Green, R. et al (2018) Implementing Seclusion in Forensic Mental Health Care: A Qualitative Study of Staff Decision Making. Archives of Psychiatric Nursing

Abstract

Forensic mental health nursing is a complex role and there is a tension between maintaining safety and promoting a therapeutic and patient centred approach. The use of restrictive practises such as seclusion is an issue. Two focus groups with registered nurses exploring attitudes and factors used in decision-making about seclusion use were analysed using interpretive description. Participants described the need to reduce the use of seclusion and the problematic nature of its utility as an ongoing intervention in contemporary mental healthcare. It was clear that there were complexities and competing variables involved in the decision-making process.

Key Words:

Seclusion; Decision-Making; Nurses; Forensic

Highlights

- There is increasing focus on staff/organisational factors on the use of seclusion.
- Nurses decision making to seclude is affected by a number of different considerations.
- Contributory factors are professional and take into account the wider context.
- Nurses being supported with reflection is a key factor in reducing seclusion.

INTRODUCTION

The management of aggression, violence and behavioural disturbance remains a challenging problem for mental health services. However, the need for hospital-based management of 'difficult-to-manage behaviours' in in-patient settings remains and part of this in-patient care requires the use of seclusion and restraint to ensure safety and enable recovery.

Seclusion and restraint has its origins in the inhumane treatment of individuals with psychiatric disorders in the 18th century and earlier. During this period, service users were locked up in unclean rooms with little daylight and/or held in restraints (Newton-Howes, 2013). Towards the end of the 18th century there were improvements for individuals confined to the asylums such as banning the use of manacles and chains.

More recently, the movement in mental health has been towards a more service user focused and community centred approach, which has led to a gradual reduction in hospital bed figures over the past three decades (Newton-Howes, 2013). As a result of this trend this has meant the number of acutely ill or highest-risk service users in in-patient settings remains high, as does the need to provide safe and appropriate care. In this context, seclusion continues to remain an important clinical device.

Defining the term seclusion depends on who is putting forward the definition i.e. policy makers, medical bodies or legal sectors. In 1990, the Royal College of Psychiatrists defined seclusion as:

> *' the supervised confinement of a patient specifically placed alone in a locked room…for the protection of the patient, staff or others from serious harm.'*

From a pragmatic perspective, seclusion can be defined as the voluntary or involuntary short-term isolation of a service user in either a specifically designed room, usually low-stimulating, bare or sparsely decorated (seclusion room), locked from the outside with a window for observation. The aim is to minimise the harm a service user can do to themselves and to others.

In spite of its wide use, seclusion continues to be seen as a controversial method (Kontio et al., 2010; Soininen et al., 2013) and there is no agreement about its usefulness (Sailas & Wahlbeck, 2005). The use of seclusion represents an ethical dilemma for mental health nurses - the dual role of caring and of implementing coercive measures gives particular rise to complexity and therapeutic challenges for nurses (Gustafsson and Salzmann-Eriskson, 2016) and there is an inherent conflict in balancing ethics and safety (Riahi, Thomson and Duxbury, 2016). The legitimate use of control is a fundamental responsibility and is key to ethical practise and professional integrity (Cleary, Hunt and Walter, 2010).

In the last few years a series of mental health documents such as ‘Mental Health Crisis in Care: physical restraint in crisis’ (Mind, 2013) have identified an urgent need for change with prevalence rates of physical restraint and seclusion noted as being of significant concern. In 2014, ‘Positive and Proactive Care: reducing the need for restrictive interventions’ (DoH, 2014) was published and this document prescribed a framework for adult health and social care services to develop and promote cultures where restrictive interventions were to be used only as a last resort and for the shortest duration possible. The document defines restrictive interventions as:

> ‘deliberate acts on the part of other person(s) that restrict and individual’s, movement, liberty and/or freedom to act independently in order to reduce significantly the danger to the person or others’ (p.14).

