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Article:
Griffin, B. orcid.org/0000-0002-2563-1509, Baker, J., Vogt, K.S. et al. (2 more authors) (Accepted: 2025) Service users' experiences of restrictive practices in adult inpatient mental health services. A systematic review and meta-ethnography of qualitative studies. Journal of Mental Health. ISSN 0963-8237 (In Press)

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Service users' experiences of restrictive practices in adult inpatient mental health services. A systematic review and meta-ethnography of qualitative studies

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Service users' experiences of restrictive practices in adult inpatient mental health services. A systematic review and meta-ethnography of qualitative studies

Abstract

Background. There is a focus globally on reducing restrictive practices in mental healthcare. However, we know little about how service users experience restrictive practices generally. Aim. To explore and synthesise experiences of restrictive practices in adult inpatients mental health settings and to report on the depth and breadth of the literature. Methods. CINAHL, PsycINFO, Scopus, MEDLINE and Embase were searched. Qualitative studies exploring the service user experience of restrictive practices were included and analysed using meta-ethnographic synthesis. Results. Twenty-seven papers were included. Restrictive practices are experienced negatively by service users, who feel punished and powerless when the therapeutic relationship is weak, and communication is lacking. The third-order constructs were: 1) anti-therapeutic and dehumanising, 2) a vicious cycle, 3) an abuse of power and 4) the critical role of support and communication (subthemes: i) the impact of communication and ii) how support and communication can minimise negative impacts). Conclusions. Participants suggest that increasing supportive communication and detailing the decision making for using restrictive practices, would reduce feelings of coercion and increase trust in staff. Future research into the experience of restrictive practice should aim to capture the experience of informal restrictive practices such as locked doors and coercive language.

PRSIMA/PROSPERO Statement: The review has been conducted and reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; see Supplemental Materials Table S1) and the Meta-Ethnography Reporting Guidelines (eMERGE; see Supplemental Materials Table S2). The protocol was registered on PROSPERO (registration number: CRD42023399272; URL: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42023399272) .

Keywords: restrictive practice; coercion; experience; qualitative; review

Introduction

Restrictive practices are defined as deliberate acts to restrict a service user's movement, liberty and/or freedom, to take control of a potentially dangerous or harmful situation in inpatient services (Department of Health, 2015; NICE, 2015). Such practices include formal measures such as restraint, seclusion, and rapid tranquilisation, but also informal measures such as ward rules, such as locked doors, restrictions on movements around the ward and even coercive language (NICE, 2015). These interventions should only be used as a last resort after implementing de-escalation techniques and should not be put in place for longer than is necessary (Allikmets et al., 2020; Department of Health, 2014). Restrictive practices continue to be used in inpatient mental health settings globally, despite considerable debate about their use and the potential implications for patient's human rights (Amara, 2023; Hallett & McLaughlin, 2022; Maker & McSherry, 2019; World Health Organization, 2023).

Healthcare staff have reported feeling reliant on these measures to be able to protect themselves and other inpatients on wards (Moghadam et al., 2014), expressing concerns that the elimination of restrictive practices would negatively impact both patient and staff physical safety (Gerace & Muir-Cochrane, 2019; Snipe & Searby, 2023). Similarly, service users have stated some interventions are necessary to keep themselves and others physically safe (Butterworth et al., 2022; Cusack et al., 2018; Muir-Cochrane & Oster, 2021). Although staff and service users understand the physical safety aspect of restrictive practices, these measures can also create trauma and anxiety, and negatively impact therapeutic relationships (Chieze et al., 2019; Martin, 2023; Mellow et al., 2017; Wynn, 2004).

Globally, there is a focus on reducing restrictive practices in mental healthcare (World Health Organization, 2021). It could be argued that restrictive practices vary

widely. More intrusive measures, such as seclusion and restraint, are typically experienced by an individual patient on the ward, whereas less intrusive measures are applied across a whole ward (Paradis-Gagne et al., 2021). Here, we argue that all measures that have the intent to limit a person's movement are restrictive in nature and impact on the autonomy of individuals, thus should be viewed collectively. Similarly, previous research has demonstrated that wards that have high rates of using one restrictive measure, are more likely to have higher rates of other restrictive practices (Bowers et al., 2015). This is also the case for individual patients.

We know little about how service users experience both formal and informal measures of restrictive practices as a collective experience. This could mean that the priorities of reduction efforts and developed interventions may not be best suited to the needs of inpatients. For example, focusing on reducing formal measures such as seclusion and restraint, rather than focusing on the interaction between formal and informal measures. Synthesising the existing literature on a range of interventions could be the first step to exploring and reporting a thematic account of the wider experience. Similarly, without considering the wider context of restrictive practices (for example, times when restrictive practices may have been used effectively) and how this is experienced by service users, we cannot identify times where restrictive practices are used effectively and in the least harmful way.

Previous systematic and scoping reviews have focused on the experience of specific interventions under the restrictive practice umbrella, for example focusing on seclusion alone (Askew et al., 2019; Mellow et al., 2017), restraint alone (Evans & FitzGerald, 2014) or seclusion and restraint (Chieze et al., 2019). Only two published reviews have used the term 'restrictive practice', limiting themselves to specific inpatient settings (acute settings; Butterworth et al., 2022); secure settings, (Lawrence et

al., 2021), with specialist wards (i.e., PICU and eating disorder wards) being excluded. Lawrence et al. (2021) also combined service user and staff perspectives together, preventing conclusions relating to the service user perspective specifically. Search terms in these reviews referred to restraint, seclusion, segregation, sedation and 'blanket bans' (referring to restrictions given to all patients which can vary between wards) in Butterworth et al. (2022) and coercion, physical restraint and seclusion in Lawrence et al. (2021). Based on these search terms, previous reviews could have excluded certain measures that are restrictive in nature such as segregation (in the case of Lawrence et al., 2021) and restrictions on a person's ability to act independently, for example locked doors, constant observations and coercion and compulsion related to treatment (Department of Health and Social Care, 2021).

While the complexity of the subject matter is considerable, a review synthesising the available literature and service user experiences across all interventions, both formal and informal, and all adult inpatient mental health settings should be carried out to understand how best to move forward in both practice and research, as it is likely that inpatients will experience various forms of restrictive practice. Thus, the aim of the current systematic review was to explore and synthesise service users' experiences of restrictive practices in adult inpatient mental health settings, and to report on the depth and breadth of the literature. The current review addressed this by including additional interventions and measures (long- and short-term sedation, coercion and compulsion in relation to treatment, and constant observations) that were not considered in previous reviews, and across a wider range of adult inpatient mental health settings (e.g., including PICU and specialist treatment wards). An extensive list of what constitutes restrictive practice in the context of this paper is outlined in the eligibility criteria. This work builds on previous reviews by using a

meta-ethnographic synthesis approach to answer, “What are service users’ experiences of restrictive practice while in adult inpatient mental health services?”.

Materials and Methods

The review was conducted and reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; see Supplemental Materials Table S1) and the Meta-Ethnography Reporting Guidelines (eMERGE; see Supplemental Materials Table S2). The protocol was registered on PROSPERO (registration number: CRD42023399272; URL: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42023399272).

Ethical considerations

Quotes used in the meta-ethnographic synthesis were extracted from published peer-reviewed journal articles in the public domain. No new data or access to participants was involved in this review. As such, no ethical review was required.

Eligibility criteria

English language empirical qualitative research, conducted in adult (18-65 years) inpatient mental health settings (specialist wards such as eating disorder wards were included), reporting services users’ experiences of restrictive practices were eligible for inclusion. For the purpose of this review, restrictive practices refers to any of the following interventions or measures: locked doors, preventing a person from entering certain areas of the living space and segregation, seclusion, manual and mechanical restraint, rapid tranquilisation (also referred to as chemical restraint) and long-term sedations, coercion and compulsion related to treatment (also referred to as coercive language and treatment pressures) and constant observations. Interventions and

measures were included based on the National Institute for Health and Care Excellence (NICE) guidance (NICE, 2015) and under guidance from experts in the field supervising the project (JB and JJ).

Quantitative and mixed methods research that did not adequately separate quantitative and qualitative findings was not eligible for the purpose of meta-ethnographic synthesis. Similarly, studies solely reporting experiences of perceived coercion, involuntary admission and 'blanket bans' put in place due to organisational policy or as part of an individualised care plan, as well as studies that solely focused on staff accounts or did not adequately separate staff and service user accounts were not eligible for inclusion. Books, reviews, government policy, conference abstracts and grey literature were not eligible. Studies carried out with adolescents or children or solely focused on older adults (aged over 65) were not included, as well as research carried out in forensic units due to the additional legal proceedings which may impact their treatment.

Search strategy

Across the literature and in practice, the following are used interchangeably: restrictive interventions, restrictive measures, coercion and coercive intervention. Similarly, individual measures are referred to differently across the literature, thus the search needed to consider and address this. Search terms (example available in the Supplemental Material S1) were therefore developed using the SPIDER framework (Cooke et al., 2012): Sample (service users), Phenomenon of Interest (restrictive practice and inpatient mental health), Design (interviews/focus groups), Evaluation (experience) and Research Type (qualitative), using search terms used in previous reviews of a similar scope (Baker et al., 2021; Butterworth et al., 2022) and under

supervision from an expert in the research area (JB) and expert in the methodology of systematic reviews and meta-ethnography (JJ). CINAHL, PsycINFO, Scopus, MEDLINE and Embase were searched by the primary author (BG) from inception to 24 February 2023, and updated to 20 September 2023 with no limitations on publication date. Reference lists of eligible studies and relevant previous reviews were also scanned.

Study selection

Eligible papers were extracted to the systematic review software Rayyan, where duplicate entries were removed. Rayyan is an online platform designed to aid screening and organisation of references for systematic reviews. The platform supports collaboration between reviewers to allow for blind screening. Here ineligible sources, for example book chapters and conference abstracts, were also identified by Rayyan, then checked and removed. Study selection consisted of two stages. First, full double screening of titles and abstracts was carried out independently by two reviewers (BG, JR), who then met to resolve any disagreements. Full-text screening was carried out by one reviewer, who then met with the research team (JJ, JB and KV) to discuss and confirm eligible papers. See figure 1 for PRISMA flow diagram.

FIGURE 1 INSERTED HERE

Data extraction

Single author (BG) extraction was carried out and recorded in a Microsoft Excel worksheet: sampling profile (population, characteristics, size), country of origin, study aims, restrictive practice reported, methodology and key findings. Qualitative data, including quotations from participants (first-order constructs) and key concepts reported

by the original authors (second-author constructs) were extracted into a second Microsoft Word document.

Method of quality assessment

The Critical Appraisal Skills Programme (CASP) qualitative research checklist was used to assess the eligible studies. The first author (BG) appraised all papers independently, with 20% checked with a member of the research team (JR) to enhance rigour. This tool has been used previously in qualitative reviews, where a numerical value out of 10 is given with a higher score indicating greater quality (Sattar et al., 2020). While a limitation of the CASP is the subjective nature of the questions, focusing on methodology rather than conceptual strengths (Sattar et al., 2021), the tool was used to allow for 'higher quality papers' to be used as index papers for the meta-ethnographic synthesis. No papers were rejected because of their quality appraisal scores. However, higher quality papers were analysed first, and lower quality papers were analysed last and were thus less likely to significantly influence the number of created categories and constructs than higher quality papers.

Data synthesis

A meta-ethnographic approach was used to analyse and synthesise the findings from across the eligible studies to enable new insights into service users' experiences and perspectives, whilst considering the context. Meta-ethnography is a sophisticated method of synthesis of empirical qualitative papers that allows for greater higher-order interpretations (themes derived from empirical studies) in context, when compared to commonly used methods of narrative synthesis (Sattar et al., 2021). The use of this method allows for a greater understanding of service users' experiences of several interventions and practices, that is applicable to policy makers, staff and researchers in

inpatient mental health. The approach relies on the process of reciprocal translation to develop new interpretations, known as 'third-order' constructs to understand a chosen phenomenon (Sattar et al., 2021). The first stage involved the lead researcher (BG) reading the extracted first-order (quotes including in the original papers) and second-order (the original authors themes and/or interpretations) constructs, before moving to the second stage; grouping similar concepts from the second-order constructs from each paper, whilst considering the primary interpretation. The third stage comprised of the researcher carrying out reciprocal translation; synthesising concepts within categories to allow for rich and interpretative themes to be developed, while considering how the papers related or opposed the previous paper (for full details of this process see Supplemental File S3). This hierarchical process is based on the quality appraisal ratings from the CASP research checklist. This process continues through all the papers within that category. Alongside this, a translations table was created which included the first- and second-order constructs for each category, which was cross referenced to develop the third-order constructs (see Supplemental File Table S3).

The first author (BG) is a PhD student, with no prior experience working in, or being a patient of, inpatient mental health services. Her work was supervised by clinicians in the area, including a mental health nurse (JB), a clinical psychologist (JJ) and a trainee clinical psychologist (KV), all of whom have experience conducting research in this area. JR is also a PhD student with no prior experience working in, or being a patient of, inpatient mental health services, but is currently researching transitions in mental healthcare. Throughout this process, BG reflected on their interpretation of the categories, ensuring that the original author's interpretations and participants quotes were accurately considered and reported. All authors reviewed the developed third-order constructs.

Results

A total of 27 papers were included in the review (see Table 1 for the study characteristics table), published from 1998 (Johnson, 1998) to 2023 (Cusack et al., 2023; Li et al., 2023; Lynge et al., 2023; Mac Donald et al., 2023). Fifteen studies were conducted in Europe (Allikmets et al., 2020; Bendall et al., 2022; Cusack et al., 2023; Haglund & Von Essen, 2005; Hoekstra et al., 2004; Kontio et al., 2012; Kuosmanen et al., 2007; Lanthén et al., 2015; Lynge et al., 2023; Mac Donald et al., 2023; Nyttingnes et al., 2016; Scholes et al., 2022; Tully et al., 2022; Verbeke et al., 2019; Wynn, 2004), four in North America (Ezeobele et al., 2014; Faschingbauer et al., 2013; Holmes et al., 2004; Johnson, 1998), three in Africa (Aluh et al., 2022; Mayers et al., 2010; Ntsaba & Havenga, 2007), three in Asia (Achir Yani Syuhaimie Hamid & Catharina Daulima, 2018; Chien et al., 2005; Li et al., 2023) and two in Australia (Meehan et al., 2000; Sambrano & Cox, 2013). Studies mainly recruited current inpatients (n = 18), however seven included former service users (Cusack et al., 2023; Hoekstra et al., 2004; Lanthén et al., 2015; Lynge et al., 2023; Mayers et al., 2010; Sambrano & Cox, 2013; Verbeke et al., 2019) and two used a combination of both (Bendall et al., 2022; Nyttingnes et al., 2016). Twenty-four studies included patients from non-specialised settings (i.e., acute and general psychiatric hospitals), one study recruited from a PICU (Allikmets et al., 2020), one study from specialised eating disorder units (Mac Donald et al., 2023) and one from an unspecified specialised care unit (Holmes et al., 2004). Twenty-three of the 27 studies reported gender, while only eight reported the ethnicity of participants (see Table 1 for full reported ethnicity and gender for each paper). The most common method of data collection was one-to-one interviews (n = 24), with two studies using focus groups (Aluh et al., 2022; Nyttingnes et al., 2016) and one using a combination of interviews and examining clinical records (Chien et al., 2005). Two of the 27 studies

explicitly reported the inclusion of lived experience researchers (Lynge et al., 2023; Mayers et al., 2010). Studies focused on a range of restrictive practices including: seclusion-only (n = 8), restraint-only (including physical holding, mechanical restraint and chemical restraint; n = 8), restrictive practice (n = 2), sedation, seclusion and restraint (n = 2), coercion (n = 2), locked doors only (n = 1), formal coercion and restraint (n = 1), seclusion and restraint (n = 1), deprivation of liberty (n = 1) and involuntary treatment (n = 1).

The full list of restrictive practices reported for each paper can be found in Table 1 and the way in which restrictive practices were represented in each third-order construct is presented in Online Supplementary Table S4. The CASP scores for the papers, following the scoring system used in previous research (Sattar et al., 2020), were as follows: two studies were considered low (scores less than or equal to 5), nine studies were considered moderate (scores of 6 or 7), 14 were considered high quality (scores of 8 or 9) and two studies were considered 'higher' quality (scores of ten) (see Online Supplementary Material Appendix S2).

TABLE 1 INSTERTED HERE

Reciprocal translations

The analysis resulted in four main third-order constructs, which demonstrate the mainly negative experience of restrictive practice, from the perspective of service users. The third-order constructs were: 1) anti-therapeutic and dehumanising, 2) a vicious cycle, 3) an abuse of power and 4) the critical role of support and communication (which includes the subthemes: i) the impact of

communication and ii) how support and communication can minimise negative impacts). Table 2 shows the studies represented within each theme.

