Received: 22 December 2022 | Revised: 17 August 2023 | Accepted: 30 August 2023

DOI: 10.1111/jpm.12979

ORIGINAL ARTICLE

WILEY

Patient perspective on observation methods used in seclusion room in an Irish forensic mental health setting: A qualitative study

Shobha Rani Shetty[1,2] | Shauna Burke[1] | David Timmons[1] | Harry G. Kennedy[3,4,5] | Mary Tuohy[1] | Morten Deleuran Terkildsen[6,7,8]

[1]National Forensic Mental Health Service, Central Mental Hospital, Dublin, Ireland

[2]School of Nursing Midwifery and Health Systems, University College Dublin (UCD), Dublin, Ireland

[3]Forensic Psychiatry, Trinity College Dublin, Dublin, Ireland

[4]Forensic Psychiatry, Aarhus University, Dublin, Ireland

[5]Forensic Psychiatry, University of Bari 'Aldo Moro', Dublin, Ireland

[6]Department of Forensic Psychiatry, Centre for Forensic Psychiatric Research and Development (CerF), Aarhus University Hospital Psychiatry, Aarhus N, Denmark

[7]DEFACTUM, Central Denmark Region, Aarhus N, Denmark

[8]Department of Clinical Medicine, Faculty of Health, Aarhus University, Aarhus N, Denmark

Correspondence
Shobha Rani Shetty, Mental Health Nursing, UCD School of Nursing Midwifery and Health Systems, Belfield, Dublin Ireland.
Email: shobha.shetty@ucd.ie

Accessible Summary

What is known on the subject?

- Nurses' observation of patients in seclusion is essential to ensure patient safety.
- Patient observation in seclusion assists nurses in adhering to the requirements of mental health legislation and hospital policy.
- Direct observation and video monitoring are widely used in observing patients in seclusion.
- Coercive practices may cause distress to patient-staff relations.

What the paper adds to existing knowledge?

- We add detailed information on specific observation methods in seclusion and compare them from the perspective of patients.
- Nurses communicating with patients ensures relational contact and that quality care is provided to patients even in the most distressed phase of their illness.
- Providing prior information to patients on observation methods in seclusion and the need for engaging patients in meaningful activities, while in seclusion are emphasized.
- Observation via camera and nurses' presence near the seclusion room made patients feel safe and gave a sense of being cared for in seclusion.
- Pixellating the video camera would give a sense of privacy and dignity.

What are the implications for practice?

- The overarching goal is to prevent seclusion. However, when seclusion is used as a last resort to manage risk to others, it should be done in ways that recognize the human rights of the patient, in ways that are least harmful, and in ways that recognize and cater to patients' unique needs.
- A consistent approach to relational contact and communication is essential. A care plan must include patient's preferred approach for interacting while in seclusion to support individualized care provision.
- Viewing panels (small window on the seclusion door) are important in establishing two-way communication with the patient. Educating nurses to utilize them correctly helps stimulate relational contact and communication during seclusion to benefit patients.
- Engaging patients in meaningful activities when in seclusion is essential to keep them connected to the outside world. Depending on the patient's presentation in the seclusion room and their preferences for interactions, reading newspapers, poems, stories, or a book chapter aloud to patients, via the viewing panel could help ensure such connectedness.

- More focus should be placed on providing communication training to nurses to strengthen their communication skills in caring for individuals in challenging care situations.
- Patient education is paramount. Providing prior information to patients using a co-produced information leaflet might reduce their anxiety and make them feel safe in the room.
- When using cameras in the seclusion room, these should be pixelated to maintain patients' privacy.

Abstract

Introduction: A lack of research investigating the specific role that various observational techniques may have in shaping the therapeutic relations in mental health care during seclusion warranted this study.

Aim: The aim of the study was to explore patients' experience of different methods of observation used while the patient was in seclusion.

Method: A retrospective phenomenological approach, using semi-structured interviews, ten patients' experiences of being observed in the seclusion room was investigated. Colaizzi's descriptive phenomenological method was followed to analyse the data.

Results: Communicating and engaging patients in meaningful activities can be achieved via the viewing panel. The camera was considered essential in monitoring behaviour and promoting a sense of safety. Pixelating the camera may transform patient view on privacy in seclusion.

Discussion: The mental health services must strive to prevent seclusion and every effort should be made to recognise the human rights of the patient. The study reveals numerous advantages when nurses actively engage in patient communication during the process of observation.

Implications for Practice: Different observation methods yield different benefits; therefore, staff education in using these methods is paramount. Empowering the patient with prior information on seclusion, engaging them in meaningful activities and proper documentation on patient engagement, supports the provision of individualised care in seclusion.

KEYWORDS

camera, communication, mental health nurse, observation, safety, seclusion, seclusion room

1 | INTRODUCTION

A higher incidence of aggression and violence reported in forensic mental health settings (Bowers et al., 2011; Dickens, Picchioni, & Long, 2013; Trestman, 2017) validates the importance given to risk assessment and risk management strategies in these settings. An in-depth risk assessment, use of interpersonal techniques such as de-escalation, physical interventions including physical restraints and restrictive measures such as seclusion and rapid tranquilization are availed by the health care professionals to prevent and manage aggression and violence in forensic settings (Flammer et al., 2020; Kennedy et al., 2020).

Seclusion refers to isolating the patient in a locked room, monitored by staff using security cameras in the room and/or through a small window on the seclusion door (Berg et al., 2023: Cullen et al., 2018). Monitoring encompasses visually observing and communicating with the patient in seclusion.

In the Republic of Ireland, the Mental Health Commission Rules (MHC, 2009, page 17) governing the use of seclusion and mechanical means of bodily restraint defines seclusion as 'the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving'. While in seclusion, the patient is put on direct observation by a registered mental health nurse day and night and monitored by closed-circuit television (CCTV). The legally binding MHC Rules Ireland (2009 page 10) defines direct observation in seclusion as the 'ongoing observation of the patient by a registered nurse who is within sight and sound of the

seclusion room at all times but is outside the seclusion room'. The MHC Rules further permit the continuous observation of the patient after 1 h which incorporates the patient being directly observed by nurses through the viewing panel (a small window on the seclusion door fitted with a curtain/blind from outside). The nurse can also view the patient via a CCTV monitor located within sight and sound of the seclusion room. The nurse communicates/interacts with the patient via the viewing panel and a written record of the patients' behaviour is made every 15 min.

