric and Mental Health Nursing.* **13**(1), pp.90-99.

Martinez, R., Grimm, M. and Adamson, M. 1999. From the other side of the door: Patient views of seclusion. *Journal of psychosocial nursing and mental health services.* **37**, pp.13-22.

Mason, M. 2010. Sample size and saturation in PhD studies using qualitative interviews. *Forum qualitative Sozialforschung.* **11**(3), pp.11-19.

Mason, T. 1997. An ethnomethodological analysis of the use of seclusion. *Journal of Advanced Nursing.* **26**(4), pp.780-789.

Mason, T. and Whitehead, E. 2001. Some Specific Problems of Secluding Female Patients. *Medicine, Science and the Law.* **41**(4), pp.315-324.

Mayer, P. 2009. *Guidelines for writing an expert opinion report.* Zurich: Plant Science Centre.

Mayers, P., Keet, N., Winkler, G. and Flisher, A. 2010. Mental Health Service Users' Perceptions and Experiences of Sedation, Seclusion and Restraint. *International Journal of Social Psychiatry.* **56**(1), pp.60-73.

McCabe, S. 2005. Developing Rational Nursing Actions: What's the Problem with Psychiatric Nurses? *Perspectives in Psychiatric Care.* **41**(4), pp.181-183.

McLaughlin, P., Giacco, D. and Priebe, S. 2016. Use of Coercive Measures during Involuntary Psychiatric Admission and Treatment Outcomes: Data from a Prospective Study across 10 European Countries. *Plos One.* **11**(12).

Meadows, K.A. 2003. So you want to do research? 2: developing the research question. *British Journal of Community Nursing.* **8**(9), pp.397-403.

Meehan, T., Bergen, H. and Fjeldsoe, K. 2004. Staff and patient perceptions of seclusion: has anything changed? *Journal of Advanced Nursing.* **47**(1), pp.33-38.

Meehan, T., Vermeer, C. and Windsor, C. 2000. Patients' perceptions of seclusion: a qualitative investigation. *Journal of Advanced Nursing.* **31**(2), pp.370-377.

Melia, K. 1982. "Tell it as it is'--qualitative methodology and nursing research: understanding the student nurse's world. *Journal of Advanced Nursing.* **7**(4), pp.327-335.

Mellow, A., Tickle, A. and Rennoldson, M. 2017. Qualitative systematic literature review: the experience of being in seclusion for adults with mental health difficulties. *Mental Health Review Journal.* **22**(1), pp.1-15.

Mental Capacity Act 2005. UK.

MIND. 2013. *Mental Health crisis care: physical restraint in crisis.* [Leaflet]. London: MIND.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G. and Grp, P. 2009. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement (Reprinted from Annals of Internal Medicine). *Physical Therapy.* **89**(9), pp.873-880.

Moran, A., Cocoman, A., Scott, P.A., Matthews, A., Staniuliene, V. and Valimaki, M. 2009. Restraint and seclusion: a distressing treatment option? *Journal of Psychiatric and Mental Health Nursing.* **16**(7), pp.599-605.

Morgan, D. 2014. *Pragmatism as a Paradigm for Mixed Methods Research.* 55 City Road: Sage Publications, Inc.

Morrison, P. 1990. A multidimensional scalogram analysis of the use of seclusion in acute psychiatric settings. *Journal of Advanced Nursing.* **15**, pp.59-66.

Morrison, P. and Lehane, M. 1995. The effect of staffing levels on the use of seclusion. *Journal of Psychiatric and Mental Health Nursing.* **2**(6), pp.365–366.

Morse, J. 1997. "Perfectly Healthy, but Dead": The Myth of Inter-Rater Reliability. *Qualitative Health Research.* **7**(4), pp.445-447.

Morse, J. 2015. Analytic Strategies and Sample Size. *Qualitative Health Research.* **25**(10), pp.1317-1318.

Morse, J. and Field, P. 1995. *Qualitative research methods for health professionals.* 2nd ed. Thousand Oaks: Sage Publications.

Moylan, L. 2015. A Conceptual Model for Nurses' Decision-making with the Aggressive Psychiatric Patient. *Issues in Mental Health Nursing.* **36**(8), pp.572-582.

Moylan, L. and Cullinan, M. 2011. Frequency of assault and severity of injury of psychiatric nurses in relation to the nurses' decision to restrain. *Journal of Psychiatric and Mental Health Nursing.* **18**(6), pp.526-534.

Muir-Cochrane, E. 1995. An exploration of ethical issues associated with the seclusion of psychiatric patients. *Collegian.* **2**(3), pp.14-20.

Muir-Cochrane, E. 1996b. An investigation into nurses' perceptions of secluding patients on closed psychiatric wards. *Journal of Advanced Nursing.* **23**(3), pp.555-563.

Muir-Cochrane, E. and Harrison, B. 1996a. Therapeutic interventions associated with seclusion of acutely disturbed individuals. *Journal of Psychiatric and Mental Health Nursing.* **3**(3), pp.319-325.

Muir-Cochrane, E., O'Kane, D. and Oster, C. 2018. Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint. *International Journal of Mental Health Nursing.* **27**(5), pp.1511-1521.

Munhall, P. 2012. *Nursing research : a qualitative perspective.* 5th ed. Sudbury, MA: Jones & Bartlett Learning.

Nagayama, Y. and Hasegawa, M. 2014. Nursing care process for releasing psychiatric inpatients from long-term seclusion in Japan: Modified grounded theory approach: Release from long-term seclusion. *Nursing & Health Sciences.* **16**(3), pp.284-290.

National Institute for Clinical Excellence (NICE). 2011. *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services.* London.

National Institute for Clinical Excellence (NICE). 2015. *Violence and aggression: short-term management in mental health, health and community settings (NG10).* London: NICE.

Needham, H. and Sands, N. 2010. Post-seclusion debriefing: a core nursing intervention. *Perspect Psychiatr Care.* **46**(3), pp.221-233.

Newman, J., Paun, O. and Fogg, L. 2018. Effects of a Staff Training Intervention on Seclusion Rates on an Adult Inpatient Psychiatric Unit. *Journal of Psychosocial Nursing and Mental Health Services.* **56**.

Nielsen, L., Bech, P., Hounsgaard, L. and Gildberg, F.A. 2017. 'Mechanical restraint—Confounders, risk, alliance score': Testing the clinical validity of a new risk assessment instrument. *Nordic Journal of Psychiatry.* **71**(6), pp.441-447.

Nielsen, L., Gildberg, F., Bech, P., Dalgaard, J., Munksgaard, G. and Hounsgaard, L. 2018. Forensic mental health clinician's experiences with and assessment of alliance regarding the patient's readiness to be released from mechanical restraint. *International Journal of Mental Health Nursing.* **27**(1), pp.116-125.

Nijman, H., Muris, P., Merckelbach, H., Palmstierna, T., Wistedt, B., Vos, A., van Rixtel, A. and Allertz, W. 1999. The Staff Observation Aggression Scale–Revised (SOAS-R). *Aggressive Behaviour.* **25**, pp.197-209.

Noble, H. and Smith, J. 2018. Reviewing the literature: choosing a review design. *Evidence Based Nursing.* **21**(2), pp.39-41.

Noblit, G. and Hare, R. 1988. *Meta-ethnography: synthesising qualitative studies.* Newbury Park, CA: Sage.

Noda, T., Sugiyama, N., Ito, H., Soininen, P., Putkonen, H., Sailas, E. and Joffe, G. 2012. Secluded/restrained patients' perceptions of their treatment: Validity and reliability of a new questionnaire. *Psychiatry and Clinical Neurosciences.* **66**(5), pp.397-404.

Norman, I. and Ryrie, I. 2013. Mental Health Nursing: Origins and Traditions. In: Norman, I. and Ryrie, I. eds. *The art and science of mental health nursing : principles and practice.* 3rd ed. Maidenhead: Open University Press, pp.62-85.

Norris, M. and Kennedy, C. 1992. The view from within: How patients perceive the seclusion process. *Journal of Psychosocial Nursing & Mental Health Services.* **30**(3), pp.7-13.

Norvoll, R. and Pedersen, R. 2018. Patients' moral views on coercion in mental healthcare. *Nursing Ethics.* **25**(6), pp.796-807.

Nowell, L. 2015. Pragmatism and integrated knowledge translation: exploring the compatabilities and tensions. *Nursing Open.* **2**(3), pp.141-148.

Nowell, L.S., Norris, J.M., White, D.E. and Moules, N.J. 2017. Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods.* **16**(1), p160940691773384.

Nursing & Midwifery Council (NMC). 2015. *The code: Professional standards of practice and behaviour for nurses and midwives.* [Leaflet]. London.

O'Rourke, M., Wrigley, C. and Hammond, S. 2018. Violence within mental health services: How to enhance risk management. *Risk Management and Healthcare Policy.* **11**, pp.159-167.

Ogloff, J. and Daffern, M. 2006. The dynamic appraisal of situational aggression: an instrument to assess risk for imminent aggression in psychiatric inpatients. *Behavioral Sciences & The Law.* **24**, p6.

Oliver, D., Serovich, J. and Mason, T. 2005. Constraints and Opportunities with Interview Transcription: Towards Reflection in Qualitative Research. *Social Forces.* **84**(2), pp.1273-1289.

Ormston, R., Spencer, L., Barnard, M. and Snape, D. 2014. The Foundations of Qualitative Research. In: Ritchie, J., et al. eds. *Qualitative Research Practice.* 2nd ed. London: Sage, pp.1-25.

Osborn, L. and Stein, C. 2017. Community Mental Health Care Providers' Understanding of Recovery Principles and Accounts of Directiveness with Consumers. *Psychiatric Quarterly.* **88**(4), pp.755-767.

Owen, C., Tarantello, C., Jones, M. and Tennant, C. 1998. Violence and aggression in psychiatric units. *Psychiatric Services.* **49**(11), pp.1452-1457.

Paechter, C. 2013. Researching sensitive issues online: implications of a hybrid insider/outsider position in a retrospective ethnographic study. *Qualitative Research.* **13**(1), pp.71-86.

Paré, G., Trudel, M.-C., Jaana, M. and Kitsiou, S. 2015. Synthesizing information systems knowledge: A typology of literature reviews. *Information & Management.* **52**(2), pp.183-199.

Paterson, B. and Duxbury, J. 2007. Restraint and the Question of Validity. *Nursing Ethics.* **14**(4), pp.535-545.