Anti-therapeutic and dehumanising

Service users reported their experiences of restrictive practices to be contradictory to what is expected of healthcare. Service users described feeling that the staff on the wards used unjustifiable force when implementing restrictive interventions (Aluh et al., 2022; Chien et al., 2005; Lynge et al., 2023; Mayers et al., 2010; Meehan et al., 2000; Sambrano & Cox, 2013), which led participants to then experiencerestrictive practice as a punishment (Achir Yani Syuhaimie Hamid & Catharina Daulima, 2018; Chien et al., 2005; Holmes et al., 2004; Li et al., 2023; Mac Donald et al., 2023; Ntsaba & Havenga, 2007; Nyttingnes et al., 2016; Sambrano & Cox, 2013). Studies also reported that service users felt dehumanised due to restrictive practices, describing being treated like a prisoner (Bendall et al., 2022; Ezeobele et al., 2014; Haglund & Von Essen, 2005; Ntsaba & Havenga, 2007; Sambrano & Cox, 2013; Scholes et al., 2022) or like an animal (Allikmets et al., 2020; Chien et al., 2005; Mayers et al., 2010; Scholes et al., 2022). Treatment by the staff during seclusion or restraint (including physical, mechanical and chemical) events created feelings of humiliation and embarrassment (Allikmets et al., 2020; Aluh et al., 2022; Chien et al., 2005; Faschingbauer et al., 2013; Lynge et al., 2023; Ntsaba & Havenga, 2007; Nyttingnes et al., 2016; Sambrano & Cox, 2013). This was particularly exacerbated when service users' physical and personal needs (i.e., toileting, feeding and basic hygiene) were not met or cared for by staff during these events (Chien et al., 2005; Kontio et al., 2012; Ntsaba & Havenga, 2007). These experiences were linked with seclusion, restraint and rapid tranquilisation in studies which looked only at these forms of restrictive practices.

Service users also described the physical side effects of restrictive practices

(e.g., sleeping for consecutive days, being unable to walk and talk and involuntary movements) which they experienced because of restrictive practices relating to forced medication (Aluh et al., 2022; Sambrano & Cox, 2013) or being physically handled (e.g., physical restraint) (Achir Yani Syuhaimie Hamid & Catharina Daulima, 2018; Lynge et al., 2023). Other service users described restrictive practice as being an extension of stigma and discrimination against them due to their mental health (Aluh et al., 2022; Nyttingnes et al., 2016; Verbeke et al., 2019), often being treated as a symptom rather than a person (Mayers et al., 2010), which were not linked to specific restrictive practices but could be experienced in relation to a range of restrictive practices.

A vicious cycle

Experiencing restrictive practice at the hands of ward staff left service users questioning whether the measures resolved aggression, as they are intended to, or exacerbate feelings of anger and distress (Aluh et al., 2022; Bendall et al., 2022; Faschingbauer et al., 2013; Mac Donald et al., 2023; Scholes et al., 2022). Service users detailed how restrictive practices (particularly restrictions on leave, locked doors, and physical, mechanical and chemical restraint) were used to prevent aggression towards themselves and others (i.e., ward staff and other service users). They made participants feel frustrated, angry and more likely to partake in self-harm and risk behaviours, which participants reported led to further and stricter restrictive practice measures, such as seclusion and rapid tranquilisation (Aluh et al., 2022; Bendall et al., 2022; Haglund & Von Essen, 2005; Mac Donald et al., 2023; Scholes et al., 2022; Tully et al., 2022). Participants felt that the use of restrictive practice led to negative emotions in service users such as anxiety (Faschingbauer et al., 2013; Wynn, 2004) and fear (Achir Yani Syuhaimie Hamid & Catharina Daulima, 2018; Haglund & Von Essen, 2005; Holmes et

al., 2004; Lanthén et al., 2015; Meehan et al., 2000; Ntsaba & Havenga, 2007; Wynn, 2004), which was reported to manifest itself as anger (Holmes et al., 2004; Lanthén et al., 2015; Meehan et al., 2000; Wynn, 2004). Some studies reported service users feeling traumatised about receiving care from the same staff that can use restrictive practice (Aluh et al., 2022; Cusack et al., 2023; Scholes et al., 2022), particularly so for service users with a history of sexual abuse (Scholes et al., 2022), and the impact this could have on behaviour and emotions after restrictive practices had been used. An additional negative impact, especially for seclusion events, was the feeling of prolonged isolation infringing on service users' feelings of reality, trust, and implications for mental function (Hoekstra et al., 2004; Meehan et al., 2000), describing it as difficult to readjust to the ward environment after the event if no debriefing or re-orientation had been offered (Mayers et al., 2010).

TABLE 2 INSTERTED HERE

An abuse of power

Service users expressed that restrictive practice was experienced as a method of giving power to staff (Bendall et al., 2022; Ezeobele et al., 2014; Johnson, 1998; Kuosmanen et al., 2007; Mayers et al., 2010), using these methods as a way of controlling service users when decisions were questioned or resisted (Aluh et al., 2022; Nyttingnes et al., 2016; Sambrano & Cox, 2013) or taunting service users through 'games that cannot be won' (as described by service users; (Bendall et al., 2022)). This abuse of power left service users feeling powerless in return (Ezeobele et al., 2014; Haglund & Von Essen, 2005; Ntsaba & Havenga, 2007), leading them to implement their own coping strategies to regain feelings of control over their care (Hoekstra et al., 2004; Meehan et al., 2000). Service users expressed that they often felt it was easier to

conform to staffs' restrictive practice methods (Bendall et al., 2022; Holmes et al., 2004; Meehan et al., 2000) than question or resist.

The critical role of support and communication

The impact of communication. The experience of poor communication on the wards was demonstrated through: not being involved in decisions around the use of restrictive practice or being allowed to suggest alternatives (Mayers et al., 2010; Meehan et al., 2000; Tully et al., 2022; Verbeke et al., 2019), the lack of information provided about what led to the restrictive interventions being implemented (Chien et al., 2005; Ezeobele et al., 2014; Kontio et al., 2012; Mayers et al., 2010) and not being told how and when the intervention will end (Allikmets et al., 2020; Ntsaba & Havenga, 2007). Some studies reported service users trying to elicit a response or gain answers from staff but eventually 'giving up' seeing it as a futile attempt (Ntsaba & Havenga, 2007; Tully et al., 2022).

Service users acknowledged that restrictive practices are often necessary in providing physical safety for critically ill patients (Aluh et al., 2022; Bendall et al., 2022; Chien et al., 2005; Cusack et al., 2023; Lanthén et al., 2015; Li et al., 2023; Mac Donald et al., 2023; Tully et al., 2022), and that when staff expressed the reason for using restrictive practice, service users felt no need to defend themselves (Chien et al., 2005; Faschingbauer et al., 2013; Lanthén et al., 2015; Wynn, 2004) but when there was no explanation, feelings of coercion were exacerbated (Verbeke et al., 2019).

How support and communication can minimise negative impacts. Service users reported open communication between service users and staff and therapeutic support as suggestions for better ways to manage aggression (Achir Yani Syuhaimie Hamid &

Catharina Daulima, 2018; Allikmets et al., 2020; Faschingbauer et al., 2013; Kontio et al., 2012; Wynn, 2004), both before the restrictive events as a method of de-escalation (Faschingbauer et al., 2013; Kontio et al., 2012; Lanthén et al., 2015; Scholes et al., 2022; Wynn, 2004) and after the event as a method of debriefing (Faschingbauer et al., 2013). Caring and empathetic staff that treated service users as human, contributed to the therapeutic effects of restrictive practice (Chien et al., 2005; Faschingbauer et al., 2013; Kontio et al., 2012; Lanthén et al., 2015), such as enhancing feelings of physical safety (Lanthén et al., 2015).

Discussion

Restrictive practices experienced during inpatient mental healthcare appear to be perceived as a negative experience for service users, who feel punished and powerless when the staff-service user relationship is weak, and communication is lacking. Despite this, service users acknowledged that restrictive practices are often necessary in providing physical safety in times of crisis but the ways in which this is communicated could be improved. This experience seems to have impacted the trust that participants had in their treatment and the staff responsible to their care, which resulted in anxiety, fear and long-lasting psychological effects.

The current review advances on previous reviews by including a variety of inpatient settings (including PICU and eating disorder wards) and a wide range of interventions under the restrictive practice umbrella, to provide an account of the collective experience of restrictive practices, primarily the addition of locked doors and constant observation. However, patients from non-specialist wards (including acute and general psychiatric settings) comprised the majority of the participants included in studies in the review and seclusion and restraint (physical and chemical) were still the most frequently mentioned interventions. Despite this, all developed third-order

constructs included a range of restrictive practices (see Supplementary Material Table S4), with third-order construct 2) a vicious cycle, being developed primarily based on the experience of informal interventions such as locked doors, 'house rules' and coercive language related to treatment primarily. The review also highlights the discrepancies with the terminology used in this area, with different names used to describe the same interventions, for example coercion (Verbeke et al., 2019), deprivation of liberty (Kuosmanen et al., 2007) and restrictive practice (Tully et al., 2022) were all used to refer to seclusion, restraint, involuntary treatment (related to medication), locked doors and blanket bans. There were also examples of one phrase being used to describe different interventions, such as coercion being used to describe seclusion, restraint and forced medication (Aluh et al., 2022; Nyttingnes et al., 2016; Verbeke et al., 2019), as well as psychological and verbal pressures to take medication (Bendall et al., 2022). This work updates previous reviews (Butterworth et al., 2022); search concluding in 2021) by including eight additional papers published after 2022.

A key novel finding of this review, was the idea of restrictive practices creating a vicious cycle, in which service users questioned whether restrictive practice was supposed to de-escalate anger and aggression (towards self and/or others) or cause it. The negative feelings of anger, fear and anxiety as experienced by service users, have been mentioned in previous reviews (Butterworth et al., 2022; Chieze et al., 2019), however the cyclical nature of restrictive practice whereby these emotions, and the ways in which they are expressed, are met with further restrictions has not yet been explored. Previous work by Bowers (Bowers, 2014), developed a model of conflict (adverse events, including aggression and self-harm) and containment (referred as restrictive practices in the current review) in inpatient mental healthcare, identifies flashpoints from which conflict arises and staff react with containment. This work formed the basis

for the Safewards intervention which has been shown to successfully reduce conflict and containment on wards (Bowers et al., 2015). While the model considers a variety of flashpoints, ranging from patient characteristics to the ward environment (including locked doors and rules), it does not explicitly consider containment as a flashpoint. Considering the cyclical nature of restrictive practices in this context could extend the scope of the Safewards model and intervention, to also considering how restrictive practices used with lack of communication and explanation can lead to further, more explicit restrictions being used.

The experience of restrictive practices as a whole being anti-therapeutic and dehumanising, was found in previous reviews on the experience of restraint and seclusion resulting in re-traumatisation and negative physical and psychological impacts (Butterworth et al., 2022; Chieze et al., 2019). Similarly, the importance of communication has been shown in previous reviews (Butterworth et al., 2022; Cusack et al., 2018). However, a key finding from the current review is that supportive communication, that emphasises the role of physical safety in making decisions to use restrictive practice and involves the service user in these decisions, could reduce feelings of coercion and add a therapeutic element to restrictive practice. It is important to note that the studies included in this review had participants that were current patients, as well as participants who had been discharged and were reflecting on previous inpatient stays. Therefore, the acknowledgement of physical safety could come from reflections of the care they received and not necessarily their thoughts during crisis or when restrictive practices were being used.

Strengths and limitations

The use of meta-ethnographic synthesis is a strength of the current review as it preserves the properties of the original papers' primary data, while allowing new

emerging insights from the current authors interpretation of service users' experience of restrictive practice (Atkins et al., 2008; Sattar et al., 2021). There were several limitations of the current review to note. Firstly, the subjective nature of the CASP could have impacted the development of the third-order constructs; meaning objectively high-quality papers might have been subjectively rated lower and thus have less impact on the constructs than is needed. Secondly, the current review could not report on the experience of different ethnicities as only eight papers reported ethnicity. Third, the approach chosen for the current review, ordering based on higher quality scores, prioritises higher quality papers and allows them to influence the results section more strongly. However, this process prevents a sense of change over time being developed, meaning how these experiences change overtime cannot be commented on fully in this review. Fourth, as mentioned above, there are discrepancies as to what specific interventions constitute restrictive practices and the variations with the language used for individual practices. It is important to note the differences in the ways in which healthcare providers actually carry out the practices also. Therefore, while caution was taken to include all variations in terminology, it is possible that certain interventions and thus papers using these terms, have been missed. Fifth, grey literature was omitted from the current review. It is possible that important service user perspectives are missed as a result of this.

Practical and research recommendations

While service users acknowledge the need for restrictive practice in circumstances of crisis or when a service user is critically ill, practitioners should use the least restrictive practice they can in a situation, including the review of when locked doors and blanket restrictions are being used. Ensuring that patients feel psychologically safe, as well as physically safe should be a priority. Supportive and effective

communication can help to achieve this, as it can allow service users to be involved in decision making around their care and in turn build trust after an incident (Chien et al., 2005; Faschingbauer et al., 2013; Lanthén et al., 2015; Wynn, 2004). Methods of de-escalation should utilise a reciprocal process, involving both service users and staff, allowing space for self-regulation of both parties (Price et al., 2024). Staff should prioritise empathetic communication to aid trust and rapport during conflict (Gerace et al. 2018). While the cyclical nature of restrictive practice needs to be explored further, it demonstrates the need for debriefing and discussion (for both service users and staff) after the event, to ensure incidents are not happening repeatedly or to work through anger caused by restrictive practices. Staff should be supported in this, through effective training and evaluation of organisational policy and priorities.

Incorporating service users' voices, including in the conceptualisation of research, should be a priority for researchers in mental health. As highlighted in this review, decisions are often made without involving service users, thus ensuring the research that informs policy and practice is carried out collaboratively could help mitigate the feeling that research is being 'done to service users' rather than being done with and for service users. The review identified that most of the research in this area has explored experiences of seclusion and/or restraint, therefore it is suggested that future research should further consider service users' experiences of locked doors and constant observations, particularly service users' perspectives on the use of cameras and artificial intelligence to monitor activity in bedrooms for constant observations or during seclusion and restraint (Appenzeller et al., 2019). It is also suggested that researchers consistently report on the ethnicities and gender of participants and be transparent about the generalisability of their findings. A previous review has demonstrated that ethnic minorities could be more likely to receive restrictive practices

in inpatient mental health, however disparities in reporting and definitions (relating to both ethnicities and restrictive practices) makes it difficult for conclusions to be drawn from published literature (Pedersen et al., 2023).

Conclusions

Service users experience restrictive practice as an anti-therapeutic and dehumanising method of containment, that can create a vicious cycle. Service users suggest that increasing supportive communication and detailing the decision making behind the choice to use restrictive practices, would reduce feelings of coercion and increase the trust in the staff responsible for their care. Future research into the experience of restrictive practice should aim to capture the service user voice, particularly around the experience of locked doors and constant observations, to aid improvements in policy and practice.

Required Statements

Declaration of Interest – Declaration of Interest: None

Funding Statement - This report is independent research supported by the NIHR Yorkshire and Humber Patient Safety Translational Research Centre and the University of Leeds [under grant PSTRC2016-006]. The views expressed in this publication are those of the authors and not necessarily those of the National Institute for Health Research, the Department of Health and Social Care or the University of Leeds.

Author Contributions – The authors confirm contribution to the papers as follows: Conceptualisation and Design: BG, JJ, JB and KV; Data Collection and Screening: BG and JR; Analysis and Interpretation of Results: BG; Draft Manuscript Preparation: BG. All authors reviewed the results and approved the final version of the manuscript.

Transparency Declaration – The author(s) confirm that the manuscript is an honest, accurate, and transparent account of the study being reported. Edits to the original protocol have been registered on PROSPERO (https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42023399272).

Data Availability - Data availability is not applicable to this article as no new data were created or analysed in this study.

Research Material Availability – Additional research material that supports the analysis of this study are available from the corresponding author upon reasonable request.

Patient Consent for Publication – Not required.

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Table 1. Study characteristics table.