Direct observation and video monitoring are used internationally in observing patients in seclusion to improve patient safety. It also assists nurses in adhering to the requirements of mental health legislation and hospital policy. Another method of observing is via ceiling-fixed, wide-angled anti-ligature mirror which is less invasive. Observation involves a nurse allocated to care for a patient for a specified period to ensure the patient's safety (Ray & Allen, 2015).

In almost all cases, the reason for seclusion is imminent serious violence to others while violence to self is possible, therefore, constant observation of patients is essential.

2 | RATIONALE

Current forensic mental health research underlines a need to study how to balance care and custody in forensic mental health practices in ways where the promotion and sustainment of strong care relations are realized while risks posed by patients are managed accordingly (Mann et al., 2014; Terkildsen, Kennedy, et al., 2022; Terkildsen, Vestergaard, et al., 2022).

For nurses working in recovery-orientated secure settings, however, the use of explicit power (in the form of risk management strategies) has been depicted in literature as providing nurses with a role marred by a specific ambivalence (Martin & Street, 2003; Terkildsen, Kennedy, et al., 2022; Terkildsen, Vestergaard, et al., 2022). On the one hand, they are to engage patients in rehabilitative practices. Such practices are dependent on strong therapeutic/care relations (Terkildsen, Kennedy, et al., 2022; Ward, 2013; Clarke et al., 2016) with patients in which power is sought more symmetrically distributed (Mann et al., 2014). Conversely, and as seen above, studies reveal that a crucial component of the nursing role also involves the prevention and management of aggression and violence to ensure the safety of the patient, other patients, staff, and society in general (Dickens, Piccirillo, & Alderman, 2013). When other preventive measures are unsuccessful, these strategies may include seclusion as a last resort when a patient is at imminent risk of harming others (Chieze et al., 2019; Council of Europe: Committee for the Prevention of Torture, 2017; Mental Health Commission Ireland, 2014; Power et al., 2020).

Current research on using seclusion in mental health has demonstrated diverse experiences of seclusion practices for the therapeutic relationship between patients and staff. These experiences may range from patients experiencing support and safety (Ezeobele et al., 2014; Iversen et al., 2011) to experiences of being in a situation of neglect and lack of care (Askew et al., 2019; Hansen et al., 2022; Holmes et al., 2015; Ntsaba & Havenga, 2008) and nurses' feelings of delivering extra care via seclusion (Holmes et al., 2015). Feeling a connection to staff and having relevant access to communication between patients and staff during seclusion has, however, commonly been underlined as a salient condition that may help promote strong patient–staff relationships that ameliorate the adverse effects of seclusion (Berg et al., 2023, Ezeobele et al., 2014, Askew et al., 2019). Moreover, it is commonly agreed the physical environment may promote or inhibit such contact and communication, and thereby draw correlations between the layout and function of seclusion rooms and their instruments and the possibilities for achieving desirable patient–staff relational outcomes (Askew et al., 2019; Hansen et al., 2022; Holmes et al., 2015).

However, despite the emphasis on understanding the interaction between the physical design and the psychological function of seclusion practices, instruments and rooms as well as the potential for fostering communication and connection between patients and staff, there has been a lack of research investigating the specific role that various observational techniques and instruments may have in shaping these therapeutic relations in mental health care during seclusion. Therefore, a gap exists that, if further studied, may help develop future seclusion practices that promote strong patient–staff therapeutic relationships and ensure the safety of patients and staff remains an unexplored area in the field.

This study aims to fill this gap, by exploring the patients' experiences of different observation methods in seclusion and their influence on their connection and relations to staff, by patients in an Irish forensic mental health hospital, in order to inform future seclusion practices. Integrating patient perspectives in the development and implementation of such mental health practices are important to ensure their future success (Terkildsen, Vestergaard, et al., 2022, Kontio et al., 2010).

3 | METHODS

3.1 | Study design

A retrospective phenomenological approach was used in this study. Phenomenology helps describe the meaning of participant's experience both in terms of what was experienced and how it was experienced (Teherani et al., 2015). The retrospective design allowed participants to reflect on their past experience and establish meanings to their experiences. Nonetheless, retrospective studies are sometimes criticized for relying on participants' memories of events from the past (Cohen et al., 2011).

The SRQR (Standards for Reporting Qualitative Research: A Synthesis of Recommendations) checklist (O'Brien et al., 2014) was used to guide the reporting of the study.

3.2 | Researcher characteristics and reflexivity

Interviews were carried out by the first and the second author, who have no clinical contact with the participants. Both authors are

qualified mental health nurses and have experience in conducting interviews. The interviewers separately maintained a reflective diary after every interview. Reflective diary enables the researcher to write down observations or assumptions made during the interview (Wojnar & Swanson, 2007). Reflexivity was maintained by discussing any assumptions, among two researchers who carried out the interviews and with other researchers in the team who are experts in phenomenology to minimize researchers' bias if any.

3.3 | Setting

This study was conducted in one forensic mental health hospital that had 97 inpatients at the time of data collection. There were eight wards categorized into three clusters, that is, acute (one female and two male wards), medium (three male wards) and rehabilitation and recovery (two male wards) clusters. A structured pathway of care allows patients to move from acute to medium to rehabilitation and recovery clusters based on their clinical presentation and risk assessment. The female ward provided care to patients in all three clusters. Patients were above 18 years and may have a minimum length of stay of 6–7 years in the forensic mental health service. The acute wards utilized seclusion as a last resort in managing patients who were at risk to others. In this study, patients in medium secure wards/category were selected with the perception that patients further on their pathway of care can better reflect on their experience.

3.4 | Sampling strategy

This study was carried out in July 2021 and only those participants who were admitted to the service in the past 5 years were included. Out of 43 patients in the medium secure units/category, 23 were admitted to the service in the past 5 years. Purposive sampling technique was used to select the participants. The inclusion criteria included:

- Patients in Medium Secure units/category
- Patients admitted to the hospital in the last 5 years (since 2016)
- Has experience of being nursed in seclusion room.

Exclusion criteria

- Patients in acute wards
- Patients who were admitted to the hospital for more than 5 years.
- Patients who were admitted in the past 5 years and had no experience of being nursed in the seclusion room.