Patton, M. 2002. *Qualitative research & evaluation methods.* 3rd ed. Thousand Oaks, CA: Sage.

Peplau, H.E. 1988. The Art and Science of Nursing: Similarities, Differences, and Relations. *Nursing Science Quarterly.* **1**(1), pp.8-15.

Perez, C. 2020. *Invisible Women: Exposing Data Bias in a World Designed for Men.* London: Penguin.

Pettit, S., Bowers, L., Tulloch, A., Cullen, A., Moylan, L., Sethi, F., McCrone, P., Baker, J., Quirk, A. and Stewart, D. 2017. Acceptability and use of coercive methods across differing service configurations with and without seclusion and/or psychiatric intensive care units. *Journal of Advanced Nursing* **17**(4), pp.966-976.

Plutchik, B., Karasu, R., Conte, R., Siegel, R. and Jerrett, R. 1978. Toward a rationale for the seclusion process. *The Journal of Nervous and Mental Disease.* **166**(8), pp.571-579.

Pope, C. and Mays, N. 2006. *Qualitative research in health care.* 3rd ed. Malden, MA: Blackwell Pub./BMJ Books.

Pratt, C., Gill, K., Barrett, N. and Roberts, M. 2014. Psychiatric Rehabilitation in Acute Care and Hospital Settings. In: Pratt, C.W., et al. eds. *Psychiatric Rehabilitation* 3rd ed. San Diego: Academic Press, pp.433-463.

Raheim, M., Magnussen, L., Sekse, R., Lunde, A., Jacobsen, T. and Blystad, A. 2016. Researcher-researched relationship in qualitative research: Shifts in positions and researcher vulnerability. *International Journal of Qualitative Studies on Health and Well-being.* **11**(1), pp.1-12.

Rainbow, P. 1984. *The Foucault Reader: An Introduction to Foucault's Thoughts.* London: Penguin.

Ramluggan, P., Chalmers, C. and Anjoyeb, M. 2018. The practice of seclusion: a review of the discourse on its use. *Mental Health Practice.* **21**(7), pp.17 - 23.

Reed, F., Fitzgerald, L. and Bish, M. 2016. Mixing methodology, nursing theory and research design for a practice model of district nursing advocacy.(Report). *Nurse Researcher.* **23**(3), p37.

Reilly, J., McDermott, B. and Dillon, J. 2019. Standardized drug and alcohol questions at admission to an acute adult mental health unit: clarifying the burden of dual diagnoses across a five-year period. *Australasian Psychiatry.* **27**(3), pp.270-274.

Renwick, L., Stewart, D., Richardson, M., Lavelle, M., James, K., Hardy, C., Price, O. and Bowers, L. 2016. Aggression on inpatient units: Clinical characteristics and consequences. *International Journal of Mental Health Nursing.* **25**(4), pp.308-318.

Riahi, S., Thomson, G. and Duxbury, J. 2016. An integrative review exploring decision-making factors influencing mental health nurses in the use of restraint. *Journal of Psychiatric and Mental Health Nursing.* **23**(2), pp.116-128.

Richards, H. and Emslie, C. 2000. The 'doctor' or the 'girl from the University'? Considering the influence of professional roles on qualitative interviewing. *Family Practice.* **17**(1), pp.71-75.

Richardson, B. 1987. Psychiatric inpatients' perceptions of the seclusion-room experience. *Nursing Research.* **36**(4), pp.234-238.

Ritchie, J., Lewis, J., Elam, G., Tennant, R. and Rahim, N. 2014a. Designing and selecting samples In: Ritchie, J., et al. eds. *Qualitative Research Practice.* 2nd ed. London: Sage, pp.111-143.

Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. 2014b. *Qualitative research practice: a guide for social science students and researchers.* 2nd ed. London: Sage.

Ritchie, J. and Ormston, R. 2014. The Applications of Qualitative Methods to Social Research. In: Ritchie, J., et al. eds. *Qualitative Research Practice.* 2nd ed. London: Sage pp.27-46.

Roberts, D., Crompton, D., Milligan, E. and Groves, A. 2009. Reflections on the Use of Seclusion: In an Acute Mental Health Facility. *Journal of Psychosocial Nursing and Mental Health Services.* **47**(10), pp.25-31.

Robins, C., Sauvageot, J., Cusack, K., Suffoletta-Maierle, S. and Frueh, C. 2005. Consumers' Perceptions of Negative Experiences and “Sanctuary Harm” in Psychiatric Settings. *Psychiatric Services* **56**(9), pp.1134-1138.

Rogers, D. 2012. Research, Practice, and the Space Between: Care of the Self Within Neoliberalized Institutions. *Cultural Studies ↔ Critical Methodologies.* **12**(3), pp.242-254.

Rosenberg, W. and Donald, A. 1995. Evidence based medicine: an approach to clinical problem-solving. *BMJ.* **310**(6987), pp.1122-1126.

Rubin, H. and Rubin, I. 2005. *Qualitative interviewing: the art of hearing data.* 2nd ed. Thousand Oaks, CA: Sage.

Rutakumwa, R., Mugisha, J.O., Bernays, S., Kabunga, E., Tumwekwase, G., Mbonye, M. and Seeley, J. 2019. Conducting in-depth interviews with and without voice recorders: a comparative analysis. *Qualitative research : QR.* **20**(5), pp.146879411988480-146879411988581.

Sackett, D., Rosenberg, W., Muir Gray, J., Haynes, B. and Richardson, W. 1996. Evidence Based Medicine: What It Is And What It Isn't: It's About Integrating Individual Clinical Expertise And The Best External Evidence. *BMJ: British Medical Journal.* **312**(7023), pp.71-72.

Saldaña, J. 2013. *The coding manual for qualitative researchers.* 2nd ed. London: Sage.

Sambrano, R. and Cox, L. 2013. ‘I sang Amazing Grace for about 3 hours that day’: Understanding Indigenous Australians' experience of seclusion. *International Journal of Mental Health Nursing.* **22**(6), pp.522-531.

Saunders, B., Kitzinger, J. and Kitzinger, C. 2015. Anonymising interview data: challenges and compromise in practice. *Qualitative Research.* **15**(5), pp.616-632.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H. and Jinks, C. 2018. Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity.* **52**(4), pp.1893-1907.

Schardt, C., Adams, M., Owens, T., Keitz, S. and Fontelo, P. 2007. Utilization of the PICO framework to improve searching PubMed for clinical questions. *BMC Medical Informatics and Decision Making.* **7**, pp.16-16.

Scott, C.R. 2005. Anonymity in Applied Communication Research: Tensions Between IRBs, Researchers, and Human Subjects. *Journal of Applied Communication Research.* **33**(3), pp.242-257.

Scott, K. and McSherry, R. 2009. Evidence-based nursing: clarifying the concepts for nurses in practice. *Journal of clinical nursing.* **18**(8), pp.1085-1095.

Seale, C. 1997. Ensuring rigour in qualitative research. *European journal of public health.* **7**(4), pp.379-384.

Seale, C. 2004. *Qualitative research practice.* London: Sage.

Sethi, F., Parkes, J., Baskind, E., Paterson, B. and O'Brien, A. 2018. Restraint in mental health settings: is it time to declare a position? *British journal of psychiatry.* **212**(3), pp.137-141.

Sheehan, K. and Burns, T. 2011. Perceived Coercion and the Therapeutic Relationship: A Neglected Association? *Psychiatric Services.* **62**(5), pp.471-476.

Shuster, E. 1997. Fifty years later: The significance of the Nuremberg Code,. *New England Journal of Medicine.* pp.1436-1440.

Silver, C. 2007. Staff resistance to restraint reduction: identifying and overcoming barriers. *Journal of Psychosocial Nursing* **45**, pp.45-50.

Silverman, D. 2016. *Qualitative research.* 4th ed. London: Sage Publications.

Simon, R. and Shuman, D. 2007. *Clinical Manual of Psychiatry and Law.* Washington, DC: American Psychiatric Publishing, Inc.

Slemon, A., Jenkins, E. and Bungay, V. 2017. Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry.* **24**(4).

Smith, G., Ashbridge, D., Davis, R. and Steinmetz, W. 2015. Correlation Between Reduction of Seclusion and Restraint and Assaults by Patients in Pennsylvania’s State Hospitals. *Psychiatric Services.* **66**(3), pp.303-309.

Smith, G., Davis, R., Bixler, E., Lin, H., Altenor, A., Altenor, R., Hardentstine, B. and Kopchick, G. 2005. Pennsylvania State Hospital system's seclusion and restraint reduction program. *Psychiatric services.* **56**(9), p1115.

Smith, J. and Firth, J. 2011. Qualitative data analysis: the framework approach. *Nurse researcher.* **18**(2), p52.

Soininen, P., Putkonen, H., Joffe, G., Korkeila, J., Puukka, P., Pitkänen, A. and Välimäki, M. 2013a. Does experienced seclusion or restraint affect psychiatric patients' subjective quality of life at discharge? *International Journal of Mental Health Systems.* **7**.

Soininen, P., Putkonen, H., Joffe, G., Korkeila, J. and Välimäki, M. 2014. Methodological and ethical challenges in studying patients' perceptions of coercion: a systematic mixed studies review. *BMC Psychiatry.* **14**(1), p162.

Soininen, P., Valimaki, M., Noda, T., Puukka, P., Korkeila, J., Joffe, G. and Putkonen, H. 2013b. Secluded and restrained patients' perceptions of their treatment. *International Journal of Mental Health Nursing.* **22**(1), pp.47-55.

Soininen, P., Välimäki, M., Noda, T., Puukka, P., Korkeila, J., Joffe, G. and Putkonen, H. 2012. Secluded and restrained patients' perceptions of their treatment. *International journal of mental health nursing.* **22**.

Soliday, S. 1985. A Comparison of Patient and Staff Attitudes toward Seclusion. **173**(5), pp.282-286.

Spencer, L., Ritchie, J., Morrell, G., O'Connor, W. and Ormston, R. 2014a. Analysis in Practice. In: Ritchie, J., et al. eds. *Qualitative Research Practice.* London: Sage, pp.295-345.

Spencer, L., Ritchie, J., Ormston, R., O'Connor, W. and Barnard, W. 2014b. Analysis: Principals and Processes. In: Ritchie, J., et al. eds. *Qualitative Research Practice.* London: Sage, pp.270-293.