Author (Year)	Country of Origin	Research Aims	Participant Group and Sample Size	Sample Profile		Recruitment Method	Research Setting	Restrictive Practice Reported	Methodology	Analysis Method
				Male Sex Proportion (%)	*Ethnicity Proportion (%)*					
Allikmets et al. (2020)	UK	To appraise the current care of acutely unwell and violent patients with the intervention of seclusion from a patient perspective	10 male PICU inpatients, detained under section 2 or 3 of the Mental Health Act	100%	Not reported	Not reported	Carried out by senior psychiatrists who did not work on the unit	Seclusion	A qualitative approach using a structured questionnaire in a face-to-face interview	Miles & Huberman (1994) method
Achir Yani Syuhaimie Hamid & Catharina Daulima (2018)	Indonesia - Central Java Province	To examine the experience of restraint use among individuals with violent behaviour in mental health hospital	Eight psychiatric inpatients diagnosed with a mental disorder and being or had experienced restraint	Not reported	Not reported	Purposive sampling	Conducted in three districts in Central Java Province	Restraint	In-depth interviews using a phenomenological approach	Colazzi's (1978) data analysis steps
Aluh et al. (2022)	Nigeria	1) To explore service users' perceptions and experiences of coercion is psychiatric hospitals in Nigeria 2) To explore suggestions on strategies to reduce the use of coercion in mental health care	30 service users who have previously been admitted to one of two major psychiatric hospitals	63%	Not reported	Attending nurses disseminated information about the study to eligible, interested service users	In two major neuropsychiatric hospitals, outside of the wards in the halls	Formal coercion (compulsory admission, seclusion, physical restraint, mechanical restraint and chemical restraint)	Focus groups guided by semi-structured discussion guide	Thematic analysis
Bendall et al. (2022)	UK	1) Explore how patients and staff members experience and make sense of restrictive practice 2) Explore how patients and staff	Nine service users (eight current inpatients, one discharged)	56%	Asian British Pakistani 11% Black British 11%	Inpatient participants were recruited by staff members known to them	Research took place on two adult acute wards, one male and one female, within a large city	A range of restrictive practice (coercion, restriction of movement, forced	Qualitative semi-structured interviews	Thematic analysis

		members respond to restrictive practices?			Black British African 22% Mixed White and Black African 11% White British 22% White Irish 22%		mental health hospital	medication, restraint)		
Chien et al. (2005)	Hong Kong	Explore the perspectives of Chinese psychiatrics inpatients with violent behaviours concerning the effects of the use of restraint on them	30 psychiatric inpatients, with violent behaviours from two acute admission wards	60%	American Asian 12% American Chinese 12% Chinese 77%	Convenience sample from two acute admission wards in 1400-bed mental hospital	Conducted in in an interview room attached to the admission wards within 1-2 days of the removal of restraint	Restraint (bilateral limb holders, safety vests and triangular bandages)	In-depth semi-structured interviews and examination of clinical records	Miles & Huberman (1994) method
Cusack et al. (2023)	UK	To explore the service user perspectives of their personal experiences of restraint	11 participants recruited based on having experienced physical restraint within acute mental health inpatient settings	Not reported	Not reported	Recruited via posters, blogs and social media through Rethink and National Service User Network (NSUN)	Four interviews in person (environment chosen by participants) and seven via telephone	Physical restraint	Dialogical narrative approach, using unstructured narrative interviews	Frank (2010) guiding questions "What is at stake and for whom? How does the story define or redefine those stakes? How does the story change people's sense of what is permitted, possible, responsible or irresponsible?"
Ezeobele et al. (2014)	United States of America	To explore and describe the psychiatric patients' lived seclusion experience	20 inpatient service users on acute wards, with a high risk for violent acts	60%	Not reported	Purposive voluntary sampling	Conducted in a 250-bed free-standing psychiatric acute care hospital where	Seclusion	Semi-structured interviews utilising a phenomenological approach	Colazzi's (1978) data analysis steps

							85% of patients are involuntarily admitted			
Faschingbauer et al. (2013)	United States of America	What is the lived experience of inpatient psychiatric patients who are placed in seclusion?	12 inpatient psychiatric patients upon completion of a seclusion episode	50%	Caucasian 67% Native American 17% African American 17%	Purposive sampling	Carried out at least 24 hours after the seclusion episode, but before 7 days, taking place in a closed conference room off the mental health unit	Seclusion	In-depth unstructured interviews utilising a phenomenological approach	Van Manen's (1990) phenomenological approach for text analysis
Haglund et al. (2005)	Sweden	1) To describe voluntarily admitted patients' perceptions of advantages and disadvantages about being cared for on a psychiatric ward with a locked entrance door. 2) To study whether voluntarily admitted patients perceive any coercion connected to being cared for on such wards	20 voluntarily admitted psychiatric patients to a locked psychiatric ward	50%	Not reported	In collaboration with ward managers, a maximum variation sampling was used	Data collected on seven Swedish psychiatric inpatient wards	Locked doors	In-person interviews	Content analysis
Hoekstra et al. (2004)	Netherlands	Gain a better understanding of the seclusion room experience of chronic psychiatric patients, the way in which they cope with their seclusion room experience, and the effect of seclusion on the subsequent	Seven previous inpatient service users whose seclusion room experiences had taken place some time ago and were currently undergoing treatment at	43%	Not reported	Not reported	Five out seven interviews were held in patients home, and two in the treatment environment	Seclusion	Qualitative research design, in line with Grounded Theory utilising interviews	Grounded theory

		relations with care provider	the VLMT Transmural Team of Mediant.							
Holmes et al. (2004)	Canada	To describe the experience of patients with a severe and persistent psychiatric disorder regarding their stay in the seclusion room	6 patients of a specialised care unit	Not reported	Not reported	Not reported	Took place in a specialised care unit located in a psychiatric hospital in Eastern Canada, in a private room	Seclusion	Non-directive interviews, utilising the Heideggerian phenomenological research framework	Colazzi's (1978) data analysis steps
Johnson et al. (1998)	United States of America	To understand the meaning of the experience of being restrained	10 participants	50%	African American 20% Caucasian 80%	Participants were initially referred by staff of two inpatient psychiatric units	Not reported	Leather restraints	Unstructured interviews	Analysed using a modification of Dickelmann, Allen and Tanner (1989) and Dickelmann (1995)
Kontio et al. (2012)	Finland	Explored 1) psychiatric inpatients experiences of seclusion/restraint, 2) their suggestions for improvements in seclusion/restraint, 3) alternatives to seclusion/restraint in psychiatry	30 inpatients from acute wards	63%	Not reported	Utilising nurses and physicians	Six acute closed wards in two psychiatric hospitals	Seclusion and restraint	Interviews	Inductive qualitative content analysis
Kuosmanen et al. (2007)	Finland	To find out whether patients had experienced deprivation of their liberty during psychiatric hospitalisation and to explore their views about this	51 patients admitted to an acute ward, who were in the process of being discharged during the study period	49%	Not reported	Utilising psychiatric nurses who were trained to conduct study interviews	Two closed acute psychiatric hospital wards	Deprivation of liberty (leaving the ward, locked wards, restrictions on communication, confiscation of property, coercive measures [seclusion, mechanical restraint and forced medication])	Semi-structured interviews	Inductive content analysis

Lanthen et al. (2015)	Sweden	To examine psychiatric patients' experience of mechanical restraints and to describe the care the patients received	10 former psychiatric patients	50%	Not reported	Utilising outpatient units as well as patient organisations	Location decided by the participants	Mechanical restraint	Interviews	Content analysis
Li et al. (2023)	China	To identify perspectives on physical restraint among patients with mental health conditions and to seek effective interventions targeting the psychological trauma which is caused by physical restraint	26 service users who had undergone or witnessed physical restraint in the last 6 months during psychiatric hospitalisation (15 experienced restraint, 11 witnessed)	46%	Not reported	Not reported	In a quiet room, public psychiatric hospital	Physical restraint	Semi-structured interviews	Thematic analysis
Lynge et al. (2023)	Denmark	To explore 1) how patients experience and possibly prefer these two types of coercion and 2) what could be done to avoid coercion according to patients	Nine participants that had been admitted to a psychiatric facility	67%	Not reported	One participant through outpatient clinics. Utilised a user-driven workshop for people with psychiatric disorders	Unclear	Physical holding and mechanical restraint	Semi-structured interviews	Thematic analysis
Mac Donald et al. (2023)	Denmark	To explore experiences and perspectives on involuntary treatment in patients with anorexia nervosa who had experienced multiple involuntary treatment events	Seven adult female participants that had multiple past involuntary treatment events related to anorexia nervosa over a period of at least one	0%	Not reported	Recruited purposively through flyers, homepage posts and Facebook posts, selected specialised residential units, Danish patients	Either in-person or telephone. In-person carried out in place of residence or Aarhus University Hospital	Involuntary treatment including involuntary admission, detention mechanical restraint, physical restraint, nasogastric tube feeding and	Semi-structured interviews	Thematic analysis using an inductive approach

			month within the past 5 years			organisation and Danish society for eating disorders		constant observations		
Mayers et al. (2010)	Western Cape Province, Cape Town	1) To describe the perceptions and experiences of service users of the use of sedation, seclusion and restraint during a psychiatric emergency, 2) to identify the preferred choices of service users should they be placed in a situation that requires the use of sedations, seclusion or restraint	43 participants from psychiatric hospitals with experience of restrictive interventions	49%	Not reported	Convenience sampling from 17 established service user support groups	Not reported	Sedation, seclusion and restraint	Interviews using semi-structured questionnaire	Content analysis
Meehan et al. (2000)	Australia	Explore how patients receiving acute inpatient treatment in a mental health facility describe and construct meanings about their seclusion experience	12 patients	58%	Not reported	Convenience sampling	Two open acute care units on the campus of a large tertiary mental health facility	Seclusion	Semi-structured, thematically organised interview schedule	Meaning categorisation (Kvale, 1996)
Ntsaba & Havenga (2007)	Lesotho	To explore and describe the psychiatric in-patients' experience of being secluded in a specific hospital in Lesotho	11 local inpatients	36%	Not reported	Purposive sampling	A specific psychiatric hospital in Lesotho	Seclusion	Semi-structured phenomenological interviews	Tesch's method of open coding
Nyttingness et al. (2016)	Norway	To increase knowledge of the effects of coercion	Approximately 35 patients and ex-patients	Not reported	Not reported	Not clear	15 full-day dialogue seminars on coercion and voluntariness	Coercion (restraint, seclusion, forced medication, CTO's, 'minor	Verbatim notes taken from the seminars	Thematic analysis

								coercive incidents')		
Sambrano & Cox (2013)	Australia	To understand how some Indigenous clients' experienced seclusion in acute mental health settings in Australia	Three outpatient participants with experience of being in seclusion within an acute mental health facility	67%	Aboriginal 67% Aboriginal and Torres Strait Islander 33%	Recruited current outpatients from a metropolitan mental health service	Metropolitan mental health service	Seclusion	Interviews	Qualitative analysis utilising the hermeneutic circle
Scholes et al. (2022)	England	To investigate women's experiences of restrictive interventions within inpatients mental health services	20 participants recruited across acute services and rehabilitation services	0%	Black African or Black Caribbean 10% White-British 90%	Recruited from three NHS Trusts in the North of England, participants self-referred from posters on the wards or by information leaflets distributed at community meetings	Not clear	Restrictive interventions (physical restraint, seclusion, and rapid tranquilisation)	Semi-structured interviews	Thematic analysis
Tully et al. (2022)	England	To explore experiences of restrictive practices as inpatients	22 current mental health inpatients (combination of acute, PICU and rehabilitation services)	0%	Asian 4.5% Black African 4.5% Black British 4.5% Black Caribbean 4.5% Mixed White and Black Caribbean 4.5%	Recruited from hospitals across the North-west of England, through referral from ward staff or through self-referral	Not clear	Restrictive practice (restraint, seclusion, rapid tranquilisation, locked doors, routines on the ward forcing everyone to get out of bed at the same time or 'blanket rules')	Semi-structured interviews	Thematic analysis

					White British 77%					
Verbeke et al. (2019)	Belgium	To propose an interactional model of the relational aspects of coercion that enhances theoretical understanding, based on the assumptions of patients	12 previous service users who had been hospitalised in a Belgian psychiatric institution	33%	Caucasian 100%	First five through a community-based organisation, following seven through snowball sampling	Interviews carried out in person, location unclear	Coercion (seclusion, restraint and involuntary treatment, diagnostic labelling, involuntary medication, pressure to take medication, house rules and being forced to do activities or have a daily routine)	In-depth interviews utilising open-ended questions	Interpretive Phenomenological Analysis (IPA)
Wynn (2004)	Norway	For patients to share their experiences regarding restraint	12 inpatients	75%	Not reported	Purposive sampling, selected on the basis of having recently been subjected to restraint which was reported to researchers by staff	Carried out at the psychiatric Departments at a University Hospital	Restraint (physical and pharmacological)	Interviews	Grounded theory

Table 2. Studies represented within each theme.

	Third Order Constructs				
	1.Anti-therapeutic and dehumanising	2.A vicious cycle	3.An abuse of power	4.The critical role of support and communication	
Authors				4a.The impact of communication	4b.How support and communication can minimise negative impact
Allikmets et al., (2020)	✓			✓	✓
Achir Yani Syuhaimie Hamid & Catharina Daulima (2018)	✓	✓			✓
Aluh et al., (2022)	✓	✓	✓	✓	
Bendall et al., (2022)	✓	✓	✓	✓	
Chien et al., (2005)	✓			✓	✓
Cusack et al., (2023)		✓		✓	
Ezeobele et al., (2014)	✓		✓	✓	
Faschingbauer et al., (2013)	✓	✓		✓	✓
Haglund et al., (2005)	✓	✓	✓		
Hoekstra et al., (2004)		✓	✓		
Holmes et al., (2004)	✓	✓	✓		
Johnson et al., (1998)			✓		
Kontio et al., (2012)	✓			✓	✓
Kuosmanen et al., (2007)			✓		
Lanthen et al., (2015)		✓		✓	✓
Li et al., (2023)	✓			✓	
Lynge et al., (2023)	✓				
Mac Donald et al., (2023)	✓	✓		✓	
Mayers et al., (2010)	✓	✓	✓	✓	
Meehan et al., (2000)	✓	✓	✓	✓	
Ntsaba & Havenga (2007)	✓	✓	✓	✓	
Nyttingness et al., (2016)	✓		✓		
Sambrano & Cox (2013)	✓		✓		
Scholes et al., (2022)	✓	✓			✓
Tully et al., (2022)		✓		✓	
Verbeke et al., (2019)	✓			✓	
Wynn (2004)		✓		✓	✓

Online Supplementary Material

Table S1. Completed PRISMA checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	2-3
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	3
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	3
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	3-4
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	4
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Supplement S1.
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	4-5
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	5
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any	4-5

		assumptions and simplifications made.	
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	5
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	N/A
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	6
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	5
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	N/A
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	Figure 1.
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	Page 6-7 and Table 1.
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	Supplement S2.
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	N/A
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	7-9
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	6
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	N/A
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	9-11

Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	10
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	11
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	Required statements; 19

Table S2. Completed eMERGE checklist

Table S2. Completed eMERGe checklist			Page number
Phase 1—Selecting meta-ethnography and getting started			
Introduction			
1	Rationale and context for the meta-ethnography	Describe the gap in research or knowledge to be filled by the meta-ethnography, and the wider context of the meta-ethnography	2-3
2	Aim(s) of the meta-ethnography	Describe the meta-ethnography aim(s)	3
3	Focus of the meta-ethnography	Describe the meta-ethnography review question(s) (or objectives)	3
4	Rationale for using meta-ethnography	Explain why meta-ethnography was considered the most appropriate qualitative synthesis methodology	6
Phase 2—Deciding what is relevant			
Methods			
5	Search strategy	Describe the rationale for the literature search strategy	4
6	Search processes	Describe how the literature searching was carried out and by whom	4
7	Selecting primary studies	Describe the process of study screening and selection, and who was involved	4-5
Findings			
8	Outcome of study selection	Describe the results of study searches and screening	Figure 1 and pg. 6
Phase 3—Reading included studies			

Methods			
9	Reading and data extraction approach	Describe the reading and data extraction method and processes	5
Findings			
10	Presenting characteristics of included studies	Describe characteristics of the included studies	6-7 and Table 1
Phase 4—Determining how studies are related			
Methods			
11	Process for determining how studies are related	Describe the methods and processes for determining how the included studies are related: - Which aspects of studies were compared AND - How the studies were compared	7
Findings			
12	Outcome of relating studies	Describe how studies relate to each other	6
Phase 5—Translating studies into one another			
Methods			
13	Process of translating studies	Describe the methods of translation**:** - Describe steps taken to preserve the context and meaning of the relationships between concepts within and across studies- Describe how the reciprocal and refutational translations were conducted- Describe how potential alternative interpretations or explanations were considered in the translations	Supplement S3.
Findings			

14	Outcome of translation	Describe the interpretive findings of the translation.	7-9
Phase 6—Synthesizing translations			
Methods			
15	Synthesis process	Describe the methods used to develop overarching concepts (“synthesised translations”). Describe how potential alternative interpretations or explanations were considered in the synthesis	6; Supplement S3/Table S3
Findings			
16	Outcome of synthesis process	Describe the new theory, conceptual framework, model, configuration, or interpretation of data developed from the synthesis	7-9
Phase 7—Expressing the synthesis			
Discussion			
17	Summary of findings	Summarize the main interpretive findings of the translation and synthesis and compare them to existing literature	9-10
18	Strengths, limitations, and reflexivity	Reflect on and describe the strengths and limitations of the synthesis: - Methodological aspects—for example, describe how the synthesis findings were influenced by the nature of the included studies and how the meta-ethnography was conducted.- Reflexivity—for example, the impact of the research team on the synthesis findings	10
19	Recommendations and conclusions	Describe the implications of the synthesis	10-11

Appendix S1. Example search strategy Scopus

Search #	Search Terms
1	TITLE-ABS-KEY("service user" OR patient* OR client*)
2	TITLE-ABS-KEY(restrain* OR sedat* OR seclu* OR "rapid tranquili*" OR "blanket ban" OR segregat* OR restrict* OR force* OR "forced medication" OR "restrictive practice" OR "restrictive intervention" OR "physical intervention" OR locked OR coercion OR "coerc* practice" OR "coerc* intervention" OR "coerc* measure*" OR "coerc* adj3 compulsion")
3	TITLE-ABS-KEY("mental hospital*" OR "psych* hospital*" OR "acute in$patient*" OR "mental health in$patient*" OR "psych in$patient*" OR "mental health" OR psychiatr* OR "psych* setting*")
4	TITLE-ABS-KEY(experience* OR perception* OR attitude* OR view* OR feeling* OR account OR observation OR thought* OR understanding OR perspective OR suggestion)
5	TITLE-ABS-KEY("qualitative research" OR "qualitative study" OR "qualitative methods" OR "qualitative design" OR "mixed method" OR interview* OR "focus group*")
6	1 AND 2 AND 3 AND 4 OR 5