With regard to medium and low secure services there is a national focus to reduce the frequency of restrictive interventions over the next two years, which include a reduction in the use of seclusion (NHS England, 2016)

To understand the reasons behind the use of seclusion, studies have typically been undertaken into the characteristics of patients but there is an increasing awareness of the effect of staff factors and local organisational/ward cultures on the use of seclusion and on reduction strategies (Boumans, Egger, Bouts and Hutschemaekers, 2015 and Larue, Piat, Racine et al, 2010). Some research has noted the need to understand attitudes towards seclusion as an important factor in reducing the use of seclusion (Happell and Harrow, 2010; Mann-Poll, Smit, van Doeselaar and Hutschemaekers, 2013; Okanli, Yilmaz & Kavak, 2016). There is a suggestion that the attitudes of nurses are of particular interest as they are the professional group most likely to implement/make decisions about seclusion and so should be involved in strategies and efforts to reduce seclusion within organisations (Happell and Koehn, 2011, Happell, Dares, Russell et al, 2012; Kontio, Valimaki, Putkonen etc al, 2010).

The aim of the present paper was to specifically explore the decision-making process behind qualified nurses’ decisions to implement the use of seclusion in forensic mental health care.

METHOD

This study explored the decision-making process behind nurses' decision to use seclusion. An inductive approach was chosen, i.e. interpretive description (Thorne, Kirkham, & O´Flynn-Magee, 2004), which was based on applied as well as theoretical nursing. The study was a qualitative investigation of a clinical phenomenon (decision-making behind seclusion) which captured themes and subjective perceptions. Therefore, interpretive description was a well-suited approach to inform clinical understanding.

Setting, Characteristics, and Selection of Participants

Data collection was undertaken at a mental health service in the North of England in March 2017. For the purpose of this study, the research was conducted at the medium secure service site. Within secure services, many but not all of those admitted have been in contact with the criminal justice system and will have either been charged with or convicted of a violent criminal offence (NHS England, 2013).

Participant recruitment was purposive (Given, 2008). Purposive sampling is a form of non-probability sampling undertaken when strict levels of statistical reliability and validity are not required because of the exploratory nature of the research. The inclusion criteria were registered nurses who had implemented seclusion within the preceding 12 months and currently working on a medium secure ward. This information was gained by the first author who reviewed completed incident reporting forms which recorded seclusion as an intervention and noted the registered nurse involved in the decision-making process. Twenty-three participants were identified and invited to take part in the two focus groups being conducted. The first author sent individual e-mail invitations and a participant information sheet to each

participant two weeks before data collection commenced. Participants had up until the day before data collection began to consider participating in the research. They responded with their reply via email to the first author. A total of 12 participants agreed to take part in the research. Table 1 describes the demographic information for the participants in more detail.

Table 1 here.

Data Collection

The two focus groups were conducted in a building separate from the medium secure ward areas. The first focus group consisted of four participants; the second focus group had eight participants. The focus groups were conducted over a period of one week in 2017; they were tape-recorded and transcribed verbatim by an administrator at the service. Focus groups lasted approximately thirty minutes each. The questions for the focus groups schedule consisted of nine questions which provided a semi-structure format for the focus groups. A semi-structured format grants the researcher leeway to pursue angles of the dialogue they deem important to the research (Leavy, 2014). The schedule guide can be found in Table 2.

Table 2 here.

Data Analysis

Each transcript was analysed using thematic analysis (Braun and Clarke, 2006). Thematic analysis provides a flexible approach to data analysis that identifies, analyses and reports on patterns within data (Braun and Clarke, 2006). After reading and re-reading the transcripts to familiarise themselves with the data, the author

coded and organised the data into themes. Throughout the analytic process, thematic maps were used to capture the relationships between codes, between themes and between different levels of themes (Braun and Clarke, 2006). As outlined by Braun and Clarke (2006), the analytic procedure was characterised by a process of 'defining and refining' themes. This ensured each theme captured the intended aspect of the data set.

Rigor

There has been a great deal of unresolved debate about rigour in qualitative research (Grbich 1999). In assessing the quality of the data collected in this study several factors were considered. Credibility or confidence in the data were gained by the first author's prolonged engagement with the data (Lincoln and Guba 1981). Consistency was maintained by keeping an audit trail and this involved asking a colleague to check over the author's decision and analysis processes. Transferability (neutrality) was evaluated by providing the raw data to a colleague so they could interpret how themes had emerged.