Srivastava, A. and Thomson, S. 2009. Framework Analysis: A Qualitative Methodology for Applied Policy Research. *Journal of Administration and Governance.* **4**(2), pp.72-79.

Staggs, V. 2013. Nurse staffing, RN mix, and assault rates on psychiatric units. *Research in Nursing & Health.* **36**(1), pp.26-37.

Staggs, V. 2015. Trends in Use of Seclusion and Restraint in Response to Injurious Assault in Psychiatric Units in U.S. Hospitals, 2007–2013. *Psychiatric Services.* **66**(12), pp.1369-1372.

Steele, R. 1993. Staff Attitudes Toward Seclusion and Restraint: Anything New? *Perspectives in Psychiatric Care.* **29**(3), pp.23-28.

Steinert, T., Bergbauer, G., Schmid, P. and Gebhardt, R. 2007. Seclusion and restraint in patients with schizophrenia: clinical and biographical correlates. *Journal of Nervous & Mental Disease.* **195**(6), pp.492-496.

Steinert, T., Birk, M., Flammer, E. and Bergk, J. 2013. Subjective distress after seclusion or mechanical restraint: one-year follow-up of a randomized controlled study. *Psychiatric Services.* **64**(10), pp.1012-1017.

Steinert, T., Lepping, P., Bernhardsgrütter, R., Conca, A., Hatling, T., Janssen, W., Keski-Valkama, A., Mayoral, F. and Whittington, R. 2010. Incidence of seclusion and restraint in psychiatric hospitals: a literature review and survey of international trends. *Social Psychiatry and Psychiatric Epidemiology.* **45**(9), pp.889-897.

Stickley, T. 2006. Should service user involvement be consigned to history? A critical realist perspective. *Journal of psychiatric and mental health nursing.* **13**(5), pp.570-577.

Stige, B., Malterud, K. and Midtgarden, T. 2009. Toward an agenda for evaluation of qualitative research. *Qual Health Res.* **19**(10), pp.1504-1516.

Stolker, J., Nijman, H. and Zwanikken, P. 2006. Are patients' views on seclusion associated with lack of privacy in the ward? *Archives of Psychiatric Nursing.* **20**(6), pp.282-287.

Strauss, A. and Corbin, J. 2010. *Basics of qualitative research : techniques and procedures for developing grounded theory.* 3rd ed. Thousand Oaks: Sage Publications.

Streubert, H. and Carpenter, D. 2011. *Qualitative research in nursing : advancing the humanistic imperative.* 5th ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Substance Abuse and Mental Health Services Administration (SAMHSA). 2010. *Promoting Alternatives to the Use of Seclusion and Restraint - Issue Brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services.* Rockville, MD: US Department of Health and Human Services.

Sullivan, D., Wallis, M. and Lloyd, C. 2004. Effects of patient-focused care on seclusion in a psychiatric intensive care unit. *International Journal of Therapy and Rehabilitation.* **11**(11), pp.503-508.

Swallow, V., Newton, J. and Van Lottum, C. 2003. How to manage and display qualitative data using 'Framework' and Microsoft Excel. *Journal of Clinical Nursing.* **12**(4), pp.610-612.

Swanson, J., Swartz, M., Elbogen, E., Van Dorn, R., Wagner, H., Moser, L., Wilder, C. and Gilbert, A. 2008. Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health.* **17**(3), pp.255-267.

Tamminen, K. and Green, B. 2014. Seclusion and restraint: making the right decisions. *British Journal of Mental Health Nursing.* **3**(5), pp.200-201.

Tashakkori, A. and Teddlie, C. 2016. *Handbook of mixed methods in social & behavioral research.* Second edition. ed. Thousand Oaks, California: SAGE.

Taylor, J. 2011. The intimate insider: negotiating the ethics of friendship when doing insider research. *Qualitative Research.* **11**(1), pp.3-22.

Te Pou. 2014. *Do Seclusion Reduction Initiatives Increase Risk to Staff Safety? An integrative review of evidence of association and causality from 2004 to 2014, with recommendations for practice.* Auckland: The National Mental Health Centre of Research, Information and Workforce Development: .

Tillett, S. and Newbold, E. 2006. Grey literature at The British Library: revealing a hidden resource. *Interlending & Document Supply.* **34**(2), pp.70-73.

Tingleff, E.B., Hounsgaard, L., Bradley, S.K. and Gildberg, Frederik a. 2019. Forensic psychiatric patients’ perceptions of situations associated with mechanical restraint: A qualitative interview study. *International Journal of Mental Health Nursing.* **28**(2), pp.468-479.

Tong, A., Sainsbury, P. and Craig, J. 2007. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care.* **19**(6), pp.349-357.

Topp, L. 2018. Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums, 1838-1844. *Social history of medicine : the journal of the Society for the Social History of Medicine.* **31**(4), pp.754-773.

Torraco, R.J. 2005. Writing Integrative Literature Reviews: Guidelines and Examples. *Human Resource Development Review.* **4**(3), pp.356-367.

Treece, E. and Treece, J. 1986. *Elements of research in nursing (18th ed).* St Louis: Mosby.

Ulrich, C., Zhou, Q., Ratcliffe, S., Ye, L., Grady, C. and Watkins-Bruner, D. 2012. Nurse Practitioners' attitudes about cancer clinical trials and willingness to recommend research participation. *Contemporary Clinical Trials.* **33**(1), pp.76-84.

United Nations. 1991. *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.* http://www.equalrightstrust.org/content/un-principles-protection-persons-mental-illness-and-improvement-mental-health-care: United Nations.

United Nations. 2013. *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, 1 February 2013 (A/HRC/22/53). Para 78.* Geneva: United Nations Human Rights Council (UNHRC).

University of South Carolina (USC). 2014. *Research Design.* [Online]. [Accessed 15th August]. Available from: www.library.sc,edu

Van de Sande, R., Noorthoorn, E., Nijman, H., Wierdsma, A., Staak, C.v.d., Hellendoorn, E. and Mulder, C. 2017. Associations between psychiatric symptoms and seclusion use: Clinical implications for care planning. *International Journal of Mental Health Nursing.* **26**(5), pp.423-436.

Van de Sande, R., Noorthoorn, E., Wierdsma, A., Hellendoorn, E., Staak, C., Mulder, C. and Nijman, H. 2013. Association between short-term structured risk assessment outcomes and seclusion. *International Journal of Mental Health Nursing.* **22**(6), pp.475-484.

Van den Hoonaard, W. 2003. Is Anonymity an Artifact in Ethnographic Research? *Journal of Academic Ethics.* **1**(2), pp.141-151.

Van der Merwe, M., Bowers, L., Jones, J., Muir-Cochrane, E. and Tziggili, M. 2009. *Seclusion: a literature review.* London: City University London.

Van der Merwe, M., Muir-Cochrane, E., Jones, J., Tziggili, M. and Bowers, L. 2013. Improving seclusion practice: implications of a review of staff and patient views. *Journal of Psychiatric and Mental Health Nursing.* **20**(3), pp.203-215.

Van Doeselaar, M., Sleegers, P. and Hutschemaekers, G. 2008. Professionals' attitudes toward reducing restraint : the case of seclusion in the Netherlands. *Psychiatric Quarterly.* **79**(2), pp.97-109.

VanDerNagel, J., Tuts, K., Hoekstra, T. and Noorthoorn, E. 2009. Seclusion: the perspective of nurses. *International Journal of Law Psychiatry.* **32**(6), pp.408-412.

Vatne, S. and Holmes, C. 2006. Limit setting in mental health: historical factors and suggestions as to its rationale. *Journal of Psychiatric and Mental Health Nursing.* **13**(5), pp.588-597.

Veltkamp, E., Nijman, H., Stolker, J.J., Frigge, K., Dries, P. and Bowers, L. 2008. Patients' Preferences for Seclusion or Forced Medication in Acute Psychiatric Emergency in the Netherlands. *Psychiatric Services.* **59**(2), pp.209-211.

Verbeke, E., Vanheule, S., Cauwe, J., Truijens, F. and Froyen, B. 2019. Coercion and power in psychiatry: A qualitative study with ex-patients. *Social Science & Medicine.* **223**, pp.89-96.

Vogl, S. 2013. Telephone Versus Face-to-Face Interviews: Mode Effect on Semistructured Interviews. *Sociological Methodology.* **43**(1), pp.133-177.

Walsh, J., Stevenson, C., Cutcliffe, J. and Zinck, K. 2008. Creating a space for recovery-focused psychiatric nursing care. *Nursing Inquiry.* **15**(3), pp.251-259.

Ward, D., Furber, C., Tierney, S. and Swallow, V. 2013. Using Framework Analysis in nursing research: A worked example. *Journal of Advanced Nursing.* **69**(11), pp.2423-2431.

Wardhaugh, J. and Wilding, P. 1993. Towards an explanation of the corruption of care. *Critical Social Policy.* **37**, pp.4-31.

Weaver, K. and Olson, J.K. 2006. Understanding paradigms used for nursing research. *Journal of advanced nursing.* **53**(4), p459.

Webster, S., Lewis, J. and Brown, A. 2014. Ethical Considerations in Qualitative Research. In: Ritchie, J., et al. eds. *Qualitative Research in Practice.* 2nd ed. London: Sage, pp.77-110.

White, C., Woodfield, K., Ritchie, J. and Ormston, R. 2014. Writing up Qualitative Research. In: Ritchie, J., et al. eds. *Qualitative Research* 2nd ed. London: Sage.

Whitecross, F., Seeary, A. and Lee, S. 2013. Measuring the impacts of seclusion on psychiatry inpatients and the effectiveness of a pilot single - session post - seclusion counselling intervention. *International Journal of Mental Health Nursing.* **22**(6), pp.512-521.

Whittemore, R. 2005. Combining Evidence in Nursing Research: Methods and Implications. *Nursing Research.* **54**(1), pp.56-62.

Whittemore, R. and Knafl, K. 2005. The integrative review: updated methodology. *Journal of Advanced Nursing.* **52**(5), pp.546-553.

Whittington, R., Bowers, L., Nolan, P., Simpson, A. and Neil, L. 2009. Approval ratings of inpatient coercive interventions in a national sample of mental health service users and staff in England. *Psychiatric Services.* **60**(6), pp.792-798.

Whittington, R. and Mason, T. 1995. A New Look at Seclusion - Stress, Coping and the Perception of Threat. *Jounal of Forensic Psychiatry.* **6**(2), pp.285-304.