Appendix S2. CASP Qualitative Checklist

	CASP Quality Criteria									
	1	2	3	4	5	6	7	8	9	10
Allikmets et al. (2020)										
Achir Yani Syuhaimie Hamid & Catharina Daulima (2018)										
Aluh et al. (2022)										
Bendall et al. (2022)										
Chien et al. (2005)										
Cusack et al. (2023)										
Ezeobele et al. (2014)										
Faschingbauer et al. (2013)										
Haglund et al. (2005)										
Hoekstra et al. (2004)										
Holmes et al. (2004)										
Johnson et al. (1998)										
Kontio et al. (2012)										
Kuosmanen et al. (2007)										
Lanthen et al. (2015)										
Li et al. (2023)										
Lynge et al. (2023)										
Mac Donald et al. (2023)										
Mayers et al. (2010)										
Meehan et al. (2000)										
Ntsaba & Havenga (2007)										
Nyttingness et al. (2016)										
Sambrano & Cox (2013)										
Scholes et al. (2022)										
Tully et al. (2022)										
Verbeke et al. (2019)										
Wynn (2004)										

Appendix S3. Example reciprocal translation

Descriptive group: Psychological battle during and after restrictive practice (third order construct: a vicious cycle)

- **Categories:**
- **Vicious cycle**
- **Emotional impacts**

Paper 2 described how participants question whether restrictive practice resolves aggression or exacerbates it. Restrictive practice might not be experienced by patients as a way of ensuring safety by reducing aggression but also as a way of provoking aggressive behaviour to which further restrictive measures are used in retaliation. Similarly, paper 3 described how coercion evoked aggressive behaviours and made patients want to abscond, which in turn led to stiffer measures demonstrating the cycle of aggression and coercion. Participants in paper 3 felt that coercion was not an effective way of managing people with mental health problems but caused more distress. Also, paper 3 mentioned that patients found it traumatic to be receiving treatment from the people who are using coercive practices. Paper 5 also described a vicious cycle whereby restrictions on leave and losing access to activities lead to feeling trapped which impaired mood and led to increased likelihood of incidents such as self-harm which then led to further restrictions. Participants in paper 5 also described acting out (self-harming or acting aggressively) to be heard but that they eventually gave up as it was pointless to keep arguing as the decision wasn't in their hands. Paper 7 described the emotional impacts of restrictive practices, particularly anxiety, hurt and anger. In paper 9, patients described the fear they felt from mechanical restraints, describing it as a strong negative feeling and was characterised by many as the worst fear they had experienced. Like paper 7, paper 9 described emotions of anger which manifested from fear. Paper 10, like paper 7 and 9 also described the fear participants felt because of restrictive practices. Similarly, paper 10 described feelings of anger before, during and after the seclusion episode, with anger being directed at staff. Paper 10 also adds that the social isolation and physical characteristics of the seclusion room can infringe on the sense of reality and made service users experience dysfunctional thought patterns and losing control. This in turn overwhelmed service users and acted as a cue for hallucinatory and delusional experiences. Paper 11 described similar emotions to the above in anger and fear, as well as powerlessness, sadness, hurt from humiliation and dismay. This came from the seclusion room environment and being unable to report their painful experiences to higher authorities. Paper 13 reported that restrictive practice measures that are put in place to reduce anger and distress, exacerbated increase in risk behaviour or led to further restrictive interventions, as described in paper 2, 3 and 5. Also, paper 13 highlights the re-traumatisation that women felt due to elements of restrictive interventions particularly for patients with previous sexual trauma, and how powerless they felt in relation to experiencing nightmares and flashbacks after restrictive intervention. Paper 15 reported patients feeling anger, fear and anxiety during the experience, while some felt restraint calmed them down, some reported being in restraint made them scared and aggressive. Paper 16 adds that the seclusion event impaired their sense of self-confidence and in turn made them in-secure and lack trust in subsequent situations. This meant in this study that respondents lacked the trust needed to be open and vulnerable with staff as they were afraid of being harmed. Paper 16 also reports feelings of loneliness because of the experience. Paper 17, similar to the above reports fear, anger, sadness, as well as shame and feeling abandoned. Patients also reported experiencing behaviours that made them feel ashamed and humiliated. Like paper 16, paper 21 reports a decrease in self-confidence, and well as feeling fear, depressed, nervous and struck by panic. Paper 21 additionally demonstrates frustration patients felt because of

locked doors. Paper 22 adds the stress participants felt, particularly if there was no debriefing and reorientation once the person had returned to the open ward, and expressed patients fear of re-hospitalisation if they had witness staff's disrespectful attitude and actions towards other service users. Paper 23 also expressed feeling fear, trauma, anger, helplessness and the self-blame.

Update paper 26, 27:

Like paper 3, paper 26 reported service users' upset at being treated by people that have used restrictive practice on them and witnessed it with other people. Like paper 13, paper 26 also highlighted the impact restrictive practice had on a service user that had a history of abuse and the re-traumatisation that this caused whilst an inpatient. Like paper 3, 10 and 13, paper 27 described patients use of resistance behaviours (yelling, crying and shutting the world out), particularly aggression towards self (self-harm) and others (kicking and spitting) as a result of feeling trapped and hunted by staff.

Table S3. Translation table

Descriptive groupings (*Third order construct name*)	First order constructs (participant quotes)	Second order constructs (Primary author themes)
The anti-therapeutic nature of restrictive practice (*Anti-therapeutic and dehumanising*)	"Scared, angry, humiliated." (Participant 3) / "Felt lost, completely lost, game over." (Participant 6) / "Angry and animalistic…cage, cold…felt treated like an animal. (Participant 8) / "[When] they come in, you just want to come out, it gets me more frustrated…makes me angry when they pin you down like an animal and they go out one by one. Not sure why they bother coming in…I reckon they should not have put me in seclusion because I was unwell and it's a hospital." (Participant 7) / "All they came to do it bend me over and give me meds and throw food on the floor and leave…if you treat me like a 31-year-old man I would be ok. When you breach human rights, they make you feel worthless. I think supervised confinement is not the answer, people are meant to be care for, not tortured." (Participant 2)	Allikmets et al. (2020) (1) - Physical aggression against patients
	'it [being detained on the ward] makes me feel like a monster, like I've done something really wrong' [Sarah]. / 'I don't understand it, I mean if you're a criminal and such things then I'd understand it a bit more but we're not we're not supposed to be criminals here, know what I mean? Most of the people here have never been in prison so I don't know why we're treated like prisoners' [Malik].	Bendall et al. (2022) (2) – Over powered by staff (Dehumanising)
	"E get some kind of injection, you give some patients here, the body will change automatic, some will start turning their eye, some will start shaking their body and I want the hospital look into... it." (FGD3, male participant with MBDPS) / "I was injected with sleeping injection, so I slept off that night. When I woke up in the morning, they've injected my both laps. I can't even walk for like a week and some days." (FGD3, male participant with MBDPS) / "So, it's an injustice that some people are being stigmatised and unwelcome in their very home because of what they believe in ….So, you decide because you have the upper hand in the family to take care of me, give me food three times a day, to call in security people from even this facility to come and take me away for admission." (FGD3, male participant with	Aluh et al (2022) (3) – Experience of chemical restraint (Undesirable effects, safety concerns) Perception of coercion (Coercion as an extension of stigma towards people with mental health problems), Experience of

	depression) / “I have pains all over but my family is trying to cover up with something like I shut the doors, I didn’t want to open the doors for anybody. Why I didn’t want to open the doors for anybody is because of.... they said some parable;...if somebody call you somebody, you call that person somebody. If they don’t call you person, don’t call the person ‘person’. Who address you as a human, you also address that person as a human. That’s why I shut the door because my family never addressed me as a normal human.” (FGD2, male participant with MBDPS) / “My experiences are basically use of chain. The first day they admitted me at Study site 1, they forced me to pull off my shirt, I refused. They dragged me and they chained me. The pain was so excruciating. That’s my own experience of physical abuse.”(FGD2, male participant with bipolar disorder) / “No, nobody supposed to be treated as an animal. For you to be forced to have a chemical, to be injected, or to be chained is not normal. I don’t think it’s normal.”(FGD2, male participant with MBDPS) / “Ok. I was chained in Study site 1 for reason of leaving the hospital. In case I want to leave the hospital voluntarily. So, I cannot leave, so they had to chain my leg to the bed all night, I couldn’t even use the washroom. That was a bad experience. I think I have bladder infection.” (FGD2, male participant with schizophrenia) / “and there was one other time..., they was chaining somebody. I was now trying to tell the guy please o, the chain is too tight on that guy. The person that was using the chain came and used the chain to whip me, ...and restrict me to my bed... I felt very bad. Because I was telling him that the chain is too tight on that person’s leg, he used the chain on me. So... they themselves, they abuse the process...those people that are using... both the chemicals and chains, they abuse the process and it’s bad. I feel it’s very bad.” (FGD1, male participant with bipolar disorder) / “I was trying to desist them from,... giving me injection and when they wanted to give me injection, I was trying to resist them, they...chained me and they keep me out there, at the pole there... that place where they’re doing ward round.”(FGD4, male participant with schizophrenia)	mechanical restraint (Chained like an animal)
	“I cannot get things that I want to do or get out . . . nobody was listening . . . uh . . . I mean . . . the staff . . . the doors are shut behind you . . . and you are there alone . . .’ / I thought I was in the prison cell again . . .uh . . . I was unable to get out . . . I was left there for 3 hours . . .” / “The seclusion experience reminded me of the time I was in a jail cell . . . the seclusion forced me to revisit the bad experience I had in jail again . . . the seclusion room had no ‘peep holes’ like they have in the jail . . . I	Ezeobele et al. (2014) (4) - Alone in the world (Rejection and deprivation, Like being in a jail cell, Being destroyed)

	thought how to get out of the room . . . uh . . . I mean . . . uh . . .if there was a ladder I would have climbed out of there. . .” / “I felt violated . . . I felt everything had been stripped from me . . . I felt ashamed because I wanted to cooperate with the staff, you know . . .”	
	“At times my existence was ignored. . . no matter what I said to the staff passing by, they did not stop, or respond to my requests. I felt that I did not exist over there.” (Patient 16) / “This must be my fault. . . having such violent behavior cause much more trouble and workload to the staff. I am afraid of my inability to control my behavior during my stay.” (Patient 25) / “The staff wouldn’t release me, even for a while, so that I could use the washroom. They brought me a bedpan but did not change the bed sheets for me, even though they were contaminated. They only un-cuffed one hand for me to eat. . . I couldn’t do anything. It was just like being chained up in a prison.” (Patient 22) / “I was afraid that someone might hurt me suddenly while I was being restrained. Being restrained could be terrible if you did not know for sure what would happen next. . . especially at night, or over a long period. I was scared. . . nobody seemed willing to help me calm this fear and I was afraid the staff were never going to take the restraint off.” (Patient 27)	Chien et al. (2005) (6) – Negative and non-therapeutic impacts of restraint (Lack of concern and empathy, Powerlessness and uncertainty)
	“And that’s another thing…that’s out of control behavior, is when you are fi ghting so hard that you hurt yourself. That’s really out of control.” It was about 3 a.m. when this happened, and I can’t sleep very well. I have night terrors from my PTSD. So, basically after I was in the seclusion room until about 7:00 or 8:00 in the morning. I don’t know; it was by the time the next shift came on I was locked in that seclusion room. I was awake the whole time I was in there. I was not threatening anybody.” / I don’t ever have a problem urinating myself, never. I could use the bathroom just fi ne, I can talk just fi ne, I can walk just fine. But, to urinate myself and do that just because I was not given the chance to use the bathroom.… They refused to come and talk to me. They refused to give me a blanket. They refused to let me go to the bathroom. They refused to give me a pillow. They refused everything. All my rights were gone.” / They would not do anything for me, they just kind of basically were laughing that almost set me off again, because, you know, these are your nurses, they are	Faschingbauer et al. (2013) (7) – Patient emotional response [humiliation]

	supposed to be taking care of you, and you don't feel like you are being taken care of when someone is making fun or laughing at your situation." / "Oh, they [the staff] said she's out of control when I'm just having fun, joking around with a few patients. I just wish he would have come up to me and asked me politely, and said, Hey, you know? What's going on?" / "Then they [security guards] proceeded to spread me out on the bed, and they're jamming knees into my shoulders and holding me on the bed, twisting my legs up behind me. It was the most uncomfortable and painful thing I've ever experienced. I yelled constantly, "I'm done! I'm done, okay! Let me go! I'm not going to do anything"—and then I was put into the seclusion room." ". . . I felt fear and anger, especially toward those who put me into the seclusion room. Nurses and physicians used power and authority over patients. I didn't know where I was and how long it lasted, it was terrible . . ." (R29) / ". . . I thought I was in heaven, feelingmuch better when I was restrained. I did not have nightmares, I was safe . . ." (R5) / ". . I was dirty, I sweated all the time. They washedmy hair once a week and I didn't have a chance to brushmy teeth. I was thirsty and I peed into the floor-drain . . ." (R29) / ". . . I kicked the door a long time so that they could understandmy need to get to the toilet. Once I relieved myself on the porridge plate and put two sandwiches on it to prevent the smell . . ." (R2) / ". . . I didnot have anything to do in the seclusion/restraint room, it was a long time, boring, distressing . . . (R2) / ". . . I shouted and hacked the wall in the seclusion room. I strangled myself in front of the monitor and four men came and restrained me . . ." (R22) ". . . I felt restraint was a safe and quiet place to rest and sleep when there was nothing to do or no stimuli . . ." (R23) / ". . . I only wanted the real presence of a human being,with nurses and physicians, more communication, human touch . . . (R24)" / ". . . A nurse sat besideme during the whole restraint but he didn't say anything, only read the magazine . . . (R7)" "I was hauled back here and placed in seclusion…five policemen to drag me out of the house, even though I was offering no resistance and then I was stripped and placed in seclusion. Yes. Quite barbaric is what I thought of it." / "I felt like a prisoner.Yeah, but I've never been in prison. I've got no criminal record at all." / Well if I had been put on cat red [close observation], I might have read a nice book or	Kontio et al. (2012) (8) - Patient experience during seclusion/restraint Meehan et al. (2000) (10) - Use of seclusion

	tried to talk to somebody to try and lift my mood, but because I was in there with nothing and nobody there was nothing to lift [my] mood." "When I was secluded it was like I was in a prison. You see, Madame, I was once imprisoned at … because of not having an identification book (passport), we were locked up, eating food and passing stools in the same room, do you hear that?" (Voice loud and nostrils flaring). / "…the windows of that room are high up the wall and are very small. I wanted to see people outside but in vain because of … small windows on a tall wall that I could not reach … just like those that are in prison". / "the seclusion room (was) a place of therapy for patients or a place where (they) were being tortured?" / "You know nurses used to beat me. They slapped and punched me … when I refused to be secluded. They insulted (me) and pushed me in the seclusion room. I cannot mention those insults, they were bad" (voice loud and shaky). / "I was secluded for three weeks!" / "They (nurses) took my belongings, including my briefcase, which had important documents. They did not explain as to where they kept them. I concluded that they were reading my documents and were prying into my privacy". / "One patient stated that he was "suffering from diabetes mellitus thus requiring more frequent toileting needs and meals". / "I could not eat the food with dirty hands…I decided to stay hungry!" "I came back drunk and I wasn't allowed to be drinking so they called the coppers . . . I was pissed off coz the nurses rang the police; it didn't have nothing to do with them. They psychiatric nurses could have done it. And the nurse thought I was arguing about when they put me in the car. I was saying to the police 'this has nothing to do with you, this is a psychiatric matter, psychiatric nurses should be here to take me back.' . . . Yeah [the police where he was going into seclusion] said 'take off all your clothes, put the gown on' . . . Like I was a prisoner, like I was a prisoner of some sort!" / "you would be sitting in the park minding your own business . . . and again, you get taken away from your family." / "I'd get forced! I'd get forced! They would just take me to seclusion and just give me the injection! And they just leave me for the night let me out in the morning. You know? And when I'm there, and, Ahhh!!! [Peter yells in anger." / "You aren't allowed to raise your voice for any matter, or you get locked up in isolation . . . I mean everyone has bad days." / "I came back to the ward and I started getting noisy and that. I wasn't violent, I was just angry. So they put me in seclusion and gave me a needle." / "Or something just to show, don't mess with	Ntsaba & Havenga (2007) (11) - Psychiatric inpatients' experience of being in a prison, Seclusion experience as a punishment, Personnel factors (physical needs not been met) Sambrano & Cox (2013) (12) - Police involvement in the seclusion process and the criminalisation of clients, Experience of being punished, Use of force, Power dynamics and the dehumanising effects of treatment, abuse and neglect