Ethical considerations

After consultation with the local Research Governance Lead for the Trust it was deemed that the project did not require ethical and research and development approval, however, ethical considerations were adhered to. For the project, all participants had an information sheet that contained an assurance of anonymity, information regarding the study, the possibility to withdraw and the voluntariness of participation. Signed informed consent was obtained and the findings presented in a way that no one could be recognised.

FINDINGS

The data analysis resulted in the identification of four themes: 1) seclusion as a last resort, 2) presenting behaviours, 3) organisational influences and 4) professional judgement. All themes describe factors that were taken into account by participants of the focus groups when making a decision whether or not to implement seclusion

THEME 1: SECLUSION AS A LAST RESORT

There was virtual unanimity from participants about seclusion being a last resort approach for managing a risk of violence towards others and that other approaches were available and should always be tried first wherever possible.

Use of the Intensive Nursing Suite (INS) was particularly supported amongst both participants in the groups. INS's are on ward areas away from the communal spaces where individual patients are supported by nursing staff when they are becoming distressed. It enables the provision of more structured and bespoke nursing support until the patient is able to return to the ward. It was described by one nurse as a *"fall back"* that could be used instead of going to seclusion and a good option that allowed nurses to closely monitor the patient. One participant commented that every acute ward should have more than one INS and added:

> *"I'd like to say that there has been a noticeable reduction in seclusion and I think that's good …we are using it for less time as well" (Participant number 1).*

More than one participant commented on the use of physical restraint as an option but felt there were some risks associated with this – the physical risks to a patient from using physical restraint for too long were described as *"potentially quite significant really"* with a participant expressing the view that they felt restraint should be more of a last resort. They noted the physical healthcare risks associated with restraint, including accidental injury and compromised respiratory function, and also that some patients might be distressed at being physically restrained by staff for long periods i.e. seclusion might be less distressing than physical restraint and present less risks to physical health in some cases.

THEME 2: PRESENTING BEHAVIOURS

It was clear that a potential risk to others (violence/aggression) was considered to be the precipitant to considering seclusion as an intervention by participants.

There was an acknowledgement that knowing a patients' history enables nurses to try to 'pre-empt' an incident and that this was a function of relational security and risk assessment. Relational security is about using knowledge of a patient to inform appropriate responses and interventions and the group reflected on the importance of having a detailed knowledge of the patients in their care and using this to aid their decision making. One commented that:

> *"sometimes you need to leave them alone for a while…it's about knowing the patient…sometimes you've got to give them the benefit of the doubt" (Participant number 2).*

Participants understood that not only did they have a responsibility to the individual patient but also to the wider patient group and to members of staff too. Some participants noted that their role was to take control of a difficult situation and to make sure that everyone, including the patient, was safe with one participant suggesting that seclusion was beneficial rather than having someone's behaviour *"escalate"* on the ward and presenting a risk to others (and also potentially placing themselves at risk).

THEME 3: ORGANISATIONAL INFLUENCES

From the participants accounts there were clear various organisational factors which were influential in their decision making behind the use of seclusion. One participant noted that:

> *"you have got to make a judgement based on lots of different factors. The first thing you do is a risk assessment of the area, of the environment, the situation, of other staff and his (the patients) presentation" (Participant number 3).*

Other participants noted the range of influences that might impact on their decision with one stating that there was a lot to think about and *"it's not something (secluding someone)" we as nurses take lightly" (Participant number 6).*

One participant reflected that they felt *"certain nurses seclude people more than others"* and another noted how important values were in making the decision whether to seclude or not.

"it depends on your passion as well...I think some people maybe don't have the energy or are set in their ways about how things should run" (Participant number 4).

One participant described having to be *"strong"* about your decision as some nursing assistants were very experienced and might have another view. This was described as particularly challenging if you were a new staff nurse. While it was evident that a number of competing demands and factors influenced nurse, decision making (and that the process was a dynamic one with changes and fluctuations between factors), the impact of other team members on the process featured most prominently in relation to this overall theme.