Wieman, D., Camacho-Gonsalves, T., Huckshorn, K. and Leff, S. 2014. Multisite study of an evidence-based practice to reduce seclusion and restraint in psychiatric inpatient facilities. *Psychiatr Services.* **65**(3), pp.345-351.

Wijayanti, A. 2019. 'Pasung' and other forms of physical restraint: a critical review of the treatment gap for severe mental illness in low-resource settings. *European Psychiatry.* **56**(sS), pp.S374-S374.

Wiles, K., Bahal, N., Engward, H. and Papanikitas, A. 2016. Ethics in the interface between multidisciplinary teams: a narrative in stages for inter-professional education. *London journal of primary care.* **8**(6), pp.100-104.

Wilkinson, S. 1988. The role of reflexivity in feminist psychology. *Women's Studies International Forum.* **11**(5), pp.493-502.

Williams, L., Rycroft-Malone, J. and Burton, C.R. 2017. Bringing critical realism to nursing practice: Roy Bhaskar's contribution. *Nursing philosophy.* **18**(2), pp.e12130-n/a.

Wilson, C., Rouse, L., Rae, S. and Kar Ray, M. 2017. Is restraint a ‘necessary evil’ in mental health care? Mental health inpatients’ and staff members’ experience of physical restraint. *International Journal of Mental Health Nursing.* **26**(5), pp.500-512.

Wilson, C., Rouse, L., Rae, S. and Kar Ray, M. 2018. Mental health inpatients’ and staff members’ suggestions for reducing physical restraint: A qualitative study. *Journal of Psychiatric & Mental Health Nursing.* **25**(3), pp.188-200.

World Health Organisation (WHO). 2017. *Strategies to end the use of seclusion, restraint and other coercive practices. WHO QualityRights training to act, unite and empower for mental health (pilot version).* Geneva: WHO.

Wynaden, D., Chapman, R., McGowan, S., Holmes, C., Ash, P. and Boschman, A. 2002. Through the eye of the beholder: to seclude or not to seclude. *International journal of mental health nursing.* **11**(4), pp.260-268.

Yang, C., Hargreaves, W. and Bostrom, A. 2014. Association of Empathy of Nursing Staff With Reduction of Seclusion and Restraint in Psychiatric Inpatient Care. *Psychiatric Services 'ps.psychiatryonline.org'.* **65**(2), pp.251-254.

Yin, R.K. 2014. *Case study research : design and methods.* Fifth edition. ed. Los Angeles: SAGE.

York, S. 2009. *Suicide, lunacy and the asylum in nineteenth-century England* PhD thesis, The University of Birmingham.

Zheng, C., Li, S., Chen, Y., Ye, J., Xiao, A., Xia, Z., Liao, Y., Xu, Y., Zhang, Y., Yu, L., Wang, C. and Lin, J. 2019. Ethical consideration on use of seclusion in mental health services. *International journal of nursing sciences.* **7**(1), pp.116-120.

Appendix

Appendix one: Seclusion in the host organisation

Each ward involved in the research has a similar seclusion suite. Each suite has:

- An ante-chamber with a fixed bench (see figure 1);
- A seclusion room with a lockable door with viewing windows and a hatch and a mattress (see figure 2); and
- A separate bathroom with a toilet and shower.

Figure 1 Ante-chamber

Figure 2 Seclusion room

Seclusion use is in line with statutory guidance and local policy: Use of Seclusion or Long-Term Segregation (Humber Teaching NHS Foundation Trust, 2019). The policy should be read in conjunction with Chapter 26 of the Mental Health Act (1983) Code of Practice (DoH, 2015).

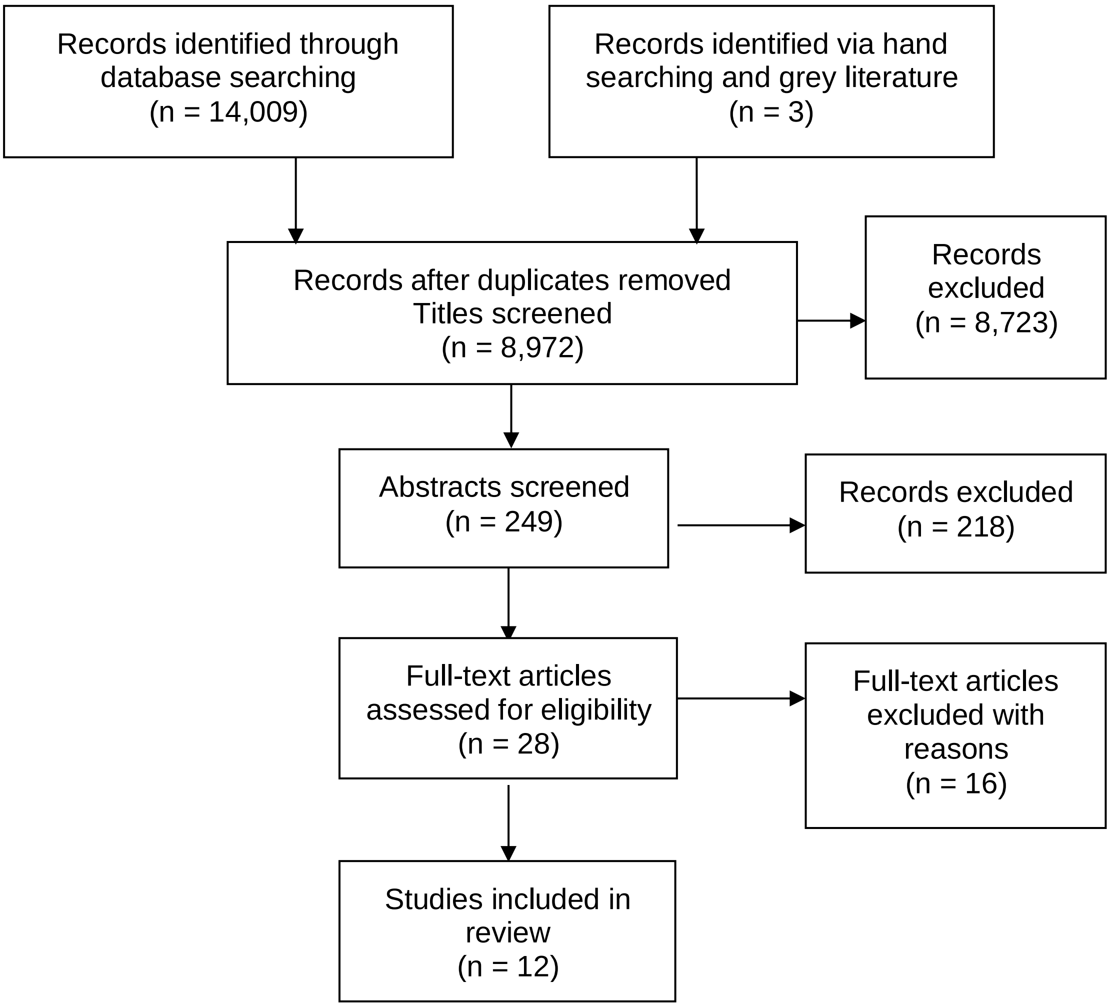
Each patient should have a seclusion management plan with individualised exit criteria.

A suitably-skilled professional (this can be a registered or an unregistered member of staff who has completed the training) should be within sight of the seclusion area at all times throughout a period of seclusion with the means to summon assistance from others if required. Consideration is given the gender of the patient and professional. The aim of observation is to safeguard the patient, monitor their condition and behaviour to identify the earliest time at which seclusion can end. If a patient has met the exit criteria, a review to end seclusion can be requested with the nurse in charge in consultation with a medic or the Responsible Clinician (usually the Consultant Psychiatrist) at any time and does not need to wait until the next scheduled review.

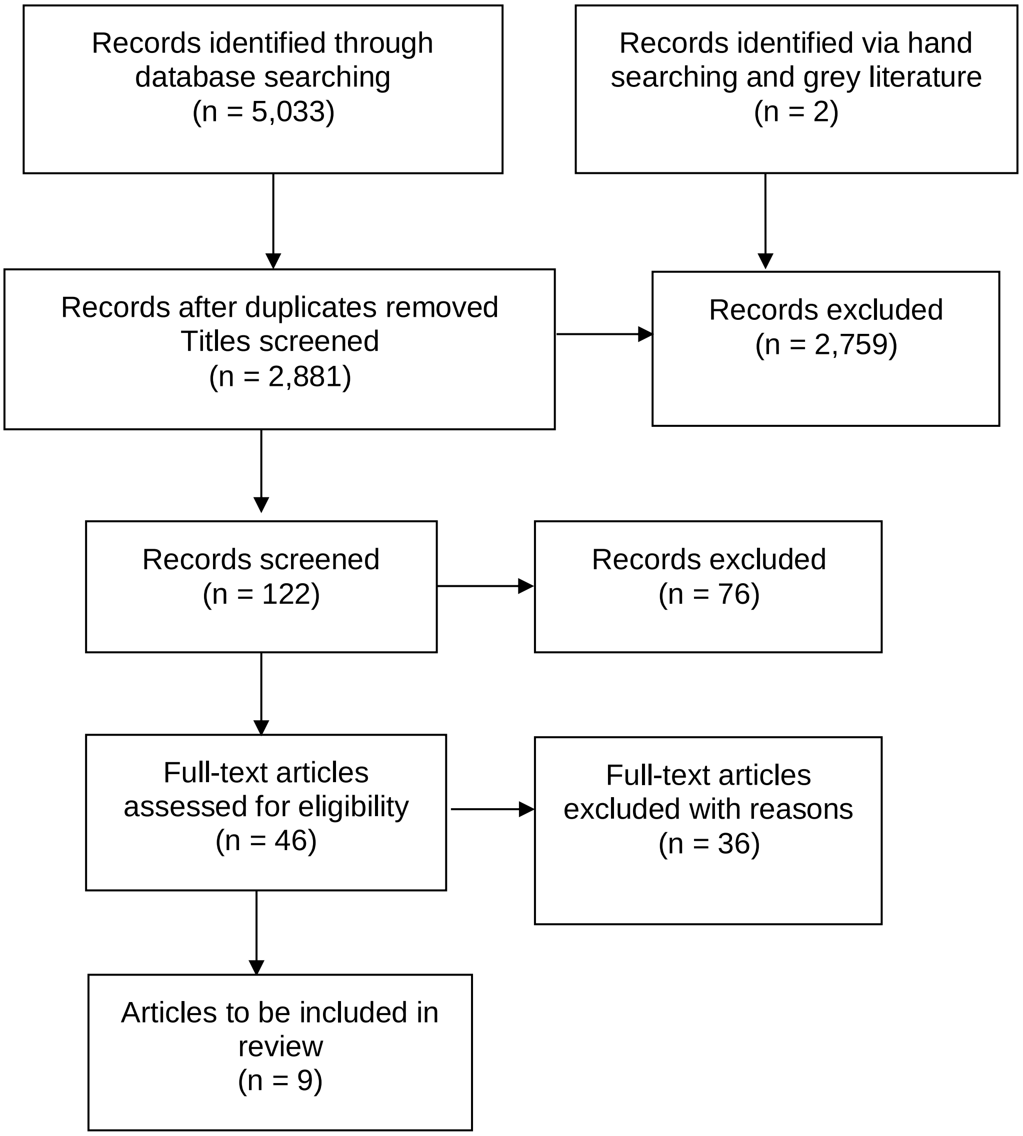
A record of the patient's behaviour should be made at least every 15 minutes on the electronic communication record. It should cover the patient's appearance, what they are doing and saying, and any physical ill health.