	them. Don't mess with their standards and all that kind of stuff coz you get locked up." / "Oh! Just getting your head shoved into the ground, being aroused by security. Having your arms tied behind your back. Not being able to move, yelling, trying to yell to get them off you . . . Oh Jesus, let me go please! Just leave me alone!" / "And there was one time they hog-tied me. They got me on the ground and put my legs and arms up behind me and held me down. It was kind of like being hog-tied. That was very distressing coz I couldn't breathe normally when I was under a lot of pressure . . . I think the nurses, when it comes to seclusion, they are very heavy handed. When it comes to putting someone in seclusion . . . the nurses hold you, you've got your arms behind your back or they hold your clothes. It feels like you want to break free but you can't. And the nurses won't let you go. That's why it feels heavy handed. Coz you're trying to break out of it but they won't let you go." / "They could a strung me up with my socks or something like that. Said I got access to my socks and hung myself. They would cover it all up, the fucking white pricks . . . it makes me angry. They do that to, you know, all the Murris" / "I just don't like the idea of them when you're getting locked up by the coppers and they come in there are five blokes or six blokes they pin you down just to give you an injection. They could do anything in there when they keep you in the cell like that by yourself. They can do anything; they are capable of killing someone, why couldn't they do that to me?" / How the nurses talk to them up there, it very, very, very rude. They can have just a question and they get a bad response back. A real bad response like 'don't mess with us coz I work here', you know?" / "That was the only thing; I just got wild how I was treated. They took my, they sort of like, broke my spirit." / "They were pumping me up with most all the drugs they was giving me. When I was first locked, they sort of like took me from my reality, into a person that was dopey, not worried about how they was thinking about me and how they was treating me, like rubbish." / "In isolation they drug you up. So you're just going around like this . . . [shows the researcher a zombie-like expression]. And then you can't even talk properly and the talk is all blah, blah, blah, frothing at the mouth, dribbles all that." / "Well they put me in isolation and I needed to go to the toilet. I'm knocking, knock, knock, knock. [Calling] '[Come on, I need to go toilet. Can someone open up please?' Nothing, nothing, nothing. So, [calling again] 'I need to go the toilet can someone open up please?' I thought oh stuff this ok. Pee my pants. Then I laid down and I was wet laid down and wait till they come in to let me out. Then I had to clean the mess up then I could get back into the ward . . . [I thought] Oh, just smart arseholes, fine I'll clean	

	the mess up kind of attitude." / I blacked out, when they pinned me down. I blanked out from that stab wound in the head . . . it wasn't even treated! It wasn't even treated! They just locked me up with my stab wound in the head! I had headaches for about 3 days, no medic . . . no aspirins, or no Panadols or anything to stop the headaches; I thought I would a had a blood clot in my head or anything like that. I could a been dead!" "They are watching me, and they are looking at me like I'm from the zoo. Not a human being." (P20). / "It takes your dignity away. . . they've stripped my clothes off and put me in ligature-proof clothes." (P7) / ". . . as a woman it just made me feel worthless. Cheap-. . .all I could do was lie back and cry about it." (P18) / ". . .there's been times where they've pulled my trousers off. . . being exposed like that, it can have a big effect. . . afterwards. . . you feel embarrassed. . . your dignity's gone." (P11) / "If my shirt lifts up, they always get a towel or they pull it down, they are aware. It gives back some of your dignity." (P11) / "When I was in seclusion, two men came in. . . they were very dignified and while they were injecting me, they turned round and faced the wall." (P15) / "I was screaming for them to get off me. . . they just opened my legs and did a vaginal check. . .. I don't know what they were checking for. . ." (P18) / "There isn't a toilet in there, you had to piss in a sick bowl. . ." (P7) / "If you're in strongs [type of seclusion garment], you've got to have two staff to shower you, and they'll stand there and watch you while you shower, it's horrible." (P15) / "You're not allowed knickers. . .you're not allowed a bra on. . ." (P7) / "conscious when you're in that dress [seclusion garment] how you sleep, because if you sleep with your legs open or something they can see right up." (P5) / "I woke up in the morning with just all blood down me legs and everything, it was horrendous. I've never been so embarrassed in me life. (P15)" / "If you start your period you have to put on one of those pull up pads because you don't have knickers. It's degrading." (P7)" / "Instead of being ill and vulnerable, you feel like somebody's who's murdered or massacred somebody and you're a convict." (P10) / "We're not in prison, we're in hospital. You get better treatment in prison." (P18) / "It is very uncomfortable, it's really thick and heavy, they don't do 'em for bigger people, they're really tight fitting, they're quite embarrassing." (P17) / "I came here for help. Not come here to be beaten up. I'm still black and blue now." (P19) / "Just looking at four walls, I used to count the lights, I used to count the bricks round the wall." (P15) / "They let me have	Scholes et al. (2022) (13) - Dehumanisation

	my guitar in there, my pen and paper. I wrote a song in there. [staff] interact with me all day long about things that interest me. . .seemed to really help the loneliness in there." (P2) / "I lost my vision, my balance from the blow to the head. I think I was suffering from concussion." (P9) / "Sometimes they listen to you, if you're saying you're being a bit too hard on me arm, can you just loosen up a little bit, they will loosen their arm, which then makes me feel at ease because I feel like I'm being listened to." (P12) / "Then they'll start saying, well if you don't calm down we'll fetch the men in. So obviously you calm down then, you stop resisting." (P15) / "There was a guy and he's actually been suspended now, he was purposefully hurting me in restraint, bending my wrists. He admitted he gets a buzz out of restraint." (P11) / "When you get restrained by a man it's different, they're quite built up. And you've got like eight men on top of you. . .you can't even move." (P7) / "Men on this ward need to go to a restraint course again. . . they need to know when you're restraining a size 6 person, they can't have 8 men on top of me." (P7) "They said: 'we think you are too busy' and I said: 'but what if that's who I am?' 'No', they said, 'we decided you can't go home this weekend'. So, I felt that from the moment you enter psychiatry, your whole behaviour is seen as a part of your disease." (Participant 1) / "I had an argument at my work and went to my psychologist to find out how to handle it. And he didn't believe me. He said: 'you're in a state of psychosis and you're imagining this situation'. I was truly hurt by that." (Participant 2) / "Just the idea that in every hospital patients and staff have different toilets. I don't understand it: is my urine from a different quality than that of the staff? So, patients are not human beings, but far more objects treated as diseases." (Participant 11) / "I felt as if I were a child in a boarding school, you can't decide anything for yourself. Not even if you want chocolate paste or cheese on your sandwich, that's really absurd." (Participant 2) / "If I'm hospitalized with postpartum psychosis, isn't it then clear that motherhood means something to me? And yet you take that away from me? I don't get that. Taking away my children, taking away my motherhood, is taking away a part of my identity." (Participant 1) / "My father and daughter stood at the door of the hospital and were not allowed in. My father later told the nurse that he had wanted to see me in that state of mind, but she looked down on him, and said 'could you have calmed him down then?' At least he should	Verbeke et al. (2019) (14) - Segregation, De-subjectivation

	have been able to try. It is a very difficult moment when you are abruptly cut off from your own family." (Participant 12) "I was bad, that is why they put me there . . . they don't visit. I have no visitors, no one comes to see me . . . my sister doesn't come, my brothers don't come . . . and I have no one. I don't even have friends that come. I have nobody . . . I feel sadder, the others don't come ... I wonder why they [the staff] don't come . . . ask questions. . . . [for example] how I feel . . . I want to know why they [the staff] don't come and ask me that. I would say they don't want anything to do with me." / "Sometimes you're hungry, they don't open the door, you want to go to the bathroom, they [the staff] don't open the door. You think that's normal. When we urinate on the floor, they come and open the door and tell you to go get the mop and clean up the mess. Why when I hurt myself, they don't come and ask me what's wrong?" / "Sometimes they turn on the light or they leave it off, they put the paper in the window." "The first time I got four bruises, a cracked nail and a bloodshot eye. They actually held me that hard though I didn't even resist." (Interview 8) / About two months ago I actually defended myself. I punched [staff name] and in return he bent my rib." (Interview 3) / "Suddenly ten people arrive without saying anything, completely stone-faced. And I'm thinking: "what the hell is this about, now they've come to kill me". (Interview 9) / "You feel a little powerless in a way. That may be the purpose, I can't say. Ten against one, that's tough […] when I was threatened with the needle I accepted, or whatever you would call it." (Interview 5) / "Woke up with piss in my pants and stuff like that, right, just couldn't do a thing. Just lying all wet and moist […] And afterwards, I recall, I couldn't talk to people, look people in the eyes and stuff like that. You had to start all over being human." (Interview 7) / "Once, I was yelling for water, but no one came and gave it to me. And I yelled [in a coarse voice]: "water, water!", because I couldn't say it louder than that, and no one arrived. It lasted maybe two hours." (Interview 9) / "I became calm… I've always felt good about the belt [mechanical restraint], because then it's quiet for the time being. […] But I'm just sad that we're not allowed to smoke anymore. That's actually the biggest problem." (Interview 1) / "I've tried to get grounded many, many times, and I think it's	Holmes et al. (2004) (17) - Patient perception of seclusion Lynge et al. (2023) (19) - Experiences with physical holding and mechanical restraint, Improving the mental healthcare

	humiliating, I think it's patronizing, and I think it adds some element of punishment to the mental health care which doesn't belong there." (Interview 9) Gabriel (7): My experience is that psychiatry pathologizes the soul. That is abuse. / Einar (15): Shielding [open door seclusion] is what I experience as the most humiliating.1 It's imprisonment and torture. / Johan (7): It's unbelievably humiliating to be put in belts [mechanical restraints]. Just as bad as Communism and Nazism. / Astrid (3): It's like for people with war-experiences, who have been in concentration camps and such places. / Gabriel (16): It's about time that those who coerce understand that this actually is a war .When we say this is a violation, and staff says it isn't, then it is a war. / Gerd (15): At work, we have a bit of being told what to do [by others].We are wage slaves, aren't we? On many arenas, we have to be coerced to find our place. We can live with that, and it isn't necessarily that bad. But here [in the seminars], we have been talking about the abuse. / While Randi (07) had experienced 'that the art of medicine can exist within the psychiatric field', she later said that 'I think it's wise to listen to different points of view, including the critical ones. Health professionals should also come here [to the seminars]' (14). / Johan (6): Quite a bit has been decided by the church and medical associations regarding what a human being is. Currently, it swings towards biochemistry. But do we have free will? Is there an 'I'? Many [with psychosis] haven't been heard, noticed at school or during their upbringing. My own experience with psychosis is fear and emotions, a lot of shame, from not belonging. / Ludvig (11): Psychiatrists are recruited from the natural sciences, but cannot understand existential, moral or spiritual crises. / Johan (5):Medication and all the pessimists make it worse. It's a lie that you can't get well frompsychosis…I see it as a spiritual crisis, and I have never been functioning as well as now, after many psychoses. / Gerd (3): The diagnosis makes people depressed. It says that your life has no value, that your judgements are wrong. / Astrid (6): I became unwell because of life, but I got the deepest wounds after [the involuntary treatment]. When I read my records afterwards I vomited because of what was written in it. I felt that I didn't exist in that text. Me and the care system were at totally different places. / Torgeir (13): I had my life crisis early [and was admitted], psychiatry are about life crises / Einar 11: I have never felt ill, and I don't now neither. That's [from the perspective of the health professionals] the worst of all symptoms: I'm 'lacking insight'. / Kirsten (13): Psychiatric care frightened the wits out of me, and if I encounter another crisis, it wouldn't even occur to me to seek	Nyttingness et al. (2016) (20) - Expressions of physicatry as abuse and war, Unwanted medical model

	psychiatric help again. For a long time, I didn't even dare to visit the GP for physical things, out of fear it could lead to another sudden and totally incomprehensible admission. ‘‘The rattling of the keys, it’s a bit like being locked up in a prison’’ (woman 1). “they took my hands like this, you know, and the one put their knee on my back in my kidneys and they pulled me … we’re also human beings, we are not animals.” / “I would come up with something that will please them otherwise if I don’t please them, I know he’s going to increase that haloperidol …he would ask me …what can you sing for us? Even if you haven’t got a song, you have to compose your song.” / “now you have this security system, these guards …they, to me, they seem as if they are not trained to handle patients.” “I was emotional, yelling, disrupting people around, did not want to listen to others and threw people with stones. My brain was chaotic at that moment; I was not able to control it” (Su). / “I wanted to run away, run out of the hospital; I was against the nurse who prevented me from running, keeping me tied up. I tried to remove the bond and little by little, I could escape and run, but, I was arrested again” (Re). / “I didn’t know how they put in restraint and what I was doing but they punished me with physical restraint” (Tm). / “So sad, I had a punishment from them because I kicked the door and hit the other patient” (Ab). / “I didn’t do their orders, I didn’t take medicine and I didn’t join activities. I rejected all because they didn’t understand me” (Si). / “I saw people on TV as I used to be” (Re). / “I felt the loss of my rights as a human being because they did not let me free to do what I want. I felt physical limitations, limitations in thinking, and being isolated. When in restraint, nobody was beside me; they abandoned me, and as the person, I was being punished” (Su). / “The restraint left a mark on the hands and feet. Having tied the feet, hands and body hurts; I feel so sore and stiff” (Sw). / “My head was dizzy, heavy and dark vision. My body was limp, powerless” (Si). / “All of the body felt stiff ... I couldn’t move freely while being tied up and not given a chance to tilt right and left, I was so tormented” (Re).	Haglund et al. (2005) (21) – Disadvantages (Non-caring environment) Mayers et al. (2010) (22) – A violation of rights (Excessive/inappropriate force, Lack of respect for basic human dignity) Hamid & Daulima (2018) (23) - Aggressive behaviour as one of the main reasons of restraint, Physical and psychosocial impact of the restraint use

Update	“It (physical restraint) is a terrifying experience, I was scared and had no idea what would happened to me next. I thought I was going to be tortured by them (medical staff).” (cried, experienced patient, No. 2) / “I saw a patient being physically restrained and his yelling made me terrified. Since that I have talked and acted carefully, because you never know when you might be physically restrained.” (witness patient, No. 1) / “After this (being physically restrained), I could not sleep well at all. I have been having nightmares; I dreamt that I was physically restrained again, and it was scary.” (embraced herself with arms, experienced patient, No. 1) / “I am afraid of the belt or something like that. Even when I'm walking on the street, I feel afraid when a group of people come towards me, as it reminds me of the day I was belted to the bed.” (experienced patient, No. 7) / “I felt like a criminal when I was restrained, and I couldn't make any decisions for myself, I couldn't do anything on my own.” (experienced patient, No. 2) / “I hate that (physical restraint)! It is wrong, illegal, and inhumane. When I was restrained, I, you know, it made me feel useless.” (distressed, experienced patient, No. 10) / “To me, it (physical restraint) is nothing but a punishment and a warning. When I was belted to the bed, it felt like a punishment. And it seem only to warn you to behave well, or you will get restrained again.” (experienced patient, No. 6) / “It is just a warning to us, liked a reminder that if we break the rules of the ward, we will be punished by being physically restrained.” (witness, No. 3) "It is an assault whether it’s been done few or many times." / "Well, because it feels like an assault." / "Um … the worst experiences they’ve definitely been this being strapped tight and then just lying alone."	Li et al. (2023) (25) – the negative effects of physical restraint on patients Mac Donald et al. (2023) (27) – Coercive treatment (Augmenting suffering

