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, however, there is limited in-depth understanding of the deeply personal experience.

What this paper adds to existing knowledge

- This systematic review found that the published research may have flaws with the quality of analysis, mainly due to limited researcher reflexivity.
- The review of qualitative research revealed that during seclusion patients feel vulnerable, neglected and abused, disconnected from the experience and that it is dangerous to their mental health.

What are the implications for practice

- For clinicians facilitating the seclusion process to use their therapeutic skills to provide patients with a sense of being cared for.
- For clinical supervision to allow space to explore interpersonal dynamics during seclusion in order to enhance therapeutic staff-patient interaction.

Abstract

Introduction

There is limited understanding of patients' seclusion experience. A 2013 systematic review provides some insight, however, more knowledge is required in order to improve patient care. This is a systematic review of qualitative research into the patient experience of seclusion. The qualitative focus enables the phenomena to be the central focus.

Question

'What are adult psychiatric inpatients' experience of seclusion?' and 'what is the quality of the applicable research?'.

Method

Electronic searches for qualitative research published between 2006–2017 were undertaken. Data was excluded if it was not explicitly related to seclusion. Research was appraised using three standardised appraisal criterion. Themes were generated through thematic synthesis.

Results

Eight papers met inclusion criteria, four had been translated into English. Four themes were identified; 'feeling vulnerable', 'feeling neglected and abused', 'disconnecting', 'seclusion is dangerous to mental health'. Participants felt vulnerable and without control. They experienced staff and room as neglectful and abusive. Participants mentally disconnected. The experience threatened participants' mental health.

Discussion

Participants' experience is an amalgamation of interpersonal experience and the environment. Disconnecting may be a coping strategy.

Implications for practice

The findings have implications for seclusion practice, staff training and clinical supervision. Specific attention needs to be paid to the staff-patient interaction.

Relevance Statement

This systematic review provides up to date qualitative understanding of psychiatric inpatients' experience of a restrictive intervention (seclusion) usually carried out by nurses. Nursing practice involves decision making regarding the initiation of seclusion, ongoing assessment of secluded inpatients and providing inpatients with the debrief after seclusion. The findings offer recommendations regarding the clinical practice of seclusion procedures and debrief. They also provide readers with information to enhance clinical supervision and inform staff training. Given the high level of responsibility nurses have with seclusion, the findings are likely to be of great interest.

Keywords: patient experience, qualitative methodology, seclusion and restraint, systematic literature reviews.

Introduction

There is a drive internationally to reduce the use of restrictive interventions (RIs), by replacing interventions such as seclusion with a more therapeutic alternative, e.g. 'time out' (Bowers et al., 2012; LeBel, 2008). Seclusion is used in inpatient settings in emergency situations where staff and patients may be in danger. It has been 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 (MHA) (1983): Code of Practice, 2015, p. 417). The patient remains in the room alone until clinical staff have deemed it safe for them to be released.

In-depth international research regarding how patients experience seclusion and it's psychological impact has been undertaken. Quantitative studies using questionnaires and psychometric measures have given some insight into the patient experience of seclusion (Georgieva, Mulder & Wierdsma 2012; Larue et al., 2013; Martinez, Grimm & Adamson, 1999; Whitecross, Seeary & Lee, 2013 and Whittington et al., 2009). Larue et al. (2013) presented patients who had experienced RI with a questionnaire about their perceptions and found that some identify positive aspects, such as calmness and a sense of safety. Most patients found it a distressing experience, for example, Martinez et al.'s (1999) study using questionnaire data identified feelings of neglect, vulnerability and worthlessness. In some cases, symptoms of mental illnesses have been identified as a consequence of seclusion, for example, Whitecross et al. (2013) found that 47% of patients reported symptoms of PTSD on the Impact of Event Scale – Revised. However, these papers do not provide enough analysis regarding the individual experience to allow a detailed understanding of these feelings and their ongoing impact.

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 highlighted 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. The papers in the review 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, from 2009 there have been several relevant changes in legislation and clinical guidance in England. The procedure of seclusion and the facilities are now inspected against specific patient safety standards and this is likely to have impacted on seclusion practices or

experiences. For example, seclusion facilities have been changed as a result of these inspections. Similar changes have been introduced 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 potentially having a direct impact on the use and experience of these interventions.

Since the previous review was undertaken, the use of RIs has received more attention internationally and this has resulted in further research into the patient experience (e.g. Fish, 2018; Fugger et al., 2016; Guzmán-Parra et al., 2019; Spinzy et al., 2018). Therefore, an updated systematic review of patient experiences of seclusion is necessary in order to widen knowledge which will help inform future practice.