Appendix two: PRISMA diagrams

Professional Study



Patient Study



Appendix three: Critical appraisal

Professional Study

	Steele, R. (1993)		**MuirCochrane (1995, 1996a, 1996b)**		**Johnson, D. (1997)**		**Mason & Whitehead (2001)**		**Wynaden et al (2002)**	
1. Was there a clear statement of aims?	No	attitudes towards confinement	Yes	map perceptions & provide conceptual framework	Yes	to formulate a checklist to support decisions	No	explaining patterns of seclusion use	Yes	identify factors impacting on decision-making processes
2. Was the methodology appropriate?	??	no methodological discussion, aim collected attitudes and opinions	Yes	strong links made to philosophy, study was theory building	Yes	quantitative to identify best practice	Yes	quantitative with one open question	Yes	understanding/ experiential data for practice improvement
3. Was research design appropriate to address the aims of research?	No	limited description of methodological planning and design	??	not sure which GTA method used. Two months is brief for GTA	Yes	postal survey developed from literature	Yes	survey with limited description	Yes	In-depth interviews to elicit perceptions
4. Was recruitment strategy appropriate to the aims of the research?	No	recruitment process not clear, mixed care sample possible bias	Yes	2 wards with nurses with average 8yrs experience	??	randomised sample - not clear how but good response rate	No	high response rate, no decliners, no anonymity	Yes	purposive sample nurses/medic from a PICU
5. Was data collected in a way that addressed research issue?	No	small sample, no details re collection	Yes	inductive & reflective data stated theoretical saturation	Yes	tool not validated but minimised social desirability bias	Yes	rated symptom severity on seclusion & +1 hour	Yes	information-rich cases clear audit trail
6. Relationship between researcher & participants was considered?	No	no details given	No	no details given or reflexivity on researcher influence	Yes	author was manager but anonymity provided	No	no details given	No	no details given
7. Have ethical issues been considered?	No	no details given	??	For one paper (not other 2) anonymity difficult in local settings	??	not discussed but educational so approval from institution likely	No	hospital named participants may be identified	Yes	local approval, informed consent & confidentiality
8. Was data analysis sufficiently rigorous?	No	basic statistical analysis limited to percentages	Yes	Clear audit trail & used quotes, credible matching other studies	No	basic analysis some reliability, no ref to sampling errors	No	basic statistical analysis but no qualitative analysis	Yes	description and quotes included credible as used quotes
9. Is there a clear statement of findings?	??	staff confident they made good decisions not affected by patient	Yes	core category of controlling - nurses are utilitarianist	Yes	similar influences upon initiation & release - fear of violence	Yes	seclusion use is erratic	Yes	culture affects decisions, nurses look at behaviour not cause
10. How valuable is the research?	??	discuss behaviour, release when in control, assess reaction to release, assist entry to ward	??	release depends on patient ability to be in control, nurses prioritise safety	Yes	reluctance to admit non-patient factors as relevant	Yes	Decisions social cultural, change with experience conflict with policy	Yes	staff set criteria & want patient to commit to plan & show pre-crisis behaviour

	Larue et al (2010)		Boumans et al (2015)		Goulet & Larue (2018)		Fish et al., (2019)		Haugom et al., (2019)	
1. Was there a clear statement of aims?	Yes	do nursing interventions meet policy/ protocols	Yes	effect of institutional project on coercion	Yes	understanding to promote better practice	Yes	to understand experience of staff and patients	Yes	how staff explain ethical challenges to seclusion
2. Was the methodology appropriate?	Yes	little known so in-depth exploration	Yes	Experimental - pragmatic study in uncontrolled settings	Yes	understand the points of view of staff and patients	Yes	exploration of staff and patients experience	Yes	exploratory
3. Was research design appropriate to address the aims of research?	Yes	collected experiences in practice setting	Yes	longitudinal using a number of time points	Yes	immersion in setting using a case study	Yes	clear explanation of reasons for ethnography	Yes	written data might reduce social biased reports
4. Was recruitment strategy appropriate to the aims of the research?	Yes	nurses within 48 hours of episode	Yes	full ward participation not sure who agreed to this	Yes	used a representative mixture of healthcare staff	Yes	1 declined , small sample potential for bias-all white British staff	Yes	64 units across Norway so representative sample
5. Was data collected in a way that addressed research issue?	Yes	interviews with clear pre-test, clear audit trail	Yes	validated survey, ward data and vignettes	Yes	multiple data sources to acknowledge complexity	Yes	detailed description of fieldwork& interviews	Yes	data possibly not in-depth as semi-structured form
6. Relationship between researcher & participants was considered?	Yes	researchers outsiders to setting	Yes	no reference but all data collected anonymously electronically	Yes	no details given and no evidence of reflexivity	Yes	detailed reflexivity throughout processes	Yes	existing knowledge may have biased analysis
7. Have ethical issues been considered?	Yes	approval, informed consent & anonymity	Yes	approval under ethical review board	??	no reference to ethics, 8-30 post incident to avoid trauma	Yes	all processes clearly considered & described	Yes	data was anonymous, ethical process described
8. Was data analysis sufficiently rigorous?	Yes	trustworthy as double blind intra-coder control	Yes	reporting and analysis clear and reliable, numeric focus	Yes	clearly outlined, interrater reliability, triangulated	Yes	data triangulated - quotes increase credibility	Yes	detailed description, team coding, trustworthy
9. Is there a clear statement of findings?	Yes	culture affects decisions, post incident reviews not routine	Yes	attitudes/opinions change within settings and over time	Yes	staff & patient perspectives should be heard	Yes	statement related to patients rather than staff	Yes	staff balance controlling behaviour & good care
10. How valuable is the research?	Yes	nurses want pre-crisis behaviour before release	Yes	diminished communication & perceptions of safety staff less likely to release	Yes	release dependent upon implicit standards & compliance	Yes	theme for termination: keep calm & play the game	Yes	follow plan & get patient to agree, staff recognise power

Patient Study

	Kennedy et al., (1994)		**Martinez et al., (1999)**		**Meehan (2000)**		**Hoekstra et al., (2004)**		**El Badri & Mellsop (2008)**		**Kontio et al., (2012)**	
1. Was there a clear statement of aims?	Yes	experience of patients + auditory hallucinations & seclusion	Yes	understand decisions to promoter shorter seclusions	Yes	Patients perceptions of seclusion	Yes	to understand experience & effect on relationships	??	mot specific just to understand perceptions	Yes	explore perceptions of seclusion and restraint
2. Was the methodology appropriate?	Yes	exploratory and a gap in the literature	Yes	used a method convenient to patients	Yes	how do patients describe/construct meanings	Yes	exploratory speaking to patients	Yes	mixed methods	Yes	describe experience & suggest improvements
3. Was design appropriate to address the aims of research?	Yes	validated tool to measure seclusion experience	No	mixed methods to triangulate	Yes	naturalistic interview study with patients post seclusion	Yes	grounded theory – cyclical interviews	Yes	mixed method questionnaire to triangulate	Yes	Little known exploratory face to face interviews
4. Was recruitment strategy appropriate to the aims of the research?	Yes	first 25 inpatients who met criteria and consented	No	mixed age groups, secluded and non-secluded-needed to separate comments	??	Sample described but not clear how recruited	Yes	inpatients who had been secluded	??	patients who had been and not been secluded	Yes	clear audit trail, comments only used if related to seclusion
5. Was data collected in a way that addressed issue?	Yes	within 5 days of seclusion	No	Diff ages may have diff experiences focus groups -not always honest	Yes	been secluded in last 7 days, semi-structured interview guide	Yes	not clear when secluded, face to face interviews	No	limited info, from outpatient clinics	Yes	2-7 post incident, credentials of researchers – all nurses/academics
6. Relationship between researcher & participants was considered?	No	no details given but this was a survey	No	Not stated	??	Nurse researcher worked on ward before – possible trust/coercion	No	no details given	No	no details given	Yes	no links to setting
7. Have ethical issues been considered?	Yes	care taken to ensure capacity and this was monitored ongoing	Yes	survey anonymous, 2 researchers in groups so could offer support	??	no details but suggests it may be as de-brief was discussed	Yes	approval given, patients all in therapy for support	??	an anonymous survey	Yes	consent discussed and mitigation for distress outlined
8. Was data analysis sufficiently rigorous?	No	only basic % given	No	only basic % given, no details for qualitative element	Yes	limited discussion, credibility as team agreed themes	Yes	creation of themes and data saturation evident	No	only basic % given, no details for qualitative element	Yes	clearly outlined and team coding
9. Is there a clear statement of findings?	Yes	no relationship between seclusion & hallucinating to staff visits and seclusion duration	Yes	seclusion is a mean for staff to be in control	Yes	patients negative about seclusion	??	central themes autonomy, trust, loneliness	??	Seclusion is experienced as negative	Yes	patients in seclusion aren't given enough attention
10. How valuable is the research?	Yes	staff negotiate a contract for release	Yes	Seclusion increases agitation which increases durations	Yes	seclusion has unspoken rules and staff want compliance	Yes	not able to make choices, care inequitable, self-reliance	Yes	patients do not know what is required to exit	Yes	seclusion seen as negative and lasted too long, made recommendations

