Being in a Seclusion Room: The Forensic Inpatients' Perspective.

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Overall Abstract for Thesis Portfolio

Objective: The aim of this thesis portfolio is to explore and understand the patient experience of seclusion.

Methods: A qualitative systematic review was undertaken of research exploring the experience of seclusion. Thematic synthesis was used to develop analytical themes to explore the inpatient experience of seclusion. Alongside this a qualitative research project was undertaken using Interpretative Phenomenological Analysis to explore forensic psychiatric inpatients' experience of being in a seclusion room.

Results: The systematic review found eight studies which met inclusion criteria and all were of high methodological quality. The thematic synthesis identified four analytical themes: feeling vulnerable, feeling neglected and abused, disconnecting and seclusion is dangerous to mental health. The empirical research project identified four superordinate themes: intense fear, not getting the care I needed, I am being abused and power struggle.

Conclusion: This thesis portfolio has highlighted the emotional and interpersonal challenges associated with the experience of seclusion. It draws attention to the relevance of the seclusion room in the overall experience and how a forensic population may have a power struggle dynamic within their experience. It provides direction for future research and emphasises the importance of improving seclusion practices by making changes to staff-patient interaction to reflect the emotional needs of the patients.

Contents

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Chapter 1: Introduction to the Thesis Portfolio

This thesis portfolio consists of a qualitative systematic review of the psychiatric inpatient experience of seclusion and a qualitative empirical research project exploring forensic psychiatric inpatients' experience of being in a seclusion room. Both are written up in the form of academic papers for submission to the Journal of Psychiatric and Mental Health Nursing. In addition, the portfolio includes an introduction to the meaning of seclusion within a psychiatric inpatient setting, an extended methodology chapter and an overall discussion chapter.

Thomas and Harden's (2008) method of thematic synthesis was used to synthesise the findings of eight studies and an in-depth quality appraisal was undertaken. The quality appraisal ensured the trustworthiness of the papers included in the review and identified specific recommendations to ensure the methodological quality of future research into this topic. The thematic synthesis identified commonly occurring themes across the studies and four analytic themes were identified, answering the question of what are adult psychiatric inpatients' experience of seclusion.

The empirical research project addresses gaps in the literature identified in the systematic review. The study used Interpretive Phenomenological Analysis (IPA) to answer the question of what are forensic inpatients' experiences of being in a seclusion room. Participants were recruited from a forensic Medium Secure Unit (MSU). An MSU is a hospital for the rehabilitation of people with complex mental health problems who have been in contact with the criminal justice system. They are assessed as presenting with a serious risk of harm to self and others and require this level of security due to a risk of absconding. The results provided four superordinate themes which have clinical implications as well as identifying areas for future research.

Chapter 2: Introduction to Seclusion and the Wider Legal Context

This section aims to provide context to the whole thesis portfolio, before more focused introductions in the individual academic papers. It provides more detailed information regarding the procedure, context and relevance of seclusion to Clinical Psychology. It introduces relevant legislation and how this is then transferred into clinical practice. This topic is not covered to the same depth in the Systematic Review or Empirical Paper, as this may be presumed knowledge within the readership of the journal. Outside of forensic or inpatient services, however, the legal and historical context of seclusion is unlikely to be widely known.

According to the Department of Health (DoH) guidance: Positive and Proactive care (2014), restrictive interventions (RIs) are interventions used in health and social care settings which deliberately restrict an individual's freedom, in order to control a dangerous situation where there is a possibility of harm to self or others. The guidance states that when RIs are used, the chosen intervention should represent the least restrictive option to meet immediate need. Seclusion is a form of RI and its use is legally regulated, being defined by the Mental Health Act (MHA) (1983): Code of Practice (2015, p.417) as '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'.

How this translates into clinical practice is that typically, seclusion would occur if a patient was deemed to be a risk of imminently perpetrating violence towards others where de-escalation techniques (verbal attempts to calm the patient) had proven to be ineffective. Physical restraint (deliberate physical contact or holding in order to prevent or restrict the movement of another person) would often occur prior to seclusion and the patient would most likely be escorted to a seclusion room under the restraint of several members of staff. In some instances, patients may remain under restraint in the seclusion room until the staff deem it safe for them to release the person, leave the room and close the door. It is of note that the MHA Code of Practice (2015) also explains that seclusion should not be used solely as a way to manage a patient's self-harming behaviour.

The Code of Practice gives specific procedural guidelines regarding the practice of seclusion. It should not be used as punishment and should not be used due to staff shortages. It should only be used in hospitals and in relation to inpatients detained under the MHA. If there is an emergency situation involving an informal patient (a patient not detained under MHA), seclusion can be used as a last resort and then there would need to be an emergency assessment for detention under the MHA. The Code of Practice is clear that seclusion should only take place in rooms that are specifically designed for seclusion use and are not used for any other function. These rooms should be a safe environment where the patient can be viewed at all times. There should be limited furnishings including a pillow, blanket, bed and mattress. The patient and staff should have the ability to communicate without needing to open the door and the room needs to have access to washing and toilet facilities. Such facilities are intended to serve to cater to the patient's basic physical needs and provide comfort and as much dignity as possible. However, in order to develop a safe environment, which is also robust enough to withstand physical attacks from patients detained therein, and which also reduces risks to the patient by removal of ligature points, the room is necessarily sparse. Therefore, it may be unlikely to be experienced as a comforting environment by the patient.

While a patient is detained in a seclusion room, there is a requirement for their emotional and physical wellbeing, in addition to their risk, to be assessed on a continuous basis. The Code of Practice outlines specific procedures that should be incorporated into the hospital's seclusion policy. This is that within the first hour of seclusion, a patient should have been assessed by a psychiatrist and then every two hours by two nurses. In addition, the patient should also be reviewed by the multi-disciplinary team and throughout the duration of seclusion, a staff member should be observing the patient at all times. The Code of Practice also highlights the need for consideration of the gender of staff who observe the patient. It proposes that the trauma history of the patient should inform the gender of the staff carrying out the ongoing observations.

The National Institute of Clinical Excellence (NICE, 2015) give recommendations on the nature of the interactions between staff and patients. They describe how staff should engage positively with patients, explaining why they are being observed and showing the patient that they are valued and are being listened to. In addition to a formal post incident review, the patient should also be given the opportunity for debrief after seclusion. During the debrief, staff should assess if there is the need for additional support for any trauma experienced and promote relaxation and feelings of safety.

The DoH (2014) propose that services should have RI reduction programmes in place which should be reviewed and updated at least annually. The guidance highlights the need to have the programme and its reviews available for inspection by the Care Quality Commission (CQC). The CQC has a duty under the MHA to monitor how services use their powers when patients are detained in hospital. Recent investigations by the CQC of mental health trusts in England and Wales raise concerns regarding the use of RIs (Monitoring the Mental Health Act in 2014/15, 2015 and Monitoring the Mental Health Act in 2016/17, 2017). In 2014/15, the CQC found poor seclusion practices at several hospitals and deemed some of the facilities to be unfit for use (CQC Brief Guide: Seclusion Rooms, 2015). In 2016/17, the CQC expressed concerns regarding patients not being given the opportunity for an appropriate debrief, therefore limiting the opportunity patients have to address the potentially traumatising aspects of the RI they experienced.

Given that seclusion occurs at times of high levels of distress, the emotional impact of its use has received attention worldwide. The research regarding this is discussed in the systematic review and empirical paper.

Chapter 3: Systematic Review

What are Adult Psychiatric Inpatients' Experience of Seclusion: A Systematic Review of Qualitative Studies

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Accessible Summary

What is known on the subject

- Seclusion involves isolating a patient in a room away from other patients in order to contain aggressive behaviour and it is used in psychiatric hospitals.
- Research has found that seclusion is often viewed by patients as negative and is experienced as humiliating, inducing anger and lacking in positive communication with staff.

What this paper adds to existing knowledge

- This systematic review identifies ‘feeling vulnerable’, ‘feeling neglected and abused’, ‘disconnecting’ and ‘seclusion is dangerous to mental health’ as themes from qualitative literature to understand patients’ seclusion experience.
- It highlights the varied quality of current qualitative research on this topic and draws attention to specific areas in need of improvement.

What are the implications for practice

- A review of current guidelines and standards is recommended in order to ensure they accurately reflect patient needs regarding the room and its facilitates.
- Improvements to clinical guidelines and practice is recommended to focus on enhancing the therapeutic staff-patient interaction.

Abstract

This review aimed to answer the question ‘what are adult psychiatric inpatients’ experience of seclusion?’ and appraise the quality of relevant research. To do this, robust qualitative research was reviewed, and themes generated through thematic synthesis. This involves a process of coding, developing descriptive themes and identifying analytical themes. Eight papers met inclusion criteria and were reviewed. Four analytical themes were identified; ‘feeling vulnerable’, ‘feeling neglected and abused’, ‘disconnecting’ and ‘seclusion is dangerous to mental health’. Participants who had been secluded found it a negative and highly emotive experience. In the build up to and during seclusion, participants felt vulnerable to harm and felt that they had no control. They experienced staff as neglectful and abusive, both physically and emotionally. The seclusion room itself was perceived as a neglectful environment and participants felt that they were treated inhumanely. In order to cope with intense emotions such as fear, shame and sadness, participants disconnected from their experience such as becoming preoccupied with their own thoughts. The entire experience posed a threat to participants’ already fragile mental health. The findings of the current review have implications for clinical practice,

national guidelines and pose questions that require further exploration in future research.

Keywords: seclusion, experiences, review, thematic, synthesis, qualitative

Background

In England and Wales, the Mental Health Act (1983) (MHA) provides legislation for the detention, treatment and rights of people with a mental health disorder. In the accompanying Code of Practice (in England), seclusion is a restrictive intervention (RI) and defined 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' (Mental Health Act (1983): Code of Practice, 2015, p. 417). According to the Department of Health's (DoH) Positive and proactive care: Reducing the need for restrictive interventions (2014) guidelines, only patients detained under the MHA should be considered for seclusion (unless in an emergency). Guidance from the National Institute of Clinical Excellence (NICE) (Violence and Aggression: short-term management in mental health, health and community settings, 2015) further adds that seclusion should be a short-term intervention, reviewed at least every two hours.

The psychological impact of seclusion has received much attention. In-depth research regarding the experience and impact of seclusion has been undertaken. Some studies have attempted to explore the patient experience of seclusion quantitatively (Georgieva, Mulder & Wierdsma 2012; Larue et al., 2013; Martinez, Grimm & Adamson, 1999; Whitecross, Seeary & Lee, 2013 and Whittington et al., 2009) with findings showing mixed patient experiences, but that it was seen by most, to be negative. However, the use of quantitative data restricts the findings by not allowing for an in-depth understanding of individual experience. Qualitative research comes from the position that all experiences are subjective, individualised and constructed within each participant's view of their world. Qualitative methodology allows for the exploration of the meaning of the experience for the participants and develops an understanding of how the participants interpret and make sense of their experience. Therefore, qualitative research is being increasingly used to help make sense of patient experiences of this intervention. Martinez et al. (1999) and Larue et al. (2013) include some qualitative data but it is not analysed qualitatively, which limits the value in its contribution to current knowledge of seclusion experiences.

Van Der Merwe et al., (2013) undertook a systematic review of qualitative and quantitative papers on staff and patient views of seclusion. Their review found 18 papers on patient perceptions of seclusion dated from 1972 – 2006. The review focused on the overwhelmingly negative view of seclusion within the literature with common themes such as anger, humiliation and poor communication between patients and staff across the 18 studies. While this gives an overview of existing literature, it is hindered by several limitations which may restrict the usefulness of its findings to current psychiatric inpatient practices. Firstly, all studies were from western countries and the majority were from North America. This is relevant because different countries have different mental health legislation regarding detainment and seclusion practices. The seclusion practices the majority of the study participants will have experienced will have been related to the legislation from the USA. Secondly, the review only included papers that are now over ten years old. Since this research was undertaken, it is likely that there have been changes in practices in various countries. For example, there have been several changes in legislation and clinical guidance in England which is likely to have impacted on seclusion practices. Up until 1st April 2009, seclusion procedures were not specifically inspected by the Care Quality Commission (CQC) as they are in England today. At that time, the Mental Health Act Commission was in place which was a monitoring body, rather than a regulator, that aimed to safeguard the rights of people detained under the MHA. From then on, the CQC replaced the MHA Commission. Amongst other changes, the CQC has implemented a definition of seclusion that may have been broader than that used in clinical practice (for instance, it does not specify seclusion in a specific seclusion room in order to meet the definition). In addition to this change, the 1983 MHA was significantly updated in 2008. This update included an amendment to the Mental Capacity Act (2005) regarding deprivation of liberty. Changes in England have been mirrored elsewhere, for example the Norwegian legislation, Mental Health Care Act (1999), was updated in 2006. This update affected the guidelines for the use of coercive interventions, including seclusion, therefore having a direct impact on patient experience of these interventions.

The changing legislative and clinical practice context since the previous review was undertaken means an updated systematic review of patient experiences of seclusion is necessary in order to develop more contemporary knowledge to help inform future practice. A qualitative systematic review allows for the important nuances in the experiences of participants from various settings, countries and cultures to be included in the findings. It will avoid the loss of the subjectivity of the experiences, which is the risk with quantitative research. The nature of experiences are that they are highly individualised and therefore require the explorative space that qualitative methodology gives. This review synthesises qualitative research from 2006 – 2017 on patient experiences of seclusion using Thomas and Harden's (2008) method of Thematic Synthesis. It also provides a thorough quality appraisal of the studies which meet inclusion criteria. The cut off of 2006 allows for a follow on from Van Der Merwe et al.'s (2013) review.

Method

Literature search strategy

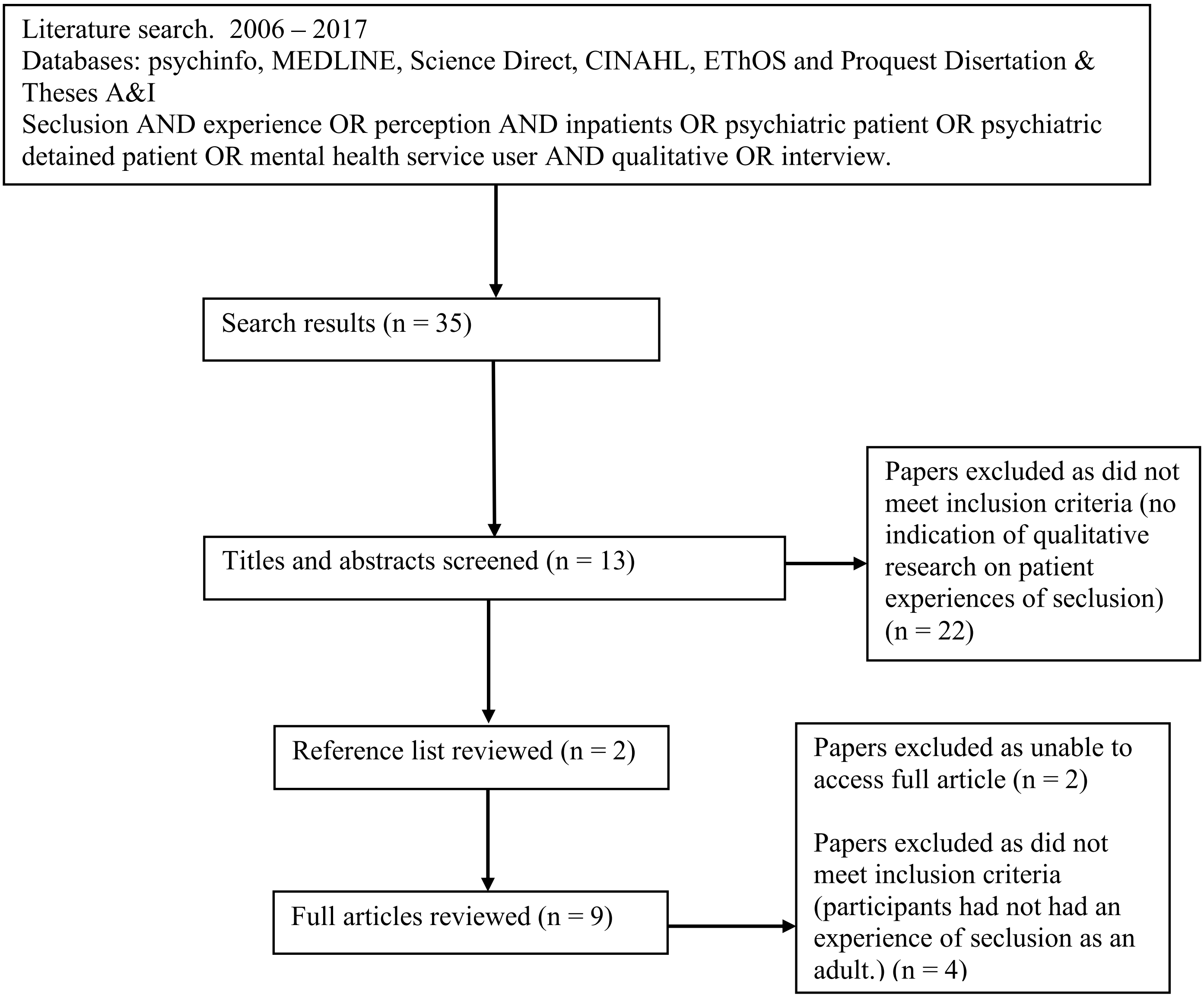
Electronic searches of seven databases was undertaken in order to identify post 2006 qualitative research on psychiatric inpatients experience of seclusion. The search was limited to papers dated between 2006 to 2017 and all were required to be in English. The search terms and boolean operators were 'seclusion' AND 'experience' OR 'perception' AND 'inpatients' OR 'psychiatric patient' OR 'psychiatric detained patient' OR 'mental health service user' AND 'qualitative' OR 'interview'. Due to the legal definition and specific criteria of the intervention 'seclusion', this term was required for all papers and was not substituted.

The search identified 28 papers from the following databases; psychinfo, MEDLINE, Science Direct and CINAHL. An additional search of grey literature was then undertaken which identified seven papers from the following databases; EThOS and Proquest Dissertations & Theses A&I, giving a total of 35 papers.

The titles and abstracts of all 35 papers were screened. To meet inclusion criteria, papers were required to be qualitative research on patient experiences of seclusion. 13 papers met this criteria and their reference lists were reviewed and a further two papers met the criteria for inclusion.

The full text of all 15 articles were sought for review. Two of the articles were excluded as they only had the abstracts published and the authors did not respond to the reviewer's request to see the full article. The full papers of the remaining 13 studies were reviewed and those where the participants had had an experience of seclusion as an adult were included for final appraisal. Four papers did not meet this criteria. Therefore, a total of nine papers met criteria for quality appraisal. See Figure 1 PRISMA flow diagram.

Figure 1.1. PRISMA Flow Diagram.



Procedure of Quality Appraisal

As is common in qualitative systematic reviews, including Thematic Sythesises, the reviewer developed an appraisal criteria, based on several robust guidelines (Burbeck, Candy, Low & Rees, 2014; Harden et al. 2006; Rees, Oliver, Woodman & Thomas, 2009 and Thomas et al., 2007). This approach ensures a high-quality appraisal that takes into consideration the subjective nature of qualitative research whilst developing an auditable replicable procedure.

The Critical Appraisal Skills Program (CASP) is a structured tool used to assess the quality of qualitative papers. It has been used in many systematic reviews, including Thematic Synthesises (Rylatt & Cartwright, 2015; Burbeck et al., 2014). CASP has a ten question checklist system to rate the design, methodology, data collection, ethics and analysis as either ‘yes’, ‘no’ or ‘can’t tell’. The structured nature of the tool means that it can be replicated, however, this may be overly structured for qualitative research as it can impose a realist ontological and positivist epistemological assumption on the research (a position which implies true factual knowledge can be sought through objective research). In order to overcome this shortfall, additional recommended standards were incorporated into the appraisal to address the reflective and interpretative nature of qualitative research. These standards included those developed by Dixon-Wood et al. (2006) and Popay, Roger and Williams (1998).

Dixon-Wood et al.’s (2006) approach gives focus on the relevance of the papers in order to maximise the amount of papers included in the review and leaves more detailed interpretation of credibility and contribution to the synthesis itself. Due to the specific nature of the research question and the complex topic, there are limited papers, therefore, there is a need to be inclusive. Unlike CASP, Popay et al.’s (1998) standards place emphasis on the researcher’s reflexivity and consideration of external social factors in their write up of the paper. Therefore, the reviewer also appraised papers on their ability to adapt to issues that arise due to the social setting of the study. This was deemed to be particularly relevant due to the difficult environments (psychiatric hospitals) where the research took place. For example, in psychiatric hospitals where seclusion is implemented, the researchers have to follow specific procedures (i.e. locking doors, carrying alarms etc.) to reduce the risk to themselves and others.

Additional standards of Popay et al. (1998) included assessing how much the findings illuminate the topic and allow the reader to interpret the meanings and assessing if the descriptions provided in the papers were detailed enough to be able to interpret the context and meaning of what was being researched. The guidelines also focus on the analysis and interpretative credibility. Therefore, the data was appraised based on how the research describes the data, gives sufficient quotations and then moves onto analysis of the meaning and significance of it. See appendix B for more specific details on the quality appraisal strategy.

The appraisal led to the exclusion of one paper due to the data being analysed quantitatively. The quality of the remaining eight papers was recorded and considered during the development of themes.

Procedure of Thematic Synthesis

Qualitative reviews are well suited to questions regarding ‘experience’ (Stern, Jordan & McArthur, 2014). Thomas and Harden’s (2008) Thematic Synthesis was the method used to synthesise the findings. This allows for clear identification of themes arising from the data and facilitates higher order construct and theory development. Thematic Synthesis allows the data to be organised into descriptive and then analytical themes to highlight commonalities between studies without compromising the subjective nature of the participants’ experiences (Barnette-Page & Thomas, 2009). The initial step was to extract the data. In line with their approach, the results sections were extracted from the papers. These sections were then reviewed and findings that were not explicitly related to seclusion (such as quotes about restraint without seclusion) were excluded. Five of the eight papers included some data that was not related to seclusion (Haw et al., 2011; Kontio et al., 2012; Larsen & Terkelsen, 2014; Ling et al. and Mayers et al., 2010) and therefore these pieces of data were not included in the synthesis. The data was transferred verbatim into QSR’s NVivo v11 software which was used in order to help organise codes and themes. This approach has been used in other qualitative systematic reviews and had been found to be advantageous as it ensures an accurate record of decision making and enhances transparency (Houghton et al., 2016).