Qualitative methodology is being increasingly used to develop an understanding of the deeply personal experience of seclusion. Qualitative research comes from the position that all experiences are subjective, individualised and constructed within each participant's view of their world (Braun and Clarke, 2013). This research can provide deeper understanding of the complex psychological impact of seclusion. The explorative space that qualitative methodology gives means that this review will give new knowledge regarding the patient experience. This will increase awareness of psychological experience. A qualitative systematic review helps to present this research in a robust way that can be used for the development of guidelines for clinical practice and/or training packages (Houghton et al, 2016). With an improved understanding of the patient experience, guidelines for clinical practice and training packages can more accurately reflect the needs of patients. It is hoped that this would result in a reduction of the distressing impact of seclusion and lead to a more positive outcome for the patient.

Aims and Objectives

This review aims to synthesise international qualitative studies from 2006 – 2017 on patient experiences of seclusion using Thomas and Harden's (2008) method of Thematic Synthesis. It also aims to provide a thorough quality appraisal of the research which meet inclusion criteria. The cut off of 2006 allows for a follow on from Van Der Merwe et al.'s (2013) review, ensuring that this review focuses on up-to-date research.

Method

This review aims to answer the question 'what are adult psychiatric inpatients' experience of seclusion?' and appraise the research quality.

Literature search strategy

Identification

Electronic searches of a total 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 literature 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.

Screening

The titles and abstracts of all 35 papers were screened. To meet inclusions criteria, papers were required to provide indication of qualitative research on patient experiences of seclusion. 13 papers met this criteria and their reference lists were reviewed and a further 2 papers met the criteria for inclusion.

Eligibility

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. 4 papers did not meet this criteria.

Included

A total of 9 papers met criteria for quality appraisal.

See Figure 1.1. PRISMA Flow Diagram for literature search strategy.

Procedure of Quality Appraisal

The reviewer developed an appraisal criterion (see appendix B), based on several robust guidelines, which is an approach often used in qualitative systematic reviews (Burbeck, Candy, Low & Rees, 2014; Harden et al. 2006; Rees, Oliver, Woodman & Thomas, 2009 and Thomas et al., 2007). Developing a detailed appraisal criterion ensures a high-quality appraisal that takes into consideration the subjective nature of qualitative research whilst developing an auditable replicable procedure. In this case, the standards from the Critical Appraisal Skills Program (CASP), Dixon-Wood et al. (2006) and Popay, Roger and Williams (1998) were used.

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). Dixon-Wood et al.'s (2006) and Popay, Roger and Williams' (1998) standards were incorporated into the appraisal to address the reflective and interpretative nature of qualitative research.

Dixon-Wood et al.'s (2006) standards were used to focus on the relevance of the papers in order to maximise the amount of papers included in the review. The reviewer also appraised papers on their ability to adapt to issues that arise due to the social setting of the study, such as complex dynamics in the researcher-participant relationship, based on Popay et al.'s (1998) standards. Popay et al.'s standards (1998) were also followed to appraise the data based on how the research describes the data, gives sufficient quotations and then moves onto analysis of the meaning and significance of it.

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. 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.

To consider potential subjectivity in the analysis, the reviewer used a reflective journal alongside the synthesis to document exploration of own assumptions, emotional reactions and cultural positioning whilst reading and analysing the data.

Results

Quality appraisal

The appraisal led to the exclusion of one paper due to the data being analysed quantitatively. The remaining eight 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. Five papers researched seclusion as part of an overall exploration of several RIs and the remaining three focused exclusively on seclusion. The quality of all eight papers was recorded and considered during the development of themes.

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 transparency regarding researcher reflexivity was apparent in seven studies. 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. Two of the four did not provide sufficient quotes to be able thoroughly appraise the rigor of their analysis. Another provided limited information regarding analysis method used and one mixed methods paper had a large sample size that appeared to restrict the researchers' ability to analyse the qualitative data in detail.

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. 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.

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 commented on the poor facilities of the seclusion room in a hospital in the USA and 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 in hospital in the USA: "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. One participant in an acute ward in Finland stated: "I strangled myself" (Kontio et al., 2012, p. 20).

Feeling neglected and abused

Both the seclusion room and the experience of staff contribute to this theme. 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 who had been secluded in a large acute hospital, 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). The term "stripped" was widely used throughout the studies and a total of five participants used a form of this word in their interviews.

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 in an addiction hospital in Canada describes 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. This participant described neglect to the extent that he/she

became incontinent: “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, who was seclusion in Lesotho at a time when the country’s mental health legislation did not specifically address seclusion, reported staff abuse. He/she 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 in a forensic psychiatric hospital in the UK described his/her experience of the room as similar to homelessness. He/she stated: “it was horrible in there. Like rough sleeping for five days.” (Haw, Stubbs, Bickle & Stewart, 2011, p.574). Homelessness represents an experience of absolute neglect and deprivation of basic needs such as privacy, warmth or hygiene.