	Faschingbauer et al., (2013)		Larue et al., (2013)		Soinnen et al., (2013		Goulet & Larue (2018)		Askew et al., (2019)	
1. Was there a clear statement of aims?	Yes	investigate from a patient perspective	Yes	describe perceptions	Yes	perceptions of co-operation after seclusion or restraint	Yes	understanding to promote better practice	Yes	forensic patients experience of seclusion
2. Was the methodology appropriate?	Yes	literature is limited so research needed – only 2 US studies	??	focussed on seclusion and restraint – not decision-making	Yes	rate items based on previous research	Yes	understand the points of view of staff and patients	Yes	listening to the patient voice of being the room
3. Was research design appropriate to address the aims of research?	Yes	phenomenological exploration of patients experience	??	mixed questionnaire for patients with and without restraint	Yes	well thought out design but included restraints as well	Yes	immersion in setting using a case study	Yes	Interpretative phenomenology of in-depth accounts
4. Was recruitment strategy appropriate to the aims of the research?	No	states patients needed to be co-operating so results might be biased	??	participants appear to have been strictly gate-kept by nursing staff	Yes	clear outline provided	Yes	used a representative mixture of healthcare staff	Yes	clear outline provided – all male so possible bias
5. Was data collected in a way that addressed research issue?	Yes	In depth unstructured interviews – 2-7 days post incident with rationale	Yes	7-30 days post-seclusion, interview using a validated tool	Yes	within 5 days of S/R	Yes	multiple data sources to acknowledge complexity	Yes	within 28 days of interview, tool developed by patients
6. Relationship between researcher & participants was considered?	Yes	independent social worker researcher not involved in providing care	Yes	MH nurse trained researcher not connected to the setting	??	no details given but this was an anonymous survey	Yes	no details given and no evidence of reflexivity	Yes	no connection to the ward and power imbalance discussed
7. Have ethical issues been considered?	Yes	describes approval, informed consent and privacy	Yes	clearly described, built in support for patients who may be distressed	Yes	practical steps of consent process described	??	no reference to ethics, 8-30 post incident to avoid trauma	Yes	approval given, support and re-traumatisation considered
8. Was data analysis sufficiently rigorous?	Yes	Clearly outlined and analysis by team with knowledge of seclusion	Yes	process described, qualtve data team rated, statistical data triangulated	Yes	detailed analysis, presentation and discussed	Yes	clearly outlined, interrater reliability, triangulated	Yes	IPA process described, verified by independent researcher
9. Is there a clear statement of findings?	??	3 themes – respect & communication, emotional response, insight	Yes	Relational aspects of seclusion could be better	Yes	Patients didn't get enough attention from staff,	Yes	staff & patient perspectives should be heard	Yes	patients experience fear in seclusion
10. How valuable is the research?	Yes	Patients wanted timetable to know when staff would be back	Yes	Patients think they are secluded for too long	Yes	Patients are not listened to and opinions don't count	Yes	release dependent upon implicit standards & compliance	Yes	staff control experience and duration, staff abilities questioned

Appendix four: Gantt chart – PhD Timeline

	Oct-15	Jan-16	Apr-16	Jul-16	Oct-16	Jan-17	Apr-17	Jul-17	Oct-17	Jan-18	Apr-18	Jul-18	Oct-18	Jan-19	Apr-19	Jul-19	Oct-19	Jan-20	Apr-20	Jul-20	Oct-20
Study 1: Professional Study																					
Planning	■	■	■	■																	
Literature Review						■	■	■										■			
Ethics Application					■	■															
Interviewing							■	■	■	■											
Data Analysis									■	■	■	■	■								
Presentation to Employer															■						
Study 2: Patient Study																					
Planning								■	■												
Literature Revew													■	■				■			
Ethics Application										■	■				■						
Interviewing												■	■	■	■	■					
Data Analysis														■	■	■	■	■			
Presentation to Employer																					▨
Writing																					
Transfer Report						■	■														
Professional Literature Review										■	■										
Professional Interview Paper												■	■								
Patient Literature Review																					▨
Patient Interview Paper																					▨
Thesis																	■	■	■	■	

Appendix five: Ethics approvals

Ms Haley Jackson
Humber NHS Foundation Trust
Westlands Unit
Wheeler Street
Hull
HU3 5QE

Health Research Authority

mail: hra.approval@nhs.net

22 February 2017 Dear Hayley

Letter of HRA Approval

Study title:	**What factors influence decisions made by mental health professionals when terminating seclusion episodes?**
IRAS project ID:	**217447**
Protocol number:	**N/A**
HRA reference:	**17/HRA/0545**
Sponsor	**University of Leeds**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time,

before their participation is assumed.

- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net.

Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **217447**. Please quote this on all correspondence.

Yours sincerely

Isobel Lyle | Senior Assessor

Health Research Authority
Room 002, TEDCO Business Centre, Rolling Mill Rd,
Jarrow NE32 3DT Hra.approval@nhs.net or
Isobel.lyle@nhs.net

T: 0207 972 2496

www.hra.nhs.uk

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Letter of HRA Approval

Haley Jackson

Humber NHS Foundation Trust

Westlands Unit
Wheeler Street
Hull

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales? You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

I do once I receive this letter?

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non- NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter? You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: NHS Research Ethics Officer

E-mail: governance-ethics@leeds.ac.uk

Telephone: 0113 343 7587

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below. Your IRAS project ID is **244043**. Please quote this on all correspondence.

Yours sincerely,

Sharon Northey

Senior Assessor

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dear Haley,

IRAS Project ID: 244043
Short Study Title: Experience of MH service users in decisions to end seclusion

Date complete amendment submission received: 17th July 2019

Amendment No./ Sponsor Ref: Non-Substantial Amendment 1, 10/07/2019

Amendment Date: 10 July 2019
Amendment Type: Non-substantial

Outcome of HRA and HCRW Assessment

This email also constitutes HRA and HCRW Approval for the amendment, and you should not expect anything further.

Implementation date in NHS organisations in England and Wales

35 days from date amendment information together with this email, is supplied to participating organisations (providing conditions are met)