Patient boredom was noted by one participant as something they had observed on their ward. They felt that evenings and weekends were sometimes a more unsettled time as there was less going on. The participant had observed an improvement in this following concerted efforts on their ward to address patient activity and that this had resulted in less tension and agitation amongst patients.

THEME 4: PROFESSIONAL JUDGEMENT

Participants noted a number of different occasions when they had been unsure of their decision making with someone commenting that it was a 'judgement call' a lot of the time and that sometimes it would be helpful to receive feedback on their decisions. Someone remarked *"it's good to receive feedback, it helps" (Participant number 3).* Further, one of the focus group participants remarked:

"I think people forget as well how daunting secluding someone is, I remember the first time I did it and it's awful, it's not nice" (Participant number 9).

Some spoke of an occasion when their decision had been queried by someone more senior and described feeling angry and anxious about this. One participant commented that she had found it difficult to sleep on her days off as she had been concerned about a decision to seclude that she had made and she described having *"nagging doubts"* as she was aware of a colleague who had been asked questions about the decision she had made.

A number of participants, when asked about what might support them with some of the complexities around seclusion and decision making, identified the value of sharing practise and talking about shared experiences. Some participants commented that the focus group was the only opportunity they had been given to discuss the issues with their peers and that there was some re-assurance in hearing that colleagues faced similar challenges.

"we should share good practise and scenarios to talk it through with each other" (Participant number 9).

"this kind of situation brings on anxiety and can be difficult to manage, it's about sharing knowledge…table tops are a very good idea" (Participant number 4).

The two focus groups were predominantly comprised of registered nurses with substantial experience in secure services but many noted that new staff nurses

would benefit from support in this area and that new nurses needed support, debriefing and supervision to say they have done well. They also noted that some staff did not have experience of seclusion (due to the ward they worked on) but could get moved to provide cover and so everyone should be included.

DISCUSSION

The main contribution from this study is a detailed description of qualified nursing nurses' decision-making processes to implement the use of seclusion in forensic mental health care. Participants highlighted a range of decision making factors, attitudes and influences on the use of seclusion but there is no current or definitive position on which are the most significant. It was clear from the accounts that there were complexities and competing variables involved in the decision-making process for the registered nurses.

The participants described how seclusion should be used as a last resort and these views were entirely congruent with the literature (Mayor, 2005; McKenna et al., 2017). However, on a different note an interesting perspective is provided by Haw, Stubbs, Bickle and Stewart (2011) who studied patient's preferences and noted that coercive measures can undermine the therapeutic relationship with patients. Selection of the least coercive measure would, they suggest, aid in maintaining a therapeutic alliance which may reduce the need for future coercive measures as staff understand and work collaboratively with the patient. Their study conducted with 79 patients at a medium secure unit in the UK noted that some patients described worries about being restrained it was sometimes painful/getting injured and this has resonance with some participants descriptions of physical restraint and associated concerns with the physical health of patients. People with severe and enduring

mental illness experience a higher incidence of physical health conditions (and some medications can cause health complications) so this is a clear reality for registered nurses and illustrates the complexity of decision making. In some instances, at least, it seems likely that seclusion is viewed as the safer option (Laiho, Kattainen, Astedt-Turki et al., 2012).

The participants considered that a potential risk to others (violence/ aggression) was considered to be a precipitant to considering seclusion as an intervention however there was an acknowledgement that knowing a service user's history enables nurses to try to 'pre-empt' an incident too. Larue, Piat, Racine et al (2010) found that 'care givers' who have a more positive attitude towards mental health and an understanding of aggressive behaviour are better able to manage their emotions and to work collaboratively with patients. They further noted that some nurses understanding of patient's behaviour was superficial at best and this was likely to lead to a reactive rather than a preventative approach – there was a focus on merely *observing* behaviour rather than trying to find out or understand what it meant. Kontio, Valimaki, Putkonen et al (2010) describe the importance of 'understanding where patients are coming from' or 'tuning in' to inform appropriate and ethically sound care and to intervene prior to the need for restrictive interventions. Hence, nurses are engaged in a constant process of assessment and gather and select 'cues' that are weighted and turned into decisions (Laiho, Kattainen, Astedt-Kurki et al, 2012). Within this research, the importance of knowing the patient and their 'cues' was an essential feature of the participants decision to seclude.