The first and the second authors sent an invitation letter to all 23 patients meeting the inclusion criteria in three male medium secure wards and one female ward. Both researchers are known to patients as teaching faculty in the service. Those who were interested in participating in the study contacted the researchers by sending an expression of interest form via an internal post-system. The first and the second author met all interested participants to provide a participant information sheet and a copy of the consent form. Seven days later, if they were still interested, a date, time and venue were arranged for a semi-structured interview. The consultant psychiatrist was informed of patients' participation in the research. All 10 participants who showed an interest in partaking were included in the study.

3.5 | Ethical considerations

Ethical permission was sought from the Audit, Research and Ethics committee in the service (Approval Ref No: AUD/18062021/SR). An informed consent was obtained from each participant prior to conducting the interview. Confidentiality of the participant was maintained by carrying out the interview in the board room, away from the wards. Interviews were conducted by two researchers, not involved in the patient care. There were no other staff members present. A numerical code was assigned to all recordings and all identifiable data were removed from the transcript to maintain anonymity. The participant information sheet detailed that they could withdraw from the study at any time with no effect on their care.

3.6 | Data collection method

Data were collected using semi-structured interviews by the first and the second author. Face-to-face semi-structured interviews helps gather personal experiences from the key informants (DeJonckheere & Vaughn, 2019). Open-ended questions and prompts were used in the interview which lasted approximately 30 min. Table 1 provides the semi-structured interview guide. Written consent was taken, and the aim and objectives of the study was reiterated at the beginning of the interview. The interviews were recorded using T-pro app.

3.7 | Data analysis

Colaizzi (1978) descriptive phenomenological method with distinctive seven step framework for rigorous analysis was used in this study. This framework depends on rich first-person accounts of experience (Meyers, 2019). Initially, the researchers read and re-read the transcripts to become familiar with the data. There were several statements indicating patients' views on the seclusion room. A conscious decision was made to separate these statements and they were excluded from this analysis. Significant statements were identified and labelled to formulate meanings. At this stage many themes arose from the analysis that were clustered into main themes. Based on these themes, a full and inclusive description of the phenomenon was written. We then structured the themes and descriptions to capture patients' experience of observation. The last step in Colaizzi's (1978) seven steps is seeking verification from the

TABLE 1 Semi-structured Interview Guide.

Q1: Were you aware that you were being observed in seclusion?
Q2: What was your thoughts on being observed in seclusion room?
Prompts: 1. Why did you think that way?
2. At that time, how did you feel about being observed?
3. What was difficult?
4. Now, when you look back at that time in seclusion, what is your view on registered nurses observing patients in seclusion?
Q3: We would like to explore your experience of different methods used for observation in seclusion. How do you describe your experience of staff observing you via the viewing panel while you were in seclusion?
Q4: What was your experience of staff observing you via a camera in seclusion room?
Q5: The images on the camera can be pixelated (blurred). What are your views on this?
Prompts: 1. Why do you think that way?
2. What are your concerns?
Q6: There is another option that involves the use of a mirror where the nurses would look at the mirror that would reflect an image of the room without looking at you directly. What is your view on this method for observation?
Q7: Given a choice, which are the following you would have preferred when you were in seclusion?
Choices: 1. Not observed at all
2. Be observed directly or using camera
3. Using video camera
4. Video camera with pixellation
Q8: Drawing from your experience and understanding, overall what is your preferred method of observation?

participants. This step was not followed as the participants were not interviewed for a second time.

4 | RESULTS

Ten patients, eight male and two female patients who had experienced seclusion in the last 5 years participated in the study. All the participants reported that they were aware of being observed by nurses while they were in the seclusion room. Analysis of data using Colaizzi's (1978) framework generated the themes given in Table 2.

Participants were asked to describe their experience of being observed in the seclusion room via two methods: direct observation using a viewing panel and a camera in the room. Further, their view on the use of a mirror in the room for observation was also explored. Participants experience and views on each of these methods of observation is described here.

4.1 | Viewing panel communicated human connection, comfort and reassurance

a. Promoting connections in seclusion

Patients considered nurses being present and communicating via the viewing panel promoting a sense of human connection. They had a sense of being seen and valued the interaction with nurses.

TABLE 2 Themes and subthemes identified from the analysis.

Themes and subthemes
1. Viewing panel communicates human connection, comfort and reassurance
a) Promoting connections in seclusion
b) Relieving the sense of isolation
c) Fostering reassurance and comfort
d) Engaging in meaningful activities
2. Camera for monitoring behaviour, recognizing emergencies and ensuring safety
a) Monitoring patients' mental health
b) Recognizing medical emergencies
c) Promotes a sense of safety and being cared for
d) Pixellating the cameras for privacy and dignity
3. Mirror as an aid
4. The viewing panel and camera as preferred methods of observation
5. Observation portrays a sense of caring
6. Observation is for patients' safety

Participant 5 acknowledged '… because they (nurses) checking in on you and you (the patient) see a live person.... they (nurses) might say hello to you (the patient)… they (nurses) might make some contact with you that way…it makes you (the patient) feel good like you're still alive like you're human being, yeah… there was contact… human contact'.

b. Relieving the sense of isolation

Nurses communicating with patients via the panel gave a sense of hope and a feeling of relief that the nurses were still there if needed. The quote below from participant 10 highlights patients' lack of information on seclusion. They underlined how they would benefit from prior information to reduce the sense of being left alone in the seclusion room.

> '…I thought they (nurses) were going off and they weren't coming back at one stage because it (felt) so long… I was psychotic and I thought they had left me in there on my own, …they came back, and I was happy then…I prefer (staff coming to) the window to be honest with you because I'm still connected to the world' (P10).

c. Fostering reassurance and comfort

The viewing panel provided an opportunity to communicate with nurses thus promoted a sense of comfort and being treated individually. Talking to patients in seclusion and just being there outside the seclusion room was comforting and reassuring to the patients.

> Participant 9 described '…talking to a staff member, making sure I been heard and listen to …it was reassuring…just talking to me…by being nice…was reassuring'.

d. Engaging in meaningful activities

Patients regarded nurses reading newspapers via the viewing panel as a meaningful activity that kept them connected with the outside world.

> Participant 10 enthusiastically shared '… nurses coming to the door was helpful, (mentioned a nurse) came to the door, she used to read the newspaper to me because we weren't allowed newspapers or books or anything (inside the seclusion room)…nurses reading the newspaper occupies your time …something to do…'.