The synthesis took a three stage approach; line by line coding, developing descriptive themes and inductive thematic analysis. Examples and details regarding the process are included in table 1.

Table 1

Stages of Synthesis

Stages	Process	Examples from the data
Stage One	Coding each line of text according to its context and meaning.	"Staff did the best thing, covered me with a blanket and gave me music and water too" coded as 'staff provided physical care'.
	Grouping codes together into 34 higher order codes.	'Staff provided physical care', 'communication is helpful', 'understanding staff's actions' and 'wanted to cooperate with staff before seclusion' grouped into the higher order code 'care from staff can improve the experience'.
Stage Two	Developing eight descriptive themes by looking for similarities and differences between each of the codes. Naming the descriptive themes in a way that captures the meaning of the groups of codes.	Descriptive theme 'inhumane' created to capture the meaning of codes 'dehumanising', 'dignity', 'everything stripped from me' and 'human rights violated'.
Stage three	Inductive thematic analysis of the descriptive themes to create analytic themes by using the descriptive themes to answer the review question.	Analytic theme 'feeling vulnerable' developed from the descriptive themes 'physical harm' and 'loss of control'.

The reviewer used a reflective journal alongside the synthesis to facilitate reflection and consider the subjectivity in the analysis.

Results

Quality appraisal

Table 2 outlines the studies and highlights the main aspects of the quality of the research paper. The appraisal revealed that while the studies were all of sufficiently high standards of design and methodological quality, there were still aspects of the research that either required improvement or were not adequately commented on in the article in order to assess the quality. In particular, the absence of evidence regarding researcher reflexivity was apparent in seven studies (Ezeobele, Malecha, Mock, Mackey-Godine & Hughes, 2014; Faschingerbauer et al., 2013; Haw et al., 2011; Kontio et al., 2012; Larsen & Terkelsen, 2014; Ling et al., 2015 and Ntsaba & Havenga, 2007). This was deemed to be particularly important in research of this kind given the potentially difficult social environment (locked psychiatric hospital) and the relationship between participant (a person with significant mental health problems locked in hospital with limited community access) and researcher (a professional of a different socio-economic status who has freedom to access the hospital and community). Four papers also lacked details regarding the quality of analysis (Haw et al., 2011; Larsen & Terkelsen, 2014; Ling et al., 2015 and Mayers et al., 2010), two of which (Ling et al., 2015 and Mayers et al., 2010) did not provide sufficient quotes to be able to thoroughly appraise the rigor of their analysis. Another provided limited information regarding analysis method used (Ntsaba & Havenga, 2007) and one mixed methods paper had a large sample size (Haw et al., 2011) that appeared to restrict the researchers' ability to analyse the qualitative data in detail.

Table 2

Summary of Studies

Authors and Location	Title	Context	Methodology	Analysis	Key Findings	Quality Appraisal
Ezeobele, Malecha, Mock, Mackey-Godine & Hughes (2014) USA.	Patients' lived seclusion experience in acute psychiatric hospital in the United States: a qualitative study.	250 bedded psychiatric acute care hospital. N = 20, adult, 12 male and 11 female.	One-to-one semi-structured interviews to explore and describe participants' lived experience of seclusion. Interviews audio recorded and then transcribed.	Interpretive phenomenological analysis.	Four themes identified. 'Alone in the world', 'staff exert power and control', 'resentment towards staff' and 'time for meditation'.	High quality design, method and analysis. Findings of high relevance. Ethical issues considered. Limited evidence of reflexivity regarding role of researcher, participants and social environment.
Faschingerbauer, Peden-McAlpine & Tempel (2013) USA.	Use of seclusion: Finding the voice of the patient to influence practice.	Psychiatric inpatient hospital. N = 12, adult, six male and six female.	One-to-one unstructured interviews to understand participants' lived experience of being placed in seclusion. Interviews audio recording and then	Phenomenological text analysis.	Three themes identified. 'Patient hope for respect and open communication', 'patient emotional response to the seclusion process' and 'patient insight	High quality design, method and analysis. Findings of high relevance. Ethical issues considered. Limited evidence of reflexivity

			transcribed.		into behaviour and importance of positive coping skills’.	regarding role of researcher, participants and social environment.
Haw, Stubbs, Bickle & Stewart (2011) UK.	Coercive treatments in forensic psychiatry: a study of patients’ experiences and preferences.	Forensic psychiatric inpatient hospital. Low and medium secure wards. N = 57, adult, 27 male and 30 female.	One-to-one or two-to-one (dependent on risk) semi-structured interview to report on participants’ experiences of and preferences for physical restraint, forced medication and seclusion. Interviews transcribed by researcher during the interview.	Mixed quantitative and qualitative. Qualitative analysis was theoretical thematic analysis.	The study provided several themes related to the three RIs. Those related solely to seclusion or seclusion along with other RIs were ‘a quiet time for reflection’, ‘prevents violence to self and others’, ‘unpleasant physical environment’, ‘unpleasant thoughts and emotions’, ‘control’, ‘loss of privileges’ ‘indifference’, ‘attitudes and experience of staff conducting coercive	High quality design and methodology. Data collection and analysis restricted due to large sample size. Good consideration of need to be adaptive based on ethical issues.

					treatments’ and ‘coercive treatment as a positive, negative or neutral experience’.	
Kontio et al. (2012) Finland.	Seclusion and restraint in psychiatry: patients’ experiences and practical suggestions on how to improve practices and use alternatives.	Six closed acute wards in two psychiatric hospitals. N = 30.	Open ended focused interviews to explore participants’ individual experiences of seclusion/restraint and their perceptions regarding the improvement of seclusion/restraint practices and alternatives to seclusion/restraint. 25 interviews audio recorded and then transcribed, five interviews not recorded and transcribed by researcher during interview. (Quotes translated into English for write	Inductive content analysis.	The study identified three categories of topics the participants discussed and developed groups within those categories. The category ‘patients’ experiences of seclusion/restraint had the following groups; ‘lack of information’, ‘way of being treated’, ‘feelings during seclusion/restraint’, ‘problems in the care of basic needs’, ‘lack of activity’ and ‘problems in patient-staff communication’.	High quality design and methodology. Good quality analysis but interpretation limited. Findings of high relevance. Ethical issues considered. Sparse reflexivity regarding relationship between researcher and participants.

up).	The category ‘suggestions regarding the improvement of seclusion/restraint’ had the following themes; ‘humane treatment’, ‘external evaluators’, ‘up-to-date information’, ‘written agreements’ and ‘patient friendly environment’. The category ‘patient suggestions of alternative to seclusion/restraint’ had the following groups; ‘empathic patient-staff interaction’, ‘meaningful activities’, ‘therapeutic community’ and ‘biological treatments’.

Larsen & Terkelsen (2014) Norway.	Coercion in a locked psychiatric ward: perspectives of patients and staff.	Locked psychiatric ward. N = 12, nine male and three female.	Ethnographic fieldwork. Data collected through participant observation and conversations or interviews with participants over four months. (Quotes translated into English for write up).	Analysis of text using phenomenological approach to develop themes.	Four themes identified. 'Corrections and house rules', 'coercion is perceived as necessary', 'the significance of material surroundings' and 'being treated as a human being'.	High quality design and methodology. Rigorousness of analysis unclear. Inadequate consideration of relationship between researcher and participants. Ethical issues considered but restricted by the limited reflexivity of researcher.
Ling, Cleverley & Perivolaris (2015) Canada.	Understanding mental health service user experiences of restraint through debriefing: a qualitative analysis.	Urban mental health and addiction hospital. N = 55.	Analysis of qualitative data written on the Restraint Event Client-Patient Debriefing and Comment Form voluntarily completed by patients during post restraint (seclusion, chemical and	Thematic analysis	Eight themes related to all three RIs were 'lost autonomy', 'interpersonal tension', 'feeling unheard', 'fear and rejection', 'needing comfort', 'lost trust', 'neutrality' and 'change of scenery'.	High quality design and methodology. Rigorousness of analysis unclear due to lack of quotes provided. Limited consideration of relationship between researcher and

			physical) debrief to describe patients' perspective of what occurred before, during and after restraint.			participants. Limited evidence of consideration of ethical issues.
Mayers, Keet, Winkler & Flisher (2010) South Africa.	Mental health service users' perceptions and experiences of sedation, seclusion and restraint.	Service user support groups. Participants who had experienced sedation, seclusion and restraint in the past. N = 59.	Two consecutive focus groups with eight participants in each group to develop a semi-structured interview schedule design to described participants' experiences, perceptions and preferences for sedation, seclusion and restraint. Face-to-face interviews with 43 participants carried out using the interview schedule. Interviews and groups audio recorded and then transcribed. (Quotes translated	Content analysis	Three themes related to all three RIs were identified. 'Inadequate communication', 'a violation of rights' and 'experience of distress'.	High quality design and methodology. Rigorousness of analysis unclear due to lack of quotes provided. High degree of reflexivity regarding role of researcher, participants and social environment. Ethical issues considered.

			into English for write up).			
Ntsaba & Havenga (2007) Lesotho.	Psychiatric in-patients' experience of being secluded in a specific hospital in Lesotho.	Psychiatric inpatient hospital. N = 11, four male and seven female.	Semi-structured phenomenological interviews to explore and describe participants' experience of being secluded in this specific hospital. (Quotes translated into English for write up).	Open coding and development of themes.	Four themes identified. 'Experience of being in a prison', 'seclusion is like a punishment', 'not being supported and cared for' and 'emotional response to the experience'.	High quality design and methodology. Good analysis but limited information regarding approach used. Findings of high relevance and contribution to the field. Ethical issues considered. Limited evidence of reflexivity regarding role of

researcher,
participants and
social
environment.

Thematic Synthesis

Four analytical themes were identified in the data: feeling vulnerable, feeling neglected and abused, disconnecting and seclusion is dangerous to mental health. See table 3 for an outline of all the themes and how they developed from the data.

Table 3

Theme Development

Analytical Theme	Descriptive Theme	Higher Order Codes
Feeling vulnerable	Physical harm	Physical pain Seclusion is a consequence of violence Seclusion protects from harm Self-harm
	Loss of control	Long duration Out of control The only alternative
Feeling neglected and abused	Inhumane	Dehumanising Dignity Everything stripped from me Human rights violated
	The experience of staff	Care from staff can improve the experience Staff are mean Staff do not care about patients Staff cause patients' anger
	The room is a negative experience	The room lacks comfort The room is like imprisonment The room fails to meet patients' basic human needs
Disconnecting	Disconnect from experience	Feeling empty Memory loss regarding reason for seclusion No memory of seclusion experience Neutral opinion Not knowing
	Thoughts and reflections	Spirituality Thoughts of danger Thoughts of family Wanting forgiveness
Seclusion is dangerous to mental health	Emotional response to experience	Anger Fear Shame Hopelessness Powerlessness Humiliation Sadness

Four papers contributed to all four themes and four contributed to some but not all. Table 4 provides details regarding the papers which contributed to each theme development.

Table 4

Theme Contribution

Study	**Themes**			
	Feeling vulnerable	Feeling neglected and abused	Disconnecting	Seclusion is dangerous to mental health
Ezeobele et al. (2014)	X	✓	✓	✓
Faschingerbauer et al. (2013)	✓	✓	✓	✓
Haw et al. (2011)	✓	✓	✓	✓
Kontio et al. (2012)	✓	✓	✓	✓
Larsen & Terkelsen (2014)	✓	✓	X	✓
Ling et al. (2015)	✓	✓	X	✓
Mayers et al. (2010)	✓	✓	X	X
Natsaba & Havenga (2007)	✓	✓	✓	✓

Feeling vulnerable

Study participants described experiences of being in a vulnerable state during the lead up to seclusion and while in seclusion. While in this state, the participants described being at the mercy of someone else's decisions and choices which are often against their wishes. At this point, participants described feeling that they are unable to have any sense of control or choice. For example, one participant stated

"I had no other alternative but to sleep on a wooden floor" (Mayers et al., 2010, p. 67).

Participants described feeling vulnerable from physical abuse from staff. This participant is describing an experience of restraint whilst being secluded.

“they’re jamming knees into my shoulders and holding me on the bed, twisting my legs up behind me” (Faschingbauer, Peden-McAlpine & Tempel, 2013, p. 36).

Participants also felt vulnerable to harm from themselves and commented on their self-harm.

“I strangled myself” (Kontio et al., 2012, p. 20).

Feeling neglected and abused

Whilst in a vulnerable state, some participants had an experience of feeling less than human and that their human rights were violated and they were treated in a degrading way. One participant commented on how her treatment left her feeling.

“I felt violated…I felt everything had been stripped from me.” (Ezeobelle, Malecha, Mock, Mackey-Godine & Hughes, 2014, p. 307).

Participants described feeling abandoned by staff and having their basic needs neglected. The neglect they experienced was related to their emotional and physical needs. Participants felt that they wanted care but staff lacked empathy and compassion towards them. The staff who were part of the patients’ care team were instead experienced as abusive or uncaring. This participant is describing his/her experience of being left alone in the seclusion room and the emotional neglect he/she experienced.

“you are by yourself and you know they don’t care” (Ling, Cleverley & Perivolaris, 2015, p. 389).

Participants described having physical care needs that were not addressed by staff while they were in seclusion.

"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." (Faschingbauer et al., 2013, p. 36).

Participants described accounts of abuse by staff which ranged from emotional abuse (such as being made fun of) to physical assaults. One participant stated

"nurses used to beat me. They slapped and punched me…when I refused to be secluded. They insulted (me) and pushed me in the seclusion room. I cannot mention those insults, they were bad." (Ntsaba & Havenga, 2007, p. 9)

The room environment was also experienced as neglectful. One participant described his/her experience of the room as similar to homelessness which represents an experience of absolute neglect and deprivation of basic needs such as privacy, warmth or hygiene.

"it was horrible in there. Like rough sleeping for five days." (Haw, Stubbs, Bickle & Stewart, 2011, p.574).

Disconnecting

During their seclusion, participants described experiences of mentally avoiding the experience. This was in the form of thoughts about family, spirituality etc., some of which were positive. However, for some participants mentally disconnecting meant they could not remember the seclusion experience or recall feeling confused and disorientated and unable to make sense of it.

"I didn't know where I was and how long it lasted" (Kontio et al, 2012, p. 19).

Participants described their thoughts while in seclusion. Some of these thoughts and internal monologues appeared to serve as a distraction coping strategy. One participant describes feeling connected with God while he/she was in seclusion which he/she identified as positive.

"I had good communication with God…and…I was praying to God to forgive my actions." (Ezeobelle et al., 2014, p. 309).

However, other thoughts appeared to increase their sense of vulnerability. One participant describes how his/her experience brought back memories of a past traumatic events.

"the seclusion forced me to revisit the bad experience I had in jail again." (Ezeobelle et al., 2014, p. 307).

Seclusion is dangerous to mental health

In response to the seclusion experience, participants described the fear and intense emotions it induced. These emotions were overwhelming and participants appeared to struggle to find ways to improve their wellbeing. The room and staff had limited ability to sooth them, leaving them in an emotionally dysregulated and vulnerable state.

"It brings on intense feelings of shame, embarrassment and humiliation." (Haw, Stubbs, Bickle & Stewart, 2011, p. 575).

Given the participants' unstable mental state at the time of seclusion, the experience and the emotions it induces pose a risk to participants' mental health. One participant describes how she feared for her life during seclusion.

"I was afraid and powerless…I did not know what they were going to do to me…I do not have any family at this hospital and uh…you know…they outnumbered me…I was not able to concentrate…I felt I was going to die…" (Ezeobelle et al., 2014, p. 307).

Another participant felt that seclusion further exacerbated his emotional distress.

"After a while it only makes you feel worse." (Larsen & Terkelsen, 2014, p. 430).

Discussion

The search and quality appraisal led to eight qualitative studies between 2006 – 2017 being eligible for the review, five of which researched seclusion as part of an overall exploration of several RIs. All papers were deemed to have high quality designs and methodologies. The criteria that was most commonly not met was evidence of reflexivity regarding the role of the researcher, participants and social environment. However, rather than an absence of reflexivity, it may be that journal word count limits restricted researchers' ability to report it in the paper. Despite the thorough and clear quality appraisal process, it is recognised that to some degree the appraisal remains subjective. It may be that another reviewer has a different approach to appraisal. A reflective journal alongside research supervision was used in order to take into consideration potential subjectivity and allow for reflection on alternative interpretations of the papers' quality.

Thematic synthesis of the data revealed emotionally powerful themes which suggest that seclusion is an exceptionally challenging experience for psychiatric inpatients. The process of it is frightening for patients and leaves them in a vulnerable state with inadequate resources available to help them to cope with the distress. They desire care but instead are left feeling neglected and abused. The overall seclusion experience develops from an amalgamation of the interpersonal experience of staff and the physical environment.

Participants discussed their vulnerable seclusion experience from being escorted under staff's restraint into the seclusion room to being in the locked room. Participants appeared to feel vulnerable to their own harm as well as harm from staff throughout the duration of the experience. A key part to the participants' interpretation of their experience was influenced by the treatment from staff. Staff were often experienced as abusive and/or neglectful and exacerbating participants' distress. The NICE guidelines (Violence and Aggression: short-term management in mental health, health and community settings, 2015) and the Mental Health Act (1983): Code of Practice (2015) are the guidelines used for the practice of seclusion and restraint in England. At present, there is minimal guidance for the therapeutic nature of staff contact during restraints and seclusions. The core recommendations focus on the physical environment, the documentation and the qualifications of staff members. The 2015 NICE guidelines provide limited indication of how staff should respond. It suggests that staff should provide the patient with information about why they are under observation, that they should engage positively with the patient and that they should be approachable, listen and ensure the patient feels valued. Based on the findings of this review, it could be argued that these guidelines do not place the same emphasis on the importance of staff-patient interaction during the seclusion experience.

The experience of the room further led to feelings of neglect and in some cases, feeling dehumanised. In England the CQC monitor the facilities of the room to ensure they are in line with guidelines' standards. Participants described the room in a way that demonstrated their experience of feeling neglected, regardless of which country's standards were monitoring the room they were secluded in. This suggests that current standards may not sufficiently address patients' emotional needs that this review has highlighted.

During seclusion, participants found themselves disconnecting from the experience. This was in the form of distraction by their imagination and thoughts. It was also in the form of a confused and disorientated state and some participants were unable to recall certain aspects of their experience. Research has found that individuals with a history of developmental abuse may respond to experiences of extreme trauma and intense fear with a sense of detachment from self or the world, emotional numbing and amnesia (Brown, 2016; Holmes et al. 2005 and Irwin, 1999). Hammer, Springer, Menditto & Coleman (2011) found that psychiatric inpatients with histories of childhood physical and sexual abuse are more likely to experience high rates of seclusion and restraint when compared to other inpatients. Given this evidence, it may be that for some participants in this review, separating from the reality of what was happening was a dissociative coping strategy. Overall, the seclusion experience was described as highly emotive and posed a risk to participants' already fragile mental state.

By ensuring that only data related to seclusion experience was used in the synthesis it is possible that some relevant data was mistakenly excluded. This may be due to the criteria being that only data from the results section that was indicated to specifically relate to seclusion was eligible for inclusion in the coding. If it was not possible to distinguish between quotes regarding seclusion and those regarding other RIs, the quotes had to be excluded. This is to ensure the synthesis accurately answers the review question specifically regarding seclusion, and results do not become inaccurate by the influence of data regarding different RIs. Also, four of the papers had their participants' interviews translated into English for the purpose of the write up. It is possible that in this process, some of the subtle personal and cultural meanings of the participants' stories have been misunderstand and misrepresented. However, these papers remained included due to their high quality, high relevance and the value that multi-cultural data from a different perspective could bring to the review. While a thematic synthesis allows for participants' subjective experiences to be given priority, it is recognised that a review of this kind is somewhat influenced by the reviewer. Therefore, another reviewer may have found different themes or have described the themes differently. The use of ongoing reflection was prioritised in order to consider this in the development of the themes and to ensure that the themes are imbedded in the data. The reviewer documented the reflections and referred back to them throughout the synthesis process.

Conclusion and Implications

This review has highlighted common themes in inpatients' experience of seclusion which transcend the differing environments where participants will have experienced seclusion. A sense of vulnerability is apparent for the duration of their experience. Feeling neglected and/or abused by staff was a frequent experience and feeling neglected by the room was common, despite there being some differences between the rooms participants were secluded in. Participants described a high degree of emotional distress during their experience and appeared to manage their distress by mentally disconnecting.

This review highlights areas that require further research and aspects of seclusion practice that would benefit from being reconsidered. Current qualitative research into this topic places insufficient value on the researchers' reflexivity. This could hinder the depth and rigor of analysis, resulting in potential findings that are unintentionally overlooked. The use of reflexivity is described as a method which improves rigor, trustworthiness and richness of qualitative research (Probst, 2015 and Yardley, 2015). Future research into this topic with the use and reporting of detailed researcher reflexivity should be implemented to improve the quality of the analysis and potentially produce new knowledge.

The majority of research into seclusion experiences does not focus on seclusion exclusively; rather it includes it in a wider exploration of RI experiences. Therefore, further research specifically exploring seclusion in depth is required in order to understand the deeply personal meaning of the experience for patients. This research is vital in order to improve the existing guidelines regarding the wellbeing of the acutely distressed patient during seclusion. The guidelines are continuously reviewed and updated to reflect the findings of new research.

This review demonstrates that staff interaction is a core part of seclusion, something that is not adequately reflected in current guidelines. These findings could be used to inform a review of the guidelines to ensure there is the focus on staff interaction to reflect the priorities of patients. Further research into the staff-patient interaction may help to inform therapeutic techniques and approaches staff can use to improve their interaction with secluded patients. While current guidelines intend to ensure the safety of the patient and staff, the review found that the room itself is experienced as emotionally harmful. These findings suggest that more needs to be known about how the room is experienced in order to consider what it is about the room that is experienced as harmful.

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Chapter 4: Empirical Research Project

Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective

Word count: 5018

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Accessible Summary

What is known on the subject

- Existing qualitative research has found inpatients to experience seclusion as highly distressing, with feelings of vulnerability, abuse and neglect often featuring in participants' accounts.
- The physical environment of the seclusion room and the interaction with clinical staff shape patients' personal seclusion experience.

What the paper adds to existing knowledge

- This paper provides more in-depth knowledge than before on one specific component of seclusion, the experience of being in the seclusion room, and draws attention to the specific psychological needs of patients during that aspect of their experience.
- This research provides new knowledge by exclusively exploring forensic inpatients' experience of the seclusion room, an under researched and often stigmatised population.