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 several participants across six studies, mentally disconnecting meant they could not remember the seclusion experience or recall feeling confused and disorientated and unable to make sense of it. One participant stated: “I didn’t know where I

was and how long it lasted" (Kontio et al, 2012, p. 19) when discussing his/her seclusion incident.

Participants described their thoughts while in seclusion. Some of these thoughts and internal monologues appeared to serve as a distraction coping strategy. This participant in the USA describes feeling connected with God while he/she was in seclusion, "I had good communication with God…and…I was praying to God to forgive my actions." (Ezeobelle et al., 2014, p. 309) something which he/she identified as positive..

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. One participant stated: "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, who was secluded in hospital in Norway, felt that seclusion further exacerbated his emotional distress. His interview was translated from Norwegian into English and he stated: "After a while it only makes you feel worse." (Larsen & Terkelsen, 2014, p. 430).

Discussion

The review concluded that all studies had sufficiently high standards of design and methodological quality. However, the absence of transparency regarding researcher reflexivity was identified as a considerable limitation. A locked psychiatric hospital is a strikingly different environment to the community and the researcher-patient relationship is particularly unique in this setting. Reflexivity was deemed to be especially vital to the quality of the analysis. Also, four of the papers (Haw et al., 2011; Larsen & Terkelsen, 2014; Ling, Cleverley & Perivolaris, 2015 and Mayers et al., 2010) in this review did not provide sufficient details of the quality of the analysis.

Thematic synthesis of the data revealed emotionally powerful themes which suggest that seclusion is an exceptionally challenging experience for psychiatric inpatients. These common themes transcend the differing environments where participants experienced seclusion. 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. The sense of vulnerability is apparent for the duration of the experience and in order to manage their distress, participants mentally disconnected from the experience. They desire care but instead are left feeling neglected and/or abused by staff and neglected by the seclusion room. A key finding of this review is that 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. This review found that a core part of 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. In most instances, the quotes were participants interpreting legal procedures as abusive. Patients' early life experiences may influence how certain procedures (for example, observations) are perceived to be abusive, rather than as a form of care. However, some participants reported incidents of actual abuse from staff.

This review adds new knowledge to the understanding of the patient experience. Previously, the relevance of staff-patient interaction has not been identified as playing the main role in the overall experience. Where seclusion is deemed to be necessary, clinicians have responsibility to ensure ongoing therapeutic interaction with the patient. Khatib, Ibrahim and Roe's recent study (2018) in an Israeli hospital highlighted the power of staff verbal interaction and subtle body language in patients' experience of RIs. Empathic verbal interactions and facial experience had the ability to induce calmness in patients while they

were in restraint. Therapeutic interaction also needs to take into consideration the patients' individual life experiences and how these may be influencing their interpretation of staff actions. Services could also benefit from allowing patients the opportunity to raise and discuss concerns regarding the actions of staff during seclusion to ensure that actual abuse is not taking place.

This review extends the findings of previous research. Brophy et al.'s (2016) Australian study exploring the impact RIs have on patients, feeling dehumanised was identified as a result of experiencing RIs. These findings have been mirrored in Wilson et al.'s 2017 study of restraint experiences. The present review found that the experience of the physical environment led to further feelings of neglect and in some cases, feeling dehumanised. Van Der Merwe et al. (2013) also found that patients were distressed by their physical surroundings while in seclusion. Participants described the room in a way that demonstrated their experience of feeling neglected, irrespective of what the facilities were. This and Van Der Merwe et al. (2013) findings support the need for clinicians to sensitively consider how patients are experiencing the physical environment and to offer emotional support and demonstrate care for the patient.

Not previously identified in other reviews, this review found that 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 in response to being retraumatised. Mental health staff, patients and their families have expressed concerns that seclusion is a traumatic intervention that could trigger memories of historical trauma (Brophy et al., 2016; Muir-Cochrane, O'Kane & Oster, 2018). Strout's 2010 review of qualitative literature found that physical restraint is also experienced as retraumatising.

Overall, the seclusion experience was described as highly emotive and posed a risk to participants' already fragile mental state. These findings have significant relevance to mental health nursing as it demonstrates that there is a clear need to intervene therapeutically to eliminate the risk of retraumatising already vulnerable patients. It also supports the need to offer a thorough debrief which is individually tailored to take into consideration the patient's early life experience and current coping strategies. Ryan and Happell (2009) found an incongruity between what patients wanted from a debrief and what nurses perceived they wanted. Nurses offering emotional support was of high importance to patients, whereas nurses felt a focus on explaining the reason for seclusion was desired. To ensure that the debrief is effectively meeting the needs of the patients, nurses may find benefit from in-depth training, developed collaboratively with patients, on therapeutic debriefing.