4.2 | Camera for monitoring behaviour, recognizing emergencies and ensuring safety

Patients perceived the camera in seclusion room as a method of observation to monitor behaviour, recognize emergencies and promote safety. Patients highlighted the use of a camera as an imperative continuous support/aid for nurses to carry out their role.

a. Monitoring patients' mental health

Participant 1 recalled an incident while they were in the seclusion room and how staff were able to intervene immediately, highlighting the value of observation via camera. Other patients reported usefulness of camera in preventing self-harm.

> '… I think it's (cameras) necessary, because I remember one incident, I was punching myself in the stomach (in seclusion)…I think it's necessary to have the camera…they're (nurses) able to come in there calm me down and it's necessary because you can harm yourself, they (nurses) can monitor your behaviour…'
>
> (P1).

b. Recognizing medical emergencies

Recognizing medical emergencies were frequently mentioned as a benefit of having a camera in the seclusion room in terms of responding to an adverse event and acting quickly.

> Participant 3 stated '… in case there is an emergency or something… in case something wrong with meds (medication side effects) or emergency like something to do with your heart or stroke or something you know'. Furthermore, participant 7 added '…someone (in seclusion room) could be taking a fit or something …staff can see that through camera and come straight in…'.

c. Promotes a sense of safety and being cared for

Camera-assisted observation was perceived by participants as an additional resource that promoted a sense of safety. There was an expectation to be cared for in seclusion, and they believed that the camera assisted the nurses in doing so.

> Participant 2 said '…because the person could hurt themselves or harm themselves, they need to be observed and looked after, that is the reason for it (camera) isn't it? you're in seclusion…so people (nurses) need to keep you safe, so you won't do anything'.

d. Pixellating the cameras for privacy and dignity

The researchers further explored participants' views on cameras in the seclusion room being pixelated. Participants expressed a lack of control over observation via camera hence they felt pixelating the cameras would promote a sense of privacy and dignity in the situation. Their perception of camera recording indicated a lack of knowledge of being cared in seclusion.

> Participant 1 stated 'I prefer it (*camera image*) blurred. It's for anonymity… it be better if it's blurred on the recording because you don't know who's going to see it… I wasn't well so I was acting inappropriate, so I needed to be out of the situation… I think from my own personal point of view I need the camera blurred because when you're so sick you could do anything… you want your privacy respected especially in the toilet area….I am sure that's (*pixellation*) good for your dignity….certain standard of privacy, because you are a human being and you're at your lowest and you need it (*dignity*)…'.

4.3 | Mirror as an aid

Participants were further asked about their views on the idea of using a mirror in seclusion room for observation. Participants had a lack of experience with this method of observation and thus did not perceive mirror as their preferred method for observing patients in the seclusion room.

P3 described mirror as far-fetched '… I don't know… it's (*mirror used for observation*) a bit far-fetched…far-fetched like camera like a mirror, why not just look at someone instead of using a mirror you know'.

However, participant 8 expressed that mirror may be used if the patient was very dangerous where other method of observation was not appropriate.

> '…no not for me no not unless someone was really, really dangerous'
>
> (P8).

Similarly, participant 6 agreed by saying ' … I suppose it is acceptable when you think about it… it just there as an aid to make sure you're ok, I don't see why that's a problem'.

4.4 | The viewing panel and camera as preferred methods of observation

Participants were asked which method they would recommend for observation of patients in seclusion room. Seven out of ten participants preferred direct observation using a camera and the viewing panel.

> One of the participants stated '… I had a horrible time when I was in there my mind went against me and I think there should be camera. I think there should be one to one as well. I think both… everyone's set of circumstances are different… my opinion is there should be both…'
>
> (P10).

Further, participant 5 listed three benefits of using both the camera and the panel for observation. They included safety of the patient, early recognition of deterioration and timely intervention.

> '…I prefer both (*camera and the panel*), just to be on the safe side…sometimes you (*patient*) not even know you're hurting yourself …so staff can come straight to you…the benefits is one, you (*patient*) know that you're safe, two you (*patient*) know that if you do something you're watched and they (*nurses*) will come and help you and three, you know that you won't do stuff (harming oneself) because you are being watched, that makes yourself good for yourself anyway. Some people don't be thinking when they're in there (*seclusion room*)'.

4.5 | Observation portrays a sense of caring

Further, participants were asked if there was a choice of nurses not observing patients in the seclusion room, would they have preferred that. Almost all of them said that they prefer to be observed via one or the other method when in seclusion.

Participant 9 explained observation by nurses meant someone caring for patients.

> '…I would have preferred to be observed…it gave me reassurance…to make me feel that someone cares about me…I think it's important to be observed'
>
> (P9).

Participant 2 claimed patients being not observed in seclusion is dangerous to the patients.

> '…that would be dangerous for the patient because they need to observed nearly all the time because of the suicide risk so the camera is necessary'
>
> (P2).

4.6 | Observation is for patients' safety

Almost all participants expressed the view that nurse's observation in the seclusion room is essential to ensure patients' safety and an underpinning theme of acceptance emerged. Participants considered observation as both a preventative and safety measure. Being observed by nurses made patients feel safe in seclusion even though they did not know what was going on outside.

> 'I didn't mind being observed….I thought it (*observing*) is good because I didn't really know what was going on outside, but I knew I was safe you know and I knew they (*nurses*) were safe because obviously they (*nurses*) were looking after you (*patient*)'
>
> (P5).

The findings show that nurses observing patients in seclusion communicated a sense of safety, being cared for, and a connection with the external world.

5 | DISCUSSION

This study explored forensic mental health patients' opinions and experience of being observed in the seclusion room, using three methods, the viewing panel, a camera and the use of a mirror. All ten participants accepted that observation in seclusion was primarily being used for patient's safety.

In forensic mental health, seclusion may be seen as a necessary intervention to ensure the safety of the individual patient, other patients in the ward and the forensic mental health staff (Harpøth et al., 2022; Kennedy et al., 2020). Patients in forensic mental health wards are often admitted for extended periods (Uhrskov Sørensen

et al., 2020), making their social life and care and treatment regime highly dependent on strong patient–staff relations. Utilizing seclusion measures does, however, underline the custodial role of forensic mental health staff (Martin & Street, 2003; Terkildsen, Kennedy, et al., 2022; Terkildsen, Vestergaard, et al., 2022), and this role could prevent close patient–staff relationships, promote negative relational experiences and thereby act counterproductive to the individual patient's recovery process (Mann et al., 2014; Marshall & Adams, 2018).