Some participants noted that their role was to take control of a difficult situation and to make sure that everyone, including the service user, was safe, which

suggests that seclusion was beneficial rather than having someone's behaviour *"escalate"* on the ward and presenting a risk to others (and also potentially placing themselves at risk). Kontio, Valimaki, Putkonen et al (2010) studied the attitude of medical and nursing staff towards seclusion and noted that participants over emphasised their role in the care of aggressive patients and, when faced with choosing between a patients and another person's best interests/safety, they would tend to prefer the latter. This is perhaps indicative of some of the ethical dilemmas regularly faced by mental health nurses in that they have to maintain the safety of all (patients and staff) and this may sometimes mean temporarily curtailing someone's autonomy. Laiho, Astedt-Kuri, Putkonen and Lindberg (2012) noted that nursing staff justified the use of seclusion as a safety measure to control aggressive behaviour. This illustrates the complexity and the often-multi-factorial nature of the decision-making process.

Participants noted a number of different occasions when they had been unsure of their decision making with regard to seclusion use and that sometimes it would be helpful to receive feedback on their decisions through sharing practice and talking about shared experiences. It was highlighted too that new staff nurses would benefit from support, debriefing and supervision in this area to say they have done well. Laiho, Astedt-Kurki, Putkonen and Lindberg (2012) found that younger/newer staff tended to be less critical of restrictive measures than experienced staff. Focus group participants suggested that new staff nurses should attend some form of reflection as part of their development although this finding would also suggest their attendance is critical in order to shape their thinking which, in turn, should influence practise. Wynaden, Orb, McGowan et al (2001) described nurses as having a moral responsibility to explore their own feelings about seclusion and of its legal and ethical

consequences while Van der Merwe, Muir-Cochrane and Jones (2013) cited the danger in seclusion use becoming habituated towards and that reflection and team debriefings play a vital role in addressing this. Boumans, Egger, Souren et al (2012) found that team reflexivity was related to the tendency to prevent seclusion and Mann-Poll, Smit, Koekkoek and Hutschemaekers (2015) recommend that supervision and debrief sessions are facilitated as a matter of routine.

It is important to acknowledge some of the limitations of qualitative research and how this may have influenced our data collection and interpretation. The two focus groups were predominantly comprised of registered nurses with substantial experience in secure services this may limit the impact of the findings. We think that additional focus groups are needed that comprise of newly registered nurses in secure care. The results must, therefore, be generalized to other registered nurses employed in secure care with caution. Another limitation of this study is that it was restricted to one medium secure in the England within a delimited geographic territory, which does not allow the consideration of cultural and practicing differences among different facilities and locations.

However, the interpretations formulated in this study were valid for the study sample within the investigated context. The themes presented here are supported by evidence from the data itself (Braun & Clarke, 2006; Guest, McQueen, & Namey, 2012). The techniques of thematic analysis (Braun & Clarke, 2006) enabled the unique perceptions of individual participants to be recognised, which could have been rejected as anomalous using other methods (Bird, 1998; Braun & Clarke, 2006; Flick, 2009). Additionally, purposive sampling was used to ensure that a range of experiences within the service was represented (Guest et al., 2012).

In conclusion, this study was able to add to the very limited body of knowledge regarding the decision making practices in the use of seclusion by registered nurses in secure care. It identified that there is a need to reduce the use of seclusion and the problematic nature of its utility as an ongoing intervention in contemporary forensic mental healthcare.

Future research should explore how best to support, develop and train registered nurses regarding seclusion through sharing practice and talking and learning about shared experiences through reflective practice sessions.

Declarations of Interest

None declared.

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References

Bird, A. (1998). *Philosophy of science*. Oxon: Routledge.