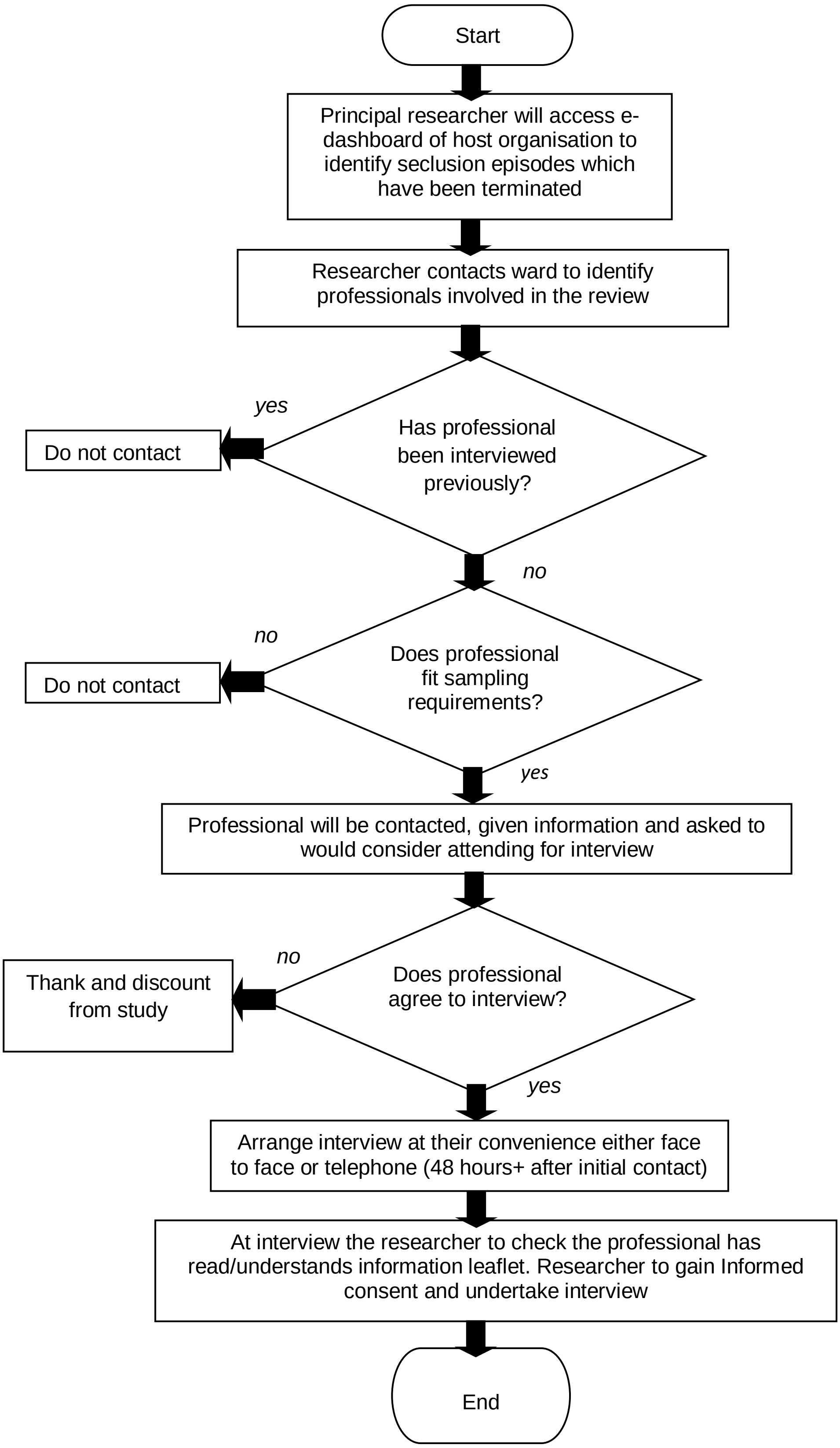
For NHS/HSC R&D Office information

Amendment Category A

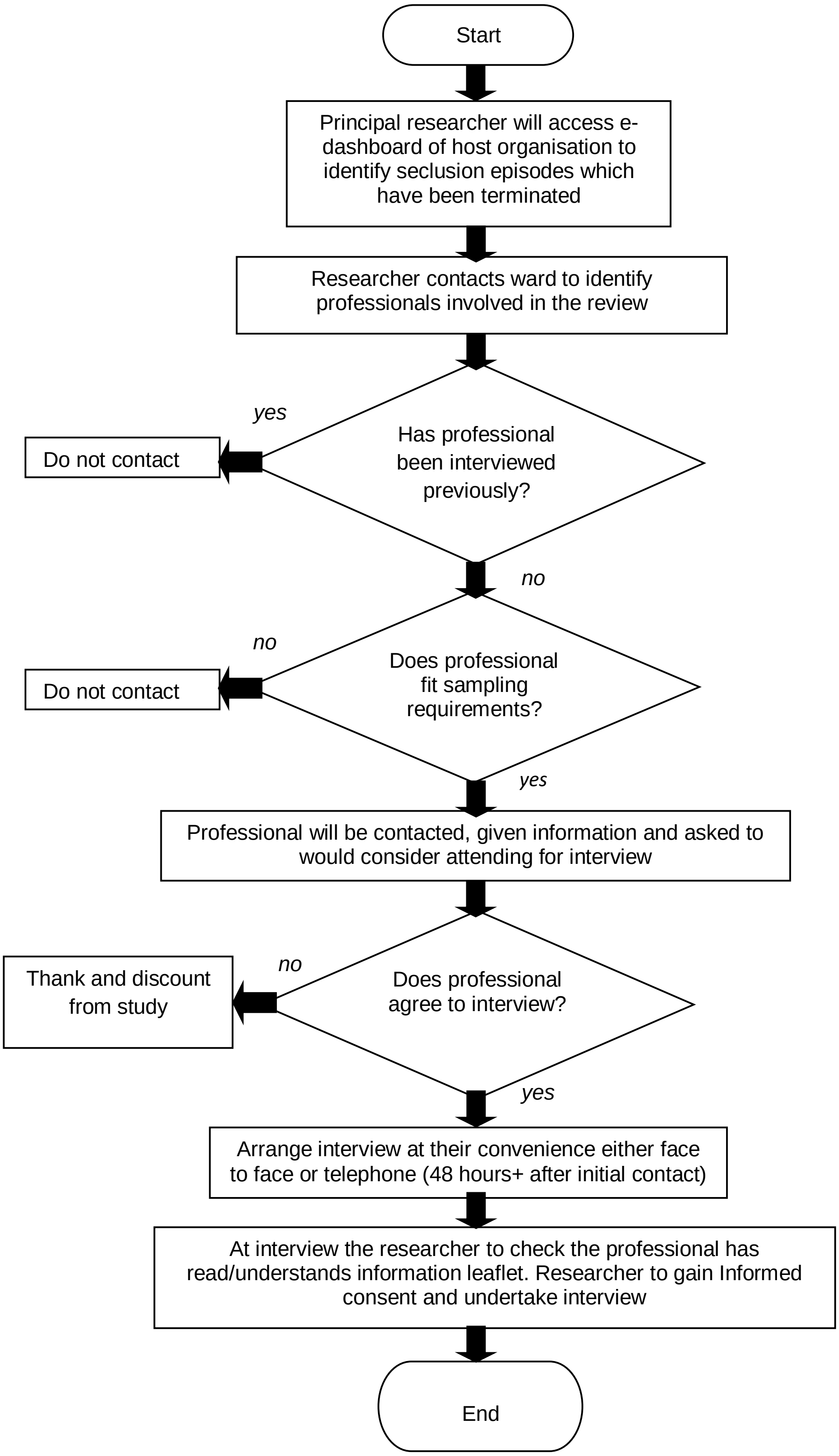
Thank you for submitting an amendment to your project. We have now categorised your amendment and please find this, as well as other relevant information, in the table above.

Appendix six: Recruitment and consent flow chart

Professional study



Patient Study



Appendix seven: Example of interview table

Professional Study

No.	Date	Role/Grade	Time in MH	M/F	Work area	Length Min/Secs	Interviewee Summary	Reflection
1	13th May 2017	MHN B6	20yrs	M	Male Treatment	33.01 (18.49+ 14.12)	Care plan supports process sets boundaries and expectations. Patient not involved in writing this but needs to understand, not agree but adhere to plan. Importance of knowing patient, trust and communication. Decision/risk assessment process is not clear cut – affected by patient actions pre/post initiation. 'Sweet Spot'. Decision should be MHN led – short shifts problematic for continuity	Difficult – I recorded half and returned to try to get interviewee to expand. I tended to jump to next question rather than letting conversation flow. I had produced a list of questions and rather than explore the answers the interviewee gave I tried to stick to the schedule and work down the questions
2	15th May 2017	Assistant Psycholgy B4	4yrs	F	Male/ Female Treatment	24.31	Not much experience but feel comfortable participating. Preparation prior to review - some reviews feel predetermined. ++ staff at MDT review felt uncomfortable and confusing for patient. Not aware of exit plan but expectations set – patient to be manageable, not violent, compliant. Release dependent upon availability of nursing staff.	Interviewee gave short answers. Interview seemed to elicit practical aspects of review. Did not have much experience of involvement and looked uncomfortable. I found it difficult to explore responses – on reflection I am not sure I listened too closely – have decided to try and make notes of points to explore. Reading it back it was more about her recalling the process rather than her thoughts about what was guiding the decision-making
Discussed pilot interviews in supervision. I reflected I was struggling to make interviews last long enough (link to literature novice interviewers). Supervisors said they contained little depth and suggested there was very little probing or exploration of thoughts and feelings. Suggestion to use more pre-prepared questions to support collection of more data and greater insights.								
3	14th July 2017	OT B6	9yrs	F	Male Treatment	32.04	Important to know patient history, risk assessment not clear but looking at behaviours, for safety and calmness. Is it normal for that patient? Involve patient if possible. Staff give instruction, look for compliance, testing out plans, want a safe exit. Drug use increases unpredictability. Not sure opinion of OT is always valued – making up numbers – OT think about activities patients could do. Outcome is obvious prior to some reviews	Use revised questionnaire but interviewee talked more than first two so I let the interview flow as much as possible – she covered many of the points I had in the schedule – it had a little more flow but still struggled to get real depth.
4	15th July 2017	MHN B5	7mnths	F	Male Treatment	32.56	Consider risk, patients baseline, reason for seclusion. Look for safety, level of compliance, settled behaviour. Staff devise exit plan, work to build engagement, rapport, check between reviews, undertake gradual release. It becomes apparent patient is moving towards being ready – look for open discussions, patient agreement and understanding of plan. Staff consider wide factors but take positive risks and work collaboratively. Patient may present differently to doctors.	Tried to use broad questions this time – experience, thoughts, example. It flowed better and I was able to bring in topics from schedule. I tried write down key words and go back and explore. I also tried to focus on flow rather than changing subject – some of my questions were not asked clearly
Discussed again in supervision – continue to try use more probing and exploratory questions - still not eliciting enough depth. Advised think about exploring the effect of training								

Patient Study

	Date	Age	M F	Place	Time in	Length of interview	Time since	Patient diagnosis and current situation	Interviewee Summary	Reflection
D	5th Sept 2018	29yo	F	PICU	46hrs 10mns	25mins Not recorded	8 days	Diagnosis of treatment resistive paranoid schizophrenia, multiple illicit substance misuse and was currently homeless. Had been secluded on a previous admission. Had been secluded on PICU but was interviewed on treatment unit. Continued to express psychotic beliefs	Participant described being brought to the unit by the police in handcuffs. She said didn't understand why and described being frightened. She felt police and staff were laughing at her, they brought her food she didn't want, injected her illegally and made her use a cardboard bowl as a toilet. She said staff didn't speak to her.	Patient declined to allow me to record preferring me to take notes. I think she thought she may benefit from talking to me but then realised she wouldn't. She wanted to stay to talk about her seclusion experience but had poor recall. I found it difficult to follow up on some points raised as she was unable to give any depth or offer much description. She stayed for around 25 minutes but then left appearing anxious. I planned to and tried to stick to the interview schedule closely but couldn't as the she did not always respond. I informed the ward staff she was distressed.
E	19th Sept 2018	35yo	M	PICU	9days 13hrs 10 in (229 hrs)	27mins Not recorded	12 days	Diagnosis Paranoid schizophrenia, multiple personality disorder, alcohol and illicit substance misuse. Transferred to PICU then to treatment unit, interviewed upon treatment unit. Had been secluded on a previous admission in a different hospital	He wasn't negative about the seclusion experience although was critical of the room. He struggled to manage his psychosis (hearing voices) whilst secluded saying at times he was frightened as he did not know how long he would be in. He found it difficult to recall details of what was said and was not really aware of what was going on outside the room. He said staff were supportive but didn't involve him in decisions. He didn't think he was ready to go back on the ward (which was noisy at that time). No debrief but it would be helpful.	Participant declined to allow me to record interview preferring me to take notes. Participant engaged really well and said at the end he should have let me record it as it wasn't as difficult as he thought it was going to be. I used the checklist so the latter part of the interview felt a disjointed
F	9th Oct 2018	62yo	F	PICU	6hrs 20 min	42mins Not recorded	16 days	Diagnosis of bi-polar affective disorder. Has had numerous admissions to units locally and nationally.	Described being brought in by the police. Very angry, described being claustrophobic, caged, maltreated, laughed at. Felt staff did not speak to her. Dr told me I had to start communication with the staff and take medication. Felt they didn't take adequate care of her physically – they need RGNs on the wards. The staff brought me clothes before the doctor came. No debrief and episodes felt undignified.	Didn't record as I wasn't expecting to interview her today as I thought she would be in hospital longer but she was being discharged later that day. Staff said she was well and had capacity. She willingly agreed to participate but became upset. I offered her the opportunity to stop but she wanted to carry on. I think the distress was more about the admission in general rather than specifically about seclusion. It was unclear if she had ever been secluded before. I suspect she had but she was vague. I spoke to the staff about her thoughts of wanting to die. They planned to speak to her before she was leaving the ward and do a full risk assessment.
	Discussed recent episode in supervision. Also reflected on how it has been easier to recruit females rather than males. Suggested to try to make an effort to get more men and to ensure all I record the number and gender of those who decline to take part. I was struggling to get a balance between people who were acutely unwell and only recently out of seclusion against others who had been out longer but were more recovered and engaged better.									