Psychological battle during and after restrictive practice (*A vicious cycle)*	"Some people here are quite aggressive so [pause] maybe they need to be restricted. But if they weren't restricted in the first place, I wonder if they were going to be that aggressive in the final instance kind of thing" [Malik]. "Because the way you approach someone that's how the person will retaliate to you. that's true. The way you approach someone is how that person will retaliate to you." (FGD2, male participant with MBDPS) / "...when I notice coercion practises on me. I feel so aggressive [sic]. So, I feel so aggressive because...had it been they used peacefully, it will be better for me than to use coercive issue. (FGD3, female participant with schizophrenia) / "To me, is abnormal because it deals with mental health. Okay. Chaining, injections and all that, it affects psychologically. So, it's not proper." (FGD1, male with MBDPS) / "Still being in that same environment, looking at the same people that did that thing, perhaps those ones may not be related to the person in the hospital but then, it can never go well, even in terms of...receiving health care from them, medications here and there, the person will never be the same, will never be happy because he has been...abused, bullied."(FGD2, male with MBDPS) "It's quite difficult 'cause you get in a cycle of self-harming and stuff…'cause I cannot go out so I'm like stuck on the ward so I start struggling more 'cause I do not have any distractions" (Mary). "It's mostly fear really, a real horror show, it was terrible." (Interview 7) / "I have never been so afraid in my entire life." (Interview 4) / "To be left to someone else's good will because you do not have, sort of, it's not possible for you to get up, you cannot talk yourself out of the situation, you cannot sort of..." (Interview 1) / "It felt a bit like a movie, sort of, eeeh it felt a bit like, sort of eeeh, it's just like this sort of, this is just fake almost kind of. . . this is just not real." (Interview 2) "The only thing I remember is when they first put me in there and I was just screaming and kicking and yelling because I didn't want a needle and then I remembered just bursting into tears and I think I cried myself to sleep." / "I was feeling very low, I couldn't have felt any lower I thought, until they put me in seclusion	Bendall et al. (2022) (2) – Making sense of restrictive practice (Provocation) Aluh et al. (2022) (3) – Perception of coercion (Coercion as a vicious cycle, Anti-therapeutic and traumatic) Tully et al. (2022) (5) – Powerlessness (Restrictions perceived as punitive) Lanthen et al. (2015) (9) – Physical presence, instruction and composed behaviour can reduce discontent and trauma (Fear, powerlessness and feelings unreality) Meehan et al. (2000) (10) - Emotional impact, sensory deprivation

	and then I realized you could go lower. But by then there was nothing I could do about it. They even take away your option to change the circumstances to try and lift your mood." / "It's humiliating, having male staff seeing me naked and you've got to face them…Yeah, there was females there too, but they don't care if there's male staff there watching while you're naked, couldn't care less." / "I feel like crying for them because I know how awful it is. But I hold it in, I don't want to be emotionally attached to anyone here because I know…that at any given time someone could get plucked out of the environment." / "You get very depressed when you are in there a long time…you are completely isolated and you start to go mad because you cannot talk to anyone…the silence starts to drive you mad except for that blowing sound [fan in the ceiling] so you start talking to yourself, trying to keep yourself, you know, sane." / "I reckon they should have paintings on the walls or on the roof or Something…I don't know, anything to keep your mind occupied…I think it was worse for me in a way because I was so bored…Yeah, I'd like to see a seclusion room with nice pretty things in, not things that you can get out and hurt yourself with or smash anything, but even just paintings on the walls to relax you or a nice quilt to look at, because there's nothing to look at but the walls and that fan and the window, but unless you're on cat red you just staring at another wall." "… I was angry to eat food in a dirty and bad smelling room". / "You know, being secluded is like locking up a person in a stinking toilet!" / "That bed looked like a grave. I was so afraid … I had a feeling that I was in the process of dying". "I was sexually assaulted when I was a kid, and I don't like male staff on me 'cos I feel like they're gonna assault me again." (P14) / "They were very adamant on where they placed their hands because they knew the abuse. . . they'd know like which parts of my body not to touch." (P12) / "One male, he was heavy handed on the bottom of my legs, which then brought back memories for me and the abuse and it really distressed me afterwards." (P12) / "You're constantly walking on eggshells. You think. . . if you do something wrong they'll threaten you with seclusion…" (P7) / "I'm not a mouse, I'm a tiger, and I will fight back like. . . I'm not gonna stand there and let you take me down to that floor. . ." (P12) / "You feel violated, it's horrible. It's not a place you want to go. . . I went worse when I went in seclusion." (P15)	Ntsaba & Havenga (2007) (11) – Negative emotional responses to the seclusion experience Scholes et al. (2022) (13) – Powerlessness, Dehumanisation (Treated like a criminal)

	"I just panicked", and another stated: 'I had only one thought in my head . . . and that was to defend myself against them . . . and they were five men". / 'The worst part was not being able to move my body . . . I was completely helpless". / "I can't take much of that kind of treatment" / "still hurt a bit" / "spending so much time in restraint was not a positive experience" R3: I can hardly remember anything afterwards. I will wake up and find myself in the seclusion room. Then I ring the bell and usually they will let me out. / R2: Once I was very scared, it was very scary. They were sitting next to the seclusion room, and then I thought there was blood and all . . . quite extraordinary. Then I let go of my urine and then there were all sorts of candles under the bed. / R3: I have made an arrangement, it's in black and white. That I will get my medication the moment I am to be secluded. And it didn't happen. Last time I was secluded I didn't even get my medication for the night. So without my normal medication I spent all night eh watching every hour go by more or less. / R7: I'm still having problems with enclosed spaces. I remember that at first . . . when I'd just got out of the . . . when it was about half a year ago, that I didn't lock the loo and the shower at my parents' place. That I just didn't lock any door, so I could always get out. And that I couldn't bear the sound of keys, a bunch of keys, you know, I'll never forget the sound, this click of this heavy door and eh . . . well, it sticks in your mind. / R7: A terrible feeling of loneliness. Especially these heavy doors and . . . they slam shut behind you and . . . I have never ever experienced such loneliness. R3: Sometimes I feel very lonely and one hour will seem like three hours. Every 10 minutes you look at the clock to see if someone might be coming. / R7: For I remember that I was about to start screaming but that this nurse stroked my hair and I thought that was such a sweet thing to do. I was deeply moved, and then I calmed down completely and the urge to scream was over. Just that little gesture of stroking my hair. Yes, I thought that was very sweet. / R3: I've talked about it with my dad and with my sister too. Somehow, I feel it may even be incredible, in a way. As if what you feel and what you experience at such a time that this to other people is . . . that other people cannot fully live this experience. "It was quiet, it was quiet. I wanted to get out of there because I was depressed to be alone, to be locked up. I was depressed from being alone, without people." / I have to	Wynn (2004) (15) - Patients' experiences of the use of physical and pharmacological restraint Hoekstra et al. (2004) (16) - Trust, Loneliness

	get undressed in front of them. There are men and women. I'm totally naked and they put a johny shirt on me. They take everything off, everything. I don't want to undress in front of men but I have no choice." 'You just want to kick up the door, in order to get out'' (woman 17) / I think it affects your self-confidence in the long term, as a person. I think that being . . . being independent as a person, that is taken away from you. After all you are an adult who should manage on your own, and this makes it into something mental, which means that it is taken away from you and that can make you sensitive in this sort of situation (woman 1) / ''Yeah, and there's an uneasy feeling, a 'disadvantage-feeling', that's when I start thinking about suicide'' (man 16) "It wasn't nice for me… I wouldn't like to be in such a situation because they don't treat the people very nicely … it's not a nice effect … and I wouldn't like to be hospitalized again." "I feel sorry because being tied up was very painful ... so tortured. I also got annoyed, sad, angry and vengeful because the restraint was very strong, as a result, I felt so sick over my body" (Su). / "Restraint makes me frustrated, when having restraint I just surrendered; I feel a lonely and anxious" (Ab).	Holmes et al. (2004) (17) - Emotional impacts of the seclusion room experience, Haglund et al. (2005) (21) – Disadvantages (Frustration, Confinement, Feeling worse emotionally) Mayers et al. (2010) (22) - Experience of distress Hamid & Daulima (2018) (23) - Physical and psychosocial impact of the restraint use
Update	"I have been man-handled by men and women and it's got to the case where I've been frightened for my life really and then before I know it, I've disassociated them and that's it. It doesn't matter whether you put me on my back or my front, I've been raped both ways from a very early age so the intensity of that, it's just like recreating more abuse really." / "It has been physical, very physical and hurt and very, very intense and for me, it's recreated severe trauma from the past." / "Some of the nurses who have known me over many years will know me. If they are on duty, they would let people know that there would be times when I can't take my meds…it's not because I don't want to take them." / "I think sometimes when wards get fraught and there is not enough staff, then people will result to try to deal with it as quickly as possible and that is not always the right way."	Cusack et al. (2023) (26) – a story of trauma

	"and it becomes something like an escape, here and now. It is as if it is such a primal instinct that emerges in you. You feel like a hunted animal and you cannot get your more human reasoning into it at all. You resort to that reptile brain, and just feel … you think of ways out and 'escape'. All the time you are hunted somehow" / "So um … she thought I should have a tube on top of this meal that I had already had almost the double of … and then I got really scared, um … so I, um … escaped down to the yard." / "Well, for instance, I try to run past them somehow, and then you are just like hunted down to the other unit or the other end. Not 'hunted', but it feels that way. And then, for instance there is always a table down in shielded [refers to the closed ward] kind of like this one. And then, you know, then maybe I'm standing there, and then two of the staff walk that way and two that way. And then one is standing so you can't jump over the table. So, it like turns into a … hunt." / "I'm close to thinking that it's worse this with there being seven people holding you tight for an hour than it is if you are [mechanically] restrained for an hour …because you just keep going on and on and on fighting back when there are so many people on top of you, um … at least I calm down faster, because I know that those straps, they do not give in, but in principle a human being could (laughs a little), um" / "like the consequence was that if you don't cooperate, um … then it's like yes, um … then you get it [nasogastric tube feeding] anyway, then you're just belt restrained."	Mac Donald et al. (2023) (27) – Coercive treatment (Feeling trapped)
Power imbalance and how it's perceived by service users (*An abuse of power*)	"cos as a patient you're never going to win" [Sarah] / "I don't think freedom should be restricted, but yeah obviously that's the game they play and that's the game you have to play and that's why like I said, I'm playing their game now innit" [Joseph] / "if you don't give urine sample or do certain things, they'll stop you from getting your leave" [Joseph] / "cos I've done everything they wanted, they basically raped me" [Joseph] / "they raped me by taking everything that I said I didn't want to give basically" [Joseph] / "basically I'm not allowed to leave before taking the medication" [Munira] / "they would often check or threaten they might take your walks away" [Chris] / "I think for them [staff] it gives them structure um and sometimes they can use it [restrictive practices] almost like a weapon" [Sarah]. "like if you've annoyed one of them then maybe they won't make your tea … you won't go down for that cigarette" [Sarah] / 'just what's wrong with him? I wanted to punch him but my spirit just said like forget about it, who cares anyways just let him do what he wants, there's something wrong with him" [Joseph].	Bendall et al. (2022) (2) – Overpowered by staff ('Just playing their game', Threatening 'weapon'), Surviving restrictive practice (Surrender)

	"If you begin to, you know, argue with the people that brought you here or with the medical personnel that is attending to you, it would be difficult, they will coerce you, but if you agree if you obey, if you begin to bear all whatever they say, or even make some little argument before you give in, they will not coerce. The only coercion will be just that of persuasion with words, not by whipping or chaining you." (FGD4, male participant with schizophrenia) / "When you willingly adhere to instructions. Like for instance, they tell you do this, you do it, you do that.... you're not giving them any reason to forcefully coerce you." (FGD1, female participant with MBDPS)	Aluh et al. (2022) (3) – Perception of coercion (Coercion as a control tool)
	". . . the nurse told me to take my medicines . . . the nurse did not explain the situation to me . . . rather . . . uh . . . the nurse called four big guys and they held me . . . the nurse refused to listen to me . . . uh . . . I was . . . um . . . I was afraid and powerless . . . I did not know what they were going to do to me . . . I did not have any family at this hospital and uh . . . you know . . . they outnumbered me . . . I was not able to concentrate . . . I felt I was going to die . . ." / "The nurse should use a calm tone of voice to talk to me . . . answer my questions . . . have compassion . . . don't be violent towards the patient no matter how frustrated the nurse gets . . . uh . . . I mean . . . the nurse should just walk away."	Ezeobele et al. (2014) (4) - Staff exert power and control
	"…you start talking to yourself, trying to keep yourself, you know, sane and then they think you're mad because you're talking to yourself but it's just that you can't stand the silence anymore, you just start saying things just to hear something." / "I just paced around, sung to myself, talked to myself, did all these stupid little things that you do when you've got nothing else to do and you can't go no where else" / "I just became so distressed that I didn't speak and stopped talking and just stopped moving and just thought maybe if I just keep still enough they'd come in eventually and let me out and by the time I was out I didn't dare talk to anyone or do anything, you know, cause I was frightened I'd go back in."	Meehan et al. (2000) (10) - Maintaining control
	"…I did not know what to do and who to turn to for help…" (tears filled her eyes).	Ntsaba & Havenga (2007) (11) – Emotional responses to the seclusion experience (Negative emotional responses – Powerlessness)

	"I never ate their food, I never ate their food . . . I just didn't want a hand out . . . I don't want hand outs, from dogs like that." / "Told a nurse at hospital 'here's your fucking medication, now get fucked I'm not having it'. She put four to six nurses on me, throw me into the room. So I sang Amazing Grace for about 3 hours that day. Three or 4 hours till they let me out."	Sambrano & Cox (2013) (12) - Resistance
	R3: You see, when I'm wearing a straitjacket there's absolutely nothing I can do myself. I mean . . . when you're restrained, you can't do anything, you can't even turn round!" / R3: If someone feels something is out of the question, it just isn't on. No matter what you do . . . it doesn't make a blind bit of difference. / R1: I also thought eh . . . I was always ashamed. The clothes they gave me, that you couldn't choose them yourself or something. My clothes were in one of these wardrobes. They were mine alright but they would give me all different things I was supposed to wear. You couldn't select them yourself. When I would take a shower in the morning they'd already put all the stuff on the bed. / R5: It's a memory to me, history. I think . . . the seclusion itself . . . it's seven years ago. So a long time has passed since then.	Hoekstra et al. (2004) (16) - Autonomy
	"In the isolation room, it happens that I cry, I bang on the door, I'm like that . . . I take my eyeglasses, I break them. I said to myself, if I am often like this, they will see, they will see that there is something wrong with me . . . I want to talk." / "Once I'm in there, with the initial minutes that I'm there . . . both sides of the conflict (nurse/patient) are at peace . . . I'm comfortable in this side room, with the mattress down, and just lying, and lying on the mattress, sort of sitting on the mat initially, and lying down as a cooperative body language for the nurses."	Holmes et al. (2004) (17) - Coping strategies whilst in the seclusion room
	". . . it was sad, it was a shock . . ." / ". . . unnecessary exercise of power . . . was humiliating . . ." / ". . . it was hair-splitting . . ." / ". . . it would be good to hear the justifications; it is hard when you have to interpret everything alone; I need to talk this through . . ." / ". . . I understand that a hospital has to have rules . . ." / ". . . restrictions are based on medical reasons . . ." / ". . . rules are OK . . ."	Kuosmanen et al. (2007) (18) - Patients feelings about deprivation of liberty, Reasons for deprivation of liberty
	Johan (4): I begged and pleaded for something other than medications, but that was interpreted as lack of insight. That is incredibly humiliating. / Kirsten (13): The professionals around me told me I looked better, that things were moving in the right	Nyttingness et al. (2016) (20) - Staff disregarding

	direction and so on. I tried time and again to tell them that I must be allowed to get off my medication, that I felt terrible with them inside, but they wouldn't listen. / Astrid (4): I said that I considered reducingmy medication when I was discharged. My psychiatrist totally lost his composure and threatened me by saying it was possible to giveme ECT, which I had had previously […]. He described an alternative life with less medication as Hell, and said other patients had ended up like animals in that situation. / Kirsten (13): For me it was the coercion that made me suicidal. Fortunately, I survived, but it wasn't because of the mental health care…I'm still working on being able to forgive. I hope one day I'll be able to, but I don't think I'll ever be asked for forgiveness by those who committed this abuse against me. / Maria (3): To be overmedicated is a straitjacket. You are unable to let people know or to communicate. It's like a pressure cooker, it can explode. Nowadays I cooperate well with the services, and we regulate the level of medication up or down, based on my needs. / Marianne (10): But there is also a lot of unregulated coercion, directed by household rules. For example, being discouraged to bring many personal objects into the ward. Being searched, having limited access to leave, and a lot of other stuff, is not written in the law. / Brit (10): There are so many subtle mechanisms contributing… If you want help, you have to takemedication. You have to become the person that the health professionals want. / Brit (14): This [effect of minor incidents] is connected with power. It [professionals' account] is put forward as an objective truth when it's written in your medical records. If you were humiliated in such a way by a person on an equal footing it is easier to think that this may not be the truth, even though they mean it. But now it's in your records, and you know that others read it as the objective truth. Also, this happens when you are at your most vulnerable. / Astrid (14): One thing this forum does for me is to understand my own history in a wider context. These are small humiliations that you feel you must tolerate, but they influence you, and added up, it becomes huge. As single episodes, they are details; you are misunderstood and so on, that happens in all areas of life. But the sum is so huge that it becomes the truth. To meet with others who have similar experiences has been important in order to comprehend that my experiences are, in fact, true. ''People domineer others . . . I was not allowed to go out before I had talked to the physician'' (man 7).	complaints, minor coercive events Haglund et al. (2005) (21) - Staff's power