Boumans, C., Egger, J., Bouts, R., & Hutschemaekers, G. (2015). Seclusion and the importance of contextual factors: An innovation project revisited. *International Journal Of Law And Psychiatry*, *41*, 1-11. http://dx.doi.org/10.1016/j.ijlp.2015.03.001

Boumans, C., Egger, J., Souren, P., Mann-Poll, P., & Hutschemaekers, G. (2012). Nurses' decision on seclusion: patient characteristics, contextual factors and reflexivity in teams. *Journal Of Psychiatric And Mental Health Nursing*, *19*(3), 264-270. http://dx.doi.org/10.1111/j.1365-2850.2011.01777.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research In Psychology*, *3*(2), 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

Cleary, M., Hunt, G., & Walter, G. (2010). Seclusion and its context in acute inpatient psychiatric care. *Journal Of Medical Ethics*, *36*(8), 459-462. http://dx.doi.org/10.1136/jme.2010.035402

Department of Health. (2014). *Positive and Proactive Care: reducing the need for restrictive interventions.* (pp. 9-43). London: Department of Health.

Flick, U. (2009). *An introduction to qualitative research* (4th ed.). London: Sage Publications.

Given, L. (2008). *The Sage encyclopaedia of qualitative research methods*. Los Angeles, Calif.: Sage Publications.

Grbich, C. (1999). *Qualitative Research in Health.* Australia: Allen & Unwin Ltd.

Guest, G., MacQueen, K., & Namey, E. (2012). *Applied thematic analysis*. Los Angeles: Sage Publications.

Gustafsson, N., & Salzmann-Erikson, M. (2016). Effect of Complex Working Conditions on Nurses Who Exert Coercive Measures in Forensic Psychiatric

Care. *Journal Of Psychosocial Nursing And Mental Health Services*, *54*(9), 37-43. http://dx.doi.org/10.3928/02793695-20160817-06

Happell, B., Dares, G., Russell, A., Cokell, S., Platania-Phung, C., & Gaskin, C. (2012). The Relationships between Attitudes toward Seclusion and Levels of Burnout, Staff Satisfaction, and Therapeutic Optimism in a District Health Service. *Issues In Mental Health Nursing*, *33*(5), 329-336. http://dx.doi.org/10.3109/01612840.2011.644028

Happell, B., & Harrow, A. (2010). Nurses' attitudes to the use of seclusion: A review of the literature. *International Journal Of Mental Health Nursing*, *19*(3), 162-168. http://dx.doi.org/10.1111/j.1447-0349.2010.00669.x

Happell, B., & Koehn, S. (2011). Impacts of Seclusion and the Seclusion Room: Exploring the Perceptions of Mental Health Nurses in Australia. *Archives Of Psychiatric Nursing*, *25*(2), 109-119. http://dx.doi.org/10.1016/j.apnu.2010.07.005

Haw, C., Stubbs, J., Bickle, A., & Stewart, I. (2011). Coercive treatments in forensic psychiatry: a study of patients' experiences and preferences. *Journal Of Forensic Psychiatry & Psychology*, *22*(4), 564-585. http://dx.doi.org/10.1080/14789949.2011.602097

Kontio, R., Välimäki, M., Putkonen, H., Kuosmanen, L., Scott, A., & Joffe, G. (2010). Patient restrictions: Are there ethical alternatives to seclusion and restraint?. *Nursing Ethics*, *17*(1), 65-76. http://dx.doi.org/10.1177/0969733009350140

Laiho, T., Kattainen, E., Åstedt-Kurki, P., Putkonen, H., Lindberg, N., & Kylmä, J. (2012). Clinical decision making involved in secluding and restraining an adult psychiatric patient: an integrative literature review. *Journal Of Psychiatric And Mental Health Nursing*, n/a-n/a. http://dx.doi.org/10.1111/jpm.12033

Larue, C., Piat, M., Racine, H., Ménard, G., & Goulet, M. (2010). The Nursing Decision Making Process in Seclusion Episodes in a Psychiatric Facility. *Issues In Mental Health Nursing*, *31*(3), 208-215. http://dx.doi.org/10.3109/01612840903131800

Leavy, P. (2014). *The Oxford handbook of qualitative research* (1st ed.). New York: Oxford University Press.