The seclusion of patients is often accompanied by negative experiences (Ezeobele et al., 2014). Several other studies have reported patients expressing a feeling of neglect and lack of care while in seclusion, ultimately portraying a lack of therapeutic connection and relation (Askew et al., 2019; Hansen et al., 2022; Holmes et al., 2015; Meehan et al., 2000; Ntsaba & Havenga, 2008). However, strong patient–staff relational contact during seclusion may ameliorate such adverse effects. According to Iversen et al. (2011), Steinert et al. (2013), Møllerhøj and Os Stølan (2018) and Kontio et al. (2012), acknowledging that well-known and caring staff is closeby if needed, and having contact with them may greatly promote feelings of support and safety. Conversely, lacking contact with staff during seclusion may lead to feelings of isolation, solitary confinement, and sensory deprivation, which may cause irritability, mood swings and extreme boredom (Meehan et al., 2000). Though the experiences of patients in our study resonate with existing studies, we argue that our focus on the observational techniques applied during seclusion provides a critical springboard to help further understand and help promote relational connectedness between staff and patients, thereby alleviating the adverse effects described as having been experienced when going through a session of seclusion. Specifically, our study demonstrates how the specificities of observational techniques and their application may help support the possibility of upholding a crucial patient–staff therapeutic relationship that is often seen as severely hindered during seclusion sessions.

Our study demonstrates that even though seclusion was ultimately experienced as a custodial practice that radically reduced personal autonomy, we found that desirable therapeutic effects were promoted by using viewing panels and cameras as observation techniques. More concretely, our study showed being aware that a nurse was outside the seclusion room monitoring either via viewing panel or via camera promoted feelings of having a relational connection to staff and ultimately provided patients with a sense of safety. However, though both provided a sense of presence, viewing panels and cameras did yield substantially critical differences in patients' experiences, which needs to be included to guide future seclusion practices. According to Berg et al. (2023), staff needs to tailor communication with patients in seclusion in ways that accommodate their unique needs to promote more positive seclusion experiences. Our study supports these insights by Berg et al. (2023) but argues that different observation techniques may provide very different possibilities for how such tailored communication between staff and patients may unfold. As demonstrated through the experiences of our patients, we argue that viewing panels may be specifically well suited to uphold and promote communication because they, according to patients, permitted the staff to easily communicate information (i.e. by staff reading newspapers or books), which in turn became experienced as providing engagement, hope and a connection to reality in circumstances when patients may be experiencing psychotic symptoms.

Moreover, according to Tulloch et al. (2022) and Berg et al. (2023), good communication between staff and patients in seclusion creates the basis for a strong patient–staff connection. Focusing on observational techniques, we argue that different observational techniques during seclusion provide very different possibilities (if any currently) for upholding especially non-verbal forms of staff–patient communication. Our study highlighted that many participants (eight out of ten) preferred the additional observation via viewing panel because it promoted hope through therapeutic two-way communication. Though overall acknowledged as an acceptable form of observation, the patients did not attribute the same experiences of having two-way verbal and non-verbal communication between staff and patients when using cameras. Using cameras as an observation method was mainly experienced as a method of providing security. According to Varpula et al. (2020), enhanced camera surveillance in the seclusion room that covers multiple angles may assist nurses in being more aware of patient activities in the seclusion room. For example, cameras can also help identify subtle safety hazards in the clinical setting needing management (Yanes et al., 2016).

Moreover, cameras in seclusion rooms can be a valuable method to let nurses know when patients are ready to come out of seclusion (Holmes et al., 2015). Despite providing staff and patients with an imparted sense of safety for the patients, especially in recognizing medical and psychiatric emergencies, our study underlined adverse effects experienced by patients. As demonstrated in our study, several participants experienced the use of cameras as equated to less direct personal contact with nurses compared to viewing panels. Therefore, we argue that the sole use of a camera during seclusion may inhibit vital patient–staff connections by hindering interactions and preventing effective verbal and non-verbal communication. Moreover, relying solely on cameras during seclusion may create an atmosphere of detachment from the outside world. According to Varpula et al. (2022), more vigilant observation and video observation with two-way communication to prevent adverse events may be called for. We agree but infer that though CCTV cameras may assist when observing patients during seclusion, it is crucial to supplement such technologies with the use of direct forms of observation, for example, viewing panels, to support patient–staff communication further and thereby reap the therapeutic benefits and counter the mentioned adverse outcomes, that is, feelings of detachment.

Using videos for observation may, however, raise other concerns that may not be salient when viewing panels are used. Though providing safety, the participants in this study tended to link privacy inside the seclusion room with maintaining a person's dignity. Here, cameras were perceived as giving rise to specific concerns about the relationship between staff and patients. As seen in our study,

using cameras could compromise privacy and underlined a need to ensure that staff does not capture a patient in a potentially undignified situation when using cameras in the seclusion room. Such experiences linking infringing on patients' privacy due to the presence of a camera in the room have been documented in previous studies (Department of Health, & Human Services, Australia, 2018; Martinez et al., 1999). Following the patients in our study, we argue that such breaches in privacy are crucial to address in the development of future seclusion practices and specifically recommend pixellating the camera as a positive remedy to maintain dignity and privacy in seclusion.

Participants' view on using a mirror reflects their lack of experience with such measures for observation in a seclusion room. This method requires further exploration. While seclusion is used as a last resort in managing aggression and violence, the study findings identify nurses' role in engaging in therapeutic care to patients using the observation panel and the camera. This study offers new insight into patients' experiences in a forensic setting of observations in seclusion.

As underlined in the CHIME-S framework (Connectedness, Hope and Optimism, Identity, Meaning, Empowerment, Safety and Security) for forensic mental health patients proposed by Senneseth et al. (2022), providing safety and security is an essential component of the recovery process. This leads us to state that though, ultimately, viewed as a custodial practice; seclusion practices do not necessarily need to stand in opposition to the recovery process if conducted according to patients' perspectives and needs. As seen in this paper, we argue that observation techniques during seclusion are instrumental in accommodating the needs of patients but argue that care should be taken when deciding how to observe, as diverse forms of observation such as viewing panels, cameras and mirrors yield very different potentials for such accommodation.

The authors acknowledge that retrospective studies have the limitation of depending on participants' memory of their experience. However, due to patients' clinical presentation at the time of seclusion and from an ethical perspective, it was not possible to interview patients while they were in seclusion.