What are the implications to practice

- The findings support the need for a caring and non-threatening therapeutic interaction with a secluded patient for the duration of time they are in the seclusion room.
- The findings suggest that necessary nursing procedures, such as observations, should be carried out discretely and sensitively to avoid patients feeling abused and frightened.

Abstract

Contemporary qualitative research has explored patients' experience of seclusion and have found it to be a highly distressing and potentially traumatising experience for patients. The majority of the existing literature has researched seclusion within the context of other restrictive interventions, resulting in findings that can only be considered an overview of the experience. The studies also rarely access participants with histories of considerable violence and imprisonment. This study aimed to answer the question 'what are forensic psychiatric inpatients' experience of being in a seclusion room?'. Seven inpatients in a medium secure hospital were interviewed and Interpretative Phenomenological Analysis (IPA) was used to analyse the data. Four superordinate themes were identified; 'intense fear', 'not getting the care I needed', 'I am being abused' and 'power struggle'. While participants were in the seclusion room they experienced extreme fear. Staff interaction played a considerable role in shaping the participants' experience. Staff actions were interpreted as neglectful and abusive. Participants experienced struggling for power with staff, seeking out power when left in a powerless position. These findings have implications for the practice of seclusion, suggesting that a carefully tailored therapeutic interaction is required in order to safeguard the mental health of forensic inpatients.

Keywords: experience, forensic, inpatient, IPA, qualitative, seclusion.

Introduction

The modern day use of Restrictive Interventions (RIs) to manage dangerous behaviour in psychiatric inpatient settings has been centre of attention in research, policies and television documentaries. Seclusion has been one of the RIs which has been the focus of several studies attempting to understand the patient experience of it in order to help inform the way it is implemented. Both clinicians and patients have expressed their concerns that seclusion could be re-traumatising already mentally unwell patients (Brophy et al., 2016 and Muir-Cochrane, O'Kane & Oster, 2018), further heightening the value of such research.

Recent qualitative studies have aimed to gain an in-depth understanding of the patients' perspective of seclusion, with findings suggesting an overwhelmingly negative experience. Studies have found the experience to be severely distressing for participants, with emotions such as fear, anger and humiliation emerging from the data (Ezeobelle et al., 2014; Faschingbauer et al., 2013, Haw et al., 2011; Kontio et al., Ling et al., 2015; Martinez et al., 1999; Ntsaba & Havenga, 2007 and Sambrano & Cox, 2013). Findings suggest that participants experience the physical environment of the room as distressing, for example, studies by Ezeobelle et al., (2014), Haw et al., (2011) and Ntsaba and Havenga (2007) found participants experience the room negatively and similar to a prison cell. Participants' experience also appears to have been influenced by the interaction they received from staff. Faschingbauer et al., (2013) found that participants' experience improved when staff were attentive and explained what was happening. In contrast, Ezeobelle et al., (2014) found participants felt hopeless and powerless in response to a perceived lack of compassion from staff.

These studies reveal that seclusion has the potential to be highly traumatic for those who experience it, and that there are several complex components that contribute to the overall experience. While this body of research gives an insight into the patient experience, it is limited because in many studies, seclusion is considered alongside several different RIs (e.g. forced medication) in the same study (Brophy et al., 2016; Haw et al., 2011; Kontio et al., 2012; Larsen & Terkelsen, 2014; Ling et al., 2015 and Mayers et al., 2010). The limitation this poses is that subtle and discrete aspects of seclusion, which may still be highly relevant to the patient experience, cannot be analysed in-depth. In addition, the majority of studies have large sample sizes (Brophy et al., 2016; Ezeobele et al., 2014; Haw et al., 2011; Kontio et al., 2012; Ling et al., 2015 and Mayers et al., 2010) restricting the depth of analysis, as indicated in Braun and Clarke (2013).

Faschingbauer et al., (2013), Ntsaba and Havenga (2007) and Sambrano and Cox (2013) are three qualitative studies focusing specifically on psychiatric inpatients' experience of seclusion. Faschingbauer et al. (2013) had similar findings to what has been found in the other qualitative research exploring RIs. While the findings suggest that there are some similarities between seclusion experiences in various settings and with differing populations, there are limitations to this study that may have hindered its ability to collect a rich amount of data. The researchers maintained a specific and restricted inclusion criteria for their participants. Participants were required to be engaging in treatment and behaving pro-socially on the ward. This is likely to have reduced the number of participants with persistent anti-social behaviour in the study's sample. This is relevant given the link between antisocial personality and aggressive behaviour, which is by definition more likely to lead to seclusion. Certainly, Vitacco et al.'s (2009) research found anti-social tendencies to be associated with aggressive behaviour. In addition, their research highlighted the complicated relationship between clinical presentation and type of aggression. For example, anger and active symptoms of mental illness predicted reactive aggression (e.g. responding to hallucinations) whereas psychopathic traits predicted planned and calculated aggression. Given that research has identified staff-patient relational factors to play a role in the seclusion experience (Ezeobelle et al., 2014;

Faschingbauer et al., 2013; Ling, Cleverley & Perivolaris, 2015 and Ntsaba & Havenga, 2007), choosing a sampling methodology which underrepresented patients with anti-social characteristics may have resulted in a unique experience being absent from the findings.

Natsaba and Havenga's (2007) research used less restrictive inclusion criteria. Their findings were similar to Faschingbauer et al.'s (2013). However, additional themes regarding punishment and imprisonment emerged from the interviews. Their participants described feeling punished, and that the physical nature of the seclusion room triggered memories of being in a prison cell for those who had previously experienced imprisonment. While this research identified emotive themes, the in-depth personal meaning of seclusion was not explored. For example, while punishment was identified as a theme, the meaning and experience of what it was like to have felt punished, was not explored. The relationship between researcher and participant and how that influences recruitment, data collection or analysis was not reflected upon in their article. There may have been elements about this relationship that impacted on the findings which is missing from the analysis.

Sambrano and Cox (2013) conducted a phenomenological study into the patient experience of seclusion. Their small sample (3) enabled an in-depth reflection and consideration of the deeply personal meaning of the participants' experiences. Their research specifically explored the perspective of a marginalised group within society. They also identified themes surrounding abuse and neglect as well as complex power dynamics that existed between staff and patients during seclusion. They conclude their research by discussing how the societal context of the seclusion practice plays a role in patients' lived experience. It is recognised that both the external environment and relational factors play a role in the subjective seclusion experience. Sambrano and Cox's (2013) research has highlighted how seclusion experiences can be influenced by wider factors, such as the societal context.

While all three studies offer a more detailed exploration of the seclusion experience, they do not distinguish between the different aspects of seclusion. The lead up to seclusion, being in the room and the debrief after seclusion are incorporated together. The problem this poses is that there are different procedures occurring at these points and therefore, each component may have a different meaning and experience for participants. For example, the lead up to seclusion involves staff restraint by multiple staff members, being in the room involves isolation and the debrief is a one-to-one interaction.

The majority of research into seclusion is conducted with a narrow and specific sample of psychiatric inpatients from an acute hospital ward. One study (Haw et al., 2011) conducted research on a forensic psychiatric ward. The findings suggested that participants experience difficult thoughts and emotions during seclusion, that they find the environment unpleasant and worse than prison, but also that it can also be a positive opportunity for quiet reflection.

By carrying out research in the forensic setting, Haw et al. (2011) had access to participants with different clinical needs and histories. The following factors may influence participants' experience of seclusion. Forensic inpatients will have had experience of prison, may have been incarcerated for several years, have committed serious interpersonal crimes and often be a group ostracised from society. Participants may have more anti-social interpersonal styles and be expected to engage in long term rehabilitation. Völlm et al. (2018) highlight the high prevalence of personality disorder (particularly anti-social and borderline) in long stay forensic inpatient settings (approximately 47%). Patients with these personality disorders are often found to have more difficulty responding to rehabilitation (Bahorik & Eack, 2010; McCarthy & Duggan, 2010 and Stinson, 2016) than those with exclusively axis I disorders. While Haw et al.'s (2011) study potentially accesses new data, its qualitative methodology is hindered by the use of a large sample and data being only small extracts of interviews.

While it is recognised that seclusion is a necessary intervention in order to ensure staff and patient safety, on-going research is essential in order to positively influence the implementation. More in-depth understanding of the deeply personal meaning and experience of being in seclusion from the perspective of various client groups is required. In Brophey et al.'s (2016) research, participants expressed concern that marginalised and stigmatised groups would be more likely to receive RIs and would be more vulnerable to traumatisation from the experience.

Maguire, Young and Martin (2012) considered a stigmatised group in their study of a RI reduction programme. They evaluated the efficacy of a mainstream RI reduction programme applied to forensic hospitals. They found difficulties reducing seclusion in these hospitals and hypothesised that the personality traits of forensic inpatients are not amenable to the short term therapeutic interventions of mainstream RI reduction programmes. Currently, ostracised populations, such as forensic inpatients, are underrepresented in the research. Given that the behaviour of forensic inpatients may be one which is more likely to result in seclusion, and that this population may find responding to RI reduction programmes more difficult, it is a patient group that requires representation in the literature. Current practice may not accurately reflect the needs of these patients.

In summary, the majority of contemporary research has given an overview of the seclusion experience, but within the context of various different aspects of RIs. Studies have also tended to exclude more complex presentations. This has resulted in a gap in the research. By researching a specific component of seclusion, it gives the opportunity for new features of the experience to be identified, leading to improved understanding of the experience for clinical recommendations as well highlighting areas for further research. This research focuses on one specific aspect of seclusion with an under researched population. It aims to answer the question, what are forensic inpatients' experience of being in a seclusion room?

Method

Design

IPA focuses on how participants make sense of a personal lived experience, their reflections and the meaning they attach to it (Smith, Flowers and Larkin, 2012). This method enables in-depth understanding of the phenomenon from a deeply personal perspective. IPA is informed by hermeneutics, the theory of interpretation

(Smith et al., 2012). It has a two stage interpretation process, with the researcher's role being to attempt to make sense of the participant trying to make sense of their experience, known as a double hermeneutic (Shaw, 2010). Epistemologically, IPA adopts a contextualist position, recognising that while the data analysis and results are grounded in the participants' own accounts, they are inevitably influenced by the researcher's own perceptions. All experiences have personal meaning and the interpretation of it will differ across time and context. As this study aimed to understand the individual personal experience of seclusion, IPA was deemed to be the best methodological approach to explore this phenomenon.

Ethics

Ethical approval was obtained from the university's Faculty of Medicine and Health Sciences Research Ethics Committee, the NHS Health Research Authority and the Research and Development Committee of the NHS trust participants were recruited from.

Participants

A small homogenous sample (n=7), was recruited from a forensic medium secure hospital in England by one of two methods. The researcher was not a staff member and spent six days as a visitor on the wards, discussing the study and her role. They were asked by clinicians at the hospital if they would be interested in taking part and three consented to be contacted by the researcher. Two participants were recruited and one declined. The other five participants independently approached the researcher on the ward. Participants needed to have experienced seclusion in hospital as an adult, have mental capacity to consent and be orientated to time, place and person. In order to ensure participants were not put at risk of being retraumatised, only those whose most recent seclusion was 28 days or more prior to the interview were eligible. All participants were men of working age. They had all experienced seclusion more than once and they all had spent time in prison. Six participants were recruited from rehabilitation wards and one was recruited from an assessment ward. Participants were offered £10 for their contribution of time. This was in line with the hospital's protocol of reimbursing their patients for involvement in service development projects and the BPS Code of Human Research Ethics (2014) recommendation of a reasonable amount.

Data collection

The study was conducted over three wards. Data was collected through one-to-one semi-structured interviews with the lead author. The interview topic guide was developed in consultation with service users. All interviews took place on the ward where the participant resided in a quiet room. Interviews lasted between 25 and 105 minutes. They were recorded and then transcribed.

Analysis and quality assurance

Analysis followed Smith et al.'s (2012) guidelines and was carried out in a systematic format, moving back and forth through different ways of thinking about the data, which was documented to provide an audit trail. The first stage involved the researcher reading and immersing into the data and noting anything of importance in a descriptive and interpretative sense. The second stage involved developing initial themes and then searching the transcript for connections between themes. This process was carried out for each transcript individually and then the researcher looked for patterns and connections across all the transcripts.

Yardley (2000) offers flexible principles of good quality research and these were applied to the research process and write. The principles were interpreted and applied with the contextualist position. The researcher regularly reflected on the process during the interview stage and throughout the analysis to ensure that the analysis was grounded in participants' data. This was facilitated by the use of a reflective journal and discussions with supervisors. The quality was further enriched through triangulation by the researcher meeting with another IPA researcher to review coding and theme development, as per Yardley's (2015) recommendations. All aspects of the reflection and supervision were documented in order to ensure the auditability of analysis.

Reflexivity

Due to the complex nature of undertaking emotive research in a secure and potentially hostile setting, it is essential to reflect on dynamics and interpersonal factors that may have contributed to the analysis. The presence of a power imbalance throughout data collection was unavoidable, and was commented on by one participant when he highlighted his awareness of not having keys when the researcher did. During the interviews, the power struggle was often played out in the dynamics between researcher and participant. For example, the researcher asking questions and recording the interview gave the researcher power, the participant raising his voice, altering his body posture or choosing to talk off topic, gave the participant power. These observations have benefitted the research, as they have been used to enrich the interpretive nature of the analysis.

Findings

The analysis revealed four superordinate themes; intense fear, not getting the care I needed, I am being abused and power struggle.

Intense fear

Whilst in the seclusion room, participants had an experience of intense fear. This fear was related to the physical aspects of the seclusion experience, which included staff and the environment. It was also associated with participants' own thoughts. Participants described an experience of ruminating whilst in the room and felt fearful of these thoughts.

Ali talked about how staff needed to enter the room while he was secluded because he covered the observation panel and hid. The extremeness of his fear was apparent during interview when he talked about his disturbing thoughts that he may be killed.

> *…every time they open the door, they kinda like all in gloves and there was about 12 of them, I thought, what the fuck's going on here, that's why I was getting you know like ideas in my head thinking they're gonna fuckin' kill me.*

Liam, who was the only participant to disclose a traumatic experience of childhood abuse, described how he felt anxious while in seclusion and that this was related to him being engrossed in his own thoughts. His thoughts initially revolved around the potential immediate consequences of his behaviour prior to seclusion and then progressed to thoughts about long term consequences and future behaviour.

> *Worrying that, I might do it again, d'ya know what I mean? Or praps, worse…Yeah…Well like, hurting someone worse, and get in even more trouble.*

Not getting the care I needed

All participants experienced a feeling of neglect. Participants directly commented on this or described needing some form of basic care (e.g. warmth) that they did not get.

Feeling neglected by both the room and staff was highly central to Aaron's experience. He spoke about a feeling of abandonment. He described being *left*, (by staff) without basic needs being addressed and that this was a *horrible* experience. The use of the word *left* and by describing it this way demonstrates that this was a feeling of neglect, rather than using an un-emotive statement to acknowledge that there was only him in the room.

> *Left in a seclusion room for a week without my clothes. I shit up the walls.*

Jay, who of all participants, had spent the least about of time in hospital, more explicitly described feeling alone and abandoned, which challenged his expectation of care in a hospital setting.

> *I just remember being really distressed… Makes you more, made me more, determined that, I'm really on my own. And, seems no matter where you get put for care, ultimately, there is no help. It's just feels totally like, abandoned, helpless…*

I am being abused

Participants reflected on how the actions of staff were sometimes interpreted as a form of abuse. Participants often discussed these experiences alongside themes of fear. Abuse experiences ranged from physical abuse to abuse of a sexual nature. No participants made allegations of actual abusive behaviour. However, they described interpreting the behaviour of staff when they entered the room or the fact that staff constantly observed them, as feeling as though they were a victim of staff's abuse. Staff entering the room to access things such as a bed pan or to do an assessment was experienced in some cases as a form of abuse. For example, as a result of Peri's unsafe behaviour while in the seclusion room, some of the furnishings had to be removed. While he felt that this was a necessary action of staff, he explained that it left him feeling *abused*.

Two participants described feeling violated sexually as a result of being observed using the bathroom. Ali described having a vivid visual memory of staff observing him in the shower. He experienced this as a form of abuse.

> *I felt like I was being like, visually abuse or something. It didn't feel, feeling right at all.*

For some participants, staff's behaviour was interpreted as a deliberate act to neglect their basic needs. For example, Avie's described the room as cold and that he was not given a blanket. While feeling desperate for care, he interpreted this as a cruel and deliberate act of neglect. This is demonstrated by his use of the word *abusing*, with abuse being associated with cruelty and deliberate action on the part of a perpetrator. Rather than commenting on being without a blanket, he commented on staff not providing him with one, implying that he felt staff had decided, on purpose, to neglect him.

> *I felt that they're, that's some sort of abusing me.*

Power struggle

Participants experienced a loss and gain of power throughout seclusion. When they experienced powerlessness, they were in a vulnerable position and staff were perceived to be in a powerful position. Participants felt that staff had control over their seclusion experience and the duration of it. This led to participants behaving passively in the hope that it would result in them getting what they wanted e.g. to leave the room. Both David and Avie described actively trying not to *argue* with staff for fear of the consequences, e.g. staying in seclusion for longer or being restrained.

This theme was highly central to Peri's experience. Of all the participants, he had spent the longest amount of time incarcerated (in high secure prison and high and medium secure hospital) which was almost half of his life. He reflected on his experience of power in those institutions. He then considered several seclusion experiences and felt that he deliberately sought out power as a result of feeling powerless. For example, by refusing to leave the seclusion room and openly masturbating. He explained why he felt the need to do that.

> *In a place where all the control is taken off you, yeah, you've suddenly got a bit of control. 'Cause I think that's the thing, if you're in an environment that is controlled on every level, yeah, I think, in a way, it creates behaviours in people, yeah, 'cause they need some- everyone needs a level, some people are comp, complete control freaks, yeah, and need every aspect of their life controlled, to have control of it, yeah? But then, then you're in an environment where you don't have any control, everybody's trying to grab that little bit of control.*

Of all the participants, the presence of a power dynamic was most strongly felt during David's interview. He less explicitly described his struggle to gain power but shared reflections which were interpreted to be so. For example, as a way to feel powerful, he assessed the capabilities, qualifications and salaries of staff in response to staff assessing his risk and felt that a lack of training explained the long duration of his seclusion.

> *a nurse is not gonna take the risk, of saying right well I think he's fine…A doctor they have a lot more training they can, sit there and look at it psychiatrically, if need be, given them medication. Nurses can't do that.*

Discussion

The aim of this research was to unearth the deeply personal experience of being in a seclusion room as a forensic psychiatric inpatient. The analysis revealed four super ordinate themes that capture the participants' key experiences whilst in the room.

Being in the seclusion room was a frightening experience, independent of duration or frequency. Some participants felt victims of staff's abuse, which represents immense powerlessness. Participants desired care, with some openly disclosing this and others describing an experience of unmet needs. Some of their emotive language demonstrated that they wanted their needs to be addressed (be that physical or emotional) but instead they felt they received neglect and abandonment. Participants desperately sought out ways to feel powerful in order to have a sense of control. Some of this was through disruptive behaviour. The use of such behaviour (e.g. violence, damaging furnishings) will inevitably have resulted in participants having their power withdrawn via staff decisions (e.g. longer in seclusion, having furnishings removed from the room).

Previous research has found fear to be a prevalent, overwhelming emotion for non-forensic inpatients while in a seclusion room (Kontio et al., 2012; Martinez et al., 1999; Ntsaba & Havenga, 2007 and Steinert et al, 2013). Ntsaba and Havenga (2007) discuss how elements of the environment led to secluded patients being so fearful that they felt their life was in danger. However, they also identify how their participants' fear stemmed from anticipation of what might happen next. Ling et al (2015) and Wynn (2004) explore participants' experience of restraint and their findings also identify fear stemming from participants' thoughts about what could happen (e.g. being restrained again while asleep). The present study suggests that fear is prevalent for a forensic inpatient population also, and that it is highly intense whilst in the room. These findings, alongside the above mentioned research, propose that fear during seclusion cannot be explained by environmental factors alone and that there are powerful personal internal strategies (e.g. rumination) initiating or maintaining fear. Given the mental state of patients during seclusion, the intensity of these internal factors are likely to be high.

Experiencing a lack of care is a theme that has arisen in several studies exploring seclusion experiences (Faschingerbauer et al., 2013; Haw et al., 2011; Ling et al, 2015 and Ntsaba & Havenga, 2007) and has also been highlighted by nursing staff as a concern they have about how seclusion is implemented (Alty, 1997). In the present study, being without care left participants feeling neglected and abandoned, something Ezeobelle et al.'s (2014) participants also reported. These commonalities amongst studies span over several years, countries and hospital environments, suggesting that recent changes to seclusion practice may not be addressing the factors that influence patients' experience of care. It may also be that there are common characteristics of inpatients who experience seclusion that makes them more vulnerable to feeling neglected, such as histories of abuse (Hammer et al., 2011), psychotic symptomology (Keski-Valkama et al., 2010) or being a marginalised group within society (Happell & Koehn, 2010). For the participants in the present study, the experience of care centred around their experience of staff.

Feeling as though the seclusion experience is abusive has been identified in earlier research. For some participants of that research, they reported incidents of emotional and physical abuse from staff (Ntsaba & Havenga, 2007). In the present study, no accusations were made regarding abuse, but participants described experiencing staff as though they were perpetrating abuse against them. This highlights that actual abuse does not need to occur in order for a patient to feel as though they have experienced the trauma of abuse. This experience left participants in a vulnerable position, experiencing intense fear and feeling neglected. The participants' interviews that contributed to the, 'I am being abused theme' included their stories of seclusion that occurred both prior to the introduction of the 2015 NICE guidelines and after. This suggests that this is an experience that transcends various policy attempts to ensure ethical seclusion use, and is more related to the deeply personal meaning.