While this review clearly indicates the traumatic experience of seclusion, by eliminating it's use without offering an alternative, could lead to anxiety amongst staff and patients. Wilson et al (2017) found that nursing staff and patients both felt that RIs were a

necessary intervention. Further exploration of the perception and experience of alternatives to seclusion are required in order to influence and improve clinical practice.

Limitations

There are factors that need to be taken into consideration when reading this review and it is recognised that there are limitations. Despite the thorough and clear quality appraisal process, 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.

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

Implications for research

It is recognised that seclusion is implemented to ensure the safety of others. This review highlights areas that require further research and aspects of seclusion practice that would benefit from being improved. 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 to generate

knowledge and understanding of the experience which could enable staff to remain connected to and be able to support patients during this experience.

As the review found that the physical environment is experienced as emotionally harmful, further research is required in order to understand how the physical surroundings can be psychologically harmful during seclusion.

Implications for practice

This review demonstrates that staff interaction is a core part of seclusion. It also highlights that in some settings patients may be vulnerable to abuse from staff when being secluded. In order to ensure the safety of patients, accusations of abuse should be formally investigated, regardless of the patients' mental state. To reflect the priorities of patients, improve patient care and ensure seclusion is carried out in a way that safeguards patients' mental health, the staff-patient interaction needs to be considered in-depth. Staff training should ensure there is sufficient focus on therapeutic interactions. Clinical supervision with a specific focus on the staff-patient relationship could allow for staff to develop their understanding of how to support and care for their patients during the seclusion experience. Further exploration of the staff-patient interaction may help to inform therapeutic techniques and approaches staff can use to improve their interaction with secluded patients. Decisions regarding seclusion facilities may benefit from more input from patients. Understanding that seclusion may be experienced as a trauma resulting in dissociation may influence the frequency of its use and encourage staff to find alternative therapeutic options, leading to a reduction in the use of RIs.

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 theme 'feeling vulnerable' developed from the descriptive

	analytic themes by using the descriptive themes to answer the review question.	themes ‘physical harm’ and ‘loss of control’.

Table 2

Summary of Studies

Authors and Location	Title	Context	Methodology	Analysis	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 eight 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.	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 (no information provided regarding type of psychiatric 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 transcribed.	Phenomenological text analysis.	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.

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.	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.
Kontio et al. (2012) Finland.	Seclusion and restraint in psychiatry: patients' experiences and practical suggestions on how	Six closed acute wards in two psychiatric hospitals. N = 30 (no information provided	Open ended focused interviews to explore participants' individual experiences of seclusion/restraint and their perceptions regarding the	Inductive content analysis.	High quality design and methodology. Good quality analysis but interpretation limited. Findings of

	to improve practices and use alternatives.	regarding gender of participants).	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 up).		high relevance. Ethical issues considered. Sparse reflexivity regarding relationship between researcher and participants.
Larsen & Terkelsen (2014) Norway.	Coercion in a locked psychiatric ward: perspectives of patients and staff.	Locked psychiatric ward (no information provided regarding type of psychiatric hospital). N = 12,	Ethnographic fieldwork. Data collected through participant observation and conversations or interviews with participants over four	Analysis of text using phenomenological approach to develop themes.	High quality design and methodology. Rigorousness of analysis unclear. Inadequate

		nine male and three female.	months. (Quotes translated into English for write up).		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 (no information provided regarding gender of participants).	Analysis of qualitative data written on the Restraint Event Client-Patient Debriefing and Comment Form voluntarily completed by patients during post restraint (seclusion,	Thematic analysis	High quality design and methodology. Rigorousness of analysis unclear due to lack of quotes provided. Limited consideration of

			chemical and physical) debrief to describe patients' perspective of what occurred before, during and after restraint.		relationship between researcher and 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 (no information provided regarding type of hospital participants had resided in). 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	Content analysis	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

		(no information provided regarding gender of participants).	43 participants carried out using the interview schedule. Interviews and groups audio recorded and then transcribed. (Quotes translated into English for write up).		social environment. Ethical issues considered.
Ntsaba & Havenga (2007) Lesotho.	Psychiatric in-patients' experience of being secluded in a specific hospital in Lesotho.	Psychiatric inpatient hospital (no information provided regarding type of psychiatric 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.	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.

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

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
Ntsaba & Havenga (2008)	✓	✓	✓	✓

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