	"In hospital when I still getting frustrated asking for medication … the night sister she told me that I must come out, I must come out, she's going to give me some medication, and you know what she did to me? She put me in seclusion" / "the blankets, they are also wet, then I had no other alternative but to sleep on a wooden fl oor …the windows, they were broken". / "They undress you … and then they put … you in …seclusion-room which is filthy wet." / "You know that tablet is like a sjambok [whip], it punishes you and the side effects are very severe." "What if they wanted to just beat me? I' m not saying they would have. But, I' m just saying that' s the thoughts I had in my mind. What if one of the nurses would have came in or just triggered, or their mind snapped? How can I protect myself? Or if the hospital would have got on fire? Who said they was fast enough for them to unchain me to get me out? Those were my thoughts and I was afraid. More than ' fraid, I was terrified. Thoughts like that came to my head the place catch on fire, and I'm locked up to the bed and can' t move. And they try to get all these patients out, and here I am. . . . What type of chance would I have to live?" / "…giving up the freedom totally…I think it' s the sense of helplessness. If anything were to go wrong, that' d be it. If you were in restraints, the delay of time it takes to get the restraints off…You know. Being in restraints would be terrible if you didn't know for sure, that people around you weren' t going to hurt you. I can't imagine it."	Mayers et al. (2010) (22) – A violation of rights (The use of seclusion as punishment, sedation keeps us quiet) Johnson et al. (1998) (24) - Powerlessness
Critical role of support and communication (third order construct: the critical role of support and communication)	"Seclusion is not good for anyone. I don't know why putting someone on their own would help." (Participant 10) / "Two feelings: one, they bring food and water which allows me to carry on living and, two, scared they were going to inject me more. I never get told how long I will be there, and I can't phone my family." (Participant 2) / "Threatened, worried about medications, worried about how heavy handed they are, bad bad bad." (Participant 6) / "Some of them were non-tolerant and ignorant, some of them don't care, so I don't get involved." (Participant 2) / "tactics of forced medication and threats" (participant 9) / "Seclusion is not good for anyone. I don't know why putting someone on their own would help." (Participant 10) / "Two feelings: one, they bring food and water which allows me to carry on living and, two, scared they were going to inject me more. I never get told how long I will be there, and I can't phone my family." (Participant 2) / "Threatened, worried about medications, worried about how heavy handed they are, bad bad bad." (Participant 6) / "Some of them were non-tolerant and ignorant, some of them don't care, so I don't get involved." (Participant 2) / "tactics of forced medication and threats" (participant 9) /	Allikmets et al (2020) (1) - Lack of social and psychological support, The need for improving or replacing the practice of seclusion

	"It could have been solved another way, I think the staff bully you…If in supervised confinement, you should be allowed newspapers/books or a bible. It's boring, you end up going mad. (Participant 2) / "Therapy, the ward. Should have MP3 players to lend or that you pay a deposit for. Music therapy is life." (Participant 2) / "Buttons on the wall that you can press, and it plays sounds, sensory sounds, like thunder, and classical music." (Participant 4) / "People should respond when you are trying to communicate. Should always be an attempt to communicate. Try and engage in communicated, not passive, be persistent and eventually there will be a moment of clarity." (Participant 6) / "I don't think there was another option but it is inhumane, excessive." (Participant 4)	
	"I was kicking the door and screaming because somebody was pumping gas through a tube inside the room . . . the staff was instigating and inciting my behavior . . . ah. . . . I feel that the staff do not care . . . uh . . . I am angry at them and feel like hurting staff." / "I would rather go without asking a technician for help. . . they only want to sit on their chair relaxed . . . they have too much pride, uh . . . no . . . humility . . . uh . . . I think . . . they need to choose if they want to be a servant or a King . . . um . . . to be a servant is the most humble thing to do . . . uh . . . I felt violated . . . by the way they treated me." / "the nurses hollered at me . . . spoke to me in a derogatory tone . . . and made jokes . . . the nurse should have. . . ah . . . listened to me . . . uh . . . before responding and not . . . uh . . . reacting to my verbiage of calling them stupid, ignorant and belligerent . . ." / "seclusion could have been avoided if the nurses were empathetic . . . uh . . . spoke to me in a positive way and acted as if . . . ah . . . um . . . their supervisor was present…" / "I did not know why I was secluded . . . I was angry and told staff to get out of my room . . . staff said I was yelling too long . . . the nurses got some guys and I was escorted to the seclusion room . . . the nurse did not tell me why I was being secluded . . ." / "staff should use one person that the patient knows and trusts to talk to them . . . if staff would have talked to me and say ah . . . you are not supposed to do that . . . instead of yelling at me like a child . . . the staff should listen before responding . . . they need to learn how to talk to patients with respect . . . learn"	Ezeobele et al. (2014) (4) – Resentment towards staff (Unresolved anger, staff lacked humility, Lack of explanation from staff, need for staff education)
	"When I had my ward round on Tuesday, I asked my consultant for more leave but he's not even given me more leave he's just kept it as it is and it's just felt like	Tully et al. (2022) (5) - Not being heard, Impact of restrictions on relationships

	I've not been heard so I felt like I've gone in to ward round for nothing" (Christabel). / "By self-harming because it's like that's the way I can physically show them that this is what you are doing to me…Yeah 'cause I think with me like if I cannot explain it, I end up showing it by self-harming" (Edith). / "I: So what's changed now, what's kind of stopped you fighting it now? P: 'Cause there's no point…I just go along with it. Just go along, take me meds…" (Valentina). / "It makes you feel a bit rubbish inside because it's like you wish you could get your point across like a man can, but you cannot because you are not built like a man" (Edith). / "No nobody will give them (the men) nothing…but the good thing is they say no to them they could really break anything or shout…at least they have that power" (Chimamanda). / "So I knew it was against article three which is humiliation and degrading and stuff so erm I rang human rights and they told me the CQC so I rang them, they emailed the head" (Viola). / "Well I think men bottle a lot of things up y'know, they just get on with it and do what they have gotta do but I'd rather get it out than bottle it up for years and it become like a festered wound inside your soul eating away at you and making you angry" (Harriet). / "It's very difficult having fixed yourself and made yourself better that you do not get enough time with family to amend that relationship after all the suffering that's been caused and time's a healer and it's that time what you put in that heals that, it just does not heal overnight" (Ada). "I: How important is that kind of social network to you for your kind of coping and your wellbeing? P: It's really important like those two and a half years I was out it was so helpful like my friends especially y'know it got me through so much it really did. I: Gosh so what's it like being here then without that network of support? P: It's horrible, it's not easy" (Marie)./ "Yeah from my daughter d'y'know what I mean from bonding with her and I just feel like it's tight like I feel like she needs her Mum right now…I'm her birth Mum d'y'know what I mean so she needs to bond with me" (Christabel). / "We just look out for each other. If someone's gonna do something, if we know someone's down and they are having a bad day, we'd be there for them and we'd sit and talk to them. We do more than what the staff do" (Millicent). "If I had to decide about my own care as a patient, I would need to have more knowledge about my illness condition. I feel very anxious and frustrated about my lack of information about my illness condition, or my treatment plan or the reason and necessity for applying restraint to me." (Patient 28)	Chien et al. (2005) (6) – Negative and non-therapeutic impacts of restraint (Failure to provide information)

	“Because I have a lot of frustration…I have already learned a lot of these [coping] behaviors. I’ve kind of taught myself the ropes and how to cope, and it’s being re-emphasized.” / “I’m sure I could have done my part to use better coping skills, I guess, to alleviate that. But, before they put me in there, I was just trying to blow off steam. In my workbooks, it said you could punch a pillow if you feel frustrated. That is what I was doing, and they had a problem with that, so then they put me in there. So that’s how that happened.” / “Looking back on it, I probably could have calmed myself down if I would have done something positive, maybe. I just think being in a unit for what would have been like 2 weeks on that day, it’s just…I was, like, kind of craving for something to change [for the better].”	Faschingbauer et al. (2013) (7) - Patient insight into behaviour and the importance of positive coping
	. . I didn’t understand why they put me into the seclusion room and I never got information on this. The staff was reluctant to provide information on why and how long, what next . . . (R2) / . . . I wondered why the staff lacked willingness to explain issues concerning my treatment and reasons and plans, I think it is their job and duty . . . (R6) / . . . Six male nurses put me in the seclusion room before I saw the physician. I talked with the physician and I sat on the floor and we didn’t have chairs to sit on. It was humiliating for me . . . (R6) / . . . I resisted the restraint but they put me onto the bed with bands and belts, my hands and legs were turned by force. They used physical strength and force and harsh words . . . (R8) / . . . Nurses on the ward were professional and polite but nurses in the seclusion room were harsh and unfriendly . . . (R19) / . . . It was like shock treatment, punishment and deprivation of liberty, nothing good in it . . . (R2) / . . . My seclusion experience was much better and more humane than my restraint experience. It was part of my care . . . (R25) / . . . They told me how aggressive and unpredictable I was before seclusion. I understood that this was the only alternative and a part of my treatment . . . (R11) / . . . There was no chance to talk about my experience . . . (R6) / . . . I need a human being beside me. I want to talk about my fears with the physician and nurse. I like to have a connection to them, now they are in a hurry all the time . . . (R7) / . . . Discussion with familiar nurses can help and decrease fears and anger. My primary nurse talks kindly and asks me to think about solutions, alternatives . . . (R26) / . . . It is essential to try to solve the difficult situation by discussion instead of using coercion (e.g., seclusion room) . . . (R4) / . . . I need physical activities when I am	Kontio et al. (2012) (8) - Patient experience before seclusion/restraint, Patient experience after seclusion/restraint, Patients’ suggestions on alternatives to seclusion/restraint Meehan et al. (2000) (10) - Staff/patient interaction

	restless, a boxing-sack on the ward, going out for cycling or walking. Something sensible to do . . . (R6) / . . . If I just had an access to the coffee machine and got a cup of hot coffee, nothing else would be needed . . . (R5) / . . . Nurses and patients can together create a safe and cozy atmosphere and community . . . (R19) / . . . A peaceful environment is also important. A single-room if possible. After medication I'd rather go to my own room to sleep than to the seclusion room . . . (R2) / . . . Quiet, beautiful place to go on the ward, quiet room with relaxing music . . . (R15) / Instead of seclusion/restraint, patients would prefer biological treatments, first of all, appropriate medication. Brain modulation treatments were also mentioned. . . Medicine may help me and my nightmares. I hope that I can get relaxing medicine and then I can go to my own room and bed to rest . . . (R7) / . . . There are new treatments, like electric shock and magnetic stimulation. Why couldn't one try these instead of the ancient ones, like restraint . . . (R13) "If they had asked ''what is this?'' then I could have responded that I was terribly anxious and needed to get the aggression out of my system . . . then we could get into a dialogue that could make the use of restraint completely unnecessary" / "I think things would have turned out better . . . if they had just left me alone in my room" / "they should just have sent me home" / "I was fantasizing and hysterical . . . I don't know why" / "it was completely unnecessary . . . it was an abusive act". / 'It was a humiliating experience" / "has made me more cautious . . . I'm afraid it will happen again" / "I think they treated me badly" / "it's not a good thing for me, I don't think so" / "it wasn't such a big deal . . . I've been in restraint before"	Ntsaba & Havenga (2007) (11) - Not being supported and cared for Verbeke et al. (2019) (14) - Power resides in interactions Wynn et al. (2004) (15) - Patients opinions about if/how physical and pharmacological restraint could have been avoided, Patients thoughts about the consequences of having been restrained
Update	"Some of the nurses who have known me over many years will know me. If they are on duty, they would let people know that there would be times when I can't take my meds…it's not because I don't want to take them." / "I think sometimes when wards get fraught and there is not enough staff, then people will result to try to deal with it as quickly as possible and that is not always the right way.	Cusack et al. (2023) (26) – a story of trauma
Necessary for physical safety (third order construct: the critical role of support and communication)	"whichever reason you're here for, you're here, you know, to be protected, to be safe" [Aisha]. / "at the time yeah you're probably agitated and stuff 'why are you holding me down?' but then it's for your own benefit, yeah" [Aisha] / "if someone is refusing to take medication and stuff, or they want to go out for fresh air, you know it's their [staff] right to hold you down and take you to your room and inject you" [Aisha]. / "I just remember being terrified, but now I look back I had to be restrained because I was going to hurt myself or bite somebody"' [Sarah].	Bendall et al. (2022) (2) – Making sense of restrictive practice (To be protected, to be safe)

	"…Coercion is something that is necessary. That is a must, based on the mental illness ... because at the point where the illness begins, ... the patient in question, may not necessarily understand,... and may not even want to come to dialogue. Because at that point in time..., there's restlessness .... at that point in time, there's apprehension... depending on the ailment. And so coercion is a must. it's a must that must be used."(FGD1, male participant with Bipolar Disorder) / "There are some patients that truly need to be forced. They're mentally insane [sic], yes. Psychoses, real ones....the people that are diagnosed with drugs has a better understanding than those that are real psychoses." (FGD2, male with MBDPS)	Aluh et al. (2022) (3) – Perception of coercion (Coercion as a necessity)
	"I don't know . . . um . . . hm . . . I don't remember . . . I must have been out of it and . . . um . . . well I may be um . . . really bad . . . what happened on the day I was secluded . . . I do not even remember what you asking me . . . the seclusion . . . are you kidding me…" / "Seclusion calmed me down . . . I guess it is a 'cool down' room. . . . Um . . . hm . . . I felt good . . . and . . . I had good communication with God . . . and . . . I was praying to God to forgive my actions."	Ezeobele et al. (2014) (4) - Time for medication
	"P: Yeah last year was the first year that I'd actually been out of the hospital environment and dealing with the bereavement without any support network round me and my head fell off and that's why I got ill. I: Yeah ok, so there's something about the hospital environment that does support you and… P: It does, it's like a safety net" (Maya). / "I feel quite well now, so I feel quite frustrated sometimes with some of the restrictive practices that are in place" (Noor). / "You feel institutionalized because you have been in hospital for so long, you have got staff around you 24/7…it's like even though I hate being in half the time, you feel safer because…it's not like you can just go out whenever you want and just think if you are very suicidal all of a sudden, d'y'know what I mean?" (Flora). / "The men seem to get a lot more…I mean we only get three leaves a day, the men are out I do not know how many times…the men always seem to get more…The men seem to move on quicker than women as well." (Valentina).	Tully et al. (2022) (5) – Powerlessness (Restrictions providing safety and support)
	''It is very important to have immediate and safe control of my aggression, as I don't have any power of self-control at that moment. I need help from others to prevent and limit the physical harm caused by my violence.'' / "At the end of the day, we have	Chien et al. (2005) (6) – Positive and therapeutic

	to leave the decision regarding our care to the nursing staff, because we are in an unsound mental condition when we are aggressive and confused. And then we have to trust that the nurses and doctors, who prescribed or applied this restraint, know what the best thing for us is." (Patient 2) / "The nurse came to my bedside and told me who she was and said she would be available nearby for my requests during the shift. She also came to talk to me from time to time. This showed that she cared about me and she let me talk with her if I needed to." (Patient 8) / "I can see why you feel sad and distressed. It is not your fault. The restraint will not last for long. When you have managed to control your symptoms with the help of your medication, you will be able to manage your illness yourself, very soon." (Patient 10) / "I could be nasty when I was ill and aggressive, but the nurses were handling my situation quite well. They approached me in a caring and calm manner and explained to me what was happening to me. When I was being restrained, I felt relieved and clearly remembered the moment that the nursing officer explained to my parents in front of me. . . about why the restraint had been applied and what had been done to me." (Patient 21) / "helping them to maintain their dignity". / ''see beyond our mental symptoms or violent behaviors and respond to us as a person''. "Well, I'd like to find out what I did in the first place. I mean, if he would have come to me, he could have at least approached me like a responsible adult, and he could just come up to me with "Sir" or call me by my name, or whatever, "Hey, could you just calm your swearing down?" or "Are you angry or is something bothering you?" / "I know that I don't like to be told what to do. I like to be asked if I would do something, rather than told to do it. That approach to me would have been able to avoid seclusion completely." / "I feel that if they would have known that I was claustrophobic and a little of my background, the outcome could have been different. I mean, being cooped up in one floor, you can't really exercise. And that's how I was trying; normally I would blow off the steam that away. I would go for a leisurely jog or walk, but you know, I can't do that in here." / "That's why I didn't put up a fight or nothing, she explained the process.…Then the nurse said, "Well you seem like you're doing better." And she said, "I'll be back in 30 minutes, and if you feel like you want to get out, you can get out." And I was like, alright that's fair enough."	aspects of restraint (Safety and trust, Caring and concerns, explanation frequent interactions, being respected) Faschingbauer et al. (2013) (7) - Patient hope for respect and open communication