Previous literature exploring various coercive inpatient experiences has revealed themes centring around the powerlessness of patients (Haw et al., 2000; Meehan, Vermeer & Windsor, 2000; Ryan & Happell, 2009 and Sibitz et al., 2011). These studies have described participants' experience of a loss of control and power imbalance between staff and patients. The current study revealed a power dynamic, described as a power struggle, that has been less identified in previous research into the experience of RIs. A minimal amount studies has found suggestions of a power struggle dynamic. Meehan et al. (2000) found that patients were able to cope with the loss of control by engaging in behaviour that did not necessarily reflect how they were feeling, but was a way to "play the game" and be released from seclusion. This was referring to passive behaviour where patients presented themselves as powerless, but ultimately were misleading staff which subtly shifts the power in the direction of the patient. Some of the more overt power-seeking behaviours, like those identified in the current study, have been captured in previous seclusion research, for example, masturbation in seclusion (Kehl Richardson, 1987) and refusing to eat (Sambrano & Cox, 2013). In Sambrano and Cox's (2013) study, the procedure of seclusion was somewhat different to in other research, as police transferred them into the seclusion room rather than clinicians. Two of the three participants had had experiences of prison prior to hospital. These are forensic elements that may not be present in other studies.

The nature of a forensic population may be a key influencing factor to the power struggle that is apparent in the findings of this study. Within forensic psychiatry, Holmes (2002) used grounded theory to explore the power dynamics between nurses and patients. He found that overall, nurses constantly hold a powerful position over patients in the secure environment. The participants (nurses) felt that due to having a role as disciplinarian and carer, it made it impossible to have a therapeutic relationship of equal power. While they felt that they were able to give patients some freedom or control, this was carefully calculated and ultimately had the intention of ensuring nursing staff could have the ability to control their patients' behaviour in the long term. Holmes identified that patients may develop ways to gain power over nurses, for example, by remaining silent during therapeutic meetings. While Haw et al.'s (2011) study in a forensic hospital did not identify themes alluding to patients gaining power, this may be a reflection of the methodological approach (large sample size and minimal quantities of qualitative data) which limited the extent to which participants' accounts could be analysed.

This research has highlighted the deeply personal experience of seclusion and that there may be factors related to patients' mental health and history that contribute to their experience. It has drawn attention to how personal experiences are not always openly shared by patients, meaning that presumptions should not be made regarding a patient's experience. The Power Threat Meaning Framework (PTM) (Johnstone and Boyle, 2018) can be used to understand the interaction between the themes. According to PTM, participants may experience seclusion as a trauma that is interpreted as threatening. They cope with the threat using long standing survival strategies (e.g. seeking power).

Implications for Practice

This study illuminates the emotional experience and interpersonal dynamics that are present for participants whilst secluded. In order to maintain the safety of staff and patients, the use of seclusion is a necessary intervention. The complex interaction between the themes should be considered when it is implemented and how patients' behaviour can be affected by aspects that may have previously gone unnoticed by staff. The use of necessary nursing procedures (e.g. observation or assessment) should be applied sensitively, taking into consideration the history of the patient and their mental health difficulties. Staff training on how to formulate patients' behaviour using a theoretical model such as PTM, can help staff individually tailor their therapeutic response to such behaviour.

The importance of the power struggle that this study highlights, gives further insight into how to improve nursing practice. A staff response which focuses on regaining more power is likely to result in increased in power-seeking behaviour from patients. Rather, staff should provide care, considering that patients may feel frightened, neglected and abused. In order to help staff develop therapeutic skills, ensuring clinical supervision allows space for staff to reflect on their experience of secluding a patient may help them to identify any power seeking behaviour they unintentionally engage in.

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Chapter 5: Methodology and Design

Qualitative Methodology

Qualitative methodology aims to examine how people think, feel and behave. It also aims to explore the perspectives and meaning people attach to experiences (Sullivan, 2010). While quantitative research requires the reduction of a phenomena to numerical values, qualitative research is concerned with interpreting and understanding the phenomena from the naturalistic data (Smith, 2015). In order to make sense of the research results, they need to be understood within their ontological and epistemological positions.

Ontology is concerned with whether or not there is an objective reality or truth and epistemology is concerned with if it is possible to know this objective truth about reality. Ontology can be considered a continuum with realism (our representations of the world are reflections of the way the world actually is) at one end and relativism (our representation of the world is socially constructed) at the other. Quantitative research standardly holds a positivist epistemology underpinned by ontological realism, meaning that it takes the standpoint that objective research enable the facts of reality to be found. In contrast, according to the epistemological stance of social constructionism, reality cannot be known as it does not exist outside of our own personal social construction of it (Sullivan, 2010). A researcher of psychology places themselves somewhere along the continuum.

The present research approaches the research question from a contextualist epistemogical assumption, underpinned by ontological critical realism. The researcher's position is that reality is influenced by an individual's perception and interpretation of it and it can differ across time and context. All experiences have personal meaning and knowledge of another's reality will always be influenced by one's own perspective. With this in mind, the use of qualitative methodology allows for interpretation of participants' own individual reality, whilst acknowledging through reflexivity, the influence of the researcher's own perceptions. Qualitative studies can offer clinical implications as the findings will be transferable, in that they can be transferred from one population and have its relevance considered for another.

Interpretive Phenomenological Analysis (IPA)

IPA focuses on how participants make sense of their lived experiences (Braun and Clarke, 2013). By exploring the meaning participants attach to their experiences and the reflections they have, a more in-depth understanding of the phenomenon can be developed from a deeply personal perspective. IPA is informed by three philosophical approaches, phenomenology, hermeneutics and idiography (Smith et al., 2012).

Phenomenology is concerned with the study of human experience and how we come to understand it. This approach considers personal experience as unique and connected to our relationship with the world (Smith et al., 2012). The IPA researcher needs to be interpretative in order to make meaning out of participants' dialogue. The theory of interpretation is known as hermeneutics. In IPA, the researcher is trying to make sense of the participant trying to make sense of the experience, known as the double hermeneutic (Shaw, 2010). In order to do this, the researcher interprets beyond the explicit claims of the participants. The concept known as the hermeneutic circle is applied to analysis by considering that in order understand the whole, the researcher must look at the parts and in order to understand the parts, the researcher must look at the whole (Smith et al., 2012). For example, when analysing dialogue, the meaning of the word (the part) only becomes clear when considered in the context of the whole sentence (the whole). The implications of this is that while analysis must be systematic, it is also iterative, meaning that the researcher must move back and forth through different ways of thinking about the data, rather than maintaining a rigid step by step process (Smith et al., 2012). The third philosophical influence upon IPA is idiography, an approach concerned with the in-depth exploration of a particular person's relationship to a specific phenomenon within a particular context (Smith et al., 2012). Therefore, analysis must involve a detailed case-by-case analysis.

In the case of this empirical research project, the phenomenon explored is the experience of seclusion. The content of participants' interviews is the dialogue that is analysed and the researcher's thorough analysis ensures the phenomenon is explored in-depth for each participant.

Method

Design

Participants were recruited from a male-only medium secure forensic hospital. In such hospitals, schizophrenia, delusional or schizotypal disorders, personality disorders and mood disorders would be the common diagnoses patients are given (Ricketts et al., 2001). Given this, it likely that some patients would experience a certain degree of unease or suspiciousness about a stranger present on the wards. This dynamic may restrict participation in research. In order to overcome this, the researcher spent a block of six days on the ward, introducing herself to the inpatients, building rapport and making her intensions known by explaining the study. Some patients were forthcoming and expressed an interest, requested more information and consented to participate. In addition to this, staff at the hospital had introduced the study to patients prior to the researcher's visit and some consented to being directly approached by the researcher. This meant that these patients were expecting to be approached directly, which may have reduced any sense of threat when seeing the researcher.

One-to-one interviews were the chosen data collection method. The interviewer followed a topic guide (see appendix C), which was developed in consultation with NHS forensic inpatients. In qualitative research, an interview can be considered to be a conversation with a purpose (Smith et al., 2012), rather than a simple question and answer process. The researcher allowed some flexibility from the topic guide in order to promote the flow of conversation and put the participant at ease. In IPA, recognising that the interview is a social interaction assists with detailed and meaningful interpretation of the data. The interviews were recorded on a dictaphone and transcribed afterwards. This method enables the interview to be more conversational in nature than if the researcher had taken notes. This allows for the development of rapport and produces rich data suitable for qualitative analysis. Given the sensitivity of the topic, maintaining rapport was vital for participants to feel comfortable discussing their experience. In addition, it also enhanced the analysis as the researcher could become immersed in the data by listening to the audio recording.

Participants

Smaller sample sizes in qualitative research allow for more rich and detailed findings (Braun and Clarke, 2013). In IPA, a number between four and ten participants is recommended (Smith et al., 2012). All participants had capacity to consent to participate and were orientated to time, place and person. Three patients were approached by members of hospital staff regarding the study and consented to be contacted by the researcher (see appendix D for consent form). When approached by the researcher, two agreed to participate and one declined. Five participants approached the researcher independently and requested to participate. All participants had prior experience of imprisonment and all had been in hospital for more than one year. Participants offered this demographic information but there was no requirement to do this as part of the interview. See appendix E for more information regarding participant demographics.

Ethical considerations

In line with the BPS Code of Human Research Ethics (2014), the following principles were taken into consideration in the design of this study; respect for individuals' autonomy, privacy and dignity, scientific integrity, social responsibility, maximising benefit and minimising harm.

The researcher was not a member of hospital staff, had no clinical links to any of the patients and was not employed by the NHS Trust participants were recruited from. This was made clear to participants in order to emphasise that the research was optional and separate from their treatment. It was explained that participating would not influence any treatment decisions (e.g. tribunals) and they were made aware that they could exercise their right to withdraw and it also would not have any consequence on their treatment.

Given the emotive topic, the potential distress to participants was considered throughout the duration of the interview. The use of a topic guide rather than an interview schedule meant that participants could talk about and expand upon aspects of their experience as and when they felt comfortable to do so. The researcher gave participants a copy of the topic guide so that they were aware of what the interview would entail and could highlight if there were any particular questions they did not want to answer. In order to help maintain confidentiality, interviews took place in a room on the ward out of view from communal areas. At the end of the interview, participants were given a paper debrief form (appendix F) so that they could keep a visual reminder of the support available should they feel distressed afterwards.

Given the location of the interviews, risk to researcher needed to be carefully considered. Before data collection commenced, the researcher attended breakaway training, had a hospital security induction and was given a personal alarm. In order to ensure her safety, the researcher made herself known to all ward staff and when conducting interviews she informed them of her location, the participant's name and the expected duration of interview. This was deemed essential, as the whereabouts of visitors is required to be known at all times and hospital patients are required to be regularly observed for their safety and the safety of others. It also gave ward staff an opportunity to raise any issues that could suggest that the participant is not safe to be interviewed (e.g. the interview could trigger aggression or deterioration in the patients' mental health). While this meant that some hospital staff will have known the identity of the participants, they will not have been aware of the content of the interview.

The six day block at the hospital allowed enough time for the researcher to explain the study in detail, in an accessible manner and for participants to ask questions. Participants were given an information sheet (see appendix G) and if after a minimum of 24 hours they continued to wish to participate, were asked to sign a consent form (appendix H). Participants were informed that they would be reimbursed for their time. In line with the BPS Code of Human Research Ethics

(2014), a reasonable amount was offered (£10 consistent with the hospital's policy for service improvement involvement).

The dictaphone used for recording interviews was security cleared by the hospital. The recordings were then transferred onto a password protected study laptop to be transcribed. At this point, the data on the dictaphone was immediately deleted. In the transcription, each participant was assigned a number and pseudo-name. Participants were reminded that as they are inpatients under close observation, staff and other patients may be aware that they are participating in research. However, the content of the interviews remains confidential, unless they disclosed information about risk to self or others or indicate the occurrence of an unreported serious crime. There were no risk issues disclosed during the course of the study. Participants were made aware that information regarding their mental wellbeing would be shared with the nurse in charge on their ward. All participants agreed with this. Paper copies of signed consent forms remain stored at the University of East Anglia in the research supervisor's office in a locked cabinet. All data will be destroyed after ten years.

See appendices I and J for documents regarding confirmation of ethical approval.

Analysis

Data analysis followed Smith et al.'s (2012) guidelines. In the first stage, the researcher spent time immersing into the data by listening to the recordings and transcribing verbatim. Two interviews were transcribed by a transcription service who were required to sign a confidentiality waver. In these instances, the researcher immersed into the data by listening to the recordings, reading the transcripts and editing the transcriptions if necessary. A reflective journal was used alongside these processes (see appendix K for an example extract) and referred back to at various points throughout the analysis. This approach is consistent with the concept of the hermeneutic circle that underpins IPA. The researcher had written field notes in the reflective journal following each interview and these notes were revisited as part of the immersing process.

Stage two involved noting anything of importance in a descriptive and interpretative sense. Descriptive noting often occurred within the first stage and was then further expanded upon when the researcher re-read the transcript. The interpretative notes focused on the participants use of language (linguistic comments) and their understanding of the topic they were discussing (conceptual comments). Each of these processes were documented (see appendix L for examples of descriptive, linguistic and conceptual noting of transcript extracts).

The third stage involved developing emergent themes (see appendix M for examples of the development of emergent themes). The reflective journal was used to enhance the interpretive nature of this process and to provide notes to refer back to when moving forward through the analysis stages (see appendix N for an example extract). The researcher focused on chunks of transcript at a time and then progressed onto searching for connections between the themes (see appendix O for an example of connected themes). Connected themes were then given a statement to reflect their meaning. This process was carried out for each transcript individually, before moving onto the next participant. Appendix P presents the themes for each participant along with examples of quotes that contributed to the theme. Some themes were particularly relevant to the participant's personal experience. Indications such as duration of time spent talking about the subject or emotive language are examples of content that was interpreted as demonstrating personal relevance.

The researcher then looked for patterns and connections across all the transcripts. According to Smith et al. (2012), occurrence across cases is important when working with a larger sample and can support the presence and significance of that superordinate theme. Appendix Q demonstrates the occurrence of the four superordinate themes across the seven participants.

Trustworthiness

Yardley (2000) poses four dilemmas for qualitative health research quality; sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. Good quality studies will fulfil these criteria in different ways, depending on the methodological approach used and the epistemological and ontological position. These principles were interpreted in line with IPA's contextualist position that it is unavoidable that the analysis, and therefore results, will be influenced by the researcher's own perspective . These were applied to the study and during the write up. Table 1 outlines the steps that were taken in order to ensure the trustworthiness of the research.

Table 1

Quality assurance

Guideline	**Steps taken**
Sensitivity to context	The use of one-to-one interviews gave participants privacy when discussing emotive topics. Demonstrating empathy and sensitivity to power imbalance by ensuring participants have control over what they disclose. Spending time on the wards prior to data collection in order to build rapport with participants and reduce any sense of threat.
Commitment and rigor	In-depth interviews. Purposeful sampling. Systematic analysis. Sufficiently interpretative analysis facilitated by the use of a reflective journal to document reflections after the interview, individual research supervision, peer qualitative research supervision, transcription and analysis process and then referring back to the reflections during analysis.

	Referring back to the reflections to ensure the analysis was grounded in participants' data.
Transparency and coherence	Documenting each stage of the research process.
Impact and importance	Findings provide new knowledge that has clinical importance and relevance for the direction of future research.

Shenton (2004) highlights the importance of triangulation in order to ensure as much as possible that the findings are grounded in the experiences of the participants. The researcher used the reflective diary to help identify her own characteristics and preferences and also met with another IPA researcher to review coding and theme development, as per Yardley's (2015) recommendations. A section of a transcript and part of the analysis was shared and reviewed in order to gain another perspective. It also served as a creditability check, thus enriching the trustworthiness of the research. The second-coder often identified the same codes as identified by the researcher and in some cases, used slightly different wording to represent the code. The process was discussed face-to-face to understand the meaning behind the choice of wording for the codes. This helped to establish if the meanings were similar and gave a new perspective on some of the codes which assisted the researcher to engage in interpretative analysis more thoroughly. The researcher then replicated this triangulation process in supervision. The second-coder and supervisors did not have access to any participants' personally identifiable information.

Reflexivity

Shenton (2004) highlights the importance of researchers acknowledging their beliefs and assumptions in order to ensure their research can be considered trustworthy. As found in Probst's (2015) study, reflexivity can often be used to enhance the ethical nature of research. During the early stages when the researcher was planning the methodology, she documented her reflections which helped with decisions regarding ethical procedures. The researcher considered her prior experience working with a forensic inpatient population and some of the difficulties that may arise when discussing emotive topics. She was concerned that the presence of anyone other than the researcher during the interview would hinder participants' ability to be open and honest. Therefore, she designed the study to only have one-to-one interviews and this was discussed with the ethics panel, who initially suggested that hospital staff should be present in the room. After sharing her reflections with the panel, this study was able to be more ethical in terms of care for participants' wellbeing (participant privacy and minimising harm) and quality of the data collected (scientific integrity).

The researcher reflected on how her views and experiences during the research impacted on interview style, thus potentially influencing data collected. These reflections could then be reviewed when listening to the audio recordings during the first stage of analysis. For example, the researcher documented the intimidating body language of one participant and how she responded to it. This helped her consider power imbalances during the analysis of his transcript. The researcher documented the emotions present during one particular interview and this was considered during analysis of this participant's use of language.

The researcher initiated immersing into the data before data collection commenced. She documented her reflections of spending time on the ward before she had recruited participants. She reviewed these reflections to help with the depth of analysis as this enabled her to consider any preconceptions she may hold that could be influencing the interviews and analysis. The researcher also viewed the hospital's seclusion room and spent time shut in the room alone. This gave the researcher a unique experience and opportunity to develop more understanding of the phenomenon being explored. She documented her emotions and thoughts while she was in the room and looking around. For example, she documented feeling *frightened* and that she felt an awareness of how little control secluded patients have. This helped her to reflect during analysis on how this may be influencing her coding and theme development. By reviewing the documented reflections, she was able to ensure her themes were grounded in the transcripts, rather than her own experience, and was able to emotionally connect with the participants' transcripts, providing a thorough interpretative analysis. The researcher identified times when she thought a break from analysis would benefit the quality and documented this in the journal.

The researcher also reflected on her experience of the analysis process and her thoughts as she progressed through the stages. This helped to identify aspects that may be influencing certain aspects of analysis. For example, she reflected on her emotional reaction while transcribing (see appendix R) to help consider personal factors that may be influencing her coding. When identifying emergent themes, the researcher documented her train of thinking in order to follow her thought processes that led up to the development of the themes.

She acknowledged how her prior experience of working in forensic and inpatient settings will have influenced the development of themes and the way these are represented in the write up. For example, before conducting interviews, she already had an awareness of the relevance of power and control in such institutions and had had experiences of being part of that dynamic. For example, having power (contributing to decisions regarding a patient's access to the community) and losing power (being assaulted by a patient). The researcher used these experiences to enhance the way she approached her analysis using the hermeneutic circle. She was able to move back and forth through her own reflections as well as the data, to make sense of the connections and patterns that were emerging. For example, one participant commented on how the staff who are more "in charge" decide when to "let you out". The researcher interpreted the parts (particularly the words "in charge" and "let you out") by considering how they were used in hospitals she had previously worked at. She then considered their meaning in the context of the whole sentence (the whole) which then led her to further interpret the meaning of the words. The researcher acknowledges her ontological position that understanding of another's reality will always be influenced by one's individual perception. Therefore, the themes represented are influenced by her previous work experience.

Write up and Dissemination

The write up of this study has been in the form of an empirical paper and publication will be sought. It has been written for a journal that is particularly concerned with the clinical implications of research and may be more likely to be accessed by clinicians than academics. This approach to dissemination aims to promote the use of the findings to help inform day-to-day decision making when implementing seclusion.

All participants were offered feedback of the results and they will be given a written summary of the findings in accessible language. The findings will be disseminated to the NHS Trust where the participants were recruited from. The researcher also plans to present the study and its results at a Clinical Psychology Research Conference either as a verbal presentation or in the form of a poster.

Chapter 6: Discussion and Critical Evaluation

This chapter provides an overview of the results from the entire thesis portfolio. It provides an account of the strengths and weaknesses of the research project and systematic review and concludes by discussing the clinical implications and considerations for future research.

Overview of Results

The aim of this project was not to promote nor suggest abolishment of the use of seclusion. Rather, it was to illuminate the deeply personal experience of this intervention from a patient perspective and offer clinical and research recommendations. It is clearly a challenge to implement an intervention which has been identified as distressing for patients. It can pose an ethical dilemma for clinicians trying to decide how best to ensure safety of all patients and staff, including the patient exhibiting dangerous behaviour. Clinicians have a duty to protect the safety of their patients and ethical practice would be considered to be that which involves making difficult decisions about the implementation of RIs. These results offer potentially new considerations for how to work through these decisions and continue to ensure compassionate and caring practice. They also highlight areas that would benefit from further clinically relevant research.

Consistent with the previous research, the portfolio suggests that seclusion has the potential to be a traumatic experience for psychiatric inpatients. In the empirical research project, the purposeful sample of forensic inpatients has provided an understanding of the experience from the perspective of an under researched population. The exclusive focus on the seclusion room enabled the in-depth exploration of this one aspect of the seclusion experience.

The systematic review has identified common themes from recent qualitative literature that suggests patients experience a feeling of vulnerability, that they feel neglected and abused, that they disconnect from the experience and that they experience intense negative emotions to the extent that it poses a risk to their mental health. Reviewing the quality of qualitative research has found lack of reflexivity to be a major limitation in the methodological rigour of the studies.

The empirical research project has provided new knowledge into the experience of forensic inpatients. Similar to other studies into seclusion (Ezeobelle et al., 2014; Faschingerbauer et al., 2013; Haw et al., 2011; Ling et al., 2015; Kontio et al., 2012; Martinez et al., 1999; Ntsaba & Havenga, 2007 and Steinert et al, 2013), themes included intense fear, feeling that they did not receive the care they needed and feeling as though they were being abused. Three of these studies (Ezeobelle et al., 2014; Haw et al., 2011 and Ntsaba & Havenga, 2007) found that while participants experience seclusion as broadly negative, there was some indication that a minority of participants had a positive experience. However, this finding was not replicated in this research project. A potential new finding of this research, perhaps reflecting a specific experience of the forensic participants, was the identification of a power struggle occurring in seclusion. See appendix S for additional quotes to support the four superordinate themes.

The exclusive focus on the time spent in the room acknowledges the complexity of the experience and provides a more detailed understanding of this one component. The findings suggest that being in the room has an emotional and interpersonal impact, irrespective of the pre and post seclusion experience.