Lincoln, S., & Guba, E. (1981). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Mann-Poll, P., Smit, A., Koekkoek, B., & Hutschemaekers, G. (2015). Seclusion as a necessary vs. an appropriate intervention: a vignette study among mental health nurses. *Journal Of Psychiatric And Mental Health Nursing*, *22*(4), 226-233. http://dx.doi.org/10.1111/jpm.12176

Mann-Poll, P., Smit, A., van Doeselaar, M., & Hutschemaekers, G. (2013). Professionals' Attitudes After a Seclusion Reduction Program: Anything Changed?. *Psychiatric Quarterly*, *84*(1), 1-10. http://dx.doi.org/10.1007/s11126-012-9222-6

Mayor, S. (2005). Restraint should be last resort for violent behaviour. *BMJ*, *330*(7489), 438-0. http://dx.doi.org/10.1136/bmj.330.7489.438-d

McKenna, B., McEvedy, S., Maguire, T., Ryan, J., & Furness, T. (2017). Prolonged use of seclusion and mechanical restraint in mental health services: A statewide retrospective cohort study. *International Journal Of Mental Health Nursing*, *26*(5), 491-499. http://dx.doi.org/10.1111/inm.12383

MIND. (2013). *Mental health crisis care: physical restraint in crisis* (pp. 4-30). London: MIND.

Newton-Howes, G,. & Mullen, R. (2011). Coercion in psychiatric care: systematic

review of correlated and themes. *Psychiatric Services 62*: 465–70.

NHS. (2013). *NHS Standard Contract For Medium and Low Secure Mental Health Services (Adults)* (pp. 1-36). NHS England.

NHS. (2016). *MH3 Reducing Restrictive Practices within Adult Low and Medium Secure Services*. NHS England.

Okanli, A., Yilmaz, E., & Kavak, F. (2016). Patients' Perspectives on and Nurses' Attitudes toward the Use of Restraint/Seclusion in a Turkish Population. *International Journal Of Caring Sciences*, *9*(3), 932-938.

Riahi, S., Thomson, G., & Duxbury, J. (2016). An integrative review exploring decision-making factors influencing mental health nurses in the use of restraint. *Journal Of Psychiatric And Mental Health Nursing*, *23*(2), 116-128. http://dx.doi.org/10.1111/jpm.12285

Sailas, E., & Wahlbeck, K. (2005). Restraint and seclusion in psychiatric inpatient wards. *Current Opinion In Psychiatry*, *18*(5), 555-559. http://dx.doi.org/10.1097/01.yco.0000179497.46182.6f

Soininen, P., Putkonen, H., Joffe, G., Korkeila, J., Puukka, P., Pitkänen, A., & Välimäki, M. (2013). Does experienced seclusion or restraint affect psychiatric patients' subjective quality of life at discharge?. *International Journal Of Mental Health Systems*, *7*(1), 28. http://dx.doi.org/10.1186/1752-4458-7-28

Soininen, P., Välimäki, M., Noda, T., Puukka, P., Korkeila, J., Joffe, G., & Putkonen, H. (2013). Secluded and restrained patients' perceptions of their treatment. *International Journal Of Mental Health Nursing*, *22*(1), 47-55. http://dx.doi.org/10.1111/j.1447-0349.2012.00838.x

Thorne, S., Kirkham, S., & O'Flynn-Magee, K. (2004). The Analytic Challenge in Interpretive Description. *International Journal Of Qualitative Methods*, *3*(1), 1-11. http://dx.doi.org/10.1177/160940690400300101

Van Der Merwe, M., Muir-Cochrane, E., Jones, J., Tziggili, M., & Bowers, L. (2013). Improving seclusion practice: implications of a review of staff and patient views. *Journal Of Psychiatric And Mental Health Nursing*, *20*(3), 203-215. http://dx.doi.org/10.1111/j.1365-2850.2012.01903.x

Wynaden, D., Orb, A., McGowan, S., Castle, D., Zeeman, Z., & Headford, C. et al. (2001). The use of seclusion in the year 2000: What Has Changed?. *Collegian*, *8*(3), 19-25. http://dx.doi.org/10.1016/s1322-7696(08)60018-9