	"…I hope that I ama human being in a psychiatric hospital and in the seclusion room too. I want polite, humane behaviour from the staff . . ." (R3) / ". . . The staff is for patients. I did not like it that two nurses stood indifferently near me in the seclusion room and talked by themselves . . ." (R9) / ". . . I want to talk with an outside evaluator, patient representative (ombudsman, chaplain) about my thoughts and especially after seclusion/restraint . . ." (R26) / ". . . I want information on why I have to be restrained and how long it will last. I did not have any idea about the time and plans and what was wrong and when to get a cigarette . . ." (R10) / ". . . I was in the meeting where we planned my treatment. I wanted to have this treatment plan for myself and I want everything on paper. Written papers can help me, because I cannot remember the oral plans and talks . . ." (R27) / ". . . Opportunity to go to the toilet when you are in the seclusion room, now there is a locked door . . . (R2) . . . Beautiful colours on the walls and ceiling, cosy room with peacefulmusic, soft chairs . . ." (R5) / ". . . TV, radio,magazines, boxing-sack, something to do in this room, now there is nothing . . . (R7)	Kontio et al. (2012) (8) - Patients' suggestions regarding the improvement of seclusion/restraint practices
	"That part I remember quite a lot of was not who did it and so on, but just that they did it and that it made me feel safe." (Interview 3) / "It was, it was like the only way there was, so to speak, since nothing else worked. I wasn't able to speak, so it was a little hard to, like, just take a few deep breaths." (Interview 1) / When, with a shit load of people, fix what they are supposed to fix and then out again fast and then there were only the few left to carry on further contact with me, so it was very, it was like an isolation measure, sort of. Everyone in and step on the gas and then out again. So it became as calm as possible as fast as possible, so I think that it was quite professionally done actually." (Interview 1) / "Everything happens in total silence and eh it's sort of just, the only thing that happens is that you feel that they are talking over your head; you just hear, "Yes you take that one there and you take this and have you got that buckle?" And stuff like that." (Interview 9) / "I remember it was a total horror show, and then you get imprinted by that if you think about the psychiatry and so how you perceive the psychiatry and doctors and all that; you are a little cautious with doctors what you tell them and such, so they do not misinterpret you." (Interview 7) / "This is probably, I believe, quite a major intervention and too many actually. Maybe then especially if you are, so to say, "clear in the head" when it happens and so and that you remember it, then it becomes kind of like a trauma." (Interview 4) / "A psychiatric nurse was left, and he touched my arm and	Lanthen et al. (2015) (9) - Safety and understanding, Composed and professional attitude, Physical presence and giving information, debriefing and processing

	just asked if there was something he could do for me; and then I said yes you can keep holding your arm there, because it felt so safe." (Interview 2) / "I think that it is enormously important that you get to know what is going on, that you, that someone tells you what is going on and what you are supposed to do." (Interview 8) / After experiencing a mechanical restraints situation like this, I think it's really good to have a debriefing session just like after an incident. (Interview 4)	
	"When someone is in distress the last thing they want is restraint or seclusion. . ." (P9) / "You don't need to be drugged up because of feeling distressed. A woman needs communication." (P1) / "They should actually just sit down and say what's going on, like we don't have to go through this procedure restraining. . . all these patients in here need is just talking." (P12) / "cool down, so I reflect on what's happened. . ." (P12) / "they just leave you and hope you forget. . ." (P7) / "It's quite hard to go through some of the questions, you don't really know the answers yourself. . . staff find it helpful for themselves." (P17) / "I don't speak to any of the staff that restrained me, it's like breaking trust with certain staff." (P12) / "I don't think they even care to be honest. It's just a wage packet at the end of the month. Restraint is just something normal to them. . . they don't give a fuck about us." (P18) / "Every restraint I have someone on my head who is the person you have the best bond with so they can talk you down." (P11) / "Someone to talk to them about past trauma. . .something that can help them feel a little bit better in the future, feel like a woman and not an object. Some therapy that would make them feel human again." (P18)	Scholes et al. (2022) (13) - Relationships and communication
	"When I felt like they believed in me, I could start to believe in myself again. While, when I just had to fall in line and it was just a matter of following rules, I felt like an object. I didn't feel like a human being anymore. People who treated me humanely were the ones who helped me the most." (Participant 8) / "Because of a lack of contact, professionals underestimate and overestimate patients. If they would work more with the individual, then this estimation would be better. Then freedom would not be unnecessarily limited and safety, on the other hand, would be guaranteed when necessary" (Participant 3) / "A friend of mine is a nurse and once she had to seclude someone, for her it was also traumatic. Afterwards, she talked to that patient and said to him: 'you know, it was hard for me to seclude you, but we were afraid'.	Verbeke et al. (14) - Positive encounters

	Just say those things, then maybe I'll think that they didn't mean for it to be taken so hard after all and that I can trust these people." (Participant 7) ''Here, the staff has more authority. You don't just go and try and push your way in'' (woman 8) / ''It makes it better for the staff too, they have more control over where everybody is because you can't just come and go like you want, but they have to unlock the door and say whether or not you're allowed to go out'' (woman 10). / ''To have the protection of a locked door, a sort of security'' (man 3) / ''There's a bit of a sanctuary feel about it'' (woman 8) / ''The staff doesn't have to run around and chase those trying to run away. They can devote more time for patients instead of running around'' (man 12). "The nurse explained the purpose of restraint, told me the duration, asked my complaints, provided food and drink and bathing" (Sm). / "The nurse accompanied me during restraint, looked at my condition, gave me advice so I was not angry anymore, and told me if I had been more calm down, I would be released" (Tm). / "When tied up, I was full of eating and drinking, rice, side dishes, vegetables and fruit" (Ro).	Haglund et al. (21) – Advantages (Protection against the outside, control over patients, secure and efficient care, safety, More time for patients) Hamid & Daulima (2018) (23) - Professional healthcare supports during the restraint use
	"I know many patients hate it (physical restraint), but I would say sometimes it was useful, because it would make me calm down. When I was yelling and trying to hit them, using the ties to reduce my body movement gave me a chance to keep me calm." (smiled, experienced, No. 11) / "Every time I felt panic and helpless, I couldn't help myself messing up the room and disturbing orders in ward, although I knew what I had done was wrong. After the physical restraint, I felt secure and protected when I was forced to my bed, so maybe devices (physical restraint) worked under such circumstances." (experienced patient, No. 8) / "I was scared when a patient was shouting in the ward; you had no idea what he/she would do or who would be hurt next. It was so great that the nurse put them down. It (physical restraint) made me feel secure and let me know I was protected." (smiled and peaceful, witnessed, No. 6) "They literally pinned my arms behind my back, both arms and literally forced me, put me on the bed so they sat me down one on either side and it was like that for a while. At times Finlay acknowledged how nurses' own safety was at risk: I didn't	Li et al. (2023) (25) – the positive outcomes of physical restraint (Alleviating critical conflicts, Physical restraint makes patients feel secure and protected) Cusack et al. (2023) (26) – a story of saving a life

	really care what damage I would inflict on me or them.” / “But they saved my life, I owe them everything so when people argue that it's not our job to be security guards, blah, blah, blah, hold on a second you know what you are getting into, you are saving people's lives.” / “There are less wards, less hospitals, there is less space, and there is more pressure.” "When you then … when you come more out on the other side, then you are able to see that what they did back then, at least some of it, has helped to you still being here" / "Hmm … I think now I’m able to look at it a little more objectively, um … because it’s something else when you’re exposed to it than when you look at it from the outside. Um, but from the outside then I would be able to rationalize that I was is situations where there was simply no other option than that." / "So, I also think it’s a bit about that I … that I … I have gotten this self-care, um … and dare to take [use] it and treat myself properly." / "I’m not as destructive towards myself anymore, um, as I was back then. Because they gave me involuntary treatment, but that was also a way of punishing myself just like the eating disorder was, and the self-harm and all those things. It was somehow that I had to punish myself. And now, I don’t punish myself."	Mac Donald et al. (2023) (27) – Leaving coercion (a changing perspective)

Appendix S4. List of included studies

1. Achir Yani Syuhaimie Hamid, M., & Catharina Daulima, N. H. (2018). The experience of restraint-use among patients with violent behaviors in mental health hospital. *Enfermería Clínica*, *28*, 295–299. https://doi.org/10.1016/S1130-8621(18)30173-6
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27. Wynn, R. (2004). Psychiatric inpatients' experiences with restraint. *The Journal of Forensic Psychiatry & Psychology*, *15*(1), 124–144. https://doi.org/10.1080/1478994041000165518

Appendix S5. List of excluded studies

Included, and did not adequately separate, the experience of staff, carers and/or relatives

1. Goulet, M. H., & Larue, C. (2017). A Case Study: Seclusion and Restraint in Psychiatric Care. *Clinical Nursing Research*, *27*(7), 853–870. https://doi.org/10.1177/1054773817713177
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3. Jacob, J. D., Holmes, D., Rioux, D., Corneau, P., & MacPhee, C. (2017). Convergence and divergence: An analysis of mechanical restraints. *Nursing Ethics*, *26*(4), 1009–1026. https://doi.org/10.1177/0969733017736923
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5. Larsen, I. B., & Terkelsen, T. B. (2013). Coercion in a locked psychiatric ward. *Nurs Ethics., 21*(4), 426–436. https://doi.org/10.1177/0969733013503601
6. Muir-Cochrane, E., Van der Merwe, M., Nijman, H., Haglund, K., Simpson, A., & Bowers, L. (2012). Investigation into the acceptability of door locking to staff, patients, and visitors on acute psychiatric wards. *International Journal of Mental Health Nursing*, *21*(1), 41–49. https://doi.org/10.1111/J.1447-0349.2011.00758.X
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9. Wilson, C., Rouse, L., Rae, S., & Kar Ray, M. (2017). Is restraint a 'necessary evil' in mental health care? Mental health inpatients' and staff members' experience of physical restraint. *International Journal of Mental Health Nursing*, *26*(5), 500–512. https://doi.org/10.1111/INM.12382

Used a quantitative methodology, non-journal article, or not suited for inclusion in meta-ethnographic synthesis (due to low quality qualitative section)

1. Canvin, K., & Rugkåsa, J. (2011). Patient experiences of leverage (informal coercion) in England: findings from a qualitative study. *Psychiatrische Praxis*, *38*(S 01), OP04_TP. https://doi.org/10.1055/S-0031-1277808
2. Digman, B. E. (2004). *Hearing their voices: Psychotic patient perceptions of living with mental illness. A fifteen-year follow-up*. University of Hawai'i at Manoa ProQuest Dissertations Publishing.
3. Greenberg, W. M., Moore-Duncan, L., & Herron, R. (1996). Patients' attitudes toward having been forcibly medicated. *The Bulletin of the American Academy of Psychiatry and the Law*, *24*(4), 513–524. https://europepmc.org/article/med/9001749
4. Johnson, M. E. (1997). *The Phenomenology of Being Restrained* [Dissertations]. https://ecommons.luc.edu/luc_diss/3714

5. Kennedy, B. R., Williams, C. A., & Pesut, D. J. (1994). Hallucinatory experiences of psychiatric patients in seclusion. *Archives of Psychiatric Nursing*, *8*(3), 169–176. https://doi.org/10.1016/0883-9417(94)90050-7
6. Larue, C., Dumais, A., Boyer, R., Goulet, M. H., Bonin, J. P., & Baba, N. (2013). The Experience of Seclusion and Restraint in Psychiatric Settings: Perspectives of Patients. *Issues in Mental Health Nursing*, *34*(5), 317–324. https://doi.org/10.3109/01612840.2012.753558
7. Naber, D., Kircher, T., & Hessel, K. (1996). Schizophrenic patients' retrospective attitudes regarding involuntary psychopharmacological treatment and restraint. *European Psychiatry*, *11*(1), 7–11. https://doi.org/10.1016/0924-9338(96)80452-4
8. Orihuela, P. O., Morenilla, A. L. P., & Carrasco, M. Z. (2019). Physical restraint: analysis of conditions in which occurs, the concomitant use of pharmacological restraint and patients' subjective opinion. *European Neuropsychopharmacology*, *29*, S594–S595. https://doi.org/10.1016/J.EURONEURO.2018.11.878
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10. Richardson, B. K. (1987). Psychiatric inpatients' perceptions of the seclusion-room experience. *Nursing Research*, *36*(4), 234–238. https://doi.org/10.1097/00006199-198707000-00012
11. Spinzy, Y., Maree, S., Segev, A., & Cohen-Rappaport, G. (2018). Listening to the Patient Perspective: Psychiatric Inpatients' Attitudes Towards Physical Restraint. *Psychiatric Quarterly*, *89*(3), 691–696. https://doi.org/10.1007/S11126-018-9565-8/METRICS

Setting and/or participants not suitable for inclusion

1. Chambers, M., Gallagher, A., Borschmann, R., Gillard, S., Turner, K., & Kantaris, X. (2014). The experiences of detained mental health service users: Issues of dignity in care. *BMC Medical Ethics*, *15*(1), 1–8. https://doi.org/10.1186/1472-6939-15-50/TABLES/1
2. Fish, R., & Hatton, C. (2017). Gendered experiences of physical restraint on locked wards for women. *Disability & Society*, *32*(6), 790–809. https://doi.org/10.1080/09687599.2017.1329711
3. Knight, S., Jarvis, G. E., Ryder, A. G., Lashley, M., & Rousseau, C. (2022). 'It Just Feels Like an Invasion': Black First-Episode Psychosis Patients' Experiences With Coercive Intervention and Its Influence on Help-Seeking Behaviours. *Journal of Black Psychology, 49*(2), 200–235. https://doi.org/10.1177/00957984221135377
4. Ling, S., Cleverley, K., & Perivolaris, A. (2015). Understanding Mental Health Service User Experiences of Restraint Through Debriefing: A Qualitative Analysis. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *60*(9), 386. https://doi.org/10.1177/070674371506000903
5. Sequeira, H., & Halstead, S. (2002). Control and restraint in the UK: Service user perspectives. *The British Journal of Forensic Practice*, *4*(1), 9–18. https://doi.org/10.1108/14636646200200003/FULL/PDF
6. Yahyavi, S. T., & Shahvari, Z. (2022). Psychiatric Inpatients' Lived Experiences of Physical Restraint: A Qualitative Study in Iran. *Iranian Journal of Psychiatry and Behavioral Sciences 2022 16:2*, *16*(2). https://doi.org/10.5812/IJPBS-126620

Non-English papers

1. Armgart, C., Schaub, M., Hoffmann, K., Illes, F., Emons, B., Jendreyschak, J., Schramm, A., Richter, S., Leßmann, J., Juckel, G., & Haußleiter, I. (2013). [Negative emotions and understanding - patients' perspective on coercion]. *Psychiatrische Praxis*, *40*(5), 278–284. https://doi.org/10.1055/S-0033-1343159
2. Cano, N., Boyer, L., Garnier, C., Michel, A., Belzeaux, R., Chabannes, J. M., Samuelian, J. C., & Harle, J. R. (2011). L'isolement en psychiatrie : point de vue des patients et perspectives éthiques. *L'Encéphale*, *37*(SUPPL. 1), S4–S10. https://doi.org/10.1016/J.ENCEP.2010.04.013
3. Frajo-Apor, B., Stippler, M., & Meise, U. (2011). ["In psychiatry, nothing more degrading can happen to you"]. *Psychiatrische Praxis*, *38*(6), 293–299. https://doi.org/10.1055/S-0030-1266138
4. Palazzolo, J. (2004). À propos de l'utilisation de l'isolement en psychiatrie : le témoignage de patients. *L'Encéphale*, *30*(3), 276–284. https://doi.org/10.1016/S0013-7006(04)95440-1

Aims did not meet inclusion criteria

1. Gerle, E., Fischer, A., & Lundh, L.-G. (2018). "Voluntarily Admitted Against My Will": Patient Perspectives on Effects of, and Alternatives to, Coercion in Psychiatric Care for Self-Injury. *Journal of Patient Experience, 6*(4), 265–270. https://doi.org/10.1177/2374373518800811
2. Klingemann, J., Świtaj, P., Lasalvia, A., & Priebe, S. (2021). Behind the screen of voluntary psychiatric hospital admissions: A qualitative exploration of treatment pressures and informal coercion in experiences of patients in Italy, Poland and the United Kingdom. *Int J Soc Psychiatry*, *68*(2), 457–464. https://doi.org/10.1177/00207640211003942
3. Lawrence, R. E., Div, M., Perez-Coste, M. M., Bailey, J. L., Desilva, R. B., & Dixon, L. B. (2019). Coercion and the Inpatient Treatment Alliance. *Psychiatric Services*, *70*, 1110–1115. https://doi.org/10.1176/appi.ps.201900132
4. Norvoll, R., & Pedersen, R. (2016). Exploring the views of people with mental health problems' on the concept of coercion: Towards a broader socio-ethical perspective. *Social Science & Medicine*, *156*, 204–211. https://doi.org/10.1016/J.SOCSCIMED.2016.03.033
5. Olofsson, B., & Jacobsson, L. (2001). A plea for respect: involuntarily hospitalized psychiatric patients' narratives about being subjected to coercion. *Journal of Psychiatric and Mental Health Nursing*, *8*(4), 357–366. https://doi.org/10.1046/J.1365-2850.2001.00404.X
6. Shozi, Z., Saloojee, S., & Mashaphu, S. (2023). Experiences of coercion amongst involuntary mental health care users in KwaZulu-Natal, South Africa. *Frontiers in Psychiatry*, *14*, 1113821. https://doi.org/10.3389/FPSYT.2023.1113821/BIBTEX
7. Sibitz, I., Scheutz, A., Lakeman, R., Schrank, B., Schaffer, M., & Amering, M. (2011). Impact of coercive measures on life stories: qualitative study. *The British Journal of Psychiatry*, *199*(3), 239–244. https://doi.org/10.1192/BJP.BP.110.087841

Table S4. Restrictive practices represented in each theme

	Third Order Constructs				
Restrictive Practice Reported	1.Anti-therapeutic and dehumanising	2.A vicious cycle	3.An abuse of power	4.The critical role of support and communication	
				4a.The impact of communication	4b.How support and communication can minimise negative impact
Seclusion	✓	✓	✓	✓	✓
Physical restraint	✓	✓	✓	✓	✓
Mechanical restraint	✓	✓	✓	✓	✓
Locked doors	✓	✓	✓	✓	
Constant observation	✓	✓		✓	
Prevention of movement around the ward	✓	✓		✓	
Rapid tranquilisation/forced medication	✓	✓	✓	✓	✓
Coercion and compulsion related to treatment	✓	✓	✓	✓	
Blanket restrictions/'house rules'	✓	✓	✓	✓	
Nasogastric tube feeding	✓	✓		✓	