Strengths and Limitations of the Empirical Research Project

A major strength of the empirical study is its contribution to research of seclusion experiences. The study provides new knowledge which has direct clinical implications for an intervention that is of concern to clinicians, service users and policy makers. By researching a small forensic population, it has provided in-depth understanding of their seclusion experience. The study has provided information that a forensic inpatient population have similar experiences of seclusion to a non-forensic population. This suggests that despite the clinical differences to general psychiatric inpatients, fear, feeling abused and not receiving needed care is a common response in the context of seclusion. In addition, the study found a power struggle dynamic to be prevalent for participants. This could suggest that elements associated with forensic psychiatry (e.g. being an ostracised group from mainstream society, clinical components related to offending behaviour or specific characteristics associated with forensic detention) is contributing to this experience or, that it is a unique experience which occurs in the context of being in the room. Unlike previous studies, by specifically researching the participants' experience of being in the seclusion room, this study has demonstrated that this component of seclusion is an aspect that deserves clinical attention in its own right.

The methodology used in this study has facilitated the in-depth exploration of participants' personalised meaning of being in a seclusion room. Previous research has generally provided overviews of a patient perspective, often from a positivist epistemological position. This study has been able to explore the subtle idiosyncrasies of the patient experience and the meaning surrounding them. The use of an interpretative methodology means that the study can go beyond summarising the verbal accounts of participants.

As highlighted in the systematic review, reflexivity is lacking from previous qualitative research. This study involved a high degree of auditable reflexivity which has enhanced the interpretative qualities of the analysis. The researcher completed security inductions immediately prior to commencing data collection, including spending time in the seclusion room herself, and was able to reflect on this in connection to the study.

There are limitations that need to be taken into account. While not being a staff member at the hospital may have meant that participants felt more able to open up honestly, it could alternatively have meant that participants were not able to build enough rapport to elaborate as much as they would have done with a familiar staff member. This means that it possible that there was some data that the researcher was unable to access.

It is also possible that participants' recollections of their experiences are inaccurate. This may be due to the research design enabling participants to share information about any seclusion room experience they wish to disclose. Some participants spoke about seclusion experiences from several years ago. Smith and

Gudjonsson's (1995) study with forensic inpatients found that the presence of anxiety hinders patients' ability to remember information, which in turn increases the chance of confabulation (replacing gaps in memory with incorrect information believed to be true). The findings of their study are relevant, given that fear was a core part of participants' experience. However, this was not considered to be a considerable limitation as analysis focuses on the meaning, reflections and interpretation participants place on their experience. Therefore, potentially inaccurate memories are part of the experience, as it is the memories (inaccurate or accurate) that is what is influencing the meaning participants place on it. As the researcher did not seek to corroborate the reported seclusion incidents, it is possible that participants were deliberately lying or providing distorted accounts of their previous experiences. However, there was no incentive for the participants to lie, therefore while this is a possibility, it is unlikely.

While the sample was purposely a forensic inpatient population, the study is limited by the participants all being from the same hospital, all of working age and all male. The implications of this is that there may be considerable unexplored similarities (e.g. hospital culture) that influence participants' experience or their reporting of the experience. However, all participants had been inpatients and prisoners at various locations, resulting in differing experiences of hospital and prison security (i.e. low, medium or high), cultures and NHS Trust and HMP procedures.

Strengths and limitations of the systematic review

The thematic synthesis approach and narrow review question (what are adult psychiatric inpatients' experience of seclusion?) enabled a more thorough exploration of the qualitative research than Van Der Merwe et al.'s (2013) systematic review. The strength of the current systematic review is that it produces new knowledge by providing a detailed insight into the experience of seclusion from the perspective of psychiatric inpatients.

However, there are limitations that need to be taken into consideration. Due to the small quantity of qualitative research on the topic, there was a need to be inclusive. Some studies that were included in the review had findings that need to be interpreted with caution. Four papers had participants' quotes translated into English for the purpose of the write up. This may have resulted in certain quotes being misrepresented and could limit the ability to interpret the meaning of the language participants used. Also, five papers researched seclusion within the context of several RIs. In order to ensure that quotes regarding a different RI were not being incorrectly used to answer the review question, only quotes which explicitly referred to seclusion were included in the synthesis. There may have been some relevant quotes which could have contributed to the synthesis that were excluded.

The systematic review also aimed to appraise the quality of the research. The appraisal revealed that all papers had high quality designs and methods. This further strengthens the trustworthiness of the review's findings. However, as should be considered with all appraisals of qualitative research, there will inevitably be a degree of subjectivity.

Clinical Implications

While it is recognised that RIs such as seclusion can be distressing, there continues to be a need for them in order to maintain patient and staff safety. Therefore, the findings of the empirical research and systematic review have particular implications for clinical practice to improve the ethical use of seclusion. The MHA Code of Practice (2015) places emphasis on the importance of the seclusion room. It states that the room must be purpose built for seclusion only and should not be used for any other purpose. It provides requirements for what facilities the room should contain. Both the systematic review and the empirical research found the room environment to play a role in patients' negative experience in that it contributed to feelings of intense fear and feelings of neglect and abuse. While the current requirements ensure the safety of patients, there are still aspects about the facilities in the room that cause distress. The MHA Code of Practice (2015) and NICE guidelines (Violence and Aggression: short-term management in mental health, health and community settings, 2015) do not provide recommendations for how to manage this distress whilst keeping the patient safe. This could be an area for further development in the revision of these guidelines.

The guidelines also state how observation should be carried out. However, carrying out such observation in a way that ensures the therapeutic nature of staff-patient interaction is maintained, is not a focus in the guidelines. Also, it may be challenging for service providers to approach observation in this way. Given that the findings of the empirical research demonstrate that observations can be experienced as abusive, there is a need for service providers to place more emphasis on how to protect patients' emotional wellbeing and relationship with staff whilst still ensuring their safety through observation.

Current practice guidance may also underestimate the importance of understanding the experience of fear during seclusion, something that was identified in both the systematic review and empirical research. For example, at present the 2015 NICE guidelines do not provide recommendations regarding how to support patients who feel frightened during seclusion. There is acknowledgement of the need to support the wellbeing of patients during the debrief, however, the empirical research project would suggest that this is insufficient. Given that intense fear occurs whilst in the seclusion room, there is a requirement for guidelines providing direction for clinicians regarding the therapeutic nature of the interaction while the patient is in the room. Whilst there is an appropriate focus on therapeutic interaction to reduce risk of aggression, there is no guidance regarding how to support patients with fear. Seclusion practice could be improved if guidelines provided recommendations for how to reduce patients' fear as well as aggression, taking into consideration that patients may not openly disclose that they feel frightened.

In order to improve therapeutic interaction during the seclusion process, training and clinical supervision could be enhanced to help support staff understand the behaviour of their patients and therefore tailor their interactions accordingly. The Power Threat Meaning (PTM) framework (Johnstone and Boyle, 2018) proposes that mental distress and problematic behaviour can be interpreted as survival strategies in response to a sense of threat. An individual's problematic patterns of survival strategies can be understood as partly originating from traumatic life experiences (power), the impact this had on the individual (threat), and the thoughts and beliefs they have to make sense of it (meaning). This framework could be used to facilitate staff's understanding of patients' responses to seclusion. Clinical supervision could be used to help staff to consider how their approach interacts with their patient's psychological formulation.

The findings of the project can be considered within the PTM framework. Forensic psychiatric inpatients are known to have suffered high levels of developmental trauma and adversity (Stinson, Quinn and Levenson, 2016) and all will have experienced imprisonment. Seclusion can be formulated as a traumatic experience where there is a withdrawal of power from the patient (power). In response, the patient experiences intense fear, feels highly vulnerable and powerless (threat). The patient then attempts to find meaning in this experience and may, for example, interpret it as abuse (meaning). The way the patient behaves in response to this is their survival strategy.

Recommendations for Future Research

Given that previous research has researched the seclusion experience as a whole and within the context of various other experiences, the experience of more individual components of seclusion remains unexplored and unknown. Future research could focus on the experience of the lead up to seclusion, the seclusion debrief and how the experiences may interact. Knowledge surrounding these components could lead to further improvements to seclusion practices. It may also provide information to identify aspects to target to help reduce the need for RIs.

The empirical research project has highlighted the presence of a power struggle between staff and patients during the time spent in the seclusion room. As this is a novel theme, further research into this specific aspect could help to further improve clinical practice. There are several directions for this research. First, it would be helpful to identify whether this is a phenomenon unique to forensic units, and if so which aspects of the environment or experience contribute to this. More generally, research could focus on the role power plays in the overall seclusion experience. For example, the relevance of power struggles to the duration of seclusion or behaviour during seclusion. This research may inform ways staff can adapt their therapeutic approach during seclusion to reduce risk as rapidly as possible. It would also be beneficial to research staff's experience of power during seclusion. This will further enrich clinical recommendations that can be made to improve staff-patient interaction during seclusion. Also, factors which may contribute to a patient being more vulnerable to experiencing a power struggle (e.g. clinical presentations) could be explored in order to help individually tailor the therapeutic interactions.

Overall Conclusion

This thesis portfolio provides an insight into the patient experience of seclusion. It gives rich and detailed information regarding the experience of an intricate aspect of seclusion, provides an insight into the experience for an under researched population and emphasises the prevalence of a negative experience.

By highlighting the deeply personal meaning and experience of being in a seclusion room, it has provided implications for clinical practice in terms of immediate changes but also in terms of improvements to national guidelines. It has also provided suggestions for further research to enable more understanding of this experience, and crucially, how to reduce the negative impact and use of it.

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Appendix A: Author Guidelines for Journal

Journal of Psychiatric and Mental Health Nursing

Editor-in-Chief: Lawrie Elliott - Editors: Richard Gray, Marie Crowe & Charley Baker

Impact Factor: 1.131
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Online ISSN: 1365-2850

Author Guidelines

Content of Author Guidelines: 1. Aims and Scope, 2. Authorship, appeals and permissions 3. Submission of Manuscripts, 4. Manuscript Types, 5. Manuscript Format and Structure, 6. After Acceptance.

1. AIMS AND SCOPE

The *Journal of Psychiatric and Mental Health Nursing* is an international journal which publishes research and scholarly papers that advance the development of policy, practice, research and education in all aspects of mental health nursing. We publish rigorously conducted research, literature reviews, essays and debates, and consumer practitioner narratives; all of which add new knowledge and advance practice globally.

All papers must have clear implications for mental health nursing either solely or part of multidisciplinary practice. Papers are welcomed which draw on single or multiple research and academic disciplines. We give space to practitioner and consumer perspectives and ensure research published in the journal can be understood by a wide audience. We encourage critical debate and exchange of ideas and therefore welcome letters to the editor and essays and debates in mental health.

Please read the instructions below carefully for details on the submission of manuscripts, the journal's requirements and standards as well as information concerning the procedure after a manuscript has been accepted for publication in the *Journal of Psychiatric and Mental Health Nursing*.

Authors are encouraged to visit: Wiley Author Services for further information on the preparation and submission of articles and figures.

2. AUTHORSHIP, APPEALS AND PERMISSIONS

2.1 Authorship and Acknowledgments

Authorship: Authors submitting a paper do so on the understanding that the manuscript has been read and approved by all authors and that all authors agree to the submission of the manuscript to the Journal.

The *Journal of Psychiatric and Mental Health Nursing* adheres to the definition of authorship set up by The International Committee of Medical Journal Editors (ICMJE). According to the ICMJE authorship criteria should be based on 1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, 2) drafting the article or revising it critically for important intellectual content and 3) final approval of the version to be published. Authors should meet conditions 1, 2 and 3.

It is a requirement that all authors have been accredited as appropriate upon submission of the manuscript. Contributors who do not qualify as authors should be mentioned under Acknowledgments.

Acknowledgments: Under Acknowledgments please specify contributors to the article other than the authors accredited. Please also include specifications of the source of funding for the study and any potential conflict of interests if appropriate. Suppliers of materials should be named and their location (town, state/county, country) included.

2.2 Appeal of Decision

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Correspondence to the journal is accepted on the understanding that the contributing author licences the publisher to publish the letter as part of the journal or separately from it, in the exercise of any subsidiary rights relating to the journal and its contents.

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3. SUBMISSION OF MANUSCRIPTS

Manuscripts should be submitted electronically via the online submission site http://mc.manuscriptcentral.com/jpm. Full instructions and support are available on the site and a user ID and password can be obtained on the first visit. Support can be contacted by phone (+1 434 817 2040 ext. 167) or e-mail (support@scholarone.com). If you cannot submit online, please contact the Editorial Assistant by e-mail (JPMHNedoffice@wiley.com).

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Launch your web browser and go to the journal's online Submission Site: http://mc.manuscriptcentral.com/jpm.

- Log-in or click the 'Create Account' option if you are a first-time user.
- If you are creating a new account.

- After clicking on 'Create Account', enter your name and e-mail information and click 'Next'. Your e-mail information is very important.
- Enter your institution and address information as appropriate, and then click

'Next.'
- Enter a user ID and password of your choice (we recommend using your e-mail address as your user ID), and then select your area of expertise. Click 'Finish'.

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· Log-in and select 'Author Center'

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· After you have logged in, click the 'Submit a Manuscript' link in the menu bar.

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· Click the 'Next' button on each screen to save your work and advance to the next screen.

· You are required to upload your files.
- Click on the 'Browse' button and locate the file on your computer.
- Select the designation of each file in the drop-down menu next to the Browse button.
- When you have selected all files you wish to upload, click the 'Upload Files' button.

· Review your submission (in HTML and PDF format) before sending to the Journal. Click the 'Submit' button when you are finished reviewing.

3.3 Manuscript Files Accepted

The text file must be anonymous, and must contain the entire manuscript including abstract, keywords, text, references, tables, and figure legends, but *no* embedded figures. Figure tags should be included in the file. The title page will be uploaded as a separate file from the main text to avoid identification of the author during the review process, and should contain title, short title, author names, qualifications, affiliations, and highlight the corresponding author details and email, and any acknowledgments. The text should be double spaced on A4 (or nearest equivalent) with wide margins (5cm/1in), leaving the right hand margin unjustified and turning the hyphenation off. Use tabs, not spaces, to separate the data in tables and ensure all pages are clearly numbered. Manuscripts should be formatted as described below.
Manuscripts should be uploaded as Word documents or Rich Text Format (.rft) files (not write-protected) and not as PDFs, plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable for printing. The files will be automatically converted to HTML and PDF on upload and will be used for the review process.

A covering letter/e-mail must also be included with each submission stating, on behalf of all the authors, that the work has not been published and is not being considered for publication elsewhere. It should also confirm the contact details and e-mail address of the correspondence author, in case there is a problem with the electronic file. All papers will then be peer-reviewed. Authors should ensure they keep an up-to-date copy of their paper for reference.

3.4 Blinded Review

Before peer review, all manuscripts are screened by the editors for their suitability for publication in the journal on the basis that they meet the criteria laid out in the Aims and Scope. Papers that pass the initial screening are assigned to an Editor and double-blind peer reviewed. The names of the reviewers will thus not be disclosed to the author submitting a paper and the name(s) of the author(s) will not be disclosed to the reviewers.

To allow double-blinded review, please upload your main manuscript and title page as separate files.

<u>Exception to the double-blind rule</u>

The editorial team requires that all clinical trials are registered in a publicly accessible registry. Registration of systematic reviews and observational studies is also actively encouraged. Reviewers are encouraged to check protocols as part of the review process and consequently will be able to identify authors names and organisational affiliations. Registered studies will therefore be subject to single blind review (i.e. the reviewer may be aware of the name and affiliation of the author but reviewers will remain anonymous). The registration number should be supplied in the main body of the paper for example the methods section and can be obtained retrospectively. The title page should also be included in paper.

3.5 Suspension of Submission Mid-way in the Submission Process

You may suspend a submission at any phase before clicking the 'Submit' button and save it to submit later. The manuscript can then be located under 'Unsubmitted Manuscripts' and you can click on 'Continue Submission' to continue your submission when you choose to.

3.6 E-mail Confirmation of Submission

After submission you will receive an e-mail to confirm receipt of your manuscript. If you do not receive the confirmation e-mail after 24 hours, please check your e-mail address carefully in the system. If the e-mail address is correct please contact your IT department. The error may be caused by spam filtering software on your e-mail server. Also, the e-mails should be received if the IT department adds our e-mail server (uranus.scholarone.com) to their whitelist.

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4. MANUSCRIPT TYPES

Research and review papers:

The journal welcomes methodologically, ethically and theoretically rigorous original research (primary or secondary) which adds new knowledge to the field and advances the development of policy and practice in psychiatric and mental health nursing. We will consider research papers of up to 5,000 words and review papers of up to 7,000 words. The decision on the final word count rests solely with the Editor and Associate Editors.

Consumer and practitioner narratives:

As part of its mission to facilitate the translation of research into psychiatric and mental health nursing practice and give space to practitioner and consumer perspectives, *JPMHN* aims to engage with and be relevant to all those who are involved in the development of mental health knowledge, policy and practice. The journal therefore welcomes consumer and practitioner narratives which have the potential to improve mental health nursing practice and/or advance knowledge.

The narrative can be authored by a single person concerning their own experience, or jointly, for example, one person relating their own experience and another person providing context and analysis. In either case, the paper should contextualise the experience with reference to relevant literature (in the arts and/or the sciences) and answer the following questions: how does this experience fit within the context of the literature and how does it inform other consumers, practitioners or researchers?

Joint authors of consumer narratives should ensure that there is a genuine and equal collaboration, and that the contextualisation and analysis avoids any interpretation of someone else's experience that has not been validated with that person.

This section will be subject to full double blind peer review. Papers must contribute to theoretical, conceptual, or methodological knowledge, and/or practice development. There is no need to provide an abstract, however an accessible summary is required (See MANUSCRIPT FORMAT AND STRUCTURE section 5.2). No more than 10 references are allowed. We will consider papers of up to 5000 words. The decision on the final word count rests solely with the Editor and Associate Editors.

Letters to the Editor

Purpose

- To provide readers of the journal with a mechanism for submitting comments, questions or criticisms about published articles as well as brief reports and commentary unrelated to previously published articles.
- To respond to a paper recently printed in the Journal.
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- To draw readers' attention to new evidence or other issues relevant to the Journal aims.
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Guidelines

- Keep your points simple and focused;
- Avoid personal comments about the authors;
- Provide evidence to support your position;
- You need to reference the points you make in the same way you would in a research paper.
- Correspondence may be edited for length and grammatical correctness. Authors will be asked to approve editorial chances prior to publication.
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Purpose

- To explore a contemporary topic relevant to mental health nursing practice/service user care.
- To provide a rigorously developed theoretical perspective on a topic relevant to the Journal aims.

Guidelines

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  - o Clearly related to the aims of the Journal.
  - o A broad understanding of relevant literature is demonstrated.
  - o Well-developed integration of ideas and concepts.
- The topic should be of international relevance and be written in clearly expressed English.
- There is no need to include an accessible summary or abstract, however, authors should provide and introductory paragraph which sets out the purpose of the article.
- Word length between 3-5,000 words.

5. MANUSCRIPT FORMAT AND STRUCTURE

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Abstract: The abstract should be less than 200 words in length and should be followed by six keywords in alphabetical order for indexing purposes. You should as far as possible use the following structure for research papers: Introduction; Aim/Question; Method; Results; Discussion; Implications for Practice. For consumer and practitioner narratives this should be: Introduction; Aim; Methods (if applicable); Thesis; Implications for Practice

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Many readers looking for information online will use search engines such as Google, Yahoo or similar. By optimizing your paper for search engines, you will increase the chance of someone finding it. This in turn will make it more likely to be viewed and/or cited in another work. We have compiled these guidelines to enable you to maximize the web-friendliness of the most public part of your paper.

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Authors are asked to:

- Limit the summary to less than 250 words in total
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Main text: This should begin on a separate page. Authors should follow established guidelines for their study design where these exist/apply:

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- Non-randomised controlled trials: TREND checklist
- Observational research: STROBE checklists
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Abbreviations should be written in full at the beginning of a sentence. Footnotes should be avoided. Spellings should conform to those used in the Concise Oxford Dictionary. SI units should be used throughout and authors should refer to Units, Symbols and Abbreviations published by the Royal Society of Medicine.

Information on CONSORT:

Journal of Psychiatric & Mental Health Nursing requires a completed CONSORT 2010 checklist and flow diagram as a condition of submission when reporting the results of a randomized trial. Templates for these can be found here or on the CONSORT website which also describes several CONSORT checklist extensions for different designs and types of data beyond two group parallel trials. At minimum, your article should report the content addressed by each item of the checklist. Meeting these basic reporting requirements will greatly improve the value of your trial report and may enhance its chances for eventual publication.

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The editor and publisher recommend that citation of online published papers and other material should be done via a DOI (digital object identifier), which all reputable online published material should have - see www.doi.org/ for more information. If an author cites anything which does not have a DOI they run the risk of the cited material not being traceable.

5.4 Tables, Figures and Figure Legends

Figures and tables should be numbered consecutively and their positions indicated clearly in the text. Each should have an appropriate caption or legend that clearly describes it. In the full-text online edition of the journal, figure legends may be truncated in abbreviated links to the full screen version. Therefore, the first 100 characters of any legend should inform the reader of key aspects of the figure. Illustrations should be referred to in the text, e.g. as Fig. 1, Fig. 2, etc., in order of appearance.

Preparation of Electronic Figures for Publication

Although low quality images are adequate for review purposes, print publication requires high quality images to prevent the final product being blurred or fuzzy. Submit EPS (line art) or TIFF (halftone/photographs) files only. MS PowerPoint and Word Graphics are unsuitable for printed pictures. Do not use pixel-oriented programmes. Scans (TIFF only) should have a resolution of at least 300 dpi (halftone) or 600 to 1200 dpi (line drawings) in relation to the reproduction size (see below). Please submit the data for figures in black and white or submit a Colour Work Agreement Form (see Colour Charges below). EPS files should be saved with fonts embedded (and with a TIFF preview if possible).

For scanned images, the scanning resolution (at final image size) should be as follows to ensure good reproduction: line art: >600 dpi; halftones (including gel photographs): >300 dpi; figures containing both halftone and line images: >600 dpi.

Further information can be obtained at Wiley's guidelines for figures

Check your electronic artwork before submitting it:

http://authorservices.wiley.com/bauthor/eachecklist.asp

Colour Charges

It is the policy of Journal of Psychiatric and Mental Health Nursing for authors to pay the full cost for the reproduction of their colour artwork. Therefore, please note that if there is colour artwork in your manuscript when it is accepted for publication, Wiley require you to complete and return a Colour Work Agreement Form to the Production Editor before your paper can be published. Any article received with colour work will not be published until the form has been returned. If you are unable to access the internet, or are unable to download the form, please contact the Production Editor.

6. AFTER ACCEPTANCE

Upon acceptance of a paper for publication, the manuscript will be forwarded to the Production Editor who is responsible for the production of the journal.