5.1 | What the study adds to existing research

Previous studies (Askew et al., 2019, 2020; Ezeobele et al., 2014; Larsen & Terkelsen, 2014) have captured patient experiences of seclusion, however, none of these studies compared the influence of different observational techniques may have for patients' experiences. This study explicitly compared and discussed the implications of using specific observation methods in seclusion seen from the perspective of patients.

A recent video observation study by Varpula et al. (2022) identified hazards in seclusion room based on video recordings of the room. It is evident from our study that camera in the room is essential in managing safety and security of the patient. However, the presence of camera may also be seen as compromising patients' privacy and dignity. Hence, we recommend pixellating the video camera. Moreover, cameras may be experienced as hindering two-way relational contact with staff.

The need for communicating with the patient in seclusion was a recurring theme in this study. Providing prior information to patients on observation methods in seclusion and the need for engaging patients while in seclusion were emphasized. Tulloch et al. (2022) highlighted the importance of nurses' communicating with patients to minimize the negative effects of seclusion. We demonstrated the highly important role that different modes of observation may have for patient-staff connection and communication and, that the patients in seclusion can be engaged in meaningful activities using different communication tools. Observation is to ensure patient's well-being through communication and engagement and not mere 'looking at' a patient.

5.2 | Implications for practice

Findings from this study highlighted the need for continued focus among mental health nurses in providing relational care and support for patients in seclusion. Communication is the key to ensuring a human connection in isolation. Enquiring about patients' well-being from outside the door and reading aloud news, poems or anything that they are interested in, was reported as engaging in meaningful activity that helps overcome their anxiety, fear and boredom to an extent. This is an example of providing individualized care for patients in seclusion. Hence, encouraging nurses to document the communication methods used with patients in seclusion would encourage continuity in care. In this regard, communication training and relational skills training for mental health nurses to manage challenging care situations are recommended (Tulloch et al., 2022).

Irrespective of the observation method we have demonstrated that a lack of information on seclusion among patients was evident in this study. Hence, to further develop future seclusion interventions in ways that promote relational care should work, a co-produced information leaflet may be made available to patients on seclusion highlighting the different methods of observation used in the seclusion room. Thus, providing accessible information to patients might reduce their anxiety and make them feel safe in the room. However, not all observation methods provide equal possibilities for promoting and sustaining relational contact and communication between patients and staff. For mental health nurses' future practices, we argue that viewing panels may be important if nurses become educated to utilize them correctly because they help stimulate relational contact and communication during seclusion to benefit patients. The use of camera for observation appears more useful in the early identification of emergencies. However, lack of direct two-way contact may mean mental health nurses lose a vital possibility for sustaining relational contact with patients during seclusion. Moreover, understanding of video recording and an apprehension who will be watching the video further strengthens the need for providing information to patients.

The presence of a camera in the room may affect how patients view their privacy and dignity maintained in seclusion room. Camera may be considered invading privacy and dignity especially when using the toilet facility. Based on our findings, we recommend mental health services to consider pixellating the camera to give a sense of privacy to patients in seclusion.

All forms of observation described in our study depend on education to reap their potential benefits. In the field of mental health nursing, our study therefore underlines a paramount need for future education on observation tools and methods to promote recovery-orientated service.

The overarching goal for all mental health services is to prevent seclusion however when seclusion is used as a last resort to manage risk to others, it should be done in ways that recognize the human rights of the patient, in ways that are least harmful, and in ways that recognize and cater to patients' unique needs.

For future research, the perspectives and experiences of mental health nurses comparing observational methods would be relevant. The professional perspective might usefully include the advantages of CCTV for improved observation of blind spots, the advantages of recording CCTV for future insight-related work and for monitoring best practices for legal compliance, audit, training and quality management.

6 | CONCLUSION

This study explored Irish forensic mental health service users' experience of being observed in the seclusion room. Participants recommend the use of both the viewing panel and camera in the room for observation. Participants viewed observation in seclusion as essential. While the use of the viewing panel for observation communicated human connection, comfort and reassurance, the camera provided a sense of safety especially in emergencies. There were mixed reactions to use of a camera for observation. Concerns were raised about patients' privacy and dignity in the seclusion room. Pixellating the camera seemed acceptable to participants in assuring privacy and dignity. A third method, the use of mirror was seen as an aid for observation.

We believe that the study findings have several implications for mental health practice. A key finding from this study is the importance of communication with patients be it before, during or after the seclusion. A co-produced information leaflet on observation methods in seclusion rooms may empower patients in this regard. While in seclusion, nurses may make use of different plans of action to interact with patients. Presence of nurses outside the seclusion room also communicates comfort and security. Using both the viewing panel and camera for interaction and observation is essential.

7 | RELEVANCE STATEMENT

This study strengthens the necessity for nurse–patient communication during seclusion from the patients' perspective. While every mental health service must strive to prevent coercive practices, in some challenging situations, seclusion may be used as a last resort. Hence, continuous observation is essential in ensuring patient safety, to give a sense of caring and to intervene in emergency situations. Direct observation may be carried out using a viewing panel (a small window on the seclusion door) and/or via the camera. Communicating and engaging patients in meaningful activities ensures individualized care in seclusion. It is evident that patients reported feeling safe and cared for, in nurses' presence and interaction. Hence, nurses must be afforded further training opportunities to enhance their communication skills in challenging situations. Educating patients in some of the care practices is paramount to reduce their anxiety thus helping them cope better in such situations. Technology is useful in aiding nurses to enhance their observation however care must be taken to protect the human rights of the patients. Basic rights such as their right to privacy and dignity can be achieved by pixelating the camera in the seclusion room. This study further supports preventing coercive practices in mental health settings and promoting patient involvement in their care and treatment.

AUTHOR CONTRIBUTIONS

SRS and SB conducted the interviews and wrote and developed the manuscript. MDT, DT, HGK and MT critically reviewed the manuscript. All authors approved the final manuscript, confirmed they met the authorship criteria and agreed with its content. The authors report no conflict of interest.

ACKNOWLEDGEMENTS

This study was fully supported by the National Forensic Mental Health Service, Central Mental Hospital, Portrane, Ireland. Open access funding provided by IReL.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

ETHICS STATEMENT

This study has ethical permission from the Audit, Research & Ethics Committee, National Forensic Mental Health Service, Ireland (Approval Ref No: AUD/18062021/SR).