Appendix eight: Coding frameworks

Professional study

1	**Managing Safety** 1.1Preceding event 1.2Ongoing risk 1.3Preventing further violence 1.4Responsibility 1.5Fear/anxiety 1.6 Other	**5**	**External Factors** 5.1 Physical environment 5.2 Ward acuity 5.3 Resources 5.4 Staff factors 5.5 Policy/ procedures 5.6 Carer/advocate involvement 5.7 Other
2	**Assessment** 2.1 Holistic Assessment 2.2 Knowledge of patient 2.3 Assessing risks 2.4 MDT assessments 2.5 Assessing MH 2.6 Different to secluded 2.7 Other	**6**	**Compliance** 6.1 Expectations 6.2 Acceptance 6.3 Ability to follow direction 6.4 Ability to maintain 6.5 Remorse and reflection 6.6 Other
3	Control 3.1 Conditions for release 3.2 Treatment 3.3 Planning 3.4 Ability to understand 3.5 Presentation 3.6 Other	**7**	Release and Reflection 7.1 Point of release 7.2 Stepped release 7.3 Effect of release on others 7.4 Support after release 7.5 Premature release 7.6 Barriers to release 7.7 Other
4	Interaction 4.1 Communication 4.2 Engagement 4.3 Negotiation 4.4 Relationship 4.5 Patient Involvement 4.6 Other	**8**	**Other points raised** 8.1 Changing practice 8.2 Segregation 8.3 Experience// background 8.4 Disagreeing with decision 8.5 Patient experience 8.6 Patient preference 8.7 Repeatedly secluded

Patient study

1	**Being secluded** 1.1 Secluded before 1.2 Prior to seclusion 1.3 Wanting to be secluded 1.4 Not secluded before 1.5 Understanding why 1.6 Entering seclusion 1.7 Being re-secluded	6	**Patient influence** 6.1 Abiding by the rules 6.2 Acting 6.3 Bargaining 6.4 Becoming calmer 6.5 Show understanding 6.6 Self-awareness/reflection 6.7 Being sorry 6.8 Agreeing
2	**Experience** 2.1 Negative feelings 2.2 Positive feelings 2.3 What it was like 2.4 Use of medication 2.5 How long it felt 2.6 That's not me 2.7 At first and now	6	**Staff influence** 6.1 Staff skills 6.2 Difference in staff skills 6.3 Unhelpful behaviours 6.4 Helpful behaviours 6.5 Staff controlling
3	**Communication** 3.1 Staff direction 3.2 Staff offering support 3.3 Staff explaining 3.4 Asking my opinion 3.5 Being listened to 3.6 Abusive to staff 3.7 Not communicating 3.8 Explaining how I felt 3.9 Talking amongst themselves	7	**Point of release** 7.1 Quiet of calm enough 7.2 Preparing me for release 7.3 Feeling ready 7.4 Turning point 7.5 Transitional period 7.6 Coming out
4	**Relationship with staff** 4.1 Knowing staff 4.2 Difference in staff 4.3 Trusting 4.4 Staff being supportive 4.5 Staff not attentive 4.6 self-preservation 4.7 Powerful or powerless 4.8 Staff not liking me	9	**Post release** 8.1 Back to my room 8.2 Other patients 8.3 Support from staff 8.4 Attitude after release 8.5 Attitude towards staff 8.6 De-brief
5	**Planning for release** 5.1 Expectations of staff 5.2 Expectations of patients 5.3 Review Process 5.4 Awareness of a plan 5.5 Understanding the plan 5.6 Involvement in the plan 5.7 Explaining how I felt 5.8 Talking among themselves	10	**Other points raised** 10.1 Involvement of family 10.2 What else could staff do

Appendix nine: Coding summary table examples

Professional study

	1.1 Preceding event	1.2 Ongoing risk
Nurses Summary	Nurses try to understand what happened in the preceding event and consider the likelihood it may happen again. Although reason for and severity of event may affect the time a patient is secluded and how release is planned, nurses stress importance of looking at patient in present. Often focus is on behaviour rather than cause of event. They consider effect and strengths of team but address their anxieties. The team have to deal with consequences of your decision, if it's wrong you're not going to keep support and trust of team, there goes your credibility. They work to gain trust of patient acknowledging event was difficult. Nurses reflect on event as a learning opportunity.	Ongoing threats, delusional beliefs, time in seclusion, concerns about safety affect decisions plus readiness to move to next stage and on to release. Has behaviour peaked and what is patient capable of? Risk constantly assessed by observation, engagement, listening, checking out, level of co-operation, are triggers resolved, factors in wider environment and issues of resource are considered. Consider what is usual for this patient. Nurses want to do the right thing but need to be sure before opening the door they have mitigated for risk factors. Nurses build up trust during seclusion and use supportive close 1:1/2:1 staffing (for safety as well?)
Medics Summary	Medics want to know and understand what happened in the lead up to the seclusion. They discuss this with the staff and the patient. The level of aggression before the episode has a bearing on decisions made by medics. They take into account how the staff will manage the situation if the patient is released.	Medics look at how is presenting and assess if they think this will continue. They are looking not only for the level of violence and aggression but also at what might be driving the behaviour. If they are still violent and aggressive they are not ready to be released. On-call medics might not know the patient so they take their time to make sure they understand the risks.
HCA Summary	There is a link between what has happened and the decision to release in terms of the length of time a patient may be secluded and the way in which they are released. However a HCA questioned this saying we should be looking at how a person is in the present moment.	We risk assess from the minute someone is secluded and throughout the episode. We discuss risk with patient and get them to promise not to repeat violence. Qualified staff make the decision but listen to our views. If we know someone and we have a MAPA team we are more likely to agree with the decision than if we don't know them or if we don't think have enough staff.
AHP Summary	AHPs are less likely to be involved in preceding situation but think higher levels of aggression leading up to seclusion make staff more hesitant when making decision to release. It is important to understand why patient was secluded. Staff make careful considerations and want to be sure the service user will not need re-secluding as that can be difficult. Other service users may be worried about what they have seen although they express concerns for the well-being of the service user secluded	If verbal and physical threats are continuing or there is a potential for further violence staff consider safety for self, service user and others. In contrast - staff should act on what they see not potential. Episode may last longer if ability to communicate or socially interact is impaired or by fear/distress. If presentation changes ie. settled, manageable, remorseful then there is less potential for further aggression. Being sure to avoid having to re-seclude

Patients study

	4.1 Knowing Staff	4.2 Difference in staff	4.3 Trusting
Relationship with staff	Patients who have been in hospital a while or before know most staff. It’s easier to talk to staff we know, they know about us, what we do and our families. I can’t be bothered to talk to strangers, staff I don't know and don't trust bank staff, they are not calming. For some they don't want to get to know staff. Staff groups are big, with frequent changes certain staff were there, then they weren’t, don't see the same staff twice. One patient wanted female staff and mostly it was.	Some staff talk, listen & we have good relationships with. Once calm Dr/SN will come and see us - Drs say what's what, they open the door and come in-others just watch us. Non-regular staff can't do anything so no point talking to them, HCAs can be militant or judgmental, they can't make a decision have to refer to SN/Drs so I don't ask them if I want anything - we are told to wait until the Dr comes, Dr says the SN will know when we are ready to come out. Police were viewed negatively	It’s hard to trust staff when you been through a trauma, they have just locked you up, you’re insecure, feel they may pounce back on you and put you back in, How do we come together? Patients trust most staff we have to we are in a vulnerable position. It does not affect relationships, but it’s difficult to trust staff you don't know, being forced to take meds you don't want. Staff don't always trust us, they should work to gain our trust, they could have done more. They want to trust me before I am released. We trust staff more than other patients.
	6.1 Abiding by the rules	6.2 Acting	6.3 Bargaining
Influence of SU	Staff want to know you will be calm, talk nicely, agree with what they say, play by the rules. If you don’t, you don’t come out. If you do they may let you in the airlock but want to know you will go back in if asked, agree I wouldn’t do anything ‘stupid’, Qualified staff make the rules, Dr said I had to prove .., they are usually fair, they listen but instructed and. I did what was asked. It is difficult being told what to do there are so many rules here, why should I? I walked out on condition I would not shout, spent time in the quiet area to see if I was quiet enough. Once I got a grip I said all the things I thought they wanted hear, tried to behave, be calm. I wasn’t in a position to do much, it was do this, don’t do that, then that would be it, it would be over, which I felt a bit better about as I knew I would be out soon.	Some patients put things on 'act' in front of staff. I was only pretending to sleep so I didn’t have to talk to them. I had to do something to make them let me out, show them I could act calm and not argue. I said things like sorry, I won’t be fighting, break your mugs, cut myself, all the things I thought they wanted to me to say. I wanted out and so I made myself look calm but I wasn’t, not really, smiling, saying it is okay now but inside I was screaming you set of fuckers open the door. Whereas others did not, I didn't act differently towards any of them. I just am who I am I don’t act I just am.	It's not really about bargaining it's more about doing as your told, do this, this and this and then you can come out. Anti-psychotic medication can be used as a bargaining chip, they say you can come out if you take this. I’m all right with it as I rely upon staff when I am unwell.

Appendix ten: Reflective summary

The PhD was part-time study and took five years to complete. The journey has been both enjoyable and challenging. However, I have grown both academically and personally as a result. I have had the opportunity to have protected time for study, attend national and international conferences and undertake health research training.

My ability to read, understand, apply and conduct research has grown exponentially. The knowledge I have gained has enabled me to be involved in and lead on other research projects. This has been recognised with the Trust I work for, as I not only support with other research, but have been invited to be Principle Investigator on a commercial study running locally. My ability to write academically has been developed as during the five year period, I have had five papers published in national and international peer reviewed journals, and written three blogs which have been published online. I have also been asked by colleagues to supervise and support their MSc dissertation work. I have grown in confidence and my ability to contribute and engage at higher level meetings in my organisation has increased. Furthermore, I have been invited and participated in a number of discussions at a national level in regards to seclusion, restraint and sexual safety on inpatient wards.

In the future I hope to be able to write a successful grant application and conduct further nursing research, although want to retain my clinical role to ensure my work remains meaningful to current practices. I have given thought to future training needs which include:

- courses on statistics/statistical analysis as I recognise this as a weakness;
- grant writing workshops;
- presentations skills; and
- social media skills.

This work on seclusion has opened my eyes to the effect seclusion and restraint has upon patients. I am now an advocate of the importance of the patient voice and presence being heard in the selection of and education of mental health professionals and teams.

During the final stages and proof reading of the thesis it was suggested to me that the word seclusion implied a quiet place away from others for reflection and privacy. Perhaps the word seclusion is more palatable for health professionals and service providers than the more apt description of solitary confinement.