6.1 Proof Corrections

The corresponding author will receive an e-mail alert containing a link to a website. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site.

Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following website: www.adobe.com/products/acrobat/readstep2.html . This will enable the file to be opened, read on screen, and printed out in order for any corrections to be added. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available; in your absence, please arrange for a colleague to access your e-mail to retrieve the proofs.

Proofs must be returned to the typesetter at charliehuang@toppanleefung.com within three days of receipt. Please note that if you have registered for production tracking e-mail alerts in Author Services, there will be no e-mail for the proof corrections received stage

Appendix B: Quality Appraisal Strategy

Table B1.

Quality appraisal

Appraisal question	**Paper**							
	Ezeobele et al. (2014)	Faschingbauer et al. (2013)	Haw et al. (2011)	Kontio et al. (2012)	Larsen and Terkelsen (2014)	Ling et al. (2015)	Mayers et al. (2010)	Ntsaba and Havenga (2007)
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes (but room for improvement)	Yes	Yes	Can't tell	Yes	Yes	Yes

Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes (but room for improvement)	Yes	Yes	Yes (but issues identified)	Yes	Yes
Has the relationship between researcher and participants been adequately considered?	Can’t tell	Can’t tell	Yes	No	No	No	Yes	Can’t tell
Have ethical issues been taken into consideration?	Yes	Yes	Yes	Yes	Yes	Can’t tell	Yes	Yes
Was the data analysis sufficiently rigorous?	Yes (but room for improvement)	Yes	Yes (but room for improvement)	Yes (but room for improvement)	Can’t tell	Can’t tell	Can’t tell	Yes
Is there a clear statement of findings?	Yes (but more information needed)	Yes	Yes	Yes	Can’t tell	Yes	Yes (but room for improvement)	Yes

Does the research as reported illuminate the subjective meaning and context of those being researched?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there evidence of adaption and responsiveness of research design to circumstances and issues of real-life social settings met during the course of the study?	Unclear	Limited (restricted inclusion criteria)	Yes	Yes	Yes	Yes	Yes	No

How valuable is the research?	Valuable – adds to existing knowledge, identifies areas for future research, considers how the research can be used. However, does not answer research question in great detail, therefore limiting the amount of new knowledge to be gained.	Valuable – findings are similar to historical studies, suggesting no change. Discussion on implications for staff training.	Valuable – adds to existing knowledge, identifies areas for future research, considers how the research can be used.	Valuable – highlights serious human rights issues and provides reflections on how recommended improvements can be implemented.	Valuable – adds unique findings to the literature as data collection included more than solely interviews. However, no discussion how research could be used or transferred to other populations.	Valuable – limited new knowledge but researchers discuss contribution study makes to existing understanding and identify areas for future research.	Valuable – provides a new approach to data collection.	Valuable – provides new knowledge and highlights implications regarding mental health legislation.

Appendix C: Topic Guide

University of East Anglia

TOPIC GUIDE

Version 2.0.

Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective

1. Can you tell me about a time when you were secluded in a seclusion room?
PROMPTS:
Tell me what you remember.
Can you tell me about the room?
Can you tell me how long you were secluded for?
How many times have you experienced seclusion?
Can you tell me more?

2. Can you tell me about the experience of being in that room?
PROMPTS:
Can you tell me about your experience?
Can you talk about your experience?
Can you tell me more about that?

3. Can you describe the experience of being in that room?
PROMPTS:
What was it like?
Can you describe more?
What was that like for you?
Tell me more about that.

4. What do you think about it?
PROMPTS:
What personal meaning does it have?
Can you say a bit more?

5. What do you think about the memory of the experience?
PROMPTS:
What meaning does it have?
Tell me more about that.

Appendix D: Consent to be Contacted

University of East Anglia

Consent form for researcher to contact participant
Version 1.0.

Title of research: Being in a Seclusion Room: The Forensic Inpatients' Perspective

Name of researcher: Louise Enderby

Please initial

I confirm that a member of my care team can pass on my name and the ward where I reside to the researcher. ☐

I confirm that I understand that the researcher will talk to me when she is on the hospital ward. ☐

I understand that this does not mean I have to take part in the research. ☐

________________	________________	________________
Name	Date	Signature
________________	________________	________________
Name of Person taking consent	Date	Signature

A copy of this form will be stored in a locked draw at the University of East Anglia, a copy will go in your patient records and you will keep a copy yourself.

Appendix E: Participant Demographics Table

Table E1

Participant demographics

Participant	**Demographics**
Peri	13 years in prison 8 years high secure hospital 1 year in medium secure hospital Aged 46 years Multiple seclusion experiences in two hospitals
Avie	15 months in prison 9 years in hospital Age 28 years Multiple seclusion experiences in various hospitals
Ali	Prison before hospital Over 10 continuous years in hospital Personality disorder
Aaron	15 years in hospital 6 months in prison Possible learning difficulties
Liam	Prison before hospital 13 years in hospital Psychosis and personality disorder
David	3 years in prison 10 years in hospital Personality disorder Age 36 years
Jay	3 years in prison 1 year in medium secure hospital 2 experiences of seclusion in hospital

Appendix F: Debrief Sheet

University of East Anglia

DEBRIEF SHEET

Version 1.0.

Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective

Thank you for taking part in the above study. If you have any further questions you are welcome to speak to the researcher or a member of staff.

If you feel that your participation has caused you any distress, then please speak to a member of the clinical team. They are aware of the research topic and will be able to offer support if needed.

Appendix G: Information Sheet

INFORMATION SHEET

Version 2.0.

Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective

Name of Researcher: Louise Enderby

Supervisors: Dr Paul Fisher and Dr Peter Beazley

Introduction to the research

I am writing to you to ask whether you would be interested in taking part in a research study I am conducting as part of my training as a Clinical Psychologist. I would like to know about your experience of seclusion and how you feel about it.

My research aims to help understand the lived experience of seclusion for people who are patients in a forensic psychiatric hospital. The findings will help professionals make improvements to seclusion practices.

What does participating involve?

If you would like to take part, then after reading this information, I will ask you to sign a consent form and will interview you about your experience of being in a seclusion room. The interview will last about one hour and will be recorded on a small recording device (dictaphone) that I will bring and switch on when the interview starts. Ward staff will be told that you are being interviewed for research. The interview will take place in an interview room at the hospital so that it cannot be overheard. You will receive £10 as a thank you for your time.

What will happen to my recorded interview?

I will put your recorded interview onto a password protected laptop and delete it from the dictaphone. It will be typed up (transcribed). It may be that your interview is typed up by an administrator working for a transcription service. If this happens, the administrator will be bound to confidential rules and will be given the recorded interview as a password protected file. They will not be given any information about you. Your transcribed interview will be analysed. Analysing your interview means that I will listen to the recording and read the transcription and find important themes. Your interview transcription will be kept securely for ten years (this is the university's policy) and after that it will be destroyed.

What about confidentiality?

What you say in interview will remain confidential. I will let the ward psychiatrist (the Responsible Clinician) know that I will be on the ward to conduct research. I do not work in the hospital and staff involved in your care will not be told what you have said. I will give a brief handover to staff about your wellbeing. I am obligated to disclose to staff if you say something about risk to yourself, others or if you disclose a serious crime that has **not** been reported already. If you disclose a breach of ward rules this will have to be disclosed to ward staff. If you disclose malpractice by staff at the hospital, I will inform local NHS safeguarding and they will investigate it. The transcription of your interview will be coded so that you cannot be identified.

What happens when the research is finished?

This research is going to be written up and submitted to the university as part of my training as a Clinical Psychologist. After this, I will present the research to mental health staff and will also write it up to get it published in a journal that mental health practitioners read. I plan to use the findings to suggest improvements that could be made to staff training. Pieces of what you have said will appear when the research is written up but your name will not be used.

What are the benefits?

You might find that this research study feels beneficial to you because you will be making a difference to clinical practice. That is because professionals who work in hospitals and make decisions about patients' treatment will find out more about the experience of being in a seclusion room and they can use this to make better decisions. Also, it is an opportunity to have your experiences listened to and taken seriously. You can be honest and open about seclusion and I am non judgemental.

Are there any negatives?

You might find that there are some negatives to taking part in this research. You could be talking about things that are upsetting and you might find this difficult. I am trained on how to support people through difficult emotions and I will help you feel as comfortable as possible. You will have a choice about what you say and if you need a pause in the interview. I will be respectful to what you need and I understand that people cope in different ways.

Staff will know that you are taking part but they will not know what you have said. It is possible that other service users will know that you are taking part if they see you being interviewed. Other service users will not be given any information about what you have said.

How can I take part?

You will be given 24 hours or longer to decide if you would like to take part in the research study. Your participation is entirely voluntary. You can contact me or a member of the clinical staff team if you would like to take part in the research. You are able to withdraw from the research study without giving a reason and your interview will be deleted. This will not have any impact on your hospital treatment or length of stay. If you ask to withdraw from the research study after analysis has commenced (one week after the interview), then it will not be possible to identify your interview from other participants'.

What if I want to complain?

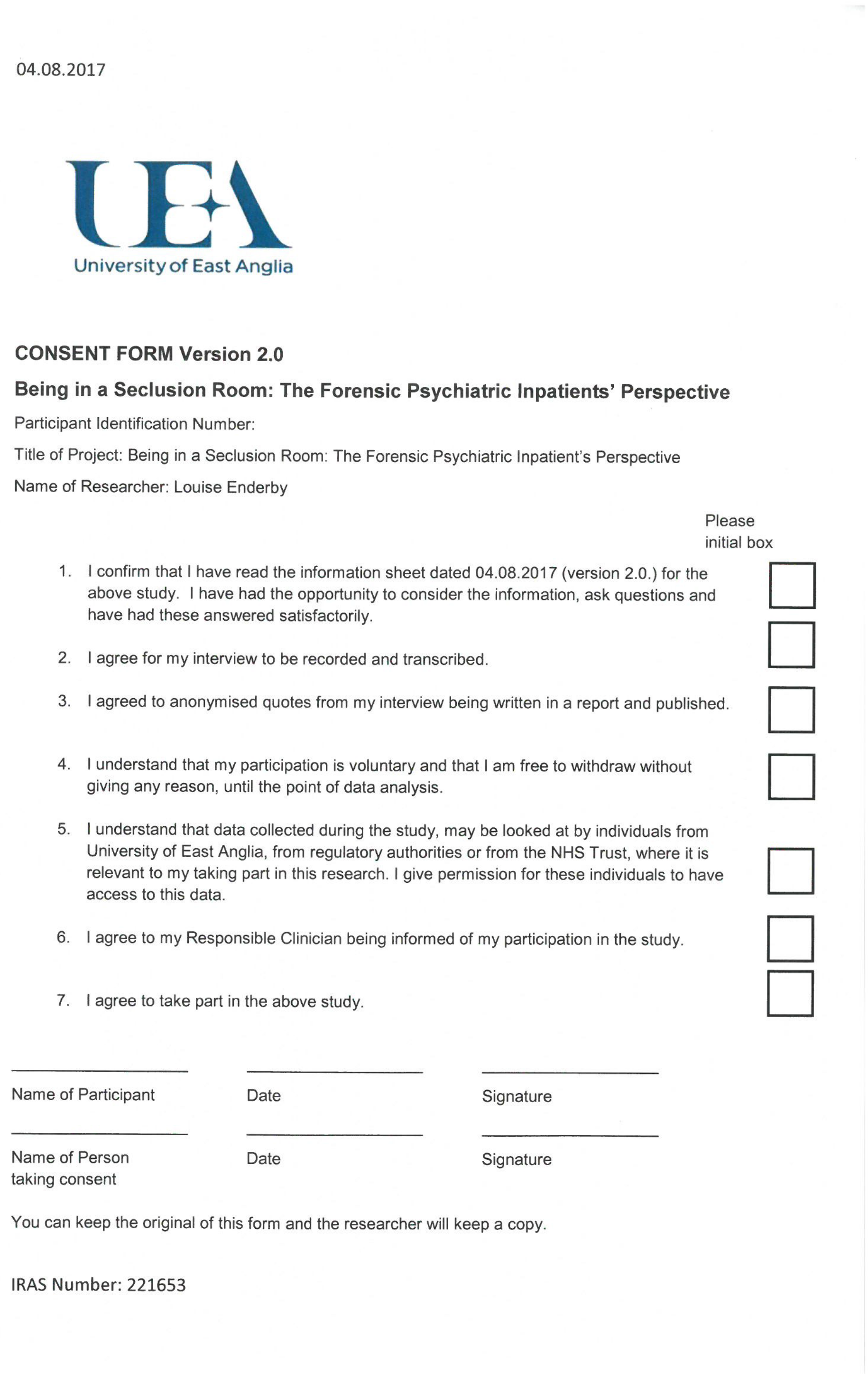
If you want to make a complaint, you can speak to a member of hospital staff who can contact me on your behalf. Alternatively, you can call the university (01603 456161) and speak to one of the research supervisors (Dr Paul Fisher or Dr Peter Beazley). If you would like to complain about any member of the research team you can contact Professor Ken Laidlaw, Clinical Psychology Programme Director, at the university (01603 456161).

Please let me know if you have any questions about the information on this sheet.

Louise Enderby

Trainee Clinical Psychologist, University of East Anglia

Appendix H: Consent Form



04.08.2017

University of East Anglia

CONSENT FORM Version 2.0

Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective

Participant Identification Number:

Title of Project: Being in a Seclusion Room: The Forensic Psychiatric Inpatient's Perspective

Name of Researcher: Louise Enderby

Please initial box

1. I confirm that I have read the information sheet dated 04.08.2017 (version 2.0.) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I agree for my interview to be recorded and transcribed. ☐
3. I agreed to anonymised quotes from my interview being written in a report and published. ☐
4. I understand that my participation is voluntary and that I am free to withdraw without giving any reason, until the point of data analysis. ☐
5. I understand that data collected during the study, may be looked at by individuals from University of East Anglia, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data. ☐
6. I agree to my Responsible Clinician being informed of my participation in the study. ☐
7. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature
____________________	____________________	____________________
Name of Person taking consent	Date	Signature

You can keep the original of this form and the researcher will keep a copy.

IRAS Number: 221653

Appendix I: HRA Approval

Miss Louise Enderby
Clinical Psychologist in Training
Cambridgeshire and Peterborough Foundation Trust Elizabeth House
Fulbourn Hospital
Cambridge
CB21 5EF

Skipton House 80 London Road London SE1 6LH

Tel: 0207 104 8010 Email: hra.approval@nhs.net

09 August 2017 Dear Miss Enderby

Study title:

IRAS project ID: REC reference: Sponsor

[redacted]

[redacted]

Being in a Seclusion Room: The Forensic Psychiatric Inpatients’ Perspective
221653
17/SC/0341

University of East Anglia

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.

IRAS project ID	221653

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 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.

  In addition to the guidance in the above, please note the following:

- • HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- • Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the After Ethical Review document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- • The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

  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.

IRAS project ID	221653

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 use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

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 221653. Please quote this on all correspondence. Yours sincerely

Miss Helen Penistone Assessor

Email: hra.approval@nhs.net

Copy to:

Mrs Tracy Moulton
Dr Bonnie Teague, Norfolk and Suffolk NHS Foundation Trust

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	Version	Date
Covering letter on headed paper [Cover letter]		04 August 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance letter]	v1	14 June 2017

GP/consultant information sheets or letters [Email to RC]	V1	29 June 2017
Interview schedules or topic guides for participants [Topic guide]	V2	04 August 2017
IRAS Application Form [IRAS_Form_03072017]		03 July 2017
Other [HRA schedule of events]	1	06 July 2017
Other [Statement of activities]	2	06 July 2017
Other [Summary CV for secondary supervisor]	v1	28 March 2017
Other [Improvements to original proposal after markers' feedback]	v1	14 June 2017
Other [Consent form for researcher to contact participant]	v1	29 June 2017
Other [Participant debrief sheet]	v1	29 June 2017
Participant consent form [Consent form]	2.0	04 August 2017
Participant information sheet (PIS) [PIS]	V2	04 August 2017
Referee's report or other scientific critique report [Feedback from Thesis Proposal Markers]	v1	10 January 2017
Research protocol or project proposal [Thesis proposal]	v1	14 December 2016
Summary CV for Chief Investigator (CI)	v1	31 March 2017
Summary CV for student	v1	31 March 2017
Summary CV for supervisor (student research)	v1	20 March 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Procedure flow chart]	v1	29 June 2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Miss Louise Enderby Tel: 01603591709
Email: l.enderby@uea.ac.uk

Appendix J: Trust Letter of Access

Norfolk and Suffolk NHS
NHS Foundation Trust

Research and Development
The Knowledge Centre
Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE

Telephone 01603 421255
E mail: RDofficemailbox@nsft.nhs.uk

Louise Enderby
ClinPsyD Trainee
Department of Clinical Psychology
Elizabeth Fry Building
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

23rd August 2017

Dear Louise

Re: NSFT Letter of Access for research

This letter should be presented to each participating organisation before you commence your research at that site. The participating organisation is: **Norfolk and Suffolk NHS Foundation Trust**.

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on **23rd August 2017** and ends on **30th September 2017** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from **Norfolk and Suffolk NHS Foundation Trust**. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation from the individual organisation of their agreement to conduct the research.

The information supplied about your role in research at the organisation has been reviewed and you do not require an honorary research contract with the organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to the organisation.

You are considered to be a legal visitor to the organisations premises. You are not entitled to any form of payment or access to other benefits provided by the organisation or this organisation to employees and this letter does not give rise to any other relationship between you and the organisation, in particular that of an employee.

While undertaking research through the organisation you will remain accountable to your substantive employer but you are required to follow the reasonable instructions of the organisation or those instructions given on their behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the organisations policies and procedures, which are available to you upon request, and the Research Governance Framework.

Chair: Gary Page
Chief Executive: Michael Scott
Trust Headquarters: Hellesdon Hospital,
Drayton High Road, Norwich, NR6 5BE
Tel: 01603 421421 Fax: 01603 421440 www.nsft.nhs.uk

You are required to co-operate with the organisation in discharging its/their duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the organisations premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each organisation prior to commencing your research role at that organisation.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the organisations premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation(s) do not accept responsibility for damage to or loss of personal property.

This organisation may revoke this letter and any organisation(s) may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation(s) or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

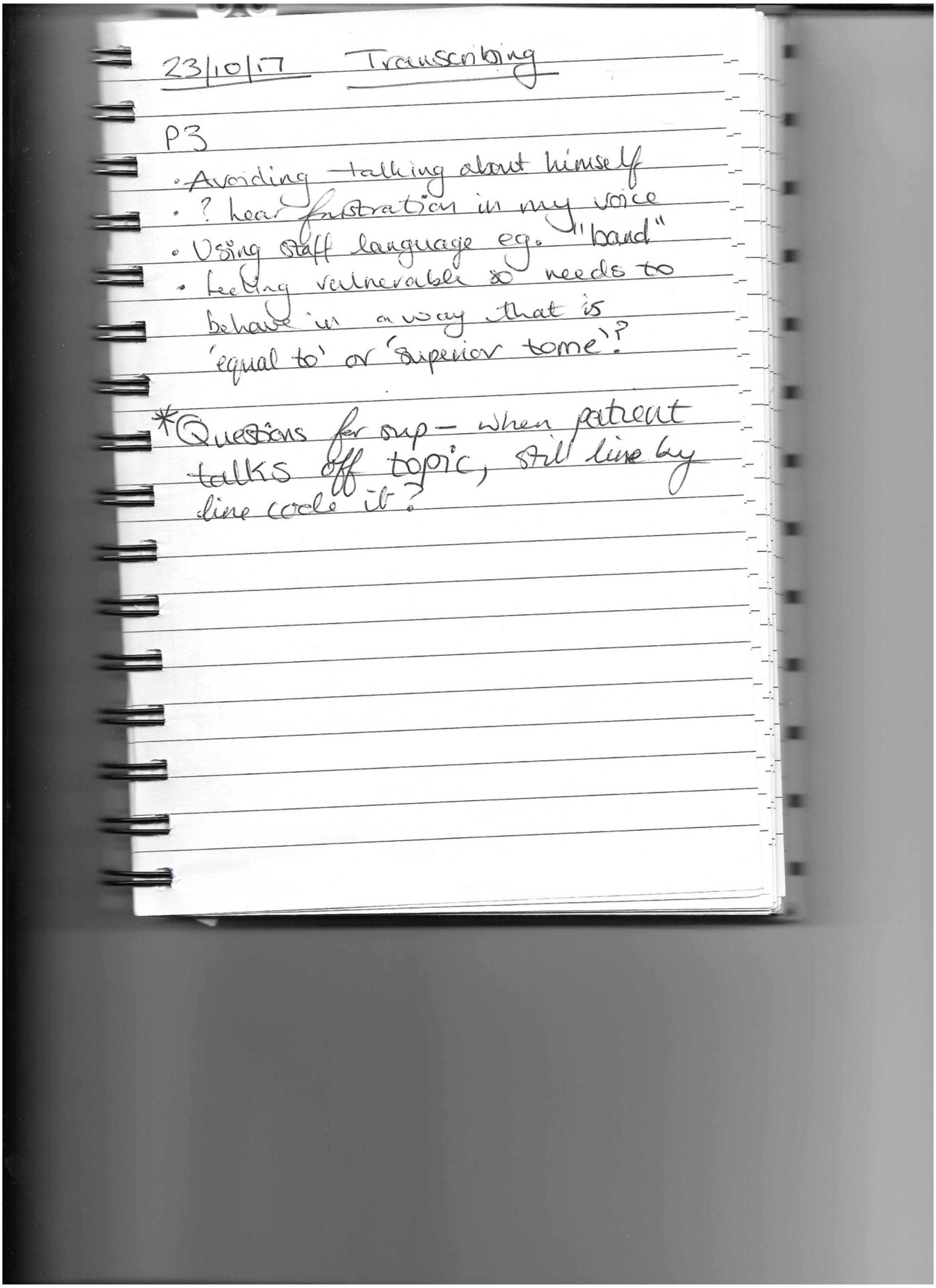
No organisation will indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in each participating organisation] and [the R&D office] in this organisation.

Yours sincerely

Bonnie Teague
Research Manager

Appendix K: Journal Extract of Transcribing Process



23/10/17 Transcribing

P3

- Avoiding talking about himself
- ? hear frustration in my voice
- Using staff language eg. "band"
- feeling vulnerable so needs to behave in a way that is 'equal to' or 'superior tome'?