ORCID

Shobha Rani Shetty https://orcid.org/0000-0001-9196-1381
Shauna Burke https://orcid.org/0000-0002-6001-7651
Harry G. Kennedy https://orcid.org/0000-0003-3174-3272
Morten Deleuran Terkildsen https://orcid.org/0000-0002-0974-3164

REFERENCES

Askew, L., Fisher, P., & Beazley, P. (2019). What are adult psychiatric inpatients' experience of seclusion: A systematic review of qualitative studies. *Journal of Psychiatric and Mental Health Nursing*, *26*(7–8), 274–285. https://doi.org/10.1111/jpm.12537

Askew, L., Fisher, P., & Beazley, P. (2020). Being in a seclusion room: The forensic psychiatric inpatients' perspective. *Journal of Psychiatric and Mental Health Nursing*, *27*, 272–280. https://doi.org/10.1111/jpm.12576

Berg, J., Lipponen, E., Sailas, E., Soininen, P., Varpula, J., Välimäki, M., & Lahti, M. (2023). Nurses' perceptions of nurse–patient communication in seclusion rooms in psychiatric inpatient care: A focus group study. *Journal of Psychiatric and Mental Health Nursing*., *30*(4), 781–794. https://doi.org/10.1111/jpm.12907

Bowers, L., Stewart, D., Papadopoulos, C., Dack, C., Ross, J., Khanom, H., & Jeffery, D. (2011). *Inpatient violence and aggression: A literature*. Report from the conflict and containment reduction research Programme. Available at:. www.kcl.ac.uk/iop/depts/hspr/research/ciemh/mhn/projects/litreview/LitRevAgg.Pdf

Chieze, M., Hurst, S., Kaiser, S., & Sentissi, O. (2019). Effects of seclusion and restraint in adult psychiatry: A systematic review. *Frontiers in Psychiatry*, *10*, 491. https://doi.org/10.3389/fpsyt.2019.00491

Clarke, C., Lumbard, D., Sambrook, S., & Kerr, K. (2016). What does recovery mean to a forensic mental health patient? A systematic review and narrative synthesis of the qualitative literature. *The Journal of Forensic Psychiatry & Psychology*, *27*(1), 38–54. https://doi.org/10.1080/14789949.2015.1102311

Cohen, L., Manion, L., & Morrison, K. (2011). *Research methods in education*. Routledge.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential–phenomenological alternatives for psychology* (pp. 48–71). Oxford University Press.

Council of Europe: Committee for the Prevention of Torture. (2017). *Means of restraint in psychiatric establishments for adults (revised CPT standards)*. In: Council of Europe CPT/Inf(2017)6 (Revised ed.). Council of Europe.

Cullen, A. E., Bowers, L., Khondoker, M., Pettit, S., Achilla, E., Koeser, L., Moylan, L., Baker, J., Quirk, A., Sethi, F., Stewart, D., McCrone, P., & Tulloch, A. D. (2018). Factors associated with use of psychiatric intensive care and seclusion in adult inpatient mental health services. *Epidemiology and Psychiatric Sciences*, *27*(1), 51–61. https://doi.org/10.1017/S2045796016000731

DeJonckheere, M., & Vaughn, L. M. (2019). Semi structured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health*., *7*, e000057. https://doi.org/10.1136/fmch-2018-000057

Department of Health & Human Services. (2018). *Surveillance and privacy in designated mental health services, audio surveillance devices*. Victorian Government.

Dickens, G., Piccirillo, M., & Alderman, N. (2013). Aggression in forensic mental health. *International Journal of Mental Health Nursing*, *22*, 532–544. https://doi.org/10.1111/j.1447-0349.2012.00888.x

Dickens, G. L., Picchioni, M. M., & Long, C. G. (2013). Aggression in specialist secure and forensic inpatient mental health care: Incidence across care pathways. *The Journal of Forensic Practice*, *15*(3), 206–217. https://doi.org/10.1108/JFP-09-2012-0017

Ezeobele, I. E., Malecha, A. T., Mock, A., Mackey-Godine, A., & Hughes, M. (2014). Patients' lived seclusion experience in acute psychiatric hospital in the United States: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, *21*, 303–312.

Flammer, E., Frank, U., & Steinert, T. (2020). Freedom restrictive coercive measures in forensic psychiatry. *Frontiers in Psychiatry*, *11*, 146. https://doi.org/10.3389/fpsyt.2020.00146

Hansen, A., Hazelton, M., Rosina, R., & Inder, K. (2022). What do we know about the experience of seclusion in a forensic setting? An integrative literature review. *International Journal of Mental Health Nursing*, *31*, 1109–1124. https://doi.org/10.1111/inm.13002

Harpøth, A., Kennedy, H., Terkildsen, M. D., Nørremark, B., Carlsen, A. H., & Sørensen, L. U. (2022). Do improved structural surroundings reduce restrictive practices in psychiatry? *International Journal of Mental Health Systems*, *16*, 53. https://doi.org/10.1186/s13033-022-00562-7

Holmes, D., Murray, S. J., & Knack, N. (2015). Experiencing seclusion in a forensic psychiatric setting: A phenomenological study. *Journal of Forensic Nursing*, *11*(4), 200–213. https://doi.org/10.1097/JFN.0000000000000088

Iversen, V. C., Sallaup, T., Vaaler, A. E., Helvik, A., Morken, G., & Linaker, O. (2011). Patients' perceptions of their stay in a psychiatric seclusion area. *Journal of Psychiatric Intensive Care*, *7*(1), 1–10.

Kennedy, H. G., Mullaney, R., McKenna, P., Thompson, J., Timmons, D., Gill, P., O'Sullivan, O. P., Braham, P., Duffy, D., Kearns, A., Linehan, S., Mohan, D., Monks, S., McLoughlin, L., O'Connell, P., O'Neill, C., Wright, B., O'Reilly, K., & Davoren, M. (2020). A tool to evaluate proportionality and necessity in the use of restrictive practices in forensic mental health settings: The DRILL tool (Dundrum restriction, intrusion and liberty ladders). *BMC Psychiatry*, *20*, 515. https://doi.org/10.1186/s12888-020-02912-6

Kontio, R., Joffe, G., Putkonen, H., Kuosmanen, L., Hane, K., Holi, M., & Välimäki, M. (2012). Seclusion and restraint in psychiatry: patients' experiences and practical suggestions on how to improve practices and use alternatives. *Perspectives in Psychiatric Care*, *48*(1), 16–24.

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*, 65–76.