*Questions for sup – when patient talks off topic, still line by line code it?

Appendix L: Extract of Transcript Noting

Table L1

Extract of interview with transcript noting

Transcript	**Comments**
Just, I’ve been in ones, I mean I bin I bin in seclusion rooms in other hospitals and they’ve been cameras in the corner of the rooms, and when, I mean obviously when you walk through there’s cameras everywhere and you try an’, don’t take any notice of them but there’s one staring at you in the corner of the room you know peoples watching ya. It feels very very uncomfortable.	I been in seclusion rooms with cameras in the corner. There's cameras everywhere and you try and not take notice of them but theres one staring at you and you know people are watching you. Feels very uncomfortable. *Being watched. Feeling uneasy and uncomfortable about being watched. Privacy invaded? Feeling anxious or unsafe?*
It kinda makes you, kinda extremely paranoid and like I mean, it’s not very nice being, locked in a cell. You try, and behave yourself but when you got a camera in the corner of the room and someone at the observation panel every five minutes. You’re in there to de-escalate your aggression or anger, and it makes you more angry. So,	Being watched makes you extremely paranoid. It's not very nice being locked in a cell. You try and behave yourself but when there's cameras and someone at the observation panel it makes you more angry. *Being watched is detrimental to mental heatlh, makes him paranoid and angry. Using third person, separating himself from the event. Cell and behaving - reminders of police cells, punishment?*
Just being watched 247. It’s really, it’s really off puttin’.	
I mean I mean I don’t I don’t really know how to explain but when, you know what I mean when you walk through town you don’t notice some of the cameras ‘cause you kinda forget they’re there.	

When you **know**, there’s one in the corner of the room starting at ya, it’s like, you don’t know how to act. An, like, it’s not very nice being locked behind a cell door and you try and behave yourself so you can go de-escalation area so you can eventually get back to the ward, but you can’t it winds you up. Every little movement its, say if you stand up too fast. They’ll think, oh, he stood up a bit fast he looks a bit aggressive, we’ll give him in there for another couple of hours and just on and on like that.	When you know you're being watched you don't know how to act. Locked behind a cell door. You try and behave yourself so you can get out but you can't because it winds you up. Every little movement. They'll say he looks a bit aggressive we'll give him another couple of hours. *Unable to relax or be genuine when being watched. Trying to behave a certain way to get what he wants. Skeptical of staff's assessment of him. Cell - reminders of punishment, police/prison. Staff have immense power over him he feels the need to carefully consider every aspect of his behaviour.*
STAFF INTERUPTION	

It just. It’s not. With, when somebody’s got a mental illness, and I mean when somebody’s got, my illness I tend to, with my illness is a personality disorder but I tend to flutter in and out with schizophrenia at times. Due to stress or substance misuse or anything like that. And I have heard stuff in my head that, other people can’t hear and I have seen things that other people can’t see. And, when, I bin in seclusion rooms, I mean used to, kinda, I’ve have discussion with people and they just said it’s your self conscious you’re kinda like talking to yourself but I never believed anyone in in telling me that. And, I do believe I hear stuff that other people can’t hear. And when you’re actually, in a room and it’s quite silent, if you ain’t got the member staff singing Christmas songs at you, trying to wind you up, but when you in the room and you’re on your own, them kinda, noises or voices, or screams or anything like that, seem to come back to ya. And, I mean they didn’t they didn’t even open the um, cell door, for like, they open it and dropped the odd sandwich in but, I mean they didn’t, I had no medication at all, for them 38 hours, so in my head I was thinking that they were trying to, (sigh), people might call me delusional but it my head I thought they were trying to kill me off I thought they’d just had enough of me and they just wanted me t’, harm myself, seriously bad or just, and I mean I did headbutt the metal cell door.	Staff member singing Christmas songs, trying to wind you up. In the room and it's silent, hear voices or screams. They didn't even open the cell door, for medication. They opened it and dropped the odd sandwich in. I had no medication for 38 hours. In my head I thought they were trying to kill me off. I thought they'd had enough of me and they just wanted me to harm myself seriously bad. I headbutted the metal cell door. *Staff members intensionally wanting to harm him. Fearful of being killed. Feeling in a vulnerable state due to deteriorated mental health. No interaction from staff - just basic needs "dropped the odd sandwich in".*

And, they tried to get the doctor out to come and see me but she didn't wana come in the cell with me so I was made out to be some like, violent animal. It's quite hard because when you're actually in a cell, and you're on your own…you think it's kind of the end of it. As in like the end of life. Like you just, gonna be stuck in that cell, like most of the time until like, it's weird because, I mean there's no difference from me to you apart from I'm man and you're female, but like you've got a set of keys and I haven't, you know you there's that power. And when you know you like, when you think of it like you're both human beings, but yet, one can lock up the other, it's it's it it messes my head up that, some man can have the power over me to lock me in a cell for, so many times it really, I I I (sigh) I I mean I see the need in hospital for seclusion 'cause obviously, there's quite a few like, violent people come in hospital and that. But I mean, I mean I had a psychology session today with my psychologist and, I said to him like I d – I don't feel like I fit into the category of a violent person. It's just I do like minor things and end up in seclusion for a ridiculously long time. But, (sigh) I mean, (sigh) not not not so much on this ward 'cause this is a rehab ward but on the assessment ward, I mean all you gotta do is kinda raise your voice, and if, the staff will threaten you with (name of seclusion ward). It's like (sigh), and it after after so many my threats it's just think ah fuck this shit I'm just gonna kick off I I had enough, and then you end up on (name of seclusion ward) so, they kind of get what they want. (long pause). I don't really know what else to say.	They tried to get the doctor to see me but she didn't want to come in the cell so I was made out to be some violent animal. It's hard because in the cell you're on your own. You think it's the end of life. You're going to be stuck in that cell. There's no difference between me and you other than I'm a man and you're female but you've got keys and I haven't, that's power. We're both human beings but one can lock up the other, it messes my head up that someone can have power over me to lock me in a cell. I understand the need for seclusion due to violence. I don't feel I fit into the category of a violent person. I do minor things and end up in seclusion for a ridiculously long time. *Feeling perceived as a violent animal. Thinking that he will die, fearful. Feeling stuck. Feeling powerless and aware of how much power staff have over him.* <u>Awareness of a power imbalance. Staff have power over me. Perceived as violent and less than human.</u>

Regular font = descriptive noting
Italics = linguistic noting
<u>Underlined</u> = conceptual noting

Appendix M: Emergent Themes

Table M1

Extract of interview analysis with emergent themes

Transcript	**Comments**	**Themes**	**Themes**	**Themes**
Just, I've been in ones, I mean I bin I bin in seclusion rooms in other hospitals and they've been cameras in the corner of the rooms, and when, I mean obviously when you walk through there's cameras everywhere and you try an', don't take any notice of them but there's one staring at you in the corner of the room you know peoples watching ya. It feels very very uncomfortable.	I been in seclusion rooms with cameras in the corner. There's cameras everywhere and you try and not take notice of them but theres one staring at you and you know people are watching you. Feels very uncomfortable. *Being watched. Feeling uneasy and uncomfortable about being watched. Privacy invaded? Feeling anxious or unsafe?*	Being watched feels unsafe		
It kinda makes you, kinda extremely paranoid and like I mean, it's not very nice being, locked in a cell. You try, and behave yourself but when you got a camera in the corner of the room and someone at the observation panel every five minutes. You're in there to de-escalate your aggression or anger, and it makes you more angry. So,	Being watched makes you extremely paranoid. It's not very nice being locked in a cell. You try and behave yourself but when there's cameras and someone at the observation panel it makes you more angry. *Being watched is detrimental to mental heatlh, makes him paranoid and angry. Using third person, separating himself from the event. Cell and*	Being watched is dangerous to my mental health	Being watched is frightening	

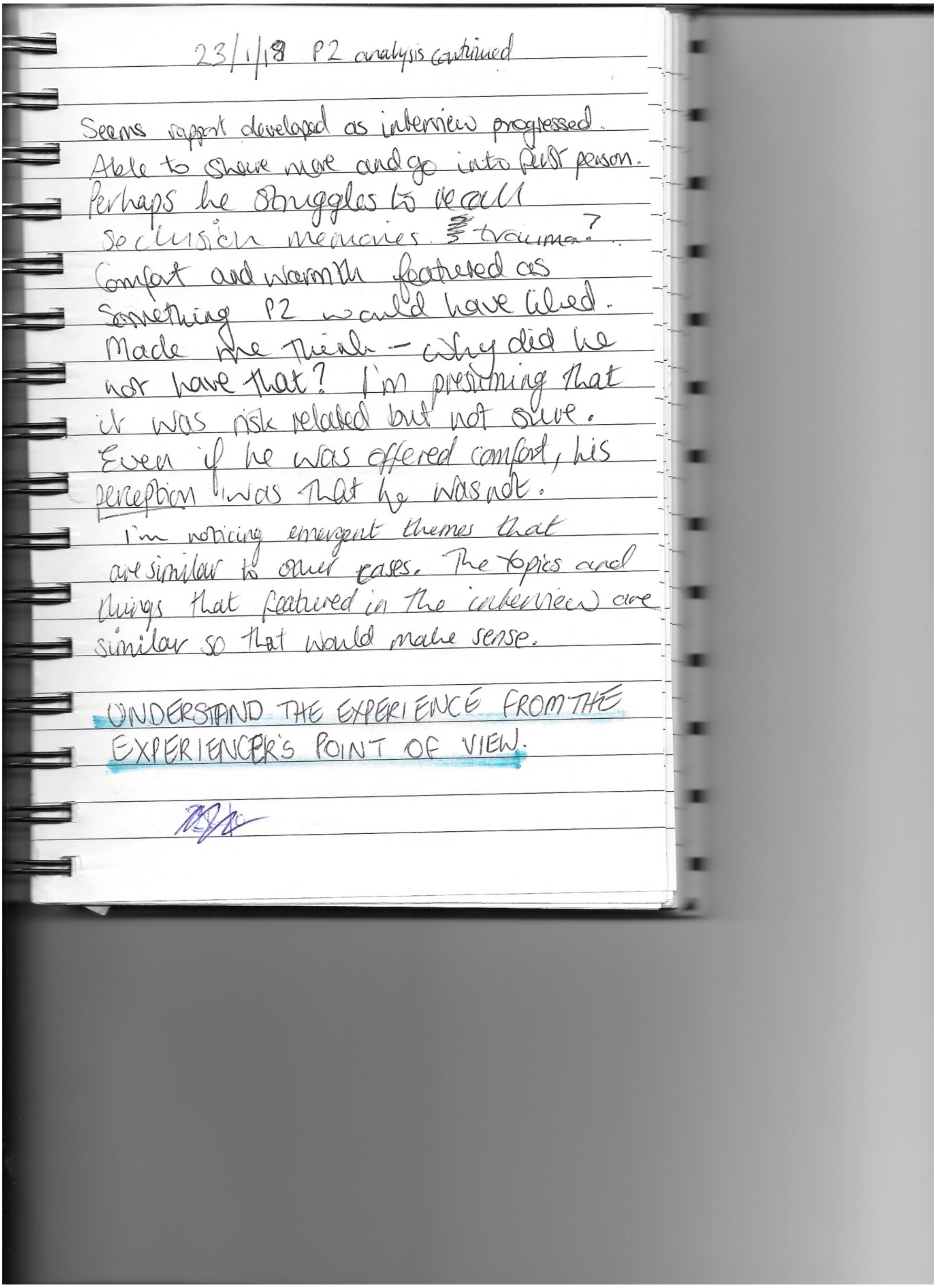
	behaving - reminders of police cells, punishment?			
Just being watched 247. It's really, it's really off puttin'.				
I mean I mean I don't I don't really know how to explain but when, you know what I mean when you walk through town you don't notice some of the cameras 'cause you kinda forget they're there.				
When you **know**, there's one in the corner of the room starting at ya, it's like, you don't know how to act. An, like, it's not very nice being locked behind a cell door and you try and behave yourself so you can go de-escalation area so you can eventually get back to the ward, but you can't it winds you up. Every little movement its, say if you stand up too fast. They'll think, oh, he stood up a bit fast he looks a bit aggressive, we'll give him in there for another couple of hours and just on and on like that.	When you know you're being watched you don't know how to act. Locked behind a cell door. You try and behave yourself so you can get out but you can't because it winds you up. Every little movement. They'll say he looks a bit aggressive we'll give him another couple of hours. *Unable to relax or be genuine when being watched. Trying to behave a certain way to get what he wants. Skeptical of staff's assessment of him. Cell -*	Staff are powerful	Having to put on an act	

	reminders of punishment, police/prison. Staff have immense power over him he feels the need to carefully consider every aspect of his behaviour.			
STAFF INTERUPTION				

It just. It's not. With, when somebody's got a mental illness, and I mean when somebody's got, my illness I tend to, with my illness is a personality disorder but I tend to flutter in and out with schizophrenia at times. Due to stress or substance misuse or anything like that. And I have heard stuff in my head that, other people can't hear and I have seen things that other people can't see. And, when, I bin in seclusion rooms, I mean used to, kinda, I've have discussion with people and they just said it's your self conscious you're kinda like talking to yourself but I never believed anyone in in telling me that. And, I do believe I hear stuff that other people can't hear. And when you're actually, in a room and it's quite silent, if you ain't got the member staff singing Christmas songs at you, trying to wind you up, but when you in the room and you're on your own, them kinda, noises or voices, or screams or anything like that, seem to come back to ya. And, I mean they didn't they didn't even open the um, cell door, for like, they open it and dropped the odd sandwich in but, I mean they didn't, I had no medication at all, for them 38 hours, so in my head I was thinking that they were trying to, (sigh), people might call me delusional but it my head I thought they were trying to kill me off I thought they'd just had enough of me and they just wanted me t', harm myself, seriously bad or just, and I mean I did headbutt the metal cell door.	Staff member singing Christmas songs, trying to wind you up. In the room and it's silent, hear voices or screams. They didn't even open the cell door, for medication. They opened it and dropped the odd sandwich in. I had no medication for 38 hours. In my head I thought they were trying to kill me off. I thought they'd had enough of me and they just wanted me to harm myself seriously bad. I headbutted the metal cell door. *Staff members intensionally wanting to harm him. Fearful of being killed. Feeling in a vulnerable state due to deteriorated mental health. No interaction from staff - just basic needs "dropped the odd sandwich in".*	Feeling vulnerable	Staff perpetrating abuse	Fear of being killed
And, they tried to get the doctor out to come and see me but she didn't wana come in the cell with me so I was made out to be some like, violent animal. It's quite hard	They tried to get the doctor to see me but she didn't want to come in the cell so I was made out to be	Feeling powerless	Staff have power over me	Hopeless

because when you’re actually in a cell, and you’re on your own…you think it’s kind of the end of it. As in like the end of life. Like you just, gonna be stuck in that cell, like most of the time until like, it’s weird because, I mean there’s no difference from me to you apart from I’m man and you’re female, but like you’ve got a set of keys and I haven’t, you know you there’s that power. And when you know you like, when you think of it like you’re both human beings, but yet, one can lock up the other, it’s it’s it it messes my head up that, some man can have the power over me to lock me in a cell for, so many times it really, I I I (sigh) I I mean I see the need in hospital for seclusion ‘cause obviously, there’s quite a few like, violent people come in hospital and that. But I mean, I mean I had a psychology session today with my psychologist and, I said to him like I d – I don’t feel like I fit into the category of a violent person. It’s just I do like minor things and end up in seclusion for a ridiculously long time. But, (sigh) I mean, (sigh) not not not so much on this ward ‘cause this is a rehab ward but on the assessment ward, I mean all you gotta do is kinda raise your voice, and if, the staff will threaten you with (name of seclusion ward). It’s like (sigh), and it after after so many my threats it’s just think ah fuck this shit I’m just gonna kick off I I had enough, and then you end up on (name of seclusion ward) so, they kind of get what they want. (long pause). I don’t really know what else to say.	some violent animal. It's hard because in the cell you're on your own. You think it's the end of life. You're going to be stuck in that cell. There's no difference between me and you other than I'm a man and you're female but you've got keys and I haven't, that's power. We're both human beings but one can lock up the other, it messes my head up that someone can have power over me to lock me in a cell. I understand the need for seclusion due to violence. I don't feel I fit into the category of a violent person. I do minor things and end up in seclusion for a ridiculously long time. *Feeling perceived as a violent animal. Thinking that he will die, fearful. Feeling stuck. Feeling powerless and aware of how much power staff have over him.* <u>Awareness of a power imbalance. Staff have power over me. Perceived as violent and less than human.</u>			

Appendix N: Journal Extract of Analysis Reflections



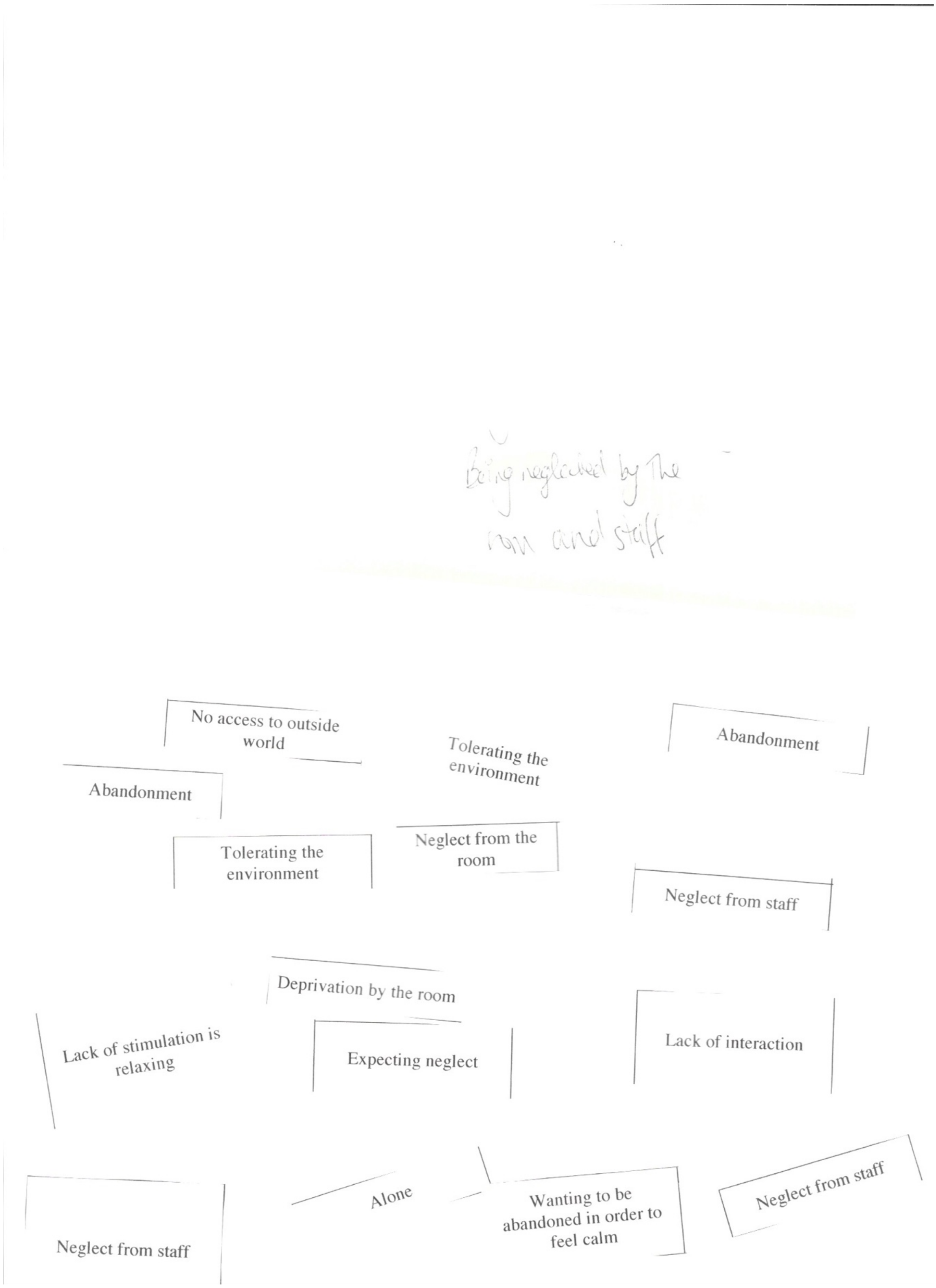
23/1/18 P2 analysis continued

Seems rapport developed as interview progressed. Able to share more and go into first person. Perhaps he struggles to recall seclusion memories. trauma? Comfort and warmth featured as something P2 would have liked. Made me think – why did he not have that? I'm presuming that it was risk related but not sure. Even if he was offered comfort, his perception was that he was not.

I'm noticing emergent themes that are similar to other cases. The topics and things that featured in the interview are similar so that would make sense.

UNDERSTAND THE EXPERIENCE FROM THE EXPERIENCER'S POINT OF VIEW.

Appendix O: Example of Connected Themes



Being neglected by the room and staff

No access to outside world

Tolerating the environment

Abandonment

Abandonment

Tolerating the environment

Neglect from the room

Neglect from staff

Deprivation by the room

Lack of stimulation is relaxing

Expecting neglect

Lack of interaction

Neglect from staff

Alone

Wanting to be abandoned in order to feel calm

Neglect from staff

Appendix P: Themes for Each Participant and Examples of Quotes that Contributed.

Table P1

Overarching themes for participant 1

Participant 1	
Theme	**E.g.s of quotes**
Feeling traumatised *Highly central to this participant's experience*	• Ah my god you remem, you made me remember something there, (smiling)…I crapped on the wall…excrement on the wall. I was not happy that time.
I need medication to cope in seclusion *Highly central to this participant's experience*	• But not for long, cause, medication kicks in, you just relax…meds to help.
Feeling punished	• Kick off, then go to places like (name of ward) exclusion rooms. I I mean I been in police cells before, they're they're not that much bigger than seclusion room itself
Being abused	• They shouldn't do that to you should they • No, I can't believe that. They did that to me.
Being powerless *Highly central to this participant's experience*	• I need the toilet so bad, they wouldn't let me out the, out the cell, so I peed in the corner of the cell.
Feeling safe to be violent	• If you need to vent in there, you kick the door, y, you can't cause damage, t, t, to it anybody, you're not hurting anybody in there.
Feeling calm	• Free your mind. Y, y, y, just relax, yeah. Free you mind, anything.
My experience changes over time	• The first time you're in there you won't like it, but then you learn to relax, like I did.
Being neglected by the room and by staff *Highly central to this participant's experience*	• Left in a seclusion room for a week without my clothes. I shit up the walls.
Receiving basic care	• Dr (name), I think his name was, at the time, and he spoke to me

	for a while.

Table P2

Overarching themes for participant 2

Participant 2	
Theme	**E.g.s of quotes**
Spending time ruminating and becoming distressed by them	• Worrying that, I might do it again, d'ya know what I mean? Or praps, worse…yeah. Well like, hurting someone worse, and get in even more trouble.
Having a hyperawareness of surroundings	• the lights seem really bigger the things seem really bigger • it seems smaller than it, probably actually was
Feeling violated	• I duno why but they kept looking in on me so I duno, I duno why • embarrassing obviously, going to the toilet in a bucket.
Wanting to be cared for *Highly central to this participant's experience*	• Someone to talk to even though, er, it doesn't have to be in the room, just someone to talk er to, um…wherever just, a door maybe or a s, s, one of the staff asking if you're alright
Feeling abused by staff *Highly central to this participant's experience*	• off putting because they were males, dya know what I mean, I don't like males staring me don't like it. Obviously. You understand why don't ya
Fearful of impending danger	• you can't breathe and you, you know, you just e, eager to get out and you can't. • I was sexually abused as a kid and I don't like um, don't like it, especially if they're being boisterous and they think they're hard I don't like it
Being neglected by staff and by the room *Highly central to this participant's experience*	• Not even to talk to me if I was alright or not they just keep looking in or whatever but they didn't talk to me…no. • And I only got a, like a…mattress, that's all I had. • Well no medication for a start.

	For two days. (laughs) it's the most important thing for a mental patient.

Table P3

Overarching themes for participant 3

Participant 3	
Theme	**E.g.s of quotes**
I feel good if staff show they trust me *Highly relevant to this participant's experience*	• 'Cause I could physically touch them…it makes a massive difference 'cause there's there is that bit of trust • …for me, very very small things like that, that makes a **massive** difference.
The way staff interact with me makes me feel cared for *Highly relevant to this participant's experience*	• when I was in seclusion I always felt, listen to sometimes they get frustrated and it's because, the same behaviours would be coming over and over and over again and you could they were getting a little frustrated but they were getting frustrated, on in a way on my behalf. 'Cause was like, we know you can do this! Kick in the arse, come on! Sort of, because they cared. • What made the difference is, the staff and the way they dealt with it and they listened
I feel safe if I know staff are available for me *Highly relevant to this participant's experience*	• the fact that all I had to do is go up and knock on the door, and there was always someone there to talk to. • that's…a way why I felt so safe. On the first, time I was secluded. In a way even on the second one, because there was always people there to talk to.
Feeling vulnerable	• I didn't argue the facts, because, I didn't know what the policies and procedures were because I hadn't been there very long and I also know I mean I'm in a high secure hospital and if you start kicking

	off, they're gonna say, well, tough shit, and well, get heavy handed. • I should have been able to bring, criminal charges, against them for assault. And negligence.
Assessing staff's capabilities gives me the upper hand	• A doctor they have a lot more training they can, sit there and look at it psychiatrically, if need be, given them medication. Nurses can't do that. • And you had three different bands of that. So obviously different experience. But they've not had any, nurse, professional training. Erm, so they're not necessarily gonna have enough
My thoughts frighten me and focusing on the environment distracts from painful thoughts and emotions *Highly relevant to this participant's experience*	• So you got like about that much plastic (gestures) and then it dips down, for about that far (gestures). And another bit of plastic and it dips down and that's all the way down the bed. No it's the bits that stick up are flat, and they're about that wide. • You got like, the room, and off to one side is, the, toilet area. And again that's all moulded, plastic, and there's a shower head that just comes out of the wall with a, touch button. Erm you don't, for obvious reasons, have soap, toilet……'ang on you do have toilet roll. You don't have soap or a towel. There is, toilet roll, um – • because of the seriousness of what was going in my head, and the fact that I had no understanding what was going even after speaking to, a very knowledgeable nurse for over two hours. • You just, it's not possible. Burn yourself out.
Keeping in mind that I'm being assessed in order to get what I need	• I mean, what they can do if you ask nicely, it's obviously done on your, mental state and how you are
Angry with staff for their decisions and	• I would have absolutely nothing

behaviour	to do with them. And they tried to push it I would say look you either back off or, I put in a complaint for harassment. I would, just, nothing to do with them. Not interested if I was on that ward they could shove it up their fucking arse.
Loosing and gaining power *Highly relevant to this participant's experience*	• there's nothing you can do about it. You just have to, put up with it. • they can actually lock, you out of the toilet area. Then you have to use a piss pot • I think that was, just used as a punishment. Erm, and to bully me out of, what I was saying.
Feeling neglected by staff and the environment	• I didn't feel cared for at all. Just completely ignored. • Canvas. Is what it feels like. It's canvas. It's not, but that's what it feels like. It is quite stiff. Erm, it's not the most comfortable thing to be in, but, you're not gonna get something that's comfortable

Table P4

Overarching themes for participant 4

Participant 4	
Theme	**E.g.s of quotes**
The only care comes from medication *Highly relevant to this participant's experience*	• they used to give me a strong injection, and that's how I used to cope.
Continuous and overwhelming fear *Highly relevant to this participant's experience*	• Yeah, it, it was very scary. Hmm, the fact that I didn't wanna be in, in here. If they keep me here for about four or five days I'll go crazy.
Feeling powerless	• I wanted to leave then. So I said, "Okay," and I didn't argue or anything in case they said another two or three days. • I started begging and saying, "Look, I write a letter of apology and please, I'm begging you, let

	me out. I can’t cope in here, I can’t cope in here.”
Having some control gives a sense of safety	• I was able to, allowed to take a shower once a day. Sometimes two times a day • you could put your clothes there and get some food; put a couple of crisp packets there, and that, that used to make me feel better.
Feeling abused by staff	• I felt that they’re, that’s some sort of abusing me.
The more alien the experience and environment, the more frightening it is to me.	• The fact that I didn’t like the place. It was very, it, it was, it seemed smaller than a cell, prison cell. It’s about 1/5 of this room. Think how small that was.
Being desperate for care but instead feel abandoned and neglected *Highly relevant to this participant’s experience*	• I should have been given a blanket or something to keep me warm. There was no blankets. I just, I just, well I, I was just like that [arms crossed tight] just to feel my own body warmth. And just go to sleep like that. • for suppertime they only gave me a couple of biscuits and a cup of tea, and they used to, but and they did that for lunch and dinner as well, as far as I can remember I think so. Yeah, yeah they did. That was for lunch and they gave me a couple of biscuits and a cup of tea. They never gave me a full meal even.

Table P5

Overarching themes for participant 5

Participant 5	
Theme	**E.g.s of quotes**
Feeling powerless and desperately finding ways to regain some power *Highly relevant to this participant’s experience*	• I was kind of misbehaving there was a mattress in there an’ I put it up against the observation panel. And um, they wouldn’t let me use the toilet, it’s controlled by an electric door. • I felt like, if I was to speak up, to management, or like, top heads of

	the, hospital, that then it would get brought back on me that I was making allegations and it felt like to me that I couldn't speak up or can't speak up. Because…what was I gonna say um, because I would then, get like tainted with being a either grass or I'm not meant to be trusted or I was making false allegations. And I thought well, the whole team that were looking after me for a week and two days on seclusion they'd all back each up other anyway.
Intense fear *Highly relevant to this participant's experience*	• every time they open the door, they kinda like all in gloves and there was about 12 of them, I thought, what the fuck's going on here, that's why I was getting you know like ideas in my head thinking they're gonna fuckin' kill me. • in my head I thought they were trying to kill me off
Feeling uncared for *Highly relevant to this participant's experience*	• Just, just like, (sigh) sort of like…like no one cares • So I was kinda, just, treated and spoken to like a bit of shit really. Just, I mean you meant to be in hospital and cared for
Feeling abused *Highly relevant to this participant's experience*	• I felt like I was being like, visually abuse or something. It didn't feel, feel right at all.

Table P6

Overarching themes for participant 6

Participant 6	
Theme	**E.g.s of quotes**
The pain of feeling uncared for *Highly relevant to this participant's experience*	• I just remember being really distressed. Makes you more, made me more, determined that, I'm really on my own. And, seems no matter where you get put for care, ultimately, there is no help. It's just feels totally like,

	abandoned, helpless
I am in danger	- it's really intrusive and really cold feeling and, kinda like, it's like an interrogation room like you see on a film. It's horrible. It's like you don't feel safe in there. It's very like, it's awful
Desperate for needs to be understood by staff	- when you finally alone with the door closed, I was just screaming and shouting. Erm…I, covered up the observation panel with, the mattress that's on the floor. So they had to go outside and look in ways

Table P7

Overarching themes for participant 7

Participant 7	
Theme	**E.g.s of quotes**
Loosing and gaining power and control *Highly central to this participant's experience*	- in a place where all the control is taken off you, yeah, you've suddenly got a bit of control. 'Cause I think that's the thing, if you're in an environment that is controlled on every level, yeah, I think, in a way, it creates behaviours in people, yeah, 'cause they need some- everyone needs a level, some people are comp- complete control freaks, yeah, and need every aspect of their life controlled, to have control of it, yeah? But then, then you're in an environment where you don't have any control, everybody's trying to grab that little bit of control. - At the time it didn't feel like that. At the time I didn't really give a fuck. It was, kind of, empowering.
Supressing emotions *Highly central to this participant's experience*	- it's been, hard work, trying to like, keep in, the rage you might feel about what's going on, because like, anyone put in that situation, after a period of time, of being in that room for days on

	end, yeah, you would get a bit bored, you get a bit angry, and then you’ve got to be able to, like, process that, but not show them, the people who are going to release you from that that you feel that. • I was, like, I was a little bit angry but I just tried to keep it in ‘cause, that would impact on me getting out • I don’t really, being locked in a room doesn’t really bother me.
Feeling vulnerable and needing care	• Didn’t really, like, well it was not, like, nice, you’ve only got them blankets and what have you, you’re just like, naked aren’t you? • the rest of the time the staff on that ward were looking after you.
Feeling like a victim of abuse and neglect *Highly central to this participant’s experience*	• A bit lonely, a bit, felt abused. • The only time they come out, come in is, like, when they do, like, a, an MDT on ya, like, maybe the doctor, your psychologist, you, the nursing team, or the security, probably, depending on what it is. And then you’ve got to, like, you can’t, well, you’re not allowed to, like, you’ve got to lay on the bed. • And you can’t, like, you’ve got to be, like, wary about moving, because, like, one false move and they will jump on you.
Feeling angry with staff	• Sometimes you get a bit angry because you’re repeatedly saying the same thing, what they want to hear, yeah? But every nurse review it’s like, “Well, why am I saying this because they don’t believe me, so it’s pointless.” • Depends on what they’re talking to you about, some used to do your head in, some just talked to you for the sake of talking to you because they were bored.
Feeling cared for by staff	• it felt okay ‘cause I trusted my doctor, like, she was German…And I knew nothing

	would ever happen. - And some people would talk to you about other stuff, and that was, kind of like, with (name of staff member) it was, like, kind of, cool.
The experience was a way I could learn	- I think that altered me, that, (sigh) I learnt something from every kind of seclusion. - If it's used to manage someone's behaviour and then, effectively, get somebody out and get them on the straight and narrow, and effectively, alright, maybe it took me, like, loads of seclusions, yeah, to get my head straight, yeah?
My privacy is intruded *Highly central to this participant's experience*	- And you're kinda you're vulnerable, exposed… I didn't like the fact that I couldn't be alone…I don't, I like, I never understood the need to observe people, all the time.
The physical environment influences my experience in different ways	- They're better than the old ones, like, that I've, like. Being in prison they always used to be, like, like a browny, kind of beigey colour - Not having fresh air's kind of like hard work. Even though there's ventilation but it's not the same. Having lights constantly on you, like the lights, like these lights even do my head in.
Feeling punished	- the reason I got put in there for 10 days was I assaulted a member of staff, yeah?
I felt physically restrained by the environment	- 'Cause like, you kind of feel like physically restrained by that room.
I needed to distract myself from the experience in order to cope	- a lot of times I used to do in seclusion, just do exercises. Just to pass the time.

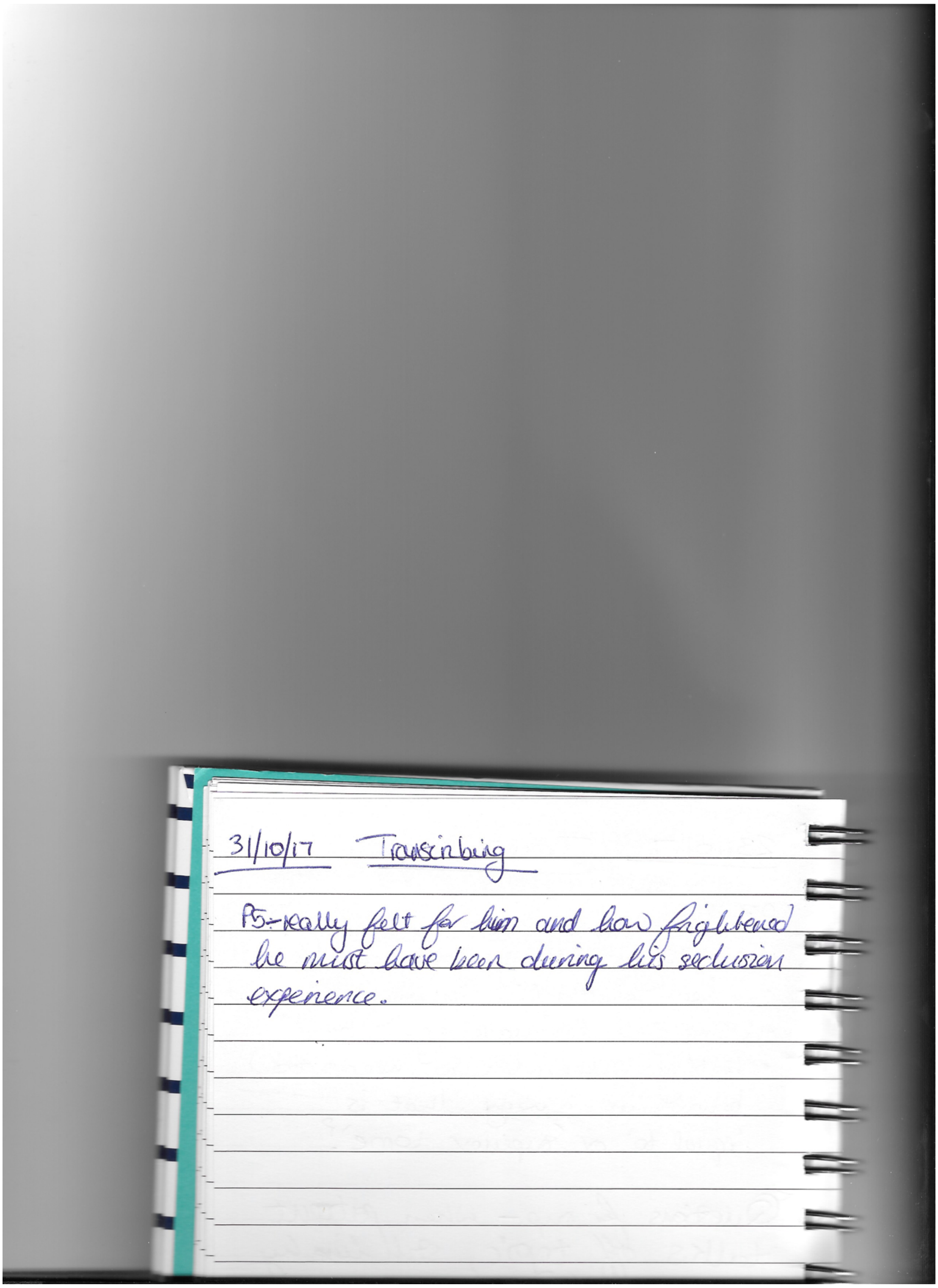
Appendix Q

Table Q1

Occurrence of superordinate themes across participants

Theme	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**Relevant for more than half the sample?**
Power struggle	✓	X	✓	✓	✓	X	✓	YES
Not getting the care I needed	✓	✓	✓	✓	✓	✓	✓	YES
I am being abused	✓	✓	X	✓	✓	X	✓	YES
Intense fear	X	✓	✓	✓	✓	✓	X	YES

Appendix R: Journal Extract of Emotional Reaction While Transcribing



31/10/17 Transcribing

P5:- really felt for him and how frightened he must have been during his seclusion experience.

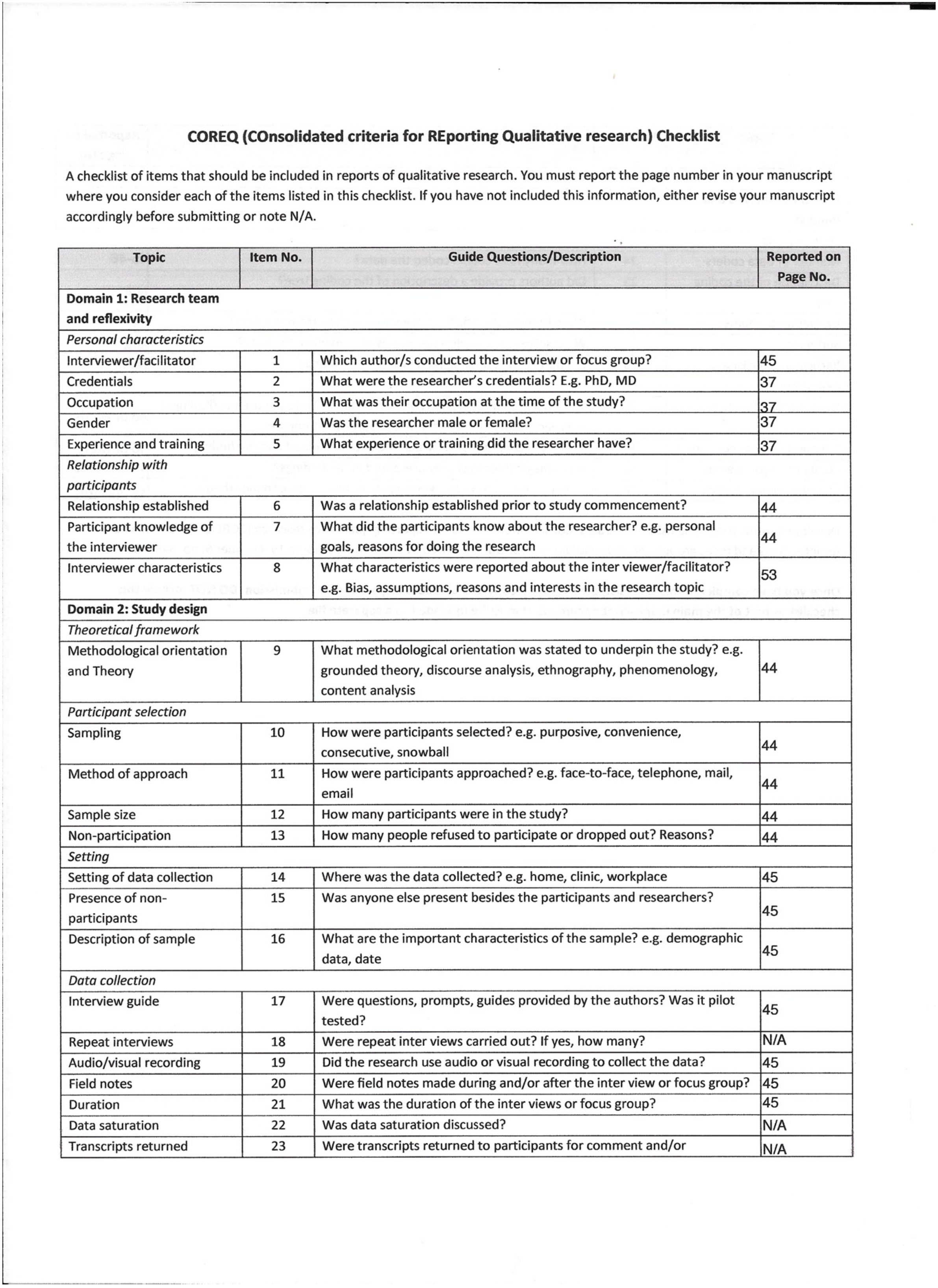
Appendix S: Additional Quotes to Support Superordinate Themes

Table S1

Additional Quotes

Superordinate theme	**Quotes**
Intense fear	"Yeah it, it was very scary. Hmm, the fact that I didn't wanna be in, in here. If they keep me here for about four or five days I'll go crazy." "you can't breathe and you, you know, you just e, eager to get out and you can't."
Not getting the care I needed	"I didn't feel cared for at all. Just completely ignored." "Someone to talk to even though, er, it doesn't have to be in the room, just someone to er talk to, um…wherever just, a door maybe or a s, s, one of the staff asking if you're alright."
I am being abused	"And you can't, like, you've got to be, like wary about moving, because, like, one false move and they will jump on you." "A bit lonely, a bit, felt abused."
Power struggle	"At the time it didn't feel like that. At the time I didn't really give a fuck. It was, kind of, empowering." "There's nothing you can do about it. You just have to, put up with it."

Appendix T: COREQ Checklist Required for Submission to Journal



COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	45
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	37
Occupation	3	What was their occupation at the time of the study?	37
Gender	4	Was the researcher male or female?	37
Experience and training	5	What experience or training did the researcher have?	37
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	44
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	44
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	53
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	44
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	44
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	44
Sample size	12	How many participants were in the study?	44
Non-participation	13	How many people refused to participate or dropped out? Reasons?	44
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	45
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	45
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	45
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	45
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	45
Field notes	20	Were field notes made during and/or after the inter view or focus group?	45
Duration	21	What was the duration of the inter views or focus group?	45
Data saturation	22	Was data saturation discussed?	N/A
Transcripts returned	23	Were transcripts returned to participants for comment and/or	N/A

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	45-46
Description of the coding tree	25	Did authors provide a description of the coding tree?	N/A
Derivation of themes	26	Were themes identified in advance or derived from the data?	44
Software	27	What software, if applicable, was used to manage the data?	N/A
Participant checking	28	Did participants provide feedback on the findings?	N/A
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	46 onwards
Data and findings consistent	30	Was there consistency between the data presented and the findings?	46 onwards
Clarity of major themes	31	Were major themes clearly presented in the findings?	46 onwards
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	46 onwards

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.