Larsen, I. B., & Terkelsen, T. B. (2014). Coercion in a locked psychiatric ward: Perspectives of patients and staff. *Nursing Ethics*, *21*(4), 426–436. https://doi.org/10.1177/0969733013503601

Mann, B., Matias, E., & Allen, J. (2014). Recovery in forensic services: Facing the challenge. *Advances in Psychiatric Treatment*, *20*(2), 125–131. https://doi.org/10.1192/apt.bp.113.011403

Marshall, L. A., & Adams, E. A. (2018). Building from the ground up: Exploring forensic mental health staff's relationships with patients. *The Journal of Forensic Psychiatry & Psychology*, *29*(5), 744–761. https://doi.org/10.1080/14789949.2018.1508486

Martin, T., & Street, A. F. (2003). Exploring evidence of the therapeutic relationship in forensic psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing*, *10*(5), 543–551.

Martinez, R. J., Grimm, M., & Adamson, M. (1999). From the other side of the door: Patient views of seclusion. *Journal of Psychosocial Nursing and Mental Health Services*, *37*(3), 13–22.

Meehan, T., Vermeer, C., & Windsor, C. (2000). Patients' perceptions of seclusion: A qualitative investigation. *Journal of Advanced Nursing*, *31*(2), 370–377.

Mental Health Commission. (2014). *Seclusion and restraint reduction strategy*. Dublin.

Mental Health Commission Rules. (2009). *Rules governing the use of seclusion and mechanical means of bodily restraint issued pursuant to section 69(2) of the Mental Health Act, 2001*. Mental Health Commission.

Meyers, A. (2019). *A Phenomenological Study of the Lived Experiences of Counseling Students in a Co-Facilitated Experiential Group*. Graduate Theses and Dissertations. University of Arkansas, Fayetteville. Retrieved from https://scholarworks.uark.edu/etd/3272

Møllerhøj, J., & Os Stølan, L. (2018). 'First and foremost a human being…': User perspectives on mental health services from 50 mentally disordered offenders. *Nordic Journal of Psychiatry*, *72*(8), 593–598.

Ntsaba, G. M., & Havenga, Y. (2008). Psychiatric in-patients' experience of being secluded in a specific hospital in Lesotho. *Health SA Gesondheid*, *12*(4), 3–12. https://doi.org/10.4102/hsag.v12i4.267

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine*, *89*(9), 1245–1251. https://doi.org/10.1097/ACM.0000000000000388

Power, T., Baker, A., & Jackson, D. (2020). 'Only ever as a last resort': Mental health nurses' experiences of restrictive practices.

International Journal of Mental Health Nursing, *29*, 674–684. https://doi.org/10.1111/inm.12701bs_bs_banner

Ray, R. E., & Allen, D. E. (2015). Why do nurses continue to watch patients to maintain safety? *Journal of the American Psychiatric Nurses Association*, *21*(6), 381–383.

Senneseth, M., Pollak, C., Urheim, R., Logan, C., & Palmstierna, T. (2022). Personal recovery and its challenges in forensic mental health: Systematic review and thematic synthesis of the qualitative literature. *BJPsych Open*, *8*(e17), 1–15. https://doi.org/10.1192/bjo.2021.1068

Steinert, T., Birk, M., Flammer, E., & Bergk, J. (2013). Subjective distress after seclusion or mechanical restraint: One-year follow-up of a randomized controlled study. *Psychiatric Services*, *64*(10), 1012–1017.

Teherani, A., Martimianakis, T., Stenfors-Hayes, T., Wadhwa, A., & Varpio, L. (2015). Choosing a qualitative research approach. *Journal of Graduate Medical Education*, *7*, 669–670. https://doi.org/10.4300/JGME-D-15-00414.1

Terkildsen, M. D., Kennedy, H., Jentz, C., & Sørensen, L. U. (2022). Online video games and patient–staff power relations. A qualitative study of care and custody in forensic psychiatry. *Journal of Psychiatric and Mental Health Nursing*, *29*, 493–503. https://doi.org/10.1111/jpm.12813

Terkildsen, M. D., Vestergaard, L. K., Møllerhøj, J., & Sørensen, L. U. (2022). Forensic psychiatric Patients' perspectives on COVID-19 prevention measures: A qualitative study. *Journal of Forensic Psychology Researrch and Practice*, 1–23. https://doi.org/10.1080/24732850.2022.2118095. Online publication.

Trestman, R. L. (2017). Treating aggression in forensic psychiatric settings. *The Journal of the American Academy of Psychiatry and the Law*, *45*(1), 40–43.

Tulloch, L., Walker, H., & Ion, R. (2022). "It's the last resort" forensic mental health nurses experience on the use of seclusion; implications for use and elimination in clinical practice. *The Journal of Forensic Psychiatry & Psychology*, *33*(6), 828–845. https://doi.org/10.1080/14789949.2022.2122857

Uhrskov Sørensen, L., Bengtson, S., Lund, J., Ibsen, M., & Långström, N. (2020). Mortality among male forensic and non-forensic psychiatric patients:Matched cohort study of rates, predictors and causes-of-death. *Nordic Journal of Psychiatry*, *74*(7), 489–496. https://doi.org/10.1080/08039488.2020.1743753

Varpula, J., Valimaki, M., Lantt, T., Berg, J., Soininen, P., & Lahti, M. (2022). Safety hazards in patient seclusion events in psychiatric care: A video observation study. *Journal of Psychiatric and Mental Health Nursing*, *29*, 359–373.

Varpula, J., Valimaki, M., Lantta, T., Berg, J., & Lahti, M. (2020). Nurses'perceptions of risks for occupational hazards in patient seclusion andrestraint practices in psychiatric inpatient care: A focus group study. *International Journal of Mental Health Nursing*, *29*, 703–715.

Ward, T. (2013). Addressing the dual relationship problem in forensic and correctional practice. *Aggression and Violent Behavior*, *18*(1), 92–100.

Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing*, *25*(3), 172–180. https://doi.org/10.1177/0898010106295172

Yanes, A. F., McElroy, L. M., Abecassis, Z. A., Holl, J., Woods, D., & Ladner, D. P. (2016). Observation for assessment of clinician performance: A narrative review. *BMJ Quality & Safety*, *25*(1), 46–55.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Shetty, S. R., Burke, S., Timmons, D., Kennedy, H. G., Tuohy, M., & Terkildsen, M. D. (2023). Patient perspective on observation methods used in seclusion room in an Irish forensic mental health setting: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, *00*, 1–12. https://doi.org/10.1111/jpm.12979